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 and fax numbers and e-mail address. Letters related to material published in *Psychiatric Services* will be sent to the authors for possible reply. Send letters to John A. Talbott, M.D., Editor, *Psychiatric Services*, American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005; fax, 202-682-6189; e-mail, psjournal@psych.org.

Managed Care and Academic Psychiatry

To the Editor: In the April 2002 Taking Issue column, Drs. Chinman and Borus (1) commented on some of the features of the managed behavioral health care program that we described in an article in the same issue (2). We take this opportunity to respond to their questions about our program in the department of psychiatry at Johns Hopkins School of Medicine.

We did not have detailed utilization data or any financial data from CMG, the for-profit managed care organization that held the contract before we assumed the risk. Such data were considered proprietary, although CMG was very cooperative in providing data necessary for continuity of care for active patients during the last three months of its contract.

Drs. Chinman and Borus wrote, "Thus it is hard to accept on faith that the data for 1998 to 2000 demonstrate improved management." No attempt was made in our report to assert that management improved. Our more modest goal was to describe the transition from a for-profit managed care organization to our department of psychiatry and to report utilization and financial data for the first two years of managing the new contract.

These authors also wrote, "Finally, despite the large positive differences between income and expenses under this contract, the department and MSC [Johns Hopkins Medical Services Corporation] each made only $18,000 the first year and $29,000 the second." We do not know where they obtained these figures—they were not in our report, and we hope they could not be computed from data we provided. In any case, not counting the fee-for-service revenues from the clinical services we provided, the department had a positive balance of about $70,000 for each of the two years. This amount was the maximum possible because of our limited risk exposure. MSC, which had agreed by contract to full risk exposure, retained a balance of $294,000 for the first year and $519,000 for the second.

Drs. Chinman and Borus requested more demographic data on the population. But then they accurately described the population that we studied. They added, "It is unlikely to include a substantial Medicaid or disabled Medicare component." They are correct in that we have no Medicaid members. However, although U.S. Family Health Plan members are prohibited from accessing their Medicare benefits, except for services not covered under the TRICARE uniform benefit, members who are 65 years and older and eligible for Medicare constitute 25 percent of our enrolled population. Drs. Chinman and Borus sound a valid caveat about generalizing our data to diverse populations.

Finally, Drs. Chinman and Borus commented on the integration of our program with primary care physicians. They wrote, "However, it is not clear who these physicians were and what incentives they were given to work closely with behavioral health providers." The primary care physicians are employees of Johns Hopkins MSC and work at physician practices owned or leased by MSC. The issue of incentives for collaboration is truly a Taking Issue topic. We did not address it in the report, and it seems to us that if primary care and mental health services are to be integrated in a system, incentives—both financial incentives and those fostering integration required by the position description—will have to be in place. We are grateful to Drs. Chinman and Borus for reminding us of the work that is yet to be done.

Peter J. Fagan, Ph.D.
Chester W. Schmidt, Jr., M.D.
Barbara Cook, M.D.

References

1. Chinman GA, Borus JF: Getting in the game. Psychiatric Services 53:371, 2002
2. Fagan PJ, Schmidt CW Jr, Cook B: A model for managed behavioral health care in an academic department of psychiatry. Psychiatric Services 53:431–436, 2002

Evidence-Based Practices Need to Beware of Experts

To the Editor: Congratulations are due to *Psychiatric Services* for its 2001 series highlighting the importance of evidence-based practices. The message from editors and authors of articles in the series is resoundingly clear: public policy and treatment practices must be guided by the evidence. Despite the many, many benefits of practices that are based on evidence, some difficulties in definitively pointing to "sufficient research support" have been noted. Consensus among experts is one proposed way to resolve muddled data about any specific practice.

For example, in the 1990s the Agency for Health Care Policy and Research (AHCPR) (1) used expert opinion to bolster claims of an evidence base. In fact, AHCPR's third level of evidence rested almost entirely on expert opinion. Practice guidelines that rely entirely on expert consensus have been developed and published (2). In 2001, the Substance Abuse and Mental Health Services Administration listed expert opinion as sufficient for identifying an individual practice as evidence based and therefore suitable for federal funding.

The assumption here is that—by virtue of their expertise—advocates, clinicians, and researchers are able to set aside biases and judge an individual practice objectively on the basis of

the data. Unfortunately, research evidence does not support these assertions. Study after study has shown that the anecdotal base on which expert judgment rests yields conclusions that are no better than those of the naïve public (3).

