Mestringstiltak med brukermedvirkning for personer som har langvarige helseutfordringer

Notat fra Kunnskapssenteret
Systematisk litteratursøk med sortering
Juni 2015

kunnskapssenteret

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Nasjonalt kunnskapssenter for helsetjenesten fremskaffer og formidler kunnskap om effekt av metoder, virkemidler og tiltak og om kvalitet innen alle deler av helsetjenesten. Målet er å bidra til gode beslutninger slik at brukerne får best mulig helsetjenester. Kunnskapssenteret er formelt et forvaltningsorgan under Helse-direktoratet, men har ingen myndighetsfunksjoner og kan ikke instrueres i faglige spørsmål.

Nasjonalt kunnskapssenter for helsetjenesten
Oslo, juni 2015

Sammendrag

I samarbeid med Nasjonal kompetansetjeneste for læring og mestring innen helse (NK LMH), har Nasjonalt kunnskapssenter for helsetjenesten utført et systematisk litteratursøk med påfølgende sortering av mulig relevante publikasjoner. Formålet var å finne forskning som ser på effekt av mestringstiltak med brukermedvirkning, for personer som har langvarige helseutfordringer.

Metode

Vi har utført to systematiske litteratursøk; ett for å finne systematiske oversikter og ett for å finne nordiske primærstudier. Vi har søkt i ulike forskningsdatabaser frem til 5. mars 2015. To forskere har vurdert, uavhengig av hverandre, alle titler og sammendrag og trukket ut informasjon fra hver relevant publikasjon om formål, populasjon, tiltak, utfall, brukermedvirkning, metode og forfatternes egne konklusjoner. Vi har ikke analysert og kvalitetsvurdert de inkluderte systematiske oversiktene eller primærstudiene.

Resultater

Søk etter systematiske oversikter

- Av totalt 6900 referanser inkluderte vi 43 systematiske oversikter
- Den engelske termen for å beskrive det vi her definerer som et mestringstiltak, varierer. I 21 av 43 oversikter brukes den engelske termen «self-management interventions/programs/education»
- I samtlige systematiske oversikter har én eller flere inkluderte primærstudier en form for brukermedvirkning som del av mestringstiltaket. I 12 av 43 oversikter beskriver forfatterne denne brukermedvirkningen
- I 26 av 43 oversikter konkluderer forfatterne med at mestringstiltak har positiv effekt, i 13 av 43 usikker effekt, og i to av 43 ingen eller liten effekt
- Det er relativt stor variasjon i hvilke typer utfall som inngår i oversiktene
- Vi har ikke analysert og kvalitetsvurdert de inkluderte systematiske oversiktene

Søk etter nordiske primærstudier

- To nordiske primærstudier er inkludert fra totalt 3479 referanser

Tittel:
Mestringstiltak med brukermedvirkning for personer som har langvarige helseutfordringer

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Publikasjonstype:

Systematisk litteratursøk med sortering

Systematisk litteratursøk med sortering er resultatet av å
- søke etter relevant litteratur ifølge en søkestrategi og
- eventuelt sortere denne litteraturen i grupper presentert med referanser og vanligvis sammendrag

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Svarer ikke på alt:

- Ingen kritisk vurdering av studienes kvalitet
- Ingen analyse av studiene
- Ingen anbefalinger

Hvem står bak denne publikasjonen?

Kunnskapssenteret har gjennomført oppdraget etter forespørsel fra og i samarbeid med NK LMH

Når ble litteratursøket utført?

Søk etter studier ble avsluttet mars, 2015.

- Det ene mestringstiltaket med brukermedvirkning er et norsk pasientopplæringstiltak kalt «Startkurs» for personer som har sykelig overvekt. Det andre er en dansk tilpasning av pasientopplæringsprogrammet «Chronic Pain Self-Management Programme» for personer som har kroniske smerter
- Effekt ble målt på ulike utfall og i begge primærstudiene konkluderte forfatterne med positiv effekt på disse
- Vi har ikke analysert og kvalitetsvurdert de inkluderte primærstudiene

Summary

The Norwegian Knowledge Centre for the Health Services has, in collaboration with the Norwegian National Advisory Unit on Learning and Mastery in Health (NK LMH), conducted a systematic literature search with subsequent sorting of possible relevant publications. The purpose was to find research on the effect of interventions with user involvement, aimed at promoting self-efficacy or coping, for people with long-term health challenges.

Method

We have conducted two systematic literature searches; one to identify systematic reviews, and one to identify Nordic primary studies. We searched in several research databases up to March 5th 2015. Two researchers have, independently, screened all titles and abstracts and extracted information from each relevant publication about the aim, population, intervention, outcomes, user involvement, method and the authors' conclusions. We have not analysed or quality assessed the included systematic reviews or primary studies.

Results

Search for systematic reviews

- Out of a total of 6900 references, we included 43 systematic reviews
- The English term to describe what we here define as interventions to promote self-efficacy or coping, varies. In 21 of 43 systematic reviews the English term "self-management interventions / programs / education" is used
- In all the systematic reviews at least one of the included primary studies have a form of user involvement as part of the intervention. The user involvement is described by the authors in 12 of the 43 systematic reviews
- In 26 of 43 systematic reviews the authors conclude that interventions with user involvement to promote self-efficacy or coping have a positive effect, in 13 of 43 uncertain effect, and in two of 43 little or no effect
- We have not analysed or quality assessed the included systematic reviews

Title:
Interventions with user involvement to promote self-efficacy or coping, for patients with long term health challenges

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Type of publication:

Systematic reference list

A systematic reference list is the result of a search for relevant literature according to a specific search strategy. The references resulting from the search are then grouped and presented with their abstracts.

Doesn't answer everything:

- No critical evaluation of study quality
- No analysis or synthesis of the studies
- No recommendations

Publisher:

Norwegian Knowledge Centre for the Health Services

Updated:

Last search for studies: March, 2015.

Search for Nordic primary studies

- We identified two relevant Nordic primary studies out of a total of 3479 references
- One of the interventions with user involvement is a Norwegian patient education course for people with morbid obesity. The second is a Danish adaptation of the patient education program, "Chronic Pain Self-Management Programme" for people with chronic pain
- The effects of the interventions were measured using different outcomes, and in both studies, the authors reported positive effects
- We have not analysed or quality assessed the included primary studies

Innhold

Forord

Nasjonalt kunnskapssenter for helsetjenesten fikk i forespørsel fra Siw Bratli, leder ved Nasjonal kompetansetjeneste for læring og mestring innen helse (NK LMH), om å samarbeide om å finne forskningslitteratur om mestringstiltak med brukermedvirkning for personer som har langvarige helseutfordringer.

Prosjektgruppen har bestått av:
- Marita Sporstøl Fønhus, seniorforsker, Kunnskapssenteret og NK LMH
- Una Stensberg, forsker, NK LMH
- Elisabet Hafstad, bibliotekar, Kunnskapssenteret

Gro Jamtvedt	Atle Fretheim	Marita Sporstøl Fønhus
Avdelingsdirektør	*Seksjonsleder*	*Prosjektleder*

Innledning

Styrker og svakheter ved litteratursøk med sortering

For å få et overblikk over tilgjengelig forskningslitteratur for en gitt problemstilling, er systematisk litteratursøk en god start. I et systematisk litteratursøk presenterer vi resultatene fra søkene i sin helhet, og sorterer ut forskningslitteraturen som er vurdert som relevant. Vanligvis skjer utvelgelsen på grunnlag av titler og sammendrag. For dette oppdraget har vi også innhentet relevante artikler i fulltekst.

I våre søk etter forskningslitteratur har vi kun benyttet oss av databaser. Vi har ikke søkt i referanselister, kontaktet fageksperter eller søkt etter upublisert forskningslitteratur. Dermed kan vi ha gått glipp av potensielt relevante systematiske oversikter og primærstudier. Vi har ikke analysert og kvalitetsvurdert de inkluderte systematiske oversiktene eller primærstudiene.

I en fullverdig kunnskapsoversikt ville vi ha sammenstilt, analysert og diskutert resultatene og angitt hvor stor tillit vi har til resultatene basert på kritisk vurdering av dokumentasjonen.

Begrunnelse for valg av søkestrategi

I søkene etter systematiske oversikter (søk 1) ble alle med publikasjonsdato før 2006 ekskludert da systematiske oversikter fort blir utdaterte. I søkene etter nordiske effektstudier (søk 2) satte vi ingen tidsbegrensning bakover i tid. For å fange opp så mye relevant forskningslitteratur som mulig, satte vi innledningsvis ingen språkbegrensninger. Kun forskningsartikler som var skrevet på engelsk, norsk, svensk eller dansk ble imidlertid inkludert i siste utvelgelsesrunde (vurdering av artikler/rapporter i fulltekst).

Problemstilling

Hva finnes av forskningslitteratur som ser på effekt av mestringstiltak med brukermedvirkning, for personer som har langvarige helseutfordringer?

Metode

Søk etter forskningslitteratur

Vi søkte systematisk etter forskningslitteratur i følgende databaser:

- Embase
- MEDLINE
- PsycINFO
- CINAHL
- AMED
- ERIC
- British Nursing Index
- Web of Science
- SveMed+
- Cochrane Library
- CRD

I samarbeid med prosjektleder planla og utførte bibliotekar Elisabet Hafstad samtlige søk. Søk etter studier ble avsluttet 5. mars 2015.

Vi la bestillingen til grunn ved utarbeiding av litteratursøket og søkte etter forskningslitteratur som oppfylte våre inklusjonskriterier med tanke på publikasjonstype, populasjon, tiltak og utfall. Det ble brukt metodefilter for systematiske oversikter i søket etter den type publikasjoner (søk 1). I søket etter nordiske primærstudier (søk 2) ble «geografisk filter» for studiested satt til å gjelde studier utført i Norden. Vi la innledningsvis ikke inn noen språkbegrensning søkene. Kun forskningsartikler som var skrevet på engelsk, norsk, svensk eller dansk ble imidlertid innhentet i fulltekst. Den fullstendige søkestrategien ligger i vedlegg 1.

Inklusjonskriterier

Populasjon:	Voksne som har langvarige (kroniske) helseutfordringer
Tiltak:	Mestringstiltak* drevet i samarbeid mellom brukere og fagpersoner, hvor enten bruker eller fagperson leder tiltaket
Sammenlikning:	Ingen mestringstiltak (som annet tiltak, venteliste, vanlig oppfølging)

Utfall:	Viktige utfall er mestring, livskvalitet, sosialt nettverk/relasjoner/støtte, angsts- og depresjonssymptomer og bruk av helse-, omsorgs- og sosialtjenester
Studiedesign	I søk 1: systematiske oversikter. I søk 2: primærstudier som omhandler effekt av tiltak
Språk:	Ingen begrensing i søket, men ved siste inklusjonstrinn vil kun artikler skrevet på de nordiske språkene eller på engelsk bli vurdert

* Vi har her valgt en bred definisjon på mestringstiltak. Det inkluderer alle type tiltak som anvender en eller annen form for opplæring eller undervisning som har til hensikt å øke mestringsevnen og evnen til egenomsorg hos de som deltar.

Utvelgelse av forskningslitteratur

Vi (to forskere) gikk gjennom alle titler og sammendrag for å vurdere relevans i henhold til inklusjonskriteriene. Vurderingene ble gjort uavhengig av hverandre, og vi sammenlignet i etterkant. Der det var uenighet om vurderingene, kom vi til enighet gjennom diskusjon.

Deretter innhentet vi fulltekstversjoner av de aktuelle publikasjonene. Vi gjennomgikk, uavhengig av hverandre, publikasjoner i fulltekst, og vurderte dem opp mot inklusjonskriteriene. Der det var uenighet om vurderingene kom vi til enighet gjennom diskusjon.

Fra hver av de inkluderte systematiske oversiktene hentet vi ut informasjon om formålet, populasjonen, tiltaket, utfallene, brukermedvirkning og oversiktsforfatternes egne konklusjoner. Vi presenterer disse i tabellform.

Fra hver av de inkluderte nordiske primærstudiene innhentet vi informasjon om formålet, populasjonen, tiltaket, utfallene, brukermedvirkning, metode og oversiktsforfatternes egne konklusjoner.

Vi har ikke analysert og kvalitetsvurdert de inkluderte systematiske oversiktene eller primærstudiene.

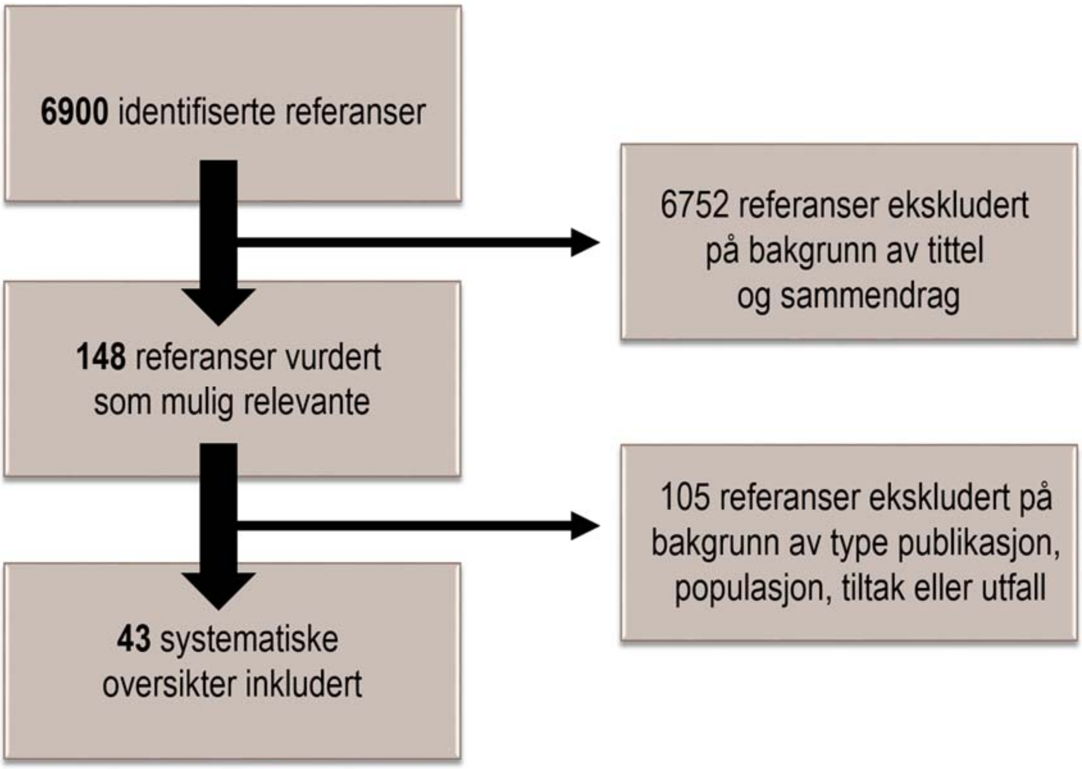
Resultat

Resultat av litteratursøk

Søk etter systematiske oversikter (søk 1)

Søket etter oppsummert forskning resulterte i 6900 referanser. Vi vurderte 148 av dem som mulig relevante. Disse innhentet vi og gjennomgikk i fulltekst, og 43 ble inkludert.

Årsakene til eksklusjon er at publikasjonstypen, populasjonen, tiltakene eller utfallene ikke er relevante for vår problemstilling (se vedlegg 2).

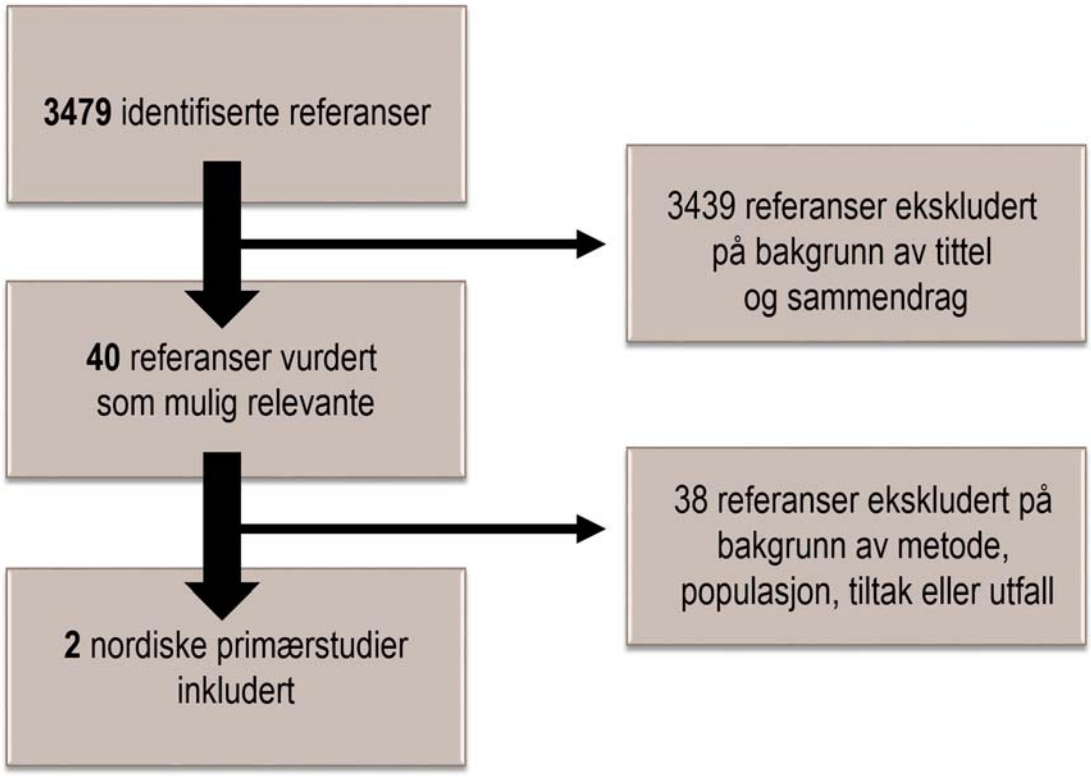


Figur 1. Flytskjema over identifisert forskningslitteratur fra søk 1.

Søk etter nordiske primærstudier (søk 2)

Søket etter nordiske primærstudier resulterte i 3479 referanser. Vi vurderte 40 av disse til å være mulig relevante og innhentet disse i fulltekst. Ved nøyere gjennomgang av fullteksten, inkluderte vi to.

Årsakene til eksklusjon er at metoden, populasjonen, tiltakene eller utfallene ikke er relevante for vår problemstilling.



Figur 2. Flytskjema over identifisert forskningslitteratur fra søk 2.

Resultat av sortering

Systematiske oversikter (søk 1)

De 43 inkluderte systematiske oversiktene (1-43) er presentert i tabell 1 og sortert etter navn på førsteforfatter(e).

