**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 e-mail address. Letters commenting on 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, at psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (mc.manuscriptcentral.com/appi-ps).**

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## A Medical Model for Today

In the March Open Forum, Barber suggests that recovery has become the basis for a modernized definition of the medical model in mental health (1). This shift would indeed align psychiatry to emerging science and practice, and it is strengthened by both practice and understanding in other areas.

In February, 18 leaders in substance use policy, research, practice, and recovery gathered at the Betty Ford Institute to share their ideas about further exploring the value of recovery supports in substance abuse treatment, co-occurring disorders, and addiction. Although we did not have the Open Forum commentary, I believe that this group would have been very supportive of Barber's conclusions. In particular, the group would have embraced her overarching perspective that a recovery-focused framework mirrors the actual evolution of the medical model while reflecting attitudes about mental health (and about substance use by proxy) held by consumers and their families. Barber's proposed approach to addressing each person's clinical recovery, illness management, and personal recovery would also have been welcomed.

Unique aspects of recovery from mental illness and from substance use disorders are evident. For example, although progress has been made in medication treatment of mental disorders and substance use disorders, many people seeking recovery from the latter continue to be concerned that some will use medications to avoid fuller treatment, sustaining their dependence and not attaining wellness and recovery. This is the nature of addiction. Accurate epidemiological differentiation of the presenting illness and the derived various pathways to its remission can also lead to unique considerations in substance abuse treatment. However, for the most part, similar approaches to those suggested by Barber are evolving in the treatment of substance use disorders, with associated improved outcomes (2,3). There are also more opportunities for improved outcomes via recovery supports that are brought to bear earlier on problematic substance use, suicidality, trauma, pain management, and so forth.

White and Davidson (4), who have sought to strengthen the conceptual bridge between the mental health and addictions fields, have noted that "a recovery revolution now is occurring within and across the addictions and mental illness problem arenas that challenge practice within both of these fields, as well as their historical segregation." They noted that the evolving system is more culturally competent, trauma informed, evidence based, inclusive of families, based on strengths, and connected to communities served. When clinical practices such as these (2,3) and the new practices described by Le Boutillier and colleagues (5) are implemented, improved ownership of personal health and the health of families has been noted, along with increases in treatment completion, personal hope, and community service.

Barber points the way to improved practice through a recovery framework that encompasses the individual, family, and community and the best science and practice and that recognizes the value of addressing both the illness and recovery from it. Although her commentary is grounded in her work in the mental health field, this person-centered medical model has great relevance not only for mental health but also for substance use and each community's health in general. It should be the basis for a new medical model.

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## Mental Illness Recognition and Referral by Catholic Priests in North Carolina

Deinstitutionalization ushered in an era of community-based care in which early recognition and treatment of mental illness is emphasized. Identifying individuals with mental illness or substance abuse problems and getting them into treatment is a persistent difficulty. Some persons seek treatment directly from health care professionals, but researchers have found that many turn first to clergy (1–3). Clergy have been described as a kind of "gateway" to the health care system,

particularly for persons from ethnic minority groups, who may be impeded by financial difficulties, be unfamiliar with local resources, or have concerns about stigma (2).

However, little is still known about what clergy do when they encounter people with psychiatric problems. They may feel uncomfortable or inadequately trained to recognize mental illness (1,4). They may also feel disinclined to refer people to mental health providers who do not have a similar religious worldview or if they believe that providers might undermine a person's religious faith (1,2,5). These factors could delay or preclude treatment.

Because Catholics constitute a quarter of the U.S. population and represent the largest single religious denomination in the country, we conducted an online survey of Catholic priests in North Carolina to better understand how comfortable and capable they are with identifying and responding to individuals with mental illness. We also wanted to understand the importance that priests place on a shared worldview with providers. A 16-question survey was distributed to all Catholic priests (approximately 300) in North Carolina via diocesan Listservs. It included a questionnaire eliciting demographic information (age, years as a priest, level of mental health training, and parish setting) and information about the respondent's comfort level with identifying and responding to mental illness. Four vignettes described cases of mania, major depression, domestic abuse, and moderate alcohol use. Respondents chose to handle cases themselves or refer to a fellow priest, family or friends, a mental health professional, a primary care physician, or other. Data were collected between October and November 2011. The study was granted exemption by the institutional review board of the University of North Carolina at Chapel Hill.

Forty-eight priests completed the survey (response rate of 15%–20%). Most (87%) felt comfortable recognizing mental illness, and most (87%–92%) sent vignette patients for additional services when circumstances were severe (for example, mania, domestic abuse, and suicide risk). Most (85%) felt that it was either "critical" or "important" that providers have a similar religious or philosophical worldview, which suggests that although priests may have concerns about providers' handling of specific matters of faith or morals, most understood the need to involve other providers in a crisis.

Although the low response rate limits its generalizability, Catholic priests appeared to understand and feel comfortable with their role in the caregiving system. Future research could explore the types of people and problems that priests encounter and the referral process and identify areas of common ground to facilitate collaboration. Nonetheless, priests can be seen as able and willing partners in community mental health providers' efforts to identify and treat people with mental illness, domestic abuse, or substance abuse problems.

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***Editor's note:*** This letter is part of TRAININGrounds, an occasional series of reports by trainees to highlight the academic work of psychiatric residents and fellows and to encourage research by trainees in psychiatry. Prospective authors should contact Joseph M. Cerimele, M.D., series editor, to discuss possible submissions: Mount Sinai School of Medicine, 1 Gustave L. Levy Place, Box 1230, New York, NY 10029 (e-mail: joseph.cerimele@mssm.edu).

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