In fact, concern about the harm caused by clinical judgment led to the special series in *Psychiatric Services* on evidence-based treatment. Although consumer advocates' input into the form and quality of services is essential for service implementation, there is no evidence that as experts these individuals are monolithic in voice or have opinions that are any more accurate than those of clinicians. Nor do researchers necessarily perform better as experts. Rosenthal's (4) classic series of studies shows that the expectancies of the experimenter can influence the most rigorous of research designs. Moreover, therapy allegiances have been shown to bias the analysis and reporting of research findings (5). Cognitive-behavioral researchers are likely to obtain experimental results that are superior to those achieved through psychodynamic efforts, while dynamic researchers who undertake similar studies will obtain contrary results. Interpretation of the evidence is not cut-and-dried.

The moral from these data is clear: beware of experts. No assertion that a practice is evidence based should rest solely on opinion. However, despite this concern, we are not yet ready or able to throw experts out of the process. Policy makers and service administrators, in particular, must rely on authorities to identify the evidence-based practices that should be supported by public dollars.

Two actions will help policy makers assess expert opinion. First, "Show me the data!" Experts should be able to produce the studies that support a specific practice as being effective for a particular group. A consensus panel that promotes supported employment for persons with schizophrenia will be able to list far more studies that demonstrate its success than will a group that calls for inpatient psychoanalytic treatment. Second, mix up the backgrounds of members of consensus panels. The best way to avoid biases created by therapy allegiances is to develop groups of experts who represent the diversity of key therapeutic principles related to a specific population or problem. Any consensus that they achieve about an evidence base and corresponding practice is likely to escape the individual prejudice of therapy allegiances.

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References

1. Agency for Health Care Policy and Research: Depression in Primary Care. Publication 93-0550. Rockville, Md, AHCPR, 1993
2. Frances AJ, Docherty J, Kahn DA: The expert consensus guideline series: treatment of schizophrenia. Journal of Psychiatry 57(suppl):1–58, 1996
3. Meehl PE: Credentialed persons, credentialed knowledge. Clinical Psychology: Science and Practice 4:91–98, 1997
4. Rosenthal R: On the social psychology of the psychological experiment: the experimenter's hypothesis as unintended determinant of experimental results. American Scientist 51:268–283, 1963
5. Luborsky L, Diguer L, Seligman DA, et al: The researcher's own therapy allegiances: a "wild card" in comparisons of treatment efficacy. Clinical Psychology: Science and Practice 6:95–106, 1999

Best Practices: Don't Forget the Sickest Patients

To the Editor: In the February 2002 issue, Carpinello and her colleagues (1) described New York State's campaign to implement evidence-based practices for people with serious mental disorders. However, as is often the case in discussions of best practices, the treatment needs of patients with chronic schizophrenia who remain in state hospitals were virtually ignored.

Given the authors' emphasis on research evidence, the omission of social-learning-based inpatient programs for these patients is surprising. First, such patients are the most severely mentally ill and the most expensive to treat, and their care is most influenced by political and administrative decisions (2). Second, data on inpatient social learning programs for people with chronic schizophrenia provide some of the strongest evidence for the effectiveness of any intervention in psychiatry (2). Unfortunately, the number of behaviorally oriented inpatient programs that follow the empirically validated techniques first described by Paul and Lentz (3) is small, despite the effectiveness of such programs, which is all the more reason for the inclusion of their component behavioral procedures into the best practices movement.

The six-year study by Paul and Lentz (3) demonstrated the clear superiority of an intensive behavioral milieu over other types of inpatient treatment. More than 97 percent of patients who had been considered nondischargeable from a state hospital setting could be discharged within two years of entering the social learning program, in most cases with significantly fewer medications and with positive community outcomes. This and later reports described specific techniques for functional assessment of behavior, milieu management, group administration, staff prompting in response to a wide range of patient behaviors, and assessment of staff fidelity to these procedures. Programs that have adopted similar procedures have also demonstrated remarkable success in enabling long-stay state hospital patients to be discharged from the hospital and to live successfully in the community (4).

