Author’s response to reviews

Title: Pilot Randomised Controlled Trial of the ENGAGER collaborative care intervention for prisoners with common mental health problems, near to and after release

Authors:

Charlotte Lennox (charlotte.lennox@manchester.ac.uk)
Tim Kirkpatrick (tim.kirkpatrick@plymouth.ac.uk)
Rod Taylor (r.taylor@exeter.ac.uk)
Roxanne Todd (roxanne.todd@manchester.ac.uk)
Clare Greenwood (chgreenwood1@sheffield.ac.uk)
Mark Haddad (mark.haddad.1@city.ac.uk)
Caroline Stevenson (caroline.stevenson@manchester.ac.uk)
Amy Stewart (amy.stewart@plymouth.ac.uk)
Deborah Shenton (dshenton@plymouth.ac.uk)
Lauren Carroll (lauren.carroll@plymouth.ac.uk)
Sarah Brand (sarah.brand@plymouth.ac.uk)
Cath Quinn (cath.quinn@plymouth.ac.uk)
Rob Anderson (r.anderson@exeter.ac.uk)
Mike Maquire (mike.maquire@southwales.ac.uk)
Tirril Harris (tirril.harris@kcl.ac.uk)
Jenny Shaw (jennifer.j.shaw@manchester.ac.uk)
Richard Byng (richard.byng@plymouth.ac.uk)

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Author’s response to reviews:

Dear Editor,
Many thanks for the opportunity to provide a revised manuscript.

Here are our responses to the comments.

1. The overall format of this new intervention is well described and easy to follow with one exception: what the authors call “Mentalisation based approaches”. I suggest authors could improve this specific aspect description beyond the footnote “Mentalisation is the ability to understand the mental state, of oneself or others”. Providing examples could be helpful.

The footnote has been removed and the following text added to the main document:

Mentalising is a natural human ability. It is the capacity to think about our own mind and the minds of others and understand how emotions, thoughts, wishes and impulses lie behind and influence our behaviour and the behaviour of others. Good mentalising involves being able to acknowledge that often we do not accurately know what people are thinking and feeling but that often we can make more or less accurate guesses. Good mentalising also involves having an authentic interest in other peoples’ emotions and thoughts and not making quick assumptions about why a person may have behaved as they did. For example, rather than assuming why your client has started to drink again, instead being open and curious to exploring with them what was happening for them.

2. Regarding the participants in the study, what was the rationale for including only males in the sample? Was it a pragmatical (e.g. not sufficient women to run subgroups analysis of sex effects, no access to women prisoners) or clinical decision (e.g. women tend to respond very differently from men with similar interventions up to the point of requiring sex tailored interventions)?

The rational for only including males was both pragmatic and clinical. The number of females in prison is much smaller, and the prisons are geographically remote, therefore impacting the feasibility of a trial. Also treatment and resettlement needs are substantially different. This has been added to the manuscript.
3. Also regarding the description of participants: how did the researchers identified those with a severe and enduring mental illness? Was it based on clinical records or clinical interview? Was any structured instrument applied?

Participants with severe and enduring mental illness were identified by reviewing clinical records and in discussion with the prison in-reach team. This has been added to the manuscript.

4. In line 381 there is a “the” ending the sentence that needs to be erased.

This has been removed.

5. Please include a paragraph about training requirements of researchers for the proper application of the protocol and describe if any methods for evaluating protocol integrity and fidelity were perform to guarantee similar quality between researchers participating in patients’ care.

All researchers received training in Good Clinical Practice and in the requirements of the study protocol. Joint training for researchers at both sites was undertaken prior to commencing recruitment to the trial to ensure a consistency of approach, from consent to data collection. In addition weekly team meetings via video conference allowed both research sites to ensure a similar quality. This has been added to the manuscript.

6. Please include information on how ENGAGER intervention differs from “treatment as usual” regarding number of hours of contact with professionals involved in patients’ care.

The Engager supervisor and practitioner meet jointly with the individual on at least two occasions in prison and once in the community to engage with individuals and to develop and
review the shared understanding. Engager practitioners meet with individuals at least weekly in prison and the community after release for 8-16 weeks, according to their needs. Practitioners actively review progress, assertively follow-up and liaise with others involved in the individual’s care and resettlement including families, peer mentors and other agencies and organisations identified in the development of the shared plan. Practitioners plan, work towards and deliver a positive ending. In contrast treatment as usual consists of general practice contact for some and rarely psychological therapy. Those with opiate addiction are often seen frequently by substance misuse services.

This has been added to the manuscript.