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Eine systematische Untersuchung der Qualität europäischer Leitlinien im Bereich Psychiatrie

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Meinen Eltern

Inhalt

1. Einleitung

Evidenzbasierte Medizin ist der gewissenhafte, explizite und vernünftige Gebrauch der momentan besten Evidenz für die Entscheidungsfindung zum Wohle des individuellen Patienten [71]. Seit den frühen neunziger Jahren gewinnen die Grundsätze der evidenzbasierten Medizin zunehmend an Bedeutung.

Ein Ansatz, dieses Konzept in die Praxis umzusetzen, liegt in der Anwendung von Leitlinien [37]. Laut Definition des amerikanischen Institute of Medicine sind Leitlinien systematisch entwickelte Statements, deren Ziel es ist, die Entscheidungsfindung sowohl des Arztes als auch des Patienten hinsichtlich der angemessenen Behandlung unter bestimmten klinischen Gegebenheiten zu unterstützen [31].

Die Aufgabe von Leitlinien besteht darin, die zunehmende Menge an medizinischer wissenschaftlicher Evidenz sowie die Expertenmeinung bezüglich eines bestimmten Gesundheitsproblems zu werten, eventuell vorhandene konträre Standpunkte zu klären und in einer Nutzen-Schadenabwägung das Vorgehen der Wahl zu definieren [11].

Anders als Übersichtsarbeiten und HTA-Berichte (Health Technology Assessment) wollen Leitlinien klinisch tätigen Ärzten konkret ausformulierte Entscheidungshilfen bereitstellen [42].

Während der im englischen Sprachraum verwendete Begriff „guidelines“ sowohl für Leitlinien als auch für Richtlinien steht, muß im Deutschen streng unterschieden werden. Richtlinien sind im Gegensatz zu Leitlinien von rechtlich legitimierten Institutionen formulierte Handlungsregeln, die in deren Rechtsraum bindend sind und bei Nichtbeachtung definierte Sanktionen nach sich ziehen [17].

Die Anzahl der veröffentlichten Leitlinien hat in den letzten Jahren auch in Europa stark zugenommen, wodurch der potentielle Anwender mit einer unübersichtlichen

Auswahl an Leitlinien konfrontiert wird: sowohl nationale als auch regionale Organisationen einer Vielzahl europäischer Länder produzieren Leitlinien zu nahezu sämtlichen Themen der verschiedenen medizinischen Fachgebiete [36].

Diverse Gründe können als ursächlich für die zunehmende Bedeutung von Leitlinien angenommen werden: steigende Kosten im Gesundheitssystem, verursacht zum Beispiel durch immer modernere Untersuchungsmethoden und den steigenden Altersdurchschnitt der Bevölkerung; differierende Ansichten über angemessene Behandlung zwischen Politikern, Krankenkassen und den versorgenden Einrichtungen; und auch der Wunsch von Seiten der Ärzte und der Patienten auf bestmögliche Behandlung [102].

Obwohl von mehreren Autoren grundlegende Kriterien für die Entwicklung von Leitlinien definiert wurden [46, 81], kann nicht grundsätzlich davon ausgegangen werden, daß diese Prinzipien bei allen Leitlinien produzierenden Organisationen Berücksichtigung finden. Bisher durchgeführte Untersuchungen weisen darauf hin, daß die Qualität von Leitlinien aus unterschiedlichen Fachgebieten der Medizin oft nicht befriedigend ist beziehungsweise zwischen den Leitlinien unterschiedlicher Organisationen stark variiert [12, 18, 19, 34, 35, 40, 50, 80].

Um als reliabel und valide zu gelten und dadurch zum intendierten Ergebnis zu führen, müssen die in den Leitlinien gegebenen Empfehlungen evidenzbasiert sein [15], was bei einer großen Anzahl der in den oben genannten Studien evaluierten Leitlinien aufgrund erheblicher Defizite in der Systematik des Entwicklungsprozesses jedoch nicht der Fall war. Die praktische Anwendung von Leitlinien, deren Empfehlungen nicht evidenzbasiert sind, kann zu suboptimaler und potentiell gefährlicher Behandlung führen [103].

Auch im Bereich der Psychiatrie nehmen Leitlinien seit den späten achtziger Jahren an Bedeutung und Anzahl zu. Bislang wurden jedoch noch keine Studien durchgeführt, die gezielt die Qualität von psychiatrischen Leitlinien untersuchten.

Mit dieser Arbeit, in der die Qualität von psychiatrischen Leitlinien verschiedener nationaler Organisationen aus insgesamt 14 europäischen Ländern anhand des Appraisal of Guidelines for Research and Evaluation (AGREE) Instrument [95] evaluiert wird, soll diese Lücke geschlossen werden.

2. Material und Methoden

2.1 Identifizierung der Leitlinien

Folgende Suchstrategie wurde verwendet, um die relevanten europäischen Leitlinien aus dem Bereich der Psychiatrie zu identifizieren: Drei Briefrunden wurden in den Jahren 2001, 2002 und 2003 an sämtliche europäische nationale psychiatrische Gesellschaften sowie weitere Organisationen, die möglicherweise Leitlinien herausgeben, wie zum Beispiel Gesundheitsministerien und Health Techonology Assessment Center, versandt. In diesen Anschreiben wurde um Zusendung bzw. Nennung aller Leitlinien aus dem Bereich der Psychiatrie des jeweiligen Landes gebeten. Bei Ausbleiben einer Reaktion auf diese Briefe von Seiten der angeschriebenen Gesellschaften wurde telefonischer Kontakt zu den zuständigen Personen der betreffenden Organisationen hergestellt und auf diese Weise nochmals an die Bearbeitung des Anschreibens erinnert.

Zusätzlich erfolgte eine MEDLINE-Recherche sowie eine umfangreiche Internetrecherche auf Deutsch und Englisch mit den Suchbegriffen „Leitlinien“, „guidelines“ sowie den verschiedenen psychiatrischen Diagnosen (z. B. „Schizophrenie“, „Demenz“ bzw. „schizophrenia“, „dementia“). Die Internetseiten von Leitlinien produzierenden Gesellschaften wurden nach Leitlinien sowie nach Links auf weitere Seiten durchsucht.

Außerdem wurde die Publikation „Guidelines in mental health: a bibliography“ des College Research Unit, London [98], durchgesehen und die relevanten Leitlinien bei den Fachgesellschaften angefordert oder im Buchhandel erworben.

Eingeschlossen wurden alle Leitlinien aus dem Bereich der Psychiatrie, die von nationalen Organisationen (psychiatrische Fachgesellschaften oder andere nationale Leitlinien produzierende Institutionen) entwickelt wurden und im Jahr 1998 oder später publiziert wurden.

Ausgeschlossen wurden regionale oder lokale Leitlinien. Ebenfalls ausgeschlossen wurden Publikationen, die vor 1998 veröffentlich wurden, da diese aufgrund des Alters eventuell nicht nach inzwischen etablierten qualitativen Standards entwickelt wurden und so das Ergebnis verfälschen könnten. Nicht in dieser Untersuchung berücksichtigt wurden zudem Leitlinien, die sich vorwiegend mit Syndromen (z. B. Umgang mit suizidalen Tendenzen) oder auch mit der Organisation der Behandlung (z. B. Behandlung auf geschlossenen Stationen) befaßten.

2.2 Bewertung der Leitlinien anhand des AGREE-Instruments

Die Bewertung der Leitlinien erfolgte mit der englischen Version des Appraisal of Guidelines for Research and Evaluation (AGREE) Instrument [95]. Das AGREE Instrument wurde von der AGREE Collaboration, einer internationalen Expertengruppe, entwickelt [96]. Ziel war dabei, eine Qualitätsbeurteilung von Leitlinien zu ermöglichen. Dieses Instrument bewertet den Prozeß der Leitlinienentwicklung und das Ausmaß der Dokumentation dieses Prozesses, nicht aber den Inhalt der Leitlinie oder die den Empfehlungen zugrunde liegende Evidenzqualität. Die internale Konsistenz des Instruments lag bei Cronbach alpha-Werten zwischen 0.64 und 0.88 in einem befriedigenden Bereich [96].

Die in dieser Arbeit verwendete deutsche Übersetzung der Titel der Domänen und der Items basiert auf der inzwischen zur Verfügung stehenden deutschen Version des AGREE Instruments (siehe Anhang, S. 62).

Jede Leitlinie wurde von zwei unabhängigen Untersuchern evaluiert. Bei Leitlinien, die nicht auf Deutsch, Englisch, Französisch oder Italienisch verfaßt waren, wurden muttersprachliche Psychiater gebeten, die jeweilige Leitlinie zu bewerten und dabei jedem Item ein Zitat der relevanten Textstelle sowie eine Erklärung der Entscheidungsfindung beizufügen. Im Anschluß erfolgte eine ausführliche Telefonkonferenz mit dem jeweiligen ausländischen Bewerter, in der die Bewertung jedes Items und die vergebenen Punktzahlen ausführlich diskutiert wurden.

Das AGREE Instrument besteht aus 23 Items, die in die folgenden sechs Domänen unterteilt sind. Jede Domäne bewertet dabei einen bestimmten Teilbereich der Qualität einer Leitlinie.

1. Geltungsbereich und Zweck (scope and purpose), Item 1 – 3: hier wird überprüft, ob in der jeweiligen Leitlinie die Ziele, der Anwendungsbereich sowie die Zielpopulation beschrieben werden.

2. Beteiligung von Interessengruppen (stakeholder involvement), Item 4 – 7: diese Untergruppe fragt nach dem Maß der Einbeziehung verschiedener für die Erstellung der Leitlinie relevanter Berufsgruppen.

3. Methodologische Exaktheit der Leitlinienentwicklung (rigour of development), Item 8 – 14: in diesem Teilbereich wird die Methodik des Entstehungsprozesses der Leitlinie betrachtet.

4. Klarheit und Gestaltung (clarity and presentation), Item 15 – 18: diese Fragen beschäftigen sich mit der optischen und sprachlichen Darstellung der Empfehlungen.

5. Anwendbarkeit (applicability), Item 19 – 21: hier werden mögliche Anwendungshindernisse im Kosten- und Organisationsbereich überprüft.

6. Redaktionelle Unabhängigkeit (editorial independence), Item 22 – 23: mit diesen Items kann die Unabhängigkeit von Geldgebern bzw. Interessenskonflikte bei der Erstellung der Leitlinie beurteilt werden.

Das AGREE Instrument wurde durch vier zusätzliche Items ergänzt, die in die jeweils passenden Domänen eingefügt wurden.

12a: Die Leitlinien beinhaltet aktuelle Evidenz, die einen wichtigen Einfluß auf die Maßnahmen haben kann.

16a: In der Leitlinie werden Maßnahmen erwähnt, die unpassend, unnötig oder obsolet sind.

19a: Nationale Besonderheiten werden in der Leitlinie berücksichtigt.

21a: Die Leitlinie beschreibt Methoden, die dazu geeignet sind herauszufinden, in welchem Ausmaß und von wem die Empfehlungen in der Praxis genutzt werden.

Jedes Item des Fragebogens wird auf einer vierstufigen Likert-Skala bewertet. „1“ bedeutet dabei „trifft überhaupt nicht zu“, „2“ „trifft nicht zu,“, „3“ „trifft zu“ und „4“ „trifft uneingeschränkt zu“.
Sind in der Leitlinie keine Informationen zu einem bestimmten Bereich vorhanden, muß die Frage mit „1“ (trifft überhaupt nicht zu) beurteilt werden.

Für jede der sechs Domänen wurde der standardisierte Domänenwert mit folgender Formel berechnet:
[(erreichte Punktzahl - minimal mögliche Punktzahl) / (maximal mögliche Punktzahl - minimal mögliche Punktzahl)] x 100 (siehe Abb. 1).

Abbildung 1: Beispiel für die Berechnung des Domänenwertes einer Domäne mit drei Items

	Item 1	Item 2	Item 3	Summe
Bewerter 1	2	1	3	6
Bewerter 2	3	1	4	8
Summe	5	2	7	**14**

Maximal mögliche Punktzahl: 3 (Items) x 4 (Punkte) x 2 (Bewerter) = 24
Minimal mögliche Punktzahl: 3 (Items) x 1 (Punkt) x 2 (Bewerter) = 6
Standardisierter Domänenwert:
[(14 – 6) / (24 – 6)] x 100 = 44,4%

Der niedrigste erzielbare Domänenwert liegt bei 0%, der höchste bei 100%. Die Domänenwerte der sechs einzelnen Domänen sollen laut Anweisung des AGREE Instruments unabhängig voneinander betrachtet werden, ein Gesamtwert soll nicht gebildet werden.

Am Ende des Instruments besteht die Möglichkeit, die Gesamtqualität der Leitlinie zu einzuschätzen. Der Bewerter kann zwischen vier Beurteilungen wählen: „Nachdrücklich zu empfehlen“, „Zu empfehlen (unter Vorbehalt, nach Änderung)“, „Nicht zu empfehlen“ und „Unsicher“.

2.3 Auswertung der Ergebnisse

2.3.1 Vergleich der Leitlinien nach Diagnosen, Ländern und Publikationsjahren

Jede der Leitlinien wurde mit dem AGREE Instrument sowie den vier zusätzlichen Items bewertet. Für jede der sechs Domänen des AGREE Instruments wurde anschließend der standardisierte Domänenwert berechnet.

Nach der Bewertung mit dem AGREE Instrument wurden die Leitlinien nach Diagnosen, Ländern sowie Publikationsjahr sortiert, die Qualität innerhalb der jeweiligen Gruppen verglichen und zur Veranschaulichung in Diagrammen dargestellt.

2.3.2 Dichotomisierung der Items

Für weitere Auswertungen wurden alle 23 Items des AGREE Instruments sowie die vier zusätzlichen Items dichotomisiert. Eine Wertung von drei oder vier Punkten auf der vierstufigen Likert-Skala wurde als positive Bewertung des Items angesehen, Wertungen von einem oder zwei Punkten als negativ. Wurde ein Item also mit einem oder zwei Punkten bewertet, zählte es als nicht erfüllt. Bei einer Bewertung mit drei oder vier Punkten wurde ein Item als erfüllt betrachtet. Der Schwerpunkt lag dabei auf den sieben Items der Domäne „Methodologische Exaktheit der Leitlinienentwicklung“, da das Hauptinteresse der Frage galt, inwieweit die Leitlinien gemäß den Vorgaben der evidenzbasierten Medizin entwickelt wurden. Leitlinien, die diese Voraussetzung nicht erfüllen, können nicht als verläßliche Grundlage des medizinischen Entscheidungsprozesses angesehen werden.

2.3.3 Erstellung von „Structured guideline summaries“

Für jede der 61 Leitlinien wurde im Anschluß an die Bewertung mit dem AGREE Instrument eine als „Structured guideline summary“ bezeichnete Zusammenfassung auf Englisch verfaßt (siehe Anhang, S.72 ff). Diese Zusammenfassungen beinhalten unter anderem die genaue Referenz der jeweiligen Leitlinie, ein Inhaltsverzeichnis sowie eine detaillierte Beschreibung der Qualität, bei der auf die einzelnen Items des AGREE Instruments eingegangen wird. Zusätzlich bietet jedes „Summary“ eine kurze Gesamtbeurteilung, in der begründet wird, ob die Leitlinie empfohlen werden kann oder nicht.

Die meisten dieser „Structured guideline summaries“ sind im Rahmen des „EU-PSI Project“ [27] Teil der „Mental health library“ und sollen potentiellen Leitliniennutzern einen raschen Überblick über die verschiedenen Publikationen ermöglichen.

2.3.4 Statistische Auswertung

Aufgrund der zum Teil sehr kleinen Stichprobe der Leitlinien, sowohl bei der Aufteilung in die unterschiedlichen Diagnosen als auch in die Ursprungsländer, erfolgte die Auswertung der Ergebnisse in den meisten Kategorien nur qualitativ.

Bezüglich der sechs Publikationsjahre (1998 – 2003) interessierte die Frage, ob sich die Qualität der Leitlinien neueren Datums im Vergleich mit älteren Publikationen verbessert hat. Zur statistischen Analyse von Alterseffekten wurde die Korrelation nach Spearman ermittelt sowie der exakte Test nach Fisher durchgeführt. Die statistische Auswertung wurde mit SPSS (Version 11.5) durchgeführt, zur graphischen Darstellung kam Microsoft Excel für Windows XP zur Anwendung.

3. Ergebnisse

3.1 Bewertete Leitlinien

61 nationale Leitlinien im Bereich Psychiatrie aus 14 europäischen Ländern (Deutschland n = 11, Großbritannien n = 7, Tschechien n = 8, Frankreich n = 6, Schweden n = 5, Dänemark n = 5, Niederlande n = 5, Finnland n = 3, Italien n = 3, Norwegen n = 3, Österreich n = 2, Belgien n = 1, Ungarn n = 1, Slowenien n = 1) wurden erfaßt.

Diese 61 Leitlinien deckten folgende Diagnosen ab: Schizophrenie n = 15, affektive Erkrankungen n = 8, Angst- und Zwangsstörungen n = 8, Demenz n = 6, Krankheiten aus dem Bereich der Kinder- und Jugendpsychiatrie n = 5, Essstörungen n = 3, Elektrokonvulsivtherapie n = 3, Behandlung mit Antipsychotika n = 3, Substanzmissbrauch n = 2, andere Diagnosen (z. B. „Psychische Krankheiten mit organischer Ursache“) n = 8.

35 Leitlinien zur Behandlung verschiedener Erkrankungen aus dem Bereich der Kinder- und Jugendpsychiatrie, die in einem von der deutschen Gesellschaft für Kinder- und Jugendpsychiatrie herausgegebenen Buch veröffentlicht sind und denen ein identischer Entwicklungsprozeß zugrunde liegt, wurden als eine Leitlinie betrachtet, um eine Überrepräsentation und damit eine mögliche Ergebnisverfälschung zu vermeiden.

3.2 Domänenwerte der einzelnen Leitlinien, geordnet nach Diagnosen

Die Tabellen 1-10 zeigen die Domänenwerte der einzelnen Leitlinien sortiert nach Diagnosen sowie die Mittelwerte der Domänenwerte der Leitlinien:

Tabelle 1: Standardisierte Domänenwerte (%) der Leitlinien zur Schizophrenie (n=15)

	Geltungsbereich und Zweck	Beteiligung von Interessengruppen	Methodologische Exaktheit der Leitlinienentwicklung	Klarheit und Gestaltung	Anwendbarkeit	Redaktionelle Unabhängigkeit
Deutschland [22]	22.2	16.7	41.7	73.3	13.3	0
Großbritannien [76]	11.1	58.3	100.0	80.0	46.7	50.0
Großbritannien [56]	55.6	75.0	83.3	73.3	46.7	83.3
Tschechien [51]	33.3	41.7	62.5	60.0	53.3	0
Frankreich [29]	56.0	75.0	42.0	53.0	27.0	0
Schweden [94]	11.1	25.0	25.0	46.7	20.0	0
Schweden [73]	22.2	0	50.0	26.7	13.3	0
Dänemark [58]	11.1	0	12.5	26.7	46.7	0
Niederlande [16]	33.3	8.3	41.7	66.7	13.3	66.7
Finnland [91]	22.2	25.0	83.3	93.3	13.3	100.0
Italien [60]	44.4	16.7	8.3	53.3	0	0
Norwegen [85]	11.1	8.3	25.0	33.3	6.7	0
Österreich [48]	44.4	33.3	58.3	100.0	6.7	0
Belgien [20]	66.7	58.3	33.3	53.3	20.0	50.0
Slowenien [49]	22.2	0	33.3	73.3	13.3	16.7
Mittelwert (± SD)	**31.1** (± 18.4)	**29.4** (± 26.5)	**46.7** (± 26.6)	**60.9** (± 22.2)	**22.7** (± 17.2)	**24.4** (± 35.6)

SD = Standardabweichung

Tabelle 2: Standardisierte Domänenwerte (%) der Leitlinien zu affektiven Erkrankungen (n=8)

	Geltungsbereich und Zweck	Beteiligung von Interessengruppen	Methodologische Exaktheit der Leitlinienentwicklung	Klarheit und Gestaltung	Anwendbarkeit	Redaktionelle Unabhängigkeit
Deutschland [26]	22.2	25.0	41.7	80.0	13.3	0
Tschechien [101]	33.3	41.7	62.5	66.7	13.3	0
Frankreich [4, 7]	89.0	50.0	83.0	73.0	20.0	0
Schweden [93]	22.2	25.0	29.2	26.7	40.0	0
Schweden [72]	33.3	0	50.0	13.3	20.0	0
Niederlande [57]	22.2	0	54.2	73.3	13.3	66.7
Italien [82]	22.0	33.0	29.0	40.0	7.0	0
Österreich [47]	22.2	25.0	20.9	66.7	40.0	0
Mittelwert (± SD)	**33.3** (± 23.1)	**25.0** (± 17.8)	**46.3** (± 20.5)	**55.0** (± 24.9)	**20.9** (± 12.5)	**8.3** (± 23.6)

SD = Standardabweichung

Tabelle 3: Standardisierte Domänenwerte (%) der Leitlinien zu Angst- und Zwangsstörungen (n=8)

	Geltungsbereich und Zweck	Beteiligung von Interessengruppen	Methodologische Exaktheit der Leitlinienentwicklung	Klarheit und Gestaltung	Anwendbarkeit	Redaktionelle Unabhängigkeit
Deutschland [24]	11.1	25.0	54.2	86.7	6.7	33.3
Deutschland [9]	55.6	41.7	87.5	93.3	6.7	50.0
Tschechien [53, 64, 65, 66]	33.3	41.7	62.5	63.3	60.0	0
Tschechien [67]	33.3	41.7	62.5	66.7	33.3	0
Frankreich [4, 6]	67.0	50.0	79.0	87.0	13.0	0
Niederlande [99]	33.3	8.3	54.2	73.3	6.7	66.7
Finnland [90]	44.4	25.0	16.7	40.0	20.0	0
Norwegen [84]	22.2	8.3	45.8	46.7	20.0	0
Mittelwert (± SD)	**37.5** (± 17.8)	**30.2** (± 16.0)	**57.8** (± 21.5)	**69.2** (± 19.5)	**18.3** (± 12.7)	**18.8** (± 27.4)

SD = Standardabweichung

Tabelle 4: Standardisierte Domänenwerte (%) der Leitlinien zu anderen Diagnosen (n=8)

	Geltungsbereich und Zweck	Beteiligung von Interessengruppen	Methodologische Exaktheit der Leitlinienentwicklung	Klarheit und Gestaltung	Anwendbarkeit	Redaktionelle Unabhängigkeit
Deutschland [69]	44.4	41.7	100.0	73.3	0	50.0
Deutschland [68]	33.3	25.0	87.5	86.7	0	50.0
Deutschland [70]	33.3	8.3	95.8	66.7	0	50.0
Großbritannien [77, 79]	33.0	83.0	100.0	93.0	33.0	50.0
Tschechien [62]	33.3	25.0	50.0	66.7	20.0	0
Schweden [92]	22.2	16.7	25.0	40.0	20.0	0
Dänemark [88]	44.4	33.3	12.5	46.7	0	0
Ungarn [1]	22.2	33.3	20.8	46.7	33.3	0
Mittelwert (± SD)	**33.3** (± 8.4)	**33.3** (± 22.6)	**61.5** (±38.4)	**65.0** (± 19.4)	**13.3** (± 15.1)	**25.0** (± 26.7)

SD = Standardabweichung

Tabelle 5: Standardisierte Domänenwerte (%) der Leitlinien zur Demenz (n=6)

	Geltungsbereich und Zweck	Beteiligung von Interessengruppen	Methodologische Exaktheit der Leitlinienentwicklung	Klarheit und Gestaltung	Anwendbarkeit	Redaktionelle Unabhängigkeit
Deutschland [23]	22.2	16.7	37.5	80.0	13.3	0
Deutschland [10]	55.6	41.7	79.2	80.0	20.0	0
Großbritannien [8]	33.3	25.0	8.3	80.0	26.7	0
Großbritannien [75]	22.2	58.3	100.0	93.3	33.3	50.0
Frankreich [4, 5]	33.3	33.3	75.0	33.3	13.3	0
Italien [97]	22.2	33.3	33.3	53.3	0	0
Mittelwert (± SD)	**31.5** (± 13.0)	**34.7** (± 14.4)	**55.6** (± 34.5)	**80.0** (± 14.6)	**17.8** (± 11.7)	**16.7** (± 25.8)

SD = Standardabweichung

Tabelle 6: Standardisierte Domänenwerte (%) der Leitlinien zur Kinder- und Jugendpsychiatrie (n=5)

	Geltungsbereich und Zweck	Beteiligung von Interessengruppen	Methodologische Exaktheit der Leitlinienentwicklung	Klarheit und Gestaltung	Anwendbarkeit	Redaktionelle Unabhängigkeit
Deutschland [21]	33.3	16.7	58.3	80.0	0	50.0
Großbritannien [77, 78]	11.1	58.3	100.0	80.0	26.7	50.0
Tschechien [43]	33.3	41.7	37.5	60.0	0	0
Dänemark [87]	44.4	33.3	12.5	46.7	0	0
Niederlande [13]	44.4	41.7	45.8	66.7	13.3	66.7
Mittelwert (± SD)	**33.3** (± 13.6)	**38.3** (± 15.1)	**50.8** (± 32.2)	**66.7** (± 14.1)	**8.0** (± 11.9)	**33.3** (± 31.2)

SD = Standardabweichung

Tabelle 7: Standardisierte Domänenwerte (%) der Leitlinien zur Behandlung mit Antipsychotika (n=3)

	Geltungsbereich und Zweck	Beteiligung von Interessengruppen	Methodologische Exaktheit der Leitlinienentwicklung	Klarheit und Gestaltung	Anwendbarkeit	Redaktionelle Unabhängigkeit
Großbritannien [55]	33.3	66.7	87.5	53.3	66.7	83.3
Dänemark [33]	22.2	0	37.5	26.7	0	0
Dänemark [89]	44.4	33.3	12.5	46.7	0	0
Mittelwert (± SD)	**33.3** (± 11.1)	**33.3** (± 33.3)	**45.8** (± 38.2)	**42.2** (± 13.9)	**22.2** (± 38.5)	**27.8** (± 48.1)

SD = Standardabweichung

Tabelle 8: Standardisierte Domänenwerte (%) der Leitlinien zu Eßstörungen (n=3)

	Geltungsbereich und Zweck	Beteiligung von Interessengruppen	Methodologische Exaktheit der Leitlinienentwicklung	Klarheit und Gestaltung	Anwendbarkeit	Redaktionelle Unabhängigkeit
Deutschland [25]	11.1	8.3	25.0	66.7	6.7	0
Tschechien [61]	33.3	41.7	62.5	60.0	26.7	0
Norwegen [83]	33.3	58.3	37.5	60.0	20.0	0
Mittel-Wert (± SD)	**25.9** (± 12.8)	**36.1** (± 25.5)	**41.7** (± 19.1)	**62.2** (± 3.9)	**17.8** (± 10.2)	**0** (± 0)

SD = Standardabweichung

Tabelle 9: Standardisierte Domänenwerte (%) der Leitlinien zur EKT (n=3)

	Geltungsbereich und Zweck	Beteiligung von Interessengruppen	Methodologische Exaktheit der Leitlinienentwicklung	Klarheit und Gestaltung	Anwendbarkeit	Redaktionelle Unabhängigkeit
Tschechien [44]	33.3	25.0	62.5	66.7	6.7	0
Frankreich [2, 3]	77.8	25.0	87.5	86.7	6.7	0
Niederlande [100]	33.3	25.0	62.5	66.7	26.7	66.7
Mittelwert (± SD)	**48.2** (± 25.7)	**25.0** (± 0)	**70.8** (± 14.4)	**73.3** (± 11.6)	**13.3** (± 11.6)	**22.2** (± 38.5)

SD = Standardabweichung

Tabelle 10: Standardisierte Domänenwerte (%) der Leitlinien zum Substanzmißbrauch (n=2)

	Geltungsbereich und Zweck	Beteiligung von Interessengruppen	Methodologische Exaktheit der Leitlinienentwicklung	Klarheit und Gestaltung	Anwendbarkeit	Redaktionelle Unabhängigkeit
Frankreich [28]	33.3	25.0	37.5	46.7	26.7	0
Finnland [45]	33.3	16.7	12.5	26.7	33.3	0
Mittelwert (± SD)	**33.3** (± 0)	**20.8** (± 5.9)	**25.0** (± 17.7)	**36.7** (± 14.1)	**30.0** (± 4.7)	**0** (± 0)
Mittelwert aller Leitlinien (± SD)	**33.5** (± 16.2)	**30.7** (± 20.0)	**51.4** (± 27.6)	**63.1** (± 20.4)	**18.5** (± 15.4)	**19.7** (± 29.3)

SD = Standardabweichung

Mittelt man alle Leitlinien, so wurde der höchste mittlere Domänenwert in der Domäne „Klarheit der Präsentation“ erzielt (Domänenwert 63.1%, SD = 20.4), den zweithöchsten Wert zeigte die Domäne „Methodologische Exaktheit der Leitlinienentwicklung“ (51.4%, SD = 27.6). Am niedrigsten waren die durchschnittlichen Domänenwerte in den Domänen „Anwendbarkeit“ (18.5%, SD = 15.4) und „Redaktionelle Unabhängigkeit“ (19.7%, SD = 29.3).
Im mittleren Bereich lagen die Domänenwerte in den Untergruppen „Geltungsbereich und Zweck“ (33.5%, SD = 16.2) und „Beteiligung von Interessengruppen“ (30.7%, SD = 20.0).

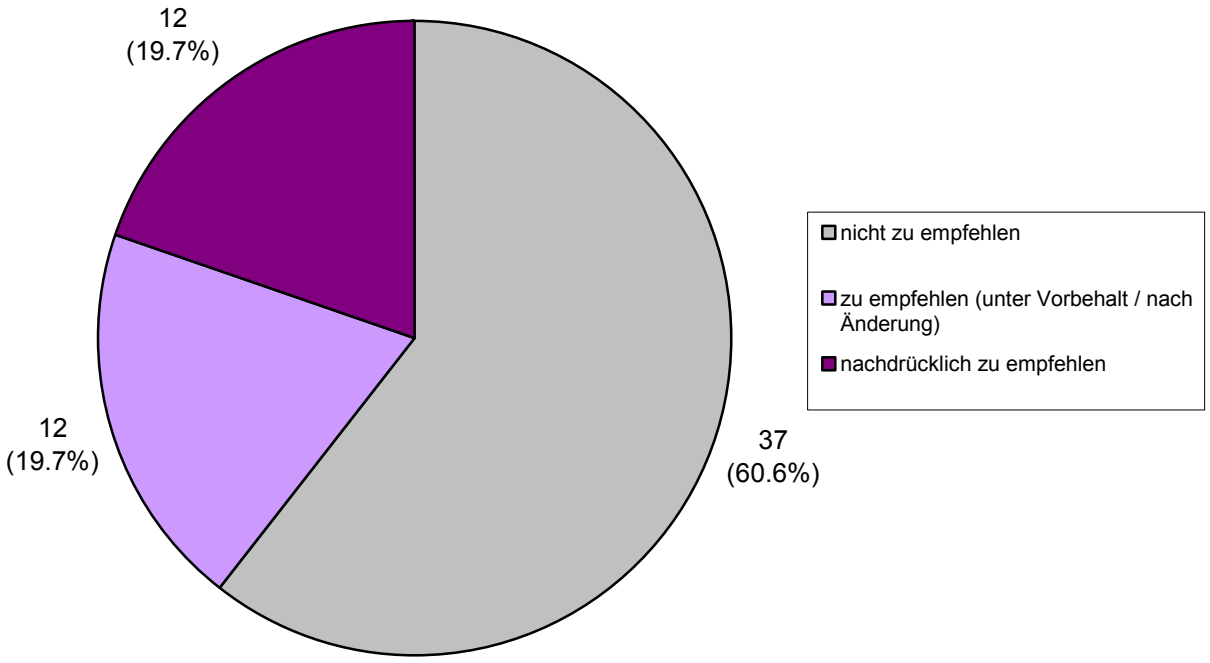
Der Vergleich der mittleren Domänenwerte der verschiedenen Diagnosen läßt keine eindeutigen Tendenzen hinsichtlich qualitativer Unterschiede erkennen: sowohl die Leitlinien zur Elektrokonvulsivtherapie (n = 3) als auch die Leitlinien zur Kinder- und Jugendpsychiatrie (n = 5) erzielten in zwei Domänen den jeweils höchsten mittleren Domänenscore, aufgrund der geringen Anzahl der Leitlinien kann daraus keine Aussage zur besonders hohen Qualität abgeleitet werden.

Umgekehrt gilt das gleiche für die Leitlinien zum Substanzmissbrauch (n = 3), die in vier Domänen den niedrigsten mittleren Domänenwert erhielten.

3.3 Gesamtbewertung

Nach den Vorgaben des AGREE Instruments wurde jede der 61 Leitlinien nach Bewertung der einzelnen Items einer Gesamtbewertung unterzogen.

Abbildung 2: Gesamtbewertung der Leitlinien

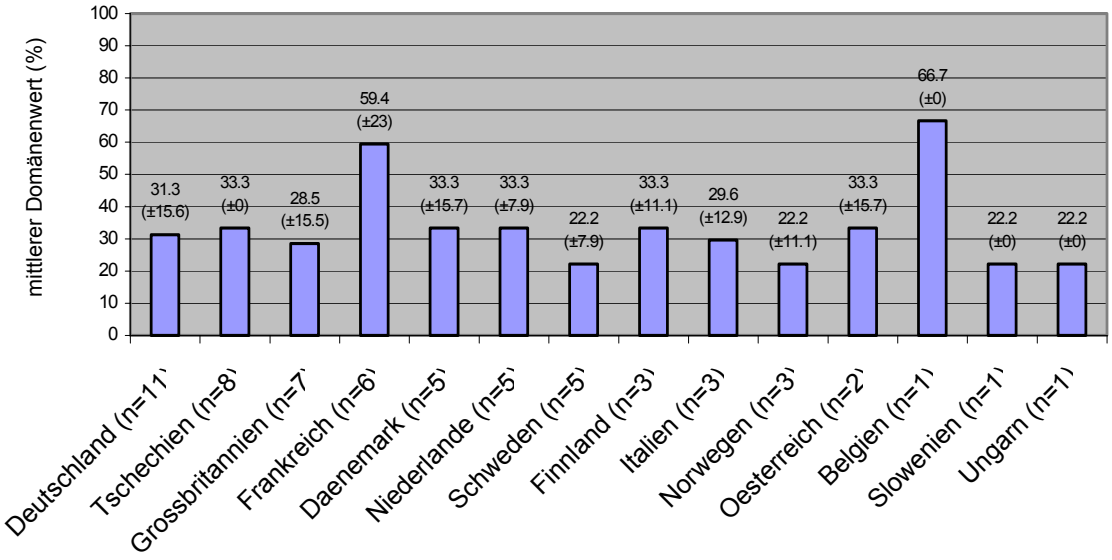


Mehr als die Hälfte der bewerteten Leitlinien wurde mit „Nicht zu empfehlen“ beurteilt, ungefähr ein fünftel der Leitlinien erhielt das Urteil „Zu empfehlen (unter Vorbehalt / nach Änderung)“ und lediglich ein fünftel konnte als „Nachdrücklich zu empfehlen“ bezeichnet werden.

3.4 Vergleich der Leitlinien, geordnet nach Ländern

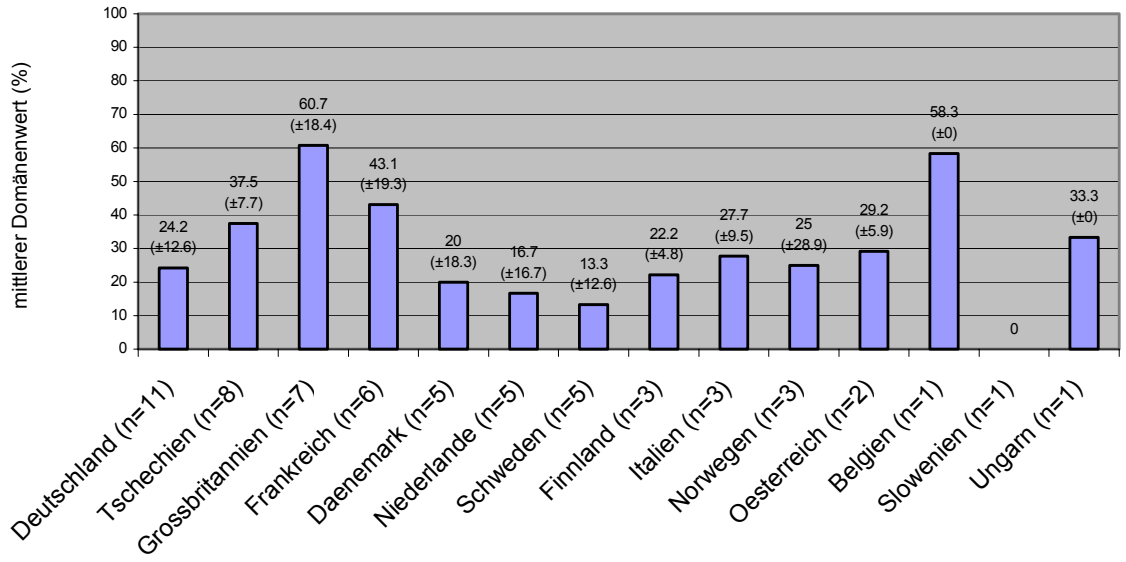
In den Abbildungen 3-8 werden die mittleren durchschnittlichen Domänenwerte der sechs Domänen nach Ländern geordnet dargestellt.

