

LETTERS

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A Question of Disclosure

To the Editor: The May 2008 issue focusing on the results of Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) was excellent. However, I wish to take exception to the article by Dr. Duckworth and Mr. Fitzpatrick (1), who are medical director and executive director, respectively, of the National Alliance on Mental Illness (NAMI). The authors express doubts about placing any restrictions on the availability of second-generation antipsychotics, claiming that restrictions "will hurt clinical care" and that cost savings will be "illusory." Their article strongly supports the position of the pharmaceutical industry.

In the same issue the article by Rosenheck and colleagues (2) notes that second-generation antipsychotics cost \$10 billion more per year than first-generation agents. I agree that all individuals with schizophrenia should be given a trial of second-generation drugs, but unless these drugs are superior for that individual, first-generation agents should be routinely used. If the newer agents are no more

effective for, say, half of all patients—I am guessing here—that would be savings of \$5 billion a year.

Whether we like it or not, the funding of mental health services is a zero-sum game. Five billion dollars will buy a lot of case managers, social workers, clubhouses, supported employment, and supported housing. The views expressed by Dr. Duckworth and Mr. Fitzpatrick thus do not represent my views as a member of NAMI nor, I suspect, the views of many other NAMI members.

The other issue raised by Duckworth and Fitzpatrick's article is the claim at the end of the article that the authors have "no competing interests" in writing about the issue of second-generation antipsychotics. The guidelines for articles submitted to *Psychiatric Services* state that "conflicts of interest may be direct . . . or indirect. . . . Reporting must include all arrangements that may present an appearance of bias" and should cover "the 12-month period preceding acceptance of the manuscript." The authors in this case are both employees of NAMI, which receives more than half its budget from pharmaceutical companies. According to the Eli Lilly Web site (3), that company gave NAMI chapters 62 separate grants in 2007; in the first quarter of 2008 Lilly gave \$520,000 to the national office of NAMI. These sums do not include gifts from other companies that market second-generation antipsychotics.

Thus it would seem appropriate for the authors to have acknowledged this potential conflict of interest so that readers could make their own assessment about whether the opinions expressed were the result of bias.

E. Fuller Torrey, M.D.

Dr. Torrey, a longtime NAMI member, lives in Bethesda, Maryland.

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3. Lilly Grant Office: Lilly Grant Registry: Disclosure of Grants and Contributions Funded by Eli Lilly and Company. Indianapolis, Ind, Eli Lilly and Co. Available at www.lillygrantoffice.com/grantregistry.jsp

In Reply: Dr. Torrey raises an interesting point. In fact, the journal's standard disclosure forms submitted by both authors contained the following statement: "NAMI receives financial support in part from pharmaceutical and healthcare companies, but does not endorse or promote any specific treatment, medication, service, or product." We decided not to add this information as a disclosure statement in the published article because the support in question is provided to the organization and not directly to the authors.

The decision reflects the journal's policy. Neither the editor nor the staff has the resources to make determinations about the levels of budgetary support provided by commercial interests to the variety of public, academic, and private organizations where authors work. If an author's research efforts or manuscript production are not directly supported by a commercial enterprise, then the journal does not require disclosure.

However, as Dr. Torrey points out in his letter, organizations such as NAMI that work to ensure effective care for people with mental illness have historically received large sums from pharmaceutical companies. The journal's staff and I hope that the decision not to list industry support for NAMI did not prevent our readers from assessing the validity of the authors' statements.

Howard H. Goldman, M.D., Ph.D.

In Reply: The history of care for people with serious mental illness in the United States has been one of broken promises. Dr. Torrey has done more to expose this shameful history than anyone else. In so doing, he has be-

come a true hero to NAMI members throughout the country. Thus it is surprising that Dr. Torrey would suggest that monies saved by prescribing first-generation rather than second-generation antipsychotic medications would be reinvested into more community mental health services. If this were so, then the dollars saved in recent years through downsizing and closing state hospitals should have translated into more community services. Sadly, this has not happened. Rather, states have taken these dollars and reinvested them in roads, prisons—anything but services for people with serious mental illness.

