in an educational program that linked mental illness with violence, and actually may have been less likely to support some rehabilitation-based services as a result. Hence, the assertions by D. J. Jaffe (1), Mr. Stanley's colleague at the Treatment Advocacy Center, were not supported in our study: "Laws change for a single reason, in reaction to highly publicized incidences of violence. People care about public safety. I am not saying it is right. I am saying this is the reality."

As policy makers and advocates continue to sift through various opinions about public education and attitudes, they will need more research like this to help them distinguish fact from fiction.

Patrick W. Corrigan, Psy.D.
Amy C. Watson, Ph.D.

Reference

1. Jaffe DJ: Assisted outpatient treatment. Presented at the annual conference of the National Alliance for the Mentally Ill, Chicago, June 30–July 3, 1999

Caring for Young Adults With Mental Illness

To the Editor: Services that are clinically and developmentally specific to young adults with mental illness (and chemical dependence) are essential, as noted by Robert Giugliano (1) in the Open Forum in the April issue (1). Although we agree with much of what Dr. Giugliano recommends, we take issue with his advocacy for establishing a bureau for young adults. This idea appears to be the product of an underlying assumption that having a bureau means achieving results. Partitioning off one age group from another can unintentionally splinter and compartmentalize services and funding. In addition, a highly delimited bureau can create transition problems for patients and agencies after the seven years elapse between the ages of 18 and 25 years—and many young adult patients would be in the system for less than seven years before having to make the transition.

Our approach in New York City does not rely on a bureau. Instead, we identify need, engage in effective planning, and support advocacy for needed services, and on the basis of these efforts we direct funding for populations in need.

Lloyd I. Sederer, M.D.

Dr. Sederer is executive deputy commissioner of the division of mental hygiene services in the New York Department of Mental Health and Hygiene.

Reference

1. Giugliano RJ: The systemic neglect of New York's young adults with mental illness. Psychiatric Services 55:451–453, 2004

In Reply: We appreciate Dr. Sederer's recognition of the long-standing lack of appropriate and adequate housing and clinically and developmentally specific services for young adults with mental illness and co-occurring substance use disorders.

In describing the approach taken by the New York Department of Mental Health and Hygiene (DMHH), Dr. Sederer said, "we identify need, engage in effective planning, and support advocacy for needed services, and on the basis of these efforts we direct funding for populations in need." Who are the "we" in DMHH who are engaged in this approach for young adults? Unless and until there is a "we" for young adults in both DMHH and the New York State Office of Mental Health, this population will continue to be neglected.

The absence of a "we" has resulted in young adults' being worse off now than they were a few years ago when an agency decided to respond to a request for proposals for supportive housing for mentally ill young adults aging out of foster care. The program was poorly designed and underfunded. Not able to manage the young adults and not able to obtain any additional support from DMHH, the agency closed the program and returned the grant to the city. Young adults have less housing and services now than they've ever had.

There are necessary risks involved in change, and the problems of compartmentalization and splintering are certainly preferable to the complete absence of appropriate and adequate housing and services. The absence of an organized and ongoing approach to dealing with young adults has contributed to the major clinical problems this population presents and the fragmentation of the system. The current adult mental health system does not offer appropriate and adequate housing or services for adolescents when they reach age 18.

At Covenant House about 1,000 homeless mentally ill young adults have participated in our mental health day program since 1996, and we have nowhere to send them. These systemic problems are long-standing, but the time has come to actually do something about them. We look forward to working with Dr. Sederer and with the New York State Office of Mental Health to develop strategies for the solution of these problems.

Bruce J. Henry, J.D.
Robert J. Giugliano, Ph.D.

Mr. Henry is executive director of Covenant House in New York City, where Dr. Giugliano is director of mental health.

Should Therapists Give Gifts to Patients?

To the Editor: I appreciated the article "Gifts from Physicians to Patients: An Ethical Dilemma" by David Krassner (1) in the May issue. I commend his candor and his attempt to research a "forbidden" subject.

