



## *Technical Brief Disposition of Comments Report*

### **Research Review Title:** *Disparities Within Serious Mental Illness*

Draft review was available for public comment from July 31, 2015 to September 8, 2015.

**Research Review Citation:** Swinson Evans T, Berkman N, Brown C, Gaynes B, Palmieri Weber R. Disparities Within Serious Mental Illness. Technical Brief No. 25. (Prepared by the RTI International–University of North Carolina Evidence-based Practice Center under Contract No. 290-2015-00011-I). AHRQ Publication No.16-EHC027-EF. Rockville, MD: Agency for Healthcare Research and Quality; May 2016.  
[www.effectivehealthcare.ahrq.gov/reports/final.cfm](http://www.effectivehealthcare.ahrq.gov/reports/final.cfm).

### **Comments to Research Review**

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Comments on draft reviews and the authors' responses to the comments are posted for public viewing on the EHC Program Web site approximately 3 months after the final research review is published. Comments are not edited for spelling, grammar, or other content errors. Each comment is listed with the name and affiliation of the commentator, if this information is provided. Commentators are not required to provide their names or affiliations in order to submit suggestions or comments.

The tables below include the responses by the authors of the review to each comment that was submitted for this draft review. The responses to comments in this disposition report are those of the authors, who are responsible for its contents, and do not necessarily represent the views of the Agency for Healthcare Research and Quality.



| Commentator & Affiliation | Section          | Comment   | Response   |
|---------------------------|------------------|---|--|
| <b>Peer Reviewer #1</b>   | General Comments | <p>This is an interesting technical brief on a topic that is a very important issue – disparities within serious mental illness (SMI). The guiding questions from the study protocol, that is based on available evidence and input from Key Informants (KIs), provides a great framework for the technical brief. The answers to these questions could help provide a high-level overview of interventions that have been examined and show promise in eradicating SMI disparities. However, the technical brief falls short in answering the guiding questions in a way that provides a high-level, yet comprehensive understanding of the current scientific landscape. Also, there were redundant findings throughout the brief which suggest that the brief could be better organized. Lastly, there were copious amounts of unnecessary semi-colons throughout the paper. This can be easily fixed, but it suggests that the brief should be reviewed for these types of errors before resubmitting. Overall, I think that there is a great need for this type of technical brief, but more work is needed before publication.</p>  | <p>Thank you. We have restructured the report to minimize the redundancy in the findings and an editorial review was conducted to limit the use of semi-colons throughout the text.</p>  |
| <b>Peer Reviewer #1</b>   | Background       | <p>I will provide feedback based on the numbers on the bottom of the technical brief. The background section provided an adequate understanding of the issues related to disparities in SMI. However I noticed some redundancies in this section. For example, the fourth paragraph in this section states that “disparities can occur at multiple points along the health care continuum...” The seventh paragraph in this section also states that “disparities exist along a health care continuum...” I suggest that the authors consolidate these paragraphs. Another example of a redundancy is when the authors describe the disparity subgroups in paragraph 3 and once again describe the subgroups in the last paragraph of the Background section. One relatively minor thing I want to mention is that I noticed that the term Latino is mentioned in the Background section and the term Hispanic is used in other parts of the Technical Brief. Authors should be consistent with which term they would like to use. If the authors want to use the term Latinos and Hispanics interchangeably, they should state that and explain why in the beginning of the technical brief.</p> | <p>We reorganized the two paragraphs with the “continuum” statement in this section to reduce the redundancy and connect the content and the flow of the paragraphs. We consolidated the disparity group paragraphs in this section as well.</p> |

