Quality assurance

Review: questionnaire feedback to clinicians improves recognition of psychiatric disorders in high risk patients but not in all patients in non-psychiatric settings


QUESTION: Does feedback of results of routinely administered patient psychiatric questionnaires to clinicians improve the recognition, management, and outcomes of psychiatric disorders in non-psychiatric settings?

Data sources
Studies were identified by searching Medline (1966–2000), EMBASE/Excerpta Medica (1981–2000), CINAHL (1982–2000), PsycLIT (to 2000), and the Cochrane Controlled Trials Register (to 2000); hand-searching key journals; and reviewing bibliographies of retrieved papers.

Study selection
Randomised controlled trials were selected if patients were treated in non-psychiatric settings, the intervention involved the use of a standardised measure to screen for psychiatric symptoms in routine care and clinicians received feedback results, and the control condition involved routine care where clinicians did not receive feedback.

Data extraction
Data were extracted on study quality and outcomes. Main outcomes were recognition of, treatment or referral for, and outcomes of psychiatric disorders. Study quality was assessed using the Jadad and Campbell criteria.

Main results
9 studies met the selection criteria: 6 were in primary care and 3 were in general medical outpatient settings. Studies randomised either all patients regardless of their score (unselected) or only those with a probable psychiatric disorder (high risk). Pooled results of 2 studies (n = 2261) showed that recognition of psychiatric disorder in unselected patients did not improve with questionnaire feedback (table). Pooled results of 2 studies (n = 196) showed that recognition of psychiatric disorder in high risk patients improved if clinicians received feedback alone, but not in unselected patients. Feedback has no effect on initiation of treatment or long term psychiatric outcomes.

Conclusions
In non-psychiatric settings, clinicians who receive feedback from routinely administered, patient psychiatric questionnaires have improved recognition of psychiatric disorders in high risk patients but not in unselected patients. Feedback has no effect on initiation of treatment or long term psychiatric outcomes.

Table
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Population</th>
<th>Feedback v control</th>
<th>RBR (95% CI)</th>
<th>NNT (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition</td>
<td>Unselected</td>
<td>25.7% v 26.9%</td>
<td>6% (-8 to 18)</td>
<td>Not significant</td>
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<tr>
<td>High risk</td>
<td></td>
<td>43.5% v 16.3%</td>
<td>168% (64 to 337)</td>
<td>4 (3 to 7)</td>
</tr>
</tbody>
</table>

*Abbreviations defined in glossary; RBR, RBI, NNT, and CI calculated from data in article. Meta-analyses were done using a random effects model.

COMMENTARY
This systematic review by Gilbody et al documents no effect of providing clinicians with the results of routinely administered questionnaires for depression and anxiety among unselected patients in psychiatric settings, such as primary care or hospital outpatient clinics. However, there appears to be a clinical effect of feedback alone in improving the recognition of psychiatric disorders among high risk patients in non-psychiatric settings. As Gilbody et al have discussed, more complex strategies in which feedback is accompanied by increased resources (eg, an outside referral agency that administers and scores the questionnaire) and educational interventions can result in improved outcome for depression.

The results are applicable to nurses who practice in non-psychiatric settings in the community or in general hospitals. The findings support the renewed emphasis on mental health practice by generalist nurses. Mental health care in primary healthcare settings is a practice that is unemphasised by nurses and other clinicians, yet is a main contributor to expenditures for resources consumed by those with chronic physical illnesses. Evidence shows that investing in additional resources for psychosocial care in outpatient clinics for physical illness, and in primary care is both more effective and less expensive. Psychosexual care pays for itself with reductions in the use of other insured resources.

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