Abbildung 3: Domäne 1 (Geltungsbereich und Zweck)



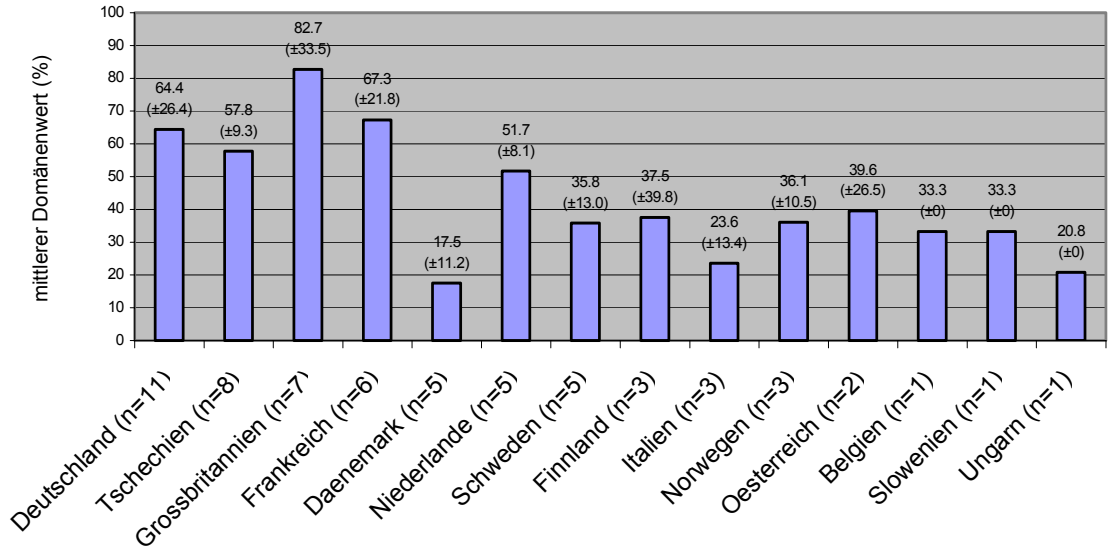
Den höchsten mittleren Domänenwert (66.7%) erzielte die belgische Leitlinie, Schweden, Norwegen, Slowenien und Ungarn erhielten die niedrigsten Werte (22.2%).

Abbildung 4: Domäne 2 (Beteiligung von Interessengruppen)



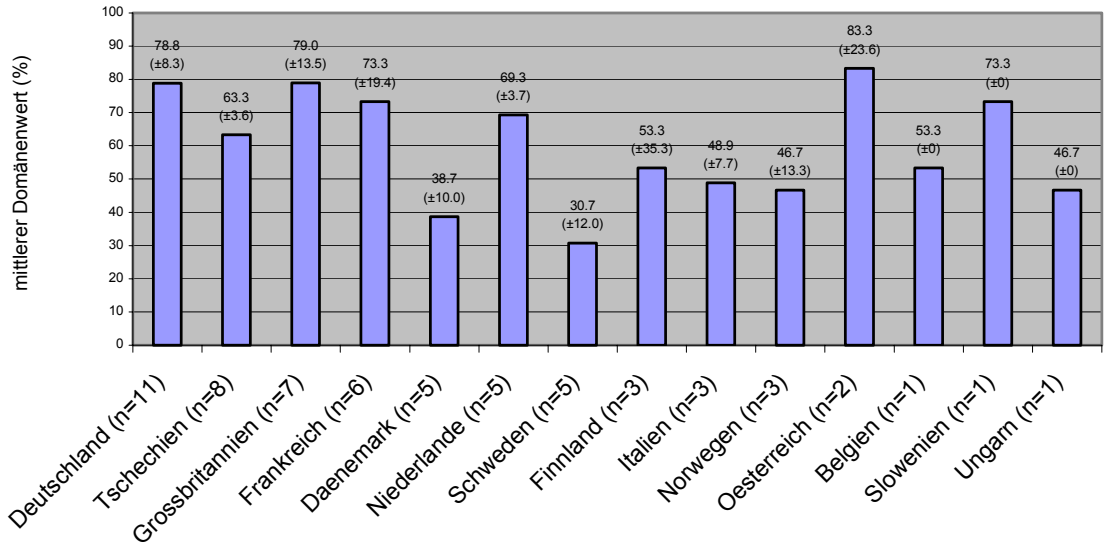
Den höchsten mittleren Domänenwert (60.7%) erreichten die Leitlinien aus Großbritannien, den geringsten (0%) die slowenische Leitlinie.

Abbildung 5: Domäne 3 (Methodologische Exaktheit der Leitlinienentwicklung)



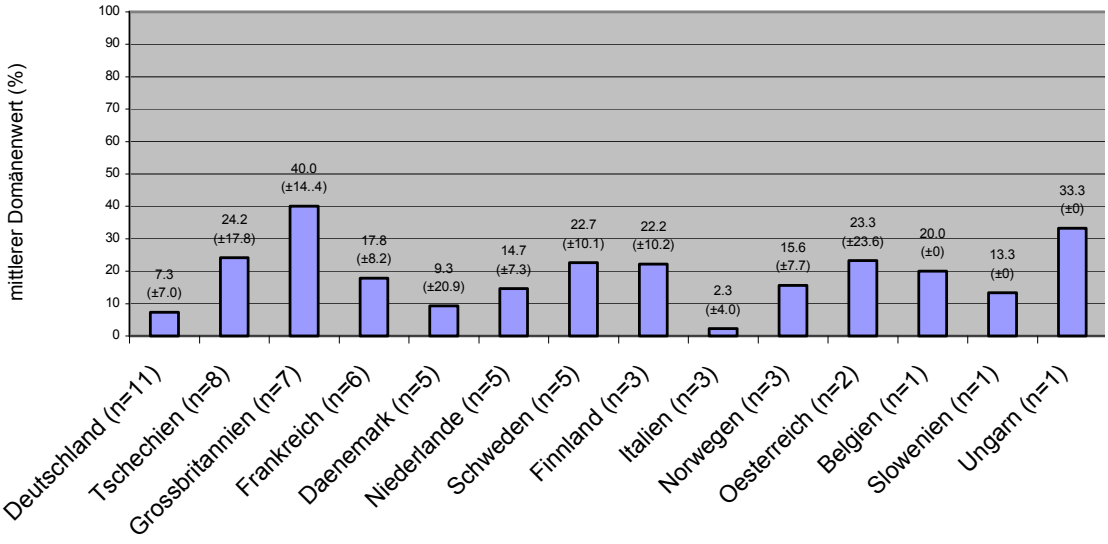
Die Leitlinien aus Großbritannien erzielten den höchsten mittleren Domänenwert (82.7%), die dänischen Leitlinien den niedrigsten (17.5%).

Abbildung 6: Domäne 4 (Klarheit und Gestaltung)



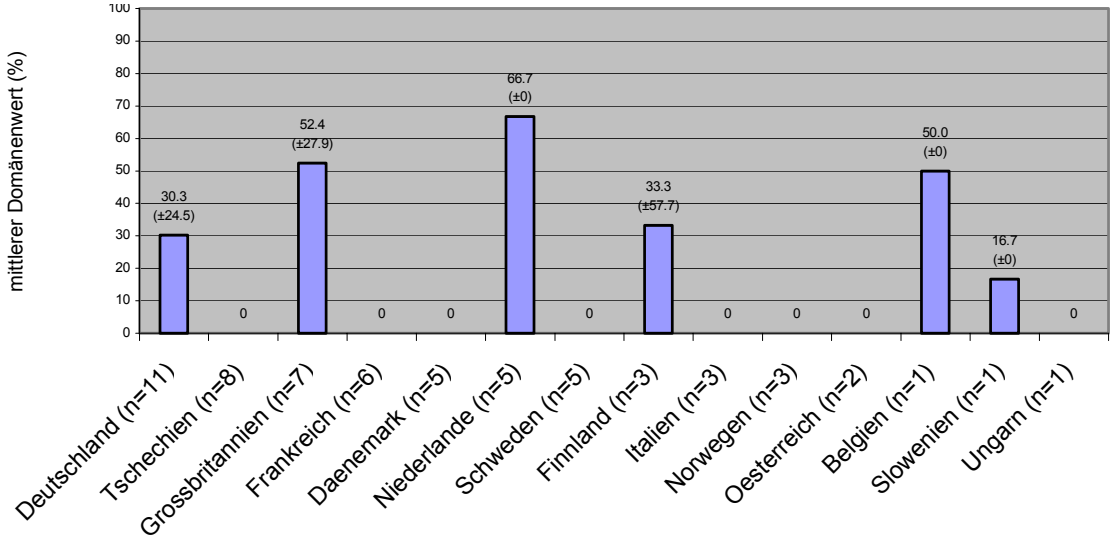
Die österreichischen Leitlinien erhielten den höchsten mittleren Domänenwert (83.3%), die schwedischen den niedrigsten (30.7%).

Abbildung 7: Domäne 5 (Anwendbarkeit)



Den höchsten mittleren Domänenwert erreichten die Leitlinien aus Großbritannien (40%), den niedrigsten die Leitlinien aus Italien (2.3%).

Abbildung 8: Domäne 6 (Redaktionelle Unabhängigkeit)



Die Leitlinien aus den Niederlanden erzielten den höchsten mittleren Domänenwert (66.7%), die Leitlinien aus Tschechien, Frankreich, Dänemark, Schweden, Italien, Norwegen, Österreich und Ungarn jeweils den niedrigsten (0%).

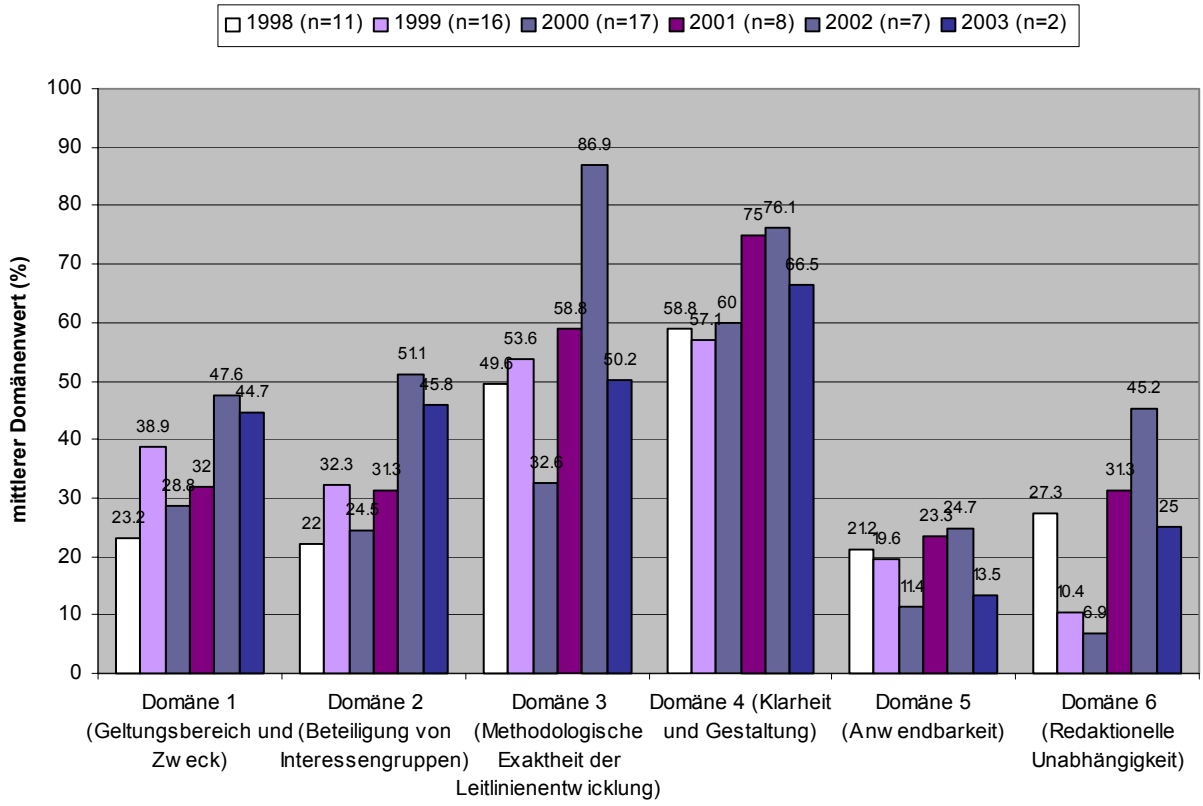
Insgesamt ergibt sich im Qualitätsvergleich der Leitlinien der unterschiedlichen Länder ein heterogenes Bild. Keines der Länder kann eindeutig als das die besten Leitlinien produzierendes bezeichnet werden.

Im Qualitätsvergleich stechen am ehesten die Leitlinien aus Großbritannien hervor, die in den Domänen 2, 3 und 5 den jeweils höchsten Wert erzielten. Dieses Ergebnis konnten die britischen Leitlinien jedoch nicht in den drei übrigen Domänen erzielen.

Eher unbefriedigende Qualität zeigten die Leitlinien aus Slowenien, die in zwei der sechs Domänen die im Vergleich niedrigsten Scores erreichten.

3.5 Vergleich der Leitlinien, geordnet nach Publikationsjahr

Abbildung 9: Vergleich der mittleren Domänenwerte der verschiedenen Publikationsjahre



Um die Qualität der Leitlinien der verschiedenen Publikationsjahre zu vergleichen, wurden die Leitlinien nach ihrem Publikationsjahr sortiert und jeweils der mittlere Domänenwert der sechs Domänen des AGREE Instruments der Leitlinien eines Publikationsjahres berechnet.

Rein optisch zeigt die Abbildung einen gewissen Trend dahingehend, daß Leitlinien mit neuerem Publikationsjahr höhere Domänenwerte erhielten.
Die Leitlinien der Jahre 2002 und 2003 erzielten in den Domänen 1 und 2 jeweils höhere durchschnittliche Domänenwerte als die Leitlinien der Jahre 1998 bis

2001. In Domäne 4 erreichten die Leitlinien der Jahre 2001, 2002 und 2003 bessere Werte als die älteren Leitlinien. In den anderen Domänen scheint das Ergebnis weniger deutlich zu sein.

Im statistischen Vergleich zeigten sich für Domäne 1 ($p=0.047$, $r=0.256$) sowie für Domäne 4 ($p=0.028$, $r=0.282$) statistisch signifikante Korrelationen zwischen Qualität und Publikationsjahr. In Domäne 2 kann die Signifikanz mit $p=0.052$ ($r=0.250$) als grenzwertig bezeichnet werden. Für die Domänen 3, 5 und 6 ergab sich keine signifikante Korrelation.

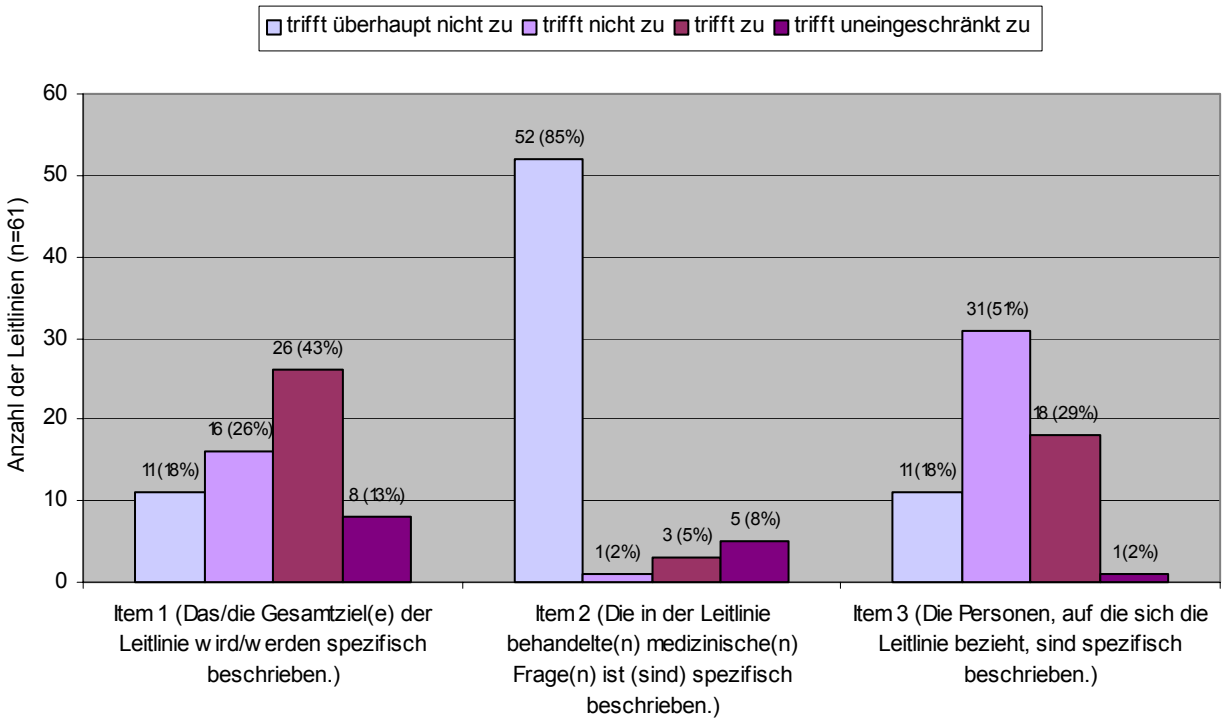
Im exakten Test nach Fisher fand sich ebenfalls ein Zusammenhang zwischen dem Alter der Leitlinie und der Höhe der erzielten Domänenwerte. Statistisch signifikante Gruppenunterschiede zeigten sich in Domäne 1 ($p<0.002$), Domäne 2 ($p<0.0005$), Domäne 3 ($p<0.001$), Domäne 4 ($p<0.027$) und Domäne 6 ($p<0.009$). Unterteilte man die Leitlinien noch einmal nach dem Publikationsjahr in zwei Gruppen – 1998-2000 und 2001-2003, so zeigte sich in den Domänen 3 ($p<0.001$) und 6 ($p<0.001$) eine signifikant höhere Qualität der neueren Leitlinien.

3.6 Auswertung der Dichotomisierung der Items

Um eine einfache Übersicht zu ermöglichen, welche Items bei welcher Anzahl von Leitlinien als erfüllt beziehungsweise nicht erfüllt angesehen werden können, wurde die vierstufige Likert-Skala dichotomisiert, d.h. ein Item gilt bei einer Leitlinie als positiv bewertet, wenn bei der Bewertung drei oder vier Punkte vergeben wurden.

Im Folgenden werden die 23 Items des AGREE-Instruments sowie die vier in die jeweils passende Domäne eingefügten zusätzlichen Items in sechs Diagrammen dargestellt.

Abbildung 10: Items der Domäne 1 (Geltungsbereich und Zweck)

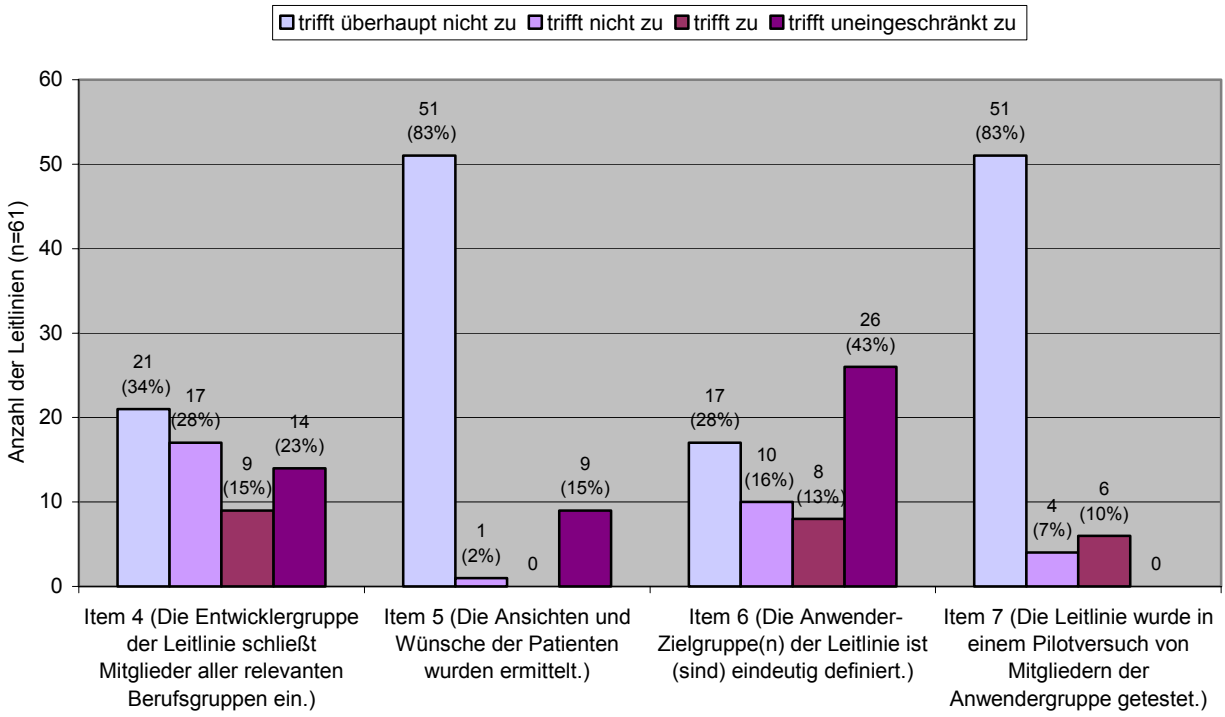


Bei Item 1 (Das/die Gesamtziel(e) der Leitlinie wird/werden spezifisch beschrieben) erreichten 34 von 61 Leitlinien (55.7%) eine Punktzahl von 3 („trifft zu“) oder 4 („trifft uneingeschränkt zu“).

Item 2 (Die in der Leitlinie behandelte(n) medizinische(n) Frage(n) ist (sind) spezifisch beschrieben) wurde bei acht von 61 Leitlinien (13.1%) mit einem Score von 3 oder 4 bewertet.

Bei Item 3 (Die Personen, auf die sich die Leitlinie bezieht, sind spezifisch beschieben) erzielten 19 von 61 Leitlinien (31.2%) eine Wertung von 3 oder 4 Punkten.

Abbildung 11: Items der Domäne 2 (Beteiligung von Interessengruppen)



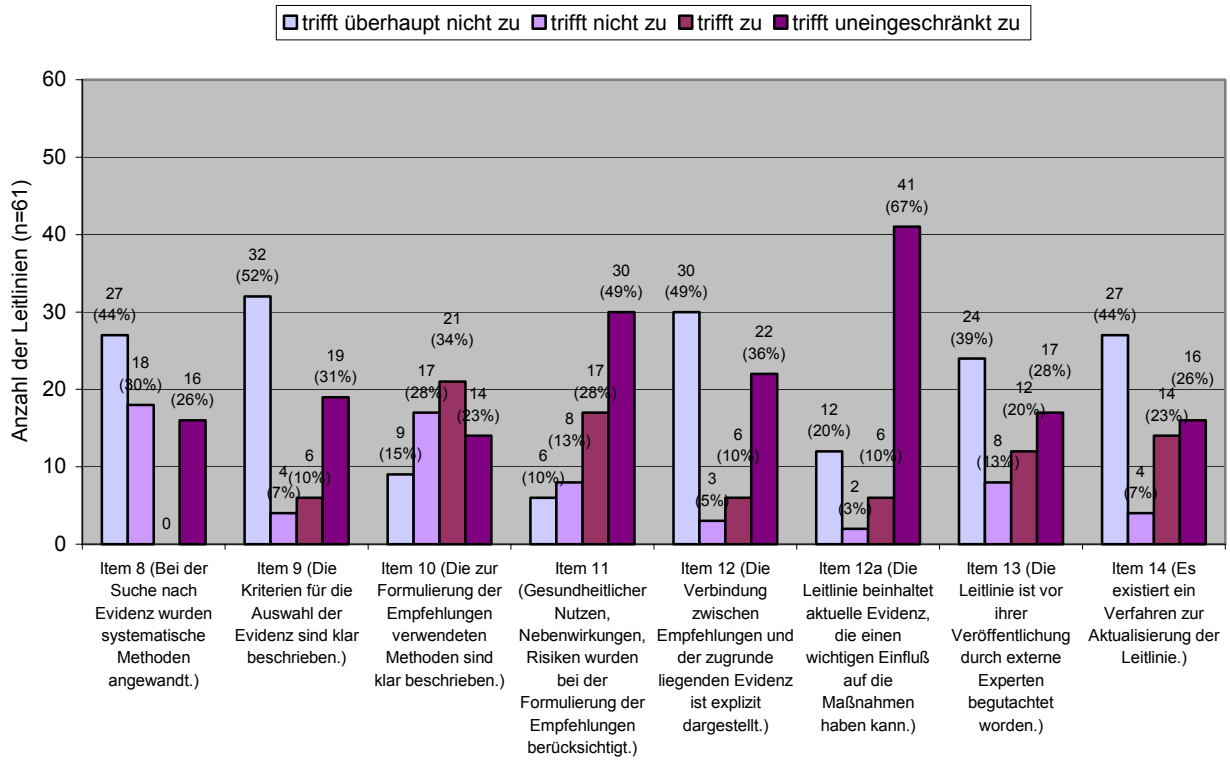
Item 4 (Die Entwicklergruppe der Leitlinie schließt Mitglieder aller relevanten Berufsgruppen ein) wurde bei 23 von 61 Leitlinien (37.7%) mit einem Score von 3 oder 4 bewertet.

Neun von 61 Leitlinien (14.8%) erzielten bei Item 5 (Die Ansichten und Wünsche der Patienten wurden ermittelt) einen Punktwert von 3 oder 4.

Bei Item 6 (Die Anwender-Zielgruppe(n) der Leitlinie ist (sind) eindeutig definiert) erhielten 34 von 61 Leitlinien (55.7%) einen Score von 3 oder 4.

Item 7 (Die Leitlinie wurde in einem Pilotversuch von Mitgliedern der Anwendergruppe getestet) wurde bei sechs von 61 Leitlinien (9.8%) mit einem Score von 3 oder 4 Punkten bewertet.

Abbildung 12: Items der Domäne 3 (Methodologische Exaktheit der Leitlinienentwicklung)



Die Items dieser Domäne überprüfen die Methodik des Entwicklungsprozesses einer Leitlinie und werden deshalb als besonders wichtig für die Bewertung angesehen.

Bei Item 8 (Bei der Suche nach Evidenz wurden systematische Methoden angewandt) erhielten 16 von 61 Leitlinien (26.2%) eine Wertung von 3 oder 4 Punkten.

Item 9 (Die Kriterien für die Auswahl der Evidenz sind klar beschrieben) wurde bei 25 von 61 Leitlinien (41%) mit einer Punktzahl von 3 oder 4 bewertet.

Bei Item 10 (Die zur Formulierung der Empfehlungen verwendeten Methoden sind klar beschrieben) erzielten 35 von 61 Leitlinien (57.4%)

einen Score von 3 oder 4.

47 von 61 Leitlinien (77.1%) erhielten bei Item 11 (Gesundheitlicher Nutzen, Nebenwirkungen, Risiken wurden bei der Formulierung der Empfehlungen berücksichtigt) einen Punktwert von 3 oder 4.

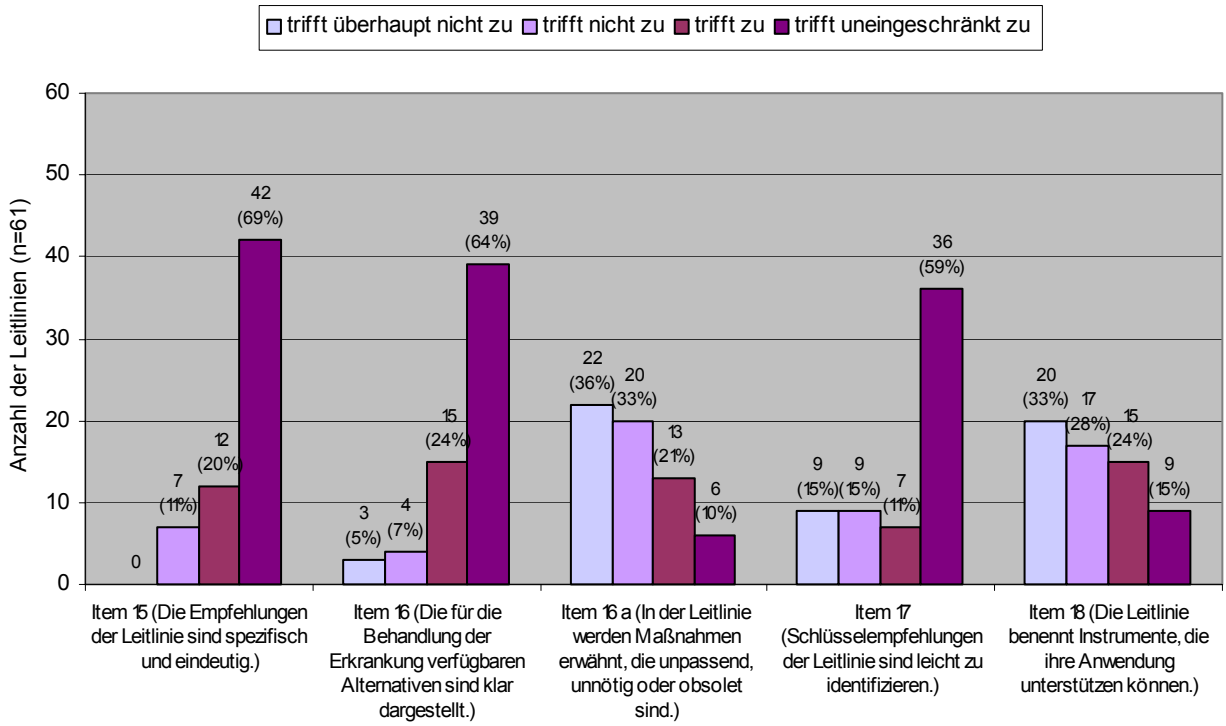
Bei Item 12 (Die Verbindung zwischen Empfehlungen und der zugrunde liegenden Evidenz ist explizit) wurden 28 von 61 Leitlinien (46%) mit 3 oder 4
Punkten bewertet.

Bei Item 12a (Die Leitlinie beinhaltet aktuelle Evidenz, die einen wichtigen Einfluß auf die Maßnahmen haben kann) wurde bei 47 von 61 Leitlinien (77.1%) ein Punktescore von 3 oder 4 vergeben.

Item 13 (Die Leitlinie ist vor ihrer Veröffentlichung durch externe Experten begutachtet worden) wurde bei 29 von 61 Leitlinien (47.6%) mit einem Score von 3 oder 4 bewertet.

Bei Item 14 (Es existiert ein Verfahren zur Aktualisierung der Leitlinie) erzielten 30 von 61 Leitlinien (49.2%) eine Wertung von 3 oder 4.

Abbildung 13: Items der Domäne 4 (Klarheit und Gestaltung)



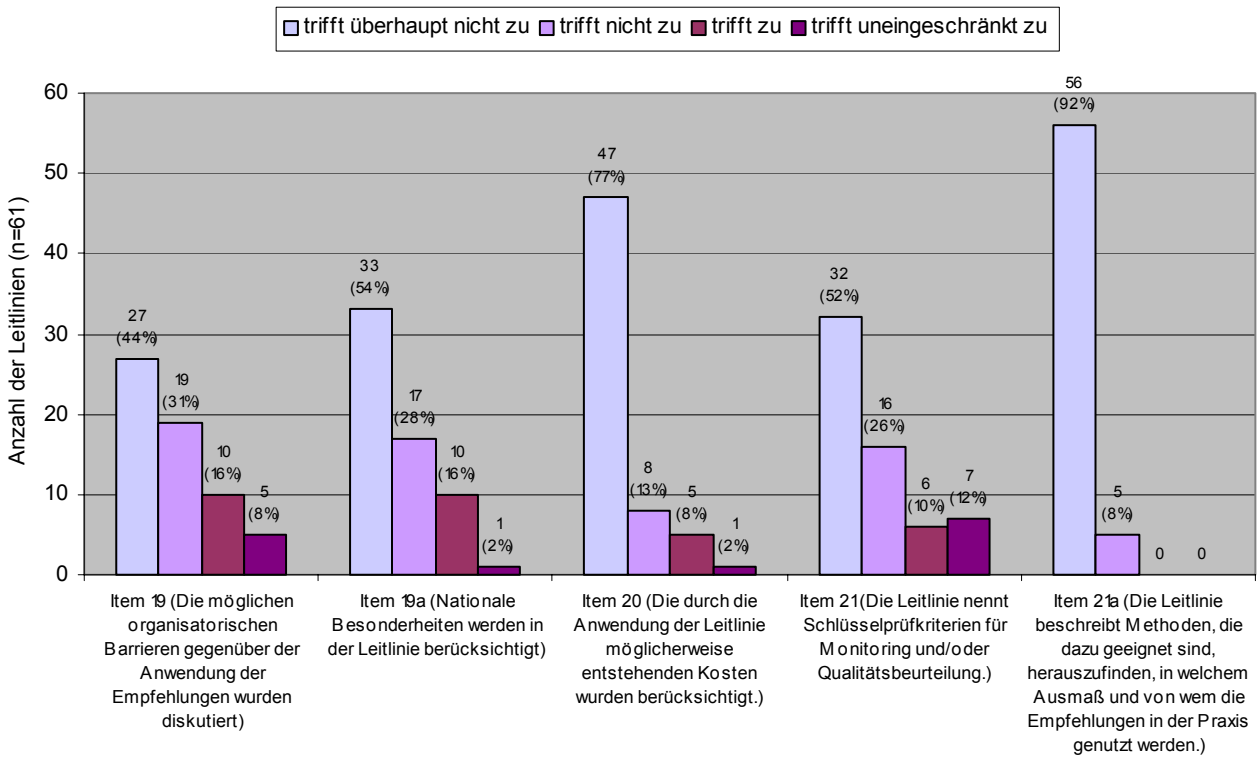
54 von 61 Leitlinien (88.6%) erhielten bei Item 15 (Die Empfehlungen der Leitlinie sind spezifisch und eindeutig) eine Wertung von 3 oder 4.

Bei Item 16 (Die für die Behandlung der Erkrankung verfügbaren Alternativen sind klar dargestellt) erzielten 54 von 61 Leitlinien (88.6%) einen Punktwert von 3 oder 4.

Item 17 (Schlüsselempfehlungen der Leitlinie sind leicht zu identifizieren) wurde bei 43 von 61 Leitlinien (70.5%) mit 3 oder 4 Punkten bewertet.

Bei Item 18 (Die Leitlinie benennt Instrumente, die ihre Anwendung unterstützen können) erhielten 24 von 61 Leitlinien (39.3%) eine Wertung von 3 oder 4.

Abbildung 14: Items der Domäne 5 (Anwendbarkeit)



Item 19 (Die möglichen organisatorischen Barrieren gegenüber der Anwendung der Empfehlungen wurden diskutiert) wurde bei 15 von 61 Leitlinien (24.6%) mit 3 oder 4 Punkten bewertet.

Bei Item 19a (Nationale Besonderheiten werden in der Leitlinie berücksichtigt) erzielten elf von 61 Leitlinien (18%) einen Punktescore von 3 oder 4. Bei 82% aller Leitlinien werden nationale Besonderheiten also nicht oder nur sehr vage erwähnt.

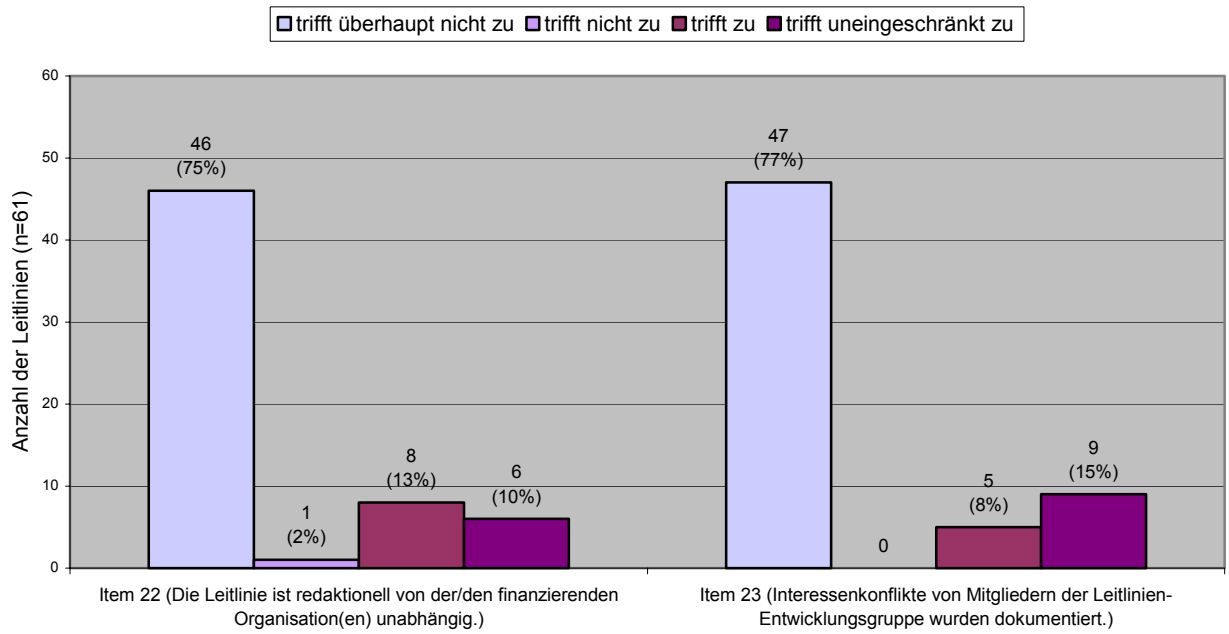
Bei Item 20 (Die durch die Anwendung der Leitlinie entstehenden Kosten wurden berücksichtigt) erreichten sechs von 61 Leitlinien (9.8%) eine Wertung von 3 oder 4.

13 von 61 Leitlinien (21.3%) erhielten bei Item 21 (Die Leitlinie nennt Schlüsselprüfkriterien für Monitoring und/oder Qualitätsbeurteilung) einen Score von 3 oder 4.

