

Correspondence

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Prisoners with mental disorders in Europe

The prevalence of psychiatric disorders in prisoners is substantially higher than in the general population.¹ Additionally, there is scientific evidence that the number of prison inmates with mental disorders is rising. As a consequence, the World Psychiatric Association has repeatedly voiced concern about the increasing number of mentally ill individuals who are being placed in correctional facilities.²

In European Union (EU) member states, forensic legal provision governing the diversion of offenders with mental disorders is diversely included in penal codes, general and mental health legislation, and it is difficult to establish whether member states place emphasis more on medical or punitive parameters in judicial deliberations.³ From a human rights perspective, depriving such prisoners of any state-of-the-art treatment cannot be accepted.⁴ However, there is a serious shortage of information and data in the field. Therefore, the European Commission funded the research project EUPRIS, which aimed to collect structured information on concepts, models and routine practices in prison mental healthcare in 24 EU member states and other European countries.⁵ The results of the study are alarming and should give rise to public policy and research activities. Even the most rudimentary health-reporting standards for mental healthcare in prison are lacking almost everywhere in Europe. Almost none of the included countries provided regular national statistics on the frequency of mental disorders of prisoners or on the availability or frequency of psychiatric treatments. A major reason for the lack of data on the prevalence of mental disorders in prisons is the deficient implementation of standardised psychiatric screening and assessment procedures at prison entry and during imprisonment. In many countries, the appointment of inadequately trained staff to perform such screenings increases considerably the risk that mental disorders or psychiatric needs of the inmates will remain undetected. Furthermore, the pathways to care in case of an acute psychotic episode differ significantly, since referral to prison hospitals, medical prison wards, forensic hospitals or general psychiatric hospital are used in various combinations depending on different national legal regulations, the availability of services and other regional circumstances. Therefore, the equivalence of care for prisoners with mental disorders has been questioned by the cooperating national experts. As a basic prerequisite for any action taken, more awareness of the deficiencies and problems must be raised by responsible authorities and decision makers. The implementation of some basic indicators used in general psychiatric research seems to be overdue.

Declaration of interest

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One ace and three faults don't win the set

The well-written paper by Álvarez-Jiménez *et al*¹ attempts to address a major concern in the management of psychosis, namely weight gain with antipsychotic medication, which has an overarching impact on the management of psychosis. The question it purports to answer is clearly focused and the search strategy thorough and systematic.

However, from the description of the conduct of included trials and assessment of the risk of bias presented in the online Table DS2, it becomes clear that several poor-quality trials were included, with only 2/10 having used an intention-to-treat analysis and 1/10 disclosing allocation concealment.

Proper randomisation is particularly important in small trials as it is relied upon to produce groups with similar baseline characteristics. Poor-quality randomisation would instead produce unequal groups with questionable validity of the results.²

The attrition rate is particularly high (up to 50%) for the control group in this case. Empirical evidence suggests that participants who adhere to medication tend to do better than those who do not, even after adjustment for all known prognostic factors and irrespective of assignment to active treatment or placebo.

In the absence of an intention-to-treat analysis, the results are biased in an unpredictable manner, compounded by the small size of the trials. Similar problems extend to the subgroup analysis. The authors confirm that the effect size is reduced in the better-quality studies. Three out of four trials in the nutritional therapy subgroup analysis were of poor quality; similarly, four out of five studies in the comparison of individual *v.* group therapy. Hence, by including poor-quality trials with larger treatment effects in the analysis, the beneficial effect of the intervention has been overestimated.

The choice of mean weight change as an outcome measure is an interesting one as it actually masks the heterogeneity between individuals in small trials. In simple terms, if one person in the intervention arm of the trial, loses 20 kg it skews the results in favour of the intervention even if the other five individuals gained 2 kg each, giving a group mean weight loss of 10 kg. It would perhaps have been more appropriate to have chosen a dichotomous definition of significant weight change (say 5%), so that it would be clear how many individuals actually benefited from the intervention.

The reviewers could have chosen to request the raw data from individual trials, to allow them the opportunity to account for