Tabell 1. De inkluderte systematiske oversiktene (n=43)

	Førsteforfatter(e), årstall og tittel til inkluderte systematiske oversikter (n=43)
1.	Anuruang 2013, *“Community-based interventions to promote management for older people: an integrative review” (1)*
2.	Attridge 2014, *“Culturally appropriate health education for people in ethnic minority groups with type 2 diabetes mellitus” (2)*
3.	Baradaran 2010, *“Effectiveness of Diabetes Educational Interventions in Iran: A Systematic Review” (3)*

Førsteforfatter(e), årstall og tittel til inkluderte systematiske oversikter (n=43)
4. Barnason 2012, “*An integrative review of interventions promoting self-care of patients with heart failure” (4)*
5. Brady 2013, *“A Meta-Analysis of Health Status, Health Behaviors, and Health Care Utilization Outcomes of the Chronic Disease Self-Management Program” (5)*
6. Brown 2011, *“Patient education in the management of coronary heart disease (Review)”(6)*
7. Carnes 2012, “*Effective Delivery Styles and Content for Self-management Interventions for Chronic Musculoskeletal Pain A Systematic Literature Review” (7)*
8. Cartin 2010, *“Community health workers in diabetes self-management education” (8)*
9. Clark 2010, *“Educational and behavioral interventions for asthma: who achieves which outcomes? A systematic review” (9)*
10. Concha 2009, “*Review of Type 2 Diabetes Management Interventions for Addressing Emotional Well-Being in Latinos” (10)*
11. Coulter 2015, *“Personalised care planning for adults with chronic or long-term health conditions” (11)*
12. Dale 2012, “*What is the effect of peer support on diabetes outcomes in adults? A systematic review” (12)*
13. Du 2011, “*Self-management programs for chronic musculoskeletal pain conditions: A systematic review and meta-analysis” (13)*
14. Effing 2014, “*Self management for patients with chronic obstructive pulmonary disease (Review)”(14)*
15. Fitzpatrick 2013, “*Problem solving interventions for diabetes self-management and control: A systematic review of the literature” (15)*
16. Foster 2007, *“Self-management education programmes by lay leaders for people with chronic conditions (Review)” (16)*
17. Franek 2013, *“Self-Management Support Interventions for Persons With Chronic Disease: An Evidence-Based Analysis” (17)*
18. Fuhr 2014, *“Effectiveness of peer-delivered interventions for severe mental illness and depression on clinical and psychosocial outcomes: a systematic review and meta-analysis” (18)*
19. Hawthorne 2009, *“Culturally appropriate health education for Type 2 diabetes in ethnic minority groups: a systematic and narrative review of randomized controlled trials” (19)*
20. Health Quality Ontario 2009, *“Behavioural Interventions for Type 2 Diabetes” (20)*
21. Henderson 2011, *“The effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically diverse communities: a systematic literature review” (21)*
22. Jensen 2014, *“Effectiveness and characteristics of multifaceted osteoporosis group education—a systematic review” (22)*
23. Jones and Riazi 2010, *“Self-efficacy and self-management after stroke: a systematic review” (23)*
24. Kroon 2014, *“Self-management education programmes for osteoarthritis” (25)*
25. Jonker 2009, *“Promotion of self-management in vulnerable older people: a narrative literature review of outcomes of the Chronic Disease Self-Management Program (CDSMP)” (24)*
26. Larsen 2014, *“Limited evidence of the effects of patient education and self-management interventions in psoriasis patients: A systematic review” (26)*
27. Lennon 2013, “*Self-management programmes for people post stroke: a systematic review” (27)*
28. Lew 2014, “*State of the Science: Diabetes Self-Management Interventions Led By Nurse Principal Investigators” (28)*
29. Lloyd-Evans, *“A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness”* (29)

Førsteforfatter(e), årstall og tittel til inkluderte systematiske oversikter (n=43)
30. Mason 2008, *“Educational Interventions in Kidney Disease Care: A Systematic Review of Randomized Trials” (30)*
31. McGillon 2014, *“Impact of self-management interventions on stable angina symptoms and health-related quality of life: a meta-analysis” (31)*
32. Millard 2013, *“Self-Management Education Programs for People Living with HIV/AIDS: A Systematic Review” (32)*
33. Nolte and Osborne 2013, “*A systematic review of outcomes of chronic disease self-management interventions” (33)*
34. Panagioti 2014, *“Self-management support interventions to reduce health care utilisation without compromising outcomes: a systematic review and meta-analysis” (34)*
35. Quinones 2014, *“Educational group visits for the management of chronic health conditions: A systematic review” (35)*
36. Ricci-Cabello 2014, *“Characteristics and effectiveness of diabetes self-management educational programs targeted to racial/ethnic minority groups: a systematic review, meta-analysis and meta-regression” (36)*
37. Siantz 2014, *“Chronic disease self-management interventions for adults with serious mental illness: a systematic review of the literature” (37)*
38. Steinsbekk 2012, *“Group based diabetes self-management education compared to routine treatment for people with type 2 diabetes mellitus. A systematic review with meta-analysis” (38)*
39. Tang 2011, *“A Review of Volunteer-Based Peer Support Interventions in Diabetes” (39)*
40. Thorpe 2013, *“Facilitating Healthy Coping in Patients With Diabetes A Systematic Review” (40)*
41. Yehle and Plake 2010, “*Self-efficacy and Educational Interventions in Heart Failure. A Review of the Literature” (41)*
42. Zeh 2012, *“The impact of culturally competent diabetes care interventions for improving diabetes-related outcomes in ethnic minority groups: a systematic review” (42)*
43. Zwerink 2014, “*Self management for patients with chronic obstructive pulmonary disease” (43)*

Fra hver systematiske oversikt innhentet vi informasjon om:

- formål (aim)
- populasjon (population)
- tiltak og sammenlikning (intervention and comparison)
- utfall (outcomes)
- type brukermedvirkning (type of user involvement)
- oversiktsforfatternes egne konklusjoner (review author’s conclusions)

Informasjonen vi innhentet er basert på hva forfatterne har oppgitt i den aktuelle publikasjonen og er presentert i vedlegg 3. Fra denne informasjonen kommer det frem at oversiktsforfatterne har beskrevet eller diskutert brukermedvirkning i 12 av de 43 oversiktene (3, 5-7, 12, 16, 18, 29, 34-36, 39). De resterende systematiske oversiktene er likevel inkludert fordi de omfatter primærstudier som vi antar har en eller annen form for brukermedvirkning i mestringstiltaket.

I 10 systematiske oversikter er mestringstiltakene som undersøkes rettet mot personer som har langvarige (kroniske) helseutfordringer generelt (1, 5, 11, 16, 17, 21, 24, 33-35).

Mange av de systematiske oversiktene dreier seg om mestringstiltak for en avgrenset målgruppe:

- 14 er i hovedsak om personer som har diabetes (2, 3, 8, 10, 12, 15, 19, 20, 28, 36, 38-40, 42)
- fire er om personer som har hjerte- og karsykdom (4, 6, 31, 41)
- tre er om personer som har psykiske lidelser/problemer (18, 29, 37)
- to er om personer som har kronisk muskelsmerte (7, 13)
- to er om personer som har kronisk obstruktiv lungesykdom (14, 43)
- to er om personer som har hjerneslag (23, 27)
- én er om personer som har astma (9)
- én er om personer som har osteoporose (22)
- én er om personer som har artrose (25)
- én er om personer som har psoriasis (26)
- én er om personer som har nyresykdom (30)
- én er om personer som har hiv/aids (32)

Vi fant at de engelske termene som brukes for å beskrive det vi her definerer som mestringstiltak, varierer. I 21 av de 43 inkluderte systematiske oversiktene brukes den engelske termen «self-management interventions / programs / education» (5, 7, 8, 13, 14, 16, 17, 23-28, 31-34, 36-38, 43). I to av disse 21 systematiske oversiktene er effekten av et spesifikt type mestringstiltak, «the Chronic Disease Self-Management Program», oppsummert (5, 24). Andre termer som brukes om mestringstiltak er «health education» (2, 19), «disease education/management» (3, 10, 21, 22, 30, 41, 42), «peer support/delivered interventions» (12, 18, 29, 39), «patient education» (4, 6) «behavioural interventions» (20), «education and behavioural interventions» (9), «educational group visits» (35) og «interventions facilitating healthy coping» (40).

Fem av de systematiske oversiktene dreier seg om kulturelt tilpassede mestringstiltak til personer for personer som har etnisk minoritetsbakgrunn (2, 10, 19, 21, 42), og er i hovedsak rettet mot personer som har diabetes (2, 10, 19, 42).

I 26 systematiske oversikter konkluderer forfatterne med at de undersøkte mestringstiltakene har positiv effekt (1, 4, 5, 7, 9, 11-16, 19-22, 24, 27, 31, 32, 34-38, 42, 43). I de fleste av disse, formidler imidlertid forfatterne de positive resultatene med forsiktighet og oppfordrer til mer forskning for å kunne konkludere sikrere. I 13 systematiske oversikter konkluderer forfatterne med at det er usikkert hvorvidt de undersøkte mestringstiltakene har effekt eller ikke (2, 3, 6, 8, 10, 17, 18, 23, 26, 29, 30, 40, 41). Også her oppfordrer forfatterne gjerne til mer forskning. I to systematiske oversikter konkluderer forfatterne med at det mest sannsynlig er liten eller ingen effekt av de undersøkte mestringstiltakene (25, 33). Ingen av oversiktsforfatterne konkluderer med at mestringstiltakene har negativ eller skadelig effekt. I to systematiske oversikter mangler konklusjon (28, 39).

Sju av de systematiske oversiktene (2, 5, 7, 11, 43, 16, 38) er nærmere omtalt av Kunnskapssenteret eller NK LMH (se http://www.kunnskapssenteret.no/ og http://mestring.no/).

Nordiske primærstudier (søk 2)

Av de to nordiske primærstudiene er én fra Norge (44) og én fra Danmark (45) (se tabell 2). Den ene studien dreier seg om personer som har sykelig overvekt (44), og den andre om personer som har kroniske smerter.

Tabell 2. De inkluderte primærstudier fra Norden (n=2).

Førsteforfatter(e), årstall og tittel til inkluderte systematiske oversikter (n=43)
1. Fagermoen 2014, *"Personer med sykelig overvekt hadde økt mestringsforventning og selvfølelse etter pasientkurs" (44)*
2. Mehlsen 2015, "A prospective evaluation of the chronic pain self-management programme in a danish population of chronic pain patients" (45)

Informasjonen vi innhentet er basert på hva forfatterne har oppgitt i den aktuelle publikasjonen og er presentert i vedlegg 3. Fra denne informasjonen kommer det frem at brukermedvirkning er en forutsetning i mestringstiltakene i begge studiene (44, 45). Hva denne brukermedvirkningen gikk ut på ble imidlertid kun beskrevet i én av primærstudiene (44).

I den ene studien var mestringstiltaket et pasientopplæringstiltak («Startkurs») som ble tilbudt ved lærings- og mestringssentre på Østlandet i 2009 (44). Mestringstiltaket i den andre studien bestod av en dansk, tilpasset versjon, av pasientopplæringsprogrammet «Chronic Pain Self-Management Programme» (45).

I følge opplysninger gitt i de to publikasjonene, har begge studiene benyttet prospektive, kvasi-eksperimentell forskningsmetode. Denne bestod av to faser: én før tiltaket og én etter tiltaket. Deltakerne fungerte som kontroller for seg selv ved å testes før og etter tiltaket ble gitt («within subject design»). Effektmålene ble i begge studiene registrert ved bruk av spørreskjema (44, 45).

I den ene studien ble effekt målt i form av mestringsforventning og selvfølelse (44). I den andre ble smerte, fysisk funksjonsnedsettelse, fysiske symptomer, smertekatastrofering («pain catastrophizing»), sykdomsbekymring og symptomer på depresjon og angst målt.

I begge studiene konkluderte forfatterne at mestringstiltaket hadde en positiv effekt (44, 45).

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Vedlegg

Vedlegg 1. Søkestrategier og logg

Søkestrategier

Cochrane Library

#1 MeSH descriptor: [Chronic Disease] this term only

#2 MeSH descriptor: [Neurodegenerative Diseases] explode all trees and with qualifier(s): [Psychology - PX]

#3 MeSH descriptor: [Asthma] explode all trees and with qualifier(s): [Psychology - PX]

#4 MeSH descriptor: [Pulmonary Disease, Chronic Obstructive] explode all trees and with qualifier(s): [Psychology - PX]

#5 MeSH descriptor: [Arthritis] explode all trees and with qualifier(s): [Psychology - PX]

#6 MeSH descriptor: [Diabetes Mellitus] explode all trees and with qualifier(s): [Psychology - PX]

#7 MeSH descriptor: [Hypertension] explode all trees and with qualifier(s): [Psychology - PX]

#8 MeSH descriptor: [Myocardial Ischemia] explode all trees and with qualifier(s): [Psychology - PX]

#9 MeSH descriptor: [Heart Failure] explode all trees and with qualifier(s): [Psychology - PX]

#10 MeSH descriptor: [Stroke] explode all trees and with qualifier(s): [Psychology - PX]

#11 MeSH descriptor: [Neoplasms] explode all trees and with qualifier(s): [Psychology - PX]

#12 MeSH descriptor: [Mental Disorders] explode all trees and with qualifier(s): [Psychology - PX]

#13 MeSH descriptor: [Fibromyalgia] this term only and with qualifier(s): [Psychology - PX]

#14 MeSH descriptor: [Fatigue Syndrome, Chronic] this term only and with qualifier(s): [Psychology - PX]

#15 MeSH descriptor: [Irritable Bowel Syndrome] this term only and with qualifier(s): [Psychology - PX]

#16 MeSH descriptor: [Osteoporosis] explode all trees and with qualifier(s): [Psychology - PX]
#17 MeSH descriptor: [HIV Infections] explode all trees and with qualifier(s): [Psychology - PX]
#18 ((chronic* or longterm or long-term or longstanding or long-standing) next (affliction* or ailment* or condition* or complaint* or disease* or disorder* or disabilit* or dysfunction* or ill or illness* or injur* or impairment* or incapacity or lesion* or pain or sickness*)):ab,kw,ti
#19 (asthma or diabetes or arthritis or osteoarthritis or stroke or cancer or depression or fibromyalgia or chronic-fatigue or irritable-bowel-syndrome):ti
#20 #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19
#21 MeSH descriptor: [Patient Education as Topic] this term only
#22 MeSH descriptor: [Health Education] this term only
#23 MeSH descriptor: [Self Care] this term only
#24 MeSH descriptor: [Patient Participation] this term only
#25 MeSH descriptor: [Peer Group] this term only
#26 ((patient* or inpatient* or in-patient* or outpatient* or out-patient* or client* or representative* or consumer* or caregiver* or family or families or relative* or parent* or peer* or lay or user* or citizen* or volunteer* or non-professional*) next (educat* or teaching or tutoring or training or learning or counsel* or involve* or participat* or engag* or empowerment*)):ab,kw,ti 15022
#27 ((group or group-based or groups) near/1 (learning or exercise* or teaching or education or process* or support*)):ab,kw,ti
#28 (self next (care or management)):ab,kw,ti
#29 ((mastery or mastering or empowerment* or coping or self-efficacy) next (course* or program* or therapy)):ab,kw,ti
#30 #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29
#31 #20 and #30
#32 #20 and #30 in Cochrane Reviews (Reviews and Protocols), Other Reviews and Technology Assessments
#33 (norway or norwegian or sweden or swedish or denmark or danish or finland or finnish or iceland or icelandic or scandinavia* or norden or nordic):ab,kw,ti
#34 #31 and #33 in Cochrane Reviews (Reviews and Protocols), Other Reviews, Trials and Technology Assessments

OVID (Embase, MEDLINE, PsycINFO)

1 chronic disease/ or exp neurodegenerative disease/px or exp asthma/px or exp pulmonary disease chronic obstructive/px or exp arthritis/px or exp diabetes mellitus/px or exp hypertension/px or exp myocardial ischemia/px or exp heart failure/px or exp stroke/px or exp neoplasms/px or exp mental disorders/px or fibromyalgia/px or fatigue syndrome, chronic/px or exp osteoporosis/px or exp HIV infections/px or irritable bowel syndrome/px use pmoz

2 chronic disease/ or exp degenerative disease/dm or exp asthma/dm or chronic obstructive lung disease/dm or exp emphysema/dm or exp arthritis/dm or exp diabetes mellitus/dm or exp cardiovascular disease/dm or exp cerebrovascular accident/dm or exp neoplasm/dm or exp mental disease/dm or fibromyalgia/dm or chronic fatigue syndrome/dm or irritable colon/dm or exp osteoporosis/dm or exp Human immunodeficiency virus infection/dm use oemez

3 exp chronic illness/ or exp neurodegenerative diseases/ or asthma/ or exp chronic obstructive pulmonary disease/ or exp arthritis/ or diabetes mellitus/ or exp cardiovascular disorders/ or cerebrovascular accidents/ or exp neoplasms/ or exp mental disorders/ or fibromyalgia/ or osteoporosis/ or exp HIV/ or irritable bowel syndrome/ or chronic fatigue syndrome/ use psyh

4 ((chronic* or longterm or long-term or longstanding or long-standing) adj (affliction* or ailment* or condition* or complaint* or disease* or disorder* or disabilit* or dysfunction or ill or illness* or injur* or impairment* or incapacity or lesion* or pain or sickness*)).tw.

5 (asthma or diabetes or arthritis or stroke or cancer or depression or fibromyalgia or chronic fatigue or irritable bowel syndrome).ti.

6 or/1-5

7 patient education as topic/ or health education/ or self care/ or patient participation/ or peer group/ use pmoz

8 exp health education/ or self care/ or peer group/ use oemez

9 client education/ or health education/ or support groups/ or client participation/ use psyh

10 ((patient* or inpatient* or in-patient* or outpatient* or out-patient* or client* or representative* or consumer* or caregiver* or family or families or relative* or parent* or peer* or lay or user* or citizen* or volunteer* or non-professional*) adj (educat* or teaching or tutoring or training or learning or counsel* or involve* or participat* or engag* or empowerment*)).tw.

11 ((group or group-based or groups) adj1 (learning or exercise* or teaching or education or process* or support*)).tw.

12 (self adj (care or management)).tw.

13 ((mastery or mastering or empowerment* or coping or self-efficacy) adj (course* or program* or therapy)).tw.

14 or/7-13

15 6 and 14

16 (((systematic or literature) adj (review* or overview*)) or meta-analys* or pubmed or medline or embase or cinahl).tw.

17 15 and 16

18 limit 15 to "reviews (maximizes specificity)"

19 17 or 18

20 (norway or norwegian or sweden or swedish or denmark or danish or finland or finnish or iceland or icelandic or scandinavia* or nordic).tw.

