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).

Violence and Commitment to Treatment

To the Editor: The February issue of *Psychiatric Services* featured several articles that made contributions to our understanding of violence in mental illness. We would like to add two points to this discussion.

First, there is now good evidence that people with psychotic disorders are more likely to be violent during their first episode of psychosis than later in their illness. In our own study, 61% of 88 persons with psychotic illness who had committed homicide were experiencing a first episode of psychosis (1). We conducted a systematic review of the literature for studies that reported on homicide among persons with psychosis (2). We found that 11 of 14 studies from Western countries reported that between 30% and 50% of the lifetime risk of homicide attributable to psychosis appeared to be during the first episode of psychosis. Furthermore, our review found case linkage studies from Australia and Denmark that also indicate that most violent offending by patients with schizophrenia occurs before, or at the time of, initial treatment. Three North American publications support this finding; they reported that between 28% and 72% of people who had received a verdict of not guilty by reason of insanity after committing a variety of very serious crimes had never been hospitalized. Finally, ten clinical studies of patients experiencing their first episode of psychosis have shown that an average of 18% were physically violent and 8% committed an act of serious aggression during the first psychotic episode (3).

Second, we believe that assessment of a patient's capacity to refuse treatment, not prediction of future violence, should be the primary criterion used to determine whether the patient should receive psychiatric treatment to which he or she has not consented. Dangerousness might be a reasonable criterion for involuntary detention—for example, in a hospital—but such detention does not imply treatment nor does it always automatically permit involuntary treatment other than in an extreme emergency. Furthermore, dangerousness is not the right criterion to use for involuntary treatment.

As Buchanan (4) demonstrated in his article in the February issue, if predicted serious violence is the fulcrum for involuntary commitment, the cost of detaining one person who will become violent is the detention of 15 people who will not, even when clinicians use their best predication tools. Demanding that predicted violence be the fulcrum for involuntary treatment may also result in longer periods of nontreatment for many people with mental illness who may benefit from treatment but who lack the capacity to see themselves as ill. This is exactly what we found when we compared the duration of untreated psychosis in legislative jurisdictions that demanded the prediction of harm to self or others before involuntary treatment and in legislative jurisdictions that used other legal criteria (5).

Capacity to refuse treatment should be the fulcrum of commitment law. Moreover, "commitment" should be a commitment to treatment, not to a particular outpatient or inpatient setting. The setting should be the one that imposes the least restrictive environment upon the incompetent person with mental illness. Determining the safest, least restrictive environment is the sort of decision that is appropriately guided by our imperfect attempts to predict future violence. Earlier treatment of patients and an increased focus on assessing their capacities and providing support for any incapacities that are evident may be safer and more helpful than reliance on risk assessment to make decisions about treatment.

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In Reply: Dr. Large and his colleagues make several important points. In their study, individuals undergoing a first episode of psychosis were disproportionately more dangerous. This finding suggests that availability of hospitalization and other treatment is a critical factor if violent behavior is to be reduced.

The lack of available psychiatric beds for acutely ill patients in the United States is shocking. The Treatment Advocacy Center recently released a report indicating that this country has only one-third of the public psychiatric beds needed for minimally acceptable care; 51,413 beds exist and 147,233 are needed (1). In 32 of the 50 states, the psychiatric bed shortage was reported to be critical or severe. Without a sufficient number of available beds, it is impossible to adequately treat individuals undergoing their first episode of psychosis.

E. Fuller Torrey, M.D.

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Smoking Bans in State Hospitals: Patients' Rights and Patients' Health

To the Editor: In a letter to the editor in the March issue, Kenneth Marcus (1) opines that banning smoking in state psychiatric hospitals poses "a dilemma when applied coercively to a class of patients whose lengths of stay are indeterminate." He argues that the state hospital is home to those patients and that no government body has passed measures regulating smoking in persons' homes. He asks, "[W]hy is it that I can smoke in my home, you can smoke in your home, but long-term residents of psychiatric institutions cannot smoke in their homes?"

If our goal as psychiatrists is to promote all aspects of our patients' health, why should we not preventively treat the *DSM-IV* disorder of nicotine dependence in our treatment facilities? If Dr. Marcus' main concern is for patients' civil liberties, is he prepared to argue that drinking alcohol should be allowed in psychiatric hospitals? After all, alcohol is also a legal substance that is unregulated in the home. The question would then become, "Why is it that I can drink in my home, you can drink in your home, but long-term residents of psychiatric institutions cannot drink in their homes?"

Also, many states and countries have regulated smoking in the workplace because of the harm that second-hand smoke inflicts on employees. Should employees of psychiatric hospitals be subjected to unnecessary harm?

Finally, it's fairly self-evident that patients' physical well-being would be improved by banning smoking, but it can also be argued that their long-term emotional well-being would improve when they learned that they could function well and enjoy their improved physical health without being enslaved to an addiction.

Dugald D. Chisholm, M.D.

Dr. Chisholm is in private psychiatric practice in Atascadero, California.

