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).

Hargrave v. Vermont and the Quality of Care

To the Editor: Paul S. Appelbaum's column (1) on psychiatric advance directives in the July issue of *Psychiatric Services* suggests that the sky is falling in the wake of the U.S. Court of Appeals decision in the *Hargrave v. Vermont* case. The court's modest conclusion—that Vermont cannot discriminate against people with psychiatric disabilities when it comes to expressing binding preferences for their treatment should they become incapable of making such decisions in the future—merely extends coverage of the Americans With Disabilities Act to an area that has been the exclusive domain of psychiatrists.

That Dr. Appelbaum finds the *Hargrave* decision so potentially cataclysmic says more about the profession of psychiatry and its uneasiness about consumer input than anything else. Change can be unsettling, but, as last year's report of the President's New Freedom Commission on Mental Health reminds us, transforming the existing mental health system depends on adopting a new vision of recovery in which a partnership of personalized care is central.

The commission's final report (2) states: "This partnership of personalized care means basically choosing who, what, and how appropriate health care will be provided . . . sharing in decision making, and having the option to agree or disagree with the treatment plan."

Far from being the end of high-quality public mental health care, the *Hargrave* decision may be a fresh beginning. When mental health professionals can no longer automatically override a consumer's wishes—especially with respect to psychotropic medications—they may have to resort to other tools, such as trust building, peer support, talk therapy, and other naturalistic supports that have been shown, by the late Loren Mosher and others (3), to be successful in helping people with psychiatric disabilities achieve long-term recovery and greater satisfaction with their quality of life.

As always, the Bazelon Center stands ready to help realize this new vision for public mental health in which the goal of high-quality outcomes and respect for consumer choice guide treatment decisions to promote recovery.

Michael Allen

Mr. Allen is senior staff attorney at the Bazelon Center for Mental Health Law in Washington, D.C.

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In Reply: Michael Allen's letter is misleading in several respects. Although he appears to offer an independent comment on the decision in *Hargrave*, in actuality the Bazelon Center was deeply involved in the case. Not only did the Bazelon Center participate as amicus curiae, but (as noted in its annual report) it also actively recruited former state mental health commissioners to write a second amicus brief, both facts oddly omitted from Allen's letter. Thus the letter represents a continuation of the Bazelon Center's advocacy in the case—here trying to spin the outcome into something more palatable to mental health professionals.

To be clear about the nature of the court's decision, *Hargrave* allows persons with mental illness who complete advance directives to preclude any future involuntary treatment with medications, even if they are involuntarily committed. Previous court decisions and statutes recognizing a right to refuse treatment have proven workable only because they uniformly allow refusals to be overridden, either after additional review for appropriateness or when patients are found incompetent. *Hargrave* changes all that, at least in the Second Circuit. Only Jonathan Swift could call this a "modest conclusion."

Although the opinion is quite sweeping in its implications, its actual impact remains to be determined. Hence, Mr. Allen's assertion that I characterized the decision as "potentially cataclysmic" and evidence that "the sky is falling" suggests to me that he was reading some other column than the one I wrote. As I noted, it is unclear whether any other court will adopt *Hargrave*'s approach, and in any event, the major impact is likely to be a diminution of enthusiasm among clinicians for advance directives, which may sharply restrict their use by patients, a most unfortunate result.

Finally, a word about what Allen calls "the profession of psychiatry['s] . . . uneasiness about consumer input." Psychiatrists and other mental health professionals struggle daily to build alliances with the people whose illnesses they are attempting to treat. To suggest that they have to be taught the importance of "trust-building" and working collaboratively with their patients is not only absurd but insult-

ing. What neither the decision in *Hargrave* nor the Bazelon Center have an answer to, however, is what happens when—as a result of severe mental disorder—trust cannot be built and an alliance cannot be established. To pretend that such situations do not exist hardly advances a "new vision for public mental health."

