**National Quality Forum—Evidence (subcriterion 1a)**

**Measure Number** (*if previously endorsed*)**:** 0576

**Measure Title**: Follow-Up After Hospitalization for Mental Illness

**IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:** Click here to enter composite measure #/ title

**Date of Submission**: 11/2/2020

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| **Instructions**  *Complete 1a.1 and 1a.2 for all measures. If instrument-based measure, complete 1a.3.*  *Complete* ***EITHER 1a.2, 1a.3 or 1a.4*** *as applicable for the type of measure and evidence.*  *For composite performance measures:*  *A separate evidence form is required for each component measure unless several components were studied together.*  *If a component measure is submitted as an individual performance measure, attach the evidence form to the individual measure submission.*   * All information needed to demonstrate meeting the evidence subcriterion (1a) must be in this form. An appendix of *supplemental* materials may be submitted, but there is no guarantee it will be reviewed. * If you are unable to check a box, please highlight or shade the box for your response. * Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx). |

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| **Note: The information provided in this form is intended to aid the Standing Committee and other stakeholders in understanding to what degree the evidence for this measure meets NQF’s evaluation criteria.**   1a. Evidence to Support the Measure Focus The measure focus is evidence-based, demonstrated as follows:   * Outcome: [**3**](#Note3) Empirical data demonstrate a relationship between the outcome and at least one healthcare structure, process, intervention, or service. If not available, wide variation in performance can be used as evidence, assuming the data are from a robust number of providers and results are not subject to systematic bias. * Intermediate clinical outcome: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4)that the measured intermediate clinical outcome leads to a desired health outcome. * Process: [**5**](#Note5) a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured process leads to a desired health outcome. * Structure: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured structure leads to a desired health outcome. * Efficiency: [**6**](#Note6) evidence not required for the resource use component. * For measures derived from patient reports, evidence should demonstrate that the target population values the measured outcome, process, or structure and finds it meaningful. * Process measures incorporating Appropriate Use Criteria: See NQF’s guidance for evidence for measures, in general; guidance for measures specifically based on clinical practice guidelines apply as well.   **Notes**  **3.** Generally, rare event outcomes do not provide adequate information for improvement or discrimination; however, serious reportable events that are compared to zero are appropriate outcomes for public reporting and quality improvement.  **4.** The preferred systems for grading the evidence are the Grading of Recommendations, Assessment, Development and Evaluation [(GRADE) guidelines](http://www.gradeworkinggroup.org) and/or modified GRADE.  **5.** Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multistep process, the step with the strongest evidence for the link to the desired outcome should be selected as the focus of measurement. Note: A measure focused only on collecting PROM data is not a PRO-PM.  **6.** Measures of efficiency combine the concepts of resource use and quality (see NQF’s [Measurement Framework: Evaluating Efficiency Across Episodes of Care](http://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx); [AQA Principles of Efficiency Measures](http://www.aqaalliance.org/files/PrinciplesofEfficiencyMeasurementApril2006.doc)). |

**1a.1.This is a measure of**: (*should be consistent with type of measure entered in De.1*)

Outcome

Outcome: Click here to name the health outcome

Patient-reported outcome (PRO): Click here to name the PRO

*PROs include HRQoL/functional status, symptom/symptom burden, experience with care, health-related behaviors.* (*A PRO-based performance measure is not a survey instrument. Data may be collected using a survey instrument to construct a PRO measure.)*

Intermediate clinical outcome (*e.g., lab value*): Click here to name the intermediate outcome

Process: Click here to name what is being measured

Appropriate use measure: Click here to name what is being measured

Structure: Click here to name the structure

Composite: Click here to name what is being measured

**1a.2** **LOGIC MODEL** Diagram or briefly describe the steps between the healthcare structures and processes (e.g., interventions, or services) and the patient’s health outcome(s). The relationships in the diagram should be easily understood by general, non-technical audiences. Indicate the structure, process or outcome being measured.

**1a.3** **Value and Meaningfulness:**  **IF** this measure is derived from patient report, provide evidence that the target population values the measured ***outcome, process, or structure*** and finds it meaningful. (Describe how and from whom their input was obtained.)

**\*\*RESPOND TO ONLY ONE SECTION BELOW -EITHER 1a.2, 1a.3 or 1a.4) \*\***

**1a.2** **FOR OUTCOME MEASURES including PATIENT REPORTED OUTCOMES - Provide empirical data demonstrating the relationship between the outcome (or PRO) to at least one healthcare structure, process, intervention, or service.**

**1a.3.****SYSTEMATIC REVIEW(SR) OF THE EVIDENCE (for intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measures, including those that are instrument-based) If the evidence is not based on a systematic review go to section 1a.4) If you wish to include more than one systematic review, add additional tables.**

**What is the source of the systematic review of the body of evidence that supports the performance measure? A systematic review is a scientific investigation that focuses on a specific question and uses explicit, prespecified scientific methods to identify, select, assess, and summarize the findings of similar but separate studies. It may include a quantitative synthesis (meta-analysis), depending on the available data. (IOM)**

☐ Clinical Practice Guideline recommendation (with evidence review)

☐ US Preventive Services Task Force Recommendation

☐ Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*)

☐ Other

**National Institute for Health and Care Excellence (NICE) Guideline - Transition between inpatient mental health settings and community or care home settings**

