

Evidence to recommendation framework

## Bør fastleger og annet kvalifisert helsepersonell tilby rådgivning til eldre med depresjon?

**Problem:** Eldre med depresjon

**Bakgrunn:** Eldre med depresjon kan ha nytte av enkle tiltak, der helsepersonell gir råd som øker pasientens mestring

**Tiltak:** Rådgivning, flere tiltak: Fysisk aktivitet, selvhjelps litteratur, mestring søvn og angst, problemløsningsterapi

**Sammenlikning:** Vanlig oppfølging eller venteliste

**Setting:** Primærhelsetjenesten

**Perspektiv:** Individnivå (helsepersonell, pasienter/pårørende)

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS														
PROBLEM	Is the problem a priority?	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center; width: 15%;">No</td> <td style="text-align: center; width: 15%;">Probably No</td> <td style="text-align: center; width: 15%;">Uncertain</td> <td style="text-align: center; width: 15%;">Probably Yes</td> <td style="text-align: center; width: 15%;">Yes</td> <td style="width: 10%;"></td> <td style="text-align: center; width: 15%;">Varies</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="border-left: 1px solid black; border-right: 1px solid black; width: 1px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	No	Probably No	Uncertain	Probably Yes	Yes		Varies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>		Pasienter med depresjon sliter ofte med initiativløshet og kan ha vansker med å løse problemer i hverdagen. Dette kan være utfordrende i seg selv, og kan bidra til å vedlikeholde eller forverre depresjonen.
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>												

