Letters from readers are welcomed. They will be published at the discretion of the editor as space permits and will be subject to editing. They should be a maximum of 500 words with no more than three authors and five references and should include the writer's telephone and fax numbers and e-mail address. Letters related to material published in *Psychiatric Services* will be sent to the author for possible reply. Address letters to John A. Talbott, M.D., Editor, *Psychiatric Services*, American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005; fax, 202-682-6189; e-mail, psjournal @psych.org.

Managed Care in Iowa

To the Editor: In the Managed Care column in the April 2000 issue, Drs. Sabin and Daniels (1) state that the Iowa managed care initiative is widely regarded as a successful behavioral health carve-out program. They base their assessment on interviews with multiple stakeholders, who described a climate of collaboration and creativity in addressing the challenge of serious mental illness. Much of the background information that was used in their column cited a report that I prepared at the request of the National Alliance for the Mentally Ill (NAMI) (2). However, the conclusions that I drew from the information contained in that report were different from those presented by Sabin and Daniels.

In a commentary summarizing my conclusions from the NAMI report (3), I pointed out that many of the problems that occurred in Iowa might have been minimized or avoided if appropriate mechanisms for oversight and for enforcement of standards for care had been included in the original contract specifications. In general, I believe that Sabin and Daniels accurately present the positive evolution of the Iowa managed care program that has occurred since its inception. However, the column gives the impression that the changes were proactive and instigated by the contractor out of an intrinsic desire to provide a higher standard of care. In my opinion, based partly on my experience of having been in Iowa during the period in question, it was the implementation of regulatory standards by the Iowa Department of Human Services, brought about primarily through advocacy efforts of groups such as NAMI, that prompted the changes that led to programmatic improvements.

I also disagree with the authors' assessment that Governor Branstad was "resistant to heat" and protected the stakeholders who pursued a quality improvement approach to implementation because he was not running for reelection. Reducing the county and state tax burden resulting from escalating expenditures for mental health and mental retardation services was a very important political issue in 1994, a year when Governor Branstad was running for reelection and was subsequently reelected.

Finally, the authors suggest that the evaluation of the Iowa program should be based on measurement of outcomes that it achieves, but conclude that such measurement would be possible only through rigorous evaluation of data that are rarely available. They cite an article that I published describing the paucity of data on which to evaluate the Iowa program (4). However, rather than emphasizing the important role of prospective data for accountability, they appear to excuse its absence.

Before the implementation of Medicaid managed care, the state was advised to establish a number of indicators that would have allowed evaluation in several domains of quality before program implementation—structural indicators, process indicators, and outcome indicators (5). Evaluation of quality does not require "outcome data robust enough to allow rigorous program evaluation." Simple measures, had they been incorporated into the initial contract specifications, would have facilitated program improvement based on facts rather than on marketing strategies, political agenda, and resolution of conflict.

Barbara M. Rohland, M.D.

Dr. Rohland is associate professor in the department of health services research and management at Texas Tech University Health Sciences Center in Lubbock, Texas.

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In Reply: We agree with Dr. Rohland that the contracting process is crucial for accountability and high-quality care. As she indicates, neither the state nor the managed care organization adequately anticipated the start-up problems, and the program start-up was tumultuous. One of the key lessons the turmoil in Iowa teaches is that responsible purchasing involves more than writing a contract. The public purchaser and the managed care organization must act more like a married couple than arm's-length contractees.

When the program foundered, the state and the managed care organization negotiated the way well-functioning couples do. This process is better described as one of collaborative diagnosis of problems and design of options than as "implementation of regulatory standards." Contracts and regulations are static. A successful human service program requires a more dynamic and nuanced interaction than those terms connote.

Dr. Rohland's suggestion that simple outcome measures be incorporated into contract specifications is excellent, but deciding which areas of the program to monitor and what kinds of measures to use can itself become a focus of conflict. Caring for needy individuals within limited public budgets requires trade-offs among values. Seeking a reasonable balance of values inevitably entails tension between different stakeholder positions.

