LETTERS

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 Boulevard, Suite 1825, MS#4 1906, Arlington, Virginia 22209-3901; fax, 703-907-1095; e-mail, psjournal@psych. org. Letters reporting the results of research should be submitted online for peer review (http://appi.manuscriptcentral.com).

Recovering the Momentum for Federal Support of Multisite Demonstrations

To the Editor: The October issue of *Psychiatric Services*, with its remarkable array of articles summarizing the results of multisite research demonstration studies, gives the reader cause for thought, reflection, and perhaps outrage. The history of mental health treatment is replete with examples of well-intentioned interventions, developed and perpetuated on the basis of nothing more than a potentially innovative concept, a desperate patient and provider population, a charismatic proponent, and little, if any, evidence. The studies in the October issue demonstrate that improvement in mental health service delivery can be based on firm scientific evidence that moves us beyond anecdote mixed with enthusiasm.

What better use for sadly limited federal funds than to enhance the quality of care through carefully crafted, scientifically sound, multisite studies of clinically relevant service interventions? The results have an impact on services and policy decisions throughout the nation—if not the entire globe—and bring us closer to the goal of evidence-based practice. The findings can support the efforts of consumer advocates to ensure financial resources for effective services through private insurance coverage, public Medicare and Medicaid reimbursement, and direct financing from state mental health departments.

In the face of budgetary pressures and outright cutbacks, states and local communities will inevitably seek additional funding for direct service support. Tempting as it is to respond with reprogramming of funds and reduction or elimination of knowledge enhancement efforts, there can be no more foolish and shortsighted a decision. And yet, as Sharfstein (1) points out in his commentary in the October issue, this is exactly what has happened. We have lost the momentum represented in the articles by Leff, Domino, Morrisey, Noether, and their colleagues. Rather than careful examination of clinical and psychosocial services to generate knowledge that could benefit all, we are applying a deceptively soothing balm in providing some service enhancements for a few lucky recipients in the lottery of federal funding distributions.

Hopefully the time will soon come when a carefully crafted, well-planned, and deliberate use of federal support to enhance the quality of mental health treatment through the study of the implementation of efficacious interventions in real-world settings will once again guide our national efforts.

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Past and Current Views on the Use of Seclusion and Restraint in Treatment

To the Editor: The September issue of *Psychiatric Services* presents encouraging news that agitated patients are being successfully treated without the use of restraint or seclusion.

The question of restraint has a long history of disagreement among physicians in mental hospitals. At its first meeting in 1844, the newly organized Association of Medical Superintendents of American Institutions for the Insane (now the American Psychiatric Association) passed its first proposition: "It is the unanimous sense of this convention that the attempt to abandon entirely the use of all means of personal restraint is not sanctioned by the true interests of the insane." This consensus was debated throughout the 19th century—but in the end it was always supported (1).

Nineteenth-century British psychiatrists were opposed to mechanical restraint, although "holding" by attendants was allowed. The Quakers who opened the York Retreat in 1796 opposed the use of restraint. Dr. John Conolly, who was superintendent of the Middlesex County Asylum in Hanwell, published a book in 1856 titled *Treatment of the Insane Without Mechanical Restraint* (2). In 1875, when Dr. John Bucknill, a former superintendent of a British asylum, visited American asylums, he found that the private ones used little or no restraint but the public mental hospitals used restraint often. He wrote in a *Lancet* article in 1876 that "[the superintendents] will look back to their defense [of restraint] with the same wonderment . . . that has been said in defense of domestic slavery" (3).

Perhaps the articles in *Psychiatric Services* reflect a new era in the treatment of mental patients in hospitals.

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Dr. Ozarin was formerly medical director of the U.S. Public Health Service.

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To the Editor: As chairperson of the American Psychiatric Association's committee in patient safety, I applaud the inclusion of the articles on seclusion and restraint in the September issue of *Psychiatric Services* (1–5). The safe and minimal use of seclusion and restraint is one of the committee's first three initiatives. Reading these articles makes one realize that this particular patient safety goal is well on its way to being achieved.

However, I would also argue that, for most acute psychiatric settings, total elimination of seclusion and restraint is not a practical goal unless one puts dogma ahead of both patient safety and staff safety. Rather, I would argue that the goal should be safe, judicious, and minimal use of seclusion and restraint.

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In Reply: We too are grateful for the editorial decision to dedicate a section of the September issue of *Psychiatric Services* to reports of current efforts to reduce and eliminate the use of seclusion and restraint. We hope that publication of our study from the Pennsylvania state hospital system and other such studies will lead to further research on more positive strategies to support a person in crisis.