Bei Item 21a (Die Leitlinie beschreibt Methoden, die dazu geeignet sind, herauszufinden, in welchem Ausmaß und von wem die Empfehlungen in der

Praxis genutzt werden) erzielte keine der untersuchten 61 Leitlinie eine Wertung von 3 oder 4 Punkten.

Abbildung 15: Items der Domäne 6 (Redaktionelle Unabhängigkeit)



Bei Item 22 (Die Leitlinie ist redaktionell von der/den finanzierenden Organisation(en) unabhängig) erzielten 14 von 61 Leitlinien (23%) eine Wertung von 3 oder 4.

14 von 61 Leitlinien (23%) wurden bei Item 23 (Interessenkonflikte von Mitgliedern der Leitlinien-Entwicklungsgruppe wurden dokumentiert)

4. Diskussion

Ziel dieser Untersuchung war, die Qualität von europäischen Leitlinien aus dem Bereich Psychiatrie anhand des AGREE Instruments [95] zu evaluieren. Dazu wurden 61 Leitlinien aus 14 europäischen Ländern anhand des aus sechs Domänen mit insgesamt 23 Items bestehenden Instruments bewertet. Vier zusätzliche Items wurden in die jeweils passenden Domänen eingefügt.

Die größte Anzahl der identifizierten Leitlinien behandelte Diagnosen wie Schizophrenie und affektive Erkrankungen. Zu anderen Bereichen, wie z. B. Substanzmißbrauch oder Eßstörungen, konnten dagegen nur wenige Leitlinien gefunden werden. Zu vielen Diagnosen besteht hinsichtlich der Entwicklung von Leitlinien also noch Nachholbedarf.

Insgesamt zeigen die Ergebnisse dieser Untersuchung, daß der Großteil der untersuchten Leitlinien von mittlerer Qualität ist, wobei die Spannweite der erzielten Wertungen sehr groß ist. Viele der Leitlinien sind also nicht schlecht, nur wenige allerdings konnten als sehr gut bezeichnet werden. Gaebel et al. kamen in ihrer auf Schizophrenieleitlinien beschränkten Studie zu einem ähnlichen Ergebnis [32].

In der nach den Vorgaben des AGREE Instruments vorgenommenen Gesamtbewertung der Leitlinien konnten ungefähr 40% der Publikationen als „Nachdrücklich zu empfehlen“ oder „Zu empfehlen (unter Vorbehalt / nach Änderung)“ beurteilt werden. Ungefähr 60% der Leitlinien mußten als „Nicht zu empfehlen“ gewertet werden.

Beim Vergleich der durchschnittlichen Domänenwerte der Leitlinien zu den unterschiedlichen Diagnosen ergaben sich keine aussagekräftigen Unterschiede. Sowohl die Leitlinien zur Elektrokonvulsivtherapie (n=3) als auch die Leitlinien zur Kinder- und Jugendpsychiatrie (n=5) erzielten in jeweils zwei von sechs Domänen den im Vergleich höchsten Domänenwert. Zu vermuten gewesen wäre eventuell, daß Leitlinien zu den häufiger gestellten Diagnosen, wie Schizophrenie oder

Depression, zu denen eine größere Anzahl an Leitlinien existiert, im Vergleich besser abschneiden würden. Diese Annahme konnte nicht bestätigt werden. Als Einschränkung muß jedoch die kleine Stichprobe berücksichtigt werden, die bei den am besten abschneidenden Diagnosen bei drei bzw. fünf Leitlinien lag. Aus diesem Grund war nur ein qualitativer Vergleich möglich.

Im Vergleich der Domänenwerte der Leitlinien der 14 in der Untersuchung vertretenen Länder zeigten die Leitlinien aus Großbritannien (n=7) in drei der sechs Domänen den höchsten mittleren Domänenwert. Ein Grund für die relativ hohe Qualität der britischen Leitlinien liegt möglicherweise darin, daß die Leitlinien in strukturierten Programmen von Organisationen wie dem „National Institute for Clinical Excellence (NICE)“ [54] oder dem „Scottish Intercollegiate Guidelines Network (SIGN)“ [74] entwickelt wurden. Ergebnisse aus früher durchgeführten Studien belegen, daß qualitativ hochwertige Leitlinien häufiger von strukturierten Entwicklungsprogrammen produziert werden [30]. Diese Programme werden von staatlicher Seite finanziert, wodurch die nötigen Mittel für den Entwicklungsprozeß von Leitlinien zur Verfügung stehen. Auch hier ist jedoch aufgrund der geringen Anzahl der Leitlinien mehrerer Länder nur ein qualitativer Vergleich möglich.

In der Untersuchung von Qualitätsunterschieden der Leitlinien aus den unterschiedlichen Publikationsjahren zeigte sich ein – in manchen Domänen statistisch signifikanter – Trend, daß die neueren Publikationen höhere mittlere Werte in einzelnen Domänen erreichten. Dieses Ergebnis kann, trotz der eher geringen Zahl der in dieser Arbeit bewerteten Leitlinien neueren Datums, als Hinweis auf die steigende Qualität aktueller Publikationen gewertet werden. Die Bedeutung von Leitlinien hat besonders in den letzten Jahren noch einmal deutlich zugenommen. Das Ergebnis dieser Arbeit läßt vermuten, daß Anstrengungen unternommen werden, qualitativ hochwertige Leitlinien zu produzieren. Es ist zu hoffen, daß sich diese Entwicklung in der Zukunft fortsetzen wird.

Ein Hauptinteresse der vorliegenden Arbeit galt der Frage, inwieweit die Empfehlungen der Leitlinien als evidenzbasiert bezeichnet werden können. Die Domäne „ Methodologische Exaktheit der Leitlinienentwicklung“ erzielte mit einem

durchschnittlichen Domänenwert von 51.4% erfreulicherweise das zweitbeste Ergebnis im Vergleich der sechs Domänen des AGREE Instruments. Die sieben Items der Domäne „Methodologische Exaktheit der Leitlinienentwicklung“ evaluieren diese Fragestellung. Die vierstufige Likert-Skala wurde dafür dichotomisiert und ein Item definitionsgemäß als positiv gewertet, wenn es mit drei („trifft zu“) oder vier („trifft vollständig zu“) Punkten bewertet wurde. Der prozentuale Anteil der Leitlinien, die bei den Items jeweils die geforderten Punktzahlen erreichten, lag zwischen 26% bei Item 8 („Bei der Suche nach Evidenz wurden systematische Methoden angewandt“) und 77% bei Item 11 („Gesundheitlicher Nutzen, Nebenwirkungen, Risiken wurden bei der Formulierung der Empfehlungen berücksichtigt“).

Item 8 („Bei der Suche nach Evidenz wurden systematische Methoden angewandt“) fragt nach der Suchstrategie, die der Entwicklung einer Leitlinie vorausgeht. Dieses Item erzielte mit 26% die niedrigste Wertung in dieser Domäne. Im Umkehrschluß folgt aus diesem Ergebnis, daß 74% der Leitlinienentwickler keine systematische Evidenzsuche betrieben haben. Eine systematische Literaturrecherche muß als Grundvoraussetzung für die Entwicklung von evidenzbasierten Leitlinien gelten. Auch wenn ein Teil dieser Leitlinien höhere Wertungen in anderen Domänen, wie zum Beispiel „Klarheit der Präsentation“, erzielte, können diese Leitlinien nicht als sinnvolles Werkzeug für die ärztliche Entscheidungsfindung angesehen werden, solange die Empfehlungen nicht evidenzbasiert sind.

Ein Grund für die Qualitätsmängel der untersuchten Leitlinien ist sicherlich die außerordentliche Komplexität eines systematischen Entwicklungsprozesses. Geht man davon aus, daß die Anforderungen des AGREE Instrumentes als Grundlage für eine qualitativ hochwertige Leitlinie mit evidenzbasierten Therapieempfehlungen gelten, ist offensichtlich, daß die Entwicklung einer solchen Leitlinie einen immensen Aufwand in organisatorischer, zeitlicher und damit auch in finanzieller Hinsicht bedeutet. Eine einzelne psychiatrische Organisation, besonders die eines kleinen oder ärmeren europäischen Landes,

hat nicht die Möglichkeit, diese Aufgabe mit einem zufriedenstellenden Ergebnis zu erfüllen.

In dieser Studie wurde gezeigt, daß nur elf von 61 Leitlinien (18%) in relevantem Maße nationale Besonderheiten berücksichtigen. Im Umkehrschluß werden in 82% der Leitlinien nationale Besonderheiten nicht oder lediglich sehr knapp und unspezifisch erwähnt. Die Mehrzahl der untersuchten Leitlinien orientiert sich also nicht an Besonderheiten des jeweiligen Landes, sondern gibt allgemeingültige Empfehlungen und könnte deshalb prinzipiell – abgesehen von eventuellen Qualitätsmängeln – international eingesetzt werden. Dennoch werden Leitlinien zu bestimmten Themen (z. B. Behandlung von Schizophrenie) in vielfältiger Ausführung von jeder der einzelnen Organisationen produziert. Jede Organisation führt dabei von Neuem aufwendige und vielfältige Arbeitsschritte durch, die eventuell in anderen Leitlinienprojekten schon geleistet wurden. Aufgrund des oben beschriebenen hohen Aufwandes, eine qualitativ hochwertige Leitlinie herauszugeben, werden Qualitätsmängel in Kauf genommen. Deshalb ist es fraglich, ob jedes europäische Land eigene Leitlinien produzieren muß. Ein sinnvoller Ansatz wäre eine Zusammenarbeit der einzelnen europäischen psychiatrischen Organisationen, mit dem Ziel, gemeinsam evidenzbasierte Leitlinien herauszugeben [38, 63]. Wichtige nationale Besonderheiten können im Anschluß von den jeweiligen Gesellschaften an eine internationale Leitlinie angefügt werden [14]. Ein sinnvoller erster Schritt zur Verwirklichung dieses Ziels ist das im Jahre 2002 gegründete „Guidelines International Network (G-I-N)“ [59]. Dieses Projekt wurde von einer internationalen Expertengruppe initiiert mit dem Ziel einer Qualitätsverbesserung und dem vermehrten Einsatz von Leitlinien, zum Beispiel durch die Bereitstellung einer Datenbank von Leitlinien auf der Internetseite von „G-I-N“. Derzeit sind 52 Organisationen aus 26 Ländern Mitglieder dieses Netzwerkes [39], dessen Aktivitäten in Zukunft sicher noch an Ausmaß und Bedeutung zunehmen werden.

Bei der Bewertung der Leitlinien mit dem AGREE Instrument ergaben sich verschiedene Problembereiche, die zum Teil am Aufbau der Leitlinien als auch am Bewertungsinstrument selbst liegen.

Erstens erscheinen die Leitlinien in stark differierenden Formaten und unterscheiden sich deshalb grundlegend im Aufbau. Auch wenn also eine Leitlinie für sich gesehen übersichtlich gestaltet ist, weicht die Anordnung der einzelnen inhaltlichen Themen oft stark von einer anderen, eventuell ebenfalls an sich übersichtlichen Leitlinie ab. So gestaltet sich ein erster Überblick über eine Leitlinie zeitraubender als nötig. Ein einheitliches Format, wie es zum Beispiel vom „CONSORT statement“ [52] bereits für die Auswertung von randomisierten kontrollierten Studien entwickelt wurde, wäre demnach auch für Leitlinien wünschenswert.

Zweitens sind bei einem Teil der Leitlinien die Informationen zum Entwicklungsprozeß, die maßgeblich zur Bewertung und anschließenden Beurteilung notwendig sind, in einer gesonderten Publikation veröffentlicht, die dann extra bestellt werden muß. In Einzelfällen wird in der jeweiligen Leitlinie nicht auf diese Publikation verwiesen, so daß nicht sicher davon ausgegangen werden kann, daß jeder Nutzer Kenntnis von der Existenz dieser Publikation hat. Bei einigen Leitlinien fehlt jegliche Information zum Entwicklungsprozeß, wodurch eine korrekte Beurteilung der Qualität nicht möglich ist [41]. Bei korrekter Anwendung des AGREE Instrumentes muß ein Item, zu dem keine Information vorhanden ist, mit „trifft überhaupt nicht zu“ bewertet werden. Deshalb ist die Beurteilung einer Leitlinie abhängig von der Dokumentation des Entwicklungsprozesses. Obwohl für die vorliegende Arbeit große Anstrengungen unternommen worden sind, sämtliche Zusatzpublikationen zu berücksichtigen, besteht die Möglichkeit, daß einige dieser Publikationen fehlen. Zudem können die Ergebnisse der Arbeit in dem Sinne beeinflußt sein, als daß manche Leitlinien aufgrund fehlender Dokumentation schlechter beurteilt worden sind, als eigentlich gerechtfertigt wäre. Es wäre deshalb sinnvoll, auf den ersten Seiten einer Leitlinie sämtliche relevanten Informationen zum Entstehungsprozeß zu nennen, also z. B. eine Liste der beteiligten Berufsgruppen, Einzelheiten zur Literaturrecherche und den Zeitpunkt einer geplanten Überarbeitung. Falls diese Informationen in einer gesonderten Publikation veröffentlicht sind, sollte am Anfang jeder Leitlinie ausdrücklich darauf verwiesen werden. Dadurch würde zum einen sichergestellt, daß relevante Informationen nicht übersehen werden können, und zum anderen bedeutet ein

einheitliches, klar strukturiertes Format eine große Zeitersparnis für den Benutzer der Leitlinie.

Drittens sind einige Items des AGREE Instrumentes und auch die zugehörigen Beschreibungen eher vage formuliert, so daß bei der Bewertung der Leitlinien durch verschiedenen Untersucher unterschiedliche Interpretationen möglich sind, was sich auch auf die Höhe der Scores auswirken kann.

Viertens werden in der Benutzeranleitung des AGREE Instrumentes keine Kriterien genannt, die definieren, wie eine Leitlinie insgesamt beurteilt werden soll. Für den Bewerter einer Leitlinie besteht zwar am Ende des Fragebogens die Möglichkeit, ein Gesamturteil über die Qualität der untersuchten Leitlinie abzugeben. In der Anleitung des Instrumentes wird hierzu erklärt, daß bei diesem Gesamturteil sämtliche Items berücksichtigt werden sollen. Genauere Angaben zur Gewichtung der einzelnen Domänen des Instrumentes fehlen, so daß z. B. der Bereich „Methodologische Exaktheit der Leitlinienentwicklung“ genauso wichtig ist wie die Domäne „Redaktionelle Unabhängigkeit“. So bleibt es dem Bewerter überlassen, persönliche Schwerpunkte zu setzen und dann zu einem Gesamturteil zu kommen.

Trotz intensiver Recherche (drei Briefrunden, Telefonate, Internet etc.) kann die Auswahl der in der Untersuchung bewerteten 61 Leitlinien nicht den Anspruch erheben, vollständig zu sein. Möglicherweise haben weitere Organisationen Leitlinien im Bereich Psychiatrie produziert, die anhand der bei dieser Studie angewandten Suchstrategie nicht erfaßt werden konnten. Eine zentrale Datenbank für Leitlinien ist deshalb dringend erforderlich.

Insgesamt wurde in dieser Arbeit gezeigt, daß ein Großteil der untersuchten Leitlinien von mittlerer Qualität war, einige Leitllinien aber durchaus hohe qualitative Standards erfüllten. Da nationale Besonderheiten nur in 18% der evaluierten Leitlinien berücksichtigt wurden und die zugrundeliegende Evidenz ohnehin international ist, könnte es sinnvoll sein, die Verantwortung für die

Entwicklung von evidenzbasierten Leitlinien in Zukunft in die Hände einer neu zu schaffenden europäischen Institution zu legen.

5. Zusammenfassung

In der vorliegenden Arbeit wurde die Qualität von europäischen Leitlinien aus dem Bereich der Psychiatrie mit dem Appraisal of Guidelines for Research and Evaluation (AGREE) Instrument [95] evaluiert. Die Suchstrategie zur Identifikation der Leitlinien beinhaltete drei Briefrunden in den Jahren 2001, 2002 und 2003, in denen sämtliche relevanten Organisationen kontaktiert wurden, eine Internetrecherche, eine MEDLINE-Recherche sowie die Durchsicht der Publikation „Guidelines in mental health: a bibliography“ des College Research Unit, London [98].

Eingeschlossen wurden Leitlinien, die zwischen 1998 und 2003 von nationalen europäischen Organisationen herausgegeben wurden.

61 Leitlinien aus 14 europäischen Ländern erfüllten die Einschlußkriterien und wurden anhand des AGREE Instruments bewertet. Dieser Fragebogen besteht aus 23 Items, die in sechs verschiedene Domänen unterteilt sind. Jedes Item wird anhand einer vierstufigen Likert-Skala beurteilt. Vier zusätzliche Items wurden in die jeweils passende Domäne integriert und ebenfalls untersucht. Für jede der sechs Domänen wurde der standardisierte Domänenwert nach der vom AGREE-Instrument vorgegebenen Methode berechnet. Die Leitlinien wurden nach Diagnosen, nach Ländern und nach Publikationsjahr geordnet und die mittleren Domänenwerte innerhalb dieser Gruppen verglichen. Zur Untersuchung der einzelnen Items wurde die vierstufige Likert-Skala dichotomisiert. Items, die eine Wertung von drei oder vier Punkten auf der Skala erhielten, galten als positiv bewertet.

Hauptergebnis war, daß die Qualität der Leitlinien insgesamt als eher mittelmäßig angesehen werden mußte, wobei der Qualitätsbereich der untersuchten Leitlinien sehr groß war: einige Leitlinien erfüllten hohe qualitative Standards.

Der qualitative Vergleich der standardisierten Domänenscores zwischen Leitlinien zu unterschiedlichen Diagnosen ergab keine eindeutigen Unterschiede. Aus dem Vergleich der Leitlinien der verschiedenen Länder konnten ebenfalls keine eindeutigen Schlüsse gezogen werden, wenn sich auch Hinweise zeigten, daß Leitlinien aus Nationen wie zum Beispiel Großbritannien, in denen staatlich geförderte Programme für die Produktion von Leitlinien verantwortlich zeichnen, qualitativ hochwertiger waren. Bei der statistischen Untersuchung von Qualitätsunterschieden von Leitlinie aus den sechs Publikationsjahren zeigte sich ein – in manchen Domänen statistisch signifikanter – Trend, daß Leitlinien neueren Datums von besserer Qualität waren.

Ein Hauptinteresse dieser Arbeit galt der Frage, in wieweit die Leitlinien als evidenzbasiert angesehen werden konnten, da nur evidenzbasierte Empfehlungen als verläßliche Entscheidungsgrundlage gelten können. Die Domäne „Methodologische Exaktheit der Leitlinienentwicklung“ erzielte einen mittleren Domänenscore von 51,4% und damit immerhin die zweithöchste Wertung im Vergleich der sechs Domänen. Dennoch zeigten einige der dichotomisierten Items dieser Domäne sehr schlechte Ergebnisse. Weniger als die Hälfte der Leitlinien konnte als evidenzbasiert bezeichnet werden.

Grund für die Qualitätsmängel der untersuchten Leitlinien ist wahrscheinlich der langwierige, komplexe und kostenintensive Prozeß der Leitlinienentwicklung, der einen großen organisatorischen, zeitlichen und damit finanziellen Aufwand erfordert. Einzelne psychiatrische Organisationen, besonders auch die eher ärmerer europäischer Staaten, können diese Anforderungen kaum erfüllen. Da nationale Besonderheiten nur in 18% der untersuchten Leitlinien in relevantem Maße berücksichtigt werden und die zugrunde liegende Evidenz internationale Geltung hat, erscheint eine länderübergreifende Kooperation zur Produktion von evidenzbasierten Leitlinien sinnvoll. Ein erster Schritt zur Verwirklichung dieses Zieles wurde im Jahre 2002 mit der Gründung des „Guidelines international Network (G-I-N)“ [59] gemacht.

Auszüge dieser Arbeit wurden bereits in einer internationalen Fachzeitschrift veröffentlicht [86].

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7. Abbildungs- und Tabellenverzeichnis

8. Anhang

8.1 Appraisal of Guidelines for Research & Evaluation (AGREE) Instrument [AGREE Collaboration, September 2001]

Geltungsbereich und Zweck

1. Das / die Gesamtziel(e) der Leitlinie wird / werden spezifisch beschrieben.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Dieser Teil beschäftigt sich mit dem eventuellen Einfluss einer Leitlinie auf den Gesundheitszustand der Bevölkerung oder bestimmter Patientengruppen. Die allgemeinen Ziele der Leitlinie sollten detailliert beschrieben werden. Der infolge der Leitlinienrealisierung für ein bestimmtes medizinisches Problem erwartete gesundheitliche Nutzen sollte genau bezeichnet werden.

Spezifische Angaben würden zum Beispiel sein:

- Prävention der (Langzeit-) Komplikationen von Diabetikern;
- Reduktion des Risikos weiterer vaskulärer Komplikationen bei Patienten nach Herzinfarkt;
- Rationale und kosteneffektive Verordnung von Antidepressiva

2. Die in der Leitlinie behandelte(n) medizinische(n) Frage(n) ist (sind) spezifisch beschrieben.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Eine detaillierte Beschreibung der in der Leitlinie angesprochenen medizinischen Fragen sollte vorhanden sein, insbesondere die der Schlüsselempfehlungen (siehe Punkt 15).

Beispiele - unter Bezug auf die Beispiele in Punkt 1:

- Wie oft im Jahr sollte bei Diabetikern der Hb1Ac-Wert bestimmt werden ?
- In welcher Tagesdosis sollte Acetylsalicylsäure bei nachgewiesenem akuten Herzinfarkt gegeben werden ?
- Sind bei der Behandlung der Depression Selektive Serotonin-Inhibitoren (SSRI) kosteneffektiver als Tricyclische Antidepressiva (TCA)?

3. Die Patienten, auf die sich die Leitlinie bezieht, sind spezifisch beschrieben.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Die Zielgruppe einer Leitlinie sollte klar beschrieben sein, und zwar unter Angabe von Altersgruppe, Geschlecht, Schweregrad, Beschreibung der Erkrankung und Komorbidität.

Beispiele :

- Eine Leitlinie zur Behandlung bei Diabetes mellitus bezieht sich nur auf Typ 2 Diabetiker und gilt nicht für Patienten mit kardiovaskulärer Komorbidität.
- Eine Leitlinie zur Behandlung bei Depression bezieht sich nur Patienten mit "Major-Formen" nach den DSM-IV Kriterien und gilt nicht für Patienten mit psychotischen Symptomen oder für Kinder.
- Eine Leitlinie zum Brustkrebs-Screening gilt nur für Frauen zwischen 50 und 70 Jahren ohne Krebsanamnese und ohne Brustkrebs in der Familienanamnese.

Beteiligung von Interessengruppen

4. Die Entwicklergruppe der Leitlinie schließt Mitglieder aller relevanten Berufsgruppen ein.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Dieser Punkt bezieht sich auf die Fachleute, die am Prozess der Leitlinienentwicklung in irgendeiner Phase beteiligt waren. Hierzu können gehören: die Mitglieder des Lenkungsausschusses; die mit der Auswahl, Analyse und Bewertung der Evidenz befasste Forschungsgruppe und Personen, die an der Formulierung der endgültigen Empfehlungen beteiligt waren. Dieser Punkt bezieht sich nicht auf externe Gutachter der Leitlinie (siehe hierzu Punkt 11). Es sollten Angaben über die Zusammensetzung der Leitlinienentwicklungsgruppe sowie die in ihr vertretenen Fachdisziplinen und über den relevanten Erfahrungshorizont der Experten gemacht werden.

5. Die Ansichten und Wünsche der Patienten wurden ermittelt.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Angaben über Erfahrungen der Patienten und ihre Erwartungen an die Gesundheitsversorgung sollten in die Entwicklung medizinischer Leitlinien einfließen. Es existieren verschiedene Methoden, um die Berücksichtigung der Patientenperspektiven bei der Leitlinienentwicklung sicherzustellen. Die Entwicklergruppe könnte z. B. Patientenvertreter einbeziehen, Informationen durch Patienteninterviews beschaffen oder Übersichtsartikel / Literatur zu Patientenerfahrungen berücksichtigen. Die Tatsache, dass dieser Prozess stattgefunden hat, sollte durch Belege nachgewiesen werden.

6. Die Anwender-Zielgruppe(n) der Leitlinien ist (sind) eindeutig definiert.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Die Anwender, an die sich die Empfehlungen richten, sollten in der Leitlinie klar definiert sein, damit diese unmittelbar erkennen können, ob die Leitlinie für sie von Relevanz ist. Zum Beispiel kann die Anwender-Zielgruppe eine Leitlinie zum Thema "Lumbaler Rückenschmerz" Hausärzte / Grundversorger, Neurologen, Orthopäden , Rheumatologen und Physiotherapeuten umfassen.

7. Die Leitlinie wurde in einem Pilotversuch von Mitgliedern der Anwendergruppe getestet.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Zur weiteren Validierung sollte eine Leitlinie vor ihrer Veröffentlichung innerhalb der vorgesehenen Anwendergruppe getestet worden sein. Z. B. kann eine Leitlinie in mehreren Arztpraxen oder Kliniken einem Pilotversuch unterzogen worden sein. Dieser Prozess sollte dokumentiert sein.

Methodologische Exaktheit der Leitlinienentwicklung

8. Bei der Suche nach Evidenz wurden systematische Methoden angewandt.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Die Suchstrategie für die Identifizierung von Evidenz sollte detailliert beschrieben sein; dies beinhaltet eine Auflistung der verwendeten Suchbegriffe und Quellen sowie Zeitangaben für die berücksichtigte Literatur. Bei den Quellen kann es sich um elektronische Datenbanken handeln (z. B. MEDLINE, EMBASE, CINAHL), Datenbanken systematischer Übersichtsarbeiten (Cochrane Library, DARE), von Hand durchsuchte Fachzeitschriften sowie und Kongressberichte und andere Leitlinien (z. B. aus dem US National Guideline Clearinghouse oder dem Deutschen Leitlinien-Clearingverfahren).

9. Die Kriterien für die Auswahl der Evidenz sind klar beschrieben.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Die Kriterien für den Einschluss bzw. Ausschluss der identifizierten Evidenz sollten verfügbar sein. Diese Kriterien sollten explizit beschrieben werden. Ebenso sollte die Verwendung bzw. Nicht-Verwendung der Evidenz klar begründet werden. Z. B. könnten sich Leitlinienautoren dazu entschieden haben, ausschließlich die Evidenz aus randomisierten klinischen Studien oder nur englischsprachige Artikel zu berücksichtigen.

10. Die zur Formulierung der Empfehlung verwendeten Methoden sind klar beschrieben.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Die Methoden, die zur Formulierung der Empfehlungen verwendet wurden, sollten ebenso beschrieben werden wie der Weg zur endgültigen Entscheidungsfindung. Solche Methoden sind z. B. Abstimmungsverfahren und formale Konsensustechniken (z.B. Delphi-Technik, Glaser-Technik). Bereiche, für die kein Konsens erzielt werden konnte, sollten ebenso spezifiziert werden wie die Methoden zur Lösung des Konflikts.

11. Gesundheitlicher Nutzen, Nebenwirkungen, Risiken wurden bei der Formulierung der Empfehlungen berücksichtigt.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Die Leitlinie sollte sowohl den gesundheitlichen Nutzen als auch Nebenwirkungen und Risiken der Empfehlungen berücksichtigen. Zum Beispiel können in einer Leitlinie zur Behandlung von Brustkrebs die Auswirkungen der Empfehlungen auf verschiedene Outcome-Indikatoren diskutiert werden. Diese könnten z. B. die Überlebensrate, die Lebensqualität, unerwünschte Therapiewirkungen, die Behandlung der Symptome umfassen oder auch den Vergleich verschiedener Behandlungsoptionen. Es sollten Belege vorliegen, dass diese Fragen behandelt wurden.

12. Die Verbindung zwischen Empfehlungen und der zugrunde liegenden Evidenz ist explizit dargestellt.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Die Verbindung zwischen den Leitlinienempfehlungen und der zugrunde liegenden Evidenz soll explizit dargestellt werden. Jeder einzelnen Empfehlung sollte eine Liste der zugrundeliegenden Literaturstellenzugeordnet sein.

13. Die Leitlinie ist vor ihrer Veröffentlichung durch externe Experten begutachtet worden.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Eine Leitlinie sollte vor der Veröffentlichung extern begutachtet worden sein. Die Gutachter sollen nicht an der Leitlinienentwicklung beteiligt gewesen sein. Es sollte sich um Experten aus dem medizinischen Bereich und um Methodiker handeln. Patientenvertreter können ebenfalls einbezogen werden. Eine Beschreibung der bei der Begutachtung verwendeten Methodik sollte vorliegen, ebenso ein Liste der Gutachter unter Angabe ihrer Zugehörigkeit zu Berufsverbänden, Organisationen, Institutionen usw.

14. Es existiert ein Verfahren zur Aktualisierung der Leitlinie.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Leitlinien müssen den aktuellen Stand der Forschung wiedergeben. Die Vorgehensweise für die Aktualisierung der Leitlinie sollte klar dargestellt sein. Z. B. kann ein definierter Zeitplan vorhanden sein, oder es gibt eine ständige Arbeitsgruppe, die regelmäßig aktualisierte Literaturrecherchen erhält und auf der Grundlage dieser Daten notwendige Änderungen vornimmt.

Klarheit der Präsentation

15. Die Empfehlungen der Leitlinie sind spezifisch und eindeutig.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Eine Empfehlung sollte konkrete und präzise Angaben darüber machen, welches Vorgehen in einer bestimmten Situation und für eine bestimmte Patientengruppe gemäß der gefundenen Evidenz angemessen ist.

Beispiel einer spezifischen Empfehlung: „ Bei akuter Otitis media muss man Kindern ab dem vollendeten 2. Lebensjahr Antibiotika verordnen, wenn die Beschwerden länger als drei Tage andauern oder wenn die Beschwerden trotz angemessener Behandlung mit Analgetika zunehmen; in solchen Fällen sollte 7 Tage lang mit Amoxicillin therapiert werden (Empfehlung ist durch Angabe eines Dosierungsschemas zu ergänzen)“.

Beispiel einer unpräzisen Empfehlung: „Antibiotika sind in Fällen mit unüblichem oder kompliziertem Verlauf indiziert“.

Allerdings ist die Evidenz nicht immer eindeutig, und es kann Unsicherheit bezüglich der bestmöglichen Vorgehensweise geben. In solchen Fällen sollte diese Unsicherheit in der Leitlinie angegeben werden.

16. Die für die Behandlung der Erkrankung verfügbaren Alternativen sind klar dargestellt.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Eine Leitlinie sollte die verschiedenen, für das spezielle Versorgungsproblem möglichen Vorgehensweisen hinsichtlich Screening, Prävention, Diagnostik oder Behandlung berücksichtigen. Diese Optionen sollten in der Leitlinie klar dargestellt werden. Zum Beispiel könnte eine Empfehlung zur Behandlung bei Depression folgende Alternativen beinhalten:

a. Therapie mit trizyklischen Antidepressiva

b. Therapie mit SSRI

c. Psychotherapie

d. Kombination von Pharmakotherapie und Psychotherapie

17. Schlüsselempfehlungen der Leitlinie sind leicht zu identifizieren.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Anwender der Leitlinie sollten die relevantesten Empfehlungen leicht finden können. Diese Empfehlungen beantworten die wichtigsten medizinischen Fragen, die in der Leitlinie behandelt werden. Die Hervorhebung dieser Empfehlungen kann in unterschiedlichster Weise erfolgen: etwa durch Zusammenfassung in einem Kasten, mittels Fettdruck oder Unterstreichen oder durch Darstellung als Flussdiagramm oder Algorithmus.

18. Die Leitlinie benennt Instrumente, die ihre Anwendung unterstützen können.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Damit eine Leitlinie wirksam wird, muss sie mit zusätzlichen Materialien verbreitet (disseminiert) und zur Anwendung gebracht (implementiert) werden. Bei diesen Materialien kann es sich zum Beispiel um eine separate Zusammenfassung, eine zusammenfassende Praxishilfe (Quick Reference Guide), um Fortbildungsmaterialien, Patientenbroschüren oder um Computer-gestützte Praxishilfen handeln. Diese Materialien sollten zusammen mit der Leitlinie zur Verfügung gestellt werden

Anwendbarkeit

19. Die möglichen organisatorischen Barrieren gegenüber der Anwendung der Empfehlungen wurden diskutiert.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Durch die Anwendung der Empfehlungen können Änderungen der üblichen Organisation der Gesundheitsversorgung in einer Einrichtung (Praxis, Klinik, Abteilung etc.) notwendig werden. Diese Veränderungen können die Anwendung der Empfehlungen in der täglichen Praxis behindern. Organisatorische Änderungen, die für die Realisierung der Empfehlungen notwendig sind, sollten diskutiert werden. So könnte zum Beispiel:

i. eine Leitlinie zum Schlaganfall empfehlen, dass die Patientenversorgung im Rahmen von "Stroke Units“ oder von spezialisierten Diensten koordiniert werden sollte; oder

ii. eine Leitlinie zum Diabetes mellitus in der hausärztlichen Versorgung könnte verlangen, dass die Patienten unter bestimmten Bedingungen Spezialkliniken aufsuchen sollen.

20. Die durch die Anwendung der Leitlinie möglicherweise entstehenden Kosten wurden berücksichtigt.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Für die Realisierung der Empfehlungen können u. U. zusätzliche Ressourcen erforderlich sein. Hierbei kann es sich zum Beispiel um zusätzliches, spezialisierteres Personal, um neue Geräte oder um teure Medikamente handeln, und zwar mit möglichen Auswirkungen auf Finanzbudgets. Die potenziellen Auswirkungen auf die Ressourcen sollten in der Leitlinie diskutiert werden.

21. Die Leitlinie nennt Schlüsselprüfkriterien für Monitoring und / oder Qualitätsbeurteilung.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Die Evaluation der Leitlinien-Befolgung kann ihren Gebrauch fördern. Hierfür sind klar definierte Evaluationskriterien erforderlich, die von den wichtigsten Empfehlungen der Leitlinie abgeleitet und in dieser benannt werden. Beispiele für Prüfkriterien sind:

- der HbA1c-Wert sollte < 8,0% liegen
- der diastolische Blutdruck sollte < 95 mmHg liegen
- falls die Beschwerden bei akuter Otitis media länger als 3 Tage anhalten, sollte Amoxicillin verschrieben werden.

Redaktionelle Unabhängigkeit

22. Die Leitlinie ist redaktionell von der / den finanzierenden Organisation(en) unabhängig.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Die Entwicklung von Leitlinien wird zum Teil durch Dritte finanziert (z. B. durch Regierungsstellen, Hilfswerke, Pharmaindustrie). Unterstützung kann in Form eines finanziellen Beitrages zur gesamten Leitlinienentwicklung oder zu Teilen davon erfolgen, z. B. zu den Druckkosten der Leitlinie. Es sollte eine explizite Erklärung vorhanden sein, dass die endgültigen Empfehlungen der Leitlinie nicht durch Ansichten oder Interessen der Sponsoren beeinflusst wurden.
Bitte beachten Sie: Wenn angegeben wird, dass die Leitlinie ohne externe Finanzierung entwickelt wurde, sollten Sie mit “Trifft uneingeschränkt zu“ antworten.

23. Interessenkonflikte von Mitgliedern der Leitlinien-Entwicklungsgruppe wurden dokumentiert.

Trifft überhaupt nicht zu	1	2	3	4	Trifft uneingeschränkt zu

Unter bestimmten Umständen können Mitglieder der Entwicklungsgruppe Interessenkonflikte haben. Dies trifft z. B. zu, wenn ein Mitglied der Entwicklungsgruppe auf dem von der Leitlinie betroffenen Gebiet wissenschaftlich arbeitet und dabei von einer pharmazeutischen Firma finanziell unterstützt wird.
Es sollte explizit dargelegt werden, dass alle Mitglieder der Entwicklungsgruppe sich zu möglichen Interessenkonflikten geäußert haben.

Gesamtbewertung

Würden Sie die praktischen Anwendung dieser Leitlinie empfehlen?

Nachdrücklich zu empfehlen ☐

Zu empfehlen (unter Vorbehalt / nach Änderung) ☐

Nicht zu empfehlen ☐

Unsicher ☐

8.2 Structured guideline summaries

Structured guideline summary

Title:

Praxisleitlinien in Psychiatrie und Psychotherapie. Band 1 Behandlungsleitlinie Schizophrenie.

Publication date:

1998, first version

Organisation:

Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde

Type of guideline or of guideline development process:

Guideline produced by national psychiatric association

Number of pages:

68

Contents:

1. Basics about epidemiology, course, prognosis, pathogenesis
2. Diagnosis and Classification
3. Treatment
4. Short-version of the guideline
5. Graphical display of algorithms

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline and the clinical questions covered by the guideline are not specifically described. There is a clear description that the guideline refers to patients with schizophrenia diagnosed according to DSM-IV, but there is no reference to other variables such as age ranges, severity of illness, comorbidity etc.

Score = 5 (1.7)

2. Stakeholder Involvement (Items 4-7)
The guideline development group included mainly psychiatry professors which are listed by their names, but their personal contributions are not specified. Patients' views and preferences have not been sought. The target users are only vaguely specified by the notion "the practically therapeutically active". The guideline has not been piloted among end-users.

Score = 6 (1.5)

3. Rigour of Development (Items 8-14)
There was no systematic process to search for/select the evidence. The methods used for formulating the recommendations are explained in the introduction, but details of this process are missing. There is a whole chapter describing the side-effects of antipsychotic drugs so that the risks of the recommendations have been considered in formulating the recommendations. There is only a general reference list, but no explicit link between the recommendations and the supporting evidence.

The guideline contains new evidence that could have an important impact on management. The guideline has been externally reviewed by psychiatric experts, but there are no reviews from methodological experts or patients' representatives. A procedure for updating the guideline is not provided.

