

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 Boulevard, Suite 1825, MS#4 1906, Arlington, Virginia 22209-3901; fax, 703-907-1095; e-mail, psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (<http://appi.manuscriptcentral.com>).

Reinventing Evidence-Based Interventions?

To the Editor: Although I have long admired the contributions of Dr. Sullivan, "The Role of Services Researchers in Facilitating Intervention Research" (1) and the supporting commentary by Dr. Druss (2) in the May issue are potentially harmful. The authors argue that evidence-based interventions designed by "top-down" researchers are not sustained because frontline clinicians have not had an active role in their development and evaluation. Unless the clinicians participate in the design and testing of an intervention through "bottom-up" research, implementation ends when research funding ends. The authors advocate for bottom-up research initiated by clinicians, relegating researchers to a facilitative role.

If this approach were carried to its logical conclusion, each mental health facility would develop its own bottom-up interventions that, by definition, could not be independently replicated or disseminated without becoming a top-down ap-

proach. Aside from an unsupported cost, each facility would reinvent its practice on a recurrent basis in the face of high staff turnover. Patients would continue to find themselves subject to idiosyncratic approaches of minimally established efficacy.

Dr. Druss, in turn, creates false dichotomies between top-down and bottom-up investigative approaches: rigor versus relevance, expertise versus practicality, and fidelity versus flexibility (2). In my experience, every top-down approach worth its salt is also relevant, practical, and flexible. Our own recent contributions are illustrative (3,4). Beyond an overly subjective definition of "evidence" and an epistemologic contortion regarding the production of evidence, Dr. Druss claims that evidence-based interventions need to be "reinvented" in order to accommodate different patients, providers, and organizations as well as financing and regulatory systems. "Invalidated" seems a better descriptor of the process. Where is the evidence that efficacious, top-down interventions don't work, as designed, in the real world? Even a cursory pass through the effectiveness literature on psychosocial treatment would suggest that effects most often equal or exceed those found in efficacy studies.

There are far more plausible causes of implementation failure (5) than clinicians' noninvolvement in the creation of evidence-based interventions, including an absence of dedicated funding and psychiatric leadership. In my experience, clinicians in public mental health facilities have had little or no influence on choice of interventions. Most hold a bachelor's degree or less. Typically, clinicians provide what administrators require—"services" that are able to be reimbursed, regardless of efficacy. If insurers recoil against reimbursing broadly replicated, evidence-based interventions, imagine how they would view the unique, unreplicated, and equivocal practices of individual agencies.

Finally, these articles do not accurately depict how top-down interventions are developed. Those known to me arose from a relevant, lengthy, and often in-depth, clinical experience. Theoretically grounded practice principles increasingly reflect the etiopathology of the disorder in question (3,4), an integration of theory and practice rarely seen in agency-initiated clinical research. The real question raised by Drs. Sullivan and Druss is whether the country will continue to inadequately treat the mentally ill by consigning them to the whimsy of idiosyncratic experimentation or ethically treat them with the evidence-based interventions of established efficacy and effectiveness that currently exist.

Gerard E. Hogarty, M.S.W.

Mr. Hogarty is professor of psychiatry at the Western Psychiatric Institute and Clinic of the University of Pittsburgh Medical Center.

References

1. Sullivan G, Duan N, Mukherjee S, et al: The role of services researchers in facilitating intervention research. *Psychiatric Services* 56:537-542, 2005
2. Druss BG: Medicine-based evidence in mental health. *Psychiatric Services* 56:543, 2005
3. Hogarty GE: *Personal Therapy for Schizophrenia and Related Disorders: A Guide to Individualized Treatment*. New York, Guilford, 2002
4. Hogarty GE, Flesher S, Ulrich R, et al: Cognitive enhancement therapy for schizophrenia: effects of a 2-year randomized trial on cognition and behavior. *Archives of General Psychiatry* 61:866-876, 2004
5. Milne D, Gorenski O, Westerman C, et al: What does it take to transfer training? *Psychiatric Rehabilitation Skills* 4:259-281, 2000

In Reply: Professor Hogarty takes issue with the approach we presented in our article describing the VA South Central MIRECC Clinical Partnership Program. We certainly agree that if our proposal results in "consigning [the mentally ill] to the whimsy of idiosyncratic experimentation," this would be dangerous indeed.

