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## CHADD and Public Attitudes About ADHD

**To the Editor:** Two articles on attention-deficit hyperactivity disorder (ADHD) in the May 2007 issue of *Psychiatric Services* (1,2) affirm and expand on previous research about public attitudes and knowledge of this disorder. This research will positively influence the activities of my organization, CHADD (Children and Adults With Attention-Deficit/Hyperactivity Disorder), a family-based organization with 14,000 members and 1,200 professional members that was founded in 1987.

McLeod and associates (1), who noted critics' claim that ADHD is overdiagnosed, compared national estimated prevalence with medication use and argued that ADHD is actually underdiagnosed. Other mainstream researchers have arrived at the same findings. Missing from this analysis, however, is the more difficult and significant issue of the tremendous variation in medication utilization, which two national studies have documented. The first, the result of 14 months of work by re-

porters from the *Cleveland Plain Dealer* (3), gets little attention because of the journalistic credentials of the researchers. This study, which documented ADHD medication use in every U.S. county, found that in some counties the number of people being prescribed medication was three times the expected rate, whereas in other counties not a single individual was receiving medication. There are many possible reasons for this variance, including inconsistency in implementing evidence-based treatment guidelines.

In the second national study the authors conclude that variation in stimulant use among children is second only to variation in cough-cold-allergy prescription use (4). The authors state that the reasons for regional variation are not known. They postulate that "differences in state controlled substance abuse laws, anti-Ritalin campaigns, direct-to-consumer advertising, physician practice style, the values, beliefs, and expectations of adult caregivers" are the reasons—highlighting the importance of this new research in *Psychiatric Services* on stigma and public beliefs and attitudes.

McLeod and associates conclude that "future media and educational efforts should seek to provide accurate information about ADHD." It is this understanding that has led the Centers for Disease Control and Prevention (CDC) to finance the National Resource Center on ADHD ([www.help4adhd.org](http://www.help4adhd.org)), a project of CHADD. During any given month, more than 135,000 unique users visit the CHADD Web sites, and we individually respond to an average of 880 people making 1,150 discrete inquiries. To counter stigma, CHADD hosts support groups, peer public education forums, and parent-to-parent training. In addition, through CHADD's advocacy with the U.S. Congress, the CDC is currently financing two community-based studies to examine trends in the use of ADHD medications (5).

In the second article in the May issue, dosReis and associates (2) pro-

vide helpful insights into the decision process used by urban African-American families when confronted with the possibility of ADHD. The four "distinct patterns" of decision are used by all families, but these researchers documented that culture, race, and community influence these patterns.

CHADD's experience as a national resource center and a family membership organization affirms the validity of the four distinct processes. The following statements are based on six-and-a-half years of my personal experience, which indicates that follow-up studies are needed on the impact of severity of disability and of co-occurring disorders on a parent's tendency to take one of dosReis's decision-making approaches over the other three. Those whose orientation is "immediate resolution" often have children experiencing less severe forms of ADHD, without co-occurring disorders, whose initial identification was made by behaviors interfering with academic performance. Those whose orientation is "pragmatic management" frequently have children with more severe ADHD, often with co-occurring disorders, and have come to realize that their child's problems began before they entered school and are chronic and long lasting. Those with "attributional ambivalence" seem embarrassed by the possibility of ADHD, do not have families and communities open to the biological underpinnings of ADHD, or are skeptical or afraid of medications and thus are willing to first try alternative interventions.

CHADD has little experience with agencies of government using "coerced conformance"—the fourth orientation. We do hear from parents who claim that they were told by their child's teacher to place their child on medication. Our response is that the child should receive an independent medical evaluation and that those making medical recommendations should do so within their sphere of professional competence and training. CHADD has recently published the *CHADD Educator's Manual on*

*ADHD: An In-depth Look From an Educational Perspective* ([www.chadd.org/store](http://www.chadd.org/store)).

During the past six years, to better inform the public about ADHD and to build a social movement to assist all persons with ADHD, CHADD has conducted 17 community forums targeted to the African-American and Hispanic-Latino communities and has developed a variety of partnerships with organizations representing these two communities. The research by McLeod and colleagues and dos-Reis and associates will help us with these efforts.

