Remy were drawn from the instrument development study and reflect scores associated with the 7 dimensions of the instrument but not the total instrument.[1] In the RESTORE trial, all physicians and nurses received training and were required to successfully complete a posttest prior to enrolling patients. We established interrater reliability checks on the SBS and monitored interrater reliability throughout the trial in both intervention and control PICUs. The overall κ score for the SBS was 0.87 (95% CI, 0.83-0.91). Any PICU falling below 80% agreement implemented a quality improvement plan and the interrater reliability was rechecked.

As noted in our article and in the supplementary materials, sedation assessments were completed more frequently in the intervention compared with control PICUs, presumably because the data were used by the intervention PICUs to target sedation. Adherence to sedation assessment elements in our protocol was high; the daily SBS target was prescribed on 98% of intubation study days and achieved 95% of the time in intervention patients.

We have no data on how nurse turnover or experience may have confounded the RESTORE study. As noted in our supplemental materials, the experience level of the PICU nursing workforce was good, with a median of 6.2 years (interquartile range, 5.1-8.3 years) across sites, and most nurses had bachelor's degrees (median, 80%; interquartile range, 74%-90% across sites). In addition, we had few protocol deviations stemming from enrolled patients receiving care from a nurse who was not trained in using the RESTORE protocol.

Clinical trials and observational studies[2] may differ in their conclusions for the reasons that Remy cites, and there may be additional bias introduced in observational studies that may be difficult to identify, as well as the inherent differences between a toddler with acute respiratory failure and a 50-year-old adult with a medical or surgical problem.

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Expanding Long-term Care Options for Persons With Serious Mental Illness

To the Editor In their Viewpoint, Dr Sisti and colleagues[1] addressed the need for expanded and cost-effective care options for people living with serious mental illness. As the authors pointed out, closing state psychiatric hospitals made prisons the new institutions. Although the authors noted that the best option for a person with serious mental illness is "assisted treatment in the community," they appear to believe that current community-based programs are inadequate for the most seriously ill.

Community mental health programs need to take some responsibility for these failures and for the inability to provide adequate services to enough people with the most serious mental health problems. I believe that this failure has been partially attributable to a loss of focus on the most seriously ill, coupled with inadequate funding. But more funding is not the only answer. Serving the neediest individuals in more effective ways is necessary.

Since 1948, Fountain House has served thousands of people living with the most serious forms of mental illness through a partnership model (not a peer-only model, as suggested in the Viewpoint) between members and professionally trained staff. Fountain House provides the "safety" and "sanctuary" Sisti and colleagues attributed to asylums but has also adopted a 3-part approach needed to assist patients in rejoining mainstream society: a psychiatrist trained in psychopharmacology, a primary care physician, and a supportive environment that offers hope and opportunity. People living with serious mental illness, specifically schizophrenia, experience a 22.3% rate of hospital readmission.[2] At Fountain House, our hospital readmission rate is 10%. For less than the cost of a 2-week stay in a psychiatric hospital, Fountain House provides members with housing, community support services, and access to medical and psychiatric care for an entire year.

The authors' call to action could not come at a more important time. New York is witnessing the largest shift in funding since deinstitutionalization, transitioning to Medicaid and Medicare funding and in the process seeing major reductions in state government funding. I urge the authors to reconsider the value of cost-effective, community programs that focus exclusively on people with serious mental illness.

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Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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To the Editor Dr Sisti and colleagues[1] argued that "[t]he financially sensible and morally appropriate way forward [regard-

ing mental health treatment] includes a return to psychiatric asylums that are safe, modern, and humane."

Asylums are neither "financially sensible" nor "morally appropriate." Studies have shown that individuals with even the most serious mental health conditions can be treated in the community more effectively, and at lower cost, than in institutions.[2] For example, peer-run crisis respites (homelike places where people can live temporarily during a mental health crisis), which research has found effective, cost $211 per day compared with $665 per day for hospitalization in 1 study.[3]

Asylums run counter to the Americans with Disabilities Act (ADA), which prohibits discrimination against persons with disabilities. In 1999, the US Supreme Court upheld the ADA's community integration mandate in its *Olmstead* decision, finding that unjustified segregation of persons with disabilities constitutes discrimination.

Olmstead and the ADA are part of a revolution in the mental health arena that has taken place during the last several decades. Now, at the highest levels of mental health policy making, it is understood that even persons with the most serious mental health conditions can and do recover. When the notorious Philadelphia State Hospital was shut down, some of those released were interviewed for an *Olmstead* amici curiae brief accepted by the US Supreme Court.[4] One was James Price, who spent "5 or 6 years" at the hospital. "It was hard living there," he recalled. "I had to stay in a day room and wasn't able to get out. We had a dormitory with 8 to 10 people. I got in trouble there a lot. They would put me in seclusion and restraints and give me needles." His life after release included living in his own apartment, seeing friends and family, holding a job, and volunteering at his church.

