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.

Incidence of Restraint-Related Deaths

To the Editor: Emergency measures to protect extremely disturbed patients include seclusion and use of mechanical restraints. Fisher (1) reviewed the literature on seclusion and restraint and concluded that use of these methods is efficacious in reducing patients' agitation and preventing injury to themselves and others and that it is nearly impossible to operate a program for severely symptomatic patients without the use of some form of seclusion and physical or mechanical restraints.

The issue of seclusion and restraint came into the national spotlight with intense scrutiny from the media and legislatures after the death of an adolescent patient in Connecticut in 1997 (2). A subsequent investigation revealed that use of seclusion and restraints had led to the deaths of 142 people in the decade before the teenager's death (3).

National statistics are not available on the number of persons who are secluded or restrained in treatment settings, the number of episodes, the frequency of episodes, and death or injury rates. A review of the literature did not yield any published reports about the use of restraints per patient-days in the hospital or the incidence of deaths. Accurate statistics in this area may verify, refute, or mitigate the view that use of restraints is a dangerous procedure.

In our facility, we have tracked the use of restraints since 1994. Our 150-bed inpatient psychiatric county hospital for adults admits more than 950 patients a year. About 15 percent of the patients are aged 65 or older. We accept patients for both acute and extended care, and the majority of patients are involuntarily committed. The average length of stay is 30 days.

A total of 1,403 incidents of the use of mechanical restraints were documented between 1994 and 1999, for an average annual rate of 4.6 incidents per 1,000 patient-days. The rate has fallen every year, from 9.2 incidents in 1994 to 1.5 in 1999. During this period, four patients died while hospitalized; none of the deaths were related to the use of restraints.

These findings indicate that the risk of death from restraints is very low. The risk must be balanced with the risk to patients and others if severe agitation is not immediately controlled. We recognize that these findings represent the experience of one hospital. We are currently surveying all hospitals in southern New Jersey to determine the incidence of deaths from restraints in a larger sample. We encourage other facilities to share these data so that a meta-analysis can be conducted.

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Multiple Strategies of Change

To the Editor: A reader of our article "Reengineering Clinical Psychiatry in Academic Medical Centers: Processes and Models of Change" in the January issue (1) contacted us about his concern that it painted too simple a picture of the strategies used at certain medical centers. The article describes seven models of change that have been used by academic departments of psychiatry to adapt to the rapidly evolving health care environment.

In our article we cited departments that have employed each model. However, we think it is important to clarify that most of these departments have used more than one approach. For example, multiple strategies have been used in the departments of psychiatry at the Medical College of Wisconsin, the University of Cincinnati, the University of Illinois at Chicago School of Medicine, Montefiore Medical Center and the Albert Einstein School of Medicine, Dartmouth College, the University of Connecticut, Wake Forest University, and Yale University. These departments are only a few of those that could be cited.

The combination of strategies selected by a specific department is influenced by many factors, including the interests of department leadership and faculty, the characteristics of the host medical school and university, and the nature of the state and local health system. Readers who wish to learn how the various models of change have been combined should consult the case studies cited in our article or contact the faculty members who have been reengineering clinical psychiatry at these and other departments across the country.

Michael A. Hoge, Ph.D.
Joseph A. Flaherty, M.D.

Reference

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Memorizing and Recalling DSM-IV Diagnostic Criteria

To the Editor: The *Diagnostic and Statistical Manual of Mental Disorders* constitutes the major diagnostic system used in psychiatric training, practice, and research in the United States and internationally. However, it is not easy to remember the large number of criteria for certain disorders.

Several authors have published mnemonics for memorizing diagnostic criteria (1–4). I present another approach. Remembering the criteria for a manic episode is easier when they are "homogenized" with the criteria for a major depressive episode. Then the criteria for a manic episode can be recalled through a process of association. I have used this approach for quite some time and would like to share it with other clinicians.

DMS-IV diagnostic criteria for a major depressive episode and for a manic episode are not homogeneous, which makes memorizing them rather difficult. This problem can be resolved by rearranging the criteria for a manic episode so that they follow the pattern of criteria for a major depressive episode. The rearrangement is shown in the accompanying box.

The initial statement of criterion A has been modified to correspond with the initial statement of criterion A for a major depressive episode without sacrificing the diagnostic requirements of the *DSM-IV* criteria for a manic episode. Note that the criteria for a manic episode do not include a symptom for weight change (symptom A3 of a major depressive episode). Thus symptom A3 is left blank.

The criteria for a manic episode do not include a symptom of increased energy (corresponding to symptom A6 of loss of energy for major depressive episode). Therefore, the manic symptom closest to it ("more talkative than usual or pressure to keep talking") is positioned as symptom A6. In addition, the criteria for a manic episode do not include a symptom corresponding to symptom A9 for a major depressive episode ("recurrent thoughts of death . . ."). Therefore, the manic symptom relating to thoughts ("flight of ideas or subjective experience that thoughts are racing") is positioned as symptom A9. To indicate the lack of exact correspondence in criteria A6 and A9, they are enclosed in parentheses. Finally, note that criteria B, C, and D correspond to criteria B, C, and D for a major depressive disorder.

The format of the criteria in the box is very similar to the format of the criteria for a major depressive episode. This similarity makes memorizing and recalling much easier.

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"Homogenized" Criteria for a Manic Episode

A. Four (or more) of the following symptoms (five or more if mood is only irritable) have been present for at least one week (or any duration if hospitalization is necessary) and represent a change from previous functioning; at least one of the symptoms is elevated, expansive or irritable mood.
   (1) abnormally and persistently elevated, expansive or irritable mood, as indicated by either subjective report or observation made by others
   (2) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
   (3) —
   (4) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
   (5) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
   (6) (more talkative than usual or pressure to keep talking)
   (7) inflated self-esteem or grandiosity
   (8) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
   (9) (flight of ideas or subjective experience that thoughts are racing)
B. The symptoms do not meet criteria for a Mixed Episode.
C. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

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