Author’s response to reviews

Title: Assessing social recovery of vulnerable youth in global mental health settings: A pilot study of clinical research tools in Malaysia.

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Author’s response to reviews:

We thank the reviewers for their supportive and informative comments on our paper. We respond to each reviewer’s reports in turn below.

Reviewer reports:

Edo Jaya (Reviewer 1): General: There have not been many studies on mental health in Malaysia, and more studies are needed to address the WHO mhGAP programme. The finding that I found most interesting is that asking "taboo" questions about mental health does not have any negative impact, but rather a positive impact. I know that many of my clinical psychologist
peers here in Indonesia (another South East Asian country) regarded asking about these things have a negative impact on the client/patient.

However, I have the following concerns:

1. The authors mentioned that they gained ethical approval of the study from the University of Sussex, but conducted the study in Malaysia. Do they have local ethical approval?

Response: Approval was obtained from the University of Sussex in the first instance, and then communicated to our Malaysian collaborators, Sunway University and SOLS 24/7. Their Institutional Review Boards institutions accepted the University of Sussex’s approval and considered that this sufficient to issue local approvals. This arrangement has been clarified as follows (page 4, lines 97-99):

“Sunway University and SOLS 24/7 provided local approvals to conduct the research on the basis of reliance agreements with the Institutional Review Board at the University of Sussex.”

2. In the third paragraph of the background, the authors criticized the Western models of psychiatry and clinical psychology by stating that it is largely untested. Please elaborate further.

To my knowledge, there are practicing psychiatrist and clinical psychologists in Malaysia who used Western models and are able to help patients. For example, there are psychiatrists who prescribed medications such as antipsychotics to people with psychosis and there are inpatient treatments for those people in hospitals. Another example is that in the Western models of psychiatry, homosexuality is not seen as a disorder. However, in many cultures (such as in many versions of Islam), it is seen as a disorder. How can this be a better alternative?

Response: We thank the reviewer for raising this important point and sharing these interesting reflections. We have clarified our position in the paper to emphasise our agreement that Western approaches are used - and with evidence of success - in South East Asia and Malaysia specifically. However, we consider that the exploration of the cultural validity of assessment and treatment approaches is an essential part of optimising Western approaches for local implementation. We have elaborated on these points in the following sections:

“There is evidence that Western models may have broad applications with positive impacts evidenced in South East Asia and Malaysia specifically (21–23). Nevertheless, the universality of Western approaches remains largely untested in the local context (21,24).” (page 7, lines 170-172)

“Thus, whilst Western approaches may benefit the development of psychological interventions in Malaysia, exploring the cultural validity of such approaches prior to and during implementation
is essential. For example, this may reveal potential clashes of culturally determined values with imported therapeutic models and practices, and could suggest scope for adaptation or optimisation through integrating Western approaches and Eastern philosophies (28,29) or else highlight a need for ‘bottom-up’ approaches grounded in the local setting (21).” (page 7, lines 177-182).

3. In the fourth paragraph of the background, the authors suggest the application of social recovery approach in Malaysia (e.g. Social Recovery Therapy). This is a Western model of psychiatry and clinical psychology too, right? The authors can either decide to use non-Western models or use Western models, but the authors should not criticize the current state of clinical psychology and psychiatry in Malaysia for being Western and suggest another Western model.

In addition to the clarification outlined in our response to comment 2 above, we have added further support for the potential utility of SRT in the Malaysian context:

“Social Recovery Therapy (SRT; 5) may be a particularly promising intervention for the Malaysian—and broader LMIC—setting due to its focus on social recovery through personally meaningful and valued structured activity including employment, community, leisure and social activities. SRT is guided by personalised goals and values and gives specific attention to the individual’s wider context, and particularly their social networks (8,34). The intervention is informed by psychosocial constructions of mental health and recovery rather than a Western biomedical model of mental ‘illness.’ As such, SRT is not primarily focused on diagnosis and symptom reduction; rather symptoms are attended to only insofar as they form barriers to social recovery (in addition to other personal and systemic barriers of relevance).” (page 8, lines 197-205)

4. Sample characteristic: Please provide more detailed description. What does "vulnerable" mean? What does low-income mean? How many had a diagnosis of mental health problem? How many had physical health problem?

Response: We have provided additional clarification regarding the sample, as below:

“The NGO and partner organisations serve low-income populations (defined as earning 40% less than the national average) in crime-affected localities in greater Kuala Lumpur. The low socio-economic status of the vulnerable target population also manifests as a lack of access to basic services such as housing and formal education. The organisations included orphanages which serve young people who are unable to remain in the family home due to extreme poverty, neglect and/or trauma.” (pages 10, lines 258-264)
“Potential participants were first approached by NGO staff members. Consent from the parent or caregiver with parental responsibility was sought before approaching potential participants aged under 18 years old. Interested young people were provided with information about the study. After obtaining verbal agreement for contact from the study team, each participant was invited to meet for an interview with a researcher and an interpreter. Participants were sampled using convenience sampling approach that maximised ethno-cultural diversity across Indigenous (Orang Asli), Malay, Chinese and Indian participants and the three primary languages of Malay, Mandarin and Tamil. The final sample (N=9) comprised 5 males and 4 females, aged 16 to 23 years (M= 19.78 years; SD= 2.86). No participants reported a diagnosis of physical or mental health problems.” (page 10, lines 266-274)

5. Please adjust the wordings of the tile and abstract to reflect the study better. This study is about the feasibility and acceptance of assessment tools conducted on nine vulnerable individuals possibly without a mental health diagnosis. The term social recovery approach made me thought that this manuscript is about a feasibility trial of a therapy. The term at risk mental states for psychosis made me thought that the sample consists of individuals with a diagnosis.