Score = 18 (2.3)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable by graphical algorithms. Some tools for application such as algorithms, a short-version and an internet access to the guideline are provided.

Score = 16 (3.2)

5. Applicability (Items 19-21a)
Potential organisational barriers are not consistently discussed. National particularities have not been considered. There is no consideration of cost issues. Key review criteria for monitoring and/or audit purposes are only vaguely indicated. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 7 (1.4)

6. Editorial Independence (Items 22-23)
There is no comment on external funding or conflicts of interest of the development members.

Score =2 (1.0)

7. Overall assessment
Would not recommend

Overall assessment:

The guideline has serious short-comings in five of six of the domains of the AGREE instrument. Its strongest point is its clear and rather unambiguous recommendations, although the process of how these recommendations have been obtained and what the evidence behind these recommendations is has not been specified. This led us to the overall assessment of not recommending the guideline.

Notes:

The guideline was developed within a collection of several other treatment guidelines of the German psychiatric association.

References:

Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde Praxisleitlinien in Psychiatrie und Psychotherapie. Band 1, Schizophrenie. Darmstadt: Steinkopff Verlag; 1998.

Internet Link:

http://www.dgppn.de/leitlinien/039051.pdf (this link refers to the short version only)

Structured guideline summary

Title:

Psychosocial Interventions in the Management of Schizophrenia (SIGN publication number 30)

Publication date:

October 1998, first version

Organisation:

The Scottish Intercollegiate Guidelines Network (SIGN) was established in 1993 by the Academy of Royal Colleges and their Faculties in Scotland, to develop evidence-based clinical guidelines for the National Health Service (NHS) in Scotland.

General type of guideline or of guideline development process:

Systematic development with the aim of the establishment of an evidence based guideline.

Number of pages:

15

Contents:

1. Introduction
2. What are psychosocial interventions?
3. Psychosocial interventions in clinical practice
4. Implementation of the guideline
5. Recommendations for audit and research
6. Annex
7. References

National particularities:

National particularities are not stressed

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are only described in the title of the guideline. A detailed description of the clinical questions covered by the guideline is not provided. The patients to whom the guideline is meant to apply are not specifically described.

Score = 4 (1.3)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes individuals from all the relevant professional groups. It is stated that the patients' views and preferences have been sought, patients or their representatives are included in all guideline development groups. The target users of the guideline are not clearly defined. The guideline has not been piloted among end-users, but SIGN holds a national open meeting to discuss the draft recommendations of each guideline.

Score = 11 (2.8)

3. Rigour of Development (Items 8-14)
Systematic methods such as search in electronic databases, Cochrane Library etc. were used to search for evidence. The criteria for selecting the evidence are clearly described,and there is a clear description of the methods used to formulate the recommendations. The health benefits, side effects and risks have been considered in formulating the recommendations. There are explicit links between the recommendations and the supporting evidence, and the guideline contains new evidence that could have an important impact on management. All recommendations were coded according to the level of evidence supporting them.The guideline has been externally reviewed by experts prior to its publication. All SIGN guidelines carry a review date which requires that they should be assessed two years after the publication date.

Score = 32 (4)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolet. Key recommendations are easily identifieable. The guideline is supported with a quick reference guide.

Score = 17 (3.4)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the recommendations are discussed. Local (national) particularities have not been considered. The potential cost implications of applying the recommendations have not been considered. Key review criteria for monitoring and/or audit purposes are discussed. It is stated that a monitoring of the guideline implementation will be carried out by the Clinical Standards Board for Scotland (CSBS).

Score = 12 (2.4)

6. Editorial Independence (Items 22-23)
The SIGN guideline development programme is funded by the Clinical Resource and Audit Group (CRAG) of the Scottish Executive Health Department. All members of SIGN guideline development groups are required to complete a declaration of interests.

Score =5 (2.5)

7. Overall assessment
Would strongly recommend

Overall assessment:

The editors attached great importance on the development of an evidence-based guideline. The composition of the guideline development group, the methods used to search for and selecting the evidence, the coding of the evidence, the methods used for formulating the recommendations etc. are clearly explained so that the user of the guideline gets the important background information for assessing the guideline. The recommendations are also clearly presented. Despite certain weaknesses in other fields of the AGREE instrument the guideline can therefore be strongly recommended as an evidence-based guideline.

Notes:

The guideline was developed within a collection of several other guidelines of SIGN.

References:

Scottish Intercollegiate Guidelines Network (SIGN). Psychosocial Interventions in the Management of Schizophrenia. SIGN publication No. 30. Edinburgh: SIGN: 1998

Internet Link:

www.sign.ac.uk

Structured guideline summary

Title:

Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care.

Publication date:

December 2002, first version

Organisation:

National Institute of Clinical Excellence (NICE)

Type of guideline or of guideline development process:

Evidence-based guideline

Number of pages:

64

Contents:

National particularities:

National particularities are considered in the guideline.

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives are specifically described in the title of the guideline. A detailed description of the clinical question covered by the guideline is not provided. The patients to whom the guideline is meant to apply are described in chapter two, “Notes on the scope of the guideline”.

Score = 8 (2.7)

2. Stakeholder Involvement (Items 4-7)
In appendix B of the guideline the members of the guideline development group are listed. It included doctors of various specialties, psychologists, health economists, a nurse, etc. Patients’ opinions were sought, because patient group representatives were in the appraisal committee. The target users of the guideline are clearly defined. The guideline has not been piloted among end-users.

Score = 13 (3.3)

3. Rigour of Development (Items 8-14)
Systematic reviews and meta-analyses with extensive searches were done for the establishment of the guideline. The criteria for selecting the evidence are clearly described in appendix A. There is an extensive description of the very long development process of NICE guidelines in general. How discussion were resolved is not absolutely clear (terms such as Delphi process are not mentioned). The side-effects, health benefits and risks of the recommendations are considered. In the guideline itself there are no references. The guideline did an up to date literature review, thus a lot of new evidence was collected. A number of external experts reviewed the guidelines before their publication and these are listed by name. A procedure for updating the guideline is provided.

Score = 28 (3.5)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. The different options for management of the conditions are mentioned. The guideline mentions methods that seem to be unsuitable, unnecessary or obsolete. The guidance paper is quite concise by itself, there is no further highlighting of key recommendations. There is one important tool for application which is a patient information section.

Score = 16 (3.2)

5. Applicability (Items 19-21a)
Potential organisational barriers are not discussed in detail. Some national particularities have been considered, e.g. there is a chapter on the implementation of the guideline in the National Health service. The potential cost implications of applying the recommendations are not discussed. A whole chapter is used for the description of key review criteria for monitoring and/or audit purposes. There is a description on how implementation might be monitored (chapter 3 “implementation”), but this is rather brief.

Score = 12 (2.4)

6. Editorial Independence (Items 22-23)
The guideline seems to be independent from the funding body, but this could be described more clearly. Conflicts of interest of the guideline members had to be stated and in case of relevant conflict of interest members of the appraisal group were excluded.

Score =7 (3.5)

7. Overall assessment
Would strongly recommend

Overall assessment:

This is one of the most modern and best developed guidelines identified by our search. Especially noteworthy are the use of systematic reviews that have been undertaken for the development of the guideline. Thus, this is a real evidence-based guideline. Unfortunately, the internet version of the guideline does not provide a reference list, although this would be very helpful for users.

Notes:

References:

National Institute for Clinical Excellence (NICE). Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care. Clinical Guideline 1. London: NICE; 2002.

Internet Link:

www.nice.org.uk

Structured guideline summary

Title:

Akutní ataka schizofrenie (Acute attack of schizophrenia)

Publication date:

1999

Organisation:

Czech psychiatric association

General type of guideline or of guideline development process:

Guideline produced by two experts

Number of pages:

12

Contents:

National particularities:

Some national particularities have been considered, e.g. some information about the antipsychotics that are used in the Czech Republic is given.

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is to improve the knowledge of psychiatrists and GP's in the treatment of schizophrenia. The clinical questions covered by the guideline are not described. The patients to whom the guideline is meant to apply are described as patients with schizophrenia diagnosed according to the criteria defined in ICD-10.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group consisted of an expert who was appointed by the Czech society of psychiatry and one reviewer. The patients' views and preferences have not been explicitely sought. The target users of the guideline are defined as psychiatrists, but also general practitioners and doctors from other specialties. The draft version of the guideline has been published two years before the publication of the guideline in a Czeck psychiatric journal. The readers had the possibility to make comments and then it was discussed during a meeting of the society of psychiatry.

Score = 9 (2.3)

3. Rigour of Development (Items 8-14)
There is no information about the methods that were used to search for evidence and also the criteria for selecting the evidence are not described. The methods used for formulating the recommendations are rather clearly described: an expert wrote the guideline, one reviewer commented on it, the draft was published in a Czech psychiatric journal so that others could comment on it and finally the guideline was accepted by the national psychiatric association. The health benefits, side effects and risks have been considered in formulating the recommendations. There are explicit links between the recommendations and the supporting

evidence. The guideline contains new evidence that could have an important impact on management. The guideline has been externally reviewed prior to its publication. It is stated in a general introduction that the guideline should be updated.

Score = 23 (2.9)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous and the different options for management of the condition are clearly presented. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable. The guideline is not supported with tools for application.

Score = 14 (2.8)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the guideline are somewhat discussed, e.g. it is stated that the treatment teams should include social workers, psychologists and case managers. Some national particularities have been considered, e.g. some information about the antipsychotics that are used in the Czech Republic are given. Some cost implications of applying the recommendations are discussed. Some key review criteria for monitoring and/or audit purposes are presented. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 13 (2.6)

6. Editorial Independence (Items 22-23)
The guideline has been developed by the Czech society of psychiatry, but whether it was produced really independently from the pharmaceutical companies which are presented on one of the first pages of the guideline is unclear. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1.0)

7. Overall assessment
Would not recommend

Overall assessment:

This guideline on the treatment of schizophrenia has been developed by an expert who was appointed by the Czech society of psychiatry, other relevant professional groups were not involved. The strength of this guideline is its clarity and its short presentation, so that it is a user-friendly compendium. Another strong point is that at least potential organisational barriers are discussed. This was not done by many guidelines assessed during this project. Unfortunately, there is no information about the methods that were used to search for evidence and the criteria for selecting it. These are core components of the concept of “evidence-based medicine” so that it was thought that the guideline cannot be recommended.

Notes:

References:

Libiger J. Akutni ataka schizofrenie. In: Houdek L, editor. Psychiatrie: Doporucene postupy psychiatricke pece. Prag: Ceska psychitricka spolecnost. Galen; 1999. p. 21-32

Internet Link:

Structured guideline summary

Title:

Schizophrénies débutantes: diagnostic et modalités thérapeutiques

Publication Date:

January 2003

Organisation:

Fédération Française de Psychiatrie selon la méthodologie de l'ANAES avec le soutien de la Direction Générale de la Santé

General type of guideline or of guideline development process:

Guideline developed by a consensus conference

Number of pages:

35

Contents:

1. Introduction

2. Diagnosis

3. Treatment

4. Ethical and methodological questions

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are only vaguely described in the title of the guideline. The clinical questions covered by the guideline are specifically described. The characteristic symptoms of the disease are described, but a clear description of the patients to whom the guideline is meant to apply is not provided.

Score = 8 (2.7)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes individuals from all the relevant professional groups. Patients' views and preferences have been sought. The target users of the guideline are clearly defined. The guideline has not been piloted among end users.

Score = 13 (3.3)

3. Rigour of Development (Items 8-14)
The guideline does not provide a detailed description of the methods that were used to search for evidence. The criteria for selecting the evidence are not described. The methods used for formulating the recommendations are described. The health benefits, side effects and risks have been considered in formulating the recommendations. There are explicit links between the recommendations and the supporting evidence. The guideline contains new evidence that could have an important impact on management. The guideline has not been externally reviewed by experts prior to its publication. A procedure for updating the guideline is not provided.

Score = 18 (2.3)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline mentions only some methods that seem to be unsuitable, unnecessary or

obsolete. Key recommendations are easily identifiable. The guideline is not supported with tools for application.

Score = 13 (2.6)

5. Applicability (Items 19-21a)
Potential organisational barriers in applying the recommendations have been discussed. National particularities have not been considered. There is no consideration of cost issues. Key review criteria for monitoring and/or audit purposes are only vaguely indicated. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 9 (1.8)

6. Editorial Independence (Items 22-23)
There is no comment on external funding or conflicts of interest of the group members.

Score =2 (1.0)

7. Overall assessment
Would not recommend

Overall assessment:

This guideline was developed by a consensus conference. The clinical questions covered by the guideline are indicated, and the key recommendations are easily identifiable. Unfortunately, the methods used to search for evidence and the criteria for selecting this evidence are not described, and the reference list is short. As these are very important components of an evidence-based guideline, we think that this guideline cannot be recommended.

Notes:

References:

Fédération Francaise de Psychiatrie. Schizophrénies débutantes: diagnostic et modalités thérapeutiques. Conférence de consensus, organisée par Fédération Francaise de Psychiatrie selon la méthodologie de l'ANAES avec le soutien de la Direction Générale de la Santé ; 2003 jan 23-24. http://psydoc-fr.broca.inserm.fr/conf&rm/conf/confschizo2/recommlongues.htm (accessed September 2003)

Internet Link:

http://psydoc-fr.broca.inserm.fr/conf&rm/conf/confschizo2/recommlongues.htm

Structured guideline summary

Title:

Schizofreni och schizofreniliknande tillstånd - kliniska riktlinjer för utredning och behandling

Publication date:

October 1998, first version

Organisation:

Svenska Psykiatriska Föreningen och Spri.

General type of guideline or of guideline development process:

Guidelines produced by a task force of experts.

Number of pages:

50

Contents:

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guidelines are not specifically described. A detailed description of the clinical questions covered by the guidelines is not provided. The guidelines refer to patients with schizophrenia and schizophreniform disorders diagnosed according to the criteria defined in DSM-IV and ICD-10, but there is no further description such as is suggested by the AGREE instrument.

Score = 4 (1.3)

2. Stakeholder Involvement (Items 4-7)

The guideline development group included only doctors, who are listed by name, but no further information is provided, and other professional groups such as psychologists or social workers have not been involved. The patients' views and preferences have not been solicited. The target users of the guidelines are specified to be psychiatrists, but the guidelines are claimed to be useful for patients, relatives and administrators or politicians. The guidelines have not been piloted among end users.

Score = 7 (1.8)

3. Rigour of Development (Items 8-14)
The systematic methods that were used to search for evidence are not described in detail. The criteria for selecting the evidence are not described. The methods used for formulating the recommendations are briefly described: A working group of seven people wrote a draft of the guidelines and sent it to a board of the Association of Psychiatrists. Then the guidelines were distributed at the annual meeting and final decisions were made by the board. The health benefits, side effects and risks have been considered only vaguely in formulating the recommendations. There are no explicit links between the recommendations and the supporting evidence. The guidelines do not contain new evidence that could have an important impact on management, but deal mostly with outdated books. The guidelines were sent only to the board of psychiatry for a review prior to its publication. The guidelines are to be updated every third year if there is a need for this.

Score = 14 (1.8)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Some therapeutic options for the management of schizophrenia are presented, but these are not very extensive. The guidelines mention some methods that seem to be unsuitable, unnecessary or obsolete, e.g. anticholinergic drugs should not be given routinely. Key recommendations are not easily identifiable. The guidelines are supported by some tools for their application, such as the Global Assessment of Functioning Scale, a checklist for blood-tests etc..

Score = 12 (2.4)

5. Applicability (Items 19-21a)
Potential organisational barriers in applying the guidelines are not discussed. Local (national) particularities have not been considered. The potential cost implications of applying the recommendations have not been considered. The guidelines provide a list of key review criteria for monitoring and/or audit purposes, e.g. how many involuntarily admitted patients have been informed that they are involuntary or how many treatment plans are written. The guidelines do not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 8 (1.6)

6. Editorial Independence (Items 22-23)
It is stated that the 200,000 crowns which were used for the meetings were provided by the hospital owners, and there is no explicit statement that the guidelines are independent of this funding. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

These guidelines on schizophrenia were developed by a college of Swedish doctors who are listed by name, but it is not possible to discern whether other important professional groups such as psychologists and nurses were involved. A strong point of the guidelines is that key review criteria for monitoring and audit purposes are presented in detail, as is required by the AGREE instrument. This was done by hardly any other guidelines examined during this project. It is stated that systematic methods were used to search for evidence, but this process is not described in the guidelines, and a description of the criteria for selecting the evidence is also lacking. Explicit links between the

recommendations and the supporting evidence are not provided. Considering these facts, we feel that these guidelines cannot be considered as evidence-based.

Notes:

References:

Svenska Psykiatriska Föreningen och Spri. Schizofreni och schizofreniliknande tillstånd - kliniska riktlinjer för utredning och behandling. Svensk Psykiatri Number 1. Stockholm: Spris förlag; 1998.

Internet Link:

Structured guideline summary

Title:

SBU: Evidence based nursing for the treatment of schizophrenia

Publication date:

1999, first version

Organisation:

SBU

General type of guideline or of guideline development process:

Rather a systematic review than actual guidelines

Number of pages:

71

Contents:

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guidelines is to present the scientific basis for nursing. The clinical questions covered by the guidelines are not specifically described. The patients to whom the guidelines are meant to apply are not described, and there is only a brief description of schizophrenia without any diagnostic criteria.

Score = 5 (1.7)

2. Stakeholder Involvement (Items 4-7)
It is unclear whether the guideline development group included individuals from all relevant professional groups, since only the names of three authors and six experts are listed, but not their professions. The patients' views and preferences have not been solicited, but the aim of these guidelines is rather to present a systematic review of what is known about nursing. The target users of the guidelines are not clearly defined. The guidelines have not been piloted among end users.

Score = 4 (1)

3. Rigour of Development (Items 8-14)
The systematic methods that were used to search for evidence are described in detail: Searches have been made in electronic databases such as Medline, Embase, Cinahl and the Cochrane Library, and the exact search terms are provided. The criteria for selecting the evidence are clearly described: there was a language restriction to English and Scandinavian languages. The studies were classified into 5 different groups (randomised, prospective, retrospective etc.). The 336 references found were read and irrelevant study publications were omitted skipped. The 155 studies which were left were read by 2 independent persons, 61 studies and 22 reviews remained, so that in the end 35 reports were registered and presented in a table of included studies. The aim of the guidelines is not to provide recommendations, but only to provide a systematic review; and for this the methods used for formulating the guidelines are clearly described. The health benefits, side effects and risks have not been considered in formulating the recommendations, but this item is not applicable, since no actual recommendations on specific interventions are given. There are no actual recommendations, so the question of explicit links is not applicable. The guidelines contain new evidence that could have an important impact on management. There is no information given on an external review of the guideline prior to its publication. A procedure for updating the guideline is not provided.

Score = 20 (2.5)

4. Clarity and Presentation (Items 15-18)
The guidelines discuss areas in which there is a lack of studies, but the fields it mentions are very broad. The item on the different options for management of the condition is not applicable. The guidelines mention methods that seem to be unsuitable, unnecessary or obsolete, e.g. there are some comments on case management which is unnecessary. Key recommendations are not easily identifiable, even in the conclusion section. The guidelines are not supported by tools for their application.

Score = 9 (1.8)

5. Applicability (Items 19-21a)
The item on potential organisational barriers in applying the recommendations does not relate to this kind of guidelines. Local (national) particularities have not been considered. It is stated that studies on cost implications have not been found and that there is a need for studies on this topic. The item on the presentation of key review criteria for monitoring and/or audit purposes is not applicable. The guidelines do not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 7 (1.4)

6. Editorial Independence (Items 22-23)
The guideline development was funded by SBU, which is a government agency, and there is no comment on independence of the funding body. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would recommend with provisos

Overall assessment:

The aim of these guidelines is to present the scientific basis for nursing. Therefore, an extensive systematic review has been made and the systematic methods of this search are described in detail. Some of the items of the AGREE Instrument are not applicable to this work on evidence-based nursing, but we believe that we can recommend it as a good systematic review.

Notes:

References:

SBU - Statens beredning för medicinsk utvärdering. Behandling av personer med schizofreni. Evidensbaserad omvårdnad, number 4. Stockholm: SBU; 1999.

Internet Link:

www.sbu.se

Structured guideline summary

Title:

God scocialpsykiatrisk standard i behandling af unge og voksne med skizofreni

Publication date:

2001, first version

Organisation:

Dansk Psykiatrisk Selskabs Udvalget for Socialpsykiatrisk Behandling

Type of guideline or of guideline development process:

Guideline produced by a task force of experts

Number of pages:

24

Contents:

National particularities:

National particularities have been considered, e.g. Danish national laws are specifically mentioned.

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are not specifically described. The clinical questions covered by the guideline are not described. The patients to whom the guideline is meant to apply are described as patients with schizophrenia diagnosed according to the criteria defined by ICD-10, but no further details are presented.

Score = 4 (1.3)

2. Stakeholder Involvement (Items 4-7)
The guideline development group consisted of a committee of the Danish society of Psychiatry. No further details are presented so that it is unclear whether the guideline development group included members of all relevant professional groups. The patients' views and preferences have not been sought. The target users of the guideline are not defined. The guideline has not been piloted among end users.

Score = 4 (1)

3. Rigour of Development (Items 8-14)
There is no information about the methods that were used to search for evidence, and the criteria for selecting the evidence are not described. The methods used for formulating the recommendations are not described. It seems that the health benefits, side effects and risks have not been considered in formulating the recommendations. There are some explicit links between the recommendations and the supporting evidence. The guideline contains some new evidence

that could have an important impact on management. The guideline has not been externally reviewed prior to its publication. A procedure for updating the guideline is not provided.

Score = 11 (1.4)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. The different options for management of the condition are not presented, but this item does not apply to this guideline which focusses on quality criteria. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are not very easily identifiable. The guideline is not supported with tools for application.

Score = 9 (1.8)

5. Applicability (Items 19-21a)
Some potential organisational barriers in applying the guideline are discussed, e.g. there should be special persons in job centres who could deal with the difficult placement in jobs of patients with schizophrenia. National particularities have been considered, e.g. Danish national laws are specifically mentioned. The potential cost implications of applying the recommendations have not been considered. The guideline presents key review criteria for monitoring and/or audit purposes, because this is the objective of this guideline. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 12 (2.4)

6. Editorial Independence (Items 22-23)
There is no information provided about external funding.
Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

This guideline on good social psychiatry standards in the treatment of adolescents and adults with schizophrenia was developed by a committee of the Danish society for psychiatry, and it seems that other relevant professional groups such as psychologists and social workers were not involved. Information about the methods that were used to search for evidence, the criteria for selecting the evidence and the methods used for formulating the recommendations is not provided. Therefore, a jugdement of the scientific basis of the recommendations is difficult to make so that we decided that the guideline could not be recommended.

Notes:

References:

Nordentoft M, Kelstrup A, Garde K, Helle Aggernæs K, Eldrup I, Bonde E. God scocialpsykiatrisk standard i behandling af unge og voksne med skizofreni. Udvalget for Socialpsykiatriske Behandlingsmetoder i Psykiatri. Klaringsrapport no. 6. København: Lægeforeningens forlag; 2001.

Internet Link:

Structured guideline summary

Title:

Richtlijn antipsychoticagebruik bij schizofrene psychosen

Publication date:

1998, first version

Organisation:

Nederlandse Vereniging voor Psychiatrie

General type of guideline or of guideline development process:

Guideline produced by a working group under the responsibility of the Dutch psychiatric association.

Number of pages:

22

Contents:

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is to give recommendations for the use of antipsychotics in the treatment of patients with schizophrenia. A detailed description of the clinical questions covered by the guideline is not provided. The patients to whom the guideline is meant to apply are not very specifically described.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group consists of psychiatrists and one pharmacologist; other relevant professional groups were not involved. There is no information given as to whether patients' views and preferences have been sought. The target users of the guideline are not clearly defined. The guideline was not piloted among end-users.

Score = 5 (1.3)

3. Rigour of Development (Items 8-14)
It is stated that the guideline is based on the APA guideline "Practice Guideline for the Treatment of Patients with Schizophrenia". In this American guideline, systematic methods were used to search for evidence, and the criteria for selecting the evidence as well as the methods used for formulating the recommendations are clearly described. The Dutch guideline describes only its criteria for selecting the evidence (three levels).

The health benefits, side effects and risks were considered in formulating the recommendations. There are no explicit links between the recommendations and the supporting evidence, as the only reference that is indicated is the APA guideline. The APA guideline contains new evidence that could have an important impact on management, but in the Dutch guideline a reference list is lacking. There is no information given as to external reviewing of the guideline prior to its publication. It is mentioned that the guideline should be updated within five years.

Score = 18 (2.3)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline mentions only some methods that seem to be unsuitable, unnecessary or obsolete, e.g. the contraindication for different drugs. Key recommendations are easily identifiable, e.g. many flow charts are provided. The guideline is not supported by tools for application.

Score = 15 (3)

5. Applicability (Items 19-21a)
Some potential organisational barriers in applying the recommendations are discussed. Local (national) particularities have not been considered. The potential cost implications of applying the recommendations have not been considered. The guideline presents some key review criteria for monitoring and/or audit purposes. The guideline does not describe methods that help to find out by whom and to what extent the recommendations are to be used in practice.

Score = 7 (1.4)

6. Editorial Independence (Items 22-23)
It is stated that the guideline development group worked independently and without any conflict of interest.

Score =6 (3)

7. Overall assessment
Would recommend with provisos

Overall assessment:

This guideline on the use of antipsychotics was developed by a working group under the responsibility of the psychiatric association of the Netherlands. It is presented in a well-designed booklet and its clarity and presentation are very good. It is stated that the guideline is a summary of the guideline on schizophrenia by the American Psychiatric Association. Information about the methods that were used to search for evidence and the methods used for formulating the recommendations are not provided, so that the user of the guideline needs the APA publication to assess the scientific evidence of the recommendations. The quality of the APA guideline was considered to be good by us. A positive aspect is the coding of the recommendations in three levels according to their scientific evidence. Considering these facts, we believe that the guideline can be recommended with provisos.

Notes:

References:

Buitelaar JK, van Ewijk WM, Harms HH, Kahn RS, Linszen DH, Loonen AJM, Louwerens JW, Slooff CJAJ. Richtlijn antipsychoticagebruik bij schizofrene psychosen. Amsterdam: Uitgeverij Boom; 1998.

Internet Link:

Structured guideline summary

Title:

Skitsofrenian Käypä Hoito

Publication date:

February 2001, first version

Organisation:

Suomen Psykiatriyhdistys ry

General type of guideline or of guideline development process:

Systematic development with the aim of establishing evidence based guidelines.

Number of pages:

97

Contents:

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is to guide doctors and other health carers in primary care and hospitals in the treatment of schizophrenia. The clinical questions covered by the guideline are not described. The patients to whom the guideline is meant to apply are described as patients with schizophrenia diagnosed according to the criteria defined in ICD-10. Children with schizophrenia are excluded.

Score = 5 (1.7)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes mainly psychiatrists and general practitioners, other professional groups are not involved. The patients' views and preferences have not been solicited. The target users of the guidelines are stated to be doctors and general

practitioners and other health personnel involved in the treatment of schizophrenia. The guidelines have not been piloted among end users.

Score = 7 (1.8)

3. Rigour of Development (Items 8-14)
There is only a statement that the Cochrane Library and a Medline search of the last 5 years were the sources of the search for evidence. The recommendations are coded according to four levels of evidence (A, B, C and D). The methods used for formulating the recommendations are clearly described in a separate handbook. The health benefits, side effects and risks have been considered in formulating the recommendations. There are explicit electronic links between the recommendations and the supporting evidence. The guideline contains new evidence that could have an important impact on management. The guidelines have been externally reviewed prior to its publication. A procedure for updating the guideline is provided. It is to be be updated on a yearly basis.

Score = 28 (3.5)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. The different options for management of the condition are clearly presented. The guideline mentions methods that seem to be unsuitable, unnecessary or obsolete, e.g. megadoses should be avoided and psychoanalysis is not recommended. Key recommendations are easily identifiable. The guideline is supported by several tools for application, such as a patient guide and a CD-ROM.

Score = 19 (3.8)

5. Applicability (Items 19-21a)
Some potential organisational barriers in applying the guideline are discussed. National particularities have not been considered. The cost implications of applying the recommendations have not been considered. Key review criteria for monitoring and/or audit purposes are only very vaguely presented. The guideline does not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 7 (1.4)

6. Editorial Independence (Items 22-23)
The guideline has been developed without external funding. Conflicts of interest of guideline development members have been recorded.

Score =8 (4)

7. Overall assessment
Would recommend with provisos

Overall assessment:

This is an evidence-based treatment set of guidelines which uses the Cochrane Library as its main source of evidence. On the CD-Rom version the abstracts of the Cochrane Reviews can be looked up by clicking on a link. Other sources of evidence are rated according to an A to D scoring system. The methods used for formulating the recommendations are clearly described in an additional handbook. The guidelines have been externally reviewed prior to its publication. The main weaknesses are that the guideline group consisted only of psychiatrists and GP's, that patients' views have not been solicited and that the guidelines have not been piloted among end-users. With these restrictions, the guideline can be recommended for use in practice.

Notes:

References:

Suomen Psykiatriyhdistys ry. Skitsofrenian käypä hoito. Helsinki: Duodecim; 2001

Internet Link:

www.duodecim.fi/kh

Structured guideline summary

Title:

Linee guida per la farmacoterapia della schizofrenia

Publication date:

2000, revised version

Organisation:

Società Italiana di Psicopatologia

General type of guideline or of guideline development process:

Guidelines developed by a consensus conference of experts.

Number of pages:

31

Contents:

1. Diagnosis
2. Strategy of therapy
3. Intervention
4. Treatment of extrapyramidal side effects
5. Conclusion
6. Algorithms 1-12

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guidelines is to improve the treatment of schizophrenia and make it more efficacious. A detailed description of the clinical questions covered by the guidelines is not provided. It is mentioned that the guidelines refer to patients with schizophrenia diagnosed according to ICD-10 and DSM-IV, and these criteria are listed.

Score = 7 (2.3)

2. Stakeholder Involvement (Items 4-7)
The guideline development group consists only of psychiatrists; other professional groups were not involved. There is no information given as to whether patients' views and preferences were solicited. The target users of the guideline are defined as "psychiatric colleagues". The guidelines were not piloted among end-users.

Score = 6 (1.5)

3. Rigour of Development (Items 8-14)
It is stated that the guidelines are based on a consensus conference, but further information e.g. about the search strategy is not provided. The criteria for selecting the evidence are not indicated and the methods used for formulating the recommendations are not described. The health benefits, side effects and risks were considered in formulating the recommendations. There are no explicit links between the recommendations and the supporting evidence, as a reference list is missing. Therefore, it is unclear whether the guidelines contain new evidence that could have an important impact on management. There is no information given about external reviewing of the guidelines prior to their publication.

A procedure for updating the guidelines is not provided.

Score = 10 (1.3)

4. Clarity and Presentation (Items 15-18)
The recommendations are quite specific and unambiguous. Different treatment options are clearly presented, e.g. different antipsychotics are described. The guidelines mention only some methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are not very easily identifiable. The guidelines are supported by twelve algorithms as tool for application.

Score = 13 (2.6)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the recommendations are not discussed. Local (national) particularities are not considered. The potential cost implications of applying the recommendations are not considered. The guidelines do not present key review criteria for monitoring and/or audit purposes. The guidelines do not describe methods that help to find out by whom and to what extent the recommendations are to be used in practice.

Score = 5 (1)

6. Editorial Independence (Items 22-23)
There is no information provided about external funding. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

These guidelines on the pharmacotherapy of schizophrenia were developed by a committee of psychiatrists under the responsibility of the Italian psychiatric association. The different treatment options are clearly presented and the twelve algorithms are a helpful tool for the user. Unfortunately, the exact process to obtain a consensus, the methods that were used to search for evidence and the criteria for selecting it are not indicated, and even a reference list is lacking. This makes it very difficult for the user of the guidelines to judge the scientific basis of the recommendations, so that the guideline could not be generally recommended.

Notes:

References:

Pancheri P (coordinator). Consensus conference della Società Italiana di Psicopatologia. Linee guida per la farmacoterapia della schizofrenia. Giorn Ital Psicopat 2000; 6 (Suppl. 3): 1-31

Internet Link:

Structured guideline summary

Title:

Schizofreni - kliniske retningslinjer for utredning og behandling

Publication date:

November 2000, first version

Organisation:

Statens helsetilsyn, Norway.

General type of guideline or of guideline development process:

Essentially a translation of another set of guidelines

Number of pages:

57

Contents:

National particularities:

Only a few national particularities have been considered in the chapter "organisation of care in Norway

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guidelines is to improve quality in mental health care, but a more detailed description is not given. The clinical questions covered by the guidelines are not specifically described. It is stated that the guidelines apply to patients with schizophrenia, diagnosed according to the criteria defined in ICD-10.

Score = 4 (1.3)

2. Stakeholder Involvement (Items 4-7)
This guidelines are essentially a translation of the Swedish guidelines on schizophrenia, which were reviewed by ten Norwegian experts, but a guideline development group of their own did not exist. The patients' views and preferences have not been solicited. The target users of the guidelines are defined only as various health professionals and consumers. The guidelines have not been piloted among end users.

Score = 5 (1.3)

3. Rigour of Development (Items 8-14)
The systematic methods that were used to search for evidence and the criteria for selecting the evidence are not described. The methods used for formulating the recommendations are briefly described: The translation of the Swedish guidelines was sent to ten experts for review. It was then revised and presented once again to the experts before it was submitted to the editor. The health benefits, side effects and risks have been considered only vaguely in formulating the recommendations. There are no explicit links between the recommendations and the supporting evidence. The guidelines do not contain new evidence that could have an important impact on management. The guidelines have been reviewed by ten experts prior to their publication. A procedure for updating the guidelines is not provided, but there is a global statement that it has to be revised regularly.

Score = 14 (1.8)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. The different options for management of the condition are not very clearly presented, e.g. different classes of drugs such as conventional and atypical antipsychotics are not discussed. The guidelines mention some methods that seem to be unsuitable, unnecessary or obsolete, e.g. anticholinergic drugs should not be given prophylactically. Key recommendations are not easily identifiable. The guideline is not supported by tools for application.

Score = 10 (2)

5. Applicability (Items 19-21a)
Potential organisational barriers in applying the guidelines are not discussed. Some national particularities have been considered in the chapter "Organisation of Care in Norway". The potential cost implications of applying the recommendations have not been considered. The guidelines do not present key review criteria for monitoring and/or audit purposes. The guidelines do not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 6 (1.2)

6. Editorial Independence (Items 22-23)
No information on external funding is provided. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

These guidelines on schizophrenia are essentially a translation of Swedish guidelines which have been developed by a college of Swedish doctors and were then sent to ten Norwegian experts for review and modification according to the Norwegian situation. It is stated in the Swedish guidelines that systematic methods were used to search for evidence, but this process is not described in the guidelines, and a description of the criteria for selecting the evidence is also lacking. Explicit links between the recommendations and the supporting evidence are not provided. For these reasons we felt that these guidelines could not be regarded as evidence based.

Notes:

References:

Statens helsetilsyn. Schizofreni - kliniske retningslinjer for utredning og behandling. Utredningsserie 9-2000. Oslo: Statens helsetilsyn; 2000.

Internet Link:

www.helsetilsynet.no

Structured guideline summary

Title:

4 x 8 Empfehlungen zur Behandlung von Schizophrenie

Publication date:

2002, first version

Organisation:

Österreichische Gesellschaft für Psychiatrie und Psychotherapie

General type of guideline or of guideline development process:

Mainly expert consensus process.

Number of pages:

93

Contents:

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is to give recommendations for the treatment of schizophrenia. A detailed description of the clinical questions covered by the guideline is not provided. There is a clear description that the guideline refers to patients with schizophrenia, diagnosed according to ICD-10 and DSM IV, but there is no reference to other variables such as age ranges, severity of illness, comorbidity etc.

Score = 7 (2.3)

2. Stakeholder Involvement (Items 4-7)
It is stated that the guideline development group mainly consisted of four psychiatrists, and that colleagues and “other interested persons” were involved. There is no information given whether patients’ views and preferences have been sought. The target users of the guideline are clearly defined as psychiatrists. The guideline has not been piloted among end-users.

Score = 8 (2)

3. Rigour of Development (Items 8-14)
The guideline development group used systematic methods such as search in electronic databases but also “clinical wisdom” to develop this guideline, but detailed information of the databases that

were used for the search are not mentioned. The criteria for selecting the evidence are clearly described: the recommendations are keyed in three levels of evidence from A to C.
There is a clear description of the methods used for formulating the recommendations: four psychiatrists were the main authors of the guideline, and the draft versions of the guideline have been discussed on several meetings. The health benefits, side effects and risks have been considered in formulating the recommendations. The guideline does not provide explicit links between the recommendations and the supporting evidence, but each chapter is supported with links to the used literature. The guideline contains new evidence that could have an important impact on management. There is no information given about external reviewing of the guideline prior to its publication. A procedure for updating the guideline is not provided.

Score = 22 (2.8)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline mentions methods that seem to be unsuitable, unnecessary or obsolete, e.g. some obsolete treatment strategies are mentioned. Key recommendations are easily identifiable. The guideline is supported with tools for application.

Score = 20 (4)

5. Applicability (Items 19-21a)
Potential organisational barriers are not discussed, and national particularities are not mentioned. The potential cost implications of applying the recommendations have not been considered. Key review criteria for monitoring and/or audit purposes are shortly mentioned (chapter on “therapy-control”). The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 6 (1.2)

6. Editorial Independence (Items 22-23)
There is no information given about any funding body. Conflicts of interest of guideline development members are not recorded.

Score =2 (1)

7. Overall assessment
Would recommend with (strong) provisos

Overall assessment:

The guideline development group attached great importance on the development of an easy to use guideline. Therefore, the recommendations are presented in four chapters each of which consists of eight recommendations. The clarity and presentation of the guideline are also very good and make it easy to use in practice. A shortcoming is that the guideline development process is only shortly described, and important information, for example about the precise literature search, is not provided. Since this is a crucial component of evidence-based medicine, we think that the guidelines can only be recommended with provisos.

