Author's response to reviews

Title: Suicide with psychiatric diagnosis and without utilization of psychiatric service

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Author's response to reviews: see over
Dear Prof. De Leo

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Thank you very much for your kind consideration of our manuscript to be published in BMC Public Health. We also thank Jerneja Sveticic and Maurizio Pompili, the reviewers, for their valuable comments which are indeed very helpful for us to come up with a much more improved version for publication.

We address to their comments point-to-point as below:

**Comments from Jerneja Sveticic:**

1. Title may lead the reader into thinking the study explored suicides in persons without any recognised mental health problems, when in fact all cases included in the study did receive (albeit retrogradely) psychiatric diagnoses. It would be worth conveying this message already in the title. The same applies for the last sentence of the Background in the Abstract.

   **Response:** The title now is changed to “Suicide with psychiatric diagnosis and without utilization of psychiatric service”; and a phase has been subsequently added to the last sentence of the Background in the Abstract to highlight the knowledge gap about suicides with psychiatric illnesses but not known to the health care system.

2. In describing independent variables, authors state that ‘predisposing variables’ include socio-economic characteristics, yet they include employment status, income level and financial debts in the ‘enabling variables’. Are they placed in this category because they are believed to facilitate access to health care services via individual’s financial means? If so, this should be explained.

   **Response:** Yes, according to the behavioral model, income and wealth available to individuals to pay for services are classified as enabling characteristics [1]; the definition of this item has been clarified in the 2nd paragraph, page 5 after “Enabling” resource; beside, a brief explanation of why these variables are included in “Enabling” under “Independent variables” has been included. Pl. see page 9.

3. Why did authors group mental disorders into psychotic vs. non-psychotic categories? This needs to be explained.
Response: Explanation is included in page 6 under the discussion of “need” in the section of Background.

4. The first paragraph of the Method (up to reference number 21) would be better placed at the end of the Background. The rest of this paragraph is suggested to be merged with the description of the sample (currently paragraph 2), which should also include the total number of cases included in the analysis (n=119) and the explanation why 2 cases were omitted.

Response: we consider this paragraph not so relevant to the main purpose of this manuscript. Therefore we have deleted it. And the explanation about the sample is inserted in page 8 under “Sample”.

5. In Statistical analysis (under Methods), it is unclear where the sample of 879 cases originated from. Do they represent the sample from the previous publication using psychological autopsy data or are they the total number of suicides that occurred in 2003?

Response: 879 was the total number of suicides aged 15-59 occurred in 2003.

Also, authors compare the included 121 cases with the total sample of 150 cases; however, I do not see much relevance of these comparisons, as the aim of the paper was not to compare the characteristics of suicide cases with mental disorders to those without such disorders.

Response: Agreed and that section is deleted.

6. In Results, page 7, 2nd paragraph, 4th sentence: The relevance of this information is unclear. Who made this diagnosis? What is the relevance of the time period in which the diagnosis was made? Why is not the same percentage presented for the ‘contact group’?

Response: The reason of stating “only 8 (12.3%) out of 60 had been diagnosed with psychiatric disorders in the last six-month prior to death” was to show how many deceased cases would have been excluded by adopting the operational definition of “making a contact with psychiatrist” – six-month prior to death. However, we agree with the reviewer’s comment that this appears to be irrelevant when we want to highlight the differences between the contact and non-contact group. Therefore, this result is deleted.

7. In Results, page 7, 2nd paragraph: Numbers and percentages of cases (both in ‘contact’ and ‘non-contact’ group that sought help with specific care providers do not add up. For example, in the non-contact group percentages are calculated against a total number of 63 cases, but in the first sentence the authors report of 67 cases in this group? I suggest re-structuring this paragraph so it reads more clearly and matches the results presented in Figure 1.

Response: The paragraph is now rewritten in page 10 & 11 to clearly state how many of the 121 cases had and had not made use of different types of services.
8. Figure 1 is in its current form very hard to decipher, and some numbers seem to be missing from it (e.g. number of cases that received help only from psychiatric service). It might also help if authors used more distinct colours for each circle and for marking cases that belong to ‘contact’ / ‘non-contact’ group.

Response: Agreed and it has been deleted. A table (Table 1) is used instead to replace the Figure 1 which shows clearly the numbers and percentages of different types of service use by Contact and Non-contact group. Cases with missing data are also listed in different categories.

9. In presenting Results, use of the term ‘emotional problems’ is badly chosen; a better word for it would be ‘mental health problems’. Same applies to ‘emotional treatment’.

Response: The expression of “emotional problems” is also revised to “mental health problems”.

10. The discussion could benefit from a more detailed discussion of the differences between evaluated and perceived need for receiving help in people with mental illnesses and those experiencing suicidal ideation. Authors may want to consider including findings a recent publication by Pagura et al. (2009)*.

Response: We can hardly discuss the difference between perceived need and evaluated need because by no means information of the perceived need could be obtained directly from the deceased samples of our study;

Nevertheless, thanks for the suggestion and we’ve reviewed the article by Pagura et al [2] and found it inspiring.

Pagura et al discussed the prevalence of help-seeking, perceived need, satisfaction with health professionals, and barriers to care in three different groups of community samples: 1) individuals with mental disorder(s) without suicidal behaviors, 2) individuals with suicide ideation (with or without mental disorder(s)), and 3) individuals with suicide attempt (with or without mental disorder(s)). They found that those in the 2nd and the 3rd group (with suicide ideation and suicide attempts) were significantly more likely than those in the 1st group to seek help and to perceive a need for help in the past year. The findings agreed with authors’ assumption of the study that suicide ideation and suicide attempt measured as indicators of “evaluated need” were associated with increased help seeking and perceived need over and above the presence and severity of mental disorders. It also supported Andersen’s model that an increased level of evaluated need was associated with an increased likelihood of help seeking. However, large proportions of those with suicide attempt (59%) or suicide ideation (76%) did not perceive any need for treatment. The authors explained that without perceived need, the severity of evaluated need might not promote help seeking.
It is also noted that the samples of Pagura, et al were community samples while ours were suicide deceased individuals. Direct comparison is not appropriate.