Given the consistent success of such programs over the past 25 years, one must wonder why intensive behavioral inpatient programs are almost never mentioned in discussions of best practices in psychiatry. We can only speculate as to the reasons, but we suggest that they may include a lack of awareness of behavioral treatment techniques or data on their effectiveness; a misunderstanding of behavioral interventions, including the perception that they are punitive; a political decision to emphasize "consumer-centric" care and the misperception that behavioral treatment is incompatible with this position; an in-

sufficient number of state and county mental health administrative personnel who have expertise in development of behavioral programs; and a move away from public mental health investment in patients who require continued inpatient care.

Whatever the causes, available evidence clearly indicates that such programs are the most clinically effective, cost-effective, and humane treatment options for the sickest patients we treat (5). We therefore encourage those who are in a position to set best-practice agendas for public mental health to consider the evidence on the treatment of institutionalized patients who have schizophrenia and to bring these best practices into the campaign.

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References

1. Carpinello SE, Rosenberg L, Stone J, et al: New York State's campaign to implement evidence-based practices for people with serious mental disorders. Psychiatric Services 53:153–155, 2002
2. Paul GL, Menditto AA: Effectiveness of inpatient treatment programs for mentally ill adults in public psychiatric facilities. Applied and Preventive Psychology 1:41–63, 1992
3. Paul GL, Lentz RJ: Psychosocial treatment of chronic mental patients: milieu versus social learning programs. Cambridge, Mass, Harvard University Press, 1977
4. Silverstein SM, Wong MH, Bloch A: A second chance for people with treatment-refractory schizophrenia. Psychiatric Services 53:480, 2002
5. Paul GL: Evidence-based practices in inpatient and residential facilities. Clinical Psychologist 53:3–11, 2000

Assertive Treatment and Arrest of Probationers

To the Editor: In an article in the January issue, Dr. Solomon and her colleagues (1) observed that people with mental illness on parole or probation who were jailed for a technical violation were six times more likely to have received intensive clinical monitoring. However, the authors did not describe any of the programs that provided the mental health care for the probationers and parolees in the study. These services were probably provided by a variety of agencies.

Inclusion of this information would have greatly strengthened the article. Aggregation of outcome data may increase the power of a statistical analysis, but if the aggregate data are drawn from disparate sources, the results of analysis may be suspect. By neglecting the critical underlying variable of the nature of the mental health programs while focusing on the perspective of the probation unit, the authors deprived us of the opportunity to determine what truly works in the monitoring of mentally ill offenders.

The outcomes from the Mentally Disordered Offenders (MDO) program in Cleveland challenge the assertion of Dr. Solomon and her colleagues that increased monitoring leads to a higher arrest rate. The MDO program is based in a community mental health agency with experience in serving forensic populations. The program is based on the assertive community treatment model, with a relatively low ratio of clients to case managers and a clear team organization. Probationers must have a psychotic illness to be assigned to the program. The MDO team works closely with the Cuyahoga County Court of Common Pleas probation program, which has a group of probation officers who specialize in mentally ill clients, similar to the probation units in Dr. Solomon's study.

In 1999 the MDO team cared for 250 clients, more than 80 percent of whom had a severe mental illness—more than 40 percent had a diagnosis of schizophrenia. The average age of the clients was 37 years. Their mean level of education was just over 11 years; 50 percent did not graduate from high school. Seventy percent of the team's clients were male. Drug offenses accounted for 31 percent of the convictions, followed by assault (20 percent), burglary (8 percent), and theft (6 percent).

In 1999, 32 clients (13 percent) completed their term of probation without incident. Forty-two clients (17 percent) were either returned to prison or had a warrant issued for their arrest because of a violation of the conditions of probation.

The reincarceration rate among program clients was less than two-thirds of the annual rate of 27 percent reported by Dr. Solomon and her colleagues, demonstrating that intensive case management services do not necessarily lead to higher arrest rates. If the authors had analyzed data from the individual community programs serving their study population, they might have found that some programs were more successful than others. Had they described the programs that worked, along with those that were less successful, their report would have been richer and the results could have been put to more practical use.

George F. Parker, M.D.

Dr. Parker is associate professor of clinical psychiatry and director of forensic psychiatry at Indiana University School of Medicine in Indianapolis.

Reference

1. Solomon P, Draine J, Marcus SC: Predicting incarceration of client of a psychiatric probation and parole service. Psychiatric Services 53:50–56, 2002

In reply: We agree with Dr. Parker that it is important to know what program service elements are effective in reducing reincarceration of probationers and parolees involved in the mental health system. However, this was not the objective of the study reported in the article, which examined the impact of the usual community mental health services delivered by a variety of agencies on reincarceration of probationers and parolees. Our study did not examine the type of specialized program for forensic clients that Dr. Parker describes.

