Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts

American Psychological Association

Guideline Development Panel for the Treatment of Depressive Disorders

Appendices

Table of Contents: Appendices

Cover Page……A-1

Table of Contents: Appendices……A-2

Appendix A: Descriptions of Treatments Derived from Research Included in the Systematic Reviews……A-3

Appendix B: Evidence Profiles Prepared for by APA by RTI-UNC Scientists……A-8

Appendix C: Decision Tables……A-106

Appendix D: Definition of Key Terms……A-827

Appendix E: APA Declarations/COI Form……A-831

Appendix F: Voting Procedures Established by Advisory Steering Committee (ASC)……A-848

Appendix G: Study Eligibility Criteria……A-849

Appendix H: AMSTAR Ratings: Methodological Quality of the Included Systematic Review……A-852

Appendix I: Dose, Timing, and Session Duration of Treatments……A-853

Appendix J: Treatments Considered but Not Included by Population……A-856

Appendix K: Select Demographic Characteristics of Studies Reviewed from the 10 Systematic Reviews/Meta-Analyses……A-859

Table K1: *Select Demographic Characteristics of Studies Reviewed from the 10 Systematic Reviews/Meta-Analyses*……A-859

Table K2: *Select Demographic Characteristics of Studies Reviewed from the 2 Child/Adolescent Systematic Reviews/Meta-Analyses*……A-860

Table K3: *Select Demographic Characteristics of Studies Reviewed from the 6 General Adult Systematic Reviews/Meta-Analyses*……A-870

Table K4: *Select Demographic Characteristics of Studies Reviewed from the 2 Older Adult Systematic Reviews/Meta-Analyses*……A-916

Appendix A

Descriptions of Treatments Derived from Research Included in the Systematic Reviews

Intervention		Description of Treatment
Children and Adolescents		
Psychological	Cognitive-behavioral therapy	Utilizes behavioral and cognitive strategies, particularly exposure, cognitive restructuring, changes in behavior, and development of coping skills, to address learned and conditioned behaviors, thoughts and emotional and psychophysiological reactions.
Psychological	Interpersonal psychotherapy	Brief, attachment and communication-focused therapy that centers on the biopsychosocial/cultural/spiritual model. It is designed to reduce symptoms, improve interpersonal functioning and increase social support. Number of sessions range from 6-20.
Pharmacological	Fluoxetine	A medication used to treat depression.
Psychological	Behavioral therapy	Seeks to identify and help change potentially self-destructive or unhealthy behaviors and functions on the idea that all behaviors are learned and that unhealthy behaviors can be changed. The focus of treatment is often on current problems and how to change them.
Psychological	Cognitive therapy	Brief, goal-oriented therapy with the aim of helping a patient analyze distorted thinking in order to reshape existing beliefs and cognitions and to modify associated problematic behaviors.
Psychological	Family therapy	Treatment that is designed to address specific issues affecting the health and functioning of a family with the belief that problems cannot be successfully addressed or solved without understanding the dynamics of the group.
Psychological	Play therapy	A psychotherapeutic approach used primarily to help children aged 3-12 to explore their lives and freely express repressed thoughts and emotions through play.
Psychological	Problem-solving therapy	A cognitive-behavioral intervention geared to improve an individual's ability to cope with stressful life experiences with the underlying assumption that symptoms of psychopathology can often be understood as negative consequences of maladaptive coping. It aims to help individuals adopt a realistically optimistic view of coping, understanding the role of emotions more effectively, and creatively develop an action plan aimed at reducing psychological distress and enhance well-being.

Psychological	Psychodynamic	A form of in-depth talk therapy based on the theories and principles of psychoanalysis with a focus on unconscious processes as they are manifested in an individual's present behavior. The goals are self-awareness and understanding of the influence of one's past on present behavior.
Psychological	Supportive therapy	An approach that focuses on the general nature of therapy (amount of contact), where the therapist aids the patient in identifying and expressing feelings through empathy and rapport building.
Pharmacological	Clomipramine	A medication used to treat depression.
Pharmacological	Imipramine	A medication used to treat depression.
Pharmacological	Mirtazapine	A medication used to treat depression.
Pharmacological	Paroxetine	A medication used to treat depression.
Pharmacological	Venlafaxine	A medication used to treat depression.

General Adult Population		
Psychological	Behavioral therapy	Seeks to identify and help change potentially self-destructive or unhealthy behaviors and functions on the idea that all behaviors are learned and that unhealthy behaviors can be changed. The focus of treatment is often on current problems and how to change them.
Psychological	Interpersonal psychotherapy	Brief, attachment and communication-focused therapy that centers on the biopsychosocial/cultural/spiritual model. It is designed to reduce symptoms, improve interpersonal functioning and increase social support. Number of sessions range from 6-20.
Psychological	Brief CBT	The compression of CBT material and the reduction of the average 12-20 sessions into 4-8 sessions with a concentration on specific strategies for a limited number of an individual's problems.
Psychological	Cognitive-behavioral therapy	Utilizes behavioral and cognitive strategies, particularly exposure, cognitive restructuring, changes in behavior, and development of coping skills, to address learned and conditioned behaviors, thoughts and emotional and psychophysiological reactions.
Psychological	Computerized CBT	Using a computer or the Internet to provide CBT.
Complementary/Alternative Treatment	Exercise	Activity requiring physical effort, carried out to sustain or improve health and fitness.
Psychological	Cognitive behavioral therapy (group)	Utilizes behavioral and cognitive strategies, particularly exposure, cognitive restructuring, changes in behavior, and development of coping skills, to address learned and conditioned behaviors, thoughts and emotional and psychophysiological reactions in a group setting.
Psychological	Mindfulness-based cognitive therapy (MBCT)	Uses CBT methods in collaboration with Eastern psychological strategies such as mindfulness meditation. The goal is to interrupt automatic cognitive processes that can trigger a depressive episode by teaching individuals to focus less on reacting to incoming stimuli and instead, accepting and observing them without judgment.
Complimentary/Alternative Treatment	Bright light therapy	Sitting or working near a device called a light therapy box which emits bright light that mimics natural outdoor light. Bright light therapy is thought to affect brain chemicals linked to mood and sleep.

Psychological	Couples therapy	Focuses on interpersonal issues experienced by two individuals in a committed relationship. Depending on the issues involved it can be short- or long-term, but the focus tends to be primarily on emotional issues that are harming the relationship.
Psychological	Psychotherapy (general) for social functioning	Therapy with the aim of improving social functioning, which may be impaired due to depression.
Psychological	Short-term psychodynamic psychotherapy	Aims to improve long- and short-term problems with emotional processing, behavior, and communication and relationships with others by increasing awareness of one's emotions, thoughts, and problems.
Psychological	Supportive psychotherapy	An approach that integrates psychodynamic, cognitive-behavioral, and interpersonal model and techniques with the objective of reinforcing an individual's health and adaptive patterns of thought behaviors in an effort to reduce intrapsychic conflicts.
Complimentary/Alternative Treatment	Yoga	A system of physical postures, breathing techniques, and sometimes meditation designed to promote physical and emotional well-being.
Complimentary/Alternative Treatment	Tai Chi	A form of exercise used for stress reduction and a variety of health conditions. It involves a series of movements performed in a slow, focused manner and accompanied by deep breathing.
Psychological	Cognitive-Behavioral Analysis System of Psychotherapy (CBASP)	A synthesis model of interpersonal and cognitive and behavioral therapies.

Older Adults		
Psychological	Cognitive-behavioral therapy (group)	Utilizes behavioral and cognitive strategies, particularly exposure, cognitive restructuring, changes in behavior, and development of coping skills, to address learned and conditioned behaviors, thoughts and emotional and psychophysiological reactions in a group setting.
Psychological	Life-Review Therapy (group)	Has individuals think back on their life's events to achieve a sense of peace or empowerment about their lives with the goal of helping put life in perspective.
Psychological	Cognitive-behavioral therapy (Internet)	Cognitive behavioral therapy that is delivered via the Internet.
Psychological	Interpersonal psychotherapy	Brief, attachment and communication-focused therapy that centers on the biopsychosocial/cultural/spiritual model. It is designed to reduce symptoms, improve interpersonal functioning and increase social support. Number of sessions range from 6-20.
Psychological	Multicomponent intervention (individual)	Employs a variety of methodologically distinct approaches.
Psychological	Problem-solving therapy (group)	A cognitive-behavioral intervention geared to improve an individual's ability to cope with stressful life experiences with the underlying assumption that symptoms of psychopathology can often be understood as negative consequences of maladaptive coping. It aims to help individuals adopt a realistically optimistic view of coping, understanding the role of emotions more effectively, and creatively develop an action plan aimed at reducing psychological distress and enhance well-being.
Psychological	Cognitive-behavioral therapy (individual)	Utilizes behavioral and cognitive strategies, particularly exposure, cognitive restructuring, changes in behavior, and development of coping skills, to address learned and conditioned behaviors, thoughts and emotional and psychophysiological reactions.

Appendix B

Evidence Profiles Prepared for APA by RTI-UNC Scientists

Author(s): Gerald Gartlehner, Sheila V. Patel
Date: 2/16/2015
Question: Cognitive therapy (group) compared to behavioral therapy (group) for treating major depressive disorder in adults ages 60 and older
Setting: Referral to research center (Breckenridge et al. 1985)
Bibliography (systematic reviews): Thompson et al. 1987

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive therapy (group)**	**behavioral therapy (group)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity (follow up: range 12-16 weeks; assessed with: Social Adjustment Scale); based on completers analysis												
1	randomized trials	serious [2]	not serious	not serious	very serious [3]	none	31	30	-	MD **0.01 lower** (0.2359 lower to 0.2159 higher)	⊕◯◯◯ VERY LOW	
Response (follow up: 12-16 weeks; assessed with: Depression improved (not defined)); based on completers analysis; includes those randomized to 6 weeks of delayed treatment and assessed after only 6 weeks of treatment												
1	randomized trials	serious [2]	not serious	not serious	very serious [1]	none	3/31 (9.7%)	7/30 (23.3%)	**RR 0.41** (0.12 to 1.46)	138 fewer per 1000 (from 107 more to 205 fewer)	⊕◯◯◯ VERY LOW	
Remission (follow up: 12-16 weeks; assessed with: No longer meet MDD criteria); based on completers analysis												
1	randomized trials	serious [2]	not serious	not serious	very serious [1]	none	16/31 (51.6%)	17/30 (56.7%)	**RR 0.91** (0.57 to 1.45)	51 fewer per 1000 (from 244 fewer to 255 more)	⊕◯◯◯ VERY LOW	
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	cognitive therapy (group)	behavioral therapy (group)	Relative (95% CI)	Absolute (95% CI)		
									not estimable	not estimable		
Suicidality (follow up: 6 weeks; assessed with: Beck Hopelessness Scale); based on completers analysis												
1	randomized trials	serious [2]	not serious	not serious	very serious [3]	none	27	25	-	MD **0.3 higher** (2.133 lower to 2.733 higher)	⊕◯◯◯ VERY LOW	
Suicidality (follow up: range 12-16 weeks; assessed with: Beck Hopelessness Scale); based on completers analysis												
1	randomized trials	serious [2]	not serious	not serious	very serious [3]	none	31	30	-	MD **0.5 higher** (2.0381 lower to 3.0381 higher)	⊕◯◯◯ VERY LOW	
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Few events; confidence interval crosses appreciable difference
2. Lack of blinding of outcome assessors, no ITT analysis, high dropout rate
3. Study does not meet optimal information size

Author(s): Gerald Gartlehner, Sheila V. Patel
Date: 2/16/2015
Question: Problem-solving behavioral therapy (individual) compared to pleasant events behavioral therapy (individual) for treating minor or major depressive disorder in older adults with dementia
Setting: Referral from University of Washington Medical Center geriatric and Alzheimer's disease clinics
Bibliography (systematic reviews): Teri 1997

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**problem-solving behavioral therapy (individual)**	**pleasant events behavioral therapy (individual)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response (follow up: 9 weeks; assessed with: HAMD (those with major depressive disorder no longer meet criteria and those with minor depressive disorder no longer meet criteria)); based on completers analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	13/19 (68.4%)	12/23 (52.2%)	**RR 1.31** (0.80 to 2.15)	162 more per 1000 (from 104 fewer to 600 more)	⊕⊕◯◯ LOW	
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	problem-solving behavioral therapy (individual)	pleasant events behavioral therapy (individual)	Relative (95% CI)	Absolute (95% CI)		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Very few events; confidence intervals cross appreciable difference

Author(s): Gerald Gartlehner, Sheila V. Patel
Date: 2/16/2015
Question: Cognitive behavioral therapy (group) compared to cognitive behavioral therapy (internet) for subthreshold depression in adults between 50 and 75 years old
Setting: Primary care center
Bibliography (systematic reviews): Spek 2007

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive behavioral therapy (group)**	**cognitive behavioral therapy (internet)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response (follow up: 10 weeks; assessed with: Beck Depression Inventory (change from >20 at pre-treatment to <20 at post-treatment); scale from: 0 to 63); data limited to subgroup of patients with baseline BDI >20												
1	randomized trials	serious [3]	not serious	not serious	very serious [1]	none	28/42 (66.7%)	30/45 (66.7%)	**RR 1.00** (0.67 to 1.49)	0 fewer per 1000 (from 220 fewer to 327 more)	⊕◯◯◯ VERY LOW	
Change in BDI scores (follow up: mean 10 weeks; assessed with: BDI; scale from: 0 to 63); difference in change of BDI scores was not statistically significant (p=0.62); based on ITT analysis												
1	randomized trials	serious [3]	not serious	not serious	serious [2]	none	99	102	-	mean **0.54 lower** (2.96 lower to 1.88 higher)	⊕⊕◯◯ LOW	
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive behavioral therapy (group)**	**cognitive behavioral therapy (internet)**	**Relative (95% CI)**	**Absolute (95% CI)**		
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Few events; confidence intervals cross appreciable differences
2. Sample size does not meet optimal information size
3. High dropout rates; suspected outcomes reporting bias (observer-based outcomes not reported)

Author(s): Gerald Gartlehner, Sheila V. Patel
Date: 2/16/2015
Question: Behavioral therapy (group) compared to brief psychodynamic therapy (individual) for treating major depressive disorder in adults ages 60 and older
Setting: Referral to research center (Breckenridge et al. 1985)
Bibliography (systematic reviews): Thompson 1987

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**behavioral therapy (group)**	**brief psychodynamic therapy (individual)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity (follow up: range 12-16 weeks; assessed with: Social Adjustment Scale); based on completers analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	30	30	-	MD **0.11 lower** (0.3103 lower to 0.0903 higher)	⊕◯◯◯ VERY LOW	
Response (follow up: 6 weeks; assessed with: Depression improved (not defined)); based on completers analysis; includes those randomized to 6 weeks of delayed treatment and assessed after only 6 weeks of treatment												
1	randomized trials	serious [1]	not serious	not serious	very serious [3]	none	7/30 (23.3%)	7/30 (23.3%)	**RR 1.0** (0.4 to 2.5)	0 fewer per 1000 (from 140 fewer to 350 more)	⊕◯◯◯ VERY LOW	
Remission (follow up: 6 weeks; assessed with: No longer meet criteria for MDD); based on completers analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [3]	none	17/30 (56.7%)	14/30 (46.7%)	**RR 1.21** (0.74 to 1.99)	98 more per 1000 (from 121 fewer to 462 more)	⊕◯◯◯ VERY LOW	
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**behavioral therapy (group)**	**brief psychodynamic therapy (individual)**	**Relative (95% CI)**	**Absolute (95% CI)**		
									not estimable	not estimable		
Suicidality (follow up: 6 weeks; assessed with: Beck Hopelessness Scale); based on completers analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	25	24	-	MD **2.8 lower** (5.3587 lower to 0.2413 higher)	⊕◯◯◯ VERY LOW	
Suicidality (follow up: range 12-16 weeks; assessed with: Beck Hopelessness Scale); based on completers analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	30	30	-	MD **1.6 lower** (4.0296 loweer to 0.8296 higher)	⊕◯◯◯ VERY LOW	
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Lack of blinding of outcomes assessors, no ITT analyses, high dropout rates
2. Small sample size; study does not meet optimal information size
3. Few events; confidence intervals cross appreciable differences

Author(s): Gerald Gartlehner, Sheila V. Patel
Date: 2/16/2015
Question: Cognitive therapy (group) compared to brief psychodynamic therapy (individual) for treating major depressive disorder in adults ages 60 and older
Setting: Referral to research center (Breckenridge et al. 1985)
Bibliography (systematic reviews): Thompson 1987

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive therapy (group)**	**brief psychodynamic therapy (individual)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity (follow up: range 12-16 weeks; assessed with: Social Adjustment Scale); based on completers analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	31	30	-	MD **0.12 lower** (0.3568 lower to 0.1168 higher)	⊕◯◯◯ VERY LOW	
Response (follow up: 6 weeks; assessed with: Depression improved (not defined)); based on completers analysis;includes those randomized to 6 weeks of delayed treatment and assessed after only 6 weeks of treatment												
1	randomized trials	serious [1]	not serious	not serious	very serious [3]	none	7/31 (22.6%)	3/30 (10.0%)	**RR 0.41** (0.12 to 1.46)	59 fewer per 1000 (from 46 more to 88 fewer)	⊕◯◯◯ VERY LOW	
Remission (follow up: 6 weeks; assessed with: No longer meet criteria for MDD); based on completers analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [3]	none	14/31 (45.2%)	16/30 (53.3%)	**RR 1.11** (0.66 to 1.85)	59 more per 1000 (from 181 fewer to 453 more)	⊕◯◯◯ VERY LOW	
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive therapy (group)**	**brief psychodynamic therapy (individual)**	**Relative (95% CI)**	**Absolute (95% CI)**		
									not estimable	not estimable		
Suicidality (follow up: 6 weeks; assessed with: Beck Hopelessness Scale); based on completers analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	27	24	-	MD **2.5 lower** (5.3335 lower to 0.3335 higher)	⊕◯◯◯ VERY LOW	
Suicidality (follow up: range 12-16 weeks; assessed with: Beck Hopelessness Scale); based on completers analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	31	30	-	MD **1.1 lower** (3.6861 lower to 1.4861 higher)	⊕◯◯◯ VERY LOW	
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Lack of blinding of outcomes assessors, no ITT analysis, high dropout rates
2. Small sample size; study does not fulfil optimal information size
3. Few events; confidence interval crosses appreciable differences

Question: Problem-solving therapy (group) compared to reminiscence therapy (group) for treating major depressive disorder in adults aged 55 years or older
Setting: University-sponsored depression program, specific setting not reported
Bibliography (systematic reviews): Arean 1993

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**problem-solving therapy (group)**	**reminiscence therapy (group)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem orientation)); based on completers analysis												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	19	28	-	MD **10.4 higher** (4.2546 lower to 25.055 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (problem orientation)); based on completers analysis												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	19	28	-	MD **8.3 higher** (6.8749 lower to 23.475 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem definition and formulation)); based on completers analysis												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	19	28	-	MD **2.4 higher** (2.3766 lower to 7.1766 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (problem definition and formulation)); based on completers analysis												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	19	28	-	MD **1.4 higher** (3.8604 lower to 6.6604 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (generation of alternative solutions)); based on completers analysis												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	19	28	-	MD **1.6 higher** (3.5054 lower to 6.7054 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (generation of alternative solutions)); based on completers analysis												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	19	28	-	MD **0.9 higher**	⊕⊕◯◯ LOW	

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	problem-solving therapy (group)	reminiscence therapy (group)	Relative (95% CI)	Absolute (95% CI)		
										(3.1429 lower to 4.9429 higher)		
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (decision-making)); based on completers analysis												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	19	28	-	MD **3.1 higher** (1.7877 lower to 7.9877 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (decision-making)); based on completers analysis												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	19	28	-	MD **4.1 higher** (0.3863 lower to 8.5863 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (solution implementation and verification)); based on completers analysis												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	19	28	-	MD **2.9 higher** (1.9718 lower to 7.7718 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (solution implementation and verification)); based on completers analysis												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	19	28	-	MD **1.4 higher** (3.7875 lower to 6.5875 higher)	⊕⊕◯◯ LOW	
Response (follow up: mean 12 weeks; assessed with: No longer fulfill diagnostic criteria for MDD); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	serious [1]	none	17/28 (60.7%)	8/27 (29.6%)	**RR 2.05** (1.07 to 3.94)	311 more per 1000 (from 21 more to 871 more)	⊕⊕⊕◯ MODERATE	
Response (follow up: mean 6 months; assessed with: No longer fulfill diagnostic criteria for MDD); based on ITT analysis												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**problem-solving therapy (group)**	**reminiscence therapy (group)**	**Relative (95% CI)**	**Absolute (95% CI)**		
1	randomized trials	not serious	not serious	not serious	serious [1]	none	17/28 (60.7%)	6/27 (22.2%)	**RR 2.73** (1.27 to 5.88)	384 more per 1000 (from 60 more to 1000 more)	⊕⊕⊕◯ MODERATE	
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Very few events
2. Small sample size; study does not meet optimal information size

Author(s): Gerald Gartlehner, Sheila V. Patel
Date: 3/3/2015
Question: Problem-solving therapy (in-person) compared to problem-solving therapy (video call) for treating dysthymia or major depressive disorder adults aged 50 years or older
Setting: Patient homes
Bibliography (systematic reviews): Choi 2013

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**problem-solving therapy (in-person)**	**problem-solving therapy (video call)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	42	43	-	MD **0.69 higher** (8.33 lower to 9.71 higher)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	42	43	-	MD **3.23 higher** (7.07 lower to 13.53 higher)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	42	43	-	MD **0.18 higher** (5.21 lower to 5.57 higher)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	42	43	-	MD **2.09 higher** (4.45 lower to 8.63 higher)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	42	43	-	MD **0.52 higher** (4.85 lower to 5.89 higher)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	42	43	-	MD **1.14 higher** (4.72 lower to 7 higher)	⊕◯◯◯ VERY LOW	

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**problem-solving therapy (in-person)**	**problem-solving therapy (video call)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Response (follow up: 12 weeks; assessed with: HAMD (50% or greater reduction)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [3]	none	14/42 (33.3%)	16/43 (37.2%)	**RR 0.9** (0.5 to 1.6)	37 fewer per 1000 (from 186 fewer to 223 more)	⊕◯◯◯ VERY LOW	
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. No blinding of outcomes assessors
2. Small sample, study does not meet optimal information size
3. Few events; confidence interval crosses appreciable difference

Author(s): Gerald Gartlehner, Sheila V. Patel
Date: 2/16/2015
Question: Combination cognitive behavioral therapy and non-specific therapeutic techniques (individual) with pharmacotherapy compared to pharmacotherapy as usual for treating major depressive disorder in adults

between 65 and 85 years old
Setting: Geriatric psychiatry clinic
Bibliography (systematic reviews): Sirey 2005

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**a combination of cognitive behavioral therapy and non-specific therapeutic techniques (individual) with pharmacotherapy**	**pharmacotherapy as usual**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Remission (follow up: 28 weeks; assessed with: HAMD <10 (assume misstated in article); based on completers analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	15/21 (71.4%)	10/24 (41.7%)	**RR 1.71** (0.99 to 2.96)	296 more per 1000 (from 4 fewer to 817 more)	⊕⊕◯◯ LOW	
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality (follow up: 28 weeks; assessed with: HAMD (experience hopeless ideation)); based on completers analysis												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**a combination of cognitive behavioral therapy and non-specific therapeutic techniques (individual) with pharmacotherapy**	**pharmacotherapy as usual**	**Relative (95% CI)**	**Absolute (95% CI)**		
1	randomized trials	not serious	not serious	not serious	very serious [2]	none [3]	3/21 (14.3%)	15/24 (62.5%)	**RR 0.23** (0.08 to 0.68)	481 fewer per 1000 (from 200 fewer to 575 fewer)	⊕⊕◯◯ LOW	
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Very few events; confidence interval crosses appreciable difference
2. Very few events
3. Not upgraded because of very few events

Question: Combination of dialectical behavior therapy (group) and pharmacotherapy compared to pharmacotherapy as usual for treating major depressive disorder in adults ages 60 and older
Setting: University-based medical center
Bibliography (systematic reviews): Lynch 2003

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**a combination of dialectical behavior therapy (group) and pharmacotherapy**	**pharmacotherapy as usual**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response (follow up: 28 weeks; assessed with: HAMD (reliable improvement))												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	14/17 (82.4%)	13/17 (76.5%)	**RR 1.08** (0.76 to 1.52)	61 more per 1000 (from 184 fewer to 398 more)	⊕◯◯◯ VERY LOW	
Response (follow up: 13 months; assessed with: HAMD (reliable improvement)); unclear whether those who responded at 28 weeks maintained their response at follow-up												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	1/17 (5.9%)	1/17 (5.9%)	**RR 1.00** (0.07 to 14.72)	0 fewer per 1000 (from 55 fewer to 807 more)	⊕◯◯◯ VERY LOW	
Remission (follow up: 28 weeks; assessed with: HAMD <=7)												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	12/17 (70.6%)	8/17 (47.1%)	**RR 1.50** (0.83 to 2.71)	235 more per 1000 (from 80 fewer to 805 more)	⊕◯◯◯ VERY LOW	
Remission (follow up: 13 months; assessed with: HAMD <=7); unclear whether all those remitted at 28 weeks stayed remitted at follow-up												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	13/17 (76.5%)	5/17 (29.4%)	**RR 2.60** (1.19 to 5.68)	471 more per 1000 (from 56 more to 1376 more)	⊕◯◯◯ VERY LOW	
Quality of Life												
									not estimable	not estimable		

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**a combination of dialectical behavior therapy (group) and pharmacotherapy**	**pharmacotherapy as usual**	**Relative (95% CI)**	**Absolute (95% CI)**		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality (follow up: 28 weeks; assessed with: Beck Hopelessness Scale); based on completers analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [3]	none	14	11	-	MD **2.61 lower** (7.24 lower to 2.02 higher)	⊕◯◯◯ VERY LOW	
Suicidality (follow up: 13 months; assessed with: Beck Hopelessness Scale); "Neither group changed in hopelessness from post-treatment to follow-up (MED: $F_{[1,10]} = 0.83$, NS; MED+DBT: $F_{[1,13]} = 0.00$, NS)."												
1	randomized trials	serious [1]	not serious	not serious	very serious [3]	none			-	**0 higher** (0 higher to 0 higher)	⊕◯◯◯ VERY LOW	
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Inadequate randomization, no ITT analysis, unclear whether outcome assessors were blinded
2. Small study, very few events
3. Small sample size: study does not fulfil optimal information size

Author(s): Gerald Gartlehner, Sheila V. Patel
Date: 2/16/2015
Question: Combination of cognitive behavioral therapy (individual) and desipramine compared to desipramine for treating major depressive disorder in adults ages 60 and older

Setting: Geriatric clinic for affective disorders

Bibliography (systematic reviews): Thompson 2001

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**a combination of cognitive behavioral therapy (individual) and desipramine**	**desipramine**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Change in HAMD scores (follow up: range 16-20 weeks; assessed with: HAMD; Scale from: 0 to 17); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	36	33	-	MD **3 lower** (6.09 lower to 0.09 higher)	⊕⊕◯◯ LOW	
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction (follow up: range <16 weeks; assessed with: Satisfaction among dropouts); "There was no significant difference in discontinuation due to treatment dissatisfaction across the three treatments ($X^2_{[2]}$ = 2.99; N = 102; P = 0.22)."												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none			not estimable	not estimable	⊕⊕◯◯ LOW	
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**a combination of cognitive behavioral therapy (individual) and desipramine**	**desipramine**	**Relative (95% CI)**	**Absolute (95% CI)**		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Small sample size; study does not meet optimal information size

Author(s): Gerald Gartlehner, Sheila V. Patel
Date: 2/16/2015
Question: Cognitive behavioral therapy (individual) compared to desipramine for treating major depressive disorder in adults ages 60 and older
Setting: Geriatric clinic for affective disorders

Bibliography (systematic reviews): Thompson 2001

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive behavioral therapy (individual)**	**desipramine**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Change in HAMD scores (follow up: range 16-20 weeks; assessed with: HAMD; Scale from: 0 to 17); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	31	33	-	MD **2.5 lower** (5.75 lower to 0.75 higher)	⊕⊕◯◯ LOW	
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction (follow up: range <16 weeks; assessed with: Satisfaction among dropouts); "There was no significant difference in discontinuation due to treatment dissatisfaction across the three treatments ($X^2_{[2]}$ = 2.99; N = 102; P = 0.22)."												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none			not estimable	not estimable	⊕⊕◯◯ LOW	
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive behavioral therapy (individual)**	**desipramine**	**Relative (95% CI)**	**Absolute (95% CI)**		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Small sample size; study does not meet optimal information size

Author(s): Gerald Gartlehner, Sheila V. Patel
Date: 2/19/2015
Question: Problem-solving therapy (individual) compared to paroxetine for treating dysthymia in adults ages 60 an older
Setting: Primary care practices
Bibliography (systematic reviews): Williams 2000

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**problem-solving therapy (individual)**	**paroxetine**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional capacity												
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Remission (assessed with: HAMD <=7); data limited to those who attended more than 4 sessions												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	32/63 (50.8%)	26/57 (45.6%)	**RR 1.11** (0.77 to 1.62)	50 more per 1000 (from 105 fewer to 283 more)	⊕⊕◯◯ LOW	
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events (follow up: 11 weeks; assessed with: Withdrawals due to adverse events); based on completers analysis; combination of patients with dysthymia or minor depression												
1	randomized trials	not serious	not serious	not serious	serious [2]	none	0/120 (0.0%)	12/130 (9.2%)	**RR 0.04** (0.00 to 0.62)	89 fewer per 1000 (from 35	⊕⊕⊕◯ MODERATE	

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	problem-solving therapy (individual)	paroxetine	Relative (95% CI)	Absolute (95% CI)		
										fewer to 92 fewer)		

MD – mean difference, RR – relative risk

1. Few events; confidence interval crosses appreciable difference
2. Few events

Author(s): Gerald Gartlehner, Sheila V. Patel
Date: 2/19/2015
Question: Problem-solving therapy (individual) compared to paroxetine for treating minor depressive disorder in adults ages 60 and older
Setting: Primary care practices
Bibliography (systematic reviews): Williams 2000

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**problem-solving therapy (individual)**	**paroxetine**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									-	**0 higher** (0 higher to 0 higher)		
Response												
									not estimable	not estimable		
Remission (assessed with: HAMD <=7); data limited to those who attended more than 4 sessions												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	22/50 (44.0%)	26/49 (53.1%)	**RR 0.83** (0.55 to 1.25)	90 fewer per 1000 (from 133 more to 239 fewer)	⊕⊕◯◯ LOW	
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events (follow up: 11 weeks; assessed with: Withdrawals due to adverse events); based on completers analysis; combination of patients with dysthymia or minor depression												
1	randomized trials	not serious	not serious	not serious	serious [2]	none	0/120	12/130 (9.2%)	**RR 0.04** (0.00 to 0.62)	89 fewer per 1000 (from 35 fewer to 92 fewer)	⊕⊕⊕◯ MODERATE	

MD – mean difference, RR – relative risk

1. Few events; confidence interval crosses appreciable difference
2. Few events

Author(s): Gerald Gartlehner, Sheila V. Patel
Date: 2/16/2015
Question: Combination interpersonal psychotherapy (individual) and nortriptyline compared to combination interpersonal psychotherapy (individual) and placebo for treating major depressive disorder in adults ages 50 and older
Setting: University-based psychiatric clinic
Bibliography (systematic reviews): Reynolds 1999

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a combination of interpersonal psychotherapy (individual) and nortriptyline	a combination of interpersonal psychotherapy (individual) and placebo	Relative (95% CI)	Absolute (95% CI)		
Functional Capacity												
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Remission (follow up: within 8 weeks of treatment; assessed with: HAMD <= 7 for 3 consecutive weeks); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	11/16 (68.8%)	5/17 (29.4%)	**RR 2.34** (1.04 to 5.24)	394 more per 1000 (from 12 more to 1247 more)	⊕⊕◯◯ LOW	
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Small study, very few events; confidence interval crosses appreciable difference

Author(s): Gerald Gartlehner, Sheila V. Patel
Date: 2/16/2015
Question: Combination interpersonal psychotherapy (individual) and nortriptyline compared to combination nortriptyline and medication clinic attendance for treating major depressive disorder in adults ages 50 and older
Setting: University-based psychiatric clinic
Bibliography (systematic reviews): Reynolds 1999

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a combination of interpersonal psychotherapy (individual) and nortriptyline	a combination of nortriptyline and medication clinic attendance	Relative (95% CI)	Absolute (95% CI)		
Functional Capacity												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a combination of interpersonal psychotherapy (individual) and nortriptyline	a combination of nortriptyline and medication clinic attendance	Relative (95% CI)	Absolute (95% CI)		
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Remission (follow up: within 8 weeks of treatment, assessed with: HAMD <= 7 for 3 consecutive weeks); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	11/16 (68.8%)	14/25 (56.0%)	**RR 1.23** (0.76 to 1.98)	129 more per 1000 (from 134 fewer to 549 more)	⊕⊕◯◯ LOW	
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Small study, very few events; confidence interval crosses appreciable difference

Author(s): Gerald Gartlehner, Sheila V. Patel
Date: 2/16/2015
Question: Combination interpersonal psychotherapy (individual) and placebo compared to combination nortriptyline and medication clinic attendance for treating major depressive disorder in adults ages 50 and older
Setting: University-based psychiatric clinic
Bibliography (systematic reviews): Reynolds 1999

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a combination of interpersonal psychotherapy (individual) and placebo	a combination of nortriptyline and medication clinic attendance	Relative (95% CI)	Absolute (95% CI)		
Functional Capacity												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**a combination of interpersonal psychotherapy (individual) and placebo**	**a combination of nortriptyline and medication clinic attendance**	**Relative (95% CI)**	**Absolute (95% CI)**		
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Remission (follow up: within 8 weeks of treatment; assessed with: HAMD <= 7 for 3 consecutive weeks)												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	14/25 (56.0%)	5/17 (29.4%)	**RR 0.53** (0.23 to 1.19)	138 fewer per 1000 (from 56 more to 226 fewer)	⊕⊕◯◯ LOW	
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Small study, few events; confidence intervals cross appreciable difference

Author(s): Meera Viswanathan, Sheila V. Patel
Date: 2/13/2015
Question: Cognitive behavioral therapy (group) plus pharmacotherapy* compared to pharmacotherapy for preventing relapse/recurrence in adults ages 60 and older
Setting: General practice and psychiatric service settings in Oxford and Southampton, United Kingdom
Bibliography (systematic reviews): Wilkinson2009 (primary source); Wilkinson 2012 (systematic review)

Quality assessment							№ of patients		Effect		Quality	Import-ance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive behavioral therapy (group) plus pharmacotherapy**	**pharmacotherapy**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		

Quality assessment							№ of patients		Effect		Quality	Import-ance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	cognitive behavioral therapy (group) plus pharmacotherapy	pharmacotherapy	Relative (95% CI)	Absolute (95% CI)		
Response												
									not estimable	not estimable		
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Recurrence (follow up: 6 months; assessed with: MADRS >= 10); RR adjusted for clustering and baseline value, N per protocol												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	1/18 (5.6%)	4/19 (21.1%)	**RR 0.34** (0.03 to 3.35)	139 fewer per 1000 (from 204 fewer to 495 more)	⊕⊕◯◯ LOW	
Recurrence (follow up: 12 months; assessed with: MADRS >= 10); RR adjusted for clustering and baseline value, N per protocol												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	5/18 (27.8%)	8/18 (44.4%)	**RR 0.70** (0.26 to 1.94)	133 fewer per 1000 (from 329 fewer to 418 more)	⊕⊕◯◯ LOW	
Suicidality												
									not estimable	not estimable		
Adverse Events												

Quality assessment							№ of patients		Effect		Quality	Import-ance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	cognitive behavioral therapy (group) plus pharmacotherapy	pharmacotherapy	Relative (95% CI)	Absolute (95% CI)		
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. small sample size, OIS not met, CIs do not rule out important benefits or harms

*: therapeutic doses of antidepressants equivalent to fluoxetine 20 mg or amitriptyline 150 mg

Author(s): Meera Viswanathan, Sheila V. Patel
Date: 2/13/2015
Question: Interpersonal psychotherapy (individual) plus nortriptyline compared to interpersonal psychotherapy (individual) plus placebo for preventing relapse/recurrence in adults ages 60 and older
Setting: University-based psychiatric clinic
Bibliography (systematic reviews): Reynolds 1999 (primary source); Wilkinson 2012 (systematic review)

Quality assessment							№ of patients		Effect		Quality	Import-ance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	interpersonal psychotherapy (individual) plus nortriptyline	interpersonal psychotherapy (individual) plus placebo	Relative (95% CI)	Absolute (95% CI)		
Functional Capacity												
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview)												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	5/25 (20.0%)	9/25 (36.0%)	**RR 0.56** (0.22 to 1.43)	158 fewer per 1000 (from 155 more to 281 fewer)	⊕⊕◯◯ LOW	
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview)												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	5/25 (20.0%)	14/25 (56.0%)	**RR 0.36** (0.15 to 0.84)	358 fewer per 1000 (from 90 fewer to 476 fewer)	⊕⊕◯◯ LOW	
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview)												

Quality assessment							№ of patients		Effect		Quality	Import-ance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**interpersonal psychotherapy (individual) plus nortriptyline**	**interpersonal psychotherapy (individual) plus placebo**	**Relative (95% CI)**	**Absolute (95% CI)**		
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	8/25 (32.0%)	16/25 (64.0%)	**RR 0.50** (0.26 to 0.95)	320 fewer per 1000 (from 32 fewer to 474 fewer)	⊕⊕◯◯ LOW	
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Small sample size, OIS not met, CI fails to exclude important benefit or important harm
2. Small sample size, OIS not met

Author(s): Meera Viswanathan, Sheila V. Patel
Date: 2/13/2015
Question: Interpersonal psychotherapy (individual) plus nortriptyline compared to placebo plus medication clinic attendance for be used for preventing relapse/recurrence in adults ages 60 and older
Setting: University-based psychiatric clinic
Bibliography (systematic reviews): Reynolds 1999 (primary source); Wilkinson 2012 (systematic review)

Quality assessment							№ of patients		Effect		Quality	Import-ance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**interpersonal psychotherapy (individual) plus nortriptyline**	**placebo plus medication clinic attendance**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview)												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	5/25 (20.0%)	22/29 (75.9%)	**RR 0.26** (0.12 to 0.59)	561 fewer per 1000 (from 311 fewer to 668 fewer)	⊕⊕◯◯ LOW	
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview)												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	5/25 (20.0%)	24/29 (82.8%)	**RR 0.24** (0.11 to 0.54)	629 fewer per 1000 (from 381 fewer to 737 fewer)	⊕⊕◯◯ LOW	
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview)												

Quality assessment							№ of patients		Effect		Quality	Import-ance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**interpersonal psychotherapy (individual) plus nortriptyline**	**placebo plus medication clinic attendance**	**Relative (95% CI)**	**Absolute (95% CI)**		
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	8/25 (32.0%)	26/29 (89.7%)	**RR 0.36** (0.20 to 0.64)	574 fewer per 1000 (from 323 fewer to 717 fewer)	⊕⊕◯◯ LOW	
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Sample size low, OIS not met

Author(s): Meera Viswanathan, Sheila V. Patel
Date: 2/13/2015
Question: Interpersonal psychotherapy (individual) plus placebo compared to nortriptyline plus medication clinic attendance for preventing relapse/recurrence in adults ages 60 and older
Setting: University-based psychiatric clinic
Bibliography (systematic reviews): Reynolds 1999 (primary source); Wilkinson 2012 (systematic review)

Quality assessment							№ of patients		Effect		Quality	Import-ance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**interpersonal psychotherapy (individual) plus placebo**	**nortriptyline plus medication clinic attendance**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview)												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	9/25 (36.0%)	8/28 (28.6%)	**RR 1.26** (0.57 to 2.76)	74 more per 1000 (from 123 fewer to 503 more)	⊕⊕◯◯ LOW	
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview)												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	14/25 (56.0%)	12/28 (42.9%)	**RR 1.31** (0.75 to 2.27)	133 more per 1000 (from 107 fewer to 544 more)	⊕⊕◯◯ LOW	
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview)												

Quality assessment							№ of patients		Effect		Quality	Import-ance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**interpersonal psychotherapy (individual) plus placebo**	**nortriptyline plus medication clinic attendance**	**Relative (95% CI)**	**Absolute (95% CI)**		
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	16/25 (64.0%)	14/28 (50.0%)	**RR 1.28** (0.80 to 2.05)	140 more per 1000 (from 100 fewer to 525 more)	⊕⊕◯◯ LOW	
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Small sample size, OIS not met, CI fails to exclude important benefit or important harm

Author(s): Meera Viswanathan, Sheila V. Patel
Date: 2/13/2015
Question: Interpersonal psychotherapy (individual) plus placebo compared to placebo plus medication clinic attendance for preventing relapse/recurrence in adults ages 60 and older
Setting: University-based psychiatric clinic
Bibliography (systematic reviews): Reynolds 1999 (primary source); Wilkinson 2012 (systematic review)

Quality assessment							№ of patients		Effect		Quality	Import-ance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	interpersonal psychotherapy (individual) plus placebo	placebo plus medication clinic attendance	Relative (95% CI)	Absolute (95% CI)		
Functional Capacity												
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview)												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	9/25 (36.0%)	22/29 (75.9%)	**RR 0.47** (0.27 to 0.83)	402 fewer per 1000 (from 129 fewer to 554 fewer)	⊕⊕◯◯ LOW	
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview)												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	14/25 (56.0%)	24/29 (82.8%)	**RR 0.68** (0.46 to 0.99)	265 fewer per 1000 (from 8 fewer to 447 fewer)	⊕⊕◯◯ LOW	
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview)												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	16/25 (64.0%)	26/29 (89.7%)	**RR 0.71** (0.52 to 0.98)	260 fewer per 1000 (from 18	⊕⊕◯◯ LOW	

Quality assessment							№ of patients		Effect		Quality	Import-ance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**interpersonal psychotherapy (individual) plus placebo**	**placebo plus medication clinic attendance**	**Relative (95% CI)**	**Absolute (95% CI)**		
										fewer to 430 fewer)		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Sample size low, OIS not met

Author(s): Linda Lux
Date: 4/22/2015
Question: Cognitive behavioral therapy (individual) compared to usual care for treating major depressive disorder in adults ages 60 and older
Setting: Primary care practices
Bibliography (systematic reviews): Laidlaw 2008

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	cognitive behavioral therapy (individual)	usual care	Relative (95% CI)	Absolute (95% CI)		
Functional Capacity												
0									not estimable	not estimable		
Response												
0									not estimable	not estimable		
Remission (follow up: 18 weeks; assessed with: No longer meet DSM-IV criteria; HAMD<=7; BDI<=13); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	14/21 (66.7%)	8/23 (34.8%)	**RR 1.92** (1.01 to 3.62)	320 more per 1000 (from 3 more to 911 more)	⊕⊕◯◯ LOW	
Remission (follow up: 42 weeks; assessed with: No longer meet DSM-IV criteria; HAMD<=7; BDI<=13); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	11/21 (52.4%)	8/23 (34.8%)	**RR 1.51** (0.75 to 3.01)	177 more per 1000 (from 87 fewer to 699 more)	⊕⊕◯◯ LOW	
Quality of Life (follow up: 18 weeks; assessed with: WHOQOL Psychological); based on those who started treatment												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	20	20	-	MD **2.5 higher** (0.39 higher to 4.61 higher)	⊕⊕◯◯ LOW	
Quality of Life (follow up: 42 weeks; assessed with: WHOQOL Psychological); based on those who started treatment												
1	randomized trials	not serious	not serious	not serious	very serious	none	20	20	-	MD **1.45 higher** (0.86 lower to 3.76 higher)	⊕⊕◯◯ LOW	
Quality of Life (follow up: 18 weeks; assessed with: WHOQOL Social Relationships); based on those who started treatment												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	20	20	-	MD **0.1 higher** (1.22 lower to 1.42 higher)	⊕⊕◯◯ LOW	

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive behavioral therapy (individual)**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**		
Quality of Life (follow up: 42 weeks; assessed with: WHOQOL Social Relationships); based on those who started treatment												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	20	20	-	MD **0.3 higher** (0.59 lower to 1.19 higher)	⊕⊕◯◯ LOW	
Quality of Life (follow up: 18 weeks; assessed with: WHOQOL Environment); based on those who started treatment												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	20	20	-	MD **0.55 higher** (2.26 lower to 3.36 higher)	⊕⊕◯◯ LOW	
Quality of Life (follow up: 42 weeks; assessed with: WHOQOL Environment); based on those who started treatment												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	20	20	-	MD **1.1 higher** (1.06 lower to 3.26 higher)	⊕⊕◯◯ LOW	
Quality of Life (follow up: 18 weeks; assessed with: WHOQOL Physical); based on those who started treatment												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	20	20	-	MD **2.55 higher** (0.36 lower to 5.46 higher)	⊕⊕◯◯ LOW	
Quality of Life (follow up: 42 weeks; assessed with: WHOQOL Physical); based on those who started treatment												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	20	20	-	MD **1.35 higher** (2.07 lower to 4.77 higher)	⊕⊕◯◯ LOW	
Patient Satisfaction												
0									not estimable	not estimable		
Relapse												
0									not estimable	not estimable		
Suicidality (follow up: 18 weeks; assessed with: Beck Hopelessness Scale); based on those who started treatment												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive behavioral therapy (individual)**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**		
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	20	20	-	MD **1 lower** (3.61 lower to 1.61 higher)	⊕⊕◯◯ LOW	
Suicidality (follow up: 42 weeks; assessed with: Beck Hopelessness Scale); based on those who started treatment												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	20	20	-	MD **2.6 lower** (5.44 lower to 0.24 higher)	⊕⊕◯◯ LOW	
Adverse Events												
0									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. small sample size and/or number of events, does not meet optimal information size to detect differences
2. small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): Linda Lux
Date: 4/22/15
Question: A combination of cognitive behavioral therapy (individual) and usual care compared to usual care for treating minor or major depressive disorder in adults ages 65 and older
Setting: Mental health institute; primary care practices and patient homes
Bibliography (systematic reviews): Ekkers 2011; Serfaty 2009

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**a combination of cognitive behavioral therapy (individual) and usual care**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
0									not estimable	not estimable		
Response (follow up: 10 months; assessed with BDI); Serfaty 2009; number of events not reported by group												
1	randomized trials	not serious	not serious	not serious	serious [1]	none	70	67	-	GEE estimate **3.07 lower** (5.73 lower to 0.42 lower)	⊕⊕⊕◯ MODERATE	
Change in Scores (follow up: 8 weeks; assessed with: Geriatric Depression Scale); Ekkers 2011 (rumination-focused); based on ITT analysis												
1	randomized trials	serious [2,3]	not serious	not serious	serious [1]	none	53	48	-	MD **3.2 lower** (5.52 lower to 0.88 lower)	⊕⊕◯◯ LOW	
Remission												
0									not estimable	not estimable		
Quality of Life (follow up: 10 months; assessed with: EUROQOL); Serfaty 2009; number of events not reported by group												
1	randomized trials	not serious	not serious	not serious	very serious [4]	none	70	67	-	GEE estimate **0.05 higher** (0.04 lower to 0.14 higher)	⊕⊕◯◯ LOW	
Quality of Life (follow up: 10 months; assessed with: Social Functioning Questionnaire); Serfaty 2009; number of events not reported by group												
1	randomized trials	not serious	not serious	not serious	very serious [4]	none	70	67	-	GEE estimate **1.65 lower** (3.57 lower to 0.26 higher)	⊕⊕◯◯ LOW	
Patient Satisfaction												
0									not estimable	not estimable		
Relapse												
0									not estimable	not estimable		
Suicidality												
0									not estimable	not estimable		

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a combination of cognitive behavioral therapy (individual) and usual care	usual care	Relative (95% CI)	Absolute (95% CI)		
Adverse Events												
0									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. small sample size and/or number of events, does not meet optimal information size to detect difference
2. high differential attrition
3. high drop out
4. small sample size and/or number of events, does not meet optimal information size to detect difference, confidence interval crosses appreciable difference

Author(s): Linda Lux
Date: 4/22/15
Question: A combination of cognitive behavioral therapy (individual) and usual care compared to usual care for treating minor or major depressive disorder in adults ages 60 and older with type II diabetes mellitus or chronic obstructive pulmonary disease
Setting: Primary care practices and patient homes
Bibliography (systematic reviews): Lamers 2010

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**a combination of cognitive behavioral therapy (individual) and usual care**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)[4]**		
Functional Capacity												
0									not estimable	not estimable		
Response (follow up: 3 months; assessed with: Beck Depression Inventory (>=50% reduction)); based on ITT analysis												
1	randomized trials	Not serious	not serious	not serious	serious [1]	none	183	178	-	MD **1.61 lower** (0 higher to 3.22 lower)	⊕⊕⊕◯ MODERATE	
Response (follow up: 9 months; assessed with: Beck Depression Inventory (>=50% reduction)); based on ITT analysis												
1	randomized trials	Not serious	not serious	not serious	serious [1]	none	183	178	-	MD **2.09 lower** (0.25 lower to 3.93 lower)	⊕⊕⊕◯ MODERATE	
Remission												
0									not estimable	not estimable		
Quality of Life [3] (follow up: 3 months; assessed with: Short Form-36 Mental); based on completers analysis												
1	randomized trials	serious [2]	not serious	not serious	serious [3]	none	101	102	-	MD **0.9 higher** (1.55 lower to 3.36 higher)	⊕⊕◯◯ LOW	
Quality of Life [3] (follow up: 9 months; assessed with: Short Form-36 Mental); based on completers analysis												
1	randomized trials	serious [2]	not serious	not serious	serious [3]	none	103	98	-	MD **1.87 higher** (0.59 lower to 4.34 higher)	⊕⊕◯◯ LOW	
Quality of Life [3] (follow up: 3 months; assessed with: Short Form-36 Physical); based on completers analysis												
1	randomized trials	serious [2]	not serious	not serious	serious [3]	none	101	102	-	MD **1.58 higher** (0.12 lower to 3.28 higher)	⊕⊕◯◯ LOW	
Quality of Life [3] (follow up: 9 months; assessed with: Short Form-36 Physical); based on completers analysis												
1	randomized trials	serious [2]	not serious	not serious	serious [3]	none	103	98	-	MD **0.79 higher** (1.16 lower to 2.74 higher)	⊕⊕◯◯ LOW	

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a combination of cognitive behavioral therapy (individual) and usual care	usual care	Relative (95% CI)	Absolute (95% CI)[4]		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Wide confidence intervals
2. Completers analysis
3. Confidence intervals cross appreciable difference
4. MD abstracted from study

Author(s): Linda Lux
Date: 4/22/15
Question: Problem-solving therapy (individual) compared to supportive therapy (individual) for treating major depressive disorder in adults ages 60 and older with executive dysfunction
Setting: University-based research centers and patient homes
Bibliography (systematic reviews): Alexopoulous 2003; Alexopoulous 2011; Arean 2010; Kiosses 2010

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**problem-solving therapy (individual)**	**supportive therapy (individual)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity (follow up: 12 weeks; assessed with: WHODAS II); Alexopoulous 2003; based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	12	13	-	MD **31.67 lower** (44.11 lower to 19.23 lower)	⊕⊕◯◯ LOW	
Response (follow up: 12 weeks; assessed with: HAMD >=50% reduction); Arean 2010; based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	serious [2]	none	51/110 (46.4%)	33/111 (29.7%)	**RR 1.56** (1.10 to 2.21)	166 more per 1000 (from 30 more to 360 more)	⊕⊕⊕◯ MODERATE	
Change in score (follow up: 12 weeks; assessed with: HAMD); Alexopoulous 2003; based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1] [3]	none	12	13	-	MD **6.83 lower** (11.75 lower to 1.91 lower)	⊕⊕◯◯ LOW	
Change in score (follow up: 12 weeks; assessed with: HAMD); Kiosses2010; based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1] [3]	none	15	15	-	MD **3.83 lower** (7.38 lower to 0.28 lower)	⊕⊕◯◯ LOW	
Remission (follow up: 12 weeks; assessed with: HAMD <10 for 2 consecutive weeks); Arean 2010; based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	serious [2]	none	41/110 (37.3%)	27/111 (24.3%)	**RR 1.53** (1.02 to 2.30)	129 more per 1000 (from 5 more to 316 more)	⊕⊕⊕◯ MODERATE	
Remission (follow up: 12 weeks; assessed with: HAMD <10); Alexopoulous 2003; based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1] [3]	none	9/12 (75.0%)	3/13 (23.1%)	**RR 3.25** (1.14 to 9.24)	519 more per 1000 (from 32 more to 1000 more)	⊕⊕◯◯ LOW	
Quality of Life												
									not estimable	not estimable		

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**problem-solving therapy (individual)**	**supportive therapy (individual)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Patient Satisfaction (follow up: 12 weeks; assessed with: Client Satisfaction Questionnaire); Kiosses 2010; based on completers analysis												
1	randomized trials	serious [4]	not serious	not serious	very serious [1,5]	none	13	12	-	MD **0.28 higher** (0.28 lower to 0.84 higher)	⊕◯◯◯ VERY LOW	
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. small sample size and/or number of events, does not meet optimal information size to detect difference
2. small number of events
3. wide confidence interval
4. completers analysis
5. wide confidence interval spanning benefits and harms

Author(s): Linda Lux
Date: 4/22/15
Question: Problem-solving behavioral therapy (individual) compared to usual care for treating minor or major depressive disorder in older adults with dementia

Setting: Referral from University-based geriatric and Alzheimer's disease clinics
Bibliography (systematic reviews): Teri 1997

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**problem-solving behavioral therapy (individual)**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response (follow up: 9 weeks; assessed with: HAMD (those with major depressive disorder no longer meet criteria for major depressive disorder and those with minor depressive disorder no longer meet criteria for minor depressive disorder)); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	13/19 (68.4%)	2/10 (20.0%)	**RR 3.42** (0.95 to 12.26)	484 more per 1000 (from 10 fewer to 1000 more)	⊕◯◯◯ VERY LOW	
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. High dropout, no ITT analysis
2. small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): Linda Lux
Date: 4/22/15
Question: Pleasant events behavioral therapy (individual) compared to usual care for treating minor or major depressive disorder in older adults with dementia

Setting: Referral from University-based geriatric and Alzheimer's disease clinics
Bibliography (systematic reviews): Teri 1997

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	pleasant events behavioral therapy (individual)	usual care	Relative (95% CI)	Absolute (95% CI)		
Functional Capacity												
									not estimable	not estimable		
Response (follow up: 9 weeks; assessed with: HAMD (those with major depressive disorder no longer meet criteria for major depressive disorder and those with minor depressive disorder no longer meet criteria for minor depressive disorder)); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	12/23 (52.2%)	2/10 (20.0%)	**RR 2.61** (0.71 to 9.57)	322 more per 1000 (from 58 fewer to 1000 more)	⊕◯◯◯ VERY LOW	
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. high dropout, no ITT analysis
2. small sample size: study does not meet optimal information size

Author(s): Linda Lux
Date: 4/22/15
Question: A combination of behavioral activation therapy (individual) and usual care compared to usual care for treating depressive symptoms in adults ages 63 and older with mild to moderate cognitive impairment

Setting: In-patient geriatric psychiatry facility
Bibliography (systematic reviews): Snarski 2011

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**a combination of behavioral activation therapy (individual) and usual care**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Remission												
									not estimable	not estimable		
Quality of Life (follow up: 4 weeks; assessed with: Quality of Life Inventory); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1,2]	none	25	25	-	MD **0.67 lower** (8.76 lower to 7.42 higher)	⊕⊕◯◯ LOW	
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. small sample size: study does not meet optimal information size
2. wide confidence interval spanning benefits and harms

Author(s): Linda Lux
Date: 4/22/15
Question: Interpersonal psychotherapy (individual) compared to usual care for treating major depressive disorder in adults ages 55 and older

Setting: Primary care practices

Bibliography (systematic reviews): Van Schaik 2006

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**interpersonal psychotherapy (individual)**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response (follow up: 2 months; assessed with: MADRS >=50% reduction); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	7/69 (10.1%)	6/74 (8.1%)	**RR 1.25** (0.44 to 3.54)	20 more per 1000 (from 45 fewer to 206 more)	⊕◯◯◯ VERY LOW	
Response (follow up: 6 months; assessed with: MADRS >=50% reduction); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	16/69 (23.2%)	18/74 (24.3%)	**RR 0.95** (0.53 to 1.72)	12 fewer per 1000 (from 114 fewer to 175 more)	⊕◯◯◯ VERY LOW	
Remission (follow up: 2 months; assessed with: MADRS <10); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	8/69 (11.6%)	7/74 (9.5%)	**RR 1.23** (0.47 to 3.20)	22 more per 1000 (from 50 fewer to 208 more)	⊕◯◯◯ VERY LOW	
Remission (follow up: 6 months; assessed with: MADRS <10); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	19/69 (27.5%)	20/74 (27.0%)	**RR 1.02** (0.60 to 1.74)	5 more per 1000 (from 108 fewer to 200 more)	⊕◯◯◯ VERY LOW	
Quality of Life (follow up: 6 months; assessed with: Short Form-36 Mental); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	69	74	-	**3 higher** (0.69 lower to 6.69 higher)	⊕◯◯◯ VERY LOW	
Quality of Life (follow up: 6 months; assessed with: Short Form-36 Physical); based on ITT analysis												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**interpersonal psychotherapy (individual)**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**		
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	69	74	-	**2 lower** (6.06 lower to 2.06 higher)	⊕◯◯◯ VERY LOW	
Quality of Life (follow up: 6 months; assessed with: Short Form-36 Social); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	69	74	-	**4.3 higher** (3.99 lower to 12.59 higher)	⊕◯◯◯ VERY LOW	
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Potential for unaddressed cointerventions, unclear blinding of outcome assessment
2. small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): Linda Lux
Date: 4/22/15
Question: Interpersonal psychotherapy (individual) compared to usual care for treating subthreshold depression in adults ages 60 and older
Setting:
Bibliography (systematic reviews): Mossey 1996

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**interpersonal psychotherapy (individual)**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Change in Scores (follow up: 3 months; assessed with: GDS); based on completers analysis; the difference in means within each group at 3 months failed to reach statistical significance [1]												
1	randomized trials	serious [2]	not serious	not serious	very serious [3]	none	31	36	-	**0 higher** (0 higher to 0 higher)	⊕◯◯◯ VERY LOW	
Change in Scores (follow up: 6 months; assessed with: GDS); based on completers analysis; the difference in means within each group at 6 months is significant (p<0.01) [1]												
1	randomized trials	serious [2]	not serious	not serious	very serious [3]	none	31	36	-	**0 higher** (0 higher to 0 higher)	⊕◯◯◯ VERY LOW	
Remission (follow up: 3 months; assessed with: GDS <11)												
1	randomized trials	serious [2]	not serious	not serious	very serious [3]	none	14/31 (45.2%)	15/36 (41.7%)	**RR 1.08** (0.63 to 1.87)	33 more per 1000 (from 154 fewer to 363 more)	⊕◯◯◯ VERY LOW	
Remission (follow up: 6 months; assessed with: GDS <11)												
1	randomized trials	serious [2]	not serious	not serious	very serious [3]	none	19/31 (61.3%)	14/36 (38.9%)	**RR 1.58** (0.96 to 2.59)	226 more per 1000 (from 16 fewer to 618 more)	⊕◯◯◯ VERY LOW	
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	interpersonal psychotherapy (individual)	usual care	Relative (95% CI)	Absolute (95% CI)		
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. study did not provide outcomes data, only statistical significance tests
2. completers analysis
3. small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference/non-significant P values

Author(s): Linda Lux
Date: 4/22/15
Question: Cognitive behavioral therapy (group) compared to wait list for treating major depressive disorder in adults ages 60 and older with anxiety
Setting: University-based emotional health center
Bibliography (systematic reviews): Wuthrich 2013

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive behavioral therapy**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response (follow up: 12 weeks; assessed with: Reliable Change Index); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	20/27 (74.1%)	8/35 (22.9%)	**RR 3.24** (1.69 to 6.20)	512 more per 1000 (from 158 more to 1000 more)	⊕⊕◯◯ LOW	
Remission												
									not estimable	not estimable		
Quality of Life (follow up: 12 weeks; assessed with: Short Form-36); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	27	35	-	MD **4.23 higher** (3.16 higher to 5.3 higher)	⊕⊕◯◯ LOW	
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. small sample size and/or number of events, does not meet optimal information size to detect differences

Author(s): Linda Lux
Date: 4/22/15
Question: A combination of cognitive behavioral therapy (individual) and usual care compared to a combination of talking control (individual) and usual care for treating minor or major depressive disorder in adults ages 65 and older
Setting: Primary care practices and patient homes
Bibliography (systematic reviews): Serfaty 2009

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**a combination of cognitive behavioral therapy (individual) and usual care**	**a combination of talking control (individual) and usual care**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response (follow up: 10 months; assessed with: BDI); number of events by group not reported												
1	randomized trials	not serious	not serious	not serious	serious [1]	none	70	67	-	GEE estimate **3.65 lower** (6.18 lower to 1.12 lower)	⊕⊕⊕◯ MODERATE	
Remission												
									not estimable	not estimable		
Quality of Life (follow up: 10 months; assessed with: EUROQOL); number of events by group not reported												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	70	67	-	GEE estimate **0.04 higher** (0.05 lower to 0.12 higher)	⊕⊕◯◯ LOW	
Quality of Life (follow up: 10 months; assessed with: Social Functioning Questionnaire); number of events by group not reported												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	70	67	-	GEE estimate **1.14 lower** (3.12 lower to 0.84 higher)	⊕⊕◯◯ LOW	
Relapse												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a combination of cognitive behavioral therapy (individual) and usual care	a combination of talking control (individual) and usual care	Relative (95% CI)	Absolute (95% CI)		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. small sample size: study does not meet optimal information size
2. small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Question: Cognitive behavioral therapy (group) compared to wait list for treating for subthreshold depression in adults between 50 and 75 years old
Setting: Primary care center
Bibliography (systematic reviews): Spek 2007

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive behavioral therapy (group)**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response (follow up: 10 weeks; assessed with: Beck Depression Inventory (change from >20 at pre-treatment to <20 at post-treatment)); data limited to a subgroup analysis of patients with a baseline BDI >20												
1	randomized trials	very serious [1]	not serious	not serious	serious [2]	none	28/42 (66.7%)	17/39 (43.6%)	**RR 1.53** (1.01 to 2.32)	231 more per 1000 (from 4 more to 575 more)	⊕◯◯◯ VERY LOW	
Change in Scores (follow up: 10 weeks; assessed with: BDI); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [3]	none	102	100	-	MD **3.03 lower** (5.79 lower to 0.27 higher)	⊕⊕◯◯ LOW	
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. High dropout, no ITT
2. Small sample size and/or number of events, does not meet optimal information size to detect differences
3. Confidence intervals cross appreciable difference

Author(s): Linda Lux
Date: 4/22/15
Question: Cognitive behavioral therapy (internet) compared to wait list for treating for subthreshold depression in adults between 50 and 75 years old

Setting: Primary care center

Bibliography (systematic reviews): Spek 2007

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive behavioral therapy (internet)**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response (follow up: 10 weeks; assessed with: Beck Depression Inventory (change from >20 at pre-treatment to <20 at post-treatment)); data limited to a subgroup analysis of patients with a baseline BDI >20												
1	randomized trials	very serious [1]	not serious	not serious	serious [2]	none	30/45 (66.7%)	17/39 (43.6%)	**RR 1.53** (1.01 to 2.31)	231 more per 1000 (from 4 more to 571 more)	⊕◯◯◯ VERY LOW	
Change in Scores (follow up: 10 weeks; assessed with: BDI); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [3]	none	102	100	-	MD **2.49 lower** (5.06 lower to 0.08 higher)	⊕⊕◯◯ LOW	
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive behavioral therapy (internet)**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**		
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. High drop out rates, no ITT
2. Small sample size and/or number of events, does not meet optimal information size to detect differences
3. Confidence intervals cross appreciable difference

Author(s): Linda Lux
Date: 4/22/15
Question: Cognitive, behavioral, or brief psychodynamic therapy (group) compared to wait list for treating major depressive disorder in adults ages 60 and older

Setting: Referral to research center
Bibliography (systematic reviews): Thompson 1987

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive, behavioral, or brief psychodynamic therapy (group)**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Change in Scores (follow up: 6 weeks; assessed with: HAMD); based on completers analysis; data from intervention arms combined												
1	randomized trials	very serious [1,2]	not serious	not serious	serious [3]	none	76	19	-	MD **3.74 lower** (6.05 lower to 1.43 lower)	⨁◯◯◯ VERY LOW	
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Flawed randomization process
2. completers analysis with high dropout rate
3. small sample size and/or number of events, does not meet optimal information size to detect differences

Author(s): Linda Lux
Date: 4/22/15
Question: Problem-solving therapy (group) compared to wait list for treating major depressive disorder in adults ages 55 and older

Setting: University-sponsored depression program, specific setting not reported
Bibliography (systematic reviews): Arean 1993

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**problem-solving therapy (group)**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem orientation)); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	19	20	-	MD **0.6 higher** (15.06 lower to 16.26 higher)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem definition and formulation)); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	19	20	-	MD **3.5 higher** (0.86 lower to 7.86 higher)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (generation of alternative solutions)); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	19	20	-	MD **4 higher** (0.9 lower to 8.9 higher)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (decision-making)); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	19	20	-	MD **2.9 higher** (1.75 lower to 7.55 higher)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 12 weeks; assessed with: : Social Problem-solving Inventory (solution implementation and verification)); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	19	20	-	MD **2.6 higher** (2.59 lower to 7.79 higher)	⊕◯◯◯ VERY LOW	
Response (follow up: 12 weeks; assessed with: No longer fulfill diagnostic criteria for MDD); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [3]	Strong association	17/28 (60.7%)	2/20 (10.0%)	**RR 6.07** (1.58 to 23.38)	507 more per 1000 (from 58 more to 1000 more)	⊕⊕⊕◯ MODERATE	
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	problem-solving therapy (group)	wait list	Relative (95% CI)	Absolute (95% CI)		
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. High differential attrition, completers analysis
2. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference
3. Small sample size and/or number of events, does not meet optimal information size to detect differences

Author(s): Linda Lux
Date: 4/22/15
Question: Problem-solving therapy (in-person) compared to attention control (phone call) for treating dysthymia or major depressive disorder adults aged 50 years or older
Setting: Patient homes
Bibliography (systematic reviews): Choi 2013

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**problem-solving therapy (in-person)**	**attention control (phone call)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	42	36	-	MD **0.3 lower** (8.02 lower to 7.42 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	42	36	-	MD **2.41 higher** (8.12 lower to 12.94 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	42	36	-	MD **0.56 higher** (4.6 lower to 5.72 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	42	36	-	MD **0.58 higher** (6.19 lower to 7.35 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	42	36	-	MD **0.85 lower** (5.4 lower to 3.7 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	42	36	-	MD **2.88 higher** (2.3 lower to 8.06 higher)	⊕⊕◯◯ LOW	
Response (follow up: 12 weeks; assessed with: HAMD (50% or greater reduction)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	14/42 (33.3%)	8/36 (22.2%)	**RR 1.50** (0.71 to 3.16)	111 more per 1000 (from 64 fewer to 480 more)	⊕⊕◯◯ LOW	
Remission												
									not estimable	not estimable		
Quality of Life												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**problem-solving therapy (in-person)**	**attention control (phone call)**	**Relative (95% CI)**	**Absolute (95% CI)**		
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): Linda Lux
Date: 4/22/15
Question: Problem-solving therapy (video call) compared to attention control (phone call) for treating dysthymia or major depressive disorder adults aged 50 years or older
Setting: Patient homes
Bibliography (systematic reviews): Choi 2013

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**problem-solving therapy (video call)**	**attention control (phone call)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	43	36	-	MD **0.99 lower** (9.44 lower to 7.46 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	43	36	-	MD **0.82 lower** (11.38 lower to 9.74 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	43	36	-	MD **0.38 higher** (5.12 lower to 5.88 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	43	36	-	MD **1.51 lower** (8.36 lower to 5.34 higher)	⊕⊕◯◯ LOW	
Functional Capcity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	43	36	-	MD **1.37 lower** (6.18 lower to 3.44 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	43	36	-	MD **1.74 higher** (3.53 lower to 7.01 higher)	⊕⊕◯◯ LOW	
Response (follow up: 12 weeks; assessed with: HAMD (50% or greater reduction)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	16/43 (37.2%)	8/36 (22.2%)	**RR 1.67** (0.81 to 3.45)	149 more per 1000 (from 42 fewer to 544 more)	⊕⊕◯◯ LOW	
Remission												
									not estimable	not estimable		

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	problem-solving therapy (video call)	attention control (phone call)	Relative (95% CI)	Absolute (95% CI)		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): Linda Lux
Date: 4/22/15
Question: Problem-solving behavioral therapy (individual) compared to wait list for treating minor or major depressive disorder in older adults with dementia
Setting: Referral from University-based geriatric and Alzheimer's disease clinics
Bibliography (systematic reviews): Teri 1997

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**problem-solving behavioral therapy (individual)**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response (follow up: 9 weeks; assessed with: HAMD (those with major depressive disorder no longer meet criteria for major depressive disorder and those with minor depressive disorder no longer meet criteria for minor depressive disorder))												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	13/19 (68.4%)	4/20 (20.0%)	**RR 3.42** (1.35 to 8.66)	484 more per 1000 (from 70 more to 1000 more)	⊕◯◯◯ VERY LOW	
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. high dropout, unclear whether ITT done
2. Small sample size and/or number of events, does not meet optimal information size to detect differences

Author(s): Linda Lux
Date: 4/22/15
Question: Pleasant events behavioral therapy (individual) compared to wait list for treating minor or major depressive disorder in older adults with dementia
Setting: Referral from University-based geriatric and Alzheimer's disease clinics
Bibliography (systematic reviews): Teri 1997

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**pleasant events behavioral therapy (individual)**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response (follow up: 9 weeks; assessed with: HAMD (those with major depressive disorder no longer meet criteria for major depressive disorder and those with minor depressive disorder no longer meet criteria for minor depressive disorder)); based on completers analysis; 18% dropout												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	12/23 (52.2%)	4/20 (20.0%)	**RR 2.61** (1.00 to 6.81)	322 more per 1000 (from 0 fewer to 1000 more)	⨁◯◯◯ VERY LOW	
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. High dropout rate, unclear whether ITT done
2. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): Linda Lux
Date: 4/22/15
Question: Interpersonal psychotherapy (individual) compared to placebo for treating major depressive disorder in older adults
Setting:
Bibliography (systematic reviews): Sloane 1985

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**interpersonal psychotherapy (individual)**	**placebo**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Change in Scores (follow up: 6 weeks; assessed with: HAMD); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	19	14	-	MD **5.2 lower** (9.6 lower to 0.8 lower)	⨁◯◯◯ VERY LOW	
Remission												
									not estimable	not estimable		
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. high differential attrition not accounted for, completers analysis
2. small sample size and/or number of events, does not meet optimal information size to detect differences

Author(s): Linda Lux
Date: 4/22/15
Question: A combination of interpersonal psychotherapy (individual) and nortriptyline compared to a combination of placebo and medication clinic attendance for treating major depressive disorder in adults ages 50 and older

Setting: University-based psychiatric clinic
Bibliography (systematic reviews): Reynolds 1999

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**a combination of interpersonal psychotherapy (individual) and nortriptyline**	**a combination of placebo and medication clinic attendance**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Remission (follow up: 8 weeks; assessed with: HAMD <= 7 for 3 consecutive weeks); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	11/16 (68.8%)	10/22 (45.5%)	**RR 1.51** (0.86 to 2.66)	232 more per 1000 (from 64 fewer to 755 more)	⊕⊕◯◯ LOW	
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): Linda Lux
Date: 4/22/15
Question: A combination of interpersonal psychotherapy (individual) and placebo compared to a combination of placebo and medication clinic attendance for treating major depressive disorder in adults ages 50 and older
Setting: University-based psychiatric clinic
Bibliography (systematic reviews): Reynolds 1999

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a combination of interpersonal psychotherapy (individual) and placebo	a combination of placebo and medication clinic attendance	Relative (95% CI)	Absolute (95% CI)		
Functional Capacity												
									not estimable	not estimable		
Response												
									not estimable	not estimable		
Remission (follow up: 8 weeks; assessed with: HAMD <= 7 for 3 consecutive weeks); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	10/22 (45.5%)	5/17 (29.4%)	**RR 0.65** (0.27 to 1.54)	103 fewer per 1000 (from 159 more to 215 fewer)	⊕⊕◯◯ LOW	
Quality of Life												
									not estimable	not estimable		
Patient Satisfaction												
									not estimable	not estimable		
Relapse												
									not estimable	not estimable		
Suicidality												
									not estimable	not estimable		
Adverse Events												
									not estimable	not estimable		

MD – mean difference, RR – relative risk

1. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): MV
Date: 5/29/15
Question: Multicomponent intervention (individual) compared to wait list for treating symptoms of depression in temporarily homebound African-American adults ages 55 and older
Setting: Home-based
Bibliography: Gitlin, 2013

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**multicomponent intervention (individual)**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity (follow up: 4 months; assessed with: 18 item-questionnaire over past month, response ranging from 1 [no difficulty] to 5 [unable to perform]); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	106	102	-	MD **0.1 fewer** (0.27 fewer to 0.07 more)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 8 months; assessed with: 18 item-questionnaire over past month, response ranging from 1 [no difficulty] to 5 [unable to perform]); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	106	102	-	MD **0.2 more** (0.08 fewer to 0.48 more)	⊕⊕◯◯ LOW	
Response (follow up: 4 months; assessed with: PHQ-9 (>=5 point reduction)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	serious [2]	none	57/106 (53.8%)	38/102 (37.3%)	**RR 1.44** (1.06 to 1.96)	164 more per 1000 (from 22 more to 358 more)	⊕⊕⊕◯ MODERATE	
Response (follow up: 4 months; assessed with: PHQ-9 (moved to lower symptom category)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	68/106 (64.2%)	58/102 (56.9%)	**RR 1.13** (0.90 to 1.41)	74 more per 1000 (from 57 fewer to 233 more)	⊕⊕◯◯ LOW	
Remission (follow up: 4 months; assessed with: PHQ-9 (<=4, time period without symptoms not specified)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	39/106 (36.8%)	25/102 (24.5%)	**RR 1.50** (0.98 to 2.29)	123 more per 1000 (from 5 fewer to 316 more)	⊕⊕◯◯ LOW	
Remission (follow up: 4 months; assessed with: CES-D (<=7, time period without symptoms not specified)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	serious [2]	none	46/106 (43.4%)	24/102 (23.5%)	**RR 1.84** (1.22 to 2.78)	198 more per 1000 (from 52 more to 419 more)	⊕⊕⊕◯ MODERATE	
Quality of Life (follow up: 4 months; assessed with: 12 items of the Quality of Life in Alzheimer's Disease scale with 1 item, "relationship with caregiver," eliminated); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	serious [2]	none	106	102	-	MD **2.5 more** (1.11 more to 3.89 more)	⊕⊕⊕◯ MODERATE	

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**multicomponent intervention (individual)**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**		
Quality of Life (follow up: 8 months; assessed with: 12 items of the Quality of Life in Alzheimer's Disease scale with 1 item, "relationship with caregiver," eliminated); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	106	102	-	MD **0.9 more** (0.76 fewer to 2.56 more)	⊕⊕◯◯ LOW	
Patient Satisfaction												
Relapse												
Recurrence												
Suicidality												
Adverse Events												

MD – mean difference, RR – relative risk

1. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference
2. Small sample size and/or number of events, does not meet optimal information size to detect differences

Author(s): MV
Date: 5/29/15
Question: Life review therapy (individual) compared to usual care for treating subclinical depression in adults ages 65 and older
Setting:
Bibliography: Serrano 2004

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	life review therapy (individual)	usual care	Relative (95% CI)	Absolute (95% CI)		
Functional Capacity												
Response												
Remission												
Quality of Life (follow up: 8 weeks; assessed with: Life Satisfaction Index); based on completers analysis												
1	randomized trials	serious [1]	not serious	not serious	serious [2]	none	20	23	-	MD **5.46 more** (1.2 more to 9.72 more)	⊕⊕◯◯ LOW	
Patient Satisfaction												
Relapse												
Recurrence												
Suicidality (follow up: 8 weeks; assessed with: Beck Hopelessness Scale); based on completers analysis												
1	randomized trials	serious [1]	not serious	not serious	serious [2]	none	20	23	-	MD **4.71 fewer** (7.08 fewer to 2.34 fewer)	⊕⊕◯◯ LOW	
Adverse Events												

MD – mean difference, RR – relative risk

1. Completers analysis
2. Small sample size and/or number of events, does not meet optimal information size to detect differences

Author(s): MV
Date: 5/29/15
Question: Life review therapy (group) compared to usual care for moderate depressive symptoms in adults ages 55 and older
Setting: Urban and rural mental health care service sites
Bibliography: Korte 2012

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**life review therapy (group)**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
Response (follow up: 3 months; assessed with: CES-D (>=5 point reduction while crossing cut-off value of 16 for clinically relevant depressive symptoms)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	serious [1]	none	31/100 (31.0%)	12/102 (11.8%)	**RR 2.635** (1.440 to 4.830)	192 more per 1000 (from 52 more to 451 more)	⊕⊕⊕◯ MODERATE	
Remission												
Quality of Life (follow up: 3 months; assessed with: EuroQol-5D); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	100	102	-	MD **0.03 more** (0.03 fewer to 0.09 more)	⊕⊕◯◯ LOW	
Quality of Life (follow up: 6 months; assessed with: EuroQol-5D); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [2]	none	100	102	-	MD **0.01 more** (0.03 fewer to 0.05 more)	⊕⊕◯◯ LOW	
Patient Satisfaction												
Relapse												
Recurrence												
Suicidality												
Adverse Events												

MD – mean difference, RR – relative risk

1. Small sample size and/or number of events, does not meet optimal information size to detect differences
2. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): MV
Date: 5/29/15
Question: Life review therapy (individual) compared to supportive therapy (individual) for treating major depressive disorder in adults ages 64 and older receiving pharmacotherapy to treat depression
Setting:
Bibliography: Serrano 2012

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**life review therapy (individual)**	**supportive therapy (individual)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
Response												
Remission												
Quality of Life (follow up: 10 weeks; assessed with: Quality of Life in Depression Scale); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	9	8	-	MD **0.3 more** (8.45 fewer to 9.05 more)	⊕◯◯◯ VERY LOW	
Quality of Life (follow up: 7 months; assessed with: Quality of Life in Depression Scale); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	9	8	-	MD **2.2 fewer** (10.74 fewer to 6.34 more)	⊕◯◯◯ VERY LOW	
Patient Satisfaction												
Relapse												
Recurrence												
Suicidality (follow up: 10 weeks; assessed with: Beck Hopelessness Scale); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	9	8	-	MD **2.1 more** (3.61 fewer to 7.81 more)	⊕◯◯◯ VERY LOW	
Suicidality (follow up: 7 months; assessed with: Beck Hopelessness Scale); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	9	8	-	MD **0.2 more** (5.13 fewer to 5.53 more)	⊕◯◯◯ VERY LOW	
Adverse Events												

MD – mean difference, RR – relative risk

1. High attrition, completers analysis
2. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): LL
Date: 5/29/15
Question: Reminiscence therapy (group) compared to wait list for treating major depressive disorder in adults ages 55 and older
Setting: University-sponsored depression program, specific setting not reported
Bibliography: Arean 1993

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	reminiscence therapy (group)	wait list	Relative (95% CI)	Absolute (95% CI)		
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem orientation)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	28	20	-	MD **9.8 fewer** (23.15 fewer to 3.55 more)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem definition and formulation)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	28	20	-	MD **1.1 more** (3.6 fewer to 5.8 more)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (generation of alternative solutions)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	28	20	-	MD **2.4 more** (2.58 fewer to 7.38 more)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (decision-making)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	28	20	-	MD **0.02 fewer** (4.56 fewer to 4.16 more)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (solution implementation and verification)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	28	20	-	MD **0.3 fewer** (4.86 fewer to 4.26 more)	⊕◯◯◯ VERY LOW	
Response (follow up: 12 weeks; assessed with: no longer fulfill diagnostic criteria for MDD); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	8/27 (29.6%)	2/20 (10.0%)	**RR 2.96** (0.70 to 12.48)	196 more per 1000 (from 30 fewer to 1000 more)	⊕◯◯◯ VERY LOW	
Remission												
Quality of Life												
Patient Satisfaction												
Relapse												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	reminiscence therapy (group)	wait list	Relative (95% CI)	Absolute (95% CI)		
Recurrence												
Suicidality												
Adverse Events												

MD – mean difference, RR – relative risk

1. Potential for error from errors in reporting number randomized to Reminiscence Therapy (n=27) vs. number completed (n=28)
2. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): MV
Date: 5/29/15
Question: Life review course (group) compared to educational video for treating subclinical depression in older adults ages 51 and older
Setting:
Bibliography: Pott, 2012

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**life review course (group)**	**educational video**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity (follow up: 3 months; assessed with: Reminiscence Function Scale: Boredom reduction); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	83	88	-	MD **0.82 lower** (2.35 lower to 0.71 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 9 months; assessed with: Reminiscence Function Scale: Boredom reduction); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	83	88	-	MD **0.31 lower** (1.81 lower to 1.19 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 3 months; assessed with: Reminiscence Function Scale: Bitterness revival); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	83	88	-	MD **0.2 lower** (1.65 lower to 1.25 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 9 months; assessed with: Reminiscence Function Scale: Bitterness revival); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	83	88	-	MD **0.49 lower** (1.96 lower to 0.98 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 3 months; assessed with: Reminiscence Function Scale: Identity); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	83	88	-	MD **0.57 higher** (1.03 lower to 2.17 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 9 months; assessed with: Reminiscence Function Scale: Identity); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	83	88	-	MD **0.24 lower** (1.82 lower to 1.34 higher)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 3 months; assessed with: Reminiscence Function Scale: Problem solving); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	83	88	-	MD **1.04 more** (0.29 fewer to 2.37 more)	⊕⊕◯◯ LOW	
Functional Capacity (follow up: 9 months; assessed with: Reminiscence Function Scale: Problem solving); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	83	88	-	MD **0.57 more** (0.83 fewer to 1.97 more)	⊕⊕◯◯ LOW	
Response												

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	life review course (group)	educational video	Relative (95% CI)	Absolute (95% CI)		
Remission												
Quality of Life (follow up: 9 months; assessed with: EuroQol-5D); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	83	88	-	MD **0.02 more** (0.3 fewer to 0.07 more)	⊕⊕◯◯ LOW	
Quality of Life (follow up: 3 months; assessed with: EuroQol-5D); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	83	88	-	MD **0** (0.05 fewer to 0.05 more)	⊕⊕◯◯ LOW	
Patient Satisfaction												

MD – mean difference, RR – relative risk

1. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): MV
Date: 5/29/15
Question: A combination of in-person life review (individual) and computer supplements compared to wait list for treating subsyndromal to moderate depression in adults ages 65 and older
Setting:
Bibliography: Preschl 2012

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	a combination of in-person life review (individual) and computer supplements	wait list	Relative (95% CI)	Absolute (95% CI)		
Functional Capacity												
Response												
Remission												
Quality of Life (follow up: 6 weeks; assessed with: Life Satisfaction Index); based on completers analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	20	16	-	MD **1 fewer** (3.36 fewer to 1.36 more)	⊕◯◯◯ VERY LOW	
Quality of Life (follow up: 6 weeks; assessed with: WHO-5); based on completers analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	20	16	-	MD **1.4 more** (2.1 fewer to 4.9 more)	⊕◯◯◯ VERY LOW	
Patient Satisfaction												
Relapse												
Recurrence												
Suicidality												

MD – mean difference, RR – relative risk

1. Completers analysis
2. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): MV
Date: 5/29/15
Question: Cognitive bibliotherapy (self-guided) compared to behavioral bibliotherapy (self-guided) for treating mild to moderate depression in adults ages 60 and older
Setting:
Bibliography: Scogin 1989

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive bibliotherapy (self-guided)**	**behavioral bibliotherapy (self-guided)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity (follow up: 4 weeks; assessed with: Dysfunctional Attitudes Scale); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	21	19	-	MD **4.3 fewer** (19.76 fewer to 11.16 more)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 6 months; assessed with: Dysfunctional Attitudes Scale); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	15	14	-	MD **14.5 fewer** (29.12 fewer to 0.12 more)	⊕◯◯◯ VERY LOW	
Response												
Remission												
Quality of Life												
Patient Satisfaction												
Relapse												
Recurrence												
Suicidality												
Adverse Events												

MD – mean difference, RR – relative risk

1. High attrition; completers analysis
2. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): MV
Date: 5/29/15
Question: Cognitive bibliotherapy (self-guided) compared to attention control (self-guided) for treating mild to moderate depression in adults ages 60 and older
Setting:
Bibliography: Scogin 1987

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive bibliotherapy (self-guided)**	**attention control (self-guided)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity (follow up: 8 weeks; assessed with: Cognitive Error Questionnaire); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	8	6	-	MD **8.1 fewer** (27.39 fewer to 11.19 more)	⊕◯◯◯ VERY LOW	
Response												
Remission												
Quality of Life												
Patient Satisfaction												
Relapse												
Recurrence												
Suicidality												
Adverse Events												

MD – mean difference, RR – relative risk

1. potential for failure of randomization and imbalance through inclusion of third arm midway through analysis; completers analysis
2. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): MV
Date: 5/29/15
Question: Behavioral bibliotherapy (self-guided) compared to usual care for treating subthreshold depression in adults ages 75 and older
Setting:
Bibliography: Joling 2011

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**behavioral bibliotherapy (self-guided)**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
Response (follow up: 3 months; assessed with: CES-D (>=5 point reduction)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	40/86 (46.5%)	37/84 (44.0%)	**RR 1.06** (-36.93 to 39.04)	26 more per 1000 (from 1000 fewer to 1000 more)	⊕⊕◯◯ LOW	
Response (follow up: 3 months; assessed with: CES-D (>=5 point reduction while crossing cut-off value of 16 for clinically relevant depressive symptoms)); based on ITT analysis												
1	randomized trials	not serious	not serious	not serious	very serious [1]	none	31/86 (36.0%)	25/84 (29.8%)	**RR 1.21** (0.79 to 1.87)	62 more per 1000 (from 62 fewer to 259 more)	⊕⊕◯◯ LOW	
Remission												
Quality of Life												
Patient Satisfaction												
Relapse												
Recurrence												
Suicidality												
Adverse Events												

MD – mean difference, RR – relative risk

1. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): MV
Date: 5/29/15
Question: Cognitive bibliotherapy (self-guided) compared to wait list for treating mild to moderate depression in adults ages 60 and older
Setting:
Bibliography: Scogin 1989; Scogin 1987

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive bibliotherapy (self-guided)**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity (follow up: 4 weeks; assessed with: Dysfunctional Attitudes Scale); Scogin 1989; based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	21	21	-	MD **0.4 fewer** (14.16 fewer to 13.36 more)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 4 weeks; assessed with: Cognitive Error Questionnaire); Scogin 1987; based on completers analysis												
1	randomized trials	very serious [3]	not serious	not serious	serious [4]	none	9	8	-	MD **29.1 fewer** (55.01 fewer to 3.19 fewer)	⊕◯◯◯ VERY LOW	
Response												
Remission												
Quality of Life												
Patient Satisfaction												
Relapse												
Recurrence												
Suicidality												
Adverse Events												

MD – mean difference, RR – relative risk

1. high attrition rate; completers analysis
2. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference
3. potential for failure of randomization and imbalance through inclusion of third arm midway through analysis; completers analysis
4. Small sample size and/or number of events, does not meet optimal information size to detect differences

Author(s): MV
Date: 5/29/15
Question: Cognitive bibliotherapy (self-guided) compared to wait list for treating minor or major depressive disorder in adults ages 55 and older with disability
Setting:
Bibliography: Landreville 1997

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	cognitive bibliotherapy (self-guided)	wait list	Relative (95% CI)	Absolute (95% CI)		
Functional Capacity (follow up: 4 weeks; assessed with: Functional Autonomy Measurement System: Functional competence); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	serious [2]	none	10	13	-	MD **1.89 more** (0.43 more to 3.35 more)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 4 weeks; assessed with: Functional Autonomy Measurement System: Functional performance); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [3]	none	10	13	-	MD **1.84 more** (0.17 fewer to 3.85 more)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 4 weeks; assessed with: Functional Autonomy Measurement System: Functional dependence); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [3]	none	10	13	-	MD **3.76 fewer** (8.92 fewer to 1.4 more)	⊕◯◯◯ VERY LOW	
Functional Capacity (follow up: 4 weeks; assessed with: Functional Autonomy Measurement System: Excess disability); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [3]	none	10	13	-	MD **0.05 fewer** (1.26 fewer to 1.16 more)	⊕◯◯◯ VERY LOW	
Response (follow up: 4 weeks; assessed with: Beck Depression Inventory (reliable change and score reduced to <=11)); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [3]	none	4/10 (40.0%)	3/13 (23.1%)	**RR 1.73** (0.50 to 6.05)	168 more per 1000 (from 115 fewer to 1000 more)	⊕◯◯◯ VERY LOW	
Response (follow up: 4 weeks; assessed with: Geriatric Depression Scale (reliable change and score reduced to <=10)); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [3]	none	1/10 (10.0%)	1/13 (7.7%)	**RR 1.30** (0.09 to 18.33)	23 more per 1000 (from 70 fewer to 1000 more)	⊕◯◯◯ VERY LOW	
Response (follow up: 4 weeks; assessed with: DSM-III (no longer meet criteria for major depression) and DSM-IV (no longer met criteria for minor depression)); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [3]	none	7/10 (70.0%)	7/13 (53.8%)	**RR 1.30** (0.68 to 2.48)	162 more per 1000 (from 172	⊕◯◯◯ VERY LOW	

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**cognitive bibliotherapy (self-guided)**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**		
										fewer to 797 more)		
Remission												
Quality of Life												
Patient Satisfaction												
Relapse												
Recurrence												
Suicidality												

MD – mean difference, RR – relative risk

1. High attrition; completers analysis
2. Small sample size and/or number of events, does not meet optimal information size to detect differences
3. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): MV
Date: 5/29/15
Question: Behavioral bibliotherapy (self-guided) compared to wait list for treating mild to moderate depression in adults ages 60 and older

Setting:

Bibliography: Scogin 1989

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**behavioral bibliotherapy (self-guided)**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity (follow up: 4 weeks; assessed with: Dysfunctional Attitudes Scale); based on completers analysis												
1	randomized trials	very serious [1]	not serious	not serious	very serious [2]	none	19	21	-	MD **3.9 more** (9.49 fewer to 17.29 more)		
Response												
Remission												
Quality of Life												
Patient Satisfaction												
Relapse												
Recurrence												
Suicidality												
Adverse Events												

MD – mean difference, RR – relative risk

1. High attrition; completers analysis
2. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): MV

Date: 5/29/15

Question: Coping improvement (group) compared to interpersonal support (group) for treating mild to severe depressive symptoms in adults ages 50 and older with HIV

Setting: Community setting (AIDS service organization or local community health center)
Bibliography: Heckman 2011

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**coping improvement (group)**	**interpersonal support (group)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
Response (follow up: 4 months; assessed with: GDS (≥50% reduction)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	19/104 (18.3%)	15/105 (14.3%)	**RR 1.28** (0.69 to 2.38)	40 more per 1000 (from 44 fewer to 197 more)	⊕◯◯◯ VERY LOW	
Response (follow up: 8 months; assessed with: GDS (≥50% reduction)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	21/104 (20.2%)	28/105 (26.7%)	**RR 0.76** (0.46 to 1.24)	64 fewer per 1000 (from 64 more to 144 fewer)	⊕◯◯◯ VERY LOW	
Remission												
Quality of Life												
Patient Satisfaction												
Relapse												
Recurrence												
Suicidality												
Adverse Events												

MD – mean difference, RR – relative risk

1. Risk of bias from failure to conceal allocation from study coordinator
2. 2. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): MV
Date: 5/29/15
Question: Coping improvement (group) compared to therapy upon request (individual) for treating mild to severe depressive symptoms in adults ages 50 and older with HIV

Setting: community setting (AIDS service organization or local community health center)
Bibliography: Heckman 2011

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**coping improvement (group)**	**therapy upon request (individual)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
Response (follow up: 4 months; assessed with: GDS (≥50% reduction)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	serious [2]	none	19/104 (18.3%)	7/86 (8.1%)	**RR 2.24** (0.99 to 5.09)	101 more per 1000 (from 1 fewer to 333 more)	⊕⊕◯◯ LOW	
Response (follow up: 8 months; assessed with: GDS (≥50% reduction)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [3]	none	21/104 (20.2%)	14/86 (16.3%)	**RR 1.24** (0.67 to 2.29)	39 more per 1000 (from 54 fewer to 210 more)	⊕◯◯◯ VERY LOW	
Remission												
Quality of Life												
Patient Satisfaction												
Relapse												
Recurrence												
Suicidality												
Adverse Events												

MD – mean difference, RR – relative risk

1. risk of bias from failure to conceal allocation from study coordinator
2. 2. Small sample size and/or number of events, does not meet optimal information size to detect differences
3. 2. Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Author(s): MV
Date: 5/29/15
Question: Interpersonal support (group) compared to therapy upon request (individual) for treating mild to severe depressive symptoms in adults ages 50 and older with HIV

Setting: community setting (AIDS service organization or local community health center)
Bibliography: Heckman 2011

Quality assessment							№ of patients		Effect		Quality	Importance
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**interpersonal support (group)**	**therapy upon request (individual)**	**Relative (95% CI)**	**Absolute (95% CI)**		
Functional Capacity												
Response (follow up: 4 months; assessed with: GDS (≥50% reduction)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	15/105 (14.3%)	7/86 (8.1%)	**RR 1.76** (0.75 to 4.11)	62 more per 1000 (from 20 fewer to 253 more)	⊕◯◯◯ VERY LOW	
Response (follow up: 8 months; assessed with: GDS (≥50% reduction)); based on ITT analysis												
1	randomized trials	serious [1]	not serious	not serious	very serious [2]	none	28/105 (26.7%)	14/86 (16.3%)	**RR 1.64** (0.92 to 2.91)	104 more per 1000 (from 13 fewer to 311 more)	⊕◯◯◯ VERY LOW	
Remission												
Quality of Life												
Patient Satisfaction												
Relapse												
Recurrence												
Suicidality												
Adverse Events												

MD – mean difference, RR – relative risk

1. Risk of bias from failure to conceal allocation from study coordinator
2. Wide CIs spanning both benefits and harms

Appendix C
Decision Tables

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 2- Comparative Effectiveness of Problem-solving Behavioral Therapy (individual) vs. Pleasant Events Behavioral Therapy (individual) for treating minor or major depressive disorder in older adults with dementia
[Treatment 1: Problem-solving Behavioral Therapy (individual);
Treatment 2: Pleasant Events Behavioral Therapy (individual)]

Factor	Explanation/Comments
I. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
II. Treatment Outcomes/Consequences	
• **Benefits** of Treatment 1 and/or Treatment 2	
• **Harms** of Treatment 1 and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
III. Patient Values and Preferences	

IV. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 2- Comparative Effectiveness of Problem-solving Behavioral Therapy (individual) vs. Pleasant Events Behavioral Therapy (individual) for treating minor or major depressive disorder in older adults with dementia

Question: Problem-solving behavioral therapy (individual) compared to pleasant events behavioral therapy (individual) for treating minor or major depressive disorder in older adults with dementia [note that caregivers were involved in both treatments]

[Treatment 1: Problem-solving Behavioral Therapy (individual); Treatment 2: Pleasant Events Behavioral Therapy (individual)]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Response (follow up: 9 weeks)			X	
Outcomes for which no estimable information was found: functional capacity, remission, quality of life, patient satisfaction, relapse, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: Problem-solving Behavioral Therapy (individual); Treatment 2: Pleasant Events Behavioral Therapy (individual)]

Bibliography (systematic reviews): Teri et al., 1997

		№ of patients		Effect		Quality
№ of studies		**problem-solving behavioral therapy (individual)**	**pleasant events behavioral therapy (individual)**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response (follow up: 9 weeks; assessed with: HAMD (those with major depressive disorder no longer meet criteria and those with minor depressive disorder no longer meet criteria)); based on completers analysis						
1	See footnote #1	13/19 (68.4%)	12/23 (52.2%)	RR 1.31 (0.80 to 2.15)	162 more per 1000 (from 104 fewer to 600 more)	⊕⊕◯◯ LOW
Remission						
				not estimable	not estimable	
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- Very few events; confidence intervals cross appreciable difference

Number needed to treat (NNT) (95% Confidence Interval)

Response (follow up: 9 weeks; assessed with: HAMD (those with major depressive disorder no longer meet criteria and those with minor depressive disorder no longer meet criteria)): NNT = 6 (NNT(harm) 8 to ∞ to NNT(benefit) 2)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Problem-solving Behavioral Therapy (individual); Treatment 2: Pleasant Events Behavioral Therapy (individual)]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Response			X*			o

*No statistical difference. The study was not designed to be able to determine equivalence. Rather study not sufficiently powered to provide meaningful information.

	Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2: No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Teri et al., 1997

- **Dropout**:
  - 18% (16 of 88) of total sample but does not provide breakdown by treatment condition
- **Sx worsening**:
  - No individuals in either treatment condition (pleasant events or problem solving) worsened
  - 20% of typical care control and 5% of waitlist worsened

Note any other information on burdens from published studies:

Teri et al., 1997

- **Burden**:
  - Homework in both behavioral conditions (i.e., pleasant events & problem solving)
  - Treatment conditions required an "*involved, cognitively intact provider to help organize their [participants] days and activities*"

Note any additional information on harms:

-none to add

Note any additional information on burdens:

-none to add

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"
[Treatment 1: Problem-solving Behavioral Therapy (individual); Treatment 2: Pleasant Events Behavioral Therapy (individual)]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
2. Adverse events leading to withdrawals	o	o	o	o	o	X
3. Other serious adverse events	o	o	o	o	o	X
4. Other adverse events	o	o	o	o	o	X
5. Burdens	o	o	X	o	o	

Assign an overall global rating across outcomes:

☐ Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
X Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

III) Patient Values and Preferences *What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?* *How variable are these?* *How certain is the panel about these?* **Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*	**<u>Patient values and preferences based on:</u>** *Information from research studies:* -"if can engage families, patients more likely to remain engaged and involved" (Reynolds' studies) *Information from community members on panel:* -"caregivers like to be involved" *Information from clinicians on panel:* -"caregivers like to be involved" -"varies whether patient wants caregiver involved" -"relevance of culture for family involvement" (may be important for individuals from some cultures) *Information from other sources (also list sources):*

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High		High
X*	Moderate	X*	Moderate
	Low		Low
	Unknown		Unknown

*treatment involves both patient and caregiver due to both being involved in care

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

X Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Moderate variability and moderate certainty for pt values and preferences considering that treatment involves both patient and caregiver.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	No demographic information on race/ethnicity. Caregivers are also target clients.
Interventions	Problem solving condition predominantly female.
Comparators	Treatment 2 condition half male half female.
Outcomes	
Timing or Time frame	
Settings	

Notes/Comments:

Teri et al., 1997

p. 160

	“ *Procedures.* — Patients with dementia and their caregivers were recruited from referrals from the University of Washington Medical Center (UWMC) Geriatric & Family Services Clinic and the UWMC Alzheimer's Disease Research Center. To be eligible for study inclusion, all patient-subjects had to meet NINCDS-ADRDA criteria for probable AD (McKhann et al., 1984), have at least a 6-month history of cognitive problems, and live with their caregivers in the community. They also had to meet Research Diagnostic Criteria (RDC) and *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R) criteria for major or minor depressive disorder (not including the exclusionary criteria for dementia) and have a Hamilton Depression Rating Scale score of at least 10. ”

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

[Treatment 1: Problem-solving Behavioral Therapy (individual); Treatment 2: Pleasant Events Behavioral Therapy (individual)]

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*

		Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We recommend using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
	X	Recommendation for Either Treatment. **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
		No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:

We recommend using either treatment 1 or treatment 2 when both are being considered.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

No evidence of differential efficacy between these two interventions for reducing depressive symptoms for depression response on HAM-D in patient and caregiver populations.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 3- Comparative Effectiveness of Cognitive Behavioral Therapy (group) vs. Cognitive Behavioral Therapy (internet) for subthreshold depression in adults between 50 and 75 years old
[Treatment 1: Cognitive Behavioral Therapy (group); Treatment 2: Cognitive Behavioral Therapy (internet)]

Factor	Explanation/Comments
V. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
VI. Treatment Outcomes/Consequences	
• **Benefits** of Treatment 1 and/or Treatment 2	
• **Harms** of Treatment 1 and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
VII. Patient Values and Preferences	
VIII. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 3- Comparative Effectiveness of Cognitive Behavioral Therapy (group) vs. Cognitive Behavioral Therapy (internet) for subthreshold depression in adults between 50 and 75 years old

Question: Cognitive behavioral therapy (group) compared to cognitive behavioral therapy (internet) for subthreshold depression in adults between 50 and 75 years old

[Treatment 1: Cognitive Behavioral Therapy (group); Treatment 2: Cognitive Behavioral Therapy (internet)]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Response (follow up: 10 weeks)				X
Change in BDI scores (follow up: mean 10 weeks)			X	
Outcomes for which no estimable information was found: functional capacity, remission, quality of life, patient satisfaction, relapse, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because the evidence quality for response is very low and serious adverse events are not reported and those are critical outcomes, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: Cognitive Behavioral Therapy (group); Treatment 2: Cognitive Behavioral Therapy (internet)]

Bibliography (systematic reviews): Spek et al., 2007

			№ of patients		Effect		Quality
№ of studies	**Study design**		**cognitive behavioral therapy (group)**	**cognitive behavioral therapy (internet)**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity							
					not estimable	not estimable	
Response (follow up: 10 weeks; assessed with: Beck Depression Inventory (change from >20 at pre-treatment to <20 at post-treatment); scale from: 0 to 63); data limited to subgroup of patients with baseline BDI >20							
1	randomized trials	See footnote #1 See footnote #3	28/42 (66.7%)	30/45 (66.7%)	RR 1.00 (0.67 to 1.49)	0 fewer per 1000 (from 220 fewer to 327 more)	⊕◯◯◯ VERY LOW
Change in BDI scores (follow up: mean 10 weeks; assessed with: BDI; scale from: 0 to 63); difference in change of BDI scores was not statistically significant (p=0.62); based on ITT analysis							
1	randomized trials	See footnote #2 See footnote #3	99	102	-	mean **0.54 lower** (2.96 lower to 1.88 higher)	⊕⊕◯◯ LOW
Remission							
					not estimable	not estimable	
Quality of Life							
					not estimable	not estimable	
Patient Satisfaction							
					not estimable	not estimable	
Relapse							
					not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- Few events; confidence intervals cross appreciable differences
Footnote #2- Sample size does not meet optimal information size
Footnote #3 – High dropout rates; suspected outcomes reporting bias (observer-based outcomes not reported)

Number needed to treat (NNT) (95% Confidence Interval)
Response (follow up: 10 weeks; assessed with: Beck Depression Inventory (change from >20 at pre-treatment to <20 at post-treatment); scale from: 0 to 63); data limited to subgroup of patients with baseline BDI >20: NNT = 0/Not estimable (NNT(harm) 6 to ∞ to NNT(benefit) 5)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"
[Treatment 1: Cognitive Behavioral Therapy (group); Treatment 2: Cognitive Behavioral Therapy (internet)]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Response			X			o
2. Change in BDI scores			X			o

<u>Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2:</u>

	No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Spek et al., 2007

- **Dropout**:
    - 34.3% (35 of 102) internet-based CBT vs. 43.4% (43 of 99) group-based CBT
        - Most common reason for dropout in internet group was "lack of time"
        - More individuals *completed* group CBT compared to internet-based CBT
- **Sx worsening**:
    - 3.5% (2 of 57) worsened in group CBT
    - 14.3% (8 of 56) worsened in internet-CBT
    - 13.3% (8 of 60) worsened in waitlist

Additional Articles:

Titov et al. (in press)

- Dropout: 20.7% (6 of 29) internet-delivered CBT (iCBT)
- 12% (3 of 25) waitlist dropout

Note any other information on burdens from published studies:

Spek et al., 2007

- For Internet-based treatment authors argued there was "low-threshold accessibility," less stigma, could work at own pace, review material, receive treatment at any time or place; also would need computer skills and access to internet

Additional Articles:

Titov et al. (in press):

- Homework assignments for each lesson

Note any additional information on harms:

-In group CBT, easier for therapist to monitor risk of self-harm vs. harder to monitor in technology format

Note any additional information on burdens:

-Typically groups have time burden, internet has technology burden
-Groups- because of need to coordinate with other participate with other participants, there is constraint of having to participate at certain time whereas internet can be done at one's own pace and schedule.
-Possible lower cost burden of technology
-Can possibly control quality better for internet delivered therapy, but possibly less flexibility

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Cognitive Behavioral Therapy (group); Treatment 2: Cognitive Behavioral Therapy (internet)]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
2. Adverse events leading to withdrawals	o	o	o	o	o	X
3. Other serious adverse events	o	o	o	o	o	X
4. Other adverse events	o	o	o	o	o	X
5. Burdens	o	o	X	o	o	o

Assign an overall global rating across outcomes:

☐ Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
X Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

III) Patient Values and Preferences

What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?

How variable are these?

How certain is the panel about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

Titov et al. (in press): [From harms and burdens search]

- "Homework assignments for each lesson"
- "80% reported being satisfied or very satisfied with iCBT"
- "15% reported feeling neutral and 5% were somewhat dissatisfied with iCBT"
- "All iCBT participants reported they would recommend it to a friend and that it was 'worth their time'"

[Possible studies to include from APA staff search of pt values and preferences studies]:

**No studies identified examining group psychotherapy vs. internet psychotherapy in older adults.

Information from community members on panel:

Information from clinicians on panel:

-VA clients, majority request individual therapy vs. group. Most accept internet resources as adjunct when offered but also want face-to-face contact as well. Lower level familiarity and internet access among older veterans, though more access and comfort among 50 – 75 year olds.

-Older adult population may not feel as comfortable with internet as would a younger population and might be less likely to have access.

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High		High
	Moderate		Moderate
	Low	X	Low
X	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

☐ Some variation or some uncertainty

X Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Socioeconomic status and technology literacy. In older age range, possible difficulty using technology due to sensory impairments, though could impact group participation as well. N able to generalize to other population with differing severities.
Interventions	Comfort with and access to internet could limit generalizability
Comparators	
Outcomes	
Timing or Time frame	Do not have long-term outcome information.
Settings	

Notes/Comments:

Spek et al., 2007, p. 2

"Participants were recruited by advertisements in free regional newspapers, and by personal letters sent by the Municipal Health Care Service of the city of Eindhoven. The letters (n=15 697) were sent in cohorts to all inhabitants of Eindhoven, born between 1949 and 1955 . In each mailing round, inhabitants of Eindhoven who were born in the same year received letters. The letters and advertisements provided information about the study and the address of the study homepage. The study homepage contained general information about depression, information about the study, and an application form including the screening instrument, the Edinburgh Depression Scale (EDS; Cox et al. 1987, 1996; Matthey et al. 2001). In all communications it was made clear that only people who had both depressive symptoms and internet access were eligible for the study. "

"Participants who scored above the cut-off score of 12 on the EDS (n=699) were invited for an in-person structured clinical interview for depression, the World Health Organization Composite International Diagnostic Interview (WHO CIDI ; WHO, 1997). To be included in the study, participants had to meet the following criteria: an EDS score of 12 or more, but no compliance with the DSM-IV diagnostic criteria of depression, signed informed consent, age between 50 and 75 years, access to the internet and the ability to use the internet. Exclusion criteria were suffering from any other psychiatric disorder in immediate need of treatment and suicidal ideation."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

[Treatment 1: Cognitive Behavioral Therapy (group); Treatment 2: Cognitive Behavioral Therapy (internet)]

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*

		Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We recommend using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
	X	Recommendation for Either Treatment. **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
		No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:

We recommend using either treatment 1 or treatment 2 when both are being considered, equally efficacious.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

While the strength of evidence is very low/insufficient the panel felt there was reason to consider both of these interventions in the context of older adults living with subsyndromal symptoms of depression.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 6- Comparative Effectiveness of Problem-solving Therapy (group) vs. Reminiscence Therapy (group) for treating major depressive disorder in adults aged 55 years or older
[Treatment 1: Problem-solving Therapy (group); Treatment 2: Reminiscence Therapy (group)]

Factor	Explanation/Comments
X. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
X. Treatment Outcomes/Consequences • **Benefits** of Treatment 1 and/or Treatment 2 • **Harms** of Treatment 1 and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
XI. Patient Values and Preferences	
XII. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 6- Comparative Effectiveness of Problem-solving Therapy (group) vs. Reminiscence Therapy (group) for treating major depressive disorder in adults aged 55 years or older

Question: Problem-solving therapy (group) compared to reminiscence therapy (group) for treating major depressive disorder in adults aged 55 years or older

[Treatment 1: Problem-solving Therapy (group); Treatment 2: Reminiscence Therapy (group)]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem orientation)			X	
Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (problem orientation))			X	
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem definition and formulation))			X	
Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (problem definition and formulation)			X	
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (generation of alternative solutions)			X	
Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (generation of alternative solutions)			X	
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (decision-making)			X	

Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (decision-making			**X**	
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (solution implementation and verification)			**X**	
Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (solution implementation and verification)			**X**	
Response (follow up: mean 12 weeks; assessed with: No longer fulfill diagnostic criteria for MDD)		**X**		
Response (follow up: mean 6 months; assessed with: No longer fulfill diagnostic criteria for MDD)		**X**		
Outcomes for which no estimable information was found: remission, quality of life, patient satisfaction, relapse, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

Assign global strength of evidence grade across outcomes (from evidence profiles only):

Global SOE Grade:

☐ High
☐ Moderate
☐ Low
X Insufficient/ Very Low

Notes/Comments:

Because serious adverse events are not reported and this is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: Problem-solving Therapy (group); Treatment 2: Reminiscence Therapy (group)]

Bibliography (systematic reviews): Arean et al., 1993

		№ of patients		Effect		Quality
№ of studies		**problem-solving therapy (group)**	**reminiscence therapy (group)**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem orientation)); based on completers analysis						
1	See footnote #2	19	28	-	MD **10.4 higher** (4.2546 lower to 25.055 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (problem orientation)); based on completers analysis						
1	See footnote #2	19	28	-	MD **8.3 higher** (6.8749 lower to 23.475 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem definition and formulation)); based on completers analysis						
1	See footnote #2	19	28	-	MD **2.4 higher** (2.3766 lower to 7.1766 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (problem definition and formulation)); based on completers analysis						
1	See footnote #2	19	28	-	MD **1.4 higher** (3.8604 lower to 6.6604 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (generation of alternative solutions)); based on completers analysis						
1	See footnote #2	19	28	-	MD **1.6 higher** (3.5054 lower to 6.7054 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (generation of alternative solutions)); based on completers analysis						
1	See footnote #2	19	28	-	MD **0.9 higher** (3.1429 lower to 4.9429 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (decision-making)); based on completers analysis						
1	See footnote #2	19	28	-	MD **3.1 higher** (1.7877 lower to 7.9877 higher)	⊕⊕◯◯ LOW

Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (decision-making)); based on completers analysis						
1	See footnote #2	19	28	-	MD **4.1 higher** (0.3863 lower to 8.5863 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (solution implementation and verification)); based on completers analysis						
1	See footnote #2	19	28	-	MD **2.9 higher** (1.9718 lower to 7.7718 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (solution implementation and verification)); based on completers analysis						
1	See footnote #2	19	28	-	MD **1.4 higher** (3.7875 lower to 6.5875 higher)	⊕⊕◯◯ LOW
Response (follow up: mean 12 weeks; assessed with: No longer fulfill diagnostic criteria for MDD); based on ITT analysis						
1	See footnote #1	17/28 (60.7%)	8/27 (29.6%)	**RR 2.05** (1.07 to 3.94)	311 more per 1000 (from 21 more to 871 more)	⊕⊕⊕◯ MODERATE
Response (follow up: mean 6 months; assessed with: No longer fulfill diagnostic criteria for MDD); based on ITT analysis						
1	See footnote #1	17/28 (60.7%)	6/27 (22.2%)	**RR 2.73** (1.27 to 5.88)	384 more per 1000 (from 60 more to 1000 more)	⊕⊕⊕◯ MODERATE
Remission						
				not estimable	not estimable	
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- Very few events
Footnote #2- Small sample size; study does not meet optimal information size

	Number needed to treat (NNT) (95% Confidence Intervals) Response (follow up: mean 12 weeks; assessed with: No longer fulfill diagnostic criteria for MDD): NNT = 3 (NNT(benefit) 1 to 16) Response (follow up: mean 6 months; assessed with: No longer fulfill diagnostic criteria for MDD): NNT = 3 (NNT(benefit) 1 to 6) **Next, list and rate each benefit from the evidence profile information:**

Note- Potential ratings are indicated with an "o"

[Treatment 1: Problem-solving therapy (group); Treatment 2: Reminiscence Therapy (group)]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem orientation)						X*
2. Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (problem orientation))						X*
3. Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem definition and formulation))						X*
4. Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (problem definition and formulation)						X*
5. Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (generation of alternative solutions)						X*
6. Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (generation of alternative solutions)						X*

7. Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (decision-making)						X*
8. Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (decision-making						X*
9. Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (solution implementation and verification)						X*
10. Functional Capacity (follow up: 6 months; assessed with: Social Problem-solving Inventory (solution implementation and verification)						X*
11. Response (follow up: mean 12 weeks; assessed with: No longer fulfill diagnostic criteria for MDD)	X	o				
12. Response (follow up: mean 6 months; assessed with: No longer fulfill diagnostic criteria for MDD)	X	o				

- Not an appropriate measure of functional capacity

Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Arean et al., 1993

- **Dropout**:
    - 32.1% (9 of 28) problem solving vs. 25.9% (7 of 27) reminiscence

Note any other information on burdens from published studies:

Arean et al., 1993

- **Burden**:
    - Group sessions were 90-minutes

Note any additional information on harms:

Nothing to add

Note any additional information on burdens:

Possible additional homework for PST

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Problem-solving Therapy (group); Treatment 2: Reminiscence Therapy (group)]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
13. Adverse events leading to withdrawals	o	o	o	o	o	X
14. Other serious adverse events	o	o	o	o	o	X
15. Other adverse events	o	o	o	o	o	X
16. Burdens	o	o	X	o	o	o

Assign an overall global rating across outcomes:

X Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

III) Patient Values and Preferences *What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?* *How variable are these?* *How certain is the panel about these?* **Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*	**<u>Patient values and preferences based on:</u>** *Information from research studies:* Nothing to add *Information from community members on panel:* Nothing to add *Information from clinicians on panel:* -Many older veterans at one VA seem to enjoy reminiscence -Reminiscence is a go-to intervention for individuals with cognitive impairment in eclectic treatment *Information from other sources (also list sources):*

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High		High
	Moderate		Moderate
	Low		Low
X	Unknown	X	Unknown

s

Unknown varaiblity and unknown certainty. XX

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

☐ Some variation or some uncertainty

X Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Unknown variability and unknown certainty.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Slightly younger sample, 55 and older. Community sample had to be able to travel to the university.
Interventions	Diverse pt population and therapist population. PhD students were providers of therapy.
Comparators	
Outcomes	Problem solving outcomes did not address functioning. Attrition rates might limit applicabil
Timing or Time frame	Only goes 3 months post-treatment.
Settings	Community setting.

Notes/Comments:

Arean et al., 1993, p. 1004

"Announcements of a university-sponsored depression program for adults over the age of 55 years were placed in community newspapers, churches, synagogues, and senior citizen centers. Interested individuals were required to complete the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and the Geriatric Depression Scale (GDS; Yesavitch et al., 1983). Individuals with scores of 20 or higher on the BDI and 10 or higher on the GDS were invited to participate in a 1.5-hr semistructured clinical intake interview (scheduled 2 weeks later) and to complete a battery of self-report inventories, including a second BDI and a second GDS."

"Criteria for inclusion in the study involved (a) meeting the RDC requirements for a diagnosis of unipolar, major depressive disorder; (b) scores of 20 or greater on the BDI and 10 or greater on the GDS on both the screening and pretreatment evaluations; (c) HRSD scores of 18 and above; and (d) meeting the age of 55 years or older, not exceeding 80 years. Exclusionary criteria included a diagnosis of bipolar disorder, psychosis, dementia, depression secondary to a physical disorder (e.g., hypothyroidism; not simply a reaction to physical illness), borderline or antisocial personality disorder, active substance, or current involvement in psychological or pharmacological treatment for depression."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.
[Treatment 1: Problem-solving Therapy (group); Treatment 2: Reminiscence Therapy (group)]

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
X	***Conditional*** *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*

		Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We recommend using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
		Recommendation for Either Treatment. **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
		No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:

We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

While effect size strong, only one study, some constraints in design of study (trainee therapists and dropout).

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 8- Comparative Effectiveness of Combination Cognitive Behavioral Therapy and Non-specific Therapeutic Techniques (individual) with Pharmacotherapy vs. Pharmacotherapy as Usual for treating major depressive disorder in adults between 65 and 85 years old
[Treatment 1: Combination Cognitive Behavioral Therapy and Non-specific Therapeutic Techniques (individual) with Pharmacotherapy; Treatment 2: Pharmacotherapy as Usual]

Factor	Explanation/Comments
II. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
V. Treatment Outcomes/Consequences • **Benefits** of Treatment 1 and/or Treatment 2 • **Harms** of Treatment 1 and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
XV. Patient Values and Preferences	

XVI. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 8- Comparative Effectiveness of Combination Cognitive Behavioral Therapy and Non-specific Therapeutic Techniques (individual) with Pharmacotherapy vs. Pharmacotherapy as Usual for treating major depressive disorder in adults between 65 and 85 years old

Question: Combination cognitive behavioral therapy and non-specific therapeutic techniques (individual) with pharmacotherapy compared to pharmacotherapy as usual for treating major depressive disorder in adults between 65 and 85 years old

Treatment 1: Combination Cognitive Behavioral Therapy and Non-specific Therapeutic Techniques (individual) with Pharmacotherapy; Treatment 2: Pharmacotherapy as Usual]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Remission (follow up: 28 weeks)			X	
Suicidality (follow up: mean 28 weeks)			X	
Outcomes for which no estimable information was found: functional capacity, response, quality of life, patient satisfaction, relapse, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because response and serious adverse events are not reported and those are critical outcomes, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: Combination Cognitive Behavioral Therapy and Non-specific Therapeutic Techniques (individual) with Pharmacotherapy; Treatment 2: Pharmacotherapy as Usual]

Bibliography (systematic reviews): Sirey et al., 2005

		№ of patients		Effect		Quality
№ of studies		**a combination of cognitive behavioral therapy and non-specific therapeutic techniques (individual) with pharmacotherapy**	**pharmacotherapy as usual**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response						
				not estimable	not estimable	
Remission (follow up: 28 weeks; assessed with: HAMD <10 (assume misstated in article); based on completers analysis						
1	See footnote #1	15/21 (71.4%)	10/24 (41.7%)	**RR 1.71** (0.99 to 2.96)	296 more per 1000 (from 4 fewer to 817 more)	⊕⊕◯◯ LOW
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- Very few events; confidence interval crosses appreciable difference

Number needed to treat (NNT) (95% Confidence Interval)
Remission (follow up: 28 weeks; assessed with: HAMD <10 (assume misstated in article); based on completers analysis: NNT = 3 (NNT(benefit) 1 to 46)

Next, list and rate each benefit from the evidence profile information:
Note- Potential ratings are indicated with an "o"
[Treatment 1: Combination Cognitive Behavioral Therapy and Non-specific Therapeutic Techniques (individual) with Pharmacotherapy; Treatment 2: Pharmacotherapy as Usual]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Remission						X

Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2:

		№ of patients		Effect		Quality
№ of studies		a combination of cognitive behavioral therapy and non-specific therapeutic techniques (individual) with pharmacotherapy	pharmacotherapy as usual	Relative (95% CI)	Absolute (95% CI)	
Suicidality (follow up: 28 weeks; assessed with: HAMD (experience hopeless ideation)); based on completers analysis						
1	See footnotes #2 and #3	3/21 (14.3%)	15/24 (62.5%)	**RR 0.23** (0.08 to 0.68)	481 fewer per 1000 (from 200 fewer to 575 fewer)	⊕⊕◯◯ LOW
Adverse Events						
				not estimable	not estimable	

Footnote #2- Very few events
Footnote #3- Not upgraded because of very few events

Note any other information on harms from published studies:

Sirey et al., 2005

- **Dropout**:
    - 13.5% (7 of 52) total dropped out based on completer analysis

Additional Article(s):

Sirey et al (2010)

- Dropout:
    - 9.1% (3 of 33) TIP (Combination Cognitive Behavioral Therapy and Non-specific Therapeutic Techniques (individual) with Pharmacotherapy)
    - 18.9% (7 of 37) Pharmacotherapy as usual

Note any other information on burdens from published studies:

Sirey et al., 2005

- TIP (i.e., combination treatment) includes 3 30-min meetings + 2 follow-up phone check-ins

Additional Article(s):

Sirey et al (2010) described TIP intervention as an adjunct to pharmacotherapy prescribed by a PCP; includes 3 30-min meetings and 2 f/u phone calls; not "psychotherapy" but includes motivational interviewing, problem solving tasks and psychoeducation.

Note any additional information on harms:

Low intensity pharmacotherapy that often characterizes general medicine has potential for harm in that patients get an inadequate opportunity to optimize antidepressant pharmacotherapy and thus less likely achieve response and remission and thus might be more likely to give up.

Note any additional information on burdens:

Additional contacts required for the combination treatment

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Combination Cognitive Behavioral Therapy and Non-specific Therapeutic Techniques (individual) with Pharmacotherapy; Treatment 2: Pharmacotherapy as Usual]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
2. Adverse events leading to withdrawals	o	o	o	o	o	X
3. Other serious adverse events	o	o	o		X	o
4. Other adverse events	o	o	o	X	o	o
5. Burdens	o	X	o	o	o	o

Assign an overall global rating across outcomes:

X Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

III) Patient Values and Preferences

What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?

How variable are these?

How certain is the panel about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

[Possible studies to include from APA staff search of pt values and preferences studies]:

-**Hanson & Scogin (2008): "**We examined older adults' ratings of the acceptability of geriatric depression treatments. **We presented 120 community-dwelling participants with vignettes describing an older adult experiencing either mild to moderate or severe depression. Participants rated the acceptability of three different treatments: cognitive therapy (CT), antidepressant medication (AM), and a combination treatment of CT and AM (COM). For general acceptability, participants rated COM as a more acceptable treatment for depression than both CT and AM. With respect to perceived negative aspects of treatments, they rated CT as a more acceptable treatment for mild to moderate depression than both AM and COM. Participants rated both COM and CT as more acceptable treatments for severe depression than AM.** Results indicate that combining psychotherapy and AM may be viewed as most acceptable by community-dwelling, nondepressed older adults."

-**Kitchen et al (2013): "**The purpose of this study was **to investigate depression treatment preferences and anticipated service use in a sample of adults aged 55 years or older who reside in rural Wyoming.** Sixteen participants (mean age = 59) completed 30- to 60-minute, semi-structured interviews. Qualitative methods were used to characterize common themes. Social/provider support and community gatekeepers were perceived by participants as important potential facilitators for seeking depression treatment. In contrast, perceived stigma and the value placed on self-sufficiency emerged as key barriers to seeking treatment for depression in this rural, young-old sample. **Participants anticipated presenting for treatment in the primary care sector and preferred a combination of medication and psychotherapy for treatment.** Participants were, however, more willing to see mental health professionals if they were first referred by a clergy member or primary care physician."

-**Steidtmann et al (2012):** "Background: Findings regarding the relationship between patient treatment preference and treatment outcome are mixed. **This is a secondary data analysis investigating the relationship between treatment preference, and symptom outcome and attrition in a large 2-phase depression treatment trial.** Methods: Patients met DSM-IV criteria for chronic forms of depression. **Phase I was a 12-week, nonrandomized, open-label trial in which all participants (n=785) received antidepressant medication(s) (ADM). Phase I non-remitters were randomized to Phase II, in which they received 12 weeks of either Cognitive-Behavioral System of**

Psychotherapy (CBASP) + ADM (n=193), Brief Supportive Psychotherapy (BSP) + ADM (n=187), or ADM only (n=93). Participants indicated their treatment preference (medication only, combined treatment or no preference) at study entry. Symptoms were measured at 2-week intervals with the 24-item Hamilton Rating Scale for Depression (HAM-D). Results: **A large majority of patients reported a preference for combined treatment. Patients who preferred medication only were more likely to endorse a chemical imbalance explanation for depression, whereas those desiring combined treatment were more likely to attribute their depression to stressful experiences.** In Phase I, patients who expressed no treatment preference showed greater rates of HAM-D symptom reduction than those with any preference, and patients with a preference for medication showed higher attrition than those preferring combined treatment. In Phase II, baseline treatment preference was not associated with symptom reduction or attrition. Conclusions: Treatment preferences may moderate treatment response and attrition in unexpected ways. Research identifying factors associated with differing preferences may enable improved treatment retention and response."

Information from community members on panel:

Agree with clinician feedback.

Information from clinicians on panel:

Patients often feel more supported with the combination treatment.

Many patients would like additional support when they start pharmacotherapy (contact/support).

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High		High
	Moderate	X	Moderate
X	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

X Similar values and little uncertainty

☐ Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Similar values and little uncertainty.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	
Interventions	Not full course CBT, rather 3 30 minute visits.
Comparators	
Outcomes	
Timing or Time frame	
Settings	Enrollment based on older adults presenting to geriatric psychiatry clinic, could be different from older adults who present to primary care. Pharmacotherapy in one setting while psychotherapy in another risks fragmentation of care and less than ideal outcomes.

Notes/Comments:

Sirey et al., 2005, p. 184

"Consecutive admissions to an outpatient geriatric psychiatry clinic were approached and fully informed about the study procedures. All patients agreed to participate (N=59) and signed informed consent forms. A structured diagnostic interview (the Structured Clinical Interview for DSM-IV) confirmed the diagnosis of major depressive disorder. Seven patients were excluded (three had cognitive impairment defined as a Mini-Mental Health Examination score <24, three did not have major depressive disorder, and one patient already had begun antidepressant therapy). All study participants had a score of 17 or greater on the 24 item Hamilton Depression Rating Scale. The 52 participants who met study criteria were randomly assigned to either pharmacotherapy as usual or pharmacotherapy with the TIP intervention."

"The study group was 54% women (N=28), mostly Caucasian (N=49), with a mean age of 73.2 years (SD=5.8, range=65–85). The majority of the patients were married (N=29, 56%) or lived with someone (N=33, 65%)."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

[Treatment 1: Combination Cognitive Behavioral Therapy and Non-specific Therapeutic Techniques (individual) with Pharmacotherapy; Treatment 2: Pharmacotherapy as Usual]

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
X	***Conditional*** *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*

		Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We recommend using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
		Recommendation for Either Treatment. **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
		No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:

Conditional recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Very low/insufficient evidence thus going with conditional vs. strong recommendation. Benefits vs. harms for treatment 1 clearly outweigh treatment 2 and patients preferences/values tend to prefer treatment 1 vs. 2.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 10- Comparative Effectiveness of Combination of Cognitive Behavioral Therapy (individual) and Desipramine vs. Desipramine for treating major depressive disorder in adults ages 60 and older
[Treatment 1: Combination of Cognitive Behavioral Therapy (individual) and Desipramine; Treatment 2: Desipramine]

Factor	Explanation/Comments
II. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
II. Treatment Outcomes/Consequences • **Benefits** of Treatment 1 and/or Treatment 2	
• **Harms** of Treatment 1 and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
XIX. Patient Values and Preferences	
XX. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 10- Comparative Effectiveness of Combination of Cognitive Behavioral Therapy (individual) and Desipramine vs. Desipramine for treating major depressive disorder in adults ages 60 and older

Question: Combination of cognitive behavioral therapy (individual) and desipramine compared to desipramine for treating major depressive disorder in adults ages 60 and older

[Treatment 1: Combination of Cognitive Behavioral Therapy (individual) and Desipramine; Treatment 2: Desipramine]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a <u>strong</u> recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	<u>Rate the quality of the evidence grade for each outcome from the evidence profiles:</u>

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Change in HAMD scores (follow up: range 16-20 weeks)			X	
Patient Satisfaction (follow up: range <16 weeks)			X	
Outcomes for which no estimable information was found: functional capacity, remission, response, quality of life, relapse, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because response and serious adverse events are not reported and those are critical outcomes, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: Combination of Cognitive Behavioral Therapy (individual) and Desipramine; Treatment 2: Desipramine]

Bibliography (systematic reviews): Thompson 2001

Quality assessment		№ of patients		Effect		Quality
№ of studies		**a combination of cognitive behavioral therapy (individual) and desipramine**	**desipramine**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response						
				not estimable	not estimable	
Change in HAMD scores (follow up: range 16-20 weeks; assessed with: HAMD; Scale from: 0 to 17); based on ITT analysis						
1	See footnote #1	36	33	-	MD **3 lower** (6.09 lower to 0.09 higher)	⊕⊕◯◯ LOW
Remission						
				not estimable	not estimable	
Quality of Life						
				not estimable	not estimable	

Patient Satisfaction (follow up: range <16 weeks; assessed with: Satisfaction among dropouts); "There was no significant difference in discontinuation due to treatment dissatisfaction across the three treatments ($X^2_{[2]}$ = 2.99; N = 102; P = 0.22)."						
1	See footnote #1			not estimable	not estimable	⊕⊕◯◯ LOW
Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- Small sample size; study does not meet optimal information size

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Combination of Cognitive Behavioral Therapy (individual) and Desipramine; Treatment 2: Desipramine]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Change in HAMD scores (follow up: range 16-20 weeks)			X			
2. Patient Satisfaction (follow up: range <16 weeks)			X			

Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Thompson et al., 2001

- **Dropout**:
    - 34% (12 of 35) desipramine only vs. 33% (12 of 36) CBT+meds

Other articles:
Nelson et al (1995) found that serious adverse reaction rate due to desipramine for depressed patients aged 75 and older were similar to that in younger patients, suggesting that "very old (subjects) were not unusually sensitive to antidepressant drug treatment." Earlier studies found that desipramine treatment caused clinically significant changes in EKG parameters in 40% of depressed subjects between ages 60 and 85 (Kutcher et al., 1986) and a statistically significant increase in circulating growth hormone (hGH) in elderly depressed patients (Wilkins et al., 1989). Finally, in a case study with a 68-year old woman with depressive symptoms, desipramine needed to be discontinued due to the development of delirium including inattention, drowsiness, word finding difficulties, and "confusing spells" (Kutcher & Shulman, 1985).

Note any other information on burdens from published studies:

Thompson et al., 2001

- **Burden**:
    - Medication-only sessions were 30-minutes in duration
    - CBT sessions were 50-60 mins

Note any additional information on harms:

Possibility of suicide/intentional overdose TCA. [Applicable to all tri-cyclics- add to other tri-cyclic relevant tables.]

Note any additional information on burdens:

Small possibility with medication of confusion due to anticholerginic side effects. No longer a first line medication.

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Combination of Cognitive Behavioral Therapy (individual) and Desipramine; Treatment 2: Desipramine]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
3. Adverse events leading to withdrawals	o	o	o	o	o	X
4. Other serious adverse events	o	o	o	o	o	X
5. Other adverse events	o	o	o	o	o	X
6. Burdens	o	X	o	o	o	o

Assign an overall global rating across outcomes:

☐ Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
X Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

III) Patient Values and Preferences

What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?

How variable are these?

How certain is the panel about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

[Possible studies to include from APA staff search of pt values and preferences studies]:

-**Hanson & Scogin (2008): "**We examined older adults' ratings of the acceptability of geriatric depression treatments. **We presented 120 community-dwelling participants with vignettes describing an older adult experiencing either mild to moderate or severe depression. Participants rated the acceptability of three different treatments: cognitive therapy (CT), antidepressant medication (AM), and a combination treatment of CT and AM (COM). For general acceptability, participants rated COM as a more acceptable treatment for depression than both CT and AM. With respect to perceived negative aspects of treatments, they rated CT as a more acceptable treatment for mild to moderate depression than both AM and COM. Participants rated both COM and CT as more acceptable treatments for severe depression than AM.** Results indicate that combining psychotherapy and AM may be viewed as most acceptable by community-dwelling, nondepressed older adults."

-**Kitchen et al (2013):** "The purpose of this study was **to investigate depression treatment preferences and anticipated service use in a sample of adults aged 55 years or older who reside in rural Wyoming.** Sixteen participants (mean age = 59) completed 30- to 60-minute, semi-structured interviews. Qualitative methods were used to characterize common themes. Social/provider support and community gatekeepers were perceived by participants as important potential facilitators for seeking depression treatment. In contrast, perceived stigma and the value placed on self-sufficiency emerged as key barriers to seeking treatment for depression in this rural, young-old sample. **Participants anticipated presenting for treatment in the primary care sector and preferred a combination of medication and psychotherapy for treatment.** Participants were, however, more willing to see mental health professionals if they were first referred by a clergy member or primary care physician."

-**Steidtmann et al (2012):** "Background: Findings regarding the relationship between patient treatment preference and treatment outcome are mixed. **This is a secondary data analysis investigating the relationship between treatment preference, and symptom outcome and attrition in a large 2-phase depression treatment trial.** Methods: Patients met DSM-IV criteria for chronic forms of depression. Phase I was a 12-week, nonrandomized, open-label trial in which all participants (n=785)

received antidepressant medication(s) (ADM). Phase I non-remitters were randomized to Phase II, in which they received 12 weeks of either Cognitive-Behavioral System of Psychotherapy (CBASP) + ADM (n=193), Brief Supportive Psychotherapy (BSP) + ADM (n=187), or ADM only (n=93). **Participants indicated their treatment preference (medication only, combined treatment or no preference) at study entry.** Symptoms were measured at 2-week intervals with the 24-item Hamilton Rating Scale for Depression (HAM-D). Results: **A large majority of patients reported a preference for combined treatment. Patients who preferred medication only were more likely to endorse a chemical imbalance explanation for depression, whereas those desiring combined treatment were more likely to attribute their depression to stressful experiences.** In Phase I, patients who expressed no treatment preference showed greater rates of HAM-D symptom reduction than those with any preference, and patients with a preference for medication showed higher attrition than those preferring combined treatment. In Phase II, baseline treatment preference was not associated with symptom reduction or attrition. Conclusions: Treatment preferences may moderate treatment response and attrition in unexpected ways. Research identifying factors associated with differing preferences may enable improved treatment retention and response."

-Meta analysis by Cuijpers et al , dep and anxiety journal 2012, pts preferred combo to meds along

Information from community members on panel:

Information from clinicians on panel:

None

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	Variability in Patient Values & Preferences	✓	Certainty in Patient Values & Preferences
	High	X	High
	Moderate		Moderate
X	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

X Similar values and little uncertainty

☐ Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Older adults prefer combination of psychotherapy and medication over taking medication alone.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	You would not use tricyclics (tcas) in older adult with cardiac problems or blood pressure drops from lying to standing (contraindication due to safety).
Interventions	Optimal use of tricyclics is facilitated by access to blood level data.
Comparators	
Outcomes	
Timing or Time frame	
Settings	

Notes/Comments:

Thompson et al., 2001, p. 227

"The study was conducted at the Veterans Affairs Palo Alto Health Care System and Stanford University School of Medicine, in a clinic specializing in the treatment of older adults with affective disorders. Study subjects were required to meet the following criteria: 1) age 60 years or older; 2) a current diagnosis of major depressive disorder (MDD) as determined by the Research Diagnostic Criteria (RDC) applied to the Schedule for Affective Disorders and Schizophrenia (SADS); 3) a score of 14 or greater on the Ham-D; 4) a score of 16 or greater on the BDI; 5) a score of 26 or greater on the Mini-Mental State Exam; 6) no medical or psychiatric contraindications; 7) no evidence of serious alcohol abuse; 8) no evidence of a psychotic disorder; 9) no evidence of bipolar disorder; 10) no immediate suicide risk; 11) not taking another medication for the treatment of depression; and 12) adequate transportation to reach the outpatient clinic."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

[Treatment 1: Combination of Cognitive Behavioral Therapy (individual) and Desipramine; Treatment 2: Desipramine]

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
X	***Conditional*** *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*

		Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We recommend using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
		Recommendation for Either Treatment. **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
		No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:

We make a qualified recommendation for treatment 1 vs. treatment 2, especially in the context of severe depression.

[*note in full guideline document that issues of severity are not addressed here and possibly in other tables.]

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Emphasizing patient preferences and values in decision to make qualified recommendation for 1 over 2. No evidence for strong differential effect between treatments.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 11- Comparative Effectiveness of Cognitive Behavioral Therapy (individual) vs. Desipramine for treating major depressive disorder in adults ages 60 and older
[Treatment 1: Cognitive Behavioral Therapy (individual); Treatment 2: Desipramine]

Factor	Explanation/Comments
XI. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
II. Treatment Outcomes/Consequences • **Benefits** of Treatment 1 and/or Treatment 2 • **Harms** of Treatment 1 and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do <u>not</u> include financial cost)*	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
XIII. Patient Values and Preferences	
XIV. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 11- Comparative Effectiveness of Cognitive Behavioral Therapy (individual) vs. Desipramine for treating major depressive disorder in adults ages 60 and older

Question: Cognitive Behavioral Therapy (individual) compared to Desipramine for treating major depressive disorder in adults ages 60 and older

[Treatment 1: Cognitive Behavioral Therapy (individual); Treatment 2: Desipramine]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Change in HAMD scores (follow up: range 16-20 weeks)			X	
Patient Satisfaction (follow up: range <16 weeks)			X	
Outcomes for which no estimable information was found: functional capacity, remission, response, quality of life, relapse, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because response and serious adverse events are not reported and those are critical outcomes, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: Cognitive Behavioral Therapy (individual); Treatment 2: Desipramine]

Bibliography (systematic reviews): Thompson et al., 2001

Quality assessment		№ of patients		Effect		Quality
№ of studies		**cognitive behavioral therapy (individual)**	**desipramine**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response						
				not estimable	not estimable	
Change in HAMD scores (follow up: range 16-20 weeks; assessed with: HAMD; Scale from: 0 to 17); based on ITT analysis						
1	See footnote #1	31	33	-	MD **2.5 lower** (5.75 lower to 0.75 higher)	⊕⊕◯◯ LOW
Remission						
				not estimable	not estimable	
Quality of Life						
				not estimable	not estimable	

Patient Satisfaction (follow up: range <16 weeks; assessed with: Satisfaction among dropouts); "There was no significant difference in discontinuation due to treatment dissatisfaction across the three treatments ($X^2_{[2]}$ = 2.99; N = 102; P = 0.22)."						
1	See footnote #1			not estimable	not estimable	⊕⊕◯◯ LOW
Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- Small sample size; study does not meet optimal information size

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Cognitive Behavioral Therapy (individual); Treatment 2: Desipramine]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Change in HAMD scores (follow up: range 16-20 weeks)			X			o
2. Patient Satisfaction (follow up: range <16 weeks)			X			o

Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Thompson et al., 2001

- **Dropout**:
    - 34% (12 of 35) desipramine only vs. 23% (7 of 31) CBT alone

Other articles:
Nelson et al (1995) found that serious adverse reaction rate due to desipramine in depressed patients aged 75 and older were similar to that in younger patients, suggesting that "very old (subjects) were not unusually sensitive to antidepressant drug treatment." Earlier studies found that desipramine treatment caused clinically significant changes in EKG parameters in 40% of depressed subjects between ages 60 and 85 (Kutcher et al., 1986) and a statistically significant increase in circulating growth hormone (hGH) in elderly depressed patients (Wilkins et al., 1989). Finally, in a case study with a 68-year old woman with depressive symptoms, desipramine needed to be discontinued due to the development of delirium including inattention, drowsiness, word finding difficulties, and "confusing spells" (Kutcher & Shulman, 1985).

Note any other information on burdens from published studies:
Thompson et al., 2001

- **Burden**:
    - Med alone condition sessions were 30-minutes in duration
    - CBT sessions were 50-60 mins

Note any additional information on harms:

Possibility of suicide/intentional overdose on TCA.

Note any additional information on burdens:

No real difference in burdens in regards to time.
More side effects associated with medication than with CBT alone.
While in practice TCA is less burdensome in regards to time demands, this is off set by the side effect profile which adds an additional burden.
Small possibility with medication of confusion due to anticholerginic side effects. No longer a first line medication.

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Cognitive Behavioral Therapy (individual); Treatment 2: Desipramine]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
3. Adverse events leading to withdrawals	o	o	o	o	o	X
4. Other serious adverse events	o	o	o	o	X	
5. Other adverse events	o		o	X	o	
6. Burdens	o	o	o	X		o

Assign an overall global rating across outcomes:

☐ Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
X Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

III) Patient Values and Preferences

What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?

How variable are these?

How certain is the panel about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

[Possible studies to include from APA staff search of pt values and preferences studies]:

-**Dwight Johnson et al. (2013):** *Objective:* "Among **older white and Mexican origin male primary care patients**, we examined preferences for features of depression care programs that would encourage depressed older men to enter and remain in treatment. *Method:* **Sixty-three (45 white, 18 Mexican origin) older men were recruited in six primary care clinics. All had clinical depression in the past year and/or were receiving depression treatment.** Participants completed a conjoint analysis preference survey regarding depression treatments, providers and treatment enhancements. *Results:* The data suggest that **white men preferred medication over counseling [odds ratio (OR): 1.64 95% confidence interval (CI): 1.12–2.41], while Mexican origin men preferred counseling (OR: medication over counseling: 0.28, 95% CI: 0.12–0.66). Both white and Mexican origin men preferred treatment that included family involvement (vs. none) (white: OR: 1.60, 95% CI 1.12–2.30; Mexican origin: OR: 3.31 95% CI 1.44–7.62) and treatment for insomnia (vs. treatment for alcohol use) (white: OR: 1.72, 95% CI 1.01–2.91; Mexican origin: OR: 3.93 95% CI 1.35–11.42). White men also preferred treatment by telephone (OR: 1.80, 95% CI 1.12–2.87).** *Conclusions:* Findings could inform development of patient-centered depression treatment programs for older men and suggest strategies, such as attention to sleep problems, which providers may employ to tailor treatment to preferences of older men."

-**Hanson & Scogin (2008): "**We examined older adults' ratings of the acceptability of geriatric depression treatments. **We presented 120 community-dwelling participants with vignettes describing an older adult experiencing either mild to moderate or severe depression. Participants rated the acceptability of three different treatments: cognitive therapy (CT), antidepressant medication (AM), and a combination treatment of CT and AM (COM). For general acceptability, participants rated COM as a more acceptable treatment for depression than both CT and AM. With respect to perceived negative aspects of treatments, they rated CT as a more acceptable treatment for mild to moderate depression than both AM and COM. Participants rated both COM and CT as more acceptable treatments for severe depression than AM.** Results indicate that combining psychotherapy and AM may be viewed as most acceptable by community-dwelling, nondepressed older adults."

-**Cooper et al (2003):** **"**Background: Ethnic minority patients are less likely than white patients to receive guideline-concordant care for depression. It is uncertain whether racial and ethnic differences exist in patient beliefs, attitudes, and preferences for treatment. Methods: **A telephone survey was conducted of 829 adult patients (659 non-Hispanic whites, 97 African Americans, 73 Hispanics) recruited from primary care offices across the United States who reported 1 week or more of depressed mood or loss of interest within the past month and who met criteria for Major Depressive Episode in the past year.** Within this cohort, we examined differences among African Americans, Hispanics, and whites in acceptability of antidepressant medication and acceptability of individual counseling. Results: **African Americans (adjusted OR, 0.30; 95% CI 0.19-0.48) and Hispanics (adjusted OR, 0.44; 95% CI, 0.26-0.76) had lower odds than white persons of finding antidepressant medications acceptable. African Americans had somewhat lower odds (adjusted OR, 0.63; 95% CI, 0.35-1.12), and Hispanics had higher odds (adjusted OR, 3.26; 95% CI, 1.08-9.89) of finding counseling acceptable than white persons. Some negative beliefs regarding treatment were more prevalent among ethnic minorities; however adjustment for these beliefs did not explain differences in acceptability of treatment for depression.** Conclusions: **African Americans are less likely than white persons to find antidepressant medication acceptable. Hispanics are less likely to find antidepressant medication acceptable, and more likely to find counseling acceptable than white persons**. Racial and ethnic differences in beliefs about treatment modalities were found, but did not explain differences in the acceptability of depression treatment. Clinicians should consider patients' cultural and social context when negotiating treatment decisions for depression. Future research should identify other attitudinal barriers to depression care among ethnic minority patients."

-**Gum et al (2006):** **"**PURPOSE: For depressed older primary care patients, this study aimed to examine (a) characteristics associated with depression treatment preferences; (b) predictors of receiving preferred treatment; and (c) whether receiving preferred treatment predicted satisfaction and depression outcomes. DESIGN AND METHODS: **Data are from 1,602 depressed older primary care patients who participated in a multisite, randomized clinical trial comparing usual care to collaborative care, which offered medication and counseling for up to 12 months**. Baseline assessment included demographics, depression, health information, prior depression treatment, potential barriers, and treatment preferences (medication, counseling). At 12 months, services received, satisfaction, and depression outcomes were assessed. RESULTS: **More patients preferred counseling (57%) than medication (43%). Previous experience with a treatment type was the strongest predictor of preference. In addition, medication preference was predicted by male gender and diagnosis of major depression (vs dysthymia).** The collaborative care model greatly improved access to preferred treatment, especially for counseling (74% vs 33% in usual care). **Receipt of preferred treatment did**

not predict satisfaction or depression outcomes; these outcomes were most strongly impacted by treatment condition. IMPLICATIONS: Many depressed older primary care patients desire counseling, which is infrequently available in usual primary care. Discussion of treatment preferences should include an assessment of prior treatment experiences. A collaborative care model that increases collaboration between primary care and mental health professionals can increase access to preferred treatment. If preferred treatment is not available, collaborative care still results in good satisfaction and depression outcomes."

-**Prins et al (2008): "**Patients' illness representations and beliefs about treatment for depression and anxiety, as well as their perceived needs, are important for treatment**. A systematic review was conducted of 71 studies describing the beliefs or perceived needs of patients and non-patients.** Patients give multi-dimensional explanations for depression and see both psychological and medication treatment as helpful. **People who suffer from depression have more positive beliefs about biological etiology and medication treatment than healthy people, or those with less severe depressive symptoms.** Anxiety patients view psychological interventions as their best treatment option. Between 49% and 84% of the patients with depression or anxiety perceive a need for treatment, mostly for counseling and medication. **All patients prefer psychological treatment forms to medication. A majority of patients view antidepressants as addictive and many perceive stigma and see practical and economic barriers to care. The most vulnerable groups in terms of seeking and receiving mental health care for depression and anxiety seem to be minority groups, as well as younger and older patients.** More research is required into the specific needs of anxiety and depression patients. Open communication between patient and provider could lead to valuable improvements in treatment."

-**Raue et al (2009): "**Objective: **The authors examined the association of treatment preferences with treatment initiation, adherence, and clinical outcome among non-senior adult and senior primary care patients with depression.** Methods: Sixty primary care participants meeting DSM-IV criteria for major depression were randomly assigned to receive treatment congruent or incongruent with their primary stated preference. **Participants received either 20 weeks of escitalopram, with monitoring by a care manager, or 12 weekly sessions of interpersonal psychotherapy followed by two monthly booster sessions.** Adherence to treatment and depression severity were reassessed at weeks 4, 8, 12, and 24. Results: **Participants expressed stronger preferences for psychotherapy than for antidepressant medication. Preference strength was a more sensitive measure of outcome than was congruence versus incongruence of preference with the assigned treatment. Across age groups, preference strength was significantly associated with treatment initiation and 12-week adherence rate but not with depression severity or remission.** Conclusion: A continuous measure of preference strength may be a more useful measure in clinical practice than preferences per

se. Future research should focus on whether and how greater facilitation of the treatment decision-making process between patient and clinician influences clinical outcome."

-<u>van Schaik et al (2004)</u>: "Patients' preferences in the treatment of depression are important in clinical practice and in research. Antidepressant medication is often prescribed, but adherence is low. This may be caused by patients preferring psychotherapy, which is often not available in primary care. In randomized clinical trials, patients' preferences may affect the external validity. **The aim of this article is to study patients' preferences regarding psychotherapy and antidepressant medication and the impact of these preferences on treatment outcome. A systematic review of the literature was performed. The majority of patients preferred psychotherapy in all available studies. Antidepressants were often regarded as addictive and psychotherapy was assumed to solve the cause of depression.** Discussing and supporting preferences as part of a quality improvement program of depression care, resulted in more patients receiving the treatment that was most suitable to them. In two patient-preference trials, preferences did not influence treatment outcome. It can be concluded that a substantial percentage of well-informed patients prefer psychotherapy. Patients with strong preferences, mostly for psychotherapy, are likely not to enter antidepressant treatment or randomized clinical trials if their preferences are not supported."

Information from community members on panel:

Information from clinicians on panel:

Most patients prefer psychosocial approaches with the exception of those individuals with severe depression, particularly among African American patients. Clear preference for psychosocial treatments but some switch in preference after understanding work involved.

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	Variability in Patient Values & Preferences	✓	Certainty in Patient Values & Preferences
	High	X	High
	Moderate		Moderate
X	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

X Similar values and little uncertainty

☐ Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Older adults generally prefer psychosocial treatment over medication.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	You would not use tricyclics (tcas) in older adult with cardiac problems or blood pressure drops from lying to standing (contraindication due to safety).
Interventions	Optimal use of tricyclics is facilitated by access to blood level data.
Comparators	
Outcomes	
Timing or Time frame	
Settings	

Notes/Comments:

Thompson et al., 2001, p. 227

"The study was conducted at the Veterans Affairs Palo Alto Health Care System and Stanford University School of Medicine, in a clinic specializing in the treatment of older adults with affective disorders. Study subjects were required to meet the following criteria: 1) age 60 years or older; 2) a current diagnosis of major depressive disorder (MDD) as determined by the Research Diagnostic Criteria (RDC) applied to the Schedule for Affective Disorders and Schizophrenia (SADS); 3) a score of 14 or greater on the Ham-D; 4) a score of 16 or greater on the BDI; 5) a score of 26 or greater on the Mini-Mental State Exam; 6) no medical or psychiatric contraindications; 7) no evidence of serious alcohol abuse; 8) no evidence of a psychotic disorder; 9) no evidence of bipolar disorder; 10) no immediate suicide risk; 11) not taking another medication for the treatment of depression; and 12) adequate transportation to reach the outpatient clinic."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.
[Treatment 1: Cognitive Behavioral Therapy (individual); Treatment 2: Desipramine]

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
X	***Conditional*** *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*

		Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We recommend using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
		Recommendation for Either Treatment. **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
		No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:

We make a qualified recommendation for treatment 1 vs. treatment 2.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Emphasizing patient preferences and values and safety in decision to make qualified recommendation for 1 over 2. No evidence for strong differential effect between treatments.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 12- Comparative Effectiveness of Problem-solving therapy (individual) vs. Paroxetine for treating dysthymia in adults ages 60 and older
[Treatment 1: Problem-solving therapy (individual); Treatment 2: Paroxetine]

Factor	Explanation/Comments
V. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
VI. Treatment Outcomes/Consequences • **Benefits** of Treatment 1 and/or Treatment 2 • **Harms** of Treatment 1 and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do <u>not</u> include financial cost)*	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
VII. Patient Values and Preferences	
VIII. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 12- Comparative Effectiveness of Problem-solving therapy (individual) vs. Paroxetine for treating dysthymia in adults ages 60 and older

Question: Problem-solving therapy (individual) compared to paroxetine for treating dysthymia in adults ages 60 and older

[Treatment 1: Problem-solving therapy (individual); Treatment 2: Paroxetine]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Remission (assessed with: HAMD <=7)			X	
Adverse Events (follow up: 11 weeks; assessed with: Withdrawals due to adverse events)		X		
Outcomes for which no estimable information was found: functional capacity, response, quality of life, relapse, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because response and serious adverse events are not reported and those are critical outcomes, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:
[Treatment 1: Problem-solving therapy (individual); Treatment 2: Paroxetine]

Bibliography (systematic reviews): Williams et al., 2000

Quality assessment		№ of patients		Effect		Quality
№ of studies		**problem-solving therapy (individual)**	**paroxetine**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional capacity						
				not estimable	not estimable	
Response						
				not estimable	not estimable	
Remission (assessed with: HAMD <=7); data limited to those who attended more than 4 sessions						
1	See footnote #1	32/63 (50.8%)	26/57 (45.6%)	**RR 1.11** (0.77 to 1.62)	50 more per 1000 (from 105 fewer to 283 more)	⊕⊕◯◯ LOW
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Relapse						
				not estimable	not estimable	

	MD – mean difference, RR – relative risk Footnote #1- Few events; confidence interval crosses appreciable difference <u>Number needed to treat (NNT) (95% Confidence Interval)</u> Remission (assessed with: HAMD <=7); data limited to those who attended more than 4 sessions: NNT = 19 (NNT(harm) 8 to ∞ to NNT(benefit) 4)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Problem-solving therapy (individual); Treatment 2: Paroxetine]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Remission (assessed with: HAMD <=7)			X*			o

*No statistical difference. The study was not designed to be able to determine equivalence. Rather study not sufficiently powered to provide meaningful information.

Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2:

Quality assessment		№ of patients		Effect		Quality
№ of studies		problem-solving therapy (individual)	paroxetine	Relative (95% CI)	Absolute (95% CI)	
Adverse Events (follow up: 11 weeks; assessed with: Withdrawals due to adverse events); based on completers analysis; combination of patients with dysthymia or minor depression						
1	See footnote #2	0/120 (0.0%)	12/130 (9.2%)	**RR 0.04** (0.00 to 0.62)	89 fewer per 1000 (from 35 fewer to 92 fewer)	⊕⊕⊕◯ MODERATE

Footnote #2- Few events

Number needed to treat (NNT) (95% Confidence Interval)
Adverse Events (follow up: 11 weeks; assessed with: Withdrawals due to adverse events); based on completers analysis; combination of patients with dysthymia or minor depression: NNT(harm) = 11 (NNT(harm) 7 to 25)

Note any other information on harms from published studies:

Williams et al., 2000

- **Dropout**:
  - 22.6% (31 of 137) paroxetine vs. 18.1% (25 of 138) PST-PC
- **Dropout due to adverse events:**
  - 8.8% (12 of 137) paroxetine vs. 0% (0 of 138) PST-PC

Other studies:
Arean et al (2008) [quasi-experimental design, depressed primary care 60 and older]: 5.9% (16 of 269) of PST-PC group dropped out
Geretsegger et al (1995) [RCT, depressed inpatients 65 and older]: paroxetine group showed higher incidence of anxiety and agitation, but fewer anticholinergic side effects compared to amitriptyline group.
Ghose (1996) [RCT, depressed patients aged 72-86]: 18.75% (3 of 16) of paroxetine group dropped out due to adverse events (i.e., rash & upper gastrointestinal symptoms). An additional paroxetine subject experienced a reversible increase in liver enzymes.
Burrows et al (2002) [RCT, nursing home residents aged 80-97]: Two participants that received paroxetine developed delirium, and participants that received paroxetine were more likely to experience a decrease in Mini Mental State Exam scores.
Bourin (2002) noted in a review of the literature that there is "wide interindividual variation in the pharmacokinetics of paroxetine in adults as well as in the elderly with higher plasma concentrations and slower elimination noted in the latter. Elimination is also reduced in severe renal and hepatic impairment, however, serious adverse events are extremely rare even in overdose….paroxetine is well tolerated in the treatment of depression in those between the ages of 65 and 75, although few studies have examined its use in those of 75 and older."

Note any other information on burdens from published studies:

Williams et al., 2000

- PST-PC utilizes fewer and briefer (30-min) sessions (compared to traditional PST) and can be administered by nonphysicians - however the site with the best response used a PhD behavioral therapist

Note any additional information on harms:

None to add
Greater side effects paroxetine older adults related to anti-cholinergic effects

Note any additional information on burdens:

Slightly more time requirement for PST condition per session, more visits

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Problem-solving therapy (individual); Treatment 2: Paroxetine]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
2. Adverse events leading to withdrawals				o	X	
3. Other serious adverse events	o	o	X	o	o	o
4. Other adverse events	o	o	o	X	o	o
5. Burdens	o	X	o	o	o	o

Assign an overall global rating across outcomes:

☐ Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
X Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

III) Patient Values and Preferences

What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?

How variable are these?

How certain is the panel about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

-Preference for behavioral interventions vs. pharmacotherapy in older age populations

-Berkowitz et al 2012, experience with previous treatment may modify preferences

Information from community members on panel:

-There is a power differential between consumer and provider. PST may help with that differential and may facilitate a collaborative working relationship and empower the consumer.

Information from clinicians on panel:

-Preference from older adult populations to receive care in primary care facilities due to stigma issues

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	Variability in Patient Values & Preferences	✓	Certainty in Patient Values & Preferences
	High		High
X	Moderate	X	Moderate
	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

X Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Moderate variability in pt values and preferences and moderate certainty depending on where you look. Some preference for care in primary care settings due to stigma.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Population with minor depression limits generalizability to other populations.
Interventions	Significant variability in outcomes as a function of sites
Comparators	
Outcomes	
Timing or Time frame	Do not have long term followup
Settings	Primary care settings

Notes/Comments:

Williams et al., (2000), pp. 1520-1521

"Patients aged 60 years or older were recruited through referral and screening at community, Veterans Affairs, and academic-affiliated primary care clinics. The 4 participating centers were chosen for geographic diversity and diversity of clinical populations. Eligible patients met Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition(DSMIII-R) criteria for dysthymia or criteria for minor depression and scored 10 or higher on the 17-item Hamilton Depression Rating Scale (HDRS). Criteria for minor depression were adapted from the DSM-IV research criteria. We required symptoms for at least 4 weeks rather than 2 weeks, and 3 or 4 symptoms, rather than 2 to 4 symptoms. A past history of major depression was not an exclusion criterion. Depression diagnoses were made by a research psychiatrist or psychologist using the Primary Care Evaluation of Mental Disorders (PRIME-MD), a diagnostic instrument designed for use in primary care. Patients were excluded for: major depression, psychosis, schizophrenia or schizo-affective disorder, bipolar affective disorder, alcohol or other substance abuse within the past 6 months, antisocial personality disorder, borderline personality disorder, serious suicidal risk, moderate or severe cognitive impairment (Folstein Mini Mental State Examination score), and medical illness with a prognosis of less than 6 months to live. In addition, patients in current treatment were excluded, with an exception for patients willing to discontinue treatment who were taking 50 mg or less of amitriptyline or its equivalent."

	"Patients were randomized to receive paroxetine (n=137), PST-PC (n=138), or placebo (n=140). Sociodemographic and clinical characteristics were similar for the 3 treatment groups (TABLE 1). The average age of participants was 71 years (range, 60-93 years), 172 (41.5%) were women, and 90 (21.8%) were from minority ethnic groups. Patients averaged 3.4 chronic medical conditions and scored a mean (SD) of 24.4 (12.8) on the Duke Severity of Illness Scale. The most common systems affected by illness were cardiovascular in 294 patients (70.8%), endocrine in 239 (57.6%), musculoskeletal in 194 (46.8%), and gastrointestinal in 123 (29.6%). Comorbid anxiety disorders were present in 121 participants (29.2%). Of the 415 subjects, 211 (51%) met criteria for dysthymia with the remaining 204 (49%) meeting criteria for minor depression. At baseline, depression severity was mild to moderate as shown by a median HDRS score of 13 (interquartile range, 12-15) and an HSCL-D-20 score of 1.4 (interquartile range, 0.9-1.9). Mental health functioning (median, 38.9; interquartile range, 32.4-45.1) and physical functioning (median, 37.4; interquartile range, 29.347.5) were markedly impaired. At baseline, patients with dysthymia and minor depression had similar levels of impairment on all scales."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.
[Treatment 1: Problem-solving therapy (individual); Treatment 2: Paroxetine]

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*

		Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We recommend using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
	X	Recommendation for Either Treatment. **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
		No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:

We recommend using either treatment 1 or treatment 2 when both are being considered.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

In balancing these four domains, no statistical evidence for difference in evidence for efficacy, more dropout in Paroxetine, slight pt preferences and values for PST. Facilitate pt education and decision. Delivery of treatment is not uniform across sites.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 13- Comparative Effectiveness of Problem-solving therapy (individual) vs. Paroxetine for treating minor depressive disorder in adults ages 60 and older
[Treatment 1: Problem-solving therapy (individual); Treatment 2: Paroxetine]

Factor	Explanation/Comments
X. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
X. Treatment Outcomes/Consequences • **Benefits** of Treatment 1 and/or Treatment 2 • **Harms** of Treatment 1 and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do <u>not</u> include financial cost)*	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
XXI. Patient Values and Preferences	
XII. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 13- Comparative Effectiveness of Problem-solving therapy (individual) vs. Paroxetine for treating minor depressive disorder in adults ages 60 and older

Question: Problem-solving therapy (individual) compared to paroxetine for treating minor depressive disorder in adults ages 60 and older

[Treatment 1: Problem-solving therapy (individual); Treatment 2: Paroxetine]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Remission (assessed with: HAMD <=7)			X	
Adverse Events (follow up: 11 weeks; assessed with: Withdrawals due to adverse events)		X		
Outcomes for which no estimable information was found: functional capacity, response, quality of life, relapse, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because response and serious adverse events are not reported and those are critical outcomes, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: Problem-solving therapy (individual); Treatment 2: Paroxetine]

Bibliography (systematic reviews): Williams et al., 2000

		№ of patients		Effect		Quality
№ of studies		**problem-solving therapy (individual)**	**paroxetine**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				-	0 higher (0 higher to 0 higher)	
Response						
				not estimable	not estimable	
Remission (assessed with: HAMD <=7); data limited to those who attended more than 4 sessions						
1	See footnote #1	22/50 (44.0%)	26/49 (53.1%)	RR 0.83 (0.55 to 1.25)	90 fewer per 1000 (from 133 more to 239 fewer)	⊕⊕◯◯ LOW
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- Few events; confidence interval crosses appreciable difference

Number needed to treat (NNT) (95% Confidence Interval)

	Remission (assessed with: HAMD <=7); data limited to those who attended more than 4 sessions: NNT = 11 (NNT(harm) 4 to ∞ to NNT(benefit) 9) **Next, list and rate each benefit from the evidence profile information:**

Note- Potential ratings are indicated with an "o"
[Treatment 1: Problem-solving therapy (individual); Treatment 2: Paroxetine]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Remission (assessed with: HAMD <=7)			X*			o

*No statistical difference. The study was not designed to be able to determine equivalence. Rather study not sufficiently powered to provide meaningful information.

Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2:

		№ of patients		Effect		Quality
№ of studies		problem-solving therapy (individual)	paroxetine	Relative (95% CI)	Absolute (95% CI)	
Adverse Events (follow up: 11 weeks; assessed with: Withdrawals due to adverse events); based on completers analysis; combination of patients with dysthymia or minor depression						
1	See footnote #2	0/120	12/130 (9.2%)	RR 0.04 (0.00 to 0.62)	89 fewer per 1000 (from 35 fewer to 92 fewer)	⊕⊕⊕◯ MODERATE

Footnote #2- Few events

Number needed to treat (NNT) (95% Confidence Interval)
Adverse Events (follow up: 11 weeks; assessed with: Withdrawals due to adverse events): NNT(harm) = 11 (NNT(harm) 7 to 25)

Note any other information on harms from published studies:

Williams et al., 2000

- **Dropout**:
    - 22.6% (31 of 137) paroxetine vs. 18.1% (25 of 138) PST-PC
- **Dropout due to adverse events:**
    - 8.8% (12 of 137) paroxetine vs. 0% (0 of 138) PST-PC

Other studies:
Arean et al (2008) [quasi-experimental design, depressed primary care 60 and older]: 5.9% (16 of 269) of PST-PC group dropped out
Geretsegger et al (1995) [RCT, depressed inpatients 65 and older]: paroxetine group showed higher incidence of anxiety and agitation, but fewer anticholinergic side effects compared to amitriptyline group.
Ghose (1996) [RCT, depressed patients aged 72-86]: 18.75% (3 of 16) of paroxetine group dropped out due to adverse events (i.e., rash & upper gastrointestinal symptoms). An additional paroxetine subject experienced a reversible increase in liver enzymes.
Burrows et al (2002) [RCT, nursing home residents aged 80-97]: Two participants that received paroxetine developed delirium, and participants that received paroxetine were more likely to experience a decrease in Mini Mental State Exam scores.
Bourin (2002) noted in a review of the literature that there is "wide interindividual variation in the pharmacokinetics of paroxetine in adults as well as in the elderly with higher plasma concentrations and slower elimination noted in the latter. Elimination is also reduced in severe renal and hepatic impairment, however, serious adverse events are extremely rare even in overdose….paroxetine is well tolerated in the treatment of depression in those between the ages of 65 and 75, although few studies have examined its use in those of 75 and older."

Note any other information on burdens from published studies:

Williams et al., 2000

- PST-PC utilizes fewer and briefer (30-min) sessions (compared to traditional PST) and can be administered by nonphysicians - however the site with the best response used a PhD behavioral therapist

Note any additional information on harms:

None to add

Greater side effects paroxetine older adults related to anti-cholinergic effects

Note any additional information on burdens:

Slightly more time requirement for PST condition per session, more visits

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Problem-solving therapy (individual); Treatment 2: Paroxetine]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
2. Adverse events leading to withdrawals				o	X	
3. Other serious adverse events	o	o	X	o	o	o
4. Other adverse events	o	o	o	X	o	o
5. Burdens	o	X	o	o	o	o

Assign an overall global rating across outcomes:

☐ Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
X Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

III) Patient Values and Preferences *What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?* *How variable are these?* *How certain is the panel about these?* **Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*	**<u>Patient values and preferences based on:</u>** *Information from research studies:* -Preference for behavioral interventions vs. pharmacotherapy in older age populations -Berkowitz et al 2012, experience with previous treatment may modify preferences *Information from community members on panel:* -There is a power differential between consumer and provider. PST may help with that differential and may facilitate a collaborative working relationship and empower the consumer. *Information from clinicians on panel:* -Preference from older adult populations to receive care in primary care facilities due to stigma issues *Information from other sources (also list sources):*

Next rate the variability of and your certainty about patient values and preferences:

✓	Variability in Patient Values & Preferences	✓	Certainty in Patient Values & Preferences
	High		High
X	Moderate	X	Moderate
	Low		Low
	Unknown		Unknown

Moderate variability and moderate certainty

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

X Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Moderate variability in pt values and preferences and moderate certainty depending on where you look. Some preference for care in primary care settings due to stigma.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Population with minor depression limits generalizability to other populations.
Interventions	Significant variability in outcomes as a function of sites
Comparators	
Outcomes	
Timing or Time frame	Do not have long term followup
Settings	Primary care settings

Notes/Comments:

Williams et al., (2000), pp. 1520-1521

"Patients aged 60 years or older were recruited through referral and screening
At community, Veterans Affairs, and academic-affiliated primary care clinics. The
4 participating centers were chosen for geographic diversity and diversity of
clinical populations. Eligible patients met Diagnostic and Statistical Manual of Mental Disorders,Revised Third Edition (DSMIII-R)
criteria for dysthymia or criteria for minor depression and scored 10
or higher on the 17-item Hamilton Depression Rating Scale (HDRS). Criteria
for minor depression were adapted from the DSM-IV research criteria. We
required symptoms for at least 4 weeks rather than 2 weeks, and 3 or 4 symptoms,
rather than 2 to 4 symptoms. A past history of major depression was not an exclusion criterion. Depression
diagnoses were made by a research psychiatrist or psychologist using the
Primary Care Evaluation of Mental Disorders (PRIME-MD), a diagnostic instrument
designed for use in primary care. Patients were excluded for: major depression, psychosis, schizophrenia
or schizo-affective disorder, bipolar affective disorder, alcohol or other substance abuse within the past 6
months, antisocial personality disorder, borderline personality disorder, serious suicidal risk, moderate or severe
cognitive impairment (Folstein Mini Mental State Examination score), and medical illness with a prognosis of
less than 6 months to live. In addition, patients in current treatment were excluded, with an exception for patients
willing to discontinue treatment who were taking 50 mg or less of amitriptyline or its equivalent."

