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 Boulevard, Suite 1825, MS#4 1906, Arlington, Virginia 22209-3901; fax, 703-907-1095; e-mail, psjournal@psych. org. Letters reporting the results of research should be submitted online for peer review (http://appi.manuscriptcentral.com).

Use of Practitioner-Based Alternative Therapies by Psychiatric Outpatients

To the Editor: Persons with affective and anxiety disorders use complementary and alternative therapies at elevated rates to treat psychiatric and physical symptoms (1–4). Little is known about the use of such therapies among persons with schizophrenia. In our study of health service utilization and comorbid medical illness among outpatients with schizophrenia or affective disorders, patients were asked questions about frequency of visits to alternative care practitioners and the health problems that motivated them to seek this treatment. Items from the Medical Expenditure Panel Survey (MEPS) (4) were used.

Potential participants for the study were patients with schizophrenia and with an affective disorder who were selected randomly from patient rosters of one urban and one suburban psychiatric outpatient center in the Baltimore metropolitan region. Seventy-three percent of those eligible provided informed consent and completed an in-person interview. A total of 100 participants with schizophrenia and 100 participants with an affective disorder were interviewed. Half of each diagnostic group was recruited from each outpatient center.

Participants were asked whether they had visited a provider of any of 12 categories of alternative treatment during the previous 12 months and reasons for this visit. The categories included chiropractic; acupuncture; nutritional advice or lifestyle diets; massage therapy; herbal remedies; biofeedback training; training or practice of meditation, imagery, or relaxation techniques; homeopathic treatment; spiritual healing or prayer; hypnosis; traditional medicine (for example, Chinese medicine); and other treatments.

Thirty-seven percent and 68 percent of patients in the schizophrenia and affective disorder samples, respectively, were women. The proportions of Caucasians were 48 percent and 69 percent, respectively, and of African Americans, 45 percent and 29 percent. Seventy-three percent in the schizophrenia group and 72 percent in the affective disorders group had a high school diploma. The mean±SD ages for the groups were 42.2±9.2 and 45.7±8.3, respectively.

Eleven percent of patients with schizophrenia and 30 percent of patients with an affective disorder had consulted an alternative care practitioner for either physical or psychiatric symptoms. The highest consultation rates among the schizophrenia patients were for spiritual healing or prayer (4 percent), nutritional advice or lifestyle diets (3 percent), and chiropractic (3 percent). The highest consultation rates in the affective disorder group were for herbal remedies (10 percent), spiritual healing or prayer (9 percent), and acupuncture (8 percent). Only 16 percent of patients with affective disorder reported seeking alternative care specifically for mental illness or emotional problems, compared with 36 percent of patients with schizophrenia.

Only previous college attendance was associated with visiting an alternative care practitioner among patients with affective disorder (χ^2=4.13, df=1, p=.042). The number of comorbid conditions was the only variable associated with visiting such a practitioner among the patients with schizophrenia. The median number of comorbid conditions was 2.5 for those who reported a visit, compared with 1.0 for those who did not (Wilcoxon p=.001).

An analysis of the 1996 MEPS sample (4) found national rates of use of practitioner-based alternative care by persons in the general population across self-reported mental conditions of between 9 percent and 11 percent, including a rate of 9 percent among 40 participants who reported a psychotic disorder and a rate of 10 percent among 846 participants who reported an affective disorder. These rates are comparable to those in our outpatient schizophrenia sample (11 percent) but not to those in our outpatient affective disorders sample (30 percent).

The results of our analysis underscore the need for providers in mental health and primary care settings, where depression is common, to ask their patients about use of alternative treatments. Such information could indicate the presence of psychiatric or physical symptoms that are not addressed by traditional care (4) or otherwise provide a more complete picture of how patients perceive traditional care, its deficits, and ways in which it could be improved.

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Psychiatrists' Acceptance of Medicaid Patients

To the Editor: In the April issue, Wilk and colleagues (1) raised concerns about Medicaid patients' access to psychiatrists and the low rate of acceptance of Medicaid patients by psychiatrists, a concern that has been raised by others (2). We examined the relationship between Medicaid reimbursement rates and psychiatrists' self-reported acceptance of Medicaid patients and found that low Medicaid reimbursement rates were associated with low participation by psychiatrists for service code 90807 (individual psychotherapy with medical evaluation for 45 minutes).

On the basis of the assumption that psychiatrists' sensitivity to reimbursement rates might occur in the lower range of rates, we divided Medicaid reimbursement rates by a median split. We found a positive correlation ($r=.52$, $p=.03$) between rates for service code 90807 (median split=$64.10) and psychiatrists' self-reported acceptance of Medicaid patients for the lower half of the range of the reimbursement rate but not the upper half. We found no such relationship for codes 90801 (diagnostic interview exam) and 90862 (pharmacologic management), nor did we find simple, significant correlations between these three codes and the full distribution of reimbursement rates ($r=-.03$, .25, and .20, respectively). Details of multivariate analyses of variables that affect acceptance of Medicaid patients by psychiatrists are described elsewhere (1).

As in the study by Wilk and colleagues, we used data from an item in the 2002 National Survey of Psychiatric Practice, which was conducted by the American Psychiatric Institute for Research and Education (3). A total of 1,189 psychiatrists responded to an item about acceptance of patients by payer. Because we were unable to find Medicaid reimbursement data for 2002, we used 2001 reimbursement rates by state for codes 90801, 90807, and 90862 from an American Academy of Pediatrics data set published on its Web site. There was substantial distribution in values for both psychiatrist acceptance rates and Medicaid reimbursement rates for code 90807.