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BENEFITS & HARMS OF THE OPTIONS	What is the overall certainty of this evidence?	<table border="1"> <tr> <td>No included studies</td> <td>Very low</td> <td>Low</td> <td>Moderate</td> <td>High</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	No included studies	Very low	Low	Moderate	High	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<p><b>Summary of findings:</b></p> <hr/> <p><b>Self-help programmes (bibliotherapy) for elderly with depression</b></p> <hr/> <p><b>Bibliography:</b> <sup>1</sup></p> <table border="1"> <thead> <tr> <th>Outcomes</th> <th>No of Participants (studies) Follow up</th> <th>Quality of the evidence (GRADE)</th> <th>Effects</th> </tr> </thead> <tbody> <tr> <td>Depressive symptoms short term psychiatric scales</td> <td>0 (9 studies)</td> <td>⊕⊕⊕⊕ <b>HIGH</b></td> <td>Hedges and Olkin's d (95% CI) d=0.57 (0.37-0.77) See comment<sup>1</sup></td> </tr> </tbody> </table>	Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Effects	Depressive symptoms short term psychiatric scales	0 (9 studies)	⊕⊕⊕⊕ <b>HIGH</b>	Hedges and Olkin's d (95% CI) d=0.57 (0.37-0.77) See comment <sup>1</sup>	<p>Rådgivning innebærer flere mulige tiltak. Kvaliteten på dokumentasjonen og effektestimaten varierer. I hovedsak er det dokumentasjon av moderat kvalitet og effektestimater varierer fra svak til moderat styrke. For angstmestring, der vi ikke fant systematiske oversikter for "coping strategies", finnes en systematisk oversikt som viser at Problemløsningsterapi (som er et av de anbefalte tiltakene i anbefalingen om rådgivning) er effektiv i behandling av kombinert angst og depresjon (12 studier, effekt størrelse d -0.21 (95% CI -0.37, -0.05),<sup>6</sup> En meta-analyse av effekten av lav-intensitetsintervensjoner ved ulike alvorlighetsgrader av depresjon, indikerer at også alvorligere former for depresjon profitterer på denne type tiltak, selv om den kliniske effekten muligens er liten<sup>7</sup>.</p>		
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Is there important uncertainty about how much people value the main outcomes?	<table border="1"> <tr> <td>Important uncertainty or variability</td> <td>Possibly important uncertainty or variability</td> <td>Probably no important uncertainty or variability</td> <td>No important uncertainty or variability</td> <td>No known undesirable outcomes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> </tr> </table>	Important uncertainty or variability	Possibly important uncertainty or variability	Probably no important uncertainty or variability	No important uncertainty or variability	No known undesirable outcomes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<p><b>Bibliography:</b> <sup>2</sup></p> <table border="1"> <thead> <tr> <th>Outcomes</th> <th>No of Participants (studies) Follow up</th> <th>Quality of the evidence (GRADE)</th> <th>Anticipated effects</th> </tr> </thead> <tbody> <tr> <td>Depressive symptoms short term end of treatment depression scales</td> <td>2996 (19 studies)</td> <td>⊕⊕⊕⊖ <b>MODERATE</b><sup>1,2</sup> due to indirectness</td> <td>The mean depressive symptoms short term end of treatment in the intervention groups was <b>0.56 standard deviations lower</b> (0.71 to 0.41 lower)</td> </tr> <tr> <td>Depressive symptoms long term depression scales</td> <td>420 (14 studies) 6-8 months</td> <td>⊕⊕⊕⊖ <b>MODERATE</b><sup>1,2</sup> due to indirectness</td> <td></td> </tr> </tbody> </table>	Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated effects	Depressive symptoms short term end of treatment depression scales	2996 (19 studies)	⊕⊕⊕⊖ <b>MODERATE</b> <sup>1,2</sup> due to indirectness	The mean depressive symptoms short term end of treatment in the intervention groups was <b>0.56 standard deviations lower</b> (0.71 to 0.41 lower)	Depressive symptoms long term depression scales	420 (14 studies) 6-8 months	⊕⊕⊕⊖ <b>MODERATE</b> <sup>1,2</sup> due to indirectness	
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CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS																
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CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS								
		<p><b>Sleep quality, end of treatment</b> 905 (9 studies) ⊕⊖⊖⊖ <b>VERY LOW</b><sup>1,2,3</sup> due to risk of bias, inconsistency, indirectness</p> <p>The mean sleep quality, end of treatment in the intervention groups was <b>0.36 standard deviations higher</b> (0.16 to 0.57 higher)</p> <hr/> <p><sup>1</sup> Two of the 9 studies reported that allocation to conditions was conducted by an independent party. In none of the 10 studies was concealment of random allocation to respondents possible or reported. This also applied to the blinding of assessors. Drop-out numbers ranged from 0% to 25%. In four studies intention-to-treat analyses were conducted; in two studies this was not reported while the other studies were limited to completers-only analyses.</p> <p><sup>2</sup> The fixed effect models did show significant heterogeneity for sleep efficiency (<math>I^2 \frac{1}{4} 65.5\%</math>), time awake after sleep onset (<math>I^2 \frac{1}{4} 63.9\%</math>), sleep quality (<math>I^2 \frac{1}{4} 52.3\%</math>) and the combined sleep outcomes (<math>I^2 \frac{1}{4} 44.5\%</math>).</p> <p><sup>3</sup> Two of the nine included studies addressed elderly, and both showed no significant differences between self-help and waiting list controls. Depressed patients were not commented.</p> <hr/> <p><b>Anxiety coping strategies for elderly with depression and anxiety</b></p> <p>We did not find any evidence on the effects of anxiety coping strategies intervention for depressed patients.</p> <hr/> <p><b>Problem solving therapy compared to for elderly with depression</b></p> <hr/> <p><b>Bibliography:</b> <sup>5</sup></p> <table border="1"> <thead> <tr> <th data-bbox="786 1182 987 1209">Outcomes</th> <th data-bbox="987 1182 1144 1305">No of Participants (studies) Follow up</th> <th data-bbox="1144 1182 1339 1273">Quality of the evidence (GRADE)</th> <th data-bbox="1339 1182 1682 1305">Effects Standardised mean difference (SMD) (95% CI)</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Effects Standardised mean difference (SMD) (95% CI)					
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CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
		<p><b>Depressive symptoms</b>      1264      ⊕⊕⊕⊖ (21 studies)      <b>MODERATE</b><sup>2</sup> 3-12 months      due to inconsistency</p> <p>Depression scale      The mean depressive symptoms in the intervention groups was <b>0.40 standard deviations higher</b> (0.01 to 0.79 higher)<sup>1</sup></p> <hr/> <p><sup>1</sup> CI calculated from Cohen's d=0,40 and p=0,046 given in the paper  <sup>2</sup> The dependent variable was found to be heterogeneous, p&lt;0.01, indicating variability in study outcomes. Control-group included a variety of therapies. The types of comparison groups included alternative psychosocial therapies (e.g., rational-emotive therapy), medication treatment, support/attention control (e.g., supportive therapy, attention/placebo), and waiting-list control.</p> <hr/> <p><b>CI:</b> Confidence interval;</p> <hr/> <p><a href="#">Link (s) to summary of Evidence Profiles</a></p>	