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| Commentator & Affiliation | Section           | Comment   | Response   |
|---------------------------|-------------------|---|--|
| <b>Peer Reviewer #1</b>   | Guiding Questions | I thought the guiding questions for the technical brief were well informed and were a great way to guide the development of the technical brief.  | Thank you.   |
| <b>Peer Reviewer #1</b>   | Methods           | I thought that the Methods section was scientifically sound. However, it is in this section where I started to notice the overuse of the semi-colon. For example, at the end of line 20 on page 14, this sentence can end with a period and a new sentence can begin with “we anticipated...” Also, I wondered why the authors did not mention that “Hispanic/Latino” and “American Indian/Alaska Natives” were headings used in the search, although these search headings are mentioned in the Findings section on page 25 (line 40). Lastly, the authors reference an Asian study later on in the technical brief, but Asians were not mentioned as a search heading in the Methods section. | <p>We have revised the text in the Methods section based on the recommendations of an editor who we asked to consider our use of semicolons in the text. We have also revised this section of the report to better reflect our searches related to subgroups defined by race and ethnicity.</p> <p>Our original literature search included the Mesh term “minority groups” as a way of capturing multiple groups defined by race and ethnicity. The literature yield did include a large number of references that focused on minority groups, including Hispanic/Latino and Asian populations. However, during the peer review period, we performed an additional literature search in PubMed using the MeSH terms “Hispanic American,” “Asian American,” and “Indians, North American.” We dually reviewed the newly identified references according to the protocol we describe in the Methods section.</p> |
| <b>Peer Reviewer #1</b>   | Findings          | I thought the Findings section could greatly improve. First, the findings presented could be better organized. For example, I thought the introductory paragraphs in the “Guiding Question 3” (paragraphs located on pages 32 and 35) section should have been the introductory paragraphs for the entire Findings section.   | We arranged the report section to present the findings in Guiding Question 3 earlier in the findings section.  |

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| <b>Peer Reviewer #1</b>   | Findings | I also thought that more information was needed on the description of the interventions within the actual body of the “Guiding Question 1” section. Instead, I had to go to various tables to get a better understanding of the interventions discussed in the technical brief. Within this particular subsection, I also noticed that “Asians” are not mentioned as a search heading. Perhaps the Asian group is captured in the “among others” group mentioned in line 40 on page 25, but I think this group warrants being mentioned by name (even if the authors did not find many studies pertaining to Asians). With that said, however, this second to last paragraph on page 25 is redundant to what is in the Methods section. The authors may want to consider moving any new lit search terms mentioned in this paragraph to the Methods section, and provide the racial/ethnic categories on page 18 of the Findings sections. (This redundancy also occurs on page 29 of the brief in the “Intervention for Racial and Ethnic Minority Groups” section where Chinese Americans are first mentioned). | We rearranged the report structure to add a description of the findings to the beginning of the result findings (they were previously in Guiding Question 3). We also reorganized the report such that the descriptions of the disparity groups are in the Methods section.                                |
| <b>Peer Reviewer #1</b>   | Findings | My main issue with this section is that the findings presented are extremely surface and it is really hard for me to get a succinct understanding of the “take-aways” from this section. The authors tend to dive right into the findings in each section. As a result, I was often left to wonder about what were the high-level themes that I should take away from reading this brief. Perhaps having two or three coders read through the Findings section to identify themes might be useful. These themes could help better organize the Findings section, and thus, allow readers to more quickly discern the main “take-aways” from this section (and the report).  | We added a high-level summary of the findings table at the beginning of the findings section to provide the reader with an understanding of the “take-aways” we wanted to highlight in the subsequent sections. We have also summarized the key findings in the summary of findings section of the report. |
| <b>Peer Reviewer #1</b>   | Findings | A relatively minor issue is that the Findings section also has a copious amount of semicolons throughout (“Key Findings” section on page 27; first paragraph on page 31; last paragraph of page 35; last paragraph on page 41; first paragraph on page 42). Also, in line 37 on page 29, please put an “s” at the end of “Hispanic.”  | The entire document has been reviewed by an editor. The peer reviewer’s concern regarding the overuse of semi-colons was particularly brought to her attention.  |

