Author's response to reviews

Title: Prevention of coronary heart disease in people with severe mental illnesses: A qualitative study of patient and professionals' preferences for care

Authors:

Christine A Wright (c.wright@medsch.ucl.ac.uk)
David PJ Osborn (d.osborn@medsch.ucl.ac.uk)
Irwin Nazareth (i.nazareth@pcps.ucl.ac.uk)
Michael B King (m.king@medsch.ucl.ac.uk)

Version: 2 Date: 13 March 2006

Author's response to reviews: see over
Dear Sir or Madam

Manuscript: 1130378326917495
Prevention of coronary heart disease in people with severe mental illnesses: A qualitative study of patient and professionals’ preferences for care
Wright CA, Osborn DPJ, Nazareth I & King MB

Thank you for your comments on the above manuscript, received by e-mail on 21st February 2006. We are pleased to resubmit the revised manuscript, in which we have addressed the two Reviewers’ and the Editor’s comments as follows:

(A) Reviewer: Molly Byrne

Minor Essential Revision
(1) In the Abstract, the use of the abbreviation of CMHT:
We apologise for this oversight. As requested we have amended the first mention of this term to its full version, ‘community mental health team’ (with the abbreviation ‘CMHT’ following in brackets).

Discretionary Revision
(2) In the Introduction, provision of more information about the larger study:
The qualitative interviews formed part of the development work conducted in the first year of the project. We have added an extra paragraph (pp. 5 to 6) at the end of the Introduction to state the aims of the broader research programme – i.e. to develop appropriate interventions to prevent coronary heart disease (CHD) in severe mental illness (SMI) – and to describe the other elements of the completed development work. No other papers have been published yet. In the Conclusions section, we mention the next phase of the project (which is currently underway) – i.e. testing the feasibility and acceptability of a nurse-led service to monitor and encourage screening for CHD risk factors in SMI.

/continued …
(B) Reviewer: Donna Fitzsimons

Major Compulsory Revisions

(1) The conclusions of the paper extend beyond the data – need to acknowledge methodological limitations and adjust conclusions:
We have added a sub-section, ‘Study Limitations’ at the end of the Discussion section, where we acknowledge the methodological limitations of our study (pp. 19-20). These include the relatively small sample size, the fact that we have recruited participants from just two inner London boroughs and the potential for sample bias. In line with the Reviewer’s comments, throughout the manuscript we have amended any sentences where our conclusions extend beyond our data. For example, in the Abstract (p. 2) and Discussion (p. 16), we have added phrases such as, “The views expressed by our participants suggest that …” or “CMHT and GP staff in our sample …” (p.16).

(2) Integrate previous literature with own work, discussing differences and similarities:
We have added a paragraph in the Discussion (p.19, para 2) which explains that there has been no previous research to explore stakeholder views on how best to organise services to prevent CHD in SMI. In addition, the Background section (p.5) comments on the lack of evidence or consensus on the organisation of such services, the absence of information on obstacles to service delivery and the lack of definition of roles for primary and secondary care services in the prevention of CHD. In the Discussion section (p.17, para 2) we also note that none of the international guidelines on the monitoring of CHD in SMI have mentioned the possibility of a model that crosses the primary-secondary care interface.

(3) Scant coverage of literature on CHD in SMI; suggestion to integrate general CHD literature in Background section:
In line with these helpful comments, we have revised the Background section (p.4) to incorporate more information on CHD in general (e.g. being the leading cause of premature death; pattern of UK mortality rates; the fact it is largely preventable). In addition, we have referred to the relevant National Service Framework standards for prevention of CHD which recommend the identification of people at risk of CHD and provision of appropriate advice and treatment to reduce their risk. We have also added more information concerning the increased prevalence of CHD mortality and CHD risk factors in SMI, together with details of the recommendations in the NICE Guidelines for Schizophrenia on the type of physical health monitoring required for this patient group.

Minor Essential Revisions

(4) Sample selection, inclusion/exclusion criteria, whether patients had existing CHD:
We have added more detail to describe the procedure for recruiting staff and service users to the study (p.6, para 1). In addition, for the interviews with service users, we have stated the inclusion and exclusion criteria we used and specifically state that existing CHD was not an exclusion criteria (p. 6 para 2).

(5) What type of interview technique was employed and why:
We used a semi-structured interview technique for the interviews. This approach was chosen because it enabled us to cover all the (many) key issues that were relevant for developing CHD prevention services for this patient group whilst allowing participants the /continued …
freedom to express their views as fully as they wished on each of the key issues. There was potential for flexibility in the order of covering the key topics, to assist the flow of the discussion – for example, some participants also mentioned training issues (covered later in the interview schedule) when discussing the primary care (or secondary care) models. Furthermore, at the end of the interview, participants had the opportunity to add any further views or comments that they felt were important but had not been covered in the interview schedule. We have added an additional paragraph, addressing these two points in the Method section (p. 7, para 2).

(6) Reasons for seeking views on a specialist nurse-led model: We sought to obtain views on a specialist nurse-led model as previous authors have suggested this may be a solution to overcome the barriers to medical or preventive care for people with SMI (by bridging the gap between primary care and secondary care services). Furthermore, there has been a recent trend within the NHS towards specialist nurse-led services – for example in the fields of cancer and diabetes care). We therefore wished to obtain stakeholder views on the applicability of such a model to the prevention of CHD in SMI. We have now explained the rationale for exploring this issue in the Method section (p.8, para 2).

(7) Negative tone of the paper’s message: One of the main conclusions from the analysis of our data was that the prevention of CHD in SMI is a complicated area where simple solutions (i.e. a ‘pure’ primary care model or a ‘pure’ secondary care model) were inappropriate. Our Discussion section tries to highlight some of the obstacles or challenges that need to be overcome when designing or developing services to prevent CHD in SMI, rather than painting a necessarily pessimistic picture. We would not wish to detract from this finding too much. However, we have noted the Reviewer’s concerns about the tone of the paper and we have made some amendments in our revised manuscript which we hope will help to address these. For example, to give a more ‘balanced’ view, we have acknowledged in the Discussion section (p.18, para 1) that some CMHT staff welcomed the opportunity to expand their skills. In addition, we have ‘softened’ some of the language by adding phrases, such as … “the interface between primary care and CMHTs potentially creates multiple pitfalls … “ (p.19, line 3).

(C) Editor’s comment (in e-mail of 21st February)

“Please comment on the topic of obtaining informed consent from those with severe mental illness”: The addition of our inclusion and exclusion criteria will, we hope, make it clear to the reader that none of the service users who participated in interviews were acutely unwell – we specifically excluded those who were unable to give us informed consent due to decreased capacity. We have added a statement in the Method section (p. 7, para 1) to emphasise this fact and state that, in line with usual procedures for obtaining consent, participants received a detailed information sheet and had the opportunity to ask questions about the research before agreeing to take part.

/continued …
(D) Manuscript formatting checklist

We have gone through the checklist as suggested to ensure that our revised manuscript conforms to all of the formatting requirements.

One further amendment we would like to make to the manuscript is to list Dr David Osborn as the corresponding author (p.1). My own contract with the project will end in the summer of 2006 and thus it seems more appropriate to give your readers the contact details of a permanent member of staff.

We trust that our revised manuscript has adequately addressed the comments raised and would like to thank you for considering this resubmission. We look forward to hearing from you in due course.

With kind regards

Yours faithfully

Dr Christine A Wright
Research Fellow
MRC Cardiovascular Screening & Mental Health Project