The practical implications of the study's results are similar to those of our previous research (1–3): providers who do not have the clinical skills to work with difficult forensic clients frequently resort to monitoring clients' behaviors and using the leverage gained from violations of stipula-

tions to reincarcerate forensic clients rather than providing therapeutic treatment. In Dr. Parker's program, a team serving 250 clients may not have the time for intensive observation.

The finding of a higher reincarceration rate hearkens back to the findings of aftercare studies conducted in the 1970s. In some of those studies, patients in aftercare programs had higher rates of rehospitalization. The programs provided greater opportunities to observe clients' behaviors, which resulted in rehospitalization when clients became symptomatic. Even though the intent of intensive supervision programs is not to incarcerate probationers and parolees, studies have found that participants in these programs have higher rates of incarceration than those who receive usual supervision because others have greater opportunities to observe any criminal violations (4).

Care must be taken to ensure that service providers offer forensic clients meaningful rehabilitation and that they do not merely view themselves as extensions of probation and parole officers, whose job it is to monitor compliance with stipulations of community placement.

Phyllis Solomon, Ph.D.
Jeffrey Draine, Ph.D.
Steven Marcus, Ph.D.

References

1. Solomon P, Draine J, Meyerson A: Jail recidivism and receipt of community mental health services. Hospital and Community Psychiatry 45:793–797, 1994

2. Solomon P, Draine J: One-year outcomes of a randomized trial of case management with seriously mentally ill clients leaving jail. Evaluation Review 19:256–273, 1995

3. Draine J, Solomon P: Jail recidivism and the intensity of case management services among homeless persons with mental illness leaving jail. Journal of the American Academy of Psychiatry and the Law 22:245–261, 1994

4. Tonry M: Stated and latent functions of ISP. Crime and Delinquency 36:174–191, 1991

Problem Solving and Social Skills Training

To the Editor: I am writing in reference to the Rehab Rounds column in the January 2001 issue of *Psychiatric Services* about training in social problem solving among persons with schizophrenia (1). Dr. Liberman and his colleagues successfully demonstrated the generalization effect of social skills training through the provision of training in problem solving to the clients.

As a researcher in social skills training, I would like to share my experience that problem solving is a key element of success in any social skills training module. I have conducted three controlled studies related to social skills training (2–4). In each of the studies, the participants who received social skills training outperformed the control participants in terms of both vocational and nonvocational generalization measures. For example, in a study in which social skills were taught to people with schizophrenia to help them obtain and keep jobs (4), 14 of 30 (47 percent) of the participants in the experimental group were able to acquire a job and had maintained it at a three-month follow-up. One of the reasons for the high success rate might have been the incorporation of problem-solving training into the module. In the last session of the module and at the subsequent follow-up sessions, the main emphasis was on social problem solving using principles similar to those used in Liberman's study.

The results showed that participants who received training in social problem solving had significantly better vocational outcomes than those who received only the traditional skills training module without elements of social problem solving. Clinical observation suggested that the participants who became equipped with problem-solving skills were better able to solve problems related to getting a job. Even though they had failed in previous attempts to secure employment, they were more motivated to continue the process. They were also more motivated to solve interpersonal problems in the workplace once they had found a job.

Although social skills training has received a vast amount of support in the literature, it has been criticized for lack of a generalization effect. In addition, it has been challenged by the success of "place-train" philosophy and supported employment for people with severe mental illness (5). To me, incorporating problem solving into traditional social skills training modules is the key to further development of the skills training approach in the current mainstream of evidence-based practices.

The effect of problem solving on the generalization of social skills training should be examined in a more controlled way. Projects are under way in Hong Kong that aim to isolate the effect of problem solving by comparing social skills modules with and without a focus on problem solving.