Price is not unique. Several years after Philadelphia State Hospital shut its doors, a study funded by the Pew Charitable Trusts found that the overwhelming majority of those released were living successfully in the community.[5]

The community mental health system could do better. But asylums are not the answer.

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Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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To the Editor Dr Sisti and colleagues[1] argued that it is time to "bring back the asylum." Although we agree that people with serious mental illness too frequently end up in a cycle of homelessness and incarceration, we question whether the authors have correctly identified the cause of the problem and disagree with their proposed solution: reinstitutionalization, or new asylums to increase the number of beds for people with serious mental illness.

First, there is questionable evidence to suggest that building new psychiatric institutions would reduce the population of incarcerated mentally ill. If significant financial resources are going to be allocated to solving this problem, evidence is needed that the investment will pay off.[2]

Second, the numbers do not add up. The authors pointed to the Worcester Recovery Center and Hospital as the model institution of the future. But that facility took years to complete, cost more than $300 million to build, and has an annual operating budget of $60 million. With 320 private rooms, the cost per patient exceeds what is financially feasible.[3]

Third, asylums consign people with serious mental illness to endless confinement. Not only is this expensive, but for those with mental illness, it is generally less desirable, more stigmatizing, and produces no better clinical outcomes than community alternatives to asylums, such as supportive housing, partial hospitalization programs, and assertive community treatment.[4]

It was expected that money saved by states closing their mental hospitals would follow the patients into the community. Federal funding for community mental health services was eliminated in 1981 and block grants were given to the states (the entities responsible for the deplorable conditions in the state mental hospitals in the first place), with few requirements for their use. Perhaps if the block grants would have had specific mandates from the federal government, community-based services for people with serious mental illness could have been adopted across the United States and prisons and jails would not have become the default option for those with serious mental illness. We believe that constructing more mental hospitals to care for persons with serious mental illness misconstrues the causes of the current problem and is an unrealistic and undesirable solution.

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of Mental Health and former CEO of United Behavioral Health. No other disclosures were reported.

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To the Editor I have been diagnosed with schizophrenia. I am in recovery from this severe mental illness. The concepts of hope, self-determination, and respect direct my recovery; they give me power to bring about positive change in my life and therefore debunk the illness.

In my recovery, I am guided by the hope of living a meaningful and purpose-driven life. To say severe mental illness is in some cases untreatable or "refractory"[1] is giving up on the potential of recovery and invalidates the concept of hope. If the basis for putting individuals in an asylum is because it is believed they cannot recover, then asylums deprive the individual of hope. An asylum system that does this will no doubt become futile and progressively worse over time—ie, hopeless.

Without the self-determined choice and ability to make decisions for myself, I know the independent life I now have would not have been possible. To deprive an individual of freedom is an unacceptable injustice. An asylum is guilty of this injustice. Asylums take the freedom to choose away from the individual and give control to others to make decisions. Recovery requires personal choice that brings about greater responsibility and a better life. Asylums deny this.

I am living in society as a productive and respectable citizen. I work hard to integrate myself into the community, particularly when facing the discrimination and stigma that come from having a diagnosis. To be a part of society, and not sequestered from it, fosters dignity and respect. By isolating individuals from society, asylums deprive an individual of being human.

The past establishes the evidence. There is nothing ethical or "humane and moral"[1] about psychiatric asylums. They foster hopelessness. They disempower, leaving the individual helpless and at the mercy of another. They dehumanize, making the individual feel different from society as a whole. Dr Sisti and colleagues should learn from past wrongs and not advocate repeating them.

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1. Sisti DA, Segal AG, Emanuel EJ. Improving long-term psychiatric care: bring back the asylum. *JAMA*. 2015;313(3):243-244.

To the Editor As the parent of an adult child with refractory schizophrenia, I applaud the call by Dr Sisti and colleagues[1] to bring back the asylum. Their analysis of the problem neglected to focus on the burden placed on families struggling without adequate support to care for relatives with serious mental illness.

Having seen my son make substantial progress in a residential treatment program after living at home for several years, I can attest to the value of good-quality institutional care. Society has long been negligent in failing to fund this necessary niche in the mental health system.

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1. Sisti DA, Segal AG, Emanuel EJ. Improving long-term psychiatric care: bring back the asylum. *JAMA*. 2015;313(3):243-244.

In Reply For some persons with serious mental illness, more structured institutional or hospital settings that provide treatment, safety, and the conditions for recovery are needed. The term *asylum* harkens back to the literal and idealized meaning of the term as a place of sanctuary and healing. The letters from Mr Dudek, Ms Rogers, Dr Feldman and colleagues, and Mr Son advocating for community-based mental health programs have misunderstood our Viewpoint.

We neither mentioned nor advocated for a dismantling of community-based services, confinement of every person with serious mental illness, institutionalization as a first resort, hospitalization of patients in perpetuity, or a recreation of the awful places that horrified the US public in the mid-20th century. Our essay does not advocate a return to places like the Philadelphia State Hospital. We argued for a full array of treatment options to include community-based care and, if needed, institutionalization.