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
RESOURCE USE	Are the resources required small?	No <input type="checkbox"/> Probably No <input type="checkbox"/> Uncertain <input type="checkbox"/> Probably Yes <input checked="" type="checkbox"/> Yes <input type="checkbox"/> <i>Varies</i> <input type="checkbox"/>	Ressurser og støtte til å gjennomføre tiltakene er billige, men forutsetter faglig motivasjon og mulighet for å innarbeide rådgivning i det daglige arbeidet.	
	Is the incremental cost small relative to the net benefits?	No <input type="checkbox"/> Probably No <input type="checkbox"/> Uncertain <input type="checkbox"/> Probably Yes <input type="checkbox"/> Yes <input checked="" type="checkbox"/> <i>Varies</i> <input type="checkbox"/>	Anbefalingen beskriver tiltak som helsepersonell benytter i dag, men anbefalingen beskriver en systematikk som kan være fraværende i helsetjenesten	
EQUITY	What would be the impact on health inequities?	Increased <input type="checkbox"/> Probably increased <input type="checkbox"/> Uncertain <input checked="" type="checkbox"/> Probably reduced <input type="checkbox"/> Reduced <input type="checkbox"/> <i>Varies</i> <input type="checkbox"/>	Vi vet ikke om det kan være bestemte grupper av pasienter som vil bli tilbudt rådgivning. Flere av rådene nyttiggjøres best ved gode skrive- og leseferdigheter. Internettkunnskaper og engelskkunnskaper kan være en fordel for noen av ressursene	
ACCEPTABILITY	Is the option acceptable to key stakeholders?	No <input type="checkbox"/> Probably No <input type="checkbox"/> Uncertain <input type="checkbox"/> Probably Yes <input type="checkbox"/> Yes <input checked="" type="checkbox"/> <i>Varies</i> <input type="checkbox"/>	Referansegruppen har drøftet og stiller seg bak anbefalingen.	
FEASIBILITY	Is the option feasible to implement?	No <input type="checkbox"/> Probably No <input type="checkbox"/> Uncertain <input type="checkbox"/> Probably Yes <input type="checkbox"/> Yes <input checked="" type="checkbox"/> <i>Varies</i> <input type="checkbox"/>		

<b>Balance of consequences</b>	Undesirable consequences <i>clearly outweigh</i> desirable consequences in most settings <input type="checkbox"/>	Undesirable consequences <i>probably outweigh</i> desirable consequences in most settings <input type="checkbox"/>	The balance between desirable and undesirable consequences <i>is closely balanced or uncertain</i> <input type="checkbox"/>	Desirable consequences <i>probably outweigh</i> undesirable consequences in most settings <input type="checkbox"/>	Desirable consequences <i>clearly outweigh</i> undesirable consequences in most settings <input checked="" type="checkbox"/>
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<b>Type of recommendation</b>	We recommend against offering this option <input type="checkbox"/>	We suggest not offering this option <input type="checkbox"/>	We suggest offering this option <input type="checkbox"/>	We recommend offering this option <input checked="" type="checkbox"/>
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**Recommendation (text)**

**Vi anbefaler:**

**Fastleger, eventuelt annet kvalifisert helsepersonell, bør gi råd om selvhjelp til eldre med depresjon.**

- **Tilby assistert selvhjelpsprogram, i form av selvhjelps litteratur eller nettbaserte programmer basert på prinsipper i kognitiv atferdsterapi.**
- **Tilby regelmessig organisert fysisk aktivitet, enten individuelt eller i gruppe. Treningen skal være av en viss intensitet.**
- **Spør om pasienten har søvnvansker og gi råd og hjelp til gode søvnvaner ved behov**
- **Spør om pasienten har plager med angst og gi råd om angstmestring ved behov**
- **Gi veiledning i problemløsningsteknikker (beskrive et aktuelt problem, finne alternative løsningsforslag, prioritere og gjennomføre tiltak, og evaluere resultatet).**

**Justification**

Sterk anbefaling, fra svært lav til høy kvalitet på dokumentasjon.

