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).

Florida's Outpatient Commitment Law: Effective but Underused

To the Editor: In the Law & Psychiatry column in the January 2008 issue—"Florida's Outpatient Commitment Law: A Lesson in Failed Reform?"—Petrila and Christy (1) questioned the success of outpatient commitment by speculating about reasons that it is underused. Although outpatient commitment is used relatively infrequently, the more accurate measure of the effectiveness of a treatment mechanism is how well it works to improve patient outcomes.

Outpatient commitment—sometimes called assisted outpatient treatment—is a court order combined with outpatient treatment for individuals with severe psychiatric disorders. It is available in 42 states. Research on outpatient commitment has shown it to be effective in dramatically decreasing rates of both hospitalization and incarceration. For example, in North Carolina over one year, outpatient commitment decreased average hospital days per patient by 36% (2) and arrest rates by 73% (3). In New York, assisted outpatient treatment decreased average hospital days per patient by 56%, and the number of patients who experienced incarceration was reduced by 87% (4).

Since Florida passed its first outpatient commitment law in 2004, about half of the orders issued under the law have been in Seminole County. In June 2005 a pilot outpatient commitment program was implemented in Seminole County organized by the Seminole Community Mental Health Center and the Seminole County Sheriff's Office. A program coordinator was hired, but otherwise the program used existing services and resources and took advantage of an excellent relationship between the mental health center and local law enforcement.

During the 18-month pilot program, 51 patients were referred for consideration, 45 petitions were filed, and 36 petitions were approved, which meant that 36 patients were ordered into the program by the court. At the end of 18 months, complete data were available for 21 patients, all of whom had been in the program for six months or longer. Total psychiatric hospital days and jail days were compiled for each patient for two periods—the patient's time in the program and an identical length of time before the patient entered the program.

The average number of hospital days per patient decreased from 64.0 to 36.8, a 43% decrease. The savings in hospital costs averaged $14,463 per patient or a total of $303,728 for the 21 patients. The average number of days incarcerated per patient decreased from 16.1 to 4.5, a 72% decrease. The cost per day for an inmate with medical costs in the Seminole County Jail is $59. Thus the total cost avoided for the 21 patients was $14,455.

These results, like those of previous studies, demonstrate that outpatient commitment, when used for selected individuals with serious psychiatric disorders, significantly reduces the time spent hospitalized and incarcerated. For mental health administrators looking for ways to improve psychiatric treatment and reduce costs, outpatient commitment should be used more often.

Rosanna Esposito, J.D.
Valerie Westhead, M.D.
Jim Berko

Ms. Esposito is affiliated with the Treatment Advocacy Center, Arlington, Virginia. Dr. Westhead and Mr. Berko are with Seminole Community Mental Health Center, Fern Park, Florida.

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In Reply: We agree that outpatient commitment can work in some circumstances for some individuals. However, as we noted in our column, outpatient commitment statutes are rarely used in California and in Florida, and there are significant barriers to their use in many other states (1). Given that outpatient commitment often has been portrayed as a panacea, it is important for policy makers to begin to understand why it is used so sparingly in many jurisdictions.

One obvious reason is a lack of adequate resources. As Swartz and colleagues (2) observed in reporting on outcomes from North Carolina's experience, "Outpatient commitment can improve treatment outcomes when the court order is sustained and combined with relatively intensive community treatment. A court order alone cannot substitute for effective treatment in improving outcomes." New York State invested vast new re-

sources in its publicly funded mental health system when it enacted Kendra's Law. However, in most states, funding for community services on a per capita basis has been flat, at best, over the past few years, and fragmentation and erosion of existing service capacity are the rule more than the exception. In such a service environment, statutory change is unlikely to have more than a marginal impact from a systemic perspective.

