

Appendix – Budget impact en kosteneffectiviteit

Tabel A.1: Hoofdaspecten van economische evaluaties van interventies voor angststoornissen

ID	Auteurs (jaar)	Land	Economische evaluatie	Studie type	Analyse	Perspectief	Tijdshorizon	Industriesponsoring
1	Andersson e.a. (2015)	Zweden	TBEE	RCT	CEA, CUA	Societal	4 maanden	Nee
2	Andersson e.a. (2015)	Zweden	TBEE	RCT	CEA	Societal	2 jaren	Nee
3	Bergstrom e.a. (2010)	Zweden	TBEE	RCT	CEA	NR	6 maanden	Nee
4	Bodden e.a. (2008)	Nederland	TBEE	RCT	CEA, CUA	Societal	15 maanden	Nee
5	De Salas-Cansado e.a. (2013)	Spanje	Combi ^a	Combi ^a	CUA	Healthcare	6 maanden	Pfizer
6	De Salas-Cansado e.a. (2012)	Spanje	Combi ^a	Combi ^a	CUA	Healthcare	6 maanden	Pfizer
7	Dear e.a. (2015)	Australië	TBEE	RCT	CUA	Healthcare	1 jaar (effects), 2 maanden (costs)	Nee
8	Egger e.a. (2015)	Duitsland	TBEE	RCT	CEA, CUA ^b	Societal	6 maanden	Nee
9	Goorden e.a. (2014)	Nederland	TBEE	RCT	CUA	Societal	1 jaar	Nee
10	Gospodarevskaya e.a. (2012)	Australië	MBEE	Decision tree model + Markov model	CUA	Healthcare	31 jaren	Nee
11	Guest e.a. (2005)	UK	MBEE	Decision tree model	CEA	Healthcare	6 maanden	Wyeth
12	Hedman e.a. (2011)	Zweden	TBEE	RCT	CEA, CUA	Societal	6 maanden	Nee
13	Hedman e.a. (2014)	Zweden	TBEE	RCT	CEA, CUA	Societal	4 jaren	Nee
14	Heuzenroeder e.a. (2004)	Australië	MBEE	Epidemiologically-based CUA	CUA	Healthcare	1 jaar	Nee
15	Iskedjian e.a. (2008)	Canada	MBEE	Decision tree model	CEA	Societal	24 weeks	Lundbeck
16	Issakidis e.a. (2004)	Australië	MBEE	Epidemiologically-based CUA	CUA	Healthcare	1 jaar	Nee
17	Joesch e.a. (2012)	VS	TBEE	RCT	CBA	Healthcare	18 maanden	Onduidelijk

18	Jorgensen e.a. (2006)	UK	MBEE	Decision tree model	CEA	Societal	9 maanden	Lundbeck
19	Katon e.a. (2006)	VS	TBEE	RCT	CEA, CUA	Healthcare	1 jaar	Nee
20	Katon e.a. (2002)	VS	TBEE	RCT	CEA	Healthcare	1 jaar	Onduidelijk
21	Kolbasovsky e.a. (2007)	VS	TBEE	RCT	CEA	NR	6 maanden	Nee
22	Konig e.a. (2009)	Duitsland	TBEE	RCT (cluster)	CUA	Societal	9 maanden	Nee
23	Lambert e.a. (2010)	UK	TBEE	RCT	CEA, CUA	Healthcare (GP)	10 maanden	Nee
24	Le e.a. (2014)	VS	TBEE	RCT and preference trial ^c	CUA	Societal	1 jaar	Pfizer
25	Marchand e.a. (2004)	Canada	TBEE	RCT	CEA	Healthcare	2 jaren	Nee
26	Mavissakalian e.a. (2000)	VS	MBEE	Markov model	CUA	Healthcare	18 maanden	Nee
27	Mavranezouli e.a. (2013)	UK	MBEE	Decision tree model	CUA	Healthcare	42 weken	Nee
28	Mavranezouli e.a. (2015)	UK	MBEE	Decision tree model + Markov model	CUA	Healthcare	5 jaren en 12 weken	Nee
29	McCrone e.a. (2009)	UK	TBEE	RCT	CEA	Healthcare	1 maand	Nee
30	McHugh e.a. (2007)	VS	TBEE	RCT	CEA	NR	15 maanden	Nee
31	Mihalopoulos e.a. (2015)	Australië	MBEE	Decision tree model	CUA	Healthcare	5 jaren	Nee
32	Nordgren e.a. (2014)	Zweden	TBEE	RCT	CEA, CUA	NR	1 jaar	Nee
33	Otto e.a. (2000)	VS	TBEE	Unclear	CEA	NR	1 jaar	Nee
34	Poirier-Bisson e.a. (2013)	Canada	TBEE	Cohort ^d	CEA	NR	6 maanden	Nee
35	Roberge e.a. (2008)	Canada	TBEE	RCT	CEA	Societal	3 maanden	Nee
36	Schnurr e.a. (2013)	VS	TBEE	RCT	CEA	NR	6 maanden	Nee
37	Silva Miguel e.a. (2013)	Portugal	MBEE	Patient-level simulation	CEA, CUA	Healthcare	1 jaar	Pfizer
38	Titov e.a. (2009)	Australië	TBEE	RCT ^e	CEA	NR	6 maanden	Nee
39	Tolin e.a. (2011)	VS	TBEE	RCT	CEA	NR	3 maanden	Nee
40	Van Apeldoorn e.a. (2014)	Nederland	TBEE	RCT	CEA	Societal	2 jaren	Nee