	"Patients were randomized to receive paroxetine (n=137), PST-PC (n=138), or placebo (n=140). Sociodemographic and clinical characteristics were similar for the 3 treatment groups. The average age of participants was 71 years (range, 60-93 years), 172 (41.5%) were women, and 90 (21.8%) were from minority ethnic groups. Patients averaged 3.4 chronic medical conditions and scored a mean (SD) of 24.4 (12.8) on the Duke Severity of Illness Scale. The most common systems affected by illness were cardiovascular in 294 patients (70.8%), endocrine in 239 (57.6%), musculoskeletal in 194 (46.8%), and gastrointestinal in 123 (29.6%). Comorbid anxiety disorders were present in 121 participants (29.2%). Of the 415 subjects, 211 (51%) met criteria for dysthymia with the remaining 204 (49%) meeting criteria for minor depression. At baseline, depression severity was mild to moderate as shown by a median HDRS score of 13 (interquartile range, 12-15) and an HSCL-D-20 score of 1.4 (interquartile range, 0.9-1.9). Mental health functioning (median, 38.9; interquartile range, 32.4-45.1) and physical functioning (median, 37.4; interquartile range, 29.347.5) were markedly impaired. At baseline, patients with dysthymia and minor depression had similar levels of impairment on all scales."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

[Treatment 1: Problem-solving therapy (individual); Treatment 2: Paroxetine]

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*

		Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We recommend using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
	X	Recommendation for Either Treatment. **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
		No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:
We recommend using either treatment 1 or treatment 2 when both are being considered.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

In balancing these four domains, no statistical evidence for difference in evidence for efficacy, more dropout in Paroxetine, slight pt preferences and values for PST. Facilitate pt education and decision. Delivery of treatment is not uniform across sites.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 14- Combination Interpersonal Psychotherapy (individual) and Nortriptyline vs. Combination Interpersonal Psychotherapy (individual) and Placebo for treating major depressive disorder in adults ages 50 and older

[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Nortriptyline; Treatment 2: Combination Interpersonal Psychotherapy (individual) and Placebo]

Factor	Explanation/Comments
II. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
V. Treatment Outcomes/Consequences • **Benefits** of Treatment 1 and/or Treatment 2 • **Harms** of Treatment 1 and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
XV. Patient Values and Preferences	

XVI. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 14- Combination Interpersonal Psychotherapy (individual) and Nortriptyline vs. Combination Interpersonal Psychotherapy (individual) and Placebo for treating major depressive disorder in adults ages 50 and older

Question: Combination interpersonal psychotherapy (individual) and nortriptyline compared to combination interpersonal psychotherapy (individual) and placebo for treating major depressive disorder in adults ages 50 and older

[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Nortriptyline; Treatment 2: Combination Interpersonal Psychotherapy individual) and Placebo]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Remission (follow up: within 8 weeks of treatment; assessed with: HAMD <= 7 for 3 consecutive weeks)			X	
Outcomes for which no estimable information was found: functional capacity, response, quality of life, relapse, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because response and serious adverse events are not reported and those are critical outcomes, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Nortriptyline; Treatment 2: Combination Interpersonal Psychotherapy (individual) and Placebo]

Bibliography (systematic reviews): Reynolds et al.,1999

Quality assessment		№ of patients		Effect		Quality
№ of studies		a combination of interpersonal psychotherapy (individual) and nortriptyline	a combination of interpersonal psychotherapy (individual) and placebo	Relative (95% CI)	Absolute (95% CI)	
Functional Capacity						
				not estimable	not estimable	
Response						
				not estimable	not estimable	
Remission (follow up: within 8 weeks of treatment; assessed with: HAMD <= 7 for 3 consecutive weeks); based on ITT analysis						
1	See footnote #1	11/16 (68.8%)	5/17 (29.4%)	RR 2.34 (1.04 to 5.24)	394 more per 1000 (from 12 more to 1247 more)	⊕⊕◯◯ LOW
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- Small study, very few events; confidence interval crosses appreciable difference

	Number needed to treat (NNT) (95% Confidence Interval) Remission (follow up: within 8 weeks of treatment; assessed with: HAMD <= 7 for 3 consecutive weeks): NNT = 3 (NNT(benefit) 1 to 12)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Nortriptyline; Treatment 2: Combination Interpersonal Psychotherapy (individual) and Placebo]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Remission (follow up: within 8 weeks of treatment; assessed with: HAMD <= 7 for 3 consecutive weeks)	X	o				

	Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2: No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Reynolds et al., 1999

- **Dropout**:
  - 0% (0 of 16) IPT + nortriptyline vs. 17.6% (3 of 17) IPT + placebo
- **Dropout due to adverse events:**
  - There were no dropouts due to side effects in either IPT group.

Other studies:
Sneed et al (2014) [RCT, 45 and older]: 28.8% (15 of 52) dropped out of nortriptyline group

- 9.6% (5 of 52) of nortriptyline group experienced adverse events

van Schaik et al (2006) [RCT, 55 and older primary care]: 15.9% (11 of 69) dropped out of IPT group

Note any other information on burdens from published studies:

Other studies: none

Note any additional information on harms:

Possibility of suicide/intentional overdose on TCA.

Note any additional information on burdens:

Some difficulty with this medication and hyperglycemia.
Small possibility with medication of confusion due to anticholerginic side effects. No longer a first line medication.
While in practice TCA is less burdensome in regards to time demands, this is off set by the side effect profile which adds an additional burden.

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Nortriptyline; Treatment 2: Combination Interpersonal Psychotherapy (individual) and Placebo]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
2. Adverse events leading to withdrawals	o	o	X	o	o	o
3. Other serious adverse events	o	o	X	o	o	o
4. Other adverse events	o	X	o	o	o	o
5. Burdens	o	X	o	o	o	o

Assign an overall global rating across outcomes:

X Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

[in full guideline document, emphasize that guidelines based on assumption of fidelity to treatment]

III) Patient Values and Preferences

What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?

How variable are these?

How certain is the panel about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

Joo et al (2012) found that in a sample of primary care patients aged 60 and older, "Persons who self-identified as African American were less likely than whites to use interpersonal therapy (IPT) if they had minor depression, even after adjusting for potentially influential variables including age, cognitive functioning, and whether the dose of antidepressant was adequate. Ethnicity was not significantly associated with IPT use in persons with major depression."

[Possible studies to include from APA staff search of pt values and preferences studies]:

**While some articles (e.g. Kitchen et al, 2013) suggested that combination (i.e. psychotherapy plus medication) treatment was preferred over therapy or medication alone, not relevant here since this decision table is essentially comparing two combination (therapy plus medication/placebo) treatments, from the perspective of the client.

Information from community members on panel:

Information from clinicians on panel:

No additional information.

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High	X	High
	Moderate		Moderate
X	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

X Similar values and little uncertainty

☐ Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Older adults generally prefer combined treatment over monotherapy.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	You would not use tricyclics (tcas) in older adult with cardiac problems or blood pressure drops from lying to standing (contraindication due to safety). These data were collected from individuals with bereavement related condition.
Interventions	Optimal use of tricyclics is facilitated by access to blood level data. Placebo condition not comparable to monotherapy because the patient believes it is combination therapy (does n know it is placebo).
Comparators	
Outcomes	
Timing or Time frame	
Settings	

Notes/Comments:

Reynolds, Miller, et al. (1999), p. 203

"To be included in the study, potential subjects were required to meet the criteria of the Schedule for Affective Disorders and Schizophrenia— Lifetime Version (SADS-L) (15) and the Research Diagnostic Criteria (RDC) (16) for a definite current major depressive episode (nonpsychotic and nonbipolar, with no history of chronic
intermittent depression or dysthymia). Forty-eight subjects were diagnosed with the SADS-L and 32 with the Structured Clinical Interview for DSM-IV (17), which replaced the SADS-L as the primary diagnostic instrument in 1996. The onset of the episode was required to fall in the period between 6 months before the death of the spouse and 12 months after the death. Episodes could be either single or recurrent. No other diagnoses, with the exception of generalized anxiety disorder, panic disorder, and posttraumatic stress disorder, were allowed."

	“Most subjects were white female outpatients with mild to moderate episodes of major depression and some associated functional impairment. Most were in their 60s; however, the group randomly assigned to medication clinic, placebo, was significantly younger than the other groups. About two-thirds of the total study group reported that they were in their first lifetime episode of major depression, and a substantial minority reported either suicidal ideation (17%) or a history of suicide attempts (11%). About one-half of the study group met the RDC or DSM-IV criteria for definitely endogenous or melancholic episodes. Typically, subjects had lost a spouse or significant other 7– 9 months earlier (median=32 weeks, with no difference between treatment groups). The treatment groups did not differ significantly on measures of bereavement intensity (Texas Revised Inventory of Grief, Grief Measurement Scale, and Inventory of Complicated Grief). There was also no significant difference in depression severity (Hamilton Depression Rating Scale), cognitive impairment (Mini-Mental State), or the Brief Symptom Inventory measure of anxiety. Because the groups differed in age, as noted above, age was used as a covariate in the major outcome analysis. The distribution of all other demographic, bereavement, and clinical measures was equal among the groups.”

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Nortriptyline; Treatment 2: Combination Interpersonal Psychotherapy (individual) and Placebo]

×	***Recommendation Statement Wording Options by Strength/Grade***
X	***Strong*** *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*

		Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We recommend using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
		Recommendation for Either Treatment. **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
		No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:

We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Large effect size for benefit but limited availability of evidence, factoring in pt values and preferences.

These data were collected from individuals with bereavement related condition.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 15- Combination Interpersonal Psychotherapy (individual) and Nortriptyline vs. Combination Nortriptyline and Medication Clinic Attendance for treating major depressive disorder in adults ages 50 and older
[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Nortriptyline;
Treatment 2: Combination Nortriptyline and Medication Clinic Attendance]

Factor	Explanation/Comments
II. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
II. Treatment Outcomes/Consequences • **Benefits** of Treatment 1 and/or Treatment 2 • **Harms** of Treatment 1 and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
XIX. Patient Values and Preferences	
XL. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 15- Combination Interpersonal Psychotherapy (individual) and Nortriptyline vs. Combination Nortriptyline and Medication Clinic Attendance for treating major depressive disorder in adults ages 50 and older

Question: Combination Interpersonal Psychotherapy (individual) and Nortriptyline compared to Combination Nortriptyline and Medication Clinic Attendance for treating major depressive disorder in adults ages 50 and older

[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Nortriptyline; Treatment 2: Combination Nortriptyline and Medication Clinic Attendance]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Remission (follow up: within 8 weeks of treatment; assessed with: HAMD <= 7 for 3 consecutive weeks)			X	
Outcomes for which no estimable information was found: functional capacity, response, quality of life, relapse, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because response and serious adverse events are not reported and those are critical outcomes, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Nortriptyline; Treatment 2: Combination Nortriptyline and Medication Clinic Attendance]

Bibliography (systematic reviews): Reynolds et al., 1999

		№ of patients		Effect		Quality
№ of studies		**a combination of interpersonal psychotherapy (individual) and nortriptyline**	**a combination of nortriptyline and medication clinic attendance**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response						
				not estimable	not estimable	
Remission (follow up: within 8 weeks of treatment, assessed with: HAMD <= 7 for 3 consecutive weeks); based on ITT analysis						
1	See footnote #1	11/16 (68.8%)	14/25 (56.0%)	**RR 1.23** (0.76 to 1.98)	129 more per 1000 (from 134 fewer to 549 more)	⊕⊕◯◯ LOW
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	

Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- Small study, very few events; confidence interval crosses appreciable difference

Number needed to treat (NNT) (95% Confidence Interval)
Remission (follow up: within 8 weeks of treatment, assessed with: HAMD <= 7 for 3 consecutive weeks); based on ITT analysis: NNT = 8 (NNT(harm) 6 to ∞ to NNT(benefit) 2)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Nortriptyline; Treatment 2: Combination Nortriptyline and Medication Clinic Attendance]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Remission (follow up: within 8 weeks of treatment; assessed with: HAMD <= 7 for 3 consecutive weeks)			X			o

Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Reynolds et al., 1999

- **Dropout**:
  - 0% (0 of 16) IPT + nortriptyline vs. 28% (7 of 25) nortriptyline
- **Dropout due to adverse events:**
  - 18% of nortriptyline group withdrew due to side effects

Other studies:
Sneed et al (2014) [RCT, 45 and older]: 28.8% (15 of 52) dropped out of nortriptyline group
- 9.6% (5 of 52) of nortritpyline group experienced adverse events

van Schaik et al (2006) [RCT, 55 and older primary care]: 15.9% (11 of 69) dropped out of IPT group

Note any other information on burdens from published studies:

Other studies:none

Note any additional information on harms:

None additional.

Note any additional information on burdens:

Individuals in the IPT plus nortriptyline combo condition were more likely to put up with the side effects and not withdraw than those in the nortriptyline alone condition.

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Nortriptyline; Treatment 2: Combination Nortriptyline and Medication Clinic Attendance]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
2. Adverse events leading to withdrawals	o	o	o	o	X	o
3. Other serious adverse events	o	o	X	o	o	o
4. Other adverse events	o	o	o	X	o	o
5. Burdens	o	o	X	o	o	o

Assign an overall global rating across outcomes:

☐ Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
X Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

III) Patient Values and Preferences

What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?

How variable are these?

How certain is the panel about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

Joo et al (2012) found that in a sample of primary care patients aged 60 and older, "Persons who self-identified as African American were less likely than whites to use interpersonal therapy (IPT) if they had minor depression, even after adjusting for potentially influential variables including age, cognitive functioning, and whether the dose of antidepressant was adequate. Ethnicity was not significantly associated with IPT use in persons with major depression."

[Possible studies to include from APA staff search of pt values and preferences studies]:

-**Kitchen et al (2013): "**The purpose of this study was **to investigate depression treatment preferences and anticipated service use in a sample of adults aged 55 years or older who reside in rural Wyoming.** Sixteen participants (mean age = 59) completed 30- to 60-minute, semi-structured interviews. Qualitative methods were used to characterize common themes. Social/provider support and community gatekeepers were perceived by participants as important potential facilitators for seeking depression treatment. In contrast, perceived stigma and the value placed on self-sufficiency emerged as key barriers to seeking treatment for depression in this rural, young-old sample. **Participants anticipated presenting for treatment in the primary care sector and preferred a combination of medication and psychotherapy for treatment.** Participants were, however, more willing to see mental health professionals if they were first referred by a clergy member or primary care physician."

-**Steidtmann et al (2012):** "Background: Findings regarding the relationship between patient treatment preference and treatment outcome are mixed. **This is a secondary data analysis investigating the relationship between treatment preference, and symptom outcome and attrition in a large 2-phase depression treatment trial.** Methods: Patients met DSM-IV criteria for chronic forms of depression. Phase I was a 12-week, nonrandomized, open-label trial in which all participants (n=785) received antidepressant medication(s) (ADM). Phase I non-remitters were randomized to Phase II, in which they received 12 weeks of either Cognitive-Behavioral System of Psychotherapy (CBASP) + ADM (n=193), Brief Supportive Psychotherapy (BSP) + ADM (n=187), or ADM only (n=93). **Participants indicated their treatment preference (medication only, combined treatment or no preference) at study entry.** Symptoms were measured at 2-week intervals with the 24-item Hamilton Rating Scale for Depression (HAM-D). Results: **A large majority of patients reported a preference**

for combined treatment. Patients who preferred medication only were more likely to endorse a chemical imbalance explanation for depression, whereas those desiring combined treatment were more likely to attribute their depression to stressful experiences. In Phase I, patients who expressed no treatment preference showed greater rates of HAM-D symptom reduction than those with any preference, and patients with a preference for medication showed higher attrition than those preferring combined treatment. In Phase II, baseline treatment preference was not associated with symptom reduction or attrition. Conclusions: Treatment preferences may moderate treatment response and attrition in unexpected ways. Research identifying factors associated with differing preferences may enable improved treatment retention and response."

Information from community members on panel:

Information from clinicians on panel:

No additional.

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High	X	High
	Moderate		Moderate
X	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

X Similar values and little uncertainty

☐ Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Older adults prefer combination compared to monotherapy.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	You would not use tricyclics (tcas) in older adult with cardiac problems or blood pressure drops from lying to standing (contraindication due to safety). These data were collected from individuals with bereavement related condition.
Interventions	Optimal use of tricyclics is facilitated by access to blood level data.
Comparators	
Outcomes	
Timing or Time frame	
Settings	

Notes/Comments:
Reynolds, Miller, et al. (1999), p. 203

"To be included in the study, potential subjects were required to meet the criteria of the Schedule for Affective Disorders and Schizophrenia— Lifetime Version (SADS-L) (15) and the Research Diagnostic Criteria (RDC) (16) for a definite current major depressive episode (nonpsychotic and nonbipolar, with no history of chronic
intermittent depression or dysthymia). Forty-eight subjects were diagnosed with the SADS-L and 32 with the Structured Clinical Interview for DSM-IV (17), which replaced the SADS-L as our primary diagnostic instrument in 1996. The onset of the episode was required to fall in the period between 6 months before the death of the spouse and 12 months after the death. Episodes could be either single or recurrent. No other diagnoses, with the exception of generalized anxiety disorder, panic disorder, and posttraumatic stress disorder, were allowed."

	“Most subjects were white female outpatients with mild to moderate episodes of major depression and some associated functional impairment. Most were in their 60s; however, the group randomly assigned to medication clinic, placebo, was significantly younger than the other groups. About two-thirds of the total study group reported that they were in their first lifetime episode of major depression, and a substantial minority reported either suicidal ideation (17%) or a history of suicide attempts (11%). About one-half of the study group met the RDC or DSM-IV criteria for definitely endogenous or melancholic episodes. Typically, subjects had lost a spouse or significant other 7– 9 months earlier (median=32 weeks, with no difference between treatment groups). The treatment groups did not differ significantly on measures of bereavement intensity (Texas Revised Inventory of Grief, Grief Measurement Scale, and Inventory of Complicated Grief). There was also no significant difference in depression severity (Hamilton Depression Rating Scale), cognitive impairment (Mini-Mental State), or the Brief Symptom Inventory measure of anxiety. Because the groups differed in age, as noted above, age was used as a covariate in the major outcome analysis. The distribution of all other demographic, bereavement, and clinical measures was equal among the groups.”

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Nortriptyline; Treatment 2: Combination Nortriptyline and Medication Clinic Attendance]

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
X	***Conditional*** *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*

		Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We recommend using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
		Recommendation for Either Treatment. **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
		No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:
Conditional recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Due to pt preferences for combination treatment and difference in dropout rate and balance of benefits/harms.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 16- Combination Interpersonal Psychotherapy (individual) and Placebo vs. Combination Nortriptyline and Medication Clinic Attendance for treating major depressive disorder in adults ages 50 and older
[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Placebo;
Treatment 2: Combination Nortriptyline and Medication Clinic Attendance]

Factor	Explanation/Comments
I. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
II. Treatment Outcomes/Consequences • **Benefits** of Treatment 1 and/or Treatment 2 • **Harms** of Treatment 1 and/or Treatment 2 • **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do not include financial cost)* **Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2**	
III. Patient Values and Preferences	
IV. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 16- Combination Interpersonal Psychotherapy (individual) and Placebo vs. Combination Nortriptyline and Medication Clinic Attendance for treating major depressive disorder in adults ages 50 and older

Question: Combination Interpersonal Psychotherapy (individual) and Placebo compared to Combination Nortriptyline and Medication Clinic Attendance for treating major depressive disorder in adults ages 50 and older

[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Placebo; Treatment 2: Combination Nortriptyline and Medication Clinic Attendance]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Remission (follow up: within 8 weeks of treatment; assessed with: HAMD <= 7 for 3 consecutive weeks)			X	
Outcomes for which no estimable information was found: functional capacity, response, quality of life, relapse, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because response and serious adverse events are not reported and those are critical outcomes, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Placebo; Treatment 2: Combination Nortriptyline and Medication Clinic Attendance]

Bibliography (systematic reviews): Reynolds et al., 1999

Quality assessment		№ of patients		Effect		Quality
№ of studies		**a combination of interpersonal psychotherapy (individual) and placebo**	**a combination of nortriptyline and medication clinic attendance**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response						
				not estimable	not estimable	
Remission (follow up: within 8 weeks of treatment; assessed with: HAMD <= 7 for 3 consecutive weeks)						
1	See footnote #1	14/25 (56.0%)	5/17 (29.4%)	**RR 0.53** (0.23 to 1.19)	138 fewer per 1000 (from 56 more to 226 fewer)	⊕⊕◯◯ LOW
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Relapse						

				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- Small study, few events; confidence intervals cross appreciable difference

Number needed to treat (NNT) (95% Confidence Interval)
Remission (follow up: within 8 weeks of treatment; assessed with: HAMD <= 7 for 3 consecutive weeks): NNT = 4 (NNT(harm) 40 to ∞ to NNT(benefit) 1)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Placebo; Treatment 2: Combination Nortriptyline and Medication Clinic Attendance]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Remission (follow up: within 8 weeks of treatment; assessed with: HAMD <= 7 for 3 consecutive weeks)			X *			o

*Caveat- numbers small and can't exclude possibility of type 2 error.

	Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2: No estimable information found on serious adverse events. **Note any other information on harms from published studies:**

Reynolds et al., 1999

- **Dropout**:
    - 17.6% (3 of 17) IPT + placebo vs. 28% (7 of 25) nortriptyline
- **Dropout due to adverse events:**
    - 18% of nortriptyline group withdrew due to side effects. There were no dropout due to side effects in the IPT groups.

Other studies:
Sneed et al (2014) [RCT, 45 and older]: 28.8% (15 of 52) dropped out of nortriptyline group
- 9.6% (5 of 52) of nortriptyline group experienced adverse events

van Schaik et al (2006) [RCT, 55 and older primary care]: 15.9% (11 of 69) dropped out of IPT group

Note any other information on burdens from published studies:

Other studies:
Joo et al (2012) found that in a sample of primary care patients aged 60 and older, "Persons who self-identified as African American were less likely than whites to use interpersonal therapy (IPT) if they had minor depression, even after adjusting for potentially influential variables including age, cognitive functioning, and whether the dose of antidepressant was adequate. Ethnicity was not significantly associated with IPT use in persons with major depression."

Note any additional information on harms:

None additional.

Note any additional information on burdens:

Individuals in the IPT plus nortriptyline combo condition were more likely to put up with the side effects and not withdraw than those in the nortriptyline alone condition.

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Placebo; Treatment 2: Combination Nortriptyline and Medication Clinic Attendance]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
2. Adverse events leading to withdrawals	o	O	o	o	X	o
3. Other serious adverse events	o	O	X	o	o	o
4. Other adverse events	o	O	o	X	o	o
5. Burdens	o	O	X	o	o	o

Assign an overall global rating across outcomes:

☐ Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
X Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

III) Patient Values and Preferences

What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?

How variable are these?

How certain is the panel about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

[Possible studies to include from APA staff search of pt values and preferences studies]:

-**Kitchen et al (2013):** "The purpose of this study **was to investigate depression treatment preferences and anticipated service use in a sample of adults aged 55 years or older who reside in rural Wyoming.** Sixteen participants (mean age = 59) completed 30- to 60-minute, semi-structured interviews. Qualitative methods were used to characterize common themes. Social/provider support and community gatekeepers were perceived by participants as important potential facilitators for seeking depression treatment. In contrast, perceived stigma and the value placed on self-sufficiency emerged as key barriers to seeking treatment for depression in this rural, young-old sample. **Participants anticipated presenting for treatment in the primary care sector and preferred a combination of medication and psychotherapy for treatment.** Participants were, however, more willing to see mental health professionals if they were first referred by a clergy member or primary care physician."

-**Steidtmann et al (2012):** "Background: Findings regarding the relationship between patient treatment preference and treatment outcome are mixed. **This is a secondary data analysis investigating the relationship between treatment preference, and symptom outcome and attrition in a large 2-phase depression treatment trial.** Methods: Patients met DSM-IV criteria for chronic forms of depression. Phase I was a 12-week, nonrandomized, open-label trial in which all participants (n=785) received antidepressant medication(s) (ADM). Phase I non-remitters were randomized to Phase II, in which they received 12 weeks of either Cognitive-Behavioral System of Psychotherapy (CBASP) + ADM (n=193), Brief Supportive Psychotherapy (BSP) + ADM (n=187), or ADM only (n=93). **Participants indicated their treatment preference (medication only, combined treatment or no preference) at study entry.** Symptoms were measured at 2-week intervals with the 24-item Hamilton Rating Scale for Depression (HAM-D). Results: **A large majority of patients reported a preference for combined treatment. Patients who preferred medication only were more likely to endorse a chemical imbalance explanation for depression, whereas those desiring combined treatment were more likely to attribute their depression to stressful experiences.** In Phase I, patients who expressed no treatment preference showed greater rates of HAM-D symptom reduction than those with any preference, and patients with a preference for medication showed higher attrition than those preferring combined treatment. In Phase II, baseline treatment preference was not associated with symptom

reduction or attrition. Conclusions: Treatment preferences may moderate treatment response and attrition in unexpected ways. Research identifying factors associated with differing preferences may enable improved treatment retention and response."

Information from community members on panel:

Information from clinicians on panel:

No additional.

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High	X	High
	Moderate		Moderate
X	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

X Similar values and little uncertainty

☐ Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Older adults prefer combination therapy over pharmacotherapy.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	You would not use tricyclics (tcas) in older adult with cardiac problems or blood pressure drops from lying to standing (contraindication due to safety). These data were collected from individuals with bereavement related condition.
Interventions	Optimal use of tricyclics is facilitated by access to blood level data.
Comparators	Placebo not given in real world practice.
Outcomes	
Timing or Time frame	
Settings	Mental health specific settings.

Notes/Comments:

Reynolds, Miller, et al. (1999), p. 203

"To be included in the study, potential subjects were required to meet the criteria of the Schedule for Affective Disorders and Schizophrenia— Lifetime Version (SADS-L) (15) and the Research Diagnostic Criteria (RDC) (16) for a definite current major depressive episode (nonpsychotic and nonbipolar, with no history of chronic
intermittent depression or dysthymia). Forty-eight subjects were diagnosed with the SADS-L and 32 with the Structured Clinical Interview for DSM-IV (17), which replaced the SADS-L as our primary diagnostic instrument in 1996. The onset of the episode was required to fall in the period between 6 months before the death of the spouse and 12 months after the death. Episodes could be either single or recurrent. No other diagnoses, with the exception of generalized anxiety disorder, panic disorder, and posttraumatic stress disorder, were allowed."

	"Most subjects were white female outpatients with mild to moderate episodes of major depression and some associated functional impairment. Most were in their 60s; however, the group randomly assigned to medication clinic, placebo, was significantly younger than the other groups. About two-thirds of the total study group reported that they were in their first lifetime episode of major depression, and a substantial minority reported either suicidal ideation (17%) or a history of suicide attempts (11%). About one-half of the study group met the RDC or DSM-IV criteria for definitely endogenous or melancholic episodes. Typically, subjects had lost a spouse or significant other 7– 9 months earlier (median=32 weeks, with no difference between treatment groups). The treatment groups did not differ significantly on measures of bereavement intensity (Texas Revised Inventory of Grief, Grief Measurement Scale, and Inventory of Complicated Grief). There was also no significant difference in depression severity (Hamilton Depression Rating Scale), cognitive impairment (Mini-Mental State), or the Brief Symptom Inventory measure of anxiety. Because the groups differed in age, as noted above, age was used as a covariate in the major outcome analysis. The distribution of all other demographic, bereavement, and clinical measures was equal among the groups."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

[Treatment 1: Combination Interpersonal Psychotherapy (individual) and Placebo; Treatment 2: Combination Nortriptyline and Medication Clinic Attendance]

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
X	***Conditional*** *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*

		Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We recommend using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
		Recommendation for Either Treatment. **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
		No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:

Conditional recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Based on considerations of safety and client preferences and values.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 17- Comparative Effectiveness of CBT (group) plus Pharmacotherapy vs. Pharmacotherapy for Preventing Relapse/Recurrence
[Treatment 1: CBT (group) plus Pharmacotherapy; Treatment 2: Pharmacotherapy]

Factor	Explanation/Comments
V. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
VI. Treatment Outcomes/Consequences	
• **Benefits** of Treatment 1 and/or Treatment 2	
• **Harms** of Treatment 1 and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
VII. Patient Values and Preferences	
VIII. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 17- Comparative Effectiveness of CBT (group) plus Pharmacotherapy vs. Pharmacotherapy for Preventing Relapse/Recurrence

Question: Cognitive Behavioral Therapy (group) plus pharmacotherapy* compared to pharmacotherapy for preventing relapse/recurrence in adults ages 60 and older

[Treatment 1: CBT (group) plus Pharmacotherapy; Treatment 2: Pharmacotherapy]

*therapeutic doses of antidepressants equivalent to fluoxetine 20 mg or amitriptyline 150 mg

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Recurrence (follow up: 6 months; assessed with: MADRS >= 10); RR adjusted for clustering and baseline value, N per protocol			X	
Recurrence (follow up: 12 months; assessed with: MADRS >= 10); RR adjusted for clustering and baseline value, N per protocol			X	
Outcomes for which no estimable information was found: functional capacity, response, remission, quality of life, patient satisfaction, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*. While response to treatment is a critical outcome, the focus of the present decision table is on prevention of relapse/recurrence and thus we consider that in place of response to treatment.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: CBT (group) plus Pharmacotherapy; Treatment 2: Pharmacotherapy]

Bibliography (systematic reviews): Wilkinson et al., 2009 (primary source); Wilkinson & Izmeth, 2012 (systematic review)

		№ of patients		Effect		Quality
№ of studies		**cognitive behavioral therapy (group) plus pharmacotherapy**	**pharmacotherapy**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response						
				not estimable	not estimable	
Remission						
				not estimable	not estimable	
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	

Recurrence (follow up: 6 months; assessed with: MADRS >= 10); RR adjusted for clustering and baseline value, N per protocol						
1	See footnote #1	1/18 (5.6%)	4/19 (21.1%)	**RR 0.34** (0.03 to 3.35)	139 fewer per 1000 (from 204 fewer to 495 more)	⊕⊕◯◯ LOW
Recurrence (follow up: 12 months; assessed with: MADRS >= 10); RR adjusted for clustering and baseline value, N per protocol						
1	See footnote #1	5/18 (27.8%)	8/18 (44.4%)	**RR 0.70** (0.26 to 1.94)	133 fewer per 1000 (from 329 fewer to 418 more)	⊕⊕◯◯ LOW

MD – mean difference, RR – relative risk
Footnote #1- small sample size, OIS not met, CIs do not rule out important benefits or harms

Number needed to treat (NNT) (95% Confidence Interval)
Recurrence (follow up: 6 months; assessed with: MADRS >= 10); RR adjusted for clustering and baseline value, N per protocol: NNT = 6 (NNT(harm) 3 to ∞ to NNT(benefit) 17)
Recurrence (follow up: 12 months; assessed with: MADRS >= 10); RR adjusted for clustering and baseline value, N per protocol: NNT = 6 (NNT(harm) 3 to ∞ to NNT(benefit) 7)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

[Treatment 1: CBT (group) plus Pharmacotherapy; Treatment 2: Pharmacotherapy]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Recurrence (follow up: 6 months)						X
2. Recurrence (follow up: 12 months)						X

Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Wilkinson et al (2009)

- **Dropout**:
    - 22.7% (5 of 22) CBT-G v. 0% (0 of 23) antidepressant alone
- **Symptom Worsening:**
    - Participants in CBT-G reported a significant increase in physical symptoms on the BDI between 6 and 12 months compared to antidepressant alone group

Note any other information on burdens from published studies:

Wilkinson et al (2009)

- **Burden**:
    - CBT-G involved 8 90-min sessions with homework assignments between sessions

Note any additional information on harms:

- amitriptyline may be harmful intervention for older adults due to side effect atropinic side effects (cognitive, cognitive disturbances) (Beer's Criteria)

Note any additional information on burdens:

-big burden from community member perspective, eight 90 min sessions plus homework in between sessions
-some individuals do not feel comfortable in group settings

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: CBT (group) plus Pharmacotherapy; Treatment 2: Pharmacotherapy]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
3. Adverse events leading to withdrawals						X
4. Other serious adverse events						X
5. Other adverse events						X*
6. Burdens		X				

*There were adverse events and one death, but unable to attribute cause of death.

Assign an overall global rating across outcomes:

☐ Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

Unable to determine due to the pilot nature of this single study available (unable to rate benefits)

III) Patient Values and Preferences

What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?

How variable are these?

How certain is the panel about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

- Wilkinson et al (2009) : 88% of CBT-G participants reported good-excellent satisfaction with treatment, not rating of satisfaction in pharmacotherapy condition
- Several research studies show that older adults prefer psychotherapy over medication
- Gum et al., 2006 study, primary care pts prefer counseling over meds
- Lin et al 2005 study

Information from community members on panel:

-patients may be influenced by provider recommendations/preferences

-relative burdens of CBT-G (long sessions and homework)

Information from clinicians on panel:

-some individuals do not feel comfortable in group settings

-some older individuals may appreciate the opportunity to interact with others in a group setting

-pts might feel more comfortable receiving care in their primary care setting due to reduced stigma

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High		High
X *	Moderate	X*	Moderate
	Low		Low
	Unknown		Unknown

*in community setting

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

X Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Moderate variation in pt values and preferences and moderate certainty.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	No information about race/ethnicity. Very heterogeneous population of depression diagnos and intensity.
Interventions	Concern about single therapist delivering CBT-G intervention.
Comparators	Medication intervention not well characterized.
Outcomes	Not all randomized pts were included in the outcomes.
Timing or Time frame	
Settings	Mix of community mental health and general practice settings (treatment as usual settings

Notes/Comments:

From Wilkinson et al. (2009), p. 69:

Participants

"Patients aged 60 and over were recruited from GP surgeries and psychiatric services in Oxford and Southampton, UK. A screening visit was performed by an experienced community psychiatric nurse to assess inclusion and exclusion criteria and to obtain consent. Eligible participants had experienced an episode of major depression according to ICD-10 criteria (World Health Organisation, 1993) within the last year that had remitted for at least 2 months on antidepressant medication. They were still taking the antidepressant and scored less than10 on the MADRS. Exclusion criteria were MMSE score of less than 24 (Folstein et al.,1975),current severe alcohol problems and a diagnosis of bipolar disorder."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

[Treatment 1: CBT (group) plus Pharmacotherapy; Treatment 2: Pharmacotherapy]

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*

		Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We recommend using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
		Recommendation for Either Treatment. **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
	X	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:

No recommendation.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability. Single available study was pilot study.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 18- Comparative Effectiveness of Interpersonal psychotherapy (individual) plus Nortriptyline vs. Interpersonal psychotherapy (individual) plus Placebo plus Medication clinic attendance for Preventing Relapse/Recurrence
[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline;
Treatment 2: Interpersonal psychotherapy (individual) plus Placebo]

Factor	Explanation/Comments
X. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
L. Treatment Outcomes/Consequences	
• **Benefits** of Treatment 1 and/or Treatment 2	
• **Harms** of Treatment 1 and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
LI. Patient Values and Preferences	

LII. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 18- Comparative Effectiveness of Interpersonal psychotherapy (individual) plus Nortriptyline vs. Interpersonal psychotherapy (individual) plus Placebo plus Medication clinic attendance for Preventing Relapse/Recurrence

Question: Interpersonal psychotherapy (individual) plus nortriptyline compared to interpersonal psychotherapy (individual) plus placebo plus Medication clinic attendance **for preventing relapse/recurrence in adults ages 60 and older**

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Interpersonal psychotherapy (individual) plus Placebo **plus Medication clinic attendance**]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a <u>strong</u> recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	<u>Rate the quality of the evidence grade for each outcome from the evidence profiles:</u>

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Outcomes for which no estimable information was found: functional capacity, response, remission, quality of life, patient satisfaction, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*. While response to treatment is a critical outcome, the focus of the present decision table is on prevention of relapse/recurrence and thus we consider that in place of response to treatment.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Interpersonal psychotherapy (individual) plus Placebo plus Medication clinic attendance]

Bibliography (systematic reviews): Reynolds et al., 1999 (primary source); Wilkinson & Izmeth, 2012 (systematic review)

		№ of patients		Effect		Quality
№ of studies		**interpersonal psychotherapy (individual) plus nortriptyline**	**interpersonal psychotherapy (individual) plus placebo**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response						
				not estimable	not estimable	
Remission						
				not estimable	not estimable	
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	

Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview)						
1	See footnote #1	5/25 (20.0%)	9/25 (36.0%)	**RR 0.56** (0.22 to 1.43)	158 fewer per 1000 (from 155 more to 281 fewer)	⊕⊕◯◯ LOW
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview)						
1	See footnote #2	5/25 (20.0%)	14/25 (56.0%)	**RR 0.36** (0.15 to 0.84)	358 fewer per 1000 (from 90 fewer to 476 fewer)	⊕⊕◯◯ LOW
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview)						
1	See footnote #2	8/25 (32.0%)	16/25 (64.0%)	**RR 0.50** (0.26 to 0.95)	320 fewer per 1000 (from 32 fewer to 474 fewer)	⊕⊕◯◯ LOW

MD – mean difference, RR – relative risk

Footnote #1- Small sample size, OIS not met, CI fails to exclude important benefit or important harm
Footnote #2- Small sample size, OIS not met

Number needed to treat (NNT) (95% Confidence Interval)
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 6 (NNT(harm) 3 to ∞ to NNT(benefit) 11)
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 3 (NNT(benefit) 2 to 10)
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 3 (NNT(benefit) 2 to 18)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Interpersonal psychotherapy individual) plus Placebo plus Medication clinic attendance]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Recurrence (follow up: 12 months)			X*			o
2. Recurrence (follow up: 24 months)	X	o				
3. Recurrence (follow up: 36 months)	X	o				

*No statistical difference. The study was not designed to be able to determine equivalence. Rather study not sufficiently powered to provide meaningful information.

	Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2: No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Reynolds et al (1999)

- **Dropout**:
    - 12% (3 of 25) IPT + N v. 16% (4 of 25) IPT + placebo
- **Adverse events:**
    - One patient committed suicide 1 year after leaving the study against medical advice

Note any other information on burdens from published studies:

Reynolds et al (1999)

- **Burden**:
    - Participants in both conditions were seen monthly for 50-min

[Medication clinic is pill, education, TLC (supportive), major supportive component]

Note any additional information on harms:

-Nortriptyline higher risk of suicide completion following overdose (higher mortality with suicide attempt) (Antidepressants protective against suicide in elderly).
-Nortriptyline higher risk of suicide completion following overdose (higher mortality with suicide attempt) (black box warning meta analysis, Bridges).
-In reality in clinical practice people would not be told it was pill placebo

Note any additional information on burdens:

-Combined treatment could add time but mitigate consequences because IPT specifically fosters that
-Maintaining contact with one's therapist
[Note that cost of treatments in this study were fully covered.]

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Interpersonal psychotherapy (individual) plus Placebo plus Medication clinic attendance]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
4. Adverse events leading to withdrawals	o	o	o	o	o	X
5. Other serious adverse events	o	o	o	o	o	X
6. Other adverse events	o	o	X*	o	o	o
7. Burdens	o	o	X	o	o	o

*Based on general knowledge as opposed to specific information

*Participants had established course of treatment that demonstrated tolerability in prior acute tx. Study selected for participants who had demonstrated ability to tolerate the medication.

Assign an overall global rating across outcomes:

X * Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2

☐ Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2

☐ Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2

☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1

☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

*For extended treatment. Benefits are demonstrated over time in combination condition.

III) Patient Values and Preferences *What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?* *How variable are these?* *How certain is the panel about these?* **Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*	**<u>Patient values and preferences based on:</u>** *Information from research studies:* -75 % prefer psychotherapy to medication (across ages, all kinds of publications in this field). Older patients have concerns about multiple medications. Latino and African American communities have concerns about medications being addictive. Data suggests better outcomes for those receiving their preferred treatment. -From patient values and preferences spreadsheet: Dobscha et al (2007), Raue et al (2009), Gum et al (2006), Kitchen et al (2013) and Kessing et al (2005) *Information from community members on panel:* One of biggest obstacles is finding a therapist that is a good match, supervised setting can be beneficial. Side effects of medication Medication side effects, side effects for sex. Ability to empower pt to tell therapist if cross boundary, tell therapist about side effects. Communication between providers for combined treatment is important. *Information from clinicians on panel:* Majority veterans at a specific VA site prefer psychotherapy but willing to do medication. Values of shared decision making now than was the case in the early 90s. How much information available plays a role. Need to consider needs and values of the family. Need to consider different sub-population beliefs about roots of illness. Might need cooperation between providers of different treatments to encourage patient values and preferences. Often preferences for racial matching though not necessarily supported by efficacy. Communication across providers *Information from other sources (also list sources):*

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High		High
X	Moderate		Moderate
	Low	X	Low
	Unknown		Unknown

Moderate variability, low certainty

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

☐ Some variation or some uncertainty

X Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Moderate variability, low certainty for this population. Moderate variability based on input from community Member, lack of evidence low certainty.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Only generalizable of pts that are tx responders that are willing to accept combined tx.[General preamble, willingness to be randomized]. Population with highly recurrent depression (non-psychotic and non-bipolar). Racial/ethnic diversity of sample limited.
Interventions	Quality of providers highly controlled. Quality of medication delivery highly controlled. Controlled to prevent drift, supervision provided. Implementation is highly controlled [see above sentence… med clinic includes XYZ]
Comparators	Claims data show little psychotherapy vs. medication use. 50% co-pay for therapy for medicare but decreasing with the advent of parity.
Outcomes	Looking at maintenance/continuation not active interventions for outcomes
Timing or Time frame	Dosage of treatment, how long it is. Is 12 or 8 sessions, 3 years feasible and/or necessary Differential results over time, in third year. Not seeing differing results in the first year.
Settings	For every RCT concern about applicability of setting. Highly controlled and specialized.

Notes/Comments:

From Reynolds et al. (1999), pp. 40-41:

"The study was conducted at a university based geropsychiatric research clinic. Over a 7-year period, we recruited 187 elderly patients with recurrent, nonpsychotic, nondysthymic, unipolar major depression, of whom 180 actually began treatment. Patients were required to be 60 years or older and to meet expert clinical judgment and research diagnostic criteria, as established by structured interview with the Schedule for Affective Disorders and Schizophrenia Lifetime Version, for recurrent nonpsychotic unipolar major depression. Patients were also required to be at least in their second lifetime episode, with an interepisode wellness interval of no longer than 3 years, a Hamilton Depression Rating Scale(17-item) score of 17 or greater, and a Folstein Mini-Mental State Examination score of 27 or greater. All subjects provided written informed consent. We screened 687 subjects to yield the study group of 187.Of the 500 subjects excluded,119 had single episodes of major depression,63 had interepisode wellness intervals longer than 3 years,43 presented medical contraindications to the use of nortriptyline, and 23 had dysthymia as well as major depression. Additional reasons for exclusion included:12 who failed to meet study age criteria, 24 with delusional depression, and 135 with other psychiatric diagnoses. Excluded patients were offered treatment at the Benedum Geriatric Center at the University of Pittsburgh Medical Center, Pittsburgh, Pa. Reliable data concerning treatment history were not generally available. Of the patients who began active treatment, 48.7% were clinically referred, 42.6% were recruited through the media and community presentations, and 8.7% learned of the study by word of mouth."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Interpersonal psychotherapy (individual) plus Placebo plus Medication clinic attendance]

×	***Recommendation Statement Wording Options by Strength/Grade***
X	***Strong*** *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*

		Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We recommend using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
		Recommendation for Either Treatment. **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
		No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:

We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

In older adults with recurrent depression continuation of maintenance interpersonal psychotherapy with active medication has greater efficacy in preventing recurrence of depression than continuation of monthly maintenance IPT with pill placebo. This effect becomes apparent in years 2 and 3 of maintenance treatment.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 19- Comparative Effectiveness of Interpersonal psychotherapy (individual) plus Nortriptyline vs. Nortriptyline plus Medication Clinic Attendance for Preventing Relapse/Recurrence
[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Nortriptyline plus Medication Clinic Attendance]

Factor	Explanation/Comments
II. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
V. Treatment Outcomes/Consequences	
• **Benefits** of Treatment 1and/or Treatment 2	
• **Harms** of Treatment 1and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2	
(Note- do not include financial cost)	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
LV. Patient Values and Preferences	
LVI. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 19- Comparative Effectiveness of Interpersonal psychotherapy (individual) plus Nortriptyline vs. Nortriptyline plus Medication Clinic Attendance for Preventing Relapse/Recurrence

Question: Interpersonal psychotherapy (individual) plus nortriptyline compared to nortriptyline plus medication clinic attendance for preventing relapse/recurrence in adults ages 60 and older

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Nortriptyline plus Medication Clinic Attendance]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Outcomes for which no estimable information was found: functional capacity, response, remission, quality of life, patient satisfaction, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*. While response to treatment is a critical outcome, the focus of the present decision table is on prevention of relapse/recurrence and thus we consider that in place of response to treatment.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Nortriptyline plus Medication Clinic Attendance]

Bibliography (systematic reviews): Reynolds et al., 1999 (primary source); Wilkinson & Izmeth, 2012 (systematic review)

Quality assessment			№ of patients		Effect		Quality
№ of studies	**Study design**		**interpersonal psychotherapy (individual) plus nortriptyline**	**nortriptyline plus medication clinic attendance**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity							
					not estimable	not estimable	
Response							
					not estimable	not estimable	
Remission							
					not estimable	not estimable	
Quality of Life							
					not estimable	not estimable	
Patient Satisfaction							
					not estimable	not estimable	

Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview)							
1	randomized trials	See footnote #1	5/25 (20.0%)	8/28 (28.6%)	**RR 0.70** (0.26 to 1.86)	86 fewer per 1000 (from 211 fewer to 246 more)	⊕⊕◯◯ LOW
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview)							
1	randomized trials	See footnote #1	5/25 (20.0%)	12/28 (42.9%)	**RR 0.47** (0.19 to 1.14)	227 fewer per 1000 (from 60 more to 347 fewer)	⊕⊕◯◯ LOW
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview)							
1	randomized trials	See footnote #1	8/25 (32.0%)	14/28 (50.0%)	**RR 0.64** (0.32 to 1.26)	180 fewer per 1000 (from 130 more to 340 fewer)	⊕⊕◯◯ LOW

MD – mean difference, RR – relative risk

Footnote #1- small sample size, OIS not met, CIs do not rule out important benefits or harms.

Number needed to treat (NNT) (95% Confidence Interval)
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 12 (NNT(harm) 4 to ∞ to NNT(benefit) 6)
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 4 (NNT(harm) 3 to ∞ to NNT(benefit) 79)
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 6 (NNT(harm) 3 to ∞ to NNT(benefit) 12)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Nortriptyline plus Medication Clinic Attendance]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Recurrence (follow up: 12 months)			X*			o
2. Recurrence (follow up: 24 months)			X*			o
3. Recurrence (follow up: 36 months)			X*			o

*No statistical difference. The study was not designed to be able to determine equivalence. Rather study not sufficiently powered to provide meaningful information.

Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Reynolds et al (1999)

- **Dropout**:
    - 12% (3 of 25) IPT + N v. 14.3% (4 of 28) nortriptyline
- **Adverse events:**
    - One patient committed suicide 1 year after leaving the study against medical advice

Note any other information on burdens from published studies:

Reynolds et al (1999)

- **Burden**:
    - Participants in IPT conditions were seen monthly for 50-min
    - Participants in medication only conditions were seen monthly for 30 min
- Difference in time (30 vs. 80)

[Medication clinic is pill, education, TLC (supportive), major supportive component]

Note any additional information on harms:
-Nortriptyline higher risk of suicide completion following overdose (higher mortality with suicide attempt) (Antidepressants protective against suicide in elderly).
-Nortriptyline higher risk of suicide completion following overdose (higher mortality with suicide attempt) (black box warning meta analysis, Bridges).
-In reality in clinical practice people would not be told it was pill placebo

Note any additional information on burdens:
-Combined treatment could add time but mitigate consequences because IPT specifically fosters that
-Maintaining contact with one's therapist
[Note that cost of treatments in this study were fully covered.]

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Nortriptyline plus Medication Clinic Attendance]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
4. Adverse events leading to withdrawals	o	o	o	o	o	X
5. Other serious adverse events	o	o	o	o	o	X
6. Other adverse events	o	o	X	o	o	o
7. Burdens	o	X		o	o	o

Assign an overall global rating across outcomes:

☐ Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
X* Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

*Based on general knowledge as opposed to specific information

*Participants had established course of treatment that demonstrated tolerability in prior acute tx. Study selected for participants who had demonstrated ability to tolerate the medication.

III) Patient Values and Preferences *What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?* *How variable are these?* *How certain is the panel about these?* **Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*	**<u>Patient values and preferences based on:</u>** *Information from research studies:* -75 % prefer psychotherapy to medication (across ages, all kinds of publications in this field). Older patients have concerns about multiple medications. Latino and African American communities have concerns about medications being addictive. Data suggests better outcomes for those receiving their preferred treatment. -From patient values and preferences spreadsheet: Dobscha et al (2007), Raue et al (2009), Gum et al (2006), Kitchen et al (2013) and Kessing et al (2005) *Information from community members on panel:* One of biggest obstacles is finding a therapist that is a good match, supervised setting can be beneficial. Side effects of medication Medication side effects, side effects for sex. Ability to empower pt to tell therapist if cross boundary, tell therapist about side effects. Communication between providers for combined treatment is important. *Information from clinicians on panel:* Majority veterans at a specific VA site prefer psychotherapy but willing to do medication. Values of shared decision making now than was the case in the early 90s. How much information available plays a role. Need to consider needs and values of the family. Need to consider different sub-population beliefs about roots of illness. Might need cooperation between providers of different treatments to encourage patient values and preferences. Often preferences for racial matching though not necessarily supported by efficacy. Communication across providers. *Information from other sources (also list sources):*

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High		High
X	Moderate		Moderate
	Low	X	Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

☐ Some variation or some uncertainty

X Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Moderate variability, low certainty for this population. Moderate variability based on input from community Member, lack of evidence low certainty.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Only generalizable of pts that are tx responders that are willing to accept combined tx.[General preamble, willingness to be randomized]. Population with highly recurrent depression (non-psychotic and non-bipolar). Racial/ethnic diversity of sample limited.
Interventions	Quality of providers highly controlled. Quality of medication delivery highly controlled. Controlled to prevent drift, supervision provided. Implementation is highly controlled [see above sentence… med clinic includes XYZ]
Comparators	Claims data show little psychotherapy vs. medication use. 50% co-pay for therapy for medicare but decreasing with the advent of parity.
Outcomes	Looking at maintenance/continuation not active interventions for outcomes.
Timing or Time frame	Dosage of treatment, how long it is. Is 12 or 8 sessions, 3 years feasible and/or necessary
Settings	For every RCT concern about applicability of setting. Highly controlled and specialized.

Notes/Comments:

From Reynolds et al. (1999), pp. 40-41:

"The study was conducted at a university based geropsychiatric research clinic. Over a 7-year period, we recruited 187 elderly patients with recurrent, nonpsychotic, nondysthymic, unipolar major depression, of whom 180 actually began treatment. Patients were required to be 60 years or older and to meet expert clinical judgment and research diagnostic criteria, as established by structured interview with the Schedule for Affective Disorders and Schizophrenia Lifetime Version for recurrent nonpsychotic unipolar major depression. Patients were also required to be at least in their second lifetime episode, with an interepisode wellness interval of no longer than 3 years, a Hamilton Depression Rating Scale(17-item) score of 17 or greater, and a Folstein Mini-Mental State Examination score of 27 or greater. All subjects provided written informed consent. We screened 687 subjects to yield the study group of 187.Of the 500 subjects excluded,119 had single episodes of major depression,63 had interepisode wellness intervals longer than 3years,43 presented medical contraindications to the use of nortriptyline, and 23 had dysthymia as well as major depression. Additional reasons for exclusion included:12 who failed to meet study age criteria, 24 with delusional depression, and 135 with other psychiatric diagnoses. Excluded patients were offered treatment at the Benedum Geriatric Center at the University of Pittsburgh Medical Center, Pittsburgh, Pa. Reliable data concerning treatment history were not generally available. Of the patients who began active treatment, 48.7% were clinically referred, 42.6% were recruited through the media and community presentations, and 8.7% learned of the study by word of mouth."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Nortriptyline plus Medication Clinic Attendance]

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.*

	We <u>recommend</u> using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered: *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
X	<u>Recommendation for Either Treatment.</u> **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
	<u>No Recommendation.</u> *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:
We recommend using either treatment 1 or treatment 2 when both are being considered.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Although the added value of IPT above pharmacotherapy did not reach significance there may be other considerations to take into account. Number one being additional data not published in the present article that suggests the advantage of IPT for social role functioning and this article's place in the overall literature as evidenced by meta analyses.

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 20- Comparative Effectiveness of Interpersonal Psychotherapy (individual) plus Nortriptyline vs. Placebo plus Medication clinic attendance for Preventing Relapse/Recurrence
[Treatment 1: Interpersonal Psychotherapy (individual) plus Nortriptyline;
Treatment 2: Placebo plus Medication clinic attendance]

Factor	Explanation/Comments
II. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
II. Treatment Outcomes/Consequences • **Benefits** of Treatment 1 and/or Treatment 2 • **Harms** of Treatment 1 and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
LIX. Patient Values and Preferences	
LX. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 20- Comparative Effectiveness of Interpersonal Psychotherapy (individual) plus Nortriptyline vs. Placebo plus Medication clinic attendance for Preventing Relapse/Recurrence

Question: Interpersonal psychotherapy (individual) plus nortriptyline compared to placebo plus medication clinic attendance for preventing relapse/recurrence in adults ages 60 and older

[Treatment 1: Interpersonal Psychotherapy (individual) plus Nortriptyline; Treatment 2: Placebo plus Medication clinic attendance]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Outcomes for which no estimable information was found: functional capacity, response, remission, quality of life, patient satisfaction, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*. While response to treatment is a critical outcome, the focus of the present decision table is on prevention of relapse/recurrence and thus we consider that in place of response to treatment.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Placebo plus Medication clinic attendance]

Bibliography (systematic reviews): Reynolds et al., 1999 (primary source); Wilkinson & Izmeth, 2012 (systematic review)

		№ of patients		Effect		Quality
№ of studies		**interpersonal psychotherapy (individual) plus nortriptyline**	**placebo plus medication clinic attendance**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response						
				not estimable	not estimable	
Remission						
				not estimable	not estimable	
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview)						
1	See footnote #1	5/25 (20.0%)	22/29 (75.9%)	**RR 0.26** (0.12 to 0.59)	561 fewer per 1000 (from 311 fewer to 668 fewer)	⊕⊕◯◯ LOW
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview)						

1	See footnote #1	5/25 (20.0%)	24/29 (82.8%)	**RR 0.24** (0.11 to 0.54)	629 fewer per 1000 (from 381 fewer to 737 fewer)	⊕⊕◯◯ LOW
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview)						
1	See footnote #1	8/25 (32.0%)	26/29 (89.7%)	**RR 0.36** (0.20 to 0.64)	574 fewer per 1000 (from 323 fewer to 717 fewer)	⊕⊕◯◯ LOW

MD – mean difference, RR – relative risk

Footnote #1- Sample size low, OIS not met

Number needed to treat (NNT) (95% Confidence Interval)
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 2 (NNT(benefit) 2 to 3)
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 2 (NNT(benefit) 2 to 3)
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 2 (NNT(benefit) 2 to 3)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Placebo plus Medication clinic attendance]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Recurrence (follow up: 12 months)	X					
2. Recurrence (follow up: 24 months)	X					
3. Recurrence (follow up: 36 months)	X					

Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Reynolds et al (1999)

- **Dropout**:
  - 12% (3 of 25) IPT + N v. 0% (0 of 29) placebo
- **Adverse events:**
  - One patient committed suicide 1 year after leaving the study against medical advice. (Condition for this patient not specified. Page four of article notes: "Four (6.6%) of 61 subjects in a maintenance placebo condition left the study against medical advice, compared with 1 (1.7%) of 58 taking nortriptyline. One patient committed suicide 1 year after leaving the study against medical advice.")

Note any other information on burdens from published studies:

Reynolds et al (1999)

- **Burden**:
  - Participants in IPT conditions were seen monthly for 50-min
  - Participants in medication only conditions were seen monthly for 30 min

[Medication clinic is pill, education, TLC (supportive), major supportive component]

Note any additional information on harms:
-Nortriptyline higher risk of suicide completion following overdose (higher mortality with suicide attempt) (Antidepressants protective against suicide in elderly).

Note any additional information on burdens:

-Combined treatment could add time but mitigate consequences because IPT specifically fosters that
-Maintaining contact with one's therapist
[Note that cost of treatments in this study were fully covered.]

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Placebo plus Medication clinic attendance]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
4. Adverse events leading to withdrawals	o	o	o	o	o	X
5. Other serious adverse events	o	o	o	o	o	X
6. Other adverse events	o	X *	o	o	o	
7. Burdens	o	X	o	o	o	o

*Based on general knowledge as opposed to specific information
Dropout rate low, cannot comment on differential dropout rate.

Assign an overall global rating across outcomes:

X Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

III) Patient Values and Preferences *What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?* *How variable are these?* *How certain is the panel about these?* **Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*	**<u>Patient values and preferences based on:</u>** *Information from research studies:* -75 % prefer psychotherapy to medication (across ages, all kinds of publications in this field). Older patients have concerns about multiple medications. Latino and African American communities have concerns about medications being addictive. Data suggests better outcomes for those receiving their preferred treatment. -From patient values and preferences spreadsheet: Dobscha et al (2007), Raue et al (2009), Gum et al (2006), Kitchen et al (2013) and Kessing et al (2005) *Information from community members on panel:* One of biggest obstacles is finding a therapist that is a good match, supervised setting can be beneficial. Side effects of medication Medication side effects, side effects for sex. Ability to empower pt to tell therapist if cross boundary, tell therapist about side effects. Communication between providers for combined treatment is important. *Information from clinicians on panel:* Majority veterans at a specific VA site prefer psychotherapy but willing to do medication. Values of shared decision making now than was the case in the early 90s. How much information available plays a role. Need to consider needs and values of the family. Need to consider different sub-population beliefs about roots of illness. Might need cooperation between providers of different treatments to encourage patient values and preferences. Often preferences for racial matching though not necessarily supported by efficacy. Communication across providers. *Information from other sources (also list sources):*

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High		High
	Moderate		Moderate
	Low		Low
X	Unknown	X	Unknown

Change to low and low.

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

☐ Some variation or some uncertainty

X Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Unknown variability about pt values and preferences and unknown certainty when referencing this specific combination of treatments.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Only generalizable of pts that are tx responders that are willing to accept combined tx.[General preamble, willingness to be randomized]. Population with highly recurrent depression (non-psychotic and non-bipolar). Racial/ethnic diversity of sample limited.
Interventions	Quality of providers highly controlled. Quality of medication delivery highly controlled. Controlled to prevent drift, supervision provided. Implementation is highly controlled [see above sentence… med clinic includes XYZ]
Comparators	Claims data show little psychotherapy vs. medication use. 50% co-pay for therapy for medicare but decreasing with the advent of parity.
Outcomes	Looking at maintenance/continuation not active interventions for outcomes.
Timing or Time frame	Dosage of treatment, how long it is. Is 12 or 8 sessions, 3 years feasible and/or necessary
Settings	For every RCT concern about applicability of setting. Highly controlled and specialized.

Notes/Comments:

From Reynolds et al. (1999), pp. 40-41:

"The study was conducted at a university based geropsychiatric research clinic. Over a 7-year period, we recruited 187 elderly patients with recurrent, nonpsychotic, nondysthymic, unipolar major depression, of whom 180 actually began treatment. Patients were required to be 60 years or older and to meet expert clinical judgment and research diagnostic criteria, as established by structured interview with the Schedule for Affective Disorders and Schizophrenia Lifetime Version for recurrent nonpsychotic unipolar major depression. Patients were also required to be at least in their second lifetime episode, with an interepisode wellness interval of no longer than 3 years, a Hamilton Depression Rating Scale (17-item) score of 17 or greater, and a Folstein Mini-Mental State Examination score of 27 or greater. All subjects provided written informed consent. We screened 687 subjects to yield the study group of 187.Of the 500 subjects excluded,119 had single episodes of major depression,63 had interepisode wellness intervals longer than 3years,43 presented medical contraindications to the use of nortriptyline, and 23 had dysthymia as well as major depression. Additional reasons for exclusion included:12 who failed to meet study age criteria, 24 with delusional depression, and 135 with other psychiatric diagnoses. Excluded patients were offered treatment at the Benedum Geriatric Center at the University of Pittsburgh Medical Center, Pittsburgh, Pa. Reliable data concerning treatment history were not generally available. Of the patients who began active treatment, 48.7% were clinically referred, 42.6% were recruited through the media and community presentations, and 8.7% learned of the study by word of mouth."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Placebo plus Medication clinic attendance]

×	***Recommendation Statement Wording Options by Strength/Grade***
X	***Strong*** *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.*

	We <u>recommend</u> using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered: *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
	<u>Recommendation for Either Treatment.</u> **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
	<u>No Recommendation.</u> *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:

We <u>recommend</u> treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Treatment 1 has significantly larger benefit effect relative to harm, with respect to recurrent prevention, when compared with pill placebo with supportive medication clinic management in an older population with recurrent unipolar depression.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 20- Comparative Effectiveness of Interpersonal Psychotherapy (individual) plus Nortriptyline vs. Placebo plus Medication clinic attendance for Preventing Relapse/Recurrence
[Treatment 1: Interpersonal Psychotherapy (individual) plus Nortriptyline;
Treatment 2: Placebo plus Medication clinic attendance]

Factor	Explanation/Comments
XI. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
II. Treatment Outcomes/Consequences	
• **Benefits** of Treatment 1 and/or Treatment 2	
• **Harms** of Treatment 1 and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
XIII. Patient Values and Preferences	
XIV. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 20- Comparative Effectiveness of Interpersonal Psychotherapy (individual) plus Nortriptyline vs. Placebo plus Medication clinic attendance for Preventing Relapse/Recurrence

Question: Interpersonal psychotherapy (individual) plus nortriptyline compared to placebo plus medication clinic attendance for preventing relapse/recurrence in adults ages 60 and older

[Treatment 1: Interpersonal Psychotherapy (individual) plus Nortriptyline; Treatment 2: Placebo plus Medication clinic attendance]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Outcomes for which no estimable information was found: functional capacity, response, remission, quality of life, patient satisfaction, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*. While response to treatment is a critical outcome, the focus of the present decision table is on prevention of relapse/recurrence and thus we consider that in place of response to treatment.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Placebo plus Medication clinic attendance]

Bibliography (systematic reviews): Reynolds et al., 1999 (primary source); Wilkinson & Izmeth, 2012 (systematic review)

		№ of patients		Effect		Quality
№ of studies		**interpersonal psychotherapy (individual) plus nortriptyline**	**placebo plus medication clinic attendance**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response						
				not estimable	not estimable	
Remission						
				not estimable	not estimable	
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview)						
1	See footnote #1	5/25 (20.0%)	22/29 (75.9%)	**RR 0.26** (0.12 to 0.59)	561 fewer per 1000 (from 311 fewer to 668 fewer)	⊕⊕◯◯ LOW

Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview)						
1	See footnote #1	5/25 (20.0%)	24/29 (82.8%)	**RR 0.24** (0.11 to 0.54)	629 fewer per 1000 (from 381 fewer to 737 fewer)	⊕⊕◯◯ LOW
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview)						
1	See footnote #1	8/25 (32.0%)	26/29 (89.7%)	**RR 0.36** (0.20 to 0.64)	574 fewer per 1000 (from 323 fewer to 717 fewer)	⊕⊕◯◯ LOW

MD – mean difference, RR – relative risk

Footnote #1- Sample size low, OIS not met

Number needed to treat (NNT) (95% Confidence Interval)
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 2 (NNT(benefit) 2 to 3)
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 2 (NNT(benefit) 2 to 3)
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 2 (NNT(benefit) 2 to 3)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Placebo plus Medication clinic attendance]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Recurrence (follow up: 12 months)	X					
2. Recurrence (follow up: 24 months)	X					
3. Recurrence (follow up: 36 months)	X					

Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Reynolds et al (1999)

- **Dropout**:
    - 12% (3 of 25) IPT + N v. 0% (0 of 29) placebo
- **Adverse events:**
    - One patient committed suicide 1 year after leaving the study against medical advice. (Condition for this patient not specified. Page four of article notes: "Four (6.6%) of 61 subjects in a maintenance placebo condition left the study against medical advice, compared with 1 (1.7%) of 58 taking nortriptyline. One patient committed suicide 1 year after leaving the study against medical advice.")

Note any other information on burdens from published studies:

Reynolds et al (1999)

- **Burden**:
    - Participants in IPT conditions were seen monthly for 50-min
    - Participants in medication only conditions were seen monthly for 30 min

[Medication clinic is pill, education, TLC (supportive), major supportive component]

Note any additional information on harms:
-Nortriptyline higher risk of suicide completion following overdose (higher mortality with suicide attempt) (Antidepressants protective against suicide in elderly).
Note any additional information on burdens:

-Combined treatment could add time but mitigate consequences because IPT specifically fosters that
-Maintaining contact with one's therapist
[Note that cost of treatments in this study were fully covered.]

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Placebo plus Medication clinic attendance]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
4. Adverse events leading to withdrawals	o	o	o	o	o	X
5. Other serious adverse events	o	o	o	o	o	X
6. Other adverse events	o	X *	o	o	o	
7. Burdens	o	X	o	o	o	o

*Based on general knowledge as opposed to specific information
Dropout rate low, cannot comment on differential dropout rate.

Assign an overall global rating across outcomes:

X Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

III) Patient Values and Preferences *What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?* *How variable are these?* *How certain is the panel about these?* **Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*	**<u>Patient values and preferences based on:</u>** *Information from research studies:* -75 % prefer psychotherapy to medication (across ages, all kinds of publications in this field). Older patients have concerns about multiple medications. Latino and African American communities have concerns about medications being addictive. Data suggests better outcomes for those receiving their preferred treatment. -From patient values and preferences spreadsheet: Dobscha et al (2007), Raue et al (2009), Gum et al (2006), Kitchen et al (2013) and Kessing et al (2005) *Information from community members on panel:* One of biggest obstacles is finding a therapist that is a good match, supervised setting can be beneficial. Side effects of medication Medication side effects, side effects for sex. Ability to empower pt to tell therapist if cross boundary, tell therapist about side effects. Communication between providers for combined treatment is important. *Information from clinicians on panel:* Majority veterans at a specific VA site prefer psychotherapy but willing to do medication. Values of shared decision making now than was the case in the early 90s. How much information available plays a role. Need to consider needs and values of the family. Need to consider different sub-population beliefs about roots of illness. Might need cooperation between providers of different treatments to encourage patient values and preferences. Often preferences for racial matching though not necessarily supported by efficacy. Communication across providers. *Information from other sources (also list sources):*

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High		High
	Moderate		Moderate
	Low		Low
X	Unknown	X	Unknown

Change to low and low.

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

☐ Some variation or some uncertainty

X Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Unknown variability about pt values and preferences and unknown certainty when referencing this specific combination of treatments.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Only generalizable of pts that are tx responders that are willing to accept combined tx.[General preamble, willingness to be randomized]. Population with highly recurrent depression (non-psychotic and non-bipolar). Racial/ethnic diversity of sample limited.
Interventions	Quality of providers highly controlled. Quality of medication delivery highly controlled. Controlled to prevent drift, supervision provided. Implementation is highly controlled [see above sentence… med clinic includes XYZ]
Comparators	Claims data show little psychotherapy vs. medication use. 50% co-pay for therapy for medicare but decreasing with the advent of parity.
Outcomes	Looking at maintenance/continuation not active interventions for outcomes.
Timing or Time frame	Dosage of treatment, how long it is. Is 12 or 8 sessions, 3 years feasible and/or necessary
Settings	For every RCT concern about applicability of setting. Highly controlled and specialized.

Notes/Comments:

From Reynolds et al. (1999), pp. 40-41:

"The study was conducted at a university based geropsychiatric research clinic. Over a 7-year period, we recruited 187 elderly patients with recurrent, nonpsychotic, nondysthymic, unipolar major depression, of whom 180 actually began treatment. Patients were required to be 60 years or older and to meet expert clinical judgment and research diagnostic criteria, as established by structured interview with the Schedule for Affective Disorders and Schizophrenia Lifetime Version for recurrent nonpsychotic unipolar major depression. Patients were also required to be at least in their second lifetime episode, with an interepisode wellness interval of no longer than 3 years, a Hamilton Depression Rating Scale (17-item) score of 17 or greater, and a Folstein Mini-Mental State Examination score of 27 or greater. All subjects provided written informed consent. We screened 687 subjects to yield the study group of 187.Of the 500 subjects excluded,119 had single episodes of major depression,63 had interepisode wellness intervals longer than 3years,43 presented medical contraindications to the use of nortriptyline, and 23 had dysthymia as well as major depression. Additional reasons for exclusion included:12 who failed to meet study age criteria, 24 with delusional depression, and 135 with other psychiatric diagnoses. Excluded patients were offered treatment at the Benedum Geriatric Center at the University of Pittsburgh Medical Center, Pittsburgh, Pa. Reliable data concerning treatment history were not generally available. Of the patients who began active treatment, 48.7% were clinically referred, 42.6% were recruited through the media and community presentations, and 8.7% learned of the study by word of mouth."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

[Treatment 1: Interpersonal psychotherapy (individual) plus Nortriptyline; Treatment 2: Placebo plus Medication clinic attendance]

×	***Recommendation Statement Wording Options by Strength/Grade***
X	***Strong*** *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.*

	We <u>recommend</u> using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered: *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
	<u>Recommendation for Either Treatment.</u> **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
	<u>No Recommendation.</u> *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:

We <u>recommend</u> treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Treatment 1 has significantly larger benefit effect relative to harm, with respect to recurrent prevention, when compared with pill placebo with supportive medication clinic management in an older population with recurrent unipolar depression.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 21- Comparative Effectiveness of Interpersonal Psychotherapy (individual) plus Placebo vs. Nortriptyline plus Medication clinic attendance for Preventing Relapse/Recurrence
[Treatment 1: Interpersonal psychotherapy (individual) plus Placebo;
Treatment 2: Nortriptyline plus Medication clinic attendance]

Factor	Explanation/Comments
V. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
VI. Treatment Outcomes/Consequences • **Benefits** of Treatment 1 and/or Treatment 2 • **Harms** of Treatment 1 and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
VII. Patient Values and Preferences	
VIII. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 21- Comparative Effectiveness of Interpersonal Psychotherapy (individual) plus Placebo vs. Nortriptyline plus Medication clinic attendance for Preventing Relapse/Recurrence

Question: Interpersonal psychotherapy (individual) plus placebo compared to nortriptyline plus medication clinic attendance for preventing relapse/recurrence in adults ages 60 and older

[Treatment 1: Interpersonal psychotherapy (individual) plus Placebo; Treatment 2: Nortriptyline plus Medication clinic attendance]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Outcomes for which no estimable information was found: functional capacity, response, remission, quality of life, patient satisfaction, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*. While response to treatment is a critical outcome, the focus of the present decision table is on prevention of relapse/recurrence and thus we consider that in place of response to treatment.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: Interpersonal psychotherapy (individual) plus Placebo; Treatment 2: Nortriptyline plus Medication clinic attendance]

Bibliography (systematic reviews): Reynolds et al., 1999 (primary source); Wilkinson & Izmeth 2012 (systematic review)

		№ of patients		Effect		Quality
№ of studies		**interpersonal psychotherapy (individual) plus placebo**	**nortriptyline plus medication clinic attendance**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response						
				not estimable	not estimable	
Remission						
				not estimable	not estimable	
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview)						
1	See footnote #1	9/25 (36.0%)	8/28 (28.6%)	**RR 1.26** (0.57 to 2.76)	74 more per 1000 (from 123 fewer to 503 more)	⊕⊕◯◯ LOW

Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview)						
1	See footnote #1	14/25 (56.0%)	12/28 (42.9%)	**RR 1.31** (0.75 to 2.27)	133 more per 1000 (from 107 fewer to 544 more)	⊕⊕◯◯ LOW
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview)						
1	See footnote #1	16/25 (64.0%)	14/28 (50.0%)	**RR 1.28** (0.80 to 2.05)	140 more per 1000 (from 100 fewer to 525 more)	⊕⊕◯◯ LOW

MD – mean difference, RR – relative risk

Footnote #1- Small sample size, OIS not met, CI fails to exclude important benefit or important harm

Number needed to treat (NNT) (95% Confidence Interval)
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 14 (NNT(harm) 6 to ∞ to NNT(benefit) 3)
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 8 (NNT(harm) 8 to ∞ to NNT(benefit) 2)
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 7 (NNT(harm) 9 to ∞ to NNT(benefit) 2)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Treatment 1: Interpersonal psychotherapy (individual) plus Placebo; Treatment 2: Nortriptyline plus Medication clinic attendance]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect *	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Recurrence (follow up: 12 months)			X			o
2. Recurrence (follow up: 24 months)			X			o
3. Recurrence (follow up: 36 months)			X			o

*No statistical difference. The study was not designed to be able to determine equivalence. Rather study not sufficiently powered to provide meaningful information.

	Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2: No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Reynolds et al (1999)

- **Dropout**:
  - 16% (4 of 25) IPT + P v. 14.3% (4 of 28) Nortriptyline
- **Adverse events:**
  - One patient committed suicide 1 year after leaving the study against medical advice

Note any other information on burdens from published studies:

Reynolds et al (1999)

- **Burden**:
  - Participants in IPT conditions were seen monthly for 50-min
  - Participants in medication only conditions were seen monthly for 30 min

[Medication clinic is pill, education, TLC (supportive), major supportive component]

Note any additional information on harms:
-Nortriptyline higher risk of suicide completion following overdose (higher mortality with suicide attempt) (black box warning meta analysis, Bridges).

Note any additional information on burdens:
-Combined treatment could add time but mitigate consequences because IPT specifically fosters that
-Maintaining contact with one's therapist
[Note that cost of treatments in this study were fully covered.]

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Interpersonal psychotherapy (individual) plus Placebo; Treatment 2: Nortriptyline plus Medication clinic attendance]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
4. Adverse events leading to withdrawals	o	o	o	o	o	X
5. Other serious adverse events	o	o	o	o	o	X
6. Other adverse events	o	o	X *	o	o	o
7. Burdens	o	X	o	o	o	o

*Participants had established course of treatment that demonstrated tolerability in prior acute tx. Study selected for participants who had demonstrated ability to tolerate the medication.

Assign an overall global rating across outcomes:

☐ Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

_ Not applicable

Panel decided not to select among options. It noted that one cannot say that the two maintenance treatments are the same but there is no evidence of clear difference with respect to prevention of recurrence.

III) Patient Values and Preferences *What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?* *How variable are these?* *How certain is the panel about these?* **Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*	**<u>Patient values and preferences based on:</u>** *Information from research studies:* 75 % prefer psychotherapy to medication (across ages, all kinds of publications in this field). Older patients have concerns about multiple medications. Latino and African American communities have concerns about medications being addictive. Data suggests better outcomes for those receiving their preferred treatment. -From patient values and preferences spreadsheet: Dobscha et al (2007), Raue et al (2009), Gum et al (2006), Kitchen et al (2013) and Kessing et al (2005) *Information from community members on panel: [In maintenance population assume the first three bullets established. Maintenance population has already established the first three.]* One of biggest obstacles is finding a therapist that is a good match, supervised setting can be beneficial. Side effects of medication Medication side effects, side effects for sex. Ability to empower pt to tell therapist if cross boundary, tell therapist about side effects. Communication between providers for combined treatment is important. *Information from clinicians on panel:* When considering a maintenance population: Majority veterans at a specific VA site prefer psychotherapy but willing to do medication. Values of shared decision making now than was the case in the early 90s. How much information available plays a role. Need to consider needs and values of the family. Need to consider different sub-population beliefs about roots of illness. Might need cooperation between providers of different treatments to encourage patient values and preferences. Often preferences for racial matching though not necessarily supported by efficacy. Communication across providers. *Information from other sources (also list sources):*

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High		High
	Moderate		Moderate
X	Low	X	Low
	Unknown		Unknown

Low and low

Low variability

Low variability

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

☐ Some variation or some uncertainty

X Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Low variability in patient values and preferences but also low certainty in this population.

In this case, low certainty in this population due to lack of evidence.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Only generalizable of pts that are tx responders that are willing to accept combined tx.[General preamble, willingness to be randomized]. Population with highly recurrent depression (non-psychotic and non-bipolar). Racial/ethnic diversity of sample limited. Limi to age 60 and above.
Interventions	Quality of providers highly controlled. Quality of medication delivery highly controlled. Controlled to prevent drift, supervision provided. Implementation is highly controlled [see above sentence… med clinic includes XYZ]
Comparators	Claims data show little psychotherapy vs. medication use. 50% co-pay for therapy for medicare but decreasing with the advent of parity.
Outcomes	Looking at maintenance/continuation not active interventions for outcomes.
Timing or Time frame	Dosage of treatment, how long it is. Is 12 or 8 sessions, 3 years feasible and/or necessary
Settings	For every RCT concern about applicability of setting. Highly controlled and specialized

Notes/Comments:

From Reynolds et al. (1999), pp. 40-41:

"The study was conducted at a university based geropsychiatric research clinic. Over a 7-year period, we recruited 187 elderly patients with recurrent, nonpsychotic, nondysthymic, unipolar major depression, of whom 180 actually began treatment. Patients were required to be 60 years or older and to meet expert clinical judgment and research diagnostic criteria, as established by structured interview with the Schedule for Affective Disorders and Schizophrenia Lifetime Version for recurrent nonpsychotic unipolar major depression. Patients were also required to be at least in their second lifetime episode, with an interepisode wellness interval of no longer than 3 years, a Hamilton Depression Rating Scale (17-item) score of 17 or greater, and a Folstein Mini-Mental State Examination score of 27 or greater. All subjects provided written informed consent. We screened 687 subjects to yield the study group of 187.Of the 500 subjects excluded,119 had single episodes of major depression,63 had interepisode wellness intervals longer than 3 years,43 presented medical contraindications to the use of nortriptyline, and 23 had dysthymia as well as major depression. Additional reasons for exclusion included:12 who failed to meet study age criteria, 24 with delusional depression, and 135 with other psychiatric diagnoses. Excluded patients were offered treatment at the Benedum Geriatric Center at the University of Pittsburgh Medical Center, Pittsburgh, Pa. Reliable data concerning treatment history were not generally available. Of the patients who began active treatment, 48.7% were clinically referred, 42.6% were recruited through the media and community presentations, and 8.7% learned of the study by word of mouth."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

[Treatment 1: Interpersonal psychotherapy (individual) plus Placebo; Treatment 2: Nortriptyline plus Medication clinic attendance]

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.*

	We <u>recommend</u> using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered: *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
X	<u>Recommendation for Either Treatment.</u> **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
	<u>No Recommendation.</u> *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:

We recommend using either treatment 1 or treatment 2 when both are being considered. [In the study both were superior to pill placebo, see evidence profiles on efficacy.]

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

No evidence of significant difference in recurrence prevention between interpersonal psychotherapy (individual) plus placebo and nortriptyline plus medication clinic attendance.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 22- Comparative Effectiveness of Interpersonal Psychotherapy (individual) plus Placebo vs. Placebo plus Medication clinic attendance for Preventing Relapse/Recurrence
[Treatment 1: Interpersonal psychotherapy (individual) plus Placebo; Treatment 2: Placebo plus Medication clinic attendance]

Factor	Explanation/Comments
X. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
X. Treatment Outcomes/Consequences	
• **Benefits** of Treatment 1 and/or Treatment 2	
• **Harms** of Treatment 1 and/or Treatment 2	
• **Burdens** of Treatment 1 and/or Treatment 2 *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens between Treatment 1 and Treatment 2	
XXI. Patient Values and Preferences	
XII. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 22- Comparative Effectiveness of Interpersonal Psychotherapy (individual) plus Placebo vs. Placebo plus Medication clinic attendance for Preventing Relapse/Recurrence

Question: Interpersonal psychotherapy (individual) plus placebo compared to placebo plus medication clinic attendance for preventing relapse/recurrence in adults ages 60 and older

[Treatment 1: Interpersonal psychotherapy (individual) plus Placebo; Treatment 2: Placebo plus Medication clinic attendance]

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview)			X	
Outcomes for which no estimable information was found: functional capacity, response, remission, quality of life, patient satisfaction, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*. While response to treatment is a critical outcome, the focus of the present decision table is on prevention of relapse/recurrence and thus we consider that in place of response to treatment.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

[Treatment 1: Interpersonal psychotherapy (individual) plus Placebo; Treatment 2: Placebo plus Medication clinic attendance]

Bibliography (systematic reviews): Reynolds et al., 1999 (primary source); Wilkinson & Izmeth, 2012 (systematic review)

		№ of patients		Effect		Quality
№ of studies		**interpersonal psychotherapy (individual) plus placebo**	**placebo plus medication clinic attendance**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response						
				not estimable	not estimable	
Remission						
				not estimable	not estimable	
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview)						
1	See footnote #1	9/25 (36.0%)	22/29 (75.9%)	RR 0.47 (0.27 to 0.83)	402 fewer per 1000 (from 129 fewer to 554 fewer)	⊕⊕◯◯ LOW

Recurrence (follow up: 24 months; assessed with: HAMD >= 17 and structured psychiatric interview)						
1	See footnote #1	14/25 (56.0%)	24/29 (82.8%)	RR 0.68 (0.46 to 0.99)	265 fewer per 1000 (from 8 fewer to 447 fewer)	⊕⊕◯◯ LOW
Recurrence (follow up: 36 months; assessed with: HAMD >= 17 and structured psychiatric interview)						
1	See footnote #1	16/25 (64.0%)	26/29 (89.7%)	RR 0.71 (0.52 to 0.98)	260 fewer per 1000 (from 18 fewer to 430 fewer)	⊕⊕◯◯ LOW

MD – mean difference, RR – relative risk
Footnote #1- Sample size low, OIS not met

Number needed to treat (NNT) (95% Confidence Interval)
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 3 (NNT(benefit) 2 to 7)
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 4 (NNT(benefit) 2 to 35)
Recurrence (follow up: 12 months; assessed with: HAMD >= 17 and structured psychiatric interview): NNT = 4 (NNT(benefit) 3 to 27)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Interpersonal psychotherapy (individual) plus Placebo; Treatment 2: Placebo plus Medication clinic attendance]

Outcomes:	Large/Modest benefit of Treatment 1 relative to Treatment 2	Small benefit of Treatment 1 relative to Treatment 2	No difference in effect	Small benefit of Treatment 2 relative to Treatment 1	Modest/Large benefit of Treatment 2 relative to Treatment 1	Unable to rate
1. Recurrence (follow up: 12 months)	x	o				
2. Recurrence (follow up: 24 months)	x	o				
3. Recurrence (follow up: 36 months)	x	o				

Recurrence at 12 months seems to be a large effect, whereas moderate at 24 and 36 months.

	Second, list quantitative information from evidence profiles about harms of Treatment 1 and/or Treatment 2: No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Reynolds et al (1999)

- **Dropout**:
  - 16% (4 of 25) IPT + P v. 0% (0 of 29) placebo
- **Adverse events:**
  - One patient committed suicide 1 year after leaving the study against medical advice.

Note any other information on burdens from published studies:

Reynolds et al (1999)

- **Burden**:
  - Participants IPT conditions were seen monthly for 50-min
  - Participants in medication only conditions were seen monthly for 30 min

[Medication clinic is pill, education, TLC (supportive), major supportive component]

Note any additional information on harms:

-In reality in clinical practice people would not be told it was pill placebo

Note any additional information on burdens:

-Combined treatment could add time but mitigate consequences because IPT specifically fosters that
-maintaining contact with one's therapist
[Note that cost of treatments in this study were fully covered.]