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| Peer Reviewer #1          | Summary and Implications | I have no major issues with this section. However, if changes are made to the Findings section, relevant changes will need to be made to the Summary and Implications section as well. For example, if overarching themes are identified as I suggest in the previous section, then those themes should be mentioned in this section as well to help organize the summary.   | So noted. Thank you for the recommendation. We added a “summary of findings section” to address this in GQ4.   |
| Peer Reviewer #1          | Summary and Implications | One thing I want to mention is whether all studies relevant to this technical brief were found in the lit search and discussed. For example, the authors mention the DECIDE study on page 49 as a study under way and not yet in the literature. A paper on the DECIDE study was published in JAMA Psychiatry in 2014. The authors mentioned in the Methods section that they searched the published literature with a dates ranging from January 1, 1980, through June 4, 2015. The DECIDE paper falls within this date range but is not discussed in this technical brief. This makes me wonder what other studies may have been missed in this technical brief. | Thank you for your concern. This Technical Brief provides an overview of key issues related to the intervention, such as current indications, relevant patient populations and subgroups of interest, outcomes measured, and contextual factors that may affect decisions regarding future interventions. Because Technical Briefs generally focus on interventions with limited published data or few completed studies, the goal is to provide an early and objective description of the state of the science, a potential conceptual framework, and insight on the critical issues that will may inform future research. As such, the entire set of relevant literature on a given subgroup of interest will not be captured by our literature search. We have included a description of and a citation for the DECIDE study in the “Future Areas for Research” section of GQ4. |
| Peer Reviewer #1          | Summary and Implications | One very minor point – the semicolon issue also appears in line 34 on page 47.   | The entire document has been reviewed by an editor. The peer reviewer’s concern regarding the overuse of semi-colons was particularly brought to the editor’s attention.   |
| Peer Reviewer #1          | Next Steps               | No major issues with this section. However, please change “as” to “a” at the end of line 8 or 9 on page 51 (it was hard for me to distinguish if the line is number 8 or 9).   | Thank you, we revised the previous version of the text and this suggested change was no longer applicable.   |
| Peer Reviewer #1          | Clarity and Usability    | As previously mentioned in my review, the report can be better structured and organized. The main points could also be more clearly presented. The conclusion can be used to inform future research, but there is room for improvement here as well.   | Thank you; we have significantly revised the structure and organization of the point to highlight the main points, and enhance the conclusions from the findings to inform future research.  |

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|---------------------------|-------------------|--|--|
| Peer Reviewer #2          | General Comments  | The authors have done a good job of writing this technical brief on a complicated subject with a variety of disparity subgroups that overlap in the context of limited number eligible studies. A few minor points are in the abstract: page 7, lines 44-46, did authors mean to suggest that community mental health settings are a non-psychiatric location? This sounded counterintuitive or at best unclear; page 8 line 30-31, in using "ethno" did authors mean, "ethnic"?; and lines 33-34, in reference to African American and Hispanic patients being less likely to "travel further than white patients" needs more elucidation or perhaps should not be included in the abstract at all. | Thank you. We have revised the text to clarify the community mental health setting and the use of "ethno" and the reference we cited that you noted.                                     |
| Peer Reviewer #2          | Background        | The Background was thorough in its description of the clinical problem and the contextual factors driving the need for intervention. There are some discrepancies in the definition of SMI mentioned in this section vs. in the methods. This is an understandable challenge for the authors, however, efforts to address consistency of definition could have been enhanced (page 8, lines 7-10).   | Thank you; we revised the text to clarify the definition of SMI throughout the report.   |
| Peer Reviewer #2          | Guiding Questions | The descriptions of interventions, context of implementation, evidence regarding effectiveness of interventions and gaps in knowledge base and high priority needs for research were described well. In Guiding Question 3 on page 40, line 16-19, there is no N mentioned for the Tsai study.   | Thank you. We have added the sample size to the table.   |
| Peer Reviewer #2          | Methods           | On page 14 Table 1, lines 48-52, it is unclear if people with SMI and a primary diagnosis of substance abuse, dementia or mental retardation are included. This is an important clarification to make given the high co-morbidity of SMI diagnoses with these 3 conditions.  | People with SMI whose primary diagnosis is substance abuse, dementia, or mental retardation are excluded from this Technical Brief. We have removed the "without SMI" text from Table 1. |