However, we have addressed the importance of “perceived need” in help seeking and suggest direction for future studies (page 18 & 19).

11. First sentence of Discussion is unclear. What group are persons with mental illnesses being compared to?

Response: Community samples with mental illnesses; to have a more focused discussion, this part has been deleted.

12. In Discussion, page 9, authors cite results from an American community survey as a comparison of percentages of mentally ill people that have sought/received psychiatric care. Perhaps a more valid comparison could be made with results of some studies that employed the psychological autopsy approach and examined frequency of contacts with mental health care professionals in suicide victims, and if available, from Asian cultural background.

Response: Authors have reviewed a number of psychological autopsy studies in Asia but only two studies: Yang, et al [3] and Khan, et al [4] reported the use of mental health services. Other two important PA studies, such as Cheng, et al [5] & Vijayakumar [6] did not report findings on this area. The proportion of the non-contact group is indeed not very low in Hong Kong in comparing with findings from other developing and underdeveloped countries. This may due to the highly subsidized health care provision in Hong Kong at where the majority of population can access to the public health system. Of course, the system in Hong Kong does share some common problems experienced by other developed countries, such as too few mentally-ill patients actually receive newer evidence-based interventions; and relatively few clients can benefit from assertive community treatment which has been accepted and endorsed as treatment policy by the system [7]. Since we do not have sufficient evidence to comment on the mental health care system in Hong Kong and it’s not the major focus of this paper, so we comment on the proportion of non-contact group in a context of other similar studies in Asia. Pl. see revisions made in Page 14 & 15.

13. In Discussion, page 11, authors state that observed differences in enabling factors between ‘contact’ and ‘non-contact’ group may suggest either that the latter group had more enabling resources or had higher levels of problem solving competency, which often serves as a barrier to psychiatric services (references needed). This reads as circular reasoning, and authors are encouraged to re-phrase this conclusion.

Response: Agreed and the paragraph has been re-written. Pl. see page 16 & 17.
14. In conclusions authors present several good suggestions for engaging people with psychiatric disorders in seeking appropriate help by mental health professionals, particularly in non-medical settings. However, I feel that the specific cultural factors, significant for Asian countries, are insufficiently included in the discussion (pertaining, for example, to the availability and affordability of psychiatric services and general population’s preparedness to seek help for mental health problems).

Response: Unlike many developing countries in Asia with large populations, Hong Kong has a relatively accessible and affordable health care system for the majority of approximately 7 million of population. As we have explained in page 14 & 15, the proportion of non-contact group among the suicide deceased cases was much lower than that reported in other similar studies in Asia. The situation of Hong Kong that we report here may not be suitable to generate to other Asian countries where often have too many demands of mental health specialized services.

Nevertheless, we have discussed the readiness of seeking mental health care of this non-contact group and suggested that individual-based suicide prevention efforts might not be suitable for them. Pl. see revision on page 20 & 21.

Minor Essential Revisions

Response: The paragraph is deleted. Pl. see the response to the #12 comment.


Response: Agreed and the references which are used to support the use of mental health services among people with mental illnesses have been changed to Bland, et al, 1997 [39]. Besides, the reference [30] in page 11 is also changed to Wang, et al , 2005 [24] and Phillips, et al, 2009 [28] in the revised version to support that women are more likely than men in making use of health services among populations suffered from mental illness.

17. Page 10, 5th sentence in the 2nd paragraph: Please reference the studies that found similarities between the ‘contact’ and ‘non-contact’ group.

Response: Sorry, we’re not sure about the relevance of citing the reference about the similarities between the contact and non-contact group specifically in this paragraph. The major similarity between the two groups is psychiatric diagnosis which has been controlled for the data analysis. And so far, there is only one study which attempted to discuss the pattern of contact and non-contact group by Owens, et al. [11]. We have already mentioned that in the section of “Background”.

18. There are a few mistakes in the referencing styles used (e.g. some journal names are not abbreviated or do not have capital letters of all words in the title).
Response: Revisions have been made.

19. In Tables 1 and 2 results of Chi square statistics should be reported with degrees of freedom.

Response: Revisions have been made.

20. Columns in Tables are not aligned which makes it hard to read. Also, careful scrutiny of all cells in Tables is recommended as there are several missing brackets, some percentages are presented with no decimal number, etc. Omit the symbol <= after ‘p value’ from both Tables.

Response: Revisions have been made.

21. Note stating “According to the HK government, those who live in HK for more than 7 years are considered resident” should be placed below Table 1.

Response: Revisions have been made.

Quality of written English: Needs some language corrections before being published

Response: Revisions have been made.

Comments from Professor Maurizio Pompili:
I have some doubts about references. I would add a few references such as


Response: It has been included in the section of “Limitations” in page 20.


Response: It has been included in the section of “Background” in page 3.


Response: It has been included in the section of “Background” in page 3.
Apart from the above-mentioned changes, we have also highlighted the importance of why using a PA study method to study the non-contact group of suicide-deceased (in page 3 & 4). Details of the PA study have included in page 7 as well. We hope the above responses have adequately addressed all the concerns and comments from both reviewers. I should be grateful if the revised version would be accepted for the publication in BMC Public Health. Once again, thank you and we look forward to hearing from you.

Best regards

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References


