Appendix 16: Evidence profiles

This appendix contains evidence profiles for reviews substantially updated or added to the updated guideline. The use of evidence profiles was introduced since the previous guideline was published.

Evidence profile tables summarise both the quality of the evidence and the results of the evidence synthesis. Each table included details about the quality assessment of each outcome: quality of the included studies, number of studies and participants, and limitations, information about the consistency of the evidence (based on heterogeneity – see chapter 3), directness of the evidence (that is, how closely the outcome measures, interventions and participants match those of interest) and any other considerations (for example, effect sizes with wide confidence intervals (CIs) would be described as imprecise data). Each evidence profile also included a summary of the findings: number of patients included in each group, an estimate of the magnitude of the effect, quality of the evidence, and the importance of the evidence. The quality of the evidence was based on the quality assessment components (study design, limitations to study quality, consistency, directness and any other considerations) and graded using the following definitions:

- **High** = Further research is very unlikely to change our confidence in the estimate of the effect
- **Moderate** = Further research is likely to have an important impact on our confidence in the estimate of the effect and may change the estimate
- **Low** = Further research is very likely to have an important impact on our confidence in the estimate of the effect and is likely to change the estimate
- **Very low** = Any estimate of effect is very uncertain.

For further information about the process and the rationale of producing an evidence profile table, see GRADE (2004). Full evidence profiles are in Appendix 18 and summary profiles are included in the evidence chapters.

GRADE Grades of Recommendation Assessment Working Group (2004) Grading quality of evidence and strength of recommendations. British Medical Journal, 328, 1490-1497.

Author(s): NCCMH
Date: 2009-07-10
Question: Should collaborative care be used for depression?
Settings:
Bibliography:

Quality assessment							Summary of findings					Importance
							No of patients		Effect			
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	collaborative care	control	Relative (95% CI)	Absolute	Quality	
Number not acheiving =>50% reduction in outcome score at endpoint - Self rated												
7	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	515/1036 (49.7%)	470/784 (59.9%) 60.2%	RR 0.83 (0.75 to 0.92)	10 fewer per 100 (from 5 fewer to 15 fewer) 10 fewer per 100 (from 5 fewer to 15 fewer)	⊕⊕⊕⊕ HIGH	
Number not acheiving =>50% reduction in outcome score at endpoint - Clinician rated												
2	randomised trials	no serious limitations	no serious inconsistency[1]	no serious indirectness	serious[2]	none	290/656 (44.2%)	296/608 (48.7%) 55.7%	RR 0.86 (0.69 to 1.06)	7 fewer per 100 (from 15 fewer to 3 more) 8 fewer per 100 (from 17 fewer to 3 more)	⊕⊕⊕O MODERATE	
Number not acheiving remission at endpoint - Self rated												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	645/921 (70%)	425/559 (76%) 77%	RR 0.91 (0.86 to 0.97)	7 fewer per 100 (from 2 fewer to 11 fewer) 7 fewer per 100 (from 2 fewer to 11 fewer)	⊕⊕⊕⊕ HIGH	
Number not acheiving remission at endpoint - Clinician rated												
1	randomised trials	no serious limitations	no serious inconsistency[3]	no serious indirectness	serious[2]	none	269/477 (56.4%)	279/485 (57.5%) 57.5%	RR 0.98 (0.88 to 1.09)	1 fewer per 100 (from 7 fewer to 5 more) 1 fewer per 100 (from 7 fewer to 5 more)	⊕⊕⊕O MODERATE	
Number not acheiving remission at endpoint - DSM criteria												
7	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	171/675 (25.3%)	137/498 (27.5%) 41.7%	RR 0.85 (0.74 to 1.04)	4 fewer per 100 (from 7 fewer to 1 more) 6 fewer per 100 (from 11 fewer to 2 more)	⊕⊕⊕O MODERATE	
Number not acheiving remission at follow-up: 12 months - Self rated												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[4]	none	287/581 (49.4%)	133/282 (47.2%) 47.2%	RR 1.05 (0.9 to 1.21)	2 more per 100 (from 5 fewer to 10 more) 2 more per 100 (from 5 fewer to 10 more)	⊕⊕⊕O MODERATE	
Relapse Prevention - 12 months												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	very serious[5]	none	22/194 (11.3%)	23/192 (12%) 12%	RR 0.95 (0.55 to 1.64)	1 fewer per 100 (from 5 fewer to 8 more) 1 fewer per 100 (from 5 fewer to 8 more)	⊕⊕OO LOW	
Mean endpoint - Clinician rated (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	very serious[5]	none	22	23	-	SMD 0.05 lower (0.64	⊕⊕OO	

