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 e-mail address. Letters commenting on 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, at psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (mc.manuscriptcentral.com/appi-ps).

"Prosumers" and Recovery

To the Editor: In an open e-mail to his colleagues, psychologist Frederick Frese, Ph.D., an acknowledged "prosumer" (a mental health professional who has experienced mental illness) pointed out that of 137,000 members of the American Psychological Association, only ten were known to him to have revealed a psychiatric history. Among psychiatrists, some may reveal their status to trusted friends. However, very few have been openly willing to utilize their psychiatric histories as areas of special expertise. Among these are Suzanne Vogel-Scibilia, M.D., who speaks often of her diagnosis of bipolar disorder, and Daniel Fisher, M.D., Ph.D., a psychiatrist with a diagnosis of schizophrenia and a leadership role in the consumer movement. All acknowledge prior episodes of psychosis and psychiatric hospitalizations. Yet all are functioning as practitioners or as nationally known advocates.

Where are the others? Hidden from view, they presumably are reluctant to be forthcoming because of their fear of stigma and of being demeaned by fellow professionals. Concerned about being labeled "impaired," mental health professionals have good reason to hide a psychiatric diagnosis. In *An Unquiet Mind,* noted psychologist Kay Jamison wrote tellingly of what happened when she revealed her bipolar disorder to an old friend and colleague: an immediate drop in status, an instant perception of an unforeseen defect.

Prosumers do not reveal their status because they fear devaluation and mistrust of their skills. Yet objectively, those who are in recovery and intact enough to conduct their work may also be viewed as superior in important respects. They are able to control their symptoms, overcome external and internalized stigma, and utilize a battery of coping strategies when confronting stress. Consider the accomplishments of the aforementioned mental health professionals with major axis I diagnoses. For many years Fred Frese was director of psychology at a large state psychiatric hospital in Ohio. Dan Fisher is long-time director of the SAMHSA-funded National Empowerment Center in Massachusetts. Suzanne Vogel-Scibilia, a former president of the National Alliance on Mental Illness, has a substantial practice and is active in the American Association of Community Psychiatrists. All have lectured widely and participated in national policy-making venues. How many others could influence policy and training if they were willing to lend their personal expertise to these enterprises?

Prosumers who are able to function in their professions are to be admired. They should be proud to acknowledge their diagnoses and take credit for their coping skills in going the extra mile. Fears of disclosure demean their enormous courage in overcoming deficits and turning them into strengths. They are our role models for recovery.

Harriet P. Lefley, Ph.D.

Dr. Lefley is with the Department of Psychiatry, University of Miami School of Medicine, Miami, Florida.

Alternative Settings: Unintended Consequences

To the Editor: The November issue includes a timely review by Thomas and Rickwood (1) of residential alternatives to psychiatric hospitalization for patients who need acute care. Their main conclusion was that care provided in these settings can improve symptoms at least as well as care provided in psychiatric hospitals and that the alternative settings appear to be cost-effective. At a time when saving money is becoming increasingly important, it is essential to look closely at these findings. The authors noted the enormous variation among these services. They also remarked that the studies they reviewed did not provide much detail about the patients and the actual treatment and support provided. A recent review of nonresidential alternatives to psychiatric hospitalization also mentioned the omission of such details (2), and we agree with the authors that these aspects should be investigated further.

However, there is a point that was not emphasized by Thomas and Rickwood. Not only are details lacking about the patients and treatments, but virtually no information has been reported about what happens in the rest of the service system when a "crisis house" is introduced. Tyrer and colleagues (3) described the introduction of a home treatment team and mentioned that the number of suicides in the catchment area increased, although none of the patients who killed themselves were under the care of the home treatment team. It may have been the case that experienced staff had moved to the home treatment team and that community mental health teams thus became less effective. Something similar might happen with the introduction of crisis houses.

For economic evaluations of residential alternatives, it is also important to observe what happens in other parts of the system. For example, introduction of a home treatment team or a residential alternative may increase the number of empty hospital beds. Therefore, even though the alternative setting is cheaper per patient, the increased costs for the system of the empty beds may mean that offering care in the alternative setting is more