However, Professor Hogarty has misunderstood our main point—namely, that a balance between top-down and bottom-up approaches will enhance the success of evidence-based medicine. We are not advocating for discontinuation of the time-honored approach of researchers' generating evidence. Researchers should continue to expand this evidence base, and effective treatments should be disseminated and utilized in everyday care. The introduction of the bottom-up approach is meant to help expand this evidence base by bringing in frontline clinicians as partners.

Although research has produced a repertoire of efficacious treatments rooted in evidence, a majority of persons who have mental disorders do not enter treatment (1), and those who do are unlikely to receive care that is based on evidence (2). Quality improvement interventions have been reasonably successful in implementing evidence-based practices and demonstrating reduced costs, yet they have usually not been sustained or disseminated (3). One of many reasons for their less than optimal success is that clinicians sometimes resist them, often feeling that the interventions are imposed upon them.

As services researchers have struggled to devise ways to improve uptake and sustainability of evidence-based interventions, we have turned to other disciplines, such as marketing and organizational psychology, for new ideas. The partnership program drew primarily from the bottom-up models put forth by Dr. Duan (4) and community-participatory research (5). By drawing from these models, we do not seek to replace the traditional way of generating evidence but, rather, to identify new approaches that might prove useful. Community-participatory research has shown that involvement of multiple stakeholders often results in a higher likelihood of sustainability. Providers are key stakeholders and critical partners in the diffusion of new practices. We disagree with Professor Hogarty's state-

ment that "clinicians in public mental health facilities have had little or no influence." Although clinicians' hands might be tied by formularies and other factors, they do exercise an important influence over the care that is provided and its delivery. It has been our experience in the VA that if local providers advocate for a practice it is far more likely to be sustained than if they do not.

In emphasizing the distinction between top-down and bottom-up approaches we may have inadvertently created a false dichotomy. We meant to portray the two approaches as complementary. As Professor Hogarty notes, all interventions, whether initiated by researchers or by clinicians, begin from the bottom up. Like any other research project, each of the interventions in our program arose from clinical experience and out of the desire to improve patient care, and each is being evaluated in terms of outcomes.

An important outcome of this project is that we have formed partnerships with clinicians. Researchers in academic centers often do not appreciate the tensions that exist between clinicians and researchers in usual care settings. We view the development of trust and understanding between clinicians and researchers as a major accomplishment that will serve us well in future efforts to improve the quality of care.

Greer Sullivan, M.D., M.S.P.H.

Naihua Duan, Ph.D.

JoAnn Kirchner, M.D.

Kathy L. Henderson, M.D.

References

1. Kessler RC, Berglund P, Demler O, et al: The epidemiology of major depressive disorders: results from the National Comorbidity Survey Replication (NCS-R). *JAMA* 289:3095–3105, 2003
2. Wang PS, Berglund PA, Kessler RC: Recent care of common mental disorders in the US population: prevalence and conformance with evidence-based recommendations. *Journal of General Internal Medicine* 15:284–292, 2000
3. Wells KB, Sherbourne C, Shoenbaum M, et al: Impact of disseminating quality improvement programs for depression in managed primary care. *JAMA* 283:212–220, 2000

4. Duan N, Gonzales J, Braslow J, et al: Evidence in mental health services research: what types, how much, and then what? Presented at the National Institute of Mental Health 15th International Conference on Mental Health Services Research, Washington, DC, April 1–3, 2002
5. Community-Based Participatory Research: Assessing the Evidence. AHRQ Publication no 04-E022-2. Rockville, Md, Agency for Healthcare Research and Quality, July 2004. Available at <http://ahrq.gov/clinic/cbprinv.htm>

Barriers to Mental Health Treatment After Disasters

The literature about barriers to public mental health treatment after a disaster remains sparse. In this letter we present data to address two questions: Are perceived barriers to mental health treatment different after a disaster than they are during less exigent times? And does the implementation of a public mental health program alter perceived barriers to mental health treatment after a disaster?

