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## Recovery-Oriented Care

**To the Editor:** Davidson and colleagues (1), in an article in the May issue, "The Top Ten Concerns About Recovery Encountered in Mental Health System Transformation," make the following comment: "If mental illness is an illness like any other, it should be treated as such."

Mental illness is not like other illnesses. For example, liver disease, kidney disease, and neuromuscular disease do not affect a person's ability to interact with others, to form relationships, and to understand discussions. By the nature of mental illness, these various functions are impaired. I would consider this a fatal flaw in Davidson and colleagues' argument.

My experience with individuals who have severe neuropsychiatric damage is that much of what is described in the article as recovery-oriented care is simply not possible. In an accompanying commentary on the article, Dickerson (2) highlighted the situation: "Or will the recovery mantra come to represent another cycle of reform . . . that seems to offer

the solution but is later evaluated to have been naïve and unscientific?"

To fail to take into account the cognitive and emotional effects of the disease under treatment is to avoid the issue of the inability to interact as a caregiver with a care receiver.

*William S. Masland, M.D.*

*Dr. Masland is in private practice in Yuma, Arizona.*

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1. Davidson L, O'Connell M, Tondora J, et al: The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services* 57:640-645, 2006
2. Dickerson F: Disquieting aspects of the recovery paradigm. *Psychiatric Services* 57:647, 2006

**In Reply:** We appreciate the difficulties posed by Masland's questions, as well as the concerns raised by Dickerson in her commentary on our article in the May issue (1). They capture the very issues which moved us to write our article.

First, Masland argues that mental illness impairs a person's "ability to interact with others" and similar abilities. Although this may be true of some people with some mental illnesses some of the time, it is not true of most people with most illnesses most of the time. There is a much greater degree of heterogeneity in functioning, both within an individual and over time (2), which is why there are complexities involved in using a term such as recovery, which means different things to different people. But there simply are no data to support Masland's contention that these abilities are impaired in everyone who has a mental illness and that the impairments last for most of their lives.

Such concerns are relevant to a subgroup of persons with severe, persistent impairments. Rather than suggesting that recovery for this subgroup is "simply not possible," as Masland writes, or may "generate unrealistic expectations," as Dickerson commented, we suggest that it is precisely this subgroup for whom recov-

ery "in" mental illness is most relevant and needed. This leads to our second response, which is related to the distinction between recovery and recovery-oriented care.

Masland and Dickerson appear to miss this distinction and the shift in perspective required, which is evident in Dickerson's conclusion that "learning to live better in the face of mental illness doesn't alter" the fact that "our science has not come even close to being able to cure or prevent" it. From the perspective of the person with the disorder, she has it backward. It is especially when the illness is most severe, and because we do not yet have a cure, that people who have these disabling disorders have no choice but to live in the face of them. This is the reality that takes priority in recovery-oriented care.

We thus are not failing "to take into account the cognitive and emotional effects of the disease" or "avoid[ing] the issue of the inability to interact as a caregiver with a care receiver," as Masland states. Rather, we are raising the question of how caregivers can most effectively respond to these very effects. In the past we have been immobilized by our lack of a cure, and we have conveyed a message of hopelessness to our clients and segregated people in artificial settings, expecting them to be cured before rejoining community life. This contradiction has led to demoralization, despair, and dependency.

An alternative is to stop insisting that people become cured first and refocus our efforts on how to help people find ways to live better lives in the face of the disability. This refocusing is one change that people with mental illness are advocating under the rubric of recovery-oriented care, as del Vecchio's commentary on our article demonstrated (3), and which suggests that the "inability to interact" has been at least as much on our part (the "caregiver") as it has been on the part of the person (the "care receiver"). If cognitive and emotional deficits are due to the disease that we are charged with treating, then is it not within the role of the treater to

become a specialist in how to deal with these impairments, in the patient's life as well as in his or her relationship with the psychiatrist?

Research to prevent and cure mental illnesses should by all means continue; however, in the meantime our patients need to live their lives in the face of the illness. Once their rights to that life have been restored, there is much that we can do to support them in those efforts.

**Larry Davidson, Ph.D.**

**Maria O'Connell, Ph.D.**

**Janis Tondora, Psy.D.**

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2. Davidson L, McGlashan TH: The varied outcomes of schizophrenia. *Canadian Journal of Psychiatry* 42:34–43, 1997
3. Del Vecchio P: All we are saying is give people with mental illnesses a chance. *Psychiatric Services* 57:646, 2006

## Malignant Criminalization: From Hypothesis to Theory

**To the Editor:** In the June issue of *Psychiatric Services*, Junginger and colleagues (1) examined a “literal and popular interpretation of the criminalization hypothesis” regarding overrepresentation of persons with mental illness in jails and prisons. They found that substance abuse was “a significantly more likely causal factor for criminal offending than serious mental illness.” We appreciate this thoughtful research and wonder about unspecified drug-related offenses, such as positive urine toxicology and simple drug possession, that may be included under “parole violations” and “vice crimes” in Table 1 of the article. The numbers could be informative.

As the authors recognize, there are various interpretations of the “criminalization hypothesis.” A mental health systems perspective may see “correctional placement” substituting for housing, supported employment, or integrated treatment. From an expanded perspective, the sixfold increase in the use of U.S. jails and pris-

ons since the early 1970s makes this country the world leader in per capita incarceration—with rates five to ten times those of comparable industrialized nations (2,3). It would be surprising if this trend spared persons with mental illness and did not have a disproportionate impact on those with co-occurring disorders.