21 15 and 20

22 (editorial or newsletter or news or comment).pt.
23 21 not 22
24 remove duplicates from 23

OVID AMED

1 health education/ or exp patient education/ or self care/ or peer group/ or patient participation/
2 (self adj (care or management)).tw.
3 ((group or group-based or groups) adj1 (learning or exercise* or teaching or education or process* or support*)).tw.
4 ((patient* or inpatient* or in-patient* or outpatient* or out-patient* or client* or representative* or consumer* or caregiver* or family or families or relative* or parent* or peer* or lay or user* or citizen* or volunteer* or non-professional*) adj (educat* or teaching or tutoring or training or learning or counsel* or involve* or participat* or engag* or empowerment*)).tw.
5 or/1-4
6 chronic disease/ or exp pulmonary disease chronic obstructive/ or exp arthritis/ or exp diabetes mellitus/ or hypertension/ or exp myocardial ischemia/ or heart failure congestive/ or stroke/ or exp neoplasms/ or exp mental disorders/ or fatigue syndrome chronic/ or fibromyalgia/ or irritable bowel syndrome/ or osteoporosis/ or exp hiv infections/
7 ((chronic* or longterm or long-term or longstanding or long-standing) adj (affliction* or ailment* or condition* or complaint* or disease* or disorder* or disabilit* or dysfunction or ill or illness* or injur* or impairment* or incapacity or lesion* or pain or sickness*)).tw.
8 (asthma or diabetes or arthritis or stroke or cancer or depression or fibromyalgia or chronic fatigue or irritable bowel syndrome).ti.
9 or/6-8
10 5 and 9
11 (((systematic or literature) adj (review* or overview*)) or meta-analys* or pubmed or medline or embase or cinahl).tw.
12 10 and 11
13 (norway or norwegian or sweden or swedish or denmark or danish or finland or finnish or iceland or icelandic or scandinavia* or norden or nordic).tw.
14 10 and 13

CRD

1 MeSH DESCRIPTOR chronic disease
2 MeSH DESCRIPTOR neurodegenerative diseases EXPLODE ALL TREES
3 MeSH DESCRIPTOR asthma EXPLODE ALL TREES
4 MeSH DESCRIPTOR pulmonary disease, chronic obstructive EXPLODE ALL TREES
5 MeSH DESCRIPTOR arthritis EXPLODE ALL TREES

6 MeSH DESCRIPTOR diabetes mellitus EXPLODE ALL TREES
7 MeSH DESCRIPTOR hypertension EXPLODE ALL TREES
8 MeSH DESCRIPTOR myocardial ischemia EXPLODE ALL TREES
9 MeSH DESCRIPTOR heart failure EXPLODE ALL TREES
10 MeSH DESCRIPTOR stroke EXPLODE ALL TREES
11 MeSH DESCRIPTOR neoplasms EXPLODE ALL TREES
12 MeSH DESCRIPTOR mental disorders EXPLODE ALL TREES
13 MeSH DESCRIPTOR fibromyalgia
14 MeSH DESCRIPTOR irritable bowel syndrome
15 MeSH DESCRIPTOR osteoporosis EXPLODE ALL TREES
16 MeSH DESCRIPTOR HIV infections EXPLODE ALL TREES
17 (((chronic* or longterm or long-term or longstanding or long-standing) next (affliction* or ailment* or condition* or complaint* or disease* or disorder* or disabilit* or dysfunction or ill or illness* or injur* or impairment* or incapacity or lesion* or pain or sickness*)))
18 #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17
19 MeSH DESCRIPTOR patient education as topic
20 MeSH DESCRIPTOR health education
21 MeSH DESCRIPTOR self care
22 MeSH DESCRIPTOR peer group
23 MeSH DESCRIPTOR patient participation
24 (((patient* or inpatient* or in-patient* or outpatient* or out-patient* or client* or representative* or consumer* or caregiver* or family or families or relative* or parent* or peer* or lay or user* or citizen* or volunteer* or non-professional*) NEXT (educat* or teaching or tutoring or training or learning or counsel* or involve* or participat* or engag* or empowerment*)))
25 (((group or group-based or groups) NEAR1 (learning or exercise* or teaching or education or process* or support*)))
26 (((self NEXT (care or management))))
27 (((mastery or mastering or empowerment* or coping or self-efficacy) NEXT (course* or program* or therapy)))
28 #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27
29 #18 AND #28
30 (norway or norwegian or sweden or swedish or denmark or danish or finland or finnish or iceland or icelandic or scandinavia* or norden or nordic)
31 #29 AND #30

CINAHL

S1 (MH "Chronic Disease") OR (MH "Neurodegenerative Diseases+") OR (MH "Lung Diseases, Obstructive+") OR (MH "Arthritis+") OR (MH "Diabetes Mellitus+") OR (MH "Hypertension+") OR (MH "Cardiovascular Diseases+") OR (MH "Neoplasms+") OR (MH "Mental Disorders+") OR (MH "Fibromyalgia") OR (MH

"Fatigue Syndrome, Chronic") OR (MH "Osteoporosis+") OR (MH "HIV Infections+") OR (MH "Irritable Bowel Syndrome")
S2 TI (((chronic* or longterm or long-term or longstanding or long-standing) W0 (affliction* or ailment* or condition* or complaint* or disease* or disorder* or disabilit* or dysfunction or ill or illness* or injur* or impairment* or incapacity or lesion* or pain or sickness*))) OR AB (((chronic* or longterm or long-term or longstanding or long-standing) W0 (affliction* or ailment* or condition* or complaint* or disease* or disorder* or disabilit* or dysfunction or ill or illness* or injur* or impairment* or incapacity or lesion* or pain or sickness*)))
S3 TI (asthma or diabetes or arthritis or osteoarthritis or stroke or cancer or depression or fibromyalgia or chronic-fatigue or irritable-bowel-syndrome)
S4 S1 OR S2 OR S3
S5 (MH "Health Education") OR (MH "Patient Education+") OR (MH "Self Care+") OR (MH "Support Groups") OR (MH "Peer Group") OR (MH "Consumer Participation")
S6 TI (((patient* or inpatient* or in-patient* or outpatient* or out-patient* or client* or representative* or consumer* or caregiver* or family or families or relative* or parent* or peer* or lay or user* or citizen* or volunteer* or non-professional*) W0 (educat* or teaching or tutoring or training or learning or counsel* or involve* or participat* or engag* or empowerment*))) OR AB (((patient* or inpatient* or in-patient* or outpatient* or out-patient* or client* or representative* or consumer* or caregiver* or family or families or relative* or parent* or peer* or lay or user* or citizen* or volunteer* or non-professional*) W0 (educat* or teaching or tutoring or training or learning or counsel* or involve* or participat* or engag* or empowerment*)))
S7 TI (((group or group-based or groups) N1 (learning or exercise* or teaching or education or process* or support*))) OR AB (((group or group-based or groups) N1 (learning or exercise* or teaching or education or process* or support*)))
S8 TI ((self W0 (care or management))) OR AB ((self W0 (care or management)))
S9 TI (((mastery or mastering or empowerment* or coping or self-efficacy) W0 (course* or program* or therapy))) OR AB (((mastery or mastering or empowerment* or coping or self-efficacy) W0 (course* or program* or therapy)))
S10 S5 OR S6 OR S7 OR S8 OR S9
S11 S4 AND S10
S12 TI ((((systematic or literature) W0 (review* or overview*)) or meta-analys* or pubmed or medline or embase or cinahl or cochrane)) OR AB ((((systematic or literature) W0 (review* or overview*)) or meta-analys* or pubmed or medline or embase or cinahl or cochrane))
S13 S11 AND S12
S14 S4 AND S10 Limiters - Clinical Queries: Review - High Specificity
S15 S13 OR S14 Limiters - Exclude MEDLINE records
S16 TI ((norway or norwegian or sweden or swedish or denmark or danish or finland or finnish or iceland or icelandic or scandinavia* or norden or nordic)) OR AB

((norway or norwegian or sweden or swedish or denmark or danish or finland or finnish or iceland or icelandic or scandinavia* or norden or nordic))

S17 S11 AND S16 Limiters - Exclude MEDLINE records

SveMed+

1 ((kronisk* OR langtid* OR långtid* OR langvarig* OR långvarig*) AND (sjukdom* OR sykdom* OR sygdom* OR lidelse* OR smerte* OR smärt* OR plage* OR plåg* OR skad*)) AND exp:"Chronic Disease"

2 noexp:"Patient Education as Topic"

3 noexp:"Health Education"

4 noexp:"Peer Group"

5 noexp:"Patient Participation"

6 noexp:"Self Care"

7 ((patientutbildning OR hälsopedagogik OR patientinflytande OR patientmedverkan OR patientinvolvering) OR (patientmedvirkning OR pasientinvolvering OR patientuddannelse OR helsepædagogik OR patientindflydelse) OR (pasientutdanning OR helsepedagogikk OR pasientmedvirkning OR pasientinvolvering OR pasientinnflytelse OR brukermedvirkning OR brukerinvolvering OR brukerinnflytelse))

8 2 OR 3 OR 4 OR 5 OR 6 OR 7

9 1 AND 8

10 1 AND 8 Limits: doctype:"översikt"

British Nursing Index

Søk 1 oppsummert forskning (systematiske oversikter):

((SU.EXACT("Disabilities") OR SU.EXACT("Chronic Illness") OR TI((chronic* or longterm or long-term or longstanding or long-standing) within/0 (affliction* or ailment* or condition* or complaint* or disease* or disorder* or disabilit* or dysfunction or ill or illness* or injur* or impairment* or incapacity or lesion* or pain or sickness*)) OR AB((chronic* or longterm or long-term or longstanding or long-standing) within/ (affliction* or ailment* or condition* or complaint* or disease* or disorder* or disabilit* or dysfunction or ill or illness* or injur* or impairment* or incapacity or lesion* or pain or sickness*)) OR TI(asthma or diabetes or arthritis or osteoarthritis or stroke or cancer or depression or fibromyalgia or chronic-fatigue or irritable-bowel-syndrome)) AND (SU.EXACT("Self Care") OR SU.EXACT("Education:Patients ") OR TI((patient* or inpatient* or in-patient* or outpatient* or out-patient* or client* or representative* or consumer* or caregiver* or family or families or relative* or parent* or peer* or lay or user* or citizen* or volunteer* or non-professional*) within/0 (educat* or teaching or tutoring or training or learning or counsel* or involve* or participat* or engag* or empowerment*)) OR AB((patient* or inpatient* or in-patient* or outpatient* or out-patient* or client* or representative* or consumer* or caregiver* or family or families or relative* or parent* or peer* or lay or user* or citizen* or volunteer* or non-professional*) within/0 (educat* or teaching or tutoring or training or learning or counsel* or involve* or participat* or engag* or empowerment*)) OR TI((group or group-based or groups) within/1 (learning or exercise* or teaching or education or process* or support*)) OR AB((group or group-based or groups) within/1 (learning or exercise* or teaching or education or process* or support*)) OR TI(self within/0 (care or management)) OR AB(self within/0 (care or management)) OR TI((mastery or mastering or empowerment* or coping or self-efficacy) within/0 (course* or program* or therapy)) OR AB ((mastery or mastering or empowerment* or coping or self-efficacy) within/0 (course* or program* or therapy))) AND (TI(((systematic or literature) within/0 (review* or overview*)) or meta-analys* or pubmed or medline or embase or cinahl) OR AB(((systematic or literature) within/0 (review* or overview*)) or meta-analys* or pubmed or medline or embase or cinahl)))

Søk 2 nordiske primærstudier:
((SU.EXACT("Disabilities") OR SU.EXACT("Chronic Illness") OR TI((chronic* OR longterm OR long-term OR longstanding OR long-standing) within/0 (affliction* OR ailment* OR condition* OR complaint* OR disease* OR disorder* OR disabilit* OR dysfunction OR ill OR illness* OR injur* OR impairment* OR incapacity OR lesion* OR pain OR sickness*)) OR AB((chronic* OR longterm OR long-term OR longstanding OR long-standing) within/ (affliction* OR ailment* OR condition* OR complaint* OR disease* OR disorder* OR disabilit* OR dysfunction OR ill OR illness* OR injur* OR impairment* OR incapacity OR lesion* OR pain OR sickness*)) OR TI(asthma OR diabetes OR arthritis OR osteoarthritis OR stroke OR cancer OR depression OR fibromyalgia OR chronic-fatigue OR irritable-bowel-syndrome)) AND (SU.EXACT("Self Care") OR SU.EXACT("Education:Patients ") OR TI((patient* OR inpatient* OR in-patient* OR outpatient* OR out-patient* OR client* OR representative* OR consumer* OR caregiver* OR family OR families OR relative* OR parent* OR peer* OR lay OR user* OR citizen* OR volunteer* OR non-professional*) within/0 (educat* OR teaching OR tutoring OR training OR learning OR counsel* OR involve* OR participat* OR engag* OR empowerment*)) OR AB((patient* OR inpatient* OR in-patient* OR outpatient* OR out-patient* OR client* OR representative* OR consumer* OR caregiver* OR family OR families OR relative* OR parent* OR peer* OR lay OR user* OR citizen* OR volunteer* OR non-professional*) within/0 (educat* OR teaching OR tutoring OR training OR learning OR counsel* OR involve* OR participat* OR engag* OR empowerment*)) OR TI((group OR group-based OR groups) within/1 (learning OR exercise* OR teaching OR education OR process* OR support*)) OR AB((group OR group-based OR groups) within/1 (learning OR exercise* OR teaching OR education OR process* OR support*)) OR TI(self within/0 (care OR management)) OR AB(self within/0 (care OR management)) OR TI((mastery OR mastering OR empowerment* OR coping OR self-efficacy) within/0 (course* OR program* OR therapy)) OR AB ((mastery OR mastering OR empowerment* OR coping OR self-efficacy) within/0 (course* OR program* OR therapy))) AND (TI(norway OR norwegian OR sweden OR swedish

OR denmark OR danish OR finland OR finnish OR iceland OR icelandic OR scandinavia* OR norden OR nordic) OR AB(norway OR norwegian OR sweden OR swedish OR denmark OR danish OR finland OR finnish OR iceland OR icelandic OR scandinavia* OR norden OR nordic)))

ERIC

Søk 1 oppsummert forskning (systematiske oversikter:

((SU.EXACT("Chronic Illness") OR TI((chronic* OR longterm OR long-term OR longstanding OR long-standing) within/0 (affliction* OR ailment* OR condition* OR complaint* OR disease* OR disorder* OR disabilit* OR dysfunction OR ill OR illness* OR injur* OR impairment* OR incapacity OR lesion* OR pain OR sickness*)) OR AB((chronic* OR longterm OR long-term OR longstanding OR long-standing) within/ (affliction* OR ailment* OR condition* OR complaint* OR disease* OR disorder* OR disabilit* OR dysfunction OR ill OR illness* OR injur* OR impairment* OR incapacity OR lesion* OR pain OR sickness*)) OR TI(asthma OR diabetes OR arthritis OR osteoarthritis OR stroke OR cancer OR depression OR fibromyalgia OR chronic-fatigue OR irritable-bowel-syndrome)) AND (SU.EXACT("Patient Education") OR SU.EXACT("Health Education") OR SU.EXACT("Peer Groups") OR SU.EXACT("Social Support Groups") OR SU.EXACT("Daily Living Skills") OR TI((patient* OR inpatient* OR in-patient* OR outpatient* OR out-patient* OR client* OR representative* OR consumer* OR caregiver* OR family OR families OR relative* OR parent* OR peer* OR lay OR user* OR citizen* OR volunteer* OR non-professional*) within/0 (educat* OR teaching OR tutoring OR training OR learning OR counsel* OR involve* OR participat* OR engag* OR empowerment*)) OR AB((patient* OR inpatient* OR in-patient* OR outpatient* OR out-patient* OR client* OR representative* OR consumer* OR caregiver* OR family OR families OR relative* OR parent* OR peer* OR lay OR user* OR citizen* OR volunteer* OR non-professional*) within/0 (educat* OR teaching OR tutoring OR training OR learning OR counsel* OR involve* OR participat* OR engag* OR empowerment*)) OR TI((group OR group-based OR groups) within/1 (learning OR exercise* OR teaching OR education OR process* OR support*)) OR AB((group OR group-based OR groups) within/1 (learning OR exercise* OR teaching OR education OR process* OR support*)) OR TI(self within/0 (care OR management)) OR AB(self within/0 (care OR management)) OR TI((mastery OR mastering OR empowerment* OR coping OR self-efficacy) within/0 (course* OR program* OR therapy)) OR AB ((mastery OR mastering OR empowerment* OR coping OR self-efficacy) within/0 (course* OR program* OR therapy))) AND (TI(((systematic or literature) within/0 (review* or overview*)) or meta-analys* or pubmed or medline or embase or cinahl) OR AB(((systematic or literature) within/0 (review* or overview*)) or meta-analys* or pubmed or medline or embase or cinahl)))

Søk 2 nordiske primærstudier:

((SU.EXACT("Chronic Illness") OR TI((chronic* OR longterm OR long-term OR longstanding OR long-standing) within/0 (affliction* OR ailment* OR condition* OR complaint* OR disease* OR disorder* OR disabilit* OR dysfunction OR ill OR illness* OR injur* OR impairment* OR incapacity OR lesion* OR pain OR sickness*)) OR AB((chronic* OR longterm OR long-term OR longstanding OR long-standing) within/ (affliction* OR ailment* OR condition* OR complaint* OR disease* OR disorder* OR disabilit* OR dysfunction OR ill OR illness* OR injur* OR impairment* OR incapacity OR lesion* OR pain OR sickness*)) OR TI(asthma OR diabetes OR arthritis OR osteoarthritis OR stroke OR cancer OR depression OR fibromyalgia OR chronic-fatigue OR irritable-bowel-syndrome)) AND (SU.EXACT("Patient Education") OR SU.EXACT("Health Education") OR SU.EXACT("Peer Groups") OR SU.EXACT("Social Support Groups") OR SU.EXACT("Daily Living Skills") OR TI((patient* OR inpatient* OR in-patient* OR outpatient* OR out-patient* OR client* OR representative* OR consumer* OR caregiver* OR family OR families OR relative* OR parent* OR peer* OR lay OR user* OR citizen* OR volunteer* OR non-professional*) within/0 (educat* OR teaching OR tutoring OR training OR learning OR counsel* OR involve* OR participat* OR engag* OR empowerment*)) OR AB((patient* OR inpatient* OR in-patient* OR outpatient* OR out-patient* OR client* OR representative* OR consumer* OR caregiver* OR family OR families OR relative* OR parent* OR peer* OR lay OR user* OR citizen* OR volunteer* OR non-professional*) within/0 (educat* OR teaching OR tutoring OR training OR learning OR counsel* OR involve* OR participat* OR engag* OR empowerment*)) OR TI((group OR group-based OR groups) within/1 (learning OR exercise* OR teaching OR education OR process* OR support*)) OR AB((group OR group-based OR groups) within/1 (learning OR exercise* OR teaching OR education OR process* OR support*)) OR TI(self within/0 (care OR management)) OR AB(self within/0 (care OR management)) OR TI((mastery OR mastering OR empowerment* OR coping OR self-efficacy) within/0 (course* OR program* OR therapy)) OR AB ((mastery OR mastering OR empowerment* OR coping OR self-efficacy) within/0 (course* OR program* OR therapy))) AND (TI(norway OR norwegian OR sweden OR swedish OR denmark OR danish OR finland OR finnish OR iceland OR icelandic OR scandinavia* OR norden OR nordic) OR AB(norway OR norwegian OR sweden OR swedish OR denmark OR danish OR finland OR finnish OR iceland OR icelandic OR scandinavia* OR norden OR nordic)))

Web of Science

1 TS=((chronic* or longterm or long-term or longstanding or long-standing) NEXT (affliction* or ailment* or condition* or complaint* or disease* or disorder* or disabilit* or dysfunction or ill or illness* or injur* or impairment* or incapacity or lesion* or pain or sickness*))
2 TS=(self next (care or management))
3 TS=((group or group-based or groups) near/1 (learning or exercise* or teaching or education or process* or support*))

4 TS=((patient* or inpatient* or in-patient* or outpatient* or out-patient* or client* or representative* or consumer* or caregiver* or family or families or relative* or parent* or peer* or lay or user* or citizen* or volunteer* or non-professional*) next (educat* or teaching or tutoring or training or learning or counsel* or involve* or participat* or engag* or empowerment*))
5 #4 OR #3 OR #2
6 TS=(((systematic or literature) next (review* or overview*)) or meta-analys* or pubmed or medline or embase or cinahl)
7 TS=(norway or norwegian or sweden or swedish or denmark or danish or finland or finnish or iceland or icelandic or scandinavia* or norden or nordic)
8 #6 AND #5 AND #1 Indexes=SCI-EXPANDED, SSCI Timespan=1975-2014
9 #7 AND #5 AND #1 Indexes=SCI-EXPANDED, SSCI Timespan=1975-2014

LIBRIS (S)

db:natbib (patientutbildning OR hälsopedagogik OR patientinflytande OR patientmedverkan OR patientinvolvering)

BIBSYS

mesh = patient education as topic eller mesh = patient participation eller mesh = peer group eller mesh = self care eller mesh = health education eller tittel, ordsøk = pasientutdanning helsepedagogikk brukermedvirkning brukerinvolvering brukerinnflytelse pasientmedvirkning pasientinvolvering pasientinnflytelse

Norart.no

Nøkkelord: (pasientutdanning OR helsepedagogikk OR pasientmedvirkning OR pasientinvolvering OR pasientinnflytelse OR brukermedvirkning OR brukerinvolvering OR brukerinnflytelse)

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Campbell Library

Gjennomgang av oversikter (reviews) fra gruppene «Education» og «Social welfare»

REX (DK) (Det Kongelige bibliotek, Danmark)

Alle felter: patientmedvirkning OR patientinvolvering OR patientuddannelse OR patientindflydelse

Søkelogg søk 1

Internasjonal oppsummert forskning (systematiske oversikter)		
Søkedato	Database	Referanser før/etter dublettkontroll i EndNote
05.03.2015	Cochrane Library *Cochrane Database of Systematic Reviews : Issue 2 of 12, February 2015 * Database of Abstracts of Reviews of Effect : Issue 1 of 4, January 2015 *Health Technology Assessment Database : Issue 1 of 4, January 2015	CDSR: 168/156 DARE: 327/ 221 HTA: 43/34
05.03.2015	CRD	1450/896
05.03.2015	OVID * Embase 1974 to 2015 Week 09 * Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily, Ovid MEDLINE(R) and Ovid OLDMEDLINE(R) 1946 to Present, * PsycINFO 1806 to March Week 1 2015	Embase: 4121/2595 MEDLINE: 2545/1888 PsycINFO: 967/598
05.03.2015	CINAHL	442/315
05.03.2015	SveMed+	9/8
05.03.2015	AMED	119/53
05.03.2015	British Nursing Index	191/73
05.03.2015	ERIC	17/8
05.03.2015	Web of Science	71/55
	Til sammen før/etter dublettkontroll i EndNote:	10470/6900