The findings are part of a larger study designed to assess the mental health consequences of the September 11, 2001, attacks (1). A random sample of 832 residents of the New York City metropolitan area were interviewed approximately two years after the September 11, 2001, attacks. Respondents were read the following statement: "I'm going to read you some statements about people who needed help for problems with emotions or nerves or problems with their use of alcohol or drugs after the World Trade Center disaster. Then I will ask you to compare them to people who need professional help [during other times]." We then asked, "Would you agree or disagree that many people who needed professional help for problems with their emotions or nerves or problems with their use of alcohol or drugs after the World Trade Center disaster [did not know how to get help]?" After a response to this question was given, the question continued by asking if this barrier also affected mental health treatment in general.

The sequence continued in this way for five additional barriers: thought they could take care of the problem themselves, were too overwhelmed to get help, were worried about people thinking less of them for getting help (a stigma-related concern), did not have the money to pay for it, and were worried about taking the spot of somebody who needed help more than they did. We also asked if respondents were aware of Project Liberty, a statewide public mental health outreach program implemented after the September 11, 2001, terrorist attacks.

Two-tailed chi square tests were used to compare the responses about barriers before and after the September 11 attacks and to examine whether respondents who had knowledge of Project Liberty perceived fewer barriers to mental health treatment after the attacks than respondents with no knowledge of the program. A *p* value of .05 or less was considered significant.

Statistically significant differences were found for three of the six barriers. Respondents were more likely to agree that people were too overwhelmed to seek help after the attacks (616 respondents, or 74 percent) than during other non-disaster times (541 respondents, or 65 percent). Respondents were also more likely to agree that people were concerned about taking the spot of somebody who needed the services more after the attacks (391 respondents, or 47 percent) than during other non-disaster times (300 respondents, or 36 percent). By contrast, stigma-related concerns were believed to be less prevalent after the attacks (391 respondents, or 47 percent) than during other non-disaster times (466 respondents, or 56 percent).

Respondents who had heard of Project Liberty (474 respondents, or 57 percent) were less likely than those who had not to say that a lack of knowledge about how to get treatment was a problem in the post-disaster period (289 respondents, or 61 percent, compared with 247 respondents, or 69 percent). Respondents

who had knowledge of Project Liberty were less likely than those who did not to say that stigma was a barrier after the September 11 attacks (209 respondents, or 44 percent, compared with 193 respondents, or 54 percent).

On the basis of a random sample of New York City residents who were interviewed two years after the September 11 attacks, perceived barriers to mental health treatment appear to be different after a disaster than during other times. Awareness of Project Liberty appears to have lessened concerns about stigma and cost. Future studies should examine barriers to mental health treatment among persons who used mental health services before and after a major disaster.

Jennifer P. Stuber, Ph.D.
Sandro Galea, M.D., Dr.PH.

Dr. Stuber is a Robert Wood Johnson Health and Society Scholar at Columbia University in New York. Dr. Galea is with the Center for Urban Epidemiologic Studies at the New York Academy of Medicine in New York and with the department of epidemiology at Columbia University in New York.

Reference

1. Galea S, Vlahov D, Resnick H, et al: Trends of probable post-traumatic stress disorder in New York City after the September 11 terrorist attacks. *American Journal of Epidemiology* 158:514-524, 2003

Inclusion of Mental Health Consumers on Research Teams

Mental health consumers have moved from being passive recipients of care to being involved in a range of active roles both within the mental health system and in consumer-run agencies (1). Although studies have examined consumer inclusion in the mental health system, they have historically been conducted with little or no consumer input into the research process (2).

This trend is in opposition to the philosophical stance of the mental health consumer movement, which calls for inclusion at all levels of

mental health treatment, including research. As members of research teams, consumers can help to ensure that research is sensitive to their needs, concerns, and desired outcomes (3,4). Several studies have proposed a continuum of roles for consumers in the research process. For example, Kaufmann (2) offered several roles for consumers in research, ranging from the traditional scientific model of research in which the consumer is passive and not involved in the larger research issues of design and implementation to the full inclusion of mental health consumers in planning, implementing, and analyzing the studies. Particular emphasis is placed on consumer review, approval, and voice in the research process.

Although studies have called for more consumer inclusion on research projects, no empirical evidence has been presented about current levels of inclusion. Therefore, we examined mental health literature published in 2001 and 2002 and asked the following question: Are consumers being included on research teams?

All journals that make up the broad field of mental health in the annual Social Science Citation Index Journal Citation Report (JCR) were part of this study's sampling frame. After careful review, the JCR subdisciplines selected for this study were health policy and services; nursing; psychiatry; clinical psychology; multidisciplinary psychology; public, environmental, or occupational health; and social work.