Overutilization of the correctional system is driven by the drug war, with American incarcerations for drug offenses exceeding incarcerations for all offenses combined in the European Union, which has 100 million more people than the United States (4). Incarcerations for nonviolent drug convictions have risen faster than incarcerations for any other major crime category, accounting for more than half of new prison sentences between 1985 and 2000. The drug war purportedly targets high-level suppliers, not vulnerable self-medicating individuals, but data suggest otherwise. Cannabis accounts for half of all drug arrests nationwide, with nearly 90 percent for simple possession (4).

The President's New Freedom Commission on Mental Health encourages a broad look at systems and views mental health needs partly in the context of a health care system that leaves 45 million Americans uninsured. The Commission champions integration, benchmarking, and best practices. Global benchmarking distinguishes the United States not for its successful management of substance use but as an extreme outlier in the use of incarceration. Unmet mental health needs are shaped by a broader national health care crisis, and criminal justice involvement by persons with mental illness is embedded in a broader American criminalizing trajectory.

We theorize that criminalization has become malignant, with uncontrolled growth depleting resources and consuming individuals, communities, and service systems. This view poses research questions: What are the index offenses, earliest offenses, and intervening records of mental health consumers who receive criminal justice attention? How has drug law shaped their course? Were the ar-

restees in the Junginger study adversely affected? When in their offense career were they affected?

Our theory predicts that, absent major drug policy reform, mental health transformation will be harder, costlier, less effective, and less sustainable than the New Freedom vision entails. Psychiatric jail diversion measures, while heroic, lack the scope to address broad policy parameters that have criminalizing impacts that extend to persons with psychiatric vulnerability.

Immediate intervention could address “low-hanging fruit.” Conservative estimates endorsed by 500 economists project savings from the decriminalization of cannabis of \$7.7 billion annually, or when taxed and regulated up to \$13.9 billion (5). The latter figure is half the budget of the National Institutes of Health or the Veterans Affairs health care system and triple the combined budgets of the Substance Abuse and Mental Health Services Administration and the National Institute of Mental Health. A broader paradigm shift—former Baltimore Mayor Kurt Schmoke's “public health war on drugs”—could multiply that total fivefold, equaling all U.S. mental health expenditures. The substantial health care reinvestment would benefit everyone, including persons with mental illness and substance use disorders.

**Christopher G. Fichtner, M.D.**

**James L. Cavanaugh, Jr., M.D.**

*Dr. Fichtner is associate professor of clinical psychiatry at the University of Chicago. Dr. Cavanaugh is chairman of the board and president of the Isaac Ray Center and professor of psychiatry and director of the Section on Psychiatry and the Law at Rush University College of Medicine, Chicago.*

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**In Reply:** Of the handful of controversies in mental health, the “criminalization” of mental illness may be unique in that practically everyone with an opinion is to some extent right. As someone once said about the answer to any important question, “It depends . . . .” In the case of criminalization, it depends mostly on the subgroup of patients being considered. Thus it is possible to have one’s feet firmly planted in both camps by acknowledging an obvious association between delusions and crime in an acutely psychotic population (1), while simultaneously reporting little or no association between mental illness and crime in a presumably less acute population, as we did in the study reported in the June issue.

The disturbing fact to be explained is the overrepresentation of persons with mental illness in our jails and prisons. This fact raises obvious questions about whether (and how) persons with mental illness are handled differently by the criminal justice system, especially the police and courts. Research addressing these questions has produced equivocal results. However, we were able to state confidently that the individuals in our sample were not arrested simply for displaying symptoms of mental illness and that mental illness had no obvious effect on the vast majority of criminal offenses we investigated—again, with the caution that these individuals may have represented a less acute subgroup of patients.

If not differential handling by the police and courts, how is it that persons with mental illness are overrepresented in jails and prisons? As noted above, psychosis is associated with crime. However, the available evidence indicates that psychosis-driven

crime is rare and therefore is unlikely to account for the disproportional incarceration rates. Draine and colleagues (2) offered an explanation for the apparent criminalization of mental illness based on the “social context” in which many persons with mental illness find themselves. This social context is characterized by more powerful risk factors for crime, such as unemployment, poverty, homelessness, and especially, substance abuse. Their argument is persuasive, and parts of it were picked up by Fichtner and Cavanaugh in their letter.

Fichtner and Cavanaugh argue that the decriminalization of cannabis would effectively eliminate one pathway to jail or prison for persons with mental illness. They also imply that resources formerly used to enforce the criminalization of cannabis could be reallocated to mental health and substance abuse treatment. By their reasoning, it seems a win-win proposition for persons with mental illness who abuse substances—less jail time, more treatment.

However, we are not convinced that the decriminalization of cannabis would be totally, or even mostly, benign. Recent evidence seems to confirm historical concerns that use of cannabis increases the risk of schizophrenia and depression (3). The demonstration of a dose-response effect for both illnesses (4) suggests that our attention should be focused on getting habitual users to decrease their use rather than encouraging more widespread use by decriminalization. The positive economics of the decriminalization of cannabis may have been worked out without consideration of new costs, economic and social, contributed by cannabis-induced mental illness. Until the extent of these new costs is determined, we simply cannot know whether we would be replacing one problem with another.