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|---------------------------|--------------------------|---|---|
| Peer Reviewer #2          | Findings                 | On page 21, lines 35-36, no rationale is given on this page or referenced elsewhere as to why only PTSD was chosen as the SMI anxiety disorder. An explanation should have been provided somewhere in the document if this was the only anxiety disorder to arise in the literature that made the cut for inclusion in the Technical Brief. Also, even though there were asterisked notations about disparities overlaps being included, there should have been a better explanation provided in this section of the report about how overlapping disparity groups were handled. This explanation came later on in the Summary and implications, yet it would have been helpful to reviewers to have a more detailed explanation in this section. | PTSD was not chosen as the only anxiety disorder to represent SMI. Rather, as it happened, each of the studies that were identified as eligible happened to involve PTSD, although they also involved comorbid GAD and panic disorder.<br><br>We provided additional detail describing how we handled the overlapping disparity groups in this section. |
| Peer Reviewer #2          | Summary and Implications | This section was comprehensive in drawing from the review of the various studies discussed in the GQs. One question for the authors is whether if SMI would be looked upon as a disparity unto itself, would it be appropriate to compare it to non-SMI such that the denominator would be the population of people with any mental illness vs. the general population? It would be good to at least to discuss this and rule it out vs. to assume that the appropriate comparison should be SMI vs. general population. It is good that the authors suggest treating SMI as a disparity population and studying differences that arise within that population among disparity subgroups such as a race/ethnicity, age, gender, etc.              | We believe that the general population would be the correct comparison group given that that is where the increased mortality and increased morbidity data lies.  |
| Peer Reviewer #2          | Next Steps               | The most important point in this section pertains to the clarification of SMI population. This will also be important given that the report mainly deals with DSM III and DSM IV diagnoses. We are already on DSM-5 and given the expanded development of the Cultural Formulation and its corresponding interview, there may be subsequent related research to contribute new knowledge in the area disparity subgroups under the SMI umbrella.  | We agree and we have added additional text about the CFI and DSM-V in GQ4.  |

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|---------------------------|-----------------------|--|--|
| Peer Reviewer #2          | Clarity and Usability | The report could have been structured better as it did not map onto the reviewer's format. The main points could have been presented more clearly--I made notes as I read through and would have appreciated a more expanded list for future study/next steps such as: Collaborative Care; Telemedicine/telepsychiatry, Web-based approaches, Virtual patient-centered medical home, co-location of mental health specialists, culturally tailored care; self-management strategies including teller at home; peer-led approaches, and mobile health technology. | We agree and we completely revised the GQ4 text to help with clarity and provide a better "map" of the evidence and future needs.  |
| Peer Reviewer #3          | General Comments      | **Please change "Hispanic" to "Latino".<br>Also note that Hispanics are now called "Latinos" and they are no longer called Mexican-Americans. The term "Latinos" embrace all those that speak Spanish as their native tongue; both brown and white.  | We updated the text to reflect the various usages of the term within the literature as both "Hispanic" or "Latino". When possible, we specify the use of only one as reported in the individual study. |
| Peer Reviewer #3          | General Comments      | **Please be consistent in referencing racial group; I noticed "African American/black" and "African American." The preference for this racial group is "African-American". Also noticed "Chinese American". The global preference is "Asian-American". Please understand that within these broad racial groups are smaller subgroups, Chinese, Japanese, Korean, Vietnamese, Humong, etc. and they each have their own separate culture.   | We are using African American and Asian American throughout the text unless specified by the individual study for which we are using their terminology.  |
| Peer Reviewer #3          | Background            | Good explanation and historical references. I like that you included total SMI population at 11 million. I also liked that you placed interesting information that came out of your Literature Research in each paragraph. However, there is some colloquial language that could be cleaned up...Paragraph 3 Line 30, take out "ethno" change to "ethnic".   | Thank you. We made the change to the language accordingly.   |
| Peer Reviewer #3          | Guiding Questions     | Page 11 of 100 - First and Second Paragraphs need a space in between the two. Also second paragraph, remove word "namely", and perhaps breakout the four Guiding Questions and use "bullets" as markers.   | We have removed the word "namely" as suggested. The report is formatted according to AHRQ instructions.  |

