## LETTERS

Editor:

Intimate partner violence (IPV) is a major public health concern, with at least 1.3 million women abused annually in the United States. Mandatory arrest laws have led to a proliferation of IPV offenders entering the criminal justice system, and an expansion of jurisdiction-mandated programs has outpaced research efforts to assess the efficacy of interventions. While more research is needed on these programs, we can learn from a large and growing body of literature on violence intervention programs in general (which includes IPV, but also other forms of violence). The report of Sherman and colleagues[1] to Congress of interventions in use throughout the country, the review by Nation and colleagues[2] of 35 violence and delinquency prevention programs, and the meta-analytic review of Dowden and Andrews[3] of correctional rehabilitation program studies are just a few examples.

A growing consensus among the most rigorous attempts to identify the characteristics of successful (general) violence interventions includes the following: The first is that effective programs are intensive, with participants engaged in them for as much time per day and per week as possible. The second is that they are universal, so that the program does not select among peers in a given setting, facilitating change in the culture at the same time as in the individual. The third, and most important, is that they are comprehensive and multimodal, so that participants are exposed to a range of different activities wide enough to reach them at multiple levels of functioning: affective, cognitive, and behavioral. Without considering these features, to ask which components of a program facilitate change misses the point, for the characteristic that makes any one component successful is the fact that it is interacting with, reinforcing, and reinforced by all the others.

Studies of IPV intervention studies often address length of treatment and rigor of study design,[4] but not program intensity, universality, or comprehensiveness, as once was the critical error of evaluators of violence intervention programs in general. While IPV is not the same as general violence, the World Health Organization (WHO) has advocated a typological, unified view of violence so that the common underlying causes and manifestations (as well as how they differ) can be considered. Tailoring treatments to subtypes of violent individuals while looking at interventions from a piecemeal perspective undermines the complexity of human behavior, and ignoring available and applicable evidence is likely to lead to the wide implementation of programs that have little proven efficacy. Such an approach risks repeating the mistake that led to the conclusion, after Robert Martinson's[5] report 35 years ago, that "nothing works."

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Editor:

Jeffrey Geller's linking of a Crisis Intervention Team (CIT) program[1] that is revered by family members and consumers to what is now perceived as something barbaric is reminiscent of characterizations that stigmatize mental illness.

As a CIT class coordinator and family member, I have had officers in training, after about the third day, come up to me and acknowledge what "jerks" they had been out on the street, because they just didn't understand crisis intervention before attending CIT class.

While research data are ultimately necessary to validate and measure outcomes, common-sense application of humane actions and education, such as CIT, encourages creation of policies and resources to

treat mental illness. Geller's article contributes to stigma, which may be the major deterrent to treatment and recovery.

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Editor:

Recent papers by Price and Norris[1] and by Simpson[2] in the *Journal* have highlighted important concerns related to federal gun control legislation intended to limit possession and sale of guns by certain classes of people, including persons with psychiatric disabilities. The most recent legislation, the National Instant Criminal Background Check System Improvement Amendments Act of 2007 (hereafter, NICS Act),[3] was passed in the aftermath of the Virginia Tech tragedy and will force states to comply with now-mandatory reporting of "denied persons." The law is designed to utilize both a carrot and a stick to encourage automated compliance: The former by way of federal grant funds, the latter by way of penalties taken out of the Omnibus Crime Control bill funding currently provided to states.[4]

Regardless of the merits or concerns that individuals might raise in a discussion about this public policy directed at people who experience mental illness,[5] there is one aspect of this new legislation that should be made widely known to psychiatrists and other mental health professionals in the United States and that should require little debate: The 110th Congress' use of offensive language to refer to the people at whom the policy is directed.

In the NICS Act, which was signed into law by President Bush on January 8, 2008, the U.S. Congress used the term "mental defective" no fewer than eight times to refer to individuals who have experienced various court adjudications related to mental health problems.

The term "mental defective" was first introduced into the U.S. Code by the Gun Control Act of 1968[6] and reaffirmed in the Brady Handgun Violence Prevention Act of 1993.[2] The term "adjudicated as a mental defective" is defined in the Code of Federal Regulations as:

> (a) A determination by a court, board, commission, or other lawful authority that a person, as a result of marked subnormal intelligence, or mental illness, incompetency, condition, or disease:
>
> (1) Is a danger to himself or to others; or
>
> (2) Lacks the mental capacity to contract or manage his own affairs.
>
> (b) The term shall include—
>
> (1) A finding of insanity by a court in a criminal case; and
>
> (2) Those persons found incompetent to stand trial or found not guilty by reason of lack of mental responsibility pursuant to articles 50a and 72b of the Uniform Code of Military Justice, 10 U.S.C. 850a, 876b.[7]

The purpose of the NICS Act was to encourage automated electronic reporting by the states to the NICS of denied persons and the various prohibited categories to which they belong. The denied categories include: felons, fugitives, unlawful users of controlled substances, illegal aliens, and any person who "has been adjudicated as a mental defective or who has been committed to a mental institution."[8] The FBI is now requesting that states make this information available in a format in which individuals must be coded as belonging to one of the several categories of denied persons, including "mental defective."

The 110th Congress, in its efforts to amend the existing gun control elements of the U.S. Code, had an opportunity also to amend plainly demeaning and offensive language and failed to do so. That the U.S. Congress in the 21st century would support continued reference to citizens of our country in this frankly shocking manner represents a glaring oversight and insensitivity on the part of the Congress that must be challenged by all professional mental health organizations in their efforts to advocate on behalf of patients and to promote the battle against stigma in public life.

A solution to this language problem would be relatively straightforward. Congress should amend these statutes further by: deleting the term "adjudicated as a mental defective" and replacing it with the term "the subject of a mental health adjudication" in 18 U.S.C. § 922; deleting the term "adjudicated as a mental defective" and replacing it with the term