Author's response to reviews

Title: The development of a lay health worker delivered collaborative community based intervention for people with schizophrenia in India

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Author's response to reviews: see over
January 18th, 2012

To: Natalie Pafitis
Executive Editor
BioMed Central

Dear Natalie

I am re-submitting the paper “The development of a lay health worker delivered collaborative community based intervention for people with schizophrenia in India” (Article no: 6769778485403555) for consideration for publication in BMC Health Services Research, after addressing the comments of the two reviewers. Following their suggestions, we have included more information on the trial and the study settings, added the evidence of interventions from high income countries, and included information on how the community lay health workers were selected and trained. We have also responded to their comments and queries (please see the next page).

This submission contains this covering letter and the response to reviewers, a title page, the abstract, the text, 3 figures and 1 table. I look forward to the decision of the Journal.

Regards

[Signature]
Response of authors to reviewers’ comments for paper “The development of a lay health worker delivered collaborative community based intervention for people with schizophrenia in India”, reference number 6769778485403555

Reviewer 1

1. Awareness that the evidence base for the care of individuals with schizophrenia in non-LMIC may not apply to LMIC seems reasonable. However the paper should not ignore the literature on effectiveness of psychosocial treatments generated in non-LMIC. It would help the paper to discuss now the treatments that emerged from their literature review and applied in their model relate to the evidence based practices that have been studied in non-LMIC.

Response 1: Thank you for your suggestion. We have added the evidence of communality based interventions from high income countries i.e., community mental health teams and case management and cited two references (in “Phase 2”). We have also mentioned later (in the same page) that psychoeducation and family interventions (identified as our intervention components from the study in India) have also an evidence base in the west.

2. Related to this is the need for a bit more description of the intervention elements. Were CBT type techniques used? Behavioral? Problem solving? Motivational interviewing?

Response 2: We did not use specific classes of psychological treatment such as CBT but based our intervention components on evidence based community rehabilitation programmes (please see below, the portion of the text in the paper inserted for your reference). However, some of our intervention components, for example, rehabilitation, used techniques drawn from psychological therapies (for example, CBT), such as problem solving; persons with schizophrenia were encouraged by the CLHWs to develop positive coping strategies to deal with the illness, with solutions to problems being developed in a collaborative manner through discussions with persons with schizophrenia and their families. Similarly, the health promotion component used stress and anger management techniques (Table 1).

“We selected our initial community based intervention (CBI) components based on two sources of evidence. First, we conducted reviews of interventions for schizophrenia in LMIC [i ii]. Second, we were influenced by the experiences of a quasi-experimental study in rural India[iii], in which a community based rehabilitation model was delivered by locally recruited, non-specialist health workers, in collaboration with families, the local community and psychiatrists. The defining features of this intervention were its use of a combination of evidence-based strategies; its emphasis on utilizing available community resources; and its focus on improving awareness, promoting social inclusion and vocational rehabilitation. Results showed that the intervention significantly reduced symptoms and disabilities, compared to facility based care, with adherence being a strong predictor of outcomes. Based on this evidence, we identified a number of core components for our model: psychoeducation (providing information about the illness); adherence management (increasing regular and correct use of medication through adherence strategies and side-effect management); rehabilitation (improving functional abilities by providing social, vocational and other skills-training, and scheduling of daily activities); and referral to community agencies (enhancing community support by improving knowledge of and access to disability benefits, employment agencies and social welfare organizations). Given the burden of co-morbid physical and mental health conditions associated with schizophrenia [iv], we added an additional component on “health promotion”, to this model; this focuses on improving health of people with schizophrenia through better self-care, appropriate diet and lifestyle, and stress and anger management. In addition to these components, we also targeted the involvement of the person’s family in the intervention by employing specific strategies, for
example, by involving the family in planning the treatment; by educating them about illness and providing them with information about treatments and relapse recognition and prevention; helping families cope with difficult symptoms; and involving families in the management of adherence. Intervention components such as psycho-education and family interventions have also been found to be effective in high income countries ["""].

3. It is not clear how the CLHW’s and their supervisors were selected and trained.

Response 3: We have included this information now in “Phase 4”.

4. Given the importance of the psychiatrist as the cornerstone of treatment, it is important to understand their level of participation in the development of treatment.

Response 4: We did not do formative interviews with the psychiatrists like we did with patients and families. However the treating psychiatrists at all three sites attended monthly team meetings where they were involved in the planning of the project (for example, in defining the research questions for the formative and piloting phases). We have now inserted this in “Phase 2”.

5. It would be helpful to have a bit more description of the three study locations so that the international reader will have context.

Response 5: We have included this information now in “Phase 1”.

6. The study/model lacks information about how a person would be referred for this program. For the purposes of the anticipated study, what are the inclusion criteria? Most important, is the model intended for people who are in an acute phase? Post-acute phase? Is this for treatment seekers? What is the role of family in this treatment seeking process? What if there is disagreement between the family and the patient? It would help to describe how this is conceptualized?

Similarly, the model appears to be time-limited with a finite number of sessions. How is this conceptualized? Overall, more explanation about the beginning and the end of the program is required.

Response 6: In “Discussion”, we have now included some information on the trial – inclusion criteria, recruitment, etc. But since the details of the study protocol are described fully elsewhere (Chatterjee et al 2011), whose full reference has been inserted in the paper), we have not repeated this information here.

7. With respect to the statements (2nd paragraph after Phase 3): “A third of individuals were non-adherent with medication. Participants were willing to receive the CBI but recognised drug treatment as essential.”—Were these the same people?

Response 7: The persons who were non-adherent were not the same people who recognised drug treatment as being essential. Participants, in general, were willing to receive CBI—We have clarified this now.

• Minor Essential Revisions
Please indicate what MRC stands for.

Response 8: The MRC stands for the Medical Research Council, UK. This has been inserted in “Background”.

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Major Compulsory: A well written article that I recommend revise and resubmit. This is really two papers. The first should report findings from the qualitative data from the interviews, and the second should take up at approximately page 4 of the current manuscript and describe the pilot findings. In addition, the qualitative portion of the manuscript would benefit from additional detail of the analysis method and procedures for assuring quality of analysis.

Response 9: Following our first submission of the paper as an “original article” to the journal (13th April 2011), we were advised by the editorial team to revise and resubmit our paper as a “correspondence article”, after removing the details of the qualitative research and to present these separately as a second paper. The revised submission (October 7th 2011) took into account this suggestion by describing only very briefly the main findings of the qualitative research. Such a description is essential to provide context to the intervention development process i.e., to enable understanding of how the intervention changed following the formative phase and how this phase informed subsequent phases of development. The full description of the qualitative research we undertook, (including details of data analysis), is being prepared for a separate publication.

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5 Mari JJ, Streiner DL. An overview of family interventions and relapse on schizophrenia: meta-analysis of research findings. Psychological Medicine 1994; 24: 565-578

6 Pekkala E, Merinder I. Psychoeducation for schizophrenia. Cochrane Database Systematic Review 2002; 2: CD002831

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