Author's response to reviews

Title: Development of a mental health care package in Nepal: a formative study

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Author's response to reviews: see over
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Kathmandu

To: Editor-in-Chief of *BMC Psychiatry*

Re: REVISION Setting priorities for mental health care in Nepal: a formative study (MS: 1789035073100675)

Please accept herewith the revision of the following manuscript: ‘Setting priorities for mental health care in Nepal: a formative study.’

We appreciate the valuable feedback from the reviewers, which has allowed us to improve the paper. In our responses to the reviewer’s comments we have copied the reviewers’ comments to facilitate communication. Below the reviewer’s comments, we have written our reply and have explained the changes that we have made with the actual changes in the text inserted.

Yours Sincerely,

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Nagendra Luitel, MA
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Reviewer #1:

Discretionary revision
1. Sample and procedure
Please add description of inclusion criteria and exclusion criteria for participants.

RESPONSE:
As the study consisted of three components (the priority setting exercise, the TOC workshops and the qualitative study), we have aimed to address the reviewer’s comment for each of these sections, where this was not sufficiently done so yet. This has resulted in the following addition to the methods section:

For the priority setting exercise (page 5):
‘Inclusion was based on known track record (more than 5 years of experience in clinical services) and held positions (heads of psychiatry departments in Nepal’s universities and hospitals).’

For the TOC workshops (page 6):
‘Participants were included following convenience sampling, aiming for representation of the different stakeholder groups.’

For the qualitative study, study inclusion was already clearly described.

Reviewer #2:

Discretionary revisions:
p3: Need for explanation of the sentence. "There is also a need for the implementation of packages of care that combine evidence-based treatments for specific mental disorders rather than stand-alone interventions [7]."

RESPONSE:
Indeed, this sentence required to be changed. We have now reformulated the sentence as follows (page 3):

‘There is also a need for the implementation of packages of care that combine evidence-based treatments for multiple mental disorders rather than stand-alone interventions for single disorders’.

p3: While it may be true that training results in increased uptake of mental health services, the real question is whether the training results in improved care and better clinical outcomes...and there the evidence is lacking.

RESPONSE:
We agree with the reviewer that this paragraph could be more balanced. Especially because the current research and program is geared towards addressing barriers that have been faced in other studies and programs. One of which is exactly the lack of impact of conducting mental health trainings – as the reviewer mentions. We have addressed this now as follows (page 3):

‘At the same time, studies have demonstrated that training alone did little to improve the management of mental health problems [12]’


p5: What is meant by the "track records" of experts on the panel?

RESPONSE:
We have now clarified the inclusion criteria for the priority setting exercise (page 5):
‘Inclusion was based on known track record (more than 5 years of experience in clinical services) and held positions (heads of psychiatry departments in Nepal’s universities and hospitals).’

p6: Using perceived feasibility is generally a reasonable strategy for setting priorities but in this case it results in the exclusion of the treatment of psychoses, a condition that received the highest score for cultural relevance. The notion of feasibility is useful but can also limit ambitions.

RESPONSE:
We acknowledge this important point, and agree that this should be changed in the manuscript. In fact, the prioritization did not result in excluding psychoses from the treatment package. Indeed, given the high score on cultural relevance it seems important to include this. We have now revised this in the results section (page 9):

‘The disorders with highest ranking scores were depressive disorder, alcohol use disorder, epilepsy, anxiety disorder and psychoses – all of which had a total priority score of .75 and higher.’

p9: It is curious that developmental disorders scored so low on cultural relevance, especially given that these disorders were seen quite often in an earlier primary care mental health program in Nepal (see below).

RESPONSE:
We agree that this is surprising, and think that this is probably a reflection of the expertise and experience of the expert panel more than a reflection of the actual prevalence. While, of course the results from the priority setting exercise cannot be changed, we have included this reflection in the discussion (page 16):
‘The low priority scores given to the developmental disorders are surprising, especially given other reports about their importance [Acland, 2002]. The scarcity of mental health professionals specialized in child and adolescence may have influenced these findings.’


p10: It is reasonable to be concerned about securing a reliable and regular supply of medication, but it is also necessary to be concerned about the quality of the medication supply.

RESPONSE: While we agree with the reviewer’s comment, we cannot really include this point, as it was not addressed as such in the TOC workshops.

p10-11: What is the evidence for various strategies to change public attitudes to mental disorders? And how will PRIME employ the most effective methods for this?

p13: Although mine is a minority opinion, there is little practical evidence and fewer lessons about how to integrate mental health services into primary care. The descriptions offered are usually devoid of evidence that the programs described have improved clinical outcomes.

p14: The plan in Nepal includes stigma reduction, but what strategies will those efforts employ? And what is the evidence that those strategies are effective?