										lower to 0.53 higher)	LOW	
Mean endpoint - Self rated (Better indicated by lower values)												
11	randomised trials	no serious limitations	no serious inconsistency[6]	no serious indirectness	no serious imprecision	none	970	924	-	SMD 0.15 lower (0.24 to 0.06 lower)	⊕⊕⊕⊕ HIGH	
Mean endpoint scores (self-rated) at follow-up: 3-4 months (Better indicated by lower values)												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	109	105	-	SMD 0.36 lower (0.63 to 0.09 lower)	⊕⊕⊕⊕ HIGH	
Mean change at endpoint - Clinician rated (Better indicated by lower values)												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[4]	none	477	481	-	SMD 0.02 lower (0.15 lower to 0.11 higher)	⊕⊕⊕O MODERATE	

[1] Significant heterogeneity - study removed in sensitivity analysis (Arraya2003) and random effects model used
[2] CI compatible with both benefit and no benefit
[3] Arraya2003 removed in sensivity analysis
[4] Single study
[5] Single study and inconclusive effect size
[6] Study removed in sensitivity analysis due to heterogeneity (KATON1996major)

Author(s):
Date: 2009-02-05
Question: Should collaborative care be used for ?
Settings:
Bibliography:

Quality assessment							Summary of findings					Importance
							No of patients		Effect			
No of studies	**Design**	**Limitations**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**collaborative care**	**control**	**Relative (95% CI)**	**Absolute**	**Quality**	
Attrition - Leaving study early for any reason (incl lost to follow-up)												
17	randomised trials	no serious limitations	serious[1]	no serious indirectness	no serious imprecision	none	472/3089 (15.3%)	412/2253 (18.3%)	RR 0.95 (0.78 to 1.16)	1 fewer per 100 (from 4 fewer to 3 more)	⊕⊕⊕O MODERATE	
								18.3%		1 fewer per 100 (from 4 fewer to 3 more)		
Adherence - Non-adherance to medication												
4	randomised trials	no serious limitations	serious[1]	no serious indirectness	no serious imprecision	none	151/491 (30.8%)	240/465 (51.6%)	RR 0.58 (0.44 to 0.75)	22 fewer per 100 (from 13 fewer to 29 fewer)	⊕⊕⊕O MODERATE	
								51.3%		22 fewer per 100 (from 13 fewer to 29 fewer)		

[1] Significant heterogeneity - random effects model used

Author(s): NCCMH
Date: 2009-07-10
Question: Should medication management be used for depression (efficacy)?
Settings:
Bibliography:

Quality assessment							Summary of findings					Importance
							No of patients		Effect			
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	medication management	control	Relative (95% CI)	Absolute	Quality	
Number not acheiving =/>50% reduction in outcome score												
1	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	very serious[1]	none	10/31 (32.3%)	11/32 (34.4%) 34.4%	RR 0.94 (0.47 to 1.89)	2 fewer per 100 (from 18 fewer to 31 more) 2 fewer per 100 (from 18 fewer to 31 more)	⊕⊕OO LOW	
Mean endpoint (self rated) (Better indicated by lower values)												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[2]	none	335	269	-	SMD 0.14 lower (0.31 lower to 0.02 higher)	⊕⊕⊕O MODERATE	

[1] Single study; inconclusive effect size
[2] CI compatible with both benefit and no benefit

Author(s):
Date: 2009-02-06
Question: Should mediication management (acceptability and adherence) be used for ?
Settings:
Bibliography:

Quality assessment							Summary of findings					Importance
							No of patients		Effect			
No of studies	Design	Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	mediication management (acceptability and adherence)	control	Relative (95% CI)	Absolute	Quality	
Non-adherence to medication												
3	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	no serious imprecision	none	61/186 (32.8%)	63/154 (40.9%) 54.8%	RR 0.7 (0.51 to 0.96)	12 fewer per 100 (from 2 fewer to 20 fewer) 16 fewer per 100 (from 2 fewer to 27 fewer)	⊕⊕⊕⊕ HIGH	
Leaving study early for any reason (incl lost to follow-up)												
2	randomised trials	no serious limitations	no serious inconsistency	no serious indirectness	serious[1]	none	76/298 (25.5%)	93/296 (31.4%) 31.8%	RR 0.81 (0.63 to 1.05)	6 fewer per 100 (from 12 fewer to 2 more) 6 fewer per 100 (from 12 fewer to 2 more)	⊕⊕⊕O MODERATE	

[1] CI compatible with both benefit and no benefit