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).

Where Are the Psychiatric Physician Assistants?

To the Editor: In the October 2009 issue, Thomas and colleagues (1) documented the severe shortage of mental health practitioners who are prescribers in the United States and suggested several strategies to grow the prescriber workforce. One approach emphasized expanding the number of advanced practice psychiatric nurses. Another advocated extending prescribing privileges to psychologists. We found it curious that one group of midlevel providers, physician assistants, was not mentioned. We agree that increasing the number of midlevel prescribers is part of the solution to this critical unmet need. However, there are legitimate concerns about solutions that might endanger patient safety by demedicalizing psychiatric practice (2). Physician assistants who receive additional psychiatric training may provide a safe and cost-effective solution to this problem.

The number of physician assistant programs and graduates is expanding dramatically. During the relatively brief history of this profession, physician assistants have demonstrated a laudable record of providing primary health care services to rural and underserved communities. Physician assistants work under the supervision of physicians and have a history of successful collaborative partnerships with psychiatrists. Therefore, there may be much less political and legal resistance to expanding the number of psychiatric physician assistants than to granting prescriptive authority to other professional disciplines.

Although most physician assistants obtain postgraduate specialty training on the job, an increasing number of these medically trained providers pursue advanced training in formal year-long postgraduate fellowship programs. This specialty training seems particularly relevant because some of the clinical skills and knowledge required for mental health practice (for example, psychiatric interviewing and diagnosis, basic counseling skills, and knowledge of interpersonal dynamics) are not covered in depth during the general two-year physician assistant curriculum. Formal year-long physician assistant psychiatric training programs would enable new graduates to rapidly increase their competency to treat persons with mental illnesses, which might otherwise take many years of "on the job" experience. Unfortunately, there is a shortage of such programs. The Association of Postgraduate Physician Assistant Programs lists only two postgraduate programs in psychiatry (3).

We believe that dramatically increasing the number of psychiatric training programs for physician assistants may be an important step in developing a comprehensive mental health care workforce strategy designed to train prescribing professionals. Academic departments of psychiatry could take the lead in the development of these programs, with a primary focus on public and community psychiatry or treatment of persons with chronic mental illness so that graduates would be ready to serve in areas of greatest need. By drawing upon a department's PGY-1 psychiatry curriculum and modifying existing training resources, it is even conceivable that psychiatric physician assistant programs could be established relatively quickly.

Indeed, there is a paramount need for flexibility and creativity in crafting solutions to the desperate shortage of mental health care prescribers while maintaining a transdisciplinary commitment to patient safety. Searching for ways to increase the number of psychiatric physician assistant training programs may be an important, but seemingly overlooked, first step in achieving this critical balance.

Glenn D. Grace, Ph.D., M.S.
Richard C. Christensen, M.D., M.A.

Dr. Grace is affiliated with the North Florida–South Georgia Veterans Health System and with the Department of Clinical and Health Psychology, University of Florida, Gainesville. Dr. Christensen is with the Division of Public Psychiatry, University of Florida College of Medicine, and is director of behavioral health services at the Sulzbacher Center, Jacksonville.

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In Reply: Grace and Christensen make an interesting contribution to the discussion of shortages by suggesting that physician assistants may be well positioned to provide needed additional mental health services. Their letter provides an opportunity to clarify the take-away messages presented in our recent workforce articles.

First, to clarify the role of physician assistants in our analyses, our estimates of mental health need were based on estimates of actual service use, which included any visits with physician assistants that could be identified as mental health visits. Our supply estimates excluded psychiatric physician assistants because, as Grace and Christensen point out, very few

exist. Our shortage estimates were adjusted for the availability of primary care providers, including physician assistants, to account for the fact that some mental health services are provided in primary care settings.

Second, we do not argue for or against "demedicalizing psychiatric practice." We mentioned a variety of ways in which states have expanded services to meet mental health needs, including the extension of prescriptive authority to new professional groups. Our intention was to generate discussion about workforce shortages rather than to endorse any particular solution. Further, we agree that the safety of consumers is important. Any professional group taking on the role of mental health prescriber would require additional training and appropriate supervision.

Third, this discussion raises a broader set of issues that need to be considered in addressing mental health needs. Grace and Christensen touch on some of these issues. A key point is that training alone will not solve the problem, and there is no guarantee that new providers will practice in the public sector or in rural areas where the greatest shortages exist. We need to learn how to make practice in these areas both feasible and attractive to mental health professionals. Another point is that legal or political resistance to policy changes will surely come into play. However, maximizing the well-being of consumers should be an overriding concern in determining new mental health policies.