**E. Clarke Ross, D.P.A.**

*Dr. Ross is the chief executive officer of CHADD. Dr. Ross writes a weekly blog ([www.chadd.org](http://www.chadd.org)) about his professional and personal experiences.*

## References

1. McLeod JD, Fettes DL, Jensen PS, et al: Public knowledge, beliefs, and treatment preferences concerning attention-deficit hyperactivity disorder. *Psychiatric Services* 58:626–631, 2007
2. DosReis S, Mychailyszyn MP, Myers M, et al: Coming to terms with ADHD: how urban African-American families come to seek care for their children. *Psychiatric Services* 58:636–641, 2007
3. Easton S, Marchak E: Ritalin prescribed unevenly in US. *Cleveland Plain Dealer*. May 6, 2001, pp 1A, 14A
4. Cox E, Motheral B, Henderson R, et al: Geographical variation in the prevalence of stimulant medication use among children ages 5 to 14 years old: results from a commercially insured US sample. *Pediatrics* 111:237–243, 2003
5. Proposed Project: Longitudinal follow-up of youth with attention-deficit/hyperactivity disorder identified in community settings: examining health status, correlates, and effects associated with treatment for attention-deficit/hyperactivity disorder: new National Center on Birth Defects and Developmental Disabilities (NCBDDD), Centers for Disease Control and Prevention (CDC). *Federal Register* 72(65): 16789–16791, 2007

## Hispanics and Telepsychiatry

In an article in the March issue, Vega and his group (1) described treatment barriers facing Hispanic patients across the country. They also offered several suggestions to increase access

to mental health care for Hispanics, including telepsychiatry. Little has been written about telepsychiatry with Hispanic patients.

Telepsychiatry is an innovative and cost-effective way to increase access to mental health care (2). This increased access is the most compelling reason to utilize telepsychiatry. It is not a substitute for the patient-practitioner relationship but rather an enrichment in services.

The use of telepsychiatry to treat underserved minority groups and rural residents has been suggested, but there are obstacles to effective implementation (3,4). One obstacle is the lack of comfort with the technology, especially among elderly persons (4). Another is limitation of cultural acceptance of this treatment modality, especially in cultures that emphasize personal relationships. Third, the effects on the patient-practitioner relationship are relatively unexplored. There is some anecdotal reporting in the media of resistance to the use of telepsychiatry to serve one Hispanic subgroup, incarcerated Hispanics with mental health needs in San Juan, Puerto Rico (5). In this situation Hispanic individuals who were not employees of the prison would provide telepsychiatry services to Hispanic inmates. Prison employees rather than the inmates resisted this move and suggested that it was “second-class service.” This may indicate a cultural resistance to the technology itself or perhaps something else altogether.

Hispanic culture relies heavily on nonverbal interactions, such as frowning, tipping the head, and so forth. These communication nuances provide an additional “channel” to receive and process information and give more depth to verbal communication. These nonverbal communications may be contradictory to the words used and are usually a more accurate reflection of internal processes. Ability to view these effectively can be influenced by the technology. High-resolution equipment, such as video conferencing, can provide a more accurate real-time image than the less expensive small-screen videophones, which are limited to tele-

phone line transmission speed. Variations in technical equipment variations can influence the perception of other signs and symptoms in psychiatry as well, such as affect, psychomotor movements, and signs of movement disorders.

In our community-based outpatient clinic we recently deployed videophones to enhance medical psychiatric access to persons with serious mental illness. One Hispanic patient whose treatment included videophones reported marked satisfaction. There was already a clinical relationship between the provider and patient. Both had Spanish as a first language, and the sessions were conducted in that language. The previous solid clinical relationship allowed the videophone technology, despite its limitations, to be used when the patient's comorbid health problems prevented his travel to the facility. Videophones have been used with similar success with non-Hispanic veterans in comparable situations in our clinic.

Further investigation of the use of telepsychiatry and how culture influences its effectiveness are needed. As mental health professionals, we need to utilize all appropriate resources to improve access to care to the growing Hispanic populations. Improvements will have implications for others in the multicultural clinical environment.