A recent report from the Bazelon Center for Mental Health Law and the Milbank Memorial Fund provides empirical support for Dr. Rohland's emphasis on the importance of monitoring outcomes (1). Outcome data will enrich debate among competing political agendas. It will not, however, eliminate the need for moral and political deliberation about program goals and alternative choices (2).

James E. Sabin, M.D.
Norman Daniels, Ph.D.

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Medicare's Mental Health Coverage

To the Editor: I read with interest the article by Mickus and associates (1) in the February 2000 issue, which surveyed Michigan residents about their knowledge of mental health benefits and preferences for type of mental health providers. Although the article provided useful information about the lack of understanding of mental health benefits among the general public, the authors' characterizations of Medicare mental health benefits are fairly misleading.

Specifically, the authors state that there are "serious payment restrictions for mental health services under traditional Medicare." That is a relative statement; mental health coverage under traditional Medicare is actually quite generous compared with many private-sector insurance plans (2). In fact, Medicare coverage for inpatient mental health services in distinct units, such as psychiatric wards, and scattered beds in general hospitals is equivalent to that for physical health services. Moreover, as with physical health services covered by Medicare, there are no annual or lifetime day limits for mental health services provided in these general hospital settings.

The authors further note that "Medicare's mental health benefits do not have parity with its general health benefits in terms of inpatient service limits and copayment policies." Although lifetime coverage for mental disorders is limited to 190 inpatient days in specialty psychiatric hospitals, no such limits are placed on inpatient mental health days in general hospitals. In these instances, the equivalencies in coverage for mental and physical conditions in general hospitals represent a form of parity that exceeds even that required under the Mental Health Parity Act of 1996.

In addition, although copayments for outpatient mental health services provided by psychologists have different levels, the authors fail to note that there are equivalent copayment policies for mental versus physical disorders under traditional Medicare in virtually all other settings—inpatient, partial hospital, hospital outpatient clinic, outpatient medication management—and for other types of providers, including psychiatrists and other physicians.

Thus it is misleading for the authors to suggest that there are serious payment restrictions in traditional Medicare, particularly when their own data suggest that approximately 80 percent of those over age 65 who were surveyed reported that, if needed, they would seek mental health care from either a primary care physician or a psychiatrist. Given their data, it is difficult to see how the authors conclude that "Medicare cost limitations may represent a deterrent for a substantial number of older adults."

The Health Care Financing Administration of the U.S. Department of Health and Human Services provides a toll-free number (1-800-MEDICARE or 1-800-633-4227) to answer questions that beneficiaries may have about mental health coverage under Medicare.

Kevin D. Hennessy, Ph.D.

Dr. Hennessy is a psychologist and policy analyst in the Office of Health Policy at the U.S. Department of Health and Human Services in Washington, D.C.

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In Reply: Dr. Hennessy's main criticism focuses on our view that payment restrictions for mental health services under Medicare can have serious consequences for patients. Despite important strides toward parity in mental health coverage under Medicare since the 1980s, spending in this area remains relatively low, highlighting the deficiencies in the system. For example, Medicare places lifetime limits on inpatient days for mental disorders treated in psychiatric hospitals but not in general hospital settings. Exempting one type of facility but not another from lifetime coverage is clinically arbitrary at best and adversely affects utilization of needed services at worst.

Our greatest concern is that Medicare provides only 50 percent coverage for psychotherapy services, a serious disparity with general medical services. Studies have demonstrated that higher prices decrease utilization of outpatient mental health services compared with other outpatient services (1,2). It is apparent that this level of coverage serves as strong incentive for underutilization of outpatient psychotherapy by older individuals, particularly those on fixed incomes without supplementary coverage. This benefit structure not only provides a striking disincentive for com-

prehensive treatment, but it also ignores the efficacy of psychotherapy coupled with medication in treating late-life psychiatric illnesses, particularly affective disorders (3).