The safe and minimal use of seclusion and restraint, as Dr. Herzog indicates, should now be a requirement for all psychiatric health care providers. However, too many people continue to be injured from the use of these restrictive measures. In our Pennsylvania state hospital system, which trains staff in the most current strategies, we discovered that one in five applications of mechanical restraint resulted in an injury to the patient or staff member involved. These are high-risk activities that have no therapeutic value in supporting a person with serious mental illness, and, as we have discovered, they do far more harm than any short-term gain that their use may provide. Psychiatric treatment providers need to find more positive ways to support people who are in crisis.

Ten years ago most people in our hospital system accepted the use of seclusion and restraint and regarded these practices as clinical interventions for managing a person in crisis or as proactive interventions in anticipation of a crisis. During this period the "dogma" of the nonrestraint approach was polarizing our hospital community. However, the hospital system's leadership—physicians, nurses, direct care workers, and program staff—who supported a less traumatizing approach prevailed and drove the culture change that has resulted in a safer hospital system.

Most people served in our hospital system are first cared for within a short-stay acute care setting. People who were admitted to our civil hospitals were unable to be stabilized within such a setting. Moreover, in our three forensic units at Mayview, Norristown, and Warren state hospitals, where direct acute admissions continue to occur, reduction in the use of seclusion and mechanical restraint has been equally dramatic. Since January 2005 the three forensic centers have had an average daily census of 190 and have provided 5,700 days of care each month. During this period mechanical restraint has been used only 34 times and seclusion has been used 22 times. Several forensic units have not needed to use these measures at all in the past nine months.

Early next year the hospital system will discontinue the use of the mechanical restraint in all civil and forensic units. The traumatizing effects of these measures, for both patients and staff, have eclipsed any short-term safety benefit they may provide and are inconsistent with the recovery approach that we have adopted.

Aidan Altenor, Ph.D.

An Emergency Department's Response to a Patient's Threat to Kill the President

To the Editor: I was troubled by the Open Forum by Zitek and colleagues (1) in the August issue. The authors rightfully observed that "a comprehensive evaluation is impractical" in the psychiatric emergency service, yet they recommended a low threshold for contacting the Secret Service from the psychiatric emergency service when someone threatens the president—a knee-jerk reaction that does not allow exploration of all the options available to the physician. The usual practice for psychiatric patients with homicidal ideation is to admit them to the hospital, involuntarily if necessary, to fully explore the seriousness of the threat, and only then to warn the intended victims (through the Secret Service, in this case) as necessary.

The authors asserted that the Secret Service "has developed a level of expertise in systematic violence risk assessment that is unmatched by the average clinician working in a psychiatric emergency service setting," but they cited no references to back up their claim. Mere knowledge of an individual's history of violence and

possession of weapons does not equate to superior skills for assessing future dangerousness.

In the history as presented by the authors, Mr. K "agreed" to sign the Authorization to Review Medical/Psychiatric Files presented to him by the Secret Service agents. I wonder how much of his agreement was coercion or intimidation and how much was voluntary. Was a determination made that Mr. K had the capacity to sign the form? Did anyone warn him of the implications of signing the form and of talking to agents of the secret service? Did anyone advise him of his rights to consult with an attorney before proceeding? The casualness of the authors about these matters is amazing. A patient came voluntarily to the emergency department for treatment and left with a criminal conviction and a sentence of five years' probation without adequate warning or representation ab initio.

The authors presented three scenarios "that may warrant immediate notification of the Secret Service from the emergency service." These are a patient with a risk of elopement, an intoxicated patient, and a patient with personality disorder. To conclude that a patient is suffering from only a personality disorder on the basis of a quick interview in the emergency department is both naïve and dangerous. Further evaluation, including obtaining collateral information, is warranted. The standard procedure for eloped dangerous patients is to inform the police so that they can be apprehended and returned to the hospital, and as for the intoxicated patient, how credible is a history obtained when a patient is intoxicated?

In conclusion, threats to kill the president (or anyone else for that matter) should be taken seriously by psychiatrists in any setting and should trigger a comprehensive evaluation. Informing the Secret Service after a cursory evaluation in the emergency department and without adequate measures to protect the patient's rights is unethical. Although most of the issues raised in my letter are similar to those in Dr. Zonana's commentary, the authors' emphatic recommendation for a low threshold to call the Secret Service, without due consideration of our ethical obligations, compelled me to write.

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Oxcarbazepine and Risk of Falls Among Psychiatric Inpatients

To the Editor: Falls of institutionalized patients, particularly elderly patients, can lead to injury, long-term disability, and death. Psychiatric medications have been shown to increase the risk of falling (1–3). Quality assurance data at our psychiatric hospital suggested that oxcarbazepine, an antiepileptic used off-label for mood stabilization, particularly increased the risk of falling. We sought to quantify that risk.

