to a controlled study that compares our model of acute inpatient care with the three outpatient alternatives mentioned by Dr. Heath. The primary outcome measure should assess changes in the trajectory of the patient's life course over six to 12 months after discharge. The study should, of course, include measures of patient satisfaction and cost-effectiveness. We're all for "international research," but we're not clear on which predictors can identify the 40% of patients for whom clinicians can "dispense with inpatient care" and the 60% who need inpatient care not only to prevent their illness from worsening but also to help them toward recovery.

We disagree with Dr. Heath's last paragraph. The issue is not where you treat patients who clinicians believe need inpatient care or how quickly you discharge them—or not admit them at all. Rather the objective is to provide controlled data on what is the most cost-effective treatment model in which mental health system to improve postdischarge outcomes for patients and their families, regardless of country.

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Is "Medication Visit" a Misnomer? Psychotherapy Challenges in 90862

To the Editor: The "medication visit"—code 90862—focuses on medication management with minimal if any psychotherapy. The time allotted is 15 to 20 minutes and services covered include prescribing medication, monitoring the effect of medication and its side effects, adjusting the dosage, and minimal supportive psychotherapy. The emphasis on treating mental disorders with medications has meant that psychiatrists now provide much less psychotherapy and more medication management. The percentage of visits to psychiatrists that involved psychotherapy declined from 44.4% in 1996–1997 to 28.9% in 2004–2005 (1). Reasons for this change in practice include the drive to reduce health care costs, the availability and prescription of psychotropic drugs, and increased acceptance of medication treatment. Given the decline in formal 45- to 50-minute psychotherapy sessions with psychiatrists and the fact that not all patients that psychiatrists see for medication visits have psychotherapists, we wondered to what extent prescribing clinicians are treating psychological problems during the medication visit that are unrelated to drug treatment.

In this exploratory study, six clinicians were interviewed in depth regarding the ten patients they saw most recently for medication visits, yielding a total of 60 visits. Patients presenting for the first time were excluded. Interviews were conducted between January and June 2010. The clinicians, aged 50 to 65 years, included four women and two men, all Caucasian. Five were psychiatrists, and one was a nurse practitioner. All prescribing clinicians provided direct patient care for at least 20 hours a week, and their years in practice ranged from five to 30.

The 60 patients, whose ages ranged from 19 to 78 years, included 29 men and 31 women. Their diagnoses were major depressive disorder (N=23, 38%), bipolar or schizoaffective disorder (N=18, 30%), anxiety disorders (N=9, 15%), psychoses (N=3, 5%), and eating disorders (N=3, 5%). One patient (2%) had dissociative disorder, one had dementia, and one had attention-deficit hyperactivity disorder.

Forty-one patients (68%) brought up psychological problems during their visit, mostly interpersonal conflicts and life changes (for example, retirement or a new role as a caregiver). For each of the six clinicians, the number of patients who raised psychological problems ranged from five to eight. Of the 41 patients who raised these problems, 14 (34%) had a psychotherapist. Seventy percent of the visits (42 of 60 visits) exceeded the stipulated 15- to 20-minute limit. For the patients with no psychotherapist, referral to conventional psychotherapy was limited by logistical issues, insurance coverage, and language or cultural barriers; some patients were resistant to referral because of their good rapport with their prescribing clinician. Experienced clinicians appear to have developed their own styles of brief psychotherapy to manage the psychological issues that arise during medication visits. However, the 45- to 50-minute model of the psychotherapy session that is currently taught in residency programs does not adequately prepare the novice psychiatrist. Given that the medication visit of 15 to 20 minutes is now the context in which psychiatrists are most likely to provide psychotherapy, residency training should be adapted to teach briefer techniques that are better suited to this time frame. Further, the explicit use of brief therapeutic interventions during the medication visit might make psychotherapy more accessible to patients and improve outcomes.

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