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

[Treatment 1: Interpersonal psychotherapy (individual) plus Placebo; Treatment 2: Placebo plus Medication clinic attendance]

Outcomes:	Large/Modest harm/burden of Treatment 1 relative to Treatment 2	Small harm/burden of Treatment 1 relative to Treatment 2	No difference in effect	Small harm/ burden of Treatment 2 relative to Treatment 1	Modest/Large harm/ burden of Treatment 2 relative to Treatment 1	Unable to rate
4. Adverse events leading to withdrawals	o	o	o	o	o	X
5. Other serious adverse events	o	o	o	o	o	X
6. Other adverse events	o	o	X	o	o	o
7. Burdens	o	X	o	o	o	o

Assign an overall global rating across outcomes:

X Balance of benefits to harms/burdens clearly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 1 over Treatment 2
☐ Balance of benefits to harms/burdens is the same for Treatment 1 as Treatment 2
☐ Balance of benefits to harms/burdens slightly favors Treatment 2 over Treatment 1
☐ Balance of benefits to harms/burdens clearly favors Treatment 2 over Treatment 1

Notes/Comments:

III) Patient Values and Preferences *What are the typical patient values and preferences regarding Treatment 1, Treatment 2, and the choice between them?* *How variable are these?* *How certain is the panel about these?* **Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*	**<u>Patient values and preferences based on:</u>** *Information from research studies:* -75 % prefer psychotherapy to medication (across ages, all kinds of publications in this field). Older patients have concerns about multiple medications. Latino and African American communities have concerns about medications being addictive. Data suggests better outcomes for those receiving their preferred treatment. -From patient values and preferences spreadsheet: Dobscha et al (2007), Raue et al (2009), Gum et al (2006), Kitchen et al (2013) and Kessing et al (2005) *Information from community members on panel:* -Some prefer IPT and some prefer medication for maintenance treatment. If prefer meds prefer medication clinic. *Information from clinicians on panel:* Majority veterans at a specific VA site prefer psychotherapy but willing to do medication. Values of shared decision making now than was the case in the early 90s. How much information available plays a role. Need to consider needs and values of the family. Need to consider different sub-population beliefs about roots of illness. Might need cooperation between providers of different treatments to encourage patient values and preferences. Often preferences for racial matching though not necessarily supported by efficacy. Communication across providers. *Information from other sources (also list sources):*

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High		High
	Moderate		Moderate
X	Low	X	Low
	Unknown		Unknown

Moderate variability, low certainty

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

☐ Some variation or some uncertainty

X Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Moderate variability, low certainty for this population. Moderate variability based on input from community Member, lack of evidence low certainty.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Only generalizable of pts that are tx responders that are willing to accept combined tx.[General preamble, willingness to be randomized]. Population with highly recurrent depression (non-psychotic and non-bipolar). Racial/ethnic diversity of sample limited.
Interventions	Quality of providers highly controlled. Quality of medication delivery highly controlled. Controlled to prevent drift, supervision provided. Implementation is highly controlled [see above sentence… med clinic includes XYZ]
Comparators	Claims data show little psychotherapy vs. medication use. 50% co-pay for therapy for medicare but decreasing with the advent of parity.
Outcomes	Looking at maintenance/continuation not active interventions for outcomes.
Timing or Time frame	Dosage of treatment, how long it is. Is 12 or 8 sessions, 3 years feasible and/or necessary
Settings	For every RCT concern about applicability of setting. Highly controlled and specialized

Notes/Comments:

From Reynolds et al. (1999), pp. 40-41:

"The study was conducted at a university based geropsychiatric research clinic. Over a 7-year period, we recruited 187 elderly patients with recurrent, nonpsychotic, nondysthymic, unipolar major depression, of whom 180 actually began treatment. Patients were required to be 60 years or older and to meet expert clinical judgment and research diagnostic criteria, as established by structured interview with the Schedule for Affective Disorders and Schizophrenia Lifetime Version for recurrent nonpsychotic unipolar major depression. Patients were also required to be at least in their second lifetime episode, with an interepisode wellness interval of no longer than 3 years, a Hamilton Depression Rating Scale (17-item) score of 17 or greater, and a Folstein Mini-Mental State Examination score of 27 or greater. All subjects provided written informed consent. We screened 687 subjects to yield the study group of 187.Of the 500 subjects excluded,119 had single episodes of major depression,63 had interepisode wellness intervals longer than 3years,43 presented medical contraindications to the use of nortriptyline, and 23 had dysthymia as well as major depression. Additional reasons for exclusion included:12 who failed to meet study age criteria, 24 with delusional depression, and 135 with other psychiatric diagnoses. Excluded patients were offered treatment at the Benedum Geriatric Center at the University of Pittsburgh Medical Center, Pittsburgh, Pa. Reliable data concerning treatment history were not generally available. Of the patients who began active treatment, 48.7% were clinically referred, 42.6% were recruited through the media and community presentations, and 8.7% learned of the study by word of mouth."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

[Treatment 1: Interpersonal psychotherapy (individual) plus Placebo; Treatment 2: Placebo plus Medication clinic attendance]

×	***Recommendation Statement Wording Options by Strength/Grade***
X	***Strong*** *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We recommend treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use of treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.* **We suggest using treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.* **We suggest using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation for use of treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered.*

	We <u>recommend</u> using treatment 2 rather than treatment 1 when both treatment 2 and treatment 1 are being considered: *"We recommend…"* *"Clinicians should not…"* *"Don't…"*
	<u>Recommendation for Either Treatment.</u> **We recommend using either treatment 1 or treatment 2 when both are being considered.** *Note- Address whether there is no difference because they are efficacious to the same degree or because they are both not efficacious.*
	<u>No Recommendation.</u> *"The panel concludes that the evidence is insufficient to recommend for one treatment rather than the other treatment and that the evidence is also insufficient to state that there is no difference between the treatments in regards to benefits, harms, strength of evidence, patient values and preferences, and applicability…"*

Recommendation #_____

Recommendation written out as an action statement:

We <u>recommend</u> treatment 1 rather than treatment 2 when both treatment 1 and treatment 2 are being considered.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Evidence demonstrates a significantly greater reduction in risk in monthly maintenance IPT with pill placebo as compared with supportive clinical care, with pill placebo.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of Treatment 1	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version 6/26/14)
Topic # 23- Cognitive behavioral therapy (individual) compared to usual care for treating major depressive disorder in adults ages 60 and older

Factor	Explanation/Comments
II. Aggregate/Global Strength of Evidence (SOE) (from evidence profiles)	
V. Treatment Outcomes/Consequences • **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of Treatment *(Note- do not include financial cost)*	
Balance of Benefits and Harms/Burdens of Treatment	
XV. Patient Values and Preferences	
XVI. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 23- Cognitive behavioral therapy (individual) compared to usual care for treating major depressive disorder in adults ages 60 and older

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., When magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Remission (follow up: 18 weeks; assessed with: No longer meet DSM-IV criteria; HAMD<=7; BDI<=13)			X	
Remission (follow up: 42 weeks; assessed with: No longer meet DSM-IV criteria; HAMD<=7; BDI<=13			X	
Quality of Life (follow up: 18 weeks; assessed with: WHOQOL Psychological)			X	
Quality of Life (follow up: 42 weeks; assessed with: WHOQOL Psychological)			X	
Quality of Life (follow up: 18 weeks; assessed with: WHOQOL Social Relationships)			X	
Quality of Life (follow up: 42 weeks; assessed with: WHOQOL Social Relationships)			X	
Quality of Life (follow up: 18 weeks; assessed with: WHOQOL Environment)			X	
Quality of Life (follow up: 42 weeks; assessed with: WHOQOL Environment)			X	
Quality of Life (follow up: 18 weeks; assessed with: WHOQOL Physical)			X	
Quality of Life (follow up: 42 weeks; assessed with: WHOQOL Physical)			X	
Suicidality (follow up: 18 weeks; assessed with: Beck Hopelessness Scale)			X	
Suicidality (follow up: 42 weeks; assessed with: Beck Hopelessness Scale)			X	
Outcomes for which no studies were found: functional capacity, response, patient satisfaction, relapse, serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only). **Global SOE Grade:** ☐High ☐Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Laidlaw et al., 2008

		№ of patients		Effect		Quality
№ of studies		**cognitive behavioral therapy (individual)**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
0				not estimable	not estimable	
Response						
0				not estimable	not estimable	
Remission (follow up: 18 weeks; assessed with: No longer meet DSM-IV criteria; HAMD<=7; BDI<=13); based on ITT analysis						
1	See footnote #1	14/21 (66.7%)	8/23 (34.8%)	RR 1.92 (1.01 to 3.62)	320 more per 1000 (from 3 more to 911 more)	⊕⊕◯◯ LOW
Remission (follow up: 42 weeks; assessed with: No longer meet DSM-IV criteria; HAMD<=7; BDI<=13); based on ITT analysis						
1	See footnote #2	11/21 (52.4%)	8/23 (34.8%)	RR 1.51 (0.75 to 3.01)	177 more per 1000 (from 87 fewer to 699 more)	⊕⊕◯◯ LOW
Quality of Life (follow up: 18 weeks; assessed with: WHOQOL Psychological); based on those who started treatment						
1	See footnote #1	20	20	-	MD **2.5 higher** (0.39 higher to 4.61 higher)	⊕⊕◯◯ LOW

	Quality of Life (follow up: 42 weeks; assessed with: WHOQOL Psychological); based on those who started treatment						
	1		20	20	-	MD **1.45 higher** (0.86 lower to 3.76 higher)	⊕⊕◯◯ LOW
	Quality of Life (follow up: 18 weeks; assessed with: WHOQOL Social Relationships); based on those who started treatment						
	1	See footnote #2	20	20	-	MD **0.1 higher** (1.22 lower to 1.42 higher)	⊕⊕◯◯ LOW
	Quality of Life (follow up: 42 weeks; assessed with: WHOQOL Social Relationships); based on those who started treatment						
	1	See footnote #2	20	20	-	MD **0.3 higher** (0.59 lower to 1.19 higher)	⊕⊕◯◯ LOW
	Quality of Life (follow up: 18 weeks; assessed with: WHOQOL Environment); based on those who started treatment						
	1	See footnote #2	20	20	-	MD **0.55 higher** (2.26 lower to 3.36 higher)	⊕⊕◯◯ LOW
	Quality of Life (follow up: 42 weeks; assessed with: WHOQOL Environment); based on those who started treatment						
	1	See footnote #2	20	20	-	MD **1.1 higher** (1.06 lower to 3.26 higher)	⊕⊕◯◯ LOW
	Quality of Life (follow up: 18 weeks; assessed with: WHOQOL Physical); based on those who started treatment						
	1	See footnote #2	20	20	-	MD **2.55 higher** (0.36 lower to 5.46 higher)	⊕⊕◯◯ LOW

Quality of Life (follow up: 42 weeks; assessed with: WHOQOL Physical); based on those who started treatment						
1	See footnote #2	20	20	-	MD **1.35 higher** (2.07 lower to 4.77 higher)	⊕⊕◯◯ LOW
Patient Satisfaction						
0				not estimable	not estimable	
Relapse						
0				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- small sample size and/or number of events, does not meet optimal information size to detect differences
Footnote #2- small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Number needed to treat (NNT) (95% Confidence Interval)
Remission (follow up: 18 weeks; assessed with: No longer meet DSM-IV criteria; HAMD<=7; BDI<=13): NNT = 3 (NNT(benefit) 1 to 25)
Remission (follow up: 42 weeks; assessed with: No longer meet DSM-IV criteria; HAMD<=7; BDI<=13): NNT = 6 (NNT(harm) 9 to ∞ to NNT(benefit) 2)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Remission (follow up: 18 weeks; assessed with: No longer meet DSM-IV criteria; HAMD<=7; BDI<=13)	X	o				
2. Remission (follow up: 42 weeks; assessed with: No longer meet DSM-IV criteria; HAMD<=7; BDI<=13			o			X
3. Quality of Life (follow up: 18 weeks; assessed with: WHOQOL Psychological)	X	o				
4. Quality of Life (follow up: 42 weeks; assessed with: WHOQOL Psychological)			o			X
5. Quality of Life (follow up: 18 weeks; assessed with: WHOQOL Social Relationships)			o			X
6. Quality of Life (follow up: 42 weeks; assessed with: WHOQOL Social Relationships)			o			X
7. Quality of Life (follow up: 18 weeks; assessed with: WHOQOL Environment)			o			X
8. Quality of Life (follow up: 42 weeks; assessed with: WHOQOL Environment)			o			X
9. Quality of Life (follow up: 18 weeks; assessed with: WHOQOL Physical)			o			X
10. Quality of Life (follow up: 42 weeks; assessed with: WHOQOL Physical)			o			X

Second, list quantitative information on harms from evidence profiles:

		№ of patients		Effect		Quality
№ of studies		**cognitive behavioral therapy (individual)**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**	
Suicidality (follow up: 18 weeks; assessed with: Beck Hopelessness Scale); based on those who started treatment						
1	See footnote #2	20	20	-	MD **1 lower** (3.61 lower to 1.61 higher)	⊕⊕◯◯ LOW
Suicidality (follow up: 42 weeks; assessed with: Beck Hopelessness Scale); based on those who started treatment						
1	See footnote #2	20	20	-	MD **2.6 lower** (5.44 lower to 0.24 higher)	⊕⊕◯◯ LOW
Adverse Events						
0				not estimable	not estimable	

Footnote #2- small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Note any other information on harms from published studies:

References for harms/burdens published studies: *Laidlaw et al (2008)*

Harm

- Dropout: 4.8% (*1 of 21*) CBT v. 13% (*3 of 23*) UC
- Random sample of sessions reviewed for treatment adherence

Other studies:
None

Note any other information on burdens from published studies:

References for harms/burdens published studies: *Laidlaw et al (2008)*

Burden

- Utilized CBT treatment manual specifically developed for the study in a primary care setting
    - 18-weeks of therapy; participants received an average of 8 sessions
    - Homework assignments
    - CBT Therapists were masters-level trained
- "TAU could include any combination of physical treatment for depression, such as prescription of antidepressant medication, physical review, and referral for non-counseling interventions by Community Psychiatric Nurse teams or other services (e.g. social services). Treatment could also be no treatment if that is what the GP considered to be appropriate."

Note any additional information on harms:

Possibility of suicide/intentional overdose on TCA if usual care.

Note any additional information on burdens:

Greater time and effort required for CBT relative to care as usual
Difficult to optimize anti-depressant pharmacotherapy in usual care/primary care settings.

Next, list and rate each harm/burden :

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
11. Adverse events leading to withdrawals			o	o	o	X
12. Other serious adverse events			o	o	o	X
13. Other adverse events			o	o	o	X
14. Burdens			o	X	o	o

Assign an overall global rating across outcomes:

☐Benefits clearly outweigh harms/ burden
X Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments: While data was clear for short-term outcomes, in long term less clarify and non-significant findings limiting ability to make recommendations.

III) Patient Values and Preferences

What are the typical patient values and preferences?

How variable are these?

How certain is the GDP about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

[Possible studies to include from APA staff search of pt values and preferences studies]:

Dwight-Johnson et al (2013): "*Objective:* Among **older white and Mexican origin male primary care patients**, we examined preferences for features of depression care programs that would encourage depressed older men to enter and remain in treatment. *Method:* **Sixty-three (45 white, 18 Mexican origin) older men were recruited in six primary care clinics. All had clinical depression in the past year and/or were receiving depression treatment.** Participants completed a conjoint analysis preference survey regarding depression treatments, providers and treatment enhancements. *Results:* The data suggest that **white men preferred medication over counseling [odds ratio (OR): 1.64 95% confidence interval (CI): 1.12–2.41], while Mexican origin men preferred counseling (OR: medication over counseling: 0.28, 95% CI: 0.12–0.66). Both white and Mexican origin men preferred treatment that included family involvement (vs. none) (white: OR: 1.60, 95% CI 1.12–2.30; Mexican origin: OR: 3.31 95% CI 1.44–7.62) and treatment for insomnia (vs. treatment for alcohol use) (white: OR: 1.72, 95% CI 1.01–2.91; Mexican origin: OR: 3.93 95% CI 1.35–11.42). White men also preferred treatment by telephone (OR: 1.80, 95% CI 1.12–2.87).** *Conclusions:* Findings could inform development of patient-centered depression treatment programs for older men and suggest strategies, such as attention to sleep problems, which providers may employ to tailor treatment to preferences of older men."

Gum et al (2006): "PURPOSE: For depressed older primary care patients, this study aimed to examine (a) characteristics associated with depression treatment preferences; (b) predictors of receiving preferred treatment; and (c) whether receiving preferred treatment predicted satisfaction and depression outcomes. DESIGN AND METHODS: **Data are from 1,602 depressed older primary care patients who participated in a multisite, randomized clinical trial comparing usual care to collaborative care, which offered medication and counseling for up to 12 months.** Baseline assessment included demographics, depression, health information, prior depression treatment, potential barriers, and treatment preferences (medication, counseling). At 12 months, services received, satisfaction, and depression outcomes were assessed. RESULTS: **More patients preferred counseling (57%) than medication (43%). Previous experience with a treatment type was the strongest predictor of preference. In addition, medication preference was predicted by male gender and diagnosis of major depression (vs dysthymia). The collaborative care model greatly improved access to preferred treatment, especially for counseling (74% vs 33% in usual care). Receipt of preferred treatment did not predict satisfaction or depression outcomes; these outcomes were most strongly impacted by treatment condition**. IMPLICATIONS: **Many depressed older primary care patients desire counseling, which is infrequently available in usual primary care.** Discussion of treatment preferences should include an assessment of prior treatment experiences. A collaborative care model that increases collaboration between primary care and mental health professionals can increase access to preferred treatment. If preferred treatment is not available, collaborative care still results in good satisfaction and depression outcomes."

Steidtmann et al (2012): "Background: Findings regarding the relationship between patient treatment preference and treatment outcome are mixed. **This is a secondary data analysis investigating the relationship between treatment preference, and symptom outcome and attrition in a large 2-phase depression treatment trial.** Methods: Patients met DSM-IV criteria for chronic forms of depression. **Phase I was a 12-week, nonrandomized, open-label trial in which all participants (n=785) received antidepressant medication(s) (ADM). Phase I nonremitters were randomized to Phase II, in which they received 12 weeks of either Cognitive-Behavioral System of Psychotherapy (CBASP) + ADM (n=193), Brief Supportive Psychotherapy (BSP) + ADM (n=187), or ADM only (n=93). Participants indicated their treatment preference (medication only, combined treatment or no preference) at study entry.** Symptoms were measured at 2-week intervals with the 24-item Hamilton Rating Scale for Depression (HAM-D). Results: **A large majority of patients reported a preference for combined treatment. Patients who preferred medication only were more likely to endorse a chemical imbalance explanation for depression, whereas those desiring combined treatment were more likely to attribute their depression to stressful experiences. In Phase I, patients who expressed no treatment preference showed greater rates of HAM-D symptom reduction than those with any preference, and patients with a preference for medication showed higher attrition than those preferring combined treatment. In Phase II, baseline treatment preference was not associated with symptom reduction or attrition.** Conclusions: Treatment preferences may moderate treatment response and attrition in unexpected ways. Research identifying factors associated with differing preferences may enable improved treatment retention and response."

Information from community members on panel:

Favorability for broader methods for addressing these issues, including CBT.

Information from clinicians on panel:

Many older adults would prefer counseling to another medication, the limiting step is that they would prefer to receive mental health services in their medical home, so there is a tension there. Many older adults at first state that they prefer psychotherapy, once realize the involvement (homework and commitment), preference may diminish and they may be willing to accept phamacotherapy. Preferences could be influenced by family caregivers and thus it is clinically appropriate to include family caregivers in discussions about treatment options.

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	Variability in Patient Values & Preferences	✓	Certainty in Patient Values & Preferences
	High		High
X	Moderate	X	Moderate
	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

X Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Some variation or some uncertainty in pt values and preferences.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to impact applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	
Interventions	TAU poorly defined and primarily pharmacotherapy. Likely low intensity pharmacotherapy which might be less likely to produce response to intervention.
Comparators	
Outcomes	
Timing or Time frame	
Settings	

Notes/Comments:

Laidlaw et al., 2008

"Participants were recruited from Primary Care and were referred to the study by their GP. Inclusion criteria for participation were: (i) age 60 years and over;(ii)able to achieve a primary diagnosis of Major Depressive Disorder using DSMIV diagnostic criteria (SADS-L structured interview); (iii) scoring 7 but not above 24 on the 17-item Hamilton Depression Rating Scale(Hamilton, 1967), and scoring Beck Depression Inventory(BDI-II)(Becketal.,1996)scores of 13 but not above 28; (iv) able to provide written informed consent and (v) not having been prescribed antidepressant medication within 3 months of the date of referral to the trial. Exclusion criteria were: (i) insufficient knowledge of English to enable them to be assessed adequately and to satisfactorily provide written informed consent to treatment; (ii) significant cognitive impairment as indicated by a score of 22 or on the Mini-MentalStatus Examination (MMSE; Folstein et al., 1975), and (iii) having received more than six sessions of CBT with qualified or recognized cognitive therapists in the past and/or currently receiving psychological therapy.

Overall, 114 participants were referred for possible inclusion in the research trial and 44 individuals met inclusion criteria. In total 71 participants either declined to participate in this research trial or were ineligible because they did not meet inclusion criteria. Fife and Glasgow were the two recruitment sites for this research study. In Fife, 62 people were referred and 34 (54.83%) were not randomised to the study, whereas, in Glasgow 53 people were referred and 37 (69.81%) were not randomised to the study. Figure 1 provides a diagrammatic representation of flow of participants from referral to randomisation. Of the 44 participants recruited to the study, four participants (3 TAU and 1 CBT) were subsequently removed from further analysis since baseline data only were available for these individuals. In total, 40 participants were entered for analysis, 29 females and 11 males."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: GDPs should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
X	***Conditional*** *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

Conditional recommendation for use of CBT over usual care.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

While data was clear for short-term outcomes, in long term less clarity and non-significant findings limiting ability to make recommendations.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the GDP members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version 6/26/14)
Topic # 24- A combination of cognitive behavioral therapy (individual) and usual care compared to usual care for treating minor or major depressive disorder in adults ages 65 and older

Factor	Explanation/Comments
II. Aggregate/Global Strength of Evidence (SOE) (from evidence profiles)	
II. Treatment Outcomes/Consequences	
• **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of Treatment *(Note- do not include financial cost)*	
Balance of Benefits and Harms/Burdens of Treatment	
XIX. Patient Values and Preferences	

XX. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 24- A combination of cognitive behavioral therapy (individual) and usual care compared to usual care for treating minor or major depressive disorder in adults ages 65 and older

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., When magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Response (follow up: 10 months; assessed with BDI)		X		
Quality of Life (follow up: 10 months; assessed with: EUROQOL)			X	
Quality of Life (follow up: 10 months; assessed with: Social Functioning Questionnaire)			X	
Outcomes for which no studies were found: functional capacity, remission, patient satisfaction, relapse, suicidality, serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only). **Global SOE Grade:** ☐High ☐Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Serfaty 2009

		№ of patients		Effect		Quality
№ of studies		**a combination of cognitive behavioral therapy (individual) and usual care**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
0				not estimable	not estimable	
Response (follow up: 10 months)						
1	See footnote #1	70	67	-	GEE estimate **3.07 lower** (5.73 lower to 0.42 lower)	⊕⊕⊕◯ MODERATE
Remission						
0				not estimable	not estimable	
Quality of Life (follow up: 10 months; assessed with: EUROQOL)						
1	See footnote #2	70	67	-	GEE estimate **0.05 higher** (0.04 lower to 0.14 higher)	⊕⊕◯◯ LOW
Quality of Life (follow up: 10 months; assessed with: Social Functioning Questionnaire); Serfaty 2009; number of events not reported by group						
1	See footnote #2	70	67	-	GEE estimate **1.65 lower** (3.57 lower to 0.26 higher)	⊕⊕◯◯ LOW
Patient Satisfaction						

0				not estimable	not estimable	
Relapse						
0				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- small sample size and/or number of events, does not meet optimal information size to detect difference
Footnote #2- small sample size and/or number of events, does not meet optimal information size to detect difference, confidence interval crosses appreciable difference

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Response (follow up: 10 months; assessed with BDI)		X				
2. Quality of Life (follow up: 10 months; assessed with: EUROQOL)			X			
3. Quality of Life (follow up: 10 months; assessed with: Social Functioning Questionnaire)			X			

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

References for harms/burdens published studies: *Serfaty et al (2009)*

Harm

- Dropout: 8.6 % (*6 of 70*) CBT + UC v. 17.9% (*12 of 67*) UC
- Reasons for dropout: Participants gave the following explanations for why they dropped out of treatment: dissatisfaction with group allocation; too physically or mentally ill; moved/not contactable; refused for no reason; died; developed cognitive problems; mad at therapist.
- Symptom worsening: none noted.
- Reviewed sample of sessions for treatment adherence

Other studies
None

Note any other information on burdens from published studies:

References for harms/burdens published studies: *Ekkers et al (2011); Serfaty et al (2009)*

Burden:

- home visits were offered for treatment conditions (40% of sample received home visits)
- 12 50-min CBT sessions
- Therapists had at least 5 years of experience in CBT treatment
- Of those who provided feedback, 72% of patients (*37 of 51*) found CBT useful, 20% (*10 of 51*) did not, and 8% were unsure.

Other studies
None

Note any additional information on harms:

Panel noted this appears to be an admirably low drop out rate.

Note any additional information on burdens:

Next, list and rate each harm/burden :

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
4. Adverse events leading to withdrawals						X
5. Other serious adverse events						X
6. Other adverse events						X
7. Burdens				X		

Assign an overall global rating across outcomes:

☐Benefits clearly outweigh harms/ burden
X☐Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments:

III) Patient Values and Preferences

What are the typical patient values and preferences?

How variable are these?

How certain is the GDP about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

[Possible studies to include from APA staff search of pt values and preferences studies]:

Dwight-Johnson et al (2013): "*Objective:* Among **older white and Mexican origin male primary care patients**, we examined preferences for features of depression care programs that would encourage depressed older men to enter and remain in treatment. *Method:* **Sixty-three (45 white, 18 Mexican origin) older men were recruited in six primary care clinics. All had clinical depression in the past year and/or were receiving depression treatment.** Participants completed a conjoint analysis preference survey regarding depression treatments, providers and treatment enhancements. *Results:* The data suggest that **white men preferred medication over counseling [odds ratio (OR): 1.64 95% confidence interval (CI): 1.12–2.41], while Mexican origin men preferred counseling (OR: medication over counseling: 0.28, 95% CI: 0.12–0.66). Both white and Mexican origin men preferred treatment that included family involvement (vs. none) (white: OR: 1.60, 95% CI 1.12–2.30; Mexican origin: OR: 3.31 95% CI 1.44–7.62) and treatment for insomnia (vs. treatment for alcohol use) (white: OR: 1.72, 95% CI 1.01–2.91; Mexican origin: OR: 3.93 95% CI 1.35–11.42). White men also preferred treatment by telephone (OR: 1.80, 95% CI 1.12–2.87).** *Conclusions:* Findings could inform development of patient-centered depression treatment programs for older men and suggest strategies, such as attention to sleep problems, which providers may employ to tailor treatment to preferences of older men."

Gibson et al (2013): "High rates of antidepressant prescribing in Western countries have coincided with increasing doubts about the effectiveness of these medications, especially for the treatment of mild to moderate depression in primary care. **This narrative review constructs a patient-centered perspective on antidepressant use, which examines research on patients' attitudes to antidepressants and their treatment preferences; experiences of being prescribed antidepressants and taking antidepressants, as well as reasons for adherence or nonadherence. Key themes in the research literature suggest that patients have predominantly negative views of antidepressants and that they prefer psychotherapy to medication. Patients may agree to antidepressants because they have limited information about the medication or about other treatment options. Although they may see themselves as active in the decision to take antidepressants, they tend to accept the physicians' recommendation during the initial crisis period during which they seek help.** They may also continue taking antidepressants because of experience of withdrawal symptoms and lack of on-going support from their physician. Patients may be acting on rational concerns about an antidepressant when they choose not to comply with its prescription. This review suggests that physicians should be more active in discussing patients' concerns about antidepressants with them."

Gitlin et al (2013): "*Objective:* To examine older African American's recognition of and beliefs about depressive symptoms, preferred symptom management strategies, and factors associated with willingness to use mental health treatments. Differences between depressed and non-depressed and men and women were examined. *Design:* Cross-sectional survey. *Setting:* Home, senior center. *Participants:* 153 senior center members (56=males, 97=females) ≥55 years. *Measurements:* **Using a depression vignette**, **participants indicated if the person was depressed and their endorsement of items reflecting beliefs, stigma, symptom management, and willingness to use treatments (yes/no). PHQ-9 assessed current symptomatology.** *Results:* Overall, 24.2% reported depressive symptoms (≥5); 88.2% correctly identified the person in the vignette as depressed. **Most (≥75%) endorsed active symptom management strategies, preference for treatment in physician and therapist offices, and willingness to take medications, seek therapy, see doctor and attend support groups; <33% viewed depression as stigmatizing whereas 48% viewed depression as normal aging. Logistic regressions revealed lower education, higher physical function and feeling okay if community knew of depression diagnosis were associated with willingness to see physician if feeling depressed; being married and believing anti-depressant medications are beneficial were related to willingness to use medications. Different associations emerged for depressed/non-depressed and men and women.** *Conclusions:* Overall, this older African American sample had positive attitudes and beliefs and endorsed traditional treatment modalities suggesting that beliefs alone are unlikely barriers to underutilization of mental health services. As different factors were associated with willingness to seek physician help and use medications and factors differed for depressed/non-depressed and by sex, interventions should be tailored."

Hanson & Scogin (2008): "We examined older adults' ratings of the acceptability of geriatric depression treatments. **We presented 120 community-dwelling participants with vignettes describing an older adult experiencing either mild to moderate or severe depression. Participants rated the acceptability of three different treatments: cognitive therapy (CT), antidepressant medication (AM), and a combination treatment of CT and AM (COM). For general acceptability, participants rated COM as a more acceptable treatment for depression than both CT and AM. With respect to perceived negative aspects of treatments, they rated CT as a more acceptable treatment for mild to moderate depression than both AM and COM. Participants rated both COM and CT as more acceptable treatments for severe depression than AM.** Results indicate that combining psychotherapy and AM may be viewed as most acceptable by community-dwelling, nondepressed older adults."

Lin et al (2005): "Background: The chronic illness model encourages consideration of patients' treatment preferences. Moreover, research suggests that matching treatment to preference might affect outcomes for patients with depression. Purpose: This investigation explored factors associated with treatment preference matching and the effects of matching on depression treatment outcomes. Methods: **Treatment preferences were assessed among primary care patients with depression participating in a large randomized trial of depression management. Patients were offered antidepressant medication and/or counseling based on**

preference and several other factors. Depression was assessed at 3 and 9 months. Results: **Participants who preferred medication were older, were in worse physical health, and were more likely to already be taking antidepressants. Participants who preferred both medication and counseling evidenced greater agreement with the statement that depression is a medical illness. Overall, 72% of participants were matched with their preferred treatment; matched participants demonstrated more rapid improvement in depression symptomatology than unmatched participants.** Conclusions: Obtaining preferred treatment appears to contribute to improved treatment outcome. Continued attempts to assess for and accommodate treatment preferences might result in better response to depression treatment."

Raue et al (2012): "*Objective:* The authors hypothesized that the depression treatment preferences of elderly home care patients would vary by depression experience, with preferences for active treatments being associated with current depression and antidepressant treatment. *Methods:* The authors conducted **cross sectional secondary analyses of the TRIAD ("Training in the Assessment of Depression") study of 256 randomly selected elderly patients newly admitted to homecare.** The study assessed depression treatment preference for active (i.e., medication or psychotherapy) versus non-active or complementary approaches (e.g., religious activities, do nothing). Two separate indicators of depression experience were used: diagnoses of major or minor depression, and current or previous antidepressant treatment. *Results:* **121 patients (48%) preferred active treatment with either medication or psychotherapy as their first choice, while the remainder preferred non-active or complementary approaches. Logistic regression indicated that current antidepressant use, previous psychotherapy experience, white and Hispanic versus African-American patients, greater IADL impairment, and less personal stigma about depression were independently associated with preference for an active treatment.** *Conclusions:* Elderly homecare patients have a variety of depression treatment preferences ranging from active treatments, to religious or spiritual activities, to no treatment. **Several factors were associated with a preference for active treatment, including treatment experience, co-existing physical impairment, culture, and attitudes and beliefs.** Understanding patient preferences may form the basis of engaging older depressed home care patients in treatment."

Steidtmann et al (2012): "Background: Findings regarding the relationship between patient treatment preference and treatment outcome are mixed. This is a secondary data analysis investigating the relationship between treatment preference, and symptom outcome and attrition in a large 2-phase depression treatment trial. Methods: Patients met DSM-IV criteria for chronic forms of depression. **Phase I was a 12-week, nonrandomized, open-label trial in which all participants (n=785) received antidepressant medication(s) (ADM). Phase I nonremitters were randomized to Phase II, in which they received 12 weeks of either Cognitive-Behavioral System of Psychotherapy (CBASP) + ADM (n=193), Brief Supportive Psychotherapy (BSP) + ADM (n=187), or ADM only (n=93). Participants indicated their treatment preference (medication only, combined treatment or no preference) at study entry.** Symptoms were measured at 2-week intervals with the 24-item Hamilton Rating Scale for Depression (HAM-D). Results: **A large majority of patients reported a preference for combined treatment. Patients who preferred**

medication only were more likely to endorse a chemical imbalance explanation for depression, whereas those desiring combined treatment were more likely to attribute their depression to stressful experiences. In Phase I, patients who expressed no treatment preference showed greater rates of HAM-D symptom reduction than those with any preference, and patients with a preference for medication showed higher attrition than those preferring combined treatment. In Phase II, baseline treatment preference was not associated with symptom reduction or attrition. Conclusions: Treatment preferences may moderate treatment response and attrition in unexpected ways. Research identifying factors associated with differing preferences may enable improved treatment retention and response."

Van Schaik et al (2004): "Patients' preferences in the treatment of depression are important in clinical practice and in research. Antidepressant medication is often prescribed, but adherence is low. This may be caused by patients preferring psychotherapy, which is often not available in primary care. In randomized clinical trials, patients' preferences may affect the external validity. **The aim of this article is to study patients' preferences regarding psychotherapy and antidepressant medication and the impact of these preferences on treatment outcome. A systematic review of the literature was performed. The majority of patients preferred psychotherapy in all available studies. Antidepressants were often regarded as addictive and psychotherapy was assumed to solve the cause of depression.** Discussing and supporting preferences as part of a quality improvement program of depression care, resulted in more patients receiving the treatment that was most suitable to them. In two patient-preference trials, preferences did not influence treatment outcome. It can be concluded that a substantial percentage of well-informed patients prefer psychotherapy. Patients with strong preferences, mostly for psychotherapy, are likely not to enter antidepressant treatment or randomized clinical trials if their preferences are not supported."

In Serfaty et al (2009):

Also measured treatment preference - majority preferred CBT but was not statistically significant

Information from community members on panel:

Preference for active treatment.

Information from clinicians on panel:

Preference for active treatment but varies on what active treatment.

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High	X	High
X	Moderate		Moderate
	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

X Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Evidence of moderate variability in client preferences in part depending on the clinical context, severity of depression or co-occurring medical conditions, and most respondents prefer some form of active treatment, whether single intervention or combination, rather than wait list or no treatment.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to impact applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Individuals with both major and minor depression included in the study obscuring sub grou differences.
Interventions	High rating of acceptability/ utility of CBT from participants.
Comparators	Comparison with UC has ecological validity.
Outcomes	Relatively small advantage on Beck; statistically reliable but perhaps low clinical effect size and still a burden of residual depressive symptoms. Euroqol is relatively generic with low sensitivity to mental health outcomes.
Timing or Time frame	Appropriate in respect to modality being offered.
Settings	40% had home care which influenced acceptability. Did not seem to influence outcome.

Notes/Comments:
Serfaty et al., 2009:

Patients/Populations: "The inclusion criteria were (1) a primary diagnosis of depressive disorder made by the researcher who administered the Geriatric Mental State and History and Etiology Schedule using the computerized diagnostic program AGECAT (Automated Geriatric Examination for Computer Assisted Taxonomy),which has been validated in the community and used in international comparisons of depression; (2) a score of 14 or higher on the BDI-II to include people with less severe mixed anxiety and depression, who are frequently seen in primary care and who may respond to CBT;(3) sufficient command of English to use CBT techniques; and (4) if taking an antidepressant, a stable dose of medication for at least 8 weeks prior to randomization. The exclusion criteria were (1) intense suicidal intent requiring inpatient admission; (2) a history suggestive of alcohol misuse or drug dependence; (3) a history of bipolar affective disorder; (4) the presence of hallucinations or delusions; (5) cognitive deficits, as judged by a score of less than 24 on the Mini-Mental State Examination; (6) having received CBT in the last year; and (7) having received electroconvulsive therapy within the previous 6 months, because of possible residual effects on cognition."

	Comparators: "Treatment as usual allowed for whatever medication, routine support, or referral to other services was felt appropriate by the GP. The only constraint was to refrain from referring patients for CBT or other brief talking therapies unless absolutely necessary. Participants could discuss their problems and their physical health, and pain management could be reviewed, medication prescribed, and referrals made to luncheon clubs or day centers. Antidepressant medication as a routine part of TAU was not constrained. We envisaged that the number of participants who began taking antidepressant medication during the course of the trial would likely be small. General practitioners were notified about patients allocated to the trial for ethical reasons and to ensure that provision of therapy from other sources was limited." **Settings:** "A post hoc analysis was conducted to see whether site of therapy influenced outcome. None was found; nor was there a significant difference in the number of sessions completed between the interventions delivered at home or in a community setting."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: GDPs should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
X	***Conditional*** *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

Conditional recommendation for CBT plus usual care over usual care.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Evidence for small benefit and relatively no evidence for burden and compelling evidence that participants found it acceptable and useful to participate in CBT on top of usual care. However, at the end of the trial patients still had moderate burden of depressive symptoms.

The panel needed to return to the source data in order to understand the actual scores, in addition to the change in scores, on the BDI.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the GDP members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version 6/26/14)
Topic # 24B - A combination of cognitive behavioral therapy (group) and usual care compared to usual care for treating minor or major depressive disorder in adults ages 65 and older

Factor	Explanation/Comments
XI. Aggregate/Global Strength of Evidence (SOE) (from evidence profiles)	
II. Treatment Outcomes/Consequences	
• **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of Treatment *(Note- do not include financial cost)*	
Balance of Benefits and Harms/Burdens of Treatment	
XIII. Patient Values and Preferences	

XIV. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 24- A combination of cognitive behavioral therapy (individual) and usual care compared to usual care for treating minor or major depressive disorder in adults ages 65 and older

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., When magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Change in Scores (follow up: 8 weeks; assessed with: Geriatric Depression Scale			X	
Outcomes for which no studies were found: functional capacity, response, remission, quality of life, patient satisfaction, relapse, suicidality, serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only). **Global SOE Grade:** ☐High ☐Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Ekkers et al., 2011

Quality assessment				№ of patients		Effect		Quality
№ of studies				a combination of cognitive behavioral therapy (group) and usual care	usual care	Relative (95% CI)	Absolute (95% CI)	
Functional Capacity								
0						not estimable	not estimable	
Response								
0						not estimable	not estimable	
Change in Scores (follow up: 8 weeks; assessed with: Geriatric Depression Scale)								
1	See Footnotes #1, #2, and #3			53	40	-	MD 3.2 lower (5.52 lower to 0.88 lower)	⊕⊕◯◯ LOW
Remission								
0						not estimable	not estimable	
Quality of Life								
0						not estimable	not estimable	
Patient Satisfaction								
0						not estimable	not estimable	
Relapse								
0						not estimable	not estimable	
Suicidality								
0						not estimable	not estimable	

Adverse Events						
0				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1 - high differential attrition
Footnote #2 - high drop out
Footnote #3 - small sample size and/or number of events, does not meet optimal information size to detect difference

Next, list and rate each benefit from the evidence profile information:
Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Change in Scores (follow up: 8 weeks; assessed with: Geriatric Depression Scale)		X				

The panel had a discussion regarding the clinical significance of the effect as well as the residual symptoms.

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

References for harms/burdens published studies: *Ekkers et al (2011)*

Harm

- Dropout: 7.5 % (*4 of 53*) CBT + UC v. 50% (*20 of 40*) UC
- Reasons for dropout: Participants gave the following explanations for why they dropped out of treatment: vacation; time conflict; depression worsened; sick/too physically or mentally ill;
- Symptom worsening: one patient did not complete treatment due to worsening depression. In addition, 6% (*n* = 3) of treatment completers (CBT + UC) had a reliable change for the worse, while 5 patients in UC condition had a reliable change for the worse.
- Reviewed sample of sessions for treatment adherence

Other studies

Arean et al (2005)

- Dropout: 32% (*8 of 25*) CBT + UC v. 25.9% (*7 of 27*) UC
- Reasons for dropout: feasibility, unknown/lost contact, dissatisfied, no longer interested, wanted antidepressant

Note any other information on burdens from published studies:

References for harms/burdens published studies: *Ekkers et al (2011)*

Burden:

- Treatment (i.e., COMET) was delivered in group format
- 7-weeks, 90 mins each
- Daily homework assignments

Other studies

None

Note any additional information on harms:

Note any additional information on burdens:

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
2. Adverse events leading to withdrawals						X
3. Other serious adverse events						X
4. Other adverse events						X
5. Burdens				X		

Assign an overall global rating across outcomes:

☐Benefits clearly outweigh harms/ burden
X ☐Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments:

III) Patient Values and Preferences

What are the typical patient values and preferences?

How variable are these?

How certain is the GDP about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

[Possible studies to include from APA staff search of pt values and preferences studies]:

Dwight-Johnson et al (2013): "*Objective:* Among **older white and Mexican origin male primary care patients**, we examined preferences for features of depression care programs that would encourage depressed older men to enter and remain in treatment. *Method:* **Sixty-three (45 white, 18 Mexican origin) older men were recruited in six primary care clinics. All had clinical depression in the past year and/or were receiving depression treatment.** Participants completed a conjoint analysis preference survey regarding depression treatments, providers and treatment enhancements. *Results:* The data suggest that **white men preferred medication over counseling [odds ratio (OR): 1.64 95% confidence interval (CI): 1.12–2.41], while Mexican origin men preferred counseling (OR: medication over counseling: 0.28, 95% CI: 0.12–0.66). Both white and Mexican origin men preferred treatment that included family involvement (vs. none) (white: OR: 1.60, 95% CI 1.12–2.30; Mexican origin: OR: 3.31 95% CI 1.44–7.62) and treatment for insomnia (vs. treatment for alcohol use) (white: OR: 1.72, 95% CI 1.01–2.91; Mexican origin: OR: 3.93 95% CI 1.35–11.42). White men also preferred treatment by telephone (OR: 1.80, 95% CI 1.12–2.87).** *Conclusions:* Findings could inform development of patient-centered depression treatment programs for older men and suggest strategies, such as attention to sleep problems, which providers may employ to tailor treatment to preferences of older men."

Gibson et al (2013): "High rates of antidepressant prescribing in Western countries have coincided with increasing doubts about the effectiveness of these medications, especially for the treatment of mild to moderate depression in primary care. **This narrative review constructs a patient-centered perspective on antidepressant use, which examines research on patients' attitudes to antidepressants and their treatment preferences; experiences of being prescribed antidepressants and taking antidepressants, as well as reasons for adherence or nonadherence. Key themes in the research literature suggest that patients have predominantly negative views of antidepressants and that they prefer psychotherapy to medication. Patients may agree to antidepressants because they have limited information about the medication or about other treatment options. Although they may see themselves as active in the decision to take antidepressants, they tend to accept the physicians' recommendation during the initial crisis period during which they seek help.** They may also continue taking antidepressants because of experience of withdrawal symptoms and lack of on-going support from their physician. Patients may be acting on rational concerns about an antidepressant when they choose not to comply with its prescription. This review suggests that physicians should be more active in discussing patients' concerns about antidepressants with them."

Gitlin et al (2013): "*Objective:* To examine older African American's recognition of and beliefs about depressive symptoms, preferred symptom management strategies, and factors associated with willingness to use mental health treatments. Differences between depressed and non-depressed and men and women were examined. *Design:* Cross-sectional survey. *Setting:* Home, senior center. *Participants:* 153 senior center members (56=males, 97=females) ≥55 years. *Measurements:* **Using a depression vignette**, **participants indicated if the person was depressed and their endorsement of items reflecting beliefs, stigma, symptom management, and willingness to use treatments (yes/no). PHQ-9 assessed current symptomatology.** *Results:* Overall, 24.2% reported depressive symptoms (≥5); 88.2% correctly identified the person in the vignette as depressed. **Most (≥75%) endorsed active symptom management strategies, preference for treatment in physician and therapist offices, and willingness to take medications, seek therapy, see doctor and attend support groups; <33% viewed depression as stigmatizing whereas 48% viewed depression as normal aging. Logistic regressions revealed lower education, higher physical function and feeling okay if community knew of depression diagnosis were associated with willingness to see physician if feeling depressed; being married and believing anti-depressant medications are beneficial were related to willingness to use medications. Different associations emerged for depressed/non-depressed and men and women.** *Conclusions:* Overall, this older African American sample had positive attitudes and beliefs and endorsed traditional treatment modalities suggesting that beliefs alone are unlikely barriers to underutilization of mental health services. As different factors were associated with willingness to seek physician help and use medications and factors differed for depressed/non-depressed and by sex, interventions should be tailored."

Gum et al (2006): "PURPOSE: For depressed older primary care patients, this study aimed to examine (a) characteristics associated with depression treatment preferences; (b) predictors of receiving preferred treatment; and (c) whether receiving preferred treatment predicted satisfaction and depression outcomes. DESIGN AND METHODS: **Data are from 1,602 depressed older primary care patients who participated in a multisite, randomized clinical trial comparing usual care to collaborative care, which offered medication and counseling for up to 12 months**. Baseline assessment included demographics, depression, health information, prior depression treatment, potential barriers, and treatment preferences (medication, counseling). At 12 months, services received, satisfaction, and depression outcomes were assessed. RESULTS: **More patients preferred counseling (57%) than medication (43%). Previous experience with a treatment type was the strongest predictor of preference. In addition, medication preference was predicted by male gender and diagnosis of major depression (vs dysthymia). The collaborative care model greatly improved access to preferred treatment, especially for counseling (74% vs 33% in usual care). Receipt of preferred treatment did not predict satisfaction or depression outcomes; these outcomes were most strongly impacted by treatment condition.** IMPLICATIONS: Many depressed older primary care patients desire counseling, which is infrequently available in usual primary care. Discussion of treatment preferences should include an assessment of prior treatment experiences. A collaborative care model that increases collaboration between primary care and mental health professionals can increase access to preferred treatment.

If preferred treatment is not available, collaborative care still results in good satisfaction and depression outcomes."

Hanson & Scogin (2008): "We examined older adults' ratings of the acceptability of geriatric depression treatments. **We presented 120 community-dwelling participants with vignettes describing an older adult experiencing either mild to moderate or severe depression. Participants rated the acceptability of three different treatments: cognitive therapy (CT), antidepressant medication (AM), and a combination treatment of CT and AM (COM). For general acceptability, participants rated COM as a more acceptable treatment for depression than both CT and AM. With respect to perceived negative aspects of treatments, they rated CT as a more acceptable treatment for mild to moderate depression than both AM and COM. Participants rated both COM and CT as more acceptable treatments for severe depression than AM.** Results indicate that combining psychotherapy and AM may be viewed as most acceptable by community-dwelling, nondepressed older adults."

Kitchen et al (2013): "The purpose of this study was **to investigate depression treatment preferences and anticipated service use in a sample of adults aged 55 years or older who reside in rural Wyoming.** Sixteen participants (mean age = 59) completed 30- to 60-minute, semi-structured interviews. Qualitative methods were used to characterize common themes. **Social/provider support and community gatekeepers were perceived by participants as important potential facilitators for seeking depression treatment. In contrast, perceived stigma and the value placed on self-sufficiency emerged as key barriers to seeking treatment for depression in this rural, young-old sample. Participants anticipated presenting for treatment in the primary care sector and preferred a combination of medication and psychotherapy for treatment. Participants were, however, more willing to see mental health professionals if they were first referred by a clergy member or primary care physician."**

Kocsis et al (2009): "Background: Little is known about moderators of response to psychotherapy, medication, and combined treatment for chronic forms of major depressive disorder (MDD). We hypothesized that patient preference at baseline would interact with treatment group to differentially affect treatment outcome. Method: **We report outcomes for 429 patients who participated in a randomized multicenter trial of nefazodone, Cognitive Behavioral Analysis System of Psychotherapy (CBASP), or combination therapy for chronic forms of MDD (DSM-IV criteria) and who indicated their preference for type of treatment at study entry.** The primary outcome measures were total scores on the 24-item Hamilton Rating Scale for Depression (HAM-D-24) and categorical definitions of remission or partial response. The patients were recruited between June 1996 and December 1997. Results**: There was an interactive effect of preference and treatment group on outcome. The treatment effect varied as a function of preference, and was particularly apparent for patients who initially expressed preference for one of the monotherapies. Patients who preferred medication had a higher remission rate (45.5%) and lower mean HAM-D-24 score (11.6) at study exit if they received medication than if they received psychotherapy (remission rate, 22.2%; mean HAM-D-24 score, 21.0). Patients who preferred psychotherapy had a**

	higher remission rate (50.0%) and lower mean HAM-D-24 score (12.1) if they received psychotherapy than if they received medication (remission rate 7.7%, mean HAM-D-24 score 18.3). Nevertheless, treatment preference was not associated with risk of dropout from the study. Conclusions: These results suggest that patient preference is a potent moderator of treatment response for patients with chronic forms of MDD; however, relatively low proportions of the patient sample preferred one of the monotherapies, participants were not blinded to treatment assignment, and there was no placebo group." **Lin et al (2005):** "Background: The chronic illness model encourages consideration of patients' treatment preferences. Moreover, research suggests that matching treatment to preference might affect outcomes for patients with depression. Purpose: This investigation explored factors associated with treatment preference matching and the effects of matching on depression treatment outcomes. Methods: **Treatment preferences were assessed among primary care patients with depression participating in a large randomized trial of depression management. Patients were offered antidepressant medication and/or counseling based on preference and several other factors.** Depression was assessed at 3 and 9 months. Results: **Participants who preferred medication were older, were in worse physical health, and were more likely to already be taking antidepressants. Participants who preferred both medication and counseling evidenced greater agreement with the statement that depression is a medical illness. Overall, 72% of participants were matched with their preferred treatment; matched participants demonstrated more rapid improvement in depression symptomatology than unmatched participants.** Conclusions: Obtaining preferred treatment appears to contribute to improved treatment outcome. Continued attempts to assess for and accommodate treatment preferences might result in better response to depression treatment." **Raue et al (2012):** "*Objective:* The authors hypothesized that the depression treatment preferences of elderly home care patients would vary by depression experience, with preferences for active treatments being associated with current depression and antidepressant treatment. *Methods:* The authors conducted **cross sectional secondary analyses of the TRIAD ("Training in the Assessment of Depression") study of 256 randomly selected elderly patients newly admitted to homecare.** The study assessed depression treatment preference for active (i.e., medication or psychotherapy) versus non-active or complementary approaches (e.g., religious activities, do nothing). Two separate indicators of depression experience were used: diagnoses of major or minor depression, and current or previous antidepressant treatment. *Results:* **121 patients (48%) preferred active treatment with either medication or psychotherapy as their first choice, while the remainder preferred non-active or complementary approaches. Logistic regression indicated that current antidepressant use, previous psychotherapy experience, white and Hispanic versus African-American patients, greater IADL impairment, and less personal stigma about depression were independently associated with preference for an active treatment.** *Conclusions:* Elderly homecare patients have a variety of depression treatment preferences ranging from active treatments, to religious or spiritual activities, to no treatment. **Several factors were associated with a preference for active treatment, including treatment experience, co-existing physical impairment, culture, and attitudes and beliefs.**

Understanding patient preferences may form the basis of engaging older depressed home care patients in treatment."

Steidtmann et al (2012): "Background: Findings regarding the relationship between patient treatment preference and treatment outcome are mixed. This is a secondary data analysis investigating the relationship between treatment preference, and symptom outcome and attrition in a large 2-phase depression treatment trial. Methods: Patients met DSM-IV criteria for chronic forms of depression. **Phase I was a 12-week, nonrandomized, open-label trial in which all participants (n=785) received antidepressant medication(s) (ADM). Phase I nonremitters were randomized to Phase II, in which they received 12 weeks of either Cognitive-Behavioral System of Psychotherapy (CBASP) + ADM (n=193), Brief Supportive Psychotherapy (BSP) + ADM (n=187), or ADM only (n=93). Participants indicated their treatment preference (medication only, combined treatment or no preference) at study entry.** Symptoms were measured at 2-week intervals with the 24-item Hamilton Rating Scale for Depression (HAM-D). Results: **A large majority of patients reported a preference for combined treatment. Patients who preferred medication only were more likely to endorse a chemical imbalance explanation for depression, whereas those desiring combined treatment were more likely to attribute their depression to stressful experiences. In Phase I, patients who expressed no treatment preference showed greater rates of HAM-D symptom reduction than those with any preference, and patients with a preference for medication showed higher attrition than those preferring combined treatment. In Phase II, baseline treatment preference was not associated with symptom reduction or attrition.** Conclusions: Treatment preferences may moderate treatment response and attrition in unexpected ways. Research identifying factors associated with differing preferences may enable improved treatment retention and response."

Van Schaik et al (2004): "Patients' preferences in the treatment of depression are important in clinical practice and in research. Antidepressant medication is often prescribed, but adherence is low. This may be caused by patients preferring psychotherapy, which is often not available in primary care. In randomized clinical trials, patients' preferences may affect the external validity. **The aim of this article is to study patients' preferences regarding psychotherapy and antidepressant medication and the impact of these preferences on treatment outcome. A systematic review of the literature was performed. The majority of patients preferred psychotherapy in all available studies. Antidepressants were often regarded as addictive and psychotherapy was assumed to solve the cause of depression.** Discussing and supporting preferences as part of a quality improvement program of depression care, resulted in more patients receiving the treatment that was most suitable to them. In two patient-preference trials, preferences did not influence treatment outcome. It can be concluded that a substantial percentage of well-informed patients prefer psychotherapy. Patients with strong preferences, mostly for psychotherapy, are likely not to enter antidepressant treatment or randomized clinical trials if their preferences are not supported."

Wu et al (2014): "A substantial number of cancer patients experience depression. This study investigated treatment preferences for depression**. Breast cancer survivors (N = 134) completed an anonymous survey**

	asking preference and interest in three treatments for depression: individual counseling (IC), antidepressant medication (MED), or support groups (SG). Participants were recruited from a surgical oncology office and asked to complete the survey as they waited for their appointment. Preference was compared using Wilcoxon Signed Rank tests. **More than 50% ranked IC as first choice of treatment. Preference for IC was significantly higher than preference for MED and SG. Preference between MED and SG did not differ.** Survivors preferred counseling for treatment of depression. Cancer centers should be prepared to provide preferred treatment methods, particularly as screening, and therefore management, of psychosocial distress is to be required." *Information from community members on panel:* *Information from clinicians on panel:* *Information from other sources (also list sources):*

Next rate the variability of and your certainty about patient values and preferences:

✓	Variability in Patient Values & Preferences	✓	Certainty in Patient Values & Preferences
	High	X	High
X	Moderate		Moderate
	Low		Low
	Unknown		Unknown

Moderate variability, highly certain

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

X Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Evidence of moderate variability in client preferences in part depending on the clinical context, severity of depression or co-occurring medical conditions, and most respondents prefer some form of active treatment, whether single intervention or combination, rather than wait list or no treatment.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to impact applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Severely and chronically depressed older adults
Interventions	7 session group CBT aimed at rumination; risk of researcher allegiance
Comparators	TAU is fairly intense specialty mental health care.
Outcomes	Participants were left with clinically sig burden of depression sxs (better but not well)
Timing or Time frame	Appropriate for modality; pretty brief intervention
Settings	Specialty mental health care.

	Notes/Comments: *Ekkers et al., 2011:* “Patients were recruited from four ambulatory departments of Parnassia, a large mental health institute specialized in the treatment of the elderly (aged □65 years). All patients suffered from major depressive disorder, many with other comorbid disorders (e.g. personality disorder) and can be considered a representative sample of the patients that are regularly treated at these four departments. At baseline the TAU þ COMETgroup consisted of 15 male and 38 female patients with an average age of 71.8 (sd ¼ 5.8) years; they had no cognitive impairment (mean MMSE score 28.4; sd ¼ 1.6) and 80% was educated at secondary vocational level or higher. In this group, 25 still had a partner, 23 had previous depressive episodes, and 40 (75%) were on anti-depressant medication (ADM), 9 received ADM only, 9 received a combination of ADM and psychotherapy, 6 received psychotherapy only, 22 received a combination of ADM and supportive/structuring treatment, and 7 patients received supportive/structuring treatment only. The TAU alone group consisted of 6 male and 34 female patients with an average age of 73.9 (sd ¼ 5.7) years; they had no cognitive impairment (mean MMSE score 28.4 (sd ¼ 1.5)) and 60% was educated at secondary vocational level or higher. In this group, 13 still had a partner, 26 had previous depressive episodes, 33 (83%) were on ADM, 3 received ADM only, 6 received a combination of ADM and psychotherapy, 7 received psychotherapy only, 23 received a combination of ADM and supportive/structuring treatment, and 1 patient received supportive treatment only.”

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: GDPs should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
X	***Conditional*** *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

Conditional recommendation for group CBT (COMET) in addition to TAU.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Short term group CBT was found to be of small but meaningful benefit in severely chronically depressed older adults in specialty mental health care.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the GDP members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version 6/26/14)
Topic # 25- A combination of cognitive behavioral therapy (individual) and usual care compared to usual care for treating minor or major depressive disorder in adults ages 60 and older with type II diabetes mellitus or chronic obstructive pulmonary disease

Factor	Explanation/Comments
V. Aggregate/Global Strength of Evidence (SOE) (from evidence profiles)	
VI. Treatment Outcomes/Consequences • **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of Treatment *(Note- do not include financial cost)*	
Balance of Benefits and Harms/Burdens of Treatment	
VII. Patient Values and Preferences	

VIII. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 25- A combination of cognitive behavioral therapy (individual) and usual care compared to usual care for treating minor or major depressive disorder in adults ages 60 and older with type II diabetes mellitus or chronic obstructive pulmonary disease

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., When magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Response (follow up: 3 months; assessed with: Beck Depression Inventory (>=50% reduction)		X		
Response (follow up: 9 months; assessed with: Beck Depression Inventory (>=50% reduction));		X		
Quality of Life 3 (follow up: 3 months; assessed with: Short Form-36 Mental)			X	
Quality of Life 3 (follow up: 9 months; assessed with: Short Form-36 Mental			X	
Quality of Life 3 (follow up: 3 months; assessed with: Short Form-36 Physical)			X	
Quality of Life 3 (follow up: 9 months; assessed with: Short Form-36 Physical)			X	
Outcomes for which no studies were found: functional capacity, remission, patient satisfaction, relapse, suicidality, serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only). **Global SOE Grade:** ☐High ☐Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Lamers et al., 2010

Quality assessment		№ of patients		Effect		Quality
№ of studies		**a combination of cognitive behavioral therapy (individual) and usual care**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
0				not estimable	not estimable	
Response (follow up: 3 months; assessed with: Beck Depression Inventory (>=50% reduction))						
1	See Footnote #1	14/183 (7.7%)	11/178 (6.2%)	RR 1.24 (0.58 to 2.65)	15 more per 1000 (from 26 fewer to 102 more)	⊕⊕⊕◯ MODERATE
Response (follow up: 9 months; assessed with: Beck Depression Inventory (>=50% reduction))						
1	See Footnote #2	20/183 (10.9%)	9/178 (5.1%)	RR 2.16 (1.01 to 4.62)	59 more per 1000 (from 1 more to 183 more)	⊕⊕⊕◯ MODERATE
Remission						
0				not estimable	not estimable	
Quality of Life (follow up: 3 months; assessed with: Short Form-36 Mental)						
1	See Footnotes #1 and #3	101	102	-	MD **0.9 higher** (1.55 lower to 3.36 higher)	⊕⊕◯◯ LOW
Quality of Life (follow up: 9 months; assessed with: Short Form-36 Mental)						
1	See Footnote #1	103	98	-	MD **1.87 higher** (0.59 lower to 4.34 higher)	⊕⊕◯◯ LOW

Quality of Life (follow up: 3 months; assessed with: Short Form-36 Physical)						
1	See Footnote #1	101	102	-	MD **1.58 higher** (0.12 lower to 3.28 higher)	⊕⊕◯◯ LOW
Quality of Life (follow up: 9 months; assessed with: Short Form-36 Physical)						
1	See Footnote #1	103	98	-	MD **0.79 higher** (1.16 lower to 2.74 higher)	⊕⊕◯◯ LOW
Patient Satisfaction						
				not estimable	not estimable	
Relapse						
				not estimable	not estimable	
Suicidality						
				not estimable	not estimable	
Adverse Events						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- Confidence intervals cross appreciable difference
Footnote #2- Wide Confidence Intervals
Footnote #3- Completers analysis with high dropout

<u>Number needed to treat (NNT) (95% Confidence Interval)</u>
Response (follow up: 3 months; assessed with: Beck Depression Inventory (>=50% reduction)): NNT = 67 (NNT(harm) 27 to ∞ to NNT(benefit) 14)
Response (follow up: 9 months; assessed with: Beck Depression Inventory (>=50% reduction)): NNT = 17 (NNT(benefit) 8 to 309)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Response (follow up: 3 months; assessed with: Beck Depression Inventory (>=50% reduction)			X			
2. Response (follow up: 9 months; assessed with: Beck Depression Inventory (>=50% reduction));	.	……. X				
3. Quality of Life 3 (follow up: 3 months; assessed with: Short Form-36 Mental)			X			
4. Quality of Life 3 (follow up: 9 months; assessed with: Short Form-36 Mental			X			
5. Quality of Life 3 (follow up: 3 months; assessed with: Short Form-36 Physical)			X			
6. Quality of Life 3 (follow up: 9 months; assessed with: Short Form-36 Physical)			X			

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

References for harms/burdens published studies: *Lamers et al (2010)*

Harm

- Dropout: 25.7% (*47 of 183*) "Minimal Psychological Intervention [MPI]*" v. 0% (*0 of 178*) UC
    - *MPI is based on principles of CBT and self-management
- Reasons for dropout: lack of perceived usefulness; perceived burden; personal/family circumstances; physical decline; cognitive decline; deceased; other reasons
- Adverse events: 1 participant lost to follow-up in treatment condition because he/she was "suicidal"
- Symptom worsening: overall increase in depression symptoms for UC group
- Nurse therapists completed treatment adherence checklist after each session

Other studies:
None

Note any other information on burdens from published studies:

References for harms/burdens published studies: *Lamers et al (2010)*

Burden

- Nurse-led intervention (average 4 sessions for 1 hour each)
- Home-delivered
- 9 patients cited "perceived burden" of treatment as a reason for dropping out

Note any additional information on harms:

Note any additional information on burdens:

Next, list and rate each harm/burden :

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
7. Adverse events leading to withdrawals			.	.		…. X
8. Other serious adverse events						X
9. Other adverse events		X				
10. Burdens				X		

Assign an overall global rating across outcomes:

X☐Benefits clearly outweigh harms/ burden
☐Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments: Unconfidently.

III) Patient Values and Preferences

What are the typical patient values and preferences?

How variable are these?

How certain is the GDP about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

People want care. Some variability in preferences, particularly regarding choosing between meds or therapy. Moderate (to high) confidence in rating.

Some variation or some uncertainty.

Information from research studies:

[Possible studies to include from APA staff search of pt values and preferences studies]:

Dwight-Johnson et al (2013): "*Objective:* Among **older white and Mexican origin male primary care patients**, we examined preferences for features of depression care programs that would encourage depressed older men to enter and remain in treatment. *Method:* **Sixty-three (45 white, 18 Mexican origin) older men were recruited in six primary care clinics. All had clinical depression in the past year and/or were receiving depression treatment.** Participants completed a conjoint analysis preference survey regarding depression treatments, providers and treatment enhancements. *Results:* The data suggest that **white men preferred medication over counseling [odds ratio (OR): 1.64 95% confidence interval (CI): 1.12–2.41], while Mexican origin men preferred counseling (OR: medication over counseling: 0.28, 95% CI: 0.12–0.66). Both white and Mexican origin men preferred treatment that included family involvement (vs. none) (white: OR: 1.60, 95% CI 1.12–2.30; Mexican origin: OR: 3.31 95% CI 1.44–7.62) and treatment for insomnia (vs. treatment for alcohol use) (white: OR: 1.72, 95% CI 1.01–2.91; Mexican origin: OR: 3.93 95% CI 1.35–11.42). White men also preferred treatment by telephone (OR: 1.80, 95% CI 1.12–2.87).** *Conclusions:* Findings could inform development of patient-centered depression treatment programs for older men and suggest strategies, such as attention to sleep problems, which providers may employ to tailor treatment to preferences of older men."

Gibson et al (2013): "High rates of antidepressant prescribing in Western countries have coincided with increasing doubts about the effectiveness of these medications, especially for the treatment of mild to moderate depression in primary care. **This narrative review constructs a patient-centered perspective on antidepressant use, which examines research on patients' attitudes to antidepressants and their treatment preferences; experiences of being prescribed antidepressants and taking antidepressants, as well as reasons for adherence or nonadherence. Key themes in the research literature suggest that patients have predominantly negative views of antidepressants and that they prefer psychotherapy to medication. Patients may agree to antidepressants because they have limited information about the medication or about other treatment options. Although they may see themselves as active in the decision to take antidepressants, they tend to accept the physicians' recommendation during the initial crisis period during which they seek help.** They may also continue taking antidepressants because of experience of withdrawal symptoms and lack of on-going support from their physician. Patients may be acting on rational concerns about an antidepressant when they choose not to comply with its prescription. This review suggests that physicians should be more active in discussing patients' concerns about antidepressants with them."

Gitlin et al (2013): "*Objective:* To examine older African American's recognition of and beliefs about depressive symptoms, preferred symptom management strategies, and factors associated with willingness to use mental health

treatments. Differences between depressed and non-depressed and men and women were examined. *Design:* Cross-sectional survey. *Setting:* Home, senior center. *Participants:* 153 senior center members (56=males, 97=females) ≥55 years. *Measurements:* **Using a depression vignette**, **participants indicated if the person was depressed and their endorsement of items reflecting beliefs, stigma, symptom management, and willingness to use treatments (yes/no). PHQ-9 assessed current symptomatology.** *Results:* Overall, 24.2% reported depressive symptoms (≥5); 88.2% correctly identified the person in the vignette as depressed. **Most (≥75%) endorsed active symptom management strategies, preference for treatment in physician and therapist offices, and willingness to take medications, seek therapy, see doctor and attend support groups; <33% viewed depression as stigmatizing whereas 48% viewed depression as normal aging. Logistic regressions revealed lower education, higher physical function and feeling okay if community knew of depression diagnosis were associated with willingness to see physician if feeling depressed; being married and believing anti-depressant medications are beneficial were related to willingness to use medications. Different associations emerged for depressed/non-depressed and men and women.** *Conclusions:* Overall, this older African American sample had positive attitudes and beliefs and endorsed traditional treatment modalities suggesting that beliefs alone are unlikely barriers to underutilization of mental health services. As different factors were associated with willingness to seek physician help and use medications and factors differed for depressed/non-depressed and by sex, interventions should be tailored."

Gum et al (2006): "PURPOSE: For depressed older primary care patients, this study aimed to examine (a) characteristics associated with depression treatment preferences; (b) predictors of receiving preferred treatment; and (c) whether receiving preferred treatment predicted satisfaction and depression outcomes. DESIGN AND METHODS: **Data are from 1,602 depressed older primary care patients who participated in a multisite, randomized clinical trial comparing usual care to collaborative care, which offered medication and counseling for up to 12 months**. Baseline assessment included demographics, depression, health information, prior depression treatment, potential barriers, and treatment preferences (medication, counseling). At 12 months, services received, satisfaction, and depression outcomes were assessed. RESULTS: **More patients preferred counseling (57%) than medication (43%). Previous experience with a treatment type was the strongest predictor of preference. In addition, medication preference was predicted by male gender and diagnosis of major depression (vs dysthymia). The collaborative care model greatly improved access to preferred treatment, especially for counseling (74% vs 33% in usual care). Receipt of preferred treatment did not predict satisfaction or depression outcomes; these outcomes were most strongly impacted by treatment condition.** IMPLICATIONS: Many depressed older primary care patients desire counseling, which is infrequently available in usual primary care. Discussion of treatment preferences should include an assessment of prior treatment experiences. A collaborative care model that increases collaboration between primary care and mental health professionals can increase access to preferred treatment. If preferred treatment is not available, collaborative care still results in good satisfaction and depression outcomes."

Hanson & Scogin (2008): "We examined older adults' ratings of the acceptability of geriatric depression treatments. **We presented 120 community-dwelling participants with vignettes describing an older adult experiencing either mild to moderate or severe depression. Participants rated the acceptability of three different treatments: cognitive therapy (CT), antidepressant medication (AM), and a combination treatment of CT and AM (COM). For general acceptability, participants rated COM as a more acceptable treatment for depression than both CT and AM. With respect to perceived negative aspects of treatments, they rated CT as a more acceptable treatment for mild to moderate depression than both AM and COM. Participants rated both COM and CT as more acceptable**

treatments for severe depression than AM. Results indicate that combining psychotherapy and AM may be viewed as most acceptable by community-dwelling, nondepressed older adults."

Kitchen et al (2013): "The purpose of this study was **to investigate depression treatment preferences and anticipated service use in a sample of adults aged 55 years or older who reside in rural Wyoming.** Sixteen participants (mean age = 59) completed 30- to 60-minute, semi-structured interviews. Qualitative methods were used to characterize common themes. **Social/provider support and community gatekeepers were perceived by participants as important potential facilitators for seeking depression treatment. In contrast, perceived stigma and the value placed on self-sufficiency emerged as key barriers to seeking treatment for depression in this rural, young-old sample. Participants anticipated presenting for treatment in the primary care sector and preferred a combination of medication and psychotherapy for treatment. Participants were, however, more willing to see mental health professionals if they were first referred by a clergy member or primary care physician."**

Kocsis et al (2009): "Background: Little is known about moderators of response to psychotherapy, medication, and combined treatment for chronic forms of major depressive disorder (MDD). We hypothesized that patient preference at baseline would interact with treatment group to differentially affect treatment outcome. Method: **We report outcomes for 429 patients who participated in a randomized multicenter trial of nefazodone, Cognitive Behavioral Analysis System of Psychotherapy (CBASP), or combination therapy for chronic forms of MDD (DSM-IV criteria) and who indicated their preference for type of treatment at study entry.** The primary outcome measures were total scores on the 24-item Hamilton Rating Scale for Depression (HAM-D-24) and categorical definitions of remission or partial response. The patients were recruited between June 1996 and December 1997. Results**: There was an interactive effect of preference and treatment group on outcome. The treatment effect varied as a function of preference, and was particularly apparent for patients who initially expressed preference for one of the monotherapies. Patients who preferred medication had a higher remission rate (45.5%) and lower mean HAM-D-24 score (11.6) at study exit if they received medication than if they received psychotherapy (remission rate, 22.2%; mean HAM-D-24 score, 21.0). Patients who preferred psychotherapy had a higher remission rate (50.0%) and lower mean HAM-D-24 score (12.1) if they received psychotherapy than if they received medication (remission rate 7.7%, mean HAM-D-24 score 18.3). Nevertheless, treatment preference was not associated with risk of dropout from the study.** Conclusions: These results suggest that patient preference is a potent moderator of treatment response for patients with chronic forms of MDD; however, relatively low proportions of the patient sample preferred one of the monotherapies, participants were not blinded to treatment assignment, and there was no placebo group."

Lin et al (2005): "Background: The chronic illness model encourages consideration of patients' treatment preferences. Moreover, research suggests that matching treatment to preference might affect outcomes for patients with depression. Purpose: This investigation explored factors associated with treatment preference matching and the effects of matching on depression treatment outcomes. Methods: **Treatment preferences were assessed among primary care patients with depression participating in a large randomized trial of depression management. Patients were offered antidepressant medication and/or counseling based on preference and several other factors.** Depression was assessed at 3 and 9 months. Results: **Participants who preferred medication were older, were in worse physical health, and were more likely to already be taking antidepressants. Participants who preferred both medication and counseling evidenced greater agreement with the statement that depression is a medical illness. Overall, 72% of participants were matched with their preferred treatment; matched participants demonstrated more rapid**

improvement in depression symptomatology than unmatched participants. Conclusions: Obtaining preferred treatment appears to contribute to improved treatment outcome. Continued attempts to assess for and accommodate treatment preferences might result in better response to depression treatment."

Noel (2010): "Purpose: The purpose of the study was **to explore African American, Latino, and Non-Hispanic White adult patients with type 2 diabetes cultural perceptions of symptoms of depression and factors that predict depression care treatment preferences between these groups**. Methods: A community sample of African Americans, Latinos, and White diabetic adults receiving services in 1 of 2 central Austin, Texas facilities participated in the study. Each participant was given a survey, which consisted of the following 5 components: (1) illness screener questions, (2) demographic questions, (3) Patient Health Questionnaire, (4) Depression Treatment Questionnaire, and (5) Illness Perception Questionnaire**. A binary logistic regression was used to examine the relationship between cultural perceptions of symptoms and the predictor variables. A multinomial logistic regression analyses was used to examine the relationship between treatment and provider preferences for the symptoms of depression and ethnicity**. Results: The first research question addressed whether there were differences across ethnicity in how symptoms of depression are attributed among patients with diabetes. **There were 7 causal beliefs that were associated with differences in cultural endorsements of the causes of depressive symptoms. In addition, culture was associated with treatment preferences but not with provider preferences.** Conclusions: The utility of assessing a patient's understanding of symptoms of depression to determine how personal illness models impact treatment preferences and clinical implications of how knowledge of patient's causal attributions can aid medical and behavioral health providers working in collaborative management of diabetes and depression are discussed."

Raue et al (2012): "*Objective:* The authors hypothesized that the depression treatment preferences of elderly home care patients would vary by depression experience, with preferences for active treatments being associated with current depression and antidepressant treatment. *Methods:* The authors conducted **cross sectional secondary analyses of the TRIAD ("Training in the Assessment of Depression") study of 256 randomly selected elderly patients newly admitted to homecare.** The study assessed depression treatment preference for active (i.e., medication or psychotherapy) versus non-active or complementary approaches (e.g., religious activities, do nothing). Two separate indicators of depression experience were used: diagnoses of major or minor depression, and current or previous antidepressant treatment. *Results:* **121 patients (48%) preferred active treatment with either medication or psychotherapy as their first choice, while the remainder preferred non-active or complementary approaches. Logistic regression indicated that current antidepressant use, previous psychotherapy experience, white and Hispanic versus African-American patients, greater IADL impairment, and less personal stigma about depression were independently associated with preference for an active treatment.** *Conclusions:* Elderly homecare patients have a variety of depression treatment preferences ranging from active treatments, to religious or spiritual activities, to no treatment. **Several factors were associated with a preference for active treatment, including treatment experience, co-existing physical impairment, culture, and attitudes and beliefs.** Understanding patient preferences may form the basis of engaging older depressed home care patients in treatment."

Steidtmann et al (2012): "Background: Findings regarding the relationship between patient treatment preference and treatment outcome are mixed. This is a secondary data analysis investigating the relationship between treatment preference, and symptom outcome and attrition in a large 2-phase depression treatment trial. Methods: Patients met DSM-IV criteria for chronic forms of depression. **Phase I was a 12-week, nonrandomized, open-label trial in which**

all participants (n=785) received antidepressant medication(s) (ADM). Phase I nonremitters were randomized to Phase II, in which they received 12 weeks of either Cognitive-Behavioral System of Psychotherapy (CBASP) + ADM (n=193), Brief Supportive Psychotherapy (BSP) + ADM (n=187), or ADM only (n=93). Participants indicated their treatment preference (medication only, combined treatment or no preference) at study entry. Symptoms were measured at 2-week intervals with the 24-item Hamilton Rating Scale for Depression (HAM-D). Results: **A large majority of patients reported a preference for combined treatment. Patients who preferred medication only were more likely to endorse a chemical imbalance explanation for depression, whereas those desiring combined treatment were more likely to attribute their depression to stressful experiences. In Phase I, patients who expressed no treatment preference showed greater rates of HAM-D symptom reduction than those with any preference, and patients with a preference for medication showed higher attrition than those preferring combined treatment. In Phase II, baseline treatment preference was not associated with symptom reduction or attrition.** Conclusions: Treatment preferences may moderate treatment response and attrition in unexpected ways. Research identifying factors associated with differing preferences may enable improved treatment retention and response."

Van Schaik et al (2004): "Patients' preferences in the treatment of depression are important in clinical practice and in research. Antidepressant medication is often prescribed, but adherence is low. This may be caused by patients preferring psychotherapy, which is often not available in primary care. In randomized clinical trials, patients' preferences may affect the external validity. **The aim of this article is to study patients' preferences regarding psychotherapy and antidepressant medication and the impact of these preferences on treatment outcome. A systematic review of the literature was performed. The majority of patients preferred psychotherapy in all available studies. Antidepressants were often regarded as addictive and psychotherapy was assumed to solve the cause of depression.** Discussing and supporting preferences as part of a quality improvement program of depression care, resulted in more patients receiving the treatment that was most suitable to them. In two patient-preference trials, preferences did not influence treatment outcome. It can be concluded that a substantial percentage of well-informed patients prefer psychotherapy. Patients with strong preferences, mostly for psychotherapy, are likely not to enter antidepressant treatment or randomized clinical trials if their preferences are not supported."

Wu et al (2014): "A substantial number of cancer patients experience depression. This study investigated treatment preferences for depression**. Breast cancer survivors (N = 134) completed an anonymous survey asking preference and interest in three treatments for depression: individual counseling (IC), antidepressant medication (MED), or support groups (SG).** Participants were recruited from a surgical oncology office and asked to complete the survey as they waited for their appointment. Preference was compared using Wilcoxon Signed Rank tests. **More than 50% ranked IC as first choice of treatment. Preference for IC was significantly higher than preference for MED and SG. Preference between MED and SG did not differ.** Survivors preferred counseling for treatment of depression. Cancer centers should be prepared to provide preferred treatment methods, particularly as screening, and therefore management, of psychosocial distress is to be required."

Information from community members on panel:

Information from clinicians on panel:

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High		High
	Moderate		Moderate
	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

☐ Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to impact applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Patient population were those with chronic medical diseases, as well as depression.
Interventions	Low intensity intervention.
Comparators	
Outcomes	
Timing or Time frame	
Settings	Patients served in home settings.

Notes/Comments:
Lamers et al., 2010:

"Between October 2003 and May 2005, participants with DM or COPD were recruited in 89 primary care practices in the south of the Netherlands. The decision to include DM and COPD patients was based on the fact that these prevalent diseases are mainly treated in primary care in the Netherlands. Patients who had been diagnosed by their GP with type II DM or COPD, who were aged 60 years or over, who were community-dwelling, and who did not meet exclusion criteria [treatment with antidepressants for depression (to prevent contamination in the evaluation of the treatment effect), major psychiatric problems (bipolar depression, schizophrenia, alcohol or substance abuse), current psychosocial/ psychiatric treatment, serious cognitive problems, on a nursing home waiting list, bedridden, loss of spouse within last 3 months (since grief is exclusion criterion for depressive disorder), and not being fluent in Dutch] were sent the Patient Health Questionnaire (PHQ-9) [27] . Patients who reported having at least 2 symptoms present for more than half of the days, 1 of them being loss of interest or depressed mood, were invited to complete a structured diagnostic interview for DSM-IV axis I disorders, the Mini International Neuropsychiatric Interview (MINI) [28] . The MINI was administered at the patients' homes by nurses who had been trained by a psychiatrist and a GP, and had regular booster sessions with the psychiatrist. Patients with minor depression, mildto-moderate major depression or dysthymia (according to the MINI) were invited to participate in the trial. Patients at suicide risk and patients with severe major depression, according to the Hamilton Depression Rating Scale (score 1 18) [29] , were excluded and referred to their GP. Somatic symptoms on the Hamilton scale were assessed using an 'etiologic' approach; symptoms that could be accounted for by the chronic somatic illness would not be counted towards the depression. This is a recommended approach for the assessment of depression in persons with a physical illness [30] . After signing an informed consent form and completing a baseline questionnaire, patients were randomly allocated to the MPI or to care as usual. In all, 361 patients (185 DM; 176 COPD) were randomized. Multi-morbidities are common in elderly persons, as was indeed the case in our study: 11 patients stratified for DM also had COPD, and 23 patients stratified for COPD also had DM."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: GDPs should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
X	***Conditional*** *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

We suggest this treatment be implemented for older patients with chronic medical problems, given the minimal intensity of the intervention and the benefit for the patient, relative to worsening for those who did not receive the intervention.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the GDP members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version 6/26/14)
Topic # 26- Problem-solving therapy (individual) compared to supportive therapy (individual) for treating major depressive disorder in adults ages 60 and older with executive dysfunction

Factor	Explanation/Comments
X. Aggregate/Global Strength of Evidence (SOE) (from evidence profiles)	
C. Treatment Outcomes/Consequences • **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of Treatment *(Note- do not include financial cost)*	
Balance of Benefits and Harms/Burdens of Treatment	
XCI. Patient Values and Preferences	

CII. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 26- Problem-solving therapy (individual) compared to supportive therapy (individual) for treating major depressive disorder in adults ages 60 and older with executive dysfunction

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., When magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Functional Capacity (follow up: 12 weeks; assessed with: WHODAS II)			X	
Response (follow up: 12 weeks; assessed with: HAMD >=50% reduction)		X		
Change in score (follow up: 12 weeks; assessed with: HAMD); Alexopoulous 2003			X	
Change in score (follow up: 12 weeks; assessed with: HAMD); Kiosses 2010			X	
Remission (follow up: 12 weeks; assessed with: HAMD <10 for 2 consecutive weeks); Arean 2010		X		
Remission (follow up: 12 weeks; assessed with: HAMD <10); Alexopoulous 2003			X	
Patient Satisfaction (follow up: 12 weeks; assessed with: Client Satisfaction Questionnaire); Kiosses 2010				X
Outcomes for which no studies were found: remission, quality of life, relapse, suicidality, serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only). **Global SOE Grade:** ☐High ☐Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Alexopoulous et al., 2003; Alexopoulous et al., 2011; Arean et al., 2010; Kiosses et al., 2010

		№ of patients		Effect		Quality
№ of studies		**problem-solving therapy (individual)**	**supportive therapy (individual)**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity (follow up: 12 weeks; assessed with: WHODAS II); Alexopoulous 2003; based on ITT analysis						
1	See footnote #1	12	13	-	MD **31.67 lower** (44.11 lower to 19.23 lower)	⊕⊕◯◯ LOW
Response (follow up: 12 weeks; assessed with: HAMD >=50% reduction); Arean 2010; based on ITT analysis						
1	See footnote #2	51/110 (46.4%)	33/111 (29.7%)	**RR 1.56** (1.10 to 2.21)	166 more per 1000 (from 30 more to 360 more)	⊕⊕⊕◯ MODERATE
Change in score (follow up: 12 weeks; assessed with: HAMD); Alexopoulous 2003; based on ITT analysis						
1	See footnote #1 See footnote #3	12	13	-	MD **6.83 lower** (11.75 lower to 1.91 lower)	⊕⊕◯◯ LOW
Change in score (follow up: 12 weeks; assessed with: HAMD); Kiosses2010; based on ITT analysis						
1	See footnote #1 See footnote #3	15	15	-	MD **3.83 lower** (7.38 lower to 0.28 lower)	⊕⊕◯◯ LOW
Remission (follow up: 12 weeks; assessed with: HAMD <10 for 2 consecutive weeks); Arean 2010; based on ITT analysis						
1	See footnote #2	41/110 (37.3%)	27/111 (24.3%)	**RR 1.53** (1.02 to 2.30)	129 more per 1000 (from 5 more to 316 more)	⊕⊕⊕◯ MODERATE
Remission (follow up: 12 weeks; assessed with: HAMD <10); Alexopoulous 2003; based on ITT analysis						

1	See footnote #1 See footnote #3	9/12 (75.0%)	3/13 (23.1%)	**RR 3.25** (1.14 to 9.24)	519 more per 1000 (from 32 more to 1000 more)	⊕⊕◯◯ LOW
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction (follow up: 12 weeks; assessed with: Client Satisfaction Questionnaire); Kiosses 2010; based on completers analysis						
1	See footnote #1 See footnote #4 See footnote #5	13	12	-	MD **0.28 higher** (0.28 lower to 0.84 higher)	⊕◯◯◯ VERY LOW
Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- small sample size and/or number of events, does not meet optimal information size to detect difference
Footnote #2- small number of events
Footnote #3- wide confidence interval
Footnote #4- completers analysis
Footnote #5- wide confidence interval spanning benefits and harms

Number needed to treat (NNT) (95% Confidence Interval)
Response (follow up: 12 weeks; assessed with: HAMD >=50% reduction): NNT = 6 (NNT(benefit) 3 to 24)
Remission (follow up: 12 weeks; assessed with: HAMD <10 for 2 consecutive weeks): NNT = 8 (NNT(benefit) 3 to 112)
Remission (follow up: 12 weeks; assessed with: HAMD <10): NNT = 2 (NNT(benefit) 1 to 5)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Functional Capacity (follow up: 12 weeks; assessed with: WHODAS II)	X	o				
2. Response (follow up: 12 weeks; assessed with: HAMD >=50% reduction)	o	X				
3. Change in score (follow up: 12 weeks; assessed with: HAMD); Alexopoulous 2003	X	o				
4. Change in score (follow up: 12 weeks; assessed with: HAMD); Kiosses 2010	o	X				
5. Remission (follow up: 12 weeks; assessed with: HAMD <10 for 2 consecutive weeks); Arean 2010	o	X				
6. Remission (follow up: 12 weeks; assessed with: HAMD <10); Alexopoulous 2003	X	o				
7. Patient Satisfaction (follow up: 12 weeks; assessed with: Client Satisfaction Questionnaire); Kiosses 2010			o			X

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

References for harms/burdens published studies: *Alexopoulos 2003, 2011; Arean 2010 (same study as Alexopoulos 2011); Kiosses 2010*

Harm

- Dropout: 8.8% (*12 of 137*) PST v. 9.4% (*13 of 139*) ST
- Reasons for dropout: hospitalized due to fall; hospitalized due to medical condition; moved out of state
- Symptom worsening: In Aleoxpoulos et al (2003), three subjects (one PST subject and two ST subjects) were terminated because of worsening clinical state
- Treatment adherence was monitored in all three studies

Note any other information on burdens from published studies:

References for harms/burdens published studies: *Alexopoulos 2003, 2011; Arean 2010 (same study as Alexopoulos 2011); Kiosses 2010; Gellis et al (2008, 2010); Williams et al (2000)*

Burden

- All three studies provided treatment over 12 weekly sessions
- In Alexopoulos et al (2011)/Arean et al (2010), transportation was paid for or provided to subjects
    - Treatment was offered by 4 doctorate-level clinical psychologists and 4 licensed social workers with at least 5 years of post-licensure experience
- In Kiosses et al (2010), no homework was assigned in supportive treatment condition which is considered an active treatment
    - PATH treatment condition also included caregiver component
    - Both treatments were home-delivered
    - Delivered by 2 doctoral and 1 MSW each with at least 5 years' experience

Other studies:
Gellis et al (2008, 2010); Williams et al (2000)

- Dropout: 15.7% (*30 of 191*) PST v. 7.4% (*4 of 54)* UC
- Burden/Reasons for dropout: In Williams et al (2000), 3% (*n* = 4) dropped out because the treatment was "inconvenient" and an additional individual dropped out because he/she preferred an alternative treatment
- In Gellis et al (2008, 2010), participants who received PST were more satisfied than UC; PST was delivered by PhD-level clinical social workers; participants received an average of 6 sessions; PST includes homework

Note any additional information on harms:

None to add.

