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 e-mail address. Letters commenting on 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, at psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (mc.manuscriptcentral.com/appi-ps).

Quality of Care and Implementation Research in Children's Mental Health

To the Editor: The findings reported by Garland and colleagues (1) in the August 2010 issue advance our understanding of quality of care in children's mental health services by characterizing usual care for children with disruptive behavior problems in a public service system. In many cases, quality of care is assessed by determining whether service delivery is concordant with broad-sweeping evidence-based guidelines (2,3). Though this work is undoubtedly important, Garland and colleagues add value and nuance to the discussion of quality through their direct observation of the strategies and techniques that therapists employ to treat children and families.

Their analysis of 1,215 videotaped therapy sessions revealed that therapists use a wide range of therapeutic strategies, some of which are consistent with components of evidence-based treatments. However, the evidence-based components most frequently used were deployed at low levels of intensity, which would not be consistent with evidence-based treatment protocols. This is a sobering picture of the quality of mental health care for these vulnerable children and families, perhaps even more so when we consider that the sequencing of therapeutic strategies was not considered in this study. Indeed, the sequencing of therapeutic techniques may be critical to the effectiveness of evidence-based treatments. For example, in parent-child interaction therapy, it is important to enhance the parent-child relationship before the treatment shifts to teaching and rehearsing the principles and techniques of effective discipline (4). Although it was beyond the scope of this study to examine the sequencing of techniques and the decision-making processes of therapists, it is alarming that the mental health practitioners were not using "tried and true" techniques and more directive approaches in treating disruptive behavior problems. Frankly, children and families deserve better.

Garland and colleagues remind us of how critical it is to have a thorough understanding of systems of care before we attempt to change them and that despite the underutilization of evidence-based treatment approaches in usual care, there are also many strengths on which to build. As the empirical literature continues to highlight the research-practice gap, attention has shifted to developing the science of implementation. Given the exigencies of usual care settings and the barriers to evidence-based practice that seem so pervasive, it is imperative that we develop "empirically-supported strategies to integrate scientific knowledge and effective interventions into everyday use" (5). This requires that we carefully assess the state of usual care, including the potential barriers and facilitators to change, before attempting to design and test strategies to move evidence-based treatments (or treatment components) into real-world service systems.

I applaud *Psychiatric Services* for publishing rigorously conducted studies of quality of care, such as the report by Garland and colleagues, that set the foundation for implementation research in mental health and have the potential to facilitate the transformation of a system of care in dire need of change.

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Depression in a Random Sample of Incarcerated African-American Men

To the Editor: Approximately two million individuals are incarcerated in the United States. Correctional institutions currently house more individuals with serious and persistent mental illness than any other type of U.S. institution (1). Given the disproportionate incarceration of African-American men and the difficulty they experience in accessing mental health treatment services outside of correctional environments (2), insight into their mental health status is critical for informing novel treatment approaches for such a vulnerable population.

This study was conducted between April and August 2008 in one of the

largest maximum-security male correctional institutions in the U.S. The Beck Depression Inventory (BDI) (3) was administered to assess depressive symptoms among 134 randomly selected incarcerated African-American men. Pearson's correlation coefficients (r) were computed to examine relationships between interval and ratio variables; chi square tests evaluated differences between categorical variables. Logistic regression estimated odds ratios (ORs) and associated confidence intervals (CIs) for depression and the following participant characteristics: age, marital status (married or unmarried), education level, probation or parole status when arrested, previous incarceration, total time incarcerated, and sentence received. Participants placed a check mark at the end of a nonsignatory consent form to confirm their agreement to participate. The study was approved by the institutional review boards of the research community and the Department of Corrections. A certificate of confidentiality was received to further protect participants' rights.

Study participants' ages ranged from 25 to 74 years (mean±SD= 42.1±10.8). A majority (80%, N=107) were not married. Eighty-four percent (N=113) possessed at least a high school diploma or GED. Half of the sample (50%, N=67) reported being previously incarcerated. Most (69%, N=92) were currently incarcerated for violent offenses. On average, participants had been incarcerated for 13 years. The mean sentence length was 37.5±25.4 years. Overall, the mean BDI score was 11.22±7.03, an indicator of mild clinical depression according to recommended standards (4). Forty-three percent of the participants (N=57) were classified as clinically depressed. Among the depressed participants, 29% (N=39) were considered moderately depressed, 11% (N=15) were moderately to severely depressed, and 2% (N=3) were severely depressed.