Finally, we want to emphasize that our recent workforce studies were based on current treatment patterns. The ways in which mental health services are currently organized and delivered in the United States, however, are not necessarily the best ways. What's needed, then, is a deeper discussion about financial organization, service system structure, and the appropriate balance among treatment modalities, including individual treatments such as medication, counseling, diet, and exercise as well as systemic interventions with families, wider social networks, and communities. Long-term mental health workforce development depends not only on producing sufficient numbers of qualified professionals but also on building satisfying work environments and using the best available strategies to help create meaningful outcomes for consumers.

Kathleen C. Thomas, Ph.D.
Alan R. Ellis, M.S.W.
Joseph P. Morrissey, Ph.D.

Maltreatment and Mental Health Care: Focusing on Child Neglect

To the Editor: In an important article in the October 2009 issue, Smith and colleagues (1) reported that physical, emotional, and sexual abuse each increased the likelihood of receipt of psychiatric services by African-American children. The authors contrasted this finding with results from a previous study of mine (2) that used data from the Capella Project, a site of the LONGSCAN study (LONGitudinal Studies on Child Abuse and Neglect). The study found that maltreatment had no effect on the likelihood of receipt of mental health services in a young, predominantly African-American sample. Smith and colleagues suggested that this discrepancy was attributable to differences between our samples; the children in the Capella Project sample were younger and more racially heterogeneous and most had been recruited from families reported to child protective services. They noted that the age of the Capella Project sample was particularly likely to explain this difference: that study examined services for children aged two to seven. There is likely some truth to this explanation. Analyses of data from the sample at an older age found a stronger effect of maltreatment on receipt of mental health services (3).

I would like to suggest an additional explanation for the discrepancy in our findings. Although it was not noted in our original reports (2,3), the maltreatment experienced by children in the Capella Project, at least as reported to child protective services, was overwhelmingly likely to be neglect (4) rather than physical or sexual abuse. Child neglect is a serious public health problem and is associated with child outcomes that are generally as negative as those associated with physical and sexual abuse (5). Despite its broad and profound impact on child behavioral and emotional development, neglect remains relatively understudied, particularly in mental health services research (5). The majority of children who have been neglected do not receive adequate mental health care.

The contrast between the results of my research and of Smith and colleagues' study points to a need for increased attention to the particular mental health needs of neglected children, which are often profound and are rarely addressed adequately in the real world.

Richard Thompson, Ph.D.

Dr. Thompson is director of research, Juvenile Protective Association, Chicago.

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The Internet, Health Promotion, and Community Participation

To the Editor: Health, wellness, and full participation in life activities take on new meaning in the 21st century, when community is no longer

simply defined by neighborhood boundaries, racial or ethnic background, or social class and when health care is no longer characterized by a visit to the doctor or the hospital. New media technologies, Web environments, and mobile devices provide access to virtual opportunities for active information seeking and shaping, real-time interaction and relationship building, and collaborative community involvement (1).

Although the Internet and the participatory media culture provide support for patient-driven health care, innovative patient communities, and the development of new health care models (2), these media may present additional barriers and thus contribute to emerging disparities in health and health care and further community disenfranchisement for individuals with serious mental illness. These individuals, who are at high risk of health conditions that shorten their lives considerably, may benefit most from access to online health education information, treatment guidelines, advocacy materials, and peer support and networking opportunities.

However, as Borzekowski and colleagues (3) reported in the September 2009 issue, only a third of the 100 participants with serious mental illness in their study used the Internet, and only a small percentage had ever gone online to find pertinent health information. Data for the study, which were obtained from patients at community treatment sites, are consistent with earlier findings from the Pew Internet and American Life Project that only half of persons who were living with a disability or chronic disease had gone online, compared with 74% of those with no chronic condition (4). The Pew study found that far fewer individuals with disabilities had searched for mental health–related information (30%) than for information about a specific disease or general medical problem (73%). Taken together, these findings suggest that individuals disabled by serious mental illness may be least likely among persons living with disability or chronic disease to use the Internet as a tool for health promotion.

