

# Coverage of mental health and substance misuse topics in the Cochrane review system

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**Aims.** To assess the breadth of mental and substance coverage in the Cochrane review system.

**Methods.** All mental health and substance entries were identified from the 2005 to April 2012 Cochrane Database of Systematic Reviews.

**Results.** A total of 1019 entries focused on mental health or substance misuse, with 698 (68.5%) being completed reviews. One out of every five entries focused on serious mental illness/psychosis. Systematic reviews addressing unipolar depression, dementia and certain substance disorders also appeared well-represented. In contrast, a number of impairing disorders frequently seen in practice received less attention, with bipolar disorder, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and autism spectrum disorders each accounting for less than 2% of the entries. The majority of interventions reviewed involved medication (57.1%), although this was not the case for a number of childhood-onset disorders. Some diagnostic areas (sleep, anxiety, mood and substance) were addressed by multiple Cochrane review groups (CRGs).

**Conclusions.** The Cochrane Collaboration is well poised to be a strong guiding influence to those seeking to employ evidence-based mental health care. Broadening its diagnostic coverage and diversifying types of intervention reviewed would probably further maximize its impact. A more centralized and directed approach of prioritizing topics could help ensure more comprehensive coverage.

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Evidence-based practice (EBP) is rapidly becoming the required standard for practicing mental health clinicians, with training, credentialing and funding increasingly being linked to its use (Tanenbaum, 2005; Magnabosco, 2006; Isett *et al.* 2008; Raghavan *et al.* 2008; Cooper & Aratani, 2009; Slomski, 2012). Hence, it behooves the mental health field to examine how clinicians are to obtain the accurate, up-to-date knowledge of effectiveness research they are being asked to incorporate into their treatment decisions.

Practitioners have repeatedly reported that the time and methodological expertise required to keep abreast of the latest journal articles is prohibitive given their daily clinical demands (Armstrong *et al.* 2007; Forsner *et al.* 2010; Hannes *et al.* 2010; Gallo & Barlow, 2012). Instead, they have come to rely increasingly on systematic reviews and evidence-based treatment guidelines generated from such reviews to gather the best available evidence and to distill it into useful

recommendations for them (APA Council of Representatives, 2005; Littell, 2008; Ahmad *et al.* 2010). In recent years, a plethora of systematic reviews, guidelines and evidence-based treatment lists have arisen (APA Task Force on Evidence-Based Practice for Children and Adolescents, 2008; Stiles *et al.* 2009). Yet, clinicians have voiced doubts both about the credibility of such sources and their applicability to the types of cases seen in daily practice (Pagoto *et al.* 2007; Nelson & Steele, 2008; Forsner *et al.* 2010; Hannes *et al.* 2010). Studies indicating significant differences in treatment recommendations among evidence-based guidelines (Gaebel *et al.* 2005; Forbes *et al.* 2010; Vasse *et al.* 2012), as well as indications of publication bias (Thase, 2008; Matthew & Charney, 2009), may have contributed to such perceptions.

The mental health field would benefit from having a definitive evidence-based review source, respected for its objectivity and methodological rigour, which can be either accessed directly by practitioners or used as a source of guideline development (Barbui & Tansella, 2011). The Cochrane Systematic Review System, with over 5000 healthcare reviews (Cochrane Library, 2012), rises as the premier candidate for such a post. Cochrane reviews have been found to be more

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methodologically rigorous than other systematic reviews (Jørgensen *et al.* 2006; Moseley *et al.* 2009) and are seen as highly credible by health care providers (Rosenbaum *et al.* 2008).

Currently, the Cochrane Collaboration is composed of 53 relatively autonomous review groups (CRGs), six of which directly focus on mental health or substance misuse (depression, anxiety and neurosis; schizophrenia; developmental, psychosocial and learning problems; dementia and cognitive impairment; drugs and alcohol; and tobacco addiction). As Cochrane reviews are authored by volunteers, author interest and a CRG's agenda historically have factored heavily in determining which topics will be prioritized for review, although the prioritization process differs by CRG (Grimshaw, 2004; Nasser *et al.* 2012). Some have questioned if such a process yields adequate coverage of topics important for other stakeholders (i.e., practitioners, patients, policy makers, etc.) (Ahmad *et al.* 2010; Gill *et al.* 2011). This study will examine the Cochrane Collaboration's mental health and substance misuse entries to explore its breadth of coverage in these areas.