Tilbud om rådgivning er hovedanbefalingen for pasienter med mild grad av depresjon, men også pasienter med moderat til alvorlig depresjon kan ha nytte av dette. Anbefalingen inneholder mange tiltak. Det er dokumentasjon av varierende kvalitet for det enkelte tiltaket, og den forventede effekten varierer noe. Web-baserte selvhjelpsprogrammer har svak til moderat positiv effekt på depressive symptomer. Fysisk aktivitet har moderat til sterk effekt på depressive symptomer. Råd om søvn har en svak til moderat positiv effekt. Problemløsningsterapi har moderat effekt. Vi har ikke funnet systematiske oversikter som undersøker spesifikt effekten av råd om angstmestring, men en systematisk oversikt viser at problemløsningsterapi er effektiv ved kombinert depresjon og angst.

**Subgroup considerations**

Noe av dette er internettbasert. De som ikke har ferdigheter eller adgang til internett vil kunne ha vanskeligheter med å følge noen av tiltakene. Flere av tiltakene krever lese- og skriveferdigheter.

**Implementation considerations**

Manualer og sjekklister for tiltakene må være tilgjengelig for fastleger og annet helsepersonell.

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**Monitoring and evaluation**

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**Research priorities**

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## Evidence profile Ulike tiltak som går under anbefalingen om rådgivning

**Author(s):** Aakhus, Flottorp

**Date:** 2013-08-29

**Question:** Should self-help programmes (bibliotherapy) be used for elderly with depression?

**Settings:** Primary care

**Bibliography:** Gregory RJ et al. Cognitive Bibliotherapy for Depression: A Meta-Analysis. Professional Psychology: Research and Practice 2004, Vol. 35, No. 3, 275–280

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help programmes (bibliotherapy)	Control	Relative (95% CI)	Absolute		
<b>Depressive symptoms short term (measured with: continous measures, psychiatric scales; Better indicated by lower values)</b>												
9	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness <sup>1</sup>	no serious imprecision	none	0	-	-	0.57 higher (0.37 to 0.77 higher) <sup>2</sup>	⊕⊕⊕⊕ HIGH	CRITICAL

<sup>1</sup> Elderly only

<sup>2</sup> author's note: we computed unbiased effect sizes (d, per Hedges & Olkin, 1985) for all dependent variables included in this meta-analysis (

**Author(s):** Aakhus, Flottorp

**Date:** 2013-06-18

**Question:** Should self-help programmes (web-based) be used for elderly with depression?

**Settings:** Primary care

**Bibliography:** Richards D, Richardson T. Computer-based psychological treatments for depression: a systematic review and meta-analysis. Clin Psychol Rev 2012;32:329-42.

Quality assessment							No of patients		Effect		Quality	Importance
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<b>Depressive symptoms short term end of treatment (measured with: depression scales; Better indicated by lower values)</b>												
19	randomised trials	no serious risk of bias	no serious inconsistency	serious <sup>1</sup>	no serious imprecision <sup>2</sup>	none	1553	1443	SMD 0.56 lower (0.71 to 0.41 lower)	⊕⊕⊕○ MODERATE	CRITICAL	
<b>Depressive symptoms long term (follow-up median 6-8 months; measured with: depression scales; Better indicated by lower values)</b>												
14	randomised trials	no serious risk of bias	no serious inconsistency	serious <sup>1</sup>	no serious imprecision <sup>2</sup>	none	196	224	SMD 0.20 lower (0.09 to 0.39 lower)	⊕⊕⊕○ MODERATE	CRITICAL	

<sup>1</sup> No particular data for elderly patients, and an expected lower adherence to web-based services among elderly

<sup>2</sup> Significant heterogeneity among the trials, although all results were in favour of computer based treatment. Hence we have not rated down for inconsistency.

**Author(s):** Aakhus, Flottorp

**Date:** 2013-06-03

**Question:** Should organised physical exercise be used for elderly with depression?

**Settings:** primary care

**Bibliography:** Cooney GM et al. Exercise for depression. Cochrane Database Syst Rev 2013

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Organised physical exercise	Control	Relative (95% CI)	Absolute		
<b>Depressive symptoms post-treatment (measured with: Depression scales ; Better indicated by lower values)</b>												
35	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	711	642	-	SMD 0.62 lower (0.42 to 0.81 lower)	⊕⊕⊕○ MODERATE	CRITICAL
<b>Depressive symptoms long-term (measured with: Depression scales; Better indicated by lower values)</b>												
8	randomised trials	serious <sup>1</sup>	no serious inconsistency	no serious indirectness	no serious imprecision	none	194	183	-	SMD 0.33 lower (0.03 to 0.63 lower)	⊕⊕⊕○ MODERATE	IMPORTANT

<sup>1</sup> A substantial number of the included publications had poor follow-up data and unclear allocation