Dr. Hennessy concludes that Medicare cost limitations do not necessarily represent a serious deterrent to care on the basis of our finding that 80 percent of respondents age 65 and over would choose to receive mental health care from a primary care physician or psychiatrist. However, the fact that an individual is able to identify a provider for care does not ensure that he or she will actually receive the most appropriate care in terms of quality, amount, or specificity.

In light of the U.S. Surgeon General's recent report indicating that half of Americans who have a severe mental illness do not seek treatment (4), we believe that any gaps in benefits could have significant ramifications for individuals as well as for society. Thus we stand by our original conclusion that the disparities in Medicare coverage of mental health services are significant and may induce underutilization of necessary services to the detriment of those in need of care.

Maureen Mickus, Ph.D.
Christopher Colenda, M.D.
Andrew Hogan, Ph.D.

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The Newer Antidepressants

To the Editor: Although antidepressants introduced since the late 1980s have won widespread acceptance from physicians and patients, randomized clinical trials have generally shown response rates no better than for older drugs (1,2). We examined whether the newer antidepressants offer advantages in clinical practice that are not apparent in randomized trials.

The senior author reviewed the records of all outpatients with a current major depressive episode whom he evaluated and treated with antidepressants in his university-based office during two time periods: July 1980 through December 1987 and January 1992 through December 1996. Patients with borderline, schizotypal, schizoid, or paranoid personality disorder; rapid-cycling bipolar disorder; or a history of nonaffective psychosis were excluded from the study.

Patients were included in the study if they took at least one dose of the prescribed antidepressant. Those who received more than one drug trial were rated according to their best response. An adequate trial was defined as either four weeks of treatment, with one week or more on 200 mg of imipramine per day or the equivalent, or marked or moderate improvement.

Seventy-one patients from the 1980s and 46 patients from the 1990s met inclusion criteria. Ninety percent of the patients (N=105) had a *DSM-IV* diagnosis of major depressive disorder, and 10 percent (N=12) had a diagnosis of bipolar II disorder or bipolar disorder not otherwise specified. Patients were assigned a numerical score based on their global improvement: 4, marked improvement (full remission); 3, moderate improvement (clear improvement but still significant symptoms); 2, slight improvement; and 1, no improvement.

The 46 patients from the 1990s showed a significantly higher median improvement score than the 71 from the 1980s (median score=3.5 versus 3, p=.026, Mann-Whitney U test; mean±SD score=3.28±.89 versus 2.80±1.13). A significantly higher proportion of the 1990s patients also showed marked or moderate improvement (85 percent, or 39 patients, versus 62 percent, or 44 patients; χ^2=7.05, df=1, p=.008). Fifty percent of the 1990s patients (N=23) showed marked improvement, compared with 37 percent of the 1980s patients (N=26), but the difference was not significant.

Ninety-five percent (N=37) of the 39 responders in the 1990s responded to antidepressants not available in 1987. Only 7 percent (N=3) of the 1990s patients failed to receive an adequate antidepressant trial, compared with 31 percent (N=22) of the 1980s patients (χ^2=9.94, df=1, p=.002). In both decades the primary reason for an inadequate trial was inability to tolerate side effects.

These results need to be evaluated cautiously for several reasons, including the small sample size, the absence of structured evaluations, the use of unblinded, nonstandard assessments, and the fact that antidepressant switching and the use of psychotherapy and other psychiatric medications were uncontrolled. Our findings cannot be generalized to more severely ill inpatients, who in some studies have been reported to have poorer outcomes with some of the newer antidepressants (3,4).

Nevertheless, these naturalistic data raise the possibility that the introduction of newer antidepressants over the past decade may have led to improved outcomes for depressed outpatients in the "real world," at least in part by enabling more individuals to tolerate an adequate trial. The discrepancy between our findings and those of most randomized clinical trials may reflect the many ways in which clinical practice differs from experimental treatment (5). The fact that even in the 1990s half the patients did not achieve full remission underscores the need for further improvement in our pharmacotherapy for depression.

