CRD summary
This review found no evidence that healthcare utilisation by frequent attenders can be influenced. Treatment of (not yet diagnosed) major depressive disorders might improve the symptoms and quality of life of depressed frequent attenders, but will not reduce their consultation rate within one year of follow-up. Possible bias and a paucity of evidence suggests these conclusions may not be reliable.

Authors' objectives
To investigate the effectiveness of interventions to influence mobility, quality of life and healthcare utilisation of frequently attending patients in primary care.

Searching
MEDLINE, EMBASE and PyscINFO were searched from 1980 to November 2006 for studies in English, French, Dutch or German. Search terms were reported. References were checked for additional studies.

Study selection
Randomised controlled trials (RCTs) that described interventions in frequent attenders older than 14 years in primary care (defined as all first points of consultation sites, non in-hospital care) were eligible for inclusion. All possible frequent attender definitions were included, including definitions based on specific subgroups of primary care patients.

The included studies were performed in primary care clinics, primary healthcare for students and at a primary care out of hours service. The age range of frequent attenders varied from 18 to 75 years where reported. Definitions for frequent attenders varied. Included interventions were: depression management programmes; a psychiatric consultation-liaison programme; an educational programme; and a combination of intervention strategies. Outcomes measured included depression-free days, costs, Hamilton Depression Rating Scale score, use of antidepressant medication, rate of anxiety/depression, use of healthcare, SF-20 and number of contacts.

Data extraction
A brief summary of the results as reported by the included studies was extracted. How many reviewers extracted these data was not reported.

Methods of synthesis
The studies were synthesised narratively and individual study details were presented in a table.

Results of the review
Five RCTs were included, two of which referred to the same research programme (n=8,897, range 104 to 8,135). None of the RCTs sufficiently blinded patient and care provider. Three RCTs did not include intention-to-treat analysis. One RCT did not describe whether outcome assessors were blinded. All RCTs referred to various subgroups of frequent attenders. Follow-up was either one year after randomisation or one year after the intervention.

Three RCTs of psychiatric interventions investigated undiagnosed psychiatric morbidity of frequent attenders. Two
reports (which appeared to be from the same RCT) reported more depression-free days and a better quality of life after treating a major depressive disorder. However, more contacts, more prescriptions for anti-depressants and more costs were reported. For every structured clinical interview for DSM-IV, 2.6 depression-free days were achieved. One RCT reported no effect on morbidity and greater prescription of antidepressants.

Two RCTs of interventions focused on reducing frequent attendance reported that the interventions did not lower attendance.

**Authors' conclusions**

There was no evidence that it was possible to influence healthcare utilisation by frequent attenders. Treatment of (not yet diagnosed) major depressive disorders might improve the symptoms and quality of life of depressed frequent attenders, but will not reduce their consultation rate within one year of follow-up.

**CRD commentary**

The research question was defined in terms of participants, intervention and study design, but there were no criteria for outcomes. Relevant databases were searched for studies in four languages, but as no attempt to identify unpublished data was reported publication and language bias were possible. Study selection and validity assessment were performed in duplicate, which reduced risks of error and bias; it was unclear whether similar steps were taken during data extraction. Study quality was assessed using appropriate criteria and taken into consideration. Narrative synthesis appeared appropriate given the heterogeneity between studies. However, the two studies from which the main conclusions were derived were from the same research programme and there was some contradictory evidence from another study.

The possibility of bias suggests the authors' conclusions may not be reliable.

**Implications of the review for practice and research**

**Practice:** The authors did not state any implications for practice.

**Research:** The authors stated that frequent attenders should be defined as the top 10% of all enlisted patients.

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