Note any additional information on burdens:

None to add.

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
8. Adverse events leading to withdrawals			X	o	o	
9. Other serious adverse events			X	o	o	
10. Other adverse events			X	o	o	
11. Burdens			o	X	o	o

Assign an overall global rating across outcomes:

X Benefits clearly outweigh harms/ burden
☐Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments:

III) Patient Values and Preferences *What are the typical patient values and preferences?* *How variable are these?* *How certain is the GDP about these?* **Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*	**<u>Patient values and preferences based on:</u>** *Information from research studies:* None to add. *Information from community members on panel:* *Information from clinicians on panel:* Lot of range where some folks like having active and guided intervention such as PST and others prefer non-directive, lots of variability in preferences. *Information from other sources (also list sources):*

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
X	High		High
	Moderate	X	Moderate
	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

☐ Some variation or some uncertainty

X Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

large variation in pt values and preferences.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to impact applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Specific to individuals with particular cognitive impairment.
Interventions	
Comparators	
Outcomes	
Timing or Time frame	
Settings	Applied in a range of settings- this is a strength.

Notes/Comments:

Alexopoulous 2003:

"The subjects were consecutively recruited
over a 21⁄2-month period. They were included if they were 65 years of age or older, met DSM-IV criteria18 for unipolar major depression, and had a score of 18 or higher on the 24-item Hamilton Rating Scale for Depression (Ham-D19), a Stroop Response Inhibition 20 score below 26, and a Mattis Dementia Rating ScaleInitiation/Perseveration Domain (DRS-IP)21 score below 34; these scores were one standard deviation (SD) below the mean of our normal elderly sample. These executive function tests were selected because in earlier studies, they were shown to be associated with high risk for poor and unstable response to antidepressant pharmacotherapy.3–5 Exclusion criteria were 1) a history of other psychiatric disorders, except personality disorders, before the onset of depression; 2) suicidal ideation (score greater than 1 on the Suicidal Ideation item of Ham-D); 3) severe or acute medical illness (e.g., metastatic cancer, brain tumors, myocardial infarction within 3 months before the study); 4) neurological disorders (e.g., delirium, stroke, Parkinson disease, history of head trauma, and multiple sclerosis); and 5) a MiniMental State Exam (MMSE)22 scale score below 24. A total of 25 subjects were recruited over 21⁄2 months after we had screened 43 candidates. The mean age of the sample was 74 years (range: 66–88), and the mean education level was 13.7 years (range: 8–19; Table 1)."

Alexopoulous 2011:

"The selection criteria consisted of age 60years or older,a Structured Clinical Interview for AxisI DSM-IV Disorders(SCID-R)/DSM-IV46 diagnosis of major nonpsychoticdepression,a24-item Hamilton Depression Rating Scale(HDRS)47 score of at least 20,a Mini-Mental State Examination(MMSE)48 score of at least 24, a Mattis Dementia Rating Scale initiation/perseveration domain(DRS-IP)49 score of 33 or less, and a Stroop Color-Word Test score of 25 or less.

Individuals were excluded if they were receiving psychotherapy or antidepressantagents, reported intent to attempt suicide in the near future, had an AxisI psychiatric disorder or substance abuse other than unipolar depression or generalized anxiety disorder, had antisocial personality(DSM- V),had dementia, had a history of head trauma, had an acute or severe medical illness (ie, delirium, metastatic cancer, decompensated organ failure, major surgery, recent stroke, or myocardial infarction),used drugs known to cause depression, or could not perform any activities of daily living even with assistance.

Briefly, the randomized participants (n=221) had a mean (SD) age of 73.0 (7.8) years and a mean (SD) of 15.3 (2.8) years of education."

Arean 2010:

"To be eligible for the study, individuals had to meet DSM-IV criteria for major depression and have a score >20 on the HAMD, a score >24 on the MMSE, a score <33 on the initiation/perseveration subscale of the Mattis Dementia Rating Scale (26), and a score <25 on the Stroop Color-Word Test (27). These measures of executive function were selected for their utility in detecting executive dysfunction in late-life depression and the association of poor scores on these instruments with poor response to antidepressant medication (4).

Of the 221 participants who underwent randomized assignment, 110 were assigned to the problem-solving therapy arm and 111 to the supportive therapy arm. Those who entered the trial had depression of moderate severity and executive function test scores indicating mild to moderate impairment (Table 1). There were no significant differences in demographic or clinical variables among participants assigned to the two treatment arms. Approximately 27% of participants had taken antidepressants in the past. A small proportion in each group had generalized anxiety disorder (7.4% in the problem-solving therapy group and 6.3% in the supportive therapy group). There were no statistically significant differences in demographic characteristics, depression severity, executive function, medical burden, or disability among participants who had taken antidepressants and those who were antidepressant naive."

	Kiosses 2010 "A total of 37 potential participants were referred to the study; 30 agreed to participate and were randomized to PATH (N"15) or ST (N"15) (Fig. 1). The participants were of advanced age, and most had high-school or higher education (Table 1). Participants suffered from major depression of mild to moderate severity. Their cognitive impairment ranged from mild cognitive deficits to mild dementia. The participants' executive functioning was significantly impaired as indicated by their DRS IP scores and Stroop CW scores (Table 1); their mean scores were %2 SD below the mean of a healthy control group of older adults who did not meet any criteria for psychiatric diagnosis or cognitive impairment. The participants' memory deficits were also significant as indicated by the mean scores of Recall and Delayed Recall of Hopkins Verbal Learning Test–Revised (Table 1). In addition to their cognitive impairment, the participants had pronounced disability. The mean score of Multilevel Assessment Instrument Instrumental Activities of Daily Living score (Table 1) translates into an average impairment in at least four out of nine Instrumental Activities of Daily Living (i.e., doing housework and handyman work, doing laundry, using the telephone, shopping for groceries, preparing own meals, managing their money, getting to places out of walking distance, and taking their medication). Therefore, our sample consisted of mildly to moderately depressed elders with cognitive impairment up to the level of mild dementia and pronounced disability. There were no significant differences in demographic or clinical variables between the two treatment arms (Table 1)."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: GDPs should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
X	***Strong*** *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

Strong recommendation for use of Problem Solving Therapy over Supportive Therapy in older adults with major depression and evidence of executive impairment.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Stronger recommendation due to replication of studies.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the GDP members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version 6/26/14)
Topic # 27- A combination of behavioral activation therapy (individual) and usual care compared to usual care for treating depressive symptoms in adults ages 63 and older with mild to moderate cognitive impairment

Factor	Explanation/Comments
II. Aggregate/Global Strength of Evidence (SOE) (from evidence profiles)	
V. Treatment Outcomes/Consequences	
• **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of Treatment *(Note- do not include financial cost)*	
Balance of Benefits and Harms/Burdens of Treatment	
CV. Patient Values and Preferences	

CVI. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 27- A combination of behavioral activation therapy (individual) and usual care compared to usual care for treating depressive symptoms in adults ages 63 and older with mild to moderate cognitive impairment.

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a <u>strong</u> recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., When magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	<u>Rate the quality of the evidence grade for each outcome from the evidence profiles:</u>

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Quality of Life (follow up: 4 weeks; assessed with: Quality of Life Inventory)			X	
Outcomes for which no studies were found: functional capacity, response, remission, patient satisfaction, relapse, suicidality, serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only). **Global SOE Grade:** ☐High ☐Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Snarski et al., 2011

		№ of patients		Effect		Quality
№ of studies		**a combination of behavioral activation therapy (individual) and usual care**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response						
				not estimable	not estimable	
Remission						
				not estimable	not estimable	
Quality of Life (follow up: 4 weeks; assessed with: Quality of Life Inventory); based on ITT analysis						
1	See footnote #1 and #2	25	25	-	MD 0.67 lower (8.76 lower to 7.42 higher)	⊕⊕◯◯ LOW
Patient Satisfaction						
				not estimable	not estimable	
Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- small sample size: study does not meet optimal information size
Footnote #2- wide confidence interval spanning benefits and harms

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Quality of Life (follow up: 4 weeks; assessed with: Quality of Life Inventory)			o			X

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

References for harms/burdens published studies: *Snarski et al (2011)*

Harms

- Dropout: 36% (*9 of 25*) BA v. 48% (*12 of 25*) UC
- Reasons for dropout: resistance to tx (*n* = 1), inpatient hospital discharge (*n* = 20)
- Symptom worsening: 12% of UC group had clinically significant worsening of depression scores
- Random sessions reviewed for treatment adherence and fidelity

Other studies:
None

Note any other information on burdens from published studies:

References for harms/burdens published studies: *Snarski et al (2011)*

Burden:

- BA is 8 bi-weekly 30-min sessions across 4 weeks;
- BA requires "less cognitive ability than other psychotherapies"
- Homework in BA but omitted daily diaries due to burden
- Homework completion rates averaged 81%

Note any additional information on harms:

No additional

Note any additional information on burdens:

- homework and time burden of weekly sessions

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
2. Adverse events leading to withdrawals			o	o	o	X
3. Other serious adverse events			o	o	o	X
4. Other adverse events			o	o	o	X
5. Burdens			o	X	o	

Assign an overall global rating across outcomes:

☐Benefits clearly outweigh harms/ burden
☐Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments: Unable to rate the balance. However potential for lower dropout even with slightly greater burden of behavioral activation.

III) Patient Values and Preferences *What are the typical patient values and preferences?* *How variable are these?* *How certain is the GDP about these?* **Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*	**<u>Patient values and preferences based on:</u>** *Information from research studies:* *[Possible studies to include from APA staff search of pt values and preferences studies]:* [None relevant.] *Information from community members on panel:* Nothing specific. *Information from clinicians on panel:* Older adults like the behavioral activation component of problem solving therapy and understand it. Since patients like it they are more likely to do it. *Information from other sources (also list sources):*

Next rate the variability of and your certainty about patient values and preferences:

✓	Variability in Patient Values & Preferences	✓	Certainty in Patient Values & Preferences
	High	X 5	High
	Moderate	X 5	Moderate
X	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

X Similar values and little uncertainty

☐ Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Similar values and little uncertainty

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to impact applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Participants were inpatients vs. ambulatory. Involuntarily committed so this is a severely impaired population.
Interventions	• Treatment delivered by lead author and graduate students in psychology
Comparators	
Outcomes	No specific information on outcomes related to depression scores.
Timing or Time frame	
Settings	

Notes/Comments:
Snarski 2011:

"The following inclusion criteria were used: (a) 65 years of age or older; (b) a score of 18 or above on the MMSE; (c) deemed competent to sign a consent form by their psychiatrist; (d) deemed not actively psychotic by their psychiatrist or attending mental health care provider; (e) a score of 3 or higher on the Geriatric Depression Scale–Short Form (GDS-S); (f) and residence in the hospital for at least a 5-day acclimation period. The MMSE cutoff score of 18 was selected to include those with mild to moderate cognitive impairment. A GDS-S pretreatment score of 3 or higher was selected to indicate at least mild depressive symptomology. Additionally, this score permitted inclusion of more participants. If the participant was deemed capable and appropriate to participate in the study, informed consent was received from both the participant and psychiatrist. The consent form was approved by the University of Alabama's Institutional Review Board (IRB) and described the procedures of the study as well as informed clients that their participation was voluntary and would not influence their treatment (e.g., length of stay and quality of care). The participants in this study were residents of the state of Alabama who were committed by the probate court to receive mental health services at the Mary Starke Harper Geriatric Psychiatry Facility.

The participants were recruited within a 1-year period and ranged in age from 63 to 87, with a mean age of 71.67. Most of the participants were Caucasian (62%), had been or were currently married (84%) and completed high school (80%). The sample had fairly equal representation of the sexes, with 30 women and 20 men. In the current sample of 50 participants, 24% had a primary diagnosis of schizophrenia, 18% bipolar disorder, 18% dementia, 16% schizoaffective disorder, 10% psychotic disorder, 6% major depressive disorder, and 2% each for mood disorder NOS, obsessivecompulsive disorder, impulse control disorder, and delusional disorder."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: GDPs should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
X	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

The evidence is insufficient to recommend for or against treatment.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

The evidence is insufficient to recommend for or against treatment.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the GDP members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version 6/26/14)
Topic # 28- Cognitive behavioral therapy (group) compared to wait list for treating major depressive disorder in adults ages 60 and older with anxiety

Factor	Explanation/Comments
II. Aggregate/Global Strength of Evidence (SOE) (from evidence profiles)	
II. Treatment Outcomes/Consequences • **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of Treatment *(Note- do not include financial cost)*	
Balance of Benefits and Harms/Burdens of Treatment	
CIX. Patient Values and Preferences	

C. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 28- Cognitive behavioral therapy (group) compared to wait list for treating major depressive disorder in adults ages 60 and older with anxiety

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., When magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Response (follow up: 12 weeks; assessed with: Reliable Change Index)			X	
Quality of Life (follow up: 12 weeks; assessed with: Short Form-36)			X	
Outcomes for which no studies were found: functional capacity, remission, patient satisfaction, relapse, suicidality, serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only). **Global SOE Grade:** ☐High ☐Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Wuthrich et al., 2013

		№ of patients		Effect		Quality
№ of studies		**cognitive behavioral therapy**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response (follow up: 12 weeks; assessed with: Reliable Change Index); based on ITT analysis						
1	See footnote #1	20/27 (74.1%)	8/35 (22.9%)	RR 3.24 (1.69 to 6.20)	512 more per 1000 (from 158 more to 1000 more)	⊕⊕◯◯ LOW
Remission						
				not estimable	not estimable	
Quality of Life (follow up: 12 weeks; assessed with: Short Form-36); based on ITT analysis						
1	See footnote #1	27	35	-	MD **4.23 higher** (3.16 higher to 5.3 higher)	⊕⊕◯◯ LOW
Patient Satisfaction						
				not estimable	not estimable	
Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- small sample size and/or number of events, does not meet optimal information size to detect differences

Number needed to treat (NNT) (95% Confidence Interval)

Response (follow up: 12 weeks; assessed with: Reliable Change Index): NNT = 2 (NNT(benefit) 1 to 3)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Response (follow up: 12 weeks; assessed with: Reliable Change Index)	X	o				
2. Quality of Life (follow up: 12 weeks; assessed with: Short Form-36)	o	X				

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

References for harms/burdens published studies: *Arean et al (2005); Johnco et al (2014); Wuthrich & Rapee (2013)*

Harms

- Dropout: 25.9% (*7 of 27*) Group CBT v. 22.9% *(8 of 35*) WL
- Symptom worsening: no reliable worsening of severity in either group

Other studies:
Arean et al (2005); Johnco et al (2014)

- Dropout: 17.2% (*11 of 64*) Group CBT
- Reasons for dropout: feasibility, unknown/lost contact, dissatisfied, no longer interested, wanted antidepressant

Note any other information on burdens from published studies:

References for harms/burdens published studies: *Johnco et al (2014); Wuthrich & Rapee (2013)*

Burden

- 12 2-hour sessions (average number of session was 9)
- Homework assigned in treatment condition

Note any additional information on harms:

-No additional information

Note any additional information on burdens:

-Homework and time

Next, list and rate each harm/burden :

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
3. Adverse events leading to withdrawals			o	o	o	x
4. Other serious adverse events			o	o	o	x
5. Other adverse events			o	o	o	x
6. Burdens				x		

Assign an overall global rating across outcomes:

X Benefits clearly outweigh harms/ burden
☐Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments:

III) Patient Values and Preferences

What are the typical patient values and preferences?

How variable are these?

How certain is the GDP about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

[Possible studies to include from APA staff search of pt values and preferences studies]:

Prins et al (2008): "Patients' illness representations and beliefs about treatment for depression and anxiety, as well as their perceived needs, are important for treatment. **A systematic review was conducted of 71 studies describing the beliefs or perceived needs of patients and non-patients. Patients give multi-dimensional explanations for depression and see both psychological and medication treatment as helpful. People who suffer from depression have more positive beliefs about biological etiology and medication treatment than healthy people, or those with less severe depressive symptoms. Anxiety patients view psychological interventions as their best treatment option. Between 49% and 84% of the patients with depression or anxiety perceive a need for treatment, mostly for counseling and medication. All patients prefer psychological treatment forms to medication. A majority of patients view antidepressants as addictive and many perceive stigma and see practical and economic barriers to care. The most vulnerable groups in terms of seeking and receiving mental health care for depression and anxiety seem to be minority groups, as well as younger and older patients.** More research is required into the specific needs of anxiety and depression patients. Open communication between patient and provider could lead to valuable improvements in treatment."

Information from community members on panel:

If person is seeking any treatment, group is preferable to wait list.

Information from clinicians on panel:

Group therapy may lead to more drop out (especially if patients don't feel welcome) than individual therapy. Not specific to older adults.

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High		High
x	Moderate		Moderate
	Low	x	Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

x Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

[This is an important consideration for decision making but very little data on what patients actually prefer- encourage future authors to collect some information in this regard.]

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to impact applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Patients met criteria or subclinical criteria for both depression and anxiety
Interventions	• Lacked formal treatment adherence and therapist competence measures (only utilized weekly supervision meetings) • Conducted by lead author and two graduate students in clinical psychology
Comparators	Wait list control vs any sort of active control or even a supportive group
Outcomes	
Timing or Time frame	
Settings	

Notes/Comments:

Wuthrich 2013

"Sixty-two community dwelling participants aged 60-84 (mean age ¼ 67.44, SD ¼ 6.19, 22 ¼ male, 40 ¼ female) were recruited via advertisements in local newspapers. Participants attended the Centre for Emotional Health, Macquarie University, Sydney, Australia for assessment and treatment. All participants met DSMIV criteria or subclinical criteria (see below for definition) for both an anxiety and a mood disorder, with either anxiety or mood being the primary (most interfering) problem. In fact, the vast majority of the sample met full DSM-IV criteria for both an anxiety disorder and a mood disorder with either problem being primary (N ¼ 55), with the remaining 7 participants having at least subclinical levels of anxiety, depression or both. Exclusion criteria were: aged under 60 years, unable to read a newspaper, current self-harm, active suicidal intent, psychosis, or bipolar disorder. All participants were asked to refrain from engaging in additional treatment from a therapist or making changes to their medication status during the course of the trial."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: GDPs should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
x	***Strong*** *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

We recommend use of group CBT over wait list.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

In the presence of a moderate or large effect size and in the absence of evidence for significantly greater harms or burden, we have a strong recommendation for the intervention in relation to wait list.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the GDP members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version 6/26/14)
Topic # 29- A combination of cognitive behavioral therapy (individual) and usual care compared to a combination of talking control (individual) and usual care for treating minor or major depressive disorder in adults ages 65 and older

Factor	Explanation/Comments
I. Aggregate/Global Strength of Evidence (SOE) (from evidence profiles)	
II. Treatment Outcomes/Consequences • **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of Treatment *(Note- do not include financial cost)*	
Balance of Benefits and Harms/Burdens of Treatment	
III. Patient Values and Preferences	

IV. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 29- A combination of cognitive behavioral therapy (individual) and usual care compared to a combination of talking control (individual) and usual care for treating minor or major depressive disorder in adults ages 65 and older

Factor	Summary of Reasons for Judgment/ Evidence
l) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., When magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Response (follow up: 10 months; assessed with: BDI)		X		
Quality of Life (follow up: 10 months; assessed with: EUROQOL)			X	
Quality of Life (follow up: 10 months; assessed with: Social Functioning Questionnaire)			X	
Outcomes for which no studies were found: functional capacity, remission, patient satisfaction, relapse, suicidality, serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only). **Global SOE Grade:** ☐High ☐Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Serfaty 2009

		№ of patients		Effect		Quality
№ of studies		**a combination of cognitive behavioral therapy (individual) and usual care**	**a combination of talking control (individual) and usual care**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response (follow up: 10 months; assessed with: BDI); number of events by group not reported						
1	See footnote #1	70	67	-	GEE estimate **3.65 lower** (6.18 lower to 1.12 lower)	⊕⊕⊕◯ MODERATE
Remission						
				not estimable	not estimable	
Quality of Life (follow up: 10 months; assessed with: EUROQOL); number of events by group not reported						
1	See footnote #2	70	67	-	GEE estimate **0.04 higher** (0.05 lower to 0.12 higher)	⊕⊕◯◯ LOW
Quality of Life (follow up: 10 months; assessed with: Social Functioning Questionnaire); number of events by group not reported						
1	See footnote #2	70	67	-	GEE estimate **1.14 lower** (3.12 lower to 0.84 higher)	⊕⊕◯◯ LOW

Relapse						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- small sample size: study does not meet optimal information size
Footnote #2- small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

GEE- general estimation equation

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Response (follow up: 10 months; assessed with: BDI)		x				
2. Quality of Life (follow up: 10 months; assessed with: EUROQOL)			X			o
3. Quality of Life (follow up: 10 months; assessed with: Social Functioning Questionnaire)			x			o

[#1- Discussion regarding difference in reduction of scores between the two treatments (both had a reduction although still in depressed range and the difference between the two arms was relatively small). Unlikely to be a clinically significant effect?]

[question regarding treatment adherence- so how different were the two arms in actuality]

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

References for harms/burdens published studies: *Serfaty et al (2009)*

Harm

- Dropout: 8.6% (*6 of 70*) CBT + UC v. 13.4% *(9 of 67*) TC + UC
- Reasons for dropout: Dissatisfaction with group allocation; too physically or mentally ill; moved/not contactable; refused for no reason; died; developed cognitive problems; mad at therapist

Other studies:
None

Note any other information on burdens from published studies:

References for harms/burdens published studies: *Serfaty et al (2009)*

Burden

- Home visits were offered for treatment conditions, and done with 40% of sample
- 12 50-min CBT and Talking Control (TC) sessions
- Therapists had at least 5 years of experience in CBT treatment
- Of those who provided feedback, 72% of patients *(37 of 51)* found CBT useful, 20% *(10 of 51)* did not, and 8% were unsure;
- 63% of patients (*29 of 46*) found TC useful, 20% (*9 of 46*) did not, and 17% (*9 of 46*) were unsure

Note any additional information on harms:

No additional information.

Note any additional information on burdens:

No additional information.

Next, list and rate each harm/burden :

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
4. Adverse events leading to withdrawals			o	o	o	X
5. Other serious adverse events			o	o	o	X
6. Other adverse events			o	o	o	X
7. Burdens			x	o	o	o

Assign an overall global rating across outcomes:

☐Benefits clearly outweigh harms/ burden
X Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments: Very slightly.

III) Patient Values and Preferences

What are the typical patient values and preferences?

How variable are these?

How certain is the GDP about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

[Possible studies to include from APA staff search of pt values and preferences studies]:

Hanson & Scogin (2008): "We examined older adults' ratings of the acceptability of geriatric depression treatments. **We presented 120 community-dwelling participants with vignettes describing an older adult experiencing either mild to moderate or severe depression. Participants rated the acceptability of three different treatments: cognitive therapy (CT), antidepressant medication (AM), and a combination treatment of CT and AM (COM). For general acceptability, participants rated COM as a more acceptable treatment for depression than both CT and AM. With respect to perceived negative aspects of treatments, they rated CT as a more acceptable treatment for mild to moderate depression than both AM and COM. Participants rated both COM and CT as more acceptable treatments for severe depression than AM.** Results indicate that combining psychotherapy and AM may be viewed as most acceptable by community-dwelling, nondepressed older adults."

Steidtmann et al (2012): "Background: Findings regarding the relationship between patient treatment preference and treatment outcome are mixed. This is a secondary data analysis investigating the relationship between treatment preference, and symptom outcome and attrition in a large 2-phase depression treatment trial. Methods: Patients met DSM-IV criteria for chronic forms of depression. **Phase I was a 12-week, nonrandomized, open-label trial in which all participants (n=785) received antidepressant medication(s) (ADM). Phase I nonremitters were randomized to Phase II, in which they received 12 weeks of either Cognitive-Behavioral System of Psychotherapy (CBASP) + ADM (n=193), Brief Supportive Psychotherapy (BSP) + ADM (n=187), or ADM only (n=93). Participants indicated their treatment preference (medication only, combined treatment or no preference) at study entry.** Symptoms were measured at 2-week intervals with the 24-item Hamilton Rating Scale for Depression (HAM-D). Results: **A large majority of patients reported a preference for combined treatment. Patients who preferred medication only were more likely to endorse a chemical imbalance explanation for depression, whereas those desiring combined treatment were more likely to attribute their depression to stressful experiences. In Phase I, patients who expressed no treatment preference showed greater rates of HAM-D symptom reduction than those with any preference, and patients with a preference for medication showed higher attrition than those preferring combined treatment. In Phase II, baseline treatment preference was not associated with symptom reduction or attrition.** Conclusions: Treatment preferences may moderate treatment response and attrition in unexpected ways. Research identifying factors associated with differing preferences may enable improved treatment retention and response."

Van Schaik et al (2004): "Patients' preferences in the treatment of depression are important in clinical practice and in research. Antidepressant medication is often prescribed, but adherence is low. This may be caused by patients preferring psychotherapy, which is often not available in primary care. In randomized clinical trials, patients' preferences may affect the external validity. **The aim of this article is to study patients' preferences regarding psychotherapy and antidepressant medication and the impact of these preferences on treatment outcome. A systematic review of the literature was performed. The majority of patients preferred psychotherapy in all available studies. Antidepressants were often regarded as addictive and psychotherapy was assumed to solve the cause of depression.** Discussing and supporting preferences as part of a quality improvement program of depression care, resulted in more patients receiving the treatment that was most suitable to them. In two patient-preference trials, preferences did not influence treatment outcome. It can be concluded that a substantial percentage of well-informed patients prefer psychotherapy. Patients with strong preferences, mostly for psychotherapy, are likely not to enter antidepressant treatment or randomized clinical trials if their preferences are not supported."

Serfaty et al (2009): **Also measured treatment preference, and while the majority preferred CBT it was not statistically significant.**

Information from community members on panel:

Preference for evidence based intervention rather than a talking control condition.

Information from clinicians on panel:

Prefer CBT but not always sure of therapist fidelity to that particular intervention when referring to a community therapist.

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	Variability in Patient Values & Preferences	✓	Certainty in Patient Values & Preferences
	High	x	High
	Moderate		Moderate
x	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

X Similar values and little uncertainty

☐ Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Whatever treatment is offered, prefer something, whether in combination or alone, that includes a psychosocial intervention.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to impact applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Excluded those with substance use dependence; bipolar
Interventions	A sample of sessions was examined for adherence.
Comparators	How well described is the comparator condition.
Outcomes	Outcomes were based on patient self report vs. interview by independent evaluator.
Timing or Time frame	
Settings	

Notes/Comments:
Serfaty et al., 2009:

"The inclusion criteria were (1) a primary diagnosis of depressive disorder made by the researcher who administered the Ger atric Mental State and History and Etiology Schedule18 using the computerized diagnostic program AGECAT (Automated Geriatric Examination for Computer AssistedTaxonomy),which has been validated in the community and used in international comparisons of depression; (2) a score of 14 or higher on the BDI-II19 to include people with less severe mixed anxiety and depression, who are frequently seen in primary care and who may respond to CBT20;(3)sufficient command of English to use CBT techniques; and (4) if taking an antidepressant, a stable dose of medication for at least 8 weeks prior to randomization.

The exclusion criteria were (1) intense suicidal intent requiring inpatient admission; (2)a history suggestive of alcohol misuse or drug dependence; (3) a history of bipolar affective disorder; (4) the presence of hallucinations or delusions; (5) cognitive deficits, as judged by a score of less than 24 on the Mini-Mental State Examination21; (6) having received CBT in the last year; and (7) having received electroconvulsive therapy within the previous 6months, because of possible residual effects on cognition."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: GDPs should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
x	***Conditional*** *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

Conditional recommendation for individual CBT over a “talking” therapy.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

The evidence supports a small effect favoring CBT over talking therapy but there is considerable variability or “noise” in those data and there is no clear evidence for differential burden or harm.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the GDP members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version 6/26/14)
Topic # 30- Cognitive behavioral therapy (group) compared to wait list for treating subthreshold depression in adults between 50 and 75 years old

Factor	Explanation/Comments
V. Aggregate/Global Strength of Evidence (SOE) (from evidence profiles)	
VI. Treatment Outcomes/Consequences • **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of Treatment *(Note- do not include financial cost)*	
Balance of Benefits and Harms/Burdens of Treatment	
VII. Patient Values and Preferences	

VIII. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 30- Cognitive behavioral therapy (group) compared to wait list for treating for subthreshold depression in adults between 50 and 75 years old

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., When magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Response (follow up: 10 weeks; assessed with: Beck Depression Inventory (change from >20 at pre-treatment to <20 at post-treatment))				X
Change in Scores (follow up: 10 weeks; assessed with: BDI)			X	
Response - improvement (follow up: 10 weeks; assessed with: Reliable change of >8.6 on CES-D				X
Quality of Life (follow up: 10 weeks; assessed with: MOS Pain)				X
Quality of Life (follow up: 10 weeks; assessed with: MOS- physical functioning)				X
Quality of Life (follow up: 10 weeks; assessed with: MOS Perceived Health)				X
Quality of Life (follow up: 10 weeks; assessed with: MOS - Mental Health)				X
Quality of Life (follow up: 10 weeks; assessed with: MOS - Role Functioning)				X
Quality of Life (follow up: 10 weeks; assessed with: MOS - Social Functioning)				X
Outcomes for which no studies were found: functional capacity, remission, patient satisfaction, relapse, suicidality, serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only). **Global SOE Grade:** ☐High ☐Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Haringsma et al., 2006; Spek et al., 2007

Quality assessment		№ of patients		Effect		Quality
№ of studies		**cognitive behavioral therapy (group)**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
0				not estimable	not estimable	
Response (follow up: 10 weeks; assessed with: Beck Depression Index (change form >20 at pre-treatment to < 20 at post-treatment)); Spek 2007; data is limited to a subgroup analysis of patients with a baseline BDI >20						
1	See Footnotes #1 and #2	28/42 (66.7%)	17/39 (43.6%)	RR 1.53 (1.01 to 2.32)	231 more per 1000 (from 4 more to 575 more)	⊕◯◯◯ VERY LOW
Change in Scores (follow up: 10 weeks; assessed with: BDI) (follow up: 10 weeks; assessed with: Mean BDI Scores); Spek 2007						
1	See Footnote #2	102	99	-	MD **3.03 lower** (5.79 lower to 0.27 lower)	⊕⊕◯◯ LOW
Response - improvement (follow up: 10 weeks; assessed with: Reliable change of >8.6 on CES-D); Haringsma 2006						
1	See Footnotes #1 and #2	22/52 (42.3%)	11/58 (19.0%)	RR 2.23 (1.40 to 4.14)	233 more per 1000 (from 76 more to 596 more)	⊕◯◯◯ VERY LOW
Remission						
0				not estimable	not estimable	
Patient Satisfaction						
0				not estimable	not estimable	
Relapse						
0				not estimable	not estimable	

Quality of Life (follow up: 10 weeks; assessed with: MOS Pain); Haringsma 2006						
1	See Footnotes #1, #2, and #3	58	52	-	MD **1.24 higher** (10.76 lower to 13.24 higher)	⊕◯◯◯ VERY LOW
Quality of Life (follow up: 10 weeks; assessed with: MOS- physical functioning); Haringsma 2006						
1	See Footnotes #1, #2, and #3	58	52	-	MD **5.36 lower** (17.32 lower to 6.6 higher)	⊕◯◯◯ VERY LOW
Quality of Life (follow up: 10 weeks; assessed with: MOS Perceived Health); Haringsma 2006						
1	See Footnotes #1, #2, and #3	58	52	-	MD **3.93 higher** (5.35 lower to 13.21 higher)	⊕◯◯◯ VERY LOW
Quality of Life (follow up: 10 weeks; assessed with: MOS - Mental Health); Haringsma 2006						
1	See Footnotes #1 and #2	58	52	-	MD **7.62 higher** (0.78 higher to 14.46 higher)	⊕◯◯◯ VERY LOW
Quality of Life (follow up: 10 weeks; assessed with: MOS - Role Functioning); Haringsma 2006						
1	See Footnotes #1 and #2	58	52	-	MD **46.57 higher** (33.82 higher to 59.32 higher)	⊕◯◯◯ VERY LOW
Quality of Life (follow up: 10 weeks; assessed with: MOS - Social Functioning); Haringsma 2006						
1	See Footnotes #1 and #2	58	52	-	MD **21.89 higher** (7.97 higher to 35.81 higher)	⊕◯◯◯ VERY LOW

MD – mean difference, RR – relative risk

Footnote #1- High dropout, no ITT
Footnote #2- Small sample size and/or number of events, does not meet optimal information size to detect differences
Footnote #3- Confidence intervals cross appreciable difference

Number needed to treat (NNT) (95% Confidence Interval)
Response (follow up: 10 weeks; assessed with: Beck Depression Index (change form >20 at pre-treatment to < 20 at post-treatment)): NNT = 4 (NNT(benefit) 2 to 50)
Response - improvement (follow up: 10 weeks; assessed with: Reliable change of >8.6 on CES-D): NNT = 4 (NNT(benefit) 2 to 15)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Response (follow up: 10 weeks; assessed with: Beck Depression Inventory (change from >20 at pre-treatment to <20 at post-treatment))	X					
2. Change in Scores (follow up: 10 weeks; assessed with: BDI)	X					
3. Response - improvement (follow up: 10 weeks; assessed with: Reliable change of >8.6 on CES-D	X					
4. Quality of Life (follow up: 10 weeks; assessed with: MOS Pain)			X			
5. Quality of Life (follow up: 10 weeks; assessed with: MOS- physical functioning)			X			
6. Quality of Life (follow up: 10 weeks; assessed with: MOS Perceived Health)			X			
7. Quality of Life (follow up: 10 weeks; assessed with: MOS - Mental Health)	o	X	o			o
8. Quality of Life (follow up: 10 weeks; assessed with: MOS - Role Functioning)	X	o	o			o
9. Quality of Life (follow up: 10 weeks; assessed with: MOS - Social Functioning)	X	o	o			o

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

References for harms/burdens published studies:

Spek et al (2007); Haringsma et al (2006)

Harm

- Dropout: 32.5% *(52 of 160)* Group CBT v. 26.6% *(42 of 158)* WL
- Reasons for dropout: not being willing or able to start with group cognitive behaviour therapy within the desired time period; "course [coping with depression] was not suitable." 1 participant dropped out due to symptom worsening
- Symptom worsening: In Spek et al (2007), 3.5% *(2 of 57)* of group CBT patients had clinically significant worsening of depression scores compared to 13.3% *(8 of 60)* of those wait-listed [based on completer's analysis]; In Haringsma et al (2006), 1 participant dropped out due to symptom worsening; 14% (*n* = 8) of wait-list had worsening symptoms

Other studies:
Arean et al (2005); Johnco et al (2014)

- Dropout: 17.2% (*11 of 64*) Group CBT v. 25.9% (*7 of 27*) UC
- Reasons for dropout: feasibility, unknown/lost contact, dissatisfied, no longer interested, wanted antidepressant, career responsibilities

Note any other information on burdens from published studies:

References for harms/burdens published studies:

Burden

- Both Utilized "Coping With Depression" course
- Spek: 10 weekly group sessions led by "psychologists and trained social workers"
    - Mean number of group sessions completed was 9.1; group course was completed by 94.5% of the participants
- Haringsma: 2 hr group format
    - Reported "high treatment acceptability" based on low attrition and high participation

Note any additional information on harms:

Note any additional information on burdens:

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
10. Adverse events leading to withdrawals		X				
11. Other serious adverse events						X
12. Other adverse events						X
13. Burdens				x		

Assign an overall global rating across outcomes:

X Benefits clearly outweigh harms/ burden
☐Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments:

III) Patient Values and Preferences

What are the typical patient values and preferences?

How variable are these?

How certain is the GDP about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

[Possible studies to include from APA staff search of pt values and preferences studies]:

Gitlin et al (2013): "*Objective:* To examine older African American's recognition of and beliefs about depressive symptoms, preferred symptom management strategies, and factors associated with willingness to use mental health treatments. Differences between depressed and non-depressed and men and women were examined. *Design:* Cross-sectional survey. *Setting:* Home, senior center. *Participants:* 153 senior center members (56=males, 97=females) ≥55 years. *Measurements:* **Using a depression vignette**, **participants indicated if the person was depressed and their endorsement of items reflecting beliefs, stigma, symptom management, and willingness to use treatments (yes/no). PHQ-9 assessed current symptomatology.** *Results:* Overall, 24.2% reported depressive symptoms (≥5); 88.2% correctly identified the person in the vignette as depressed. **Most (≥75%) endorsed active symptom management strategies, preference for treatment in physician and therapist offices, and willingness to take medications, seek therapy, see doctor and attend support groups; <33% viewed depression as stigmatizing whereas 48% viewed depression as normal aging. Logistic regressions revealed lower education, higher physical function and feeling okay if community knew of depression diagnosis were associated with willingness to see physician if feeling depressed; being married and believing anti-depressant medications are beneficial were related to willingness to use medications. Different associations emerged for depressed/non-depressed and men and women.** *Conclusions:* Overall, this older African American sample had positive attitudes and beliefs and endorsed traditional treatment modalities suggesting that beliefs alone are unlikely barriers to underutilization of mental health services. As different factors were associated with willingness to seek physician help and use medications and factors differed for depressed/non-depressed and by sex, interventions should be tailored."

Raue et al (2012): "*Objective:* The authors hypothesized that the depression treatment preferences of elderly home care patients would vary by depression experience, with preferences for active treatments being associated with current depression and antidepressant treatment. *Methods:* The authors conducted **cross sectional secondary analyses of the TRIAD ("Training in the Assessment of Depression") study of 256 randomly selected elderly patients newly admitted to homecare.** The study assessed depression treatment preference for active (i.e., medication or psychotherapy) versus non-active or complementary approaches (e.g., religious activities, do nothing). Two separate indicators of depression experience were used: diagnoses of major or minor depression, and current or previous antidepressant treatment. *Results:* **121 patients (48%) preferred active treatment with either medication or psychotherapy as their first choice, while the**

	remainder preferred non-active or complementary approaches. Logistic regression indicated that current antidepressant use, previous psychotherapy experience, white and Hispanic versus African-American patients, greater IADL impairment, and less personal stigma about depression were independently associated with preference for an active treatment. *Conclusions:* Elderly homecare patients have a variety of depression treatment preferences ranging from active treatments, to religious or spiritual activities, to no treatment. **Several factors were associated with a preference for active treatment, including treatment experience, co-existing physical impairment, culture, and attitudes and beliefs.** Understanding patient preferences may form the basis of engaging older depressed home care patients in treatment." *Information from community members on panel:* Active treatment is better than wait list. *Information from clinicians on panel:* *Information from other sources (also list sources):* High certainty of preference; fairly low variability in terms of group CBT to WL

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High	X	High
	Moderate		Moderate
X	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

X Similar values and little uncertainty

☐ Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to impact applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Socioeconomic status and technology literacy. In older age range, possible difficulty using technology due to sensory impairments, though could impact group participation as well. N able to generalize to other population with differing severities. Mild or subsyndromal depression; not major depression.
Interventions	Comfort with and access to internet could limit generalizability. Purely an internet based intervention without human contact or coaching.
Comparators	Waitlist
Outcomes	
Timing or Time frame	Do not have long-term outcome information.
Settings	

Notes/Comments:

Haringsma, 2006:

"Ten CMHCs, both urban and rural, and from all the regions in the Netherlands that provide the course, participated in this study, with 13 courses. The individuals in the study were older adults taking part in the CWD courses during the years 2000 and 2001. Participants were self-referred, responding to media announcements. Accepted were older adults (minimum age around 55) with current or a history of depressive symptoms. Exclusion criteria were: cognitive impairment, current bipolar disorder, schizophrenia, acute substance disorder, recent bereavement, hearing impairment, and insufficient command of the Dutch language. These are the standard procedures used by the CMHCs. Not all the individuals enrolled by the CMHCs were accepted for the study. Study participants had to be at a minimum age of 55 years and receiving no other form of psychotherapy – psychotropic medication was accepted. All CWD participants were provided with a complete description of the study, and written informed consent was obtained before enrollment in the study. Participation in the study was voluntary; consequently not all the seniors attending the CWD course took part in the study. Those who joined the study and completed the post-treatment assessment

	were reimbursed for the small contribution ($15–40) imposed by most of the CMHCs. The Medical Ethics Committee of the Leiden University Medical Center approved the study." *Spek 2007:* "Participants who scored above the cut-off score of 12 on the EDS (n=699) were invited for an in-person structured clinical interview for depression, the World Health Organization Composite International Diagnostic Interview (WHO CIDI; WHO, 1997). To be included in the study, participants had to meet the following criteria: an EDS score of 12 or more, but no compliance with the DSM-Iv diagnostic criteria of depression, signed informed consent, age between 50 and 75 years, access to the internet and the ability to use the internet. Exclusion criteria were suffering from any other psychiatric disorder in immediate need of treatment and suicidal ideation."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: GDPs should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
X	***Strong*** *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

Strong recommendation for group CBT relative to WL for treatment of subthreshhold (subsyndromal) depression.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

There is evidence of both sx improvements as well as functional improvement with group CBT and minimal burden.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the GDP members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version 6/26/14)
Topic # 31- Cognitive behavioral therapy (internet) compared to wait list for treating for subthreshold depression in adults between 50 and 75 years old

Factor	Explanation/Comments
X. **Aggregate/Global Strength of Evidence (SOE) (from evidence profiles)**	
X. **Treatment Outcomes/Consequences**	
• **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of Treatment *(Note- do not include financial cost)*	
Balance of Benefits and Harms/Burdens of Treatment	
CXI. **Patient Values and Preferences**	

XII. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 31- Cognitive behavioral therapy (internet) compared to wait list for treating for subthreshold depression in adults between 50 and 75 years old

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., When magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Response (follow up: 10 weeks; assessed with: Beck Depression Inventory (change from >20 at pre-treatment to <20 at post-treatment))				X
Change in Scores (follow up: 10 weeks; assessed with: BDI)			X	
Outcomes for which no studies were found: functional capacity, remission, quality of life, patient satisfaction, relapse, suicidality, serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only). **Global SOE Grade:** ☐High ☐Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Spek 2007

		№ of patients		Effect		Quality
№ of studies		**cognitive behavioral therapy (internet)**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response (follow up: 10 weeks; assessed with: Beck Depression Inventory (change from >20 at pre-treatment to <20 at post-treatment)); data limited to a subgroup analysis of patients with a baseline BDI >20						
1	See footnotes # 1 and # 2	30/45 (66.7%)	17/39 (43.6%)	**RR 1.53** (1.01 to 2.31)	231 more per 1000 (from 4 more to 571 more)	⊕◯◯◯ VERY LOW
Change in Scores (follow up: 10 weeks; assessed with: BDI); based on ITT analysis						
1	See footnote # 3	102	100	-	MD **2.49 lower** (5.06 lower to 0.08 higher)	⊕⊕◯◯ LOW
Remission						
				not estimable	not estimable	
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- High dropout, no ITT
Footnote #2- Small sample size and/or number of events, does not meet optimal information size to detect differences
Footnote #3- Confidence intervals cross appreciable difference

Number needed to treat (NNT) (95% Confidence Interval)
Response (follow up: 10 weeks; assessed with: Beck Depression Inventory (change from >20 at pre-treatment to <20 at post-treatment)): NNT = 4 (NNT(benefit) 2 to 43)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Response (follow up: 10 weeks; assessed with: Beck Depression Inventory (change from >20 at pre-treatment to <20 at post-treatment))	X					
2. Change in Scores (follow up: 10 weeks; assessed with: BDI)			X			

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

References for harms/burdens published studies: *Spek et al (2007); McMurchie et al (2013); Titov et al (2015)*

Harm

- Dropout: 34.3% *(35 of 102)* Internet CBT v. 42% *(42 of 100)* WL
- Reason for dropout: lack of time
- Symptom worsening: 14.3% (*8 of 56)* of internet CBT patients had clinically significant worsening of depression scores compared to 13.3% *(8 of 60)* of those wait-listed [based on completer's analysis]

Other studies:

McMurchie et al (2013); Titov et al (2015)

Harm

- Dropout: 24.2% (*15 of 62*) internet CBT (*Beat the Blues; Managing Your Mood*) vs. 15.6% *(7 of 45)* WL/UC
- Reasons for dropout: desire to participate in another treatment; withdrew; unknown

Note any other information on burdens from published studies:

References for harms/burdens published studies: *Spek et al (2007); McMurchie et al (2013); Titov et al (2015)*

Burden

- 8 weekly sessions completed from home computer
- Mean number of internet therapy sessions completed was 5.5; internet course was completed by 48.3% of participants
- internet based treatment = "low-threshold accessibility," less stigma, work at own pace, review material, receive treatment at any time or place
- Less therapist time involved
- Need computer skills and access to internet
- *McMurchie et al (2013) – Beat the Blues*
    - 8 60-min weekly sessions with homework

- Individuals who selected internet treatment were younger, more educated, more likely to have internet at home and reported more experience/comfort with using computer

- *Titov et al (2015) – Managing Your Mood*
  - 5 sessions over 8-weeks of treatment
  - Homework assignments for each lesson
  - Clinical contact available via weekly telephone calls (10 mins or less) or email

- 80% reported being satisfied or very satisfied with internet CBT, 15% neutral, and 5% somewhat dissatisfied; all reported they would recommend it to a friend and that it was "worth their time"

Note any additional information on harms:

Cuijpers (2014) meta analysis on internet based therapy (web based modules) compared to traditional face to face- they did not find a difference in drop out rates (81% of internet and 84% of face to face finished treatment)

Note any additional information on burdens:

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
3. Adverse events leading to withdrawals						x
4. Other serious adverse events						x
5. Other adverse events			X			
6. Burdens				X		

Assign an overall global rating across outcomes:

X Benefits clearly outweigh harms/ burden
☐Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments:

You tend to get higher drop out rates with internet based psychotherapies in the absence of a human coach/ therapist.

III) Patient Values and Preferences *What are the typical patient values and preferences?* *How variable are these?* *How certain is the GDP about these?* **Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*	**<u>Patient values and preferences based on:</u>** *Information from research studies:* *[Possible studies to include from APA staff search of pt values and preferences studies]:* **<u>Choi et al (2015):</u>** "Purpose: Internet treatments have the potential to improve access, especially for cultural groups who face considerable treatment barriers**. This study explored the perceived barriers and likelihood of using Internet and face-to-face treatments for depression among Chinese and Caucasian Australian participants.** Methods: Three-hundred ninety-five (289 Chinese, 106 Caucasian) primary care patients completed a questionnaire about depression history, previous help-seeking, perceived barriers to Internet and face-to-face treatment, and likelihood of using either treatment for depressive symptoms. Results**: Internet treatment reduced perceived barriers (including stigma, lack of motivation, concerns of bringing up upsetting feelings, time constraints, transport difficulties, and cost) for both groups to a similar degree, except for time constraints. There were heightened concerns about the helpfulness, suitability, and confidentiality of Internet treatments.** Chinese participants and individuals with a probable depression history reported increased perceived barriers across treatments. **Both Chinese and Caucasian groups preferred face-to-face treatment across depression severity. However, when age was controlled, there were no significant concerns about Internet treatment, and face-to-face treatment was only preferred for severe depression. Only 12 % of the entire sample refused to try Internet treatment for depression. Endorsement of perceived Internet treatment barriers (including concerns of bringing up upsetting feelings, that treatment would be unhelpful or unsuitable, lack of motivation, cost, cultural sensitivity, and confidentiality) reduced the likelihood to try Internet treatments.** Conclusions: Internet treatment reduced perceived treatment barriers across groups, with encouraging support for Internet treatment as an acceptable form of receiving help. Negative concerns about Internet treatment need to be addressed to encourage use." *Information from community members on panel:* *Information from clinicians on panel:* *Information from other sources (also list sources):*

Next rate the variability of and your certainty about patient values and preferences:

✓	Variability in Patient Values & Preferences	✓	Certainty in Patient Values & Preferences
X	High		High
	Moderate	X	Moderate
	Low		Low
	Unknown		Unknown

High variability moderate certainty

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

☐ Some variation or some uncertainty

X Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

A large amount of variability in patient preferences for this kind of treatment yet some indication that patients will indicate specific preference for or willingness to participate (or not participate) in internet based therapy.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to impact applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Mild or subsyndromal depression; not major depression
Interventions	Purely an internet based intervention without human contact or coaching
Comparators	Waitlist
Outcomes	
Timing or Time frame	
Settings	

Notes/Comments:

Spek 2007:

"Participants who scored above the cut-off score of 12 on the EDS (n=699) were invited for an in-person structured clinical interview for depression, the World Health Organization Composite International Diagnostic Interview (WHO CIDI; WHO, 1997). To be included in the study, participants had to meet the following criteria: an EDS score of 12 or more, but were excluded if they met DSM-IV diagnostic criteria for depression (ie. subsyndromal), signed informed consent, age between 50 and 75 years, access to the internet and the ability to use the internet. Exclusion criteria were suffering from any other psychiatric disorder in immediate need of treatment and suicidal ideation."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: GDPs should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
X	***Conditional*** *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

We suggest clinicians consider recommending an internet based CBT treatment over wait list for older adults with mild/ subsyndromal depression.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Some evidence for improvement, in terms of response rates, for brief internet based CBT in older adults with mild, subsyndromal depression in contrast to the passage of time. Slightly greater burden of effort involved in participating in the intervention relative to WL but no clear evidence of harms.

Were such an adult not to improve, potentially a more intensive intervention would then be offered.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the GDP members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version 6/26/14)
Topic # 32- Problem-solving therapy (group) compared to wait list
for treating major depressive disorder in adults ages 55 and older

Factor	Explanation/Comments
II. Aggregate/Global Strength of Evidence (SOE) (from evidence profiles)	
V. Treatment Outcomes/Consequences • **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of Treatment *(Note- do not include financial cost)*	
Balance of Benefits and Harms/Burdens of Treatment	
XV. Patient Values and Preferences	

XVI. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 32- Problem-solving therapy (group) compared to wait list for treating major depressive disorder in adults ages 55 and older

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., When magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem orientation))				X
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem definition and formulation)				X
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (generation of alternative solutions))				X
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (decision-making))				X
Functional Capacity (follow up: 12 weeks; assessed with: : Social Problem-solving Inventory (solution implementation and verification))				X
Response (follow up: 12 weeks; assessed with: No longer fulfill diagnostic criteria for MDD)		X		
Outcomes for which no studies were found: remission, quality of life, patient satisfaction, relapse, suicidality, serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only). **Global SOE Grade:** ☐High ☐Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Arean 1993

		№ of patients		Effect		Quality
№ of studies		**problem-solving therapy (group)**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem orientation)); based on completers analysis						
1	See footnotes #1 and #2	19	20	-	MD **0.6 higher** (15.06 lower to 16.26 higher)	⊕◯◯◯ VERY LOW
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem definition and formulation)); based on completers analysis						
1	See footnotes #1 and #2	19	20	-	MD **3.5 higher** (0.86 lower to 7.86 higher)	⊕◯◯◯ VERY LOW
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (generation of alternative solutions)); based on completers analysis						
1	See footnotes #1 and #2	19	20	-	MD **4 higher** (0.9 lower to 8.9 higher)	⊕◯◯◯ VERY LOW
Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (decision-making)); based on completers analysis						
1	See footnotes #1 and #2	19	20	-	MD **2.9 higher** (1.75 lower to 7.55 higher)	⊕◯◯◯ VERY LOW
Functional Capacity (follow up: 12 weeks; assessed with: : Social Problem-solving Inventory (solution implementation and verification)); based on completers analysis						
1	See footnotes #1 and #2	19	20	-	MD **2.6 higher** (2.59 lower to 7.79 higher)	⊕◯◯◯ VERY LOW
Response (follow up: 12 weeks; assessed with: No longer fulfill diagnostic criteria for MDD); based on ITT analysis						
1	See footnote #3	17/28 (60.7%)	2/20 (10.0%)	**RR 6.07** (1.58 to 23.38)	507 more per 1000 (from 58 more to 1000 more)	⊕⊕⊕◯ MODERATE

Remission						
				not estimable	not estimable	
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- High differential attrition, completers analysis
Footnote #2- Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference
Footnote #3- Small sample size and/or number of events, does not meet optimal information size to detect differences

Number needed to treat (NNT) (95% Confidence Interval)
Response (follow up: 12 weeks; assessed with: No longer fulfill diagnostic criteria for MDD): NNT = 2 (NNT(benefit) 1 to 3)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem orientation))			o			X
2. Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (problem definition and formulation)			o			X
3. Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (generation of alternative solutions))			o			X
4. Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (decision-making))			o			X
5. Functional Capacity (follow up: 12 weeks; assessed with: Social Problem-solving Inventory (solution implementation and verification))			o			X
6. Response (follow up: 12 weeks; assessed with: No longer fulfill diagnostic criteria for MDD)	X	o				

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

References for harms/burdens published studies: *Arean et al (1993)*

Harm

- Dropout: 32.1% (*9 of 28*) PST v. 0% (*0 of 20*) WL
- Reasons for dropout: physical illness; dissatisfaction with treatment; time conflicts; relocated; death in family; conflict with another group member; discomfort being "only male" in group; reason unknown

Other studies:
None

Note any other information on burdens from published studies:

References for harms/burdens published studies: *Arean et al (1993)*

Burden

- 4 individuals reported being dissatisfied with treatment; additional individuals reported conflict with another group member and discomfort with being the only male in the group as reasons for dropping out of treatment
- 90-min group sessions

Note any additional information on harms:

No additional

Note any additional information on burdens:

- homework and time burden of weekly sessions

Next, list and rate each harm/burden :

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
7. Adverse events leading to withdrawals			o	o	o	X
8. Other serious adverse events			o	o	o	X
9. Other adverse events			o	o	o	X
10. Burdens			o	X	o	o

Assign an overall global rating across outcomes:

☐Benefits clearly outweigh harms/ burden
☐Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments: Unable to rate the balance. Modest/large benefit but unable to rate due to overall context of study (small sample size) and lack of information of harms.

III) Patient Values and Preferences *What are the typical patient values and preferences?* *How variable are these?* *How certain is the GDP about these?* **Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*	**<u>Patient values and preferences based on:</u>** *Information from research studies:* None *Information from community members on panel:* *Information from clinicians on panel:* Patients do want something as opposed to waitlist. Variability in the acceptability of group, many accept it but many do not. *Information from other sources (also list sources):*

Next rate the variability of and your certainty about patient values and preferences:

✓	Variability in Patient Values & Preferences	✓	Certainty in Patient Values & Preferences
	High	X	High
	Moderate		Moderate
X	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

X Similar values and little uncertainty

☐ Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Similar values and little uncertainty, patients tend to prefer something as opposed to waitlist.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to impact applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	
Interventions	
Comparators	Less applicable because this is waitlist as opposed to usual care.
Outcomes	Response is a low threshold for improvement.
Timing or Time frame	
Settings	

Notes/Comments:

Arean et al., 1993, p. 1004

"

Criteria for inclusion in the study involved (a) meeting the RDC requirements for a diagnosis of unipolar, major depressive disorder; (b) scores of 20 or greater on the BDI and 10 or greater on the GDS on both the screening and pretreatment evaluations; (c) HRSD scores of 18 and above; and (d) meeting the age of 55 years or older, not exceeding 80 years. Exclusionary criteria included a diagnosis of bipolar disorder, psychosis, dementia, depression secondary to a physical disorder (e.g., hypothyroidism; not simply a reaction to physical illness), borderline or antisocial personality disorder, active substance, or current involvement in psychological or pharmacological treatment for depression. "

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: GDPs should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
X	***Conditional*** *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

We suggest using group pst over waitlist when both being considered.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

While effect size in current study was large, the small sample size and lack of information on harms/burdens and limited outcome measure reduced confidence in the findings.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the GDP members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**<u>Strong</u> <u>for</u> using**	**<u>Conditional</u> <u>for</u> using**	**No Recommendation**	**<u>Conditional</u> <u>against</u> using**	**<u>Strong</u> <u>against</u> using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version 6/26/14)
Topic # 33- Problem-solving therapy (in-person) compared to attention control (phone call) for treating dysthymia or major depressive disorder adults aged 50 years or older

Factor	Explanation/Comments
II. Aggregate/Global Strength of Evidence (SOE) (from evidence profiles)	
II. Treatment Outcomes/Consequences • **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of Treatment *(Note- do not include financial cost)*	
Balance of Benefits and Harms/Burdens of Treatment	
XIX. Patient Values and Preferences	

XX. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 33- Problem-solving therapy (in-person) compared to attention control (phone call) for treating dysthymia or major depressive disorder adults aged 50 years or older

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., When magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness))			X	
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness))			X	
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness))			X	
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness))			X	
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness))			X	
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness))			X	
Response (follow up: 12 weeks; assessed with: HAMD (50% or greater reduction))			X	
Outcomes for which no studies were found: remission, quality of life, patient satisfaction, relapse, suicidality, serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only). **Global SOE Grade:** ☐High ☐Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Choi et al., 2013

		№ of patients		Effect		Quality
№ of studies		**problem-solving therapy (in-person)**	**attention control (phone call)**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness)); based on ITT analysis						
1	See Footnote #1	42	36	-	MD 0.3 lower (8.02 lower to 7.42 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness)); based on ITT analysis						
1	See Footnote #1	42	36	-	MD 2.41 higher (8.12 lower to 12.94 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness)); based on ITT analysis						
1	See Footnote #1	42	36	-	MD 0.56 higher (4.6 lower to 5.72 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness)); based on ITT analysis						
1	See Footnote #1	42	36	-	MD 0.58 higher (6.19 lower to 7.35 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness)); based on ITT analysis						
1	See Footnote #1	42	36	-	MD 0.85 lower (5.4 lower to 3.7 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness)); based on ITT analysis						
1	See Footnote #1	42	36	-	MD 2.88 higher (2.3 lower to 8.06 higher)	⊕⊕◯◯ LOW

Response (follow up: 12 weeks; assessed with: HAMD (50% or greater reduction)); based on ITT analysis						
1	See Footnote #1	14/42 (33.3%)	8/36 (22.2%)	**RR 1.50** (0.71 to 3.16)	111 more per 1000 (from 64 fewer to 480 more)	⊕⊕◯◯ LOW
Remission						
				not estimable	not estimable	
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Number needed to treat (NNT) (95% Confidence Interval)
Response (follow up: 12 weeks; assessed with: HAMD (50% or greater reduction)): NNT = 9 (NNT(harm) 12 to ∞ to NNT(benefit) 3)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness))			X			
2. Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness))			X			
3. Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness))			X			
4. Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness))			X			
5. Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness))			X			
6. Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness))			X			
7. Response (follow up: 12 weeks; assessed with: HAMD (50% or greater reduction))			X			

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

References for harms/burdens published studies: *Choi et al (2013)*

Harm

- Dropout: 16.7% *(7 of 42)* in-person PST v. 8.3% *(3 of 36)* attention control
- Reasons for dropout: deterioration of health that resulted in hospitalization, nursing home placement or death; noncompliance; moved to another area
- Sample of PST sessions reviewed for treatment adherence; in attention control, a sample of progress notes were reviewed for fidelity

Note any other information on burdens from published studies:

References for harms/burdens published studies: *Choi et al (2013); Gellis et al (2008, 2010); Williams et al (2000)*

Burden

- Individuals were homebound and low income
- PST conducted by 2 master's-level social workers
- 6 weekly, 60-minute sessions for PST
- Attention control received 6 weekly, 30-min support calls from 2 other master's level social workers not trained in PST

Other studies:
Gellis et al (2008, 2010); Williams et al (2000)

- Dropout: 15.7% (*30 of 191*) PST v. 7.4% (*4 of 54)* UC
- Burden/Reasons for dropout: In Williams et al (2000), 3% (*n* = 4) dropped out because the treatment was "inconvenient" and an additional individual dropped out because he/she preferred an alternative treatment
- In Gellis et al (2008, 2010) –PST was delivered by PhD-level clinical social workers; participants received an average of 6 sessions; PST includes homework

Note any additional information on harms:

	No additional. **Note any additional information on burdens:** Lower burden for in-home care vs. other interventions (do not have to travel). Versus phone care not a significant burden difference.

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
8. Adverse events leading to withdrawals			o	o	o	X
9. Other serious adverse events			o	o	o	X
10. Other adverse events			o	o	o	X
11. Burdens			o	X	o	o

Assign an overall global rating across outcomes:

☐Benefits clearly outweigh harms/ burden
☐Benefits slightly outweigh harms/ burden
X Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments:

III) Patient Values and Preferences

What are the typical patient values and preferences?

How variable are these?

How certain is the GDP about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

Raue et al (2012): "*Objective:* The authors hypothesized that the depression treatment preferences of elderly home care patients would vary by depression experience, with preferences for active treatments being associated with current depression and antidepressant treatment. *Methods:* The authors conducted **cross sectional secondary analyses of the TRIAD ("Training in the Assessment of Depression") study of 256 randomly selected elderly patients newly admitted to homecare.** The study assessed depression treatment preference for active (i.e., medication or psychotherapy) versus non-active or complementary approaches (e.g., religious activities, do nothing). Two separate indicators of depression experience were used: diagnoses of major or minor depression, and current or previous antidepressant treatment. *Results:* **121 patients (48%) preferred active treatment with either medication or psychotherapy as their first choice, while the remainder preferred non-active or complementary approaches. Logistic regression indicated that current antidepressant use, previous psychotherapy experience, white and Hispanic versus African-American patients, greater IADL impairment, and less personal stigma about depression were independently associated with preference for an active treatment.** *Conclusions:* Elderly homecare patients have a variety of depression treatment preferences ranging from active treatments, to religious or spiritual activities, to no treatment. **Several factors were associated with a preference for active treatment, including treatment experience, co-existing physical impairment, culture, and attitudes and beliefs.** Understanding patient preferences may form the basis of engaging older depressed home care patients in treatment."

In Gellis et al (2008, 2010) – "participants who received PST were more satisfied than UC"

Information from community members on panel:

Information from clinicians on panel:

Some people like PST because it is active and directive. Some people prefer what provided in attention control because they can chat about what it is on their minds. The attention control included active components such as empathy and support.

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High		High
X	Moderate	X	Moderate
	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

X Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Clients have a range of preferences, some prefer structured and some prefer unstructured therapy.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to impact applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Low-income homebound older adults.
Interventions	
Comparators	Active comparator
Outcomes	
Timing or Time frame	
Settings	

Notes/Comments:

Choi et al., 2013

"Case managers at a large Meals on Wheels program and other agencies serving low-income homebound adults in central Texas referred to the project homebound adults who met the following inclusion criteria: age 50 years or older and English speaking, with depressive symptoms as identified by either a score of 10 or higher on the Patient Health Questionnaire (PHQ-9; Kroenke & Spitzer, 2002) or upon the case managers' clinical impressions.

…Study participants at baseline were between ages 50 and 89 years (31.4% between 50 and 59 years, 39.7% between 60 and 69 years, 19.8% between 70 and 79 years, and 9.1% between 80 and 89 years); 77.7% were female; 58.7% were Black or Hispanic; 84.3% had annual family income of $25,000 or less; 67%met theDSM-IV-Rdiagnostic criteria for major depressive disorder (25.6% single episode and 41.4% recurrent episode); and 59.5% reported that they had used mental health services in the preceding 12 months for depression, anxiety, or both."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: GDPs should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
X	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

No recommendation due to no evidence of a comparative effect.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

No recommendation due to no evidence of a comparative effect. Not clear where the treatment was delivered (home or transported to clinic).

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the GDP members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version 6/26/14)
Topic # 34- Problem-solving therapy (video call) compared to attention control (phone call) for treating dysthymia or major depressive disorder adults aged 50 years or older

Factor	Explanation/Comments
XI. Aggregate/Global Strength of Evidence (SOE) (from evidence profiles)	
II. Treatment Outcomes/Consequences • **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of Treatment *(Note- do not include financial cost)*	
Balance of Benefits and Harms/Burdens of Treatment	
XIII. Patient Values and Preferences	

XIV. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 34- Problem-solving therapy (video call) compared to attention control (phone call) for treating dysthymia or major depressive disorder adults aged 50 years or older

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., When magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness))			X	
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness))			X	
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness))			X	
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness))			X	
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness))			X	
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness))			X	
Response (follow up: 12 weeks; assessed with: HAMD (50% or greater reduction))			X	
Outcomes for which no studies were found: remission, quality of life, patient satisfaction, relapse, suicidality, serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only). **Global SOE Grade:** ☐High ☐Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Choi et al., 2013

		№ of patients		Effect		Quality
№ of studies		**problem-solving therapy (video call)**	**attention control (phone call)**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness)); based on ITT analysis						
1	See footnote #1	43	36	-	MD 0.99 lower (9.44 lower to 7.46 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness)); based on ITT analysis						
1	See footnote #1	43	36	-	MD 0.82 lower (11.38 lower to 9.74 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness)); based on ITT analysis						
1	See footnote #1	43	36	-	MD 0.38 higher (5.12 lower to 5.88 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness)); based on ITT analysis						
1	See footnote #1	43	36	-	MD 1.51 lower (8.36 lower to 5.34 higher)	⊕⊕◯◯ LOW
Functional Capcity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness)); based on ITT analysis						
1	See footnote #1	43	36	-	MD 1.37 lower (6.18 lower to 3.44 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness)); based on ITT analysis						
1	See footnote #1	43	36	-	MD 1.74 higher (3.53 lower to 7.01 higher)	⊕⊕◯◯ LOW
Response (follow up: 12 weeks; assessed with: HAMD (50% or greater reduction)); based on ITT analysis						
1	See footnote #1	16/43 (37.2%)	8/36 (22.2%)	**RR 1.67** (0.81 to 3.45)	149 more per 1000 (from 42 fewer to 544 more)	⊕⊕◯◯ LOW

Remission						
				not estimable	not estimable	
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Number needed to treat (NNT) (95% Confidence Interval)
Response (follow up: 12 weeks; assessed with: HAMD (50% or greater reduction)): NNT = 7 (NNT(harm) 21 to ∞ to NNT(benefit) 2)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness))			X			o
2. Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (total resourcefulness))			X			o
3. Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness))			X			o
4. Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (personal resourcefulness))			X			o
5. Functional Capacity (follow up: 12 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness))			X			o
6. Functional Capacity (follow up: 24 weeks; assessed with: Resourcefulness Scale for Older Adults (social resourcefulness))			X			o
7. Response (follow up: 12 weeks; assessed with: HAMD (50% or greater reduction))			X			o

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

References for harms/burdens published studies: *Choi et al., (2013)*

Harm

- Dropout: 11.6% *(5 of 43)* telehealth-PST v. 8.3% *(3 of 36)* attention control
- Reasons for dropout: deterioration of health that resulted in hospitalization, nursing home placement or death; noncompliance
- Sample of PST sessions reviewed for treatment adherence; in attention control, a sample of progress notes were reviewed for fidelity

Note any other information on burdens from published studies:

References for harms/burdens published studies: *Choi et al (2013); Choi et al (2014) – same trial as Choi et al (2013)*

Burden

- Individuals were homebound and low income
- PST conducted by 2 master's-level social workers
- 6 weekly, 60-minute sessions for PST
- Attention control received 6 weekly, 30-min support calls from 2 other master's level social workers not trained in PST

Other studies:

Choi et al (2014) – ***same trial as Choi et al (2013) above***

- **Burden**
  - "Despite initial skepticism, almost all participants had extremely positive attitudes toward tele-PST" at follow-up
  - Tele-PST involved videoconferencing (Skype) for sessions 2 - 6
  - Laptops were provided to participants
  - One tele-PST participant stated she was unable to maintain privacy as family members would come in the room during her Skype sessions

Note any additional information on harms:

No additional.

Note any additional information on burdens:

No additional.

Next, list and rate each harm/burden :

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
8. Adverse events leading to withdrawals			o	o	o	X
9. Other serious adverse events			o	o	o	X
10. Other adverse events			o	o	o	X
11. Burdens			X	o	o	o

Assign an overall global rating across outcomes:

☐Benefits clearly outweigh harms/ burden
☐Benefits slightly outweigh harms/ burden
X Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments:

III) Patient Values and Preferences *What are the typical patient values and preferences?* *How variable are these?* *How certain is the GDP about these?* **Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*	**Patient values and preferences based on:** *Information from research studies:* *[Possible studies to include from APA staff search of pt values and preferences studies]:* [None relevant] Some research found that video conferencing acceptable to patients. *Information from community members on panel:* *Information from clinicians on panel:* Video includes a convenience factor. Some patients do not trust technology and are concerned about privacy issues. *Information from other sources (also list sources):*

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High		High
X	Moderate	X	Moderate
	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

X Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Clients have a range of preferences, some prefer structured and some prefer unstructured therapy.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to impact applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Access to technology. Low-income homebound older adults.
Interventions	Access to technology
Comparators	Active comparator
Outcomes	
Timing or Time frame	
Settings	

Notes/Comments:

Choi et al., 2013

"Case managers at a large Meals on Wheels program and other agencies serving low-income homebound adults in central Texas referred to the project homebound adults who met the following inclusion criteria: age 50 years or older and English speaking, with depressive symptoms as identified by either a score of 10 or higher on the Patient Health Questionnaire (PHQ-9; Kroenke & Spitzer, 2002) or upon the case managers' clinical impressions.

…Study participants at baseline were between ages 50 and 89 years (31.4% between 50 and 59 years, 39.7% between 60 and 69 years, 19.8% between 70 and 79 years, and 9.1% between 80 and 89 years); 77.7% were female; 58.7% were Black or Hispanic; 84.3% had annual family income of $25,000 or less; 67%met theDSM-IV-Rdiagnostic criteria for major depressive disorder (25.6% single episode and 41.4% recurrent episode); and 59.5% reported that they had used mental health services in the preceding 12 months for depression, anxiety, or both."

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: GDPs should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
X	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

No recommendation due to no evidence of a comparative effect.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

No recommendation due to no evidence of a comparative effect. Technology could be an additional barrier or additional convenience.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the GDP members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version 6/26/14)
Topic # 35- A combination of interpersonal psychotherapy (individual) and nortriptyline compared to a combination of placebo and medication clinic attendance for treating major depressive disorder in adults ages 50 and older

Factor	Explanation/Comments
V. Aggregate/Global Strength of Evidence (SOE) (from evidence profiles)	
VI. Treatment Outcomes/Consequences • **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of Treatment *(Note- do <u>not</u> include financial cost)*	
Balance of Benefits and Harms/Burdens of Treatment	
VII. Patient Values and Preferences	

VIII. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 35- A combination of interpersonal psychotherapy (individual) and nortriptyline compared to a combination of placebo and medication clinic attendance for treating major depressive disorder in adults ages 50 and older

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., When magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Remission (follow up: 8 weeks; assessed with: HAMD <= 7 for 3 consecutive weeks)			X	
Outcomes for which no studies were found: functional capacity, response, quality of life, patient satisfaction, relapse, suicidality, serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only). **Global SOE Grade:** ☐High ☐Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Reynolds et al., 1999

		№ of patients		Effect		Quality
№ of studies		**a combination of interpersonal psychotherapy (individual) and nortriptyline**	**a combination of placebo and medication clinic attendance**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response						
				not estimable	not estimable	
Remission (follow up: 8 weeks; assessed with: HAMD <= 7 for 3 consecutive weeks); based on ITT analysis						
1	See footnote #1	11/16 (68.8%)	10/22 (45.5%)	RR 1.51 (0.86 to 2.66)	232 more per 1000 (from 64 fewer to 755 more)	⊕⊕◯◯ LOW
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

[Number needed to treat is 5 (4.29) per Pim]

Number needed to treat (NNT) (95% Confidence Interval)

Remission (follow up: 8 weeks; assessed with: HAMD <= 7 for 3 consecutive weeks); based on ITT analysis: NNT = 4 (NNT(harm) 14 to ∞ to NNT(benefit) 1)

Next, list and rate each benefit from the evidence profile information:
Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Remission (follow up: 8 weeks; assessed with: HAMD <= 7 for 3 consecutive weeks)						x

[With a relatively small sample and the RR crosses 1, panel opts for unable to rate. Otherwise, would rate no effect.]
[This may have more to do with uncertainty than clinical effect.]

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

References for harms/burdens published studies: *Reynolds et al (1999*); *Reynolds et al (2010)* – IPT + escitalopram

Harm

- Dropout: 0% *(0 of 16)* IPT + N v. 18.2% *(4 of 22)* P + MC
- Adverse effects: No one in the IPT + N group reported side effects; 8% (*n* = 1) of the P + MC group reported side effects as a reason for dropping out
    - 25% (*n* = 3) of individuals in the P + MC group dropped out due to refusing treatment
- Treatment adherence: "The psychotherapists were trained to and maintained at research levels of proficiency in interpersonal psychotherapy by two of the co-investigators (E.F. and C.C.)"; sessions were audiotaped and reviewed for treatment integrity and compliance

Other studies:
Reynolds et al (2010) – IPT + escitalopram

- Dropout: 11.7% (*7 of 60*) IPT + E
- Reason for dropout: nonresponse (*n* = 3), withdrew consent (*n* = 4)
- Adverse events: one subject left trial due to persistent hyponatremia before randomization

Note any other information on burdens from published studies:

References for harms/burdens published studies: *Reynolds et al (1999); Reynolds et al (2010)* – IPT + escitalopram

Burden

- Medication clinic included weekly visits but "no specific psychotherapy"
- IPT delivered in weekly, 50-min sessions with "experienced clinicians" (two master of social work, one master of education, and one doctoral-level clinical psychologist)
    - Mean number of IPT + N sessions = 9.3
- Same clinicians provided either medication clinic treatment or interpersonal psychotherapy depending on random assignment

Other studies:

Reynolds et al (2010) – IPT + escitalopram

- 16 weekly sessions; in both tx arms, 60% of participants reported missing less than one dose weekly;
- IPT visits lasted 60-75 min and included manualized IPT and DCM
- treatment delivered by mental health specialists in primary care (i.e., nurses, social workers and psychologists)
- treatment fidelity was documented

Note any additional information on harms:

Note any additional information on burdens:

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
2. Adverse events leading to withdrawals						x
3. Other serious adverse events						x
4. Other adverse events						x
5. Burdens				x		

Assign an overall global rating across outcomes:

☐Benefits clearly outweigh harms/ burden
X Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments:

Benefits likely outweigh harms/burden as the numbers needed to treat suggest a benefit relative to the slight burden of the intervention.

III) Patient Values and Preferences

What are the typical patient values and preferences?

How variable are these?

How certain is the GDP about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

[Possible studies to include from APA staff search of pt values and preferences studies]:

-**Kitchen et al (2013): "**The purpose of this study was **to investigate depression treatment preferences and anticipated service use in a sample of adults aged 55 years or older who reside in rural Wyoming.** Sixteen participants (mean age = 59) completed 30- to 60-minute, semi-structured interviews. Qualitative methods were used to characterize common themes. Social/provider support and community gatekeepers were perceived by participants as important potential facilitators for seeking depression treatment. In contrast, perceived stigma and the value placed on self-sufficiency emerged as key barriers to seeking treatment for depression in this rural, young-old sample. **Participants anticipated presenting for treatment in the primary care sector and preferred a combination of medication and psychotherapy for treatment.** Participants were, however, more willing to see mental health professionals if they were first referred by a clergy member or primary care physician."

-**Steidtmann et al (2012):** "Background: Findings regarding the relationship between patient treatment preference and treatment outcome are mixed. **This is a secondary data analysis investigating the relationship between treatment preference, and symptom outcome and attrition in a large 2-phase depression treatment trial.** Methods: Patients met DSM-IV criteria for chronic forms of depression. Phase I was a 12-week, nonrandomized, open-label trial in which all participants (n=785) received antidepressant medication(s) (ADM). Phase I non-remitters were randomized to Phase II, in which they received 12 weeks of either Cognitive-Behavioral System of Psychotherapy (CBASP) + ADM (n=193), Brief Supportive Psychotherapy (BSP) + ADM (n=187), or ADM only (n=93). **Participants indicated their treatment preference (medication only, combined treatment or no preference) at study entry.** Symptoms were measured at 2-week intervals with the 24-item Hamilton Rating Scale for Depression (HAM-D). Results: **A large majority of patients reported a preference for combined treatment. Patients who preferred medication only were more likely to endorse a chemical imbalance explanation for depression, whereas those desiring combined treatment were more likely to attribute their depression to stressful experiences.** In Phase I, patients who expressed no treatment preference showed greater rates of HAM-D symptom reduction than those with any preference, and patients with a preference for medication showed higher attrition than those preferring combined treatment. In Phase II, baseline treatment preference was not associated with symptom reduction or attrition. Conclusions: Treatment preferences may moderate treatment response and attrition in unexpected ways. Research identifying factors associated with differing preferences may enable improved treatment retention and response."

Information from community members on panel:

Information from clinicians on panel:

Patients seem to really like IPT.

Information from other sources (also list sources):

In general, data suggest that African/American and Latino populations are less likely to endorse a biological explanation of depression than white populations suggesting they are also less likely to prefer medication treatment (panel member).

Also, the two studies noted above do not appear to offer psychotherapy alone as an option for gauging preferences.

Patients seem to like IPT for real-life problems such as bereavement (this study), role transitions and interpersonal or role conflict.

Moderate variability in preferences, note that preferences may vary across racial or ethnic groups

Highly certain about moderate variability

Select middle option of moderate variability or some uncertainty

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High	X	High
X	Moderate		Moderate
	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

X Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to impact applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Bereavement related depression; most participants were white females
Interventions	Nortriptyline was a mainstay of psychopharm tx when study was conducted; other medications more likely prescribed now
Comparators	
Outcomes	
Timing or Time frame	
Settings	Research mental health specialty clinic; not primary care

Notes/Comments:
Reynolds et al., 1999

"To be included in the study, potential subjects were required to meet the criteria of the Schedule for Affective Disorders and Schizophrenia— Lifetime Version (SADS-L) (15) and the Research Diagnostic Criteria (RDC) (16) for a definite current major depressive episode (nonpsychotic and nonbipolar, with no history of chronic intermittent depression or dysthymia). Forty-eight subjects were diagnosed with the SADS-L and 32 with the Structured Clinical Interview for DSM-IV (17), which replaced the SADS-L as our primary diagnostic instrument in 1996. The onset of the episode was required to fall in the period between 6 months before the death of the spouse and 12 months after the death. Episodes could be either single or recurrent. No other diagnoses, with the exception of generalized anxiety disorder, panic disorder, and posttraumatic stress disorder, were allowed. Diagnostic reliability was ensured through the use of a structured diagnostic assessment together with independent clinical confirmation by a senior psychiatrist (M.D.M., R.E.P.). A bereavement intensity score of 45 or more on the Texas Revised Inventory of Grief (18) was required as an indication of active grieving.

Most subjects were white female outpatients with mild to moderate episodes of major depression and some associated functional impairment. Most were in their 60s; however, the group randomly assigned to medication clinic, placebo, was significantly younger than the other groups. About two-thirds of the total study group

	reported that they were in their first lifetime episode of major depression, and a substantial minority reported either suicidal ideation (17%) or a history of suicide attempts (11%). About one-half the study group met the RDC or DSM-IV criteria for definitely endogenous or melancholic episodes. Typically, subjects had lost a spouse or significant other 7– 9 months earlier (median=32 weeks, with no difference between treatment groups). The treatment groups did not differ significantly on measures of bereavement intensity (Texas Revised Inventory of Grief [18], Grief Measurement Scale [19, 20], and Inventory of Complicated Grief [21]). There was also no significant difference in depression severity (Hamilton Depression Rating Scale [22]), cognitive impairment (Mini-Mental State [23]), or the Brief Symptom Inventory (24) measure of anxiety. Because the groups differed in age, as noted above, age was used as a covariate in the major outcome analysis. The distribution of all other demographic, bereavement, and clinical measures was equal among the groups.”

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: GDPs should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
X	***Conditional*** *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

We suggest using IPT + nortriptyline relative to placebo + supported medication clinic for individuals with bereavement related depression.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

While the panel determined unable to rate in terms of the outcome, the panel also noted there was likely benefit of the intervention. The estimated number to treat of 5 constituted some evidence for the benefit yet confidence was circumscribed. In addition, sources suggest that patients do prefer combination or psychotherapy to medication alone, particularly for depression related to real life problems such as bereavement or role conflict.

[With a relatively small sample and the RR crosses 1, panel opts for unable to rate. Otherwise, would rate no effect.]
[This may have more to do with uncertainty than clinical effect.]

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the GDP members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version 6/26/14)
Topic # 36- A combination of interpersonal psychotherapy (individual) and placebo compared to a combination of placebo and medication clinic attendance for treating major depressive disorder in adults ages 50 and older

Factor	Explanation/Comments
X. Aggregate/Global Strength of Evidence (SOE) (from evidence profiles)	
X. Treatment Outcomes/Consequences	
• **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of Treatment *(Note- do not include financial cost)*	
Balance of Benefits and Harms/Burdens of Treatment	
XXI. Patient Values and Preferences	

XII. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 36- A combination of interpersonal psychotherapy (individual) and placebo compared to a combination of placebo and medication clinic attendance for treating major depressive disorder in adults ages 50 and older

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., When magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Remission (follow up: 8 weeks; assessed with: HAMD <= 7 for 3 consecutive weeks)			X	
Outcomes for which no studies were found: functional capacity, response, quality of life, patient satisfaction, relapse, suicidality, serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only). **Global SOE Grade:** ☐High ☐Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Reynolds et al., 1999

		№ of patients		Effect		Quality
№ of studies		**a combination of interpersonal psychotherapy (individual) and placebo**	**a combination of placebo and medication clinic attendance**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				not estimable	not estimable	
Response						
				not estimable	not estimable	
Remission (follow up: 8 weeks; assessed with: HAMD <= 7 for 3 consecutive weeks); based on ITT analysis						
1	See footnote #1	10/22 (45.5%)	5/17 (29.4%)	RR 0.65 (0.27 to 1.54)	103 fewer per 1000 (from 159 more to 215 fewer)	⊕⊕◯◯ LOW
Quality of Life						
				not estimable	not estimable	
Patient Satisfaction						
				not estimable	not estimable	
Relapse						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1- Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference. [Number needed to treat estimate is 7 (6.2) - consistent with a small but clinically meaningful effect]

Number needed to treat (NNT) (95% Confidence Interval)

Response (follow up: 3 months; assessed with: Beck Depression Inventory (>=50% reduction)): NNT = 6 (NNT(harm) 8 to ∞ to NNT(benefit) 2)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Remission (follow up: 8 weeks; assessed with: HAMD <= 7 for 3 consecutive weeks)						x

[With a relatively small sample and the RR crosses 1, panel opts for unable to rate. Otherwise, would rate no effect.] [This may have more to do with uncertainty than clinical effect.]

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

References for harms/burdens published studies: *Reynolds et al., 1999*

Harm

- Dropout: 17.6% *(3of 17)* IPT + P v. 18.2% *(4 of 22)* P + MC
- Adverse effects: No one in the IPT + P group reported side effects; 8% (*n* = 1) of the P + MC group reported side effects as a reason for dropping out
    - 25% (*n* = 3) of individuals in the P + MC group dropped out due to refusing treatment
    - 8% (*n* = 1) of the IPT + P group dropped out due to treatment refusal; 17% (*n* = 2) dropped out due to medical problems
- Treatment adherence: "The psychotherapists were trained to and maintained at research levels of proficiency in interpersonal psychotherapy by two of the co-investigators (E.F. and C.C.)."; sessions were audiotaped and reviewed for treatment integrity and compliance

Other studies:
None

Note any other information on burdens from published studies:

References for harms/burdens published studies: *Reynolds et al., 1999*

Burden

- Medication clinic included weekly visits but "no specific psychotherapy"
- IPT delivered in weekly, 50-min sessions with "experienced clinicians" (two master of social work, one master of education, and one doctoral-level clinical psychologist)
    - Mean number of IPT + P sessions = 6.2
- Same clinicians provided either medication clinic treatment or interpersonal psychotherapy depending on random assignment

Note any additional information on harms:

Note any additional information on burdens:

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
2. Adverse events leading to withdrawals						X
3. Other serious adverse events						X
4. Other adverse events						x
5. Burdens				x		

Assign an overall global rating across outcomes:

☐Benefits clearly outweigh harms/ burden
X Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments: Benefits likely outweigh harms/burden as the numbers needed to treat suggest a benefit relative to the slight burden of the intervention.

III) Patient Values and Preferences

What are the typical patient values and preferences?

How variable are these?

How certain is the GDP about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

[Possible studies to include from APA staff search of pt values and preferences studies]:

-**Kitchen et al (2013): "**The purpose of this study was **to investigate depression treatment preferences and anticipated service use in a sample of adults aged 55 years or older who reside in rural Wyoming.** Sixteen participants (mean age = 59) completed 30- to 60-minute, semi-structured interviews. Qualitative methods were used to characterize common themes. Social/provider support and community gatekeepers were perceived by participants as important potential facilitators for seeking depression treatment. In contrast, perceived stigma and the value placed on self-sufficiency emerged as key barriers to seeking treatment for depression in this rural, young-old sample. **Participants anticipated presenting for treatment in the primary care sector and preferred a combination of medication and psychotherapy for treatment.** Participants were, however, more willing to see mental health professionals if they were first referred by a clergy member or primary care physician."

