Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's telephone number and e-mail address. Letters related to material published in *Psychiatric Services*, which will be sent to the authors for possible reply, should be sent to Howard H. Goldman, M.D., Ph.D., Editor, *Psychiatric Services*, American Psychiatric Association, 1000 Wilson Blvd., Suite 1825, Arlington, VA 22209-3901; fax, 703-907-1095; e-mail, psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (mc.manuscriptcentral.com/appi-ps).

Revisiting the MacArthur Study

To the Editor: I read the debate in the February issue (1) revisiting the MacArthur Violence Risk Assessment Study with interest. It presented opposing views of the results of the MacArthur study that was conducted between 1992 and 1995 to determine the prevalence of community violence in a cohort of patients discharged from psychiatric hospitals. On the basis of follow-up data from 951 patients, the study essentially found no significant difference in the prevalence of violence between the patients and other people living in the same neighborhoods (2).

In the February debate, Dr. Torrey and Mr. Stanley presented several points on which they disagree with the findings or the methodology of the MacArthur study. Dr. Monahan, Dr. Steadman, and the MacArthur Study Group then responded to each point. Dr. Torrey and Mr. Stanley argued at one point that the results of the MacArthur study are not applicable to all patients with mental illness. To illustrate their concern, they cited press coverage of the MacArthur study and a reference to the study in my 2007 article on criminal recidivism (3) as implying that "the results were applicable to all psychiatric patients." As noted by Dr. Monahan and Dr. Steadman in their response, the MacArthur study did not make that claim. Neither did my article.

My article discussed eight central risk factors that are predictive of criminal behavior, including violent crimes—albeit to a lesser extent because such crimes are low-frequency events. These risk factors broadly apply to individuals whether or not they are mentally ill, and they have been established through an extensive body of research (4). However, this research has received relatively little attention in the psychiatric literature. The risk factors are substance abuse, family problems, lack of healthy recreational pursuits, low levels of performance or satisfaction with school or work, history of antisocial behavior, antisocial personality pattern, antisocial cognition, and antisocial attitudes, including associating with criminal companions. The MacArthur study's negative finding is consistent with the established relationship between known risk factors and criminal behavior. In particular, the study used an appropriate control group of individuals who lived in the same neighborhoods as the study patients and were therefore likely to share many of the same risk factors.

My article also made the point, which was based on a review of recent literature, that active psychosis is an additional risk factor for violent crime. Since publication of the landmark MacArthur study, several studies have been published that provide new evidence that active psychosis is a risk factor independent of substance abuse or other known risk factors. For example, a rigorous national prospective study of 1,410 adults with schizophrenia recently found that "psychotic symptoms were strongly associated with both minor and serious violence" (5).

Given the predictive strength of identifiable risk factors and the fact that some are modifiable, the important question for the field is no longer whether persons with mental illness are more violent than others. Rather, the question is how to engage high-risk individuals in treatments that effectively target modifiable risk factors for criminal behavior. Thanks to the authors for an interesting debate and to the journal for this opportunity for clarification.

J. Steven Lamberti, M.D.

Dr. Lamberti is associate professor of psychiatry and director of the Severe Mental Disorders Program at the University of Rochester Medical Center, Rochester, New York.

References

1. Torrey EF, Stanley J, Monahan J, et al: The MacArthur Violence Risk Assessment Study revisited: two views ten years after its initial publication. Psychiatric Services 59:147–152, 2008
2. Steadman HJ, Mulvey EP, Monahan J, et al: Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Archives of General Psychiatry 55:393–401, 1998
3. Lamberti JS: Understanding and preventing criminal recidivism among adults with psychotic disorders. Psychiatric Services 58:773–781, 2007
4. Andrews DA, Bonta J: Psychology of Criminal Conduct, 4th ed. Cincinnati, Ohio, Anderson, 2006
5. Swanson JW, Swartz MS, Van Dorn RA, et al: A national study of violent behavior in persons with schizophrenia. Archives of General Psychiatry 63:490–499, 2006

In Reply: We thank Dr. Lamberti for his clarification. In his 2007 article he noted that the MacArthur study reported a "lack of an association between psychosis and crime," and his was one of many similar references that we had noted over the years. He is correct that his article did not claim that the MacArthur results can be generalized; however, once a finding is repeated often enough in the literature, it develops a life of its own and tends to be generalized.