Our preliminary, suggestive observation warrants further study with better designs and more complex models. The period between 2001 and 2002 was one of significant change for Medicaid. States faced budget deficits and cut eligibility, benefits, and reimbursement. Therefore, the discrepancy in time between the 2001 reimbursement rates and the 2002 data on psychiatrists' acceptance of Medicaid patients is a weakness of these analyses. Also, many factors affect psychiatrists' decisions to accept Medicaid patients, including administrative burden and cross-cultural preferences, among others, and these factors were not included in the analyses.

Another important consideration is the possibility of a more pronounced association between reimbursement levels and the volume of new Medicaid patients that psychiatrists can accept, whereas our analyses examined the association between accepting "any" new Medicaid patients and reimbursement. Furthermore, the relationship between reimbursement rates and acceptance may be reciprocal and complex and not simply positive—for example, when a low rate of psychiatrist participation spurs higher state Medicaid reimbursement rates. Such inverse correlations would be investigated best on a state-by-state basis, which was not possible with our data.

The observation made in this letter is potentially important for child psychiatrists, clinic psychiatrists, international medical graduates, and early-career psychiatrists, who have caseloads with large proportions of patients whose care is covered by Medicaid (4).

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Criminal Arrests and the Threshold for Competence

To the Editor: The article by Quanbeck and colleagues (1) in the July issue outlined the relationship between criminal arrests and community treatment history among patients with bipolar disorder. Specifically, the study found that patients who had been arrested were more likely to be male, to have a history of substance abuse, and to have a treatment history characterized by more frequent, briefer hospitalizations. Patients in the comparison group were more likely to have been treated under a mental health conservatorship and held in the hospital under civil commitment law. The authors suggested that legal interventions that promote stabilization of mania in an inpatient setting as well as drug screening may help prevent criminal offenses among patients with bipolar disorder.

The findings of this study suggest to me that one of the legal interventions that needs to be addressed is the level at which people are deemed to be mentally competent. The findings suggest that the group with more rearrests was deemed to be competent on the grounds that they were not held under mental health conservatorship or civil commitment. The fact that they committed more crimes suggests that they were not really competent and therefore that the standard for competence is set too low. In the same issue of *Psychiatric Services* a study of the Clark County Mental Health Court program by Herinckx and colleagues (2) provided clear evidence that patients who are provided with more treatment commit fewer crimes. This finding suggests that these persons are not committing crimes because they are inherently criminal in nature but because they are ill.

Both these articles suggest to me that the current competency laws are contributing to the criminalization of the mentally ill. I suggest that the threshold for competence needs to be reevaluated by the medical and legal professions if patients with mental illness are going to be treated instead of criminalized.

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In Reply: I agree wholeheartedly with Dr. Kane's suggestion that addressing the issue of competency to accept treatment in civil commitment statutes has the potential to reduce the criminalization problem that exists in the United States. For those with severe mental illness, civil commitment statutes provide an important buffer between the voluntary mental health and criminal justice systems. Over time, these statutes have become more rigorous in the protection of due process and liberty interests of persons with mental illness (1). Before deinstitutionalization, a patient could be committed to a state hospital for an extended period if two physicians determined that the patient was mentally ill and "in need of treatment." In the late 1960s civil commitment laws were altered, and patients could be involuntarily confined only if they were mentally ill and presented a danger to themselves or others or were gravely disabled.

In my opinion, these laws would be more effective if they addressed the deficit in insight that many individuals with severe mental illness suffer.

Approximately 50 percent of patients with schizophrenia and bipolar disorder suffer from a lack of insight into their illness (2). Insight is a multidimensional ability that includes three components: a realization that one is mentally ill, an attribution of one's symptoms to the illness, and acknowledgment of a need for treatment. Studies of individuals with bipolar disorder have shown impaired insight to be strongly correlated with nonadherence to community treatment, a need for involuntary treatment, revolving-door psychiatric admissions, and a poor clinical outcome. As we found in the study that we reported in the July issue, this pattern of community treatment utilization is also characteristic of patients with bipolar disorder who are arrested.

Unfortunately, in most states, mental health laws governing the involuntary treatment of patients do not take insight into consideration. Persons who do not recognize they are suffering from a mental disorder fail the critical first step in assessing capacity. They do not possess an understanding of the nature of their medical condition and are thus unable to accurately weigh the benefits and risks of treatment. Current civil commitment laws assume that patients have full capacity to act in their own best interests when deciding whether or not to choose treatment voluntarily. Although the American Psychiatric Association's 1983 model commitment statute included a determination of capacity in its ideal civil commitment procedures, only Utah considers capacity to accept voluntary treatment in its statute. In British Columbia's Mental Health Act, which is the civil commitment statute in Dr. Kane's jurisdiction, criteria for involuntary hospitalization also include a capacity assessment (4). A patient can be committed if he or she has a mental disorder that requires treatment in order to prevent substantial mental or physical deterioration or for the protection of self or others. Voluntary admission would be unsuitable if the person is too ill to be legally capable of making a request for admission or consenting to treatment—for example, if the person does not believe that he or she is ill and in need of treatment. Including these criteria in civil commitment statutes has the potential to successfully engage persons with severe mental illness in community treatment and could help prevent criminal arrest and its adverse consequences.

Cameron Quanbeck, M.D.

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