Author's response to reviews

Title: Gender differences in coerced patients with schizophrenia

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Author's response to reviews: see over
Dear Executive Editor,

we sincerely thank you for the referee’s reports pertaining to our manuscript ‘Gender differences in coerced patients with schizophrenia’ and the chance to resubmit a revised version. The reviewers provided very useful suggestions. We changed the manuscript in accordance with their remarks and the editorial requests. Please find enclosed a revised version of the manuscript, and below a detailed report addressing each of the individual remarks. As we have moreover performed a thorough revision of language by a native speaker we are sending the article without track changes as they made the text quite confusing and sometimes hard to follow. We do hope that this revised version will be acceptable for publication in the BMC Psychiatry.

Yours sincerely,

On behalf of all authors,

[Signature]

Alexander Nawka, MD
Reviewer: Bruno Biancosino

Reviewer's report:

1) Abstract: (line 2) “patiets” has to be changed into “patients”.

Answer: The typographical error in the abstract has been corrected.

2) Results: It would be of interest to specify the period of the study when patients were identified.

Answer: The identification (recruitment) of patients participating in the study was done during the main phase of the study, i.e. between July 2003 and December 2005. This has been mentioned in the Methods section:

“…each participating center recruited all involuntarily admitted patients between July 2003 and December 2005.”

Reviewer: Rolf Wynn

Reviewer's report:

Introduction

1) Do the different countries included in the study have similar legal provisions for the use of coercion? What are the implications for the study?

Answer: We thank the reviewer for this important comment, which allows us to specify a relevant issue of the EUNOMIA study, which was not possible to discuss in the manuscript. Procedures of the use of coercive measures and the respective legislations do vary in Europe according to the different socio-cultural contexts. Actually one of the goals of the EUNOMIA study was to summarize and evaluate this information throughout Europe in order to develop European
recommendations for good clinical practice in involuntary hospital admissions and in the use of coercive measures. However, these differences have only limited implications for the study, as all participating centers in the twelve European countries have used the same definitions for “coercive practices” (i.e. seclusion/forced medication/mechanical restraint) as well as what are the reasons that triggered the use of coercive measures. Although it is impossible to totally overcome the different legal provisions in all participating centers, the study design of EUNOMIA enabled the most reliable international comparison among different countries on this topic so far. For more information, a number of papers as well as a whole book, based on the EUNOMIA dataset, have been recently published on this topic:


Methods

2. How reliable were the diagnoses? Did you independently verify the diagnoses of the patients or were these data taken directly from medical records?
Diagnoses were established in the participating hospitals using ICD-10 criteria and were obtained from medical records. Psychiatric symptoms were assessed by means of the 24-item version of the Brief Psychiatric Rating Scale (BPRS), which was used by study researchers whose inter-rater reliability has been assessed throughout the study and found to be satisfactory (interclass correlation coefficient of 0.78).

3. Do you know if there might be differences in how schizophrenia is diagnosed in the different countries that participated? If so, might this have consequences for your study?

Answer: As all the participating centers have used ICD-10 criteria to diagnose schizophrenia it is not likely that there were significant differences. Moreover, eventual differences have not been detected in the other analyses derived from this study:


4. Did you differentiate between forced medication as an emergency procedure and forced long-term (i.e. depot) medication?

Answer: According to the definition for this study “forced medication aims at the restriction of the psychological “inner” latitude of patients by medication administered against the patient’s will”. We did not differentiate between forced “acute” medication and forced “long-term” medication, but practically there have been only exceptional cases of “long-term medication” use in Sweden and UK.

5. Did physical restraint include holding by staff?

Answer: Physical restraint was defined as either fixation of at least one of the patient’s limbs with a mechanical device or being held by a staff member for longer than 15 minutes. Holding by staff technique was used however only in a few centers, mostly in UK.

6. You mention consent-procedures but who performed the ethical review of the study?

Answer: The ethical review of the study was performed by the national or regional review boards at each participating site. The list of the review boards can be found in the answer to the editorial request and it has been added in the manuscript.

7. Regarding the analysis: Have you considered including a control sample of non-coerced patients with schizophrenia and to see which of your predictors (including gender) that predict the use of coercion?

Answer: We thank the reviewer for suggesting us a very interesting analysis. We have thought about this comparison, but the gender comparison of the coerced patients already presents significant material for one paper. However, this idea is worth exploring in future studies.
Results/Discussion/Conclusion

8. Some key-numbers of the overall sample should be included.

Answer: Thank you for this comment. In table 1, figures of the overall sample have been added in the first column “Total sample” including sociodemographic, clinical and social functioning characteristics.

9. The response rate seems to be 41%? How does this impact your results? Was the response/consent-rate consistent across the sample?

Answer: Thank you for this comment, which gives us the chance to comment on a rather complex issue. 41% is the percentage of patients that were enrolled in the study from those who were eligible at admission. A significant proportion of patients was discharged before they could be asked to participate or they were clinically too unwell to be included. Although 41% could be seen as a low “recruitment rate”, it may be considered as reasonable for a study on involuntary admitted patients who were experiencing coercive measures. This “recruitment rate” was consistent across the sample.

10. Does the study have any clinical implications? The authors briefly mention ‘targeted treatments’ and ‘appropriate consideration’ but do not give any concrete examples of how the results could be utilized/relevant clinically.

Answer: There are implications in respect to the training of hospital staff, which have been added in the Conclusions of the paper.

“To conclude, there are implications which might be used in the education of hospital staff, such as the fact that the overall frequency of aggressive behaviors by schizophrenia patients is actually higher in women than in men, although severe aggressive behaviors are more frequent in men.”
Needs some language corrections before being published

Answer: The manuscript has been thoroughly revised by an English native speaker and language amendments have been made.

Additional Editorial requests:

Please include the specific names of all ethics committees that granted approval for your study, in each country in which data was obtained.

Answer: The list of all ethics committee was included in the manuscript in the methods part:

- Research Ethics Committee, Medical University Sofia, Sofia, Bulgaria
- The Ethics Committee of the General Teaching Hospital, Prague, Czech Republic
- Ethics committee at the Faculty of Medicine at Dresden University of Technology, Dresden, Germany
- Scientific Board of the Psychiatric Hospital of Thessaloniki, Thessaloniki, Greece
- The Tel Aviv University IRB-Helsinki Committee, Tel Aviv, Israel
- Ethical Committee of the Second University of Naples, Naples, Italy
- Lithuanian Bioethical Committee, Vilnius, Lithuania
- Commission of Bioethics at Wroclaw Medical University, Wroclaw, Poland
- Ethical Committee of the Michalovce Psychiatric Hospital, Michalovce, Slovak Republic
- Ethical Committee (ComitéÉtico) of University Hospital of San Cecilio. Granada, Spain
- Research Ethics Committee of Örebro University Hospital, Örebro, Sweden
- East London and The City Research Ethics Committee, London, UK"