Stephen L. Stern, M.D.
Nicholas A. Votolato, Pharm.B., B.C.P.P.
John P. Hatch, Ph.D.
Charles L. Bowden, M.D.

Dr. Stern, Dr. Hatch, and Dr. Bowden are associated with the department of psychiatry at the University of Texas Health Sci-

ence Center at San Antonio. When the data for this study were collected, Dr. Stern was affiliated with Ohio State University in Columbus, where Mr. Votolato is associated with the departments of psychiatry and pharmacy.

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Oral Self-Mutilation

To the Editor: A 47-year-old male with schizophrenia who was in a mental hospital in Fukuoka, Japan, lost many of his lower front teeth within two months of admission, a period in which his mental condition was seriously unstable.

We later learned that every day, when he went to the toilet, he took the bottle of toilet cleaner, hid in a private room, and drank a little of the cleaner. The cleaner contained hydrochloric acid, which burned his throat and esophagus and caused severe pain. However, the fact that he ingested only small amounts each time saved him from serious illness or death.

After a few months, with his mental condition improving, the patient visited the hospital's dental department, where his teeth were found to be severely eroded. The strong acid solution had dissolved the enamel and dentin of his lower anterior teeth, disclosing dental pulp; almost all the crowns had been lost. Dental department records showed that his anterior teeth were intact two years before.

The patient acknowledged that he had continued his self-mutilative behavior, with severe pain and agony, over a period of two months. Because toilet cleaners contain concentrated chemicals such as hydrochloric acid, it is advisable to store them away from toilets of mental hospitals.

Toshiyuki Saito, D.D.S., Ph.D.
Toshihiko Koga, D.D.S., Ph.D.

The authors are faculty members in the department of preventive dentistry at Kyushu University in Fukuoka, Japan.

The Jerusalem Syndrome

To the Editor: The Jerusalem syndrome, which afflicts mainly ardent religious believers who go to Jerusalem and suffer psychotic decompensation while there, is gaining recognition in the professional literature as well as in the media (1,2). We recently encountered for the first time a patient, apparently suffering from the Jerusalem syndrome, who believed that a "Jerusalem syndrome organization" was acting against him, thus making his diagnostic category the object of his paranoia.

The patient, a 38 year-old U.S. citizen, divorced and father of two, was brought to the psychiatric emergency room of the mental health center in Jerusalem after being arrested by the police for assault. He refused to discuss his past psychiatric history, but his family reported that he had always been "strange and unbalanced," eventually leaving his home, cutting all ties with his parents and his wife and children, and disappearing for years on end.

He decided to come to Jerusalem to devote himself to the study of the Bible, both the Old and New Testaments. He worked in a hotel in return for a bed and spent most of his time reading religious material. A few months before his admission to the mental health center, he began claiming that the Jerusalem syndrome organization was after him. He identified other tourists staying at the hotel as well as the hotel staff as being secret agents of the organization. He believed that his roommate was following him and performing electric shocks on him, which he felt throughout his body.

Eventually, the patient identified more and more people as hostile secret agents of the organization, and he became increasingly restless and aggressive. He reported that the agents set him free periodically, leaving him alone, only to reappear in increased numbers and from all directions. After physically assaulting one such "agent" from hotel personnel in an attempt to defend himself against the organization, he was taken by the police for psychiatric evaluation and treatment.

On admission to the mental health center, the patient was found to be overtly psychotic, negativistic, delusional, and hallucinatory. He accused the staff of being part of the Jerusalem syndrome organization intent on poisoning him through food, drink, and medications. Treatment with haloperidol seemed to improve his capacity to cooperate but, to date, he still believes that the organization is pursuing him.

Natasha Fastovsky, M.D.
Alexander Teitelbaum, M.D.
Josef Zislin, M.D.
Gregory Katz, M.D.
Rimona Durst, M.D.

The authors are associated with Jerusalem Mental Health Center of Kfar Shaul Hospital in Jerusalem, Israel.

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