The Buffalo Psychiatric Center is a state-operated inpatient hospital that houses 240 psychiatric patients, with an average length of stay of five years. Our analysis was conducted under the authority of a quality improvement program, and our institutional review board did not deem it necessary to review the protocol post hoc. We preserved patient confidentiality by maintaining records on a secure server. The design was a rolling cohort study. The population included all patients who were receiving oxcarbazepine for any duration greater than one day between January 1, 2001, and March 31, 2003. Patients entered the cohort on January 1, 2001, or on their date of admission, whichever came later. They left the cohort on their date of discharge or on March 31, 2003, whichever came earlier. We obtained demographic and medication information from administrative databases. The hospital tracks falls through an incident reporting system.

We calculated falls per 100 patient-days for each patient while the patient was taking the medication and while the patient was not taking the medication; with this method, patients acted as their own controls. We stratified by age to examine potential confounding and sought to strengthen a case for causality by dose stratification.

The cohort included 51 patients—23 men and 28 women—whose mean±SD age was 59.4±16.0 years. Eleven patients were African American, and 40 were white. One patient with a history of head injury, congenital ataxia, and 63 falls was excluded to avoid bias. There were 162 falls and 32,336 patient-days.

The number of falls was significantly higher among patients who were taking oxcarbazepine. Among patients taking the drug the number was .69 falls per 100 patient-days (95 percent confidence interval [CI]=.54 to .84). Among those not taking the drug the number was .38 (CI=.30 to .47). Age stratification showed higher rates for older patients. For patients aged 50 through 65 years (N=20), the rate among those taking the drug was .75 (CI=.52 to .99), and for those not taking the drug it was .46 (CI .32 to .60). For patients over age 65 years (N=17), the corresponding rates were 1.14 (CI =.83 to 1.44) and .43 (CI=.28 to .58). Dose stratification showed a trend toward higher rates at higher doses, although the differences were not statistically significant.

According to the package insert, oxcarbazepine can induce hyponatremia, dizziness, drowsiness, fatigue, abnormal vision, incoordination, and abnormal gait; all these adverse effects might affect the risk of falls.

Strengths of our study included the cohort design, which offers a higher level of evidence than a case-control study, and a relatively long study period. The use of patients as their own controls probably reduced confound-

ing. Weaknesses included the fact that we did not explicitly control for potential confounders, including coexisting neurologic disorders, and used pharmacy records rather than medication administration records, therefore not accounting for medication refusals. The study did not use an outside control group.

Our results indicate that psychiatrists should use caution when prescribing oxcarbazepine for patients who are at risk of falls, especially elderly patients.

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When this work was done, Dr. Merrill was affiliated with the Buffalo Psychiatric Center and with the department of preventive medicine of the State University of New York at Buffalo. He is currently a hospitalist at South Buffalo Mercy Hospital. Dr. Belz is with the School of Pharmacy at the university.

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Family Participation in the Treatment of Persons With Serious Mental Illness

To the Editor: Standardized programs for families of persons with serious mental illness can reduce the risk of relapse, enhance social functioning, and cut costs (1,2). Practice guidelines (3) and the President's New Freedom Commission strongly recommend family involvement. However, very few families receive services (3). Numerous reasons for the lack of family services exist, and engaging families is a major challenge.

For the past six years, the Oklahoma City Veterans Affairs (VA) Medical Center has provided the SAFE Program (Support and Family Education), a series of 18 psychoeducational workshops for families of veterans with serious mental illness (4). Ninety-minute sessions are provided monthly by a psychologist to educate and support families. (The curriculum is available at http://w3.ouhsc.edu/safeprogram.) Although the program is positively received, families of only 5 percent of veterans with serious mental illness have participated. The purpose of this project was to study the efficacy of three engagement strategies.

All veterans who were receiving outpatient mental health care between January and October 2004 from one psychiatrist at the Oklahoma City VA Medical Center were invited to participate. To be included in the study the veteran's family had to live within 90 miles of the medical center and the veteran had to have a diagnosis of a serious mental illness or posttraumatic stress disorder (PTSD). Veterans were excluded if they were imminently dangerous or had acute psychosis.

Of the 527 eligible veterans, 363 (69 percent) had regular contact with a family member who lived within 90 miles. Of these 363 veterans, 165 (46 percent) allowed a family member to be contacted. Most of the 165 veterans were male (152 participants, or 92 percent). The mean±SD age was 57.62±11.48 years, and most were white (154 participants, or 93 percent). The most common diagnoses were major depression (74 participants, or 45 percent), PTSD (48 participants, or 29 percent), and schizophrenia (15 participants, or 9 percent). The family members most commonly identified were the wife (128 participants, or 78 percent) and the mother (eight participants, or 5 percent).