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| **Source of Systematic Review:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | **Transition between inpatient mental health settings and community or care home settings**  2016  National Institute for Health and Care Excellence. Transition between inpatient mental health settings and community or care home settings**.**  . London (UK): National Institute for Health and Care Excellence (NICE); 2016 Aug. 22 p. (NICE clinical guideline; NG53).  https://www.nice.org.uk/guidance/ng53/resources/transition-between-inpatient-mental-health-settings-and-community-or-care-home-settings-pdf-1837511615941 |
| Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR. | 1.6.1. Discuss follow-up support with the person before discharge. Arrange support according to their mental and physical health needs. This could include:  contact details, for example of:   * a community psychiatric nurse or social worker * the out-of-hours service * support and plans for the first week * practical help if needed * employment support.   1.6.7. Follow up with a person who has been discharged within 7 days. |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | **2020 submission:**  1.6.1. Moderate (+) or Poor to Moderate (-/+ )evidence  1.6.7. Moderate (+) to Good (++) evidence  ++ All or most of the checklist criteria have been fulfilled, and where they have not been fulfilled the conclusions are very unlikely to alter.  + Some of the checklist criteria have been fulfilled, and where they have not been fulfilled, or are not adequately described, the conclusions are unlikely to alter.  – Few or no checklist criteria have been fulfilled and the conclusions are likely or very likely to alter. |
| Provide all other grades and definitions from the evidence grading system | **2020 submission:**  ++ All or most of the checklist criteria have been fulfilled, and where they have not been fulfilled the conclusions are very unlikely to alter.  + Some of the checklist criteria have been fulfilled, and where they have not been fulfilled, or are not adequately described, the conclusions are unlikely to alter.  – Few or no checklist criteria have been fulfilled and the conclusions are likely or very likely to alter. |
| Grade assigned to the **recommendation** with definition of the grade | **2020 submission:**  Recommendation statements not graded. |
| Provide all other grades and definitions from the recommendation grading system | **2020 submission:**  Recommendation statements not graded |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | **2020 submission:**  10 studies were included in the evidence statements corresponding to these recommendation statements related to follow-up support. 6 were RCTs and 4 were qualitative studies. 5 were rated moderate, 4 were rated good, and 1 was rated poor. |
| Estimates of benefit and consistency across studies | **2020 submission:**  “The absence of relevant, high quality recent effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.” |
| What harms were identified? | **2020 submission:**  “The absence of relevant, high quality recent effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.” |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | **2020 submission:**  N/A |

**National Institute for Health and Care Excellence (NICE) Guideline - Schizophrenia**

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| **Source of Systematic Review:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  **Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care**  [National Collaborating Centre for Mental Health](https://www.guideline.gov/search?f_Guideline_Developer_String=National%20Collaborating%20Centre%20for%20Mental%20Health&fLockTerm=National%2BCollaborating%2BCentre%2Bfor%2BMental%2BHealth)  2009  National Collaborating Centre for Mental Health. Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Mar. 41 p. (NICE clinical guideline; no. 82).  http://guidelines.gov/content.aspx?id=14313 |
| Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR. | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission**  Getting Help Early   * Healthcare professionals should facilitate access as soon as possible to assessment and treatment, and promote early access throughout all phases of care.   Initiation of Treatment (First Episode)  Early Referral  • Urgently refer all people with first presentation of psychotic symptoms in primary care to a local community-based secondary mental health service (for example, crisis resolution and home treatment team, early intervention service, community mental health team). Referral to early intervention services may be from primary or secondary care. The choice of team should be determined by the stage and severity of illness and the local context.  • Carry out a full assessment of people with psychotic symptoms in secondary care, including an assessment by a psychiatrist. Write a care plan in collaboration with the service user as soon as possible. Send a copy to the primary healthcare professional who made the referral and the service user.  • Include a crisis plan in the care plan, based on a full risk assessment. The crisis plan should define the role of primary and secondary care and identify the key clinical contacts in the event of an emergency or impending crisis.  Early Post-Acute Period  In the early period of recovery following an acute episode, service users and healthcare professionals will need to jointly reflect upon the acute episode and its impact, and make plans for future care. |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission**  Guideline was not graded. |
| Provide all other grades and definitions from the evidence grading system | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission**  N/A |
| Grade assigned to the **recommendation** with definition of the grade | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission**  N/A |
| Provide all other grades and definitions from the recommendation grading system | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission**  N/A |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission**  N/A |
| Estimates of benefit and consistency across studies | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission**  N/A |
| What harms were identified? | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission**  N/A |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission**  N/A |