## Methods

Two methods were used to extract mental health and substance related entries from the 2005 to April 2012 Cochrane Systemic Reviews Database. First, all the entries for each CRG were assessed as to whether or not they related to a mental health or substance misuse topic based on the entry's title. Second, the database was searched for 196 mental health and substance related keywords (e.g. mood, anxiety, dyslexia, delinquency, amphetamines, etc.) to locate any additional relevant entries. In cases where the title was ambiguous, an examination of the entry's objectives, type of participants and types of intervention sections was employed to classify the entry. A total of 1019 mental health and substance misuse entries were obtained through these two methods.

Each entry was characterized as to its current status (protocol or review) and the CRG from which it originated. Entries were also coded as to diagnostic topic area and type of intervention. The diagnostic topic was coded primarily based on the entry's title, but in cases where the title was ambiguous, examination of the entry's type of population and types of intervention sections was used for clarification. The 64 diagnostic topic areas (see Table 1) are based on categories in the DSM-IV-TR (American Psychiatric Association, 2000). With respect to type, interventions were characterized as involving medication (e.g. psychopharmacological drugs, Chinese herbal medicines, St John's Wart, etc.), psychotherapy/counselling (e.g. cognitive

behavioural therapy, family therapy, support groups, etc.), other (e.g. acupuncture, exercise, occupational therapy, electro-convulsive therapy (ECT), etc.) and the different combinations of these three categories.

## Results

### Topic coverage

A total of 1019 entries focused on mental health or substance misuse. One out of every five entries (20.0%) focused on serious mental illness/psychosis (see Table 1). Substance misuse represented the next most common diagnostic topic, representing 16.5% of all entries. However, coverage within substance was uneven with over a third ( $n=61$ ) of all the substance entries dedicated to smoking, twice the number focused on alcohol or opiates. Cognitive impairment was the third most popular topic, with one of out every eight (12.6%) entries addressing cognitive impairments. The majority of these were dementia interventions.

Nearly 12% (11.6%) of the entries targeted mood disorders. Relatively few of the mood entries, however, concentrated specifically on bipolar disorder ( $n=18$ ). The number of anxiety disorder entries was less than half of those seen for mood disorders (5.5%), with a quarter of all anxiety reviews/protocols ( $n=14$ ) addressing anxiety disorders within the context of a medical situation (e.g. dental anxiety, preoperative anxiety, etc.). No other diagnostic group exceeded 5% of the sample.

Of particular note, entries focused on dually diagnosed or comorbid populations represented only 4.6% of the sample, which is significantly less than their percentage in typical clinical practice (Kessler *et al.* 2010; Einfeld *et al.* 2011). Somatic disorders also composed 4.6% of the sample, however, it is worth noting that relatively few entries in this category ( $n=7$ ) reflected traditional DSM-IV-TR somatoform disorders, with the majority of this group instead being composed of disorders whose classification as somatoform is controversial (e.g. chronic fatigue, fibromyalgia, etc.) (Brown, 2007). A number of disorders with onsets in infancy, childhood and adolescence were more sparsely represented in the Cochrane database. Autism spectrum, attention deficit hyperactivity disorder (ADHD), tic disorders, enuresis/encopresis, externalizing disorders, child maltreatment, intellectual/learning disabilities, speech disorders and developmental motor delays combined represented only 10% (10.4%) of the mental health and substance misuse sample.