The main purpose of our undertaking the debate in the February issue

was to make clear that on the basis of data from the MacArthur study that became available after the original publication, it is erroneous to cite the study as having shown a "lack of an association between psychosis and crime." Dr. Lamberti is also correct that several more recent studies have clearly shown that "active psychosis is an additional risk factor for violent crime." In his 2007 article, Dr. Lamberti cited the 2006 study by Swanson and colleagues (1), and we would add three others (2–4).

The most important point made by Dr. Lamberti, and also by subsequent publications on the MacArthur study, is that the treatment of individuals with psychoses significantly reduces the incidence of their violent behavior. The question he raises about "how to engage high-risk individuals in treatments" must take into account the fact that approximately half of such individuals are unaware of their own illness and of the need for treatment. In these cases treatment must sometimes be mandated, by using such mechanisms as assisted outpatient treatment, which has been demonstrated to significantly reduce violent behavior among individuals with severe psychiatric disorders (5).

E. Fuller Torrey, M.D.
Jonathan Stanley, J.D.

References

1. Swanson JW, Swartz MS, Van Dorn RA, et al: A national study of violent behavior in persons with schizophrenia. Archives of General Psychiatry 63:490–499, 2006
2. Swanson JW, Swartz MS, Essock SM, et al: The social-environmental context of violent behavior in persons treated for severe mental illness. American Journal of Public Health 92:1523–1531, 2002
3. Monahan J, Steadman HJ, Robbins PC, et al: An actuarial model of violence risk assessment for persons with mental disorders. Psychiatric Services 56:810–815, 2005
4. Swanson JW, Van Dorn RA, Monahan J, et al: Violence and leveraged community treatment for persons with mental disorders. American Journal of Psychiatry 163: 1404–1411, 2006
5. Swanson JW, Swartz MS, Borum R, et al: Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. British Journal of Psychiatry 176:324–331, 2000

Do Consumers Use the Word "Recovery"?

To the Editor: Recovery has been celebrated as the guiding vision for mental health service delivery since Anthony declared the 1990s the "decade of recovery" (1). Both the President's New Freedom Commission (2) and the Kirby Commission in Canada (3) have made recovery the basis for transforming mental health services throughout North America, which is the result of decades of outcome research, consumer activism, and advances in psychiatric rehabilitation (4,5). Yet a recent Canadian study found that most recovering consumers were not using the word "recovery" to describe their experience and were not hearing about recovery from service providers.

In the context of a multisite, qualitative study of stakeholder perspectives on recovery conducted in 2006–2007, we asked 59 consumers with a diagnosis of bipolar disorder, schizophrenia, or major depression about their use of the word "recovery" and their sources of information on recovery. All had been receiving formal mental health services for at least six months before the study, most as long-term service recipients.

Fifty-one consumers (86% of the sample) described themselves as being in recovery. However, 40 consumers (69%) declined to use the word when speaking with other people; only 13 (21%) used the word with others. On the question about consumers' sources of information on recovery, service providers were named as a source only 27 times (40% of 67 responses). Another 29 responses (41%) indicated that consumers had no sources of information before this study or that they had investigated recovery on their own. Ten responses (19%) identified peers as the source of information on recovery. One respondent did not answer the question.

Consumers also explained that providers often used the word "recovery" in a medical sense or that providers preferred to use synonyms for the term. Providers spoke to them about how to "get better" by using various means, such as medications, therapies, symptom control, stress management techniques, and follow-up care after hospital discharge. Nor were discussions always positive—a number of consumers stated that they were told they would never recover from mental illness.

Peers, described as visiting consumer leaders or other members of self-help organizations, were the source of empowerment for consumers who used the word "recovery." A wide-ranging expansion of peer services in Canada would enhance mental health consumers' access to real-life models of recovery and would provide settings both supportive of their struggles and receptive to the contributions that they can make to one another's personal development.

Recovery is an individual and unique journey. However, it must be recognized that mental health services and providers play a critical role in facilitating and supporting people in the recovery process. Although consumer self-help groups exist in Canada, the transformation to recovery-oriented services here is at an early stage. Unlike the U.S. experience, the recovery initiative in Canada lacks a strong culture of consumer advocacy and a civil rights tradition.

We believe that the results of this study speak to the need for mental health providers to better understand recovery principles, learn to work from a recovery perspective, and empower consumers to take responsibility for their own recovery. This process starts when providers use the word themselves. The recovery vision will not easily take hold among consumers in the current Canadian context unless providers integrate the word "recovery"—and a belief in what the word implies—into their practice.