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In Reply: I appreciate Dr. Chisholm's response, but the dilemma remains, notwithstanding. The question before us is: If promoting patients' health is a core professional goal of psychiatrists, if an improved sense of well-being would come from patients' feeling physically healthy and learning that they can function "without being enslaved to an addiction," what justifies our confining this beneficence to a small, largely disadvantaged, largely disempowered group of individuals who constitute what we might call a "captive audience"? Why do we not bestow this beneficence on all psychiatric patients? All staff? All citizens? Is it morally acceptable to single out long-term psychiatric inpatients (as distinct from everyone else) for a coercive intervention just because we can?

My understanding of my professional role as a psychiatrist is as follows: if I agree to treat someone for, say, an anxiety disorder, and if this person also has a family history of cancer of the colon, I cannot then decide, willy-nilly, to order a colonoscopy to be performed involuntarily simply because I believe it to be indicated. I would have to engage my patient in a conversation aimed at obtaining his or her informed consent. Alternatively, if I thought the patient lacked the decisional capacity to think with me about this issue, I would consider petitioning the court of probate (as per statute), and a formal hearing would ensue. At no point would I be entitled to say, "Since my patient is a member of the class of, say, male psychiatrists in private practice in Atascadero, California, due process is suspended."

Dr. Chisholm's point concerning alcohol is an interesting one. I would want to give it more thought, but preliminarily I would say that banning alcohol on inpatient units is justified because of its acute intoxicating effects and therefore its potential for disruption of the therapeutic milieu (not because of its addictive nature).

I do agree (as I said before) that the effects of second-hand smoke should be minimized for everyone (not just employees). But I would agree even more heartily if those employees were similarly enjoined from smoking in their homes so that visitors, passers-by, other residents, housing employees, and the like were similarly protected from "unnecessary harm."

The essential point is that psychiatric patients have long been considered to be what might be called, in the current lexicon, "decisionally challenged." The recovery movement has been laboring to dispel that stigmatized image. Smoking as a public health matter is a political issue as well as a wellness issue. The fate of Prohibition is a cautionary tale illustrating what can happen when "health values" are unilaterally im-

posed upon a diverse population where the power gradient is more level. (We owe, by the way, the fact that we can legally consume alcohol in our homes to the repeal of Prohibition.) But by singling out institutionalized psychiatric patients for "special treatment," we are in danger of living up to John Kenneth Galbraith's description of this country as a "democracy of the fortunate." Before we ask a stigmatized and historically disempowered group to have the courage of our convictions, perhaps we should demonstrate that courage, on the larger political scene, ourselves.

Kenneth Marcus, M.D.

Surprising Predictor of Rehospitalization

To the Editor: Recurrent readmission to inpatient psychiatric services is a vexatious problem for all involved in mental health services. Klinkenberg and Calsyn (1) proposed system responsiveness as the most important element associated with high readmission rates. One approach to system responsiveness has been discharge planning. Caton and colleagues (2) found that adequate discharge planning significantly influenced treatment adherence and rehospitalization in the first three months after an index hospitalization.

This letter describes an unexpected finding from a pilot study evaluating a discharge planning intervention for patients with a history of recurrent psychiatric hospitalization.

Patients who were hospitalized twice or more in the 18 months before an index hospitalization and who were 18 years of age or older, fluent in English, and able to give informed consent were invited to participate in the discharge planning study, which received approval from the local institutional review board. Thirty-one patients were enrolled during 2005–2006 and followed monthly for six months after discharge in order to determine their adherence to the treatment plans and to assess clinical outcome.

The treatment intervention was a discharge planning process that included providers from all agencies involved in the patient's care in the creation of a systematic plan to address major service domains—that is, food and shelter, case management, clinical care (both medication and psychological support), and psychosocial rehabilitation. Before discharge and at each follow-up, the patient's understanding of, agreement with, and motivation for three domains (case management, medication, and psychosocial rehabilitation) were rated on a 5-point Likert scale. Also assessed were the complexity of the patient's medication plan; the patient's level of expectation in regard to food, housing, and security; and the overall adequacy of the discharge plan. Assessments and ratings were carried out by research staff within two days of discharge.

Overall, 13 patients (42%) were readmitted within six months of the index hospitalization. Results of logistic regression showed that only patients' understanding of their case management plans predicted readmission. Patients who had a poor understanding of case management had nearly sevenfold higher odds of being readmitted within six months (Wald χ^2=4.25, df=1, p=.03; odds ratio=6.86, 95% confidence interval=1.1–42.8). Poor understanding was rated by the research staff as failure to understand the purpose of case management and elements of case management.

This result raises an intriguing possibility that among patients with a history of recurrent hospitalization, cognitive understanding at discharge of a key component of follow-up treatment—case management—predicts rehospitalization within six months. Several elements of this finding surprised us. We expected that provisions in the treatment plan related to food, shelter, and security would be associated with psychiatric readmission, especially because many patients rated such arrangements as lacking, or that medication adherence would predict longer community tenure. That patients' understanding of case management—but not any other domain of discharge planning—predicted readmission raises the prospect that recently discharged individuals who may underestimate or minimize the importance of receiving help from others in the community because of a lack of cognitive understanding of case management are at greater risk of rehospitalization. We wonder whether this poor understanding of case management is related to the abstract nature of what this activity entails and thus signifies a deficit in neurocognition or whether these patients have a specific block against the idea of interpersonally oriented activities—a deficit that, regardless of cause, may not be fully appreciated by those treating them.

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