Author's response to reviews

Title: Ten-year audit of clients presenting to a specialised service for young people experiencing or at increased risk for psychosis

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Author's response to reviews: see over
18th September, 2014.

To: The Editorial Office, BMC Psychiatry

Re: Revised Manuscript “Ten-year audit of clients presenting to a specialised service for young people experiencing or at increased risk for psychosis” (Conrad et al.)

We wish to submit a revised version of the above named manuscript for possible publication in BMC Psychiatry. Please thank the Reviewers for their useful comments on our original manuscript. As detailed below, we have tried to address the concerns that were raised.

As also noted previously, during the manuscript review phase, please send all correspondence to myself (Terry.Lewin@hnehealth.nsw.gov.au). If the paper is subsequently accepted for publication, the official Corresponding Author should be the first author, Dr. Agatha Conrad (Agatha.Conrad@hnehealth.nsw.gov.au).

We look forward to receiving feedback about this revised paper.

Yours sincerely,

Research Manager and Conjoint A/Prof. Terry Lewin (for the authors)

Response to Reviewers

Reviewer 1: Johanna Wigman

Discretionary Revisions

With much interest I have read this paper that describes an evaluation of all presentations to “PAS”. I think this paper provides us with relevant and important information, especially for comparison with other specialized clinics in this field. Content wise, I do not have much comments. However, I do feel that the manuscript can be optimized in a few ways. Below, I’ve put some suggestions for the authors to polish their manuscript to optimize it for reading.

1. The paper is mainly descriptive in nature. Although the authors acknowledge this at the end of the Discussion, it would be helpful and informative if they would state this in their Abstract and at the beginning of the Introduction section. In this way, the reader knows immediately what to expect. I found myself expecting something different after reading the Abstract. This is no problem, because the findings reported are interesting anyway, but it would be better to match expectations and actual content, I feel.

Response: As suggested, we have included a sentence in the Abstract acknowledging the descriptive nature of this paper (Page 2): “This largely descriptive service evaluation paper focuses
on the ‘baseline characteristics’ of referred clients (i.e., previously assessed characteristics or those identified within the first two months following service presentation).” As detailed in Response 2 (below), we have also modified the first section of the Introduction, to help clarify the nature of this paper (and establish an appropriate set of expectations for readers).

2. The introduction, although interesting, is quite long and wordy. I wonder if it is really necessary to discuss in such depth definitions, outcomes and risk factors for UHR status, DUP and comorbidity, if the main goal of the paper is to describe service users of which the UHR-individuals are only a sub-population. Although the information discussed is relevant and interesting, perhaps it can be shortened and adjusted to relevance: what part of this elaborate discussion is really relevant for the introduction of the PAS, its services and its clients? From this perspective, the most relevant paragraph is likely the one on “Limited reporting about implementation of specialized psychosis related services”.

Response: We acknowledge that the Introduction is lengthy. However, it does highlight a number of important issues (e.g., risk conceptualisation, potential benefits, early detection/intervention approaches, comorbidity considerations, limited reports from similar service) and sets the scene for the subsequent description and evaluation of PAS, which (as the Reviewer notes) has a relatively broad set of inclusion criteria, and is not simply about UHR individuals. To better orient readers to the overall nature of this paper, and enable them to selectively attend to different components of the Introduction (depending on their existing knowledge and clinical/research interests), we have included a new opening paragraph (Page 3):

“Overview - service evaluation/research context
This is primarily a descriptive paper about the implementation and multi-layered evaluation of .... some common assessment and methodological issues.”

3. Similarly, the Methods section (in particular the Data sources section) is quite elaborate and wordy, and sometimes difficult to follow. For example: I found the sentence on page 10 “Importantly, baseline classification of clients into groups was based on all available data for the first three of these timeframes” difficult to understand, even with the following explanatory sentence. Could the authors rephrase this please?

Response: We have simplified the particular sentence identified by the Reviewer, as follows (Page 11): “Importantly, ‘baseline’ classification of clients into groups was based on all available service data up to and including two months post-PAS presentation.” More generally, given the role of the current paper as the cornerstone for our multi-layered service audit, ideally, we would like to retain the level of detail provided in the Methods section.

4. The strongest parts of the paper are the Results and the Discussion section. Here, some really interesting and relevant information is presented in a clear way.

Response: We thank the Reviewer for their positive comments.

5. Although I understand that the focus of PAS (and thus of the current paper) is on psychosis, would it be possible for the authors to discuss (briefly) in the discussion also the position of PAS and other psychosis-related services to other youth mental health services that focus on other psychopathological presentations? I would be very interested in reading about this, because it would help to get a better overview of the organization of youth mental health care in Australia. This would also be productive for comparison of (youth) mental health services and their clients across different countries.

Response: We are not in a position to make detailed comments about other Australian services (beyond those with a psychosis focus), and such comments would clearly be outside of the scope of the current paper. However, as the Reviewer is aware, the organization of youth mental health care, both in Australia and elsewhere, is currently receiving considerable attention (e.g., with
respect to policy, efficacy, effectiveness, accessibility and efficiency). Accordingly, we have added Reference 58 (Rickwood et al., 2014) to page 24 and included a brief quotation about our new (Australia wide) ‘headspace centres’.