**National Institute for Health and Care Excellence (NICE) Guideline – Psychosis and Schizophrenia**

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| **Source of Systematic Review:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | **2020 submission:**  No updates. NICE “checked this guideline in March 2019 and found no new evidence that affects the recommendations in this guideline.” Thus, the guideline was not updated.  **2016 Submission:**  **Psychosis and schizophrenia in adults: treatment and management.**  2014  National Collaborating Centre for Mental Health. Psychosis and schizophrenia in adults: prevention and management. London (UK): National Institute for Health and Care Excellence (NICE); 2014 Mar. 58 p. (NICE clinical guideline; no 178).  https://www.nice.org.uk/guidance/cg178/resources/psychosis-and-schizophrenia-in-adults-prevention-and-management-35109758952133 |
| Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR. | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  **1.2 Preventing psychosis**  1.2.1 Referral from primary care  1.2.1.1 If a person is distressed, has a decline in social functioning and has:   * transient or attenuated psychotic symptoms **or** * other experiences or behaviour suggestive of possible psychosis **or** * a first-degree relative with psychosis or schizophrenia  refer them for assessment without delay to a specialist mental health service or an early intervention in psychosis service because they may be at increased risk of developing psychosis. **[new 2014]**   1.2.2 Specialist assessment   * 1.2.2.1 A consultant psychiatrist or a trained specialist with experience in at-risk mental states should carry out the assessment. **[new 2014]**   **1.3 First episode psychosis**  1.3.1 Early intervention in psychosis services   * 1.3.1.3 Early intervention in psychosis services should aim to provide a full range of pharmacological, psychological, social, occupational and educational interventions for people with psychosis, consistent with this guideline. **[2014]** * 1.3.1.4 Consider extending the availability of early intervention in psychosis services beyond 3 years if the person has not made a stable recovery from psychosis or schizophrenia. **[new 2014]**   1.3.3 Assessment and care planning   * 1.3.3.1 Carry out a comprehensive multidisciplinary assessment of people with psychotic symptoms in secondary care. This should include assessment by a psychiatrist, a psychologist or a professional with expertise in the psychological treatment of people with psychosis or schizophrenia.   1.4.6 Early post-acute period   * 1.4.6.1 After each acute episode, encourage people with psychosis or schizophrenia to write an account of their illness in their notes. **[2009]** * 1.4.6.2 Healthcare professionals may consider using psychoanalytic and psychodynamic principles to help them understand the experiences of people with psychosis or schizophrenia and their interpersonal relationships. **[2009]** * 1.4.6.3 Inform the service user that there is a high risk of relapse if they stop medication in the next 1–2 years. **[2009]** * 1.4.6.4 If withdrawing antipsychotic medication, undertake gradually and monitor regularly for signs and symptoms of relapse. **[2009]**   1.4.6.5 After withdrawal from antipsychotic medication, continue monitoring for signs and symptoms of relapse for at least 2 years. **[2009]** |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  For questions about the effectiveness of interventions, the GRADE approach was used to grade the quality of evidence for each outcome (Guyatt et al., 2011). For questions about the experience of care and the organisation and delivery of care, methodology checklists (see section 3.5.1) were used to assess the risk of bias, and this information was taken into account when interpreting the evidence. The technical team produced GRADE evidence profiles (see below) using GRADE profiler (GRADEpro) software (Version 3.6), following advice set out in the GRADE handbook (Schünemann et al., 2009). Those doing GRADE ratings were trained, and calibration exercises were used to improve reliability (Mustafa et al., 2013).  A GRADE evidence profile was used to summarise both the quality of the evidence and the results of the evidence synthesis for each ‘critical’ and ‘important’ outcome. The GRADE approach is based on a sequential assessment of the quality of evidence, followed by judgment about the balance between desirable and undesirable effects, and subsequent decision about the strength of a recommendation. Within the GRADE approach to grading the quality of evidence, the following is used as a starting point:  • RCTs without important limitations provide high quality evidence  • observational studies without special strengths or important limitations provide low quality evidence.  For each outcome, quality may be reduced depending on five factors: methodological limitations, inconsistency, indirectness, imprecision and publication bias. For the purposes of the guideline, each factor was evaluated using criteria provided in Table 4. For observational studies without any reasons for down-grading, the quality may be up-graded if there is a large effect, all plausible confounding would reduce the demonstrated effect (or increase the effect if no effect was observed), or there is evidence of a dose-response gradient (details would be provided under the ‘other’ column). Each evidence profile includes a summary of findings: number of participants included in each group, an estimate of the magnitude of the effect, and the overall quality of the evidence for each outcome. Under the GRADE approach, the overall quality for each outcome is categorised into one of four groups (high, moderate, low, very low).  <https://www.nice.org.uk/guidance/cg178/evidence/appendix-13-490503567> |
