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, 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).

A Not-for-Profit, Managed, Single-Payer System

To the Editor: As usual, Dr. Sharfstein raised important questions in his Taking Issue column "Some Interesting Lessons From Canada" in the March issue (1). Referring to a study published in the same issue, "Inequity in Mental Health Care Under Canadian Universal Health Coverage" (2), he pointed out that even in a country with universal health care access, disparities based on socioeconomic status still exist. Most strikingly, in the Canadian study the expected and desired inverse gradient "between socioeconomic status and utilization rates of mental health services" was in the opposite direction for psychiatrists in Toronto. The investigators could not determine whether less access for poor patients was patient driven or provider driven.

Dr. Sharfstein then asked several financially related questions about how this disparity problem could be addressed if a universal plan was implemented in the United States. I would like to venture a response to the questions about managed care, in part referring to our 15 years of experience directing managed mental health systems for culturally diverse populations of both higher and lower socioeconomic classes (3).

Dr. Sharfstein asked "Would managed care effectively address the equity issue in Canada? In a universal health care access plan in the United States, could managed care help avoid the distributive equity problem experienced in Canada?" My answer is a tentative yes. Despite the well-documented problems of managed care, if managed care is operationalized in a certain way, it could effectively improve the equity problem in Canada and in the United States (4). To begin to operationalize such a plan, it may be best to have only not-for-profit managed care so that the profit motivation does not divert too much of the funding and take priority over patient care.

To address the patient-driven part of the problem, another study in the same issue of *Psychiatric Services* suggests an answer (5). A simple $10 payment to low-income African-American patients with depression improved appointment adherence. When managed care systems control the funding, the contract created by the payer could stipulate that some of that funding be used in a similar way.

Financial incentives could also work for providers. Historically, psychiatrists who served poor patients in the United States generally make a lower income. A "pay for performance" component of a not-for-profit managed universal health care system could divert funds to pay a significant bonus to psychiatrists who serve poor populations and who demonstrate reasonable outcomes.

Whether one likes it or not, "money talks" to most everyone. The key may be to use the money in a socially responsible way.

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Medicare Part D and Decompensation

To the Editor: We recently evaluated a woman in the emergency department who was disabled by recurrent major depression. One month before her visit, she became extremely distressed and hopeless when she received a brochure outlining the Medicare Part D program and became overwhelmed by the complexity of the possible prescription benefit plans. This hopelessness led her to abruptly discontinue her ten medications for depression and cardiac disease, and she attempted suicide by overdose one week later.

Caring for this patient prompted us to compare the Medicare Part D prescription plans ourselves. A Medicare Web site (1) listed the 18 companies that offer a total of 44 different plans in Massachusetts—a daunting list. We called the customer service number for each company to request a Web site that would provide a drug formulary. Two offices left us on hold indefinitely, two were not open, two provided us with incorrect Web site information, and two did not have formularies accessible online at that time. Of the ten companies' formularies that were online, only one explained the cost of prescription drugs for Medicaid recipients. We searched the formularies for the ten medications used by the patient, using generic and brand names as written in her medication list. Of the various plans,

one offered all ten of her medications on its formulary; most offered from four to nine of them. In many cases, it was impossible to know the monthly cost of this list of drugs because of varying premiums, deductibles, copayments, and limits.

Among patients with mental illness, anticipation of changes in treatment providers or treatment plans can have a destabilizing effect. This case demonstrates the potential for psychiatrically and medically compromised patients to decompensate as they are faced with a complicated array of coverage options. Given 44 possible plans, each with relative advantages and disadvantages, covered and noncovered medications, and varying copayment options, it is understandable that individuals will experience stress over making such a decision. This stress is likely to be compounded when such a decision is made in the context of life-threatening illness, financial hardship, financial penalties for not choosing a plan in a timely fashion, and the possibility that a single plan will vary its formulary over time (2). In addition, considering the difficulty we faced as we researched the formularies over several hours, we wonder how physicians will obtain these lists when necessary.

Educating ourselves and our patients and maintaining their optimal treatment as they enroll in the Medicare Part D program will be an important and extremely challenging task.

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Patients' Views on Suicidality and Antidepressants

To the Editor: Reports in the popular media and public health advisories issued by the U.S. Food and Drug Administration have raised concerns that antidepressant medications may heighten the risk of suicidal thoughts and behaviors (1–4). We explored how adult patients with a diagnosis of major depression from an academic ambulatory psychiatric clinic might be affected by these news stories about antidepressants. As part of a larger anonymous survey on quality of life and depression, we examined two questions. Are patients paying attention to these stories in the media? Is the news affecting their confidence in antidepressant medications?

In the written survey, 630 patients were asked, "In the past several months, there have been several news stories about a potential unexpected effect of taking certain types of antidepressants. What has been the focus of these news stories?" This question was followed by, "How closely have you been following the stories?" A total of 278 patients returned the survey, for a 44 percent response rate. Of these, 242 (87 percent) completed the section on news stories about antidepressants. Those who completed this section did not differ from those who did not in gender, race, age, severity of depression, suicidality, and stigma concerns.