**John Junginger, Ph.D.**  
**Keith Claypoole, Ph.D.**

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search on serious mental illness and rates of violence. *Schizophrenia Bulletin* 30: 21–30, 2004

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4. Van Os J, Bak M, Hanssen M, et al: Cannabis use and psychosis: a longitudinal population-based study. *American Journal of Epidemiology* 156:319–327, 2002

## Community Reintegration of Prisoners With Mental Illness

**To the Editor:** I appreciated the focus on correctional psychiatry in the June 2006 issue of *Psychiatric Services*, as it highlighted an increasingly important part of public-sector psychiatry. Wilson and Draine (1) conducted an admirably thorough survey of existing reentry programs for prisoners with mental illness and accurately focused on the importance of public safety. However, I believe they did not sufficiently emphasize a critical reason for the development of such programs: saving money by prevention of return to prison.

The commissioner of the Indiana Department of Corrections (DOC) has explicitly stated that his support for improving prisoner reentry is motivated by budget concerns: “If we can reduce our rate of recidivism by 5%, we save over 80 million dollars for the taxpayers of Indiana. That is our goal” (2). Indiana, with six other states, has adopted the Transition From Prison to Community Initiative (TPCI) model, proposed by the National Institute of Corrections and Abt Associates (3). This model requires states to restructure the reentry process and implement evidence-based practices in order to reduce recidivism; it includes mental health problems among the important dynamic factors that can influence the risk of recidivism.

As part of the TPCI implementation in Indiana, DOC invited representatives from Indiana Medicaid,

the Department of Family and Children, and the Division of Mental Health and Addiction to join a workgroup on the reentry of offenders with mental illness. This workgroup quickly focused on the critical importance of reinstatement of Medicaid benefits to a smooth transition from prison to community care for people with severe mental illness, which was noted by Morrissey and colleagues (4) in the June issue of *Psychiatric Services*. Medicaid benefits are routinely terminated for virtually all offenders who are sent to prison, because the length of stay is almost always longer than one year—in contrast to the shorter stays for jail detainees, also noted by Morrissey and colleagues (5) in a second article in the June issue. Although no new programs are currently envisioned in Indiana, the process of Medicaid reinstatement should become much more efficient for all Medicaid-eligible offenders currently in state prison, as the process will begin before release from prison. In addition, communication between DOC personnel and local mental health providers is expected to improve.

Mental health advocates should never underestimate the power of the budget to influence policy decisions. In this time of tightened budgets, we must be alert to opportunities that will support the practice of good psychiatry and we must partner with the agencies that play an important role in the lives of people with severe mental illness, including Medicaid and correctional authorities.

**George Parker, M.D.**

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

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**In Reply:** We appreciate Dr. Parker's comment on our paper, and we wholeheartedly agree that the power of the budget's bottom line drives many policy decisions in both behavioral health services and criminal justice systems. Dr. Parker's point underscores our main points. Mental health professionals are allowing the criminal justice system to redefine the goal of mental health treatment services. Mental health professionals can work harder to counter this trend with proposals that are driven by the public health interest in the client's welfare, as opposed to the public safety focus of the criminal justice system.

If we persist in allowing budgetary concerns to have the last word, then we will uphold the status quo. The mental health system can continue to save money by ignoring this population, while the criminal justice system continues to assume responsibility for this client population because that system cannot say no.

**Amy Blank Wilson, L.S.W.**

**Jeffrey Draine, Ph.D.**

**In Reply:** We welcome Dr. Parker's letter, which allows us another opportunity to stress that prisons and jails are different institutions, with different populations of offenders who have different mental health needs. As a result, in policy discussions we have to avoid lumping jails and prisons together because there is no one-size-fits-all correctional program. Rather, mental health inter-

ventions must be tailored to each setting.

We agree that Medicaid restoration is a crucial step in prison reentry programs similar to those in Indiana, because all inmates will have lost benefits and having benefits at release will likely increase service use in the community. But Medicaid restoration is often not an issue in jails because of the much shorter stays in jails. The key for anyone considering a Medicaid benefits restoration program for a local jail is to first determine the average length of stay of detainees with mental illness. Stays of several weeks or less are unlikely to have any effect on detainee Medicaid status; stays of several months or more begin to mimic those in prisons and are much more likely to lead to benefit termination under current Medicaid policies. Therefore, a restoration program makes sense in the latter case but not in the former. Long jail stays result primarily from delays in criminal court processing; thus focusing on court-based interventions could have large effects in these situations.

In reply to another of Dr. Parker's comments about cost savings in the Indiana corrections budget, we note that cost savings for one system (state corrections) often lead to cost shifting and cost increases for other systems (federal, county, and municipal governments). In effect, the system that benefits from a new program is not the one that ends up paying for it. This has been an insidious problem in mental health programming in the United States for many years. Real progress in community reintegration of persons with mental illness from prisons and jails will require us to take a broad societal view to determine ways of overcoming these asymmetries. We agree that new partnerships are needed to identify common ground, mutual benefits, and necessary contributions for joint action across these agency silos.

