The omission of nonsmokers from our analysis was intentional. This group was not included because we wished to examine a dose-response relationship (in durations of smoking and of abstinence). Including nonsmokers in this case would bias the dose-response relationship (2) because of a different case-control ratio among lifetime nonsmokers [see Table 2 in the online supplement]. An interesting question is whether among people who die violently, lifetime smoking is associated with death from suicide (rather than from homicide or accident). We performed this analysis and entered lifetime smoking and depressive symptoms as independent variables. The analysis indicated that both variables significantly predicted suicide among males [see online Table 3]. Therefore, the possibility remains that smoking makes a residual contribution to suicide, as other recent studies have indicated (3,4). The absence of a causal association between smoking and depression in studies using Mendelian randomization (5) does not contradict our result. What is implied by our study is precisely that smoking has an association with suicide independent of depression. Collectively, our results do not prove causation, but ruling it out on the basis of parsimony seems, in our opinion, to be premature.

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Medications for Maltreated Children: Wrong Conclusions?

TO THE EDITOR: The authors of the article about Medicaid expenditures on psychotropic medication for maltreated children in the December issue drew the wrong conclusion (1). The finding that mood stabilizers and antidepressants were overprescribed for children and adolescents with a history of abuse is most likely a result of the unavailability and underprescribing of evidence-based psychotherapy. For this reason, any cost savings from a reduction in the use of antidepressants will result in less or no treatment for this population, which is anathema to health care goals.

Instead of wasting the time of patients' psychiatrists by requiring them to conduct drug reviews—a requirement that essentially treats them as medical students—we should transfer any Medicaid cost savings from reducing drug use to psychotherapy services, start prescribing and delivering such services, and monitoring their outcomes.

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Medications for Maltreated Children: Wrong Conclusions? In Reply

IN REPLY: We respectfully disagree with Dr. Masters' characterization of our study. In the article, we merely reported the pharmacological drivers of Medicaid expenditures in our sample, and we were careful to distance our results from any language that implies clinical appropriateness. "Overprescribing" is predicated on a clinical conclusion about the quality of care. As services researchers, we cannot discuss appropriateness because we lacked clinical information about our participants that would have permitted us to make such statements. The fact that there was increased spending on antidepressants and antimanic drugs is a pharmacoeconomic fact that is based on our data; it should not be interpreted as evidence of inappropriate use of these drugs.

The fact remains that Medicaid agencies experience considerable pressure to contain their spending, and drug spending has been a target of cost containment since the 1970s. Dr. Masters is right to emphasize the need for better forms of cost containment; many cost containment efforts have indeed produced mixed results (1,2). The statement in our article about "Focusing quality improvement and prior authorization programs . . .", in context, was merely meant to suggest targets for such efforts, given that cost containment programs exist in all Medicaid programs. It was not an endorsement of any approach to cost containment. That would be a separate study.

We also agree with Dr. Masters' call to enhance the full array of biobehavioral and psychosocial interventions for vulnerable children, and we have made this exact point in prior work (3). The last thing that child mental health services researchers would wish for is a reduction in resources to serve needy children. We fully endorse the need to devote greater resources to the care of such children, and we thank Dr. Masters for drawing our collective attention to this important issue.

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Delineating Responsibility: Primary Care Provider Perspective

TO THE EDITOR: In their Integrated Care column in the December issue, Williams and colleagues (1) called on psychiatrists to take on a more active role in treating tobacco use disorders. Despite reduced smoking rates in the U.S. population at large, the problem of nicotine dependence persists among people with mental illness. Among those with mental illness, 50% to 80% smoke, and 34% to 44 % of all cigarettes in the United States are consumed by people with mental illnesses (2).

As Williams and colleagues pointed out, psychiatrists are well suited to address nicotine dependence. We recently completed a survey of the perspectives of primary care providers (PCPs) in regard to the integration of primary and behavioral health care. Specifically, we sought to understand what PCPs view as appropriate responsibilities for psychiatric providers in the realm of general medical ailments. Our results provide a different perspective and yet echo Williams and colleagues' plea.

Briefly, we distributed a Web-based survey to 100 PCPs, all of whom care for at least one patient at the independent community mental health center where we work. Most patients served at our clinic have a serious mental illness, usually a psychotic disorder. Twenty experienced PCPs completed the survey; the mean±SD age was 51±10 years, and they had an average of 19 ±10 years' experience. Half of the providers had more than ten patients with a psychotic disorder. We asked about their comfort level in caring for patients with psychotic disorders and about their satisfaction with communication with psychiatric providers, and we found mixed levels of comfort and satisfaction. Both questions were right-skewed, with 75% of responses in the neutral to negative range. Next, we asked whether PCPs were comfortable with the management of certain general medical conditions by mental health care providers. Sixty percent of PCPs did not feel comfortable with psychiatric providers managing hypertension, and 55% were uncomfortable with psychiatric providers managing elevated glucose and HgbA1C with oral hypoglycemic medications or elevated lipids or triglycerides. By contrast, all respondents felt comfortable with psychiatric providers managing smoking cessation, including prescribing varenicline. Finally, we asked PCPs to identify their priorities for improving care to persons with psychotic disorders, and 68% cited communication as the top need.

Mounting evidence supports the value of integrated psychiatric and primary care, in its various permutations (colocated, in house, facilitated referral, and care management) (3,4). Communication is essential to any form of integration, and it is not surprising that this was ranked as PCPs' highest priority to improve care. How information is exchanged and how roles are defined, for patient and provider, remain challenging. Clear delineation of responsibilities has the advantage of minimizing diffusion of responsibility. Our results indicate that treatment of nicotine dependence is the health priority PCPs are comfortable delegating to psychiatric providers. In an urban environment such as ours, where access to care is not a problem, the debate about treatment responsibility may be a luxury not possible in other parts of the country. However, all providers can agree that smoking cessation is a critical health issue and that psychiatric providers should offer evidence-based smoking cessation treatments.

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