The results reported from Seminole County are important, though it would be helpful if they were presented more fully in a venue in which the underlying data could be examined more closely. It would also be interesting to know more about individuals enrolled in the program who did not do well and the reasons for a lack of success. There is no question, as Esposito and her colleagues observe, that outpatient commitment can be very helpful for some individuals. However, there is also no question that if it is going to be adopted as a tool for system change, we need to know much more about the practical reasons it appears to be so often ignored.

John Petrila, J.D., LL.M.
Annette Christy, Ph.D.

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Special-Needs Soldiers in Israel: Another View

To the Editor: In a column in the November issue, "Efforts to Support Special-Needs Soldiers Serving in the Israel Defense Forces," Bodner and colleagues (1) claimed that "providing treatment and support to special-needs populations can decrease psychopathology and suicide rates." Their argument is based on a case study of MACAM (the acronym for the title in Hebrew of the Center for the Advancement of Special Populations). MACAM is a unique program for "special populations" recruited into the Israeli army. Bodner and colleagues' column draws heavily on my own work, which explores what I term "institutional ethnopsychology" in Israel (2).

My use of the term ethnopsychology follows its use by Gaines (3), which should be distinguished from its more common usage in psychological literature as folk psychology (see Lillard [4]). As I apply it, "institutional ethnopsychology" refers to rehabilitation programs that are directed at managing selected ethnoclass groups. In contrast, the psychological rationale for ethnopsychological models is fused with popular wisdom and cultural beliefs about social difference. Standard ethnopsychological programs treat sociocultural attributes "as cognitive, emotional, behavioural and structural characteristics of the individual . . . abstracted from the individual's social, economic, cultural and political context" (2). The models are normally applied by teachers, social workers, youth counselors, and others rather than by psychologists or psychiatrists. However, by focusing on an individual's disorders and pathologies, the models obscure the role of socioeconomic, cultural, and political forces in shaping social difference and hierarchies.

My article showed how culturally ingrained beliefs about the Mizrahi population (Jews of Middle Eastern and North African origin) are integrated into the therapeutic discourse and the logic of practice applied in the MACAM program (1). In my case, over 95% of MACAM participants were of Mizrahi origin and from disadvantaged neighborhoods. My analysis of ethnopsychology in the MACAM program thus referred to a set of beliefs about soldiers rather than to literal descriptions of the soldiers' condition. As presented in the column by Bodner and colleagues, my analysis has been substantially misread and misinterpreted, with these authors depicting MACAM soldiers as a group of random individuals suffering from mental disorders rather than a distinct ethno-class group suffering from social exclusion and marginalization.

Bodner and colleagues' omission of the soldiers' ethnicity from their text is particularly striking given that their subject—suicide rates among special populations—has been closely linked to ethnicity (5). This blind spot raises interesting and relevant issues for readers of *Psychiatric Services.* One issue is the relevance of class, ethnicity, and social context to suicide rates. A second is the denial of ethnicity in a national therapeutic discourse and the resulting therapies. Third, ethnicity's absence provides an intriguing case of what happens when knowledge crosses disciplinary boundaries. In this instance, salient sociopolitical dimensions were filtered out. These issues hint at how much my work has been distorted in the transition. The impact of such issues on theory and practice deserve, I believe, further attention in *Psychiatric Services.*

Nissim Mizrachi, Ph.D.

Dr. Mizrachi is with the Department of Sociology and Anthropology, Tel Aviv University, Israel.

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In Reply: Dr. Mizrachi suggests that we may have misinterpreted his work, and he reemphasizes the importance of ethnopsychological analysis. We appreciate his comments, and we are not in any disagreement with the pos-

sible importance of ethnicity. However, this issue was not the focus of our recent work.

Specifically, Mizrachi suggests that "Bodner and colleagues' omission of the soldiers' ethnicity from their text is particularly striking given that their subject—suicide rates among special populations—has been closely linked to ethnicity." It is our opinion that the ethnicity factor is not relevant to this specific work. To explore the effects of intervention on rates of suicide (rather than rates of suicide attempts as in the study Mizrachi mentioned), we employed the classification method used by the Israeli Defense Forces (IDF). The IDF uses valid and reliable criteria to identify recruits who may develop adjustment difficulties (not major psychiatric disorders as per Mizrachi's comment) during their service and to classify them into distinct categories. We described these criteria in our column and elsewhere (1); the criteria have also been used in other studies (2).