**Joseph P. Morrissey, Ph.D.**

**Henry J. Steadman, Ph.D.**

**Kathleen M. Dalton, M.A.**

## **“Antipsychiatry” and “Consumerism”: Perspectives and Definitions**

**To the Editor:** I read the Rismillers' Open Forum, "Evolution of the Antipsychiatry Movement Into Mental Health Consumerism," in the June issue and the follow-up letters to the editor that were published in the August issue with special interest because I have taught and researched this topic for many years (1). The Rismillers trace the history of the antipsychiatry movement, although they misinterpret and overstate its demise. However, their emphasis on mental health "consumerism" and numerous historical and factual errors about the "ex-mental patient" self-help movement are the primary concerns of their critics. The debate hinges on individual versus social perspectives, a dichotomy that highlights the individualistic, pro-psychiatry bias of the Rismillers. Their critics reveal a social "antipsychiatry" perspective, despite some of their claims to the contrary. Also, an underlying problem is the failure of all parties to define key terms. [A bibliography documenting statements made in this letter and providing additional sources for interested readers is available online at [ps.psychiatryonline.org](http://ps.psychiatryonline.org).]

The Rismillers discuss "mental health consumerism" and project a psychologistic perspective that underestimates the size of the ex-patient movement and ignores its preference for the "survivor" label over the "consumer" label (2). Their critics understate the radical nature of the ex-patient movement. In fact, more than 60 percent of ex-patient groups support antipsychiatry beliefs and consider themselves to be "psychiatric survivors." Many in the "mad liberation" movement believe they are victims of psychiatric treatments that harmed them. Patients are not "consumers" choosing from a menu of psychiatric services, like shoppers at a cafeteria deciding what to have for lunch. The victim-survivor perspective of ex-patient groups promotes "alternatives" to psychiatry. They seek empowerment through group ac-

tivism, what they call "taking the 13th step," toward a sociopolitical understanding of the problems of living similar to the perspectives of Szasz and Foucault.

The essence of the antipsychiatry perspective is its opposition to involuntary "treatment." The idea of "treating" someone against his or her will, whether by psychoanalysis or chemotherapy, is considered a non sequitur. Accordingly, the Rismillers are more pro-psychiatry and their critics are more antipsychiatry in their perspectives. The Rismillers correctly characterize antipsychiatry as evolving "from being campus based to being patient based" as it morphed into the grassroots activism of the ex-patient movement. However, their argument that the antipsychiatry movement evolved into the ex-patient movement, as a necessary and sufficient "cause," cannot be known. Clearly, the founders of the antipsychiatry movement are often cited as revered heroes by participants in the emerging ex-patient movement, but this does not verify a direct causal connection between the two.

Antipsychiatry promotes skepticism about the concept of "mental illness" as disease. Without carefully defining terms, the Rismillers suggest that antipsychiatry dwindled because scientific advances regarding the nature of mental illness allowed psychiatry to address key grievances of its critics. However, antipsychiatry and the ex-patient movement have always argued that brain disease is what neurologists diagnose and treat, and there is little evidence of physical lesions in the brain that constitute a distinct class of "psychiatric" diseases.

The antipsychiatry and ex-patient movements believe that alternative views of reality are sociocultural phenomena, not "mental illnesses." The Rismillers argue, by contrast, that schizophrenia is at least "partially biologically based," gaining support from neurotransmitter research, twin studies, and psychopharmacological advances. However, one extensive review of research on the cause of schizophrenia analyzed 1,046 studies published be-

tween 1991 and 1995 and concluded that the science does not support a unitary cause that correlates with an underlying physical lesion (3). While most research concentrates on biochemical and genetic causes, these studies present the weakest findings in the literature, leaving the disease hypothesis unsupported.

The Rismillers ignore the extensive literature questioning the scientific evidence for "blaming the brain" and the use of psychotropic drugs or electroshock, genetic theories of mental illness and twin studies of schizophrenia, and the reliability of the *DSM*, which is so popular in psychiatry today (4). This literature is well known within the ex-patient movement. Far from explaining the demise of antipsychiatry, it rationalizes the movement by providing a perspective of scientific support for its reformist stance vis-à-vis psychiatry. It also helps explain the expansion of the ex-patient movement, which was recently estimated at 7,467 groups comprising 41,363 members (5).

Given the extensive critical literature on the concept of "mental illness" and the size of the ex-patient movement, the objective observer might conclude that psychiatry is less scientific and more political than the Rismillers suggest and that the ex-patient movement is more scientific, more antipsychiatry, and a more important social movement than most people understand it to be. Acknowledging different perspectives and carefully defining terms may help clarify this debate.

**Robert E. Emerick, Ph.D.**

*Dr. Emerick is professor emeritus in the Department of Sociology at San Diego State University.*

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## The Cost of Low-Demand Housing Programs

**To the Editor:** I read with concern the article by Martinez and Burt (1) in the July issue, which focused on a sample of homeless adults with co-occurring disorders who were given housing with no requirement for abstinence from substance use. One “successful” outcome noted by the authors was that 81 percent of participants remained housed for at least one year. The fact that people choosing to remain drug users while housed in permanent supportive housing units tended to remain in their apartments should not be viewed as a success. The absence of any mention in this report of people turning their lives around and obtaining gainful employment or leaving to rent their own apartments is a glaring failure, not only of the study but also of permanent supportive housing as a remedy.

The article speaks glowingly of the “low-demand” approach to people with substance abuse issues. With no requirement for sobriety, these individuals most likely continue to use drugs and alcohol. But what of the people with mental health issues? They too will be admitted with the “low-demand” approach, and they will not be required to take their medications or to discontinue using and abusing substances. What we see on the streets every day are individuals with mental illness abusing drugs or alcohol and not taking their medications. The explosive episodes that sometimes result can be deadly to the unsuspecting bystander. The article is very clear in reporting that most of the residents had both mental health

issues and drug and alcohol addictions. But the study fell short by not examining the impact of the behavior of residents when these issues are not addressed. In essence “low demand” means low expectation of success.