Response: We have revised the title to ensure clarity regarding the focus on core tools and processes specifically for the assessment of social recovery:

Title: “Assessing social recovery of vulnerable youth in global mental health settings: A pilot study of clinical research tools in Malaysia.”

We have also ensured that the focus on assessment is made clearer in the abstract text:

“Participants completed a battery of social recovery assessment tools (including time use, unusual experiences, self-schematic beliefs and values).” (page 3, line 71-72)

“We provide preliminary evidence for the feasibility and acceptability of social recovery assessment tools in a low-resource context, comparing the experiential process of engaging young Malaysian participants in social recovery assessments with prior accounts from a UK sample.” (page 4, lines 86-88)

6. In the results section we can find that many of the results seem to be in line with the results of previous studies from the UK. The similarities of the findings from Malaysia and the UK, i.e. non-Western and Western context does not seem to be discussed and only fleetingly mentioned. This is an interesting similarity that can be discussed.

Response: We have added a sentence explicitly drawing attention to the similarity in experiences in the present setting compared to our prior work in the UK (page 22, lines 595-601):
“Thus, our findings suggest that the experiences of Malaysian young people echo those from our previous UK samples and perhaps underscore the intuitiveness of social recovery concepts, and the potential utility and possible universality of related clinical research tools across diverse contexts. Moreover, the essence of social recovery appeared to have some resonance for current participants insofar as they seemed to share a sense of structured activity as personally meaningful and facilitative of social connection—and reflected that engagement in such activity can be complicated by individual, psychological and systemic barriers.”

Laurie Heatherington (Reviewer 2): This manuscript describes the results of a qualitative study testing the feasibility and acceptability (participants' responses to) of a set of measures relevant to the assessment of serious mental health problems in young adults in Malaysia. The introductory material reveals that the authors are experienced in assessing and treating young adults with psychosis in the UK, and seeking to test this core set of measures of social recovery/psychosocial functioning for their potential useful in the Malaysian context.

There is much to recommend about this work in general. The manuscript documents the dearth of mental health treatment in Malaysia as well as the need to start at the beginning, and in a culturally sensitive way, to first test the usefulness and feasibility of a means of identifying those at risk. The sample included participants from several ethnic groups in this multi-ethnic society. Clearly, it is a first step in an important, ongoing collaboration to develop mental health treatment services in an area of great need.

The measures were presumably translated (although we need more information about that - were they also backtranslated?) and presented in a semi-structured interview. More information is needed about the interviewers and the interview settings.

Response: Please see page 13, lines 342-346 for clarification regarding measures:

“Assessments were not translated in advance but were administered by the first author in the English language. Interpreters provided interpretation as needed for participant comprehension. The interviewer checked understanding of interpreted questions and responses with all parties through further questioning and additional interpretation was conducted as needed. Interpreters variably used first, second, or third person pronouns within and across interviews.”

We have also provided further details about the interviews, as below:
“Sessions were conducted in a private location convenient to the participant; in clinic or meetings rooms on NGO premises, in the participant’s home or place of work.” (page 12-13, lines 335-337)

Most participants completed most measures although there was some attrition, and participants made useful comments about improving the measure or the administration. Time to completion ranged from 53 minutes to just over two hours, quite a range. With only nine participants, it is hard to have a reliable sense of how long the battery will typically take. A larger sample would significantly improve the strength of the evidence on this dimension, and in general. If adjustments to the measure and the administration of it (e.g., breaking it into sections) were to be made on the basis of this pilot data, then testing it on a larger sample would provide stronger evidence.

Response: We thank the author for raising this important point and agree that a larger sample would have enabled stronger inferences to be drawn. We have elaborated on the study limitations, as below (page 23-24, lines 646-649):

“Replicating the present study with a larger sample of young people would generate more robust evidence regarding the time taken to administer assessment measures. This could help to facilitate the formal translation and validation of social recovery tools in Malaysia.”

The other major concern is the sampling. It is not exactly clear how this set of nine young people, none of whom were showing signs of incipient mental illness were identified and recruited. Also, then, by definition, this does not test the feasibility of the battery in a population for whom the measure is eventually intended. It seems that the authors learned a lot from this initial testing that will be helpful moving forward to develop the assessments in Malaysia, and they are encouraged to continue to develop their important research program.

Response: We thank the reviewer for their endorsement of this programme of work. We have clarified the sampling procedure (page 10, lines 270-274):

Participants were sampled using convenience sampling approach that maximised ethno-cultural diversity across Indigenous (Orang Asli), Malay, Chinese and Indian participants and the three primary languages of Malay, Mandarin and Tamil. The final sample (N=9) comprised 5 males and 4 females, aged 16 to 23 years (M= 19.78 years; SD= 2.86).”
We have also emphasised that more work is needed on the specific applicability of social recovery assessments tools to young people with serious mental health problems (page 23, lines 645-646):

“Nevertheless, further testing in Malaysia would usefully involve young people with confirmed serious mental health problems including psychosis.”