-**Steidtmann et al (2012):** "Background: Findings regarding the relationship between patient treatment preference and treatment outcome are mixed. **This is a secondary data analysis investigating the relationship between treatment preference, and symptom outcome and attrition in a large 2-phase depression treatment trial.** Methods: Patients met DSM-IV criteria for chronic forms of depression. Phase I was a 12-week, nonrandomized, open-label trial in which all participants (n=785) received antidepressant medication(s) (ADM). Phase I non-remitters were randomized to Phase II, in which they received 12 weeks of either Cognitive-Behavioral System of Psychotherapy (CBASP) + ADM (n=193), Brief Supportive Psychotherapy (BSP) + ADM (n=187), or ADM only (n=93). **Participants indicated their treatment preference (medication only, combined treatment or no preference) at study entry.** Symptoms were measured at 2-week intervals with the 24-item Hamilton Rating Scale for Depression (HAM-D). Results: **A large majority of patients reported a preference for combined treatment. Patients who preferred medication only were more likely to endorse a chemical imbalance explanation for depression, whereas those desiring combined treatment were more likely to attribute their depression to stressful experiences.** In Phase I, patients who expressed no treatment preference showed greater rates of HAM-D symptom reduction than those with any preference, and patients with a preference for medication showed higher attrition than those preferring combined treatment. In Phase II, baseline treatment preference was not associated with symptom reduction or attrition. Conclusions: Treatment preferences may moderate treatment response and attrition in unexpected ways. Research identifying factors associated with differing preferences may enable improved treatment retention and response."

	Information from community members on panel: *Information from clinicians on panel:* Patients seem to really like IPT. *Information from other sources (also list sources):* In general, data suggest that African/American and Latino populations are less likely to endorse a biological explanation of depression than white populations suggesting they are also less likely to prefer medication treatment (panel member). Also, the two studies noted above do not appear to offer psychotherapy alone as an option for gauging preferences. Patients seem to like IPT for real-life problems such as bereavement (this study), role transitions and interpersonal or role conflict. *Moderate variability in preferences, note that preferences may vary across racial or ethnic groups* *Highly certain about moderate variability* *Select middle option of moderate variability or some uncertainty*

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High	X	High
X	Moderate		Moderate
	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

X Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to impact applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Bereavement related depression; most participants were white females. Study done in accordance with DSM-IV 2 month exclusion criterion for bereavement; exclusion criterion not in place with DSM-5.
Interventions	Nortriptyline was a mainstay of psychopharm tx when study was conducted; other medications more likely prescribed now (study was double blind)
Comparators	
Outcomes	
Timing or Time frame	
Settings	Research mental health specialty clinic; not primary care

Notes/Comments:
Reynolds et al., 1999

"To be included in the study, potential subjects were required to meet the criteria of the Schedule for Affective Disorders and Schizophrenia— Lifetime Version (SADS-L) (15) and the Research Diagnostic Criteria (RDC) (16) for a definite current major depressive episode (nonpsychotic and nonbipolar, with no history of chronic intermittent depression or dysthymia). Forty-eight subjects were diagnosed with the SADS-L and 32 with the Structured Clinical Interview for DSM-IV (17), which replaced the SADS-L as our primary diagnostic instrument in 1996. The onset of the episode was required to fall in the period between 6 months before the death of the spouse and 12 months after the death. Episodes could be either single or recurrent. No other diagnoses, with the exception of generalized anxiety disorder, panic disorder, and posttraumatic stress disorder, were allowed. Diagnostic reliability was ensured through the use of a structured diagnostic assessment together with independent clinical confirmation by a senior psychiatrist (M.D.M., R.E.P.). A bereavement intensity score of 45 or more on the Texas Revised Inventory of Grief (18) was required as an indication of active grieving.

Most subjects were white female outpatients with mild to moderate episodes of major depression and some associated functional impairment. Most were in their 60s; however, the group randomly assigned to medication clinic, placebo, was significantly younger than the other groups. About two-thirds of the total study group

	reported that they were in their first lifetime episode of major depression, and a substantial minority reported either suicidal ideation (17%) or a history of suicide attempts (11%). About one-half the study group met the RDC or DSM-IV criteria for definitely endogenous or melancholic episodes. Typically, subjects had lost a spouse or significant other 7– 9 months earlier (median=32 weeks, with no difference between treatment groups). The treatment groups did not differ significantly on measures of bereavement intensity (Texas Revised Inventory of Grief [18], Grief Measurement Scale [19, 20], and Inventory of Complicated Grief [21]). There was also no significant difference in depression severity (Hamilton Depression Rating Scale [22]), cognitive impairment (Mini-Mental State [23]), or the Brief Symptom Inventory (24) measure of anxiety. Because the groups differed in age, as noted above, age was used as a covariate in the major outcome analysis. The distribution of all other demographic, bereavement, and clinical measures was equal among the groups.”

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: GDPs should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
X	***Conditional*** *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

We suggest using IPT + placebo relative to placebo + supported medication clinic (clinical management) for individuals with bereavement related depression.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

While the panel determined unable to rate in terms of the outcome, the panel also noted there was likely benefit of the intervention. The estimated number to treat of 7 constituted some evidence for the benefit yet confidence was circumscribed. In addition, sources suggest that patients do prefer combination or psychotherapy to medication alone, particularly for depression related to real life problems such as bereavement or role conflict.

[With a relatively small sample and the RR crosses 1, panel opts for unable to rate. Otherwise, would rate no effect.]
[This may have more to do with uncertainty than clinical effect.]

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the GDP members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 37- Multicomponent intervention (individual) compared to wait list for treating symptoms of depression in temporarily homebound African-American adults ages 55 and older

Factor	Explanation/Comments
II. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
V. Treatment Outcomes/Consequences • **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of the Treatment *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens of Treatment	
XV. Patient Values and Preferences	
XVI. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 37- Multicomponent intervention (individual) compared to wait list for treating symptoms of depression in temporarily homebound African-American adults ages 55 and older

Factor	Summary of Reasons for Judgment/ Evidence

I) Aggregate Strength of Evidence (SOE) (from evidence profiles)

What is the global strength/quality of the evidence?

**Note:*

- The higher the SOE, the more likely a strong recommendation is warranted.

-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).

Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Functional Capacity (follow up: 4 months; assessed with: 18 item-questionnaire over past month, response ranging from 1 [no difficulty] to 5 [unable to perform])			X	
Functional Capacity (follow up: 8 months; assessed with: 18 item-questionnaire over past month, response ranging from 1 [no difficulty] to 5 [unable to perform])			X	
Response (follow up: 4 months; assessed with: PHQ-9 (>=5 point reduction))		X		
Response (follow up: 4 months; assessed with: PHQ-9 (moved to lower symptom category))			X	
Remission (follow up: 4 months; assessed with: PHQ-9 (<=4, time period without symptoms not specified))			X	
Remission (follow up: 4 months; assessed with: CES-D (<=7, time period without symptoms not specified))		X		
Quality of Life (follow up: 4 months; assessed with: 12 items of the Quality of Life in Alzheimer's Disease scale with 1 item, "relationship with caregiver," eliminated)		X		
Quality of Life (follow up: 8 months; assessed with: 12 items of the Quality of Life in Alzheimer's Disease scale with 1 item, "relationship with caregiver," eliminated)			X	
Outcomes for which no estimable information was found: patient satisfaction, relapse, recurrence, suicidality, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Gitlin et al., 2013

		№ of patients		Effect		Quality
№ of studies		**multicomponent intervention (individual)**	**wait list**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity (follow up: 4 months; assessed with: 18 item-questionnaire over past month, response ranging from 1 [no difficulty] to 5 [unable to perform]); based on ITT analysis						
1	See Footnote #1	106	102	-	MD 0.1 fewer (0.27 fewer to 0.07 more)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 8 months; assessed with: 18 item-questionnaire over past month, response ranging from 1 [no difficulty] to 5 [unable to perform]); based on ITT analysis						
1	See Footnote #1	106	102	-	MD 0.2 more (0.08 fewer to 0.48 more)	⊕⊕◯◯ LOW
Response (follow up: 4 months; assessed with: PHQ-9 (>=5 point reduction)); based on ITT analysis						
1	See Footnote #2	57/106 (53.8%)	38/102 (37.3%)	**RR 1.44** (1.06 to 1.96)	164 more per 1000 (from 22 more to 358 more)	⊕⊕⊕◯ MODERATE
Response (follow up: 4 months; assessed with: PHQ-9 (moved to lower symptom category)); based on ITT analysis						
1	See Footnote #1	68/106 (64.2%)	58/102 (56.9%)	**RR 1.13** (0.90 to 1.41)	74 more per 1000 (from 57 fewer to 233 more)	⊕⊕◯◯ LOW
Remission (follow up: 4 months; assessed with: PHQ-9 (<=4, time period without symptoms not specified)); based on ITT analysis						
1	See Footnote #1	39/106 (36.8%)	25/102 (24.5%)	**RR 1.50** (0.98 to 2.29)	123 more per 1000 (from 5 fewer to 316 more)	⊕⊕◯◯ LOW

Remission (follow up: 4 months; assessed with: CES-D (<=7, time period without symptoms not specified)); based on ITT analysis						
1	See Footnote #2	46/106 (43.4%)	24/102 (23.5%)	**RR 1.84** (1.22 to 2.78)	198 more per 1000 (from 52 more to 419 more)	⊕⊕⊕◯ MODERATE
Quality of Life (follow up: 4 months; assessed with: 12 items of the Quality of Life in Alzheimer's Disease scale with 1 item, "relationship with caregiver," eliminated); based on ITT analysis						
1	See Footnote #2	106	102	-	MD 2.5 more (1.11 more to 3.89 more)	⊕⊕⊕◯ MODERATE
Quality of Life (follow up: 8 months; assessed with: 12 items of the Quality of Life in Alzheimer's Disease scale with 1 item, "relationship with caregiver," eliminated); based on ITT analysis						
1	See Footnote #1	106	102	-	MD 0.9 more (0.76 fewer to 2.56 more)	⊕⊕◯◯ LOW
Patient Satisfaction						
				not estimable	not estimable	
Relapse						
				not estimable	not estimable	
Recurrence						
				not estimable	not estimable	
Suicidality						
				not estimable	not estimable	
Adverse Events						
				not estimable	not estimable	

MD – mean difference, RR – relative risk

Footnote #1 - Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference
Footnote #2 - Small sample size and/or number of events, does not meet optimal information size to detect differences

Number needed to treat (NNT) (95% Confidence Interval)
Response (follow up: 4 months; assessed with: PHQ-9 (>=5 point reduction)): NNT = 6 (NNT(benefit) 3 to 31)
Response (follow up: 4 months; assessed with: PHQ-9 (moved to lower symptom category)): NNT = 14 (NNT(harm) 17 to ∞ to NNT(benefit) 4)
Remission (follow up: 4 months; assessed with: PHQ-9 (<=4, time period without symptoms not specified)): NNT = 8 (NNT(harm) 797 to ∞ to NNT(benefit) 4)
Remission (follow up: 4 months; assessed with: CES-D (<=7, time period without symptoms not specified)): NNT = 5 (NNT(benefit) 3 to 13)

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Functional Capacity (follow up: 4 months; assessed with: 18 item-questionnaire over past month, response ranging from 1 [no difficulty] to 5 [unable to perform])			X			
2. Functional Capacity (follow up: 8 months; assessed with: 18 item-questionnaire over past month, response ranging from 1 [no difficulty] to 5 [unable to perform])			X			
3. Response (follow up: 4 months; assessed with: PHQ-9 (>=5 point reduction))	X					
4. Response (follow up: 4 months; assessed with: PHQ-9 (moved to lower symptom category))			X			
5. Remission (follow up: 4 months; assessed with: PHQ-9 (<=4, time period without symptoms not specified))		X (based on NNT-summary document)				
6. Remission (follow up: 4 months; assessed with: CES-D (<=7, time period without symptoms not specified))	X					
7. Quality of Life (follow up: 4 months; assessed with: 12 items of the Quality of Life in Alzheimer's Disease scale with 1 item, "relationship with caregiver," eliminated)	X					
8. Quality of Life (follow up: 8 months; assessed with: 12 items of the Quality of Life in Alzheimer's Disease scale with 1 item, "relationship with caregiver," eliminated)			X			

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Gitlin et al (2013)

Harm

- Dropout: 16% (*17 of 106*) "Beat the Blues" tx vs. 8.8% (*9 of 102*) WL
  - Statistically significant difference in attrition rates
- Reasons for dropout: nursing home placement; moved; too ill; dissatisfied; unknown
- Symptom worsening: 6% (*n* = 5) participants worsened in the treatment condition; 12% (*n* = 11) worsened in WL
- Treatment adherence: Treatment fidelity of interviewers and interventionists was monitored by using checklists applied to randomly selected audiotaped sessions and interventionist case presentations at supervisory meetings.

Note any other information on burdens from published studies:

Burden

- Home-based intervention called "Beat the Blues" [BTB] that was "tailored to older African Americans"
- 10 1-hr sessions over a 4-month period
- Delivered by social workers
- 6% (*n* = 5) of individuals reported dropping out of treatment due to dissatisfaction

Other studies:

None

Note any additional information on harms:

Note any additional information on burdens:

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
9. Adverse events leading to withdrawals				X		
10. Other serious adverse events						X
11. Other adverse events		X				
12. Burdens				X		

Assign an overall global rating across outcomes:

X Benefits clearly outweigh harms/ burden
☐Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments:

Some variability in the benefits depending on how assessed but the overall pattern is consistent with a clear benefit outweighing harms.

III) Patient Values and Preferences

What are the typical patient values and preferences?

How variable are these?

How certain is the panel about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

Conner et al. (2010). "Attitudes and beliefs about mental health among African American older adults suffering from depression. Journal of Aging Studies.
Abstract: Depression among older adults is a major public health concern leading to increased disability and mortality. Less than 3% of older adults utilize professional mental health services for the treatment of depression, less than any other adult age group. And despite similar rates of depression, African Americans are significantly less likely to seek, engage and be retained in professional mental health services than their white counterparts. Cultural differences in the way depression symptoms are manifested, defined, interpreted and labeled may in part explain some of these racial differences in help-seeking behaviors. Focus group methodology was utilized to identify and explore attitudes and beliefs about depression and mental health treatment utilization among 42 older African Americans who had recently suffered a major depressive episode. **Thematic analysis of identified six overarching themes: (a) perceptions of depression, (b) the African American experience, (c) seeking treatment as a last resort, (d) myths about treatment, (e) stigma associated with seeking treatment and (f) culturally appropriate coping strategies**. We discuss implications for practice, education and research."
Cooper et al. (2003). "The acceptability of treatment for depression among African-American, Hispanic, and White primary care patients. Medical Care.
Abstract: *Background*: Ethnic minority patients are less likely than white patients to receive guideline-concordant care for depression. It is uncertain whether racial and ethnic differences exist in patient beliefs, attitudes, and preferences for treatment. *Methods*: A telephone survey was conducted of 829 adult patients (659 non-Hispanic whites, 97 African Americans, 73 Hispanics) recruited from primary care offices across the United States who reported 1 week or more of depressed mood or loss of interest within the past month and who met criteria for Major Depressive Episode in the past year. Within this cohort, we examined differences among African Americans, Hispanics, and whites in acceptability of antidepressant medication and acceptability of individual counseling. *Results*: **African Americans (adjusted OR, 0.30; 95% CI 0.19-0.48) and Hispanics (adjusted OR, 0.44; 95% CI, 0.26-0.76) had lower odds than white persons of finding antidepressant medications acceptable**. African Americans had somewhat lower odds (adjusted OR, 0.63; 95% CI, 0.35-1.12), and Hispanics had higher odds (adjusted OR, 3.26; 95% CI, 1.08-9.89) of finding counseling acceptable than white persons. Some negative beliefs regarding treatment were more prevalent among ethnic minorities; however adjustment for these beliefs did not explain differences in acceptability of treatment for depression. *Conclusions*: African Americans are less likely than white persons to find antidepressant medication acceptable. Hispanics are less likely to find antidepressant medication acceptable, and more likely to find counseling acceptable than white persons. Racial and ethnic differences in beliefs about treatment modalities were found, but did not explain differences in the acceptability of depression treatment. Clinicians should consider patients' cultural and social context when negotiating treatment decisions for depression. Future research should identify other attitudinal barriers to depression care among ethnic minority patients."

Gitlin et al. (2012): "*Objective:* To examine older African American's recognition of and beliefs about depressive symptoms, preferred symptom management strategies, and factors associated with willingness to use mental health treatments. Differences between depressed and non-depressed and men and women were examined. *Design:* Cross-sectional survey. *Setting:* Home, senior center. *Participants:* 153 senior center members (56=males, 97=females) ≥55 years. *Measurements:* **Using a depression vignette**, **participants indicated if the person was depressed and their endorsement of items reflecting beliefs, stigma, symptom management, and willingness to use treatments (yes/no). PHQ-9 assessed current symptomatology.** *Results:* Overall, 24.2% reported depressive symptoms (≥5); 88.2% correctly identified the person in the vignette as depressed. **Most (≥75%) endorsed active symptom management strategies, preference for treatment in physician and therapist offices, and willingness to take medications, seek therapy, see doctor and attend support groups; <33% viewed depression as stigmatizing whereas 48% viewed depression as normal aging. Logistic regressions revealed lower education, higher physical function and feeling okay if community knew of depression diagnosis were associated with willingness to see physician if feeling depressed; being married and believing anti-depressant medications are beneficial were related to willingness to use medications. Different associations emerged for depressed/non-depressed and men and women.** *Conclusions:* Overall, this older African American sample had positive attitudes and beliefs and endorsed traditional treatment modalities suggesting that beliefs alone are unlikely barriers to underutilization of mental health services. As different factors were associated with willingness to seek physician help and use medications and factors differed for depressed/non-depressed and by sex, interventions should be tailored."

Raue et al. (2012). Depression treatment preferences in home health care. Psychiatric Services.
Abstract: "*Objective:* The authors hypothesized that the depression treatment preferences of elderly home care patients would vary by depression experience, with preferences for active treatments being associated with current depression and antidepressant treatment. *Methods:* The authors conducted cross sectional secondary analyses of the TRIAD ("Training in the Assessment of Depression") study of 256 randomly selected elderly patients newly admitted to homecare. The study assessed depression treatment preference for active (i.e., medication or psychotherapy) versus non-active or complementary approaches (e.g., religious activities, do nothing). Two separate indicators of depression experience were used: diagnoses of major or minor depression, and current or previous antidepressant treatment. *Results:* **121 patients (48%) preferred active treatment with either medication or psychotherapy as their first choice, while the remainder preferred non-active or complementary approaches. Logistic regression indicated that current antidepressant use, previous psychotherapy experience, white and Hispanic versus African-American patients, greater IADL impairment, and less personal stigma about depression were independently associated with preference for an active treatment**. *Conclusions*: Elderly homecare patients have a variety of depression treatment preferences ranging from active treatments, to religious or spiritual activities, to no treatment. Several factors were associated with a preference for active treatment, including treatment experience, co-existing physical impairment, culture, and attitudes and beliefs. Understanding patient preferences may form the basis of engaging older depressed home care patients in treatment."

	Information from community members on panel: Preference for active intervention to WL although some variability in comfort with home visits. *Information from clinicians on panel:* *Information from other sources (also list sources):* *Reynolds, 2014 Psychiatric Services; participants (especially African Americans) had a strong preference for community or home based interventions* *High certainty, moderate variability*

Next rate the variability of and your certainty about patient values and preferences:

✓	Variability in Patient Values & Preferences	✓	Certainty in Patient Values & Preferences
	High	X	High
X	Moderate		Moderate
	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

X Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Evidence that patients value the opportunity to have care provided in community or home care settings. Which can decrease the barrier associated with referral to specialty mental health care settings due to both convenience and stigma.

Notes/Comments:

Patient values and preferences based on:

Information from research studies:
None

Information from community members on panel:

Information from clinicians on panel:

Patients do want something as opposed to waitlist.

Variability in the acceptability of group, many accept it but many do not.

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High	X	High
	Moderate		Moderate
X	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

X Similar values and little uncertainty

☐ Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Similar values and little uncertainty, patients tend to prefer something as opposed to waitlist.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Home bound, under resourced, medically complex (co-morbid physical conditions) population. Vulnerable.
Interventions	Intervention was culturally tailored.
Comparators	Treatment better than WL.
Outcomes	
Timing or Time frame	10 sessions provided over a period of up to 4 months.
Settings	Provided in home.

Notes/Comments:
From Gitlin et al 2013

Patients/Populations:

"Recruitment involved outreach to the community at large (senior center members and nonmembers living in the Philadelphia, Pennsylvania, region) and temporarily homebound elderly persons in a short-term assistance program (In-Home Support Program [IHSP]) administered by the senior center (32). For the latter, 12 IHSP senior center care managers were trained to use the Patient Health Questionnaire-9 (PHQ-9) in routine assessments. Individuals scoring 5 or higher were provided with information about mental health services and BTB [the intervention: Beat The Blues]. Participants from IHSP who were interested in BTB were contacted by the on-site research coordinator at the senior center who, by telephone, explained study procedures and readministered the PHQ-9 within 2 weeks to confirm depressive symptoms.

Recruitment from the community at large involved print media, presentations, and distribution of institutional review board–approved study brochures at health fairs, agencies, senior housing, and libraries. The senior center research coordinator explained study procedures and administered the PHQ-9 by telephone to individuals who expressed interest by telephone or postcard. Those who

were eligible at this initial screening (PHQ-9 score ≥5) were readministered the PHQ-9 within 2 weeks by telephone. Eligible individuals had PHQ-9 scores of 5 or higher, consistent with depressive symptoms, at 2 testing occasions 2 weeks apart and were African American, aged 55 years or older, English-speaking, and cognitively intact (Mini-Mental State Examination score ≥24).

Participants met other criteria to minimize loss to follow-up, including telephone access and expectation of remaining in the region. Individuals were excluded if they had histories of serious mental illness, life-limiting illness, or involvement in another depression trial or were a long-term care resident." p. 244

"Table 1 shows characteristics of participants at baseline. Participants had a mean age of 69.6 years, and most were women (78.4%), were unemployed (90.9%), were not married (88.0%), lived alone (56.7%), had no more than a high school education (50.5%), and had some financial difficulty (67.8%). An average of 6.4 health conditions were reported, with high blood pressure (79.3%), high cholesterol level (58.7%), arthritis (76.4%), and diabetes (42.8%) most frequently reported. Forty participants (19.3%) reported antidepressant medication use, and 35 (17.0%) reported antianxiety medication use. In the 4 months before enrollment, 97 (46.6%) spoke to physicians or clergy, 40 (19.2%) spoke to mental health specialists, and 16 (7.8%) participated in support groups for depressive symptoms. Participants enrolled from the IHSP were older than community participants (72.2 vs. 68.5 years), had more health conditions (7.1 vs. 6.2 conditions) and pain (4.5 vs. 3.9, as measured by the Short Form-36 pain item), had less education (less than high school, 37.3% vs. 14.8%; high school, 32.2% vs. 28.2%; beyond high school, 30.5% vs. 57.1%), and were less likely to be employed (0.48% vs. 8.65%). There were no differences in PHQ-9 scores between IHSP and community participants. Most (71.1%) were moderately to severely depressed: 60 (28.9%) scored mild, 73 (35.1%) scored moderate, 50 (24.0%) scored moderately severe, and 25 (12.0%) scored severe." p. 246-247

Intervention:

"The BTB [Beat the Blues] intervention involved up to ten 1-hour inhome sessions that occurred weekly for the first few weeks then biweekly for up to 4 months. The intervention involved 5 interrelated components: care management involving a systematic assessment of unmet care needs, referral and linkage involving resource identification and linking participants to social and medical services, depression education instructing participants in symptom recognition, stress reduction techniques (for example, signal breadth or music) for coping with stress-inducing events, and behavioral activation to identify personal activity goals and a plan of action to accomplish them. The intervention sought to help participants identify and complete behavioral goals despite negative mood states and to break the behavior–mood cycle by addressing environmental circumstances that provide low levels of positive reinforcement and minimal control (33). Participants received all 5 treatment components, with each component tailored to participants' prioritized care needs, preferred language in referring to depressive symptoms, depression knowledge level, preferred stress reduction technique, and personal activity goals. Activity goals included, but were not limited to, managing chronic conditions, socialization, exercise, addressing unmet care needs, preparing family

	meals, traveling, and attending classes. Each treatment component supported participants becoming behaviorally activated: Providing education helped participants understand linkages between behavior and mood; care management, referral, and linkage helped minimize external factors contributing to depressed mood and preventing behavioral activation; and stress reduction helped participants manage situational stress associated with conditions contributing to depressive symptoms." p. 245 "The study withdrawal rate was higher in the intervention group than in the wait-list group." p. 244 **Comparators:** "Participants in the wait-list control group did not receive any study-based intervention between baseline and 4 months. They received BTB in its entirety after completion of their 4-month reassessment. Six licensed social workers served as interventionists and received 35 hours of intervention training. Each participant remained with the same interventionist." p. 245 **Outcomes:** "Self-reported depression severity at 4 months (primary outcome) and depression knowledge, quality of life, behavioral activation, anxiety, function, and remission at 4 and 8 months." p. 243 **Setting:** **"**A senior center and participants' homes from 2008 to 2010." p. 243

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
X	***Strong*** *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

Strong recommendation for use of a multicomponent individual intervention compared to WL.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Overall good evidence of moderate efficacy and low evidence of harms or burdens. In-home delivery may be particularly beneficial for a population with limited ability or motivation to access other services.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 38- Life review therapy (individual) compared to usual care for treating subclinical depression in adults ages 65 and older

Factor	Explanation/Comments
II. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
II. Treatment Outcomes/Consequences • **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of the Treatment *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens of Treatment	
XIX. Patient Values and Preferences	
XL. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 38- Life review therapy (individual) compared to usual care for treating subclinical depression in adults ages 65 and older

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Quality of Life (follow up: 8 weeks; assessed with: Life Satisfaction Index)			X	
Suicidality (follow up: 8 weeks; assessed with: Beck Hopelessness Scale)			X	
Outcomes for which no estimable information was found: functional capacity, response, remission, patient satisfaction, relapse, recurrence, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low x Insufficient/ Very Low **Notes/Comments**: Because response to treatment and serious adverse events are not reported and those are critical outcomes, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Serrano et al., 2004

Quality assessment		№ of patients		Effect		Quality
№ of studies		**life review therapy (individual)**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				Not estimable	Not estimable	
Response						
				Not estimable	Not estimable	
Remission						
				Not estimable	Not estimable	
Quality of Life (follow up: 8 weeks; assessed with: Life Satisfaction Index); based on completers analysis						
1	See Footnote #1 and #2	20	23	-	MD 5.46 more (1.2 more to 9.72 more)	⊕⊕◯◯ LOW
Patient Satisfaction						
				Not estimable	Not estimable	
Relapse						
				Not estimable	Not estimable	
Recurrence						
				Not estimable	Not estimable	

MD – mean difference, RR – relative risk
Footnote #1 - Completers analysis
Footnote #2 - Small sample size and/or number of events, does not meet optimal information size to detect differences

Next, list and rate each benefit from the evidence profile information:
Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Quality of Life (follow up: 8 weeks; assessed with: Life Satisfaction Index)						X

COMMENTS:

Confidence is limited by a lack of intention to treat analyses.

Second, list quantitative information on harms from evidence profiles:

Quality assessment		№ of patients		Effect		Quality
№ of studies		life review therapy (individual)	usual care	Relative (95% CI)	Absolute (95% CI)	
Suicidality (follow up: 8 weeks; assessed with: Beck Hopelessness Scale); based on completers analysis						
1	See Footnote #1 and #2	20	23	-	MD 4.71 fewer (7.08 fewer to 2.34 fewer)	⊕⊕◯◯ LOW
Adverse Events						
				Not estimable	Not estimable	

MD – mean difference, RR – relative risk

Footnote #1 - Completers analysis
Footnote #2 - Small sample size and/or number of events, does not meet optimal information size to detect differences

Note any other information on harms from published studies:

Serrano et al (2004)
Harm

- Dropout: 20% (*5 of 25*) life review tx vs. 8% (*2 of 25*) usual care
- Reasons for dropout: moved; hospitalized due to illness; died; not motivated to continue (2); of the latter 2, one was in the experimental, and the other, the control group.
- Treatment adherence: Intervention sessions were tape-recorded and were scored by a psychologist blind to the purpose of the study to ensure that the intervention was presented according to the protocol.

Note any other information on burdens from published studies:

Burden

- Tx delivered by first author of the study
- 4 weekly, individual sessions delivered between weeks 3 – 6 of the study
- No homework

Other studies:
None

Note any additional information on harms:

Note any additional information on burdens:

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
3. Adverse events leading to withdrawals						X
4. Other serious adverse events						X
5. Other adverse events						X
6. Burdens				X		

Assign an overall global rating across outcomes:

☐Benefits clearly outweigh harms/ burden
☐Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments:

Unable to rate the balance due to inability to rate benefits.

III) Patient Values and Preferences *What are the typical patient values and preferences?* *How variable are these?* *How certain is the panel about these?* **Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*	**<u>Patient values and preferences based on:</u>** *Information from research studies:* [None found] *Information from community members on panel:* Many patients may consider Lifereview as more beneficial than usual care *Information from clinicians on panel:* *Information from other sources (also list sources):*

Next rate the variability of and your certainty about patient values and preferences:

✓	Variability in Patient Values & Preferences	✓	Certainty in Patient Values & Preferences
	High	✓	High
	Moderate		Moderate
✓	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

X Similar values and little uncertainty

☐ Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

For older patients, the clinical experience of the panel members and community input suggest low variability and high certainty and acceptance and desire for life review therapy.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Subsyndromal depression, patients limited to one town in Spain
Interventions	Delivered by one therapist, who was the senior author of the paper
Comparators	Usual Care
Outcomes	Life satisfaction, no direct measure of suicidality (Beck Hopelessness Scale)
Timing or Time frame	Time frame is just end of treatment, no follow up
Settings	Outpatient social service setting

Notes/Comments:
From Serrano et al., 2004

Patients/Populations:

"One hundred twenty older adult volunteers who were clients of Social Services in Almansa (Albacete), Spain, were recruited. Participants in the study were receiving 1 hr of social services per day, 5 days per week, from the private corporation Service Assistant Almansa's Home, which also helped with recruitment.

Seventy-six individuals scored 16 or higher on the CES–D. Within this group, 12 scored below 28 on the MEC and were excluded, and 14 decided not to participate (response rate = 78%). The remaining sample of 50 participants was assigned to **matched pairs** according to baseline CES–D, gender, and age. Within each pair, one participant was randomly assigned to the experimental group and the other to the control group. The control group received social services as usual. The experimental group received the life review intervention while continuing with social services. During

the intervention, 7 participants dropped out of the study (retention rate = 86%). Of these, 3 moved to another city, 1 was hospitalized due to illness, 1 died, and 2 were not motivated to continue. Of the latter 2, one was in the experimental, and the other, the control group. Dropouts were not significantly different from those who continued on their baseline CES–D, Beck Hopelessness Scale (BHS), Life Satisfaction Index, or number of specific events recalled. If anything, they were somewhat less depressed and more hopeful, although not significantly so." p. 273

Table 1
Background Data for Participants in the Study

Variable	Experimental group (n = 20)	Control group (n = 23)	Statistical test
Age, *M* (*SD*)	75.8 (8.1)	78.4 (7.3)	$t(41) = 1.11$
Education (frequency)			$\chi^2(3, N = 43) = 5.08$
Able to read and write	0.0%	15.0%	
Completed elementary school	73.9%	60.0%	
Completed secondary school	26.1%	20.0%	
Attended university	0.0%	5.0%	
Gender			$\chi^2(1, N = 43) = 0.95$
Male	17.4%	30.0%	
Female	82.6%	70.0%	

Note. None of the differences are statistically significant.

p. 273

Interventions:

"The intervention was individually administered on a weekly basis by Juan Pedro Serrano. Participants were told that the study was investigating effects of memory recall on mood and that the interviews were designed to evoke memories. The life review consisted of autobiographical retrieval practice that entailed focusing on a particular life period each week—childhood, adolescence, adulthood, and summary. Intervention sessions were tape-recorded and were scored by a psychologist blind to the purpose of the study to ensure that the intervention was presented according to the protocol." p. 274

	Comparators: "The remaining sample of 50 participants was assigned to matched pairs according to baseline CES–D, gender, and age. Within each pair, one participant was randomly assigned to the experimental group and the other to the control group. The control group received social services as usual. The experimental group received the life review intervention while continuing with social services." p. 273

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
X	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

The panel concludes that the evidence is insufficient to recommend adoption of this treatment but the panel also determines that additional study of this approach or therapy is warranted.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Sufficient evidence that suggests that this is useful for further investigation. May be potentially useful as treatment but there is no sufficient data currently to suggest otherwise.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 39- Life review therapy (group) compared to usual care
for moderate depressive symptoms in adults ages 55 and older

Factor	Explanation/Comments
I. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
II. Treatment Outcomes/Consequences • **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of the Treatment *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens of Treatment	
III. Patient Values and Preferences	
IV. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 39- Life review therapy (group) compared to usual care for moderate depressive symptoms in adults ages 55 and older

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Response (follow up: 3 months; assessed with: CES-D (>=5 point reduction while crossing cut-off value of 16 for clinically relevant depressive symptoms))		X		
Quality of Life (follow up: 3 months; assessed with: EuroQol-5D)			X	
Quality of Life (follow up: 6 months; assessed with: EuroQol-5D)			X	
Outcomes for which no estimable information was found: functional capacity, remission, patient satisfaction, relapse, recurrence, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Korte et al., 2012

		№ of patients		Effect		Quality
№ of studies		**life review therapy (group)**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				Not Estimable	Not Estimable	
Response (follow up: 3 months; assessed with: CES-D (>=5 point reduction while crossing cut-off value of 16 for clinically relevant depressive symptoms))						
1	See Footnote #1	31/100 (31.0%)	12/102 (11.8%)	RR 2.635 (1.440 to 4.830)	192 more per 1000 (from 52 more to 451 more)	⊕⊕⊕◯ MODERATE
Remission						
				Not Estimable	Not Estimable	
Quality of Life (follow up: 3 months; assessed with: EuroQol-5D)						
1	See Footnote #2	100	102	-	MD **0.03 more** (0.03 fewer to 0.09 more)	⊕⊕◯◯ LOW
Quality of Life (follow up: 6 months; assessed with: EuroQol-5D)						
1	See Footnote #2	100	102	-	MD **0.01 more** (0.03 fewer to 0.05 more)	⊕⊕◯◯ LOW
Patient Satisfaction						
				Not Estimable	Not Estimable	
Relapse						
				Not Estimable	Not Estimable	

Recurrence						
				Not Estimable	Not Estimable	
Suicidality						
				Not Estimable	Not Estimable	
Adverse Events						
				Not Estimable	Not Estimable	

MD – mean difference, RR – relative risk

Footnote #1 - Small sample size and/or number of events, does not meet optimal information size to detect differences

Footnote #2 - Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Number needed to treat (95% Confidence Interval)

Response (follow up: 3 months; assessed with: CES-D (>=5 point reduction while crossing cut-off value of 16 for clinically relevant depressive symptoms)): NNT = 5 (NNT(benefit) 3 to 13)

Next, list and rate each benefit from the evidence profile information:
Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Response (follow up: 3 months; assessed with: CES-D (>=5 point reduction while crossing cut-off value of 16 for clinically relevant depressive symptoms))	X					
2. Quality of Life (follow up: 3 months; assessed with: EuroQol-5D)			X			
3. Quality of Life (follow up: 6 months; assessed with: EuroQol-5D)			X			

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Korte et al (2012)

Harm

- Dropout: 8% (*8 of 100*) life review (narrative) tx vs. 0% (*0 of 102*) usual care
- Reasons for dropout: no motivation; health problems
- Treatment adherence: To check whether the intervention was implemented as intended, one session was audiotaped by all participating mental health-care services. Two researchers independently scored a treatment integrity measure and solved a few disagreements by consensus

Note any other information on burdens from published studies:

Burden

- 6% of tx individuals dropped out due to lack of motivation
- Tx delivered in group for 2hrs over 8 sessions
- "therapists…experienced in working with older adults implemented the intervention…(after) participat(ing) in a 2-day training program supervised by a narrative therapist and a life-review therapist"

Other studies:

None

Note any additional information on harms:

Note any additional information on burdens:

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
4. Adverse events leading to withdrawals			X			
5. Other serious adverse events						X
6. Other adverse events						X
7. Burdens				X		

Assign an overall global rating across outcomes:

X☐Benefits clearly outweigh harms/ burden
☐Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments: Very low drop out rate for the life review intervention (as well as no drop outs for usual care).

III) Patient Values and Preferences

What are the typical patient values and preferences?

How variable are these?

How certain is the panel about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

Gitlin et al. (2012). "Identification of and beliefs about depressive symptoms and preferred treatment approaches among community-living older African Americans. American Journal of Geriatric Psychiatry. Abstract: *Objective*: To examine older African American's recognition of and beliefs about depressive symptoms, preferred symptom management strategies, and factors associated with willingness to use mental health treatments. Differences between depressed and non-depressed and men and women were examined. Design: Cross-sectional survey. *Setting*: Home, senior center. Participants: 153 senior center members (56=males, 97=females) ≥55 years. *Measurements*: Using a depression vignette, participants indicated if the person was depressed and their endorsement of items reflecting beliefs, stigma, symptom management, and willingness to use treatments (yes/no). PHQ-9 assessed current symptomatology. *Results*: Overall, 24.2% reported depressive symptoms (≥5); 88.2% correctly identified the person in the vignette as depressed**. Most (≥75%) endorsed active symptom management strategies, preference for treatment in physician and therapist offices, and willingness to take medications, seek therapy, see doctor and attend support groups**; <33% viewed depression as stigmatizing whereas 48% viewed depression as normal aging. Logistic regressions revealed lower education, higher physical function and feeling okay if community knew of depression diagnosis were associated with willingness to see physician if feeling depressed; being married and believing anti-depressant medications are beneficial were related to willingness to use medications. Different associations emerged for depressed/non-depressed and men and women. *Conclusions*: Overall, this older African American sample had positive attitudes and beliefs and endorsed traditional treatment modalities suggesting that beliefs alone are unlikely barriers to underutilization of mental health services. As different factors were associated with willingness to seek physician help and use medications and factors differed for depressed/non-depressed and by sex, interventions should be tailored."

Information from community members on panel:

Active intervention preferred.

Information from clinicians on panel:

Fairly flexible intervention and some clients appreciate that; can also be easier for individuals with working memory challenges. Less demand in terms of HW. Also provides some flexibility for different cultural experiences and can therefore be culturally responsive.

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High	X	High
	Moderate		Moderate
X	Low		Low
	Unknown		Unknown

Low variability, high certainty

Next combine across ratings into an overall rating on the following scale:

XX☐ Similar values and little uncertainty

☐ Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

This intervention is a flexible intervention that would generally be tolerable and acceptable to a large portion of the relevant population.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Less severely depressed population, relatively few physical health conditions. Fairly broad /representative population within Dutch population.
Interventions	Flexible and able to be culturally relevant. Was well tolerated (low drop out). Administered well trained competent providers.
Comparators	
Outcomes	
Timing or Time frame	
Settings	

Notes/Comments:
From Korte et al., 2012

Patients/Populations:

"Participants were recruited from September 2008 to September 2009, in collaboration with Dutch mental health-care services, through advertisements in newspapers and information booklets, plus a radio interview and commercial. In total, 14 Dutch mental health-care services, in both urban and rural areas, participated in this study. Therapists at these services, experienced in working with older adults, implemented the intervention. Before being allowed to offer the intervention, they were required to participate in a 2-day training program, supervised by a narrative therapist and a life review therapist. They also participated in two half-day follow-up discussion sessions and a booster training. Inclusion criteria were age 55 years and the presence of moderate depressive symptoms, operationalized by a score of 10 on the Center for Epidemiologic

	Studies Depression Scale (CES-D; Radloff, 1977; Beekman et al. 1997). Applicants were excluded if diagnosed with current severe major depressive episode (MDE; eight or nine out of a total of nine symptoms) or with a moderate to high suicide risk according to the Mini International Neuropsychiatric Interview (MINI; Sheehan et al. 1998; Van Vliet & De Beurs, 2007). Furthermore, applicants were excluded if they had a score of 9 on the CES-D (Radloff, 1977), had started taking antidepressant medication or benzodiazepines recently (within the previous 2 months), were currently receiving any psychological treatment, or if the health-care professionals assessed the presence of other serious psychopathology, in which case they were referred for psychological treatment. Participants were randomly assigned either to life review therapy or to care as usual, by means of a centrally conducted, independent randomization process. The randomization was stratified by gender and presence of current MDE (no current MDE or mild to moderate current MDE), using a computer-generated sequence of numbers." p. 1164 "Participants had a mean age of 63 years (S.D.=6.5, range=55–83) and were predominantly female (Table 1). Their education was distributed evenly across three categories (<11 years, 11–14 years, and >14 years). About one-third of the participants were retired. On average, participants had one to two chronic medical conditions (mean=1.5, S.D.=1.4) and they had experienced two to three critical life events in the past 3 years (mean=2.3, S.D.=1.5). Table 2 shows that participants at baseline scored an average of 20.5 (S.D.=8.6) on the CES-D, reflecting clinically relevant depressive symptoms." p. 1168 **Interventions:** "The intervention, 'The stories we live by', is conducted in groups of four to six participants and consisted of eight similarly structured sessions of 2 h each. The intervention has three core elements. First, the integration of difficult life events from the past; second, the development of agentic life stories, which helps the participants to cope with present life events and to formulate new goals ; third, the retrieval of specific positive memories, which can serve as building blocks of the new life stories. To check whether the intervention was implemented as intended, one session was audiotaped by all participating mental health-care services. Two researchers independently scored a treatment integrity measure and solved a few disagreements by consensus. The measure addressed five criteria that were crucial in correctly delivering the intervention. All criteria were assigned one (unsatisfactory), two (satisfactory) or three points (good), with a total score ranging from 5 to 15 (5–8=unsatisfactory, 9–11=satisfactory, 12–15=good). The therapists scored satisfactory (60%: eight out of 14 sessions) or good (40%: six out of 14 sessions)." p.1165

	Comparators: "Participants in the control condition received no intervention. However, they had unrestricted access to care as usual, that is they were not withheld from any treatment (e.g. they may receive psychological treatment). After conclusion of the RCT, the intervention was offered to them." p. 1166 **Outcomes:** "Only the intervention condition completed an extended follow-up (t3; 9 months after the intervention) whereas the control condition received the intervention after 6 months. The primary outcome measure was depressive symptoms (CES-D). Secondary outcome measures were anxiety symptoms measured on the Hospital Anxiety and Depression Scale (HADS), positive mental health, quality of life assessed by the Euroqol questionnaire (EQ-5D), and current mild to moderate MDE (five to seven out of nine symptoms on the MINI). Moderating variables were sociodemographic attributes (age, gender and educational level), personality (neuroticism, extraversion, openness to experience, agreeableness and conscientiousness; NEO-FFI), reminiscence functions (identity, problem solving, bitterness revival and boredom reduction), past MDEs (MINI), chronic medical conditions (Statistics Netherlands, 1989) and critical life events (Social Readjustment Rating Scale). A more detailed description of the measures can be found in Korte et al. (2009)." p. 1165

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
X	***Strong*** *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

Strong recommendation for life review therapy relative to usual care in a population of ambulatory older adults with mild to moderate severity of depression and relatively mild medical co-morbidities.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Evidence of moderate efficacy with respect to the number needed to treat and evidence of low harm or burden and low dropout.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 42 - Life review course (group) compared to educational video for treating subclinical depression in older adults ages 51 and older

Factor	Explanation/Comments
V. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
VI. Treatment Outcomes/Consequences	
• **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of the Treatment	
(Note- do <u>not</u> include financial cost)	
Balance of Benefits to Harms/Burdens of Treatment	
VII. Patient Values and Preferences	

VIII. Applicability of Evidence	
❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 42 - Life review course (group) compared to educational video for treating subclinical depression in older adults ages 51 and older

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Functional Capacity (follow up: 3 months; assessed with: Reminiscence Function Scale: Boredom reduction)			X	
Functional Capacity (follow up: 9 months; assessed with: Reminiscence Function Scale: Boredom reduction)			X	
Functional Capacity (follow up: 3 months; assessed with: Reminiscence Function Scale: Bitterness revival)			X	
Functional Capacity (follow up: 9 months; assessed with: Reminiscence Function Scale: Bitterness revival)			X	
Functional Capacity (follow up: 3 months; assessed with: Reminiscence Function Scale: Identity)			X	
Functional Capacity (follow up: 9 months; assessed with: Reminiscence Function Scale: Identity)			X	
Functional Capacity (follow up: 3 months; assessed with: Reminiscence Function Scale: Problem solving)			X	
Functional Capacity (follow up: 9 months; assessed with: Reminiscence Function Scale: Problem solving)			X	
Response (follow up: 3 months; assessed with: CES-D)		X		
Response (follow up: 9 months; assessed with: CES-D)			X	
Quality of Life (follow up: 9 months; assessed with: EuroQol-5D)			X	
Quality of Life (follow up: 3 months; assessed with: EuroQol-5D)			X	
Outcomes for which no estimable information was found: remission, patient satisfaction, relapse, recurrence, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Pot et al., 2010

		№ of patients		Effect		Quality
№ of studies		life review course (group)	educational video	Relative (95% CI)	Absolute (95% CI)	
Functional Capacity (follow up: 3 months; assessed with: Reminiscence Function Scale: Boredom reduction); based on ITT analysis						
1	See Footnote #1	83	88	-	MD 0.82 lower (2.35 lower to 0.71 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 9 months; assessed with: Reminiscence Function Scale: Boredom reduction); based on ITT analysis						
1	See Footnote #1	83	88	-	MD 0.31 lower (1.81 lower to 1.19 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 3 months; assessed with: Reminiscence Function Scale: Bitterness revival); based on ITT analysis						
1	See Footnote #1	83	88	-	MD 0.2 lower (1.65 lower to 1.25 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 9 months; assessed with: Reminiscence Function Scale: Bitterness revival); based on ITT analysis						
1	See Footnote #1	83	88	-	MD 0.49 lower (1.96 lower to 0.98 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 3 months; assessed with: Reminiscence Function Scale: Identity); based on ITT analysis						
1	See Footnote #1	83	88	-	MD 0.57 higher (1.03 lower to 2.17 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 9 months; assessed with: Reminiscence Function Scale: Identity); based on ITT analysis						
1	See Footnote #1	83	88	-	MD 0.24 lower (1.82 lower to 1.34 higher)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 3 months; assessed with: Reminiscence Function Scale: Problem solving); based on ITT analysis						
1	See Footnote #1	83	88	-	MD 1.04 more (0.29 fewer to 2.37 more)	⊕⊕◯◯ LOW
Functional Capacity (follow up: 9 months; assessed with: Reminiscence Function Scale: Problem solving); based on ITT analysis						

1	See Footnote #1	83	88	-	MD 0.57 more (0.83 fewer to 1.97 more)	⊕⊕◯◯ LOW
Response (follow up: 3 months; assessed with: CES-D); based on ITT analysis						
1	See Footnote #2	83	88	-	MD 3.74 fewer (6.2 fewer to 1.28 fewer)	⊕⊕⊕◯ MODERATE
Response (follow up: 9 months; assessed with: CES-D); based on ITT analysis						
1	See Footnote #1	83	88	-	MD 1.91 fewer (4.47 fewer to 0.65 more)	⊕⊕◯◯ LOW
Remission						
				Not Estimable	Not Estimable	
Quality of Life (follow up: 9 months; assessed with: EuroQol-5D); based on ITT analysis						
1	See Footnote #1	83	88	-	MD 0.02 more (0.3 fewer to 0.07 more)	⊕⊕◯◯ LOW
Quality of Life (follow up: 3 months; assessed with: EuroQol-5D); based on ITT analysis						
1	See Footnote #1	83	88	-	MD 0 (0.05 fewer to 0.05 more)	⊕⊕◯◯ LOW
Patient Satisfaction						
				Not Estimable	Not Estimable	

MD – mean difference, RR – relative risk

Footnote #1 - Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference
Footnote #2 - Small sample size and/or number of events, does not meet optimal information size to detect differences

Next, list and rate each benefit from the evidence profile information:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Functional Capacity (follow up: 3 months; assessed with: Reminiscence Function Scale: Boredom reduction)			X			
2. Functional Capacity (follow up: 9 months; assessed with: Reminiscence Function Scale: Boredom reduction)			X			
3. Functional Capacity (follow up: 3 months; assessed with: Reminiscence Function Scale: Bitterness revival)			X			
4. Functional Capacity (follow up: 9 months; assessed with: Reminiscence Function Scale: Bitterness revival)			X			
5. Functional Capacity (follow up: 3 months; assessed with: Reminiscence Function Scale: Identity)			X			
6. Functional Capacity (follow up: 9 months; assessed with: Reminiscence Function Scale: Identity)			X			

7. Functional Capacity (follow up: 3 months; assessed with: Reminiscence Function Scale: Problem solving)			X			
8. Functional Capacity (follow up: 9 months; assessed with: Reminiscence Function Scale: Problem solving)			X			
9. Response (follow up: 3 months; assessed with: CES-D)	X					
10. Response (follow up: 9 months; assessed with: CES-D)			X			
11. Quality of Life (follow up: 9 months; assessed with: EuroQol-5D)			X			
12. Quality of Life (follow up: 3 months; assessed with: EuroQol-5D)			X			

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Pot et al. (2010)

Harm

- Dropout: 4.8% (*4 of 83*) life review course ("Looking for Meaning") vs. 15.9% (*14 of 88*) minimal intervention/20 min educational video ("The Art of Growing Older")

Note any other information on burdens from published studies:

Burden

- Tx delivered in group for 2hrs over 12 sessions
- Mental health care professionals offering the intervention were responsible for screening and diagnosing people who wanted to participate in the study and obtaining informed consent.
- Treatment delivered by "two mental health care professionals with a therapeutic background or a qualification in behavioral sciences (e.g., psychology) or social work, who for this purpose completed a two-day training program in advance and one day's training during the course."

Other studies:

- None

Note any additional information on harms:

Note any additional information on burdens:

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
13. Adverse events leading to withdrawals						X
14. Other serious adverse events						X
15. Other adverse events						X
16. Burdens				X		

Assign an overall global rating across outcomes:

X Benefits clearly outweigh harms/ burden
☐Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments:

Dropout rate was greater for controls and there was a modest benefit of treatment.

III) Patient Values and Preferences

What are the typical patient values and preferences?

How variable are these?

How certain is the panel about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

[No relevant studies]

Information from community members on panel:

Would expect moderate variability in preferences for group therapy over computerized intervention.

Information from clinicians on panel:

It can be difficult to attract subsyndromal patients to therapy. Appears to be prevention, not treatment, trail. Some individuals with depression symptoms find connecting with others to be valuable.

Information from other sources (also list sources):

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High		High
✓	Moderate	✓	Moderate
	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

X Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Patients will vary with respect to their treatment preferences and motivation to enter treatment in the absence of fully syndromal depression.

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	Subsyndromal depression, limited to Netherlands
Interventions	Preventive, not treatment
Comparators	Weak control condition
Outcomes	
Timing or Time frame	Effects are not maintained past 3 months
Settings	Outpatient setting

Notes/Comments:
From Pot et al., 2010

Patients/Populations:

"Participants were recruited in two ways: (i) via advertisements in local and national newspapers and magazines targeted at an older audience, and (ii) with the help of professionals affiliated to one of 11 regional mental health care organizations in both rural and urban areas of the Netherlands that participated in this study. Inclusion criteria for this study were being aged 50 years or older and having at least slight depressive symptoms but no current depressive disorder. People with a depressive disorder were excluded because the "Looking for Meaning" course is intended as a preventive intervention and not as a treatment for disorders. People with a low score on the Center for Epidemiological Studies Depression Scale (i.e. CES-D=0–4) were also excluded, because improvement would be hardly possible. In addition, people who were already receiving psychotropic or psychological treatment were excluded. Mental health care professionals offering the intervention were responsible for screening and diagnosing people who wanted to participate in the study and

obtaining informed consent. All the older adults scoring 24 or higher on the CES-D, indicating major depression, were further examined with the Mini International Neuropsychiatric Interview (MINI; Sheehan *et al.*, 1998) in order to rule out the presence of major depression. Diagnosis of major depressive disorder resulted in exclusion from the study." p. 573

"In total, 171 older adults participated in the trial: 83 in the experimental group and 88 in the comparison group (Figure 1). Ninety-seven participants were excluded because they did not fulfill the inclusion criteria. At the 3-month follow-up assessment, 152 (88.9%) participants were retained in the trial and at the 9-month follow-up assessment the response was 84.2% (144 respondents). The total sample consisted of 124 females (72.5%) and 47 males (27.5%). The age of the participants ranged from 51 to 90 years (M=64.3; SD=7.4) and the mean CES-D score at baseline was 20.7 (SD=7.6). There were no significant differences at baseline between the experimental and comparison conditions on sample characteristics and primary and secondary outcomes, indicating that the randomization had been successful (Tables 1 and 2)." p. 575

Interventions:

"Subjects in the experimental group were assigned to the life review-based prevention course "Looking for Meaning" developed for older adults (Franssen and Bohlmeijer, 2003). Groups typically consisted of eight participants. The course was conducted 574 A. M. Pot *et al.* by two mental health care professionals with a therapeutic background or a qualification in behavioral sciences (e.g. psychology) or social work, who for this purpose completed a two-day training program in advance and one day's training during the course. The 12 sessions of two hours each are similarly structured, including sensory recall exercises, creative activity, and verbal exchange of experiences. Each session is centered on a topic related to the course of life, also making an explicit link between the past and the present. The sessions are entitled: Your name; Smells from the past; Houses you've lived in; Recognizing your resources; Hands; Photographs; Friendship; Balance; Thread of life and turning points; Longing and desire; the Future in me; and Identity. The participants are encouraged to make use of the senses in order to evoke memories. In addition, creative exercises may open up new ways of expression besides the verbal mode. The course also offers the possibility of further reading and reflection; poems, short stories and literature suggestions are included in the course material. Based on the experiences of participants in the pilot study (Bohlmeijer *et al*., 2005), three sessions were replaced or changed. Participants in the pilot indicated that they missed verbal exchange, and would also like to learn about problem solving techniques. These elements were added to the course after the pilot. The integration of psychotherapeutic frameworks like cognitive therapy or problem solving is recommended when life review is applied in older adults with depressive symptomatology (Westerhof *et al.*, in press)." p. 573-574

	Comparators: "The participants assigned to the comparison group watched the video "*The Art of Growing Older*" (Parnassia, 2003). This 20-minute educational video supplied information about factors and skills that promote growing older successfully. This intervention was considered a minimal intervention as no treatment was involved." p. 574

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
X	***Conditional*** *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

Clinician's may consider group lifereview therapy as an intervention for older adults with subsyndromal depressive symptoms.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Not sure if this is a treatment or prevention study. While this was described as a prevention study, it did not actually test the prevention hypothesis. Whether or not this will serve as an effective prevention trial is undetermined.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 46 - Behavioral bibliotherapy (self-guided) compared to usual care for treating subthreshold depression in adults ages 75 and older

Factor	Explanation/Comments
X. **Aggregate/Global Strength of Evidence (SOE)** **(from evidence profiles)**	
L. **Treatment Outcomes/Consequences** • **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of the Treatment *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens of Treatment	
CLI. **Patient Values and Preferences**	
LII. **Applicability of Evidence**	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 46 - Behavioral bibliotherapy (self-guided) compared to usual care for treating subthreshold depression in adults ages 75 and older

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Response (follow up: 3 months; assessed with: CES-D (>=5 point reduction))			X	
Response (follow up: 3 months; assessed with: CES-D (>=5 point reduction while crossing cut-off value of 16 for clinically relevant depressive symptoms))			X	
Outcomes for which no estimable information was found: functional capacity, remission, quality of life, patient satisfaction, relapse, recurrence, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

Assign global strength of evidence grade across outcomes (from evidence profiles only):

Global SOE Grade:

☐ High
☐ Moderate
☐ Low
X Insufficient/ Very Low

Notes/Comments:

Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Joling et al., 2011

		№ of patients		Effect		Quality
№ of studies		**behavioral bibliotherapy (self-guided)**	**usual care**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				Not Estimable	Not Estimable	
Response (follow up: 3 months; assessed with: CES-D (>=5 point reduction))						
1	See Footnote #1	40/86 (46.5%)	37/84 (44.0%)	RR 1.06 (-36.93 to 39.04)	26 more per 1000 (from 1000 fewer to 1000 more)	⊕⊕◯◯ LOW
Response (follow up: 3 months; assessed with: CES-D (>=5 point reduction while crossing cut-off value of 16 for clinically relevant depressive symptoms))						
1	See Footnote #1	31/86 (36.0%)	25/84 (29.8%)	RR 1.21 (0.79 to 1.87)	62 more per 1000 (from 62 fewer to 259 more)	⊕⊕◯◯ LOW
Remission						
				Not Estimable	Not Estimable	
Quality of Life						
				Not Estimable	Not Estimable	
Patient Satisfaction						
				Not Estimable	Not Estimable	
Relapse						
				Not Estimable	Not Estimable	

Recurrence						
				Not Estimable	Not Estimable	
Suicidality						
				Not Estimable	Not Estimable	
Adverse Events						
				Not Estimable	Not Estimable	

MD – mean difference, RR – relative risk

2. Footnote #1 - Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

<u>Number needed to treat (NNT) (95% Confidence Interval)</u>
Response (follow up: 3 months; assessed with: CES-D (>=5 point reduction)): NNT = 40 (NNT(harm) 9 to ∞ to NNT(benefit) 5)
Response (follow up: 3 months; assessed with: CES-D (>=5 point reduction while crossing cut-off value of 16 for clinically relevant depressive symptoms)): NNT = 16 (NNT(harm) 13 to ∞ to NNT(benefit) 4)

Next, list and rate each benefit from the evidence profile information:
Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Response (follow up: 3 months; assessed with: CES-D (>=5 point reduction while crossing cut-off value of 16 for clinically relevant depressive symptoms))			X			
2. Quality of Life (follow up: 3 months; assessed with: EuroQol-5D)			X			

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Joling et al (2011)

Harm

- Dropout: 20.9% (*18 of 86*) "Coping with Depression (CWD) self-help manual" bibliotherapy vs. 7.1% (*6 of 84*) UC
  - Statistically significant difference in attrition rates
- Reasons for dropout: unwilling; cognitive problems; died; unknown
- Symptom worsening: 53% of treatment participants and 56% of UC had no change/deterioration (category combined by researchers)

Note any other information on burdens from published studies:

Burden

- 41% of treatment sample reported reading the self-help materials
- Participants in the intervention group were visited for a maximum of 1 hour by a specially trained home care nurse three times during a period of 12 weeks.

Other studies:

None

Note any additional information on harms:

Note any additional information on burdens:

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
3. Adverse events leading to withdrawals						X
4. Other serious adverse events						X
5. Other adverse events						X
6. Burdens				X		

Assign an overall global rating across outcomes:

☐Benefits clearly outweigh harms/ burden
☐Benefits slightly outweigh harms/ burden
☐Benefits and harms/ burden are balanced
X Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments:

The two arms appear to be equivalent in terms of access to care, yet some participants clearly saw reading the materials as a burden given the low number of individuals who did the bibliotherapy and there was a relatively high attrition rate.

III) Patient Values and Preferences

What are the typical patient values and preferences?

How variable are these?

How certain is the panel about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

Dakin et al (2013): "*Objectives*: The future of psychotherapy research lies in the development of easy-to-use, efficient treatments that target specific characteristics and needs of patients with a given disorder. Meeting this aim will involve understanding why people seek psychotherapy and the therapeutic features that they feel are most helpful in their recovery. Identifying key features of treatment that patients feel lead to improvement may help identify the active ingredients of psychotherapy and further refine treatment. *Design*: We selected **22 older adults** who participated in a larger randomized trial of psychotherapy for late-life depression to **participate in individual, semi-structured qualitative interviews**. *Setting*: Interviews took place at the University of California, San Francisco or in the participant's home. *Participants*: **All participants were age 60 years or older with major depression and co-occurring executive dysfunction.** *Measurements*: Participants were asked about their depression experience, their expectations for treatment, most and least helpful aspects of treatment, effects of treatment, and recommended improvements to treatment. Data were transcribed, coded, and analyzed using NVivo (QSR International, Cambridge, MA). *Results*: The most commonly noted causes for seeking treatment were depression related to interpersonal relationships, health conditions, grief/loss, finances, housing, and challenges due to executive dysfunction**. Participants had few expectations about treatment and they found support, the problem-solving therapy process, and focus on interpersonal relationships to be the most helpful processes in treatment.** *Conclusion*: Suggestions for psychotherapy include increasing the number of sessions, discussing problems in a more proactive way, and considering participant choice in treatment. This research demonstrates the value of mixed-methods approaches, in that qualitative approaches assist in contextualizing and interpreting quantitative data."

Hanson et al (2008): "We examined older adults' ratings of the acceptability of geriatric depression treatments. We presented 120 community-dwelling participants with vignettes describing an older adult experiencing either mild to moderate or severe depression. **Participants rated the acceptability of three different treatments: cognitive therapy (CT), antidepressant medication (AM), and a combination treatment of CT and AM (COM). For general acceptability, participants rated COM as a more acceptable treatment for depression than both CT and AM.** With respect to perceived negative aspects of treatments, **they rated CT as a more acceptable treatment for mild to moderate depression than both AM and COM.** Participants rated both COM and CT as more acceptable treatments for severe depression than AM. Results indicate that combining psychotherapy and AM may be viewed as most acceptable by community-dwelling, nondepressed older adults."

Raue et al (2012): "*Objective:* The authors hypothesized that the depression treatment preferences of elderly home care patients would vary by depression experience, with preferences for active treatments being associated with current depression and antidepressant treatment. *Methods:* The authors conducted

	cross sectional secondary analyses of the TRIAD ("Training in the Assessment of Depression") study of 256 randomly selected elderly patients newly admitted to homecare. The study assessed depression treatment preference for active (i.e., medication or psychotherapy) versus non-active or complementary approaches (e.g., religious activities, do nothing). Two separate indicators of depression experience were used: diagnoses of major or minor depression, and current or previous antidepressant treatment. *Results:* **121 patients (48%) preferred active treatment with either medication or psychotherapy as their first choice, while the remainder preferred non-active or complementary approaches. Logistic regression indicated that current antidepressant use, previous psychotherapy experience, white and Hispanic versus African-American patients, greater IADL impairment, and less personal stigma about depression were independently associated with preference for an active treatment.** *Conclusions:* Elderly homecare patients have a variety of depression treatment preferences ranging from active treatments, to religious or spiritual activities, to no treatment. **Several factors were associated with a preference for active treatment, including treatment experience, co-existing physical impairment, culture, and attitudes and beliefs.** Understanding patient preferences may form the basis of engaging older depressed home care patients in treatment." *Information from community members on panel:* *Information from clinicians on panel:* Some experience that individuals prefer to do the work in session with the clinician; must be highly motivated to do HW or the work independently. *Information from other sources (also list sources):* Moderate variability; high certainty / check off some variability

Next rate the variability of and your certainty about patient values and preferences:

✓	**Variability in Patient Values & Preferences**	✓	**Certainty in Patient Values & Preferences**
	High	X	High
X	Moderate		Moderate
	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

X Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	75+ in age; mild depression; broad Dutch sample of community dwellers
Interventions	Less than half randomized to CWD actually read at least half of the materials
Comparators	Usual care
Outcomes	
Timing or Time frame	
Settings	Community residing; general practices

Notes/Comments:
From Joling et al., 2011

Patients/Populations:

"Community-dwelling elderly people, aged 75 years and older, with subthreshold depression, able to give informed consent, and with sufficient knowledge of the Dutch language, were eligible for participation. Eligible subjects were recruited from the study sample of a larger project for frail elderly people. These patients received a health survey questionnaire, including the CES-D. Patients were considered to have subthreshold depression and/or anxiety if they had a score above the cutoff of 16 on the CES-D for two subsequent measurements, which were at least 3months apart but did not meet *Diagnostic and Statistical Manual of Mental Disorders-IV* criteria for major depression and/or clinical anxiety, as assessed with the Mini-International Neuropsychiatric Interview. A CES-D score of 16 is widely accepted as an indication for clinically relevant symptoms of depression. Patients with serious cognitive decline according to the "self-rated" Informant Questionnaire on Cognitive Decline

	in the Elderly were excluded. Patients who met all the inclusion criteria were invited to participate in our study." p. 257 "Of the 170 participants, 24 (14.1%) dropped out during the intervention period (Fig. 1). The proportion of dropouts in the intervention group (18/86) was significantly higher than in the usual care group (6/84) (OR = 3.44, 95% CI: 1.29–9.16, Wald $\chi 2 = 6.12$ with 1 *df*, p = 0.013). The mean CES-D scores at baseline were 21.5 and 22.5 for completers and dropouts, respectively, indicating no significant difference. Older participants (OR = 1.14, 95% CI: 1.02–1.27, Wald $\chi 2 = 5.57$ with 1 *df*, p = 0.018) and those who were not living independently (OR = 142.86, 95% CI: 0.001–0.058, Wald $\chi 2 = 21.11$ with 1 *df*, p = 0.000) were more likely to drop out than other participants. No other differences in baseline characteristics were found between completers and dropouts." p. 260 **Interventions:** "After randomization, the participants in the intervention group received a cognitive behavior therapy based bibliotherapy intervention, which consisted of an information leaflet the "Coping with Depression" (CWD) self-help manual. The CWD course includes instructions on cognitive behavior self-help with mood management skills and exercises, and it has been found to be effective in reducing depressive symptoms in several randomized clinical trials, in group, individual and minimal-contact format. For our study, the CWD manual was adapted for individual use in a sample of patients who were aged 75 years and older. The intervention protocol was developed in collaboration with the Netherlands Institute for Mental Health and Addiction. Participants in the intervention group were visited for a maximum of 1 hour by a specially trained home care nurse three times during a period of 12 weeks. During the first visit, the nurse gave the participant a leaflet containing information and tips on how to deal with subthreshold depression. During the second visit from the nurse, 1 or 2 weeks later, the leaflet was briefly discussed, and the CWD self-help manual was given to the participants. During the last visit, 8 or 9 weeks after the first visit, the CWD course was evaluated with the participant. On average, a nurse visited the participants three times and telephoned them twice during the intervention period to discuss their progress, answer questions, and encourage them to continue with the course. However, the participants were free to decide whether they would read the information and do the exercises described in the manual." p. 258-259 **Comparators:** "Participants in both groups had unrestricted access to usual care for their depression or anxiety symptoms. Their use of healthcare services and prescribed medications was recorded." p. 259

	Outcomes: *"*The primary outcome measure was the CES-D scale. This instrument was designed for screening and monitoring depression and consists of 20 items with a score ranging between 0 and 60. Higher scores indicate greater psychological distress, and scores of 16 and above indicate the presence of clinically significant depression. The CES-D has been widely used in older community samples24 and has good psychometric properties in elderly samples. The Dutch translation had similar psychometric properties in three previously studied samples of elderly in the Netherlands. The CES-D score was measured at baseline after the period of watchful waiting (pretest) and 3 months after baseline (posttest). Bibliotherapy was part of a stepped-care program, but all the other steps in the program were offered after the posttest measurement." p. 259 **Settings:** *"*Thirty-three general practices in the north-western region of the Netherlands." *p. 256*

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
	Conditional *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
X	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

The panel cannot make a recommendation for use of self guided bibliotherapy for individuals age 75+ given the limited benefit, potential burden and high attrition without the clinician's knowledge of the patient's motivation or capacity to participate in a self guided intervention.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

Slightly greater burden for self guided bibliotherapy with no clear evidence of benefit; however, those who did not prefer self guided bibliotherapy chose not to participate in the intervention after being assigned to the condition. This intervention would be recommended only for individuals known to have sufficient motivation and cognitive capacity to participate.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): [List intervention and populations for vote below. For example: "Use of intervention A in population A."					

American Psychological Association
Decision Table Template for Generating Recommendations (version February, 2015)
Topic # 51 - Coping improvement (group) compared to therapy upon request (individual) for treating mild to severe depressive symptoms in adults ages 50 and older with HIV

Factor	Explanation/Comments
II. Aggregate/Global Strength of Evidence (SOE) **(from evidence profiles)**	
V. Treatment Outcomes/Consequences • **Benefits** of the Treatment	
• **Harms** of the Treatment	
• **Burdens** of the Treatment *(Note- do not include financial cost)*	
Balance of Benefits to Harms/Burdens of Treatment	
LV. Patient Values and Preferences	
LVI. Applicability of Evidence	

❖ **Recommendation Direction** *Based on the net benefit and other factors, what is the treatment decision?*	
❖ **Strength of Recommendation**	
❖ **Recommendation (text)**	
❖ **Justification for recommendation**	

Recommendation Worksheet

Topic # 51 - Coping improvement (group) compared to therapy upon request (individual) for treating mild to severe depressive symptoms in adults ages 50 and older with HIV

Factor	Summary of Reasons for Judgment/ Evidence
I) Aggregate Strength of Evidence (SOE) (from evidence profiles) *What is the global strength/quality of the evidence?* **Note:* *- The higher the SOE, the more likely a strong recommendation is warranted.* *-Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear).*	Rate the quality of the evidence grade for each outcome from the evidence profiles:

Outcomes	Quality of Evidence Grade for Outcomes			
	High	Moderate	Low	Insufficient/ Very Low
Response (follow up: 4 months; assessed with: GDS (≥50% reduction))			X	
Response (follow up: 8 months; assessed with: GDS (≥50% reduction))				X
Outcomes for which no estimable information was found: functional capacity, remission, quality of life, patient satisfaction, relapse, recurrence, and serious adverse events.				

Note- Response to treatment and serious adverse events were deemed *critical* outcomes by the panel. All other outcomes were deemed *important*.

	Assign global strength of evidence grade across outcomes (from evidence profiles only): **Global SOE Grade:** ☐ High ☐ Moderate ☐ Low X Insufficient/ Very Low **Notes/Comments**: Because serious adverse events are not reported and that is a critical outcome, the SOE is rated as insufficient/ very low.

II) Balance of Benefits and Harms/Burdens

What is the balance between benefits and harms/burdens?

**Note- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.*

First, list quantitative information on benefits from evidence profiles:

Bibliography (systematic reviews): Heckman et al., 2011

		№ of patients		Effect		Quality
№ of studies		**coping improvement (group)**	**therapy upon request (individual)**	**Relative (95% CI)**	**Absolute (95% CI)**	
Functional Capacity						
				Not Estimable	Not Estimable	
Response (follow up: 4 months; assessed with: GDS (≥50% reduction))						
1	See Footnotes #1 and #2	19/104 (18.3%)	7/86 (8.1%)	RR 2.24 (0.99 to 5.09)	101 more per 1000 (from 1 fewer to 333 more)	⊕⊕◯◯ LOW
Response (follow up: 8 months; assessed with: GDS (≥50% reduction))						
1	See Footnotes #1 and #3	21/104 (20.2%)	14/86 (16.3%)	RR 1.24 (0.67 to 2.29)	39 more per 1000 (from 54 fewer to 210 more)	⊕◯◯◯ VERY LOW
Remission						
				Not Estimable	Not Estimable	
Quality of Life						
				Not Estimable	Not Estimable	
Patient Satisfaction						
				Not Estimable	Not Estimable	
Relapse						
				Not Estimable	Not Estimable	

Recurrence						
				Not Estimable	Not Estimable	
Suicidality						
				Not Estimable	Not Estimable	
Adverse Events						
				Not Estimable	Not Estimable	

MD – mean difference, RR – relative risk

Footnote #1 - risk of bias from failure to conceal allocation from study coordinator
Footnote #2 - Small sample size and/or number of events, does not meet optimal information size to detect differences
Footnote #3 - Small sample size and/or number of events, does not meet optimal information size to detect differences, confidence intervals cross appreciable difference

Number needed to treat (NNT) (95% Confidence Interval)
Response (follow up: 4 months; assessed with: GDS (≥50% reduction)): NNT = 10 (NNT(benefit) 5 to 138)
Response (follow up: 8 months; assessed with: GDS (≥50% reduction)): NNT = 26 (NNT(harm) 15 to ∞ to NNT(benefit) 6)

Next, list and rate each benefit from the evidence profile information:
Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
1. Response (follow up: 4 months; assessed with: GDS (≥50% reduction))		X				
2. Response (follow up: 8 months; assessed with: GDS (≥50% reduction))			X			

#1 based on NNT (if 95% CI encompasses 0, rating might well be no effect)

Second, list quantitative information on harms from evidence profiles:

No estimable information found on serious adverse events.

Note any other information on harms from published studies:

Heckman et al. (2011)

Harm

- Dropout: 13.5% (*14 of 104*) coping group vs. 5.8% (*5 of 86*) ITUR control
  - Statistically significant difference in attrition rates
  - 25 individuals in the ITUR control group received individual therapy
- "No adverse events were reported"
- Treatment adherence: "facilitators followed detailed manuals to increase fidelity to intervention protocol. Facilitators completed intervention content checklists at the conclusion of each session to encourage a more thorough coverage of all assigned topics."

Note any other information on burdens from published studies:

Burden

- 12, 90-min group sessions in treatment group
- Groups had two cofacilitators
- Most intervention facilitators had a Masters degree in Psychology or Social Work and had provided mental health support services to persons living with HIV/AIDS for more than 10 years
- 41% of coping group individuals attended 8 or fewer sessions
- Participants received $5 cash honorarium for each group session they attended; ITUR received $20 for participating in each of the three brief phone contacts in the study (all participants had the ability to earn a total of $60)

Other studies:

None

Note any additional information on harms:

Note any additional information on burdens:

Next, list and rate each harm/burden:

Note- Potential ratings are indicated with an "o"

Outcomes:	Large/Modest benefit	Small benefit	No effect	Small harm/ burden	Modest/Large harm/ burden	Unable to rate
3. Adverse events leading to withdrawals						X
4. Other serious adverse events						X
5. Other adverse events						X
6. Burdens				X		

Assign an overall global rating across outcomes:

☐Benefits clearly outweigh harms/ burden
☐Benefits slightly outweigh harms/ burden
X Benefits and harms/ burden are balanced
☐Harms/ burden slightly outweigh benefits
☐Harms/ burden clearly outweigh benefits

Notes/Comments:

This reflects a conservative choice by the panel.

III) Patient Values and Preferences

What are the typical patient values and preferences?

How variable are these?

How certain is the panel about these?

**Note-The greater variability in patient values and preferences, or greater uncertainty (for any reason), the more likely a conditional recommendation is warranted.*

Patient values and preferences based on:

Information from research studies:

Wu et al. (2014). Individual counseling is the preferred treatment for depression in breast cancer survivors. Journal of Psychosocial Oncology.
Abstract: "A substantial number of cancer patients experience depression. This study investigated treatment preferences for depression. Breast cancer survivors (N = 134) completed an anonymous survey asking preference and interest in three treatments for depression: individual counseling (IC), antidepressant medication (MED), or support groups (SG). Participants were recruited from a surgical oncology office and asked to complete the survey as they waited for their appointment. Preference was compared using Wilcoxon Signed Ranks tests. **More than 50% ranked IC as first choice of treatment. Preference for IC was significantly higher than preference for MED and SG. Preference between MED and SG did not differ.** Survivors preferred counseling for treatment of depression. Cancer centers should be prepared to provide preferred treatment methods, particularly as screening, and therefore management, of psychosocial distress is to be required."
Gitlin et al. (2012). Identification of and beliefs about depressive symptoms and preferred treatment approaches among community-living older African Americans. American Journal of Geriatric Psychiatry.
Abstract: "*Objective*: To examine older African American's recognition of and beliefs about depressive symptoms, preferred symptom management strategies, and factors associated with willingness to use mental health treatments. Differences between depressed and non-depressed and men and women were examined. Design: Cross-sectional survey. *Setting*: Home, senior center. Participants: 153 senior center members (56=males, 97=females) ≥55 years. *Measurements*: Using a depression vignette, participants indicated if the person was depressed and their endorsement of items reflecting beliefs, stigma, symptom management, and willingness to use treatments (yes/no). PHQ-9 assessed current symptomatology. **Results**: Overall, 24.2% reported depressive symptoms (≥5); 88.2% correctly identified the person in the vignette as depressed**. Most (≥75%) endorsed active symptom management strategies, preference for treatment in physician and therapist offices, and willingness to take medications, seek therapy, see doctor and attend support groups**; <33% viewed depression as stigmatizing whereas 48% viewed depression as normal aging. Logistic regressions revealed lower education, higher physical function and feeling okay if community knew of depression diagnosis were associated with willingness to see physician if feeling depressed; being married and believing anti-depressant medications are beneficial were related to willingness to use medications. Different associations emerged for depressed/non-depressed and men and women. *Conclusions*: Overall, this older African American sample had positive attitudes and beliefs and endorsed traditional treatment modalities suggesting that beliefs alone are unlikely barriers to underutilization of mental health services. As different factors were associated with willingness to seek physician help and use medications and factors differed for depressed/non-depressed and by sex, interventions should be tailored."

	Raue et al (2012): "*Objective:* The authors hypothesized that the depression treatment preferences of elderly home care patients would vary by depression experience, with preferences for active treatments being associated with current depression and antidepressant treatment. *Methods:* The authors conducted **cross sectional secondary analyses of the TRIAD ("Training in the Assessment of Depression") study of 256 randomly selected elderly patients newly admitted to homecare.** The study assessed depression treatment preference for active (i.e., medication or psychotherapy) versus non-active or complementary approaches (e.g., religious activities, do nothing). Two separate indicators of depression experience were used: diagnoses of major or minor depression, and current or previous antidepressant treatment. *Results:* **121 patients (48%) preferred active treatment with either medication or psychotherapy as their first choice, while the remainder preferred non-active or complementary approaches. Logistic regression indicated that current antidepressant use, previous psychotherapy experience, white and Hispanic versus African-American patients, greater IADL impairment, and less personal stigma about depression were independently associated with preference for an active treatment.** *Conclusions:* Elderly homecare patients have a variety of depression treatment preferences ranging from active treatments, to religious or spiritual activities, to no treatment. **Several factors were associated with a preference for active treatment, including treatment experience, co-existing physical impairment, culture, and attitudes and beliefs.** Understanding patient preferences may form the basis of engaging older depressed home care patients in treatment." *Information from community members on panel:* *Information from clinicians on panel:* *Information from other sources (also list sources):* In this study, participants preferred an active treatment to either waiting or making a request themselves.

Next rate the variability of and your certainty about patient values and preferences:

✓	Variability in Patient Values & Preferences	✓	Certainty in Patient Values & Preferences
	High		High
x	Moderate	x	Moderate
	Low		Low
	Unknown		Unknown

Next combine across ratings into an overall rating on the following scale:

☐ Similar values and little uncertainty

X ☐ Some variation or some uncertainty

☐ Large variation or significant uncertainty

Write synthesized summary statement incorporating the ratings of variability and certainty with qualitative descriptions of patient values and preferences:

Based on this study as well as other relevant studies, it seems that clients have a preference for active tx over waiting for tx or having to make that choice. In

Notes/Comments:

IV) Applicability of Evidence

How relevant/generalizable is the evidence to the clinical target populations?

Consider which factors are most likely to affect applicability and make judgments of applicability based on those factors. Use this PICOTS framework to record limitations of evidence pertaining to applicability that may affect strength of recommendation grade assigned.

PICOTS Framework for applicability limitation/concerns

Parameter	Potential Applicability Issues
Patients / Populations	50+, HIV +; range in severity of depressive sxs; substantial proportion of AA men living in poverty; about half MSM- fairly circumscribed participant group
Interventions	Universal intervention (included some who did not have sxs)
Comparators	Choice for an active tx
Outcomes	
Timing or Time frame	
Settings	

Notes/Comments:
From Heckman et al., 2011

Patients/Populations:

"Based on national epidemiologic data (Centers for Disease Control, Prevention 2006), the study's cohort appeared to be representative of persons 50-plus years of age living with HIV/AIDS in the United States. Most participants were African American (49%), male (67%), and earned less than $10,000 per year (54%). The average participant was 55.3 years of age (range = 50–76), had completed 13.0 years of education, and had been living with HIV for 12.5 years. Fifty-one percent of participants self-identified as gay or bisexual. Forty-four percent of participants self-reported taking one or more psychotropic medications at pre-intervention (most commonly anti-depressants and anxiolytics). The mean GDS value at pre-intervention was 12.01 (SD = 7.8). Based on GDS cutoffs, 42% of participants had ''normal'' levels of depressive symptoms at study entry (GDS values 0–9), 36% had ''mild'' depressive symptoms (GDS values 10–19), and 22% had ''moderate-to-severe'' depressive symptoms (GDS values 20–30). While the three intervention conditions did not differ at

pre-intervention on any demographic variable shown in Table 1, slight differences were observed on the GDS at pre-intervention, F(2,290) = 2.5, P = .081. Tukey HSD post-hoc comparisons found that coping intervention participants (M = 13.2) reported marginally greater GDS values at preintervention than ITUR controls (M = 10.8), P = .073. Intervention participation and attrition The number of intervention sessions that coping (M = 7.4, SD = 4.3) and interpersonal support intervention (M = 7.5, SD = 4.3) participants attended was comparable, F(1,207) = 0.6, P = .80. A categorical breakdown of the number of intervention sessions attended by coping intervention participants was: 0 sessions (8%); 1–4 sessions (20%); 5–8 sessions (13%); 9–11 sessions (42%); and 12 sessions (17%). Intervention session attendance in interpersonal support intervention participants was: 0 sessions (11%); 1–4 sessions (17%); 5–8 sessions (13%); 9–11 sessions (43%); and 12 sessions (16%). No preintervention variable predicted number of intervention sessions attended by participants (i.e., gender, education, years since HIV diagnosis, HIV/AIDS status, ethnicity; all Ps[.10)." p. 106

Interventions:

"Coping Improvement Group Intervention. Individuals in this condition (n = 104) participated in a 12-session, coping improvement group intervention based on Lazarus and Folkman's Transactional Model of Stress and Coping. Separate intervention groups were conducted for MSM, heterosexual men, and women. In our formative research, HIV-infected older adults expressed a reluctance to participate in an AIDS mental health group intervention if groups were heterogeneous in sexual orientation (Heckman et al. 2006). Each 90 min intervention group consisted of six to eight participants and was co-facilitated by two clinicians. Most intervention facilitators had a Masters degree in Psychology or Social Work and had provided mental health support services to persons living with HIV/AIDS for more than 10 years. The intervention's 12 sessions addressed the following topics: participant-facilitator introductions and participants' sharing of personal histories (Sessions 1 and 2); appraisal and changeability of stressors related to one's HIV infection (e.g., treatment side effects) and stressors related to normal aging (e.g., comorbid health conditions; Sessions 3 and 4); developing and implementing adaptive problem- and emotion-focused coping skills (Sessions 5 through 9); optimizing coping efforts through the use of interpersonal supports (Sessions 10 and 11); and termination issues and the voluntary sharing of personal contact information (e.g., e-mail addresses, telephone numbers; Sessions 12).

Interpersonal Support Group Intervention. Individuals in this condition (n = 105) participated in a 12-session, interpersonal support group intervention. Similar to the coping intervention, each 90 min group was conducted separately for MSM, heterosexual men, and women and was co-facilitated by two Masters-level clinicians. For each session, the first 45 min focused on a topic assigned by the co-facilitators (e.g., HIV-related nutrition, treatment adherence, sexual risk reduction). During this time, participants viewed a brief, commercially-available videotape on the assigned topic and discussed how the videotape required adaptation to be relevant for HIV-infected older adults. For the final 45

	min, participants discussed how the session's topic pertained to their personal lives. Similar to the coping intervention, all participants were encouraged to share personal contact information at the end of the final session to facilitate communication among participants upon intervention termination. Participants in both active intervention conditions received a $5 cash honorarium for each of the twelve intervention session they attended (paid to them at the end of the session). All ITUR control participants received $20 for each of the three brief telephone contacts in which they participated during the clinical trial (for a total possible amount of $60). By offering this additional $60 to ITUR controls, all participants had the opportunity to earn $60 above-and-beyond the $150 they could earn for completing all four assessment instruments. This practice also ensured that there was no ''Condition x Incentive Payment Amount'' confound. For both interventions, facilitators followed detailed manuals to increase fidelity to intervention protocol. Facilitators completed intervention content checklists at the conclusion of each session to encourage a more thorough coverage of all assigned topics." p. 105 **Comparators:** "Individual Therapy upon Request (ITUR) Control Group. ITUR controls (n = 86) received no active intervention but had access to standard psychosocial services available in the community (e.g., AIDS-related support groups, 12-step programs, individual therapy) and received three brief telephone contacts during the intervention period to ensure that no clinical concerns had developed. No limitations were imposed on participants' use of community- based services. ITUR controls experiencing acute periods of distress were encouraged to contact the study team to request brief and time-limited individual therapy (not to exceed 12 sessions). Twenty-five ITUR controls (i.e., 29%) requested and received brief individual therapy during the study (average 5.8 sessions, mode = 3). All ITUR participants who requested individual therapy received therapy. ITUR participants who received individual therapy were included in all intervention-outcome analyses." p. 104-105

Treatment Decision

Based on the net benefit and other factors, what is the treatment decision?