Is warehousing better than living on the street? Perhaps, but take a look at the big picture. At the end of a resident’s stay at the facility before he or she ends up back on the street, the only benefit that can be documented is one of fiscal savings. The revolving door that characterizes the lives of homeless people—in and out of shelters—is only protracted. According to the article, instead of staying for six months in a shelter and winding up back on the street, a homeless person can now expect a one- to three-year stay before ending up back on the street. The authors did not report—and may not know—what became of the study participants after their stay in permanent supportive housing. What percentage were evicted and for what reasons? How many (if any) find sobriety while living in permanent supportive housing, and to what may we attribute this successful outcome? What was the caseworker’s level of persistence? Was it a particular faith-based outreach program that caused this life-changing outcome?

The study by Martinez and Burt showed that the housing model was less expensive than its New York counterpart, but it did little to show that permanent supportive housing ends homelessness. Rather it illustrates a myopic view of homeless human beings, relegating them to mere dollars and cents on a chart of the costs of homelessness. The true cost of homelessness is in the lives lost to drugs, alcohol, and mental illness. There is also a great cost to our global reputation as a country where we expect and allow individuals to remain in their addictions, choosing to warehouse them so that the rest of the world will not see our dirty little secrets.

**Fran Reichenbach**

*Ms. Reichenbach is a homeless advocate in Hollywood, California.*

## Reference

1. Martinez TE, Burt MR: Impact of permanent supportive housing on the use of acute care health services by homeless adults. *Psychiatric Services* 57:992–999, 2006

**In Reply:** We thank Ms. Reichenbach for her comments, but she misrepresents the value of supportive housing. Our study examined one impact of supportive housing: reducing the use of hospital emergency department and inpatient services during the first two years after homeless people stopped living on the streets or in shelters. As noted, 81 percent of study participants maintained housing for at least a year. The study did not measure outcomes beyond the first few years after people moved into safe and supportive homes of their own, but other research has shown that about 75 percent of tenants stay in supportive housing for at least two years—and many stay much longer. Many of those who do move out have received the support they needed to recover from addiction, stabilize their mental illness, find steady work, reunify with family members, establish new roles as community participants, and rent their own apartments—and they never return to the revolving-door of life on the streets and in shelters, treatment facilities, jails, and hospitals.

Low-demand models of supportive housing don’t ignore problems related to untreated mental illness or the use of drugs or alcohol. In fact, a major focus of the service interventions in supportive housing is to help tenants recognize and seek care for these problems so that they can begin to take steps toward recovery and a successful life in the community.

We have unpublished data from our study on the types of services that the supportive housing projects provided, as well as tenants’ use of mental health and substance abuse treatment services in hospital and community settings. Despite their high rates of mental illness and substance use disorders, many study participants had not received any treatment outside of a jail, emergency department, or public hos-

pital during their years of homelessness. These chronically homeless individuals would still be living on the streets if they were required to be sober or compliant with medications as preconditions for living in supportive housing. Once chronically homeless people move into supportive housing, counselors, case managers, and primary care providers persistently and persuasively focus on helping tenants to recognize and begin to address problems related to mental illness or substance use and to access appropriate care. Notably, the supportive housing tenants who made the greatest use of these on-site support services were most likely to have the greatest reductions in the use of hospital emergency departments and inpatient care.

The values inherent in a low-demand approach to supportive housing are based on evidence that lives do change and that people with a long history of homelessness, mental illness, and addiction can take steps toward recovery. A core belief, supported by the evidence, is that the most dramatic successes begin when a homeless person moves from the streets into housing embedded with supportive services.

Our study demonstrated that for those who would not likely achieve sobriety and stability while living on the streets, supportive housing not only ended their homelessness but also reduced the costs associated with revolving-door care in hospitals and other institutions.

**Tia E. Martinez, J.D.**  
**Martha R. Burt, Ph.D.**

## Legal Consequences of Seclusion and Restraint

**To the Editor:** We would like to comment on the recent letters in the April (1) and July (2) issues of *Psychiatric Services* regarding the feasibility of eliminating the use of restraint and seclusion. In our judgment, developments in the law compel hospital administrators and clinicians to strive for elimination in order to minimize the significant legal risks associated with each use of restraint and seclusion.

In 1982 the U.S. Supreme Court ruled that the use of restraint is a drastic deprivation of personal liberty, that “[t]he right to be free from undue bodily restraint is the core of the liberty interest protected by the Due Process Clause,” and that the use of any such intervention must reflect the exercise of professional judgment (3). At the time of the court’s decision, restraint and seclusion were widely used to control the behavior of people with mental health conditions, and professional judgment appeared to embrace these practices.

Much has changed in the quarter century since the Supreme Court considered the issue, and what constitutes the exercise of professional judgment has evolved to reflect a growing consensus that the use of restraint and seclusion is dangerous, arbitrary, and nearly always avoidable. Researchers and clinicians have chronicled the significant physical and psychological risks—including death, disabling physical injuries, and significant trauma—inherent in each use of these interventions. The policies of virtually every national mental health advocacy and professional organization state that restraint and seclusion are safety interventions of last resort.

In addition, many effective, inexpensive alternatives to restraint and seclusion have demonstrated that these practices can be significantly reduced, which undermines their legitimacy in a treatment setting. The use of restraint and seclusion correlates with the beliefs of the organization’s leadership and the facility’s culture far more than with any clinical factor (4).