Reviewer 2: Andor E Simon

Reviewer's report:

n/a

Level of interest: An article of insufficient interest to warrant publication in a scientific/medical journal.

Response: We clearly have a different view to this Reviewer about the merits of reporting issues and findings arising from the ‘baseline’ component of our comprehensive multi-layered service audit.

We acknowledge that the current paper is largely descriptive (see Responses 1 and 2 above) and that, as a service evaluation project, it may not be of direct interest to everyone; however, we feel that it still has much to offer – particularly given the proximity of our specialised service to the clinical ‘coalface’ of youth mental health and early psychosis.

From our perspective, formal research projects tend to derive their strength from forward planning, including the judicious choice of samples, methods, measures and analysis strategies. On the other hand, service evaluation projects, such as the current one, derive strength from their real-world clinical relevance and the comprehensive and thoughtful manner in which the obtained data need to be processed, aggregated, analysed and interpreted (i.e., value adding to the available clinical and service data).

If the overall purpose of clinical and service based research is to improve knowledge and the quality and effectiveness of interventions, and to facilitate the translation of evidence into practice (and practice back into further research), then we need to utilise the fully armoury of potential methods – from service evaluations, surveys, qualitative and naturalistic studies, RCTs, systematic reviews, and so on – all of which add a different perspective and help to solve different but related pieces of the particular scientific/medical puzzle.

Some of these views are reflected in the Discussion section – for example:

(Page 23)

“Future directions

The current paper is largely descriptive in nature and we acknowledge that it is difficult to directly compare psychosis related services operating in different countries and within different health care models .... Notwithstanding, we encourage others to undertake similar comprehensive service audits, primarily because they assist in the review and refinement of services, but also because they stimulate consideration and investigation of related research, treatment and translational issues.”

(Page 25):

“There are both advantages and disadvantages to using real-world service level data, as opposed to data collected within a formal research framework, which largely boil down to breadth versus depth issues ... On the other hand, research studies typically use standardised scales and structured assessments to more comprehensively assess clinical characteristics, risk factors, treatment fidelity, and selected outcomes.”
Reviewer 3: Tim Ziermans

The manuscript is well-written and presents a clear, predominantly descriptive, report of individuals referred to a specialised service audit for young people with (ultra-high risk [UHR] for) psychosis over a period of 10 years. I am particularly content that the authors draw special attention to the need for better comparison groups of individuals considered to be at UHR for psychosis, a commonly overlooked shortcoming in UHR studies. I believe the manuscript presents a valuable addition to the literature and only have two discretionary revisions to suggest.

1. Table 2. I believe it would be even more informative to present the data in a way that combined ICD-10 diagnoses are illustrated. For example, how often did bipolar patients also receive a schizophrenia diagnosis. The percentages suggest there may be substantial overlap.

Response: We have reviewed the ‘diagnostic profiles’ in Table 2 and made several changes to the way in which this information is framed. Firstly, we modified the categories, so that (for example) there is greater clarity within the ‘other clinical records’ section, and to facilitate more direct comparisons with the formal ICD-10 diagnoses. Secondly, we recalculated all of the percentages, such that individuals can now only contribute once to each of the 10 categories (by excluding multiple service occasions or illness episodes that resulted in exactly the same categorization) – which had the effect of lowering some of the percentages. Thirdly, we have included aggregate rates [in square brackets] for ‘formal diagnoses’ and ‘other clinical records’ to facilitate reporting and discussion (e.g., Page 15-16).

In response to the Reviewer’s specific question about bipolar disorder and schizophrenia, we have also added the following paragraph to the text (Page 16): “To further examine within-psychosis comorbidity, we pooled the formal ICD-10 diagnoses and the corresponding problems/issues identified in the other clinical records. For example, within the existing psychosis group, 52.9% (N = 153) were identified as having schizophrenia and 23.2% (N = 67) with bipolar disorder, with only a small overlap between these conditions (N = 17, or 5.9%). Similarly, within the recent psychosis group, the corresponding aggregated rates were: schizophrenia, 41.5% (N = 164); bipolar disorder, 15.7% (N = 62); and overlap, 1.5% (N = 6). Thus, the within-psychosis overlap between the schizophrenia and bipolar disorder categories was minimal.”

2. More information on the logistic regression analyses could be provided. E.g. the authors state that both univariate and multivariate analyses were conducted, but do not report a statistical strategy according to which they operated. Were the combined predictors entered in blocks? In enter/stepwise fashion? I recommend adding a table to clarify this, including Wald statistics and confidence intervals.

Response: We have clarified the nature of the multivariate logistic regressions, as follows (Page 14): “Univariate and multivariate (two-step hierarchical) logistic regressions were used to examine predictors of treatment intensity within PAS.” The 5 potential confounders (included at step 1) and the 9 predictors of interest (included at step 2) are detailed on Page 19, within the “PAS treatment status” section (i.e., where the actual findings are reported).

As suggested, we have added another table (Table 5), which details the univariate and multivariate associations with PAS treatment status (including confidence intervals); however, given the amount of information in this table, we have omitted directly reporting the Wald statistics (which are referred to in the table footnote).