| Provide all other grades and definitions from the evidence grading system | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  For questions about the effectiveness of interventions, the GRADE approach was used to grade the quality of evidence for each outcome (Guyatt et al., 2011). For questions about the experience of care and the organisation and delivery of care, methodology checklists (see section 3.5.1) were used to assess the risk of bias, and this information was taken into account when interpreting the evidence. The technical team produced GRADE evidence profiles (see below) using GRADE profiler (GRADEpro) software (Version 3.6), following advice set out in the GRADE handbook (Schünemann et al., 2009). Those doing GRADE ratings were trained, and calibration exercises were used to improve reliability (Mustafa et al., 2013).  A GRADE evidence profile was used to summarise both the quality of the evidence and the results of the evidence synthesis for each ‘critical’ and ‘important’ outcome. The GRADE approach is based on a sequential assessment of the quality of evidence, followed by judgment about the balance between desirable and undesirable effects, and subsequent decision about the strength of a recommendation. Within the GRADE approach to grading the quality of evidence, the following is used as a starting point:  • RCTs without important limitations provide high quality evidence  • observational studies without special strengths or important limitations provide low quality evidence.  For each outcome, quality may be reduced depending on five factors: methodological limitations, inconsistency, indirectness, imprecision and publication bias. For the purposes of the guideline, each factor was evaluated using criteria provided in Table 4. For observational studies without any reasons for down-grading, the quality may be up-graded if there is a large effect, all plausible confounding would reduce the demonstrated effect (or increase the effect if no effect was observed), or there is evidence of a dose-response gradient (details would be provided under the ‘other’ column). Each evidence profile includes a summary of findings: number of participants included in each group, an estimate of the magnitude of the effect, and the overall quality of the evidence for each outcome. Under the GRADE approach, the overall quality for each outcome is categorised into one of four groups (high, moderate, low, very low).  <https://www.nice.org.uk/guidance/cg178/evidence/appendix-13-490503567> |
| Grade assigned to the **recommendation** with definition of the grade | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  The description of the process of moving from evidence to recommendations indicates that some recommendations can be made with more certainty than others. This concept of the 'strength' of a recommendation should be reflected in the consistent wording of recommendations within and across clinical guidelines. There are three levels of certainty:   * recommendations for interventions that must (or must not) be used: Recommendations that an intervention must or must not be used are usually included only if there is a legal duty to apply the recommendation, for example to comply with health and safety regulations. In these instances, give a reference to supporting documents. These recommendations apply to all patients. * recommendations for interventions that should (or should not) be used: For recommendations on interventions that 'should' be used, the GDG is confident that, for the vast majority of people, the intervention (or interventions) will do more good than harm, and will be cost effective. * recommendations for interventions that could be used: For recommendations on interventions that 'could' be used, the GDG is confident that the intervention will do more good than harm for most patients, and will be cost effective   Recommendations are marked as **[2009]**, **[2009, amended 2014]**, **[2014]** or **[new 2014]**.   * **[2009]** indicates that the evidence has not been reviewed since 2009. * **[2009, amended 2014]** indicates that the evidence has not been reviewed since 2009 but changes have been made to the recommendation wording that change the meaning. * **[2014]** indicates that the evidence has been reviewed but no changes have been made to the recommendation.   **[new 2014**] indicates that the evidence has been reviewed and the recommendation has been updated or added. |
| Provide all other grades and definitions from the recommendation grading system | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  The description of the process of moving from evidence to recommendations indicates that some recommendations can be made with more certainty than others. This concept of the 'strength' of a recommendation should be reflected in the consistent wording of recommendations within and across clinical guidelines. There are three levels of certainty:   * recommendations for interventions that must (or must not) be used: Recommendations that an intervention must or must not be used are usually included only if there is a legal duty to apply the recommendation, for example to comply with health and safety regulations. In these instances, give a reference to supporting documents. These recommendations apply to all patients. * recommendations for interventions that should (or should not) be used: For recommendations on interventions that 'should' be used, the GDG is confident that, for the vast majority of people, the intervention (or interventions) will do more good than harm, and will be cost effective. * recommendations for interventions that could be used: For recommendations on interventions that 'could' be used, the GDG is confident that the intervention will do more good than harm for most patients, and will be cost effective   Recommendations are marked as **[2009]**, **[2009, amended 2014]**, **[2014]** or **[new 2014]**.   * **[2009]** indicates that the evidence has not been reviewed since 2009. * **[2009, amended 2014]** indicates that the evidence has not been reviewed since 2009 but changes have been made to the recommendation wording that change the meaning. * **[2014]** indicates that the evidence has been reviewed but no changes have been made to the recommendation. * **[new 2014**] indicates that the evidence has been reviewed and the recommendation has been updated or added. |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  NICE guideline recommendations are based on the best available evidence. We use a wide range of different types of evidence and other information – from scientific research using a variety of methods, to testimony from practitioners and people using services. |
| Estimates of benefit and consistency across studies | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  All primary-level studies included after the first scan of citations were acquired in full and re-evaluated for eligibility at the time they were being entered into the study information database. More specific eligibility criteria were developed for each review question and are described in the relevant clinical evidence chapters. Eligible systematic reviews and primary-level studies were critically appraised for methodological quality (risk of bias) using a checklist (see The Guidelines Manual (NICE, 2012b) for templates). The eligibility of each study was confirmed by at least one member of the GDG. |
| What harms were identified? | No identified harms are cited. |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | **2020 submission:**  No updates.  **2016 Submission:**  Numerous (>100) studies related to follow-up for patients with mental illness have been published since the publication of this guideline, none of which contraindicate the need for appropriate follow-up after hospitalization for mental illness. |

