Reviewer's report

Title: The rise of assertive community interventions in South Africa: Assessing the impact of a modified assertive intervention on readmission rates; a three year follow-up

Version: 3

Date: 15 November 2013

Reviewer: Hans Kroon

Reviewer's report:

This is a small-scale study with a long follow-up of a case management intervention inspired by the ACT model. Studies of outreach outside of the USA and UK are particularly relevant, since UK studies cast doubts about its effectiveness as found in the USA. In this study ACT was adapted to the local under-resourced situation, and these modifications are so substantial that this study cannot be seen as an evaluation of ACT.

The introduction accurately describes the state of the art. I have several questions and comments about the study itself.

Major Compulsory Revisions

1) Please use the CONSORT flow diagram in Flowchart I. I am not sure which patients are analyzed and excluded from analysis. At 12 month follow-up members of the control group could change to the assertive intervention and two did. At that point an intention to treat analysis was no longer possible, but in their analysis the authors should try to approach such an analysis more closely. I can understand that the two patients that were transferred to ACT are excluded from the control group, but they should not be analyzed as if they were randomized to the assertive intervention. The two patients who were discharged and the four who were referred to long term wards should remain in the analysis. This will probably lead to more days in hospital in the ACT condition, but provides a more accurate description of the success of this modified ACT.

2) The DACTS (please add an “S” to the abbreviation) score suggests that the team deviates substantially from the assertive community team model. Some details are given (higher case load and lower contact frequency), what are other main modifications (or shortcomings)? The fact that the team tried to use existing resources instead of direct provision of services should be described as a deviation from the ACT model.

3) I miss details about the care as usual. If possible add a table in which the two types of services are compared on key issues (especially service intensity/frequency of contact, outreach, team organization and composition).

Minor Essential Revisions

4) Please describe the method and procedure of randomization. Explain why the
groups do not have (approximately) equal sizes.

5) Three inclusion criteria (presenting for admission, schizophrenia/schizo-affective disorder, informed consent) are described. Were the "high frequency criteria" also applied? What are they?

6) Initially 34 patients were randomized, 5 were excluded afterwards, and 2 added. This makes 31 and not 32 patients. Please explain.

7) “Follow-up data was collected from subject files and directly from subjects where files did not provide sufficient information.” How do the authors know that the files were complete or not?

8) The discussion states that measurement of psychopathology points to an actual reduction of the need for admission in the ACT group. However, these measurements are not described in the results section. Please clarify.

9) Limitations of the study should be described in the discussion (for instance low power, no intention to treat analysis).

10) The conclusion states that the intervention is cost-effective. This term should be avoided since no cost data are provided.

Discretionary Revisions

11) The median age is rather low. I assume that both patients with a first episode of psychosis and severely mentally ill with a long treatment history were included?

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: Yes, but I do not feel adequately qualified to assess the statistics.

Declaration of competing interests:

I declare that I have no competing interests