What strength grade is assigned to the recommendation?

Note: Panels should aim to avoid making no recommendation. If no recommendation is made, as much reliable information as possible about treatment choice should be provided.

Based on the above factors, select the recommendation decision. Wording examples are provided.

×	***Recommendation Statement Wording Options by Strength/Grade***
	Strong *recommendation for use.* **We recommend the treatment:** *"We recommend…"* *"Clinicians should…"* *"Do…"*
X	***Conditional*** *recommendation for use.* **We suggest using the treatment:** *"We suggest…"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Conditional *recommendation against use.* **We suggest not / against using the treatment:** *"We suggest…[not/against]"* *"Clinician's might…"* *"We conditionally recommend…"* *"We make a qualified recommendation that…"*
	Strong *recommendation against use.* **We recommend not / against using the treatment:** *"We recommend…[not using]"* *"Clinicians should not…"* *"Don't…"*
	No Recommendation. *"The panel concludes that the evidence is insufficient to recommend for or against …"*

Recommendation #_____

Recommendation written out as an action statement:

Conditional recommendation for group intervention for men living with HIV and chronic stress, given the evidence of a small short term benefit and small burden of participating in sessions.

Provide a concise summary of the reasoning behind the above recommendation, including relative value attributed to the strength of evidence, patient values/preferences, and applicability of the research evidence:

A conditional recommendation for use in middle aged men living with HIV and chronic stress because there is evidence for a small short term benefit and evidence of small burden.

Voting Grid (If needed)

If a consensus is not reached through informal discussion and debate, the panel members can use the grid below to record their individual views (or votes) about the recommendation. When using the voting grid below to vote, please consider the strength of the evidence, balance of benefits to harms/burdens, patient values and preferences, and applicability of the evidence. Please remember the following points:

- The higher the strength of evidence (SOE), the more likely a strong recommendation is warranted.

  (Recommendations are typically based on High or Moderate grade SOE, but may be based on Low grade evidence when appropriate (e.g., when magnitude of harms is low [with SOE high/moderate for harms] and patient preferences are clear.)

- The larger the difference between benefits and harms, the more likely a strong recommendation is warranted. The smaller the difference (the more balanced) the more likely a conditional recommendation is warranted.

- The greater variability in patient values and preference, or greater uncertainty (for any reason) the more likely a conditional recommendation is warranted.

- Consider any applicability issues based on PICOTS and whether any differences would be large enough to make a difference in outcomes likely.

Considering all the above factors, for each proposition below, please mark with an "X" the cell that best corresponds to your assessment of the available evidence, in terms of advantages versus disadvantages.

Balance between desirable and undesirable consequences of intervention	**Desirable clearly outweigh Undesirable**	**Desirable probably outweigh undesirable**	**Trade-offs equally balanced or uncertain**	**Undesirable probably outweigh desirable**	**Undesirable clearly outweigh desirable**
Recommendation Strength and Direction	**Strong for using**	**Conditional for using**	**No Recommendation**	**Conditional against using**	**Strong against using**
Use of (as opposed to no use of): **[List intervention and populations for vote below. For example: "Use of intervention A in population A."**					

Appendix D

Definition of Key Terms

Advisory Steering Committee (ASC). The Advisory Steering Committee is a group of distinguished psychologists appointed by the APA Board of Directors (BOD) to oversee APA's CPG development process. The ASC selects which nominated topics will be considered for guidelines and assembles the Panels who write the guidelines, but they are not directly involved in conducting SRs, nor in writing CPGs. In addition, while the ASC reports to the BOD and was initially constituted by a subcommittee representing the Board of Professional Affairs (BPA), the Board of Scientific Affairs (BSA), and the Committee for the Advancement of Professional Practice (CAPP), the ASC operates autonomously from APA governance to prevent real or perceived COIs.

Agency for Healthcare Research and Quality (AHRQ). One of 12 agencies within the Department of Health and Human Services, AHRQ supports research that helps people make more informed decisions and improves the quality of health care services. AHRQ's mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans, with the following focus areas: comparing the effectiveness of treatments; quality improvement and patient safety; health information technology; prevention and care management; and health care value. AHRQ develops systematic reviews on topics of greatest public health impact. Topic nomination is an open process through AHRQ's Effective Healthcare Program; APA plans to use this mechanism to support SRs for CPG development.

Applicability. Consistent with the aim of comparative effectiveness research, that is, to help consumers, clinicians, purchasers, and policy makers to make informed decisions that will improve health care at both the individual and population levels. Applicability is analogous to as external validity or generalizability (IOM, 2011a).

Benefit. A positive or valued outcome of an action or event.(IOM, 2011a).

Bias. A systematic deviation or process that favors one outcome over others (Gluud, 2006). Bias may lead to under- or over-estimation of treatment effects. It is impractical and most likely impossible to quantify every potential source of bias that may influence an individual study (Chavalarias & Ioannidis, 2010); however, a number of specific methodological flaws or limitations in research design, implementation, analysis, and evaluation often produce biased outcomes.

Comparative effectiveness research (CER). The generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, and monitor a clinical condition or to improve the delivery of care. The purpose of CER is to help consumers, clinicians, purchasers, and policy makers to make informed decisions that will improve health care at both the individual and population levels. Also referred to as clinical effectiveness research (IOM, 2011a).

Confidence interval (CI). A confidence interval is a range around an estimate that conveys how precise the estimate is; for example an estimate of the risk of an event occurring or an estimate such as a risk ratio that compares the risk with and without an intervention. The confidence interval is a guide to how sure we can be about the quantity we are interested in. The narrower the range between the two numbers, the more confident we can be about what the true value is; the wider the range, the less sure we can be. The width of the confidence interval reflects the extent to which chance may be responsible for the observed estimate (with a wider interval reflecting more chance). 95% Confidence Interval (CI) means that we can be 95 percent confident that the true

size of effect is between the lower and upper confidence limit. Conversely, there is a 5 percent chance that the true effect is outside of this range (Treweek et al., 2013).

Effectiveness. The impact of an intervention compared to active treatment.

Efficacy. The impact of an intervention compared to an inactive control.

Estimate of effect. The observed relationship between an intervention and an outcome expressed as, for example, a number needed to treat to benefit, odds ratio, risk difference, risk ratio, standardized mean difference, or weighted mean difference.

Evidence. Information on which a decision or guidance is based. Evidence is obtained from a range of sources, including randomized controlled trials, observational studies, and expert opinion of clinical professionals or patients (IOM, 2011b).

Functional impairment. Limitations to carry out certain function the social and occupational spheres of life due to physical or mental illness.

GRADE (GRADE collaboration and Framework). The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Consortium Working Group, which began in the year 2000, is an international collaboration of scholars with an interest in addressing the shortcomings of present grading systems for CPGs in health care. The working group has developed a sensible and transparent framework for grading strength of evidence and strength of recommendations, typically referred to as “GRADE” (or the GRADE system). Many international organizations provided input into the development of the approach and have started using it (Guyatt et al., 2011; for further information, see http://www.gradeworkinggroup.org/).

Guideline Development Panel (GDP). A multidisciplinary Guideline Development Panel is assembled for the purpose of developing a specific CPG. GDPs are tasked with generating treatment recommendations from systematic reviews, and drafting the content of the CPGs. These activities take place independently from APA governance/staff, the ASC, and Systematic Review Teams, who play no part in developing the CPG recommendations. There is some interaction between the SRT and GDP to ensure that the systematic review will meet the needs of the CPG developers; yet, the nature of the interaction is transparent and circumscribed to maintain the objectivity and validity of both the systematic review and the CPG.

Harm. A hurtful or adverse outcome of an action or event, or with regard to CPGs, a treatment or health care decision/recommendation, whether temporary or permanent (IOM, 2011b).

Institute of Medicine (IOM). A private, nonprofit institution that provides objective, timely, authoritative information and advice concerning health and science policy to the government, the corporate sector, the professions, and the public under a congressional charter.

Meta-analysis. The use of quantitative statistical methods in a systematic review to integrate the results of included studies.

Outcome. A change resulting from an intervention. In evaluations, a potential consequence of an intervention that is measured after the intervention has been implemented, that is used to assess the potential beneficial and harmful effects of the intervention. **Critical outcomes** are the outcomes of greatest importance for answering key questions in systematic reviews (Boyd et al., 2012).

Patient-centeredness. Respect for and responsiveness to individual patient preferences, needs, and values; helps ensure that patient values and circumstances guide clinical decisions (IOM. 2011a).

PICOTS (questions) - Systematic reviews seek to answer clearly formulated key questions that will simplify decision-making about real world practices, and thereby inform CPG recommendations. These key questions are developed using the PICOTS framework, an acronym denoting components that should be specified in each key question: Patient populations (P), Interventions (I), Comparison conditions (C), Outcomes (O), Timing or timeframe (T), and Settings (S). For this reason, the key questions in systematic reviews are frequently referred to as *PICOTS* (or *PICOTS questions)*. *Timing* and *Settings* are newer additions to the framework; hence, key questions may also be called PICOS (or PICO questions) by some investigators.

Publication bias. A bias caused by only a subset of all the relevant data being available. The publication of research can depend on the nature and direction of the study results. Studies in which an intervention is not found to be effective are sometimes not published. Because of this, systematic reviews that fail to include unpublished studies may overestimate the true effect of an intervention. In addition, a published report might present a biased set of results (e.g. only outcomes or sub-groups where a statistically significant difference was found).

Quality of evidence. The extent to which one can be confident that the estimates of an intervention's effectiveness are adequate to support a particular decision or recommendation (IOM, 2011b; Schünemann, Hill, Guyatt, Akl, & Ahmed, 2011). AHRQ uses “strength of evidence” (SOE) to refer to the same basic concept.

Randomized controlled trial (RCT). An experiment in which two or more interventions, often including a control intervention or no intervention, are compared by randomly allocating participants to the interventions. The term ‘trial’ is sometimes used to refer to randomized controlled trials (RCTs); however, the term may also be used to refer to quasi-randomized trials (which do not randomly assign participants to groups).

Relative Effects. A quantitative measure for evaluating harms and benefits of treatment, expressed as the ratio of two indicators of the frequency of the outcome. A *risk ratio* (RR) is the ratio between the risk (incidence) of the outcome event in the intervention group and the risk in the control group. For example, if the risk of the outcome event in the intervention group is 5% (5 per 100) and the risk in the control group is 20% (10 per 100), the RR is .05 / .20 = .25. If the RR is less than 1, the risk of the outcome event in the intervention group is less than the control group. If the RR is equal to 1, the risk in the two groups is equal. If the RR is greater than 1, the intervention increases the risk of the outcome compared to the control group.

An odds ratio (OR) is also a measure of relative effects, in this case, the odds (not risk) in the intervention group compared to the odds (not risk) in the control group. An odds is a mathematical formula for the probability of an event happening divided by the probability of that event not happening or, mathematically: odds = p / (1-p). Thus, if the risk in the intervention group is 5% (i.e., .05), then the odds in the intervention group is .05 / .95 = .05 (with rounding). If the risk in the control group is .20, then the odds in the control group is .20 / .80 = .25. The odds ratio is then .05 / .25 = .20. Odds ratios can be interpreted similarly to risk ratios. However, when the risk of the outcome event is high, the odds ratio will be different from the risk ratio.

Risk of bias. The extent to which flaws in the design and execution of a collection of studies could bias the estimate of effect for each outcome under study (IOM, 2011b).

Strength of Evidence. The extent to which one can be confident that the estimates of an intervention's effectiveness are adequate to support a particular decision or recommendation (IOM, 2011b; Schünemann et al., 2011). GRADE uses “quality of evidence” to refer to the same basic concept.

Strength of Recommendation. The strength of a recommendation reflects the extent to which one can be confident that the desirable outcomes of a treatment alternative outweigh the undesirable outcomes, across the range of patients to whom the recommendations apply (IOM, 2011b; Schünemann et al., 2011).

Study Quality. For an individual study, study quality refers to all aspects of a study’s design and execution and the extent to which bias is avoided or minimized. A related concept is internal validity; that is, the degree to which the results of a study are likely to be true and free of bias (IOM, 2011b).

Systematic Review (SR) - A rigorous approach to synthesizing data from research studies on the benefits, harms and effectiveness of alternative treatment options that pertain to a particular clinical population (IOM, 2011b). Systematic reviews use pre-specified criteria for screening, selecting, appraising, grading, and synthesizing outcomes, from a body of research studies, to answer specific clinical questions in areas of uncertainty. SRs seek to minimize bias by using explicit, standardized procedures (Green et al., 2008). The use of standardized criteria enhances the reliability of the findings and confidence in the conclusions about the relative advantages of alternate treatment approaches (IOM, 2011a).

Transparency. Methods are explicitly defined, consistently applied, and available for public review so that observers can readily link judgments, decisions, or actions to the data on which they are based. Allows users to assess the strengths and weaknesses of the systematic review or CPG (IOM, 2011a).

Treatment Recommendation. In the context of CPGs, treatment recommendations are statements that propose a course of action with respect to a specific health care service, test, psychotherapy or pharmacotherapy etc., or procedure. Well-constructed recommendations specify what should be offered or provided to patients, as well as under what specific conditions the recommendation applies (Rosenfeld & Shiffman, 2009; Shiffman, 2009). In addition, the IOM (2011b) specifies that CPG recommendations should include alternative treatment options.

Appendix E

APA Declarations/COI form

American Psychological Association

Clinical Practice Guideline Initiative

CONFLICT OF INTEREST POLICY

and

DECLARATION OF INTERESTS

2018

Covered Individual (please type your name and current date)

Name:

Date:

Please indicate with an 'X' your role(s) in the initiative:

___ Advisory Steering Committee (ASC) Member

___ Guideline Development Panel (GDP) Member

→ *If GDP Member, please name the topic of the Panel:*

___ Consultant

___ APA Staff Member

Instructions:

Please read the Conflict of Interest Policy, fill out the Declaration of Interests, and sign the statement at the end. (ASC Members: Please also read supplementary instructions.)

Conflict of Interest Policy

It is the aim of the American Psychological Association ("APA") to transact all of its business, including the APA clinical practice guideline initiative, lawfully and impartially. In some situations, the relationship of a Covered Individual (as defined below) with a third party, financial or otherwise, could reasonably be construed to create a conflict between the interests of APA and the interests of the Covered Individual.

Covered Individuals are required to disclose to APA any actual, potential, or perceived conflict of interest (COI) with APA or with their role in the clinical practice guideline initiative, including conflicts from the past 12 months and expected conflicts in the upcoming 12 months. A COI may be of a financial, intellectual, or other nature, as defined below. APA requires Covered Individuals to disclose COIs prior to official appointment to a committee/Panel or as a consultant, as well as at the time points noted below. The existence of COIs will not necessarily preclude participation in the guideline initiative, although it may require limiting a Covered Individual's role. APA staff involved in the initiative may also be asked by their supervisors to disclose COIs, following the same policy as for Covered Individuals.

This policy is designed to promote transparency, to protect the integrity of the guideline initiative, and to provide a mechanism to help protect Covered Individuals and APA from legal concerns associated with conflicts of interest.

Covered Individuals: This policy applies to members of the Advisory Steering Committee and the Guideline Development Panels of the APA clinical practice guideline initiative and to consultants who are formally engaged by APA for work on the initiative.

Term: Covered Individuals shall be bound by this conflict of interest policy during the official term of their position on the committee/Panel or as a consultant.

Definition of COI: A 2011 report from the Institute of Medicine includes the following definition of COI: "a divergence between an individual's private interests and his or her professional obligations such that an independent observer might reasonably question whether the individual's professional actions or decisions are motivated by personal gain, such as financial, academic advancement, clinical revenue streams, or community standing." (See Institute of Medicine, 2011, p. 78; the definition is drawn from Schünemann et al., 2009, p. 565.)

The Institute of Medicine report also discusses intellectual COIs relevant to clinical practice guidelines, which it defines as "academic activities that create the potential for an attachment to a specific point of view that could unduly affect an individual's judgment about a specific recommendation" (Institute of Medicine, 2011, p. 78; this definition is drawn from Guyatt et al., 2010, p. 739.)

COIs can arise in various situations and may involve the individual or a member of the individual's family (spouse, domestic partner, parent, child, or other close relative). Examples of potential COIs include, but are not limited to, the following:

- Receiving payment for directly providing, or training other professionals to provide, health services related to the topic(s) of the guideline(s) being developed.
- Receiving honoraria for presentations or discussions of scientific or clinical issues related to the topic(s) of the guideline(s) being developed.
- Receiving royalties for books or other materials that address scientific or clinical issues related to the topic(s) of the guideline(s) being developed.
- Receiving funding, in the form of grants or contracts, for research on scientific or clinical issues related to the topic(s) of the guideline(s) being developed.

- Serving in a governance or other volunteer position in an organization that provides health services, promotes research related to health services, or develops or advocates for health service policies, related to the topic(s) of the guideline(s) being developed.
- Having strongly held opinions or other intellectual biases that might compromise objectivity in addressing the topic(s) of the guideline(s) being developed.
- Having a significant ownership interest in or significant capacity to influence decisions of a firm or organization that is an APA competitor, customer, or supplier, or a firm that conducts research or provides health services related to the topic(s) of the guideline(s) being developed.
- Being employed by or performing other work (including consulting) for a competitor, customer, or supplier of APA, regardless of the nature of that work.
- Conduct of APA business of any kind, or arranging for such business, with a firm that one owns or controls.
- Acceptance of any money, property, or anything of value from a person or firm doing or seeking to do business with APA.
- Receipt of direct or indirect economic benefit as a consequence of acquisition, lease, or sale by APA of any property, facilities, materials, or services.

COI Reporting: Covered Individuals must complete a Declaration of Interests form (appended below) disclosing any actual, potential, or perceived COIs prior to appointment to a committee/Panel or as a consultant, and thereafter on an annual basis. If, during the year, a change occurs in a Covered Individual's COIs or in his/her family members' COIs, the Covered Individual must report that information immediately to APA staff who work on the clinical practice guideline initiative, who will share it with the relevant committee/Panel Chair or Vice Chair. Covered Individuals are expected to provide any updates regarding their COIs orally at the beginning of all official committee/Panel meetings.

In addition, Covered Individuals should disclose any professional papers or presentations on which they are listed as authors, prior to publication or delivery, that pertain to the topic(s) of the guideline(s) with which they are involved. This disclosure should be made to APA staff involved in the initiative.

If a Covered Individual is unsure whether particular information should be reported, or if the information is sensitive or confidential, the Individual may first consult with APA staff involved in the initiative about whether and how to report it. With the individual's permission, the staff may then seek further guidance from the Chair or Vice Chair of the relevant committee/Panel.

Disclosure of any actual, potential, or perceived COI is the responsibility of everyone participating in the clinical practice guideline initiative. In general, if any Covered Individual or APA staff member is aware of circumstances that may constitute a COI involving another participant in the initiative, then he/she should first discuss it with that participant. If such a discussion is not appropriate or if the discussion does not produce a satisfactory result, then he/she should discuss it with APA staff and/or the relevant committee/Panel Chair or Vice Chair.

COI Review and Management: Each Covered Individual's completed Declaration of Interests form will be reviewed by APA staff and by the Chair and/or Vice Chair of the relevant committee/Panel (or only by APA staff for consultants). The individual's résumé or curriculum vitae, as well as publicly available materials about the individual, may also be examined in the course of the review. The primary purpose of the review is to determine whether the individual has any actual, potential, or perceived COIs that would preclude the individual from participation in the clinical practice guideline development initiative or require resignation from any role that he/she already has in the initiative.

Having one or more COIs does not necessarily mean that a Covered Individual cannot be involved in the initiative. If the reviewers determine that an individual's COIs do not preclude participation, then the reviewers will identify what actions, if any, may be needed to resolve or manage the impact of the COIs on the integrity (both actual and perceived) of the initiative. Examples of such actions may include

limitations on the individual's participation in discussions, deliberations, or voting on specific matters and not being counted in determining a quorum for all or portions of a particular committee/Panel meeting. Such actions would not prevent the individual from briefly stating his/her position or answering questions on relevant matters. Possible actions for managing the impact of COIs will be discussed with the Covered Individual, but final decisions on which actions are taken are made by APA staff in consultation with the relevant committee/Panel Chair and/or Vice Chair. In some cases, the APA General Counsel may participate in making such decisions. Also, in some cases in which the Covered Individual is a member of a Guideline Development Panel or a consultant, the Chair and/or Vice Chair of the Advisory Steering Committee may participate in making such decisions.

If any new COIs are reported or discovered during the period after a Declaration of Interests form has been submitted, APA staff and the relevant committee/Panel Chair and/or Vice Chair will determine whether any further actions are required for managing their impact on the initiative.

For Covered Individuals who are members of a committee/Panel, information about all actual, potential, and perceived COIs are shared with all other members of the committee/Panel. Information about all actions taken to resolve or manage the impact of COIs are also shared with all members of the committee/Panel.

Record of COIs: APA retains a copy of all completed Declaration of Interests forms and related documents. Summary information about Covered Individuals' COIs and of actions taken to manage their impact will be available for public view. (No information will be publicly released about people who are nominated or considered for positions on a committee/Panel or as consultants but not selected.) Additional information about COIs and actions taken may appear in meeting minutes and summaries, which will also be available for public view. It is also possible that additional information will be made public in response to inquiries.

References

Guyatt, G., Akl, E. A., Hirsh, J., Kearon, C., Crowther, M., Gutterman, D…Schünemann, H. (2010). The vexing problem of guidelines and conflict of interest: A potential solution. *Annals of Internal Medicine, 152*(11), 738–741.

Institute of Medicine (2011). *Clinical practice guidelines we can trust*. Washington, DC: National Academies Press.

Schünemann, H. J., Osborne, M., Moss, J., Manthous, C., Wagner, G., Sicilian, L.,…Jaeschke, R.. (2009). An official American Thoracic Society policy statement: Managing conflict of interest in professional societies. *American Journal of Respiratory Critical Care Medicine, 180*(6), 564–580.

Declaration of Interests

The purpose of this Declaration is to identify your actual, potential, and perceived conflicts of interest with APA and with your role in the APA clinical practice guideline initiative. Having conflicts of interest does not necessarily preclude participation in the initiative. Decisions about how conflicts should be managed will be made by APA staff in consultation with the Chair or Vice Chair of any committee or Panel of which you are a member.

Please answer the following questions by marking either 'Yes' or 'No' and then explaining any 'Yes' answers in the space immediately following or by attaching supplementary materials. When responding, please think about the full range of research, teaching, practice, writing, service work, and professional relationships in which you and your family members are involved. (You may consult with APA staff in advance if you have any questions or concerns about what information to provide on this form.)

The questions are organized into four sections:

- *Intellectual Interests*
- *Financial and Professional Interests*
- *Interests Related to APA*
- *Other Relevant Interests*

For the purposes of this Declaration, a family member is a spouse, domestic partner, parent, child, or other relative with whom you have a comparably close tie.

Please attach a CV, résumé, or other materials if these are needed to provide complete answers.

(Questions begin on next page.)

INTELLECTUAL INTERESTS

(The questions in this section concern only you, not family members.)

1. Scientific/educational/professional communications

Over the past 12 months, have you had any scientific, educational, or professional publications (including in-press) or made any scientific, educational, or professional presentations related to the topic(s) of the guideline(s) that you will be involved in developing or overseeing? Has your name been included on a relevant speakers' bureau list? Please include both paid and non-paid work.

___ Yes ___ No

Do you expect that, over the next 12 months, you will have any such publications or presentations or that your name will be included on a speakers' bureau list?

___ Yes ___ No

If 'Yes' to any of these questions, please provide a list of the relevant publications, presentations, courses, and speakers' bureaus. You may attach a copy of your CV or résumé but please make sure to add any items that do not yet appear on those documents.

[Insert material here]

----

2. Communications with general audiences

Over the past 12 months, have you made presentations to a general (non-academic, non-scientific) audience that address research, clinical, or policy issues related to the topic(s) of the guideline(s) that you will be involved in developing or overseeing? Have you been involved in organizing any events that include such presentations?

___ Yes ___ No

Over the past 12 months, have you published articles or books for a general audience or produced materials for television, radio, or the Internet (e.g., blogs, online petitions, Facebook, LinkedIn, TED Talks, Twitter, YouTube) that address these issues? Please include both paid and non-paid work. You need not include formal research publications for academic or scientific audiences.

___ Yes ___ No

Do you expect that, over the next 12 months, you will be involved in any such activities?

___ Yes ___ No

If 'Yes' to any of these questions, please provide a list of the presentations and published/posted materials. You may attach a copy of your CV or résumé but please make sure to add any items that do not yet appear on those documents.

[Insert material here]

----

3. Expert witness

Over the past 12 months, have you served as an expert witness in a court case or other legal proceeding on a matter related to the topic(s) of the guideline(s) that you will be involved in developing or overseeing?

___ Yes ___ No

Do you expect that, over the next 12 months, you will serve as an expert witness in a legal proceeding?

___ Yes ___ No

If 'Yes' to either question, please explain:

[Insert material here]

FINANCIAL AND PROFESSIONAL INTERESTS

(The questions in this section concern both you and family members. For the purposes of this Declaration, a family member is a spouse, domestic partner, parent, child, or other relative with whom you have a comparably close tie.)

4. Payment for services or training

Over the past 12 months, have you or a family member received payment for directly providing, or training other individuals to provide, health services related to the topic(s) of the guideline(s) that you will be involved in developing or overseeing? (Health services include professional, community-based, and peer support services.)

___ Yes ___ No

Do you expect that, over the next 12 months, you or a family member will receive any payment for such activity?

___ Yes ___ No

If 'Yes' to either question, please explain:

[Insert material here]
----

5. Honoraria

Over the past 12 months, have you or a family member received any honoraria for presentations or discussions of scientific or clinical issues related to the topic(s) of the guideline(s) that you will be involved in developing or overseeing? (Please include honoraria that were donated to charity.)

___ Yes ___ No

Do you expect that, over the next 12 months, you or a family member will receive any such honoraria?

___ Yes ___ No

If 'Yes' to either question, please explain:

[Insert material here]
----

6. Royalties

Over the past 12 months, have you or a family member received royalties or advance payments for books, films, or other materials that address scientific or clinical issues related to the topic(s) of the guideline(s) that you will be involved in developing or overseeing? (Please include royalties that were donated to charity.)

___ Yes ___ No

Do you expect that, over the next 12 months, you or a family member will receive any such royalties or advance payments?

___ Yes ___ No

If ‘Yes’ to either question, please explain:

[Insert material here]

----

7. Endorsements

Over the past 12 months, have you or a family member received monetary or other material compensation for endorsing a product or service related to the topic(s) of the guideline(s) that you will be involved in developing or overseeing? (Please include compensation that was donated to charity.)

___ Yes ___ No

Do you expect that, over the next 12 months, you or a family member will receive such compensation for an endorsement?

___ Yes ___ No

If ‘Yes’ to either question, please explain:

[Insert material here]

----

8. Research funding

Over the past 12 months, have you or a family member received funding, in the form of grants, fellowships, or contracts, for research or research training on scientific or clinical issues related to the topic(s) of the guideline(s) that you will be involved in developing or overseeing?

___ Yes ___ No

Do you expect that, over the next 12 months, you or a family member will receive any such funding?

___ Yes ___ No

If ‘Yes’ to either question, please explain:

[Insert material here]

----

9. Employer

Over the past 12 months, have you or a family member held a job with an employer that has economic, policy, or other interests in healthcare guidelines in general or in the particular topic(s) of the guideline(s) that you will be involved in developing or overseeing? (Please consider both full- and part-time positions and both permanent and temporary positions.)

___ Yes ___ No

Do you expect that, over the next 12 months, you or a family member will hold a job with an employer that has such interests?

___ Yes ___ No

If 'Yes' to either question, please explain:

[Insert material here]

----

10. Roles in organizations

Over the past 12 months, have you or a family member served in a governance, advisory, or other position in an organization (other than APA) that provides health services, promotes research related to health services, or develops or advocates for health service policies, related to the topic(s) of the guideline(s) that you will be involved in developing or overseeing?

___ Yes ___ No

Do you expect that, over the next 12 months, you or a family member will serve in such a position?

___ Yes ___ No

If 'Yes' to either question, please explain:

[Insert material here]

----

11. Influence/ownership/stock in health-related firms

Over the past 12 months, have you or a family member had a significant capacity to influence decisions of a firm or organization that conducts research or provides health services related to the topic(s) of the guideline(s) being developed? (Health services include professional, community-based, and peer support services.)

___ Yes ___ No

Over the past 12 months, have you and/or any family member(s) held an ownership interest greater than 5% in such a firm? Have you and/or any family member(s) owned stock in such a firm that exceeded $10,000 in value at any time during the past 12 months? (Please consider the total amounts held by you and family members, e.g., whether the stock that your spouse and your parent own adds up to more than $10,000 in value.)

___ Yes ___ No

Do you or any family member hold stock options of any value in such a firm?

___ Yes ___ No

Do you expect that, over the next 12 months, you or a family member will have such capacity to influence a firm or have such ownership or stock interests?

___ Yes ___ No

If ‘Yes’ to any of these questions, please explain:

[Insert material here]

INTERESTS RELATED TO APA

(The questions in this section concern both you and family members. For the purposes of this Declaration, a family member is a spouse, domestic partner, parent, child, or other relative with whom you have a comparably close tie.)

12. APA roles

Over the past 12 months, have you or a family member been a member of any APA governance group, task force, or advisory body? (Please include roles in APA divisions.)

___ Yes ___ No

Do you expect that, over the next 12 months, you or a family member will serve as a member of such an APA group?

___ Yes ___ No

If 'Yes' to either question, please explain:

[Insert material here]

----

13. Influence/ownership/stock in firms of interest to APA

Over the past 12 months, have you or a family member had a significant capacity to influence decisions of a firm or organization that is an APA competitor, customer, or supplier?

___ Yes ___ No

Over the past 12 months, have you and/or any family member(s) held an ownership interest greater than 5% in such a firm? Have you and/or any family member(s) owned stock in such a firm that exceeded $10,000 in value at any time during the past 12 months? (Please consider the total amounts held by you and family members, e.g., whether the stock that your spouse and your parent own adds up to more than $10,000 in value.)

___ Yes ___ No

Do you or any family member hold stock options of any value in such a firm?

___ Yes ___ No

Do you expect that, over the next 12 months, you or a family member will have such capacity to influence a firm or have such ownership or stock interests?

___ Yes ___ No

If 'Yes' to any of these questions, please explain:

[Insert material here]

----

14. Paid work with other firms that do business with APA

Over the past 12 months, have you or a family member been employed by or performed other work (including consulting) for a competitor, customer, or supplier of APA, regardless of the nature of that work?

___ Yes ___ No

Do you expect that, over the next 12 months, you or a family member will be engaged in such employment or work?

___ Yes ___ No

If 'Yes' to either question, please explain:

[Insert material here]

----

15. Business ties to APA

Over the past 12 months, have you or a family member conducted APA business of any kind, or arranged for such business, with a firm that is owned or controlled by you or a family member?

___ Yes ___ No

Do you expect that, over the next 12 months, you or a family member will conduct or arrange for such business?

___ Yes ___ No

If 'Yes' to either question, please explain:

[Insert material here]

----

16. Ties to others seeking business with APA

Over the past 12 months, have you or a family member accepted any money, property, or anything of value from a person or firm doing or seeking to do business with APA?

___ Yes ___ No

Do you expect that, over the next 12 months, you or a family member will accept any money, property, or anything of value from a person or firm doing or seeking to do business with APA?

___ Yes ___ No

If 'Yes' to either question, please explain:

[Insert material here]

----

17. Other economic benefits related to APA business

Over the past 12 months, have you or a family member received any direct or indirect economic benefit as a consequence of acquisition, lease, or sale by APA of any property, facilities, materials, or services?

___ Yes ___ No

Over the past 12 months, have you or a family member received any other direct or indirect economic benefit related to APA business that are not covered in the previous questions?

___ Yes ___ No

Do you expect that, over the next 12 months, you or a family member will receive any such economic benefit?

___ Yes ___ No

If 'Yes' to any of these questions, please explain:

[Insert material here]

OTHER RELEVANT INTERESTS

(The questions in this section concern both you and family members. For the purposes of this Declaration, a family member is a spouse, domestic partner, parent, child, or other relative with whom you have a comparably close tie.)

18. Other professional activities

Over the past 12 months, have you or a family member engaged in any other scientific, academic, clinical, business, or policy activities, either paid or unpaid, related to the topic(s) of the guideline(s) that you will be involved in developing or overseeing? (This question is asking about activities not already addressed in answers to the previous questions.)

___ Yes ___ No

Do you expect that, over the next 12 months, you or a family member will engage in other such activities?

___ Yes ___ No

If 'Yes' to either question, please explain:

[Insert material here]

----

19. Legal proceedings

At any point over the last 12 months, have you or a family member been under prosecution for a crime? Have you or a family member been involved in any civil legal proceedings as either defendant or plaintiff? (Please include all such legal proceedings, including those not related to the topic(s) of the guideline(s) you will be involved in developing or overseeing.)

___ Yes ___ No

If 'Yes' to either question, please explain:

[Insert material here]

----

20. Misconduct

At any point over the last 12 months, have you or a family member been formally charged with ethical, professional, or financial misconduct by any organization? (Please include all such charges, including those not related to the topic(s) of the guideline(s) you will be involved in developing or overseeing.)

___ Yes ___ No
If 'Yes," please explain:

[Insert material here]

---

21. Additional activities

Is there any other information regarding your or family members' activities, including interactions with organizations and individuals, that you believe is relevant to the guideline(s) that you will be involved in developing or overseeing or to your working with APA? Please focus on activities that may constitute actual, potential, or perceived conflicts of interest, and include activities that occurred *more* than 12 months ago or are expected to occur *more* than 12 months from now.

___ Yes ___ No

If 'Yes," please explain:

[Insert material here]

---

22. Relationships

Do you have any concerns that your work on guideline development or with APA could have a significant negative impact on any professional or personal relationships you have with mentors, students, trainees, colleagues, supervisors, funders, friends, or relatives? (For this question, please consider all relatives in addition to spouse, domestic partner, parents, and children.)

___ Yes ___ No

If 'Yes,' please explain:

[Insert material here]

Finally, please read, complete, and sign the following statement:

I have read and I understand the requirements of APA's Conflict of Interest Policy above and I agree to abide by the Policy throughout the official term of my position in the APA clinical practice guideline initiative.

I have also fully and truthfully answered the questions in the Declaration of Interests above about all actual, potential, and perceived conflicts of interest.

If any new actual, potential, or perceived conflicts of interest arise, I agree to disclose them immediately

to APA staff and to the Chair or Vice Chair of any committee or Panel of which I am a member.

_____ _____

Signature (type name) **Date**

Please email this document to Ms. Shannon Beattie at: sbeattie@apa.org

REMINDER: ***Please attach a CV, résumé, or other materials if these are needed to provide complete answers.***

For APA Staff Use Only

Appendix F

Voting Procedures Established by Advisory Steering Committee (ASC)

1) **What % should be considered a majority for winning a vote?**

The ASC agreed that at least 70% of the whole constituted panel would constitute a strong recommendation. For conditional recommendations, agreement among more than 50% with less than 20% of panel members preferring an alternative recommendation must be reached. The denominator for voting will be the number of the entire panel membership, except in special cases, to be determined by the ASC. Such cases could include the lack of participation by a particular member in the guideline development process. APA staff will consult with ASC liaisons to panels as needed regarding special cases. However, panel members who are normally participatory, but have missed crucial conversations and/or votes due to extenuating circumstances, will still be allowed to share their opinions.

2) **Should dissenting opinions from members that disagree be added to recommendation statements?**

The ASC agreed that there may be a section in final guideline documents for any dissenting opinions that panel members have. A footnote will disclose the number of dissenting panel members and possibly their names.

Appendix G

Study Eligibility Criteria

Table G1

Study Eligibility Criteria: Populations, Interventions, Comparators, Outcomes, Timing, and Settings (PICOTS; Reproduced from Interventions to Treat Depression: An Umbrella Review (pp. 5-6) conducted by RTI-UNC Evidence-based Practice Center Team, March, 2014)

PICOTS	
Population	Adolescent (13 to 17 years) and adult (18+years) patients of all races and ethnicities with MDD (including perinatal depression), dysthymia, or SSD during all phases of treatment (acute, maintenance, continuation) Subgroups of interest include patients with: • Suicidal ideation • Treatment-resistant depression • Co-occurring anxiety disorders • Co-occurring personality disorders We do ***not*** include populations exclusively comprising patients with medical comorbidities and depression (e.g., populations with heart disease and depression or with cancer and depression)
Interventions	• Psychological and behavioral interventions • Somatic treatments (e.g., electroconvulsive therapy, exercise, light therapy, repetitive transcranial magnetic stimulation, deep brain stimulation) • CAM therapies (e.g., yoga, acupuncture, relaxation techniques, S-adenosyl-L-methionine [SAMe], omega-3 fatty acids, St. John's Wort) • Combinations of eligible interventions and combinations of eligible interventions with pharmacotherapy
Comparators	Active: • Pharmacotherapy, psychotherapy, somatic treatments, or CAM treatments (in combination or not) as listed above under interventions • Diet • Religious or spiritual activities • Meditation • Psychoeducation about depression Inactive: • For psychotherapy and CAM therapies: placebo or other inactive interventions (e.g., waiting list, no care)
Outcomes	• Efficacy: response, remission, speed of response or remission, relapse, quality of life, functional capacity, hospitalization, reduction of suicidality • Adverse events (safety and tolerability): overall adverse events, withdrawals because of adverse events, serious adverse events, specific adverse events or withdrawals because of specific adverse events; these include hyponatremia, seizures, suicidality, hepatoxicity, weight gain, gastrointestinal symptoms, sexual side effects, and drug interactions (for pharmacologic and CAM treatments)
Timing	No restrictions
Setting	All settings

Other criteria	
Time period	Articles published in 2008 and later
Study design	Systematic reviews and meta-analyses
Publication criteria	• Both U.S. and international sources; English • Articles in print: We excluded articles accepted for publication but not published yet in a journal and articles that we could not obtain during the review period • Articles published as abstracts only: We excluded studies that have been published as abstracts only if we were unable to obtain additional information
Admissible evidence	• Publications that provide sufficient detail about methods and results to enable critical appraisal of the review or meta-analysis. Included reviews had low or medium study limitations (i.e., we did not consider systematic reviews assessed as having high study limitations)

Given the particular interest of the APA in psychological and behavioral interventions, Table G2 gives a more detailed listing of therapies in that category.

Table G2

Overview and Classification of Eligible Psychological and Behavioral Therapies

Cognitive and behavioral approaches • Cognitive behavioral therapy (general) • Cognitive therapy (Beck) • Behavioral therapy • Mindfulness-based intervention therapies • Behavioral activation therapy • Rational emotive therapy • Problem solving therapy • Acceptance and commitment therapy • Dialectical behavior therapy • Compassion-focused therapy • Assertiveness training • Well-being therapy • Morita therapy	***Psychodynamic and attachment-based approaches*** • Psychodynamic (general) therapy • Psychoanalytic therapy (psychoanalysis) • Adlerian psychotherapy • Analytical psychotherapy • Object relations therapy • Self psychology therapies • Relational and intersubjective psychotherapy • Supportive-expressive therapy • Short-term dynamic psychotherapy • Brief dynamic psychotherapy • Time-limited dynamic psychotherapy
Humanistic approaches • Humanistic (general) therapy • Existential therapy • Transactional analysis therapy • Transpersonal psychology and psychosynthesis • Person or client-centered therapy • Rogerian therapy • Gestalt therapy • Psychodrama • Emotion-focused therapy • Process-experiential therapy • Logotherapy	***Couple, family, systems, or societal approaches*** • Emotionally focused therapy • Strategic therapy • Systemic therapy • Family systems therapy • Couple therapy • Ecopsychological and nature-based therapy • Feminist psychotherapy • Behavioral marital therapy • Cognitive behavioral marital therapy • Integrated behavioral couples therapy
Combined and general approaches • Supportive therapy-counseling • Interpersonal psychotherapy • Life review or reminiscence therapy • Integrative therapy • Eclectic therapy • Treatment or care as usual • Psychological intervention (broadly defined, not categorized) • Case management • Coaching	• Cognitive behavioral analysis system of psychotherapy • Solution-focused therapy • Biofeedback

Appendix H

AMSTAR Ratings

Methodological quality of the included systematic review

Systematic review	A priori study design	Duplicate study selection and data extraction	Comprehensive literature search	Publication status not used as inclusion	List of in- and excluded studies	Characteristics of included studies provided	Study quality assessed and documented	Quality assessment used in conclusions	Appropriate methods to combine findings	Likelihood of publication bias assessed	Conflict of interest stated
Cuijpers et al., 2014	N	N	Y	Y	N	Y	Y	Y	Y	Y	Y
Driessen et al., 2015	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
Cuijpers et al., 2012	N	N	Y	Y	N	Y	Y	Y	Y	Y	N
Cipriani et al., 2016	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
Zhou et al., 2015	Y	Y	Y	Y	N	Y	Y	Y	Y	N	N
Cuijpers et al., 2016	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y for review; Can't answer for studies

Appendix I

Dose, Timing, and Session Duration of Treatments

Children and Adolescents				
Treatment	**Dose Range (No. of sessions or mg)**	**Timing Range**	**Duration Range**	**Session Duration Range, minutes**
CBT	6-16 sessions	Weekly	4-18 weeks	30-120
Interpersonal psychotherapy	8-16 sessions	Weekly	6-16 weeks	30-120
Fluoxetine	0.5-60 mg/day	Daily	6-12 weeks	N/a
Clomipramine,	75-150 mg/day	Daily	8 weeks	N/a
Imipramine,	3.25-300 mg/day	Daily	5-8 weeks	N/a
Mirtazapine,	15-45 mg/day	Daily	8 weeks	N/a
Paroxetine,	10-50 mg/day	Daily	8-12 weeks	N/a
Venlafaxine	37.5-225 mg/day	Daily	8 weeks	N/a
Duloxetine	30-120 mg/day	Daily	10 weeks	N/a
Escitalopram	10-20 mg/day	Daily	8 weeks	N/a

General Adult Population				
Treatment	**Dose Range (No. of sessions, mg, or lux)**	**Timing Range**	**Duration Range**	**Session Duration Range, minutes**
CBT	6-20	Weekly	4-24 weeks	60-120
Computerized CBT	4-9	Weekly	4-9 weeks	Unavailable
CBT (group)	5-26	Weekly	5-26 weeks	45-180
Behavioral therapy	1-20	Weekly	1-20 weeks	Unavailable
Psychotherapy for social functioning	Unavailable	Unavailable	Unavailable	Unavailable
Interpersonal psychotherapy	6-17	Weekly	8-24 weeks	30-60
Cognitive therapy	8-28	Weekly	8-16 weeks	60-90
Psychodynamic	20-60	Weekly	8-96 weeks	Unavailable
Third-wave CBT	16-24	Weekly or Biweekly	16-49 weeks	Unavailable
Couples therapy	5-20	Weekly	5-20 weeks	50-120
Mindfulness CBT	8	Weekly	8 weeks	Unavailable
Supportive psychotherapy	4-20	Weekly or Biweekly	8-16 weeks	45
Cognitive behavioral analysis system of psychotherapy	24	Weekly	12 weeks-12 months	40-90
Short-term psychodynamic psychotherapy	3-80	Weekly	8-24 weeks	Unavailable
Second generation antidepressants	10-600	Daily	31-318 weeks	N/a
Bright light therapy	7,000-7,500 lux	Daily	5 weeks	60
Yoga	12-24	1-2 times per week	4-24 weeks	20
St. John’s Wort	300-1,800	Daily	6-12 weeks	N/a
Exercise	30-48	3 times per week	10 days-16 weeks	45
S-Adenosyl methionine	1,600-3,200	Daily	12 weeks	N/a
Tai chi	72	3 times per week	24 weeks	60-90
Acupuncture	9-36	Daily-Weekly	2-8 weeks	Unavailable
Omega-3 fatty acids	1,000	Daily	8 weeks	N/a

Older Adults				
Treatment	**Dose Range (No. of sessions or mg)**	**Timing Range**	**Duration Range**	**Session Duration Range, minutes**
CBT	2-20	Weekly or Biweekly	2-18 weeks	50-60
CBT (group)	7-15	Weekly	7-15 weeks	90-120
CBT (Internet)	8-10	Weekly	8-10 weeks	Unavailable
Problem-solving therapy	6-12	Weekly	6-12 weeks	90
Problem-solving therapy (group)	6-12	Weekly	6-12 weeks	90
Interpersonal psychotherapy	6-16	Weekly or Biweekly	16-20 weeks	Unavailable
Life-review therapy	4-12	Unavailable	6-8 weeks	60-120
Coping improvement	12	Unavailable	Unavailable	Unavailable
Clinical management		Unavailable	Unavailable	Unavailable
Supportive therapy	12-15	Weekly	Unavailable	Unavailable
Reminiscence therapy (group)	Unavailable	Unavailable	Unavailable	Unavailable
Behavioral bibliotherapy (self-guided)	Unavailable	Unavailable	4 weeks or less	Unavailable
Multicomponent intervetion	10	Unavailable	Unavailable	Unavailable

Appendix J

Treatments Considered But Not Included by Population

Children and Adolescents	Nefazodone vs. Placebo [Nefazodone no longer used]
	Desipramine vs. Placebo [both primary outcomes have very low quality of evidence]
	Sertraline vs. Placebo [both primary outcomes have very low quality of evidence]
	Citalopram vs. Placebo [both primary outcomes have very low quality of evidence]
	Amitriptyline vs. Placebo [both primary outcomes have very low quality of evidence]
	Fluoxetine vs. Placebo [both primary outcomes have very low quality of evidence]
	Nortriptyline vs. Placebo [very low quality of evidence for only primary outcome listed]
	Fluoxetine vs. Nortriptyline [very low quality of evidence for only primary outcome listed]
General Adult Population	SGA vs. Any Psychological Therapy Monotherapy [no benefit response data]
	SGA vs. Combination of Any SGA and Psychological Therapy [no benefit response data]
	SGA vs. CBT as a Function of Severity [all outcomes in the evidence profile have insufficient strength of evidence]
	SGA vs. Integrative Therapies (IPT) as a Function of Severity [all outcomes in the evidence profile have insufficient strength of evidence]
	SGA vs. Third-Wave CBT Monotherapy as a Function of Severity [all outcomes in the evidence profile have insufficient strength of evidence]
	SGA vs. SAMe as a Function of Baseline Depression Severity [all outcomes in the evidence profile have insufficient strength of evidence]
	SGA Switches for MDD in Adults Not Responding to an Initial Adequate SGA Treatment Attempt as a Function of Baseline Severity [all outcomes in the evidence profile have insufficient strength of evidence]
	For Patients with MDD Who Have Achieved Remission of Symptoms, How Long Should Pharmacotherapy Be Continued to Reduce Risk of Recurrence? [duration of treatment outside of scope]
	CBT vs. ADM [overall number of patients not reported; very low quality of evidence]
	CBT for Sub-populations [outside of scope]
	Group CBT vs. Low-Intensity Interventions [very low quality of evidence]
	Group CBT vs. Moderate Interventions [very low quality of evidence]
	MCBT vs. ADM [number of patients not reported]
	Acceptance and Commitment Therapy [very low quality of evidence]
	BT vs. All Other Psychotherapies [all outcomes of very low quality]

	Couple Therapy vs. Individual Therapy [outdated systematic review]
	Couple Therapy vs. ADM Alone or Minimal Therapy [outdated systematic review]
	IPT vs. TAU [all outcomes very low quality]
	IPT vs. CBT [all outcomes very low quality]
	IPT vs. Imipramine [all outcomes very low quality]
	PST vs. Supportive Therapy [outdated systematic review]
	PST vs. Other Psychosocial Interventions [outdated systematic review]
	ADM Alone vs. ADM Plus Psychotherapy [very low quality of evidence for sub-populations of interest]
	Psychotherapy Alone vs. Combination of Psychotherapy Plus ADM [very low quality of evidence for sub-populations of interest]
	Acupuncture Monotherapy vs. ADM [very low quality of evidence]
	Acupuncture Combination Therapy vs. ADM [outdated systematic review]
	Behavioral Prescription vs. Usual Care [all outcomes very low quality of evidence]
	Exercise vs. Psychological Therapies [all outcomes very low quality of evidence]
	Exercise vs. Alternative Treatments (Bright Light Therapy) [all outcomes very low quality of evidence]
	Omega-3 Fatty Acids [outdated systematic review]
	Hypericum Extracts vs. Placebo [outdated systematic review]
	Hypericum Extracts vs. Standard ADM [outdated systematic review]
	Hypericum Extracts Added to Standard ADM [all outcomes very low quality of evidence]
	Vitamin D vs. Placebo [only outcome of very low quality of evidence]
Older Adults	Cognitive Therapy (group) Compared to Behavioral Therapy (group) for Treating MDD in Adults Ages 60 and Older [very low quality of evidence]
	Behavioral Therapy (group) Compared to Brief Psychodynamic Therapy (individual) for Treating MDD in Adults Aged 60 Years and Older [very low quality of evidence]
	Cognitive Therapy (group) Compared to Brief Psychodynamic Therapy (individual) for Treating MDD in Adults Aged 60 Years and Older [very low quality of evidence]
	Problem-Solving Therapy (in-person) Compared to Problem-Solving Therapy (video call) for Treating Dysthymia or MDD in Adults Aged 50 Years or Older
	Combination of Dialectical Behavior Therapy (group) and Pharmacotherapy Compared to Pharmacotherapy as Usual for Treating MDD in Adults Aged 60 and Older [very low quality of evidence]
	Problem-Solving Behavioral Therapy (individual) Compared to Usual Care for Treating Minor or Major Depressive Disorder in Older Adults with Dementia [very low quality of evidence]

Pleasant Events Behavioral Therapy (individual) Compared to Usual Care for Treating Minor or Major Depressive Disorder in Older Adults with Dementia [very low quality of evidence]
Interpersonal Psychotherapy (individual) Compared to Usual Care for Treating MDD in Adults Aged 55 Years and Older [very low quality of evidence]
Interpersonal Psychotherapy (individual) Compared to Usual Care for Treating Subthreshold Depression in Adults Aged 60 Years and Older [very low quality of evidence]
Cognitive, Behavioral, or Brief Psychodynamic Therapy (group) Compared to Wait List for Treating MDD in Adults Aged 60 Years and Older [very low quality of evidence]
Problem-Solving Behavioral Therapy (individual) Compared to Wait List for Treating Minor or Major Depressive Disorder in Older Adults with Dementia [very low quality of evidence]
Pleasant Events Behavioral Therapy (individual) Compared to Wait List for Treating Minor or Major Depressive Disorder in Older Adults with Dementia [very low quality of evidence]
Interpersonal Psychotherapy (individual) Compared to Placebo for Treating MDD in Older Adults [very low quality of evidence]
Reminiscence Therapy (group) Compared to Wait List for Treating MDD in Adults Aged 55 Years and Older [very low quality of evidence]
A Combination of In-Person Life Review (individual) and Computer Supplements Compared to Wait List for Treating Subsyndromal to Moderate Depression in Adults Aged 65 Years and Older [very low quality of evidence]
Cognitive Bibliotherapy (self-guided) Compared to Behavioral Bibliotherapy (self-guided) for Treating Mild to Moderate Depression in Adults Aged 60 Years and Older [very low quality of evidence]
Cognitive Bibliotherapy (self-guided) Compared to Attention Control (self-guided) for Treating Mild to Moderate Depression in Adults Aged 60 Years and Older [very low quality of evidence]
Cognitive Bibliotherapy (self-guided) Compared to Wait List for Treating Mild to Moderate Depression in Adults Aged 60 Years and Older [very low quality of evidence]
Cognitive Bibliotherapy (self-guided) Compared to Wait List for Treating Minor or Major Depressive Disorder in Adults Aged 55 Years and Older with Disability [very low quality of evidence]
Coping Improvement (group) Compared to Interpersonal Support (group) for Treating Mild to Severe Depressive Symptoms in Adults Aged 50 Years and Older with HIV [very low quality of evidence]
Interpersonal Support (group) Compared to Therapy Upon Request (individual) for Treating Mild to Severe Depressive Symptoms in Adults Aged 50 Years and Older with HIV [very low quality of evidence]

Appendix K

Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts

Representations of Studies Reviewed from the 10 Systematic Reviews/Meta-Analyses

Table K1

Select Demographic Characteristics of Studies Reviewed from the 10 Systematic Reviews/Meta-Analyses (All Populations)

	Total	
Study Location	N	%
International	363	61
United States (U.S.)	225	38
Country Not Reported (NR)	5	0.8
TOTAL	593	100
Study Demographics		
Gender		
Reported	442	75
20-80% female	328	74
< 20% female	10	2
< 20% male	104	24
Not Reported (NR)	151	25
TOTAL	593	100
Race/Ethnicity (U.S. Studies)		
Reported	161	72
20-80% underrep.	86	53
< 20% underrep.	57	35
>80% underrep.	18	11
Not Reported (NR)	64	28
TOTAL	225	100

Note. 9 studies were not in the English language.

Child/Adolescent Population

Table K2

Select Demographic Characteristics of Studies Reviewed from the 2 Child/Adolescent Population Systematic Reviews/Meta-Analyses

	Total	
Study Location	N	%
International	31	40
United States (U.S.)	46	59
Country Not Reported (NR)	1	1
TOTAL	78	100
Study Demographics		
Gender		
Reported	74	95
20-80% Female	65	88
< 20% Female	5	7
<20% Male	4	5
Not Reported (NR)	4	5
TOTAL	78	100
Race/Ethnicity (U.S. Studies)		
Reported	40	87
20-80% underrep.	21	53
< 20% underrep.	12	30
>80% underrep.	7	18
Not Reported (NR)	6	13
TOTAL	46	100

Cipriani et al., 2016

Author, year	Sample Size	Country/Region	Diagnosis/Population	Mean Age	% Female	% Nonwhite
Atkinson et al., 2014	337	United States, Finland, France, Germany, Russia, Slovakia, Estonia, Ukraine, South Africa	Major depressive disorder	Overall: 13.2 G1: 13.1 G2: 13.1 G3: 13.3	Overall: 55.9 G1: 54.7 G2: 52.1 G3: 49.5	Overall: 18.6 G1: 19.6 G2: 17 G3: 19.4
Attari et al., 2006	40	Iran	Major depressive disorder	Overall: 12.9 G1: 12.5 G2: 13.2	Overall: 25 G1: 22 G2: 27	Overall: 100
Berard et al., 2006	286	Belgium, Italy, Mexico, United Kingdom, Spain, Netherlands, Canada, South Africa, United Arab Emirates, Argentina	Unipolar major depression	Overall: 15.65 G1: 15.5 G2: 15.8	Overall: 63 G1: 67 G2: 61	Overall: 35 G1: 30.8 G2: 34.4
Braconnier et al., 2003	121	France	Major depressive disorder	Overall: 16.01 G1: 16.17 G2: 15.94	Overall: 56 G1: 67.2 G2: 44	NR
Emslie et al., 1997	96	United States	Major depressive disorder	Overall: 12.4 G1: 12.2 G2: 12.5	Overall: 46 G1: 46 G2: 46	Overall: 20.9 G1: 27.1 G2: 14.6
Emslie et al., 2002a	219	United States	Major depressive disorder	Overall: 13 G1: 12.7 G2: 12.69	Overall: 49.3 G1: 49.5 G2: 49.1	Overall: 17.8 G1: 11.9 G2: 23.6
Emslie et al., 2006	203	United States, Canada	Major depressive disorder	Overall: 12 G1: 11.9 G2: 12.1	Overall: 46.8 G1: 47.5 G2: 46.1	Overall: 20.7 G1: 3 G2: 2.95
Emslie et al., 2007	354	United States	Major depressive disorder	Overall: 12.3 G1: 12.2 G2: 12.3	Overall: 46 G1: 44 G2: 47	NR
Emslie et al., 2009	312	United States	Major depressive disorder	Overall: 14.6 G1: 14.5 G2: 14.7	Overall: 59 G1: 58.6 G2: 59.4	Overall: 25 G1: 21.7 G2: 27.1
Emslie et al., 2014	463	United States, Argentina, Canada, Mexico	Major depressive disorder	Overall: 13.2 G1: 12.9	Overall: 51.2	Overall: 44.1

Author, year	Sample Size	Country/Region	Diagnosis/Population	Mean Age	% Female	% Nonwhite
				G2: 12.9 G3: 13 G4: 13.1	G1: 55.6 G2: 40.5 G3: 52.1 G4: 56.6	G1: 44.4 G2: 44.8 G3: 40.2 G4: 46.7
Findling et al., 2009	34	United States	Major depressive disorder	Overall: 16.46 G1: 16.55 G2: 16.35	Overall: 14 G1: 22 G2: 6	Overall: 27 G1: 78 G2: 19
Geller et al., 1990	48	United States	Major depressive disorder	Overall:14.3 G1: 14.2 G2: 14 G3: 14.4	Overall:52.1 G1: 64.7 G2: 25 G3: 57.9	Overall:14.6 G1: 29.4 G2: 16.7 G3: 0
Geller et al., 1992	50	United States	Major depressive disorder	Overall: 9.7 G1: 9.7 G2: 9.7	Overall: 30 G1: 26.9 G2: 33.3	Overall: 10 G1: 11.5 G2: 8.3
Hongfen et al., 2009	60	China	Depression	NR	NR	NR
Hughes et al., 1990	27	?	Depression; depression plus anxiety disorder	NR	NR	NR
Keller et al., 2001	275	United States, Canada	Major depressive disorder	Overall: 15 G1: 14.8 G2: 14.9 G3: 15.1	Overall: 62 G1: 62 G2: 58 G3: 65	Overall: 16 G1: 17.2 G2: 12.6 G3: 19.5
Klein et al., 1998	45	United States	Major depressive disorder	Overall: 15.66	Overall: 67	Overall: 42
Kutcher et al., 1994	60	Canada	Major depressive disorder	Overall: 17.8	Overall: 70	NR
Kye et al., 1996	31	United States	Major depressive disorder	Overall: 15 G1: 14.6 G2: 15.1	Overall: 14 G1: 16 G2: 12	Overall: 25 G1: 12 G2: 12
March et al., 2004	439	United States	Major depressive disorder	Overall: 14.6	Overall: 54.4	Overall: 26.2
Organon Pharmaceuticals, 2002a	126	Europe	Major depressive disorder	Overall: 12.4 G1: 12.3 G2: 12.4	Overall: 52.2 G1: 47.6 G2: 56.8	Overall: 11.9 G1: NR G2: NR
Organon Pharmaceuticals, 2002b	132	Europe	Major depressive disorder	Overall: 12.1 G1: 11.9 G2: 12.3	Overall: 53.5 G1: 52 G2: 55	Overall: 13 G1: NR G2: NR
Puig-Antich et al., 1987	38	United States	Major depressive disorder	Overall: 9.24 G1: 9.3	Overall:39.3 G1: 37.5	Overall: 28.5

Author, year	Sample Size	Country/Region	Diagnosis/Population	Mean Age	% Female	% Nonwhite
				G2: 9.18	G2: 41	G1: 21 G2: 36
von Knorring et al., 2006	244	Europe	Major depressive disorder	Overall: 16	NR	NR
Wagner et al., 2003	376	United States, Costa Rica, India, Canada, Mexico	Major depressive disorder	6-11 (Children) and 12-17 (Adolescents)	Overall: 51 G1: 57.1 G2: 44.9	Overall: 4.3 G1: 3.7 G2: 4.8
Wagner et al., 2004	174	United States	Major depressive disorder	Overall: 12.1 G1: 12.1 G2: 12.1	Overall: 53 G1: 54.1 G2: 52.8	Overall: 22 G1: 27.1 G2: 19.1
Wagner et al., 2006	264	United States	Major depressive disorder	Overall: 12 G1: 12.4 G2: 12.2	Overall: 51 G1: 51.9 G2: 51.9	Overall: 28 G1: 28.6 G2:29

Zhou et al., 2015

Author, year	Sample Size	Country	Diagnosis/Population	Mean Age	% Female	% Nonwhite
Ackerson et al., 1998	22	United States	Mild and moderate depressive symptomatology	Overall:15.11	Overall: 46	Overall: 36
Asarnow et al., 2002	23	United States	Depressive symptoms	NR	Overall: 65	Overall: 43
Bolton et al., 2007	314	Uganda	Depression, anxiety, conduct problem symptoms	Overall: 15 G1: 15 G2: 14.7 G3: 15.2	Overall: 57 G1: 57 G2:58 G3:57	Overall: 100
Brent et al., 1997	107	United States	Major depressive disorder	Overall: 15.6 G1: 15.7 G2: 15.4 G3: 15.7	Overall:75.7 G1: 75.7 G2: 77.1 G3: 74.3	Overall: 17 G1: 24.3 G2: 11.4 G3: 14.3
Butler et al., 1980	56	Canada	Depressive symptoms	NR	Overall: 37 G1: >1 G2: >1 G3: >1 G4: NR	NR
Clarke et al., 1995	150	United States	Elevated depressive symptomology	Overall: 15.3	Overall: 70	Overall: 7.5
Clarke et al., 1999	123	United States	Major depression, dysthymia	NR	NR	NR
Clarke et al., 2001	94	United States	At-risk offspring of adults treated for depression	Overall: 15 G1: 14.7 G2: 14.4	Overall: 59 G1: 65 G2: 53	Overall: 11 G1: 4 G2: 18
Clarke et al., 2002	88	United States	At-risk offspring of adults treated for depression	Overall:15.3 G1: 15.3 G2: 15.2	Overall:68.5 G1: 74.5 G2: 62.5	Overall:18.5 G1: 8.5 G2: 10
Curtis et al., 1992	19	United States	Major depression, dysthymia	Overall: 15.8 G1: 15.6 G2: 16.1	Overall: 45 G1: 42 G2: 47	Overall: >1 G1: 0 G2: >1
Dana, 1998	28	United States	Conduct disorder, concurrent conduct disorder and depression	Overall: 10.8	Overall: 13	Overall: 89
De Cuyper et al., 2004	20	Belgium	Moderate depressive symptoms	Overall: 10	Overall: 75	Overall: 0

Author, year	Sample Size	Country	Diagnosis/Population	Mean Age	% Female	% Nonwhite
Diamond et al., 2002	32	United States	Major depressive disorder	NR	Overall: 78	Overall: 69
Diamond et al., 2010	66	United States	Suicidal adolescents	Overall: 15.1	Overall: 83	Overall: 74
Eskin et al., 2008	46	Turkey	Major depression, suicide potential	Overall: 19.1 G1: 19 G2: 19.3	Overall: 69.6 G1: 74.1 G2: 63.2	NR
Ettelson, 2003	25	United States	Depression, anxiety symptomology	NR	Overall: 28 G1: 28 G2: 28	Overall: 8 G1: 0 G2: 8
Fine et al., 1991	66	Canada	Depression	NR	Overall: 83	Overall: 23
Fischer, 1995	16	United States	Depression, suicidal	NR	Overall: 20	Overall: 20
Fleming et al., 2012	32	New Zealand	Depression symptomology	Overall: 14.9	Overall: 44	Overall: 100
Hickman, 1994	9	United States	Depression	Overall: 9.6	Overall: 11	Overall: 100
Hoek et al., 2012	45	The Netherlands	Mild to moderate symptoms of depression, anxiety	Overall: 16.07 G1: 15.78 G2: 16.36	Overall: 75.6 G1: 68.2 G2: 82.6	NR
Israel & Diamond, 2013	20	Norway	Depression	Overall: 15.6	Overall: 55	NR
Jeong et al., 2005	40	South Korea	Mild depression	Overall: 16 G1: 16 G2: 16	Overall: 50 G1: 50 G2: 50	Overall: 100
Kahn et al., 1990	68	United States	Depressive symptomology	NR	Overall: 51	NR
Kerfoot et al., 2004	52	United Kingdom	Depression	Overall: 13.9 G1: 13.7 G2: 14.1	Overall: 22.5 G1: 26 G2: 19	NR
Lewinsohn et al., 1990	59	United States	Depression	Overall: 16.23 G1: 16.26 G2: 16.15 G3: 16.28	Overall: 70 G1: 52.6 G2: 61.9 G3: 68.4	NR
Liddle & Spence, 1990	31	Australia	Depressive symptomology	Overall: 15.65	Overall: 32	NR
Jeong et al., 2005	40	South Korea	Mild depression	Overall: 16	Overall: 50	Overall: 100

Author, year	Sample Size	Country	Diagnosis/Population	Mean Age	% Female	% Nonwhite
				G1: 16 G2: 16	G1: 50 G2: 50	
Kahn et al., 1990	68	United States	Depressive symptomology	NR	Overall: 51	NR
Kerfoot et al., 2004	52	United Kingdom	Depression	Overall: 13.9 G1: 13.7 G2: 14.1	Overall: 22.5 G1: 26 G2: 19	NR
Lewinsohn et al., 1990	59	United States	Depression	Overall: 16.23 G1: 16.26 G2: 16.15 G3: 16.28	Overall: 70 G1: 52.6 G2: 61.9 G3: 68.4	NR
Liddle & Spence, 1990	31	Australia	Depressive symptomology	Overall: 15.65	Overall: 32	NR
Jeong et al., 2005	40	South Korea	Mild depression	Overall: 16 G1: 16 G2: 16	Overall: 50 G1: 50 G2: 50	Overall: 100
Kahn et al., 1990	68	United States	Depressive symptomology	NR	Overall: 51	NR
Kerfoot et al., 2004	52	United Kingdom	Depression	Overall: 13.9 G1: 13.7 G2: 14.1	Overall: 22.5 G1: 26 G2: 19	NR
Lewinsohn et al., 1990	59	United States	Depression	Overall: 16.23 G1: 16.26 G2: 16.15 G3: 16.28	Overall: 70 G1: 52.6 G2: 61.9 G3: 68.4	NR
Liddle & Spence, 1990	31	Australia	Depressive symptomology	Overall: 15.65	Overall: 32	NR
Jeong et al., 2005	40	South Korea	Mild depression	Overall: 16 G1: 16 G2: 16	Overall: 50 G1: 50 G2: 50	Overall: 100
Kahn et al., 1990	68	United States	Depressive symptomology	NR	Overall: 51	NR
Kerfoot et al., 2004	52	United Kingdom	Depression	Overall: 13.9 G1: 13.7 G2: 14.1	Overall: 22.5 G1: 26 G2: 19	NR

Author, year	Sample Size	Country	Diagnosis/Population	Mean Age	% Female	% Nonwhite
Lewinsohn et al., 1990	59	United States	Depression	Overall: 16.23 G1: 16.26 G2: 16.15 G3: 16.28	Overall: 70 G1: 52.6 G2: 61.9 G3: 68.4	NR
Listug-Lunde, 2004	19	United States	Depressive symptomology	Overall:12.42 G1: 12.34 G2: 12.5	Overall:66 G1: 33 G2: 33	Overall: 100
McCarty et al., 2013	120	United States	Elevated depressive symptoms	Overall: 12.8 G1: 12.7 G2: 12.8	Overall: 60 G1: 56.5 G2: 65.5	Overall: 44.4 G1: 37.1 G2: 51.7
Merry et al., 2012	187	New Zealand	Depressive symptoms	Overall: 15.6 G1: NR G2: NR	Overall:65.8 G1: 62.8 G2: 68.8	NR
Moldenhauer, 2004	26	United States	Mild-to-moderate depression	Overall: 14.6	Overall: 73	Overall: 7.1
Mufson et al., 1999	48	United States	Major depressive disorder	Overall: 15.8 G1: 15.9 G2: 15.7	Overall: 73 G1: 70.8 G2: 75	Overall: 71 G1: 62.5 G2: 79.2
Mufson et al., 2004	63	United States	Major depressive disorder, dysthymia, depression disorder NOS, adjustment disorder w/ depressed mood	Overall: 15.1 G1: 15.3 G2: 14.9	Overall: 84 G1: 91.2 G2: 75.9	Overall: 71 G1: 76.5 G2: 65.5
Phillips, 2004	64	United States	Risk of depression	Overall: 17.7 G1: 17.7 G2: 17.8	Overall: 63.5 G1: 56.3 G2: 71	Overall: 46 G1: 50 G2: 41.9
Reed, 1994	18	United States	Major depressive disorder, dysthymia	NR	Overall:24.5 G1: 22 G2: 27	Overall: 72
Reivich, 1996	152	United States	Risk of depression	Overall: 12.7 G1: 12.7 G2: 12.8	Overall:45.5 G1: 48 G2: 46	NR
Reynolds & Coats, 1986	30	United States	Depression	Overall:15.65	Overall: 63	Overall: 0
Roberts et al., 2003	189	Australia	Depressive, anxious symptoms	Overall:11.89 G1: 11.91 G2: 11.86	Overall: 50 G1: 51 G2: 48	NR

Author, year	Sample Size	Country	Diagnosis/Population	Mean Age	% Female	% Nonwhite
Rohde et al., 2004	93	United States	Depression w/ comorbid conduct disorder	Overall: 15.1 G1: 15.1 G2: 15.1	Overall: 48.8 G1: 60 G2: 37.5	Overall: 19.4 G1: 20 G2: 18.7
Rossello & Bernal, 1999	71	Puerto Rico	Major depressive disorder and/or dysthymia	Overall: 14.7	Overall: 54	Overall: 100
Rossello et al., 2008	112	Puerto Rico	Major depressive disorder, depressive symptoms	Overall: 14.52	Overall: 55.4	Overall: 100
Spence et al., 2003	1,500	Australia	Depression	Overall: 12.9	Overall: 52 G1: 52.5 G2: 50.6	NR
Stark et al., 1987	28	United States	Clinically significant levels of depression	Overall: NR G1: NR G2: NR G3: NR	Overall: 14 G1: 14 G2: 14 G3: 14	NR
Stice et al., 2010	341	United States	Elevated depression symptoms	Overall: 15.6 G1: NR G2: NR G3: NR G4: NR	Overall: 56 G1: 57.3 G2: 54.5 G3: 53.8 G4: 59.5	Overall: 54 G1: 58.4 G2: 54.4 G3: 45 G4: 58.3
Tang et al., 2009	73	Japan	Depressed with suicidal risk	Overall: 15.25 G1: 15.26 G2: 15.24	Overall: 32.5 G1: 31 G2: 34	Overall: 100
Trowell et al., 2007	72	United Kingdom Greece Finland	Depression	Overall: 11.71 G1: 11.57 G2: 11.97	Overall: 38 G1: 26 G2: 49	Overall: 13 G1: 18 G2: 8
Vostanis et al., 1996	57	United Kingdom	Depressive disorders	Overall: 12.7	Overall: 56	Overall: 12
Weisz et al., 1997	48	United States	Mild-to-moderate depressive symptoms	Overall: 9.6 G1: 9.4 G2: 9.7	Overall: 45 G1: 44 G2: 47	Overall: 37 G1: 25 G2: 44
Wood et al., 1996	53	United Kingdom	Psychiatric patients with depressive disorders	Overall: 14.2 G1: 13.8 G2: 14.6	Overall: 69 G1: 67 G2: 71	NR
Young et al., 2006	41	United States	Elevated depressive symptoms	Overall: 13.4 G1: 13.5	Overall: 85.4	Overall: 92.7

Author, year	Sample Size	Country	Diagnosis/Population	Mean Age	% Female	% Nonwhite
				G2: 13.1	G1: 81.5 G2: 92.9	G1: 92.6 G2: 92.9
Young et al., 2010	57	United States	Elevated depressive symptoms	Overall: 14.51 G1: 14.57 G2: 14.52	Overall: 59.7 G1: 55.6 G2: 66.7	Overall: 100

General Adult Population

Table K3

Select Demographic Characteristics of Studies Reviewed from the 6 General Adult Population Systematic Reviews/Meta-analyses

	Total	
Study Location	N	%
International	307	66
United States (U.S.)	151	33
Country Not Reported (NR)	4	0.9
TOTAL	462	100
Study Demographics		
Gender		
Reported	325	70
20-80% Female	225	69
< 20% Female	5	2
<20% Male	95	29
Not Reported (NR)	137	30
TOTAL	462	100
Race/Ethnicity (U.S. Studies)		
Reported	106	70
20-80% underrep.	57	54
< 20% underrep.	39	37
>80% underrep.	10	9
Not Reported (NR)	45	30
TOTAL	151	100

Note. 7 studies were not in the English language.

Driessen et al., 2015
***Note.* * - Randomized Controlled Trial (RCT)**

Author, year	Sample Size	Country	Diagnosis/Population	Mean Age	% Female	% Nonwhite
Abbass et al., 2002	89	Canada	Major depression; somatoform disorder; panic disorder; dysthymic disorder	Overall:39.6	Overall:52	NR
Abbass et al., 2006	10	Canada	Treatment-resistant depression	Overall:49.7	Overall: 70	Overall: 0
Ajilchi et al., 2013a*	32	Iran	Depression	NR	NR	Overall: 100
Ajilchi et al., 2013b*	32	Iran	Depression	NR	NR	Overall: 100
Ambresin et al., 2012*	130	Switzerland	Unipolar depression	NR	NR	NR
Angeletti et al., 2013	35	Italy	Moderate-to-severe “male” depression comorbid w/ unipolar mood or anxiety disorder	Overall: 40	Overall:85.7	NR
Barber et al., 2005	59	United States	Depressive spectrum disorder	Overall:37.6	Overall:54	Overall:11
Barber et al., 2012*	156	United States	Major depressive disorder	Overall:37.5 G1: 38 G2: 36.2 G3: 38.3	Overall:59 G1: 54.6 G2: 60.8 G3: 62	Overall:51.9 G1: 43.6 G2: 62.7 G3: 50
Barkham et al., 1999*	116	United Kingdom	Subsyndromal depression	Overall:44.9	Overall:43	NR
Beutel et al., 2014*	156	Germany	Breast cancer w/ comorbid depression	Overall:51.8 G1: 51.7 G2: 51.9	Overall:100	NR
Burnand et al., 2002*	74	Switzerland	Major depression	Overall:36.4 G1: 36 G2: 36.7	Overall: 61 G1: 66 G2: 56	NR
Carrington, 1979*	30	United States	Depression	Overall: 32.9 G1: 33.3 G2: 32.8 G3: 32.6	Overall: 100	Overall: 100
Connolly et al., 2012*	40	United States	Moderate-to-severe depression	Overall: 40.79 G1: 41.23 G2: 41.44 G3: 41	Overall: 90 G1: 87 G2: 93 G3: 80	Overall: 84.6 G1: 83.9 G2: 75 G3: 93.3
Cooper et al., 2003*	190	United Kingdom	Post-partum depression	Overall: 27.7 G1: 28.4	Overall: 100	NR

Author, year	Sample Size	Country	Diagnosis/Population	Mean Age	% Female	% Nonwhite
				G2: 27.9 G3: 28.1 G4: 26.5		
Crowe et al., 2008	30	Australia	Major depressive disorder	Overall: 47.77	Overall: 56	NR
de Jonghe et al., 2001*	129	The Netherlands	Depression	NR	Overall: 62 G1: 63.2 G2: 61.1	NR
de Jonghe et al., 2004*	191	The Netherlands	Depression	NR	Overall: 67 G1: 67 G2: 67.1	NR
Dekker et al., 2008*	103	The Netherlands	Depression	NR	Overall: 73.8 G1: 74.6 G2: 72.7	NR
Driessen et al., 2013*	177	The Netherlands	Major depressive disorder	Overall: 38.91 G1: 38.27 G2: 39.49	Overall: 70.1 G1: 68.9 G2: 71.2	NR
Gallagher et al., 1982*	10	United States	Major depressive disorder	Overall: NR G1: 68.3 G2: 66 G3: 69	Overall: 77 G1: 60 G2: 90 G3: 80	Overall: 20 G1: 0 G2: 20 G3: 0
Gallagher-Thompson et al., 1994*	66	United States	Clinically depressed	Overall: 62	Overall: 92	NR
Gilbert et al., 1981	11	United States	Depression	NR	Overall: 0	Overall: 0
Hersen et al., 1984*	120	United States	Unipolar depression	Overall: 30.4	Overall: 100	Overall: 10
Hilsenroth et al., 2007	33	United States	Depression	Overall: 32 G1: 31 G2: 34	Overall: 69.7 G1: 61 G2: 80	NR
Johansson et al., 2012*	69	Sweden	Major depressive disorder	Overall: 45.6 G1: 45.4 G2: 45.8	Overall: 75 G1: 80.4 G2: 69.6	NR
Johansson et al., 2014	412	Canada	Somatoform, anxiety, cluster B and C personality, and major depressive disorders	Overall: 41.5	Overall: 59	NR
Joyce et al., 2012	100	Canada	Recurrent major depression	Overall: 31.8	Overall: 65	NR
Kornblith et al., 1983*	49	United States	Depression	Overall: 37.9	Overall: 100	NR

Author, year	Sample Size	Country	Diagnosis/Population	Mean Age	% Female	% Nonwhite
La Pointe et al, 1980	33	United States	Reactive depression	Overall: 35.1	Overall: 100	NR
Lehto et al., 2008*	22	Finland	Atypical depression	NR	Overall: 77	NR
Lemma et al., 2011	16	United Kingdom	Depression	Overall: 34.3	Overall: 68	Overall: 37.4
Lemma et al, 2013*	24	United Kingdom	Depression and anxiety	NR	Overall: 76	Overall: 10
Liberman et al., 1981*	24	United States	Repeated suicide attempts	Overall: 29.67 G1: 25.5 G2: 29.5	Overall: 67 G1: 58 G2: 75	NR
Lotz, et al., 2006	139	Denmark	Anxiety, depression, unspecific neurotic state, personality disorders other type	Overall: 36.2	Overall: 74.8	NR
Maina et al., 2005*	30	Italy	Minor depressive disorders	Overall: 36.8 G1: 30.2 G2: 40.7 G3: 39.5	Overall: 63 G1: 50 G2: 80 G3: 60	NR
Maina et al., 2007*	35	Italy	Major depressive disorder	Overall: 35.9 G1: 33.5 G2: 38.5	Overall: 65.7 G1: 66.7 G2: 64.7	NR
Maina et al., 2010*	54	Italy	Obsessive compulsive disorder with concurrent major depression	Overall: 31.46 G1: 30.32 G2: 32.59	Overall: 55 G1: 56 G2: 55.2	NR
Martini et al., 2011*	35	Italy	Panic disorder with concurrent depressive symptoms	Overall: 35.93 G1: 35.45 G2: 36.41	Overall: 82 G1: 75 G2: 89.5	NR
McCarthy et al., 2014	20	?	Depression with personality disorder	Overall: 43.1 G1: 41.9 G2: 44.3	Overall: 50 G1: 40 G2: 60	NR
McLean et al., 1979*	196	Canada	Depression	Overall: 39.2	Overall: 72	NR
Morris et al., 1975*	51	Canada	Depression	NR	Overall: 100	NR
Nanzer et al., 2012*	128	Switzerland	Perinatal depression	Overall: 33 G1: 33 G2: 33	Overall: 100	Overall: 12 G1: 16 G2: 8
Philips et al., 2006	123	Sweden	Various psychological problems	Overall: 22	Overall: 73	NR

Author, year	Sample Size	Country	Diagnosis/Population	Mean Age	% Female	% Nonwhite
Reis et al., 2004	58	Australia	Major depression	Overall: 45.98	Overall: 58	NR
Roffman et al., 2014	9	United States	Persistent depression	Overall: 41.1	Overall: 88	NR
Rosso et al., 2013*	88	Italy	Mild to moderate unipolar depressive disorders	Overall: 39.2 G1: 41.7 G2: 36.6	Overall: 71 G1: 67.9 G2: 73.5	NR
Salminen et al., 2008*	51	Finland	Major depressive disorder	Overall: 42.4 G1: 41.9 G2: 42.9	Overall: 69 G1: 72 G2: 65	NR
Shapiro et al., 1994*	117	United Kingdom	Depression	Overall: 40.5	Overall: 52	NR
Steuer et al., 1984	33	United States	Geriatric depression	Overall: 66	Overall: 76	NR
Thompson et al., 1987*	95	United States	Major depressive disorder	Overall: 67.07 G1: 66.88 G2: 67.07 G3: 66.71 G4: 67.63	Overall: 67 G1: 17 G2: 16 G3: 16 G4: 15	NR
Thyme et al., 2007*	39	Sweden	Depression	Overall: 33.8	Overall: 100	NR
Vitriol et al., 2009*	87	Chile	Severe depression and history of childhood trauma	Overall: 38.89 G1: 36.68 G2: 41.09	Overall: 100	Overall: 100

Cuijpers et al., 2012

Author, year	Sample Size	Country	Diagnosis/Population	Mean Age	% Female	% Nonwhite
Alexopoulos et al., 2003	25	United States	Unipolar major depression + cognitive impairment	*Older Adults 65+* Overall: 74.12 G1: NR G2: NR	Overall: 52 G1: NR G2: NR	Overall: 24 G1: NR G2: NR
Arean et al., 2010	221	?	Unipolar major depression + executive dysfunction	*Older Adults 60+* Overall: 73 G1: 72.8 G2: 73.2	NR	NR
Bright et al., 1999	98	United States	MDD, dysthymia, or depression NOS	Overall: 45.8 G1: NR G2: NR	Overall: 71.4 G1: NR G2: NR	Overall: 7 G1: NR G2: NR
Chen, Li, & Li, 2012	60	China	Mild to moderate depression	Overall: ≥ 60	NR	NR
Cooper et al., 2003	193	United Kingdom	Postpartum depression	Overall: 27.6 G1: 28.4 G2: 27.9 G3: 26.5	Overall: 100	NR
Evans et al., 1995	72	United States	Depression + stage II cancer in men	Overall: 53.9 G1: 54.2 G2: 53.7 G3 53.8	Overall: 0	Overall:59.1 G1: 40.7 G2: 47.6 G3: 45.8
Freedland et al., 2009	123	United States	Major or minor depression after coronary artery bypass surgery	Overall: 60.7 G1: 62 G2: 59 G3: 61	Overall: 50 G1: 56 G2: 50 G3: 43	Overall: 18.3 G1: 12 G2: 33 G3: 10
Fuchs et al., 1977	36	United States	Depression in women	Overall: 28.8 G1: 26 G2: 28.5 G3: 31.1	Overall: 100	NR
Goldman et al., 2006	38	Canada	MDD	Overall: 39.5 G1: NR	Overall: 63.2	Overall: 11 G1: NR

Author, year	Sample Size	Country	Diagnosis/Population	Mean Age	% Female	% Nonwhite
				G2: NR	G1: NR G2: NR	G2: NR
Greenberg et al., 1998	34	?	MDD	Overall: 39.64 G1: NR G2: NR	Overall: 73.5 G1: NR G2: NR	NR
Holden et al., 1989	60	United Kingdom	Postnatal depression	Overall: 26 G1: 27.6 G2: 24.6 G3: 26.2	Overall: 100	NR
Kelly et al., 1993	68	United States	Depression and HIV in men	Overall: 34 G1: NR G2: NR G3: NR	Overall: 0	Overall: 38 G1: NR G2: NR G3: NR
King et al., 2000	464	United Kingdom	Depression or anxiety/depression	Overall: 36.8 G1: NR G2: NR G3: NR	Overall: 74.8 G1: NR G2: NR G3: NR	Overall: 11.1 G1: NR G2: NR G3: NR
Kiosses et al., 2010	30	United States	MDD, cognitive impairment, and disability	*Older Adults 65+* Overall: 79.41 G1: 80.46 G2: 78.36	Overall: 70 G1: 66.7 G2: 73.3	Overall: 26.7 G1: 26.7 G2: 26.7
Maina et al., 2005	30	Italy	Dysthymia, minor depressive disorder, or adjustment disorder with depression	Overall: 36.8 G1: 30.2 G2: 40.7 G3: 39.5	Overall: 63 G1: 50 G2: 80 G3: 60	NR
Markowitz et al., 2005	94	United States	Dysthymia	Overall: 42.3 G1: NR G2: NR G3: NR G4: NR	Overall: 63 G1: NR G2: NR G3: NR G4: NR	Overall: 36 G1: NR G2: NR G3: NR G4: NR
Markowitz et al., 2008	26	United States	Dysthymia and alcohol abuse	Overall: 38.4 G1: 40.8	Overall: 32	Overall: 31 G1: 28.6