**American Psychiatric Assosciation (APA) Guideline- Schizophrenia**

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| **Source of Systematic Review:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | **2020 submission:**  **The American Psychiatric Association**  **Practice Guideline For The Treatment Of Patients**  **With Schizophrenia Third Edition**  American Psychiatric Association  2019  American Psychiatric Association (2019). Practice Guideline for the Treatment of Patients With Schizophrenia Third Edition; 2019 Dec. 184 p.  <https://psychiatryonline.org/doi/full/10.1176/appi.books.9780890424841.Schizophrenia03>  **2016 Submission:**  **Practice Guideline for the Treatment of Patients With Schizophrenia Second Edition**  American Psychiatric Association  2004  American Psychiatric Association (2004). Practice Guideline for the Treatment of Patients With Schizophrenia Second Edition; 2004 Feb. 184 p. http://psychiatryonline.org/pb/assets/raw/sitewide/practice\_guidelines/guidelines/schizophrenia.pdf |
| Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR. | **2020 submission:**  **Assessment and Determination of Treatment Plan**   1. APA *recommends* (1C) that the initial assessment of a patient with a possible psychotic disorder include the reason the individual is presenting for evaluation; the patient’s goals and preferences for treatment; a review of psychiatric symptoms and trauma history; an assessment of tobacco use and other substance use; a psychiatric treatment history; an assessment of physical health; an assessment of psychosocial and cultural factors; a mental status examination, including cognitive assessment; and an assessment of risk of suicide and aggressive behaviors, as outlined in APA’s *Practice Guidelines for the Psychiatric Evaluation of Adults* (3rd edition). 2. APA *recommends* (1C) that patients with schizophrenia have a documented, comprehensive, and person-centered treatment plan that includes evidence-based nonpharmacological and pharmacological treatments.   **Pharmacotherapy**   1. APA *recommends* (1A) that patients with schizophrenia be treated with an antipsychotic medication and monitored for effectiveness and side effects.\*   \*This guideline statement should be implemented in the context of a person-centered treatment plan that includes evidence-based nonpharmacological and pharmacological treatments for schizophrenia.  **Psychosocial Interventions**   1. APA *recommends* (1B) that patients with schizophrenia who are experiencing a first episode of psychosis be treated in a coordinated specialty care program.\* 2. APA *recommends* (1B) that patients with schizophrenia be treated with cognitive-behavioral therapy for psychosis (CBTp).\* 3. APA *recommends* (1B) that patients with schizophrenia receive supported employment services.\* 4. APA *recommends* (1B) that patients with schizophrenia receive assertive community treatment if there is a history of poor engagement with services leading to frequent relapse or social disruption (e.g., homelessness; legal difficulties, including imprisonment).\* 5. APA *suggests* (2C) that patients with schizophrenia receive interventions aimed at developing self-management skills and enhancing person-oriented recovery.\* 6. APA *suggests* (2C) that patients with schizophrenia who have a therapeutic goal of enhanced social functioning receive social skills training.\*   **2016 Submission:**  Stable Phase [A, A-, B, C, D, E, F, G]  “Treatment programs need to combine medications with a range of psychosocial services to reduce the need for crisis-oriented hospitalizations and emergency department visits and enable greater recovery [I].”  Acute Phase Treatment [A, A-, B, C, D, E, F, G]  “It is recommended that pharmacological treatment be initiated promptly, provided it will not interfere with diagnostic assessment, because acute psychotic exacerbations are associated with emotional distress, disruption to the patient’s life, and a substantial risk of dangerous behaviors to self, others, or property [I].”  Acute Phase Treatment [A, A-, B, C, D, E, F, G]  “Psychosocial interventions in the acute phase are aimed at reducing overstimulating or stressful relationships, environments, or life events and at promoting relaxation or reduced arousal through simple, clear, coherent communications and expectations; a structured and predictable environment; low performance requirements; and tolerant, nondemanding, supportive relationships with the psychiatrist and other members of the treatment team. Providing information to the patient and the family on the nature and management of the illness that is appropriate to the patient’s capacity to assimilate information is recommended [II]. Patients can be encouraged to collaborate with the psychiatrist in selecting and adjusting the medication and other treatments provided [II].” |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | **2020 submission:**  High (denoted by the letter A) = high confidence that the evidence reflects the true effect. Further research is very unlikely to change our confidence in the estimate of effect.  Moderate (denoted by the letter B) = moderate confidence that the evidence reflects the true effect. Further research may change our confidence in the estimate of effect and may change the estimate.  Low (denoted by the letter C) = low confidence that the evidence reflects the true effect. Further research is likely to change our confidence in the estimate of effect and is likely to change the estimate.  **2016 Submission:**  The evidence base for practice guidelines is derived from two sources: research studies and clinical consensus. Where gaps exist in the research data, evidence is derived from clinical consensus, obtained through broad review of multiple drafts of each guideline. Both research data and clinical consensus vary in their validity and reliability for different clinical situations; guidelines state explicitly the nature of the supporting evidence for specific recommendations so that readers can make their own judgments regarding the utility of the recommendations. The following coding system is used for this purpose:  [A] Randomized, double-blind clinical trial. A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; and both the subjects and the investigators are “blind” to the assignments.  [A–] Randomized clinical trial. Same as above but not double blind.  [B] Clinical trial. A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally. Does not meet standards for a randomized clinical trial.  [C] Cohort or longitudinal study. A study in which subjects are prospectively followed over time without any specific intervention.  [D] Control study. A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time.  [E] Review with secondary data analysis. A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis.  [F] Review. A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.  [G] Other. Opinion-like essays, case reports, and other reports not categorized above |
| Provide all other grades and definitions from the evidence grading system | **2020 submission:**  No other grades.  **2016 Submission:**  The evidence base for practice guidelines is derived from two sources: research studies and clinical consensus. Where gaps exist in the research data, evidence is derived from clinical consensus, obtained through broad review of multiple drafts of each guideline (see Section VI). Both research data and clinical consensus vary in their validity and reliability for different clinical situations; guidelines state explicitly the nature of the supporting evidence for specific recommendations so that readers can make their own judgments regarding the utility of the recommendations. The following coding system is used for this purpose:  [A] Randomized, double-blind clinical trial. A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; and both the subjects and the investigators are “blind” to the assignments.  [A–] Randomized clinical trial. Same as above but not double blind.  [B] Clinical trial. A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally. Does not meet standards for a randomized clinical trial.  [C] Cohort or longitudinal study. A study in which subjects are prospectively followed over time without any specific intervention.  [D] Control study. A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time.  [E] Review with secondary data analysis. A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis.  [F] Review. A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.  [G] Other. Opinion-like essays, case reports, and other reports not categorized above |
| Grade assigned to the **recommendation** with definition of the grade | **2020 submission:**  Each guideline statement is separately rated to indicate strength of recommendation and strength of supporting research evidence. Strength of recommendation describes the level of confidence that potential benefits of an intervention outweigh potential harms. This level of confidence is a consensus judgment of the authors of the guideline and is informed by available evidence, which includes evidence from clinical trials as well as expert opinion and patient values and preferences.  There are two possible ratings: recommendation or suggestion. A **recommendation** (denoted by the numeral 1 after the guideline statement) indicates confidence that the benefits of the intervention clearly outweigh harms.  A **suggestion** (denoted by the numeral 2 after the guideline statement) indicates greater uncertainty.  **2016 Submission:**  [I] Recommended with substantial clinical confidence.  [II] Recommended with moderate clinical confidence. |