Within these subcategories, the investigator determined whether the journals were appropriate for the study. Appropriate journals included applied mental health services research on populations with severe mental illness. For example, psychiatric journals that primarily report on neurobiological studies were excluded, because consumer involvement in these types of studies is not to be expected. Fifty-one journals were selected on the basis of these criteria; three journals were excluded because of lack of institu-

tional access, leaving 48 journals for inclusion in the study.

Once the journals were selected, research assistants looked at randomly selected issues for the years 2001 and 2002. These years were selected as the most recent completed years at the time the study began in early 2003. Approximately one-quarter of all available issues for each journal were surveyed with a random selection process. After extensive training, the assistants determined how many studies included consumers and at what level consumers were included. The study excluded any articles that were not direct-service studies, such as conceptual studies, thought pieces, meta-analyses of previously published data, or editorials.

Consumer inclusion was operationalized as any study that mentions consumer involvement in the methods section. This involvement may consist of being given the results of the study, in development or administration of scales, as investigator, or in some other manner, based on the roles cited in the literature discussed above. The research assistants used a form developed by the primary investigator to rate the level of inclusion for each article in the journals.

Only 6 percent of the articles selected for our study (16 of 250) explicitly stated in the methods section that mental health consumers were involved at some level with the research project. A flaw of this study is the assumption that the methods section would state whether mental health consumers were included on the research team. A better method would be to directly contact the lead author of each report to determine whether consumers were included.

This small-scale study found that consumers are not widely included on mental health research teams. If future studies replicate these findings, the implications are then clear that research on such a highly personalized and unique phenomenon as severe mental illness is in dire need of more consumer input on research teams. Consumers have become increasingly involved in all oth-

er aspects of the mental health system, but it seems likely that they are still not being systematically included in research on their own illnesses and services for these illnesses. Giving consumers a voice in the research context is a first step toward a more sensitive set of outcome goals and measurements for the field (5). Researchers can help this process both by including mental health consumers on their research teams and by explicitly identifying that they have done so in the methods sections of their research reports.

John Q. Hodges, Ph.D., M.S.W.

Dr. Hodges is affiliated with the School of Social Work at the University of Missouri–Columbia.

References

1. Solomon P: Peer support/peer provided services: underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal* 27:392–401, 2004
2. Kaufmann C: Roles for mental health consumers in self-help group research. *Journal of Applied Behavioral Science* 29:257–271, 1993
3. Griffiths K, Jorm A, Christensen H: Academic consumer researchers: a bridge between consumers and researchers. *Australian and New Zealand Journal of Psychiatry* 38:191–196, 2004
4. Kaufmann C, Campbell J: Voice in the mental health consumer movement: an examination of services research by and for consumers, 1994. Available at <http://mimh200.mimh.edu/mimhweb/pie/database/getarticle.asp?value=105>
5. Wykes T: Blue skies in the Journal of Mental Health? Consumers in research. *Journal of Mental Health* 12:1–6, 2003

Guidelines for Behavioral Emergencies

The current emphasis on psychiatric treatment in the least restrictive setting has led to a decrease in the number of inpatient psychiatric beds. The number of episodes of psychiatric care has more than doubled since 1970. In addition, payment for psychiatric management is frequently in proportion to a patient's "dangerousness" rather than to the severity of mental illness. The result of the three trends is a large number of episodes of psychiatric

emergency care and a higher concentration of aggressive psychiatric patients in emergency settings (1).

The Expert Consensus Guidelines on behavioral emergencies that were published in 2001 (2) provided a needed starting point for standardization of treatment in this area—treatment that is based on empirical evidence. However, more data on strategies in use and their outcomes need to be gathered before a more definitive, evidence-based approach can be developed. One of the areas of study recommended by the expert panel is the influence of race, ethnicity, and culture. Our group attempted to shed some light on this area by assembling two additional expert panels from outside North America, one from Italy and one from countries of the former Soviet Union.

In order to maximize the value and comparability of our data, we attempted to follow the methods used by the North American expert panel. We used the same questionnaire (translated into Italian and Russian) and mailed it to recognized experts in emergency psychiatry. A comparison of the three different sets of consensus guidelines reveals some similarities, which help legitimize some aspects of the original guidelines.