Notes:

References:

Katschnig H, Donat H, Fleischhacker WW, Meise U: 4 x 8 Empfehlungen zur Behandlung von Schizophrenie. Linz: Edition pro Mente; 2002.

Internet Link:

Structured guideline summary

Title:

Recommandations de la conférence de consensus belge sur le traitement de la schizophrénie

Publication date:

1999, first version

Organisation:

Consensus conférence

General type of guideline or of guideline development process:

Guideline developed by a consensus conference

Number of pages:

46

Contents:

1. Why a Belgian consensus conference on the treatment of schizophrenia?
2. Schizophrenia and schizophrenic disorders
2.1 Introduction
2.2 Diagnosis and differential diagnosis
2.3 Epidemiology
3. Presentation of the functioning of the jury of the Belgian consensus conference on the treatment of schizophrenia
4. Recommendations of the jury of the Belgian consensus conference on the treatment of schizophrenia
4.1 Prodromes of schizophrenia
4.2 The first episode of schizophrenia
4.3 Long-term treatment
4.4 Prevention

National particularities:

There is a short discussion about the situation in Belgium.

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is to bring together all responsible parties in order to provide clear recommendations for the treatment of schizophrenia and to help de-stigmatize schizophrenia among the non specialized medical public. A detailed description of the clinical questions covered by the guidelines is provided, and the recommendations are given as answers to these questions. There is a general chapter on the diagnosis of schizophrenia, but a description of age ranges, comorbidity etc. of the target population of the guideline is not provided.

Score = 9 (3)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes individuals from all the relevant professional groups, and one of the main aims of the guideline developers was to bring together members of all important professional groups. The patients' views and preferences have been solicited, as patients and relatives took part in the consensus conference. The target users of the guideline are not clearly defined. The guideline has not been piloted among end users.

Score = 11 (2.8)

3. Rigour of Development (Items 8-14)
It is stated that the experts should work according to the principles of evidence-based medicine, but a detailed description of the systematic methods that were used to search for evidence and the criteria for selecting the evidence is not provided. The methods used for formulating the recommendations are clearly described. The health benefits, side effects and risks are not discussed in much detail because it appears that the guideline developers wish rather to provide global answers to questions on the treatment of schizophrenia. There are no explicit links between the recommendations and the supporting evidence. According to its reference list, the guideline contains some new evidence that could have an important impact on management, and the reference list is very short. There was a jury which was independent of the organizing committee, but it seems that the jury was involved at several stages in the development process, so that the process cannot be considered as real external reviewing. A procedure for updating the guideline is not provided.

Score = 17 (2.1)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. The different options for management of the condition are clearly presented. The guideline makes very little mention of methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable. The guideline is not supported by tools for application.

Score = 13 (2.6)

5. Applicability (Items 19-21a)
There is no specific point in the guidelines in which potential organisational barriers in applying the recommendations are discussed. Local (national) particularities have been rather vaguely considered, e.g. there is a discussion on the conditions in Belgium. The potential cost implications of applying the recommendations are briefly considered, e.g. the problem of higher costs of new drugs is mentioned. The guideline does not present key review criteria for monitoring and/or audit purposes. The guideline does not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 8 (1.6)

6. Editorial Independence (Items 22-23)
It is stated that the guidelines are editorially independent of the funding pharmaceutical companies. Conflicts of interest of guideline development members have not been recorded.

Score =5 (2.5)

7. Overall assessment
Would not recommend

Overall assessment:

A main aim of the guideline developers was to obtain a consensus among all the relevant professional groups (even a journalist and a philosopher were involved), and patients and relatives were also participants in the consensus conference. From this point of view the guideline is one of the best in the field. The different steps of the development process are described in detail, and the guideline is very clearly arranged. However a description of the systematic methods that were used to search for evidence, e.g. the search strategy and links between the recommendations and the evidence supporting them, is lacking, and the reference list that is provided in the guidelines is very short. As these are very important components of the concept of evidence based medicine, we felt that the guideline cannot be recommended.

Notes:

References:

De Clercq M, Peuskens J, Cosyns P. Recommandations de la conférence de consensus belge sur le traitement de la schizophrénie. Bruxelles: De Boeck and Larcier; 1999.

Structured guideline summary

Title:

Shizofrenija. Priporočila in smernice za zdravljenje z zdravili (Pharmacological treatment of schiozphrenia)

Publication date:

January 2000, first version

Organisation:

Slowenian psychiatric association

General type of guideline or of guideline development process:

Guideline produced by a task force of specialists

Number of pages:

27

Contents:

National particularities:

National particularities have not been assessed

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is to help the physician to use the drugs in the treatment of schizophrenia. The clinical questions covered by the guideline are not described. The patients to whom the guideline is meant to apply are described as patients with schizophrenia. No further details are given.

Score = 5 (1.7)

2. Stakeholder Involvement (Items 4-7)
The guideline development group consisted only of doctors, other professional groups were not involved. The patients' views and preferences have not been sought. The target users of the guideline are not clearly defined. The guideline has not been piloted among end users.

Score = 4 (1)

3. Rigour of Development (Items 8-14)
There is no information given about the systematic methods that were used to search for evidence and the criteria for selecting the evidence are not described. The methods used for formulating the recommendations are shortly described: the group members used literature and their experience from clinical practice, and they used a consensus technique to arrive final decisions. The health benefits, side effects and risks have been considered in formulating the recommendations, e.g. there is a whole chapter on extrapyramidal side-effects. There are no explicit links between the recommendations and the supporting evidence. The guideline contains new evidence that could have an important impact on management. The guideline has been reviewed by the board of psychiatry prior to its publication. A procedure for updating the guideline is not provided.

Score = 16 (2)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous and the different options for management of the condition are clearly presented. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable, e.g. tables and algorithms are provided. The guideline is supported with some tools for application, e.g. tables for the dosage of different drugs are provided.

Score = 16 (3.2)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the guideline are not discussed. National particularities have not been considered. The cost implications of applying the recommendations are not discussed, but this item does not apply, because in Slovenia there is no restriction on drug costs. Key review criteria for monitoring and/or audit purposes are not presented. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 7 (1.4)

6. Editorial Independence (Items 22-23)
The independence of the guideline development group has not been explicitely stated. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1.0)

7. Overall assessment
Would not recommend

Overall assessment:

This Slovenian guideline on the drug treatment of schizophrenia was developed by doctors, and other relevant professional groups such as pharmacologists or health economists were not involved. The recommendations are presented in a small booklet, that might be a useful tool for the use in daily practice. A strong point of this guideline is its clarity and presentation with tables and algorithms.

Unfortunately, there is no information about the methods that were used to search for evidence and the criteria for selecting it. The lack of this information makes it difficult for the reader of the guideline to judge the level of scientific evidence supporting each recommendation. Therefore, this guideline can not be considered as evidence-based.

Notes:

References:

Kocmur M, Tavcar R, Žmitek A. Shizofrenija. Priporocila in smernice za zdravljenje z zdravili. Ljubljana: Viceversa, Slovenske psihiatricne publikacije; 2000.

Internet Link:

Structured guideline summary

Title:

Praxisleitlinien in Psychiatrie und Psychotherapie. Band 5 Behandlungsleitlinie Affektive Erkrankungen

Publication date:

April 2000, first version

Organisation:

Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde

General type of guideline or of guideline development process:

Systematic development with the aim of the establishment of an evidence based guideline.

Number of pages:

126

Contents:

1. Basics about epidemiology, course, prognosis, pathogenesis
2. Diagnosis and Classification
3. Treatment
4. Short-version of the guideline
5. Graphical display of algorithms

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline and the clinical questions covered by the guideline are not specifically described. There is a clear description that the guideline refers to patients with schizophrenia diagnosed according to DSM-IV, but there is no reference to other variables such as age ranges, severity of illness, comorbidity etc. as it is suggested by the AGREE instrument.

Score = 5 (1.7)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes psychiatry professors which are listed by their names, but also representatives of other professional groups. Patients' views and preferences have not been sought. The target users are only vaguely specified by the notion "the practically therapeutically active". The guideline has not been piloted among end-users.

Score = 7 (1.8)

3. Rigour of Development (Items 8-14)
There was no systematic process to search for/select the evidence. The methods used for formulating the recommendations are explained in the foreword, but details of this process are missing. There is a whole chapter describing the side-effects of antipsychotic drugs so that the risks of the recommendations have been considered in formulating the recommendations. There is only a general reference list, but no explicit link between the recommendations and the supporting evidence. The guideline contains new evidence that could have an important impact on management. The guideline has been externally reviewed by psychiatric experts. A procedure for updating the guideline is not provided.

Score = 18 (2.3)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline mentions only some methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifieable by graphical algorithms. Some tools for application such as algorithms, a short-version and an internet access to the guideline are provided.

Score = 17 (3.4)

5. Applicability (Items 19-21a)
Potential organisational barriers are not consistently discussed. Local (national) particularities have not been considered. There is no consideration of cost issues. Key review criteria for monitoring and/or audit purposes are only vaguely indicated. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 7 (1.4)

6. Editorial Independence (Items 22-23)
There is no comment on external funding or conflicts of interest of the group members.

Score =2 (1.0)

7. Overall assessment
Would not recommend

Overall assessment:

The guideline has serious short-comings in five of six of the domains of the AGREE instrument. Its strongest point is its clear and rather unambiguous recommendations, which make it easy to use in the daily routine. However, most of the principles of evidence based medicine such as a clear description of the process of how the recommendations have been obtained, what the evidence behind these recommendations is and how it must be coded has not been specified. This led us to the overall assessment of not recommending the guideline.

Notes:

The guideline was developed within a collection of several other treatment guidelines of the German psychiatric association.

References:

Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde. Praxisleitlinien in Psychiatrie und Psychotherapie. Band 5, Affektive Erkrankungen. Darmstadt: Steinkopff Verlag, 2000.

Internet Link:

http://www.dgppn.de/leitlinien/079094.pdf (this link refers to the short version only)

Structured guideline summary

Title:

Afektivni Poruchy (Affective disorders)

Publication date:

1999

Organisation:

Czech psychiatric association

General type of guideline or of guideline development process:

Guideline produced by an expert

Number of pages:

8

Contents:

1. Diagnostic process
2. Therapeutic process
2.1. First episode of depressive disorder
2.2. Second or the other episode of monopolar depressive disorder
2.3. Second or the other episode of depressive disorder, if manic episode has been preceded (bipolar course)
2.4. Mania
2.5. Psychotic depression
2.6. Prophylaxis
2.7. Prevention
2.8. Personal and technical conditions

National particularities:

Some national particularities, mainly the high costs for Czech patients, have been considered

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is to improve the knowledge of psychiatrists and GP's, but also of doctors from other specialities in the treatment of affective disorders. The clinical questions covered by the guideline are not described. The patients to whom the guideline is meant to apply are described as patients with affective disorders diagnosed according to the criteria defined in ICD-10.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group consisted of an expert who was appointed by the Czech society of psychiatry and one reviewer. The patients' views and preferences have not been sought. The target users of the guideline are defined as psychiatrists and general practitioners, but also as doctors from other specialties. The draft version of the guideline has been published two years before the publication of the guideline. The readers had the possibility to make comments and it was then discussed on a meeting of the society of psychiatry before its release.

Score = 9 (2.3)

3. Rigour of Development (Items 8-14)
There is no information about the methods that were used to search for evidence and also the criteria for selecting the evidence are not described.

The methods used for formulating the recommendations are relatively clearly described: an expert wrote the guideline, one reviewer commented on it, the draft was published in a Czech psychiatric journal so that others could comment on it and finally the guideline was accepted by the national psychiatric association. The health benefits, side effects and risks have been considered in formulating the recommendations. There are explicit links between the recommendations and the supporting evidence, but there is no coding of the quality of the evidence. The guideline contains new evidence that could have an important impact on management. The guideline has been externally reviewed by one reviewer prior to its publication. It is stated in a general introduction that the guideline should be updated.

Score = 23 (2.9)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous and the different options for management of the condition are clearly presented. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable. The guideline provides some information about different scales which can be used for the assessment of those with affective disorders.

Score = 15 (3)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the guideline are discussed. Some national particularities have been considered. The cost implications of applying the recommendations are not discussed. Key review criteria for monitoring and/or audit purposes are not presented. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 7 (1.4)

6. Editorial Independence (Items 22-23)
The guideline has been developed by the Czech society of psychiatry, but whether it was produced really independently from the pharmaceutical companies which are presented on one of the first pages of the guideline is unclear. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1.0)

7. Overall assessment
Would not recommend

Overall assessment:

This guideline on the treatment of affective disorders has been developed by an expert who was appointed by the Czech society of psychiatry, other relevant professional groups were not involved. The strength of this guideline is its clarity and its short presentation, so that it is a user-friendly compendium. Another strong point is that at least potential organisational barriers are discussed. This was not done by many guidelines assessed during this project. Unfortunately, there is no information about the methods that were used to search for evidence and the criteria for selecting it. These are core components of the concept of “evidence-based medicine” so that it was thought that the guideline cannot be recommended.

Notes:

References:

Vinar O. Afektivni poruchy. In: Houdek L, editor. Psychiatrie: Doporucene postupy psychiatricke pece. Prag: Ceska psychitricka spolecnost. Galen; 1999, p. 33-40

Internet Link:

Structured guideline summary

Title:

Prise en charge d'un épisode dépressif isolé de l'adulte en ambulatoire

Publication date:

May 2002

Organisation:

Agence Nationale d'Accréditation et d'Evaluation en Santé (ANAES)

General type of guideline or of guideline development process:

Systematic development with the aim of the establishment of an evidence based guideline.

Number of pages:

92

Contents:

National particularities:

Some national particularities are indicated

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are to provide syntheses of the level of scientific proof of the current scientific facts and to help the practitioner and the patient to find the most appropriate care. A detailed description of the clinical questions covered by the guideline is provided. The patients to whom the guideline is meant to apply are specifically described.

Score = 11 (3.7)

2**. Stakeholder Involvement (Items 4-7)**
The guideline development group includes individuals from all the relevant professional groups, and the members of this group are listed by names and professions. The patients' views and preferences have not been sought. The target users of the guideline are clearly defined.
The guideline has not been piloted among end-users.

Score = 10 (2.5)

3. Rigour of Development (Items 8-14)
Systematic methods such as search in electronic databases, Cochrane Library etc. were used to search for evidence, and the search terms are listed. The criteria for selecting the evidence are clearly described, and the strength of the recommendations is rated in three levels from A to C. The various steps of formulating the recommendations are described in an extra methodology paper.

The health benefits, side effects and risks have been considered in formulating the recommendations. There are explicit links between the recommendations and the supporting evidence, and the guideline contains new evidence that could have an important impact on management. All recommendations were coded according to the level of evidence supporting them. The guideline has been externally reviewed by experts prior to its publication. A procedure for updating the guideline is not provided.

Score = 28 (3.5)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline mentions almost no methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable. The guideline is supported with an algorithm as tool for application.

Score = 16 (3.2)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the recommendations are only vaguely considered. Some national particularities are indicated, e. g. the number of suicides in France. The potential cost implications of applying the recommendations have not been considered. Key review criteria for monitoring and/or audit purposes are not discussed. The guideline does not describe methods that help to find out to what extent and by whom the recommendations are used in practice.

Score = 8 (1.6)

6. Editorial Independence (Items 22-23)
No information is provided on whether the guideline is independent of any funding body or not. Conflicts of interest of guideline development members have not been recorded.

Score = 2 (1)

7. Overall assessment
Would strongly recommend

Overall assessment:

The editors attached great importance on the development of an evidence-based guideline. The guideline development group consisted of all the relevant professional groups. The methods used to search for and selecting the evidence and the coding of the evidence are clearly described, and even the search terms are indicated. The user of the guideline gets the important background information for assessing the guideline. The recommendations are also clearly presented. Despite certain weaknesses in other fields of the AGREE instrument we think that the guideline can be strongly recommended.

Notes:

References:

1. Agence Nationale d'Accréditation et d'Evaluation en Santé (ANAES). Prise en charge d'un épisode dépressif isolé de l'adulte en ambulatoire. Paris: ANAES; 2002.

2. Agence Nationale d'Accréditation et d'Evaluation en Santé (ANAES). Les recommandations pour la pratique clinique. Base méthodologique pour leur réalisation en France. Paris: ANAES; 1999.

Internet Link:

www.anaes.fr

Structured guideline summary

Title:

Förstämningssjukdomar - kliniska riktlinjer för utredning och behandling

Publication date:

1998, first version

Organisation:

Svenska Psykiatriska Föreningen och Spri.

General type of guideline or of guideline development process:

Guidelines produced by a task force of experts who attempted to apply a systematic development process.

Number of pages:

37

Contents:

National particularities:

National particularities have been considered only briefly in the chapter on the organisation of care in Sweden.

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guidelines are not specifically described, but it is stated that the aim of the guidelines is to improve the care of psychiatric patients. A detailed description of the clinical questions covered by the guidelines is not provided. The guidelines refer to patients with affective disorders diagnosed according to the criteria defined in DSM-IV, but there is no further description such as is suggested by the AGREE Instrument.

Score = 5 (1.7)

2. Stakeholder Involvement (Items 4-7)
The guideline development group consisted mainly of psychiatrists and a psychologist, and it is unclear whether other important professional groups have been involved. The patients' views and preferences have not been solicited. The target users of the guidelines are specified to be psychiatrists, but it is stated that they are useful for patients, relatives and administrators, as well as politicians. The guidelines have not been piloted among end users.

Score = 7 (1.8)

3. Rigour of Development (Items 8-14)
It is claimed that the guidelines are evidence-based, but the methods which were used to search for evidence are not described. The criteria for selecting the evidence are described only vaguely: The development group used efficacy studies, effectiveness studies or, if there were no studies, they used their own experience, but the recommendations are not coded according to the level of evidence. The methods used for formulating the recommendations are briefly described: the draft version of the guidelines was discussed with the board of the Society for Psychiatry and also at the meetings of the Society for Psychiatry. Areas of disagreement within the development group and methods of resolving them are not described. The health benefits, side effects and risks have been considered only vaguely in formulating the recommendations; e.g. side-effects of tricyclic antidepressants are mentioned, but this is not done in a very detailed way. There are no explicit links between the recommendations and the supporting evidence, and the reference list is very short. The guidelines do not contain new evidence that could have an important impact on management. The guidelines were sent only to the board of psychiatry for a review prior to their publication. It is unclear whether this can be considered as a real external review. The guidelines are to be updated every third year.

Score = 15 (1.9)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. The guidelines present psychotherapy and the different drugs, but these are not explained in a very detailed way. The guidelines do not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are not easily identifiable. The guidelines are not supported by tools for application.

Score = 9 (1.8)

5. Applicability (Items 19-21a)
Potential organisational barriers in applying the guidelines are discussed in a chapter on the collaboration of the network of psychiatry and primary care; and there is a list specifying when the GP should send the patient to a psychiatrist. National particularities have been only briefly considered in the chapter on the organisation of care. The potential cost implications of applying the recommendations have not been considered. The guidelines provide a list of key review criteria for monitoring and/or audit purposes, e.g. how many patients who have attempted suicide are assessed by a psychiatrist within 48 hours or how many patients have a written treatment plan. The guidelines do not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 11 (2.2)

6. Editorial Independence (Items 22-23)
It is stated that the guideline development was sponsored by the league of health care providers, but there is no comment on independence. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

These guidelines on the treatment of affective disorders were developed by a college of Swedish psychiatrists and a psychologist who are listed by name, but it is not possible to discern whether other important professional groups have been involved. A strong point of the guidelines is that key review criteria for monitoring and audit purposes are presented in detail, as is required by the AGREE instrument. This is not done by many of the guidelines which were assessed during this project. It is stated that systematic methods were used to search for evidence, but this process is not described in the guidelines, and the description of the criteria for selecting the evidence is very short. Explicit links between the recommendations and the supporting evidence are not provided, and the reference list is rather short. Considering these facts, we felt that this guideline cannot be considered as evidence-based.

Notes:

References:

Svenska Psykiatriska Föreningen och Spri. Förstämningssjukdomar - kliniska riktlinjer för utredning och behandling. Svensk Psykiatri Number 2. Stockholm: Spris förlag; 1998.

Internet Link:

Structured guideline summary

Title:

Evidensbaserad omvårdnad. Behandling av personer med depressionssjukdomar

Publication date:

1999, first version

Organisation:

SBU, the Swedish office for health technology assessment.

General type of guideline or of guideline development process:

Rather a systematic review than actual guidelines

Number of pages:

61

Contents:

National particularities:

There is only a remark that no studies from Sweden could be found

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guidelines is to present the scientific basis for nursing in the field of depression. The clinical questions covered by the guidelines are not specifically described. The patients to whom the guidelines are meant to apply are not specifically described; there is merely an appendix with the DSM-IV criteria for affective disorder.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
It is unclear whether the guideline development group included individuals from all relevant professional groups, since only the names of the participants are listed, but not their professions. The patients' views and preferences have not been solicited, but the aim of these guidelines is rather to present a systematic review of what is known about nursing. The target users of the guidelines are not clearly defined. The guidelines have not been piloted among end users.

Score = 4 (1)

3. Rigour of Development (Items 8-14)
The systematic methods that were used to search for evidence are described in detail: searches have been made in electronic databases such as Medline, Cinahl and the Cochrane Library, and the exact search terms are provided. The criteria for selecting the evidence are clearly described: there was a language restriction to English and Scandinavian languages, and letters and commentaries were excluded. The scientific quality was coded as 1, 2 or 3 (only 1 and 2 were accepted) by two independent assessors, and 28 studies were included in the final analysis. The aim of the guidelines is not to provide recommendations on nursing, but only to provide a systematic review of research in the field of nursing; and for this the methods used in formulating the guidelines are clearly described. The health benefits, side effects and risks have not been considered in formulating the recommendations, but this item is not applicable, since no actual recommendations on specific interventions are given. There are no actual recommendations, so that the item on explicit links between references and supporting evidence is not applicable. The guidelines contain new evidence that could have an important impact on management. There is no information on an external review of the guideline prior to its publication. A procedure for updating the guidelines is not provided.

Score = 20 (2.5)

4. Clarity and Presentation (Items 15-18)
The guidelines discuss areas in which there is a lack of studies, but the fields it mentions are very broad. The item on the different options for management of the condition is not applicable. The guidelines do not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are not easily identifiable, even not in the conclusion section where there is no use of boxes etc. The guidelines are not supported by tools for their application.

Score = 7 (1.4)

5. Applicability (Items 19-21a)
The item on potential organisational barriers in applying the recommendations does not relate to this kind of guidelines. Local (national) particularities have not been considered in detail, but it is stated that it was not possible to find studies from Sweden. It is stated that studies on cost implications have not been found and that there is a need for studies on this topic. The item on the presentation of key review criteria for monitoring and/or audit purposes is not applicable. The guidelines do not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 8 (1.6)

6. Editorial Independence (Items 22-23)
The guideline development was funded by SBU, which is a government agency, and there is no comment on independence of the funding body. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would recommend with provisos

Overall assessment:

The aim of these guidelines is to present the scientific basis for nursing in the field of depression. Therefore, an extensive review was made and the systematic methods of this search and the criteria for selecting the evidence are described in detail. Some of the items of the AGREE Instrument are not applicable to this kind of guidelines on evidence-based nursing, but we believe that we can recommend it as a good systematic review.

Notes:

References:

SBU - Statens beredning för medicinsk utvärdering. Behandling av personer med depressionssjukdomar. Evidensbaserad omvårdnad, number 3. Stockholm: SBU; 1999.

Internet Link:

www.sbu.se

Structured guideline summary

Title:

Richtlijn farmacotherapie bipolaire stoornissen

Publication date:

1998, first version

Organisation:

Nederlandse Vereniging voor Psychiatrie

General type of guideline or of guideline development process:

Guideline produced by a working group under the responsibility of the Dutch psychiatric association (consensus conference).

Number of pages:

36

Contents:

1. Pharmacotherapy of manic-depressive disorder: guidelines, recommendations, options
2. Algorithm A: different steps of the treatment of acute mania
3. Algorithm B: treatment of acute mania, indications of co-medication
4. Algorithm C: different steps of the treatment of the acute (bipolar) depression
5. Algorithm D: indications for maintenance treatment
6. Algorithm E: the different steps of maintenance treatment
7. Algorithm F: the choice of the mood stabilizer
8. Algorithm G: serum levels of mood stabilizers
9. Algorithm H: rapid cycling manic-depressive disorder
10. Reference list
11. List of abbreviations
12. Appendix: recommendations for the use of lithium, carbamazepine and valproate

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline is to give recommendations for the pharmacotherapy of bipolar disorders. A detailed description of the clinical questions covered by the guideline is not provided. The patients to whom the guideline is meant to apply are not specifically described.

Score = 5 (1.7)

2. Stakeholder Involvement (Items 4-7)
The guideline development group consists only of psychiatrists; other professional groups were not involved. There is no information given as to whether patients' views and preferences were sought. The target users of the guideline are not clearly defined. The guideline was not piloted among end-users.

Score = 4 (1)

3. Rigour of Development (Items 8-14)
It is stated that the guideline is based on a literature review as well as two consensus conferences, but further information about the search strategy is not provided. The criteria for selecting the evidence are indicated: the recommendations are coded according to three levels of evidence.

The methods used for formulating the recommendations are only briefly described. The health benefits, side effects and risks were considered in formulating the recommendations, e.g. the side effects of the different drugs are described. There are only some explicit links between the recommendations and the supporting evidence. The guideline contains new evidence that could have an important impact on management. There is no information given about external reviewing of the guideline prior to its publication. It is mentioned that the guideline should be updated within five years.

Score = 21 (2.6)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented, in this guideline the pharmacotherapy of bipolar disorders. The guideline mentions only some methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable, e.g. flow charts are provided. The guideline is supported by some tools for application (Appendix: recommendations for the use of lithium, carbamazepine and valproate).

Score = 16 (3.2)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the recommendations are not discussed. Local (national) particularities are not considered. The potential cost implications of applying the recommendations are not considered. The guideline presents key review criteria for monitoring and/or audit purposes, e.g. for the treatment with lithium. The guideline does not describe methods that help to find out by whom and to what extent the recommendations are to be used in practice.

Score = 7 (1.4)

6. Editorial Independence (Items 22-23)
It is stated that the guideline development group worked independently and without any conflict of interest.

Score =6 (3)

7. Overall assessment
Would recommend with provisos

Overall assessment:

This guideline on the pharmacotherapy of bipolar disorders was developed by a working group under the responsibility of the psychiatric association of the Netherlands. It is presented in a well-designed booklet and its clarity and presentation are very good. A literature search has been made, and a reference list is provided. Unfortunately, details about the search strategy such as search terms and the databases used are lacking, and the methods used for formulating the recommendations are only briefly described. A positive aspect is the coding of the recommendations in three levels according to their scientific evidence. Considering these facts, we believe that the guideline can be recommended with provisos.

Notes:

References:

Nolen WA, Knoppert-van der Klein EAM, Bouvy PF, Honig A, Klompenhouwer JL, Ravelli P. Richtlijn farmacotherapie bipolaire stoornissen. Amsterdam: Uitgeverij Boom; 1998.

Internet Link:

Structured guideline summary

Title:

Linee guida sulla Farmacoterapia dei disturbi dell'Umore

Publication date:

June 1999

Organisation:

Società Italiana di Psicopatologia

General type of guideline or of guideline development process:

Guidelines developed by a consensus conference of experts.

Number of pages:

18

Contents:

1. Presentation
2. Pharmacotherapy of depressive disorder
3. Pharmacotherapy of bipolar disorder

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline are described. A detailed description of the clinical questions covered by the guidelines is not provided. The patients to whom the guideline is meant to apply are not described.

Score = 5 (1.7)

2. Stakeholder Involvement (Items 4-7)
It is stated that the guideline development group consists of experts, but a detailed list of names or professions is missing. There is no information given as to whether patients' views and preferences were solicited. The target users of the guideline are defined as "psychiatric colleagues". The guideline has not been piloted among end users.

Score = 8 (2.0)

3. Rigour of Development (Items 8-14)
It is stated that the guidelines are based on a consensus conference, but further information e.g. about the search strategy is not provided. The criteria for selecting the evidence and the methods used for formulating the recommendations are only vaguely described. The health benefits, side effects and risks were considered in formulating the recommendations. There are no explicit links between the recommendations and the supporting evidence. The guideline contains new evidence that could have an important impact on management. There is no information given about external reviewing of the guideline prior to its publication. A procedure for updating the guidelines is not provided.

Score = 15 (1.9)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline mentions only some methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are not very easily identifiable. The guideline is not supported with tools for application.

Score = 11 (2.2)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the recommendations are not discussed. National particularities are only very vaguely mentioned. The potential cost implications of applying the recommendations are not considered. The guideline does not present key review criteria for monitoring and/or audit purposes. The guideline does not describe methods that help to find out by whom and to what extent the recommendations are to be used in practice.

Score = 6 (1.2)

6. Editorial Independence (Items 22-23)
There is no information provided about external funding. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

This guideline was developed by a committee of experts under the responsibility of the Italian psychiatric association. Unfortunately, the exact process to obtain a consensus, the methods that were used to search for evidence and the criteria for selecting it are not indicated, and even a reference list is lacking. This makes it very difficult for the user of the guidelines to judge the scientific basis of the recommendations. Therefore, we think that the guideline could not be recommended.

Notes:

References:

Società Italiana di Psicopatologia. Linee Guida sulla Farmacoterapia dei disturbi dell'umore. Consensus conference; 1999 jun 4-5; Roma. http://sopsi.archicoop.it/societa/consen99.htm (accessed October 2003)

Internet Link:

http://sopsi.archicoop.it/societa/consen99.htm

Structured guideline summary

Title:

Depression. Medikamentöse Therapie.

Publication date:

April 2001, first version

Organisation:

Consensus statement of Austrian experts.

General type of guideline or of guideline development process:

Consensus statement of Austrian experts.

Number of pages:

23

Contents:

National particularities:

Some national particularities have been considered.

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is the drug therapy of depression, further information is not provided. The clinical questions covered by the guideline are not specifically described. The guideline refers to patients with depression according to the criteria of ICD-10.

Score = 5 (1.7)

2. Stakeholder Involvement (Items 4-7)
The guideline development group included psychiatrists and a psychologist, but other important professional groups were not involved. Patients' views and preferences have not been sought. The guideline is made for the use in daily practice and also for politicians. The guideline has not been piloted among end-users.

Score = 7 (1.8)

3. Rigour of Development (Items 8-14)
There is no information provided about the methods that were used to search for evidence and the criteria for selecting the evidence. The methods used for formulating the recommendations are not described, it is only mentioned the guideline is based on the consensus of experts. The health benefits, side effects and risks have been considered in formulating the recommendations. The guideline does not provide explicit links between the recommendations and the supporting evidence, because a reference list is missing.

Therefore, it is not possible to judge whether the guideline contains new evidence that could have an important impact on management or not. There is no information provided about an external review of the guideline prior to its publication. A procedure for updating the guideline is not provided, but it is stated that updates are planned.

Score = 13 (1.7)

4**. Clarity and Presentation (Items 15-18)**
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline mentions methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable, e.g. many tables are provided. The guideline is not supported with tools for application.

Score = 15 (3)

5. Applicability (Items 19-21a)
Potential organisational barriers in applying the recommendations are not discussed. Some national particularities have been considered, e.g. the traditional choice of drugs in Austria is mentioned. There is a short chapter on costs where it is said that costs should have no influence on the choice of drugs. The guideline presents some key review criteria for monitoring and/or audit purposes, e.g. different scales are mentioned. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 11 (2.2)

6. Editorial Independence (Items 22-23)
The development of the guideline was funded by 11 companies of the pharmaceutical industry, but there is no statement of independence.
Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

This guideline on the treatment of depression is based on the consensus of an Austrian expert group that consisted of psychiatrists and a psychologist, other relevant professional groups were not involved. The strength of this guideline is its clarity and presentation with many tables, so that it is a user-friendly compendium. Unfortunately, there is no information about the methods that were used to search for evidence and the criteria for selecting it. These are core components of the concept of “evidence-based medicine” so that it was thought that the guideline cannot be recommended.

Notes:

References:

Kasper S, Lehofer M: Depression. Medikamentöse Therapie. Wien: CliniCum; Sonderausgabe April 2001.

Internet Link:

Structured guideline summary

Title:

Praxisleitlinien in Psychiatrie und Psychotherapie. Band 2 Leitlinien zur Diagnostik und Therapie von Angsterkrankungen

Publication date:

2000, first version

Organisation:

Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde

General type of guideline or of guideline development process:

Systematic development with the aim of the establishment of an evidence based guideline.

Number of pages:

121

Contents:

1. Introduction
2. Diagnosis
3. Treatment
4. Short-version of the guideline
5. Graphical display of algorithms

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline and the clinical questions covered by the guideline are not specifically described. It is mentioned that the guideline refers to patients with anxiety disorder diagnosed according to DSM-IV, but these criteria are not listed and there is also no description of other variables such as age ranges, severity of illness, comorbidity etc.

Score = 4 (1.3)

2. Stakeholder Involvement (Items 4-7)
The guideline is based on three consensus conferences and the participants are listed by their names. It was attached importance to include members of different relevant professional groups, but important medical staff such as such as nurses or social workers were not invited. Patients' views and preferences have not been sought. The target users are the guideline refers to are general practitioners as well as specialists. The guideline has not been piloted among end-users.

Score = 7 (1.8)

3. Rigour of Development (Items 8-14)
The scientific evidence for the recommendations was prepared by special reports of the participating experts, but their search process is not described. The criteria for selecting the evidence are clearly described. The method used for formulating the recommendations was a discussion during three consecutive consensus conferences, but the rules used in these discussions to come up with conclusions are not described. Side effects are relatively shortly mentioned. There are explicit links between the recommendations and the supporting evidence. The guideline contains new evidence that could have an important impact on management. The

guideline has not been externally reviewed by psychiatric experts prior to its publication, and a procedure for updating the guideline is not provided.

Score = 21 (2.6)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline mentions methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable by graphical algorithms. Some tools for application such as algorithms, a short-version and an internet access to the guideline are provided.

Score = 18 (3.6)

5. Applicability (Items 19-21a)
Potential organisational barriers are not discussed. Local (national) particularities have not been considered. There is no consideration of cost issues. Key review criteria for monitoring and/or audit purposes are only vaguely indicated. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 6 (1.2)

6. Editorial Independence (Items 22-23)
The guideline development was funded by several pharmacuetical companies that are listed in the introduction. It is stated that many sponsors were seeked so that dependence of a single sponsor was avoided. Conflicts of interest of the development members have not been recorded.

Score =4 (2)

7. Overall assessment
Would recommend (with provisos)

Overall assessment:

The editors attached importance to meet modern requirements for guideline development. Contrarily to other guidelines from the German psychiatric association a structured consensus process and a coding system of the available evidence was used. There is an extensive reference list although the exact search strings used and the databanks used are not indicated. The recommendations are clear and rather unambiguous. Further weaknesses in other areas led us to the overall assessment of recommending the guideline with provisos.

Notes:

The guideline was developed within a collection of several other treatment guidelines of the German psychiatric association.

References:

Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde. Praxisleitlinien in Psychiatrie und Psychotherapie. Band 2, Leitlinien zur Diagnostik und Therapie von Angsterkrankungen. Darmstadt: Steinkopff Verlag; 2000.

Internet Link:

http://www.dgppn.de

Structured guideline summary

Title:

Arzneiverordnung in der Praxis, Sonderheft : Empfehlungen zur Therapie von Angst- und Zwangsstörungen

Publication date:

December 1999, first version

Organisation:

Arzneimittelkommission („commision on medication“) der Deutschen Ärzteschaft

General type of guideline or of guideline development process:

Systematic development with the aim of the establishment of an evidence based guideline.

Number of pages:

16

Contents:

1. Foreword
2. Basics about pathogenesis, classification, diagnosis
3. Treatment
4. References
5. Appendix

Local particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are specifically described in the foreword. A detailed description of the clinical question covered by the guideline is not provided. There is a clear description that the guideline refers to patients with anxiety disorder, ICD-10 criteria are indicated, but there is no reference to other variables such as age ranges, severity of illness, comorbidity etc.

Score = 8 (2.7)

2. Stakeholder Involvement (Items 4-7)
The guideline development group seems to include members of most of the relevant professional groups (cf. www.akdae.de: general “Methodology-report” of the German commission on medication), but they are not listed by name. Patients’ views and preferences have not been sought. The target users of the guideline are clearly defined as “general practitioners”. The guideline has not been piloted among end-users.

Score = 9 (2.3)

3. Rigour of Development (Items 8-14)
In a separate general methodology report of the German commission on medication it is said that systematic methods such as search in electronic databases, Cochrane Library etc. were used to search for evidence. The criteria for selecting the evidence are also only described the separate methodology report, stating as a general rule that randomised trias, meta-analyses and systematic reviews were considered. There is a clear description of the methods used for formulating the recommendations. However, finally only very few literature references are indicated in this specific

guideline. We think that it is therefore unclear by how far the methodology report has been strictly followed in the development of this specific guideline. The side effects of the recommendations are considered. The guideline provides explicit links between the recommendations and the supporting evidence. The guideline contains only some new evidence that could have an important impact on management. The “Methodology-report” gives the information that all the guidelines produced by the “Arzneimittelkommission” have been reviewed externally before they were published, but there is no list of the reviewers. The guideline will be reviewed every two years.

Score = 29 (3.7)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. Psychotherapeutic interventions are only briefly mentioned, but these are not the scope of this guideline on medication. The guideline mentions methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable. A synopsis about diagnosis and treatment is added as tool for application.