Søkelogg søk 2

Forskning om effekt (nordiske primærstudier)		
Dato	Database	Referanser før/etter dublettkontroll i EN
05.03.2015	Cochrane Library *Cochrane Database of Systematic Reviews: Issue 2 of 12, Feb 2015 * Database of Abstracts of Reviews of Effect: Issue 1 of 4, Jan 2015 *Health Technology Assessment Database: Issue 1 of 4, Jan 2015 * Cochrane Central Register of Controlled Trials: Issue 2 of 12, Feb 2015	CDSR:3/3 DARE:2/2 CENTRAL: 208/187
05.03.2015	CRD	73/66
05.03.2015	OVID * Embase 1974 to 2015 Week 09 * Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily, Ovid MEDLINE(R) and Ovid OLDMEDLINE(R) 1946 to Present, * PsycINFO 1806 to March Week 1 2015	Embase: 1670/1569 MEDLINE: 497/376 PsyINFO: 186/164
05.03.2015	OVID *AMED	39/6
05.03.2015	CINAHL	170/145
05.03.2015	SveMed+	97/86
05.03.2015	British Nursing Index	99/57
05.03.2015	ERIC	6/2
05.03.2015	Web of Science	56/14
05.03.2015	BIBSYS	585/423
05.03.2015	Norart.no	266/260
05.03.2015	Libris	127/119
	Til sammen før/etter dublettkontroll i EndNote:	4024/3479

Vedlegg 2. Ekskluderte referanser

Søk etter systematiske oversikter (søk 1)

Referanser ekskludert etter å ha blitt vurdert i fulltekst (n=105)

1. Adam 2015, *“Educational interventions for cancer pain. A systematic review of systematic reviews with nested narrative review of randomized controlled trials”*
   Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
2. Austvoll-Dalgren 2011, *“The effects of group education on patients and their next of kin”*
   Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
3. Baraniak og Sheffield 2011, *“The efficacy of psychologically based interventions to improve anxiety, depression and quality of life in COPD: a systematic review and meta-analysis”*
   Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
4. Barlow 2012, *“Group-based parent training programmes for improving parental psychosocial health”*
   Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
5. Bentsen 2012, *“Evaluation of self-management interventions for chronic obstructive pulmonary disease”*
   Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
6. Blackstock og Webster 2007, *“Disease-specific health education for COPD: a systematic review of changes in health outcomes”*
   Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
7. Boland 2013, *“The health economic impact of disease management programs for COPD: A systematic literature review and meta-analysis”*
   Eksklusjonsårsak: Oversiktsforfatterne rapporterer ikke relevante utfall.
8. Bolen 2012, *“Effectiveness and safety of patient activation interventions for adults with type 2 diabetes: systematic review, meta-analysis, and meta-regression”*
   Eksklusjonsårsak: Oversiktsforfatterne rapporterer ikke relevante utfall.
9. Bolen 2014, *“Effectiveness and safety of patient activation interventions for adults with type 2 diabetes: systematic review, meta-analysis, and meta-regression”*
   Eksklusjonsårsak: Oversiktsforfatterne rapporterer ikke relevante utfall.
10. Boren 2009, *“Costs and benefits associated with diabetes education: a review of the literature”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
11. Boren 2009, *“Heart failure self-management education: A systematic review of the evidence”*
    Eksklusjonsårsak: Fulltekst ikke tilgjengelig.
12. Boyde 2011, *“Educational interventions for patients with heart failure: A systematic review of randomized controlled trials”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
13. Brand 2014, *“Chronic disease management: improving care for people with osteoarthritis”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
14. Brady 2010, *“A meta-analytic assessment of the effects of Stanford's small group English version of the Arthritis Self Management Program”*
    Eksklusjonsårsak: Ikke en systematisk oversiktspublikasjon (konferansesammendrag).
15. Brady 2012, *“Cost implications of self-management education intervention programmes in arthritis”*
    Eksklusjonsårsak: Oversiktsforfatterne rapporterer ikke relevante utfall.
16. Brown 2013, *“Effect of patient education in the management of coronary heart disease: a systematic review and meta-analysis of randomized controlled trials”*
    Eksklusjonsårsak: Fulltekst ikke tilgjengelig.
17. The Canadian Agency for Drugs and Technologies in Health (CADTH) 2011, *“Technologies in, Education classes for diabetes management: a review of the comparative clinical and cost-effectiveness”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
18. Casimir 2014, *“The effectiveness of patient-centered self-care education for adults with heart failure on knowledge, self-care behaviors, quality of life, and readmissions: a systematic review”*
    Eksklusjonsårsak: Fulltekst ikke tilgjengelig.

Referanser ekskludert etter å ha blitt vurdert i fulltekst (n=105)

19. Cheng 2012, *“The effectiveness of caregiver psychosocial interventions on the psychosocial wellbeing, physical health and quality of life of stroke family caregivers and their stroke survivors: A systematic review.”*

    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

20. Cheng 2014, *“ The effectiveness of psychosocial interventions for stroke family caregivers and stroke survivors: a systematic review and meta-analysis”*

    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

21. Chipchase 2012, *“The long-term effectiveness of pain management programs: A systematic review and meta-analysis”*

    Eksklusjonsårsak: Fulltekst ikke tilgjengelig.

22. Cochran og Conn 2008, *“Meta-analysis of quality of life outcomes following diabetes self-management training”*

    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

23. Commodore-Mensah og Himmelfarb 2012, *“Patient education strategies for hospitalized cardiovascular patients: A systematic review”*

    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

24. Conn 2008, *“Meta-analysis of patient education interventions to increase physical activity among chronically ill adults”*

    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

25. Conn 2008, *“Meta-analysis of health behavior change interventions in type 1 diabetes”*

    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

26. Cooper 2012, *“Systematic review of the effectiveness of non-pharmacological interventions to improve quality of life of people with dementia”*

    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

27. Cooper 2014, *“The effectiveness of peer support interventions for community-dwelling adults with chronic non-cancer pain: a systematic review”*

    Eksklusjonsårsak: Fulltekst ikke tilgjengelig, kun protokoll.

28. De Bes 2012, *“Patient education in chronic skin diseases: a systematic review”*

    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

29. Deccache 2014, *“Therapeutic patient education for patients with multimorbidity: A recent literature review”*

    Eksklusjonsårsak: Fulltekst ikke tilgjengelig.

30. Denford 2013, *“Effective behavior change techniques in asthma self-care interventions: systematic review and meta-regression”*

    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

31. Dietwig 2010, *“Effectiveness of self-management interventions on mortality, hospital readmissions, chronic heart failure hospitalization rate and quality of life in patients with chronic heart failure: A systematic review”*

    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

32. Dorn 2010, *“Systematic review: self-management support interventions for irritable bowel syndrome”*

    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

33. Dorresteijn 2014, *“ Patient education for preventing diabetic foot ulceration”*

    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

34. Duke 2009, *“Individual patient education for people with type 2 diabetes mellitus”*

    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

35. Engers 2008, *“Individual patient education for low back pain”*

    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

36. Fan og Sidani 2009, *“ Effectiveness of diabetes self-management education intervention Elements: A meta-analysis”*

    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

Referanser ekskludert etter å ha blitt vurdert i fulltekst (n=105)

37. Ferreira 2013, *“Patient education programs (PEP) for patients with rheumatoid arthritis (RA): An updated systematic review”*

Eksklusjonsårsak: Ikke en systematisk oversiktspublikasjon (konferansesammendrag).

38. Fransen 2012, *“Diabetes self-management in patients with low health literacy: ordering findings from literature in a health literacy framework”*

Eksklusjonsårsak: Ikke en systematisk oversikt over effektstudier.

39. Fredericks 2010, *“Effects of the characteristics of teaching on the outcomes of heart failure patient education interventions: a systematic review”*

Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

40. Gertz 2012, *“Do patient activating interventions improve quality of life for adults with type 2 diabetes?”*

Eksklusjonsårsak: Ikke en systematisk oversiktspublikasjon (konferansesammendrag).

41. Ghisi 2014, *“A systematic review of patient education in cardiac patients: Do they increase knowledge and promote health behavior change?”*

Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

42. Gorman 2012, *“Systematic review of diabetes disease management inverventions”*

Eksklusjonsårsak: Ikke en systematisk oversiktspublikasjon (konferansesammendrag).

43. Grimmer 2014, *“The effectiveness of self-management educational interventions for osteoarthritis of the knee”*

Eksklusjonsårsak: Fulltekst ikke tilgjengelig.

44. Gucciardi 2013, *“A systematic literature review of diabetes self-management education features to improve diabetes education in women of Black African/Caribbean and Hispanic/Latin American ethnicity”*

Eksklusjonsårsak: Oversiktsforfatterne rapporterer ikke relevante utfall. Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

45. Harding 2012, *“How can informal caregivers in cancer and palliative care be supported? An updated systematic literature review of interventions and their effectiveness”*

Eksklusjonsårsak: Ikke en systematisk oversikt over effektstudier. Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

46. Heinrich 2010, *“Self-management interventions for type 2 diabetes: A systematic review”*

Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

47. Hoerth og Udlis 2014, *“Effectiveness of Group Education for Persons with Type 2 Diabetes Mellitus: A Systematic Review of the Literature”*

Eksklusjonsårsak: Fulltekst ikke tilgjengelig.

48. Hoey 2008, *“Effectiveness of Group Education for Persons with Type 2 Diabetes Mellitus: A Systematic Review of the Literature”*

Eksklusjonsårsak: Ikke relevant tiltak da det ikke er undervisningskomponenter og/eller mestringstiltak som er hovedtiltaket, men likemannsstøtte.

49. Jensen 2015, *“Effectiveness of educational interventions for informal caregivers of individuals with dementia residing in the community: Systematic review and meta-analysis of randomised controlled trials”*

Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

50. Jones 2006, *“Strategies to enhance chronic disease self-management: how can we apply this to stroke?”*

Eksklusjonsårsak: Ikke en systematisk oversikt over effektstudier.

51. Jonsdottir 2013, *“Self-management programmes for people living with chronic obstructive pulmonary disease: a call for a reconceptualisation”*

Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

52. Joshi 2014, *“Pain self-management interventions that are effective and practical in rural settings: Results from a systematic literature review”*

Eksklusjonsårsak: Ikke en systematisk oversiktspublikasjon (konferansesammendrag).

53. Jovicic 2006, *“Effects of self-management intervention on health outcomes of patients with heart failure: A systematic review of randomized controlled trials”*

Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

54. Khunti 2008, *“Educational interventions for migrant South Asians with type 2 diabetes: a systematic review”*

Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

55. Koller 2012, *“A systematic evaluation of content, structure, and efficacy of interventions to improve patients' self-management of cancer pain”*

Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

Referanser ekskludert etter å ha blitt vurdert i fulltekst (n=105)

56. Korpershoeck 2011, *“Self-efficacy and its influence on recovery of patients with stroke: a systematic review”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
57. Kroon 2013, *“Cochrane systematic review of self-management education programs for people with osteoarthritis”*
    Eksklusjonsårsak: Ikke en systematisk oversiktspublikasjon (konferansesammendrag).
58. Kruis 2013, *“Integrated disease management interventions for patients with chronic obstructive pulmonary disease”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
59. Kuebler 2010, *“., The combined effect of exercise and education in patients with fibromyalgia compared to exercise, education, or no intervention: a systematic review”*
    Eksklusjonsårsak: Fulltekst ikke tilgjengelig.
60. Kuo 2012, *“Applying self-management intervention studies to patients with chronic illness: a systematic review”*
    Eksklusjonsårsak: Fulltekst kun på kinesisk.
61. Lagger 2010, *“Efficacy of therapeutic patient education in chronic diseases and obesity”*
    Eksklusjonsårsak: Oversikt over oversikter, ikke primærstudier alene.
62. Lai 2010, *“A systematic review of interventions by healthcare professionals on community-dwelling postmenopausal women with osteoporosis”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
63. Lan 2013, *“Effectiveness of empowerment education in patients with type 2 diabetes mellitus: A systematic review”*
    Eksklusjonsårsak: Fulltekst ikke tilgjengelig.
64. Lee 2007, *“A meta-analysis of interventions for informal stroke caregivers”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
65. Lee 2008, *“Self-management education programs for age-related macular degeneration: A systematic review”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
66. Lee 2014, *“Multimodal, integrative therapies for the self-management of chronic pain symptoms”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
67. Lee 2014, *“Effectiveness of education interventions for the management of cancer pain: a systematic review”*
    Eksklusjonsårsak: Fulltekst ikke tilgjengelig.
68. Legg 2011, *Non-pharmacological interventions for caregivers of stroke survivors”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
69. Lehman 2011, *“Moving from patient-centred to family-centred care? A systematic review of psycho-educational programs for people and partners affected by arthritis”*
    Eksklusjonsårsak: Fulltekst ikke tilgjengelig.
70. Lemmens 2009, *“, A systematic review of integrated use of disease-management interventions in asthma and COPD”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
71. Lemmens 2013, *“Chronic care management for patients with COPD: A critical review of available evidence”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
72. Li 2011, *“Education programmes for people with diabetic kidney disease”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
73. Li 2012, *“Effectiveness of illness self-management programmes for adults with schizophrenia and other psychotic disorders: A systematic review”*
    Eksklusjonsårsak: Fulltekst ikke tilgjengelig, kun protokoll.
74. Llanque 2012, *“, Interventions for Hispanic caregivers of patients with dementia: A review of the literature”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.
75. Lo 2013, *“Theory-based self-management programs for promoting recovery in community-dwelling stroke survivors: A systematic review”*
    Eksklusjonsårsak: Fulltekst ikke tilgjengelig, kun protokoll.

Referanser ekskludert etter å ha blitt vurdert i fulltekst (n=105)

76. Lovell 2014, *“Patient education, coaching, and self-management for cancer pain”*
Eksklusjonsårsak: Oversikt over oversikter, ikke primærstudier alene.

77. Marim 2013, *“Effectiveness of educational programs on reducing the burden of caregivers of elderly individuals with dementia: a systematic review”*
Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

78. Martire 2010, *“Review and meta-analysis of couple-oriented interventions for chronic illness”*
Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

79. May 2010, *“Self-management of chronic low back pain and osteoarthritis”*
Eksklusjonsårsak: Oversikt over oversikter, ikke primærstudier alene.

80. McMillan 2013, *“Patient-centered approaches to health care: A systematic review of randomized controlled trials”*
Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

81. Miles 2011, *“Can we identify how programmes aimed at promoting self-management in musculoskeletal pain work and who benefits? A systematic review of sub-group analysis within RCTs”*
Eksklusjonsårsak: Ikke en systematisk oversikt over effektstudier. Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

82. Nam 2012, *“Effect of culturally tailored diabetes education in ethnic minorities with type 2 diabetes: a meta-analysis”*
Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

83. Newbould 2006, *“Lay-led self-management in chronic illness: A review of the evidence”*
Eksklusjonsårsak: Ikke en systematisk oversikt over effektstudier.

84. Niesnik 2007, *“Systematic review of the effects of chronic disease management on quality-of-life in people with chronic obstructive pulmonary disease”*
Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

85. Nunez 2009, *“A review of the efficacy of the self-management model on health outcomes in community-residing older adults with arthritis”*
Eksklusjonsårsak: Oversikt over oversikter, ikke primærstudier alene.

86. Odnoletkova 2013, *“Systematic review on the cost-effectiveness of therapeutic education to prevent the development and progression of type 2 diabetes”*
Eksklusjonsårsak: Ikke en systematisk oversiktspublikasjon (konferansesammendrag).

87. Osborne 2006, *“Can a disease-specific education program augment self-management skills and improve Health-Related Quality of Life in people with hip or knee osteoarthritis?”*
Eksklusjonsårsak: Fulltekst ikke tilgjengelig, kun protokoll.

88. Petersen 2013, *“, Multidisciplinary education for people with rheumatoid arthritis-a systematic literature review”*
Eksklusjonsårsak: Ikke en systematisk oversiktspublikasjon (konferansesammendrag).

89. Peytremann-Bridevaux 2008, *“Effectiveness of chronic obstructive pulmonary disease-management programs: systematic review and meta-analysis”*
Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

90. Pfeiffer 2011, *“Efficacy of peer support interventions for depression: A meta-analysis”*
Eksklusjonsårsak: Ikke relevant tiltak da det ikke er undervisningskomponenter og/eller mestringstiltak som er hovedtiltaket, men likemannsstøtte.

91. Richardson 2014, *“Self-management interventions for chronic disease: a systematic scoping review”*
Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

92. Sack 2012, *“A chronic care model significantly decreases costs and healthcare utilisation in patients with inflammatory bowel disease”*
Eksklusjonsårsak: En primærstudie, ikke systematisk oversikt

93. Santos 2011, *“Group interventions focused on the burden of caregivers of patients with dementia: A systematic review”*
Eksklusjonsårsak: Fulltekst kun på portugisisk

94. Shi 2014, *“Educational intervention for metabolic bone disease in patients with chronic kidney disease: a systematic review and meta-analysis”*
Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

95. Sidhu 2014, *“A systematic review of lay-led group-based self-management interventions for minority ethnic populations diagnosed with long-term conditions in high-income countries”*

Referanser ekskludert etter å ha blitt vurdert i fulltekst (n=105)

Eksklusjonsårsak: Fulltekst ikke tilgjengelig.

96. Smith 2013, *“Self-management programmes for people with osteoarthritis: A systematic review and meta-analysis”*

Eksklusjonsårsak: Fulltekst ikke tilgjengelig.

97. Smith 2015, *“A meta-analysis of education effects on chronic disease: The causal dynamics of the Population Education Transition Curve”*

Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

98. Tan 2012, *“A Meta-Analysis on the Impact of Disease-Specific Education Programs on Health Outcomes for Patients with Chronic Obstructive Pulmonary Disease”*

Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

99. Taylor 2014, *“A rapid synthesis of the evidence on interventions supporting self-management for people with long-term conditions: PRISMS - Practical systematic Review of Self-Management Support for long-term conditions”*

Eksklusjonsårsak: Fulltekst ikke tilgjengelig.

100. Thinnes og Padilla 2011, *“Effect of educational and supportive strategies on the ability of caregivers of people with dementia to maintain participation in that role”*

Eksklusjonsårsak: Fulltekst ikke tilgjengelig.

101. Thongsai og Youjaiyen, *“The long-term impact of education on diabetes for older people: a systematic review”*

Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

102. Tong 2008, *“Support interventions for caregivers of people with chronic kidney disease: a systematic review”*

Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

103. Torenholt 2014, *“Lost in translation-the role of family in interventions among adults with diabetes: A systematic review”*

Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

104. Tshiananga 2012, *“The effect of nurse-led diabetes self-management education on glycosylated hemoglobin and cardiovascular risk factors: A meta-analysis”*

Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

105. Zou 2013, *“Self-management education interventions for persons with schizophrenia: a meta-analysis”*

Eksklusjonsårsak: Brukermedvirkning ikke beskrevet, tematisert eller rapportert av oversiktsforfatterne som del av tiltakene som studeres.