41	Vera-Llonch e.a. (2010)	Spanje	MBEE	Patient-level simulation	CEA, CUA	Healthcare	1 jaar	Pfizer
42	Zhang e.a. (2013)	China	TBEE	Trial ^f	CEA	NR	3 maanden	Nee

Deze tabel is deels in het Engels om aan te sluiten bij het gebruikelijke internationale jargon.

CEA: Kosteneffectiviteit analyse, CUA: kosten-utiliteit analyse, MBEE: model-based economische evaluatie, NR: niet gerapporteerd, RCT: randomized controlled trial, TBEE: trial-based economische evaluatie.

^a Beide MBEE en TBEE componenten.

^b CUA geïncorporeerd in sensitiviteitsanalyse, niet in het referentie scenario.

^c Hybride design: Patiënten zijn verdeeld naar behandeling keuze/geen keuze en vervolgens naar exposure/farmacotherapie.

^d Cohort design met voorafgaand aan het onderzoek een randomisatie van de behandelsequentie.

^e Twee RCTs gecombineerd.

^f Randomisatie niet genoemd.

Tabel A.2: Karakteristieken en resultaten van economische evaluaties van interventies voor angststoornissen

ID	Doelgroep	Behandelalternatieven (n) ^a	Effect meting en waardering ^b	Discontov oet	Prijsjaar	Resultaten en ICERs (2014 US\$)
1	Patiënten met OCD	I: iCBT (50); II: Internet-based supportive therapy	Y-BOCS, QALYs (EQ-5D)	NA	2013	ICER iCBT versus internet-based supportive therapy: \$947/relapse avoided; \$7.307/QALY gained. iCBT resulted in more effects and QALYs at higher costs.
2	Patiënten met OCD	I: Additional booster treatment after iCBT (47), II: No additional booster treatment after iCBT (46)	Y-BOCS	NR	Unclear	ICER additional booster treatment versus no booster treatment after receiving iCBT: \$1,489/relapse avoided. The additional booster treatment was more effective at higher costs.
3	Patiënten met PS, met of zonder agoraphobia	I: iCBT (53); II: Group CBT (60)	PDSS, CGI	NA	Unclear	iCBT has superior cost-effectiveness ratios compared to group CBT. ICER NR.
4	Kinderen (8-18 jaar) met angststoornis	I: Family CBT (57); II: Individual CBT (59)	ADIS-IV, QALYs (EQ-5D)	Cost 4%, QALY unclear	2003	Individual CBT is dominant for both CEA and CUA. Individual CBT is more effective and less costly compared to family CBT. ICER NR.
5	Patiënten met refractory GAD	I: Pregabalin (451); II: Usual care (451)	QALYs (EQ-5D)	NA	Unclear	ICER pregabalin versus usual care: \$22,590/QALY gained. Pregabalin treatment resulted in more QALYs at higher costs.