### Types of intervention

On average 57.3% of the entries for mental health and substance misuse focused, all or in part, on

**Table 1.** Frequency of diagnostic groups by protocol and type of intervention (n = 1019) Diagnostic topic

	n	Sample (%)	Protocols (%)	Medication intervention (%)
<b>Severe mental illness/psychosis</b>	204	20.0	26.0	70.6
Severe mental illness/psychosis	185			
Severe mental illness/psychosis in medical context	3			
Side effects if antipsychotic medication	16			
<b>Substance disorders</b>	168	16.5	25.4	53.3
Smoking/tobacco	60			
Alcohol	31			
Opiates	27			
Cocaine	10			
Other illicit drugs	19			
Unspecified or combined alcohol + drug	10			
Substance misuse in medical context	11			
<b>Cognitive impairments</b>	128	12.6	25.8	73.4
Dementia/amnesic disorder/mild cognitive impairment	119			
Delirium	9			
<b>Mood disorders</b>	118	11.6	32.2	63.6
Depression/dysthymia	71			
Bipolar	18			
Depression + bipolar	4			
Postpartum depression	12			
Depression in medical context (excepting postpartum)	13			
<b>Anxiety disorders</b>	56	5.5	32.1	51.8
GAD, panic, agoraphobia, social phobia and specific phobia	11			
PTSD/acute stress/trauma	11			
OCD	6			
Mixed anxiety disorders	9			
Unspecified anxiety	5			
Anxiety in medical context	14			
<b>Somatic disorders</b>	47	4.6	38.3	59.6
Conversion disorder	2			
Hypochondriasis	1			
Body dysmorphic disorder	1			
Undifferentiated somatoform disorders/medically unexplained symptoms	3			
Chronic fatigue syndrome	5			
Fibromyalgia	15			
Irritable bowel/functional dyspepsia/recurrent abdominal pain in childhood	20			
<b>Comorbid conditions</b>	47	4.6	29.8	68.1
Psychiatric + intellectual/learning Disability	11			
Psychiatric + substance	8			
≥2 psychiatric diagnoses (excluding the prior 2 categories)	28			
<b>Sleep disorders</b>	45	4.4	44.4	55.6
Breathing-related sleep disorder	12			
Circadian rhythm disorder	5			
Primary insomnia	3			
Narcolepsy	2			
Restless Legs Syndrome	8			
Unspecified sleep disorder	5			
Sleep disorder in medical context	10			
<b>General emotional/adjustment disorder</b>	41	4.0	36.6	0
<b>Sexual disorders</b>	20	2.0	40.0	75.0
Sexual dysfunction	8			

Continued

Table 1. Continued

	<i>n</i>	Sample (%)	Protocols (%)	Medication intervention (%)
Sexual offenders	4			
Sexual disorders in medical context	8			
<b>Intellectual and learning disabilities</b>	18	1.8	33.3	27.8
Intellectual disability	14			
Learning disability	4			
<b>Autism spectrum disorder</b>	17	1.7	41.2	47.1
<b>Personality disorders</b>	16	1.6	75.0	56.3
<b>Speech/motor delays</b>	16	1.6	31.3	12.5
Speech/language disorders	9			
Speech/language disorder in medical context	5			
Developmental coordination disorder/motor delay	2			
Externalizing disorders (ODD, CD, DBD, aggression and delinquency)	16	1.6	37.5	12.5
Maltreatment/domestic violence	15	1.5	53.5	0
Domestic violence	6			
Maltreatment against youth	9			
ADHD	13	1.3	46.2	53.8
<b>Elimination disorders in youth (enuresis/encopresis)*</b>	12	1.2	8.3	50.0
<b>Eating disorders</b>	9	0.9	11.1	44.4
Anorexia nervosa	4			
Bulimia nervosa	3			
Mixed eating disorders	2			
<b>Tic disorders</b>	5	0.5	60.0	80.0
<b>Impulse control disorders</b>	4	0.4	75.0	75.0
Pathological gambling	3			
Trichotillomania	1			
Suicide/deliberate self-injury	4	0.4	75.0	50.0

\*Only elimination disorders affecting youth were included in this study.

interventions involving medication; in contrast, less than a third (29.3%) of mental health and substance misuse entries were about psychotherapy, counselling or other non-medication interventions. The greater emphasis on pharmacological interventions may reflect the Cochrane Collaboration's preference for using randomized clinical trials when conducting systematic reviews (Higgins & Green, 2011). Interestingly, medication interventions were significantly less prevalent (32.1%) in disorders known for childhood-onset (autism spectrum, ADHD, externalizing disorders, child maltreatment, intellectual/learning disabilities, speech and developmental motor delays) than in other disorders (60.2%) ( $\chi^2$  (3,  $N = 1019$ ) = 30.80,  $p < 0.001$ ,  $\Phi = 0.174$ ).