Score = 19 (3.8)

5. Applicability (Items 19-21a)
Potential organisational barriers are not discussed. Local (national) particularities have not been considered. The “Methodology-report” says that cost implications were considered, but there is no detailed information relating to this guideline. Key review criteria for monitoring and/or audit purposes are not presented. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 6 (1.2)

6. Editorial Independence (Items 22-23)
The guideline was developed with funding by the Bundesärztekammer and the Kassenärztliche Vereinigung. It is stated that the members of the guideline development group have to declare that they have no conflict of interest (“Method.-report”).

Score = 5 (2.5)

7. Overall assessment
Would not recommend

Overall assessment:

The editors put worth on developing a guideline according to modern requirements. The strongest point of this guideline is its clarity and its good presentation which makes it easy to use in the clinical routine. However, a major problem with this guideline is that it has not been clarified how much the rules given in a general methodology-report (www.akdae.de) have been strictly applied for this specific guideline. For example, although a systematic literature search must be undertaken according to the methodology-report, the final reference list is very short and many of the citations are not from peer-reviewed journals. We found it therefore safer to not recommend this guideline.

Notes:

The guideline was developed within a collection of several other treatment guidelines of the Arzneimittelkommission.

References:

Arzneimittelkommission der deutschen Ärzteschaft. Empfehlungen zur Therapie von Angst- und Zwangsstörungen. Arzneiverordnung in der Praxis. Köln: Arzneimittelkommission der deutschen Ärzteschaft; 1999 (Sonderheft).

Internet Link:

www.akdae.de

Structured guideline summary

Title:

Agorafobie, Socialni Fobie, Specificke Fobie, Generalizovana Uzkostna Porucha (Agoraphobia, Social phobia, Specific phobias, Generalized Anxiety disorder)

Publication date:

1999

Organisation:

Czech psychiatric association

General type of guideline or of guideline development process:

Guidelines produced by an expert

Number of pages:

60

Contents:

4.1 Characteristics of the disorder
4.2 Epidemiology
4.3 Diagnosis
4.4 Ethiopatogenesis
4.5 Course and prognosis
4.6 Differential diagnosis
4.7 Comorbidity
4.8 Diagnostic process, screening and evaluation
4.9 Therapy
4.10 General goals of the therapy
4.11 Psychopharmacotherapy
4.12 Anxiolytics
4.13 Other pharmacological groups
4.13.1 Beta-blockers
4.13.2 Antihistamines
4.13.3 Antidepressants
4.13.4 Neuroleptics
4.14 Combination of the psychoactive drugs
4.15 Treatment resistance
4.16 Psychotherapy
4.16.1 Supporting psychotherapy
4.16.2 Supporting psychotherapy at patient with generalized anxiety disorder
4.17 Cognitive-behavioral therapy at generalized anxiety disorder
4.18 Proposal of the therapeutic process
4.19 Rehabilitation
4.20 Prevention
4.21 Personal and technical conditions
4.22 Economic discretion

National particularities:

Drug costs in the Czech Republic are given.

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is to improve the knowledge of psychiatrists and GP's in the treatment of anxiety disorders. The clinical questions covered by the guideline are not described. The patients to whom the guideline is meant to apply are described as patients with anxiety disorders diagnosed according to the criteria defined in ICD-10.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group consisted of an expert who was appointed by the Czech society of psychiatry and one reviewer. The patients' views and preferences have not been sought. The target users of the guideline are defined as psychiatrists and general practitioners, but also as doctors from other specialties. The draft version of the guideline has been published two years before the publication of the guideline. The readers had the possibility to make comments and it was then discussed on a meeting of the society of psychiatry before its release.

Score = 9 (2.3)

3. Rigour of Development (Items 8-14)
There is no information about the methods that were used to search for evidence and also the criteria for selecting the evidence are not described. The methods used for formulating the recommendations are relatively clearly described: an expert wrote the guideline, one reviewer commented on it, the draft was published in a Czech psychiatric journal so that others could comment on it and finally the guideline was accepted by the national psychiatric association. The health benefits, side effects and risks have been considered in formulating the recommendations. There are explicit links between the recommendations and the supporting evidence, but there is no coding of the quality of the evidence. The guideline contains new

evidence that could have an important impact on management. The guideline has been externally reviewed by one reviewer prior to its publication. It is stated in a general introduction that the guideline should be updated.

Score = 23 (2.9)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous and the different options for management of the condition are clearly presented. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable. The guideline is not supported with tools for application.

Score = 14 (2.8)

5. Applicability (Items 19-21a)
Some potential organisational barriers in applying the guideline are discussed. National particularities have been considered, e.g. the exact costs of the different drugs in the Czech Republic are given. The cost implications of applying the recommendations are, however, only shortly discussed. Key review criteria for monitoring and/or audit purposes are not presented. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 11 (2.2)

6. Editorial Independence (Items 22-23)
The guideline has been developed by the Czech society of psychiatry, but whether it was produced really independently from the pharmaceutical companies which are presented on one of the first pages of the guideline is unclear. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1.0)

7. Overall assessment
Would not recommend

Overall assessment:

These guidelines on the treatment of anxiety disorders have been developed by experts who was appointed by the Czech society of psychiatry, other relevant professional groups were not involved. The strength of these guidelines is their clarity and their short presentation, so that it is a user-friendly compendium. Another strong point is that at least potential organisational barriers are discussed. This was not done by many guidelines assessed during this project. Unfortunately, there is no information about the methods that were used to search for evidence and the criteria for selecting it. These are core components of the concept of “evidence-based medicine” so that it was thought that the guideline cannot be recommended.

Notes:

References:
The following guidelines were summarised:

Prasko J. Agorafobie. In: Houdek L, editor. Psychiatrie: Doporucene postupy psychiatricke pece. Prag: Ceska psychitricka spolecnost. Galen; 1999. p. 41-62

Raboch J. Socialni Fobie. In: Houdek L, editor. Psychiatrie: Doporucene postupy psychiatricke pece. Prag: Ceska psychitricka spolecnost. Galen; 1999. p. 63-69

Mozny P. Specificke fobie. In: Houdek L, editor.. Psychiatrie: Doporucene postupy psychiatricke pece. Prag: Ceska psychitricka spolecnost. Galen; 1999. p. 71-75

Prasko J. Generalizovana uzkostna porucha. In: Houdek L, editor. Psychiatrie: Doporucene postupy psychiatricke pece. Prag: Ceska psychitricka spolecnost. Galen; 1999. p. 77-100

Internet Link:

Structured guideline summary

Title:

Diagnostic et prise en charge en ambulatoire du trouble anxieux généralisé de l'adulte.

Publication date:

March 2001

Organisation:

Agence Nationale d'Accréditation et d'Evaluation en Santé (ANAES)

General type of guideline or of guideline development process:

Systematic development with the aim of the establishment of an evidence based guideline.

Number of pages:

143

Contents:

National particularities:

National particularities are only very vaguely stressed

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are to provide syntheses of the level of scientific proof of the current scientific facts and to help the practitioner and the patient to find the most appropriate care. A description of the clinical questions covered by the guideline is provided. The patients to whom the guideline is meant to apply are vaguely described as adults, and the diagnostic criteria are indicated.

Score = 9 (3.0)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes individuals from all the relevant professional groups, and the members of this group are listed by names and professions. The patients' views and preferences have not been sought. The target users of the guideline are clearly defined. The guideline has not been piloted among end-users.

Score = 10 (2.5)

3. Rigour of Development (Items 8-14)
Systematic methods such as search in electronic databases, Cochrane Library etc. were used to search for evidence, and the search terms are listed. The criteria for selecting the evidence are clearly described, and the strength of the recommendations is rated in three levels from A to C. The various steps of formulating the recommendations are described in an extra methodology paper. The health benefits, side effects and risks have been considered in formulating the recommendations. There are explicit links between the recommendations and the supporting evidence, and the guideline contains new evidence that could have an important impact on management. All recommendations were coded according to the level of evidence supporting

them. The guideline has been externally reviewed by experts prior to its publication. A procedure for updating the guideline is not provided.

Score = 27 (3.4)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline mentions almost no methods that seem to be unsuitable, unnecessary or obsolet. Key recommendations are easily identifiable. The guideline is supported with different scales as tool for application.

Score = 18 (3.6)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the recommendations are only vaguely discussed. National particularities are only vary vaguely considered. The potential cost implications of applying the recommendations have not been considered. Key review criteria for monitoring and/or audit purposes are not discussed. The guideline does not describe methods that help to find out to what extent and by whom the recommendations are used in practice.

Score = 7 (1.4)

6. Editorial Independence (Items 22-23)
No information is provided on whether the guideline is independent of any funding body or not. Conflicts of interest of guideline development members have not been recorded.

Score = 2 (1)

7. Overall assessment
Would strongly recommend

Overall assessment:

The editors attached great importance on the development of an evidence-based guideline. The guideline development group consisted of all the relevant professional groups. The different steps of the development process are described in detail: a systematic literature search was made and even the exact search terms are provided. The levels of evidence were keyed according to the quality of the different studies.The user of the guideline gets the important background information for assessing the guideline. The recommendations are also clearly presented. Despite certain weaknesses in other fields of the AGREE instrument we think that the guideline can be strongly recommended.

Notes:

References:

1. Agence Nationale d'Accréditation et d'Evaluation en Santé (ANAES). Diagnostic et prise en charge en ambulatoire du trouble anxieux généralisé de l'adulte. Paris: ANAES; 2001.

2. Agence Nationale d'Accréditation et d'Evaluation en Santé (ANAES). Les recommandations pour la pratique clinique. Base méthodologique pour leur réalisation en France. Paris: ANAES; 1999

Internet Link:

www.anaes.fr

Structured guideline summary

Title:

Richtlijn farmacotherapie angststoornissen.

Publication date:

1998, first version

Organisation:

Nederlandse Vereniging voor Psychiatrie

General type of guideline or of guideline development process:

Guideline produced by a working group under the responsibility of the Dutch psychiatric association.

Number of pages:

38

Contents:

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are only vaguely described. A detailed description of the clinical questions covered by the guideline is not provided. The patients to whom the guideline is meant to apply are specifically described in the different chapters.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group consists of psychiatrists and one pharmacologist; other professional groups were not involved. There is no information given as to whether patients' views and preferences were sought. The target users of the guideline are not clearly defined. The guideline was not piloted among end-users.

Score = 5 (1.3)

3. Rigour of Development (Items 8-14)
It is stated that the guideline is based on a literature review, but further information about the search strategy is not provided. The criteria for selecting the evidence are only vaguely indicated: recommendations which are based on scientific evidence (clinical trials) are marked. The methods used for formulating the recommendations are only briefly described. The health benefits, side effects and risks were considered in formulating the recommendations, e.g. the side effects of the drugs are described. There is an explicit link between the recommendations and the supporting evidence. The guideline contains new evidence that could have an important impact on management. There is no information given about external reviewing of the guideline prior to its publication. It is mentioned that the guideline should be updated within five years.
Score = 21 (2.6)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline mentions only some methods that seem to be unsuitable, unnecessary or obsolete, e.g. the contraindication of drugs. Key recommendations are easily identifiable, e.g. flow charts are provided. The guideline is supported by some tools for application.

Score = 16 (3.2)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the recommendations are not discussed. Local (national) particularities are not considered. The potential cost implications of applying the recommendations are not considered. The guideline presents some key review criteria for monitoring and/or audit purposes. The guideline does not describe methods that help to find out by whom and to what extent the recommendations are to be used in practice.

Score = 6 (1.2)

6. Editorial Independence (Items 22-23)
It is stated that the guideline development group worked independently and without any conflict of interest.

Score =6 (3)

7. Overall assessment
Would recommend with (strong) provisos

Overall assessment:

This guideline on the pharmacotherapy of anxiety disorders was developed by a working group under the responsibility of the psychiatric association of the Netherlands. It is presented in a well-designed booklet and its clarity and presentation are very good. A literature search was made, and a reference list is provided. Unfortunately, details about the search strategy such as search terms and the databases used are lacking, and the methods used for formulating the recommendations are only briefly described. Considering these facts, we consider that the guideline can be recommended with strong provisos.

Notes:

References:

van Balkom AJLM, van Dyck R, van Megen HJGM, Timmermann L, van Vliet IM, Westenberg HGM, Witte JC. Richtlijn farmacotherapie angststoornissen. Amsterdam: Uitgeverij Boom; 1998.

Internet Link:

Structured guideline summary

Title:

Panikkihäiriö

Publication date:

November 2000, first version

Organisation:

Suomalainen Lääkäriseura Duodecim, Suomen Akatemia

General type of guideline or of guideline development process:

Consensus statement

Number of pages:

199 (whole book with lectures) 18 (small booklet with recommendations)

Contents:

(small booklet):

1.What is panic disorder?
2.How common is panic disorder and what health economic impact does it have?
3.How and when should panic disorder be treated?
4.Which are the directions for panic disorder research?

National particularities:

National particularities have not been stressed very systematically

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
It is stated that the overall objective of the guideline is an attempt at an evidence-based treatment. The clinical questions covered by the guideline are described. The patients to whom the guideline is meant to apply are described as anybody with panic disorder according to the criteria defined in ICD-10.

Score = 7 (2.3)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes individuals from all the relevant professional groups: most of them were doctors - psychiatrists and general practitioners - but there were also psychologists, nurses, people from insurance companies, a member of parliament, and a newspaper editor. The patients' views and preferences have not been solicited. The target users of the guideline are not defined. The guidelines have not been piloted among end users.

Score = 7 (1.8)

3. Rigour of Development (Items 8-14)
There were no systematic methods used to search for evidence. The criteria for selecting the evidence are not clearly described. The medium used for formulating the recommendations is described as a public, open meeting at which a panel was chosen which wrote recommendations on prestated questions after lectures and open discussions. The health benefits, side effects and risks have been briefly considered in formulating the recommendations. There are no explicit links between the recommendations and the supporting evidence. The guideline contains new evidence that could have an important

impact on management. The guideline has not been externally reviewed prior to its publication. A procedure for updating the guideline is not provided.

Score = 12 (1.5)

4. Clarity and Presentation (Items 15-18)
The recommendations are not very specific (e.g. "antipsychotics and ß-blockers are not effective"). There is some description of the different options for management of the condition (drugs, different kinds of psychotherapies) but these are not very detailed. The guidelines mention some methods that seem to be unsuitable, unnecessary or obsolete, e.g. antipsychotics or beta-blocker are without effect. Key recommendations are not easily identifiable. The guideline is supported by several tools for application, such as a book with the lectures of the meeting and a leaflet.

Score = 11 (2.2)

5. Applicability (Items 19-21a)
Potential organisational barriers in applying the guideline are discussed in a chapter on the lack of resources. Some national particularities have been considered. The cost implications of applying the recommendations have not been considered. Key review criteria for monitoring and/or audit purposes are not presented. The guideline does not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 8 (1.6)

6. Editorial Independence (Items 22-23)
No information on external funding is provided. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

The guideline was established during a consensus meeting of 200 Finnish experts. Very important components of an evidence-based guideline such as a detailed literature search, links to the supporting evidence, a coding of the evidence supporting the recommendations, clear recommendations etc. are lacking, so that we felt that the guideline can not be recommended according to the AGREE-criteria.

Notes:

References:

Suomalainen Lääkäriseura Duodecim. Panikkihäiriö konsensuskokous. Hanasaaren kulttuurikeskus. Espoo: Suomen Akatemia; 2000.

Internet Link:

Structured guideline summary

Title:

Angstlidelser - kliniske retningsninfer for utredning og behandling

Publication date:

May 2000, first version

Organisation:

Statens helsetilsyn, Norway.

General type of guideline or of guideline development process:

Essentially a translation of another set of guidelines

Number of pages:

79

Contents:

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guidelines is to improve quality in mental health care, but a more detailed description is not given. The clinical questions covered by the guidelines are not specifically described. The guidelines refer to patients with anxiety disorders diagnosed according to the criteria defined in ICD-10, but it excludes patients with secondary anxiety (e.g. caused by drug abuse or somatic problems).

Score = 5 (1.7)

2. Stakeholder Involvement (Items 4-7)
These guidelines are essentially a translation of the Swedish guidelines on anxiety disorders, which were reviewed by nine Norwegian experts, but a guideline development group of their own did not exist. The patients' views and preferences have not been solicited. The target users of the guideline are defined only as various health professionals and consumers. The guideline has not been piloted among end users.

Score = 5 (1.3)

3. Rigour of Development (Items 8-14)
The systematic methods that were used to search for evidence are not described in detail. The criteria for selecting the evidence are not described. The methods used for formulating the recommendations are only vaguely indicated: The translation of the Swedish guidelines was sent to nine Norwegian reviewers, who gave written comments to the editor. The health benefits, side effects and risks have been considered in formulating the recommendations, e.g. the side effects of the drugs are mentioned. There are no explicit links between the recommendations and the supporting evidence. The guidelines contain new evidence that could have an important impact on management. The guidelines have been reviewed by nine experts from relevant professional groups, such as professors, a psychologist, a social worker and a nurse, prior to their publication. A detailed procedure for updating the guidelines is not provided, but it is stated that revision at regular intervals is necessary.

Score = 19 (2.4)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. The different options for management of the condition are clearly presented, e.g. different drugs and different types of psychotherapy are discussed. The guidelines mention methods that seem to be unsuitable, unnecessary or obsolete, e.g. for PTSD, long term psychodynamic therapy is contraindicated. Key recommendations are not easily identifiable. The guidelines are not supported by tools for application.

Score = 12 (2.4)

5. Applicability (Items 19-21a)
Potential organisational barriers in applying the guidelines are not discussed. National particularities have not been considered. The potential cost implications of applying the recommendations have not been considered. The guidelines provide a list of key review criteria for monitoring and/or audit purposes, e.g. whether ICD-10 or DSM-IV criteria are used routinely or how many patients have improved at least 10 points on the GAF-scale. The guidelines do not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 8 (1.6)

6. Editorial Independence (Items 22-23)
The guideline development was funded by the government, but there is no statement that the guideline is editorially independent of this funding body. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

This guideline is essentially a translation of the Swedish guidelines on anxiety disorders that has been developed by a committee of Swedish psychiatrists and which has been sent to Norwegian experts for a review. It is stated in the Swedish guidelines that systematic methods were used to search for evidence, but this procedure is not described in the guidelines, and a description of the criteria for selecting the evidence is also lacking. Explicit links between the recommendations and the supporting evidence are not provided. Therefore, we felt that these guidelines could not be considered to be evidence-based.

Notes:

References:

Statens helsetilsyn. Angstlidelser - kliniske retningslinjer for utredning og behandling. Utredningsserie 4-99. Oslo: Statens helsetilsyn; 2000.

Internet Link:

www.helsetilsynet.no

Structured guideline summary

Title:

Somatoforme Störungen. Leitlinien und Quellentexte.

Publication date:

2002

Organisation:

Deutsche Gesellschaft für Psychotherapeutische Medizin (DGPM), Deutsches Kollegium für Psychosomatische Medizin (DKPM), Allgemeine Ärztliche Gesellschaft für Psychotherapie (AÄGP), Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologie (DGPT)

General type of guideline or of guideline development process:

Expert group

Number of Pages:

258

Contents:

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are specifically described. The clinical questions covered by the guideline are not specifcally described. The ICD-10 criteria are indicated, but there is no reference to other variables such as age ranges, severity of illness, comorbidity etc.

Score = 7 (2.3)

2. Stakeholder Involvement (Items 4-7)
The guideline development group seems to include members of most of the relevant professional groups, and they are listed by name and profession. Patients' views and preferences have not

been sought. The target users of the guideline are clearly defined. The guideline has not been piloted among end-users.

Score = 9 (2.3)

3. Rigour of Development (Items 8-14)
Systematic methods such as a literature search were used to search for evidence. The criteria for selecting the evidence are clearly described,and there is a clear description of the methods used to formulate the recommendations. The health benefits, side effects and risks have been considered in formulating the recommendations. There are explicit links between the recommendations and the supporting evidence, and the guideline contains new evidence that could have an important impact on management. The recommendations were coded according to the level of evidence supporting them. The guideline has been externally reviewed by experts prior to its publication. A procedure for updating the guideline is provided.

Score = 32 (4.0)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. The different options for management of the condition are clearly presented. The guideline mentions methods that seem to be unsuitable, unnecessary or obsolete, e. g. different drugs that are not indicated are presented. Key recommendations are easily identifiable. The guideline is not supported with tools for application.

Score = 16 (3.2)

5. Applicability (Items 19-21a)
Potential organisational barriers are not discussed. National particularities have not been considered. The potential cost implications of applying the recommendations are not mentioned. Key review criteria for monitoring and/or audit purposes are not presented. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 5 (1)

6. Editorial Independence (Items 22-23)
It is stated that the guideline was developed on behalf of the “Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF)“. Conflicts of interest of guideline development members have not been recorded.

Score =5 (2.5)

7. Overall assessment
Would strongly recommend

Overall assessment:

The editors attached great importance on developing a guideline according to modern requirements. The guideline is produced in the framework of the AWMF guideline project. The aim of this organisation is to produce guidelines in three steps: the first level are recommendations of expert groups, the second level follows a formalised consensus finding process (including consensus conferences and delphi conferences) and the third level are guidelines including all elements of systematic development. This guideline was produced according to level two. A strong point of this publication is that the degree of scientific evidence supporting the recommendations is indicated. We therefore think that the guideline can be strongly recommended.

Notes:

References:

Rudolf G, Eich W, editors. Leitlinien Psychosomatische Medizin und Psychotherapie. Somatoforme Störungen. Leitlinien und Quellentexte. Stuttgart: Schattauer; 2002.

Internet Link:

www.awmf-online.de

Structured guideline summary

Title:

Posttraumatische Belastungsstörung. Leitlinie und Quellentext.

Publication date:

2001

Organisation:

Deutsche Gesellschaft für Psychotherapeutische Medizin (DGPM), Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologie (DGPT), Deutsches Kollegium für Psychosomatische Medizin (DKPM), Allgemeine Ärztliche Gesellschaft für Psychotherapie (AÄGP), Deutschsprachige Gesellschaft für Psychotraumatologie (DeGPT)

General type of guideline or of guideline development process:

Expert group

Number of Pages:

157

Contents:

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are rather vaguely described. The clinical questions covered by the guideline are not specifcally described. The ICD-10 criteria are indicated, but there is no reference to other variables such as age ranges, severity of illness, comorbidity etc.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group seems to include members of most of the relevant professional groups, and they are listed by name and profession. Patients' views and preferences have not been sought. The target users of the guideline are not clearly defined. The guideline has not been piloted among end-users.

Score = 7 (1.8)

3. Rigour of Development (Items 8-14)
A detailed description of the methods that were used to search for evidence is not provided.
The criteria for selecting the evidence are clearly described,and there is a clear description of the methods used to formulate the recommendations.

The health benefits, side effects and risks have been considered in formulating the recommendations.
There are explicit links between the recommendations and the supporting evidence, and the guideline contains new evidence that could have an important impact on management. The recommendations were coded according to the level of evidence supporting them.
The guideline has been externally reviewed by experts prior to its publication.
A procedure for updating the guideline is provided.

Score = 29 (3.6)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. The different options for management of the condition are clearly presented. The guideline mentions methods that seem to be unsuitable, unnecessary or obsolete, e. g. certain psychotherapeutic interventions. Key recommendations are easily identifiable. The guideline is supported with algorithms as a tool for application.

Score = 18 (3.6)

5. Applicability (Items 19-21a)
Potential organisational barriers are not discussed. National particularities have not been considered. The potential cost implications of applying the recommendations are not mentioned. Key review criteria for monitoring and/or audit purposes are not presented. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 5 (1)

6. Editorial Independence (Items 22-23)
It is stated that the guideline was developed on behalf of the “Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF)“. Conflicts of interest of guideline development members have not been recorded.

Score =5 (2.5)

7. Overall assessment
Would recommend with provisos

Overall assessment:

The editors attached great importance on developing a guideline according to modern requirements. The guideline is produced in the framework of the AWMF guideline project. The aim of this organisation is to produce guidelines in three steps: the first level are recommendations of expert groups, the second level follows a formalised consensus finding process (including consensus conferences and delphi conferences) and the third level are guidelines including all elements of systematic development. This guideline was produced according to level two. Unfortunately, the methods that were used to search for evidence are not described. We therefore think that the guideline can be recommended with provisos.

Notes:

References:

Rudolf G, Eich W, editors. Leitlinien Psychosomatische Medizin und Psychotherapie. Posttraumatische Belastungsstörung. Leitlinie und Quellentext. Stuttgart: Schattauer; 2001.

Internet Link:

www.awmf-online.de

Structured guideline summary

Title:

Persönlichkeitsstörungen. Leitlinie und Quellentext.

Publication date:

2002

Organisation:

Deutsche Gesellschaft für Psychotherapeutische Medizin, Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologie (DGPT), Deutsches Kollegium für Psychosomatische Medizin (DKPM), Allgemeine Ärztliche Gesellschaft für Psychotherapie (AÄGP)

General type of guideline or of guideline development process:

Expert group

Number of pages:

294

Contents:

1. Foreword

2. Guideline: Personality disorders

3. Information sources 1

3.1 Diagnosis of personality disorders

3.2 Treatment of personality disorders

4. Information sources 2

5. References

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are only vaguely described. A detailed description of the clinical question covered by the guideline is not provided. There is a clear description that the guideline refers to patients with personality disorders and the diagnostic criteria are indicated in detail, but there is no reference to other variables such as age ranges or severity of illness.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The members of the guideline development group are listed by names, but all of them seem to be specialists of psychosomatic medicine. Patients' views and preferences have not been sought. The target users of the guideline are only vaguely defined as "psychotherapists". The guideline has not been piloted among end-users.

Score = 5 (1.3)

3. Rigour of Development (Items 8-14)
Systematic methods were used to search for evidence, and the search terms are indicated.

The criteria for selecting the evidence are clearly described,and there is a clear description of the methods used to formulate the recommendations. The health benefits, side effects and risks have been considered in formulating the recommendations. There are explicit links between the recommendations and the supporting evidence, and the guideline contains new evidence that could have an important impact on management. The recommendations were coded according to the level of evidence supporting them. The guideline has been externally reviewed by experts prior to its publication. A procedure for updating the guideline is provided.

Score = 31 (3.9)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. The different options for management of the condition are clearly presented. The guideline mentions methods that seem to be unsuitable, unnecessary or obsolete, e. g. different psychotherapeutic interventions that are not indicated. Key recommendations are easily identifiable. The guideline is not supported with tools for application.

Score = 15 (3.0)

5. Applicability (Items 19-21)
Potential organisational barriers are not discussed. National particularities have not been considered. The potential cost implications of applying the recommendations are not mentioned. Key review criteria for monitoring and/or audit purposes are not presented. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 5 (1.0)

6. Editorial Independence (Items 22-23)
It is stated that the guideline was developed on behalf of the “Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF)“. Conflicts of interest of guideline development members have not been recorded.

Score =5 (2.5)

7. Overall assessment
Would strongly recommend

Overall assessment:

The editors attached great importance on developing a guideline according to modern requirements. The guideline is produced in the framework of the AWMF guideline project. The aim of this organisation is to produce guidelines in three steps: the first level are recommendations of expert groups, the second level follows a formalised consensus finding process (including consensus conferences and delphi conferences) and the third level are guidelines including all elements of systematic development. This guideline was produced according to level two. A strong point of this publication is that the degree of scientific evidence supporting the recommendations is indicated. We therefore think that the guideline can be strongly recommended.

Notes:

References:

Rudolf G, Eich W, editors. Leitlinien Psychosomatische Medizin und Psychotherapie. Persönlichkeitsstörungen. Leitlinie und Quellentext. Stuttgart: Schattauer; 2002.

Internet Link:

www.awmf-online.de

Structured guideline summary

Title:

Postnatal depression and puerperal psychosis (SIGN publication number 60)

Publication date:

June 2002, first version

Organisation:

The Scottish Intercollegiate Guidelines Network (SIGN) was established in 1993 by the Academy of Royal Colleges and their Faculties in Scotland, to develop evidence-based clinical guidelines for the National Health Service (NHS) in Scotland.

General type of guideline or of guideline development process:

Systematic development with the aim of the establishment of an evidence based guideline.

Number of pages:

31

Contents:

National particularities:

National particularities are only very vaguely stressed

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are described in the chapter “remit of the guideline”. A detailed description of the clinical questions covered by the guideline is not provided. The patients to whom the guideline is meant to apply are not specifically described.

Score = 6 (2.0)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes individuals from all the relevant professional groups, and the members are listed by names and professions.
It is stated that the patients’ views and preferences have been sought, patients or their representatives are included in all guideline development groups.
The target users of the guideline are clearly defined in the chapter “remit of the guideline”.
The guideline has not been piloted among end-users, but SIGN holds a national open meeting to discuss the draft recommendations of each guideline.

Score = 14 (3.5)

3. Rigour of Development (Items 8-14)
Systematic methods such as search in electronic databases, Cochrane Library etc. were used to search for evidence. The criteria for selecting the evidence are clearly described,and there is a clear description of the methods used to formulate the recommendations. The health benefits, side effects and risks have been considered in formulating the recommendations. There are explicit links between the recommendations and the supporting evidence, and the guideline contains new evidence that could have an important impact on management. All recommendations were coded according to the level of evidence supporting them. The guideline has been externally reviewed by experts prior to its publication. All SIGN guidelines carry a review date which requires that they should be assessed two years after the publication date.

Score = 32 (4)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline mentions methods that seem to be unsuitable, unnecessary or obsolet, e. g. it is stated, that valproate should be avoided as a mood stabiliser in pregnancy. Key recommendations are easily identifieable. The guideline is supported with a quick reference guide.

Score = 19 (3.8)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the recommendations are discussed. National particularities are only very vaguely discussed. The potential cost implications of applying the recommendations have not been considered. The guideline presents key review criteria for monitoring and/or audit purposes. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 10 (2.0)

6. Editorial Independence (Items 22-23)
The SIGN guideline development programme is funded by the Clinical Resource and Audit Group (CRAG) of the Scottish Executive Health Department. All members of SIGN guideline development groups are required to complete a declaration of interests.

Score =5 (2.5)

7. Overall assessment
Would strongly recommend

Overall assessment:

The editors attached great importance on the development of an evidence-based guideline. The composition of the guideline development group, the methods used to search for and selecting the evidence, the coding of the evidence, the methods used for formulating the recommendations etc. are clearly explained so that the user of the guideline gets the important background information for assessing the guideline. The recommendations are also clearly presented. Despite certain weaknesses in other fields of the AGREE instrument the guideline can therefore be strongly recommended as an evidence-based guideline.

Notes:

The guideline was developed within a collection of several other guidelines of SIGN.

References:

1. Scottish Intercollegiate Guidelines Network (SIGN). Postnatal depression and puerperal psychosis. Sign publication No. 60. Edinburgh: SIGN; 2002.

2. Scottish Intercollegiate Guidelines Network (SIGN). SIGN 50: A guideline developer's handbook. Sign publication No. 50. Edinburgh, SIGN; 2001.

Internet Link:

www.sign.ac.uk

Structured guideline summary

Title:

Organicke dusevni poruchy (Organic mental disorders)

Publication date:

1999

Organisation:

Czech psychiatric association

General type of guideline or of guideline development process:

Guideline produced by an expert

Number of pages:

7

Contents:

National particularities:

With the exception of a statement that new expensive drugs are not easily available for the patients no local particularities are indicated

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is to improve the knowledge of psychiatrists and GP's in the diagnosis and treatment of organic psychiatric disorders. The clinical questions covered by the guideline are not described. The patients to whom the guideline is meant to apply are described as patients with organic psychiatric disorders according to ICD-10.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group consisted of an expert who was appointed by the Czech society of psychiatry and one reviewer. The patients' views and preferences have not been sought.
The target users of the guideline are defined as psychiatrists and general practitioners, but also as doctors from other specialties. The guideline was not piloted among end-users before its release.

Score = 7 (1.8)

3. Rigour of Development (Items 8-14)
There is no information about the methods that were used to search for evidence and also the criteria for selecting the evidence are not described. The methods used for formulating the recommendations are relatively clearly described: an expert wrote the guideline, one reviewer commented on it and finally the guideline was accepted by the national psychiatric association. The guideline was presented in a psychiatric journal before its release in order to allow comments on it. The health benefits, side effects and risks have been considered in formulating the recommendations. There are no explicit links between the recommendations and the supporting evidence and there is no coding of the quality of the evidence. The guideline contains new evidence that could have an important impact on management. The guideline has been externally reviewed by one reviewer prior to its publication. It is stated in a general introduction that the guideline should be updated.

Score = 20 (2.5)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous and the different options for management of the condition are clearly presented. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable. The guideline provides some information about different scales.

Score = 15 (3)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the guideline are almost not discussed. With the exception of a statement that new expensive drugs are not easily available for the patients no local particularities are indicated. The cost implications of applying the recommendations have not been discussed. Key review criteria for monitoring and/or audit purposes are not presented. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 8 (1.6)

6. Editorial Independence (Items 22-23)
The guideline has been developed by the Czech society of psychiatry, but whether it was produced really independently from the pharmaceutical companies which are presented on one of the first pages of the guideline is unclear. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1.0)

7. Overall assessment
Would not recommend

Overall assessment:

This guideline about organic psychiatric disorders has been developed by an expert who was appointed by the Czech society of psychiatry, other relevant professional groups were not involved. The strength of this guideline is its clarity and its short presentation, so that it is a user-friendly compendium. Unfortunately, there is no information about the methods that were used to search for evidence and the criteria for selecting it. There are no citations of the publications supporting the recommendations. These are core components of the concept of “evidence-based medicine” so that it was thought that the guideline cannot be recommended.

Notes:

References:

Pavlovsky P. Organicke dusevni poruchy. In: Houdek L, editor. Psychiatrie: Doporucene postupy psychiatricke pece. Prag: Ceska psychitricka spolecnost. Galen; 1999. p. 13-19

Internet Link:

Structured guideline summary

Title:

Äldrepsykiatri - kliniska riktlinjer för utredning och behandling

Publication date:

1998, first version

Organisation:

Svenska Psykiatriska Föreningen och Gothia.

General type of guideline or of guideline development process:

Guidelines produced by a task force of experts who attempted to apply a systematic development process.

Number of pages:

52

Contents:

National particularities:

Some particularities concerning the Swedish situation have been pointed out.

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guidelines is to improve the care of psychiatric patients. A detailed description of the clinical questions covered by the guidelines is not provided. The patients to whom the guidelines are meant to apply are only vaguely described as patients who are above a certain age, e.g. 65 years.

Score = 5 (1.7)

2. Stakeholder Involvement (Items 4-7)
The guideline development group consisted of seven people (four doctors and three professors), but their professions remain unclear. The patients' views and preferences have not been solicited. The target users of the guidelines are stated to be psychiatrists and other people in psychiatry (e.g. administrators), but also to include patients, relatives, decision makers as well as social welfare workers. The guidelines have not been piloted among end users.

Score = 6 (1.5)

3. Rigour of Development (Items 8-14)
It is stated that the recommendations are evidence-based, but there is no description of the methods. The criteria for selecting the evidence are briefly described: The development group used efficacy studies, effectiveness studies and, if there were no studies, it used its own experience. The methods used in formulating the recommendations are only vaguely indicated: A working group wrote a draft of the guidelines, which was then discussed with the board of the Society for Psychiatry and also at the meetings of the Society for Psychiatry. The health benefits, side effects and risks are described only in very global statements; e.g. in elderly patients the typical antipsychotics produce more side effects. There are no explicit links between the recommendations and the supporting evidence. The guidelines do not contain new evidence that could have an important impact on management: new drugs are mentioned; but it is reported that they have not been studied in old patients, although there had at least been some trials in 1998. The guidelines have been sent only to the board of psychiatry for an "external" review prior to their publication. The guidelines are to be updated every third year.

Score = 14 (1.8)

4. Clarity and Presentation (Items 15-18)
The recommendations are relatively specific and unambiguous. The different options for management of the condition are rather clearly presented, e.g. different drugs, ECT and psychotherapy are discussed. The guidelines do not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are not easily identifiable. The guidelines are supported by tools for their application, e.g. different scales and check lists.

Score = 11 (2.2)

5. Applicability (Items 19-21a)
Potential organisational barriers in applying the guidelines are briefly discussed: it is mentioned that the situation in Sweden is inhomogeneous, only some regions have psychogeriatric facilities, and there is a need for more specialists in psychogeriatrics. Local (national) particularities were considered only vaguely (psychogeriatric resources in Sweden are inhomogeneous). The cost implications of applying the recommendations have not been considered. The guidelines do not provide key review criteria for monitoring and/or audit purposes, but it is at least stated that quality indicators should be developed. The guidelines do not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 8 (1.6)

6. Editorial Independence (Items 22-23)
It is stated that the development of the guidelines was sponsored by the league of health care providers, but there is no comment on independence. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

These guidelines concerning psychogeriatrics have been developed by a college of Swedish doctors and professors, but other important professional groups such as psychologists, nurses and social workers were not involved. It is stated that systematic methods were used to search for evidence, but this process is not described in the guidelines, and a description of the criteria for selecting the evidence is also lacking. Explicit links between the recommendations and the supporting evidence are not provided. Considering these facts we felt that the guidelines could not be considered to be evidence based.

Notes:

References:

Svenska Psykiatriska Föreningen och Gothia. Äldrepsykiatri - kliniska riktlinjer för utredning och behandling. Svensk Psykiatri Number 7. Stockholm: Svenska Psykiatriska Föreningen och Förlagshuset Gothia AB; 1998.

Internet Link:

Structured guideline summary

Title:

Vejledning om behandling med antidepressiva

Publication date:

December 2000, first version

Organisation:

Sundhetsstyrelsen, Denmark

General type of guideline or of guideline development process:

Guideline developed by a task force of experts.

Number of pages:

16

Contents:

1. Diagnosis, classification and assessment of severity of depression
2. Indications for treatment with antidepressants
3. Treatment strategy
4. Adverse effects
5. Interactions
6. Special circumstances for elderly people
7. Other indications for use of antidepressants

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
It is stated that the overall objective of the guideline is to instruct general practitioners on how they should handle patients who are being treated with antidepressants and which patients should be referred to psychiatrists. The clinical questions covered by the guideline are described. The patients to whom the guideline is meant to apply are not specifically described.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes individuals from different professional groups, such as general practitioners, psychiatrists and other experts. The patients' views and preferences have not been solicited. The target users of the guideline are clearly defined as general practitioners. The guideline has not been piloted among end users.