6	Benzodiazepine-refractory patiënten met GAD	I: Pregabalin (157); II: SSRI/SNRI (125)	QALYs (EQ-5D)	NA	2008	ICER pregabalin versus SSRI/SNRI: \$38,670/QALY gained. Pregabalin treatment resulted in more QALYs at higher costs.
7	Ouderen 60 jaar en ouder die symptomen van angst, stress en zorgen ervaren	I: iCBT (35); II: Waiting list (37)	QALYs (EQ-5D)	NA	2013	ICER iCBT versus waiting list: \$6,175/QALY gained. iCBT treatment resulted in more QALYs at higher costs.
8	Volwassenen (18-70 jaar) met SAD	I: CBT (209); II: Psychodynamic therapy (207); III: Waiting list (79)	LSAS-SR, QALYs (EQ-5D)	NA	2008	ICERs CBT versus waiting list: \$4,899/response, \$7,843/remission. ICERs psychodynamic therapy versus waiting list: \$6,718/response, \$14,544/remission. Both interventions resulted in more effects at higher costs.
9	Patiënten met PS of GAD	I: Collaborative Stepped Care (114); II: Usual care (66)	QALYs (EQ-5D)	NA	Unclear	ICER Collaborative Stepped Care versus usual care: - \$6,289/QALY gained. Collaborative Stepped Care dominated usual care.
10	Sexueel mishandelde Kinderen met PTSD	I: Trauma-focused CBT; II: Trauma-focused CBT+SSRI; III: Non-directive counselling; IV: no treatment	QALYs (AQoL-4D)	5% (cost and QALY)	2010/2011	Non-directive counselling is dominated by all active treatments. ICER Trauma-focused CBT+SSRI versus Trauma-focused CBT alone: \$2,097/QALY gained. Trauma-focused CBT+SSRI resulted in more QALYs at higher costs compared to Trauma-focused CBT only.
11	Niet-depressieve patiënten met GAD	I: Venlafaxine XL; II: Diazepam	CGI	NA	2000/2001	ICERs venlafaxine XL versus diazepam: \$821/additional % remission at 6 months; \$638/additional % relapse avoided. Venlafaxine XL resulted in more effects at higher costs.
12	Patiënten met SAD	I: iCBT (64); II: Group CBT (62)	LSAS-SR, QALYs (EQ-5D)	NA	Unclear	CEA; ICER iCBT versus group CBT: -\$7,652/point improvement on LSAS-SR. iCBT dominates group CBT. CUA; ICER iCBT versus group CBT: - \$19,356/QALY gained. iCBT dominated group CBT.
13	Patiënten met SAD	I: iCBT (64); II: Group CBT (62)	LSAS-SR, QALYs (EQ-5D)	NR	Unclear	CUA; ICER iCBT versus group CBT: -\$7,469/QALY gained. iCBT dominates group CBT. CEA; ICER iCBT versus group CBT: \$10,270/point improvement on

						LSAS-SR. iCBT was less effective at lower costs compared to group CBT.
14	Patiënten (18 jaar en ouder) met GAD or PS	GAD; I: CBT, II: SNRI, III: Usual care. PD; I: CBT, II: Paroxetine, III: Imipramine, IV: Usual care	DALYs	NA	2000	GAD; ICER CBT versus usual care: \$7,252/DALY saved. PD; ICER CBT versus usual care: \$7,147/DALY saved. CBT was the most cost-effective intervention for both GAD and PD.
15	Patiënten met GAD	I: Escitalopram; II: Paroxetine	CGI	NA	2005	Canadian healthcare perspective; ICER escitalopram versus paroxetine: \$2,358/symptom-free year. Escitalopram resulted in more effects at higher costs. Societal perspective; escitalopram is dominant to paroxetine.
16	Patiënten met PS, SAD, GAD, or PTSD	I: Evidence-based optimal treatment; II: Current treatment	DALYs	NA	1997/1998	Optimal care yields greater health gains at similar costs. ICERs NR.
17	Volwassenen (18-75 jaar) met PS, GAD, SAD, or PTSD	I: CALM (349); II: Usual care (341)	QALYs (EQ-5D, SF-12)	NR	2009	The mean incremental net benefit of CALM versus usual care is positive when an AFD is valued \$3 or more. The mean incremental net benefit is positive when a QALY is worth \$3,829 or more.
18	Patiënten met matig tot ernstige GAD	I: Escitalopram; II: Paroxetine	CGI	NA	2005	Escitalopram yielded greater effectiveness at lower costs compared to Paroxetine. ICER NR.
19	Patiënten (18-70 jaar) met PS	I: CBT+SSRI (119); II: Usual care (113)	ASI, QALYs ^c	NA	Unclear	ICERs CBT+SSRI versus usual care: \$10/additional anxiety free day, and costs per QALY gained ranging from \$17,160 to \$30,030. CBT+SSRI is associated with more effects at higher costs compared to usual care.
20	Patiënten (18-65 jaar) met PS	I: Collaborative care (57); II: Usual care (58)	ASI	NA	Unclear	ICER Collaborative care: -\$4/anxiety free day. The probability that collaborative care is dominant to usual care is 70%.
21	Patiënten (18 jaar en ouder) ontslagen van de spoedeisende hulp	I: Intervention care (307); II: Usual care (300)	Emergency department visits	NA	Unclear	In the 6 months following emergency department discharge, intervention care resulted in lower emergency department visits at lower facility costs compared to usual care. Psychiatric outpatients costs were equal between conditions. ICER NR.

