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 and fax numbers and e-mail address. Letters related to material published in *Psychiatric Services* will be sent to the authors for possible reply. Send letters to John A. Talbott, M.D., Editor, *Psychiatric Services*, American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005; fax, 202-682-6189; e-mail, psjournal@psych.org.

Subspecialty Training in Schizophrenia

Does subspecialty training in schizophrenia improve the ability of clinicians to treat patients with treatment-resistant schizophrenia? We report on a naturalistic study that addressed this question.

Our clinical team, which subspecializes in schizophrenia, assumed care of 12 male and eight female adult inpatients at a state hospital. Twelve patients had schizophrenia, and eight had schizoaffective disorder. The mean±SD duration of hospitalization was 5.1±4.3 years. Outcome measures were obtained at baseline in January 1998 and at follow-up in January 1999. We used the paired t test to analyze the cost of medication and the Wilcoxon signed ranks test to analyze the other variables.

The results showed significant decreases in the number of psychotropic medications, from a median of 4.9 at baseline to a median of 1.5 at follow-up (Wilcoxon signed rank test=–66, p<.001). The dosage of antipsychotic medications in chlorpromazine equivalents also decreased, from a median of 1,450 mg to 1,033 mg (Wilcoxon signed rank test=–58, p=.001). Costs of psychotropic medication fell from a mean±SD of $16.37±$7.20 at baseline to $12.62±$7.69 at follow-up (t=2.19, df=17, p=.04).

The proportion of patients treated with clozapine increased significantly, from 44 percent at baseline to 78 percent at follow-up (Wilcoxon signed rank test=10.50, p=.03), as did the proportion of patients diagnosed as having tardive dyskinesia, from 6 percent at baseline to 65 percent at follow-up (Wilcoxon signed rank test= 27.5, p=.002). Insignificant changes were noted in the as-needed use of psychotropics; the number of as-needed medications per patient per day decreased, from a median of .030 at baseline to .018 at follow-up. The Global Assessment of Function scores increased insignificantly from a median of 30 to a median of 33.

The decrease in the number of medications was achieved by reassessing the need for each medication, changing one medication at a time, and assessing the temporal relationship between medication status and clinical status over a sufficient period of time. The lowest optimal effective dosages were found by slow downward titration, by monitoring blood levels of medication when applicable, and by clinical assessment. Two reasons for the increased proportion of patients treated with clozapine were the presence of treatment-resistant psychosis and, for many patients, the diagnosis of tardive dyskinesia (1). The significant increase in the proportion of patients diagnosed as having tardive dyskinesia may have been related to an unmasking effect caused by changing antipsychotic medication or to a lack of training of psychiatrists in the physical examination for tardive dyskinesia.

Treatment with clozapine may have contributed to the decrease in the number and dosage of psychotropic drugs in our sample, which resulted in a reduction in the cost of medications (2). Despite the significant decreases in the number and dosages of medications, no significant worsening in the clinical status of the patients was noted.

The results of this study suggest that subspecialty training in the management of patients with chronic, treatment-resistant schizophrenia results in improved patient care and reductions in the costs of medication.

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Violence in the Community as a Predictor of Violence in the Hospital

Predicting violence by persons who have a history of mental illness in the community is complicated by the fact that mentally ill persons are a heterogeneous group, with varying diagnoses and histories of co-occurring substance abuse problems (1). Clinicians generally believe that a history of violence may be a key predictor of future violence (2,3), and they expect that patients who have a history of violence will be violent after admission to a hospital.

At Rockland Psychiatric Center, we studied the relationship between a history of violence in the community and violence in the hospital. On average, the facility admits 59 patients a month for intermediate care from the counties of Westchester, Rockland, and New York. Patients stay 60 to 90 days. All patients are initially treated in community hospitals for three weeks and are admitted to Rockland Psychiatric Center for further treatment of their unstable psychiatric disorders.

The study involved a retrospective analysis of data from 59 patients consecutively admitted over a one-month period (March 15 to April 15, 1999).

Information about each patient's history of violence in the community before admission to the community hospital was collected from all available medical records. Data on violent episodes in the community within the past ten years that resulted in an arrest were obtained from the criminal justice system.

Information about episodes of hospital violence for these patients was collected from nursing reports over six months or until discharge. Violent episodes at the community hospital before transfer were counted as data for hospital violence. Acts of violence were pushing, grabbing, shoving, slapping, throwing objects, kicking, biting, choking, hitting, beating up, and making threats with or using a weapon.

The cohort included 44 men and 15 women. The predominant diagnosis was schizophrenia (49 patients, or 83 percent), followed by bipolar disorder (10 patients, or 17 percent). Although only a fourth of the patients were women, they accounted for half of the patients who were violent in the hospital. White women with no previous history of violence had the highest incidence of violence in the hospital.

Twenty-two of the 44 male patients (50 percent) had a history of violence, as did nine of the 15 females (60 percent). Sixteen patients (eight male and eight female) had one or more episodes of violence in the hospital, and five of the 16 had a history of violence. Among the 43 patients who were not violent in the hospital, 26 had a history of violence. Chi square analysis and Fischer's exact test did not show a significant association between a history of violence and violence in the hospital.

This study suggests that a history of violence may not predict violence in the hospital and that violence in the hospital may be specific to the environment and related to the hospitalization experience itself. The study involved a small number of patients and information about previous violence may not have been complete. Also, we did not examine factors such as staff members' attitudes toward patients with a history of violence or the influence of substance abuse or the hospital milieu. A larger study considering these factors is indicated.