Score = 8 (2)

3. Rigour of Development (Items 8-14)
There were no systematic methods used to search for evidence, and the criteria for selecting the evidence are not described. The methods used for formulating the recommendations are not described. The health benefits, side effects and risks have been considered in formulating the recommendations. In particular, the side-effects and interaction potential of the different drugs have been described. There are no explicit links between the recommendations and the supporting evidence. The guideline does not provide a reference list, so that there is no information whether it contains new evidence that could have an important impact on management or not. The guideline has not been externally reviewed prior to its publication. A procedure for updating the guideline is not provided.

Score = 11 (1.4)

4. Clarity and Presentation (Items 15-18)
The recommendations are quite specific and unambiguous. The different options for management of the condition are clearly presented. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are not very easily identifiable, e.g. there are very few algorithms or boxes. The guideline is supported by one tool for application - the Hamilton Depression Rating scale.

Score = 12 (2.4)

5. Applicability (Items 19-21a)
Potential organisational barriers in applying the recommendations are not discussed. Local (national) particularities have not been considered. The potential cost implications of applying the recommendations have not been considered. Key review criteria for monitoring and/or audit purposes are not presented. The guideline does not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 5 (1)

6. Editorial Independence (Items 22-23)
No information on external funding is provided. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

This Danish guideline on the treatment with antidepressants has the aim of providing recommendations for GPs in the handling of patients who are being treated with antidepressant drugs. The systematic methods that were used to search for evidence, the criteria for selecting the evidence and the methods used for formulating the recommendations are not described in the guideline; and no reference list is provided. This makes it very difficult for the user of the guideline to assess the scientific basis for the recommendations; and we thus feel that the guideline cannot be recommended as evidence-based.

Notes:

References:

Sundhedsstyrelsen. Vejledning om behandling med antidepressiva. Sundhedsstyrelsen. 2000: 9-26.

Internet Link:

www.sst.dk

Structured guideline summary

Title:

Àllásfoglalása

Publication date:

2000 (draft version)

Organisation:

Guideline developed by a committee of Hungarian psychiatrists.

General type of guideline or of guideline development process:

Collection of different guidelines, produced by a working group of Hungarian psychiatrists.

Number of pages:

88

Contents:

National particularities:

National particularities are only vaguely considered.

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is not very specifically described. The clinical questions covered by the guideline are not described.There is a statement that the guideline refers to patients with psychiatric disorders diagnosed according to ICD-10 and DSM-IV.

Score = 5 (1.7)

2. Stakeholder Involvement (Items 4-7)
The guideline development group consisted only of psychiatrists; other relevant professional groups were not involved. The patients' views and preferences were not sought. The target users of the guideline are clearly defined as psychiatrists and general practitioners. The guideline was not piloted among end-users.

Score = 8 (2)

3. Rigour of Development (Items 8-14)
It is stated that a literature search was made, but further information about this process is not provided. The criteria for selecting the evidence and the methods used for formulating the recommendations are not described. The health benefits, side effects and risks were considered in formulating the recommendations. There are no explicit links between the recommendations and the supporting evidence, since a reference list is not provided. Therefore, it is unclear whether the guideline contains new evidence that could have an important impact on management. The

guideline was not externally reviewed by experts prior to its publication, this being only the draft version of the guideline. It is stated that the guideline should be updated within three years.

Score = 13 (1.6)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous and the different options for management of the condition are clearly presented. The guideline mentions some methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable. The guideline is not supported by tools for application.

Score = 12 (2.4)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the recommendations are only briefly discussed. National particularities are rather vaguely considered. The potential cost implications of applying the recommendations were considered. Key review criteria for monitoring and/or audit purposes are only vaguely indicated. The guideline does not describe methods that help to find out by whom and to what extent the recommendations are to be used in practice.

Score = 10 (2)

6. Editorial Independence (Items 22-23)
There is no information provided about external funding. Conflicts of interest of guideline development members were not recorded.

Score =2 (1.0)

7. Overall assessment
Would not recommend

Overall assessment:

This guideline on different psychiatric disorders was developed by a working group of Hungarian psychiatrists; other relevant professional groups were not involved. The strength of this guideline is its clarity and its unambiguous presentation, so that it is a user-friendly compendium. Unfortunately, there is almost no information about the methods that were used to search for evidence and the criteria for selecting it, and a reference list is not provided. These are core components of the concept of “evidence-based medicine” so that it was considered that the guideline cannot be generally recommended.

Notes:

References:

A pszichiátriai szakmai kollégium. Àllásfoglalása. A pszichiátriai zavarok gyógykezeléséröl. Budapest, 2000 (draft version).

Internet Link:

Structured guideline summary

Title:

Praxisleitlinien in Psychiatrie und Psychotherapie,
Band 3: Behandlungsleitlinie Demenz

Publication date:

April 2000, first version

Organisation:

Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde

General type of guideline or of guideline development process:

Systematic development with the aim of the establishment of an evidence based guideline.

Number of pages:

67

Contents:

1. Basics about epidemiology, course, prognosis, pathogenesis
2. Diagnosis and Classification
3. Treatment
4. Short-version of the guideline
5. Graphical display of algorithms
6. References

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline and the clinical questions covered by the guideline are not specifically described. There is a clear description that the guideline refers to patients with Alzheimer's disease, but there is no reference to other variables such as age ranges, severity of illness, comorbidity etc.

Score = 5 (1.7)

2. Stakeholder Involvement (Items 4-7)
The guideline development group included mainly psychiatry professors which are listed by their names, but their personal contributions are not specified. Patients' views and preferences have not been sought. The target users are only vaguely specified by the notion "the practically therapeutically active". The guideline has not been piloted among end-users.

Score = 6 (1.5)

3. Rigour of Development (Items 8-14)
There was no systematic process to search for/select the evidence. The methods used for formulating the recommendations are explained in the introduction, but details of this process are missing. The side effects and risks have been considered in formulating the recommendations. There is only a general reference list, but no explicit link between the recommendations and the supporting evidence. The guideline contains new evidence that could have an important impact on management.
The guideline has been externally reviewed by psychiatric experts, but there are no reviews from methodological experts or patients' representatives. A procedure for updating the guideline is not provided, but it is mentioned, that this process will take place in the future.

Score = 18 (2.3)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline mentions only some methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable by graphical algorithms. Some tools for application such as algorithms, a short-version and an internet access to the guideline are provided

Score = 17 (3.4)

5. Applicability (Items 19-21a)
Potential organisational barriers are discussed in a few words on page 36. National particularities have not been considered. There is no consideration of cost issues. Key review criteria for monitoring and/or audit purposes are only vaguely indicated (psychological tests). The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 7 (1.4)

6. Editorial Independence (Items 22-23)
There is no comment on external funding or conflicts of interest of the development members.

Score =2 (1.0)

7. Overall assessment
Would not recommend

Own overall assessment:

The guideline has serious short-comings in five of six of the domains of the AGREE instrument. Its strongest point is its clear and rather unambiguous recommendations, which make it easy to use in the daily routine. However, most of the principles of evidence based medicine such as a clear description of the process of how the recommendations have been obtained, what the evidence behind these recommendations is and how it must be coded has not been specified. This led us to the overall assessment of not recommending the guideline.

Notes:

The guideline was developed within a collection of several other treatment guidelines of the German psychiatric association.

References:

Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde. Praxisleitlinien in Psychiatrie und Psychotherapie. Band 3 Demenz. Darmstadt: Steinkopff Verlag; 1998.

Internet Link:

http://www.dgppn.de/leitlinien/039051.pdf (this link refers to the short version only)

Structured guideline summary

Title:

Arzneiverordnung in der Praxis, Sonderheft : Empfehlungen zur Therapie der Demenz

Publication date:

January 2001, updated version

Organisation:

Arzneimittelkommission der Deutschen Ärzteschaft

General type of guideline or of guideline development process:

Systematic development with the aim of the establishment of an evidence based guideline.

Number of pages:

19

Contents:

1. Foreword
2. Basics about pathogenesis, classification, diagnosis
3. Treatment
4. References
5. Appendix

Local particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are specifically described in the foreword. A detailed description of the clinical question covered by the guideline is not provided. There is a clear description that the guideline refers to patients with dementia, ICD-10 criteria are indicated, but there is no reference to other variables such as age ranges, severity of illness, comorbidity etc.

Score = 8 (2.7)

2. Stakeholder Involvement (Items 4-7)
The guideline development group seems to include members of most of the relevant professional groups, but they are not listed by name for this specific guideline. Patients' views and preferences have not been sought, but this might be less relevant for a guideline on medication. The target users of the guideline are clearly defined. The guideline has not been piloted among end-users.
Score = 9 (2.3)

3. Rigour of Development (Items 8-14)
Systematic methods such as search in electronic databases, Cochrane Library etc. were used to search for evidence. The criteria for selecting the evidence are described in a general methodology-report, stating as a general rule that randomised trias, meta-analyses and systematic reviews were considered. There is a clear description of the methods used for formulating the recommendations. The side effects of the recommendations are considered. The guideline provides explicit links between the recommendations and the suppporting evidence, and new evidence that could have an important impact on management has been considered. The "methodology-report" at the end of the paper gives the information that all the guidelines produced

by the “Arzneimittelkommission” have been reviewed externally before they were published, but there is no list of the reviewers. The guideline will be reviewed every two years.
Score = 27 (3.4)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline mentions some methods that seem to be unsuitable, unnecessary or obsolet. Key recommendations are easily identifiable. A short version of the guideline is added as tool for application
Score = 17 (3.4)

5. Applicability (Items 19-21)
Potential organisational barriers are not discussed, and national particularities are not mentioned. The “Methodology-report” at the end of the guideline says that cost implications were considered, but there is no detailed information relating to this guideline. Key review criteria for monitoring and/or audit purposes are shortly mentioned (“therapy-control”). It is stated that there are projects about the evaluation of the extent of the guideline’s use in practice, but no detailed information is provided.
Score = 8 (1.6)

6. Editorial Independence (Items 22-23)
The guideline was developed with funding by the Bundesärztekammer and the Kassenärztliche Vereinigung. It is stated that the members of the guideline development group have to declare that they have no conflict of interest (“Method.-report”).
Score =5 (2.5)

7. Overall assessment
Would recommend with provisos

Overall assessment:

According to the methods described at the end of the guideline and in a separate methodology report (www.akdae.de) the editors put worth on the development of an evidence based guideline. The clarity and presentation of the guideline are also very good and make it easy to use in practice. However, concerning many questions of the AGREE instrument it cannot be said with certainty by how far the general method of the “Deutsche Arzneimittelkommission” has been applied for this specific guideline. E.g. the members of the guideline development group are not listed. The names of external reviewers are not provided. The search strings which were used in the search for evidence are not presented. On the other hand the reference list at the end of the guideline is much longer and includes many more articles from peer-reviewed journals than the guideline on anxiety and obsessive compulsive disorder from the same organisation so that we thought that the guideline can be recommended with provisos.

Notes:

The guideline was developed within a collection of several other treatment guidelines of the Arzneimittelkommission.

References:

Arzneimittelkommission der deutschen Ärzteschaft. Empfehlungen zur Therapie der Demenz. Arzneiverordnung in der Praxis. Köln: Arzneimittelkommission der deutschen Ärzteschaft; 2001 (Sonderheft 8).

Internet Link:

www.akdae.de

Structured guideline summary

Title:

Dementia in the community: Management strategies for primary care

Publication date:

2001, revised version

Organisation:

Alzheimer's Society

General type of the guideline or of guideline development process:

Guideline produced under the responsibility of the Alzheimer's Society

Number of pages:

48

Contents:

National particularities:

The guideline refers to some national particularities, e. g. the number of people with dementia in the UK is provided

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are specifically described. The clinical questions covered by the guideline are not specifically described. It is only stated that the guideline refers to people with dementia, but other variables such as age ranges, severity of illness, comorbidity etc. are not provided.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The members of the guideline development group are not listed, and it is therefore unclear whether it included individuals from all the relevant professional groups. Patients' views and preferences have not been sought. The target users of the guideline are clearly defined as GPs and their primary health care team colleagues. The guideline has not been piloted among end users.

Score = 7 (1.8)

3. Rigour of Development (Items 8-14)
The guideline provides no information about the methods that were used to search for evidence and the criteria for selecting the evidence.The methods used for formulating the recommendations are not described..The health benefits, side effects and risks have been considered in formulating the recommendations. A reference list is missing. Therefore, it is unclear whether the guideline contains new evidence that could have an important impact on management. The guideline has not

been externally reviewed by experts prior to its publication. A procedure for updating the guideline is not provided.

Score = 10 (1.3)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are presented. The guideline does not mentionmethods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable. The guideline is supprted with tools for application, e. g. the mini mental state examination.

Score = 17 (3.4)

5. Applicability (Items 19-21a)
Potential organisational barriers in applying the recommendations have been discussed. Some national particularities have not been considered. There is no consideration of cost issues. Key review criteria for monitoring and/or audit purposes are not indicated. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 9 (1.8)

6. Editorial Independence (Items 22-23)
There is no comment on external funding or conflicts of interest of the development members.

Score =2 (1.0)

7. Overall assessment:
Would not recommend

Overall assessment:

This guideline refers to GPs and therefore describes management strategies for primary care. has serious short-comings in five of six of the domains of the AGREE instrument. It provides clear and unambiguous recommendations and is presented in a well designed format. However, most of the principles of evidence based medicine such as a clear description of the process of how the recommendations have been obtained and what the evidence behind these recommendations is are not described. This led us to the overall assessment of not recommending the guideline.

Notes:

References:

Alzheimer's Society. Dementia in the Community: Management strategies for primary care. London: Alzheimer's Society; 2001.

Internet Link:

Structured guideline summary

Title:

Interventions in the Management of Behavioural and Psychological Aspects of Dementia (SIGN publication number 22)

Publication date:

February 1998, first version

Organisation:

The Scottish Intercollegiate Guidelines Network (SIGN) was established in 1993 by the Academy of Royal Colleges and their Faculties in Scotland, to develop evidence-based clinical guidelines for the National Health Service (NHS) in Scotland.

General type of guideline development process:

Systematic development with the aim of the establishment of an evidence based guideline.

Number of pages:

26

Contents:

National particularities:

Some local particularities from the Scottish mental health act are presented.

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are described in the introduction of the guideline. It is made clear that it relates to the behavioural and psychological aspects of dementia, but not to the of cognitive aspects of the disorder. The clinical questions covered by the guideline are not specifically indicated. There is no detailed description of the patients to whom the guideline is meant to apply.

Score = 5 (1.7)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes individuals from all the relevant professional groups.
It is stated that the patients' views and preferences have been sought.
The target users of the guideline are not clearly defined.
The guideline has not been piloted among end-users, SIGN only holds a national open meeting to discuss the draft recommendations of each guideline.

Score = 11 (2.8)

3. Rigour of Development (Items 8-14)
Systematic methods such as search in electronic databases, Cochrane Library etc. were used to search for evidence. The criteria for selecting the evidence are clearly described, and there is a clear description of the methods used to formulate the recommendations. The quality of the evidence behind the recommendations is given. The health benefits, side effects and risks have been considered in formulating the recommendations. There are explicit links between the recommendations and the supporting evidence, and the guideline contains new evidence that could have an important impact on management. The guideline has been externally reviewed by experts prior to its publication. All SIGN guidelines carry a review date which requires that they should be assessed two years after the publication date.

Score = 32 (4)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous.Different treatment options are clearly presented. The guideline mentions some methods that seem to be unsuitable, unnecessary or obsolet, but this is not very consistently done. Key recommendations are easily identifieable. The guideline is supported with a quick reference guide.

Score = 19 (3.8)

5. Applicability (Items 19-21a)
Potential organisational barriers are only shortly discussed. Some national particularities presented by the Scottish Mental Health (Scotland) Act 1984 are given. The potential cost implications of applying the recommendations have not been considered. Key review criteria for monitoring and/or audit purposes are presented. It is stated that monitoring of guideline implementation will be carried out by the Clinical Standards Board for Scotland (CSBS).

Score = 10 (2)

6. Editorial Independence (Items 22-23)
The SIGN guideline development programme is funded by the Clinical Resource and Audit Group (CRAG) of the Scottish Executive Health Department. All members of SIGN guideline development groups are required to complete a declaration of interests.
Score =5 (2.5)

7. Overall assessment
Would strongly recommend

Overall assessment:

The editors attached great importance on the development of an evidence-based guideline. The composition of the guideline development group, the methods used to search for and selecting the evidence, the coding of the evidence, the methods used for formulating the recommendations etc. are clearly explained so that the user of the guideline gets the important background information for assessing the guideline. The recommendations are also clearly presented. Despite certain weaknesses in other fields of the AGREE instrument the guideline can therefore be strongly recommended as an evidence-based guideline.

Notes:
The guideline was developed within a collection of several other guidelines of SIGN.

References:

Scottish Intercollegiate Guidelines Network (SIGN). Interventions in the Management of Behavioural and Psychological Aspects of Dementia. Sign publication No. 22. Edinburgh: SIGN; 1998

Internet Link:

www.sign.ac.uk

Structured guideline summary

Title:

Recommandations pratiques pour le diagnostic de la maladie d'Alzheimer

Publication date:

February 2000, first version

Organisation:

Agence Nationale d'Accréditation et d'Evaluation en Santé (ANAES)

General type of guideline or of guideline development process:

Recommendations derived through a systematic development procedure

Number of pages:

43

Contents:

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are to provide syntheses of the level of scientific proof of the current scientific facts and to help the practitioner and the patient to find the most appropriate care. The clinical questions covered by the guideline are specifically described. The item "patients to whom the guideline is meant to apply" is not necessarily applicable to these guidelines, because it is only concerned with the diagnosis of Alzheimer's disease, and for this the diagnostic criteria are presented.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes individuals from all the relevant professional groups, such as general practitioners, neurologists, psychiatrists, geriatricians, psychologists and radiologists. The patients' views and preferences have not been solicited, but this might not be relevant for such a guideline on diagnosis. The target users

of the guideline are stated only to be health care professionals. The guideline has not been piloted among end users.

Score = 8 (2)

3. Rigour of Development (Items 8-14)
Systematic methods were used to search for evidence, searches in seven electronic databases were made and the search terms listed. The criteria for selecting the evidence are clearly described: the development group used meta-analyses and papers of consensus conferences in English and French, and the strength of the recommendations is rated in three levels from A to C. The various steps of formulating the recommendations are described in an extra methodology paper. The health benefits, side effects and risks have been considered to a certain extent in formulating the recommendations, but this item is not really applicable to these guidelines. There are explicit links between the recommendations and the supporting evidence, and the guidelines contain new evidence that could have an important impact on management. The guidelines have been reviewed by external experts prior to their publication. A procedure for updating the guidelines is not provided.

Score = 26 (3.3)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. The different options for management of the condition are clearly presented. In these guidelines the technical examinations are described. The guidelines mention methods that seem to be unsuitable, unnecessary or obsolete, e.g. apolipoprotein E is not recommended as a routine diagnostic measure for Alzheimer. Key recommendations are easily identifiable, since they are summarized at the beginning. The guidelines are supported by tools for application, e.g. different scales which are helpful for the diagnosis.

Score = 19 (3.8)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the recommendations are discussed only in a short chapter on future actions which are necessary in this field. Local (national) particularities have not been considered. The potential cost implications of applying the recommendations have not been considered. The guidelines present almost no key review criteria for monitoring and/or audit purposes, with the exception of the criteria of DSM-IV. The guideline does not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 7 (1.4)

6. Editorial Independence (Items 22-23)
No information is provided on whether the guideline is independent of any funding body or not. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would strongly recommend

Overall assessment:

The guideline development group attempted to work out evidence-based recommendations for the diagnosis of Alzheimer. The working group consisted of all the relevant professional groups, and the different steps of the development process are described in detail: a systematic literature search was made with searches being conducted in seven electronic databases (even the exact search terms are provided) and the levels of evidence were keyed according to the quality of the different studies. Considering these facts, we believe that this guideline can be strongly recommended as an evidence-based product.

Notes:

References:

1. Agence Nationale d'Accréditation et d'Evaluation en Santé (ANAES). Recommandations pratiques pour le diagnostic de la maladie d'Alzheimer. Paris: ANAES; 2000.

2. Agence Nationale d'Accréditation et d'Evaluation en Santé (ANAES). Les recommandations pour la pratique clinique. Base méthodologique pour leur réalisation en France. Paris: ANAES; 1999.

Internet Link:

www.anaes.fr

Structured guideline summary

Title:

Guidelines for the diagnosis of dementia and Alzheimer`s disease

Publication date:

2000, first version

Organisation:

The guidelines were developed by the Dementia Study Group of the Italian Neurological Society.

General type of guideline or of guideline development process:

Guidelines developed by a committee of the Italian neurological society

Number of pages:

8

Contents:

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The aim of the guidelines is to define criteria for the diagnosis of dementias in general and Alzheimer's disease in particular. Their purpose is to describe a uniform diagnostic approach that makes it possible to identify the type and severity of cognitive and functional impairment, distinguish the various forms of dementia, and construct the premises for a correct prognostic evaluation. Further objectives of these guidelines are to encourage standard levels of care, promote collaborative research in areas of uncertainty, and define the quality characteristics distinguishing Dementia Referral Centres. The clinical questions covered by the guideline are not specifically described. The patients to whom the guideline is meant to apply are not specifically described.

Score = 5 (1.7)

2. Stakeholder Involvement (Items 4-7)
The guideline development group was the "Dementia study group of the Italian Neurological Society". All the names of its member are listed, but no further information, e.g. on the professions of the members, is provided. It is therefore unclear whether other professional groups besides doctors have been involved. The patients' views and preferences have not been solicited. The target users of the guideline are clearly defined as neurologists and other specialists involved in the process of diagnosis, but also general practitioners who observe the first signs and symptoms of dementia. The guideline has not been piloted among end-users.

Score = 8 (2.0)

3. Rigour of Development (Items 8-14)
The methods used to search for evidence are only briefly described: Existing guidelines were the basis for the present guidelines. When the recommendations were unsatisfactory or insufficient the guideline development group referred to "original scientific articles". The strength of every recommendation has been classified according to three levels (I, II and III). There is no description of the methods used to formulate the recommendations. The health benefits, side effects and risks have been considered to a certain extent in formulating the recommendations, but this question is not really relevant to diagnostic guidelines. There are explicit links between some of the recommendations and the supporting evidence. The guidelines contain new evidence that could have an important impact on management. The guidelines have not been externally reviewed by experts prior to its publication. A detailed procedure for updating the guideline is not provided.

Score = 16 (2)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different diagnostic options are clearly presented. The guidelines do not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable. The guidelines are not supported by tools for application.

Score = 13 (2.6)

5. Applicability (Items 19-21a)
Potential organisational barriers have not been discussed. National particularities have not been considered. The potential cost implications of applying the recommendations have not been considered. Key review criteria for monitoring and/or audit purposes are not presented. The guidelines do not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 5 (1)

6. Editorial Independence (Items 22-23)
It is stated that the development of the guidelines has been partially supported by the pharmaceutical industry. Conflicts of interest of guideline development members have not been recorded.

Score = 2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

The strength of these guidelines, which are mainly based on other existing guidelines, is the clarity of its recommendations. Only in the case of insufficient information in the earlier guidelines did the expert group refer to original scientific articles. There is no indication of how these new articles were identified and how the recommendations of the other guidelines were evaluated. The three levels of evidence used in the guidelines are rather vague and the reference list is short. These facts led us to the decision not to recommend the guideline.

Notes:

References:

The dementia study group of the Italian neurological society. Guidelines for the diagnosis of dementia and Alzheimer`s disease. Neurological Science 2000; 21:187-94.

Internet Link:

Structured guideline summary

Title:

Leitlinien der Deutschen Gesellschaft für Kinder- und Jugendpsychiatrie und Psychotherapie. Schizophrenie, schizotype und wahnhafte Störungen.

Publication date:

2003, second revised version

Organisation:

Deutsche Gesellschaft für Kinder- und Jugendpsychiatrie und Psychotherapie

General type of guideline or of guideline development process:

Expert group

Number of pages:

11

Contents:

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is only briefly described: the aim is to optimize diagnosis and treatment. The clinical questions covered by the guideline are not specifically described. There is a clear statement that the guideline refers to children and adolescents with schizophrenia, schizotypal and delusional disorders diagnosed according to ICD-10, and a detailed definition of the disease and its symptoms is provided.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes doctors who are listed by name, but there is no information as to whether other professional groups were involved. Patients' views and preferences were not sought. The target users are only vaguely specified as doctors. The guideline was not piloted among end-users.

Score = 6 (1.5)

3. Rigour of Development (Items 8-14)
There is no detailed information provided about the systematic methods that were used to search for evidence. The degree of scientific evidence supporting the recommendations is indicated. The methods used for formulating the recommendations are explained in the preamble. The health benefits, side effects and risks were considered in formulating the recommendations. There is only a general reference list, but no explicit link between the recommendations and the supporting evidence. The guideline contains some new evidence that could have an important impact on

management. The guideline was discussed with external experts prior to its publication. It is stated that the guideline should be updated every other year.

Score = 22 (2.8)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline mentions methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable. The guideline provides two algorithms as tools for application.

Score = 17 (3.4)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the recommendations are not discussed. National particularities are not considered. There is no consideration of cost issues. The guideline does not present key review criteria for monitoring and/or auditing purposes. The guideline does not describe methods that help to find out by whom and to what extent the recommendation are used in practice.

Score = 5 (1.0)

6. Editorial Independence (Items 22-23)
The guideline was developed without external funding. Conflicts of interest of guideline development members were not recorded.

Score = 5 (2.5)

7. Overall assessment
Would not recommend

Overall assessment:

The publication is part of a collection of guidelines by the „Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF)“. The aim of this organisation is to produce guidelines in three steps: The first level are recommendations of expert groups, the second level follows a formalised consensus finding process (including consensus conferences and delphi conferences) and the third level are guidelines including all elements of systematic development. This specific guideline was only produce according to level one. Thus, a number of principles of evidence based medicine, such as a clear description of the process of how the recommendations were obtained and what the exact evidence behind these recommendations is are not specified We therefore think that we could not generally recommend the guideline. This judgement had to take the assessments of other guidelines in our collection into account. However, the authors of the guideline are well aware of these deficiencies and stress that due to a number of problems the concept of evidence based medicine is still rather new in the field of childhood and adolescent psychiatry. Strengths of the guideline are its clear and unambiguous recommendations and its userfriendly presentation on the internet. Thus, it can be a useful tool, especially if other guidelines in this field are not available.

Notes:

The guideline is published by the AWMF in a collection including several other treatment guidelines.

References:

Deutsche Gesellschaft für Kinder- und Jugendpsychiatrie und Psychotherapie, Bundesarbeitsgemeinschaft Leitender Klinikärzte für Kinder- und Jugendpsychiatrie und Psychotherapie, Berufsverband der Ärzte für Kinder- und Jugendpsychiatrie und Psychotherapie. Leitlinien zu Diagnostik und Therapie von psychischen Störungen im Säuglings-, Kindes- und Jugendalter. Köln: Deutscher Ärzte-Verlag; 2003.

Internet Link:

www.uni-duesseldorf.de/WWW/AWMF

Structured guideline summary

Title:

Attention Deficit and Hyperkinetic Disorders in Children and Young People (SIGN publication number 52)

Publication date:

June 2001, first version

Organisation:

The Scottish Intercollegiate Guidelines Network (SIGN) was established in 1993 by the Academy of Royal Colleges and their Faculties in Scotland, to develop evidence-based clinical guidelines for the National Health Service (NHS) in Scotland.

General type of guideline or of guideline development process:

Systematic development with the aim of the establishment of an evidence based guideline.

Number of pages:

26

Contents:

National particularities:

Besides the drugs available in Scotland no local particularities are specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are shortly described: the overall aim is to provide a framework for evidence-based assessment and management of ADHD/HKD, from which locally appropriate multidisciplinary approaches can be developed. The clinical questions covered by the guideline are not specifically described. There is a description of the diagnostic criteria for the disorders, but a further description in terms of e.g. age groups as it is suggested by the AGREE-instrument is not presented.

Score = 7 (2.3)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes individuals from all the relevant professional groups. It is stated that the patients' views and preferences have been sought, patients or their representatives are included in all guideline development groups. The target users of the guideline are not clearly defined. The guideline has not been piloted among end-users, SIGN only held a national open meeting to discuss the draft recommendations of each guideline.

Score = 11 (2.8)

3. Rigour of Development (Items 8-14)
Systematic methods such as search in electronic databases, the Cochrane Library etc. were used to search for evidence. The criteria for selecting the evidence are clearly described,and there is a clear description of the methods used to formulate the recommendations. The health benefits, side

effects and risks have been considered in formulating the recommendations. There are explicit links between the recommendations and the supporting evidence, and the guideline contains new evidence that could have an important impact on management. The guideline has been externally reviewed by experts prior to its publication. All SIGN guidelines carry a review date which requires that they should be assessed two years after the publication date.

Score = 32 (4)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolet. Key recommendations are easily identifieable. The guideline is supported with a quick reference guide.

Score = 17 (3.4)

5. Applicability (Items 19-21a)
Potential organisational barriers are only shortly discussed. Only some national particularities are given, mainly a description of drugs that are available in the United Kingdom. The potential cost implications of applying the recommendations have not been considered. Key review criteria for monitoring and/or audit purposes are presented, although the guideline group states that this is difficult in this area. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.
Score = 9 (1.8)

6. Editorial Independence (Items 22-23)
The SIGN guideline development programme is funded by the Clinical Resource and Audit Group (CRAG) of the Scottish Executive Health Department. All members of SIGN guideline development groups are required to complete a declaration of interests.
Score =5 (2.5)

7. Overall assessment
Would strongly recommend

Overall assessment:

The editors attached great importance on the development of an evidence-based guideline. The composition of the guideline development group, the methods used to search for and selecting the evidence, the coding of the evidence, the methods used for formulating the recommendations etc. are clearly explained so that the user of the guideline gets the important background information for assessing the guideline. The recommendations are also clearly presented. Despite certain weaknesses in other fields of the AGREE instrument the guideline can therefore be strongly recommended as an evidence-based guideline.

Notes:

The guideline was developed within a collection of several other guidelines of SIGN.

References:

1. Scottish Intercollegiate Guidelines Network (SIGN). Attention Deficit and Hyperkinetic Disorders in Children and Young People. Sign publication No. 52. Edinburgh: SIGN; 2001

2. Scottish Intercollegiate Guidelines Network (SIGN). SIGN 50: A guideline developer's handbook. Sign publication No. 50, SIGN, Edinburgh, 2001

Internet Link:

www.sign.ac.uk

Structured guideline summary

Title:

Pedopsychiatrie (Childhood psychiatry)

Publication date:

1999

Organisation:

Czech psychiatric associations

General type of guideline or of guideline development process:

Guideline developed by an expert

Number of pages:

11

Contents:

1. Especially serious disorders
2. Risk processes for patient
3. Topically important disorders of the childhood psychiatry
4. Pervasive developmental disorders (F84)-childhood autism (F 84.0)
5. Hyperkinetic disorders
6. Conduct disorders (F 91)
7. Emotional disorders with onset specific to childhood (F 93)
8. Disorders of social functioning with onset specific to childhood and adolescence (F94)
9. Tic disorders (F95)
10. Other behavioral and emotional disorders with onset occurring in childhood and adolescence (F98)
11. Nonorganic enuresis (F98.0)
12. Nonorganic encopresis (F98.1)
13. Pica of infancy and childhood (F98.3)
14. Mental retardations (F70-F79)
15. Mild mental retardation (F70)
16. Moderate mental retardation (F71)
17. Severe mental retardation (F72)
18. Profound mental retardation (F73)
19. Neurotic disorders (F40-49)
20. Behavioral syndromes (F50-59)
21. Personality disorders (F60-69)
22. Mood disorders and suicidality
23. Suicidality
25. Schizophrenia of infancy
26. Drug abuse (F10-F19)

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is to improve the knowledge of psychiatrists and GP's in the field of child and adolescent psychiatry. The clinical questions covered by the guideline are not described. The patients to whom the guideline is meant to apply are described as patients with disorders in the field of child and adolescent psychiatry diagnosed according to the criteria defined in ICD-10.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)

The guideline development group consisted of an expert who was appointed by the Czech society of psychiatry and one reviewer. The patients' views and preferences have not been sought.
The target users of the guideline are defined as psychiatrists and general practitioners, but also as doctors from other specialties. The draft version of the guideline has been published two years before the publication of the guideline. The readers had the possibility to make comments and it was then discussed on a meeting of the society of psychiatry before its release.

Score = 9 (2.3)

3. Rigour of Development (Items 8-14)
There is no information about the methods that were used to search for evidence and also the criteria for selecting the evidence are not described. The methods used for formulating the recommendations are relatively clearly described: an expert wrote the guideline, one reviewer commented on it, the draft was published in a Czech psychiatric journal so that others could comment on it and finally the guideline was accepted by the national psychiatric association. The health benefits, side effects and risks have been considered in formulating the recommendations. There are explicit links between the recommendations and the supporting evidence, but there is no coding of the quality of the evidence. The guideline contains new evidence that could have an important impact on management. The guideline has been externally reviewed by one reviewer prior to its publication. It is stated in a general introduction that the guideline should be updated.

Score = 17 (2.1)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous and the different options for management of the condition are clearly presented. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable. The guideline is not supported with tools for application.

Score = 14 (2.8)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the guideline are not discussed. National particularities have not been considered. The cost implications of applying the recommendations are not discussed. Key review criteria for monitoring and/or audit purposes are not presented. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 5 (1)

6. Editorial Independence (Items 22-23)
The guideline has been developed by the Czech society of psychiatry, but whether it was produced really independently from the pharmaceutical companies which are presented on one of the first pages of the guideline is unclear. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1.0)

7. Overall assessment
Would not recommend

Overall assessment:

This guideline on the treatment of childhood psychiatric disorders has been developed by an expert who was appointed by the Czech society of psychiatry, other relevant professional groups were not involved. The strength of this guideline is its clarity and its short presentation, so that it is a user-friendly compendium. Another strong point is that at least potential organisational barriers are discussed. This was not done by many guidelines assessed during this project. Unfortunately, there is no information about the methods that were used to search for evidence and the criteria for selecting it. These are core components of the concept of "evidence-based medicine" so that it was thought that the guideline cannot be recommended.

Notes:

References:
Hort V. Pedopsychiatrie. In: Houdek L, editor. Psychiatrie: Doporucene postupy psychiatricke pece. Prag: Ceska psychitricka spolecnost. Galen; 1999, p 161-171

Structured guideline summary

Title:

Vejledning om behandling af børn med antidepressiva, antipsykotika og centralstimulerende midler

Publication date:

December 2000, first version

Organisation:

Sundhetsstyrelsen, Denmark

General type of guideline or of guideline development process:

Guideline produced by a task force of experts, GP's and other relevant professionals.

Number of pages:

7

Contents:

1. Introduction

2. Treatment with antidepressants

3. Treatment with antipsychotics

4. Treatment with central stimulants

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
It is stated that the overall objective of the guideline is to instruct general practitioners on how they should handle children who are being treated with antidepressants, antipsychotics or centrally stimulating drugs and which patients should be sent to psychiatrists. The clinical questions covered by the guideline are described. The guideline refers to children.

Score = 7 (2.3)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes individuals from different professional groups, such as general practitioners, psychiatrists and other experts. The patients' views and preferences have not been solicited. The target users of the guideline are clearly defined as general practitioners. The guideline has not been piloted among end users.

Score = 8 (2)

3. Rigour of Development (Items 8-14)
There were no systematic methods used to search for evidence, and the criteria for selecting the evidence are not described. The methods used for formulating the recommendations are not described. The health benefits, side effects and risks have been considered in formulating the recommendations. There are no explicit links between the recommendations and the supporting evidence. The guideline does not provide a reference list, so there is no information on whether it contains new evidence that could have an important impact on management or not. The guideline has not been externally reviewed prior to its publication. A procedure for updating the guideline is not provided.

Score = 11 (1.4)

4. Clarity and Presentation (Items 15-18)
The recommendations are quite specific and unambiguous. The different options for management of the condition are clearly presented. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are not very easily identifiable, e.g. there are very few algorithms or boxes. The guideline is not supported by tools for application.

Score = 11 (2.2)

5. Applicability (Items 19-21a)
Potential organisational barriers in applying the recommendations are not discussed. Local (national) particularities have not been considered. The potential cost implications of applying the recommendations have not been considered. Key review criteria for monitoring and/or audit purposes are not presented. The guideline does not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 5 (1)

6. Editorial Independence (Items 22-23)
No information on external funding is provided. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

This Danish guideline on the treatment with antipsychotics has the aim of providing recommendations for GPs on how to handle the treatment of children with antidepressants, antipsychotics and centrally stimulating drugs. The systematic methods that were used to search for evidence, the criteria for selecting the evidence and the methods used for formulating the recommendations are not described in the guideline and a reference list is not provided. This makes it very difficult for the user of the guideline to assess the scientific basis of the recommendations so that we felt that the guideline could not be recommended.

Notes:

References:

Sundhedsstyrelsen. Vejledning om behandling af børn med antidepressiva, antipsykotika og centralstimulerende midler. Sundhedsstyrelsen; 2000: 49-55.

Internet Link:

www.sst.dk

Structured guideline summary

Title:

Richtlijn diagnostiek en behandeling ADHD (kinderen en adolescenten)

Publication date:

1999, first version

Organisation:

Nederlandse Vereniging voor Psychiatrie

General type of guideline or of guideline development process:

Guideline produced by a working group under the responsibility of the Dutch psychiatric association.