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|---------------------------|--------------------------|--|---|
| Peer Reviewer #3          | Methods                  | You have used "mixed text", your fonts are not the same...perhaps you used the "cut and paste" feature and did not change font. This is noted on pages, 13 of 100, 14 of 100, and 15 of 100.   | The report is formatted according to AHRQ instructions, which requires different fonts and font sizes for various headers and text. |
| Peer Reviewer #3          | Methods                  | I like your methods for gathering and comparing the data. You have taken a wide range of data over the last 35 years and sifted through many publications to gather relevant material. You have then presented your literature research in a malleable format. This is a commendable feat. PICOTS is an easy to understand methodology. Table 1 is clear; your "tag-team" approach to "Data Management and Abstraction" is spot-on for ensuring mental health services accountability.   | So noted. Thank you.  |
| Peer Reviewer #3          | Findings                 | I am very sorry that you were not able to include LGBT data. This is a major drawback.   | This concern is included in the gaps GQ4 section on gaps in the evidence.   |
| Peer Reviewer #3          | Findings                 | However, I like the flowchart of Figure 1 detailing the Reading Effort you went through. Figures 2-5 are easy to read. This is the "meat under the potatoes". The last column on the right (Number of Studies by Intervention and disparity subgroup) tells the reader what direction future research will take, for example: tele-psychiatry, greater housing assistance, peer and family support, patient-centered services with an improvement in Quality of Services, (i.e. creation of new jobs and along with better service-delivery) across the board. | So noted. Thank you.  |
| Peer Reviewer #3          | Findings                 | You then go through each of the GQ and present Key Findings, Interventions, Additional Responsibilities within each category re-emphasizing the need for more better services. You also include the future use of mobile apps as well as other cutting-edge technologies.  | So noted.   |
| Peer Reviewer #3          | Summary and Implications | Very well written.   | Thank you.  |

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|---------------------------|-----------------------|--|---|
| <b>Peer Reviewer #3</b>   | Next Steps            | Reformatting your text will make this report "pop. In this section set apart each of the three with bold formatting and indent your validation paragraph underneath. Remove the phrase, As previously mentioned".  | Agreed. We made the suggested changes Thank you.  |
| <b>Peer Reviewer #3</b>   | Clarity and Usability | I think you need to reformat your text. Adequate use of paragraphs, the bold feature along with italics, underlining and bullet markers can put the luster back on the shine.  | The report is formatted according to AHRQ instructions, which requires different fonts and font sizes for various headers and text. |
| <b>Peer Reviewer #3</b>   | Clarity and Usability | You have taken a difficult subject and made it malleable. Overlapping characteristics are inherent with this subgroup and all that you have listed can and do apply to each individual client/consumer/patient/participant in the program. The question is: where do we go from here? Those who have "boots on the ground" know this and they see things a little differently that those in the think-tanks and the men and women who run the Agencies. You have done your storytelling well by "hooking" us with the main points clearly and up front, in the Background Section; quote, "...11 million adults, ...African Americans and Latino's are less likely to drive further than white patients,.....racism by providers,.....geographic differences can contribute to SMI,....and higher percentages of in-patients at state hospitals are African American diagnosed with schizophrenia. Reading this allows one to draw their own conclusions and map the need for future research. | Thank you.  |

