issues are considered during the planning of a trial.

To fully understand how a trial was organised, designed, conducted, and reported, it is necessary that the protocol be, not only publicly available, but also complete in its content. The SPIRIT 2013 Statement[3] and explanatory paper[4] address both of these issues. First, SPIRIT promotes high-quality, complete protocol content by providing evidence-based guidance on key issues to consider and address.[3,4] Second, as part of the item on reproducible research, SPIRIT explicitly emphasises the rationale and importance of providing public access to protocols and participant-level data in journals, web repositories, and trial registries.[4] This recommendation is reinforced by the recent International Committee of Medical Journal Editors requirement for protocol and data sharing statements in published final reports.

The SPIRIT group will continue to focus on promoting protocol completeness and sharing to increase value and reduce research waste for the benefit of patients, policy, and research.[5] The implementation of the SPIRIT guidance will be facilitated by the upcoming release of SEPTRE (SPIRIT Electronic Protocol Tool and Resource), a cloud-based application designed to promote quality and efficiency in protocol development, registration, and management on the basis of SPIRIT. Leveraging this technology to link with trial registries will enable accurate transfer of information from the source protocol to automatically populate registry fields. It will be important to seize the protocol-sharing opportunities offered by trial registries, which can build on their established infrastructure to serve as public repositories for protocols. For example, ClinicalTrials.gov and the Australian New Zealand Clinical Trials Registry offer the ability to upload protocol documents. The SPIRIT group will revisit emerging issues relevant to protocol development and update its guidance periodically to reflect new considerations that enhance protocol content and promote quality by design.

A-WC, DM, and DGA are members of the SPIRIT steering group.

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Mental health of incarcerated people: a global call to action

The longstanding disregard of people with mental illness who are incarcerated in low-income and middle-income countries (LMICs) is troubling. We propose some core principles for prison mental health in LMICs: stronger global governance; clear national policies that give responsibility to health services; and context-specific clinical tools and interventions. We recognise that these solutions are a form of harm reduction: ultimately, prisons and jails are not the right place for people with mental disorders.

About 90% of people in UK prisons have at least one mental or substance use disorder.[1] Although the prevalence of these disorders in prisons in LMICs is not well known, the problem of mental illness in prisons is probably greater in LMICs than in high-income countries because LMICs have fewer resources for psychiatric care.[2,3] For people with mental disorders, prisons and jails are often the sites of human rights abuses, ranging from unjust detention to physical and psychological abuse.[3] We are concerned not only for patients in forensic services, but also for the many incarcerated individuals who have mental disorders or poor mental wellbeing.

Prison mental health is underfunded and features minimally in guidelines on the development of mental health systems. Additionally, mention of forensic services or prison mental health is largely absent from international mental health data collection efforts, including WHO's Mental Health Atlas. International organisations have a leadership role to play in funding health services for people at the intersection of the criminal justice and mental health-care systems, generating evidence-based guidance on clinical practice and the enactment of human rights standards and providing tools to monitor outcomes.

Zimbabwe faces some of the key challenges of many governments in LMICs. The country has a national health service but prisons are overseen primarily by the Ministry of Justice and the division of responsibility between the Ministries of Justice and Health is unclear, leading to gaps in service delivery. We propose that national governments in LMICs move prison health care to a national health-care service, following the lead of England, Wales, and many European countries.[1] This strategy facilitates parity of services between prison and community and allows economies of scale for health-care delivery.[1]

Prisons differ from community settings in many ways, including increased security and distinct power dynamics between patients and staff,

For the **statement by the International Committee of Medical Journal Editors** see http://www.icmje.org/news-and-editorials/data_sharing_june_2017.pdf

and few interventions have been adapted or tested in LMIC prison settings. Possible interventions include interpersonal psychotherapy, which is being tested in prisons in the USA[4] and which works in low-income community settings in Uganda.[5] Community health workers, who deliver effective mental health treatments in LMICs, could be part of prison and post-release mental health interventions.

Prisons are the wrong place for people with mental illness and are poor settings for mental health treatment. Strong community-based mental health services and adequate psychiatric hospital capacity might prevent crimes from ever being committed and are a more appropriate alternative to imprisonment. However, given that, for the foreseeable future, many people with mental illness will remain in prison, it is important to provide better care for these individuals both when they are in prison and after they are released.

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