A majority of respondents (191 respondents, or 79 percent) correctly endorsed "possible increase in suicidal thoughts and behaviors" as the focus of the news stories. Of these, 45 percent followed the news stories somewhat or very closely. Logistic regression models showed that how closely the patients followed the stories was not influenced by their demographic characteristics, quality of life, severity of depression, experiences with suicidality, or concerns about stigma. Severity of depression and experiences with suicidality were measured with use of the Beck Depression Inventory (BDI) (5).

To measure how the news stories affected patients' attitudes toward taking antidepressants, we asked "Thinking back to the news stories, how have they affected your feelings about antidepressant medications?" and "Have you talked about the news stories with your psychiatrist?" Of the 191 respondents who correctly identified the content of the news stories, most (148 respondents, or 78 percent) reported that the news had "no effect" on their attitudes about taking antidepressants. In addition, the responses were not associated with demographic characteristics, current quality of life, experiences with suicidality, or stigma concerns.

Twenty-nine patients who reported feeling less willing to take antidepressants because of the news stories differed from those who reported not being affected by the stories. The 29 patients had more severe depression as indicated by elevated BDI scores (β=.060, p<.01), followed the news stories more closely (β=.949, p=.03), and talked more often with their psychiatrists about the news stories (β=2.504; p<.001). However, only 14 of the 29 patients (48 percent) who felt less willing to take medications reported talking with their psychiatrists about the stories.

In summary, a vast majority of patients being treated for depression in this clinic either did not pay attention to or were unaffected by recent news on antidepressants. However, the small minority who reported that they were less willing to take antidepressants because of the news stories seemed to have more severe depression, and only half of these patients reported talking with their psychiatrists about the news stories.

We suggest that psychiatrists consider probing for patients' reactions

to these news stories as a possible contributor to nonadherence, especially among patients with relatively severe symptoms.

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What Do People With Schizophrenia Think About Weight Management?

To the Editor: Rates of overweight and obesity are higher among individuals with schizophrenia and related disorders than in the general population (1). Evidence suggests that treatment with second-generation antipsychotic medications elevates the risk of weight gain, hyperglycemia, and hyperlipidemia and that the risk varies across agents (2–5).

Few studies have examined how individuals with schizophrenia view weight gain or weight management programs. We conducted focus groups to explore the views of patients with schizophrenia about weight gain; their knowledge about medical complications of obesity, such as diabetes and hyperlipidemia and the impact of antipsychotic medications on weight; and their interest in weight control interventions.

We conducted three focus groups in February and March 2005 for veterans with schizophrenia or schizoaffective disorder at the Bronx Veterans Affairs (VA) Medical Center who were taking antipsychotic medication. The center's institutional review board approved the study, and participants provided written informed consent. Focus groups lasted approximately 90 minutes, and the moderator followed a guide that contained general questions and suggested follow-up probes. Two independent reviewers coded each transcript, compared results, and resolved discrepancies by consensus. Participants completed brief anonymous questionnaires that asked about their age, height, weight, and previous weight loss efforts.

Twenty-three adults—22 men and one woman—participated in the groups. The mean±SD age of participants was 50±7.9 years. The mean body mass index was 30.9±4.3. Fourteen of the participants were African American, five were Hispanic, and four were non-Hispanic white. Twenty participants had tried losing weight, including 16 of the 17 individuals whose physicians recommended that they do so.

Most participants reported that weight was very important and that they weighed themselves regularly, cared about their physical health, and wanted to control weight to minimize medical complications and to look good. For some, weight control was secondary to symptom control. Participants considered a "comfortable" weight to be one that was compatible with performing daily activities without strain. Several participants worried that being thin would make them vulnerable targets on the city streets.

Opinions diverged about how much control people have over their weight. Participants believed medication and aging made weight loss more difficult and that antipsychotics contribute to weight gain by increasing appetite, decreasing energy level, and causing clumsiness (making exercise less fun). Aging also motivated some to take better care of themselves.

Additional barriers to weight loss included environmental factors, such as exposure to advertising for fast foods, readily available food delivery, and problematic home settings, such as group homes or families that undermined weight loss efforts. Participants acknowledged difficulty eating regular meals, limiting portions, and making healthy food choices.

Participants expressed interest in interventions, including nutrition and exercise programs. Most preferred combining individual and group sessions; several wanted to involve family members. Participants wanted specific, concrete information, including personalized menus and hands-on cooking demonstrations. They stated that they would feel more comfortable exercising at the VA than at commercial gyms. They wanted convenient hours and a motivating atmosphere. Opinion was split on the optimal site for nutrition and exercise programs: primary care or a mental health setting.

The key finding from our focus groups is that participants—individuals with schizophrenia who were being treated with antipsychotic medication—have concerns about weight gain and weight management that are very similar to those of the general population. They worry about their appearance and their physical health and find it difficult to adhere to diet and exercise plans. Furthermore, they believe that antipsychotic medication contributes to weight gain and makes losing

weight more difficult. [A sample of quotations from participants about some of the topics discussed in the focus groups is available in the online version of this letter at ps.psychiatryonline.org.]

This study represents a first step; focus groups are nonrepresentative samples, and our participants were mainly urban-dwelling male veterans. Regardless, our results suggest that a sizable constituency of individuals with schizophrenia is concerned about weight gain and interested in weight management programs.

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