**J. Edwin Nieves, M.D.**  
**Kathleen M. Stack, M.D.**

*Dr. Nieves is associate professor of psychiatry and Dr. Stack is assistant professor of psychiatry at Eastern Virginia Medical School in Norfolk. Both are staff psychiatrists at the Hampton Department of Veterans Affairs Medical Center in Hampton, Virginia.*

## References

1. Vega WA, Karno M, Alegria M, et al: Research issues for improving treatment of US Hispanics with persistent mental disorders. *Psychiatric Services* 58:385–394, 2007
2. Hyler SE, Gangure DP: A review of the costs of telepsychiatry. *Psychiatric Services* 54:976–980, 2003
3. Moran M: Telepsychiatry brings care to underserved populations. *Psychiatric News* 39(12):4, 2004
4. Rholand BM, Saleh SS, Roher JE, et al: Acceptability of telepsychiatry to a rural population. *Psychiatric Services* 51:672–674, 2000

5. No controls over telepsychiatry services [in Spanish]. *El Vocero de Puerto Rico*, Dec 18, 2006. Available at [www.vocero.com](http://www.vocero.com). Accessed Dec 18, 2006

**In Reply:** We share Nieves and Stack's concerns about the use of telepsychiatry to treat underserved minorities and rural residents without sufficient evidence about whether the interventions are culturally appropriate or whether differences exist between (and within) racial and ethnic groups in their use of and satisfaction with telecommunications-based care and in its outcomes. We also share their concerns about whether language translations can be effectively provided through technology and whether widespread technology literacy and acceptance exists among such populations. These and related issues are discussed in greater detail in a publication from a workshop sponsored by the Office of Rural Mental Health Research (ORMHR) that identified research gaps in "e-mental health research" (1).

A key issue that requires attention is language. Nearly half of the U.S. Latino population is either Spanish-language dominant or feels more competent speaking Spanish. Latino patients are more likely to be satisfied with mental health treatment when it is offered in Spanish. In addition, many Latinos live in rural or low-density areas situated on the periphery of cities, far from major clinical centers, where specialty mental health services are usually located.

Our experience shows that Latino patients frequently complain of the impersonality of clinics, of treatments offered without any sense of personal connection, and of clinicians who seem distracted—or who even admit to linguistic and cultural limitations. Often family members understand very little about the intent or value of treatments received by their loved ones in mental health clinics. Their exclusion from the treatment process can result in misunderstanding and unawareness of the familial role in treatment. This raises the larger question: can these

differences between providers and clients be bridged by telepsychiatry–e-mental health care?

Can telepsychiatry be culturally appropriate and acceptable, and for which aspects of care? On the face of it, e-mental health technologies show promise for overcoming barriers in the delivery of mental health care to remote and underserved populations. Yet an analysis of the literature reveals a paucity of e-mental health research about whether care delivered long-distance is as effective as care delivered in an office setting. It is also not clear what degree of participation can be attained in a population with lower access to personal computers and significant problems with poverty and literacy. It is clear that we need to increase basic research on culturally appropriate telepsychiatry–e-mental health care.

Nieves and Stack are correct: further research is needed concerning the use of e-mental health and how culture influences its efficacy, effectiveness, and efficiency. To facilitate expansion of research supported by the National Institute of Mental Health (NIMH), ORMHR is conducting an incremental series of scientific meetings that includes experts in e-mental health infrastructure design, cost-benefit analysis, research methods, and clinical interventions with racial and ethnically diverse populations. NIMH hosted a meeting entitled "Culturally and Linguistically Appropriate Care and e-Mental Health: A Rural Perspective" at a recent conference sponsored by the Center for Reducing Health Disparities at the University of California, Davis; the California Telemedicine and eHealth Center; and the California Endowment. Several manuscripts are forthcoming from that conference that may provide an impetus for feasibility and effectiveness research with Latino patients and families.