It is a mistake to understand the *Olmstead* decision as prohibiting institutionalization, as suggested by Rogers. *Olmstead* stated that unjustified segregation of mentally ill and disabled persons is illegal and discriminatory.[1] We would add that such segregation is morally abhorrent. But, in writing for the majority, Justice Ginsberg stated clearly and unequivocally "that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings." Justice Kennedy in his concurrence goes further, stating that it would be a tragedy "to drive those in need of medical care and treatment out of appropriate care and into settings with too little assistance and supervision." This is the population about whom we are concerned.

Feldman and colleagues question whether an increase in psychiatric beds would reduce the number of incarcerated persons with mental illness. Mass incarceration in the United States has resulted from a number of confounding social, economic, and juridical factors. Institutional confinement spans many settings and waxes and wanes as a result of complex social factors.[2] Although hotly debated, there is evidence that an inverse relationship exists between the availability of structured psychiatric settings and the number of incarcerated persons with mental illness.[3] It is also the case that even with robust, well-funded, comprehensive community treatment—which we support—there will remain a group of individuals who will need a structured setting within which to live. The criminal justice system has taken on the role of long-term care provider for a proportion of these individuals,[4] which is disturbing and unacceptable.

Son's experience is a reminder that community-based programs can provide essential hope when effective and that many individuals with a serious mental health illness can and do recover. By the same token, for those individuals who are unable to fully engage in such programs, the cycle of jail, homelessness, and repeated acute hospitalizations dashes hope. For individuals like Dr Miller's son, a structured residential setting may be necessary. Similarly, the needs of families caring for loved ones with very serious intellectual disabilities have reached a crisis point in some areas of the country.

Significant financial resources should be allocated to helping individuals with serious mental illness across a comprehensive range of services to provide them with dignified care that is evidence-based and scalable, which will make these services financially feasible. Integration of structured settings into accountable care organizations is one potential way to achieve cost-effectiveness and high quality and streamline a supportive transition from hospitalization to the community.[5]

In the end, there exists an important role for high-quality psychiatric hospitals.[6] The entrenched false dichotomy between community care vs institutional care has created an unfortunate ideological schism that only hurts the people who need help.

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CORRECTION

Incorrect Alignment and Omitted Data in Tables: In the Original Investigation entitled "Association of Early Imaging for Back Pain With Clinical Outcomes in Older Adults" published in the March 17, 2015, issue of *JAMA* (2015;313[11]1143-1153. doi: 10.1001/jama.2015.1871), data were aligned incorrectly in Tables 1 through 4 and the standardized difference data were omitted in Tables 1 and 2. This article was corrected online.

Revisions in Table: In the Original Investigation entitled "Association of Inpatient vs Outpatient Onset of ST-Elevation Myocardial Infarction With Treatment and Clinical Outcomes" published in the November 19, 2014, issue of *JAMA* (2014;312[19]: 1999-2007. doi:10.1001/jama.2014.15236), revisions were necessary in Table 1, which used a data set maintained by the Agency for Healthcare Research and Quality (AHRQ). The provisions of the Data Use Agreement with AHRQ state that data observations involving 10 or fewer observations should not be published; therefore, data on Native American race/ethnicity and the comorbid conditions of AIDS and peptic ulcer were removed from the Table. In addition, the data on Native American race/ethnicity were combined with the "other" category, resulting in new numbers of patients in that category as follows: n=1850 (3.2%) overall; n=1784 (3.2%) for outpatient-onset STEMI; and n=66 (2.2%) for inpatient-onset STEMI. The exclusion of these data did not change the analyses or results. This article was corrected online.

Guidelines for Letters

Letters discussing a recent *JAMA* article should be submitted within 4 weeks of the article's publication in print. Letters received after 4 weeks will rarely be considered. Letters should not exceed 400 words of text and 5 references and may have no more than 3 authors. Letters reporting original research should not exceed 600 words of text and 6 references and may have no more than 7 authors. They may include up to 2 tables or figures but online supplementary material is not allowed. All letters should include a word count. Letters must not duplicate other material published or submitted for publication. Letters not meeting these specifications are generally not considered. Letters being considered for publication ordinarily will be sent to the authors of the *JAMA* article, who will be given the opportunity to reply. Letters will be published at the discretion of the editors and are subject to abridgement and editing. Further instructions can be found at http://jama.com/public/InstructionsForAuthors.aspx. A signed statement for authorship criteria and responsibility, financial disclosure, copyright transfer, and acknowledgment and the ICMJE Form for Disclosure of Potential Conflicts of Interest are required before publication. Letters should be submitted via the *JAMA* online submission and review system at http://manuscripts.jama.com. For technical assistance, please contact jama-letters@jamanetwork.org.

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