#### Protocols v. reviews

Of the 1019 mental health and substance misuse entries, 698 (68.5%) were reviews and 321 (31.5%) were protocols. In the Cochrane Collaboration a

protocol on a topic is first published and then converted into a full systematic review within 2 years (Higgins & Green, 2011), although concerns have been raised about the ability of the Cochrane Collaboration to adhere to this timeline (French *et al.* 2005; Bow *et al.* 2010). The review, not the protocol, has the potential to provide clinicians with treatment recommendations. Protocols composed the majority ( $\geq 75\%$ ) of the entries in the suicide/self-injury, impulse control disorders and personality disorder areas, indicating that despite the number of entries as yet relatively little treatment guidance is being provided on these topics to those making health care decisions.

#### Cochrane review groups

Diagnostic groups also differed in terms of the number of CRGs involved in producing protocols/reviews. Eating disorders, impulse control disorders, autism spectrum, ADHD, personality disorders, tic disorders and general emotional/adjustment disorders had all

their entries arise from a single CRG. At the other end of the spectrum, protocols and reviews concerning sleep disorders were spread across 14 different CRGs, with anxiety, mood and substance dispersed among 9 to 11 CRGs each. Although the Cochrane system dedicates resources to CRG integration (Cochrane Collaboration, 2012), such an arrangement increases the odds of duplication of effort such as in 2007 when two separate systematic reviews were published entitled 'Psychosocial and psychological interventions for treatment of postpartum depression' (from the depression, anxiety and neurosis group) and 'Psychosocial and psychological interventions for treating antenatal depression' (from the pregnancy and childbirth group). In addition to the issue of duplication of effort, there can be difficulty in providing comprehensive guidance for clinicians when the responsibility for the issue is distributed in such a fragmented manner.

## Discussion

EBP requires clinicians to understand the current research on treatment efficacy (Tanenbaum, 2005; Magnabosco, 2006; Isett *et al.* 2008; Raghavan *et al.* 2008; Cooper & Aratani, 2009; Slomski, 2012). Many clinicians obtain that knowledge, directly or through guidelines, from conclusions and recommendations derived from systematic reviews (APA Council of Representatives, 2005; Littell, 2008; Ahmad *et al.* 2010). However, clinicians have expressed doubts about both the applicability and credibility of such sources, perhaps fostered by guidelines purporting to represent the same research base but yet espousing contradictory treatment recommendations (Gaebel *et al.* 2005; Pagoto *et al.* 2007; Nelson & Steele, 2008; Forbes *et al.* 2010; Forsner *et al.* 2010; Hannes *et al.* 2010; Vasse *et al.* 2012). Having a single systematic review source with an unquestionably high level of credibility may be beneficial to the mental health and substance misuse fields. The Cochrane Collaboration possesses the credibility to legitimately become that definitive review source (Rosenbaum *et al.* 2008); however, it is unclear if its mental health and substance abuse coverage is sufficiently broad enough for it to be used as such.

Examination for all mental health and substance related entries in the 2005 to April 2012 Cochrane database revealed a large number of such entries ( $N = 1019$ ). The majority (60.6%) of the mental health and substance misuse entries were in the areas of serious mental illness, substance (primarily smoking, alcohol and opiates), mood disorders and cognitive impairments (particularly dementia). The daily and

economic burdens posed by these diagnoses are unquestionably high (World Health Organization, 2008; Luengo-Fernandez *et al.* 2010); yet other psychiatric disorders with less coverage are as frequent and have been found to have comparable levels of burden (Kessler *et al.* 2010; Alonso *et al.* 2011; Wittchen *et al.* 2011). Coverage was noticeably thinner with comorbid conditions and various disorders whose onset typically is in infancy, childhood or adolescence. The fact that some areas (personality disorders, suicide/self-injury and impulse control disorders) are dominated by protocols, *v.* reviews, may give the illusion that there is greater guidance available in that area than is actually present at the moment, although that situation should be largely addressed through the passage of time as protocols are converted to reviews.