**William A. Vega, Ph.D.**

**Anthony Pollitt, Ph.D.**

**Robert A. Mays, Jr., Ph.D.**

*Dr. Vega is professor of psychiatry at the Robert Wood Johnson Medical School,*

*Piscataway, New Jersey. Dr. Pollitt is chief and Dr. Mays is deputy chief of the Rural Research Program, ORMHR, NIMH.*

## Reference

1. Glueckauf R, Pollitt A, Stamm BH, et al: Office of Rural Mental Health Research: interdisciplinary research issues in e-mental health: a rural perspective. *Journal of Rural Mental Health Research* 31:45–53, 2007

## "Consumer-Directed Care" and Systems Transformation

**To the Editor:** In the March 2007 issue of *Psychiatric Services*, LaBrie and colleagues (1) discussed the advent of consumer-directed care and inherent difficulties in its application to mental health care services. From the perspective of the majority of consumer advocates, "consumer-directed care" is a misnomer for this form of systems transformation. The apparent focus of consumer-directed care as defined by "scholars, policy makers, and members of the health care industry" (1) is on cost-cutting without due attention to the standard of care provided and health outcomes.

LaBrie and colleagues correctly point out that this systems transformation, if left unaltered, will likely lead to fewer individuals' seeking care, greater mental and physical health problems left untreated, confused consumers who do not have the necessary information to make informed health care choices, and greater self-stigmatization (which, in and of itself, will lead to poor health outcomes). The last thing that most consumers of mental health care need is to be made "aware of the costs of care," as many consumers are painfully aware of these costs already.

As an alternative to the so-called "consumer-directed care" movement, the recovery model and the patient- and family-centered care model offer an alternative that may be more cost-effective and more clinically efficacious. From a recovery perspective, true consumer-directed care centers on the promotion of empowerment, individualized and person-centered



care, hope, and strengths-based care, among other concepts important to consumers of care and their advocates (2). Interventions such as supported employment, assertive community treatment, illness education, and family education and support are not widely available to consumers of mental health services. LaBrie and colleagues also underestimate the ascendance of peer-support services in mental health care (3). These recovery-based interventions are designed to provide a more holistic, more collaborative, and more person-centered form of care than traditional, medical-model treatment (4).

Surely, the costs of mental health care (and health care in general) would fall if these evidence-based practices were widely available. Restricting access to such services through increased deductibles is antithetical to true consumer-directed care.

**Scott A. Peebles, Ph.D.**  
**Gareth Fenley, M.S.W.**

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## References

1. LaBrie RA, Browne C, Christensen DE, et al: Implementation of a consumer-directed approach in behavioral health care: problems and prospects. *Psychiatric Services* 58:300–302, 2007
2. National Consensus Statement on Mental Health Recovery. Rockville, Md, Substance Abuse and Mental Health Services Administration, 2006. Available at <http://download.ncadi.samhsa.gov/ken/pdf/sma05-4129/trifold.pdf>
3. Davidson L, Chinman M, Kloos B, et al: Peer support among individuals with severe mental illness: a review of the evidence. *Clinical Psychology: Science and Practice* 6:165–187, 1999
4. Peebles SA, Mabe PA, Davidson L, et al: Recovery and systems transformation for schizophrenia. *Psychiatric Clinics of North America*, in press

**In Reply:** We appreciate the positive response from Peebles and Fenley to our discussion. They also noted that “LaBrie and colleagues also underestimate the ascendance of peer-sup-

port services in mental health care.” Space limitations prevented us from fully addressing peer support services beyond urging that the care coordinator role be adapted to behavioral health services. The report by Davidson and colleagues that is cited by Peebles and Fenley offers this evaluation of the extant evidence for consumer-based and peer-supported services. As Davidson and colleagues note, “Consumer-run services and the use of consumers as providers promise to broaden the access of individuals with psychiatric disabilities to peer support, but research on these more recent developments is only preliminary and largely limited to demonstrations of their feasibility” (1).

We look forward to the report of the research by Peebles and Fenley and their group’s empirical evidence, as well as other expansions of the evidence base on the efficacy of peer support. We hope the result will be to reduce the number of people who need behavioral health treatment but lack peer support funded by their treatment plans.