A single restraint episode can be subjected to judicial review of the determination by staff that an emergency warranted its use, and these cases can result in damage awards exceeding \$1 million (5). The efforts of facility management may be scrutinized in light of the well-documented success of inexpensive, replicable tools that prevent use of restraint and seclusion. Legal consequences may include not only money damages (compensatory and punitive) but also

administrative sanctions (such as the loss of Medicaid and Medicare certification) and criminal prosecution. Moreover, legal challenges to these practices consume enormous facility resources no matter what the ultimate outcome, and the impact on its reputation and staff morale linger long after the legal dust settles.

The issues we describe are thoroughly examined in our *Risk Management Guide to Restraint and Seclusion*, which is available without charge on the Web site of the National Association of State Mental Health Program Directors ([www.nasmhpd.org](http://www.nasmhpd.org)). Legal challenges to restraint and seclusion will increase, and comprehensive, concrete action to prevent these practices will benefit both consumers and service providers.

**Stephan Haimowitz, J.D.**  
**Jenifer Urff, J.D.**

*Mr. Haimowitz and Ms. Urff are affiliated with Advocates for Human Potential, Albany, New York.*

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## Multiple Sclerosis, Mental Illness, and Forced Treatment

**To the Editor:** Bill Anthony has been a wonderful pioneer in psychiatric rehabilitation and in promoting dignity, respect, and the recovery orientation in the treatment of mental illness. His multiple sclerosis (MS) is painful news to all of us who admire him (1). But as he notes, MS is not mental illness. Anthony’s family does not have to contend with his denial of illness. He does not accuse them of having MS rather than himself. He does not

vehemently reject medical treatment for this disease that he denies having. He does not have frightening delusions or hallucinations, refuse food because it is poisoned, waste away and decompensate in front of their eyes while family members stand helplessly by unable to make him accept treatment. Nor does he threaten or attempt suicide. On the contrary, he cooperates with his doctors, takes medications, and is a rational, willing participant in his own recovery.

Of course, Anthony is right in saying that force should have no place in a helping profession and that people really cannot recover from mental illness without free will. But there are stages of illness, levels of disability, and cognitive impairments that impede even the recognition of the concept and need for recovery and that preclude the exercise of judgment that is the basis of free will. Opposition to forced treatment as a championing of human rights is admirable if one does not have to cope with the realities of a severe psychotic episode or with the rights of others.

It seems to me that sometimes a mystifying dishonesty pervades this discussion. A noble ideological principle too often is coupled with an unconscionable indifference even to acknowledging the conditions that typically generate forced treatment. Psychotic and self-destructive behaviors can lead to terrible social consequences and may affect many people other than those who are ill. Children, siblings, spouses, and aging parents are among those deeply affected and psychologically harmed by untreated psychosis—not to mention the damaging effects to the persons themselves.

Are there alternatives to involuntary hospitalization? The United Kingdom has early-intervention teams that deal with people in their first episode of psychosis and that even attempt early detection. There are also high-risk and prodromal teams, subdivided into early intervention and prodromal intervention, as well as continuing care teams with specific criteria for “ultra high-risk subjects” and modes of intervention

(2). With community outreach teams, skilled mental health workers can usually convince a frightened person to accept treatment. Services can be offered in the home before the need arises for forced treatment in a hospital setting.

I recognize and fully sympathize with the desire of consumers to end this profound insult to their integrity as human beings. We need viable alternatives, with high consumer participation, that are not ancillary but embedded in the system of care. But if all else fails, involuntary treatment in hospitals is preferable, any time, to the perils and indignities of jail, homelessness, or death on the streets. And in our current system, unfortunately it is often the only available prelude to the ultimate exercise of free choice.

**Harriet P. Lefley, Ph.D.**

*Dr. Lefley is professor in the Department of Psychiatry and Behavioral Sciences, Miller School of Medicine, University of Miami.*

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**To the Editor:** William Anthony has done superb work in psychiatric rehabilitation, and I have always admired him. I do not, however, agree with this comparison of treating multiple sclerosis (MS) and serious mental illnesses. It is like comparing apples and oranges.

It is our brains that make us uniquely human. No other mammal has such a highly developed brain. MS does not damage the brain; serious mental illnesses do. That is an essential difference. We do not let seven-year-old children determine their treatment when they are seriously ill, because their brains are not yet fully developed. In a similar vein, people in severe psychotic states have brains that are not functioning well enough to make decisions about treatment.

I have worked in jails and in shelters for homeless people, where there are large numbers of people with serious mental illnesses who have refused treatment. I fail to see the advantage of jail over involuntary treatment. The psychiatrist Daryl Treffert (1) said it all very well in “Dying With One’s Rights On,” which he wrote more than 30 years ago.

Why must we keep swinging from one extreme to another in our treatment ideologies? There is a time and place for involuntary treatment. Such treatment should be given in the kindest, most respectful, and gentle way possible, of course. Then as soon as a person has responded well enough to be functioning on a rational level, he or she should be involved in making a treatment plan.

We have all seen families deplete their resources, both emotionally and financially in an effort to save one family member who is actively psychotic and refusing treatment. Sometimes it may be better to save four members of a family by permitting the forced treatment of one. Sometimes it may even be necessary for the family to give up and hope that the mental health and welfare systems will find a way to intervene.

Dr. Anthony, I am sincerely sorry to hear of your MS. But I strongly disagree with what it has taught you about serious mental illnesses.

