Letters from readers are welcomed. They will be published at the discretion of the editor as space permits and will be subject to editing. They should be a maximum of 500 words with no more than three authors and five references and should include the primary author's telephone and fax numbers and e-mail address. Letters related to material published in *Psychiatric Services* will be sent to authors for possible reply. Address letters to John A. Talbott, M.D., Editor, *Psychiatric Services*, APA, 1400 K Street, N.W., Washington D.C. 20005; fax, 202-682-6189; e-mail, psjournal@psych.org.

A Flawed Study Design?

To the Editor: In the article entitled "Adverse Effects of Poor Management of an Inpatient's Difficult Behaviors" in the July 1999 issue, Hilton and Simmons (1) report the results of an A-B-A-B study design that purports to analyze the consequences of a "management plan" on the behavior of a psychotic man. The authors conclude that "the case reported here illustrates that poor behavioral management can have adverse effects" and that "these interventions provided what might be a prototypical example of poor behavior management in institutions."

This man was held on a male ward in Ontario's maximum-security hospital. Patients on his ward are very aggressive, psychotic, developmentally challenged, and brain injured. They do not take assault on their genitals (the target behavior) kindly, and the man was the victim of physical retaliation on several occasions.

Apart from the pejorative language and the statement, unsupported by any evidence, that front-line staff had a malevolent motivation to punish the patient, there are serious flaws in this study.

The first A component of the study occurred in the 42 days between November 7 and December 18, 1996. During this period, the man was secluded for a total of 22 days. The authors calculate that the man committed 13 assaults, for an average of .31 assaults per day. This is a gross underestimate of the assault rate. Using the authors' criteria to examine the data, I counted 16 assaults, for an average rate of .38 per day. However, the man could not assault others while in seclusion, although he often acknowledged that he would do so if he had the opportunity. Given the days the man spent in seclusion, a more realistic estimate of the assault rate was the "opportunity" rate—16 assaults in 20 days, or an average of .80 assaults per day.

At this point, the nursing staff developed a management plan to end the use of seclusion and return the man to the community of the ward. In maximum-security environments, management plans, in contrast to treatment plans, are designed to ensure a safe, secure environment for the patient, peers, and staff. The distinction is not "arbitrary" or "made to circumvent administrative barriers that would have prevented treatment," as the authors state.

The first B component of the study occurred over an eight-week period between December 19, 1996, and February 13, 1997. The man was not secluded during this period. The authors took the first six weeks of the period and counted 39 assaults, including two occasions when the man told staff he had "the urge to grab." I excluded these two incidents because they were outside the criteria used in the first A period and computed an average assault rate of .88 per day. Thus the data do not demonstrate that the assaults were "significantly more frequent during the time periods when the plan was in effect."

The second A component of the study occurred over a six-week period between February 14 and March 27, 1997, when no seclusion was used. During this period, the man committed five assaults (not eight, as the authors report), for an average rate of .12 assaults per day.

From examination of the records for the entire period of the study, it is apparent that the man had three discrete psychotic episodes between November 7, 1996, and September 29, 1997. The second A component of the study occurred following remission of the first episode. The second shorter episode of 19 days' duration occurred 21 days before the third. In it, the man was severely psychotic and aggressively assaultive and required seclusion.

The second B component of the study occurred in the six weeks between August 19 and September 29, 1997, almost six months following the termination of the second A component and three weeks into the third psychotic episode. During this period, my review of the data shows that the man committed 31 assaults (not 42, as the authors report), for an average of .74 assaults per day. However, the long time interval between the second A and B components, and the many things that transpired during that interval, do not allow for the comparison that the authors seem determined to make.

In short, the only supports for their conclusions are a flawed research design, biased data collection, and inappropriate use of statistical analysis. The front-line nursing staff of this hospital, of whose work I am proud, do not deserve to be villified by such research.

R. Ian Hector, M.D., F.R.C.P.C.

Dr. Hector is clinical director of the Oak Ridge Division of the Mental Health Centre in Penetanguishene, Ontario.

References

1 Hilton NZ, Simmons JL: Adverse effects of poor behavior management of an inpatient's difficult behaviors. Psychiatric Services 50:964–966, 1999

In Reply: Dr. Hector clearly agrees that the plan was to reduce undesirable behavior. Punishment is the technical, behavioral term for consequences that suppress behavior.

People often misunderstand the terminology and methods of behavior therapy. The case report alerted clinicians to the adverse effects of this inadequate knowledge. Whether an intervention is intended as treatment or

management, clinicians must assess the reinforcing and punishing properties of the consequences for each patient.