Treatment approaches on which all panels agreed form a core of practices on which psychiatrists who manage behavioral emergencies can rely, because they are embraced (and therefore presumed effective) by three expert panels operating in very diverse settings. One of the strategies on which all three panels agreed unanimously was the preference for intravenous formulations of antipsychotics and benzodiazepines because of the rapidity of onset. They also agreed that the first choice among intramuscular formulations should be a second-generation antipsychotic, because of its superior efficacy and safety profile compared with first-generation antipsychotics and benzodiazepines.

However, some differences between the guidelines are thought provoking and may ultimately spark discussion that leads to more refined

practice in this area of psychiatric care. In defining the short- and long-term goals of intervention in an acute crisis, the Italian and North American panels cited the control of aggressive behavior as the primary goal. However, the panel from the former Soviet Union countries felt that cooperation with the patient should be the primary goal of any intervention.

More analysis is needed in the areas of disagreement to ascertain the reasons for these differences and to determine which strategy is indeed optimal in a given setting. Our hope is that these results will carry forward the impetus that began with the publication of the original North American guidelines in 2001 and that more administrators and clinicians will allocate the time and resources needed to further refine evidence-based protocols for managing behavioral emergencies. More information on the Italian and former Soviet Union panels is available at www.psyter.org.

Mario Di Fiorino, M.D.
Arman Danielyan, M.D.
Alfredo Gemignani M.D.

Dr. Di Fiorino and Dr. Gemignani are affiliated with the department of psychiatry at Versilia General Hospital in Lido di Camaiore, Italy. Dr. Danielyan is affiliated with the National Institute of Mental Health in Yerevan, Armenia.

Reference

1. Di Fiorino M, Danielyan A, Yevchuk S, et al: The clinical management of the aggressive patient in behavioural emergency: some differences between Italy, North America, and former Soviet Union. *Bridging Eastern and Western Psychiatry* 3:16–23, 2005. Available at www.psyter.org

2. Allen MH, Currier GW, Hughes DH, et al: The Expert Consensus Guideline Series: treatment of behavioral emergencies. *Postgraduate Medicine* 110(special no):1–88, 2001

Psychiatry and the Recovery Process

To the Editor: I read with interest the commentary by Wesley Sowers, M.D., in the June Taking Issue, in which he describes how the scope of psychiatry has narrowed and calls on psychiatrists to “reclaim” psychiatry by moving in the direction of consumer- and family-driven, recovery-oriented services. From the perspective of many psychiatrists, what happens in an acute care facility is that symptoms are treated with a direct and unambiguous application of logical, rational, scientific, empirical, and objective psychopharmacologic procedures that are well known and that require little more than routine effort to carry out.

However, this perspective cannot possibly lead to a client’s recovery. Clients do not get better simply by sitting idly by and waiting for medications to take effect. The predominant processes in an individual’s progression toward recovery occur in the arenas of subjectivity and irrationality. The client who perceives that something strictly rational, rather mechanical, and routinely procedural is occurring is not sufficiently involved in the mysterious aspects that need to take place in order for the client to leave the hospital with the hope of adopting a new and healthier approach to life. This person is likely to

experience relapse in the near future. To accomplish a change of “people, places, and things,” as the 12-step literature describes, an individual needs support in developing skills in several areas—community living, social, recreational, educational, and vocational skills—so that the individual’s environment can become different from the one that precipitated the decompensation.

From the professional’s point of view, the action of treatment is confined to the brain, while to the client, the actions of significance occur in the mind. Whereas the study of the brain is largely a science, the study of the mind cannot be purely scientific, because free will operates within the realm of the mind. Free will, quite clearly, cannot be reduced to a strictly rational or mechanical process that is subject to scientific analysis. To act as if the mind can be scientifically determined is to seek to end free will on the client’s part.

What I believe is lacking in much acute psychiatric services is attention to the client’s spirit. An honest and sincere attention to spirit involves a critical contemplation of the “riddle of life,” the aspects of self that are mysterious and enigmatic. Such considerations are what make recovery a spiritual as opposed to scientific venture. In a spiritual venture, subjective, experiential, irrational, and emotional processes are more central than empirical, rational, and highly objective processes.

Alan Lunt, M.S.

Mr. Lunt, who lives in Boonton, New Jersey, is a consumer of mental health services.