Evidence tabel thema interventies

Reference: Merry SN, Hetrick SE, Cox GR, Brudevold-Iversen T, Bir JJ, McDowell H, et al. Psychological and educational interventions for preventing depression in children and adolescents. [Review][Update of Cochrane Database Syst Rev. 2004;(1):CD003380; PMID: 14974014]. Cochrane Database of Systematic Reviews [12], CD003380. 1469-493X 2011. England (Merry et al., 2011).	
Methods	Study aim: To determine whether psychological or educational interventions, or both, are effective in preventing the onset of depressive disorder in children and adolescents. (Universal and Selective prevention) Study design: Cochrane review of Randomised controlled trials Analysis: Meta-analysis Setting:
Patients	Number of studies: K= 53 Number of patients: *N*=14.406 Age: (range 4.7-19) years Sex: Inclusion: Young people aged 5 to 19 years-old, who did not currently meet diagnostic criteria for depression or who were below the clinical range on standardised, validated, and reliable rating scales of depression. Exclusion: Studies were excluded if they lacked a clear definition of participants, were on children and adolescents who met DSM-IVTR (American Psychiatric Association 2000) or ICD-10 (World Health Organization 2007) criteria for depressive disorder or fell into the clinical range on standardised, validated, and reliable rating scales of depression at the start of the study, or both, or there was no adequate assessment of participants. Baseline characteristics:
Interventions	Intervention: Psychological or educational prevention programmes. Prevention programmes were diverse and varied in those targeted, the components they included, and the focus of those components. Most programmes included some components of Cognitive Behavioral Therapy (CBT). Others included a focus on self-efficacy, stress reduction, trauma or optimism. Some programmes were gender-specific and some focused on family members. Many were school-based, while others were online or based in primary care settings. Many were group-based programmes. Control: placebo, any comparison intervention, or no intervention
Outcome	Primary: Prevalence of depressive disorder and depressive symptoms post-intervention and at follow-up. Secondary: -
Results	Of the Fifty-three studies, sixteen studies including 3240 participants reported outcomes on depressive diagnosis. The risk of having a depressive disorder post-intervention was reduced immediately compared with no intervention (15 studies; 3115 participants risk difference (RD) -0.09; 95% confidence interval (CI) 0.14 to -0.05; P<0.0003), at three to nine months (14 studies; 1842 participants; RD -0.11; 95% CI -0.16 to -0.06) and at 12 months (10 studies; 1750 participants; RD -0.06; 95% CI -0.11 to -0.01). There was no evidence for continued efficacy at 24 months (eight studies; 2084

	participant; RD -0.01; 95% CI -0.04 to 0.03) but limited evidence of efficacy at 36 months (two studies; 464 participants; RD -0.10; 95% CI -0.19 to -0.02). There was no evidence of efficacy in the few studies that compared intervention with placebo or attention controls. <u>Conclusions</u> There is some evidence from this review that targeted and universal depression prevention programmes may prevent the onset of depressive disorders compared with no intervention. However, allocation concealment is unclear in most studies, and there is heterogeneity in the findings. The persistence of findings suggests that this is real and not a placebo effect.
Quality Assessment	Study question: + Explicit clinical aim, PICO well described Search strategy: + Electronic databases: MEDLINE (1950-), EMBASE (1974-) and PsycINFO (1967-) and ERIC No language restrictions Selection process: + Explicit in- and exclusion criteria (e.g. patient group, design, intervention)? Yes By two reviewers independently made final selection? Two authors independently assessed studies for inclusion and rated their quality. Flow diagram? No Quality assessment: + Explicit list of criteria (at least allocation concealment and blinding of assessors)? By two reviewers independently? Two authors independently assessed studies for inclusion and rated their quality. How consensus was reached and level of agreement? Results individual studies reported? Data extraction: + By two reviewers independently? Data were independently extracted by four of the review authors Process clearly described? Yes Characteristics original studies: + At least design, population, primary outcomes, follow up length? Yes Handling heterogeneity: + Clinical heterogeneity?: subgroups Statistical heterogeneity: accounted for (random effects model), explored (subgroup or meta-analyses), refrain from pooling. Yes Statistical pooling: +

	Funding / conflicts of interest: ? Overall quality of evidence: + (allocation concealment and heterogeneity is a problem across studies) General conclusion:+