Reviewer’s report

Title: Building effective service linkages in primary mental health care: a narrative systematic review part 2

Version: 2 Date: 15 September 2010

Reviewer: Peter Bower

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• Major Compulsory Revisions

This is an interesting and potentially useful study, which is likely to be of interest within the mental health research and implementation communities.

The study has some major strengths, as it brings a useful conceptual analysis to this area. However, there are some methodological weaknesses that must be taken into account.

The search looks comprehensive, although a little more detail about the search terms might be useful. The restriction to 1998-2009 is not explicitly justified. I assume EBM reviews picks up Cochrane databases, but this might be explicitly stated for readers who are not so familiar with this.

The operational definitions look OK, although I’m not sure how many would see a counsellor or other mental health provider as a ‘primary care practitioner’ – I thought part of the established definition was that they saw all problems at first contact. Obviously they can provide PMHC, but is that the same thing? I would have thought that primary care involved dealing with undifferentiated problems.

How were judgments about ‘comparable health systems’ made? This either needs a theoretical definition, or at least an explicit list of what systems are considered comparable. It would also be helpful to highlight how many studies were excluded on this basis. Is there a list of excluded studies?

The quality assessment issue is potentially problematic. Although a range of studies were included (which would in theory make standardised quality assessment more problematic), the analysis of outcomes was focussed on the 42 trials. In this case, some sort of quality assessment would be conventional, and I don’t think peer reviewed publication is an acceptable proxy. If it is not possible to do this, this weakness needs to be highlighted.

The chosen method of synthesis (tabulating and assessing proportions of significant results) is essentially what is called a ‘box score’ or ‘vote counting’ approach. I can see that the authors wanted to provide a high level analysis of patterns rather than the detail associated with a meta-analysis, and the chosen method probably suffices for that, but the weaknesses of this method (i.e. the fact that it ignores issues of power, and may assign two studies with the same effect to different ‘effectiveness’ categories) are well known and should be given far
more prominence in the discussion.

Given the relatively straightforward nature of the analyses, my view is that the importance of the paper relates more to the conceptual issues surrounding the coding framework. I think this is a genuine advance, but they underplay it. I would provide more detailed description of the codes (the entries in the table are quite brief and in a summary form) as I think this is potentially of use to others, but the benefits will be limited if there is a lack of clarity over the framework. Further consideration needs to be given to the links – for example, is ‘stepped care’ a subset of ‘protocols’? How does a ‘link worker’ differ from ‘C-L’? More examples might help here, linked to the literature they have found. There is a danger that others will not be able to use the coding scheme if they have insufficient detail, which would be a missed opportunity.

It might also be useful to consider how their coding scheme links to other published systems (e.g. the EPOC list of professional behaviour change interventions?).

• Minor Essential Revisions

I would place the definitions of ‘clinical’, ‘service delivery’ and ‘economic’ outcomes in the methods.

The summaries of IMPACT and PRISM-E are useful, but it is not clear why these have been chosen, and that might be clarified. I wonder if it would be better to compare and contrast exemplars using different interventions? Also, isn’t PRISM-E an active comparison i.e. where both arms have some of their interventions? I would have thought that integrated care and enhanced referral were both examples of collaboration?

Similarly, the focus on the three systematic reviews is not clear. Are these the only reviews found: the flow diagram suggests 5? What was the logic behind the choice? I think the use of exemplars is to be encouraged, but the reasons for the choices should be clarified. Also, how is ‘collaborative care’ in the Gilbody review coded in terms of their coding scheme?

‘Recovery model’ might need defining for a general readership

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

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests