Author's response to reviews

Title: Do alternative help-seeking strategies deter people from using primary care? A survey of help-seeking for mental distress

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Author’s response to reviews:

#1319397359159349
Reviewer's report
Title: A survey of help-seeking for mental distress in a multi-ethnic inner-city area: who is consulted and does 'alternative' help-seeking deter people from using primary care?

Dear Chrissie Kouremenou,

We read and discussed both reviewers report and have copied their major and minor concerns in the text below and have also highlighted when and how we addressed their suggested changes.

We have noted that both reviewers advised different solutions with regards to the sampling. I have copied their advice from the reviews below.

Joe Westermeyer: The study should be broken into two separate analysis, one from the clinical sample and one from the community sample.

Peter Verhaak: Furthermore I suggest to limit the whole paper to the psychiatric cases. It is hard to imagine for me how to interpret answers on strategies tried and found to be helpful, given by respondents who in fact do not need the strategy, let alone that they have tried and evaluated it.

With respect to Joe Westermeyer’s suggestion and comment, we wanted to clarify that even though the GP sample had been obtained from the GP practice register, these were not a clinical sample since these people were not selected in their capacity as ‘patients’ (i.e. their clinical relevance or current service use in relation to distress). We drew a randomly selected sample of the whole GP register to get a representative sample of the general population.

`General practice registers in the UK offer the best means of sampling the general population (Kennedy et al., 1998, GUT, 43, 770-774).
Our reason to also include a sample from community agencies was related to a low response rate of this survey to a reactive sampling technique (invitation by letter). Reactive sampling depends on responses to invitations requiring more motivation & planning from prospective participants. Motivation and planning might be limited in individuals suffering from a mental health condition. Proactive sampling, on the other hand, is actively seeking recruitment into studies e.g. by 'door-knocking' that is going to all houses in a community and/or utilise community organisations that involve representative sections of the community in order to recruit a general population sample. This particular terminology was used in a Wayne Velicer's keynote at the European Health Psychology Society Conference in 2007, Maastricht. The reference from Shaw was given to support that recruitment to such psychiatric surveys with reactive sampling techniques is often low.

Hence both samples were drawing from the general population in a limited geographic area. To ensure that we could add both samples we did test for compatibility. We tested whether the community organisation sample and the GP register sample were matched on demographics such as age, children, length of stay in the UK, as much as gender, occupation and found no significant differences on any of these demographics between the two samples. We therefore feel that we can combine the samples as they were both drawn from the general population.

Regarding the suggestion of Peter Verhaak, we have followed his suggestion to focus on patients who currently met the diagnostic criteria for common mental disorder.

Reviewer: Joe Westermeyer

1) Title could be reduced to about half its current length; this would make it easier for potential readers to consider scanning or reading the article.

We changed the title to Do 'alternative help-seeking strategies deter people from using primary care? A survey of help-seeking for mental distress

2) Although the CIS-R was used to collect data, no CIS-R data are included in the report.

The CIS-R data had been used to identify individuals that fulfilled the diagnostic criteria for a common mental disorder. These individuals were identified as cases throughout the previous version of the paper we have added a clarifying sentence in the procedure section.

3) It is not clear whether 'cases' refers to people sampled in the clinical setting, people who are 'lifelong positive on the CIS-R, or people are 'currently positive' on the CIS-R.

The word 'currently' has been added to the sentences regarding selection of participants and procedures. Cases did refer to individuals who scored currently
positive on the CIS-R this information is no longer needed now that we have decided to only focus on this study.

4) Certain conclusions and recommendations are not supported by the findings, so that the authors extrapolate from their data to unproven (and unwarranted) extrapolations (e.g., that these different help seeking methods may affect outcomes, it would be useful to conduct more research along the same lines). Examples are present on pages 19 to 22.

We have gone through our discussion and looked at possible areas where we might have made extrapolations, which were not supported by our data and addressed these either by taking them out or clarifying where appropriate.

5) The Discussion could be shortened by not repeating the findings in so much detail (although pointing up general trends in similarities and differences is enlightening). The findings are not well tied into the literature: how do these findings support or undermine the studies of others?

We have addressed these by linking the findings to other studies that had been presented in the introduction.

6) New data are presented in the Discussion (e.g. that the site of the study is the most deprived borough on page 18, clinical cases tried more strategies than others on page 19).

We tried to offer in our discussion some insights into the strengths and weaknesses in this study in particular the representativeness of this sample. We have added information about the geographical area to methods under settings. We commented in the above example on range and means between cases and the total sample in table 4. Since we did not examine whether this difference is significant, we agree, with the reviewer that this might not be appropriate. In our revision, we tried to make it much clearer when ideas or thoughts were relating to previous data that had been presented.

Areas Needing More or Less Detailed Coverage

7) Did those who refused to participate resemble of differ from those who did participate in some demographic characteristics?

We obtained limited information on this as we only obtained a random sample that contained participants contact details.