Myra Piat, Ph.D.
Judith Sabetti, M.S.W.
Audrey Couture, M.Sc.

The authors are affiliated with Douglas Mental Health University Institute, McGill University, Montreal, Quebec, Canada.

Acknowledgments and disclosures

This research was funded by the Canadian Institutes of Health Research (project 7451).

The authors report no competing interests.

References

1. Anthony WA: Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. Psychosocial Rehabilitation Journal 16:11–23, 1993
2. Hogan MF: The President's New Freedom Commission: Recommendations to Transform Mental Health Care in America. Psychiatric Services 54:1467–1474, 2003
3. Kirby MJL, Keon WJ: Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada. Ottawa, Sénat du Canada, 2006
4. Roberts G, Wolfson P: The rediscovery of recovery: open to all. Advances in Psychiatric Treatment 10:37–49, 2004
5. Sowers W: Transforming systems of care: the American Association of Community Psychiatrists Guidelines for Recovery Oriented Services. Community Mental Health Journal 41:757–774, 2005

Update on a Program for LGBT Persons With Major Mental Illness

To the Editor: There is little documentation in the literature on culturally focused services for lesbian, gay, bisexual, and transgendered (LGBT) persons with major mental illness, despite the unique sociocultural issues and identities that they bring into long-term mental health care settings (1,2). We report here on a sample of individuals attending a culturally focused program for LGBT patients with a diagnosis of major mental illness.

Participants attended the Rainbow Heights Club (RHC) in Brooklyn, New York (3), which was created in 2002 in association with the LGBT Affirmative Program of South Beach Psychiatric Center in Brooklyn (4). Seventy-five individuals were assessed during May and June 2006. After informed consent was obtained, participants completed a multiple-choice questionnaire measuring level of participation and impact of the program. Data were analyzed through response frequencies and multivariate analysis of variance (MANOVA).

Study participants had been in psychiatric treatment an average of 16 years. The percentages reported here are based on the number of participants who completed each item. Among the 69 participants who completed the item about diagnosis, affective disorder was the most common diagnosis (32 participants, or 46%), followed by psychotic disorders (24 participants, or 35%), anxiety disorders (seven participants, or 10%), and other disorders (six participants, or 9%). Information about medical conditions and about substance abuse was available for 72 participants. Thirty-six (50%) reported having significant medical conditions. Three (4%) admitted to current abuse of alcohol or other drugs.

Of the 73 participants who answered the question about duration of program attendance, 31 (43%) had attended for more than two years, 22 (30%) had attended for one to two years, and 20 (27%) had attended for less than a year. Thirty-four (47% of 72 respondents) attended more than once a week, and 13 (18%) attended less than once a month. Fifty-five participants (76% of 72 respondents) stated that they found the RHC program very helpful. Thirty-six participants (54% of 67 respondents) reported being more adherent to their mental health treatment because of their involvement in the RHC. Fifty-three participants (80% of 66 respondents) reported that their psychiatric symptoms were better or much better since they began attending the RHC. Forty-one (61% of 67 respondents) reported that their relationships were better or much better since they began attending, and 26 (39%) said that their relationships were the same as before program entry.

Thirty-six participants (51% of 70 respondents) reported spending time with other members outside the club, and 66 (92% of 72 respondents) reported that it was somewhat or very helpful to think about the club when they were not there. Fifty-three participants (78% of 68 respondents) reported better or much better self-esteem since they began attending RHC. Forty-three participants (63% of 68 respondents) reported better or much better ability to manage stress, and 53 (78% of 68 respondents) reported that their sense of hope was improved or much improved.

The MANOVA tested the relationship between five independent variables (substance abuse, helpfulness of the RHC, spending time with members outside RHC, sexual identity, and age) and five dependent variables (symptom improvement, relationships, self-worth, stress, and sense of hope and purpose). A significant association was found between spending time with RHC members outside the club and the dependent variables (Wilks' λ=.719, F=3.360, df=5 and 43, p<.012). The between-subjects test indicated a significant association between spending time with RHC members outside the club and a general improvement in social relationships since joining the RHC (F=5.68, df=1 and 1, p<.021).