The psychoanalytic aspect of our education urges us to consider multilayered meanings of any therapist-patient transaction. The dynamic and forensic facets of certain transactions would encourage us to abstain from gift giving in case of misinterpretation by the patient.

In my opinion no blanket rule can realistically be made. The therapist, who has spent time establishing a relationship with the patient, must decide on an individual basis about giving a gift to that singular and unique patient.

Freud wrote about the importance of totems, and Winnicott described transitional objects. Perhaps a gift—

and we're not talking a Rolex here—can help a mind that has heretofore not been able to hold the concept of an object in its absence, and can encourage development.

I have given modest gifts at specific times in treatment, after devoting a great deal of thought to the reasons. I do believe the benefits outweighed the risks.

Sara Epstein, M.D.

Dr. Epstein is affiliated with the Los Angeles County Hospital and the University of Southern California Hospital in Los Angeles.

Reference

1. Krassner D: Gifts from physicians to patients: an ethical dilemma. Psychiatric Services 55:505–506, 2004

In Reply: Many thanks to Dr. Epstein for her comments, which are both gratifying and illuminating. Her observation that there is no blanket rule for such issues is particularly to the point. We are often discouraged from making gifts to patients; further, we are often discouraged from discussing the subject. In breaking this taboo, it was my hope to stimulate discussion of this important issue. I suspect that most clinicians have struggled with the question of whether presenting a gift is appropriate. Surely, Dr. Epstein and I are not alone.

Dr. Epstein's comments also suggest another tantalizing question: could we use gifts for therapeutic purposes? It seems that we might; however, she is correct in noting that there must be specific, well-thought-out reasons for doing so. Certainly seeking consultation or supervision from a colleague is one way to guard against inappropriate behavior.

David Krassner, M.D.

Logical Fallacy?

To the Editor: In his interesting column on evidence-based treatments in the May issue, Dennis Morrison (10) gives us a clear example of a logical fallacy often seen in the evidence-based arena. Dr. Morrison states, "[T]he board of directors of CBH issued the following mandate, 'The Center will operate only those mental health treatments, services, and programs for which there exists evidence in the professional literature of their efficacy.' " Later in the piece, he begins a sentence as follows: "When the board . . . issued its directive that we provide only treatments that work . . . ." (Who wishes to provide treatments that don't work?) This is a shining example of the common error of interpreting "not proven effective" as "proven ineffective."

Douglas A. Puryear, M.D.

Dr. Puryear is in private practice in Santa Fe, New Mexico, and on the clinical faculty of the University of New Mexico Medical School.

Reference

1. Morrison D: Real-world use of evidence-based treatments in community behavioral health care. Psychiatric Services 55:485–487, 2004

In Reply: The sentence quoted by Dr. Puryear should have read, "When the board . . . issued its directive that we provide only treatments that are proven to work."

I do not assume that ineffectiveness is synonymous with lack of evidence. Indeed, the "common factors" model suggests that a very large proportion of psychotherapy outcomes can be attributed to factors common among clinicians, not technique. The problem is that payers and the public want evidence in the form of demonstrable outcomes from treatments that can be replicated for predictable costs. The challenge to providers is to prove that their treatments are effective regardless of how they are delivered. Fully implementing evidence-based treatments is just one way to do so.

In an article in the June 2003 edition of *Behavioral Healthcare Tomorrow,* I argue that an alternative use for evidence-based treatments is to accept the outcomes they yield as a "gold standard." Providers would then compare their clinical outcomes with those demonstrated by evidence-based treatments without regard to how the treatment was rendered. In doing so, providers could prove that their treatments are clinically equivalent to evidence-based treatments for similar populations. A unique contribution of using evidence-based treatments is that they provide control over the process—and therefore the cost—but if clinicians monitor cost as well as outcome, they are often able to show financial equivalence as well. This alternative allows clinicians to practice however they please but still demonstrate the effectiveness and efficiency of their treatments compared with an external standard.

Dennis Morrison, Ph.D.

Reference

1. Morrison D: Use caution with evidence-based treatments in systems of behavioral healthcare. Behavioral Healthcare Tomorrow 12(3):37–41, 2003