Paul S. Appelbaum, M.D.

Antihostility Effects of Adjunctive Divalproex

To the Editor: In the March 2004 issue, Dr. Citrome and his colleagues (1) reported on a study in which they conducted a post hoc analysis of a large data set from a multicenter trial to compare the specific antihostility effects of divalproex when it is used alone and in combination with risperidone and olanzapine. The authors found that combination therapy was associated with a modest but statistically significant reduction in the hostility item on the Positive and Negative Symptom Scale (PANSS). Although this effect diminished and was no longer significant after day 7, the authors concluded that adjunctive divalproex "may be a helpful augmentation strategy in reducing hostility."

I would caution clinicians about the inconclusive nature of the findings of this secondary analysis. *Psychiatric Services* rarely publishes the findings from clinical trials, although it occasionally publishes reviews of such studies. Therefore, I also question the usefulness of the publication of preliminary research in a journal that has such a wide readership among clinicians who treat patients in the public sector.

The Cochrane Collaboration (2) recently reviewed all the studies of valproate for schizophrenia, including complete data from the primary publication of the multicenter trial (3) from which Dr. Citrome and his colleagues obtained their data. The Cochrane review emphasized the fact that divalproex had no sustained effect after an initial accelerated response in the four-week study. The review stated that there was "very little evidence to support the use of valproate in schizophrenia." Despite the lack of evidence, the use of valproate and other anticonvulsants has increased substantially, especially in the public sector. The New York State Office of Mental Health reported that 34.9 percent of state hospital patients with a diagnosis of schizophrenia were receiving valproate in 2001, and almost half of all patients were receiving an anticonvulsant (4).

Post hoc analyses of data are prone to type I errors, such as finding a difference when, in fact, there is no difference (5). Because of their limitations, such secondary analyses are more often used to generate hypotheses for further trials. When evaluating the usefulness of the findings of clinical trials, clinicians should consider whether the study participants are similar to their own patients, whether outcomes are clinically significant, and whether potential benefits outweigh any involved risks. Participants in the divalproex combination trial presented with an acute exacerbation of schizophrenia with prominent symptoms of hostility or excitement or both. Individuals in state psychiatric hospitals are more likely to have been given valproate or other anticonvulsants for aggressive behavior that is repetitive or persistent, and they are treated with these agents long-term.

Finally, the trial in question did not identify any adverse effects from the addition of divalproex, although the report of the full clinical trial noted that combination therapy with risperidone and olanzapine produced somnolence in 29 and 38 percent of trial participants, respectively. Sedation could also explain some of the effects of the agent, which is an issue that Dr. Citrome and his coauthors do not adequately address.

Robert Eilers, M.D.

Dr. Eilers is medical director of the division of mental health services of the New Jersey Department of Human Services in Trenton.

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In Reply: Dr. Eilers makes the excellent point that our report of the specific antihostility effect of adjunctive valproate (given as divalproex) cannot be easily generalizable to a state hospital population. Adjunctive valproate in such settings is not usually used at the "front end" of treatment but at the "back end" when other treatments have failed. Moreover, the trial specifically excluded patients who were treatment refractory.

No reports have been published of controlled trials of sufficient magnitude to adequately answer the question of whether or not adjunctive valproate is useful for patients with persistent symptoms of schizophrenia or persistent aggressive behavior (1). The high rate of use of adjunctive valproate among patients with schizophrenia in hospitals operated by the New York State Office of Mental Health (2) is indeed astonishing and is probably comparable to rates in similar settings across the country. This widespread use of adjunctive valproate does not necessarily mean that the strategy is effective, and further research is needed. Trials of longer duration and with more chronically ill patients will be needed to test this treatment approach. As noted, our study did not provide support for a specific antihostility effect for coprescribed valproate beyond the first week of treatment.

The parent study was valuable because it provided evidence that the major effect of adjunctive valproate appears to be on the positive symp-