These findings indicate that the members of a culturally focused program for LGBT individuals with major mental illness experienced improvements in symptoms, mental well-being, and socialization. Further research is necessary to validate these findings and to determine whether they are causally related to specific program elements and why program members benefit. Studies of this minority population are rare and have been limited by small samples. These preliminary findings hold promise for culturally sensitive LGBT programs for persons from sexual minority groups who have chronic and disabling psychiatric disorders.

Ronald E. Hellman, M.D.
Eileen Klein, Ph.D.
Thomas Uttaro, Ph.D.

The authors are affiliated with South Beach Psychiatric Center, Brooklyn, New York.

Acknowledgments and disclosures

The authors report no competing interests.

References

1. Hellman RE: Issues in the treatment of lesbian women and gay men with chronic

mental illness. Psychiatric Services 47: 1093–1098, 1996

2. Hellman RE, Sudderth L, Avery AM: Major mental illness in a sexual minority psychiatric sample. Journal of the Gay and Lesbian Medical Association 6:97–106, 2002

3. Rosenberg J, Rosenberg SJ, Huygens C, et al: Stigma, sexual orientation, and mental illness, in Community Mental Health Challenges for the 21st Century. Edited by Rosenberg J, Rosenberg SJ. New York, Routledge, 2006

4. Hellman RE, Klein E: A program for lesbian, gay, bisexual, and transgender individuals with major mental illness, in Handbook of LGBT Issues in Community Mental Health. Edited by Hellman RE, Dresher J. New York, Haworth, 2004

Teaching Tool to Reduce Restraint and Seclusion

To the Editor: The Open Forum (1) in the February issue and an accompanying commentary (2) both made an important and fundamental point. Restraint and seclusion are emergency interventions that should be used as infrequently as possible and only when less restrictive methods are considered and are not feasible. There is much that hospital caregivers can do—other than resort to restraint and seclusion—to prevent and deescalate potentially dangerous situations so that patients can continue treatment successfully and effectively.

This is a message that was delivered by the professional and hospital communities in a landmark teaching tool called *Learning From Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health.* The 42-page document was developed by the American Psychiatric Association, American Psychiatric Nurses Association, and National Association of Psychiatric Health Systems (NAPHS), with support from the American Hospital Association Section for Psychiatric and Substance Abuse Services. It is available on the Web sites of these associations, including the NAPHS site at www.naphs.org.

The hospital field has come a long way in changing both thinking about and practice of the use of restraint and seclusion, and the field now looks to the future. The final federal regulations are one aspect of this future view. All the protections incorporated by the Centers for Medicare and Medicaid Services (CMS) in the proposed rule on restraint and seclusion remain in effect—and are strengthened—in the final rule. The final rule ensures that only qualified, trained professionals can order and evaluate restraint or seclusion. It recognizes the skills and training of registered nurses as well as licensed independent practitioners as part of the clinical leadership team. The final rule also enhances patient safety because it comes with added CMS training requirements that will ensure more onsite professional expertise.

Many components beyond regulation have led to dramatic changes in clinical practice. Consumers' voices have been heard, professionals have worked to share knowledge, and cultures are being changed as hospital leaders continuously take action to ensure patient safety.

The field has undertaken a major effort to gather data to inform and improve clinical practice. The Hospital-Based Inpatient Psychiatric Services (HBIPS) core measures initiative has completed a year-long pilot-testing phase, with the goal of identifying measures that will be incorporated into the accreditation process of the Joint Commission (JC) as early as 2009. Several of the core measures being tested are related to restraint and seclusion. For the first time we will have national data to help facilities understand how they are operating in relation to their peers. The HBIPS was launched as a public-private partnership among NAPHS, the National Association of State Mental Health Program Directors (NASMHPD), the NASMHPD Research Institute, Inc., and the JC. These measures are being developed with the same scientific rigor as measures for heart failure and other medical conditions.

NAPHS members are committed to patient safety, to accountability, and to continuously improving practice. We look forward to continuing to work with our colleagues on these critical issues.

Jeffrey Borenstein, M.D.

Dr. Borenstein is president of the National Association of Psychiatric Health Systems, Washington, D.C., and chief executive officer and medical director of Holliswood Hospital, Holliswood, New York.

References

1. LeBel J: Regulatory change: a pathway to eliminating seclusion and restraint or "regulatory scotoma"? Psychiatric Services 59:194–196, 2008

2. Sharfstein SS: Reducing restraint and seclusion: a view from the trenches. Psychiatric Services 59:197, 2008