Søk etter nordiske primærstudier (søk 2)

Referanser ekskludert etter å ha blitt vurdert i fulltekst (n=38)

1. Adolfsson 2007 *“Patient education in type 2 diabetes-A randomized controlled 1-year follow-up study.”*
   Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
2. Adolfsson 2008 *“Patient education for people with type 2 diabetes in primary health care. Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine”*
   Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
3. Andren og Elmstahl 2008, *“Psychosocial intervention for family caregivers of people with dementia reduces caregiver's burden: Development and effect after 6 and 12 months”*
   Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
4. Austad 2014, *“. Aktivitørens helsefag: brukergrupper og sykdomslære”*
   Eksklusjonsårsak: Ikke en forskningsartikkel.
5. Ballegaard 2004, *“Long-term effects of integrated rehabilitation in patients with advanced angina pectoris: A nonrandomized comparative study”*
   Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
6. Bjørneklett 2011, *“A randomised controlled trial of quality of life and fatigue after support group intervention in primary breast cancer patients”*
   Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
7. Bonsaksen 2014, *“Trajectories of self-efficacy in persons with chronic illness: An explorative longitudinal study”*
   Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
8. Dalgard 2006, *“A randomized controlled trial of a psychoeducational group program for unipolar depression in adults in Norway (NCT00319540)”*
   Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
9. Gallefoss 2004, *“The effects of patient education in COPD in a 1-year follow-up randomised, controlled trial”*
   Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
10. Gallefoss og Bakke 2001, *“Cost-effectiveness of self-management in asthmatics: A 1-yr follow-up randomized, controlled trial”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
11. Gisladottir, M. and E.K. Svavarsdottir 2011, *“Educational and support intervention to help families assist in the recovery of relatives with eating disorders”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
12. Grønning 2012, *“The effect of an educational programme consisting of group and individual arthritis education for patients with polyarthritis--a randomised controlled trial”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
13. Grønning 2013, *“Long-term effects of a nurse-led group and individual patient education programme for patients with chronic inflammatory polyarthritis – a randomised controlled trial”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
14. Gustavsson 2011, *“Self-management of persistent neck pain: Two-year follow-up of a randomized controlled trial of a multicomponent group intervention in primary health care”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
15. Hakanson 2011, *“Learning to live with irritabel bowel syndrome. The influence of a group-based patient education programme on peoples' ability to manage illness in everyday life”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
16. Haugli 1997, *“Can chronic musculoskeletal pain be reduced by learning? Some results from an educational model trial”*
    Eksklusjonsårsak: Ikke tilgjengelig i fulltekst.
17. Haugli 2001, *“Learning to have less pain - is it possible? A one-year follow-up study of the effects of a personal construct group learning programme on patients with chronic musculoskeletal pain. Patient education and counseling”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
18. Hornsten 2008, *“ Improvements in HbA1c remain after 5 years - a follow up of an educational intervention focusing on patients' personal understandings of type 2 diabetes”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
19. Husted 2011, *“Improving glycaemic control and life skills in adolescents with type 1 diabetes: a randomised, controlled intervention study using the Guided Self-Determination-Young method in triads of adolescents, parents and health care providers integrated into routine paediatric outpatient clinics”*
    Eksklusjonsårsak: Deltakerne er ungdom, ikke voksne.
20. Håkanson 2012, *“Learning about oneself through others: experiences of a group-based patient education programme about irritable bowel syndrome”*
    Eksklusjonsårsak: Primærstudien undersøker ikke effekt av tiltak.
21. Ivarsson 2011, *“Experiences of group education. - A qualitative study from the viewpoint of patients and peers, next of kin and healthcare professionals”*

Referanser ekskludert etter å ha blitt vurdert i fulltekst (n=38)

Eksklusjonsårsak: Primærstudien undersøker ikke effekt av tiltak, fulltekst ikke tilgjengelig.

22. Jansma 2010, *“Physical and rehabilitation medicine and self-management education: A comparative analysis of two approaches”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
23. Kauppinen 1998, *“One-year economic evaluation of intensive vs conventional patient education and supervision for self-management of new asthmatic patients”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
24. Kauppinen 2001, *“Long-term economic evaluation of intensive patient education during the first treatment year in newly diagnosed adult asthma”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
25. Kemi 2009, *“Compliance and knowledge about osteoporosis during long -term educational interventions [Finnish]”*
    Eksklusjonsårsak: Artikkel er skrevet på finsk.
26. Lahdensuo 1996, *“Randomised comparison of cost effectiveness of guided self management and traditional treatment of asthma in Finland”*
    Eksklusjonsårsak: Ikke en forskningsartikkel.
27. Lahdensuo 1996, *“Randomised comparison of guided self management and traditional treatment of asthma over one year”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
28. Larson 2005, *“The impact of a nurse-led support and education programme for spouses of stroke patients: a randomized controlled trial”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
29. Löfvenmark 2011, *“A group-based multi-professional education programme for family members of patients with chronic heart failure: effects on knowledge and patients' health care utilization”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
30. Mehlsen 2011, *“Stanford Chronic Pain Self-Management Programme (CPSMP): Effects on pain catastrophizing, functional limitations, and benefit finding”*
    Eksklusjonsårsak: Ikke en forskningsartikkel.
31. Nielsen 2008, *“Multidisciplinary patient education in groups increases knowledge on osteoporosis: A randomized controlled trial”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
32. Nielsen 2010, *“Handling osteoporosis: The importance of patient education and knowledge-a qualitative study”*
    Eksklusjonsårsak: Primærstudien undersøker ikke effekt av tiltak.
33. Pitkanen 2012, *“Patient education methods to support quality of life and functional ability among patients with schizophrenia: a randomised clinical trial”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
34. Schjolberg 2014, *“Effects of an educational intervention for managing fatigue in women with early stage breast cancer”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
35. Svege 2014, *“Long-term effects of exercise therapy and patient education in patients with mild to moderate hip osteoarthritis”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
36. Telle-Hjellset 2013, *“The InnvaDiab-DE-PLAN study: a randomised controlled trial with a culturally adapted education programme improved the risk profile for type 2 diabetes in Pakistani immigrant wome”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.
37. Tveit Sekse 2014, *“Undervisning og veiledning i gruppe for kvinner behandlet for underlivskreft. En hjelp i rehabiliteringen?...”*
    Eksklusjonsårsak: Primærstudien undersøker ikke effekt av tiltak.
38. Zoffmann og Lauritzen 2006, *“Guided self-determination improves life skills with type 1 diabetes and A1C in randomized controlled trial”*
    Eksklusjonsårsak: Brukermedvirkning ikke beskrevet som en del av tiltaket som undersøkes.

Vedlegg 3. Informasjon innhentet

Informasjon innhentet fra de systematiske oversiktene

<table>
<tr><th colspan="2">Information extracted from the included systematic reviews</th></tr>
<tr><td colspan="2">1. Anuruang 2013, <i>“Community-based interventions to promote management for older people: an integrative review”(1)</i></td></tr>
<tr><td>Aim:</td><td>To review community programs promoting self-care or self-management for older people with chronic disease in Thailand.</td></tr>
<tr><td>Population:</td><td>Older people (65 years or older) in Thailand, but the authors included studies with participants in the age range 28–88 years.</td></tr>
<tr><td>Intervention and comparison:</td><td>The studies included in this review used a variety of self-care and self-management strategies. The most common intervention strategy was providing information to promote knowledge about their illness and signs and symptoms. Comparison was usual care, waiting list or no intervention.</td></tr>
<tr><td>Outcomes:</td><td>No predefined. They report the outcomes presented in the included studies such as self-care/self-management behaviors related their chronic conditions, patient satisfaction, quality of life, severity of symptoms and health status.</td></tr>
<tr><td>User involvement:</td><td>No detailed information about user involvement. The integrative review is included based on primary studies with peer or lay people.</td></tr>
<tr><td>Author’s conclusion:</td><td>Shared decision-making and mutual goal setting between interventionists and patients improved health behaviors and outcomes. Moreover, the flexibility to adopt the intervention to local characteristics demonstrated positive results. Relevance to clinical practice. Promoting effective self-care and self-management behaviors is critical to improving outcomes for chronic conditions. The tailoring and targeting of interventions appropriate to individuals and communities are likely to be most effective in leveraging behavior change. This review has identified that mutual goal setting improved health behaviors. The flexibility to adopt self-care interventions to community-based settings showed improved patient outcomes.</td></tr>
<tr><td colspan="2"><i>2.</i> Attridge 2014, “<i>Culturally appropriate health education for people in ethnic minority groups with type 2 diabetes mellitus” (2)</i></td></tr>
<tr><td>Aim:</td><td>To assess the effectiveness of culturally appropriate health education for people in ethnic minority groups with type 2 diabetes mellitus.</td></tr>
<tr><td>Population:</td><td>People over 16 years of age with type 2 diabetes mellitus from named ethnic minority groups residing in upper-middle-income or high-income countries.</td></tr>
<tr><td>Intervention and comparison:</td><td>Intervention: The effects of culturally appropriate (or adapted) health education for ethnic minority communities with type 2 diabetes mellitus were considered, both separately and in comparison, with conventional diabetes health education. One of the interventions should be culturally appropriate to the intervention group or groups. The authors also considered interventions that compared two different types of culturally appropriate health education. ’Culturally appropriate’ health education is defined here as education that is tailored to the cultural or religious beliefs and linguistic skills of the community being approached, taking into account likely literacy skills (Overland 1993). It could include adapting established health education to innovative delivery methods, such as using community-based health advocates, delivering the information to same-gender groups or adapting dietary advice to fit the likely diet of a particular community.
Comparator: The authors anticipate that ’conventional’ diabetes education varies from one country to another, also acknowledging the different models of health education interventions. Therefore the authors are defining ’conventional’ diabetes health education as ’any mode of delivery of health education that does not take into account the cultural background and context of the individual or group to whom the intervention is directed.’ Thus conventional diabetes health education should be the ’usual’ health education offered to patients with type 2 diabetes mellitus in the country being investigated. Educational intervention(s) could include any of the following: dietary advice; healthy lifestyle; information on smoking, exercise and weight reduction; and information on the use of screening services, foot care and self-monitoring of blood sugars and blood pressure.</td></tr>
<tr><td>Outcomes:</td><td>Important clinical outcome measures for diabetes health education include morbidity and mortality rates, incidence and progression of diabetic complications and improvements in patient empowerment and health-related quality of life. However, the priority attached to these may vary, both among patients and within the healthcare system, for example, after the introduction of new guidelines in diabetes care, new treatments for diabetes are provided, along with additional financial incentives for healthcare staff for improving care provided to patients with diabetes.</td></tr>
<tr><td>User involvement:</td><td>No detailed information about user involvement. The systematic review is included based on primary studies with peer leaders/people.</td></tr>
</table>

Author's conclusion:	Culturally appropriate health education has short- to medium-term effects on glycaemic control and on knowledge of diabetes and healthy lifestyles. With this update (six years after the first publication of this review), a greater number of RCTs were reported to be of sufficient quality for inclusion in the review. None of these studies were long-term trials, and so clinically important long-term outcomes could not be studied. No studies included an economic analysis. The heterogeneity of the studies made subgroup comparisons difficult to interpret with confidence. Long-term, standardised, multi-centre RCTs are needed to compare different types and intensities of culturally appropriate health education within defined ethnic minority groups, as the medium-term effects could lead to clinically important health outcomes, if sustained.

3. Baradaran 2010, "*Effectiveness of Diabetes Educational Interventions in Iran: A Systematic Review"(3)*

Aim:	To conduct a systematic review of reports published about educational intervention on Iranian patients with diabetes
Population:	Iranian patients with diabetes.
Intervention and comparison:	Education of patients with diabetes is considered a fundamental aspect of diabetes care and aims to empower patients by improving knowledge and skills. Structured educational programs for diabetes self-management are often multifaceted interventions, providing patients with information not only about diabetes but also management issues such as diet, exercise, self-monitoring of blood glucose (SMBG), and medication use. They could be individual or group based. The authors included studies with multicomponent interventions only if the effects of the educational details could be examined separately. Training interventions were classified based on the following categories: knowledge or information; lifestyle behaviors, including diet and physical activity; skill development, including skills to improve glycemic control such as SMBG and cardiovascular disease risk factors, as well as skills to prevent and identify complications (e.g., foot care); and coping skills (to improve psychosocial function), including interventions using stress management. Comparison not described, only referred to as "control group".
Outcomes:	Not predefined by the review authors. They report outcomes reported by the primary studies (such as HbA1c, biomedical outcomes, physical outcomes, hospitalisation, knowledge, quality of life etc.).
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with peer education.
Author's conclusion:	There are insufficient and conflicting findings to obtain any firm conclusions regarding diabetes education in Iran. However, the appropriate diabetes health education appears to have short-term effects on glycemic control and knowledge of diabetes. The heterogeneity of studies made subgroup comparisons difficult to interpret with confidence. There is a need for long-term, more rigorous methodology. It is also highly recommended to health policy makers in Iran that a special course for training diabetes educators be designed because it would enable them to tailor appropriate education intervention for people with diabetes.

4. Barnason 2012, "*An integrative review of interventions promoting self-care of patients with heart failure"(4)*

Aim:	To examine the interventions used to improve self-care of heart failure patients. The specific objectives were to examine the efficacy of interventions to improve heart failure self-care (self-maintenance and self-management behaviors) and patient-related factors such as knowledge about heart failure, self-efficacy for heart failure self-care (confidence) and beliefs regarding heart failure self-care.
Population:	Patients with heart failure
Intervention and comparison:	Interventions promoting self-care of patients with heart failure. Due to limited description of the patient education provided in the studies, it was not possible to determine if the education was inclusive of all of the components as recommended by national guidelines of the Heart Failure Society of America. Comparison was described as "usual care practice".
Outcomes:	Not predefined by the review authors. They report outcomes reported by the primary studies (self-care maintenance and management behaviors, levels of knowledge pertaining to heart failure and heart failure related self-care, healthcare utilisation, quality of life, functional status, heart failure symptoms etc.).
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with peer leaders or peer involvement.
Author's conclusion:	This integrative review of research uniquely contributes to the current state of knowledge of the efficacy and types of interventions used to promote self-care by patients with HF. Patient education for patients with HF may be improved by incorporating nationally recognised educational components. Furthermore, assessment of patient-related factors influencing self-care (e.g. knowledge, self-efficacy) by clinicians may be helpful. The use of cognitive–behavioral strategies to improve self-care and associated patient-related factors influencing self-care to augment HF patient education may be useful until further research can guide intervention specificity and dosage.

Information extracted from the included systematic reviews

5. Brady 2013, *"A Meta-Analysis of Health Status, Health Behaviors, and Health Care Utilization Outcomes of the Chronic Disease Self-Management Program" (5)*

Aim:	The primary objective of this meta-analysis was to determine the short-term (4–6 months) and longer-term (9–12 months) effect of the Stanford CDSMP. The authors examined changes in health behaviors, physical and psychological health status (including self-efficacy), and health care utilization reported in CDSMP studies in English-speaking countries. A secondary objective was to determine whether program effect differed by delivery mode.
Population:	People with various chronic conditions.
Intervention and comparison:	The Chronic Disease Self-Management Program (CDSMP) in English-speaking countries. The Chronic Disease Self-Management Program (CDSMP) is a 6-week community-based, self-management education program designed to help participants gain the confidence (self-efficacy) and skills to better manage their chronic conditions. It is taught by trained leaders who follow a structured protocol and given to participants who have various chronic conditions. Developed at Stanford University. Comparison not described, only referred to as "control group".
Outcomes:	Health behavior, psychological health status, physical health status and health care utilization.
User involvement:	No detailed information about user involvement. The systematic review is included based on the intervention CDSMP which is based on the principle of peer-led or mediated group interventions.
Author's conclusion:	Small to moderate improvements in psychological health and selected health behaviors that remain after 12 months suggest that CDSMP delivered in small English-speaking groups produces health benefits for participants and would be a valuable part of comprehensive chronic disease management strategy.

6. Brown 2011, *"Patient education in the management of coronary heart disease (Review)" (6)*

Aim:	1. To assess the effects of patient education compared with usual care on mortality, morbidity, health-related quality of life (HRQofL) and healthcare costs in patients with CHD. 2. To explore the potential study level predictors of the effects of patient education in patients with CHD (e.g. individual versus group intervention, timing with respect to index event).
Population:	Adults who had suffered a myocardial infarction (MI), who underwent revascularisation (coronary artery bypass grafting (CABG), percutaneous transluminal coronary angioplasty (PTCA) or coronary artery stenting), or who had angina pectoris or CHD defined by angiography.
Intervention and comparison:	For the purposes of this review, patient education was defined as the following: (1) Instructional activities organised in a systematic way involving personal direct contact between a health professional and CHD patients with or without significant others: e.g. spouse, family member; (2) Delivered as an inpatient, outpatient in a community-based intervention setting or program; (3) Include some form of structured knowledge transfer about CHD, its causes, treatments or methods of secondary prevention; (4) Delivered in a face-to-face format, in groups or on a one-to-one basis. The authors also included alternative interactive methods of educational delivery such as "telehealth" (telephone, e-mail, Internet and teleconference between educator and patient). The authors included only study interventions that met all the above criteria. Comparison was in most studies "usual care".
Outcomes:	Primary outcomes included mortality and cardiovascular events. Secondary outcomes included revascularisations, hospitalisations, quality of life, withdrawals, healthcare costs and cost-effectiveness.
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with peer leaders.
Author's conclusion:	The authors did not find strong evidence that education reduced all-cause mortality, cardiac morbidity, revascularisation or hospitalisation compared to control. There was some evidence to suggest that education may improve HRQofL and reduce overall healthcare costs. Whilst our findings are generally supportive of current guidelines that CR should include not only exercise and psychological interventions, further research into education is needed.

7. Carnes 2012, "*Effective Delivery Styles and Content for Self-management Interventions for Chronic Musculoskeletal Pain A Systematic Literature Review" (7)*

Aim:	The objective was to report the evidence for effectiveness of different self-management course characteristics and components for chronic musculoskeletal pain.
Population:	The primary condition was chronic musculoskeletal pain in adults (18 years or older). The authors defined chronic as pain lasting longer than 3 months.
Intervention and comparison:	Self-management Interventions. The authors defined a self-management program as a structured, taught, or self-taught course with distinct components principally aimed at patients (rather than carers) with the goal of improving the participants' health status or quality of life by teaching them skills to apply to everyday situations. The program had to contain at least 2 components from the following 5 groups identified and agreed by our steering group: psychological (including behavioral or

	cognitive therapy), mind-body therapies (including relaxation, meditation, or guided imagery), physical activity (including any form of exercise), lifestyle (such as dietary advice and sleep management), and pain education (such as understanding their condition and how to take medication effectively). Comparison was waiting-list or usual care.
Outcomes:	Pain intensity, physical function, self-efficacy, global health, and depression.
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with lay leaders. In about 13 % of the included studies the intervention was delivered by healthcare professionals and lay people, and in the intervention was 9 % were lay-led.
Author's conclusion:	These results provide some useful information to the clinician deciding what type of self-management approach might help patients with chronic musculoskeletal pain. Group-delivered courses with HCP input had potential to produce better outcomes than other types of courses. Longer courses did not necessarily give better outcomes. There was mixed evidence of effectiveness for the different course components. Serious consideration should be given to the development of short, group, and HCP-delivered interventions but more research is required to establish the most effective content and cost-effectiveness.

8. Cartin 2010, *"Community health workers in diabetes self-management education"(8)*

Aim:	To analyse the research literature on the effects of community health workers on the outcomes of HbA1c, blood pressure, BMI, lipids, and diabetes knowledge for people with type 1 or type 2 diabetes.
Population:	Community-dwelling adults with type 1 or type 2 diabetes.
Intervention and comparison:	Community health workers in diabetes self-management education. Community Health Worker: A non-healthcare professional community-dwelling adult who interacts with clients with diabetes. He or she provides education, support, and serves as a link between healthcare professionals and clients. (Community health workers were known by many titles including lay health workers, community health advocates, lay health educators, community health representatives, peer health promoters, community health outreach workers, peer support, indigenous healthcare workers, lay leaders). Comparison was "standard provider care".
Outcomes:	HbA1c, blood pressure, BMI, lipids and diabetes knowledge.
User involvement:	No detailed information about user involvement. The systematic review is included based on the definition of CHW (see Intervention and comparison).
Author's conclusion:	While the use of the community health worker programs showed promising outcomes, the existing evidence is insufficient and additional research is needed to determine its efficacy. In the future, community health worker interventions should be standardised creating consistent programs with consistent outcomes, and training for the community health workers.

9. Clark 2010, *"Educational and behavioral interventions for asthma: who achieves which outcomes? A systematic review"(9)*

Aim:	This review of interventions aimed at (a) describing the outcomes of clinical trials of asthma educational and behavioral interventions undertaken by different types of providers in the past decade and (b) exploring differences in program components employed by them.
Population:	Children and adults with asthma.
Intervention and comparison:	Asthma educational and behavioral interventions. They may include self-management education and support, information giving, behavioral change techniques, and efforts to enhance communication between the person with asthma and health care professionals. These diverse interventions have been provided by an equally diverse range of individuals from physicians to nurses, multidisciplinary teams, pharmacists, and lay educators. Comparison not described, only referred to as "control group".
Outcomes:	Asthma symptoms, pulmonary function, medicine use, psychosocial factors, days absent from work or school, days of restricted activity due to asthma, self-management, self-efficacy, quality of life, emergency department use, hospital in-patient stays, and office visits.
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with lay leaders/people.
Author's conclusion:	The extent to which and how different providers achieve asthma outcomes through educational and behavioral interventions is emerging from recent studies. Health care use and symptom control are evolving as the gold standard for intervention outcomes. Development of self-management and clinician–patient communication skills are program components associated with success across outcomes and providers.