**Richard A. LaBrie, Ed.D.**  
**Kristina L. Greenwood, Ph.D.**  
**Howard J. Shaffer, Ph.D., C.A.S.**

## Reference

1. Davidson L, Chinman M, Kloos B, et al: Peer support among individuals with severe mental illness: a review of the evidence. *Clinical Psychology: Science and Practice* 6:165–187, 1999

## Reduction in Postdischarge Suicide in Sweden

**To the Editor:** In an article in the February 2007 issue, Pirkola and colleagues (1) reported a reduction in postdischarge suicide after deinstitutionalization and decentralization of psychiatric hospital care in Finland in the early 1990s. Similar structural changes in psychiatric hospital care were undertaken in Sweden a few years later, with a shift in the responsibility for inpatient care from psychiatric hospitals at the county council level to institutions at the community level (2). Even though the current suicide rate in Sweden is two-thirds

of the rate in Finland (3), suicide is the fifth leading cause of the burden of disease in Sweden among men and the 11th among women (4).

Nationwide Swedish registers were used to estimate postdischarge suicide rates for three periods—1987–1992, 1993–1998, and 1999–2004—representing psychiatric inpatient care before, during, and after the structural changes. Data on all suicides (N=23,742) were collected from the National Cause-of-Death Register in Sweden for 1987 through 2004. The cases were linked to the Swedish hospital discharge register. In line with findings of Pirkola and colleagues (1), postdischarge suicide was defined as occurring within a year of discharge from a psychiatric ward.

Postdischarge suicide rates were lower in the later periods—that is, during and after structural changes. Adjusting for length of hospital stay did not alter the results. Compared with 1987–1992, the relative risk for 1993–1998 was .85 (95% confidence interval [CI]=.80–.91), and for 1999–2004 it was .89 (CI=.83–.95). [A table with additional data on suicides for these periods is available in an online supplement to this letter at [ps.psychiatryonline.org](http://ps.psychiatryonline.org).]

Restricting the analyses to immediate suicide, defined as within a week of discharge, also showed a lower relative risk in the later periods. Widening the definition to include patients hospitalized with a primary psychiatric diagnosis regardless of clinic (that is, including patients treated in general inpatient care but with psychiatric consultants in some cases) showed very similar results. Postdischarge suicide stratified by specific diagnoses was not studied, although a previous study has shown an increase in suicide rates among patients with schizophrenia in the mid-1990s in Sweden (5).

In-depth analyses of all suicides occurring in 2004 revealed that of the 1,154 cases (Sweden has a population of close to nine million), 61% (N=709) had received either general or psychiatric inpatient or outpatient care in a specialty setting (that is, not in primary care) at least once during

the past year. Of these 709 cases, 50% (N=351) had contact with inpatient or outpatient care within the week before suicide.

The findings support the conclusions drawn by Pirkola and colleagues (1), indicating that in terms of post-discharge suicide rates the downsizing of psychiatric hospital care has not been harmful. However, it must be noted that approximately 20% of persons who committed suicide had received psychiatric inpatient care in the past year and more than 60% had consulted a physician in the past year, half of them during the week before

the suicide. These findings clearly emphasize the need for better recognition of suicidal risk among professionals in both general and psychiatric care settings.

**Rickard Ljung, M.D., Ph.D.**

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### References

1. Pirkola S, Sohlman B, Heilä H, et al: Reductions in postdischarge suicide after de-institutionalization and decentralization: a

nationwide register study in Finland. *Psychiatric Services* 58:221–226, 2007

2. Silverhielm H, Kamis-Gould E: The Swedish mental health system: past, present, and future. *International Journal of Law and Psychiatry* 23:293–307, 2000
3. Suicide rates (per 100,000), by country, year, and gender. May 2003. Geneva, World Health Organization. Available at [www.who.int/mentalhealth/prevention/suicide/suiciderates/en](http://www.who.int/mentalhealth/prevention/suicide/suiciderates/en)
4. Ljung R, Peterson S, Hallqvist J, et al: Socioeconomic differences in the burden of disease in Sweden. *Bulletin of the World Health Organization* 83:92–99, 2005
5. Osby U, Correia N, Brandt L, et al: Time trends in schizophrenia mortality in Stockholm County, Sweden: cohort study. *British Medical Journal* 321:483–484, 2000

## Coming in July

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