**Mona Wasow, M.S.S.W.**

*Ms. Wasow is professor of social work, emerita, at the University of Wisconsin, Madison.*

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**In Reply:** I thank Dr. Lefley and Ms. Wasow for their kind personal words and for giving me an opportunity to clarify and reinforce the intent of the article. As Lefley states, force is only needed “if all else fails.” We are kidding ourselves if we think “all else” is routinely tried. Force has become the easy alternative to expert helping. I am certainly not surprised by the recitation of reasons for the use of

force. I have heard or seen most all of them.

I think the “massive dishonesty” and “unconscionable indifference” that Lefley notes with respect to not acknowledging the conditions that generate forced treatment are easily trumped by our seeming indifference to the massive use of force in the mental health culture. I wonder how many people refuse treatment because of their brain function, as Wasow suggests, and how many refuse treatment because of how the mental health system functions (1). And the oft-quoted phrase about treatment refusal—“Free to die with their rights on”—does have a contrasting phrase in my vocabulary. Because of our harsh practices, how many people with severe mental illnesses are “forced to live with their dreams turned off”?

The point is that we need to redouble our efforts to practice alternatives to forced treatment (2). Lefley is correct that the rationale for the use of force should be acknowledged. However, it our use of force based on this rationale that can cause great harm to the person ostensibly being helped. Rather than acknowledging this rationale for the use of force as a given, we need to challenge it with helpful alternatives. Who would have thought that we could have a goal of eliminating seclusion and physical restraint from state institutions? But we can (3). In what other creative ways can we eliminate force from our field? Lefley has provided us examples of such alternatives.

The debate about force is not about questionable ideology but about questionable practices. As Lefley implies, it is easy to admire a philosophy based on the rejection of force. The test is to make practice congruent with such a philosophy in instances in which force has traditionally been the practice of choice? I repeat my challenge to myself and to my colleagues. Let us commit to figuring out how to stop our mindless use of force. Let us use our best minds, such as those of Dr. Lefley and Ms. Wasow, to find ways to extricate our field from being society’s purveyor of force. We need

leaders to champion, develop, and demonstrate effective alternatives to force and then to permeate the field with these practices. We cannot and must not accept the use of force that pervades our field.

Also, I want to clarify for Ms. Wasow and for others who may not be familiar with the effects of this disease—MS does indeed damage the brain. Furthermore, along with myriad other difficulties, cognitive problems and depression are common symptoms of MS.

**William A. Anthony, Ph.D.**

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### Successful Use of VNS for Depression

**To the Editor:** The observation that patients using vagus nerve stimulation (VNS) for epilepsy showed improved mood led to studies resulting in approval of VNS by the U.S. Food and Drug Administration for the adjunctive long-term treatment of chronic or recurrent unipolar or bipolar depression for adults who have not had a positive response to four or more adequate antidepressant trials (1). The putative mechanisms of action include changing concentrations of neurotransmitters and functional activity of brain areas involved in mood disorders.

Ms. A is a 72-year-old divorced white female with a long history (more than 30 years) of *DSM-IV* major depressive disorder, recurrent, severe, without psychotic features. Her son committed suicide in December 2004, which led to an exacerbation of her symptoms. She has been seen in our community mental health center since February 2001. Current med-

ications are lamotrigine, bupropion, lithium, and paroxetine.

The National Depression Management Leadership Initiative of the American Psychiatric Institute for Research and Education recommends that depressed patients self-administer the brief Patient Health Questionnaire (PHQ-9) (2) as one means of improving clinical management practices. The maximum severity score is 27, and a score of less than 5 indicates minimal depression. Ms. A’s VNS scores for several months in 2005 were 17 on June 15, 19 on July 2, 16 on July 14, 22 on July 22, 26 on August 18, 15 on August 26, and 23 on September 15.

In late 2005 I discussed therapeutic options with Ms. A. Multiple medications and individual and group psychotherapies had not helped her. Electroconvulsive therapy had helped, but Ms. A insisted that she did not want this treatment again, citing past side effects, especially perceived memory deficits. We discussed VNS, and I described possible adverse effects, particularly hoarseness, cough, paresthesia, and dyspnea. Most of these effects occur only during the brief stimulation periods and are short term; they generally diminish over time, can be lessened by adjusting the settings, and can be controlled by use of a magnet (with which the patient can stop the stimulation). Ms. A was especially encouraged by research showing improvement increasing over time. Like many such patients, she was “willing to try anything” that held promise to relieve her depression.

Ms. A was given a video educational package, and she talked with staff at Cyberonics, Inc., the manufacturer of the device, and with patients who had been treated with VNS. It should be noted that by October 2004 VNS had been used with more than 32,000 people to treat seizures, representing 80,000 device-years of implant experience. The same procedure is used to treat depression.

Cyberonics facilitated referral to a prominent local neurosurgeon, who consulted with Ms. A and implanted the device without a problem. On Oc-

tober 28, 2005, I activated the system in my clinic office with equipment loaned to me by Cyberonics. Two weeks later, I increased the dose to the next step. Ms. A's PHQ-9 score was 1. She reported doing things that she had not done for years. "I'm so happy but not hyper," she said. Her PHQ-9 scores were 2 on December 8, 1 on December 21, 5 on January 18, and 1 on February 1. At this writing, April 11, 2006, her current PHQ-9 score is 5. Ms. A noted that the score was higher because of unrelated knee pain. Her knee problem led to the only significant problem with VNS so far—she was not being able to have an MRI, and assessment of her knee required other examination techniques. Ms. A has reported no adverse effects, except for a rare throat "tingle."