10. Concha 2009, *"Review of Type 2 Diabetes Management Interventions for Addressing Emotional Well-Being in Latinos" (10)*

Aim:	(1) To investigate if type 2 diabetes management programs with Latino participants address emotional well-being in addition to the standard diabetes self-care behaviors and (2) to describe the approaches taken to improve psychological and diabetes management outcomes.

Information extracted from the included systematic reviews

Population:	Not clearly stated, but primarily Latinos with a type 2 diabetes diagnosis.
Intervention and comparison:	Type 2 Diabetes Management Interventions. Intervention approaches varied across all 13 T2D management programs. The majority of the studies in this review took place in community health centers/ clinics and neighborhood centers/spaces (eg, churches or adult day care). Six studies reported using a psychocognitive theory as a framework for their intervention. Not all studies indicated that they used a specific theory; however, they did include cognitive outcomes common in most cognitive theories. Specific surface structure approaches reported in most of the interventions included the use of bilingual/bicultural materials and staff, the modification of materials to address low literacy, and the use of promotoras (ie, lay health workers) and peer leaders to relay information. The most common deep structure approaches included the assessment of diabetes health beliefs and highlighting the family as an important aspect of T2D management. In addition, some studies incorporated collective approaches toward T2D. Management by implementing group problem solving, positive socializations, group discussions, and maintaining frequent contact with participants to maintain relationships. Comparison not described. Only referred to as 'control group'.
Outcomes:	Psychological outcomes (emotional and cognitive outcomes), behavioral outcomes (physical activity, self-management etc.) and physiological outcomes (blood glucose, cholesterol, blood pressure).
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with peer leaders.
Author's conclusion:	Few type 2 diabetes interventions address emotional well-being in Latinos. More attention has been directed toward designing culturally sensitive community-based programs for improving behavior and physical outcomes. Because some Latino groups believe that negative emotions cause diabetes and because depression and anxiety are associated with poor self-management, programs should address emotional well-being as an important aspect of diabetes management.
11. Coulter 2015, *"Personalised care planning for adults with chronic or long-term health conditions"(11)*	
Aim:	The authors carried out this systematic review to find out whether a personalised approach, in which patients are encouraged to participate in setting goals and action plans and determining their support needs, leads to better outcomes than when these decisions are taken by health professionals alone.
Population:	Adults (18 years or older) with any long-term physical, psychological, sensory, or cognitive condition or combination of conditions affecting their health, treated in any setting.
Intervention and comparison:	Personalised care planning aims to ensure that individuals' values and concerns shape the way long-term conditions are managed. Instead of focusing on a standard set of disease management processes determined by health professionals, this approach encourages patients to select treatment goals and to work with clinicians to determine their specific needs for treatment and support. In personalised care planning, patients and clinicians identify and discuss problems caused by or related to the patient's condition(s), giving due consideration to both clinical tests and treatments and the practical, social, and emotional effects of their condition(s) and treatment(s) on their daily lives. They then engage in a shared decision-making process involving goal setting and action planning, focused on determining priorities, agreeing realistic objectives, solving specific problems, and identifying relevant sources of support. In some cases a family member, carer/caregiver or friend may also be included in the discussion. Management options and support needs under discussion might include any or all of the following: • clinical tests and treatments, • self-management information, • education or support, • strategies for modifying health-related behaviours, managing stress, or solving practical problems. Comparison was usual care.
Outcomes:	Primary outcomes 1. Changes in health and well-being, including each of the following three dimensions measured separately: i) physical health: measured instrumentally (e.g. blood pressure, blood lipids, body mass index, HbA1c, urinary albumin, etc.) or by observation or self report (including symptom scales, pain scores). ii) psychological health: observation or self-report scales (e.g. depression or anxiety scores). iii) subjective health status: patient-reported scales (including health-related quality of life, fatigue, self esteem, coping, activities of daily living, etc.) or proxy reports (clinicians' observations or family member/carer reports). 2. Changes in patients' self-management capabilities or indicators relevant to those capabilities: measured by self reports or observations (knowledge of their condition and its treatment or management options, self efficacy, activation, confidence or perceived competence, and ability to access relevant support). We included validated measures where possible. Non-validated measures were recorded but excluded from the meta-analysis. Secondary outcomes 1. Changes in health-related behaviours: diet, exercise, smoking, use of relaxation techniques, self-management actions, condition-relevant self monitoring, adherence to treatment recommendations, attainment of personal goals. 2. Changes in use of formal

Information extracted from the included systematic reviews	
	health services: number and length of hospital admissions, number of outpatient, emergency department, or primary care visits, and, where recorded, effects on the costs of care. We also recorded any reports of harms or adverse events associated with personalised care planning.
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with peer coaches.
Author's conclusion:	Personalised care planning leads to improvements in certain indicators of physical and psychological health status, and people's capability to self-manage their condition when compared to usual care. The effects are not large, but they appear greater when the intervention is more comprehensive, more intensive, and better integrated into routine care.
12. Dale 2012, "*What is the effect of peer support on diabetes outcomes in adults? A systematic review" (12)*	
Aim:	To systematically review evidence of the impact and effectiveness of peer support in adults living with diabetes.
Population:	Adults diagnosed with and being treated for diabetes
Intervention and comparison:	Peer support interventions that aimed at improving the care or management of diabetes. A broad range of models of peer support have been described in the context of diabetes, including face-to-face management programmes, peer coaching, telephone-based peer support, and web- and email-based support. These models vary in the extent to which they offer one-to-one or group support. They also differ in their focus, how they build on the shared knowledge and experience that peers can offer each other, and in the ways that they provide one or more of the following: 1. Emotional support, including expressions of care, encouragement, active listening, reflection, reassurance and usually the absence of criticism. 2. Appraisal support, including communication of information that is relevant to self-evaluation and the appropriateness of emotions, cognitions and behaviours; for example, motivation and encouragement to persist in problem solving. 3. Informational support, including provision of knowledge relevant to problem solving. Comparison was usual or routine care, another intervention or delivery of intervention, referred to as 'control group' or not described.
Outcomes:	Not predefined by the review authors. They report the outcomes selected by the primary studies which include clinical outcomes (HbA1c, blood pressure, cholesterol, symptoms of hypo- and hyperglycaemia, weight/BMI or body fat, fatigue), health behavior outcomes (physical activity, glucose monitoring, diet, insulin therapy, clinic and communication visits), empowerment outcomes (self-efficacy, perceived barriers, knowledge), psychological outcomes (depression/health distress, perceived social support, acceptability).
User involvement:	Yes, the authors highlight this: "The interventions varied in the extent to which peer support was intended as an adjunct to routine clinical care, or were less formal, user-initiated interventions that patients might selfselect or volunteer into. The importance of establishing a strong theoretical understanding of how a complex intervention, such as peer support, causes change is recognized as a prerequisite to optimizing its design and implementation. In addition to addressing the issue, user involvement is, to some extent, a part of every intervention included in this review.
Author's conclusion:	Peer support appears to benefit some adults living with diabetes, but the evidence is too limited and inconsistent to support firm recommendations. There remains a need for further well-designed evaluations of its effectiveness and impact. Key questions remain over its suitability to the needs of particular individuals, populations and settings, how best to implement its specific components and the sustainability of its effects.
13. Du 2011, "*Self-management programs for chronic musculoskeletal pain conditions: A systematic review and meta-analysis" (13)*	
Aim:	To evaluate the effectiveness of self-management programs on pain and disability for chronic musculoskeletal pain conditions by systematic review.
Population:	Adults (18 years or older) with chronic musculoskeletal pain conditions. Chronic musculoskeletal pain conditions include arthritis (OA, RA, or fibromyalgia), back pain, shoulder pain, neck pain, etc., and the symptom of pain persists for more than 3 months.
Intervention and comparison:	Interventions that integrated systematic therapies into a self-management or self-care program were included. Qualified self-management programs should lay emphasis on following 8 essential elements: (a) self-efficacy building; (b) self-monitoring; (c) goal-setting and action-planning; (d) decision-making; (e) problem-solving; (f) self-tailoring; (g) partnership between the views of patients and health professionals; and (h) community-based and close to home. What's more, only the trials in which interventions primarily focused on managing pain and minimizing disability were qualified for inclusion. Comparison was usual care or waiting-list control.
Outcomes:	Each eligible trial should take pain intensity and disability as its primary outcomes. Those trials in which pain and disability were not considered as primary outcomes of interest would be excluded.
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with lay leaders/people.

Information extracted from the included systematic reviews

Author's conclusion:	The encouraging evidence of this study indicates that it is recommended to provide self-management programs to adult patients with arthritis. Further research is needed on self-management for chronic back pain. Practice implications: Self-management is a safe, community-based and effective way for patients with arthritis to manage pain and disability. Core skills of self-management should be delivered using multiple approaches.
14.	Effing 2014, "*Self management for patients with chronic obstructive pulmonary disease (Review)" (14)*
Aim:	1. To evaluate whether self management interventions in COPD lead to improved health outcomes. 2. To evaluate whether self management interventions in COPD lead to reduced healthcare utilisation.
Population:	Patients with a clinical diagnosis of COPD with symptoms and meeting agreed spirometry criteria.
Intervention and comparison:	Self management interventions were defined as structured interventions for individuals with COPD aimed at improvement of self health behaviours and selfmanagement skills. These interventions required at least an iterative process of interaction between participant and healthcare provider, and ideally also included formulation of goals and provision of feedback. Interventions with fewer than two contact moments were therefore excluded. Furthermore, at least two of the following components had to be part of the intervention: smoking cessation, self recognition and self treatment of exacerbations, an exercise or physical activity component, advice about diet, advice about medication or coping with breathlessness. Content could be delivered to study participants verbally, as written material (hardcopy or digital) or via audiovisual media. An action plan was defined as a guideline for participants describing when and how to change medication in case of worsening COPD-related symptoms, indicating (the start of) an exacerbation. Explicitly, interventions involving solely participant education were excluded. Disease management programmes classified as pulmonary rehabilitation offered in a hospital or rehabilitation centre, as well as community- or home-based pulmonary rehabilitation programmes solely directed towards exercise, were also excluded. Studies with usual care as a control group and those with an active intervention as a control group were included in this review. Comparison was usual care or active intervention.
Outcomes:	Primary outcomes 1. Health-related quality of life (HRQoL) scores. 2. Number of hospital admissions. Secondary outcomes 1. Hospitalisation days. 2. Number of exacerbations requiring emergency department visits. 3. Use of (other) healthcare facilities. 4. Number of exacerbations requiring a course of oral corticosteroids or antibiotics. 5. Use of rescue medication. 6. Symptom scores. 7. Anxiety and depression. 8. Self-efficacy. 9. Days lost from work. 10. Lung function. 11. Exercise capacity.
User involvement:	No detailed information about user involvement. The systematic review is included based on one primary study with peer leader.
Author's conclusion:	Self management interventions in patients with COPD are associated with improved health-related quality of life as measured by the SGRQ, a reduction in respiratory-related and all cause hospital admissions, and improvement in dyspnoea asmeasured by the (m)MRC. No statistically significant differences were found in other outcome parameters. However, heterogeneity among interventions, study populations, follow-up time and outcome measures makes it difficult to formulate clear recommendations regarding the most effective form and content of self management in COPD.
15.	Fitzpatrick 2013, "*Problem solving interventions for diabetes self-management and control: A systematic review of the literature"(15)*
Aim:	Problem solving is deemed a core skill for patient diabetes self-management education. The purpose of this systematic review is to examine the published literature on the effect of problem-solving interventions on diabetes self-management and disease control.
Population:	Children, adolescents and adults with diabetes type 1 or 2.
Intervention and comparison:	Problem-solving interventions. Comparison: In studies with control group: usual care or waiting-list control or another intervention.
Outcomes:	Problem solving, self-management behaviors, and physiological, psychosocial, and process outcomes.
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with peer leaders/ involvement
Author's conclusion:	Studies varied greatly in their approaches to problem-solving use in patient education. To date, 36% of adult problem-solving interventions and 42 % of children/adolescent problem-solving interventions have demonstrated significant improvement in HbA1c, while psychosocial outcomes have been more promising. The next phase of problem- solving intervention research should employ intervention characteristics found to have sufficient potency and intensity to reach therapeutic levels needed to demonstrate change.
16.	Foster 2007, *"Self-management education programmes by lay leaders for people with chronic conditions (Review)" (16)*

Information extracted from the included systematic reviews	
Aim:	To assess systematically the effectiveness of lay-led self-management programmes for people with chronic conditions.
Population:	Participants of all age groups with established chronic conditions.
Intervention and comparison:	Self-management education programmes. These led by lay leaders (rather than health professionals such as doctors or nurses) are becoming common as a way of trying to promote self care for people with chronic conditions. Lay-led self-management education programmes for people with chronic conditions were defined as structured programmes for people with chronic conditions which were judged by the authors to be primarily educational, primarily addressing self-management of disease, and where the majority of the course content was delivered by lay people. Comparison was usual care.
Outcomes:	Primary outcomes were: health status (including self-rated health and health-related quality of life, disability, pain, fatigue, shortness of breath, psychological well-being), clinical measures (such as blood pressure, lung function). Secondary outcomes were: knowledge of the chronic condition, social role or activities, perceived support., attendance at courses, communication with a physician, costs of delivering the programme, cost effectiveness, effects on carers/family, adverse outcomes, such as complaints, health behaviour (including exercise, cognitive symptom management, adherence), healthcare use (including doctor visits, emergency room visits, hospital admissions and length of stay) and self-efficacy (confidence) to self care.
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with lay/peer leaders. The interpretation of who exactly qualifies as a lay leader may vary between self-management education programmes but they are all trained and accredited and adopt a philosophy of self-management rather than the medical model. Lay-led (or peer-led) education may differ from professionally-led education in important ways including: 1) lay leaders commonly, but not invariably, themselves have a chronic disease, which may or may not be the same as that affecting programme participants; thus leaders in such programmes may act as role-models for the participants; 2) the format may be less formal than education from a health professional, perhaps encouraging discussion of ways of self-care that participants find helpful which they might not feel able to raise in a professionally-led programme; and 3) lay-leaders, particularly for programmes for specific ethnic groups, may provide subtle but important interpretations of health advice that reflect particular health beliefs or explanatory models for that group.
Author’s conclusion:	Lay-led self-management education programmes may lead to small, short-term improvements in participants’ self-efficacy, self-rated health, cognitive symptom management, and frequency of aerobic exercise. There is currently no evidence to suggest that such programmes improve psychological health, symptoms or health-related quality of life, or that they significantly alter healthcare use. Future research on such interventions should explore longer term outcomes, their effect on clinical measures of disease and their potential role in children and adolescents.
17. Franek 2013, *“Self-Management Support Interventions for Persons With Chronic Disease: An Evidence-Based Analysis”(17)*	
Aim:	To systematically assess the clinical effectiveness of self-management support interventions for persons with chronic diseases
Population:	Adults (18 years or older) with chronic disease.
Intervention and comparison:	Self-Management Support Interventions for Persons With Chronic Disease. They typically consists of components such as: communication with providers, lifestyle (diet, exercise), medication management, psychological, symptom management, self-management, social support This review focuses on interventions meant to support the self-management of chronic disease in general (i.e., interventions that are not disease-specific). Comparison was usual care.
Outcomes:	Pain, disability, fatigue, dyspnea, depression, health distress, self-rated health, quality of life, exercise, cognitive symptom management, communication with health care professionals, self-efficacy, healthcare utilization.
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with lay/peer leaders. Also, typically, the intervention might be CDSMP, which is based on lay-leaders.
Author’s conclusion:	Low quality evidence showed that the Stanford CDSMP led to statistically significant, albeit clinically minimal, short-term (median 6 months) improvements across a number of health status measures, in healthy behaviours, and self-efficacy compared to usual care. Very low quality evidence showed no significant difference between the CDSMP and usual care in short-term (median 6 months) health care utilization and across some health-related quality of life scales. Moderate quality evidence showed that the CDSMP led to statistically significant, albeit clinically minimal, short-term (median 6 months) improvement in EQ-5D score compared to usual care. More research is needed to explore the long-term (12 months and greater) effect of self-management across outcomes and to explore the impact of self-management on clinical outcomes. Exploratory evidence suggests that some subgroups of persons with chronic conditions may respond better to

Information extracted from the included systematic reviews	
	the CDSMP; however, there is considerable uncertainty, and more research is needed to better identify responders and non-responders.
18. Fuhr 2014, *"Effectiveness of peer-delivered interventions for severe mental illness and depression on clinical and psychosocial outcomes: a systematic review and meta-analysis" (18)*	
Aim:	To evaluate the effectiveness of peer-delivered interventions in improving clinical and psychosocial outcomes among individuals with severe mental illness (SMI) or depression.
Population:	Adults with severe mental illness or depression diagnosed according to ICD-10 or DSM-IV criteria.
Intervention and comparison:	A broad range of different pee- delivered interventions to improve clinical and psychosocial outcomes among individuals with severe mental illness (SMI) or depression was studied (group or individual). Comparison was usual care or treatment delivered by a health professional.
Outcomes:	Clinical (e.g. change in symptoms) or psychosocial outcomes (e.g. quality of life, social functioning, hope and loneliness).
User involvement:	Yes. Peers were defined as non-professional health workers who possess knowledge of a disease or a specific stressor from personal experience rather than formal training and who may share salient target population similarities such as gender or age with the recipient. Interventions were included which placed service users in direct contact with at least one peer who provided a conventional service in an intentional, one-directional relationship. They included only studies that studied the effects of peer-delivered interventions.
Author's conclusion:	The limited evidence base suggests that peers may have a small additional impact on patient's outcomes, in comparison to standard psychiatric care in high-income settings. Future research should explore the use and applicability of peer-delivered interventions in resource poor settings where standard care is likely to be of lower quality and coverage. The positive findings of equivalence trials demand further research in this area to consolidate the relative value of peer-delivered vs. professional- delivered interventions.
19. Hawthorne 2010, *"Culturally appropriate health education for Type 2 diabetes in ethnic minority groups: a systematic and narrative review of randomized controlled trials"(19)*	
Aim:	To determine if culturally appropriate health education is more effective than 'usual' health education for people with diabetes from ethnic minority groups living in high- and upper-middle-income countries.
Population:	People with diabetes from ethnic minority groups living in high- and upper-middle-income countries
Intervention and comparison:	'Culturally appropriate health education' was defined as health education that had been tailored to the cultural or religious beliefs and linguistic and literacy skills of the community being studied. It could include adaptations of established health education to innovative delivery methods, such as using community-based health advocates, conforming to cultural requirements for same gender education groups, or adapting dietary advice to the likely dietary needs of a community. Comparison was 'conventional' diabetes health education
Outcomes:	Patient-oriented measure of quality of life as measured using validated tools, and biomedical measures of glycated haemoglobin (HbA1c) and blood pressure (BP). Our secondary outcome measures included changes in body mass index (BMI), lipid levels, recorded long-term diabetic complications, mortality rates, acute hospital admissions, and episodes of hypoglycaemia. The authors also looked for measures of patient attitude and satisfaction, empowerment and self-efficacy, validated questionnaires of knowledge of diabetes and its management, and for health economic assessments.
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with non-clinician leaders/people.
Author's conclusion:	Culturally appropriate health education was more effective than 'usual' health education in improving HbA1c and knowledge in the short to medium term. Due to poor standardization between studies, the data did not allow determination of the key elements of interventions across countries, ethnic groups and health systems, or a broad view of their cost-effectiveness. The narrative review identifies learning points to direct future research.
20. Health Quality Ontario 2009, *"Behavioural Interventions for Type 2 Diabetes"(20)*	
Aim:	The objective of this report is to determine whether behavioural interventions are effective in improving glycemic control in adults with type 2 diabetes.
Population:	Adults with type 2 diabetes (>18 years)
Intervention and comparison:	All of the interventions examined in the studies were mapped to the 2007 Self-management Mapping Guide. The interventions most often focused on problem solving, goal setting and encouraging participants to engage in activities that protect and promote health (e.g. modifying behaviour, change in diet, and increase physical activity). All of the studies examined comprehensive interventions targeted at least two self-care topics (e.g. diet, physical activity, blood glucose monitoring, foot care, etc.). Despite the homogeneity in the aims of the interventions, there was substantial clinical heterogeneity in other intervention characteristics such as duration, intensity, setting, mode of delivery (group vs. individual), interventionist, and outcomes of interest. Comparison was usual care.