Dr. Torrey points out that NAMI receives contributions from the pharmaceutical industry. However, this does not mean that NAMI's advocacy agenda is driven by these contributions. NAMI has advocated consistently over many years to protect access to a wide range of treatment and services for people with serious mental illnesses, including antipsychotic medications. This position has solid grounding in science. Antipsychotic medications are not interchangeable. A medication that works for one person may not work for another. Thus, for people with schizophrenia and related disorders, a wide range of medications must be available so that clinicians can make informed choices in partnership with their patients about what works best.

Public education advocates would not argue among themselves about whether to prioritize funding for teachers or textbooks. Advocates for people with serious mental illness should similarly not argue over whether funding for medications or case management should be prioritized. Both are desperately needed.

Kenneth Duckworth, M.D.

Michael J. Fitzpatrick, M.S.W.

ACT for People With Intellectual Disabilities and Mental Health Problems

To the Editor: There is no consensus on whether assertive community treatment (ACT) for people with in-

tellectual disabilities who also have mental health problems should be identical to ACT for people with mental illnesses.

Two studies have evaluated ACT for people with intellectual disabilities and coexisting mental health problems (1,2). However, they used versions that were significantly different from each other and from the original ACT model (3). To evaluate the suitability of this model for this population, characteristics of ACT that are necessary for people with intellectual disabilities need to be identified. We therefore report the results of a study that explored the opinions of specialist health staff.

The participants were 21 staff from four sites in the United Kingdom that deliver ACT-type services to people with intellectual disabilities. Participants included psychiatrists, psychologists, intellectual disability nurses, support workers, and occupational therapists. In-depth structured interviews were carried out in 2006 by two experienced clinicians. Participants were asked to express their opinion about each of 26 statements about ACT derived from the Dartmouth Assertive Treatment Scale (4). After complete description of the study, written informed consent was obtained from all participants. Ethical approval was obtained from Guy's Research Ethics Committee.

In general, participants' opinions were similar, although some disagreement was noted. Participants believed that ACT for people with intellectual disabilities should include most of the structural and human resource features of the original model, including a shared caseload, regular team meetings, a practicing team leader, continuity of staff, and a vocational specialist on staff. They also thought that there should be more than one psychiatrist and more than two nurses per 100 service users. In regard to organizational boundaries, they believed that there should be explicit admission criteria, but having a low intake rate, 24-hour coverage, and a rule about not closing any cases were seen as unneces-

sary, unrealistic, or inappropriate for this population. Participants indicated that hospital admissions and discharge planning should involve personnel from the ACT service, but it was not agreed whether these personnel should take responsibility for such planning.

There was disagreement about whether the ACT service should have full responsibility for treatment services, particularly housing support, employment, and rehabilitation. Participants agreed that the nature of the ACT service should be similar to that of the original model, including community delivery of services, involvement of service users' support networks, and a stage-wise treatment model for those who misuse substances. There was disagreement on whether a no-dropout policy or high levels of service time and contacts were realistic or necessary. Participants did not support direct service provision by service users and family caregivers but agreed that their involvement in service development, support roles, and provision of feedback was essential. [Three tables that provide more details about participants' responses are available as an online supplement to this letter at ps.psychiatry-online.org.]

The main limitation of this study was that participants did not share the same level of understanding about the original ACT model. In addition, they were typically serving persons with a wider range of mental health problems than those for whom ACT was originally intended. A focus on patients with more severe mental health problems—for example, by restricting future research on ACT among persons with intellectual disabilities to those who also have psychotic disorders—would better complement research on ACT among persons with mental illnesses.

We thus hope that the findings reported here are useful for generating further discussion about ACT for persons with intellectual disabilities. It remains difficult to adequately determine whether service users with intellectual disabilities and mental

health problems might benefit from ACT because of ongoing problems with the definition and implementation of the model for this service user group as well the lack of specialist professionals working with people with intellectual disabilities and mental health problems who have close knowledge and experience of ACT. Hence studies such as this one will be similarly limited. In our opinion, therefore, it may be more fruitful at present to explore the effectiveness of broader models of specialist community-based services for people with intellectual disabilities and coexisting mental health problems.

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