There were several statistically significant differences between participants whose BDI scores were in the depressed range and those whose scores did not meet the depression criterion. [A table presenting data on these differences is available in an online supplement at ps.psychiatryonline.org.] Age was significantly correlated with depression ($r=.18$, $p<.05$); older participants were more likely to experience depression. Participants with at least a high school diploma or GED were more likely than those without a high school education to experience depression ($\chi^2=3.82$, $df=1$, $p<.05$). Participants on probation or parole when arrested were less likely to experience depression than those who were not on probation or parole when arrested ($\chi^2=7.98$, $df=1$, $p<.05$).

Participants with at least a high school education were almost three times as likely as their less educated counterparts to experience depression (OR=2.88, 95% CI=.96–8.59); however, support for this finding was marginal. [See additional table in the online supplement for this analysis]. Being on probation or parole at the time of arrest was associated with lower levels of depressive symptoms (OR=.27, CI=.11–.67).

These findings suggest that corrections officials should consider age, education level, and probation-parole status when adopting treatment approaches. Helping prisoners implement a comprehensive treatment plan that could be used consistently after release could significantly improve the likelihood that they will not be reincarcerated (5), allowing them time to adjust to mainstream society after release.

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Care of Elderly Patients With Functional Disorders: A U.K. Debate

To the Editor: There is an ongoing controversy in Great Britain regarding the care of elderly persons with functional psychiatric disorders who "graduate" from working age into old age and who are traditionally called in Britain "elderly graduates" (1). These individuals often suffer from severe psychotic illnesses. Formerly these patients spent their lives in Victorian mental hospitals, but with the implementation of community care (deinstitutionalization), most now live in the community. The current debate in Britain is in regard to which of the two age-spectrum services—adult general psychiatry or old-age (geriatric) psychiatry—should be responsible for the care of these patients. The Royal College of Psychiatrists in London has suggested that patients should have a needs assessment once they are 65 to determine which of the two services is more appropriate for the individual patient (2).

In a postal survey of 311 consultant

psychiatrists in England, Green and colleagues (3) found that no coherent policy exists to determine which of the two services should look after these patients. During the 2002 annual meeting of the Royal College of Psychiatrists, the college's policy document on the care of these patients (2) was discussed. It was clear from the discussions of that meeting that there is very little research evidence to help decide which service should look after these patients and in what circumstances.

Only a few studies have investigated the needs of elderly patients with functional psychiatric disorders. Our analysis of a representative sample of elderly patients with psychosis in two South London sectors who participated in the PRiSM study (Psychiatric Research in Service Management) revealed problems with use of a needs assessment tool that had been validated with younger adults (4). Jolley and colleagues (2) suggested that each mental health provider should assess the care being delivered in their locality to elderly patients with functional psychiatric disorders when these patients reach the age of transition to the responsibility of specialist old-age mental health care. These authors argued that a needs assessment should be conducted that takes local services and resources into consideration.

We have completed a survey using a novel needs assessment schedule that was developed and validated with elderly patients with functional psychiatric disorders—the EPNS (Elderly Psychiatric Needs Schedule)—which is available from the first author (5). In this study we assessed the needs of an epidemiologically based sample of elderly patients with functional psychiatric disorders who were in contact with either old-age psychiatry or adult general psychiatry. Our objective was to explore which of the two services better meets the needs of these patients. Preliminary results suggested that the patients in contact with old-age psychiatry had significantly fewer unmet needs than those in contact with general adult psychiatry. However, this study had some methodological limitations: because it was conducted in an inner-city London area, the study should be repeated in suburban and rural areas.

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- Jeffrey L. Geller, M.D., M.P.H., re-reviews *The Ethical Way: Challenges and Solutions for Managed Behavioral Healthcare*
- Jerrold M. Post, M.D., reviews *Terrorism: A History*
- Jared Ritter, M.D., and Autumn Ambroday, D.O., review *Connected: The Surprising Power of Our Social Networks and How They Shape Our Lives*
- Caroline Fisher, M.D., reviews *Brain-Based Therapy With Adults: Evidence-Based Treatment for Everyday Practice* and *Brain-Based Therapy With Children and Adolescents: Evidence-Based Treatment for Everyday Practice*
- Kenneth L. Appelbaum, M.D., reviews *Psychiatry in Prisons: A Comprehensive Handbook*