We applaud Borzekowski and colleagues' conclusion that challenges such as the cost of access and lack of training must be overcome for people with serious mental illness to take full advantage of the Internet (3). However, we would like to underscore further, as the authors briefly suggest, that individuals with serious mental illness are particularly disadvantaged by the lack of accommodations in Web design that would allow them to overcome barriers to Internet use that result from possible illness-related impairments in cognition, concentration, executive function, and motor control. The work of Rotondi and colleagues (5) suggests that Web applications must be developed with the needs and challenges of individuals with serious mental illness in mind. Design considerations include the benefits of a flat hierarchy, explicit labeling, lower-level modules, familiar phrasing, and text presented at a lower reading level (5).

Findings from studies of Internet use suggest the need for design accommodations if further disparities in access to health information, intervention resources, and peer supports are to be avoided. As Web-based applications involve increasingly more complex skills, opportunities for health promotion may be lost. Individuals with serious mental illness may become even less able or less likely to participate in the community provided by the world online.

Joanne Nicholson, Ph.D.
Armando J. Rotondi, Ph.D.

Dr. Nicholson is affiliated with the Department of Psychiatry and Family Medicine, University of Massachusetts Medical School, Worcester. Dr. Rotondi is with the Department of Critical care Medicine, University of Pittsburgh, and the Veterans Affairs Integrated Service Network 4 Mental Illness Research, Education and Clinical Center, Pittsburgh.

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Closer Look Needed at Youths in Adult Facilities

To the Editor: In the August issue, Murrie and colleagues (1) brought much-needed attention to the paucity of research exploring the impact of incarceration in adult prisons on the mental health of juveniles. The authors effectively described the legal and political developments that have contributed to an increase of juveniles housed in adult correctional facilities. Further, they recognize that although this subgroup may be small compared with the large number of youths in juvenile facilities, providing empirical evidence of the need for a systematic approach to addressing treatment and safety needs in this subgroup may lead to numerous mental health benefits and cost savings.

Murrie and colleagues used the Massachusetts Youth Screening Instrument–Version 2 (MAYSI-2), a mental health screening measure widely used in the juvenile justice system, to gather data about the mental health problems of juveniles in adult prisons and compared their responses to MAYSI-2 national normative data for youths in juvenile facilities. However, the authors did not sufficiently address several methodological concerns, such as the potential impact of situational influences and time of measurement on the expression of

psychiatric symptoms. Also, multiple sources of data should be used to ensure diagnostic accuracy. These considerations are especially important in this population and could have been anticipated and addressed by the investigators to improve the measurement of their important research questions.

There are several considerations when gathering psychiatric data from inmates. Youths in adult prisons, similar to adult inmates, usually have limited access to various resources, such as stimulant medications, and may mislead medical or mental health staff about the severity of their distress to gain access to these resources. In addition, antisocial and borderline personality disorders are prevalent in correctional settings; inmates may malinger or be motivated by secondary gain (2). Although Murrie and colleagues studied the psychiatric symptoms of juveniles, the influence of these contextual factors on responses to questionnaires by youths in an adult prison should be considered. In addition, environment-specific events may modify the manifestation of "faking bad," or exaggerating symptom severity, such as pending legal cases, changes in housing status (for example, placement in segregation), or a desire to transfer to another facility (3). The authors recognize a temporal dimension when discussing possible explanations for the low rates of self-reported substance use in their sample, but they offer no viable solutions. I suggest using multiple sources of information at different intervals to assess these psychiatric symptoms—for example, conducting brief clinical interviews and administering personality assessments such as the Minnesota Multiphasic Personality Inventory—to better estimate the true prevalence of mental health problems of juveniles in adult prisons.

Also, I suggest that Murrie and colleagues report results by race and ethnicity. Racial-ethnic disparities with regard to diagnosis of mental disorders, treatment, and outcomes are well documented (4). There is value in discerning any disproportional representation of youths from racial-ethnic minority groups in the subgroup of juveniles incarcerated with adults. Addressing potential disparities in the mental health care of this population has important ethical, public health, and criminal justice policy implications. Incorporating these methodological features into their study would have enhanced their findings about psychiatric diagnoses and treatment needs of this population and helped to determine appropriate interventions.

Brian McGregor, Ph.D.

Dr. McGregor is a health policy fellow at the Satcher Health Leadership Institute, Morehouse School of Medicine, Atlanta.