22	Patiënten (18-65 jaar) met angststoornis	I: Optimised care (201); II: Usual care (188)	QALYs (EQ-5D)	NA	2006	Optimised care was dominated by usual care. Optimised care resulted in less QALYs at higher costs. ICER NR.
23	Patiënten (18-65 jaar) met PS	I: Occupational therapy-led lifestyle intervention (57); II: Routine GP care (60)	BAI, QALYs (EQ-5D)	NA	2001/2002	ICERs occupational therapy-led lifestyle intervention versus routine GP care: \$83/unit of BAI improvement; \$17,696/QALY gained. Occupational therapy-led lifestyle intervention yielded more effects at higher costs.
24	Patiënten (18-65 jaar) met PTSD	I: Prolonged exposure (109); II: Sertraline (91) (either by choice or randomized)	QALYs (EQ-5D)	NA	2012	<i>Overall treatment effect</i> ; prolonged exposure was dominant to sertraline. <i>Treatment choice</i> ; being able to choose between treatments was dominant to treatment assignment. ICER preferring and receiving prolonged exposure versus preferring pharmacotherapy but receiving prolonged exposure: \$29,930/QALY gained. ICER preferring and receiving pharmacotherapy versus preferring prolonged exposure but receiving pharmacotherapy: \$27,273/QALY gained.
25	Patiënten met PS	I: CBT and pharmacotherapy, II: CBT	GFI	NR	Unclear	CBT was more effective at lower costs compared to CBT and pharmacotherapy combined. ICER NR.
26	Patiënten met PS	I: Imipramine without maintenance, II: Imipramine with half-dose maintenance, III: Imipramine with full-dose maintenance	QALYs (NR)	NR	1997	The total costs and effects of Imipramine with half-dose maintenance and Imipramine with full-dose maintenance were similar and both cost saving compared to Imipramine without maintenance. ICER NR.
27	Patiënten met GAD	6 pharmacological treatments and placebo	QALYs (SF-36)	NA	2011	Sertraline resulted in the highest QALY gain at the lowest cost. ICERs NR.
28	Patiënten met SAD	Multiple pharmacological treatments, psychological treatments, placebo, waiting list	QALYs (EQ-5D)	3.5% (cost and QALY)	2015	CBT according the Clark & Wells model was the most cost-effective treatment option, followed by individual CBT and phenelzine.
29	Patiënten met PS en fobie	I: Computer-guided self-exposure (NR); II: Clinician	SRMP	NA	Unclear	ICER computer-guided self-exposure versus computer-guided relaxation: \$108/extra unit of