**Author(s):** Aakhus, Flottorp

**Date:** 2013-06-18

**Question:** Should Sleep counselling be used for elderly patients with depression and sleep problems?

**Settings:** Primary care

**Bibliography:** VanStraten,Cuijpers 2008

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Sleep counselling	Control	Relative (95% CI)	Absolute		
<b>Sleep quality, end of treatment (measured with: continous measures, psychiatric scales; Better indicated by higher values)</b>												
9	randomised trials	serious <sup>1</sup>	serious <sup>2</sup>	very serious <sup>3</sup>	no serious imprecision	none	485	420	-	SMD 0.362 higher (0.155 to 0.57 higher)	⊕○○○ VERY LOW	CRITICAL

<sup>1</sup> Two of the 9 studies reported that allocation to conditions was conducted by an independent party. In none of the 10 studies was concealment of random allocation to respondents possible or reported. This also applied to the blinding of assessors. Drop-out numbers ranged from 0% to 25%. In four studies intention-to-treat analyses were conducted; in two studies this was not reported while the other studies were limited to completers-only analyses.

<sup>2</sup> The fixed effect models did show significant heterogeneity for sleep efficiency (I<sup>2</sup> ¼ 65.5%), time awake after sleep onset (I<sup>2</sup> ¼ 63.9%), sleep quality (I<sup>2</sup> ¼ 52.3%) and the combined sleep outcomes (I<sup>2</sup> ¼ 44.5%).

<sup>3</sup> Two of the nine included studies addressed elderly, and both showed no significant differences between self-help and waiting list controls. Depressed patients were not commented.

**Author(s):** Aakhus, Flottorp

**Date:** 2013-06-18

**Question:** Should Problem solving therapy vs be used for elderly with depression?

**Settings:** Primary care

**Bibliography:** Problem-solving therapy for depression: a meta-analysis. Bell AC, D'Zurilla TJ. Clin Psychol Rev. 2009

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Problem solving therapy	Relative (95% CI)	Absolute			
<b>Depressive symptoms (follow-up 3-12 months; measured with: Depression scale ; Better indicated by higher values)</b>												
21	randomised trials	no serious risk of bias	serious <sup>1</sup>	no serious indirectness	no serious imprecision	none	632 <sup>2</sup>	632	-	SMD 0.40 higher (0.01 to 0.79 higher) <sup>3</sup>	⊕⊕⊕○ MODERATE	CRITICAL

<sup>1</sup> The dependent variable was found to be heterogeneous, p<0.01, indicating variability in study outcomes. Control-group included a variety of therapies (The types of comparison groups included alternative psychosocial therapies (e.g., rational-emotive therapy), medication treatment, support/attention control (e.g., supportive therapy, attention/placebo), and waiting-list control.)

<sup>2</sup> Total N=1264. Numbers for each group not given, and divided in two similar group sizes, until final feed-back from the authors

<sup>3</sup> CI calculated from Cohen's d=0,40 and p=0,046 given in the paper

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## References

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- <sup>1</sup> Gregory RJ et al. Cognitive Bibliotherapy for Depression: A Meta-Analysis. *Professional Psychology: Research and Practice* 2004, Vol. 35, No. 3, 275–280.
- <sup>2</sup> Richards D, Richardson T. Computer-based psychological treatments for depression: a systematic review and meta-analysis. *Clin Psychol Rev* 2012;32:329-42.
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- <sup>4</sup> Van Straten A, Cuijpers P. Self-help therapy for insomnia: A meta-analysis. *Sleep Med Rev* 2009;13:61-71.
- <sup>5</sup> Bell AC, D'Zurilla TJ. Problem-solving therapy for depression: a meta-analysis. *Clin Psychol Rev* 2009;29:348-53.
- <sup>6</sup> Cape J et al. Brief psychological therapies for anxiety and depression in primary care: meta-analysis and meta-regression. *BMC Med* 2010;8:38.
- <sup>7</sup> Bower P et al: Influence of initial severity of depression on effectiveness of low intensity interventions: meta-analysis of individual patient data. *BMJ* 2013;346:f540.

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

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

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

\*\*The Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group began in the year 2000 as an informal collaboration of people with an interest in addressing the shortcomings of present grading systems in health care. The working group has developed a common, sensible and transparent approach to grading quality of evidence and strength of recommendations. Many international organizations have provided input into the development of the approach and have started using it.

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