Although, as Mizrachi notes, "the relevance of class, ethnicity, and social context to suicide rates" is an important issue, it may be irrelevant to our investigation and is by no means supported or refuted by our findings. It is interesting that Mizrachi suggests that we deliberately ignored the issue of ethnicity and that investigations of social issues should not be the realm of psychologists and psychiatrists. We submit that we have no data about the proportions of members of different ethnic groups, either in the MACAM group or in the other classification groups described in our column. We also strongly suggest that collaborative work among scientists in different areas of social, psychological, and medical sciences has a significant advantage because it broadens perspectives and forms more integrative frameworks of thought.

Ehud Bodner, Ph.D.
Haim Einat, Ph.D.

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Smoking Bans in Long-Term Inpatient Settings: A Dilemma

To the Editor: Recent nationwide initiatives to ban smoking in state psychiatric hospitals, although laudatory in many respects, pose a dilemma when applied coercively to a class of patients whose lengths of stay are indeterminate—that is, to patients for whom the institution has become home. Neither state legislatures nor the U.S. Congress have yet passed statutes regulating smoking in individuals' homes; such measures have thus far been limited to public settings. Is there a valid rationale that can be used to justify this selective imposition? Put another way, why is it that I can smoke in my home, you can smoke in your home, but long-term residents of psychiatric institutions cannot smoke in their homes? If self-determination, equity, and respect are core principles of recovery, what justifies this selective suspension?

One is reminded of C. S. Lewis' quote: "Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. It would be better to live under robber barons than under omnipotent moral busybodies. The robber baron's cruelty may sometimes sleep . . . but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience."

Three caveats are in order. First, any policy that permits even limited smoking must respect the right of nonsmokers not to be exposed to second-hand smoke. Second, restrictive policies should be applied equitably (that is, either to all or on a case-by-case basis according to established principles); or if a specific group is subject to differential treatment, the basis upon which this discrimination is made must be explicated. Third, this argument applies only to patients for whom the institution has become home and for whom no viable and clinically appropriate residential alternative currently exists; patients who require short- or intermediate-term hospitalization for clearly defined purposes are not included.

To be clear, this is not a "right to smoke" issue. The issue is: Is there just cause to grant a specific class of individuals the right to smoke in their homes while depriving another class of individuals that same right solely on the basis of the fact that this "second class" has the distinction of being mentally disabled and residing in long-term institutional settings?

The conflict is between two sets of values: tobacco cessation and wellness on the one hand and "enlightened" paternalism (versus client choice) on the other. In other words, "we 'normal' people can tell you mentally disabled people what is good for you and insist upon your compliance, even if some of you do not agree and even if we don't apply these same rules to ourselves." As Orwell observed in *Animal Farm,* "All animals are equal, but some animals are more equal than others."

Martin Luther King, Jr., in his "Letter From Birmingham Jail," distinguished between just and unjust laws: "An unjust law is a code that a numerical or power majority group compels a minority group to obey but does not make binding on itself. . . . [A] just law is a code that a majority compels a minority to follow and that it is willing to follow itself."

Despite intentions that are understandable—intentions that might even be called beneficent—the unilateral imposition of smoking bans on long-term residents of psychiatric institutions is not consistent with our core values.

Kenneth Marcus, M.D.

Dr. Marcus is medical director of the Connecticut Department of Mental Health Services and Addiction Services, Hartford, and lecturer in psychiatry, Yale University School of Medicine, New Haven, Connecticut. The opinions expressed are those of the author and do not reflect the policy of the Connecticut Department of Mental Health and Addiction Services.

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