If the veteran consented to participate in the study, the psychiatrist provided a SAFE Program pamphlet and encouraged the veteran to ask a family member to participate. Veterans were then assigned to one of three engagement strategies: pamphlet only (no subsequent contact), pamphlet plus letter (after the appointment, a letter was sent describing ways to participate, emphasizing potential benefits, and encouraging the family to call the principal investigator), and pamphlet plus letter plus phone call (the principal investigator called the family after the letter was sent and invited the family to attend the SAFE Program). The veterans were assigned in a stepwise design (55 veterans per condition). The psychiatrist was blind to the assignment procedures. Dependent variables included a phone call by a family member to the principal investigator and any participation by a family member within six months after the invitation—that is, a family member's attendance at a SAFE Program session, a family member's accompanying a veteran to an appointment, or a request for family therapy.

There was minimal response to all three engagement strategies as measured by both dependent variables, and no significant differences were found between groups. In the pamphlet-only condition, no family members contacted the principal investigator, and family members of four veterans (7 percent) attended a program session, accompanied a veteran to an appointment, or requested family therapy. In the pamphlet-plus-letter condition, a family member of one veteran (2 percent) contacted the principal investigator, and family members of seven veterans (13 percent) attended a program session, accompanied a veteran to an appointment, or requested therapy. In the third condition, family members of two veterans (4 percent) contacted the principal investigator, and family members of four veterans (7 percent) attended a program session, accompanied a veteran to an appointment, or requested therapy.

Engaging families in the treatment of persons with serious mental illness is a complex, multidetermined process, and simple solicitations were ineffective in this study. These findings have limited generalizability, because the study was conducted at one hospital. However, the findings suggest that providers may need

to accommodate families' needs by providing services in flexible, creative ways.

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Meteorologic Factors in Emergency Evaluation, Admission, and Discharge

To the Editor: The demand for psychiatric services is not random and may fluctuate with climatic variables (1). Seasonal variability and weather have been shown to predict hospital admissions among patients with major psychiatric disorders (2). Secondary gain in obtaining shelter from the elements may account for some of these findings.

To address this issue, we examined the relationships between weather and the use of emergency psychiatric services, as well as any relationship to subsequent hospitalization or discharge, at a large, urban, military teaching hospital in Southern California, where patients would have little incentive to seek shelter from the weather. Data from 1,909 emergency department psychiatric evaluations over a one-year period (August 1, 2002, to July 31, 2003) were examined. Evaluations were divided into two groups—patients who were admitted to a psychiatric ward after evaluation (N=900) and those who were discharged from the emergency department after evaluation (N=1,009). The weather variables examined were maximum, minimum, and average temperature; precipitation; average and maximum sustained wind speed; wind direction; and sky conditions (clear to cloudy). Weather data were obtained from the Web site of the National Weather Service.

Linear (Pearson's) correlations were examined between the number of evaluations per day and weather factors. A multivariate, stepwise linear regression model was calculated to predict emergency department evaluations from these factors.

The linear analysis showed weak but significant correlations between temperature and rain and the number of psychiatric evaluations in the emergency department. On rainy days, fewer patients presented for emergency evaluations ($r=-.134$, $p<.01$). Among patients who were discharged after evaluation, fewer visited the emergency department on rainy days ($r=-.165$, $p<.01$) and on cloudy days ($r=-.117$, $p<.05$).

Warmer temperature (high, low, and average) was significantly correlated with the number of psychiatric evaluations. Patients who were discharged after evaluation ($r=.131$, $p<.05$) rather than those who were hospitalized accounted for the relationship between emergency evaluations and temperature.

No associations were found between wind variables and evaluation and disposition of patients or between any weather variable and hospitalization.

In the stepwise, multivariate model, only rain and average temperature were predictive of emergency department visits. More patients came to the department on warmer days and on days without rain. Rain accounted for 2.2 percent of the total variance ($p=.005$), and average temperature accounted for 3.5 percent of the total variance ($p=.001$). When only patients who were seen but not hospitalized were included, analysis of variance indicated that only rain was a predictor of discharge after evaluation ($r^2=.031$, $p=.001$).

Even though these correlations were found, no causality can be inferred. Because 1,909 emergency department visits were analyzed, the study had more power than was needed to yield a clinically significant result, which meant that even miniscule relationships being statistically significant. However, the amount of variance accounted for (2.2 to 3.5 percent) is more telling; these results might not have practical clinical application with such a small observed effect. Nevertheless, further investigation is warranted in cities with larger variation in weather variables, where greater effects may be seen.

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