It is to be noted that the majority of Cochrane entries focused on interventions involving medication (57.3%), although this rate is significantly lower for a group of disorders characterized by a youth-onset. Approximately half as many entries were directed towards psychotherapy, counselling or other types of non-medication intervention as compared with interventions involving medication. The strong focus towards medication interventions may make the Cochrane Collaboration somewhat less useful for mental health providers without prescription privileges.

Last, the coverage of certain diagnostic areas was spread across a large number of CRGs. For the Cochrane system to be truly useful to practicing clinicians it must thoughtfully allocate its resources so as to provide maximum coverage to topics most likely to be faced in clinical practice, neither duplicating efforts nor leaving important areas uncovered. This may be a difficult goal to achieve if coverage for a topic is distributed across a large number of CRGs.

These findings point to the importance of prioritization of review topics. Historically, the Cochrane Collaboration has embraced a 'bottom-up' structure, where the author and CRG interest primarily set review priorities (Nasser *et al.* 2012). Hence, the amount of coverage that has been devoted to a given topic could reflect a variety of factors, ranging from author interest level to the breadth of a given CRG's topic list to editorial openness towards inclusion of non-randomized studies or the publication of empty reviews (which do not have any studies meeting inclusion criteria) (Yaffe *et al.* 2012).

Yet, given its rapid growth, current size and growing role, such a guiding framework may no longer be the best fit. Consistent with this, the Cochrane Collaboration has been urged to establish a transparent system for prioritizing reviews to better meet the needs of its users (Purgato *et al.* 2011; Nasser *et al.* 2012). The Cochrane Collaboration recently identified establishing

a priority setting system as a strategic recommendation for the organization (MacLehose *et al.* 2012). In 2008, it began funding several pilot prioritization projects (i.e., using practice guidelines to determine review priorities, patient-professional partnerships such as the James Lind Alliance, prioritizing know-do gaps in low and middle income countries, etc.) (Cochrane Agenda and Priority Setting Methods Group, 2012). These and other projects have yielded data on various priority setting systems (Purgato *et al.* 2011; Wale *et al.* 2011; Handoll *et al.* 2012), but as yet there is no uniformity among the CRGs in terms of whether they engage in prioritizing review topics and, if so, the method used (Nasser *et al.* 2012). The challenges in implementing a 'top-down' priority system in a system where the reviews are completed by volunteer researchers are considerable (e.g. eliciting interest, ensuring expertise in the priority topic, etc). Maximizing author incentives (Tovey, 2010) will be important in order to effect such an organizational change.

Several limitations are important to note with regard to these findings. Classification of an entry as mental health or substance misuse, as well as classification of type of intervention, was done primarily by the information given in each entry's title. When classification was unclear based on title the appropriate section of the protocol or review was accessed to obtain clarity; however, it is possible that seemingly clear titles may not have accurately conveyed the essence of the entry resulting in misclassifications. In addition, typically a limited number of entries (>5%) are subsequently withdrawn from the Cochrane database. As information regarding withdrawal status was not factored in, it is possible that the number of mental health and substance misuse studies in the sample is a slight over-estimate of the true number of non-withdrawn entries. Last, for systematic reviews to be truly useful to practicing clinicians they must also be accessible, reflective of the current literature, provide definitive guidance with regard to treatment options providers can use and match the populations clinicians typically see (El Dib *et al.* 2007; Moher *et al.* 2007; Rosen & Noach, 2010; Tricco *et al.* 2011; Armstrong *et al.* 2012; Yaffe *et al.* 2012). The current study only examines whether the diagnostic topic areas were addressed as an entry in the Cochrane database, not whether it does or does not meet these other criteria that would assist in making it optimally useful to practicing clinicians.

## Conclusions

Although the Cochrane Systemic Review system is clearly growing in its mental health and substance

misuse coverage, as yet its most comprehensive guidance is found for medication interventions for several prevalent disorders with high burden profiles (serious mental illness/psychosis, substance, dementia and depression). Although information is available regarding other diagnoses and therapeutic interventions, it is unevenly distributed and more limited. Use of a more centralized, directed approach to broaden its diagnostic coverage and diversify types of interventions reviewed would increase Cochrane's relevance for those seeking evidence-based guidance when providing mental health and substance misuse services.

## Declaration of interest

No competing interests exist. No economic support was received.

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