LETTERS

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 Blvd., Suite 1825, Arlington, VA 22209-3901; fax, 703-907-1095; e-mail, psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (mc.manuscriptcentral.com/appi-ps).

The Ten Commandments of Services Research

To the Editor: Many mental health providers and consumers are confused by services research. How does services research differ from quality assurance efforts? How does services research differ from placebo-controlled medication trials? In addition, many researchers who do not consider themselves "services" researchers want to get into the services area or find their research grants being reviewed by a services-oriented committee. The following commandments highlight ten bits of "truth" based on my own understanding of services research and on several years of experience reviewing papers and grants.

I. I am the Lord thy God. My name is Validity—Internal and External. Worship both. Thou shall not have any gods before Me. Much of science tends to be preoccupied with internal validity, the strength of the claim that the experimental manipulation causes the outcome. This leads to the desire to control all potentially confounding variables but may reduce external validity. External validity, or the extent to which the study findings generalize to the world beyond the research project, is very important in services research.

II. Do not worship idols. Although you must have comparison conditions, they need not be exact images. Remember that you worship Internal Validity not Perfection. In medication trials we are used to seeing "placebo," which resembles the experimental condition to the fullest extent possible. In services research, although it is important to have control conditions, it is often not possible or desirable for the comparison condition to be a twin of the experimental condition.

III. Do not take the name of "effectiveness" in vain. Remember that you worship External Validity. Many researchers think that they are doing an effectiveness study if they measure outcomes beyond symptoms. That is not what effectiveness means. Effectiveness refers to the impact of a program in the real world, beyond the tightly controlled world of clinical trials.

IV. Remember the Sabbath day and keep it holy. Research assessments should not be scheduled on important religious holidays and on anyone's Sabbath. Services researchers should pay close attention to issues of culture.

V. Honor thy fathers and mothers—and grandparents, foster parents, and families of choice. Services researchers should pay close attention to issues of culture.

VI. Do not murder your data analysis section or your biostatistician. The quasi-experimental and group cluster designs of services research require complex statistics. The statistician should be a part of the study from the very beginning.

VII. Be faithful to intervention design, and use measures of program fidelity at all times. Given the complexity of many services research studies, which often test psychosocial and organizational interventions, it is essential that strategies are used to ensure that the interventions being tested are true to their descriptions.

VIII. Although thou shalt not steal, thou shalt borrow frequently. To the extent that services research often involves working in unique cultural and system contexts and adapting standard approaches, it is tempting for investigators to assume that they have to reinvent the wheel. It is important for services researchers to borrow heavily from the work of others.

IX. Sins of omission can get you into as much trouble as lying. Don't stick with the psychiatry literature. Remember sociology, anthropology, psychology, economics, marketing, education, political science. . . Services research draws heavily from a broad range of disciplines for conceptual models and approaches.

X. Do not covet the grants of your psychopharmacology clinical trials friends.

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States' Priorities for Persons With Mental Illness in the Criminal Justice System

To the Editor: Having read the State Mental Health Policy column in the September issue, "Critical Priorities Confronting State Mental Health Agencies," by Mazade and Glover (1), I find it striking that the authors—and apparently state mental health directors around the country—do not consider the vast number of individuals with mental illness in the criminal justice system to be a "priority." Given that there are nearly 300,000 individuals with mental illness currently incarcerated in the United States and about double that number on parole or probation (2), I would think that this ought to be at least one of the priority items listed.

Each of the priorities listed by the authors applies in spades to those of our clientele who find themselves in the criminal justice system. They have a high rate of comorbid medical and addictive diseases, they are perhaps the least empowered of any person with mental illness one can imagine, there are all too few psychiatrists willing to serve this population, and state legislators and administrators are unwilling to spend what the illness burden of this population demands.

Apart from all of that, it is simply morally wrong to think about the priorities of state mental health systems without considering this lost population. But then, once they are incarcerated, they are no longer a problem for the state mental health director, are they?

Erik Roskes, M.D.

Dr. Roskes is director of forensic treatment at Springfield Hospital Center, Sykesville, Maryland. The opinions expressed represent those of the author and do not necessarily reflect the views of the State of Maryland Mental Hygiene Administration.

References

1. Mazade NA, Glover RW: Critical priorities confronting state mental health agencies. Psychiatric Services 58:1148–1150, 2007
2. Ditton PM: Mental Health and Treatment of Inmates and Probationers. Pub no NCJ-174463. Washington, DC, US Department of Justice, Bureau of Justice Statistics, 1999

In Reply: To clarify, our article reported on state mental health agency (SMHA) directors' priorities, not our own. However, ongoing activities of SMHA directors throughout the country demonstrate that people with mental illness who become involved in the justice system are not a forgotten population.

Data from the National Association of State Mental Health Program Directors (NASMHPD) Research Institute indicate that in fiscal year 2005, seven of 44 SMHAs provided mental health services to adults in prison through a formal arrangement with the state department of corrections; in 38 states, the state department of corrections provides these services. In addition, over one-third of the $8 billion currently expended by SMHAs in state psychiatric hospitals is for forensic and sex offender services, and these expenditures are expected to increase. Twenty-five of 43 states use mental health courts to divert persons with mental illness from the criminal justice system. Thirty-four of 40 SMHAs have reported specific initiatives to reduce fragmentation between the SMHA and the state's corrections department, including coordinating client eligibility and combining and coordinating funding streams and service delivery systems.