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Suicidal Ideation and Advance Directives

To the Editor: Although the recent article "Suicidal Ideation and the Choice of Advance Directives by Elderly Persons With Affective Disorders" in the November 2000 issue (1) explores an interesting subject, I found it unsatisfactory in two respects.

The data presented in Table 1 are confusing, and they seem to be incorrect. The right-hand portion of the Table is headed "Patients choosing to have cardiopulmonary resuscitation (CPR) (N=100)." Yet instead of consistently adding to 100, the total number of patients listed under each characteristic varies from 99, for religion and for psychiatric history, to 124, for age. This invalidates all the percentages in this part of the table. In the text of the article, the authors provide the percentage of patients in each category who requested CPR. I gather that these data represent their real findings and that the table, which purports to compare—but does not compare—the characteristics of the patients choosing CPR with the total sample, is incorrect.

Apart from this confusion, I wish that the authors had gone further than their finding that "elderly patients who had suicidal ideation were significantly less likely to ask for CPR . . . than those who did not." It is not surprising that someone who wants to die might not want to be resuscitated. But there may be other good reasons not to want CPR. It would be important to know whether or not a patient's psychiatric illness impairs his or her judgment; if so, contrary to the stated practice of the authors, it would be preferable to wait until treatment has restored decision-making capacity before taking at face value a patient's stated wishes about CPR. These issues have been considered thoughtfully by other authors (2,3). Although further empirical study in this area would be useful, the article in the November issue failed to advance the discussion.

Cavin P. Leeman, M.D.

Dr. Leeman is clinical professor of psychiatry and faculty associate in the division of humanities in medicine at the State University of New York Downstate Medical Center in Brooklyn.

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In Reply: We appreciate Dr. Leeman's comments on our article. First, we apologize if the table was difficult to follow. The data were obtained via a retrospective chart review, and not all information was available on all patients. Admittedly, this is a methodologic failing of a retrospective review of patient care.

More important, Dr. Leeman raises other issues. Whether an elderly person with suicidal ideation should be asked about advanced directives is a

vexing question. The law requires that all elderly Medicare beneficiaries be informed on admission to a hospital of their right to pursue advanced directives unless they have been adjudicated incompetent. However, one can question whether this psychotherapeutic course is the proper one to follow. In our setting, the data showed that suicidal ideation affects patients' choice of advance directives. However, as required by Medicare, we continue to ask the question. Clearly, this is an interesting issue for debate.

As Dr. Leeman correctly points out, other factors may also influence choices about advance directives. Our data showed that age was more strongly associated with decision making about advance directives than suicidal ideation or diagnosis.

Ethical questions such as those related to advance directives continue to confront us in psychiatry and medicine. We should take time to debate them, think about them, and work through them with our patients and their families. However, we should do more than debate the issues. We need to obtain better data about end-of-life issues for our elderly population. Although we admit that data from our chart review were incomplete, better answers for our patients can come only from data-driven investigation into ethical problems. The need for such data and for more complete information continues.

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Recovery and Realism

To the Editor: We read with dismay the Taking Issue editorial by Robert A. Rosenheck, M.D., in the October 2000 issue. We believe he speaks for many in the field who simply don't believe that persons with serious and persistent mental illness can get better and recover. Hope and belief are the foundation of medicine and the first step toward recovery from any illness. Once again the psychiatric world is guilty of taking away such hope for recovery when it expresses such fatalistic positions in an editorial in one of the more widely read journals.

Schizophrenia and related disorders are not synonymous with total disability. Even before the advent of atypical antipsychotic medications, recovery was a concept that was embraced and lived in places like Fountain House and other rehabilitation programs around the country. We believe there are compelling data to prove that the new medications are superior in many domains, especially in improving negative symptoms and cognition. Symptoms in these two domains are often as problematic as positive symptoms and may be even more responsible for holding people back from success in areas such as employment.

Furthermore, to assert, as Dr. Rosenheck does, that the new medications cause diabetes and hyperlipidemia without any solid data is irresponsible. The treatment of serious and persistent mental illness has not received much positive press, and our patients even less so. Dr. Rosenheck states that "we must not be swayed by hype, glitz, or flawed research." If by "glitz" he means persuading corporate America to hire persons with serious and persistent mental illness, so be it. We have come to see that a little glitz and glamour can go a long way toward attracting more and better people into mental health care fields and may change the mindset of many Americans who see serious and persistent mental illness as a world of hopelessness, violence, and disability.

If you talk to the people who are struggling with recovery today, they will tell you they feel better and are doing more than before thanks to many factors, but the newer medications are certainly one important reason.

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In Reply: Dr. Aquila and colleagues correctly point out that people with serious mental illness can get better, that hope is an important part of recovery, and that newer medications have some demonstrable advantages. However, this is not true for all clients, and my editorial argued for a balanced perspective, consistent with the available scientific evidence.

I was recently at a conference on atypical antipsychotics at which one member of the audience expressed concern that if we claim these medications are transformingly effective, funding agencies may argue that fewer resources are needed for rehabilitation services or for supported housing. Some payers have already argued that the dramatically reduced availability of acute inpatient care for mental illness is justifiable because of the availability of these medications. I do not feel the evidence justifies such reductions.

Neither an editorial nor a letter is the place for a review of scientific evidence. However, I believe the literature does suggest that our progress has been incremental and that while some side effects are reduced, others are increased. Realism should not be seen as the enemy of hope, but rather as the backdrop that highlights its overwhelming importance.

Robert A. Rosenheck, M.D.

Dr. Rosenheck is director of the Veterans Affairs Northeast Program Evaluation Center and professor of psychiatry and public health at Yale School of Medicine in New Haven, Connecticut.