| Provide all other grades and definitions from the recommendation grading system | **2020 submission:**  Strength of recommendation describes the level of confidence that potential benefits of an intervention outweigh potential harms. This level of confidence is a consensus judgment of the authors of the guideline and is informed by available evidence, which includes evidence from clinical trials as well as expert opinion and patient values and preferences.  There are two possible ratings: recommendation or suggestion. A recommendation (denoted by the numeral 1 after the guideline statement) indicates confidence that the benefits of the intervention clearly outweigh harms. A suggestion (denoted by the numeral 2 after the guideline statement) indicates greater uncertainty.  **2016 Submission:**  Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation: [I] Recommended with substantial clinical confidence. [II] Recommended with moderate clinical confidence. [III] May be recommended on the basis of individual circumstances |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | **2020 submission:**  “The Agency for Healthcare Research and Quality’s (AHRQ) systematic review *Treatments for Schizophrenia in Adults* ([McDonagh et al. 2017](https://psychiatryonline.org/doi/full/10.5555/appi.books.9780890424841.Schizophrenia11)) served as the predominant source of information for this guideline. Databases that were searched are Ovid MEDLINE® (PubMed®), the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, and PsycINFO®. Results were limited to English-language, adult (18 and older), and human-only studies.”  “Recent, comprehensive, good- or fair-quality systematic reviews served as a primary source of evidence, supplemented by information from randomized controlled trials (RCTs) published since the systematic reviews or when no systematic reviews were available. For assessment of harms of treatment, systematic reviews of observational trials were also included. Eligibility for inclusion and exclusion of articles adhered to preestablished criteria. Specifically, the AHRQ review included articles that had at least 12 weeks of follow-up and were conducted in outpatient settings in countries that were relevant to the United States’ health care system.”  “For key question 1 on antipsychotic treatment, 698 citations were identified, 519 of which were excluded on the basis of title and abstract review, yielding 179 full-text articles that were reviewed, of which **38 were included in the final AHRQ review**. For key question 2 on psychosocial and other nonpharmacological interventions, 2,766 citations were identified, 1,871 of which were excluded on the basis of title and abstract review, yielding 895 full-text articles that were reviewed, of which **53 were included in the final AHRQ review**.”  **2016 Submission:**  “Relevant literature was identified through a computerized search of PubMed for the period from 1994 to 2002. Using the keywords schizophrenia OR schizoaffective, a total of 20,009 citations were found. After limiting these references to clinical trials and meta-analyses published in English that included abstracts, 1,272 articles were screened by using title and abstract information. The Cochrane Database of Systematic Reviews was also searched by using the keyword schizophrenia. Additional, less formal literature searches were conducted by APA staff and individual members of the work group on schizophrenia. Sources of funding were considered when the work group reviewed the literature but are not identified in this document. When reading source articles referenced in this guideline, readers are advised to consider the sources of funding for the studies” |
| Estimates of benefit and consistency across studies | **2020 submission:**  “A *recommendation* (denoted by the numeral 1 after the guideline statement) indicates confidence that the benefits of the intervention clearly outweigh harms. A *suggestion* (denoted by the numeral 2 after the guideline statement) indicates greater uncertainty. Although the benefits of the statement are still viewed as outweighing the harms, the balance of benefits and harms is more difficult to judge, or the benefits or the harms may be less clear.  When a negative statement is made, ratings of strength of recommendation should be understood as meaning the inverse of the above (e.g., *recommendation* indicates confidence that harms clearly outweigh benefits).”  **Assessment and Determination of Treatment Plan**  **Benefits**  “In an individual with a possible psychotic disorder, a detailed assessment is important in establishing a diagnosis, recognizing co-occurring conditions (including substance use disorders, other psychiatric disorders, and other physical health disorders), identifying psychosocial issues, and developing a plan of treatment that can reduce associated symptoms, morbidity, and mortality.”  “Development and documentation of a comprehensive, person-centered treatment plan assures that the clinician has considered the available nonpharmacological and pharmacological options for treatment and has identified those treatments that are best suited to the needs of the individual patient, with a goal of improving overall outcome. It may also assist in forming a therapeutic relationship, eliciting patient preferences, permitting education about possible treatments, setting expectations for treatment, and establishing a framework for shared decision-making. Documentation of a treatment plan promotes accurate communication among all those caring for the patient and can serve as a reminder of prior discussions about treatment.”  “The potential benefits of this guideline statement were viewed as far outweighing the potential harms.”  **Pharmacotherapy**  **Benefits**  “Use of an antipsychotic medication in the treatment of schizophrenia can improve positive and negative symptoms of psychosis (high strength of research evidence) and can also lead to reductions in depression and improvements in quality of life and functioning (moderate strength of research evidence). A meta-analysis of double-blind, randomized, placebo-controlled trials showed a medium effect size for overall efficacy ([Leucht et al. 2017](https://psychiatryonline.org/doi/full/10.1176/appi.books.9780890424841.Schizophrenia03)), with the greatest effect on positive symptoms. The rates of achieving any response or a good response were also significantly greater in patients who received an antipsychotic medication. In addition, the proportion of individuals who dropped out of treatment for any reason and for lack of efficacy was significantly less in those who were treated with an antipsychotic medication. Research evidence from head-to-head comparison studies and network meta-analysis ([McDonagh et al. 2017](https://psychiatryonline.org/doi/full/10.1176/appi.books.9780890424841.Schizophrenia03)) showed no consistent evidence that favored a specific antipsychotic medication, with the possible exception of clozapine.”  “The potential benefits of this guideline statement were viewed as far outweighing the potential harms.”  **Psychosocial Interventions**  **Benefits**  Across all forms of psychosocial interventions recommended or suggested in this guideline, the APA concludes that potential benefits are likely to outweigh potential harms. Benefits cited include, reduced likelihood of relapse, reduced core illness symptoms, reduced symptom severity, and improved quality of life.  **2016 Submission:**  “The literature review will include other guidelines addressing the same topic, when available. The work group constructs evidence tables to illustrate the data regarding risks and benefits for each treatment and to evaluate the quality of the data. These tables facilitate group discussion of the evidence and agreement on treatment recommendations before guideline text is written. Evidence tables do not appear in the guideline; however, they are retained by APA to document the development process in case queries are received and to inform revisions of the guideline” |
| What harms were identified? | **2020 submission:**  **Assessment and Determination of Treatment Plan**  **Harms**  “Harms may include serious adverse events; less serious adverse events that affect tolerability; minor adverse events; negative effects of the intervention on quality of life; barriers and inconveniences associated with treatment; and other negative aspects of the treatment that may influence decision-making by the patient, the clinician, or both. Some individuals may become anxious, suspicious, or annoyed if asked multiple questions during the evaluation. This could interfere with the therapeutic relationship between the patient and the clinician.”  **Pharmacotherapy**  **Harms**  “The harms of using an antipsychotic medication in the treatment of schizophrenia include sedation, side effects mediated through dopamine receptor blockade (e.g., acute dystonia, akathisia, parkinsonism, tardive syndromes, NMS, hyperprolactinemia), disturbances in sexual function, anticholinergic effects, weight gain, glucose abnormalities, hyperlipidemia, orthostatic hypotension, tachycardia, and QTc prolongation. Clozapine has additional harms associated with its use, including sialorrhea, seizures, neutropenia (which can be severe and life-threatening), myocarditis, and cardiomyopathy. Among the antipsychotic medications, there is variability in the rates at which each of these effects occurs, and no specific medication appears to be devoid of possible side effects.”  **Psychosocial Interventions**  **Harms**  Across all psychosocial interventions recommended, the APA concludes that the potential harms are not well documented but are likely to be minimal.  **2016 Submission:**  “The literature review will include other guidelines addressing the same topic, when available. The work group constructs evidence tables to illustrate the data regarding risks and benefits for each treatment and to evaluate the quality of the data. These tables facilitate group discussion of the evidence and agreement on treatment recommendations before guideline text is written. Evidence tables do not appear in the guideline; however, they are retained by APA to document the development process in case queries are received and to inform revisions of the guideline.” |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | **2020 submission:**  We are not aware of any further systematic reviews or studies published since the publication of this guideline that contraindicate the need for appropriate follow-up after hospitalization for mental illness.  **2016 Submission:**  Numerous (>100) studies related to follow-up for patients with  mental illness have been published since the publication of this guideline, none of which contraindicate the need for appropriate follow-up after hospitalization for mental illness. |