Author, year	Sample Size	Country	Diagnosis/Population	Mean Age	% Female	% Nonwhite
				G2: 35.7	G1: 21.4 G2: 41.7	G2: 33.3
McNamara et al., 1986	50	United States	Depression	NR	NR	NR
Milgrom et al., 2005	192	Australia	Postnatal depression	NR	Overall: 100	NR
Mohr et al., 2005	127	United States	Multiple sclerosis and depression	Overall: 47.98 G1: 48.60 G2: 47.35	Overall: 77.2 G1: 75.8 G2: 78.5	Overall: 11 G1: 6.5 G2: 13.8
Pellowe, 2006	52	United States	Mild to moderate depression	Overall: 20.44 G1: 20.84 G2: 20.07	Overall: 70 G1: 76 G2: 63	Overall: 8 G1: 8 G2: 8
Scott et al., 1992	121	United Kingdom	Major depressive episode	Overall: 31.8 G1: 30.6 G2: 28.8 G3: 36.2 G4: 31.6	Overall: 75.3 G1: 61.3 G2: 83.3 G3: 83.3 G4: 73.3	NR
Sharp et al., 2010	254	United Kingdom	Postnatal depression	Overall: 29.3 G1: 29.6 G2: 29.1	Overall: 100	Overall: 26 G1: 22 G2: 29.3
Shaw, 1977	32	Canada	Depression	Overall: 80.3 G1: 19.8 G2: 20.1 G3: 20.5 G4: 19.9	Overall: 69 G1: 62.5 G2: 75 G3: 62.5 G4: 75	NR
Simson et al., 2008	30	Germany	Diabetic foot syndrome and comorbid depression	Overall: 60.5 G1: 63.3 G2: 57.9	Overall: 43.3 G1: 33.3 G2: 53.3	NR
Verduyn et al., 2003	119	United Kingdom	Maternal depression	Overall: 29.87 G1: 30.1 G2: 30.8 G3: 28.7	Overall: 100	NR

Author, year	Sample Size	Country	Diagnosis/Population	Mean Age	% Female	% Nonwhite
Watson et al., 2003	66	Canada	Major depressive disorder	Overall: 41.5 G1: NR G2: NR	Overall: 67 G1: NR G2: NR	Overall: 9 G1: NR G2: NR
Wickberg & Hwang, 1996	41	Sweden	Postnatal depression	Overall: 28.4 G1: 29.5 G2: 27.2	Overall: 100	NR
Wollersheim & Wilson, 1991	32	?	Depressive disorder	Overall: 39.4 G1: NR G2: NR G3: NR	Overall: 71.8 G1: NR G2: NR G3: NR	NR

Cuijpers, Koole, van Dijke, Roca, Li, & Reynolds, 2014

Author, year	Sample Size	Country	Diagnosis/Population	Mean Age	% Female	% Nonwhite
Allart-van Dam et al., 2003	110	The Netherlands	Subclinical depressive symptoms	Overall: 45.5 G1: NR G2: NR	Overall: 61.8 G1: NR G2: NR	NR
Barrett et al., 2001	241	United States	Minor depression or dysthymia	Overall: 44.1 G1: 45.2 G2: 44.5 G3: 42.6	Overall: 63.9 G1: 57.5 G2: 67.5 G3: 66.7	Overall: 10.3 G1: 10 G2: 10 G3: 11
Haringsma et al., 2006	119	The Netherlands	Subclinical depression and major depression in older adults (55+)	Overall: 64.2 G1: NR G2: NR	Overall: 69 G1: NR G2: NR	*"90% of Dutch origin"* NR
Konnert et al., 2009	43	Canada	Subclinical depression in nursing home residents	Overall: 81.10 G1: NR G2: NR	Overall: 77 G1: 88 G2: 66.7	Overall: 0 G1: 0 G2: 0
Lara et al., 2010	377	Mexico	Pregnant women at high risk for depression	Overall: 26.95 G1: 26.43 G2: 27.96	NR	NR
Le et al., 2011	217	United States	Prevention of perinatal depression in Latinas at high risk for depression	Overall: 25.4 G2: 25.8 G2: 25	Overall: 100	*All Central American immigrants* NR
Lynch et al., 1997	29	United States	Minor depression	Overall: 48.4 G1: 46.8 G2: 49.9	Overall: 87 G1: 87.5 G2: 85.7	NR
Mossey et al., 1996	76	United States	Subdysthymic depression in "hospitalized elderly" (60+)	Overall: 71 G1: NR G2: NR	Overall: 78.2 G1: NR G2: NR	Overall: 55 G1: NR G2: NR

Author, year	Sample Size	Country	Diagnosis/Population	Mean Age	% Female	% Nonwhite
Munoz et al., 2007	41	United States	Pregnant women at high risk of major depressive episodes	Overall: 25 G1: 24.8 G2: 25	Overall: 100	*70% of the sample were Spanish speaking Latina women born in Mexico/Central America*
Pot et al., 2010	171	The Netherlands	Depressive symptoms age 50+	Overall: 64.3 G1: 64.41 G2: 64.17	Overall: 72.5 G1: 73.5 G2: 71.6	NR
Spek et al, 2007	301	The Netherlands	Subthreshold depression	Overall: 55 G1: 55 G2: 54 G3: 55	Overall: 63.5 G1: 67.6 G2: 63.6 G3: 59	NR
Van't Veer-Tazelaar et al., 2009	170	The Netherlands	Subclinical depression and anxiety	Overall: 81.1 G1: 81.8 G2: 81.1	Overall: 73.5 G1: 77.4 G2: 69.8	NR
Vazquez et al., 2012	133	Spain	Depressive symptoms in university students	Overall: 23.2 G1: 23.9 G2: 22.5	Overall: 82 G1: 80 G2: 84.1	NR
Willemse et al., 2004	216	The Netherlands	Subthreshold depression in primary care patients	Overall: 40.6 G1: 39.4 G2: 41.8	Overall: 66 G1: 66 G2: 66	NR
Williams et al., 2000	415	United States	Minor depression or dysthymia among older persons (60+) in primary care settings	Overall: 71 G1: 71 G2: 71 G3: 71	Overall: 41.6 G1: 39 G2: 41 G3: 45	Overall: 21.8 G1: 17.5 G2: 24.6 G3: 24.3

Gartlehner et al., 2015 (AHRQ review)

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Babyak et al., 2000	156	United States	Major Depressive Disorder ages 50+	Overall: 57 G1: 57 G2: 57 G3: 57	Overall: 73 G1: 79.2 G2: 73.6 G3: 65.5	Overall: 12.2 G1: 22.9 G2: 11.3 G3: 3.6
Barber et al., 2012	374	United States	Major Depressive Disorder	Overall: 37.5 G1: 38.0 G2: 36.2 G3: 38.3	Overall: 59 G1: 54.6 G2: 60.8 G3: 62.0	Overall: 52 G1: 43.6 G2: 62.7 G3: 50.0
Bastos et al., 2013	272	Brazil	Major depressive disorder in ages 26-34	Overall: 29.64 G1: 29.9 G2: 29.64 G3: 29.39	Overall: 61.3 G1: 61 G2: 63 G3: 60	NR
Behnke et al., 2013	70	Germany	Mild to moderate depression	Overall: 49.7 G1: 51.4 G2: 48.0	Overall: 67.14 G1: 68.57 G2: 65.71	NR
Bjerkenstedt et al., 2005	163	Sweden	Mild to moderate Major Depression	Overall: 50.3 G1: 49.1 G2: 50.4 G3: 51.4	Overall: 79.13 G1: 79.63 G2: 75.93 G3: 81.82	NR
Blom et al., 2007	353	The Netherlands	Major Depressive Disorder	Overall:39.93 G1: 40.0 G2: 41.0 G3: 37.7 G4: 41.0	Overall: 63.7 G1: 68.1 G2: 57.4 G3: 55.3 G4: 74.0	Overall:19.3[1] G1: 23.4 G2: 24.5 G3: 19.1 G4: 10.0
Blumenthal et al., 1999	156	United States	Major Depressive Disorder ages 50+	Overall: 57 G1: 57 G2: 57	Overall: 72.4 G1: 79.2	Overall: 12.2 G1: 22.9 G2: 11.3

[1] % of non-European sample

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				G3: 57	G2: 73.6 G3: 65.5	G3: 3.6
Blumenthal et al., 2007	202	United States	Major depressive disorder in ages 40+	Overall: 52.25 G1: 53 G2: 52 G3: 52 G4: 52	Overall: 75.3 G1: 74 G2: 75 G3: 75 G4: 77	Overall: 32 G1: 34 G2: 29 G3: 29 G4: 37
Brenner et al., 2000	30	United States	Major depressive disorder, dysthymic disorder, adjustment disorder with depressed mood, or depressive disorder NOS	Overall: 45 G1: 44.2 G2: 46.9	Overall: 63.33 G1: 66.67 G2: 60.00	Overall: 33.33 G1: 40.0 G2: 26.67
Chen et al., 2014	105	China	Primary unipolar depression	Overall: 33.12 G1: 35.37 G2: 32.11 G3: 31.89	Overall: 59 G1: 60.0 G2: 60.0 G3: 57.14	NR
David et al., 2008	170	Romania	Major depressive disorder	Overall: 37 G1: 35 G2: 39 G3: 37	Overall: 66.47 G1: 64.91 G2: 67.85 G3: 66.67	* *Roma population* Overall: 0.05 G1: 0.07 G2: 0.04 G3: 0.04
Davidson 2002	340	United States	Major depressive disorder	Overall: 42.37 G1: 43.1 G2: 40.1 G3: 43.9	Overall: 66 G1: 64.6 G2: 66.4 G3: 66.7	Overall: 24.4 G1: 23.0 G2: 24.1 G3: 26.1
Dekker et al., 2008	70	The Netherlands	DSM-IV-defined Depressive Episode	18 to 65 years old	Overall: 74 G1: 74.6 G2: 72.7 G3: 73.8	NR
DeRubeis et al., 2005	240	United States	Major depressive disorder	Overall: 40 G1: 39 G2: 42	Overall: 59 G1: 52 G2: 65	Overall: 18.5 G1: 25 G2: 12

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Dimidjian et al., 2006	241	United States	Major depressive disorder	Overall: 39.90 G1: 39.86 G2: 39.95	Overall: 66.0 G1: 72.5 G2: 57.3	Overall: 18.3 G1: 14.5 G2: 23.3
Fava et al., 2005	135	United States	Major depressive disorder	Overall: 37.3 G1: NR G2: NR G3: NR	Overall: 57 G1: NR G2: NR G3: NR	Overall: 19 G1: NR G2: NR G3: NR
Frank et al., 2011	318	United States Italy	DSM-IV-defined episode of major depression	Overall: 39.2 G1: NR G2: NR	Overall: 71.7 G1: NR G2: NR	NR
Gastpar et al., 2005	241	Germany	ICD-10 Moderate depressive disorder	Overall: 48.9 G1: 48.3 G2: 49.5	Overall: 74.4 G1: 79.4 G2: 69.4	Overall: 0.005 G1: 0.01 G2: 0
Gastpar et al., 2006	388	Germany	Moderate depressive episode	Overall: 49.83 G1: 50.8 G2: 49.3 G3: 49.4	Overall: 68 G1: 65.6 G2: 64.6 G3: 73.1	NR
Gertsik et al., 2012	42	United States	Major depressive disorder	Overall: 40.5 G1: NR G2: NR	NR	NR
Herrer et al., 1999	149	Germany	Mild to moderate depressive episodes ages 60-80	Overall: 68.8 G1: 68.4 G2: 69.1	Overall: 86.58 G1: 85.71 G2: 87.34	NR
Hegerl et al., 2010	368	Germany	Minor to moderate depression in primary care patients	Overall: 46.4 G1: 44.3 G2: 46.8 G3: 49.9 G4: 48.0 G5: 44.6	Overall: 68.2 G1: 64 G2: 66 G3: 72 G4: 76 G5: 66	NR
Hoffman et al., 2008	202	United States	Major depressive disorder	Overall: 51.7 G1: 52.8	Overall: 75.74	Overall: 32 G1: 34.0

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				G2: 51.0 G3: 51.8 G4: 51.2	G1: 74.6 G2: 76.5 G3: 74.5 G4: 77.5	G2: 29.4 G3: 28.6 G4: 36.7
Jazayeri et al., 2008	60	Iran	Major depressive disorder	Overall: 34.8 G1: 35.1 G2: 34.9 G3: 34.5	Overall: 69 G1: 75 G2: 75 G3: 56	NR
Kennedy et al., 2007	31	Canada	Major depressive episode and major depressive disorder	Overall: 35.63 G1: 30.0 G2: 41.25	Overall: 63 G1: 58.33 G2: 66.67	NR
Lam et al., 2013	99	Canada	Major depressive disorder	Overall: 43.25 G1: 42.3 G2: 44.2	Overall: 55 G1: 56 G2: 53	NR
Lenox-Smith & Jiang, 2008	406	“Europe and Australia”	DSM-IV MDD SSRI non-responders	Overall: 42.5 G1: 42 G2: 43	Overall: 67 G1: 69 G2: 64.1	NR
McGrath et al., 2013	82	United States	Major depressive disorder	Overall: 42 G1: 45.4 G2: 42.5 G3: 40.3 G4: 39.8	Overall: 61 G1: 66.6 G2: 41.7 G3: 66.6 G4: 68.3	Overall: 20.7 G1: 22.2 G2: 33.3 G3: 0.0 G4: 27.3
Menchetti et al., 2014	287	Italy	Major depressive disorder	Overall: 44.9 G1: 42.8 G2: 46.9	Overall: 73.5 G1: 74.8 G2: 72.2	NR
Mischoulon et al., 2014	189	United States	Major depressive disorder	Overall: 45 G1: NR G2: NR G3: NR	Overall: 49.7 G1: NR G2: NR G3: NR	Overall: 28 G1: NR G2: NR G3: NR
Moradveisi et al., 2013	100	Iran	Major depressive disorder	Overall: 31.37 G1: 32.62	Overall: 85	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				G2: 30.12	G1: 80 G2: 90	
Moreno et al., 2006	72	Brazil	Mild to moderate depression	Overall: 40.5 G1: 45.9 G2: 37.7 G3: 37.2	Overall: 83 G1: NR G2: NR G3: NR	NR
Mynors-Wallis et al., 2000	151	United Kingdom	Major depression in primary care	Overall: 35 G1: 36 G2: 33 G3: 34 G4: 35	Overall: 76.82 G1: 84.62 G2: 68.29 G3: 86.11 G4: 68.57	Overall: 5.3 G1: 2 G2: 5 G3: 11 G4: 3
Papakostas et al., 2007	135	United States	Major depressive disorder	Overall: 37.3 G1: NR G2: NR G3: NR	Overall: 57 G1: NR G2: NR G3: NR	Overall: 19 G1: NR G2: NR G3: NR
Qu et al., 2013	160	China	Major depressive disorder	Overall: 33.3 G1: 34.4 G2: 32.3 G3: 33.2	Overall: 59.3 G1: 60.4 G2: 57.4 G3: 60.3	NR
Raue et al., 2009	60	United States	MDD in mid-life and elderly primary care patients	Overall: 51.2 G1: NR G2: NR	Overall: 78 G1: NR G2: NR	Overall: 66 G1: NR G2: NR
Rucci et al., 2011	291	United States Italy	Unipolar major depression	Overall: 39.6 G1: 39.3 G2: 39.8	Overall: 72.2 G1: 71.1 G2: 73.2	NR
Rush et al., 2006	727	United States	Major depressive disorder	Overall: 41.8 G1: 41.9 G2: 42.6 G3: 31.1	Overall: 58.7 G1: 56.9 G2: 55.0 G3: 64.0	Overall: 24.2 G1: 25.1 G2: 21.8 G3: 25.6
Rush et al., 2008	727	United States	MDD after intolerance or lack of remission with initial SSRI	Overall: 41.8 G1: 41.9	Overall: 58.7	Overall: 24.2 G1: 25.1

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				G2: 42.6 G3: 31.1	G1: 56.9 G2: 55.0 G3: 64.0	G2: 21.8 G3: 25.6
Salminen et al., 2008	51	Finland	Mild to moderate MDD	Overall: 42.4 G1: 41.9 G2: 42.9	Overall: 68.24 G1: 72 G2: 65	NR
Schrader, 2000	240	Germany	Mild to moderate depression	Overall: 46.5 G1: 47 G2: 46	Overall: 65 G1: 59 G2: 71	NR
Segal et al., 2007	301	Canada	Major depressive disorder	Overall: 55.79 G1: 36.84 G2: 37.89	Overall: 55.8 G1: 55.9 G2: 55.7	NR
Sun et al., 2013	75	China	Depressive disorder	Overall: 42.13 G1: 43.1 G2: 42.56 G3: 40.72	Overall: 76.4 G1: 60 G2: 81.25 G3: 88	NR
Szegedi et al. 2005	251	Germany	Moderate to severe major depression	Overall: 47.25 G1: 49.0 G2: 45.5	Overall: 69 G1: 70 G2: 68	NR
Thase et al., 2007	182	United States	Major depressive disorder	Overall: 40.0 G1: 40.6 G2: 39.7	Overall: 65.4 G1: 63.1 G2: 66.7	Overall: 17 G1: 20 G2: 15.4
Trivedi et al., 2006	565	United States	Major depressive disorder	Overall: 41.1 G1: 40.8 G2: 41.5	Overall: 58.8 G1: 61.6 G2: 55.9	Overall: 21.9 G1: 20.8 G2: 23.1
Van Gurp et al., 2002	87	Canada	Major depressive disorder	NR	Overall: 62 G1: 58.5 G2: 63.6	NR
Zhang et al., 2009	180	China	Major depressive disorder	Overall: 35.85 G1: 36.2	Overall: 66.3	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				G2: 35.5	G1: 70 G2: 62.5	* *han and dai ethnicity reported*

ECRI Institute, 2015 (VA/DoD Report)

***Note.* * - Meta-analysis; ± - Systematic review**

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Key Question #4A						
Cape et al., 2010*	3,962	United Kingdom	Anxiety and Depression	NR	NR	NR
Cuijpers et al., 2009*	701	The Netherlands	Depression	NR	NR	NR
Cuijpers et al., 2013*	5,403	The Netherlands	Depression	NR	NR	NR
Driessen et al., 2010*	1,365	The Netherlands	Depression	NR	NR	NR
Nieuwsma et al., 2012*	713	United States	Depression	NR	NR	NR
Key Question #4B						
Andrews et al., 2010*	1,746	Australia	Anxiety and Depression	NR	NR	NR
Arnberg et al., 2014±	3,580	Sweden	Anxiety and mood disorders	NR	NR	NR
Barnhofer et al., 2009	28	United Kingdom	Chronic-recurrent depression	Overall: 41.93 G1: 42.07 G2: 41.79	Overall: 34 G1: 35 G2: 32	NR
Bondolfi et al., 2010	60	Switzerland	Depression	Overall: 47.5 G1: 46 G2: 49	Overall: 72 G1: 74 G2: 69	NR
Chan et al., 2012	75	China	Depression	Overall: 46.48 G1: 45.44 G2: 46.94 G3: 47.06	Overall: 79.9 G1: 75 G2: 76.5 G3: 88.2	NR
Chiesa et al., 2015	43	Italy	Major Depression	Overall: 48.81 G1: 50.91 G2: 46.70	Overall: 72.1 G1: 70 G2: 75	NR
Choi et al., 2014a	121	United States	Depression (Older Adults)	Overall: 65.21 G1: NR G2: NR	Overall: 77.7 G1: NR G2: NR	Overall: 58.68 G1: NR G2: NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Choi et al., 2014b	158	United States	Depression (Older Adults)	Overall: 64.80 G1: NR G2: NR	Overall: 78.5 G1: NR G2: NR	Overall: 57.59 G1: NR G2: NR
Conradi et al., 2007	267	The Netherlands	Depression	Overall: 42.8 G1: 44.2 G2: 42.5 G3: 41 G4: 42.8	Overall: 65 G1: 65.3 G2: 65.2 G3: 69.2 G4: 54.5	NR
Coull & Morris, 2011±	NR	United Kingdom	Anxiety and Depression	NR	NR	NR
Cramer et al., 2011	75	United Kingdom	Depression	Overall: 42.29 G1: 42.71 G2: 41.86	Overall: 100	Overall: 11 G1: 11 G2: 10
Crane & Williams, 2010	68	United Kingdom	Suicidal depression	Overall: 42	NR	NR
Cuijpers, Van Straten, & Warmerdam 2008*	673	The Netherlands	Depression	NR	NR	NR
Cuijpers, Munoz, Clarke, & Lewinsohn, 2009*	3,736	The Netherlands	Depression	NR	NR	NR
Cuijpers, Donker, van Straten, Li, & Andersson, 2010*±	810	The Netherlands	Depression	NR	NR	NR
Cuijpers et al., 2013a*	115	The Netherlands	Depression	NR	NR	NR
Cuijpers et al., 2013b*±	616	The Netherlands	Depression and suicidality	NR	NR	NR
Cuijpers et al., 2014*	6,937	The Netherlands, Sweden, United States	Major Depression	NR	NR	NR
Feng et al., 2012*	NR	Taiwan	Depression	Overall: 19.5-75.2	NR	NR
Foroushani, Schneider, & Assareh, 2011*	NR	United Kingdom	Depression	NR	NR	NR
Forkman et al., 2014	130	The Netherlands	Depression	Overall: 43.9 G1: 44.6 G2: 43.2	Overall: 76 G1: 79 G2: 73	NR
Gandy, Sharpe, & Perry, 2013±	247	Australia	Depression and epilepsy	NR	NR	NR
Garcia-Lizana & Munoz, 2010±	1,951	Australia, Canada, Sweden, United Kingdom, United States	Depression	NR	NR	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Geraedts et al., 2014	231	The Netherlands	Depression	Overall: 43.4 G1: 43 G2: 43.8	Overall: 62.3 G1: 66.4 G2: 58.3	NR
Geschwind et al., 2012	130	The Netherlands	Depression	Overall: 44 42.8 (≤2 episodes) 45.2 (≥3 episodes)	Overall: 76 70 (≤2 episodes) 81 (≥3 episodes)	NR
Godfrin & van Heeringen, 2010	106	Belgium	Depression	Overall: 45.7 G1: 44.9 G2: 46.4	Overall: 81.2 G1: 82.7 G2: 79.6	NR
Gould, Coulson, & Howard, 2012*	NR	United Kingdom	Depression	Overall: 68.4	NR	NR
Hoifodt et al., 2011±	NR	Norway	Depression and anxiety	NR	NR	NR
Huang, Delucchi, Dunn, & Nelson, 2015*±	2,245	United States	Late-life depression	Overall: 61.38	NR	NR
Huntley, Araya, & Salisbury, 2012*±	NR	United Kingdom	Depression	NR	NR	NR
Jakobsen et al., 2011a±	669	Denmark	Major Depressive Disorder	NR	NR	NR
Jakobsen et al., 2011b±	719	Denmark	Major Depressive Disorder	NR	NR	NR
Jakobsen et al., 2012±	365	Denmark	Major Depressive Disorder	NR	NR	NR
Jayasekara et al., 2014±	705	Australia	Depression (Older Adults)	NR	NR	NR
Krishna et al., 2011±	NR	United Kingdom	Depression (Older Adults)	Overall: 70.82	NR	NR
Kuyken et al., 2008	123	United Kingdom	Recurrent Depression	Overall: 49.16 G1: 48.95 G2: 49.37	Overall: 77 G1: 77 G2: 76	Overall: 1.64 G1: 1.64 G2: 0
Lopez del Hoyo et al., 2013 (*Proposed study*)	450	Spain	Depression	NR	NR	NR
Mackinnon, Griffiths, & Christensen, 2008	525	Australia	Depression	NR	NR	NR
Manicavasgar, Parker, & Perich, 2011	45	Australia	Non-melancholic depression	Overall: 46 G1: 47	Overall: 64 G1: 63	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				G2: 45	G2: 65	
Meadows et al., 2014	203	Australia	Recurrent Depression	Overall: 48.4 G1: 47.5 G2: 49.2	Overall: 81.3 G1: 81.2 G2: 81.4	NR
Mergl et al., 2011	145	Germany	Depression	Overall: 46 G1: 50 G2: 43.4 G3: 44.5	Overall: 64 G1: 65.6 G2: 65.9 G3: 60.7	NR
Milgrom et al., 2015	45	Australia	Postpartum depression	Overall: 30.1 G1: 28.5 G2: 31.6 G3: 30.1	Overall: 100	NR
Mohr et al., 2008*	1,312	United States	Depression	NR	NR	NR
Normann, Van Emmerik, & Morina, 2014*±	384	Denmark	Depression	NR	NR	NR
Okumura & Ichikura, 2014*±	3,356	Japan	Depression	NR	NR	NR
Omidi, Mohammadkhani, Mohammadi, & Zargar, 2013	90	Iran	Depression	Overall: 28 G1: 32 G2: 30 G3: 35	Overall: 66.7 G1: 80 G2: 66 G3: 53	NR
Parker, Crawford, & Hadzi-Pavlovic, 2008*	444	Australia	Depression	NR	NR	NR
Peng, Huang, Chen, & Lu, 2009±	705	China	Depression (Older Adults)	NR	NR	NR
Piet & Hougaard, 2011*±	593	Denmark	Depression	Overall: 46	Overall: 74	NR
Richards & Richardson, 2012*±	2,996	Ireland	Depression	NR	NR	NR
Rodgers et al., 2012±	NR	United Kingdom	Depression	NR	NR	NR
Segal et al., 2010	160	Canada	Recurrent Depression	Overall: 44 G1: 44 G2: 45	Overall: 58 G1: 63 G2: 53	NR
Shahar et al., 2010	45	United States	Depression	Overall: 46.6 G1: 46.58 G2: 46.74	Overall: 84 G1: 76.92 G2: 94.74	NR
So et al., 2013*	3,286	United States	Depression	NR	NR	NR
Sockol, 2015±	7,637	United States	Depression	NR	NR	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Songprakun & McCann, 2012	56	Thailand	Depression	Overall: 42.13 G1: 39.41 G2: 44.66	Overall: 73.2 G1: 81.6 G2: 65.5	NR
Spek et al., 2007*	2,334	The Netherlands	Depression and Anxiety	NR	NR	NR
Strauss, Hayward, & Chadwick, 2012	28	United Kingdom	Chronic Depression	Overall: 43 G1: NR G2: NR	Overall: 71.4 G1: NR G2: NR	NR
Strauss, Cavanagh, Oliver, & Pettman, 2014*	578	United Kingdom	Anxiety and Depression	NR	NR	NR
Stevenson et al., 2010±	704	United Kingdom	Postnatal Depression	NR	Overall: 100	NR
Titov et al., 2015	54	Australia	Depression (Older Adults)	Overall: 65.31 G1: 64.52 G2: 66.16	Overall: 73 G1: 81.5 G2: 64	NR
Tursi et al., 2013±	3,725	Brazil	Major Depression	NR	NR	NR
Twomey, O'Reilly, & Byrne, 2015*	2,851	Ireland	Anxiety and depression	NR	NR	NR
van Aalderen et al., 2012	205	The Netherlands	Depression	Overall: 48 G1: 47.3 G2: 47.7	Overall: 70.7 G1: 70 G2: 72	NR
Warmerdam et al., 2008	263	The Netherlands	Depression	Overall: 45 G1: 45.7 G2: 45.1 G3: 44.1	Overall: 71.1 G1: 69.3 G2: 64.8 G3: 79.3	NR
Williams et al., 2014	274	United Kingdom	Recurrent depression	Overall: 43 G1: 43.99 G2: 43.86 G3: 43.43	Overall: 72 G1: 71 G2: 74 G3: 70	Overall: 5 G1: 4 G2: 5.8 G3: 1.9
Wiersma et al., 2014	139	The Netherlands	Chronic depression	Overall: 42 G1: 43 G2: 40	Overall: 60 G1: 51.4 G2: 68.7	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Key Question #4C						
Abbass et al., 2014±	2,173	Canada	Mental disorders (anxiety, depression, somatoform, mixed, personality)	NR	NR	NR
Alexopoulos et al., 2011 *(demographic and clinical characteristics reported in Arean et al., 2010)*	221	United States	Depression and executive dysfunction	Overall: 72.97 G1: 72.8 G2: 73.2	NR	NR
Barbato et al., 2008*	567	Italy	Depression; Couple's distress	NR	NR	NR
Barth et al., 2013*	15,118	Switzerland	Depression	NR	NR	NR
Baumeister et al., 2011±	4,498	Germany	Depression and coronary artery disease	Overall: Range 54.1-63.6	Overall: Range 10-56	NR
Bell and D'Zurilla, 2008*	1,426	United States	Depression	NR	NR	NR
Biesheuvel-Leliefeld et al., 2015*	2,055	The Netherlands	Recurrent depression	Overall: 43.3	Overall: 70.4	NR
Bohlmeijer et al., 2011	93	The Netherlands	Depression	Overall: 49.02 G1: 48.84 G2: 49.23	Overall: 81.7 G1: 85.7 G2: 77.3	Overall: 8.6 G1: 6.1 G2: 11.4 (*other race*)
Bortolotti et al., 2008*	1,736	Italy	Depression	Overall: 35.5	Overall: 82.7	NR
Churchill et al., 2013±	224	United Kingdom	Depression	Overall: 39.05	Overall: 69.8	Overall: 19.5
Cohen, O'Leary, & Foran, 2009	35 (**couples**) = 70	United States	Depression in women + non-depressed men	Overall (W): 43.21 G1: 42.72 G2: 43.69	Overall: 100	Overall: 11.8 G1: 11.1 G2: 12.4
Cooper et al., 2011±	NR	United Kingdom	Treatment-refractory depression (Older Adults)	Overall: Range 65.6-77.1	NR	NR
Cuijpers et al., 2007*	780	The Netherlands	Depression	NR	NR	NR
Cuijpers et al., 2008b*	2,757	The Netherlands & Sweden	Depression	NR	NR	NR
Cuijpers et al., 2008c*	3,178	The Netherlands & Sweden	Depression	NR	NR	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Cuijpers et al., 2009a*	1,838	The Netherlands & Sweden	Depression	NR	NR	NR
Cuijpers et al., 2009b*	2,036	The Netherlands	Depression	NR	NR	NR
Cuijpers et al., 2009c*	1,505	The Netherlands & Sweden	Depression	NR	NR	NR
Cuijpers et al., 2010a*	2,116	The Netherlands, Sweden, United States	Chronic major depression and dysthymia	Overall: 42.96	Overall: 59.69	NR
Cuijpers et al., 2010b*	8,140	The Netherlands, Sweden, United States	Depression	NR	NR	NR
Cuijpers et al., 2011*	4,356	The Netherlands, Sweden, United States	Depression	NR	NR	NR
Cuijpers et al., 2012*	2,508	The Netherlands, Sweden, United States	Depression	NR	NR	NR
Cuijpers et al., 2014a*	3,623	The Netherlands, Germany, Sweden, United States	Depression and anxiety	NR	NR	NR
Cuijpers et al., 2014b*	4,409	The Netherlands, Australia, United States	Depression (Older Adults)	NR	NR	NR
Dennis, 2014*	3,890	Australia, Canada, China, Japan, United Kingdom, United States	Perinatal Depression	NR	Overall: 100	NR
Denton et al., 2012	24 (**couples**)	United States	Depression (women) and couples distress	Overall: 32.9 G1: 34 G2: 31.7	Overall: 100	Overall: 25 G1: 33.3 G2: 16.7
Dickens et al., 2013±	17,397	United Kingdom	Depression and coronary heart disease	Overall: Range 50.9-69.7	NR	NR
Ekers et al., 2014*	1,524	United Kingdom	Depression	NR	NR	NR
Fluckiger et al., 2014*	1,572	Germany, Norway, Switzerland, United States	Acute depression and anxiety	NR	NR	NR
Folke, Parling, & Melin, 2012	34	Sweden	Depression from unemployment	Overall: 43.24 G1: 40.56 G2: 46.25	Overall: 88.2 G1: 94.4 G2: 81.3	Overall: 0
Forman et al., 2012	132	United States	Anxiety and Depression	Overall: 26.7 G1: NR G2: NR	Overall: 79.5 G1: NR G2: NR	Overall: 30.3 G1: NR G2: NR
Gili et al., 2015±	608	Spain & United Kingdom	Depression	NR	NR	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Guidi et al., 2011*	875	Italy & United States	Major Depressive Disorder	Overall: 44.5	Overall: 66	NR
Hackett et al., 2008±	1,655	United Kingdom	Post-stroke depression	Overall: Range 60-78	NR	NR
Huang et al., 2015*	2,245	United States	Geriatric depression	Overall: 55 or older	NR	NR
Hundt et al., 2014±	1,683	United States	Depression (Veterans)	NR	NR	NR
Jakobsen et al., 2011±	648	Denmark	Major Depressive Disorder	NR	NR	NR
Kiosses et al., 2011±	1,507	United States	Late-life Major Depression	Overall: 69.78	NR	Overall: 13.74
Kiosses et al., 2015	74	United States	Depression & Cognitive Impairment (Older Adults)	Overall: 80.90 G1: 80.78 G2: 81.03	Overall: 74.32 G1: 70.27 G2: 78.38	Overall: 17.57 G1: 18.92 G2: 16.22
Klein et al., 2011	491	United States	Depression	Overall: 45.1 G1: 45.3 G2: 46.6 G3: 43.4	Overall: 53.9 G1: 55.7 G2: 58.3 G3: 47.8	Overall: 10.39 G1: 4.4 G2: 5.4 G3: 7.6
Krishna et al., 2011±	NR	United Kingdom	Depression (Older Adults)	Overall: 70.82	NR	NR
Kriston et al., 2014*	11,154 (Rx) 5,376 (Rx + Therapy)	Germany	Major Depression & Dysthymia	NR	NR	NR
Lam et al., 2013	99	Canada	Major Depressive Disorder	Overall: 43.3 G1: 42.3 G2: 44.2	Overall: 54.5 G1: 56 G2: 53	NR
Linde et al., 2015±*	5,159	Germany	Depression	Overall: 47.6	Overall: 73	NR
Ly et al., 2014	81	Sweden	Major Depressive Disorder	Overall: 36.1 G1: 36.6 G2: 35.6	Overall: 70 G1: 70 G2: 70.7	NR
McNaughton, 2009±	4,575	Canada	Depression	Overall: 41.85	Overall: 74.9	NR
Mulcahy, Reay, Wilkinson, & Owen, 2010	50 (**Mother-Infant dyads)**	Australia	Postnatal Depression	Overall (**Mother**): 32.21	Overall (**Mother**): 100	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				G1: 32 G2: 32.41 Overall (**Infant**): 6.20 months G1: 6.65 months G2: 5.74 months	Overall (**Infant**): 48 G1: 47.8 G2: 48.1	
Oestergaard et al., 2011±	NR	Denmark	Depression	NR	NR	NR
Ost et al., 2014±*	4,234	Australia, Canada, Finland, Great Britain, Iran, New Zealand, Sweden, United States	Psychiatric, somatic, and stress disorders	Overall: 39.9	Overall: 68	NR
Pinquart et al., 2007±	NR	Germany & United States	Depression (Older Adults)	Overall: 71.77	Overall: 67.1	NR
Reay et al., 2012	44 (**Mother-child dyads**)	Australia	Postnatal Depression	Overall (**Mother**): 34.5 G1: 33.8 G2: 35.2 Overall (**Child**): 2.6 G1: 2.6 G2: 2.6	Overall (**Mother**): 100 Overall (**Child**): 45.4 G1: 47.8 G2: 42.9	NR
Renner et al., 2014*	2,956	The Netherlands	Depression	NR	NR	NR
Samad, Brealey, & Gilbody, 2011*	256	United Kingdom	Depression (Older Adults)	Overall: 67.4	Overall: 66.8	NR
Shinohara et al., 2013±	955	Japan & United Kingdom	Depression	NR	Overall: Range 56-80	NR
Simon, Cordas, & Bottino, 2014±	758	Brazil	Depression (Older Adults)	NR	NR	NR
Spijker et al., 2013±	2,316	The Netherlands	Chronic Major Depressive Disorder	NR	NR	NR
Steinert et al., 2014*	966	Germany	Depression	Overall: 41.9	Overall: 64	NR
Van, Schoevers, & Dekker, 2008±	NR	The Netherlands	Depression	NR	NR	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
van Hees et al., 2013±	1,233	The Netherlands	Major Depressive Disorder	Overall: Range 29.4-40.2	Overall: Range 55-83	NR
Wampold et al., 2011*	NR	Norway, Switzerland, United States	Depression and Anxiety	NR	NR	NR
Woltz et al., 2012±	3,564	United States	Depression & heart failure	Overall: 66.8	NR	NR
Zilcha-Mano et al., 2014	156	Germany & United States	Major Depressive Disorder	Overall: 37.5 G1: NR G2: NR G3: NR	Overall: 59 G1: NR G2: NR G3: NR	Overall: 17.3 G1: NR G2: NR G3: NR
Key Question #5						
Cuijpers et al., 2008*	11,369	The Netherlands & Sweden	Depression	NR	NR	NR
Denton, Wittenborn, & Golden, 2012	24	United States	Depression; Comorbid relationship distress	Overall: 32.9 G1: 34 G2: 31.7	Overall: 100	Overall: 25 G1: 33.3 G2: 16.7
Guidi et al., 2011*	875	Italy & United States	Major Depressive Disorder	Overall: 44.5	Overall: 66	NR
Hollon et al., 2014	452	United States	Major Depressive Disorder	Overall: 43.2 G1: 43.3 G2: 43	Overall: 58.8 G1: 57.3 G2: 60.4	Overall: 6 G1: 7.5 G2: 4.4
Jakobsen et al., 2012±	365	Denmark	Major Depressive Disorder	NR	NR	NR
Kocsis et al., 2009	489	United States	Chronic Depression	Overall: 44.6 G1: 43.2 G2: 45.9	Overall: 53 G1: 47 G2: 57	Overall: 6.2 G1: 10 G2: 5.2
Rush et al., 2006	**STEP 1:** 3,671 **2:** 1,439 **3:** 390 **4:** 123	United States	Depression	Overall: 43.1 **S1:** 40.7 **S2:** 41.5 **S3:** 43.6 **S4:** 46.4	Overall: 55.2 **S1:** 62.2 **S2:** 59.1 **S3:** 50.5 **S4:** 48.8	Overall: 11.5 **S1:** 12 **S2:** 11.7 **S3:** 11.3**S4:** 10.8
Schlogelhofer et al., 2014	90	Austria	Depression (Partial Remission)	Overall: 47.8 G1: 48.3	Overall: 67 G1: 63.3	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				G2: 47.3	G2: 70.7	
Thase et al., 2007	182	United States	Depression	Overall: 40 G1: 40.6 G2: 39.7	Overall: 65.4 G1: 63.1 G2: 66.7	Overall: 8.5 G1: 10 G2: 7.7
von Wolff et al., 2012±*	1,618	Germany	Chronic Depression	Overall: 41.2	Overall: 67.1	NR
Wiles et al., 2014	469	United Kingdom	Depression	Overall: 49.6 G1: NR G2: NR	Overall: 72.3 G1: NR G2: NR	NR
Key Question #6						
Cuijpers et al., 2012±	4,734	China, The Netherlands, Sweden, United States	Depression	NR	NR	NR
Hollon et al., 2014	452	United States	Major Depressive Disorder	Overall: 43.2 G1: 43.3 G2: 43	Overall: 58.8 G1: 57.3 G2: 60.4	Overall: 6 G1: 7.5 G2: 4.4
Key Question #10						
Adamson, Ensari, & Motl, 2015*±	1,324	United States	Depression w/ comorbid neurologic disorders	NR	NR	NR
Appleton, Rogers, & Ness, 2010*±	NR	United Kingdom	Depression	NR	NR	NR
Baxendale, O'Sullivan, & Heaney 2013	58	United Kingdom	Anxiety and depression w/ comorbid focal epilepsy	Overall: 44.8 G1: 42.9 G2: 46.6	Overall: 58.6 G1: 59.1 G2: 58.1	NR
Blake, Mo, Malik, & Thomas, 2009±	641	United Kingdom	Depression (Older adults)	Overall: Range 65-82.4	Overall: 66.8	NR
Bridle, Spanjers, Patel, Atherton, & Lamb, 2012	667	Australia, China, Hong Kong, New Zealand, United Kingdom, United States	Depression (Older adults)	Overall: Range 65-80	Overall: 69	NR
Butler et al., 2008	46	United States	Depression	Overall: 50.4 G1: NR G2: NR G3: NR	Overall: 74 G1: NR G2: NR G3: NR	Overall: 3.4 G1: NR G2: NR G3: NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Carpenter, 2011*	NR	United States	Depression	NR	NR	NR
Chan et al., 2012	75	China	Depression	Overall: 46.48 G1: 45.44 G2: 46.94 G3: 47.06	Overall: 79.9 G1: 75 G2: 76.5 G3: 88.2	NR
Chan, Lo, Yang, Chen, & Lin, 2015*±	1,046	Taiwan	Depression	Overall: 42.32	NR	NR
Chu, Buckworth, Kirby, & Emery, 2009	54	United States	Depression	Overall: 25.9 G1: 26.4 G2: 26.6 G3: 24.6	Overall: 100	NR
Cooney et al., 2013±	2,326	United Kingdom	Depression	Overall: Range 22-87.9	NR	NR
Daley, 2008±	NR	United Kingdom	Depression	NR	NR	NR
Deligiannidis & Freeman, 2010±	NR	United States	Depression	NR	Overall: 100	NR
de Man-Van Ginkel et al., 2010±[2]	4,257	The Netherlands	Poststroke depression	NR	NR	NR
Dennis & Allen, 2013±	61	United Kingdom	Antenatal depression	NR	Overall: 100	NR
Eng & Reime, 2014±	1,022	Canada & Germany	Stroke w/ comorbid depression	Overall: Range 21-93	NR	NR
Even, Schroder, Friedman, & Rouillon, 2008±	570	France & United States	Nonseasonal depression	NR	NR	NR
Field, Diego, Medina, Delgado, & Hernandez, 2012	84	United States	Prenatal depression	Overall: 26.6 G1: NR G2: NR G3: NR	Overall: 100	Overall: 39 G1: NR G2: NR G3: NR
Field et al., 2013a	92	United States	Prenatal depression, anxiety, sleep disturbances	Overall: 26.6 G1: 26 G2: 24.4	Overall: 100	Overall: 48.8 G1: 48.5 G2: 49

[2] The *n* in this study included nurses.

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Field et al., 2013b	92	United States	Prenatal depression and anxiety	Overall: 24.9 G1: 24.4 G2: 24.5	Overall: 100	Overall: 49.25 G1: 49 G2: 49.5
Floyd et al., 2006	23	United States	Depression (Older adults)	NR	NR	NR
Freeman, 2009±	149	United States	Perinatal Major Depressive Disorder	NR	Overall: 100	NR
Freeman et al., 2010*	NR	United States	Major Depressive Disorder	NR	NR	NR
Gong et al., 2015*±	375	China	Prenatal depression	Overall: Range 20-40	Overall: 100	NR
Gowda et al., 2015*	4,923	Australia, Iran, Norway, Turkey, United States	Depression	Overall: 44.82	NR	NR
Jain et al., 2015±	1,173	China, India, Iran, Italy, The Netherlands, United States	Depression	NR	NR	NR
Jans, Giltay, & Willem Van der Does, 2010*	612	Australia, Germany, Hungary, Taiwan, The Netherlands, United States	Perinatal depression	NR	Overall: 100	NR
Joling et al., 2011	170	The Netherlands	Depression	Overall: 81.5 G1: 81.8 G2: 81.1	Overall: 74 G1: 69.8 G2: 77.4	NR
Josefsson, Lindwall, & Archer, 2014*±	720	Sweden	Depression	NR	NR	NR
Kasper et al., 2010	1,661	Austria & Germany	Depression	NR	NR	NR
Kinser et al., 2013	27	United States	Depression	Overall: 43.26 G1: 40.93 G2: 46.17	Overall: 100	Overall: 37.04 G1: 33.33 G2: 41.67
Klannin-Yobas, Oo, Yew, & Lau, 2015±	Ranged 18-208	France, Hong Kong, Iceland, India, & Singapore	Depression (Older adults)	NR	NR	NR
Lande, Williams, Gragnani, & Tsai, 2011	20	United States	Depression (Active duty members)	Ages 21-25: 10% Ages 26-30: 30% Ages 31-35: 10%	Overall: 35	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				Ages 36-40: 20% Ages >41: 30%		
Lavretsky et al., 2011	112	United States	Depression (Older adults)	Overall: 70.55 G1: 69.1 G2: 72	Overall: 62 G1: 64 G2: 60	NR
LeGrand & Mille, 2009	12	France	Depression (Older adults	Overall: 66.8	Overall: 100	NR
Li et al., 2014±	1,203	Australia, Iran, Norway, United States	Depression	Overall: 38.1	Overall: 72	NR
Lieverse et al., 2008 (*Proposed study*)	126	The Netherlands	Depression (Older adults)	NR	NR	NR
Lieverse et al., 2011	89	The Netherlands	Major Depressive Disorder (Older adults)	Overall: 69.34 G1: 69 G2: 69.67	Overall: 65.5 G1: 64 G2: 67	NR
Linde, Berner, & Kriston, 2008±	5,489	Germany	Depression	Overall: 45.10	Overall: 72.5	NR
Liu et al., 2009	52	Taiwan	Depression	Overall: 26.4 G1: NR G2: NR	Overall: 73 G1: NR G2: NR	Overall: 100
Liu et al., 2015	213	Australia	Obesity w/ comorbid depression, anxiety, stress	Overall: 52.5 G1: 52 G2: 53	Overall: 70 G1: 70.8 G2: 69.2	NR
Luberto, White, Sears, & Cotton, 2013±	NR	United States	Depression	NR	NR	NR
Martins, 2009*	1,953	United Kingdom	Depression	NR	NR	NR
Mead et al., 2009±	907	United Kingdom	Depression	Overall: 48.8	Overall: 70.1	NR
Milte, Sinn, & Howe, 2009±	5,899	Australia	ADHD, Depression, Alzheimer's	NR	NR	NR
Moldovan, Cobeanu, & David, 2012	96	Romania & United States	Subthreshold depression	Overall: 23.04 G1: 22.42 G2: 21.91	Overall: 87.5 G1: 91.7 G2: 87.5	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				G3: 23.08 G4: 24.73	G3: 87.5 G4: 83.3	
Mozaffari-Khrosravi et al., 2013	120	Iran	Depression	Overall: 32.6 G1: 33 G2: 32.7 G3: 32.1	Overall: 65 G1: 76.5 G2: 75 G3: 64.1	NR
Mura & Carta, 2013a±	1,318	Italy	Depression (Older adults)	Overall: 68.57	NR	NR
Mura, Moro, Patten, & Carta, 2013±	1,131	Italy	Major depressive disorder	Overall: 53.29	NR	NR
Nahas & Sheikh, 2011±	NR	Canada	Major depressive disorder	NR	NR	NR
Naylor et al., 2010	38	United States	Depression	Overall: 51.45 G1: 48.6 G2: 54.3	Overall: 84.2 G1: 94.7 G2: 73.7	Overall: 5.3 G1: 5.3 G2: 5.3
Newham, Wittkowski, Hurley, Aplin, & Westwood, 2014	59	United Kingdom	Antenatal anxiety and depression	Overall: NR G1: 31 G2: 31	Overall: 100	NR
Nieuwenhuijsen & Bultmann, 2008±	2,556	The Netherlands	Depression	Overall: 40.89	Overall: 70.17	NR
Oh et al., 2013±	764	Australia, China, Germany, Korea, United States	Depression	Overall: 73.1	Overall: 68.8	NR
Pakseresht et al., 2012	40	Iran	Major depressive disorder	Overall: 29.9 G1: 30 G2: 29.8	Overall: 52.5 G1: 55 G2: 50	NR
Park, Han, & Kang, 2014±	3,297	Australia, France, Finland, Hong Kong, Korea, The Netherlands, Sweden, United Kingdom, United States	Depression (Older adults)	65 and older	NR	NR
Prakhinkit et al., 2014	45	Thailand	Depression (Older adults)	Overall: 76.6 G1: 81 G2: 74.8 G3: 74	Overall: 100	NR
Rahimi, Nikfar, & Abdollahi, 2009*	1,754	Iran	Depression	Overall: 47.02	Overall: 68.2	NR
Rakofsky & Dunlop, 2014±	NR	United States	Bipolar Depression	NR	NR	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Rethorst, Wipfli, & Landers, 2009*	2,982	United States	Depression	NR	NR	NR
Rickhi et al., 2011	84	Canada	Unipolar Major Depression	Overall: 44.05 G1: 44 G2: 44.1	Overall: 77.2 G1: 80 G2: 74.4	NR
Robertson, Robertson, Jepson, & Maxwell, 2012*±	341	Australia, Canada, Germany, Portugal, Spain, United States	Depression	50+, 60+, 20-70, and 72.5	NR	NR
Rocha-Araujo et al., 2010±	47,062	Australia, Canada, France, Greece, Holland, New Zealand, Spain, United Kingdom, United States	Depression	NR	NR	NR
Sarubin et al., 2014	60	Germany	Major depression	Overall: 40.25 G1: 37.27 G2: 42.36	Overall: 28.3 G1: 36.4 G2: 22.6	NR
Shapiro et al., 2007	37	United States	Unipolar major depression	Overall: 44.8	Overall: 73	Overall: 10.8
Silveira et al., 2013*±	1,759	Brazil	Depression	Overall: 48.7	NR	NR
Smith, Armour, Lee, Wang, & Hay, 2010±	7,104	Australia, China, Korea	Depression	NR	NR	NR
Sniezek & Siddiqui, 2013±	605	Brazil, Canada, Norway, United States	Depression (Pregnancy)	Overall: Range 18-71	Overall: 100	NR
Songprakun & McMann, 2012	54	Thailand	Moderate depression	Overall: 42.13 G1: 39.41 G2: 44.66	Overall: 73.2 G1: 81.5 G2: 65.5	NR
Spedding, 2014*±	42,258	Australia	Depression	NR	NR	NR
Su et al., 2008	36	Taiwan	Perinatal depression	Overall: 31.1 G1: 30.9 G2: 31.3	Overall: 100	NR
Su et al., 2014	162	Taiwan	Comorbid depression w/ Chronic Hepatitis C	Overall: 53 G1: 53.1 G2: 53.6 G3: 52.3	NR	NR
Sublette et al., 2011*	916	United States	Depression	Overall: 41.7	NR	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Tsang, Chan, & Cheung, 2008±	591	Hong Kong	Depression	Overall: 57.08	Overall: 61.9	NR
Tu et al., 2014*±	3,447	China	Comorbid depression w/ heart failure	Overall: 63.7	NR	NR
Wang et al., 2013*±	936	China, Hong Kong, Sweden	Depression & anxiety	NR	NR	NR
Wirz-Justice et al., 2011	27	Switzerland	Antepartum depression	Overall: 32.2 G1: 31.7 G2: 32.7	Overall: 100	NR
Woltz et al., 2012±	3,564	United States	Depression in px w/ heart failure	Overall: Around 70.5	NR	NR
Wu et al., 2012±	NR	China & United States	Depression	NR	NR	NR
Yeung et al., 2012	39	United States	Major Depressive Disorder	Overall: 55 G1: 54 G2: 58	Overall: 77 G1: 76.9 G2: 76.9	Overall: 100
Yin & Dishman, 2014*±	2,765	China & United States	Depression and anxiety	Overall: 67.70 (Tai Chi); 53.51 (Quigong)	NR	NR
Zhang et al., 2010*	1,132	China	Post-stroke depression	NR	NR	NR
Zhang et al., 2014*±	1,998 (Depression) 1,680 (Post-stroke depression)	China	Depression & post-stroke depression	NR	NR	NR
Zhou & Lai, 2008±	NR	Australia	Depression	NR	NR	NR

Cuijpers et al., 2016

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000	220	United States	Bulimia Nervosa	Overall: 28.1 G1: 28.3 G2: 27.9	Overall: 100	Overall: 22.73 G1: 20.91 G2: 25.45
Badger et al., 2011	141 (**71 px[3]; 70 partners**)	United States	**Px**-prostate cancer survivor **Partner**-coping px's prostate cancer survivorship	Overall (**Px**): 66.99 G1: NR G2: NR Overall: (**Partner**): 61.13 G1: NR G2: NR	Overall (**Px**): 0 Overall (**Partner**): 92.9 G1: NR G2: NR	Overall (**Px**): 15.49 G1: NR G2: NR Overall (**Partner**): 18.57 G1: NR G2: NR
Badger, Segrin, Pasvogel, & Lopez, 2013	104 (**52 Px-partner dyads**)	United States	**Px**-Breast cancer survivor **Partner**-coping px's breast cancer survivorship	Overall (**Px**): 52.3 G1: 52 G2: 58 G3: 47 Overall (**Partner**): 51.3 G1: 51 G2: 53 G3: 50	Overall (**Px**): 100 Overall (**Partner**): 57 G1: 50 G2: 60 G3: 61	Overall (**Px**): 48 G1: 43.75 G2: 30 G3: 69.23 Overall (**Partner**): 53.5 G1: 56.25 G2: 35 G3: 69.23
Badger et al., 2013	140 (**70 Px-partner dyads**)	United States	**Px**-Breast cancer/improve QOL **Partner**-improve QOL	Overall (**Px**): 47.34 G1: NR G2: NR Overall (**Partner**): 42.74 G1: NR G2: NR	Overall (**Px**): 100 Overall (**Partner**): 53.8 G1: NR G2: NR	Overall (**Px**): 100 Overall (**Partner**): 93.8 G1: NR G2: NR
Badger, Segrin, Dorros, Meek & Lopez, 2007	192 (**96 Px-partner dyads**)	United States	**Px**-Breast cancer w/ depressive sx **Partner**-depression/anxiety sx	Overall (**Px**): 54.11 G1: NR G2: NR	Overall (**Px**): 100	Overall (**Px**): 14.58 G1: NR G2: NR

[3] *Px* = Patient

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				G3: NR Overall (**Partner**): 51.68 G1: NR G2: NR G3: NR	Overall (**Partner**): 26 G1: NR G2: NR G3: NR	G3: NR Overall (**Partner**): 13.54 G1: NR G2: NR G3: NR
Beeber et al., 2013	226 (**Mother-Infant dyads)**	United States	Maternal Depression	Overall (**Mother**): 26 G1: 26.3 G2: 25.8 Overall (**Infant**): 24.9 months G1: 24.7 months G2: 25 months	Overall (**Mother**): 100 Overall (**Infant**): 52 G1: 54 G2: 49	Overall (**Mother**): 77.88 G1: 73.68 G2: 72.32 Overall (**Infant**): NR G1: NR G2: NR
Bellino, Zizza, Rinaldi, & Bogetto, 2006	39	Canada	Borderline Personality Disorder	Overall: 26.4 G1: NR G2: NR	Overall: 23.4 G1: NR G2: NR	NR
Bellino, Rinaldi, & Bogetto, 2010	55	Canada	Major Depression + Borderline Personality Disorder	Overall: 26.05 G1: 25.86 G2: 26.23	Overall: 67.33 G1: 64.29 G2: 70.37	NR
Blom et al., 2007	193	The Netherlands	Major Depressive Disorder	Overall: 39.95	Overall: 63.9	Overall: 19.2 (*non-European*)
Bodenmann et al., 2008	60 (**Couples**)	Switzerland	Depression (**Px**)	Overall (**Px**): 45.34 G1: 44.35 G2: 47.33 G3: 44.35 Overall (**Partner**): 45.55 G1: 44.95 G2: 49.85 G3: 41.85	Overall (**Px**): 58.3 G1: 65 G2: 60 G3: 50 Overall (**Partner**): 42 G1: 35 G2: 40 G3: 50	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Bolton et al., 2003	224 (**completed study & re-interviewed**)	Uganda	Depression	Overall: 46.5 G1: 47.6 G2: 45.4	Overall: 52 G1: 50 G2: 53	Overall: 100
Bolton et al., 2007	314	Uganda	Depression	Overall: 15 G1: 15 G2: 14.7 G3: 15.2	Overall: 57 G1: 57 G2: 58 G3: 57	Overall: 100
Borge et al., 2008	80	Norway	Social Phobia	Overall: 37.5 G1: 37.7 G2: 37.2	Overall: 51.25 G1: 52.50 G2: 50	NR
Browne et al, 2002	707	Canada	Dysthymic Disorder	6-months: Overall: 42.4 G1: 43 G2: 40.8 G3: 43.7 2-years: Overall: 42.1 Completers: 43.1 Unavailable: 38.4	Overall (6-month): 68	NR
Carroll, Rounsaville, & Gawin, 1991	42	United States	Substance Use Dx (Cocaine)	Overall: 26.4 G1: 26.8 G2: 26.6	Overall: 26.2 G1: 19.1 G2: 33.3	Overall: 23 G1: 14.3 G2: 33.3
Clark, Tluczek, & Wenzel, 2003	66 (**Parent-infant dyads**)	United States	Postpartum Depression	Overall (**Mother**): 31.4 G1: 27.6 G2: 32.4 G3: 34.6 Overall (**Infant**): 8.9 months G1: 6.3 months G2: 8.2 months G3: 12.8 months	Overall (**Mother**): 100 Overall (**Child**): 42 G1: 61.54 G2: 33.33 G3: 63.64	Overall: 1.52 G1: 0 G2: 6.67 G1: 0
Dagöö et al., 2014	52	Sweden	Social Anxiety Disorder	Overall: 36.81 G1: 39.08 G2: 34.70	Overall: 51.9 G1: 56 G2: 48.1	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
de Mello, Myczcowisk, & Menezes, 2001	35	Brazil	Dysthymic Disorder	Overall: Range 20-60	Overall: 80 G1: 75 G2: 84	NR
Donker et al., 2013	1,843	Australia (web-based)	Depressive Symptoms	Ages 18-24: 16.66% 25-34: 29.46% 35-44: 25.50% 45-55: 18.34% >55: 10.04%	Overall: 72.38 G1: 71.45 G2: 72.95 G3: 72.74	NR
Elkin et al., 1989	250	United States	Depression	Overall: 35 G1: NR G2: NR G3: NR G4: NR	Overall: 70 G1: NR G2: NR G3: NR G4: NR	Overall 11 G1: NR G2: NR G3: NR G4: NR
Fairburn et al., 1991	75	United Kingdom	Bulimia Nervosa	Overall: 24.2	NR	NR
Field, Diego, Delgado, & Medina, 2013	44	United States	Perinatal Depression	Overall: 24.9 G1: 25.7 G2: 24.1	Overall: 100	Overall: 99 G1: 99 G2: 99
Frank et al., 1990	230 (Baseline)	United States	Depression (Recurrent)	Overall: 39.5	Overall: 78	NR
Frank et al., 2011	318	Italy United States	Depression	Overall: 39.2 G1: NR G2: NR	Overall: 71.7 G1: NR G2: NR	NR
Gao, Chan, Li, Chen, & Hao, 2010	194	China	Postnatal Depression	Overall: 28.43 G1: 28.47 G2: 28.38	Overall: 100	Overall: 100 (*Chinese*)
Gois et al., 2014	34	Portugal	Major Depression comorbid w/ Type II Diabetes	Overall: 55.14 G1: 56.82 G2: 53.81	Overall: 88.2 G1: 100 G2: 76.5	NR
Grote et al., 2009	53	United States	Perinatal Depression	Overall: 24.5 G1: 24.3 G2: 24.7	Overall: 100	Overall: 71.7 G1: 80 G2: 64.29
Holmes et al., 2007	90	Australia	Physical trauma-induced depression, anxiety, PTSD sx	Overall: 38.2 G1: 39.9 G2: 36.4	Overall: 35 G1: 29 G2: 41	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Horowitz, Garber, Ciesla, Young & Mufson, 2007	380	United States	Depressive Symptoms	Overall: 14.43 G1: NR G2: NR G3: NR	Overall: 54 G1: NR G2: NR G3: NR	Overall: 21 G1: NR G2: NR G3: NR
Johnson & Zlotnick, 2012	38	United States	Major Depression	Overall: 35 G1: 37.1 G2: 32.9	Overall: 100	Overall: 36 G1: 22 G2: 28
Klerman et al., 1987	128	United States	Stress and Distress	Overall: 28.1 G1: 28.4 G2: 27.8	Overall: 59.38 G1: 56.25 G2: 62.5	NR
Koszycki, Bisserbe, Blier, Bradweijn, & Markowitz, 2012	31	Canada	Major Depression and infertility	Overall: 35.5 G1: 34.4 G2: 36.6	Overall: 100	Overall: 21 G1: 26 G2: 15
Krupnick, Green, Stockton, Miranda, Krause, & Mete, 2008	48	United States	PTSD	Overall: 32 G1: NR G2: NR	Overall: 100	Overall: 93.8 G1: NR G2: NR
Lesperance et al., 2007[4]	284	Canada	Major Depression and Coronary Artery Disease	Overall: 58.2 G1a: 59 G2a: 57.3 G1b: 57.9 G2b: 58.4	Overall: 25 G1a: 31 G2a: 18.3 G1b: 23.2 G2b: 26.1	NR
Levkovitz et al., 2000	14	United States	Moderate to severe MDD	Overall: 52 G1: NR G2: NR	Overall: 64 G1: 57.1 G2: 71.4	NR
Lipsitz et al., 2008	70	United States	Social Anxiety Disorder	Overall: 69.4 G1: 34.2 G2: 35.2	Overall: 42.9 G1: 55.6 G2: 29.4	Overall: 50 G1: 56 G2: 44
Luty et al., 2007	117	United Kingdom	Depression	Overall: 35.2 G1: 35.2 G2: 35.2	Overall: 73 G1: 76 G2: 69	NR
Markowtiz et al., 1998	101	United States	HIV w/ Depressive Sx	Overall: 36.9 G1: 37.5 G2: 36.2 G3: 37.3	Overall: 15.84 G1: 20.83 G2: 14.81	Overall: 42.4 G1: 37.5 G2: 51.8 G3: 41.6

[4] This was a 2x2 factorial, parallel-group study.

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				G4: 36.6	G3: 16.67 G4: 7.69	G4: 38.5
Markowitz, Kocsis, Bleiberg, Christos, & Sacks, 2005	94	United States	Dysthymic Disorder	Overall: 42.3 G1: NR G2: NR G3: NR G4: NR	Overall: 63 G1: NR G2: NR G3: NR G4: NR	Overall: 36 G1: NR G2: NR G3: NR G4: NR
Markowitz, Kocsis, Christos, Bleiberg, & Carlin, 2008	26	United States	Dysthymic Disorder w/ comorbid alcohol abuse or dependence	Overall: 38.4 G1: 40.8 G2: 35.7	Overall: 30.8 G1: 21.4 G2: 41.7	Overall: 30.8 G1: 28.6 G2: 33.3
Marshall, Zurroff, McBride, & Bagby, 2008	102	Canada	Major Depressive Disorder	NR	Overall: 69	NR
Martin et al., 2001	28	United Kingdom	Depression	Overall: NR G1: 39.4 G2: 38.4	Overall: 71.4 G1: 73.3 G2: 69.2	Overall: 6.7 G1: 6.7 G2: 0
McIntosh et al., 2005	56	New Zealand	Anorexia Nervosa	NR	Overall: 100	NR
Meffert et al., 2014	22	Egypt	PTSD	Overall: 31 G1: 31.3 G2: 30.4	Overall: 81 G1: 83 G2: 78	Overall: 100
Menchetti et al., 2014	287	Italy	Depression	Overall: 44.9 G1: 42.8 G2: 46.9	Overall: 73.5 G1: 74.8 G2: 72.2	NR
Miklowitz et al., 2007	293	United States	Bipolar Depression	Overall: 40.13 G1: NR G2: NR G3: NR G4: NR	Overall: 59 G1: NR G2: NR G3: NR G4: NR	Overall: 10 G1: NR G2: NR G3: NR G4: NR
Miller & Weissman, 2002	30	United States	Depression	Overall: 32.1 G1: NR G2: NR	Overall: 100	Overall: 63.3 G1: NR G2: NR
Mitchell, Halmi, Wilson, Agras, & Kraemer, 2002	62	United States	Bulimia Nervosa	Overall: 28 G1: 28 G2: 27.1	Overall: 100	NR
Mossey, Knott, Higgins, & Talerico, 1996	76	United States	Sub-dysthymic Depression in Older Adults	Overall: 71 G1: NR G2: NR	Overall: 78.2 G1: NR G2: NR	Overall: 55 G1: NR G2: NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Mufson, Weissman, Moreau, & Garfinkel, 1999	48	United States	Major Depressive Disorder	Overall: 15.8 G1: 15.9 G2: 15.7	Overall: 73 G1: 70.8 G2: 75	Overall: 71 G1: 62.5 G2: 79.2
Mufson et al., 2004	63	United States	Major Depressive Disorder	Overall: 15.1 G1: 15.3 G2: 14.9	Overall: 84 G1: 91.2 G2: 75.9	Overall: 71 G1: 76.5 G2: 65.5
Mulcahy, Reay, Wilkinson, & Owen, 2010	50 (**Mother-Infant dyads)**	Australia	Postnatal Depression	Overall (**Mother**): 32.21 G1: 32 G2: 32.41 Overall (**Infant**): 6.20 months G1: 6.65 months G2: 5.74 months	Overall (**Mother**): 100 Overall (**Infant**): 48 G1: 47.8 G2: 48.1	NR
Neugebauer et al., 2006	19	United States	Subsyndromal Depression after miscarriage	Overall: 29.7 G1: NR G2: NR	Overall: 100	Overall: 78.9 G1: NR G2: NR
O'Hara, Stuart, Gorman, & Wenzel, 2000	120	United States	Postpartum Depression	Overall: 29.6 G1: 29.4 G2: 29.7	Overall: 100	NR
Oranta, Luutonen, Salokanga, Vahlberg, & Leino-Kilpi, 2010	103	Finland	Depression post myocardial infarction	Overall: NR G1: <60 yrs. (%): 52.9 60-74 yrs. (%): 47.1 G2: <60 yrs. (%): 34.6 60-74 yrs. (%): 65.4	Overall: 29.1 G1: 25.5 G2: 32.7	NR
Poleshuck et al., 2014	61	United States	Co-occurring depression and pelvic pain	Overall: 36.7 G1: 36.3 G2: 37.1	Overall: 100	Overall: 84 G1: 88 G2: 79
Power & Freeman, 2012	157	United Kingdom	Depression	Overall: 36.1	Overall: 61.8	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Ransom et al., 2008	79	United States	HIV and Depression	Overall: 44.4 G1: NR G2: NR G3: NR	Overall: 16.5 G1: NR G2: NR G3: NR	Overall: 22.8 G1: NR G2: NR G3: NR
Reynolds et al., 1999a	80	United States	Bereavement-related major depressive episode	Overall: 66.43 G1: 67.4 G2: 65.6 G3: 69.5 G4: 63.2	Overall: 72.5 G1: 81.3 G2: 72 G3: 88.2 G4: 54.5	Overall: 7 G1: 12.5 G2: 8 G3: 5.9 G4: 9.1
Reynolds et al., 1999b	187	United States	Recurrent Major Depression (Older Adults)	Overall: 67.6 G1: NR G2: NR G3: NR G4: NR	Overall: 74.9 G1: NR G2: NR G3: NR G4: NR	Overall: 7 G1: NR G2: NR G3: NR G4: NR
Reynolds et al., 2006	116	United States	Major Depression (Older Adults)	Overall: 76.7 G1: 77.6 G2: 77 G3: 77.4 G4: 74.8	Overall: 63.8 G1: 68 G2: 60 G3: 71 G4: 56	Overall: 5.4 G1: 7.1 G2: 8.6 G3: 5.7 G4: 5.6
Reynolds et al., 2010	124	United States	Depression (Older Adults)	Overall: 72.25 G1: 71.1 G2: 73.4	Overall: 69 G1: 73 G2: 64	Overall: 8 G1: 5 G2: 10.9
Rossello & Bernal, 1999	71	Puerto Rico	Depression	Overall: 14.70 G1: NR G2: NR G3: NR	Overall: 54 G1: NR G2: NR G3: NR	Overall: 100
Rossello, Bernal, & Rivera-Medina, 2008	112	Puerto Rico	Depression	Overall: 14.52 G1: NR G2: NR G3: NR G4: NR	Overall: 55.4 G1: NR G2: NR G3: NR G4: NR	Overall: 100
Schaal, Elbert, & Neuner, 2009	26	Rwanda	Trauma Spectrum Disorder + Depression	Overall: 19.42 G1: NR G2: NR	Overall: 61.5 G1: NR G2: NR	Overall: 100
Schramm et al., 2007	229 (**124 Intent-to-treat + 105 Completers**)	Germany	Depression	Overall (a): 41.9 G1a: 40.4 G2a: 43.4	Overall (a): 65.4 G1a: 63.5	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				Overall (b): 42 G1b: 39.5 G2b: 43.6	G2a: 67.2 Overall (b): 68 G1b: 64 G2b: 71	
Schramm et al., 2011	30	Germany	Depression	Overall: 40.2 G1: 41.1 G2: 39.4	Overall: 55 G1: 8 G2: 8	NR
Serretti et al., 2013	160	Italy	Major Depressive Disorder	Overall: 50.71 G1: 53.24 G2: 43.93	Overall: 65.6 G1: 59.5 G2: 77.7	NR
Shear, Frank, Houck, & Reynolds, 2005	95	United States	Complicated Grief	Overall: 48.4 G1: 49.4 G2: 47.3	Overall: 87.4 G1: 87.8 G2: 87	Overall: 22 G1: NR G2: NR
Sloane, Staples, & Schneider, 1985	55	United States	Major Depressive Disorder-Moderate Severity (Older Adults)	Overall: 64.4 G1: NR G2: NR G3: NR	Overall: 52.73 G1: NR G2: NR G3: NR	NR
Spinelli & Endicott, 2003	50	United States	Major Depressive Disorder (Antenatal)	Overall: 28.8 G1: 28.3 G2: 29.3	Overall: 100	Overall: 71.1 G1: 71.4 G2: 70.6
Stangier, Schramm, Heidenreich,Berger, & Clark, 2011	117	Germany	Social Anxiety Disorder	Overall: 35.5 G1: 34.6 G2: 33.9 G3: 38.1	Overall: 55.6 G1: 44.7 G2: 57.9 G3: 63.4	NR
Swartz et al., 2008	47	United States	Maternal Depression	Overall: 42.7 G1: 41.6 G2: 44.2	Overall: 100	Overall: 21.3 G1: 14.9 G2: 14.3
Talbot et al., 2011	70	United States	Depression Sx due to Sexual Abuse	Overall: 36 G1: NR G2: NR	Overall: 100	Overall: 41.4 G1: 38 G2: 45
Tang, Jou, Ko, Huang, & Yen, 2009	73	Taiwan	Depression w/ suicidal and parasuicidal behaviors	Overall: 15.25 G1: 15.26 G2: 15.24	Overall: 65.8 G1: 65.7 G2: 65.8	Overall: 100
Tanofsky-Kraff et al., 2010	38	United States	At-risk for obesity	Overall: 15.1 G1: 14.7	Overall: 100	Overall: 63 G1: 63

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				G2: 15.4 Overall (**Follow-Up**): 15.8 G1: 15.4 G2: 16.1		G2: 63
van Schaik et al., 2006	143	The Netherlands	Major Depressive Disorder	Overall: 68 G1: 68.4 G2: 67.5	Overall: 70 G1: 70 G2: 69	NR
Vos, Huibers, Diels, & Arntz, 2012	91	The Netherlands	Panic Disorder w/ Agoraphobia	Overall: 35 G1: 36.74 G2: 33.04	Overall: 76.9 G1: 74.40 G2: 79.20	NR
Weissman et al., 1979	96	United States	Acute Depression	NR	NR	NR
Wilfley et al., 1993	56	United States	Binge Eating	Overall: 44.3 G1: NR G2: NR G3: NR	Overall: 100	Overall: 14 G1: NR G2: NR G3: NR
Wilfley et al., 2002	162	United States	Binge Eating	Overall: 40.8 G1: 45.6 G2: 44.9	Overall: 82.7 G1: 82.7 G2: 82.7	Overall: 7.4 G1: 6.2 G2: 8.6
Wilson, Wilfley, Agras, & Bryson, 2010	205	United States	Binge Eating	Overall: NR G1: 46.2 G2: 50.3 G3: 48.7	Overall: 85.4 G1: 89.1 G2: 81.8 G3: 85.3	Overall: 18 G1: 13 G2: 19 G3: 22
Young, Mufson, & Davies, 2006	41	United States	Subthreshold Depression	Overall: 13.4 G1: 13.5 G2: 13.1	Overall: 85.4 G1: 81.5 G2: 92.9	Overall: 92.7 G1: 92.6 G2: 92.9
Young, Mufson, & Gallop, 2010	57	United States	Subthreshold Depression	Overall: 14.51 G1: 14.57 G2: 14.52	Overall: 59.7 G1: 55.6 G2: 66.7	Overall: 38 G1: 41.7 G2: 33.3
Zlotnick, Johnson, Miller, Pearlstein, & Howard, 2001	37	United States	Postpartum Depression	Overall: 23.4 G1: NR G2: NR	Overall: 100	Overall: 56.8 G1: NR G2: NR
Zlotnick, Miller, Pearlstein, Howard, & Sweeney, 2006	99	United States	Postpartum Depression	Overall: 22.4 G1: NR	Overall: 100	Overall: 71.7 G1: NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				G2: NR		G2: NR
Zlotnick, Capezza, & Parker, 2011	54	United States	Depression and PTSD	Overall: 23.8 G1: 24.2 G2: 23.5	Overall: 100	Overall: 61.1 G1: 64.3 G2: 57.7

Older Adult Population

Table K4

Select Demographic Characteristics of Studies Reviewed from the 2 Older Adult Population Systematic Reviews/Meta-analyses

	Total	
Study Location	N	%
International	25	47
United States (U.S.)	28	53
TOTAL	53	100
Study Demographics		
Gender		
Reported	43	81
20-80% Female	38	88
< 20% Female	0	0
<20% Male	5	12
Not Reported (NR)	10	19
TOTAL	53	100
Race/Ethnicity (U.S. Studies)		
Reported	15	54
20-80% underrep.	8	53
< 20% underrep.	6	40
>80% underrep.	1	7
Not Reported (NR)	13	46
TOTAL	28	100

Note. 2 studies were not in the English language.

Cuijpers et al., 2014

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Alexopoulos et al., 2011 (demographic and clinical characteristics reported in Arean et al., 2010)	221	United States	Depression and executive dysfunction	Overall: 72.97 G1: 72.8 G2: 73.2	NR	NR
Alexopoulos, Raue, and Arean, 2003	25	United States	Major Depression	Overall: 74.12 G1: NR G2: NR	Overall: 52 G1: NR G2: NR	Overall: 24 G1: NR G2: NR
Arean et al., 2010	28	United States	Depression and executive dysfunction	Overall: 73 G1: 72.8 G2: 73.2	NR	NR
Arean et al., 1993	75	United States	Major Depressive Disorder	Overall: 66.4 G1: 67.0 G2: 66.7 G3: 65.5	Overall: 75 G1: 79 G2: 70 G3: 75	Overall: 22.3 G1: 25 G2: 22 G3: 20
Burns et al., 2007	293	United Kingdom	Post-operative (hip surgery) depression	Overall: 80.4 G1: 80.3 G2: 81.4 G3: 80.8 G4: 79.0	Overall: 76 G1: 70 G2: 83 G3: 78 G4: 79	NR
Chan, Ng, Tien, Ho, & Thayala, 2013	26	Singapore	Depression	Overall: 69.7 G1: 68.9 G2: 70.4	Overall: 80.8 G1: 75 G2: 85.7	NR
Choi, Marti, Bruce, & Hegel, 2013	121	United States	Depression	Overall: 65.21 G1: NR G2: NR G3: NR	Overall: 77.7 G1: NR G2: NR G3: NR	Overall: 58.7 G1: NR G2: NR G3: NR
Ekkers et al., 2011	93	The Netherlands	Depression and rumination	Overall: 73 G1: 71.8 G2: 73.9	NR	NR
Floyd, Scogin, McKendree-Smith, Floyd, & Rokke, 2004	31	United States	Depression	Overall: 68 G1: NR G2: NR	NR	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Fry, 1983	162	Canada & United States	Depression	Overall: 68.5 G1: NR G2: NR	NR	NR
Gallagher & Thompson, 1982	30	United States	Major Depressive Episode	Overall: 68 G1: 68.3 G2: 66.0 G3: 69.0	Overall: 76.6 G1: 60 G2: 90 G3: 80	Overall: 6.7 G1: 0 G2: 20 G3: 0
Gitlin et al., 2013	208	United States	Depression	Overall: 69.6 G1: 68.9 G2: 70.3	Overall: 78.4 G1: 79.3 G2: 77.5	Overall: 100
Haringsma, Engels, Cuijpers, & Spinhoven, 2006	119	The Netherlands	Subclinical Depression and Major Depression	Overall: 64.2 G1: 64.2 G2: NR	Overall: 69 G1: 69 GR: NR	NR
Heckman et al., 2011	295	United States	Depressive symptoms-HIV	Overall: 55.3 G1: 55.3 G2: 55.3 G3: 55.3	NR	Overall: 48 G1: 50 G2: 46 G3: 50
Joling et al., 2011	170	The Netherlands	Depression	Overall: 81.5 G1: 81.8 G2: 81.1	Overall: 74 G1: 69.8 G2: 77.4	NR
Kiosses, Arean, Teri, & Alexopoulos, 2010	30	United States	Depression, Cognitive Impairment	Overall: 79.41 G1: 80.46 G2: 78.36	Overall: 70 G1: 66.67 G2: 73.33	Overall: 26.67 G1: 26.67 G2: 26.67
Korte, Bohlmeijer, Cappeliez, Smit, & Westerhof, 2012	202	The Netherlands	Moderate Depression	Overall: 63.3 G1: 63.3 G2: 63.3	Overall: 76.7 G1: 80 G2: 73.5	NR
Laidlaw et al., 2008	44	United Kingdom	Mild-Moderate Late Life Depression	Overall: 74.03 G1: 74 G2: 74.05	Overall: 73 G1: 60 G2: 85	NR
Lamers et al., 2010	361	The Netherlands	Depression (Chronically-ill)	Overall: 70.7 G1: 70.6 G2: 70.8	Overall: 47 G1: 46.6 G2: 46.4	NR
Landreville & Bissonnette, 1997	23	Canada	Depression (w/ physical disability)	Overall: 72 G1: 71.80 G2: 72.15	Overall: 86.96 G1: 90 G2: 84.62	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Lynch, Morse, Mendelson, & Robins, 2003	34	United States	Depression	Overall: 66 G1: NR G2: NR	Overall: 85 G1: NR G2: NR	Overall: 15 G1: NR G2: NR
Mossey, Knott, Higgins, & Talerico, 1996	76	United States	Subdysthymic depression	Overall: 71 G1: NR G2: NR	Overall: 78.2 G1: NR G2: NR	Overall: 55 G1: NR G2: NR
Pot et al., 2010	171	The Netherlands	Depression	Overall: 64.3 G1: 64.41 G2: 64.17	Overall: 72.5 G1: 73.5 G2: 71.6	NR
Preschl et al., 2012	36	Switzerland	Depression	Overall: 70 G1: 72.5 G2: 67	Overall: 66.7 G1: 75 G2: 56.3	NR
Reynolds, Miller, & Pasternak, 1999	80	United States	Bereavement-related major depressive episodes	Overall: NR G1: 67.4 G2: 65.6 G3: 69.5 G4: 63.2	NR	NR
Scogin, Hamblin, & Beutler, 1987	29	United States	Mild to moderate depression	Overall: 70.4 G1: 70.8 G2: 71.8 G3: 68.5	NR	NR
Scogin, Jamison, & Gochneaur, 1989	67	United States	Mild to moderate depression	Overall: 68.3 G1: 70.30 G2: 66.86 G3: 67.77	Overall: 85 G1: 78.26 G2: 90.9 G3: 86.36	NR
Serfaty, Haworth, & Buszewicz, 2009	204	United Kingdom	Geriatric depression	Overall: 74.1 G1: 74.4 G2: 75 G3: 72.8	Overall: 79.4 G1: 84.3 G2: 74.6 G3: 79.1	Overall: 5.9 G1: 8.6 G2: 4.5 G3: 4.5
Serrano, Latorre, Gatz, & Montanes, 2004	43	Spain	Depression	Overall: 77.19 G1: 75.8 G2: 78.4	Overall: 76.3 G1: 82.6 G2: 70	NR
Serrano Selva et al., 2012	37	Spain	Depression	Overall: 73.9 G1: NR G2: NR	Overall: 83.78 G1: NR G2: NR	NR
Sirey, Bruce, & Alexopoulos, 2005	52	United States	Major depressive disorder	Overall: 73.2 G1: NR	Overall: 54 G1: NR	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				G2: NR	G2: NR	
Sloane, Staples, & Schneider, 1985	55	United States	Major Depressive Disorder-Moderate Severity	Overall: 64.4 G1: NR G2: NR G3: NR	Overall: 52.73 G1: NR G2: NR G3: NR	NR
Snarski et al., 2011	50	United States	Mild to moderate cognitive impairment w/ depressive sx	Overall: 71.67 G1: NR G2: NR	Overall: 60 G1: NR G2: NR	Overall: 40 G1: NR G2: NR
Spek et al., 2007	301	The Netherlands	Subthreshold depression	Overall: 55 G1: 55 G2: 54 G3: 55	Overall: 63.5 G1: 67.6 G2: 63.6 G3: 59	NR
Teri, Logsdon, Uomoto, & McCurry, 1997	72 px-caregiver **dyads** (N = 144)	United States	**Px:** Dementia w/ depressive sx **Caregiver:** depressive sx	Overall (**Px**): 76.4 G1: 72.8 G2: 78.5 G3: 79.5 G4: 76.8 Overall (**Caregiver**): 66.9 G1: 67.3 G2: 64.6 G3: 66.3 G4: 68.7	Overall (**Px**): 47 G1: 70 G2: 26 G3: 60 G4: 35 Overall (**Caregiver**): 69 G1: 48 G2: 95 G3: 70 G4: 70	NR
Thompson, Coon, Gallagher-Thompson, Sommer, & Koin, 2001	100	United States	Depression	Overall: 66.8 G1: 66.8 G2: 66.5 G3: 67.2	Overall: 67 G1: 63.6 G2: 67.6 G3: 69.4	NR
Thompson & Gallagher, 1984	61	United States	Late-life depression	Overall: 67 G1: NR G2: NR G3: NR G4: NR	NR	NR
Thompson, Gallagher, & Breckenridge, 1987	91	United States	Major Depressive Disorder	Overall: 67.07 G1: 66.88 G2: 67.07 G3: 66.71	Overall: 70.3 G1: 68 G2: 59.2 G3: 66.6	NR

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
				G4: 67.63	G4: 78.9	
van Schaik et al., 2006	143	The Netherlands	Major Depressive Disorder	Overall: 68 G1: 68.4 G2: 67.5	Overall: 70 G1: 70 G2: 69	NR
Watt & Cappeliez, 2000	26	Canada	Moderate to severe depression	Overall: 66.8 G1: NR G2: NR G3: NR	Overall: 54 G1: NR G2: NR G3: NR	NR
Williams et al., 2000	415	United States	Minor depression or dysthymia	Overall: 71 G1: 71 G2: 71 G3: 71	Overall: 41 G1: 39 G2: 41 G3: 45	Overall: 21.7 G1: 18 G2: 24.9 G3: 23.1
Wuthrich & Rapee, 2013	62	Australia	Comorbid anxiety and depression	Overall: 67.44 G1: 66.92 G2: 67.80	Overall: 64.52 G1: 66.66 G2: 62.86	Overall: 17.82 G1: 18.51 G2: 17.12

Wilkinson & Izmeth, 2012

Author, year	Sample Size	Country	Diagnosis	Mean Age	% Female	% Nonwhite
Alexopoulos et al., 2000	100	United States	Major Depressive Disorder	Overall: 73.5 G1: 73.6 G2: 73.3	Overall: 64 G1: 64.9 G2: 62.8	NR
Gorwood, Weiller, Lemming, & Katona, 2007	305	Europe (7 countries)	Major Depressive Disorder	Overall: 73 G1: 73 G2: 72	Overall:78.69 G1: 78 G2: 79	NR
Bent-Hansen et al., 2003	60	Denmark	Major Depressive Disorder	NR	NR	NR
Klysner et al., 2002	121	Denmark	Unipolar Major Depression	Overall:74.5 G1: 74 G2: 75	Overall: 77 G1: 82 G2: 72	NR
Old Age Depression Interest Group, 1993	219	United Kingdom	Major Depressive Disorder	Overall: 75.2 G1: 75.9 G2: 75.5	Overall: 72 G1: 82 G2: 67	NR
Dew et al., 2001	140	United States	Depression	Overall: 67.4	Overall: 76	Overall: 7
Miller, Frank, Cornes, Houck, & Reynolds, 2003	53	United States	Major Depression	Overall: 68 G1: 68.3 G2: 65.8 G3: 68.6	Overall: 75.4 G1: 90.9 G2: 80 G3: 58.8	Overall: 7.5 G1: 0 G2: 12 G3: 5.9
Reynolds et al., 1999b	180	United States	Recurrent Major Depression	Overall: 70 G1: 64.1 G2: 74	Overall: 44.4 G1: 73 G2: 78	Overall: 6.7 G1: 8 G2: 4.5
Reynolds et al., 1999a	187	United States	Unipolar Major Depression	Overall:67.6 G1: NR G2: NR G3: NR G4: NR	Overall: 74.9 G1: NR G2: NR G3: NR G4: NR	Overall: 7 G1: NR G2: NR G3: NR G4: NR
Wilkinson et al., 2009	45	United Kingdom	Major Depression	Overall: 74 G1: 72.7 G2: 75.2	Overall: 62.2 G1: 59.1 G2: 65.2	NR
Wilson, Mottram, Ashworth, & Abou-Saleh, 2003	113	United Kingdom	Depression	Overall:77.7 G1: 76.6 G2: 76.8	Overall: 70.8 G1: 66.1 G2: 75.4	NR