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In Reply: We appreciate Dr. McGregor's concerns and share his desire to see more comprehensive research addressing juveniles incarcerated in adult prisons. When we began our research, no empirical studies had addressed the mental health needs of this group. Thus we faced a dilemma common to researchers approaching any understudied area: Should we wait until we can conduct "the perfect study," or should we begin with a broad "screening" that might identify where further inquiry is needed? This research dilemma is analogous to the clinical dilemma common in the juvenile justice system: Should we attempt a comprehensive assessment of every youth, or should we conduct a broad screening to identify which youths—or which concerns for a particular youth—warrant further assessment? Often, the only practical option in either context is to begin with broad screening.

Because our goal was a broad overview of treatment needs among youths in adult prisons—particularly as compared with youths in juvenile justice facilities—we selected the only measure that allows for comparison to a nationally representative, ethnically diverse sample of youths in juvenile justice facilities (1). The MAYSI-2 (2), more than other measures, allows us to compare "apples to apples" when investigating self-reported symptoms among juveniles across various justice contexts.

As Dr. McGregor notes, the MAYSI-2 does not provide formal diagnoses and cannot rule out symptom exaggeration or symptom minimization. Participants may have reported some symptoms for secondary gain—a possibility in any study of incarcerated juveniles or adults. It was perhaps less likely in our sample of youths, who had already been adjudicated and could not leave the Youthful Offender Program until they reached a certain age, which minimized the opportunity for secondary gain. Most of the limitations of MAYSI-2 apply to other self-report measures, and as we noted in our article, we must accept these limitations if our results are to remain in "a common metric" for comparison to juvenile justice studies. Might we learn additional detail from studies that use clinical interviews and structured personality measures? Absolutely! We hope that we—or Dr. McGregor or others—can create opportunities for research that uses such comprehensive assessments. But just as clinicians administer a screening measure to form a general impression of a patient's functioning and where further assessment is needed, we administered a screening measure to form a general impression of a population's functioning and the need for further assessment. Our study revealed many self-reported symptoms, so we certainly agree with Dr. McGregor that further research using other assessment strategies is essential.

Finally, Dr. McGregor suggests that we report results by race-ethnicity. We certainly agree with the spirit of his comment. Indeed, one of us (GMV) addressed this important question in the MAYSI-2 national normative data (1). In our study, we matched our sample and the comparison sample for race-ethnicity, but we chose not to present race-ethnicity analyses because small cell sizes for some groups (eight white participants) might have yielded misleading results. Disparities, too, warrant further assessment in this population, but only with subsamples large enough for race-ethnicity analyses to be meaningful. Instead, we refer readers to the large MAYSI-2 normative data study, which found that race effects on the MAYSI-2 scales were usually negligible.

Daniel C. Murrie, Ph.D.
Craig E. Henderson, Ph.D.
Gina M. Vincent, Ph.D.

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Action Plans for Psychiatric Services

To the Editor: This letter was prompted by reading and reflecting upon the three articles in the October issue that reported on county-level estimates of the need for mental health professionals (1–3). I am impressed by the huge amount of effort expended by these authors to make accurate estimates, and their results are indeed extremely interesting.

I have read *Psychiatric Services* assiduously for the past decade. Every month I am impressed with a specific article about a new and innovative way of helping people with mental illness.

What prompted my letter was the fact that, at this point, with the publication of so many different specific articles, it would be extremely helpful if all of this material could be put together in an action plan that could be used by counties with a shortage of professionals to develop a comprehensive and effective mental health plan. There certainly is a very large amount of material available addressing the various dimensions of mental health care. It would seem most appropriate at this point to begin a process of coalescing this accumulated material so that someone could take "off the shelf" data based on all this material.

William S. Masland, M.D.

Dr. Masland is in private practice in Yuma, Arizona.

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In Reply: Thank you for your kind comments about *Psychiatric Services.* We try to publish a journal that is both interesting and useful, and we hope that the accumulated scholarship is worthy of summary and implementation.

We support your suggestion for using our published articles to develop an action plan. While it is beyond the scope of the journal to summarize evidence and develop plans of action, others do so periodically. A decade ago the Surgeon General summarized the available evidence for the field in a report on mental health, and many of the research reports cited in the report were from *Psychiatric Services.* That document provided "courses of action" for improving mental health in the United States. More recent summaries and related recommendations emanated from the President's New Freedom Commission and its call to transform the mental health care system. Let us hope that the new year will bring more excellent papers to the journal and effective action plans to improve psychiatric services, here and abroad.

Howard H. Goldman, M.D., Ph.D.
***Editor,* Psychiatric Services**