Current PSYCHIATRY

Injustice can lead to treatment

In his editorial "New Year's resolutions to help our patients" (From the Editor, Current Psychiatry, January 2010, p. 16-18) Dr. Nasrallah decried criminalization of mentally ill individuals, which I agree, but I find that I can provide better treatment in the medium-security prison where I work part-time than in our community mental health clinic, which has been downsized. At the prison, we have a multidisciplinary staff, including primary care physicians. Patients keep their appointments and medication intake is monitored. We have enough time to see patients and adequate reimbursement for services. In fact, some patients do not want to leave because in prison they have a roof over their heads, adequate food, and competent health care.

Prisons are the only place in this country where people have the right to treatment. If only health care reform could replicate this outside of prison.

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Could diet cause psychosis?

To add to Dr. Nasrallah's New Year's resolutions ("New Year's resolutions to help our patients," From the Editor, Current Psychiatry, January 2010, p. 16-18), I suggest some fresh, out-of-the-box thinking about the basic causes of bipolar disorder and schizophrenia. It strikes me that 52 years ago, before I graduated from medical school, we knew that heart attacks, strokes, and many common cancers—breast, prostate, colon, etc.—were caused by our high-fat diet. We received no advice then or since about changing to a completely different diet. I wonder if it's possible that our epidemic of psychoses also might be caused by the miserable diet we feed ourselves and our children. In the psychiatric literature, I have not seen a good comparison study of populations who follow a different diet. In *Prevent and reverse heart disease*, Caldwell Esselstyn Jr., MD, of the Cleveland Clinic states that in the genesis of heart disease "diet trumps genetics." I wonder, is the brain any different?

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Weighing clozapine's risks

Thank you for publishing "Clozapine for schizophrenia: Life-threatening or life-saving treatment?" (Current Psychiatry, December 2009, p. 56-63). In recent years, prescription rates for clozapine and long-acting injectables have been low, which is a disservice to our patients. We have seen the amazing impact clozapine can have on our patients' lives compared with other antipsychotics, and it is a shame to not prescribe it because of red tape. I am amazed that patients will stay on a medication that has so many untoward side effects, as we saw in the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study. I think this is a testament to how effective the medication is.

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EBM can obscure realities

I appreciate Current Psychiatry's practical approach, but psychiatry's tidal wave of evidence-based medicine (EBM) guidelines can obscure obvious realities, in turn serving to dumb us down. The article "Clozapine for schizophrenia: Life-threatening or life-saving treatment?" (Current Psychiatry, December 2009, p. 56-63) is an example of how so-called "objective" statistics hide fuzzy assumptions. The idea that those rare outpatients with support systems and egos consistently functional enough to adhere to lab testing and who accept their illness are representative of all schizophrenia patients is a whopper of an assumption. The author needs to consider the more mundane possibility that patient selection and not the drug itself may make the difference.

I feel that articles on "CBM" for common sense-based medicine or "WBM" for wisdom-based medicine would provide our profession with a fresh breath and a dose of reality. The drumbeat of the EBM march is promoted as a substitute for thinking, which it isn't. It is just a tool.

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To comment on articles in this issue or other topics, send letters in care of Erica Vonderheid, Current Psychiatry, 7 Century Drive, Suite 302, Parsippany, NJ 07054, erica.vonderheid@qhc.com or visit CurrentPsychiatry.com and click on the "Send Letters" link.