In this case of chronic, treatment-resistant depression, VNS therapy was successfully and easily initiated under routine clinic conditions by an admittedly "computer-challenged" psychiatrist. In addition, the PHQ-9 proved valuable as a means of monitoring depression over time.

**Daniel D. Storch, M.D.**

*Dr. Storch is in private practice in Ellicott City, Maryland, and also sees patients at the Humanim Clinic in Columbia, Maryland. He has no personal or financial interest in Cyberonics, Inc.*

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## Psychiatric Effects of Heat Waves

**To the Editor:** Heat waves have an effect on health, sometimes lethal, which was particularly evident in Europe during the intensely hot summer of 2003 (1,2). Even though the incidence of deaths and illness related to heat waves is reported to be increas-

ing, there are no specific data on the psychiatric effects of heat waves.

Studies about the psychiatric effects of weather have produced scattered results, probably because of a lack of diagnostic specificity and the complexity of analyzing weather variables. In addition, no single methodological approach has been used to examine these effects. The methods used range from self-report questionnaires to data on emergencies and hospital admissions. Published reports have dealt mainly with suicide and violent behavior related to weather (3,4).

In view of the substantial health impact of the 2003 European heat wave and the paucity of data on psychiatric effects, we decided to analyze psychiatric emergencies in a general hospital in Barcelona during the heat wave of 2003. The period was defined as the days with a maximum temperature of at least 32 degrees Celsius (89.6 Fahrenheit), a period that lasted for 15 days that summer. We compared data from the heat wave period with data from the other summer days in 2003, examining emergency visits; hospital admissions; clinical and sociodemographic data; scores on the Severity of Psychiatric Illness Scale (SPI) (5), which measures the severity of a disorder with predictive value for admission; the treatment rendered, including use of restraints; and referral. The study was approved by the hospital Ethics Committee.

During the heat wave period, 125 psychiatric emergencies were attended to, which accounted for 14 percent of the total psychiatric emergencies attended to during the entire summer (N=872). No differences were found in the number of emergency visits or admissions. However, during the heat wave, significantly more alcohol and sedative use disorders were reported, and patients were less likely to report anxiety disorders. Overall, individuals seen during the heat wave were more likely to report a history of psychiatric conditions and treatment and greater use of psychiatric services; they also had to be restrained more often and had higher scores on the SPI scale item measuring danger-

ousness toward others. In only half of these cases was the dangerousness attributed to alcohol or drug use.

The 2003 heat wave produced intense effects in many countries, and this study provides evidence of possible psychiatric repercussions, of which mental health clinicians should be aware. Clinicians and administrators should consider primary and secondary prevention approaches to address psychiatric symptoms that may result from heat waves.

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## Imagining the Ecotrienes: A Helpful New Class of Peptides

**To the Editor:** For years I have been frustrated by society's willingness to provide persons who have psychiatric disorders with billions of dollars in second-generation antipsychotics but not with the psychosocial interventions that might help reintegrate them into the community. Despite increasing evidence that these medications provide only marginal benefits and research to suggest that

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these drugs may not be an area to which persons with mental illnesses would want to commit additional resources, there has been no shift in policy.

For numerous reasons the care provided to the medically indigent is skewed toward high-priced, high-tech interventions for acute illness. First, our understanding of illness is overly focused on the individual and his or her body. Despite, or perhaps because of, the intimate relationship between illness and psychosocial factors, such as social class, culture, and behavior, we do not intervene at those levels. Second, because of concern about moral hazard we are much more willing to provide interventions that are expensive but that people would not otherwise want unless they are ill—such as MRIs, surgery, and medication—rather than something that might be less expensive but that many people would want even if they are not ill—such as safe housing, counseling, and healthy food. Third, the manufacturers of high-priced interventions are much more willing to use their influence to advocate for public funding to pro-

vide their products to the medically indigent than are the providers of psychosocial interventions. The pharmaceutical industry has much more to gain by supporting the call from the National Alliance on Mental Illness for access to psychotropics than the construction industry has for supporting a similar call for access to supported housing.

Multiple studies have demonstrated the effectiveness of housing as a treatment for the homelessness of some persons with mental illness, but housing remains unavailable. If we want to solve this problem we need a pill that can be substituted for housing. Such an intervention would maintain the focus on the individual's body, not on broader social issues. It would avoid the problem of moral hazard—most people would rather live in a house than on the street, even if they must take a “housing pill.” Finally, the 600 lobbyists for the pharmaceutical industry could be counted on for support.

Such a medication has not yet been developed, but if we can decipher the human genome, what is stopping us from developing such a

medication? I am so confident that this can be done that I have taken the liberty of writing the abstract for a prospective review.

“The Ecotrienes: New Hope for an Old Problem: The ecotrienes (eco=environment, trienes=prostaglandin-like cellular modulators) were originally isolated from hibernating Norwegian voles. Subsequent animal and human studies have demonstrated that this class of peptides allows mammals to withstand climatic extremes and caloric deprivation. Controlled clinical trials among homeless patients with schizophrenia have consistently demonstrated that the ecotrienes are associated with a marked reduction in hospital and jail recidivism. Despite the high cost of these medications (U.S. \$9,000 per annum), pharmacoeconomic analyses suggest savings through reduced use of postdischarge resources, such as food and housing, and also shorter inpatient hospitalizations through elimination of discharge planning.”

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