		guided self-exposure (NR); III: Computer-guided relaxation				improvement on the SRMP. ICER clinician-guided self-exposure versus computer-guided relaxation: \$169/extra unit of improvement on the SRMP.
30	Patiënten met PS	I: CBT+imipramine (65); II: CBT+placebo (63); III: CBT (77); Imipramine (83); IV: Placebo (24)	PDSS	NA	2006	Individual treatment resulted in greater cost-efficacy compared to combined treatment. Imipramine was most cost-eficacious in the acute phase (3 months). CBT was the most cost-eficacious treatment in the maintenance phase (6 months). ICERs NR.
31	Volwassenen en kinderen onder 16 jaar met PTSD	I: Trauma-focused CBT (adults and children); II: SSRI (adults only); III: Usual care	QALYs (AQoL-4D), DALYs	3% (cost and QALYs)	2012	<i>Adults</i> ; ICER Trauma-focused CBT versus usual care: \$10,715/DALY and \$12,724/QALY gained. ICER SSRI versus usual care: \$154/QALY gained. <i>Children <16 years</i> ; ICER Trauma-focused CBT versus usual care: \$5,358/DALY and \$5,960/QALY gained. Trauma-focused CBT (adults and children) and SSRI (adults) resulted in more QALY/DALYs at higher costs compared to usual care.
32	Volwassenen (18 jaar en ouder) met angststoornis	I: iCBT (50); II: Attention control group ^d (50)	CORE-OM, QALYs (EQ-5D)	NA	Unclear	ICERs iCBT versus attention control group: -\$1,855/incremental improvement on CORE-OM; -\$7,650/QALY gained. iCBT dominates attention control.
33	Patiënten met PS	I: Pharmacotherapy (40); II: CBT (20); III: Group CBT (20)	CGI	NA	Unclear	Treatment effects were equal for all groups, pharmacotherapy resulted in the highest costs and CBT was associated with the lowest costs. ICERs NR.
34	Patiënten met PS met <i>non-cardiac chest pain</i>	I. Panic management (24); II. SSRI (11); III. Brief CBT (19); IV. Usual care (15)	ADIS-IV	NA	Unclear	ICER panic management versus usual care: \$103/point of improvement on ADIS-IV. ICER SSRI versus usual care: \$177/point of improvement on ADIS-IV. ICER brief CBT versus usual care: \$256/point of improvement on ADIS-IV. All interventions were more effective at higher costs compared to usual care.
35	Volwassenen (18-65 jaar) met PS met agoraphobia	I: CBT (33); II: Brief CBT (32); III: Group CBT (35)	GFI, effect sizes ^e	NA	2000	Compared with CBT, brief CBT and group CBT were less costly and had superior cost-effectiveness ratios. ICERs NR.

36	USA veterans met PTSD	I: Collaborative care (96); II: Usual care (99)	PDS	NA	2010	The effects and total costs were equal for both interventions. ICER NR.
37	Patiënten met matig tot ernstige GAD	I: Pregabalin; II: Venlafaxine XR	HAM-A, QALYs (EQ-5D)	NA	Unclear	ICER pregabalin versus venlafaxine XR: \$138/additional week with no or minimal anxiety; \$47,545/QALY gained. Pregabalin is associated with more effects at higher costs compared to Venlafaxine XR.
38	Patiënten (18 jaar en ouder) met SAD	I: Shyness programme (93); II: Waiting list (100)	SIAS and SPS, converted to YLD	NA	2008	ICER NR. ^f
39	Patiënten (18 jaar en ouder) met OCD (matige ernst, met minstens een jaar symptomen)	I: Stepped care ERP (18); II: ERP (12)	Y-BOCS	NA	Unclear	Stepped care ERP was equally efficacious as ERP, but stepped care ERP was associated with significantly lower costs compared to ERP. ICER NR.
40	Patiënten (18-65 jaar) met PS met of zonder agoraphobia	I: CBT (52); II: SSRI (47); III: CBT+SSRI (49)	HAM-A	NR	2005	ICERs NR. CBT dominates SSRI, and CBT+SSRI was more effective at higher costs compared to SSRI alone.
41	Patiënten met matig tot ernstige GAD	I: Pregabalin; II: Venlafaxine XR	HAM-A, QALYs (EQ-5D)	NA	2007	ICER Pregabalin versus venlafaxine XR: \$42/additional week with no or minimal anxiety, \$3,617/QALY gained. Pregabalin is associated with more effects at higher costs compared to venlafaxine XR.
42	Participanten (18-65 jaar) met GAD	I: Venlafaxine (50); II: Citalopram (50)	HAM-A	NA	Unclear	ICER of \$4/% cured. Venlafaxine treatment resulted in more effects at higher costs compared to Citalopram.

