Viewer’s report

Title: Accumulated coercion and short-term outcome of inpatient psychiatric care

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Reviewer: Tilman Steinert

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This paper addresses an important question, outcome of involuntary treatment. As the authors correctly point out, so far there has been not much research on this topic. The idea of this paper was that coercion is not correctly assessed dichotomously (yes/no) but a more dimensional approach is required. Therefore a score including the number of well defined coercive incidents was introduced. The outcomes chosen (GAF improvement and subjective improvement) are reasonable, no association with coercion was found. Generally, this study is well done and the paper is well written. I suggest some minor revisions.

- Abstract: It should be kept in mind, that most people will only read the abstract and use it for further research. Maybe it could be described in more detail how coercion was measured. The reader could assume that simply incidents have been added, what would not be correct.

- Introduction, 1st sentence: “…is based on the assumption that coercion… will lead to a better outcome”. That is only half of the truth. The other is that coercion is used because of danger to self and others. In many countries, coercive treatment only for improvement of mental health is not allowed. This sentence should be revised.

- Method: The dimensional definition of coercion by including different kinds of assessments seems very reasonable. However, why change coercion from a dichotomous to a dimensional variable for good reasons and, on the other hand, use a dichotomous outcome variable (improved yes/no)? For subjective assessment, patient-assessed CGI (PGI) would have been more appropriate, but that cannot be changed any more. But for doctor’s assessment, with GAF differences a continuous variable was available and could have been used for calculations. The transformation into a dichotomous outcome obligatorily leads to a loss of information. At least, the authors should explain why they transformed GAF differences into a dichotomous outcome and why they chose the cut-off of 10. The next problem to be discussed is that a difference of 10 is clinically more significant in lower than in higher GAF scores. Probably, most of the patients scored below 50, but that should be described.

- The coercion score was composed of subjective and objective elements. As a whole, there was no correlation with outcomes. It would be of interest also, whether either the subjective or the objective parts were associated with outcomes.

- Discussion, p.9, line 5: “A possible explanation is… that measures were
different.” To my mind, a more probable explanation is that patient satisfaction and outcome are quite different aspects. There is some evidence available that patients treated under coercion are less satisfied with their doctors even if treatment outcome is not worse than in voluntary patients.

- Discussion: Some sentence could be written on the result that patients with lower GAF and higher BPRS were more likely to be improved (e.g., ceiling effect for the more healthy patients)

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests