Author’s response to reviews

Title: Predictors of quality of life among inpatients in a forensic hospital. Implications for occupational therapists.

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Author’s response to reviews:

Dear Editor

We are very appreciative of the helpful points raised by the referees who have helped us make this a better manuscript. We hope the manuscript is now in a form acceptable for publication. We remain ready to respond to any further points that might arise.

We have taken on board each point as follows:

Editor Comments:

1) Please remove the Aims subheading in the abstract and put that sentence in the Background subheading.
DONE

2) Please check manuscript for typos. I found two, but there may be more. There is a typo in "vairable" on page 5 line 46. There is a typo in "incluued" on page 5 line 51.
3) The Ethics section in the declaration section is confusing. You state "The funding agency had no role in design and conduct of the study; in the collection, analysis, and interpretation of the data; or in the preparation, review, or approval of the manuscript" However also in that section and in the Funding subheading that there was no funding. Can you please clarify.

DONE. WE HAVE NOW WRITTEN -

"There are no sources of funding to declare."

4) Please be consistent with using the "quality of life" abbreviation. You use both "quality of life" and "QOL" throughout the manuscript. Once you establish the abbreviation after the first use of the word you should just continue to use the abbreviation.

DONE

5) For p-values, please put <0.001 instead of 0.000

DONE

6) Always include a digit before a decimal point. ex .767 should be 0.767

DONE

7) please be consistent with the abbreviation of year in Table 1. Either use yrs or years

DONE

Reviewer reports:

Tom Palmstierna (Reviewer 1): This paper is a very relevant contribution on how to care for the forensic psychiatric patients. It is unique in its approach and relevant. Methods are relevant. Even though this is a cross-sectional study, i.e. patients "flowing" through the system with shorter periods of stay may be underrepresented, it is a good picture on the needs for those patients that reside in these institutions. I only would like the authors to comment shortly on this issue.
DONE. IN LIMITATIONS WE HAVE ADDED –

“Finally, this is a cross-sectional study, so patients who have shorter periods of stay may be underrepresented.”

Also, I would like the authors to have some more and deeper reflections on how, and if, improving QOL for these patients could, or could not compromise the task in forensics of protecting the society from "dangerous" patients.

WE HAVE RESPONDED IN THE INTRODUCTION AS FOLLOWS –

“Additionally, it is known that QOL is a positive protective factor in reducing both short term and long term criminal recidivism and therefore emphasis on this outcome contributes to public protection (21, 22). A number of theories associate QOL with reduced recidivism. For example, the conjecture that risk of criminal offending reduces when individuals have a ‘good life’ is central to the Good Lives Model (23). In addition, the relationship between social indicators of quality of life and recidivism has been shown in numerous studies. For example, the association between reduced recidivism and engagement in meaningful leisure activities, work and adequate management of finances has been demonstrated (21-27). Because QOL and subjective wellbeing are associated with reducing recidivism, the concept of QOL is of central importance within forensic mental health.”

Apart from these comments, I think this paper is suitable for publication.

T.H. Pham (Reviewer 2):

This article aims to analyze the predictive factors of QOL among patients hospitalized in a forensic psychiatric hospital.
This study consists on a naturalistic, observational study. Fifty-two patients with schizophrenia or schizoaffective disorder were included in the study. QoL was measured using the WHOQOL-brief, the Engagement in Meaningful Activity Survey (EMAS), the institutional atmosphere was measured using the Essen Climate Evaluation Schema (EssenCES) social and occupational functioning was assessed using the Social and Occupational Functioning Scale (SOFAS). Security levels, length of stay and exit data are considered.

Regression analyzes show that the level of safety and the caregiver's interest in the clinical course of the patient (EssenCES) account for 40% of the variance of QOL. The commitment to activities contributes largely to the 30% variance on QOL.

The introduction insists on the importance of considering QOL for patients to improve their mental health. Since the study is concerned with schizophrenic patients, the authors may mention different researchs on general psychiatric populations (eg Karow, A., Wittmann, L., Schöttle, D., Schäfer, & Lambert, M. (2014). Dialogues in clinical neuroscience, 16 (2), 185-195) in order to considerer the specificities of the QOL perception among these patients within the different environments.

“QOL has long been regarded as a core outcome for service users with a diagnosis of schizophrenia in general mental health settings (7-13). For instance, numerous studies have found that higher levels of clinical symptoms are associated with reduced QOL for patients with schizophrenia (9-13). In particular, many cross-sectional and longitudinal studies showed that lower depressive symptoms and a higher level of social functioning significantly predicted improved QOL (14). Multivariate analyses explained 53% of the total variance in one such study where the significant predictors were depressive symptoms and social functioning (14). Furthermore, a recent meta-analysis confirmed an association between neurocognition and expert reported QOL (i.e daily functioning), but indicated that there is largely no association between neurocognition and self reported QOL (15). Similarly, recent studies have shown that negative symptoms are associated with expert-related QOL however there are no significant associations with self reported QOL. Moreover, it has been shown that psychosocial interventions are associated with improved QOL (16) and in particular, meaningful and satisfying daily activities were consistently associated with QOL (17, 18).”
In the introduction, the literature on the assessment of QOL in forensic psychiatry is rather limited and needs more references (eg. Trizna, M., & Adamowski, T. (2016). Assessment of needs and clinical parameters in forensic patients in low and medium security wards. Archives of Psychiatry and Psychotherapy, 3, 48-57.

WE APPRECIATE THIS ALSO AND WE HAVE REFERENCED THIS INTERESTING STUDY BOTH IN THE INTRODUCTION AND DISCUSSION

This study demonstrates that the achievement of patient-oriented activities, the level of institutional security (pavilions / neighborhoods), and the caregiver's interest in the patient's clinical outcome contribute to QOL among forensic patients.

AGREED.

Method:

Participants are patients with schizophrenia or schizoaffective disorder from the National Forensic Mental Health Service. They are divided into three groups according to the level of security of the pavilions. They are between the ages of 20 and 65. The diagnosis is made by clinicians on the basis of the DSM-V criteria.

AGREED

The Method part is well written and includes enough elements to test the hypotheses. Ethical aspects are well described.

THANK YOU

There is a need to justify the rationale for using a generic rather than a specific measure (whereas the study includes specific population) that were used in several studies mentioned in the introduction (Eg. the quality of life scale used in Skantze et al. or the Schizophrenia Quality of Life Scale used in the study by Long et al.).

FUTURE, CROSS-VALIDATION STUDIES WOULD BE VALUABLE. WE HAVE ADDED THE FOLLOWING:

“The most widely used definition of QOL was provided by the World Health Organization Quality of Life (WHOQOL) Group in 1995. Hence, the most widely used scale for measuring QOL for service users with schizophrenia is the WHOQOL Bref (41). This measure is deemed to adequately capture the salient QOL concepts for service users in a forensic setting and has been used to validate more specific forensic quality of life measures (5) and is used as an outcome measure in routine clinical practice at the research site.”

Results:

Mentioning the acronym "SCID" is confusing as diagnoses were not based on a structured interview such as SCID-I. ("SCID") (see p.12).

THANK YOU FOR POINTING OUT THAT SCID-I IS VALID FOR DSM-IV-TR, NOT DSM-V. IT IS USED HERE BASED ON BOTH INTERVIEW AND CHART REVIEW. WE HAVE CLARIFIED AS FOLLOWS:

“All participants were diagnosed with schizophrenia or schizoaffective disorder by a consultant psychiatrist. Diagnoses were made in accordance with the Diagnostic and Statistical Manual of Mental Disorders IV-TR (40) using SCID-I based on interview and chart review”

Table 1. Descriptive characteristics need to be improved by providing more detailed statistical data (SD, range) for the age and duration of stay while the only median is mentioned.

DONE

As for table 2, the descriptive statistics relating to the four WHOQOL-short domains could have been added (Physical Health, Psychological Health, Social Relation, Environment).

DONE
Tables 1 and 2 are just described, a further comment is needed.

DONE

With regards to the significant results on the WHOQOL-Brief total score, there is a necessity to carry out the same analyzes on the different factors / domains of the WHOQOL-short. This may provide a clearer picture for the QOL dimensions instead of the conceptually limited total score only!!

DONE SEE TABLES AND TEXT

Discussion:

It would be important to begin by resuming the aims of the study before discussing its principal results. The discussion mainly focuses on the positive impact of occupational activities on QOL while ignoring other dimensions.

DONE

In term of the writing sequence, the limits of the study should follow the interpretations of the results.

DONE

The discussion did not include several important limitations.

Let's first mention the sample size question (52 patients). Moreover, both the emotional state and the social desirability of the participants at the time of the QOL evaluation have not been controlled despite their potential effect on QOL perception. There is no control of axes I and II comorbidity. Finally, the study did not consider the cognitive profile of patients nor the intensity of positive and negative symptoms (see article by Karow, A., Wittmann, L., Schöttle, D., Schäfer, M., 2014). The degree of insight can also influence the outcome (eg Karow, A., & Pajonk, FG (2006). 637-641.)

THANK YOU _ EACH OF THESE POINTS HAS NOW BEEN DONE
Formal aspects:

Orthographic verifications are needed (eg. variables, opportunities).
DONE

The authors may avoid repetitions:

-p. 9: clinicians who were not working directly with service users to minimize response bias.
DONE

-p. 10: Participants were provided with questionnaires by clinicians who were not working directly with service users
DONE

-at the section study size: service users.
DONE

The title of Table 1 should be revised
DONE

In Table 2, column N is unnecessary. It is enough to specify the number in the title for example in order to lighten the picture.
DONE

References need to be corrected according to the standards of the BMC Psychiatry.
DONE