Deze tabel is deels in het Engels om aan te sluiten bij het gebruikelijke internationale jargon.

ADIS-IV: Anxiety Disorders Interview Schedule, AQoL-4D: Assessment of Quality of Life, ASI: Anxiety Sensitivity Index, BAI: Beck Anxiety Inventory, CBT: cognitive behavioural therapy, CGI: Clinical Global Impressions, CORE-OM: Clinical Outcomes in Routine Evaluation Outcome Measure, DALY: disability-adjusted life year, ERP: exposure and response prevention, EQ-5D: EuroQol 5D, GAD: generalized anxiety disorder, GFI: Global Functioning Index, HAM-A: Hamilton Anxiety Rating Scale, iCBT: internet delivered CBT, ICER: incremental cost-effectiveness ratio, LSAS-SR: Liebowitz Social Anxiety Scale, NA: not applicable, NR: not reported, OCD: obsessive-compulsive disorder, PD: panic disorder, PDS: Posttraumatic Diagnostic Scale, PDSS: Panic Disorder Severity Scale, PTSD: post-traumatic stress disorder, QALY: quality-adjusted life year, SAD: social anxiety disorder, SF-36/12: Short Form 36/12, SIAS: Social Interaction Anxiety Scale, SNRI: Serotonin–norepinephrine reuptake inhibitor, SRMP: self-rated main problem, SPS: Social Phobia Scale, SSRI: selective serotonin reuptake inhibitor, Y-BOCS: Yale–Brown Obsessive Compulsive Scale, YLD: years lived with disability.

^a Sample size (*n*) of the intervention conditions only applicable to trial-based economic evaluations.

^b Valuation method of utilities only applicable to cost-utility analyses.

^c Valuation method unclear

^d Attention control group received treatment after 10 weeks.

^e Effect sizes of multiple outcome measures used.

^f Results unclear, the cost-effectiveness of the Shyness programme versus waiting list is not described in the results.

Tabel A.3: Kwaliteitscheck met de uitgebreide CHEC-lijst (artikelen 1-16)

Item	Studie ID															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1.Is the study population clearly described?	1	1	1	1	1	1	1	1	0	1	1	1	1	1	0.5	1
2.Are competing alternatives clearly described?	0.5	1	1	0.5	0.5	0.5	1	0.5	0.5	1	0.5	1	1	1	0.5	0.5
3.Is a well-defined research question posed in answerable form?	0.5	0.5	1	1	1	1	1	1	1	1	1	1	1	1	1	1
4.Is the economic study design appropriate to the stated objective?	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
5.Are the structural assumptions and the validation methods of the model properly reported (models only)?	NA	NA	NA	NA	NA	NA	NA	NA	NA	1	1	NA	NA	1	1	1
6.Is the chosen time horizon appropriate in order to include relevant costs and consequences?	0	1	1	1	1	1	0	0.5	1	1	1	0.5	1	1	0	1
7.Is the actual perspective chosen appropriate?	1	1	0	1	0.5	0.5	0.5	1	1	0.5	0.5	1	1	0.5	1	0.5
8.Are all important and relevant costs for each alternative identified?	1	1	0	1	1	1	1	1	1	0	0	1	1	0	0.5	1
9.Are all costs measured appropriately in physical units?	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1
10.Are costs valued appropriately?	0.5	0.5	0	1	1	1	1	1	0.5	1	1	0	0	1	1	1
11.Are all important and relevant outcomes for each alternative identified?	1	0.5	1	1	1	1	1	1	1	1	1	1	1	1	1	1
12.Are all outcomes measured appropriately?	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
13.Are outcomes valued appropriately?	1	NA	NA	1	0.5	1	1	1	1	1	NA	1	1	1	NA	1
14.Is an appropriate incremental analysis of costs and outcomes of alternatives performed?	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