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|---------------------------|------------------|--|---|
| <b>Peer Reviewer #4</b>   | General Comments | This Technical Brief provides an overview of serious mental illness (SMI) and associated disparities in healthcare across the health services continuum. Key issues are discussed related to clinical interventions and healthcare services among targeted populations disproportionately affected by SMI. Overall, the report is well written. However SMI, access to care, and disparities definitions are not well operationalized. The various definitions of these concepts are needed in order for this report to be comprehensive and informative. In terms of the target population addressed by the report, the purpose and the title of the report should include the word “adults.” Clarifying the terminology is an important foundational aspect of the technical brief that warrants further consideration.  | Thank you, we have revised the report to clarify definitions of all throughout the report and consistently use terminology throughout.  |
| <b>Peer Reviewer #4</b>   | General Comments | <p>The report utilizes a 2002 definition of SMI and references it throughout the document. It is recommended that the report also include more recent definitions of SMI published by the National Institute of Mental Health (NIMH), the United States Government Accountability Office (U.S. GAO), the Substance Abuse and Mental Health Services Administration (SAMHSA), and any other definitions currently in use. It will be important to illustrate the nuances of the different definitions, and any associated implications. One significant recommendation of the report is to establish a consistent definition of SMI across stakeholders, and to describe the health disparities experienced by individuals with SMI relative to the general population; as such it is important to illustrate inconsistencies in the definitions upfront in the report.</p> <p>Furthermore, it would be helpful to provide a description of how “disparities” and “access” were conceptualized and defined. The Institute of Medicine, AHRQ, NIH, and other entities have slightly different foci regarding the conceptualization of disparities. A table that summarizes the various definitions would be helpful, along with a rationale and summary of which definitions were used for the purposes of the scientific review. Similarly, “access” is not defined merely by the number of times an individual or group utilizes primary or specialty care services. The scientific literature includes other definitions of access which cover broad concepts such as accessibility, acceptability and affordability.</p> | <p>The SMI definition we use is an inclusive one that is consistent with the topic nominator’s broad interest in defining SMI and is consistent with other recent AHRQ reports. While the reviewer makes an important point, that a definition that multiple stakeholders can agree on is a key step forward, the need to keep the scope of this project focused on disparities within the SMI population, rather than considering the whole SMI population as one group, does not allow a broad discussion of the various definitions of SMI in use. The reference to SAMHSA report was also added into the technical brief</p> <p>We revised the text to clarify and further describe our selection and use of these terms for our purposes. We appreciate the breadth of the conceptualization of both, but our scope limits our ability to provide broad review of all of the potential uses of these concepts.</p> |

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| Commentator & Affiliation | Section          | Comment  | Response  |
|---------------------------|------------------|--|---|
| <b>Peer Reviewer #4</b>   | General Comments | <p>The authors do a good job of addressing a very complex issue with respect to categorizing disparity subgroups relevant to SMI. The absence of discussion relevant to children ages 18 and under is a significant omission, although an explanation is provided for this decision. Children represent a subgroup subject to disparities in and of themselves. Accordingly, line 17 on page 7 which describes the purpose of the document should be amended to include the word “adult” after the word “among” and before the word “patients.” The purpose would then say “The primary goal of this Technical Brief is to describe and review the effectiveness of interventions that address disparities among adult patients with SMI in these important subgroups.” It is also recommended that the title of the document be adjusted to reflect the adult population.</p>   | <p>Thank you. We are not able to change the title of the report but have revised the text to clarify our scope was limited to an adult population.</p>  |
| <b>Peer Reviewer #4</b>   | Background       | <p>The SAMHSA’s publication of “Racial/Ethnic Differences in Mental Health Service Use among Adults” (2015; <a href="http://www.samhsa.gov/data/sites/default/files/MHServicesUseAmongAdults/MHServicesUseAmongAdults.pdf">http://www.samhsa.gov/data/sites/default/files/MHServicesUseAmongAdults/MHServicesUseAmongAdults.pdf</a>) is a very important document that should be included in this technical brief. SAMHSA’s publication clearly shows the extent to which racial and ethnic disparities persist among those with SMI in accessing mental health services.</p> <p>A citation is needed on page 8, line 22 after the sentence that reads, “Individuals with SMI often experience disparities in healthcare, specifically differences or gaps in care compared with populations without SMI. Such disparities are even more pronounced in certain subgroups of patients with SMI.” Another citation is needed on page 8, line 30 where the subgroups are specified.</p> | <p>We added this citation to the background text. We added a citation to the sentence you note and provide context and citations as appropriate for how we describe the disparity groups.</p> |