**American Psychiatric Assosciation (APA) Guidelines-Bipolar Disorder**

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| **Source of Systematic Review:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  **Practice Guideline for the Treatment of Patients With Bipolar Disorder, Second Edition**  American Psychiatric Association  2002  American Psychiatric Association (2002) Practice Guideline for the Treatment of Patients With Bipolar Disorder, Second Edition; 2002 Apr. 82 p. https://psychiatryonline.org/pb/assets/raw/sitewide/practice\_guidelines/guidelines/bipolar.pdf |
| Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR. | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  Psychiatric Management [A, C, D, E, F, G]  “Specific goals of psychiatric management include establishing and maintaining a therapeutic alliance, monitoring the patient's psychiatric status, providing education regarding bipolar disorder, enhancing treatment compliance, promoting regular patterns of activity and of sleep, anticipating stressors, identifying new episodes early, and minimizing functional impairments [I].” |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | **2020 submission:**  No updates.  **2016 Submission:**  The evidence base for practice guidelines is derived from two sources: research studies and clinical consensus. Where gaps exist in the research data, evidence is derived from clinical consensus, obtained through broad review of multiple drafts of each guideline (see Section VI). Both research data and clinical consensus vary in their validity and reliability for different clinical situations; guidelines state explicitly the nature of the supporting evidence for specific recommendations so that readers can make their own judgments regarding the utility of the recommendations. The following coding system is used for this purpose:  [A] Randomized, double-blind clinical trial. A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; and both the subjects and the investigators are “blind” to the assignments.  [C] Cohort or longitudinal study. A study in which subjects are prospectively followed over time without any specific intervention.  [D] Control study. A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time.  [E] Review with secondary data analysis. A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis.  [F] Review. A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.  [G] Other. Opinion-like essays, case reports, and other reports not categorized above |
| Provide all other grades and definitions from the evidence grading system | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  The evidence base for practice guidelines is derived from two sources: research studies and clinical consensus. Where gaps exist in the research data, evidence is derived from clinical consensus, obtained through broad review of multiple drafts of each guideline (see Section VI). Both research data and clinical consensus vary in their validity and reliability for different clinical situations; guidelines state explicitly the nature of the supporting evidence for specific recommendations so that readers can make their own judgments regarding the utility of the recommendations. The following coding system is used for this purpose:  [A] Randomized, double-blind clinical trial. A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; and both the subjects and the investigators are “blind” to the assignments.  [A–] Randomized clinical trial. Same as above but not double blind.  [B] Clinical trial. A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally. Does not meet standards for a randomized clinical trial.  [C] Cohort or longitudinal study. A study in which subjects are prospectively followed over time without any specific intervention.  [D] Control study. A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time.  [E] Review with secondary data analysis. A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis.  [F] Review. A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.  [G] Other. Opinion-like essays, case reports, and other reports not categorized above |
| Grade assigned to the **recommendation** with definition of the grade | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  [I] Recommended with substantial clinical confidence. |
| Provide all other grades and definitions from the recommendation grading system | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation: [I] Recommended with substantial clinical confidence. [II] Recommended with moderate clinical confidence. [III] May be recommended on the basis of individual circumstances |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  “A computerized search of the relevant literature from MEDLINE and PsycINFO was conducted. Sources of funding were not considered when reviewing the literature. The first literature search was conducted by searching MEDLINE and PsycINFO for the period from 1992 to 2000. Key words used were “bipolar disorder,” “bipolar depression,” “mania,” “mixed states,” etc. A total of 122 citations were found. A search on PubMed was also conducted through 2001 that used the search terms “electroconvulsive,” “intravenous drug abuse,” “treatment response,” “pharmacogenetic,” “attention deficit disorder,” “violence,” “aggression,” “aggressive,” “suicidal,” “cognitive impairment,” “sleep,” “postpartum,” “ethnic,” “racial,” “metabolism,” “hyperparathyroidism,” “overdose,” “toxicity,” “intoxication,” “pregnancy,” “breast-feeding,” and “lactation.” Additional, less formal, literature searches were conducted by APA staff and individual members of the work group on bipolar disorder” |
| Estimates of benefit and consistency across studies | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  “The literature review will include other guidelines addressing the same topic, when available. The work group constructs evidence tables to illustrate the data regarding risks and benefits for each treatment and to evaluate the quality of the data. These tables facilitate group discussion of the evidence and agreement on treatment recommendations before guideline text is written. Evidence tables do not appear in the guideline; however, they are retained by APA to document the development process in case queries are received and to inform revisions of the guideline.” |
| What harms were identified? | “The literature review will include other guidelines addressing the same topic, when available. The work group constructs evidence tables to illustrate the data regarding risks and benefits for each treatment and to evaluate the quality of the data. These tables facilitate group discussion of the evidence and agreement on treatment recommendations before guideline text is written. Evidence tables do not appear in the guideline; however, they are retained by APA to document the development process in case queries are received and to inform revisions of the guideline.” |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | Numerous (>100) studies related to follow-up for patients with mental illness have been published since the publication of this guideline, none of which contraindicate the need for appropriate follow-up after hospitalization for mental illness. |