15.Are all future costs and outcomes discounted appropriately?	NA	0	NA	0.5	NA	NA	NA	NA	NA	1	NA	NA	0	NA	NA	NA
16.Are all important variables, whose values are uncertain, appropriately subjected to sensitivity analysis?	0.5	0.5	0.5	1	1	1	0.5	1	0.5	1	1	1	1	1	1	1
17.Do the conclusions follow from the data reported?	0.5	1	1	1	1	1	1	1	1	0	0.5	1	1	1	0	1
18.Does the study discuss the generalizability of the results to other settings and patient/client groups?	1	0.5	0	0	1	1	0.5	0.5	0	1	0.5	0.5	0	1	0	0.5
19.Does the article/ report indicate that there is no potential conflict of interest of study researcher(s) and funder(s)?	0	1	1	0.5	1	1	0.5	1	1	0.5	0.5	1	1	0	0.5	0
20.Are ethical and distributional issues discussed appropriately?	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Score (%) ^a	69	75	62	82	86	89	78	86	75	80	75	83	79	87	67	82

Deze tabel is deels in het Engels om aan te sluiten bij het gebruikelijke internationale jargon.

0: no, 0.5: suboptimal, 1: yes, X: uncertain, NA: not applicable.

Tabel 3: Kwaliteitscheck met de verlengde CHEC-lijst (artikelen 17-42)

Item	Study ID																									
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
1	1	0.5	1	1	1	0.5	1	1	1	0.5	0.5	0.5	1	0.5	1	1	0.5	1	1	1	0.5	1	1	1	0.5	1
2	1	0.5	1	1	1	1	1	1	0.5	0.5	0.5	1	0.5	0.5	1	1	0.5	1	0.5	0.5	0.5	1	1	0.5	0.5	1
3	0	1	1	1	1	1	1	0.5	1	1	1	1	0.5	1	1	0.5	1	1	1	1	1	1	1	1	1	0.5
4	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
5	NA	1	NA	NA	NA	NA	NA	NA	NA	1	0.5	1	NA	NA	1	NA	NA	NA	NA	NA	1	NA	NA	NA	1	NA
6	1	0.5	1	1	1	0.5	1	1	1	1	1	0.5	0	1	1	1	1	0.5	0	0.5	1	0	0.5	1	1	0
7	0	1	0.5	0.5	0	1	0.5	1	0.5	0.5	0.5	1	0	0	0.5	0	0	0	1	0	0.5	0	0.5	1	0.5	0
8	1	0.5	1	1	X	1	1	1	0.5	1	1	1	0	0.5	0	1	0	1	0.5	0.5	1	0	1	1	1	1
9	1	1	1	1	0	1	1	1	1	1	1	1	X	0.5	1	1	0.5	1	1	0.5	1	0	0.5	1	1	1
10	1	1	1	0.5	0	1	1	1	1	0.5	1	1	0.5	1	1	0	0.5	0.5	1	1	0.5	0.5	1	1	1	0
11	1	1	1	1	0	1	1	1	0.5	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
12	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
13	1	NA	1	NA	NA	1	1	1	NA	0	1	1	NA	NA	1	1	NA	NA	NA	NA	1	NA	NA	NA	1	NA
14	0	0.5	1	1	0	1	1	1	0.5	0.5	1	1	1	0	1	1	0	1	1	0	1	0	0	0.5	1	0.5

15	0	NA	NA	NA	NA	NA	NA	NA	0	0	NA	1	NA	0	1	NA	NA	NA	NA	NA	NA	NA	NA	0	NA	NA
16	0.5	1	1	1	0	1	1	1	0	0.5	1	1	1	0	1	1	0	0.5	0	0	1	0	0	1	1	0
17	1	0	1	1	1	1	1	1	1	0.5	1	1	1	0	1	1	0.5	1	1	0.5	0.5	0	1	1	0.5	0
18	0	0	1	0	1	1	0	1	0	0	0.5	0.5	0	0.5	1	0	0	0	0	1	0	0	1	0	0	0
19	1	0.5	1	0.5	0	1	1	1	0	0	1	1	0.5	1	1	0.5	0	1	0	1	1	0	1	1	1	0
20	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Score (%) ^a	66	67	92	79	53	89	86	92	58	58	82	88	53	53	93	72	44	74	65	62	76	38	74	78	79	47

Deze tabel is deels in het Engels om aan te sluiten bij het gebruikelijke internationale jargon.

0: no, 0.5: suboptimal, 1: yes, X: uncertain, NA: not applicable.

^a Score uitgedrukt als een percentage van de maximum score, items met NA werden buiten beschouwing gelaten.

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