Information extracted from the included systematic reviews

Outcomes:	Primary outcome: glycemic control (HbA1c). Secondary outcomes: systolic blood pressure (SBP) control, lipid control, change in smoking status, weight change, quality of life, knowledge, self-efficacy, managing psychosocial aspects of diabetes, assessing dissatisfaction and readiness to change, and setting and achieving diabetes goals.
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with peer leaders or community workers.
Author's conclusion:	Based on moderate quality evidence, behavioural interventions as defined by the 2007 Self-management mapping guide (Government of Victoria, Australia) produce a moderate reduction in HbA1c levels in patients with type 2 diabetes compared with usual care. Based on low quality evidence, the interventions with the largest effects are those: in diabetics with higher baseline HbA1c (≥9.0) and in which the interventions were of at least 1 year in duration.

21. Henderson 2011, *"The effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically diverse communities: a systematic literature review"(21)*

Aim:	To assess the effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically diverse communities.
Population:	Broad group of people (mostly adults) from culturally and linguistically diverse communities.
Intervention and comparison:	Culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically diverse communities. Broad group of comparisons.
Outcomes:	The outcomes examined included changes in consumer health behaviours, utilisation ⁄ satisfaction with the service, and the cultural competence of healthcare providers.
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with non-clinician leaders/people. Terms used to describe community workers included, lay health advisors, lay health educators, lay tutors, Aboriginal health workers, bi-lingual community mentors, peer educators and promoters. The term community health worker (CHW) refers to these collective roles that have been used in this review.
Author's conclusion:	The review supported the use of trained bi-lingual health workers, who are culturally competent, as a major consideration in the development of an appropriate health service model for culturally and linguistically diverse communities.

22. Jensen 2014, *"Effectiveness and characteristics of multifaceted osteoporosis group education—a systematic review"(22)*

Aim:	This systematic review investigated quantitative studies on osteoporosis multifaceted group education. The purpose was to investigate the characteristics as well as the effectiveness of this form of osteoporosis patient education.
Population:	Adults aged 45 years and older with or without vertebral fracture.
Intervention and comparison:	The multifaceted educational programmes all consisted of three overall themes: (1) Knowledge of osteoporosis, (2) Medication and diet and (3) Exercise, but with different foci across the studies. Comparisons were no intervention, usual care or another type of intervention.
Outcomes:	(1) Health-related quality of life, (2) Psychosocial function, (3) Pain, (4) Physical activity, (5) Knowledge and (6) Medication and diet.
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with non-clinician leaders/people
Author's conclusion:	Multifaceted group education may have a positive impact on the patients' ability to engage in preventing and managing osteoporosis. Further research directed towards the complexity of multifaceted group education is needed. In addition, research investigating the educational needs of specific groups of osteoporotic patients is required.

23. Jones and Riazi 2011 *"Self-efficacy and self-management after stroke: a systematic review"(23)*

Aim:	The purpose of this review is to examine (1) the influence of self-efficacy on rehabilitation outcomes post-stroke, and (2) the evidence to support self-management interventions based on self-efficacy principals for stroke survivors.
Population:	Primary population of stroke (no restriction on age).
Intervention and comparison:	Self-management interventions based on self-efficacy principals for stroke survivors. Comparison referred to as control group, no further description by authors.
Outcomes:	Not predefined. Report the outcomes reported in the primary studies.
User involvement:	No detailed information about user involvement. The systematic review is included based on one primary study with non-clinician leaders/people.
Author's conclusion:	There is a need for researchers, to work together with other stakeholders to develop and test interventions that can support self-management skills and confidence to make continued progress after stroke. This could help to reduce some of the negative consequences of stroke such as reduced quality of life and social isolation.

Information extracted from the included systematic reviews

24. Jonker 2009, *“Promotion of self-management in vulnerable older people: a narrative literature review of outcomes of the Chronic Disease Self-Management Program (CDSMP)”(24)*	
Aim:	The aim of this study was to review intervention studies focusing on the CDSMP and to draw conclusions on the benefits of the program.
Population:	Vulnerable older people. The authors do not define what they mean by “vulnerable”.
Intervention and comparison:	The Chronic Disease Self-Management Program (CDSMP). The main aim of the CDSMP is to assist people to cope with multiple chronic diseases. Three principal assumptions that underlie the CDSMP are: 1. People with different chronic diseases have similar self-management problems and disease-related tasks. 2. People can learn to take responsibility for the day-today management of their diseases. 3. Confident, knowledgeable patients practicing self-management will experience improved health status and will utilize fewer health care resources. Two additional requirements are: 1. Self-management education should be inexpensive and widely available. 2. Trained laypersons with chronic conditions can effectively deliver a structured patient education program. The CDSMP focuses on several topics, including physical exercise, nutrition, breathing, emotions, communication and medication, which are discussed during 6-weekly sessions of 2 h each in groups of 10–15 participants The groups are supervised by two trained leaders. The underlying mechanism that explains the positive effects on health behaviour, health status, self-management behaviour and health care utilization, is assumed to be self-efficacy. This is defined as ‘believing in one’s own capability to organize and execute the courses of action required to produce given attainments’ (Bandura 1997). Comparison was waiting list and/or care as usual.
Outcomes:	Self-efficacy, Health behaviour, Health status and Health care utilization as main categories.
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with peer leaders.
Author’s conclusion:	The authors found that the CDSMP was consistently beneficial for Health behaviour, especially with regard to the variables of exercise and self-care. For Health status, the majority of studies only showed improvement in the domain of health distress. Most of the studies that investigated Self-efficacy showed convincing improvement in self-efficacy, cognitive symptom management and mental stress management. In Health care utilization, there was no significant decrease. On the whole, the studies showed that CDSMP led to an increase in physical exercise, a decrease in health distress, an improvement in self-care, and it had a beneficial effect on self-efficacy.

25. Kroon 2014, *“Self-management education programmes for osteoarthritis”* (25)	
Aim:	To assess the effectiveness of self-management education programmes for people with osteoarthritis.
Population:	People of all age groups diagnosed with OA as defined in the included trials
Intervention and comparison:	Self-management education programmes are distinct from simple patient education or skills training, as they encourage people with chronic disease to take an active role in the management of their own condition. Self-management education programmes aim to improve outcomes for patients by supporting, not replacing, medical care. Self-management education programmes are complex behavioural interventions comprising a package of interventions specifically targeted at patient education and behaviour modification. Programmes vary in the content used to educate patients about their condition and to explain how they can best manage their symptoms. Some programmes specifically focus on managing the chronic condition itself, whereas other programmes may take a more holistic approach to managing the overall general well-being of the individual. Substantial variation exists in the delivery of self-management education programmes, such as the mode (facetoface, Internet, telephone), the audience (group, individual), the duration (single session, several months, ongoing), the frequency (once a week, once every two months) and the personnel (healthcare professionals, lay leaders). Structured self-management education programmes that were judged as being primarily educational and that addressed self-management of OA, arthritis in general or living with chronic disease. Programme components that directly address self-management may include fostering skills in managing OA, such as problem solving, goal setting, decision making, self-monitoring and coping with the condition, as well as providing interventions to manage pain or improve physical and psychological functioning. Structured programmes delivered by healthcare professionals, lay leaders or both were included, irrespective of whether the programme was delivered to a group of participants or on an individual basis. Included studies were grouped and assessed according to whether they compared self-management education programmes versus: 1) an attention control group (i.e. participants received the same contact hours with programme providers, but the content delivered was unrelated to self-management of their condition); 2) a group that received no treatment or usual care or were placed on a waiting list to attend the self-management programme at a later date; 3) an information-only group (i.e. educational materials, programme handbook); 4) a group that received an alternate intervention that was not a self-management education programme (i.e. exercise or diet plan); or 5) a group that received acupuncture. This intervention was considered separately from other studies

	comparing self-management programmes versus alternative interventions (i.e. comparison described in the previous bullet) because, unlike alternative interventions in the other trials, this comparison is not a behavioural intervention. We considered the first two comparisons to be the most important for addressing the objectives of this review
Outcomes:	Primary outcomes: Participant's positive and active engagement in life, Pain, Global OA scores, Self-reported function, Quality of life and Withdrawals. Secondary outcomes: Emotional distress, Health-directed activity, Social integration and Health service navigation
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with peer leaders.
Author's conclusion:	Low to moderate quality evidence indicates that self-management education programmes result in no or small benefits in people with osteoarthritis but are unlikely to cause harm. Compared with attention control, these programmes probably do not improve self-management skills, pain, osteoarthritis symptoms, function or quality of life, and have unknown effects on positive and active engagement in life. Compared with usual care, they may slightly improve self-management skills, pain, function and symptoms, although these benefits are of unlikely clinical importance. Further studies investigating the effects of self-management education programmes, as delivered in the trials in this review, are unlikely to change our conclusions substantially, as confounding from biases across studies would have likely favoured self-management. However, trials assessing other models of self-management education programme delivery may be warranted. These should adequately describe the intervention they deliver and consider the expanded PROGRESS-Plus framework and health literacy, to explore issues of health equity for recipients.
26. Larsen 2014, *"Limited evidence of the effects of patient education and self-management interventions in psoriasis patients: A systematic review" (26)*	
Aim:	To describe the contents of educational and self-management programmes for patients with psoriasis, and to evaluate their effects.
Population:	Patients aged over 18 years with a clinical diagnosis of psoriasis, regardless of the type or stage. The authors included studies from all settings where all types of health-care professionals could provide the interventions.
Intervention and comparison:	The programme content had to include at least one face-to-face meeting with a health-care professional. The intervention had to include psoriasis education, or focus on one or more aspects of living with psoriasis, such as symptom management, cognitive problem solving, communication skills, stress management or lifestyle change. Self-management interventions had to emphasize key elements such as engagement in self-care, self-efficacy strengthening, action planning and problem solving (i.e., education only, self-management only or education and self-management combined). Comparison was different intervention, usual care or a waiting list control.
Outcomes:	To measure the effects of education and self-management interventions, the authors decided to use a holistic approach and considered all relevant parameters such as disease severity, symptom relief, illness perception, quality of life, self-efficacy and psychological status. They also decided to include studies that measured knowledge, regardless of the type of questionnaire, as well as interventions with self-customized questionnaires, provided they referred to any of the topics mentioned above.
User involvement:	No detailed information about user involvement. The systematic review is included based on one primary study with peer provider.
Author's conclusion:	This review showed that little evidence is available to support the effects of educational and self-management interventions in patients with psoriasis that are studied in RCTs. There is a significant lack of focused self-management and, compared with other chronic conditions, there appear to be few effective disease-specific tailored educational programmes for psoriasis.
27. Lennon 2013, "*Self-management programs for people post stroke: a systematic review" (27)*	
Aim:	To examine the evidence base underlying self-management programmes specific to stroke survivors.
Population:	People who have had a stroke (post stroke recruitement)
Intervention and comparison:	Self-management programmes are distinct from patient education or skills training in that they are designed to enable people to take an active part in managing their own condition, including the psychosocial consequences and lifestyle adjustments required to enhance quality of life. Programmes can include a number of different methods of delivery, they can be lay or professionally led, disease specific, or generic, using a group or one to one formats. Comparison was normal/standard care, standard post discharge rehabilitation/care, written information, wait-listed control or placebo telephone call.
Outcomes:	Not predefined. The authors reported on the outcomes measured in the primary studies. Outcomes measured physical, psychological, and social health status; knowledge; self-management behaviour; satisfaction with intervention; adverse events or complications; health resource utilisation; and feasibility.

Information extracted from the included systematic reviews

User involvement:	No detailed information about user involvement. The systematic review is included based on one primary study with peer leaders.
Author's conclusion:	This review provides some preliminary support for the potential importance of self-management interventions after stroke. The most appropriate content and best approach for delivery of these interventions remains to be determined. Further high-quality randomized controlled trials are needed to test the feasibility, acceptability, and efficacy of stroke self-management programmes.
28.	Lew 2014, "*State of the Science: Diabetes Self-Management Interventions Led By Nurse Principal Investigators" (28)*
Aim:	The purpose of this integrative review is to summarize the state of the science regarding diabetes self-management (DSM) interventions led by nurse principal investigators.
Population:	People with diabetes.
Intervention and comparison:	Diabetes self-management interventions. Comparison was mostly usual care.
Outcomes:	Clinical outcomes (HbA1c), knowledge, quality of life, self-care, self-efficacy etc.
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with peers involvement in the delivery of the nurse-led interventions.
Author's conclusion:	The conclusion is not presented separately, but rather fragmented into the result and discussion section.
29.	Lloyd-Evans 2014, *"A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness"* (29)
Aim:	This paper systematically reviews trials of community based, peer-provided support for people with severe mental illness.
Population:	Adults with severe mental illness.
Intervention and comparison:	Included interventions were community-based peer support designed to facilitate recovery from severe mental illness. Peer support has been organised in three pre-defined subgroups, which are theoretically distinct, and which include comparators that would be inappropriate to combine (e.g. in meta-analysis). i) Mutual support groups in which relationships are thought to be reciprocal in nature, even if some participants are viewed as more experienced or skilled than others; ii) Peer-support services in which support is primarily uni-directional, with one or more clearly defined peer supporters offering support to one or more programme participants (support is separate from or additional to standard care provided by mental health services); iii) Peer mental health service providers: people who have used mental health services and are employed to provide part or all of the standard care delivered by a mental health care service (i.e. the difference from standard care should be the provider rather than the role). Peer mental health providers are thus explicitly aiming to provide services which are also be provided by clinicians; the content of mutual support groups is largely unspecified and peer support per se is the intervention; peer support services are designed as a peer-provided addition to standard care.
Outcomes:	1) Hospitalisation, 2) Employment, 3) Overall psychiatric symptoms, 4) Symptoms of psychosis, 5) Depression and anxiety, 6) Quality of Life,7) Recovery (self-rated), 8) Hope, 9) Empowerment, 10) Satisfaction with services
User involvement:	Yes, they discuss different types of peer interventions, and the importance of segregating them (see 'Intervention and comparison'). They included only studies which studied the effects of peer-delivered interventions.
Author's conclusion:	Despite the promotion and uptake of peer support internationally, there is little evidence from current trials about the effects of peer support for people with severe mental illness. Although there are few positive findings, this review has important implications for policy and practice: current evidence does not support recommendations or mandatory requirements from policy makers for mental health services to provide peer support programmes. Further peer support programmes should be implemented within the context of high quality research projects wherever possible. Deficiencies in the conduct and reporting of existing trials exemplify difficulties in the evaluation of complex interventions.
30.	Mason 2008, *"Educational Interventions in Kidney Disease Care: A Systematic Review of Randomized Trials" (30)*
Aim:	To conduct a systematic review of the effectiveness of educational interventions aimed at empowering chronic disease management in people with kidney disease.
Population:	Adult (18 years or older) patients with kidney disease who were in the categories of early CKD, predialysis, or dialysis care.

Information extracted from the included systematic reviews	
Intervention and comparison:	Structured interventions that involved both informational and psychological components. Interventions involved components aimed at improving both knowledge and motivation. These components were used in various combinations and formats ranging in terms of complexity. Comparison was usual or routine care.
Outcomes:	One or more of the following outcomes: clinical (eg, blood chemistry and weight), knowledge, behavioral (eg, decision making), and psychological (eg, quality of life).
User involvement:	No detailed information about user involvement. The systematic review is included based on one primary study with peer teacher or mentor.
Author's conclusion:	Multicomponent structured educational interventions were effective in predialysis and dialysis care, but the quality of many studies was suboptimal. Effective frameworks to develop, implement, and evaluate educational interventions are required, especially those that target patients with early stages of chronic kidney disease. This could lead to possible prevention or delay in progression of kidney disease.
31. McGillon 2014, *"Impact of self-management interventions on stable angina symptoms and health-related quality of life: a meta-analysis"(31)*	
Aim:	To examine comprehensively the overall effectiveness of self-management on angina symptom profile and related SL nitrate use, functional aspects of HRQL, and psychological well-being.
Population:	Adult outpatients of all ages with ischemic heart disease.
Intervention and comparison:	Interventions employing a combination of cognitive and behavioural angina self-management techniques were included such as: supportive coaching, anxiety and stress management or counselling, incremental exercise program, nutrition planning, medication review, relaxation training, and energy conservation. Comparison received routine or usual care and were not exposed to the intervention during the study period.
Outcomes:	1. Angina symptom profile including angina frequency and stability and related SL nitrate use 2. HRQL dimensions including physical limitation, disease perception, and treatment satisfaction 3. Psychological well-being, reflected by anxiety and depression.
User involvement:	No detailed information about user involvement. The systematic review is included based on one primary study with lay facilitator.
Author's conclusion:	Self-management interventions significantly improve angina frequency and physical limitation; they also decrease the use of SL nitrates and improve depression in some cases. Further work is needed to make definitive conclusions about the impact of SM on cardiac-specific anxiety.
32. Millard 2013, *"Self-Management Education Programs for People Living with HIV/AIDS: A Systematic Review"(32)*	
Aim:	The objective of this systematic review was to (1) provide a synthesis of the literature on disease-specific self-management interventions for people living with HIV, (2) summarize the evidence of the effectiveness of health education interventions on physical and psychosocial health outcomes and health-related knowledge and behaviors among people living with HIV, and (3) to provide recommendations for future research and intervention development efforts.
Population:	Adults living with HIV/AIDS
Intervention and comparison:	Self-management education programs. Self-management, as described by Lorig and colleagues involves three tasks: medical management, role management, and emotional management, and encompasses six skills: problem solving, decision making, resource utilization, formation of a patient–provider partnership, action planning and self-tailoring. In order to be a successful self-manager, motivation, healthy behaviors, and effective collaboration with health professionals is required. Comparison varied among included studies: usual care, waiting list, another intervention, information material etc.
Outcomes:	Physical, psychosocial, and health knowledge and behavioral outcomes.
User involvement:	No detailed information about user involvement. The systematic review is included based on one primary study with peer leader.
Author's conclusion:	The review found randomized controlled trials (RCT) evidence sufficient to infer that self-management programs for people living with HIV/AIDS result in short-term improvements in physical, psychosocial, and health knowledge and behavioral outcomes. Statistically significant improvements were reported for intervention participants compared to control participants across most outcomes. There is insufficient evidence to provide conclusions regarding the long-term outcomes of HIV-specific self-management interventions.
33. Nolte and Osborne 2013, "*A systematic review of outcomes of chronic disease self-management interventions" (33)*	
Aim:	To carry out a systematic review of program outcomes used in the evaluation of group-based self-management interventions aimed at people with arthritis and other chronic conditions.
Population:	Adults with arthritis and other chronic conditions.