Let us clarify some points. Delayed time periods in no way invalidated the design. Mr. A was secluded for part of one period with no management plan and was in restraints during much of the periods with a management plan; both limited the opportunity for disruptive behaviors. We counted only the occasions on which he assaulted others or pressed the emergency button or attempted to do so, and only those on which both raters agreed (we discounted two disputed incidents). There was a statistically significant, positive association between the plan and disruptive behaviors. The reliability of Dr. Hector's counting is unknown. Nevertheless, his own figures (16 and five assaults in the periods with no management plan and 37 and 31 for the periods with the plan) also clearly show the plan was associated with increased disruptive behavior. The most parsimonious conclusion is that these increases in disruption (and perhaps the "psychotic episodes") were caused by the plan.

When we as clinicians can provide evidence that we use the most effective and least intrusive interventions, then we indeed have a service in which to take pride.

N. Zoe Hilton, Ph.D.
Janet L. Simmons, M.A.

An ACT Program for Co-Occurring Disorders

To the Editor: In many states, the care of persons with co-occurring mental illness and mental retardation remains limited to that provided in institutional settings or community group homes, where individual services are provided by vendors from separate and autonomous systems such as mental health, developmental disabilities, and vocational rehabilitation (1–3). We implemented a community living program designed to care for 21 persons with mental illness and mental retardation based on the assertive community treatment (ACT) paradigm (4).

The core interdisciplinary team was accessible 24 hours a day seven days a week, shared integrated clinical and rehabilitative responsibility for all clients, and maintained close communication with family members and employers. Residential arrangements centered mainly on clusters of apartment for one to two persons, although several clients chose to live in other housing units scattered throughout the city.

Overall, the program helped participants maintain community tenure, supported employment, and consistent contact with significant others without clinical deterioration or increase in the use of inpatient hospital services. Our experience is consistent with that of ACT programs in Michigan and overseas (5) and supports the assertion that such programs can be implemented and sustained without exceeding budgetary constraints of parent agencies and without adverse client outcomes.

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References

1. Dudley JR, Calhoun ML, Ahlgrim-Delzell L, et al: A consumer satisfaction survey of people with mental retardation and mental illness. Psychiatric Services 48:1075–1077, 1997
2. Torrey WC: Psychiatric care of adults with developmental disabilities and mental illness in the community. Community Mental Health Journal 29:461–475, 1993
3. Thomas JR: Quality care for individuals with dual diagnosis: the legal and ethical imperative to provide qualified staff. Mental Retardation 32:356–361, 1994
4. Stein LI, Santos AB: Assertive Community Treatment of Persons With Severe Mental Illness. Norton, New York, 1998
5. Van Minnen A, Hoogduin CAL, Broekman TG: Hospital vs outreach treatment of patients with mental retardation and psychiatric disorders: a controlled study. Acta Psychiatrica Scandinavica 95:515–522, 1997

Employment and Disability

To the Editor: Although I am not a regular monthly reader of *Psychiatric Services*, I am an educated consumer, and I occasionally review the letters and books sections when my case manager or therapist loans me a copy. I do know that the journal is familiar with and sympathetic to issues and concerns of mental health consumers. Having done a research paper on stigma and mental health consumerism and a survey in the process, I found the letter by Ruth Arnold (1) on employment and disability in the October 1998 issue quite empathetic, and I would like to elaborate on her observations.

Ms. Arnold is right when she says that many mentally ill persons who are receiving Social Security disability benefits would rather rely on disability payments as their mainstay and work part time to supplement their income. An increasing number are forsaking full-time employment for part-time work because they find it more therapeutic for their mental-illness-damaged lives.

For mentally disabled persons, employment is a hotbed of controversy about where, how, why, and when to perform certain jobs. Many work supervisors demand that the job be done "just so," or else the employee is not worth keeping. They watch disabled workers more closely than other employees because they are waiting to see disabled employees act like leaders, produce miracles, and work wonders. The slogan "Get an education and get a job" doesn't hold true any more. You can get all kinds of education, but if you don't please your supervisor, you're out of a job.

We need more employment specialists like Ms. Arnold who sympathize with mentally ill persons who want to use disability benefits as a mental health umbrella and who recognize the need to increase benefits for these persons to the same level as those for persons who are blind and disabled.

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Ms. Elliott lives in Indianapolis, Indiana.

Reference

1. Arnold R: Employment and disability (ltr). Psychiatric Services 49:1361, 1998