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References

1. Liberman RP, Eckman TA, Marder SR: Training in social problem solving among persons with schizophrenia. Psychiatric Services 52:31–33, 2001

2. Tsang S, Tsang HWH: Social skills training group for psychiatric out-patients: a Hong Kong experience. Journal of the Hong Kong Psychiatric Association 7:34–38, 1988

3. Tsang HWH: Social performance, work success, and social skills training for schizophrenics in Hong Kong. City Polytechnic of Hong Kong, 1992

4. Tsang HWH, Pearson V: Work-related social skills training for people with schizophrenia in Hong Kong. Schizophrenia Bulletin 27:139–148, 2001

5. Tsang HWH, Chan F, Bond G: Psychiatric rehabilitation and supported employment: an interview with Professor Gary Bond. Hong Kong Journal of Mental Health 30(l):10–31, 2002

In Reply: It is notable that Dr. Tsang, using social skills training in a Chinese culture, has also found training in problem solving to be an important element in teaching his clients a variety of social and vocational skills. Such cross-cultural replications provide another type of validation to evidence-based treatments for persons with serious and persistent mental disorders.

There are three points that can be made to further clarify—beyond the evident efficacy of the procedure—the rationale and utility of teaching

problem-solving skills to persons with schizophrenia. First, many persons with schizophrenia have cognitive deficits presumably resulting from abnormal neural circuits between the thalamus, temporal lobe, and prefrontal cortex. These deficits may hinder their ability to anticipate, cope with, and flexibly solve problems of everyday life. In fact, the relationship between neurocognitive executive functions and social and vocational functioning has been highlighted in numerous studies over the past decade (1,2).

Moreover, social problem solving has been shown to be deficient in persons with schizophrenia compared with persons with no mental disorders (3). If neurocognitive impairments contribute to the disability experienced by persons with schizophrenia, then these persons are likely to benefit if they can be equipped with a "prosthesis" to lean on for dealing with the everyday challenges and stressors of life. From this point of view, teaching individuals with schizophrenia how to use systematic, stepwise problem solving may help mitigate or overcome their biologically based deficits.

Second, the plasticity of the brain has been documented by both basic studies with animal models and demonstrations that cognitive remediation, or "training the brain," is feasible (4). Research on social skills training has shown repeatedly that persons with schizophrenia have the capacity to learn new skills if structured behavior therapy techniques and procedural learning are used to overcome neurocognitive impairments. Thus there is every reason to believe that patients with schizophrenia can acquire problem-solving skills to enhance their community reintegration and independence. The flexibility and capacity of the brain to compensate for neurodevelopmental abnormalities, when paired with a highly structured and systematic training program, may lead to a more optimistic prognosis for persons with schizophrenia.

Third, the final step in problem solving involves encouragement and reinforcement of individuals for implementing one or more alternative solutions for attaining their goals in real-life situations. Thus, homework assignments are often where the "rubber hits the road" in determining the success of the problem-solving procedure. A considerable amount of research has documented the value of using assignments in a person's natural environment to improve therapeutic outcome (5). Some of the benefit of assignments may come from the additional practice that is gained in real-life settings, some from increased motivation generated by the assignments, and some from enhanced generalization and the experiences of success that accompany generalization.

Robert Paul Liberman, M.D.

References

1. Green MF, Nuechterlein KH: Should schizophrenia be treated as a neurocognitive disorder? Schizophrenia Bulletin 25: 309–320, 1999
2. Kee KS, Kern RS, Green MF: Perception of emotion and psychosocial functioning in schizophrenia. Psychiatry Research 81:57–65,1998
3. Mueser KT, Bellack AS: Social skills and social functioning, in Handbook of Social Functioning in Schizophrenia. Edited by Mueser KT, Tarrier N. Boston, Allyn & Bacon, 1998
4. Liberman RP: Cognitive remediation in schizophrenia, in Comprehensive Treatment of Schizophrenia. Edited by Kashima H, Falloon IRH, Mizuno M, et al. Tokyo, Springer-Verlag, 2002
5. Kazantzis N, Deane FP, Ronan KR: Homework assignments in cognitive and behavioral therapy: a meta-analysis. Clinical Psychology: Science and Practice 7:189–202, 2000

Submissions Invited for Frontline Reports Column

Psychiatric Services invites contributions for Frontline Reports, a column featuring short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings.

Material submitted for the column should be 350 to 750 words. The name and address of a contact person who can provide further information for readers must be listed.

A maximum of three authors, including the contact person, can be listed; one author is preferred. References, tables, and figures are not used. Any statements about program effectiveness must be accompanied by supporting data within the text.

Material to be considered for Frontline Reports should be sent to the column editor, Francine Cournos, M.D., at the New York State Psychiatric Institute, 1051 Riverside Drive, Unit 112, New York, New York 10032. Dr. Cournos is director of the institute's Washington Heights Community Service.