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|---------------------------|-------------------|---|---|
| <b>Peer Reviewer #4</b>   | Background        | <p>Interventions for the Elderly – page 30, line 42; consider adding recent published results (Bartels, Pratt et al. 2014; Bartels, Pratt et al. 2014). These studies show that integrated Illness Management and Recovery (I-IMR) is a feasible intervention for aged individuals 50 and older. The studies also demonstrate effectiveness by improving self-management of psychiatric illness and diabetes, and by reducing the proportion of participants requiring psychiatric or general medical hospitalizations. Further, these studies show that skills training and nurse-facilitated preventive healthcare for older adults with SMI are associated with sustained long-term improvement in functioning, symptoms, self-efficacy, preventive healthcare screening, and advance care planning.</p> <p>Citations:</p> <p>Bartels, S. J., et al. (2014). "Long-term outcomes of a randomized trial of integrated skills training and preventive healthcare for older adults with serious mental illness." <i>American Journal of Geriatric Psychiatry</i> 22(11): 1251-1261.</p> <p>Bartels, S. J., et al. (2014). "Integrated IMR for psychiatric and general medical illness for adults aged 50 or older with serious mental illness." <i>Psychiatric Services</i> 65(3): 330-337.</p> | Both publications were dually reviewed and excluded for ineligible population (X7-Ineligible population: Does not focus on a disparity subgroup with SMI) because the team did not feel that the elderly population begins at age 50.   |
| <b>Peer Reviewer #4</b>   | Guiding Questions | No comments   | So noted.   |
| <b>Peer Reviewer #4</b>   | Methods           | <p>“Systematic review” may not be the most appropriate description of this current review since there was limited synthesis of findings and other standard procedures (e.g. risk of bias assessment) that the Cochrane review follows. See definition at <a href="http://ph.cochrane.org/sites/ph.cochrane.org/files/uploads/Unit_One.pdf">http://ph.cochrane.org/sites/ph.cochrane.org/files/uploads/Unit_One.pdf</a>. On a related note, it is unclear how disagreements for dual screening were handled after going through double screening and extractions. It would be helpful to specify this process in the method section.</p>   | <p>We describe systematic reviews at the beginning of the methods section as a point of contrast for this Technical Brief, noting the differences in the two types of reports.</p> <p>If an article was included by one or both reviewers at the title and abstract review stage, it was moved forward for full-text review. If an article was included by only one reviewer at full-text review, it was discussed by the reviewers (or the research team as needed) in an effort for agreement to be made on final inclusion or exclusion. We have revised the methods section to clarify these steps.</p> |

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| Commentator & Affiliation | Section                  | Comment   | Response  |
|---------------------------|--------------------------|---|---|
| Peer Reviewer #4          | Methods                  | The search terms used for racial and ethnic minorities and other disparities groups based on MeSH terms alone may lack comprehensiveness. Adding specific search terms by immigrants from specific countries of origin, and/or searching terms in titles and abstracts, may be more inclusive.  | We performed an additional literature search using the MeSH headings “Hispanic American,” “Asian American,” and “Indians, North American” to ensure that the relevant references captured all major racial and ethnic minority groups (in addition to “African Americans,” which was included in the original search). All identified references were dually reviewed and the Technical Brief has been updated accordingly. |
| Peer Reviewer #4          | Findings                 | It would be helpful to indicate how many and which interventions specifically caused the reduction of disparities. Some study populations fully consisted of disparity group(s), e.g. all elderly, all minority, etc., but other study populations might have had a mix of disparity groups and a reference group, and specifically compared the outcomes across subgroups. This would help the readers to track studies that did or did not result in disparities reduction. | We have added more summary information to the GQ3 results section concerning the interventions included for each of the disparity groups. We have also added a paragraph in the summary of findings section that states more clearly what are the most promising interventions.   |
| Peer Reviewer #4          | Summary and Implications | Although no studies were found on LGBT groups or American Indians and Native Americans, these disparities groups might still be addressed in the summary and implications of the document, rather than completely omitted. This is particularly important given that this section is expected to “address here important issues that have not been adequately addressed in the current research base and that merit high priority attention for future research.”             | We agree and both groups are highlighted in the revised text.   |
| Peer Reviewer #4          | Next Steps               | No comment  | n/a   |
| Peer Reviewer #4          | Clarity and Usability    | The document is well organized. Usability may be improved when additional adjustments are made based on the earlier comments in this review.  | Thank you. We have considered the reviewer’s comments and made edits where noted.   |

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