**American Psychiatric Assosciation (APA) Guidelines-Major Depressive Disorder**

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| **Source of Systematic Review:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  **Practice Guideline for the Treatment of Patients With Major Depressive Disorder, Third Edition**  American Psychiatric Association  2010  American Psychiatric Association (2010); 2004 Practice Guideline for the Treatsment of Patients With Major Depressive Disorder, Third Edition. 2010 Oct. 151 p.  http://psychiatryonline.org/pb/assets/raw/sitewide/practice\_guidelines/guidelines/mdd.pdf |
| Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR. | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  Psychiatric Management [A, A-, B, C, D, E, F, G]  “Psychiatric management consists of a broad array of interventions and activities that psychiatrists should initiate and continue to provide to patients with major depressive disorder through all phases of treatment [I].”  Acute Phase [A, A-, B, C, D, E, F, G]  “Treatment in the acute phase should be aimed at inducing remission of the major depressive episode and achieving a full return to the patient’s baseline level of functioning [I]. Acute phase treatment may include pharmacotherapy, depression-focused psychotherapy, the combination of medications and psychotherapy, or other somatic therapies such as electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), or light therapy, as described in the sections that follow. Selection of an initial treatment modality should be influenced by clinical features (e.g., severity of symptoms, presence of co-occurring disorders or psychosocial stressors) as well as other factors (e.g., patient preference, prior treatment experiences) [I]. Any treatment should be integrated with psychiatric management and any other treatments being provided for other diagnoses [I].” |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  The evidence base for practice guidelines is derived from two sources: research studies and clinical consensus. Where gaps exist in the research data, evidence is derived from clinical consensus, obtained through broad review of multiple drafts of each guideline (see Section VI). Both research data and clinical consensus vary in their validity and reliability for different clinical situations; guidelines state explicitly the nature of the supporting evidence for specific recommendations so that readers can make their own judgments regarding the utility of the recommendations. The following coding system is used for this purpose:  [A] Randomized, double-blind clinical trial. A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; and both the subjects and the investigators are “blind” to the assignments.  [A–] Randomized clinical trial. Same as above but not double blind.  [B] Clinical trial. A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally. Does not meet standards for a randomized clinical trial.  [C] Cohort or longitudinal study. A study in which subjects are prospectively followed over time without any specific intervention.  [D] Control study. A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time.  [E] Review with secondary data analysis. A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis.  [F] Review. A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.  [G] Other. Opinion-like essays, case reports, and other reports not categorized above |
| Provide all other grades and definitions from the evidence grading system | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  The evidence base for practice guidelines is derived from two sources: research studies and clinical consensus. Where gaps exist in the research data, evidence is derived from clinical consensus, obtained through broad review of multiple drafts of each guideline (see Section VI). Both research data and clinical consensus vary in their validity and reliability for different clinical situations; guidelines state explicitly the nature of the supporting evidence for specific recommendations so that readers can make their own judgments regarding the utility of the recommendations. The following coding system is used for this purpose:  [A] Randomized, double-blind clinical trial. A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; and both the subjects and the investigators are “blind” to the assignments.  [A–] Randomized clinical trial. Same as above but not double blind.  [B] Clinical trial. A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally. Does not meet standards for a randomized clinical trial.  [C] Cohort or longitudinal study. A study in which subjects are prospectively followed over time without any specific intervention.  [D] Control study. A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time.  [E] Review with secondary data analysis. A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis.  [F] Review. A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.  [G] Other. Opinion-like essays, case reports, and other reports not categorized above |
| Grade assigned to the **recommendation** with definition of the grade | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  [I] Recommended with substantial clinical confidence. |
| Provide all other grades and definitions from the recommendation grading system | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation: [I] Recommended with substantial clinical confidence. [II] Recommended with moderate clinical confidence. [III] May be recommended on the basis of individual circumstances |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  Relevant updates to the literature were identified through a MEDLINE literature search for articles published since the second edition of the guideline, published in 2000. For this edition of the guideline, literature was identified through a computerized search of MEDLINE, using PubMed, for the period from January 1999 to December 2006. Using the MeSH headings depression or depressive disorder, as well as the key words major depression, major depressive disorder, neurotic depression, neurotic depressive, dysthymia, dysthymic, etc. yielded 39,157 citations. An additional 8,272 citations were identified by using the key words depression or depressive in combination with the MeSH headings affective disorders or psychotic or psychosis, psychotic, catatonic, catatonia, mood disorder, etc. This yielded 13,506 abstracts, which were screened for relevance with a very modest threshold for inclusion, then reviewed by the Work Group. The Psychoanalytic Electronic Publishing database (http://www.p-e-p.org) was also searched using the terms major depression or major depressive. This search yielded 112 references. The Cochrane databases were also searched for the key word depression, and 168 meta-analyses were identified. Additional, less formal, literature searches were conducted by APA staff and individual Work Group members and included references through May 2009. Sources of funding were considered when the Work Group reviewed the literature. |
| Estimates of benefit and consistency across studies | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  “The literature review will include other guidelines addressing the same topic, when available. The work group constructs evidence tables to illustrate the data regarding risks and benefits for each treatment and to evaluate the quality of the data. These tables facilitate group discussion of the evidence and agreement on treatment recommendations before guideline text is written. Evidence tables do not appear in the guideline; however, they are retained by APA to document the development process in case queries are received and to inform revisions of the guideline.” |
| What harms were identified? | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  “The literature review will include other guidelines addressing the same topic, when available. The work group constructs evidence tables to illustrate the data regarding risks and benefits for each treatment and to evaluate the quality of the data. These tables facilitate group discussion of the evidence and agreement on treatment recommendations before guideline text is written. Evidence tables do not appear in the guideline; however, they are retained by APA to document the development process in case queries are received and to inform revisions of the guideline.” |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | **2020 submission:**  No updates. This guideline has not been updated.  **2016 Submission:**  N/A  Numerous (>100) studies related to follow-up for patients with mental illness have been published since the publication of this guideline, none of which contraindicate the need for appropriate follow-up after hospitalization for mental illness. |

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**1a.4 OTHER SOURCE OF EVIDENCE**

*If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, please describe the evidence on which you are basing the performance measure.*

**1a.4.1** **Briefly SYNTHESIZE the evidence that supports the measure.** A list of references without a summary is not acceptable.

**1a.4.2 What process was used to identify the evidence?**

**1a.4.3.** **Provide the citation(s) for the evidence.**