Intervention and comparison:	Inclusion of studies evaluating disease-specific or generic self-management interventions comparable with the Stanford curricula. If studies did not directly refer to Stanford, studies were selected that evaluated interventions that included at least two of the three keywords ‘problem-solving’, ‘action planning’, and ‘relaxation’. To be included in the review, four characteristics had to be met by the self-management program: a. Interventions were delivered in a group setting; b. Interventions were based on a formal syllabus; c. Interventions ran between four and ten sessions within a period of 3 months; d. Interventions did not include any additional components such as exercise lessons, reinforcement techniques, individual consultations, and/or home visits. Comparison only referred to as control group, with no further explanation.
Outcomes:	The most often reported outcomes, with pain, disability, depression and self-efficacy being the most commonly assessed outcome.
User involvement:	No detailed information about user involvement. The systematic review is included based on one primary study being reported with peer leader.
Author’s conclusion:	This paper is consistent with other reviews in this area, suggesting that people with arthritis receive only marginal benefits from participating in chronic disease self-management interventions. When looking at the types of outcomes that trials are based on, however, alternative explanations for these results seem probable. As evaluations heavily rely on patient self-report, current approaches to program evaluation may not be sufficient to assess the intended impact of self-management education. An in-depth investigation of the types of outcomes assessed is provided in a separate paper.
34. Panagioti 2014,	*“Self-management support interventions to reduce health care utilisation without compromising outcomes: a systematic review and meta-analysis” (34)*
Aim:	What models of self-management support are associated with significant reductions in health services utilisation without compromising outcomes, among patients with long-term conditions?
Population:	Adults (18 years or older) with a long-term condition, defined generically as ‘one that cannot be cured but can be managed through medication and/or therapy.’ This included common physical conditions such as diabetes, asthma, coronary heart disease, and mental health conditions such as depression.
Intervention and comparison:	For the purposes of the review, the authors defined a self management support intervention as: ‘An intervention primarily designed to develop the abilities of patients to undertake management of health conditions through education, training and support to develop patient knowledge, skills or psychological and social resources’. The authors included all studies, which included a significant component of self-management support. After initial screening of a proportion of the studies, they distinguished 2 categories: 1. ‘Self-management’ including provision of materials and support from a health professional or trained peer. We coded the amount of support as in three categories for descriptive purposes: ‘pure’ self-management (no support), ‘supported self-management’ (up to 2 hours of additional support for the total durationof the study) and ‘intensively supported self-management’ (more than 2 hours of additional support). 2. ‘Case management’ (with more than 2 hours of additional support, and including input from a multidisciplinary team). Comparison was usual care alone, or where the self-management support intervention was compared against a more intensive ‘usual care’ intervention (e.g. self-management versus conventional hospital use).
Outcomes:	Core types of health care utilization, outcomes relating to patient quality of life and health outcomes, including standardised measures of disease specific quality of life outcomes, generic quality of life, and depression/anxiety. The authors excluded measures of psychological or clinical variables which did not provide a direct assessment of health or quality of life, such as self-management behaviour, self-efficacy, HbA1C or forced expiratory volume (FEV), as these are likely to be unreliable indicators of health related quality of life.
User involvement:	Yes, in the inclusion criteria both professional-led and peer-led self-management interventions were of interest.
Author’s conclusion:	Self-management support interventions can reduce health service utilization without compromising patient health outcomes, although effects were generally small, and the evidence was strongest in respiratory and cardiovascular disorders. Further work is needed to determine which components of self-management support are most effective.
35. Quinones 2014,	*“Educational group visits for the management of chronic health conditions: A systematic review” (35)*
Aim:	Review the effectiveness of group visits (appointments of multiple patients) on quality of life, function, self-efficacy, utilization, and biophysical outcomes in randomized controlled trials of patients with chronic conditions.
Population:	Adults with chronic conditions.
Intervention and comparison:	Educational group visits for the management of chronic health conditions: The authors defined content delivered as follows: 1) self-management education: in addition to providing disease-specific information to patients, these programs teach patients self-management skills, such as goal-

Information extracted from the included systematic reviews

	setting and contracting, and build skills to reinterpret symptoms. These interventions are often characterized by motivational interviewing and cognitive behavioral therapy techniques; 2) didactic education: content is informational and format is usually lecture-based (e.g., pathophysiology of disease); 3) experiential education: instruction based on demonstrations (e.g., cooking). Comparison was usual care or another intervention.
Outcomes:	Many outcomes such as physical, psychological, functional, symptomatic, social, knowledge, self-efficacy.
User involvement:	Yes, the authors extract the interventions which were peer-led and discuss the findings for those types of interventions. In multiple studies lay persons or peers were part of or led the intervention.
Author's conclusion:	Group visits may improve self-efficacy and glycemic control. There was little consistent evidence of improved quality of life, functional status, or utilization. Practice implications: Group visits represent a reasonable alternative for educating patients with chronic illness, though varied participation/retention suggests they should not be the sole alternative
36.	Ricci-Cabello 2014, *"Characteristics and effectiveness of diabetes self-management educational programs targeted to racial/ethnic minority groups: a systematic review, meta-analysis and meta-regression" (36)*
Aim:	To systematically review the effectiveness of educational programs to promote the self-management of racial/ethnic minority groups with type 2 diabetes, and to identify programs' characteristics associated with greater success.
Population:	Racial/ethnic minority groups with type 2 diabetes. Racial/ethnic minority group was defined as a population group with a race or ethnicity different from that of the majority population group of the host country. Groups at higher risk of diabetes complications were identified based on available literature
Intervention and comparison:	Disease management educational programs. Interventions had to be exclusively educational, without including any other component such as financial incentives, clinician education or case management. Comparison was usual care.
Outcomes:	1) diabetes knowledge, 2) diabetes self-management behavior, and 3) clinical outcomes
User involvement:	Yes, they have reported on the use of peer providers in the descriptions of the interventions.
Author's conclusion:	Diabetes self-management educational programs targeted to racial/ethnic minority groups can produce a positive effect on diabetes knowledge and on self-management behavior, ultimately improving glycemic control. Future programs should take into account the key characteristics identified in this review.
37.	Siantz 2014, *"Chronic disease self-management interventions for adults with serious mental illness: a systematic review of the literature"(37)*
Aim:	To identify and appraise chronic disease self-management studies tested with samples of US adults living with serious mental illness.
Population:	Adults with serious mental illness.
Intervention and comparison:	Chronic disease self management (CDSM) was defined as behavioral interventions that alleviate the consequences of chronic care conditions (CCs) through medical management, maintenance or creation of new meaningful behaviors or life roles and management of emotional reactions to CCCs. CDSM programs systematically facilitate acquisition of lifestyle behaviors that minimize disability resulting from disease and delay the progression of chronic disease. These activities can include monitoring one's health, improving medication adherence, changing the way one carries out expected roles and activities, finding and utilizing resources, or otherwise improving self-efficacy in illness management, including working collaboratively with health care providers. CDSM programs can occur singularly or in combination with other health activities, such as nutrition groups or primary care visits, and often occur in collaboration with peer providers. Comparison was usual care
Outcomes:	Functional, attitudinal (knowledge, empowerment, self-efficacy etc.), behavioral medication adherence, health service use, questions on physical activity etc.), anthropometric (BMI, HbA1c, cholesterol etc.)
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with peer leaders/involvement
Author's conclusion:	Given the high chronic disease burden experienced by individuals with SMI combined with our nations health care reform, emphasis on self-management to improve population health, coupled with advancing the quality of research to evaluate CDSM programs for adults with SMI, is critically needed.
38.	Steinsbekk 2012, *"Group based diabetes self-management education compared to routine treatment for people with type 2 diabetes mellitus. A systematic review with meta-analysis" (38)*
Aim:	To assess effects of group-based DSME compared to routine treatment on clinical, lifestyle and psychosocial outcomes in type-2 diabetes patients.
Population:	Adults diagnosed with type 2 diabetes.

Information extracted from the included systematic reviews	
Intervention and comparison:	Group-based education specific for people with type 2 diabetes. The duration of education had to be at least one session lasting for one hour. Comparison was routine treatment (standard of care recommended).
Outcomes:	The main outcomes were Clinical (metabolic control measured by glycated haemoglobin and fasting blood glucose), Lifestyle (diabetes knowledge and self-management skills) and Psychosocial (quality of life and empowerment/self-efficacy). The secondary outcomes were; Body weight; Body mass index (BMI); Blood pressure (systolic/diastolic); Lipid profile (total cholesterol, HDL cholesterol, LDL cholesterol, triglycerides); Patient treatment satisfaction and Death.
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with lay leaders/people.
Author's conclusion:	Based on current evidence, there are indications that interventions delivered by a single educator, delivered in less than ten months, with more than 12 hours and between 6 and 10 sessions give the best results but more research is needed to confirm this. In general it can be concluded that group-based DSME in people with type 2 diabetes results in improvements in clinical, lifestyle and psychosocial outcomes.
39. Tang 2011, *"A Review of Volunteer-Based Peer Support Interventions in Diabetes" (39)*	
Aim:	To review volunteer-based peer support interventions and examine the implementation strategies and diabetes-related health outcomes associated with them.
Population:	Adults with diabetes
Intervention and comparison:	Self-management rather than prevention that include an explicit training component for peer supporters. Comparison included usual care, waiting list or another intervention or delivery style of intervention. Some studies referred to comparison as 'control group' or was not described.
Outcomes:	Clinical, behavioral, knowledge, and/or psychosocial outcomes
User involvement:	Predefined as a criterion to be included. All included studies have user involvement in the delivery of the intervention, either as sole provider (mostly) of intervention or in combination with a professional. Community workers, peers and patients are the terms used.
Author's conclusion:	No separate conclusion was found in the document. The discussion and conclusions are part of the result presentation.
40. Thorpe 2013, *"Facilitating Healthy Coping in Patients With Diabetes A Systematic Review" (40)*	
Aim:	To summarize recent literature on approaches to supporting healthy coping in diabetes in 2 specific areas: (1) the impact of different approaches to diabetes treatment on healthy coping and (2) the effectiveness of interventions specifically designed to support healthy coping.
Population:	Adults with type 2 Diabetes.
Intervention and comparison:	A variety of healthy coping interventions, including diabetes self-management education, support groups, problem-solving approaches, and coping skills interventions.
Outcomes:	Psychosocial and QOL outcomes.
User involvement:	No detailed information about user involvement. The systematic review is included based on one primary study with lay leader.
Author's conclusion:	Healthy coping in diabetes has received substantial attention in the past 5 years. A variety of approaches show positive results. Research is needed to compare the effectiveness of different approaches in different populations and determine how to overcome barriers to intervention dissemination and implementation.
41. Yehle and Plake 2010, "*Self-efficacy and Educational Interventions in Heart Failure. A Review of the Literature" (41)*	
Aim:	To conduct a systematic review of the literature to evaluate which components of structured educational interventions are associated with improvement in self-efficacy for self-care behaviors in heart failure patients.
Population:	Heart failure patients
Intervention and comparison:	Each of the reviewed studies used an intervention plus education to improve self-efficacy. Comparison was usual care with or without additional intervention (such as written information), a different intervention or a different delivery style of the same intervention. In studies with a comparison group, they included usual care, another intervention, waiting list or just described as 'control group'.
Outcomes:	Knowledge, self-efficacy and self-management behavior were the three main outcomes.
User involvement:	No detailed information about user involvement. The systematic review is included based on primary studies with peer mentors.
Author's conclusion:	Existing evidence suggests that it is not the amount of education (number of sessions/length of sessions) that improves self-efficacy, but some other factor or factors that remain unknown at present. Education delivery costs, flexibility, and the ability to more easily integrate new discoveries need to

Information extracted from the included systematic reviews

	be explored. Interventions that include components specifically geared toward increasing self-efficacy for self-care in patients with heart failure are needed. Learning activities need to be incorporated into patient education programs to provide practice time that may result in behavior changes. The opportunity to practice self-care behaviors within the context of the education provided to those with heart failure, along with ongoing support, needs to be explored in future studies.
42. Zeh 2012, *"The impact of culturally competent diabetes care interventions for improving diabetes-related outcomes in ethnic minority groups: a systematic review" (42)*	
Aim:	To examine the evidence on culturally competent interventions tailored to the needs of people with diabetes from ethnic minority groups.
Population:	People with Diabetes.
Intervention and comparison:	The interventions varied, but they were all defined as culturally competent individual or group based diabetes education. Comparison were usual care or other interventions (all were not described).
Outcomes:	Specific outcomes were not predefined, but the primary studies reported on 22 outcomes including: 12 clinical, five psychosocial, three lifestyle and two healthcare utilization.
User involvement:	No detailed information about user involvement. The systematic review is included based on one primary study with patients as part of the provider team.
Author's conclusion:	Benefits in using culturally competent interventions with ethnic minority groups with diabetes were identified. The majority of interventions described as culturally competent were confirmed as so, when assessed using the culturally competent assessment tool. Further good quality research is required to determine effectiveness and cost-effectiveness of culturally competent interventions to influence diabetes service commissioners.
43. Zwerink 2014, "*Self management for patients with chronic obstructive pulmonary disease" (43)*	
Aim:	1. To evaluate whether self management interventions in COPD lead to improved health outcomes. 2. To evaluate whether self management interventions in COPD lead to reduced healthcare utilisation.
Population:	Patients with a clinical diagnosis of COPD.
Intervention and comparison:	Self management interventions were defined as structured interventions for individuals with COPD aimed at improvement of self health behaviours and self management skills. These interventions required at least an iterative process of interaction between participant and healthcare provider, and ideally also included formulation of goals and provision of feedback. Furthermore, at least two of the following components had to be part of the intervention: smoking cessation, self recognition and self treatment of exacerbations, an exercise or physical activity component, advice about diet, advice about medication or coping with breathlessness. Content could be delivered to study participants verbally, as written material (hardcopy or digital) or via audiovisual media. An action plan was defined as a guideline for participants describing when and how to change medication in case of worsening COPD-related symptoms, indicating (the start of) an exacerbation. Comparison was usual care or an active intervention.
Outcomes:	Primary outcomes: 1. Health-related quality of life (HRQoL) scores, 2. Number of hospital admissions. Secondary outcomes: 1. Hospitalisation days, 2. Number of exacerbations requiring emergency department visits, 3. Use of (other) healthcare facilities, 4. Number of exacerbations requiring a course of oral corticosteroids or antibiotics, 5. Use of rescue medication, 6. Symptom scores, 7. Anxiety and depression, 8. Self efficacy, 9. Days lost from work, 10. Lung function, 11. Exercise capacity.
User involvement:	No detailed information about user involvement. The systematic review is included based on one primary study with peer leader.
Author's conclusion:	Self management interventions in patients with COPD are associated with improved health-related quality of life as measured by the SGRQ, a reduction in respiratory-related and all cause hospital admissions, and improvement in dyspnoea as measured by the (m)MRC. No statistically significant differences were found in other outcome parameters. However, heterogeneity among interventions, study populations, follow-up time and outcome measures makes it difficult to formulate clear recommendations regarding the most effective form and content of self management in COPD.

Informasjon innhentet fra de nordiske primærstudiene

Information extracted from the included systematic reviews	
1. Fagermoen 2014, *"Personer med sykelig overvekt hadde økt mestringsforventning og selvfølelse etter pasientkurs"*	
Aim:	Undersøke endringer i mestringsforventning og selvfølelse hos kursdeltakerne ett år etter fullført kurs.
Population:	
Method:	Spørreskjema ble i 2009 delt ut til deltakere på kurs for sykelig overvektige ved tre Lærings- og mestringssentre i Øst-Norge. Deltakerne besvarte 12 ulike skjemaer på fem ulike tidspunkter. Denne artikkelen presenterer resultater fra spørreskjema om mestringsforventning og selvfølelse. Skjemaene ble fylt ut på kursets første dag og 12 måneder etter kursslutt.
Intervention and comparison:	Startkurset består av 40 timer, det er gruppebasert med gjennomsnittlig 20 deltakere og gjennomføres over om lag tre måneder. På kurset samarbeider helsepersonell og erfarne brukere i å formidle sentral fagkunnskap og erfaringer. Deltakerne får informasjon om de ulike behandlingsmetodene ved sykelig overvekt for å kunne ta et informert behandlingsvalg. Kurset fokuserer på livsstilsendring med disse hovedtemaene: endring av vaner; fysisk aktivitet/ hverdagsaktivitet; ernæring og kosthold; kropp, tanker og følelser. Brukermedvirkning, bevisstgjøring og egenrefleksjon vektlegges gjennomgående i kurset. Målet er at det som formidles er hverdagsnært og relevant for deltakerne. Det innebærer at dialog med deltakerne og erfaringsutveksling er sentralt i og etter forelesningene. Erfarne brukere og tidligere kursdeltakere, formidler sine erfaringer om både motgang og suksesshistorier i egen livsstilsendring og opplevde konsekvenser av overvektbehandling. Disse bidragene synes å øke åpenhet om vanskelige og til dels tabubelagte temaer. Kursdeltakerne er på ulike stadier i sin endringsprosess og en individuell tilnærming er derfor også nødvendig. Gruppeveilederne som har helsefaglig høyskoleutdanning, ofte også tilleggsutdanning, bistår i å klarlegge hvor i prosessen kursdeltakerne er og hva som må til for å komme videre. Hver deltaker avklarer sine realistiske og konkrete mål i en skriftlig handlingsplan og denne evalueres jevnlig. Dette bidrar til å utvikle den enkeltes eierskap til endringsprosessen. Arbeid med å bevisstgjøre hva som kan sabotere gjennomføring av endringer og håndtering av tilbakefall foregår gjennom hele kurset. Bruk av ulike refleksjonsverktøy og strukturert veiledning gir deltakerne hjelp til å bli bevisste på hvordan tanker og følelser kan påvirke handlinger. Flere deltakere sier at de spiser for å dempe stress, derfor legges også til rette for stressmestring gjennom oppmerksomhetstrening. Anerkjennelse av deltakernes følelser og perspektiver uten å fordømme, kritisere eller skape skyldfølelse er grunnleggende for endringsprosesser. Gruppeveilederne fokuserer på løsninger og deltakernes ressurser, hva deltakerne ønsker å gjøre og hva de lykkes med. Samtidig utfordres deltakerne med spørsmål som fremmer refleksjon over alternative strategier, løsninger og handlinger. Ved å stille de viktige spørsmålene i stedet for å komme med de «riktige» svarene og løsningene, kan deltakerne få hjelp til å reflektere over egne tanker, følelser og atferd i ulike stadier av endringsprosessen. Dette er en vesentlig forutsetning for å ta kontroll over eget liv og endre atferd. Tilnærming og prosesser som kjennetegner Startkurset slik det er beskrevet ovenfor, betegner vi som selvstyrkende metoder. Det gruppebaserte tilbudet gir også et fellesskap med andre i samme situasjon, noe som oppleves positivt, og når oppmerksomhet på kropp og overvekten nedtones kan egenverdet styrkes. Sammenlikning (comparison): denne studien hadde et "within-subject design" med målinger før- og etter tiltaket ble gitt, på samme populasjon.
Outcomes:	Mestringsforventning og selvfølelse.
User involvement:	Brukermedvirkning, bevisstgjøring og egenrefleksjon vektlegges gjennomgående i kurset. Målet er at det som formidles er hverdagsnært og relevant for deltakerne. Det innebærer at dialog med deltakerne og erfaringsutveksling er sentralt i og etter forelesningene. Erfarne brukere og tidligere kursdeltakere, formidler sine erfaringer om både motgang og suksesshistorier i egen livsstilsendring og opplevde konsekvenser av overvektbehandling. Disse bidragene synes å øke åpenhet om vanskelige og til dels tabubelagte temaer.
Author's conclusion:	Kurs som vektlegger at deltakerne får grunnleggende kunnskap om sin sykdomssituasjon og lærer selvstyrkende metoder kan bidra til bedre mestringsforventning og selvfølelse. Resultatene samsvarer med internasjonal forskning knyttet til egenmestring.
2. Mehlsen 2015, *"A prospective evaluation of the chronic pain self-management programme in a danish population of chronic pain patients"*	
Aim:	This study evaluates the feasibility and changes in pain, pain cognition, and distress during a patient education course and a 5-month follow-up period. The Chronic Pain Self-Management Programme (CPSMP) is a lay-led patient education consisting of six manualized sessions.
Population:	Participants were eligible if they were 18 years or older, spoke Danish, had pain lasting more than 3 months, rated their pain intensity >5 on a 10-point scale.

Information extracted from the included systematic reviews

Method:	A Danish adaptation of the CPSMP was tested in four municipalities. The sample consisted of 74 women and 13 men between 26 and 80 years with a long pain history (+10 years). Participants completed questionnaires before the CPSMP, immediately after and 5 months after the program.
Intervention and comparison:	The CPSMP consisted of six 2.5 h weekly workshops focusing on how to manage pain in daily life. Two trained workshop leaders facilitated the workshops in groups of 8–16 chronic pain patients. At least one of the workshop leaders suffered from a long term pain condition. No comparison group. The study had a within-subject design' with pre-post intervention measures by use of a questionnaire.
Outcomes:	Outcomes reported were pain, physical disability, pain catastrophizing, symptoms of depression and anxiety, illness worry and physical symptoms.
User involvement:	No detailed information or discussion about user involvement. However, based on the description of the intervention (CPSMP), user involvement is a prerequisite. One of two providers (leaders) had to suffer from a long term pain condition. What type of user involvement this was (i.e. involved in planning, implementation and evaluation) is not described.
Author's conclusion:	A consistent pattern of stable improvements in pain, pain cognition and distress was observed but the scope of changes was modest. Practice implications: The Danish version of the CPSMP is feasible.