8) Did the authors provide examples of something distressing or did they further describe the nature of the distress? One might consider a wide variety of distressful events occurring which might lead to some type of help seeking (e.g. from police, fireman, attorneys, accountants or financial advisers, one’s work supervisor, etc.) but not health-care-seeking.

We did not provide examples of distress as we wanted to explore the distress from each individual’s perspective. We agree that sometimes distressing events
might lead individuals to contact other agents and we have been capturing all of these with the BEMI. The BEMI asks who people have contacted for their distress and whether this was helpful.

9) The entire title of CIS-R should be written out the first time it is used. Why did the authors not include more information from the CIS-R?

We added the full name of the Clinical Interview Schedule Revised on page 8. We did not want to present more information of the CIS-R in this study, since our main interest in the CIS-R was to demonstrate the severity of individual’s distress and to identify patients who should be using primary care services.

10) Primary care services are critiqued from the users’ perspectives, but the other care-seeking methods are not critiqued. Why did they critique some and not others?

In the UK, primary care services act as gatekeepers who manage common mental disorder within their services and make decisions about referrals to psychological, psychiatric and other mental health services. Therefore the first contact determines future treatment we therefore wanted to explore patient’s experience of this service first.

Reviewer: Peter Verhaak

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

Method:
11) Table 1: Not well arranged. I propose to leave the ranges and the absolute figures (except for the total N per ethnic group) and only give means or proportions.

The table had been rearranged leaving proportions and means as well as their statistical tests and results.

12) In the text: 114 participants are reported. The table counts up to 117 participants.

In total 117 participants participated and were interviewed in this study. However in 3 instances participants said that they would like to fill in the BEMI-C questionnaire in their own time, but did not return it to us which meant 114 participants were used in the regression. The information in the text has been updated and notations have been added to tables where necessary.

Results
13) Table 2 (and the BEMI-C) really needs reduction. Is it not possible to present figures about the ‘chapters’ in the inventory: Self directed help, Social help seeking, Spiritual help seeking, Medical help seeking and Complementary services? I would prefer figures indicating the proportion of respondents endorsing one or more of the strategies within the chapter.
The many suggestions done in the free interview BEMI-I could be discussed but do not need to be presented in a table.

Table 2 has been reduced to cover only items from BEMI-C with BEMI-I data to compare. The most popular BEMI-I items have been mentioned in the text.

14) Text: p. 13 second paragraph: this text about the relationship between ethnicity and migration status would be more conceivable when it was stated in a simple table ethnicity x status

This information has been much reduced due to the focus on cases only.

15) Table 3: again: difficult to read because of an abundance of information. Suggestion: Limit the number of strategies to the main chapters (see above). Limit the number of respondents to the psychiatric cases, and make two tables: one for ¿tried strategy¿ and one for ¿found strategy helpful¿.

Table 3 has been presented as advised and therefore split into 2 tables.

17) Table 4: In fact, you follow the suggestions made above about ¿chapters¿ in table 4, although you report the mean number of strategies within the chapter. In this way it is impossible to compare different chapters. For instance ¿spiritual¿ has a range from 0 to 1 and ¿self directed¿ has a range from 0 to 8. If you report the proportion of respondents endorsing one or more strategies, you can compare 17% of cases who endorse spirituality with 87% of cases who endorse any kind of self directed strategies.

We added this data as suggested.

18) Again: limit the table to cases

We have limited this table to cases as suggested.

19) Table 5: limit the table to cases.

We have limited this table to cases as suggested.

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Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

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Discretionary Revisions (which the author can choose to ignore)

20) Background:

authors state that no surveys have examined how many people use healers. I would like to refer to a large WHO study in the nineties, reported a.o in Psychological Medicine, 1991, p.761-774 by Gater, R. et al. In this study the pathway to mental health care is described for eleven countries all over the
world. The native healer played a role in India and Pakistan and was the most important gatekeeper to the pathway of mental health care in Indonesia.

This sentence was amended to clarify what is unique about this study.

21) Method:
The Barts Explanatory Model’s domains are very similar to the illness representations distinguished by Leventhal in 1976. Maybe the BEM is an elaboration of this large body of theory in health psychology. In that case it deserves some more explanation.

Howard Leventhal's work on Illness Representation as much as Arthur Kleinman’s on Explanatory Models work had informed the development of the BEMI. We have expanded on this literature in more detail and its influence on the BEMI in separate publications, some of which are currently under review. We added additional sentences, but did not want to expand into this too much so not to divert attention from the main aims of this paper.

22) Discussion:

p.17: what are BME participants?

These are Black and Ethnic Minority participants; this sentence has been clarified.

23) p.19-20: you give exercise + medication + herbal remedies as an example of a strategy that may lead to different outcome than a single item strategy. In the next sentence you give medication + herbal remedies as an example of one strategy counteracting the effect of another. Although both are plausible examples, the fact that the combination of medication + herbal remedies is present in both of them, might be confusing for the reader.

Has been addressed and the second example has been changed to seeking help from GP versus medical healer.

We believe the paper is stronger for the changes, and look forward to hearing from you in due course

Best Wishes

KR, KB, SP