Number of pages:

40

Contents:

1. Introduction
2. Diagnosis
3. Treatment
4. Evaluation
5. Algorithm
6. Literature and information
7. Appendices I-VI

National particularities:

National particularities have been only briefly considered, mainly by mentioning the names of some drugs available in the Netherlands.

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is to give recommendations for the diagnosis and treatment of ADHD. A detailed description of the clinical questions covered by the guideline is not provided. The patients to whom the guideline is meant to apply are specifically described: children and adolescents with ADHD. The guideline provides the ICD-10 and DSM-IV criteria.

Score = 7 (2.3)

2. Stakeholder Involvement (Items 4-7)
It is stated that the guideline development group consists of six child and adolescent psychiatrists and that comments have been received by other relevant professional groups such as psychologists and neurologists. There is no information given as to whether patients' views and preferences were sought. The target users of the guideline are clearly defined as child and adolescent psychiatrists. The guideline was not piloted among end-users.

Score = 9 (2.3)

3. Rigour of Development (Items 8-14)
It is stated that the guideline is based on a literature review (especially recent European and American guidelines) and on the clinical experience of the authors. Further information about the search strategy and the criteria for selecting the evidence is not provided. The methods used for formulating the recommendations are only briefly described. The health benefits, side effects and risks were considered in formulating the recommendations. The guideline does not provide explicit links between the recommendations and the supporting evidence. The guideline contains new evidence that could have an important impact on management. There is no information given about

external reviewing of the guideline prior to its publication. It is mentioned that the guideline should be updated within five years.

Score = 19 (2.4)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented, in this guideline the diagnosis and treatment of ADHD. The guideline mentions only some methods that seem to be unsuitable, unnecessary or obsolete, e.g. the combination of different drugs. Key recommendations are easily identifiable. The guideline is supported by some tools for application, e.g. the ICD-10 and DSM-IV criteria.

Score = 15 (3)

5. Applicability (Items 19-21a)
The potential organisational barriers to applying the recommendations are not discussed. Some national particularities are mentioned, e.g. the names of different drugs in the Netherlands. The potential cost implications of applying the recommendations were not considered. The guideline presents some key review criteria for monitoring and/or audit purposes (chapter 4 “Evaluation”). The guideline does not describe methods that help to find out by whom and to what extent the recommendations are to be used in practice.

Score = 7 (1.4)

6. Editorial Independence (Items 22-23)
It is stated that the guideline development group worked independently and without any conflict of interest.

Score =6 (3)

7. Overall assessment
Would recommend with (strong) provisos

Overall assessment:

This guideline on diagnosis and treatment of ADHD was developed by a working group under the responsibility of the psychiatric association of the Netherlands. It is presented in a well-designed booklet and its clarity and presentation are very good. A literature search has been made, and a reference list is provided. Unfortunately, details about the search strategy such as search terms and the databases used are lacking, and the methods used for formulating the recommendations are only briefly described. A coding of the recommendations according to their level of evidence is not provided. Taking all these facts into account, we consider that the guidelines can only be recommended with strong provisos.

Notes:

References:

Boer F, Buitelaar JK, van Dalen E, Gunning WB, Minderaa RB, Westermann GMA. Richtlijn diagnostiek en behandeling ADHD (kinderen en adolescenten). Amsterdam: Uitgeverij Boom; 1999.

Internet Link:

Structured guideline summary

Title:

Guidance on the use of newer (atypical) antipsychotics for the treatment of schizophrenia

Publication date:

June 2002, first version

Organisation:

National Institute of Clinical Excellence (NICE)

Type of guideline or of guideline development process:

Evidence-based guideline

Number of pages:

26

Contents:

National particularities:

There is a chapter on the consequences for the National Health Service of the guidelines, but it does not really describe the consequences

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
In the introduction there is a paragraph on “the overall context of the guidance”, but we did not find a clear specification of the overall objectives of the guideline. A detailed description of the clinical question covered by the guideline is not provided, but the extensive assessment report which is the main basis for the recommendations specifies the outcomes analysed. There is a description of what schizophrenia is, but there is no reference to other variables such as age ranges, severity of illness, comorbidity etc.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
In appendix A of the guideline the appraisal committee is listed. It included doctors of various specialties, patient groups, health economists, a nurse, statisticians etc.. Patients’ opinions were sought, because patient group representatives were in the appraisal committee. According to the introductory pages the target users of the guidelines seem to be health professionals. The guideline has not been piloted among end-users.

Score = 12 (3.0)

3. Rigour of Development (Items 8-14)
Systematic reviews and meta-analyses with extensive searches were done for the establishment of the guideline. Randomised controlled trials were the basis, but especially for rare side-effects other studies were used, as well. There is an extensive description of the very long development process of NICE guidelines in general. How discussion were resolved is not absolutely clear (terms such as Delphi process are not mentioned). The side-effects, health benefits and risks of the recommendations are considered. The full assessment report is freely available on the internet, but in the guideline itself there are no references. The guideline did an up to date literature review, thus a lot of new evidence was collected. A number of external experts reviewed the guidelines before their publication and these are listed by name. A procedure for updating the guideline is provided. There is a general NICE manuscript about updating (guide to the technology appraisal process.pdf) and a review date has been fixed (may 05, furthermore the expiry date in the assessment report is September 03).

Score = 29 (3.6)

4. Clarity and Presentation (Items 15-18)
The recommendations are a little bit broad (e.g. in the guideline itself there are not many details on the single new drugs). However, the recommendations are clear and unambiguous. The different options for management of the conditions are mentioned, because all the new drugs and a number of old drugs including their advantages and disadvantages are listed. This could be more detailed. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolete, because there is a strong focus on the new drugs. The guidance paper is quite concise by itself, there is no further highlighting of key recommendations. There is one important tool for application which is a patient information section.

Score = 13 (2.6)

5. Applicability (Items 19-21a)
Potential organisational barriers are not discussed in detail, there is only a chapter on cost issues. There is a chapter on the consequences for the National Health Service of the guidelines, but it does not really describe the consequences. There consideration of cost issues is a substantial part of the guidelines. A whole chapter is used for the description of key review criteria for monitoring and/or audit purposes. There is a description on how implementation might be monitored (chapter 7 “implementation”), but this is rather brief.

Score = 15 (3)

6. Editorial Independence (Items 22-23)
The guideline seems to be independent from the funding body, but this could be described more clearly. Conflicts of interest of the guideline members had to be stated and in case of relevant conflict of interest members of the appraisal group were excluded.

Score = 7 (3.5)

7. Overall assessment
Would strongly recommend

Overall assessment:

This is one of the most modern and best developed guidelines identified by our search. Especially noteworthy are the use of systematic reviews that have been undertaken for the development of the guideline. Thus, this is a real evidence-based guideline. The only shortcoming might be that the guidance is relatively short and does not go into detail. It is a general guidance rather than a specific guideline. However, the full assessment report is available so that the interested reader can access all background information.

Notes:

References:

National Institute for Clinical Excellence (NICE). Guidance on the use of newer (atypical) antipsychotic drugs for the treatment of schizophrenia. Technology Appraisal No. 43. London: NICE; 2002.

Internet Link:

www.nice.org.uk

Structured guideline summary

Title:

Behandling med antipsykotika

Publication date:

1998, revised version

Organisation:

Dansk Psykiatrisk Selskab, Udvalget for biologiske behandlingsmetoder

General type of guideline or of guideline development process:

Guideline produced by a committee of the Danish psychiatric Society

Number of pages:

25

Contents:

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline is to revise the previous guideline from 1989. The clinical questions covered by the guideline are not described. The guideline refers to patients with schizophrenia diagnosed according to the criteria defined in ICD-10, but also to those with schizotypical, schizoaffective and manic disorders, psychotic depression, drug induced depression etc. who are treated with antipsychotics.

Score = 5 (1.7)

2. Stakeholder Involvement (Items 4-7)
The guideline development group was a committee of the Danish society of psychiatry. The names of the members are listed, but the professions are unclear. The patients' views and preferences have not been sought. The target users of the guideline are not defined. The guideline has not been piloted among end users.

Score = 4 (1)

3. Rigour of Development (Items 8-14)
It is stated that an electronic search took place in order to search for evidence, but a detailed description of the systematic methods is missing. The criteria for selecting the evidence are not described and the methods used for formulating the recommendations are not described. The health benefits, side effects and risks have been considered in formulating the recommendations. There are some explicit links between the recommendations and the supporting evidence. The guideline contains some new evidence that could have an important impact on management. The guideline has not been externally reviewed prior to its publication. It is stated that the guideline should be updated every third year.

Score = 17 (2.1)

4. Clarity and Presentation (Items 15-18)
The recommendations are not very specific and unambiguous. The different options for management of the condition are discussed: all the different antipsychotics are described. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are not very easily identifiable. The guideline is not supported with tools for application, but it is provided in the internet.

Score = 8 (1.6)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the recommendations are not discussed. National particularities have not been considered. The potential cost implications of applying the recommendations have not been considered. The guideline does not present key review criteria for monitoring and/or audit purposes. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 5 (1)

6. Editorial Independence (Items 22-23)
There is no information provided about external funding. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would not recommend

Overall assessment:
This guideline on the treatment with antipsychotic drugs was developed by a committee of the Danish society for psychiatry, and it seems that other relevant professional groups such as nurses and pharmacists were not involved. Although it is stated that an electronic search took place, this important process is not described in detail, and information about the criteria for selecting the evidence and the methods used for formulating the recommendations is not provided. Therefore, a judgement of the scientific basis of the recommendations is almost impossible so that we came to the decision that the guideline could not be recommended.

Notes:

References:

Glenthoj B, Gerlach J, Licht R, Gulmann N, Jorgensen O. Behandling med antipsykotika. Udvalget for biologiske behandlingsmetoder. Klaringsrapport no. 5. København: Lægeforeningens forlag; 1998.

Internet Link:

www.dadlnet.dk/klaringsrapporter/1998-05/1998-05.htm

Structured guideline summary

Title:

Vejledning om behandling med antipsykotika

Publication date:

December 2000, first version

Organisation:

Sundhetsstyrelsen, Denmark

General type of guideline or of guideline development process:

Guideline produced by a task force of experts, GP's and other relevant groups

Number of pages:

21

Contents:

1. Introduction
2. Diagnosis and classification of schizophrenia
3. Treatment strategy
4. Adverse effects of treatment with anti-psychotics
5. Interactions and contraindications
6. Special circumstances of elderly patients
7. Other indications for treatment with anti-psychotic drugs

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
It is stated that the overall objective of the guideline is to instruct general practitioners on how they should handle patients who are being treated with antipsychotics and which patients should be sent to psychiatrists. The clinical questions covered by the guideline are described. The patients to whom the guideline is meant to apply are not specifically described.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes individuals from various professional groups, such as general practitioners, psychiatrists and other experts. The patients' views and preferences have not been solicited. The target users of the guideline are clearly defined as general practitioners. The guideline has not been piloted among end users.

Score = 8 (2)

3. Rigour of Development (Items 8-14)
There were no systematic methods used to search for evidence, and the criteria for selecting the evidence are not described. The methods used for formulating the recommendations are not described. The health benefits, side effects and risks have been considered in formulating the recommendations. There are no explicit links between the recommendations and the supporting evidence. The guideline does not provide a reference list, so there is no information whether it contains new evidence that could have an important impact on management or not. The guideline has not been externally reviewed prior to its publication. A procedure for updating the guideline is not provided.

Score = 11 (1.4)

4. Clarity and Presentation (Items 15-18)
The recommendations are quite specific and unambiguous. The different options for management of the condition are clearly presented. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are not very easily identifiable, e.g. there are very little algorithms or boxes. The guideline is not supported by tools for application.

Score = 11 (2.2)

5. Applicability (Items 19-21a)
Potential organisational barriers in applying the recommendations are not discussed. Local (national) particularities have not been considered. The potential cost implications of applying the recommendations have not been considered. Key review criteria for monitoring and/or audit purposes are not presented. The guideline does not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 5 (1)

6. Editorial Independence (Items 22-23)
No information on external funding is provided. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

This Danish guideline on the treatment with antipsychotics has the aim of providing recommendations for GPs in the handling of patients who are treated with antipsychotic drugs. The systematic methods that were used to search for evidence, the criteria for selecting the evidence and the methods used for formulating the recommendations are not described in the guideline; and no reference list is provided. This makes it very difficult for the user of the guideline to assess the scientific basis of the recommendations; and we thus feel that the guideline cannot be recommended as evidence-based

Notes:

References:

Sundhedsstyrelsen. Vejledning om behandling med antipsykotika. Sundhedsstyrelsen; 2000: 27-47.

Internet Link:

www.sst.dk

Structured guideline summary

Title:

Praxisleitlinien in Psychiatrie und Psychotherapie. Band 4 Behandlungsleitlinie Eßstörungen.

Publication date:

April 2000, first version

Organisation:

Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde

General type of guideline or of guideline development process:

Systematic development with the aim of the establishment of an evidence based guideline.

Number of pages:

50

Contents:

1. Basics about epidemiology, course, prognosis, pathogenesis
2. Diagnosis and Classification
3. Treatment
4. Short-version of the guideline
5. Graphical display of algorithms

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline and the clinical questions covered by the guideline are not specifically described. There is a clear description that the guideline refers to patients with different eating disorders (anorexia nervosa, bulimia nervosa, Binge eating disorder) diagnosed according to ICD-10 and DSM-IV, but there is no reference to other variables such as age ranges, severity of illness, comorbidity etc.

Score = 4 (1.3)

2. Stakeholder Involvement (Items 4-7)
The guideline development group included mainly psychiatry professors which are listed by their names, but their personal contributions are not specified. Patients' views and preferences have not been sought. The target users of the guideline are not clearly defined. The guideline has not been piloted among end users.

Score = 5 (1.3)

3. Rigour of Development (Items 8-14)
There was no systematic process to search for/select the evidence. The methods used for formulating the recommendations are only vaguely described in the introduction, and details of this process are missing.The health benefits, side effects and risks have been considered in formulating the recommendations. There is only a general reference list, but no explicit link between the recommendations and the supporting evidence. The guideline contains new evidence that could have an important impact on management. The guideline has not been externally reviewed by experts prior to its publication. A procedure for updating the guideline is not provided.

Score = 14 (1.8)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are presented. The guideline mentions some methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable by graphical algorithms. Some tools for application such as algorithms, a short-version and an internet access to the guideline are provided.

Score = 15 (3)

5. Applicability (Items 19-21a)
Potential organisational barriers in applying the recommendations are not discussed. National particularities have not been considered. There is no consideration of cost issues. Key review criteria for monitoring and/or audit purposes are only vaguely indicated. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 6 (1.2)

6. Editorial Independence (Items 22-23)
There is no comment on external funding or conflicts of interest of the development members.

Score =2 (1.0)

7. Overall assessment:
Would not recommend

Overall assessment:

The guideline has serious short-comings in five of six of the domains of the AGREE instrument. Its strongest point is its clear and rather unambiguous recommendations, which make it easy to use in the daily routine. However, most of the principles of evidence based medicine such as a clear description of the process of how the recommendations have been obtained, what the evidence behind these recommendations is and how it must be coded has not been specified. This led us to the overall assessment of not recommending the guideline.

Notes:

The guideline was developed within a collection of several other treatment guidelines of the German psychiatric association.

References:

Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde. Praxisleitlinien in Psychiatrie und Psychotherapie. Band 4, Eßstörungen. Darmstadt: Steinkopff Verlag; 2000.

Internet Link:

http://www.dgppn.de/leitlinien/031038.pdf (this link refers to the short version only)

Structured guideline summary

Title:

Poruchy Prijmu Potravy (Eating disorders)

Publication date:

1999

Organisation:

Czech psychiatric association

General type of guideline or of the guideline development process:

Guideline developed by an expert

Number of pages:

12

Contents:

National particularities:

Some national particularities have been considered, e.g. different Czech self-help groups are mentioned.

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is to improve the knowledge of psychiatrists and GP's in the treatment of eating disorders. The clinical questions covered by the guideline are not described. The patients to whom the guideline is meant to apply are described as patients with eating disorders diagnosed according to the criteria defined in ICD-10.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group consisted of an expert who was appointed by the Czech society of psychiatry and one reviewer. The patients' views and preferences have not been sought.
The target users of the guideline are defined as psychiatrists and general practitioners, but also as doctors from other specialties. The draft version of the guideline has been published two years

before the publication of the guideline. The readers had the possibility to make comments and it was then discussed on a meeting of the society of psychiatry before its release.

Score = 9 (2.3)

3. Rigour of Development (Items 8-14)
There is no information about the methods that were used to search for evidence and also the criteria for selecting the evidence are not described. The methods used for formulating the recommendations are relatively clearly described: an expert wrote the guideline, one reviewer commented on it, the draft was published in a Czech psychiatric journal so that others could comment on it and finally the guideline was accepted by the national psychiatric association. The health benefits, side effects and risks have been considered in formulating the recommendations. There are explicit links between the recommendations and the supporting evidence, but there is no coding of the quality of the evidence. The guideline contains new evidence that could have an important impact on management. The guideline has been externally reviewed by one reviewer prior to its publication. It is stated in a general introduction that the guideline should be updated.

Score = 23 (2.9)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous and the different options for management of the condition are clearly presented. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are rather easily identifiable. The guideline provides some information about different rating scales for eating disorders.

Score = 14 (2.8)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the guideline are discussed, e.g. the importance of sound knowledge of different specialists which might be involved in the treatment of those with eating disorders is mentioned. Some national particularities have been considered, e.g. different Czech self-help groups are mentioned. The cost implications of applying the recommendations are shortly discussed. Key review criteria for monitoring and/or audit purposes are not presented. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 9 (1.8)

6. Editorial Independence (Items 22-23)
The guideline has been developed by the Czech society of psychiatry, but whether it was produced really independently from the pharmaceutical companies which are presented on one of the first pages of the guideline is unclear. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1.0)

7. Overall assessment
Would not recommend

Overall assessment:

This guideline on the treatment of eating disorders has been developed by an expert who was appointed by the Czech society of psychiatry, other relevant professional groups were not involved. The strength of this guideline is its clarity and its short presentation, so that it is a user-friendly compendium. Another strong point is that at least potential organisational barriers are discussed. This was not done by many guidelines assessed during this project. Unfortunately, there is no information about the methods that were used to search for evidence and the criteria for selecting it. These are core components of the concept of “evidence-based medicine” so that it was thought that the guideline cannot be recommended.

Notes:

References:
Papezova H. Poruchy Prijmu Potravy. In: Houdek L, editor. Psychiatrie: Doporucene postupy psychiatricke pece. Prag: Ceska psychitricka spolecnost. Galen; 1999: p. 149-160.

Structured guideline summary

Title:

Alvorlige spiseforstyrelser. Retningslinjer for behandling i spesialisthelsetjenesten

Publication date:

July 2000, first version

Organisation:

Statens helsetilsyn, Norway.

General type of guideline or of guideline development process:

Guideline produced by the Statens helsetilsyn, Norway.

Number of pages:

78

Contents:

11. Reference list
12.ICD-10
13.Useful addresses

National particularities:

National particularities have been indicated only very vaguely.

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guidelines is to develop sufficient competence for the diagnosis and for the therapy of severe eating disorders. A special focus of the guidelines is the prevention of eating disorders. A detailed description of the clinical questions covered by the guidelines is not presented. The patients to whom the guidelines are meant to apply are only vaguely described as children, adolescents and adults with severe eating disorders

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group included a psychiatrist, an internist and two psychologists, who are listed by names. It seems that other professional groups have not been involved. The patients' views and preferences have been solicited: There were 10 external referees, one of them a woman from an interest group for people with eating disorders and one of them from the anorexia/bulimia society, who attended three meetings with the working group. The target users of the guidelines are specified to be people who work in somatic and psychiatric wards, outpatient departments for children and adolescents as well as adults and specialist doctors in private practice. The guidelines have not been piloted among end users.

Score = 11 (2.8)

3. Rigour of Development (Items 8-14)
No information is provided on the methods that were used to search for evidence. The criteria for selecting the evidence are not described. It is stated that the guideline development group held three meetings, that comments were received from referees and that consultations with special experts took place. The health benefits, side effects and risks have not been considered in formulating the recommendations. There are explicit links between the recommendations and the supporting evidence. The guidelines contain new evidence that could have an important impact on management. The guideline development group met three times with external experts for reviewing the guidelines prior to their publication. A procedure for updating the guidelines is not provided.

Score = 17 (2.1)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. The different options for management of the condition are clearly presented, e.g. all different types of psychotherapy are described. The guidelines mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are not easily identifiable. The guidelines are not supported by tools for application.

Score = 14 (2.8)

5. Applicability (Items 19-21a)
Potential organisational barriers in applying the guideline are discussed: there is a chapter on problems that must be solved, such as efficacy of therapy, cost-effectiveness, prevalence and risk factors and efficacy of measures. Local (national) particularities have been considered only vaguely. The cost implications of applying the recommendations have not been considered. Key review criteria for monitoring and/or audit purposes are not presented. The guidelines do not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 8 (1.6)

6. Editorial Independence (Items 22-23)
No information on external funding is provided. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

The stated overall aim of the guideline is to develop sufficient competence for diagnosis and therapy of severe eating disorders. In comparison with other guidelines, the guideline developers set great store by the involvement of patient interest groups in the development process. Another strong point is that the potential organisational barriers are discussed relatively extensively in a separate chapter. Unfortunately, there is no description of the methods that were used to search for evidence and of the criteria which were used for selecting the evidence. Therefore we felt that these guidelines could not be regarded as evidence-based

Notes:

References:

Statens helsetilsyn. Alvorlige spiseforstyrelser: Retningslinjer for behandling i spesialisthelsetjenesten. Utredningsserie 7-2000. Oslo: Statens helsetilsyn; 2000.

Internet Link:

www.helsetilsynet.no

Structured guideline summary

Title:

Zasady spravne praxe u elektrokonvulzivni terapie (Correct strategies of electroconvulsive therapy)

Publication date:

1999

Organisation:

Czech psychiatric association

General type of guideline or of guideline development process:

Guideline produced by an expert

Number of pages:

8

Contents:

1. Indication
2. Guidelines of emergencies which require the use of ECT
3. Contraindications
4. ECT for defined subgroups of the population
5. Equipment of the workplace for ECT
6. Preparation of the patient before ECT
7. Anesthesia
8. Frequency and length of therapy
9. Adjunct medication

National particularities:

Not indicated

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is to improve the knowledge of psychiatrists in the use of ECT. The clinical questions covered by the guideline are not described. The patients to whom the guideline is meant to apply are described as patients for whom ECT is indicated using ICD-10.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group consisted of an expert who was appointed by the Czech society of psychiatry and one reviewer. The patients' views and preferences have not been sought. The target users of the guideline are defined as psychiatrists and general practitioners, but also as doctors from other specialties. The guideline was not piloted among end-users before its release.

Score = 7 (1.8)

3. Rigour of Development (Items 8-14)
There is no information about the methods that were used to search for evidence and also the criteria for selecting the evidence are not described. The methods used for formulating the recommendations are relatively clearly described: an expert wrote the guideline, one reviewer commented on it and finally the guideline was accepted by the national psychiatric association. Contrary to other Czech psychiatric guidelines this guideline was not presented in a psychiatric journal in order to allow comments on it. The health benefits, side effects and risks have been considered in formulating the recommendations. There are explicit links between the recommendations and the supporting evidence, but there is no coding of the quality of the evidence. The guideline contains new evidence that could have an important impact on

management. The guideline has been externally reviewed by one reviewer prior to its publication. It is stated in a general introduction that the guideline should be updated.

Score = 23 (2.9)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous and the different options for management of the condition are clearly presented. The guideline does not mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable. The guideline provides some information about different scales.

Score = 15 (3)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the guideline are almost not discussed. National particularities have not been considered. The cost implications of applying the recommendations have not been discussed. Key review criteria for monitoring and/or audit purposes are not presented. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 6 (1.2)

6. Editorial Independence (Items 22-23)
The guideline has been developed by the Czech society of psychiatry, but whether it was produced really independently from the pharmaceutical companies which are presented on one of the first pages of the guideline is unclear. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1.0)

7. Overall assessment
Would not recommend

Overall assessment:

This guideline on the use of ECT has been developed by an expert who was appointed by the Czech society of psychiatry, other relevant professional groups were not involved. The strength of this guideline is its clarity and its short presentation, so that it is a user-friendly compendium. Unfortunately, there is no information about the methods that were used to search for evidence and the criteria for selecting it. These are core components of the concept of “evidence-based medicine” so that it was thought that the guideline cannot be recommended.

Notes:

References:

Hrdlicka M. Zasady spravne praxe u elektrokonvulzivni terapie. In: Houdek L, editor. Psychiatrie: Doporucene postupy psychiatricke pece. Prag: Ceska psychitricka spolecnost Galen; 1999. p. 173-180

Internet Link:

Structured guideline summary

Title:

Indications et modalités de l'Electroconvulsivothérapie

Publication date:

April 1999, first version

Organisation:

Agence Nationale d'Accréditation et d'Evaluation en Santé (ANAES)

General type of guideline or of guideline development process:

Recommendations derived from a systematic development process

Number of pages:

95

Contents:

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guidelines are to provide the practitioner with syntheses of the level of scientific proof of the current scientific facts and of the experts' opinions on a topic of clinical practice. The clinical questions covered by the guidelines are specifically described. The item "patients to whom the guideline is meant to apply" is not absolutely applicable in these guidelines, but the indications for ECT, e.g. depression, schizophrenia etc., are described.

Score = 10 (3.3)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes individuals from all the relevant professional groups, such as neurologists, psychiatrists, geriatricians and methodologists. The patients' views and preferences were not solicited. The target users of the guideline are stated only to be health care professionals. The guideline has not been piloted among end users.

Score = 7 (1.8)

3. Rigour of Development (Items 8-14)
Systematic methods were used to search for evidence; searches in electronic databases were done and the search terms are listed. The criteria for selecting the evidence are described: the development group used articles in English and French, and the strength of the recommendations is rated in three levels from A to C. The different steps of formulating the recommendations are described in a separate methodology paper. The health benefits, side effects and risks have been considered in formulating the recommendations. There

are explicit links between the recommendations and the supporting evidence, and the guidelines contain new evidence that could have an important impact on management. The guidelines have been reviewed by external experts prior to their publication. A procedure for updating the guidelines is not provided.

Score = 29 (3.6)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. The different options for management of the condition are clearly presented, e.g. fixed dose vs. titration of ECT. The guidelines mention methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are easily identifiable, because they are summarized at the beginning. The guidelines are supported by an information sheet for patients and relatives.

Score = 18 (3.6)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the recommendations are discussed only vaguely. Local (national) particularities have not been considered. The potential cost implications of applying the recommendations have not been considered. The guidelines do not present key review criteria for monitoring and/or audit purposes. The guidelines do not describe methods that help to find out to what extent and by whom the recommendations are used in practice.

Score = 6 (1.2)

6. Editorial Independence (Items 22-23)
No information is provided on whether the guidelines are independent of any funding body or not. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would strongly recommend

Overall assessment:

The guideline development group attempted to work out evidence-based recommendations on ECT. The working group consisted of all the relevant professional groups, and the different steps of the development process are described in detail: a systematic literature search was made with searches in electronic databases (even the exact search terms are provided) and the levels of evidence were keyed according to the quality of the different studies. Considering these facts, we think that this guideline can be highly recommended as an evidence-based product.

Notes:

References:

1. Agence Nationale d'Accréditation et d'Evaluation en Santé (ANAES). Indications et modalités de l'électroconvulsivothérapie. Paris: ANAES; 1997.

2. Agence Nationale d'Accréditation et d'Evaluation en Santé (ANAES). Les recommendations pour la pratique clinique. Guide pour leur élaboration. Paris: ANAES; 1993.

Internet Link:

www.anaes.fr

Structured guideline summary

Title:

Richtlijn Elektroconvulsietherapie

Publication date:

2000, first version

Organisation:

Nederlandse Vereniging voor Psychiatrie

General type of guideline or of guideline development process:

Guideline produced by a working group under the responsibility of the Dutch psychiatric association.

Number of pages:

34

Contents:

National particularities:

The legal aspects of ECT in the Netherlands are discussed.

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guideline are not specifically described. A detailed description of the clinical questions covered by the guideline is not provided. The indications for ECT are described.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group consists of psychiatrists, and legal advisers were involved in the development process. There is no information given as to whether patients' views and preferences were sought. The target users of the guideline are defined: specialists and institution who provide ECT. The guideline was not piloted among end-users.

Score = 7 (1.8)

3. Rigour of Development (Items 8-14)
It is stated that the guideline is based on a literature review, but detailed information about the search strategy is not provided. The criteria for selecting the evidence are indicated: the recommendations are coded according to three levels of evidence. The methods used for formulating the recommendations are only briefly described. The health benefits, side effects and risks were considered in formulating the recommendations, e.g. the indications and contraindications of ECT. There are explicit links between the recommendations and the supporting evidence. The guideline contains new evidence that could have an important impact on management. There is no information given about external reviewing of the guideline prior to its publication. It is mentioned that the guideline should be updated within five years.

Score = 23 (2.9)

4. Clarity and Presentation (Items 15-18)
The recommendations are specific and unambiguous. Different treatment options are clearly presented, e.g. the different indications of ECT. The guideline mentions only some methods that seem to be unsuitable, unnecessary or obsolete, e.g. the contraindications for ECT. Key recommendations are easily identifiable, e.g. flow charts are provided. The guideline is supported by some tools for application (Appendix I and II).

Score = 15 (3)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the recommendations are not discussed. National particularities are considered, especially the legal aspects of ECT in the Netherlands. The potential cost implications of applying the recommendations are not considered. The guideline presents key review criteria for monitoring and/or audit purposes, e.g. in the algorithm on the treatment of unipolar depression after ECT. The guideline does not describe methods that help to find out by whom and to what extent the recommendations are to be used in practice.

Score = 9 (1.8)

6. Editorial Independence (Items 22-23)
It is stated that the guideline development group worked independently and without any conflict of interest.

Score =6 (3)

7. Overall assessment
Would recommend with provisos

Overall assessment:

This guideline on ECT was developed by a working group under the responsibility of the psychiatric association of the Netherlands. It is presented in a well-designed booklet and its clarity and presentation are very good. A literature search was made, and a reference list is provided. Unfortunately, details about the search strategy such as search terms and the databases used are lacking, and the methods used for formulating the recommendations are only briefly described. A positive aspect is the coding of the recommendations in three levels according to their scientific evidence. Considering these facts, we believe that the guideline can be recommended with provisos.

Notes:

References:

van den Broek WW, Huyser J, Koster AM, Leentjens AFG, Stek M, Thewissen ML, Verwey B, Vleugels CMM, van Vliet I, Wijkstra J. Richtlijn Elektroconvulsietherapie. Amsterdam: Uitgeverij Boom; 2000.

Internet Link:

Structured guideline summary

Title:

Modalités de sevrage des toxicomanes dépendants des opiacés

Publication date:

April 1998, first version

Organisation:

Fédération Française de Psychiatrie

General type of guideline or of guideline development process:

Guideline developed by a consensus conference

Number of pages:

Entire book: 453 pages, recommendations: 26 pages.

Contents:

1. Preamble
2. Question 1 - what is the place of withdrawal in the strategies of care of opiate addicts?
3. Question 2 - what preparation for and arrangement of withdrawal?
4. Question 3 - what are the modalities and the practical conditions for withdrawal?
5. Question 4 - what care after withdrawal and follow-up?
6. Conclusion
7. Wishes of the jury

National particularities:

None specified

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objectives of the guidelines are not specifically described. A detailed description of the clinical questions covered by the guidelines is provided, and the recommendations are given as answers to these questions. The patients to whom the guidelines are meant to apply are not specifically described.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group includes individuals from all the relevant professional groups, such as psychiatrists, general practitioners, a psychologist, a pharmacologist, a nurse etc. The patients' views and preferences have not been solicited. The target users of the guidelines are not defined. The guidelines have not been piloted among end users.

Score = 7 (1.8)

3. Rigour of Development (Items 8-14)
The systematic methods that were used to search for evidence are only globally described in a publication on the general methodology of consensus conferences by the ANDEM, but details such as exact search strings or the databases which were searched through are lacking. As to the criteria for selecting the evidence in the methodology paper, it is stated that there can be a weighting and coding according to the quality of the underlying research, but no such coding has been undertaken for these specific guidelines. The methods used for formulating the recommendations are quite well described in the methodology paper, although different alternatives are presented and it is not clear which

one was used for this conference. The guidelines provide relatively detailed comments on side effects, health benefits and risks as well as on the social consequences of its recommendations. There are no explicit links between the recommendations and the supporting evidence. The guidelines contain new evidence that could have an important impact on management. The guidelines were not reviewed by experts prior to their publication. A procedure for updating the guideline is not provided.

Score = 17 (2.1)

4. Clarity and Presentation (Items 15-18)
The recommendations are not very specific, nor are they unambiguous, but are rather vague. The different options for management of the condition are clearly presented. The guidelines mention some methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are not very easily identifiable. The guidelines are not supported by tools for application.

Score = 12 (2.4)

5. Applicability (Items 19-21a)
Potential organisational barriers in applying the recommendations are discussed at least to some extent. With the exception of some French examples, no local (national) particularities have been indicated. The potential cost implications of applying the recommendations have only been briefly considered. The guidelines do not present key review criteria for monitoring and/or audit purposes. The guidelines do not describe methods for helping to determine to what extent and by whom the recommendations are used in practice.

Score = 9 (1.8)

6. Editorial Independence (Items 22-23)
No information on external funding is provided. Conflicts of interest of guideline development members have not been recorded.

Score = 2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

The guideline was developed during a consensus conference in 1998, and the development group consisted of many experts from all the relevant professional groups. But unfortunately, basic information on the development procedure of these recommendations is lacking. There is a methodology paper by the Agence Nationale pour le Développement de l'Evaluation Médicale which might have been the basis of this process, but it is left unclear to what extent this methodology paper has been followed during the development of these guidelines. Due to this lack of information we felt that the guidelines could not be recommended.

Notes:

References:

Fédération française de psychiatrie. Modalités de sevrage des toxicomanes dépendants des opiacés. Conférence de consensus; 1998 apr 23-24; Paris, France. Naves: Imprimerie du Corrézien; 2000.

Internet Link:

www.anaes.fr

Structured guideline summary

Title:

Huumeriippuvuuden Hoito Suomessa
The treatment of drug dependence in Finland

Publication date:

November 1999, first version

Organisation:

Suomolainen Lääkäriseura Duodecim, Suomen Akatemia

General type of guideline or of guideline development process:

Consensus statement

Number of pages:

241

Contents:

1. Introduction
2. Finnish drug policy
3. Children, youth and families
4. Drug and drug dependence
5. What is the prevalence of drug use in Finland and what kind of harm does it cause?
6. Drug related harm
7. What kind of evidence-based therapies are applied in the treatment of drug dependence?
8. What is evidence-based treatment?
9. Evaluation of the effectiveness of the treatment of drug dependence
10. Treatment of opioid dependence
11. Treatment of cocaine dependence
12. Treatment of orhter types of drug dependence
13. Treatment of drug dependence in young people
14. Other treatments and therapies
15. How should the treatment of drug dependence be organised in the Finnish welfare and health care system?
16. What do harm reduction programs do?
17. What are the issues and areas that should be addressed in research on drug dependence?

National particularities:

National particularities have been considered: there are several headings about how the treatment should be established in Finland, but the indications are not very precise.

Assessment with the modified AGREE instrument:

Range of scores: 4 (Strongly Agree) – 1 (Strongly Disagree)

1. Scope and Purpose (Items 1-3)
The overall objective of the guideline is a try for an evidence-based treatment of drug dependence. The clinical questions covered by the guideline are described. The patients to whom the guideline is meant to apply are not specifically described. It seems that all addictive drugs are covered.

Score = 6 (2)

2. Stakeholder Involvement (Items 4-7)
The guideline development group is described as a multiprofessional group that includes mainly doctors, but also psychiatrists, general practitioners, administrators and social scientists. The patients' views and preferences have not been sought. The target users of the guideline are not defined. The guideline has not been piloted among end users.

Score = 6 (1.5)

3. Rigour of Development (Items 8-14)
There were no systematic methods used to search for evidence. The criteria for selecting the evidence are not described. The methods used for formulating the recommendations are shortly described: there was a meeting of about 200 participants which elected a panel. Lectures were given on the basis of which the recommendations were formulated. The health benefits, side effects and risks have not been considered in formulating the recommendations. There are no explicit links between the recommendations and the supporting evidence. The guideline contains new evidence that could have an important impact on management. The guideline has not been externally reviewed prior to its publication. A procedure for updating the guideline is not provided.

Score = 11 (1.4)

4. Clarity and Presentation (Items 15-18)
The recommendations are rather vague. The different options for management of the condition are not very clearly presented. The guideline mentions some methods that seem to be unsuitable, unnecessary or obsolete. Key recommendations are not easily identifiable. The guideline is supported with some tools for application, such as a booklet and an English translation.

Score = 9 (1.8)

5. Applicability (Items 19-21a)
The potential organisational barriers in applying the guideline are discussed in a whole chapter. National particularities have been considered: there are several headings about how it should be done in Finland, but then it is not very precise. The cost implications of applying the recommendations have not been considered. The guideline does not present key review criteria for monitoring and/or audit purposes. The guideline does not describe methods that help to find out on which extent and by whom the recommendations are used in practice.

Score = 10 (2)

6. Editorial Independence (Items 22-23)
There is no information provided about external funding. Conflicts of interest of guideline development members have not been recorded.

Score =2 (1)

7. Overall assessment
Would not recommend

Overall assessment:

The guideline was established during a consensus meeting of 200 Finnish experts. Very important components of an evidence-based guideline such as a detailed literature search, links to the supporting evidence, a coding of the evidence supporting the recommendations, clear recommendations etc. are lacking so that we would not recommend the guideline.

Notes:

References:
Huumeriippuvuuden Hoito Suomessa .The treatment of drug dependence in Finland. Consensus Statement; 1999.

Internet Link:

9. Danksagung

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