RESPONSE: The reviewer asks for, or questions, the evidence base for some of the strategies that are recommended on the bases of this formative work. While we completely agree with the reviewer, we think that the current study is aimed to identify possible barriers and solutions towards the process of integrating mental health into primary health care. It does not evaluate the recommended strategies. That will precisely be the focus of the next phase of research within PRIME – evaluation of the strategies that have been developed as a result of the formative phase. To acknowledge this, the following sentence has been added to the discussion (page 16):

‘The next phase of research within PRIME will be geared towards the evaluation of the strategies and plans that have been formulated as a result of the formative phase.’

p14: PRIME may have, overall, has prioritized the treatment of psychosis, but the PRIME iteration in Nepal has not. This requires some comment.

RESPONSE: This is a misunderstanding in the first draft of the manuscript. In fact, the PRIME program in Nepal will address psychosis. The reason for the confusion may have been the presentation of the results of the prioritization exercise. This has now been addressed (page 9):
‘The disorders with highest ranking scores were depressive disorder, alcohol use disorder, epilepsy, anxiety disorder and psychoses – all of which had a total priority score of .75 and higher.’

In addition, the discussion section has now clarified that all disorders are also included in the Nepal care package (page 14):

‘The PRIME consortium has opted for depression disorder, alcohol use disorder and psychoses as priority disorders exactly because these impose the largest burden of disease and culturally acceptable interventions supported with robust evidence for effectiveness exists. The results of the prioritization exercise, based on criteria of feasibility, acceptability and commonness, are largely congruent with those, except for the high priority given to epilepsy.’

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Major points to consider:
First, The TOC model (figure 1) includes reduction of symptoms of psychosis as one of the outcomes. But psychosis is not a priority. Explain.

RESPONSE:
As mentioned above psychosis is included in the Nepal priority disorders. This has now been clarified in the text, but results and discussion sections (see also points above). Also, specifically in the TOC model, reduction of symptoms of psychosis is included (figure 1):

‘Symptoms of psychosis, tension, stress, depression and alcohol abuse are reduced’

Second, the intervention model is not delineated. How much training and for whom? How much supervision and by whom?

RESPONSE:
The reviewer asks for more detailed information regarding the care package that is being developed. However, we think that it falls outside the scope of this paper to provide such details. In the present study we have presented the formative research that has been used to inform the development of the care package, which is what we have highlighted. We agree that it is important to describe the details of the care package, yet this will be presented in a separate paper. To clarify this to the readers, we have added this reference in the discussion (page 15):

‘The details of the care package will be described in an upcoming publication.’

Third, efforts to integrate mental health services into primary care in Nepal began over 25 years ago. Yet, there is no mention of these efforts and the lessons that they might offer. For example, Acland (2002, World Mental Health Casebook) provides a detailed account of one program, including citing the need to provide services for children with developmental delays (called mental retardation in the chapter).
RESPONSE:
We fully agree with the reviewer that leaving omitting the work presented in the chapter by Sarah Acland (2002) is an oversight on our part. This work should definitely be presented in this paper. We have now included this in the introduction section (page 3), as well as a reference in the discussion (page 14). Furthermore, specifically related to developmental disorders, we have included the work by UMN/CMC in the discussion section (see point above; page 16).

‘Also in Nepal, there has been significant efforts made towards the development of a community mental health delivery program integrated in the public health system, yet without it being brought to scale [Acland, 2002].’


‘While some initiatives towards a community mental health model have been implemented [Acland, 2002], or are presently ongoing, in Nepal, the government has not yet, policy notwithstanding, adopted a plan for the integration of mental health into primary health care.’

Fourth, although it is dangerous to impose service models from high income countries, ignoring the research evidence about what works and doesn't work is even more dangerous. There is a need to recognize the difficulties entailed in providing mental health services in primary care even in the best of circumstances and with extensive resources.

RESPONSE:
We agree with the reviewer that there are many barriers in the process of integrating mental health into primary health care. The implementation and evaluation phase of PRIME will exactly delve into these points. While the current study cannot provide any conclusions around these difficulties, we do agree that it is important to acknowledge major challenges. We have added such cautionary note in the introduction, as this is an important point to set the stage for this study and for the entire PRIME program for that matter (page 3):

‘There is an urgent need to identify effective strategies that overcome such barriers in the delivering interventions. The lack of this evidence is a major challenge in the process of scaling up mental health care in LMIC [Cohen et al., 2011].’