SMHAs differ across the country in the role that they play regarding persons with mental illness in the correctional (and judicial) system. The activities of the SMHA are defined by state statutes and regulations and by dictates from the governor's office. Our experience with SMHA directors suggests that they are concerned with the corrections population from several perspectives. They are concerned that there is little opportunity for presentencing screening to identify persons who have a severe mental illness and about the transfer of inmates from prisons and jails to state hospitals and other SMHA facilities because these inmates have received no therapeutic benefit from services provided in the correctional system. They also have concerns about their restricted ability to provide services immediately after prison release because of processing delays in determining Medicaid eligibility.

SMHAs' additional investment is also reflected in their participation in the Council of State Government's Criminal Justice and Mental Health Consensus Project and in the council's current development of a "blueprint" to coordinate state mental health, substance abuse, and corrections agencies. Also, NASMHPD has an ongoing task force on mental health and corrections. Finally, a number of states applied for the U.S. Department of Justice's fiscal year 2007 Justice and Mental Health Collaboration Program.

Although in Dr. Roskes' experience persons with mental illness in corrections may be victims of an "out of sight, out of mind" SMHA policy, attributing this outcome to a conscious effort by SMHA directors to abdicate responsibility does not comport with our interactions with these directors. When asked about priorities for a given fiscal year, directors tend to report the coming year's priorities, most of which are new and emerging initiatives, which may partially explain why issues with this population were not specifically highlighted as a priority.

Our thanks to Dr. Roskes for his interest in and concern for accountability within the public mental health system.

Noel A. Mazade, Ph.D.
Robert W. Glover, Ph.D.

Dr. Mazade is executive director of the NASMHPD Research Institute, Inc., and Dr. Glover is executive director of NASMHPD.

Origins of the Quadrant Model for Persons With Co-occurring Disorders

To the Editor: In an article in the July 2007 issue, "Co-occurring Psychiatric and Substance Use Disorders: A Multistate Feasibility Study of the Quadrant Model," McGovern and colleagues (1) noted that the quadrant model has "origins traced to Ries and colleagues and Rosenthal and [is] sometimes referred to as the 'New York' model." I have spoken with Dr. Ries about his important work, and Dr. Rosenthal made an early contribution to the New York model, as noted below. However, the New York model is my work, created with help from colleagues in 1987.

In the fall of 1987 Ken Johnson and David Barry led workshops introducing the New York State Office of Mental Health (NYSOMH) "Mentally Ill Chemical Abuser (MICA) Resource Manual," which they had developed. I was asked to assist in teaching the downstate workshops.

In one workshop, held at World Trade Center Tower 2, my training colleagues and I were faced with militant staff from separate mental health and substance abuse pro-

grams, each hurling clinical polemics at their counterparts from the other service system. Ken and Dave supported my idea that trainees were talking about different clients and were defending their turf.

Having recently attended a workshop (on training managers) with multiple two-by-two teaching paradigms, I suggested that we ask the workshop students which quadrant would fit their clients if we set up a high-high, high-low, low-high, and low-low model of mental illness by substance abuse severity. We made up the first model on scrap paper over lunch, tested it on cases we knew, and then drew it on newsprint as we explained it to the students. Workshop students from the different agencies used the model as a shared reference to communicate—albeit, at first, to assert the validity of their comments about their clients.

After the NYSOMH Mentally Ill Chemical Abusers Planning Committee, chaired by Carolyn Plimley, reviewed the model, they sponsored a two-day statewide workshop in the fall of 1989 (which I chaired) to explore its use, and the de facto "New York model" came to pass. The model, the Dual Diagnosis Program Planning Grid, was presented at the directors' conference of NYSOMH in the fall of 1990. It was initially called the Mentally Ill Chemical Abuser Diagnostic Grid, but Richard Rosenthal noted the risk of implying over-simplified diagnosis with broad-stroke categories. James L. Stone, who in 1995 became commissioner of NYSOMH, attended the 1990 directors' conference and in 1998 brought the New York model to a national conference of state directors of mental health and substance abuse services, who then used the New York model to create a grid using domains of service and illness severity, the Quad IV.

The New York model, now called the Co-occurring Disorders Program Planning Model (2) with added dimensions (trauma symptom severity, level of function, time, and risk), is used as a teaching and communication tool to enable diverse clinicians to interact regarding individual clients. This clinical case and program design focus differs from the fiscal, policy, service system responsibility, and purview concerns addressed by Quad IV.

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References

1. McGovern MP, Clark RE, Samnaliev M: Co-occurring psychiatric and substance use disorders: a multistate feasibility study of the quadrant model. Psychiatric Services 58:949–954, 2007
2. Larkin S, Sathananthan G, Munzenmaier K, et al: Trauma history and risk assessment in the Co-occurring Disorder Program Planning Model: case-based implications for treatment, rehabilitation, and recovery. Presented at the Pennsylvania Conference on Co-occurring Disorders, Hershey, May 15–17, 2006

In Reply: We are grateful to learn of Dr. Larkin's response to our article. In reading his letter, we have no doubt as to the veracity of his account of the origins of the quadrant model. At the time we wrote and submitted the manuscript to *Psychiatric Services,* we had only material published in the medical and scientific literature to which to refer. We drew in particular from a 2002 report to Congress by the Substance Abuse and Mental Health Services Administration, an article published by Richard Ries, and a chapter written by Richard Rosenthal and Laurence Westreich, each of which described and outlined the model organized by four quadrant boxes of psychiatric and substance abuse severity. Subsequent conversations with Dr. Rosenthal have confirmed the contribution of Dr. Larkin's seminal idea to the original model, which over the years has undergone considerable refinement and elaboration.

We believe this model has widespread conceptual and heuristic value, and as we reported in our article, if it is connected with system-level data, it may also have pragmatic reliability and validity. We commend Dr. Larkin for his significant contribution to the creation of the model more than 20 years ago, and we are pleased to be a part of its continuing application in policy, services, and research with persons who have co-occurring psychiatric and substance use disorders.

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