Reviewer's report

Title: Horizontal equity and mental health care: A case vignette inter-rater reliability study

Version: 1 Date: 17 January 2012

Reviewer: Richard Morriss

Reviewer's report:

The decision of the Norwegian government to go down the route of using legislation to classify rights to treatment is one that I imagine other governments might wish to follow. A universal problem is equity of access to care. Therefore issues in relation to the inter-rater reliability of these decisions and whether these are more reliable as an individual or team decision are of interest internationally. I know of no similar studies in the mental health literature.

My main criticisms of this paper is that the context is not sufficiently explained for the reader who is not familiar with mental health services and practice in Norway and also the methods are sometimes unclear.

Major compulsory revisions.

Abstract and statistical methods. Did the authors use intra-class correlations which quantify the degree to which ratings by different people resemble each other (as I would have thought was required here and follows from the statistical analysis described) or inter-class coefficients which are used to explore the degree of correlation between two different variables usually measured in the same way (tested usually by approaches such as Pearson correlations)? If this is indeed inter-class correlation then I do not understand the rationale for using it nor the statistical analysis presented. In my view it would be the wrong approach for the questions posed whereas intra-class correlation would be the correct approach (used for instance in reference 8).

Background.

3rd paragraph. Given the assessment is made on the needs of the patient and the need for service provision in mental health services then there are a few relevant papers that should be discussed. Tyrer et al (2006) Int J Soc Psychiatry 2006; 52: 267-277 showed moderate to high inter-rater reliability using an instrument to assess the need for in-patient admission. Reference 8 in the paper was more than a global assessment of function paper; it showed poor inter-rater reliability among individuals working within English community mental health teams on the definition of severe mental illness, the group that team were supposed to be managing, or the assessment of clinical need.

Background last paragraph.

In the description of the Act of Patient Rights and the Clinical Guidelines for
Priority Setting in Mental Health Care, it is unclear to me what is considerable to be desirable in the three need criteria. For instance in relation to health status, is it the level of distress, the level of risk, the functional ability or quality of life or diagnosis that is important? Would a patient with a diagnosis of schizophrenia be regarded as more of a priority than agoraphobia even if the risk, distress and functioning of the patient were all similar. In terms of expected utility from treatment, does greater expected utility from treatment make the patient more likely to be accepted or less likely because primary care or other services could do that. For any condition, treatment utility is often greater in less severe cases so how might the needs under health status and expected utility from treatment be squared. In terms of cost effectiveness, which costs matter, those costs born by the patient and family, health care only, health and social care, any public services or all costs? Again the treatment of the most severe and chronic patients may be the least cost effective.

Case vignettes.

The authors need to explain on what basis they selected these vignettes, who selected them and to outline which of the three criteria in the Act of Patient Rights needed to be addressed by the individual and teams. Without knowing this it is hard to interpret the reliability results.

Description of CMCHs

It would be useful to know which CMHCs served urban and rural populations and how they varied in terms of social deprivation and other aspects of service use e.g. in-patient admission. One might expect CMHCs serving areas of high deprivation and high service use to be more selective about referrals to their teams. I have no idea what centralization or decentralization for each unit or each CMHC means. There needs to be a more comprehensive but succinct explanation of what a CMHC is and how it functions including key areas of practice. Am I right in thinking some CMHCs are split into a number of other units? Sadly I find the description of a CMHC difficult to follow.

Also very important is to give a better description of the basis for which teams and individual clinicians normally determine priorities for acceptance in the CMHC. Do they do this only on the information supplied by primary care and is this comprehensive or standardised in any way? Would they normally have as much information as supplied in the case vignettes? If not then the case vignette study has little relevance to practice.

Discussion.

The authors need to acknowledge and discuss other issues than inter-rater reliability for determining referral assessment. More important is the validity of the assessments. I note that in four of the case vignettes (20%), 50% of CMCHs regarded these cases as high priority but in 50% they were refused (most often) or a low priority (Figure1). In these cases the validity of the decision to accept or refuse the case must be in question. Another issue that might be discussed is the question of whether a team decision as opposed to an individual decision is better for the morale and coherence of the team because a team decision is more likely
to represent a range of views about acceptance of referrals.

Minor essential revisions
Page numbers must be added to the manuscript.

There needs to be a uniform reference style that meets the journal’s requirements.

What CMCH stands for must be stated in the text on the first occasion the abbreviation is used. It is not enough to state what this is only in the abstract.

In the background paragraph 3, what refusal rates across CMCHs varied between 3 and 79%? Please clarify.

Results. Paragraph 3. Last one. Please explain what a "prolonged policlini afterward" means.

Table 3 and final paragraph of results.
Please explain why average ICCs are presented and what these results tell us about the inter-rater reliability of the assessments. They seem to show that the level of agreement is good between both individuals and teams. If they do not have a purpose in the context of this study it may be better to omit these as they seem to contradict the rest of the results.

Discretionary revisions.
The authors may wish to explore whether refusal rates and lower priority rating is related to deprivation, activity of the CMCH etc.

Some of the individuals and CMCHs only used two ratings, refusal or high priority. It would be worth knowing if this was coincidence or if such teams have only one priority for treatment and the term low priority is meaningless.

**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.