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 and fax numbers and e-mail address. Letters related to material published in *Psychiatric Services* will be sent to the authors for possible reply. Send letters to John A. Talbott, M.D., Editor, *Psychiatric Services*, American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005; fax, 202-682-6189; e-mail, psjournal@psych.org.

Poverty, Social Problems, and Serious Mental Illness

To the Editor: We are pleased that our paper in the May issue (1) prompted Dr. Nelson (2) and Ms. Severson and Dr. Lieberman (3) to write commentaries. Their divergence in opinion about the status of the issues addressed in the paper reinforces our perception that there is a need for mental health service providers, researchers, and policy makers to discuss these issues.

On one hand, Dr. Nelson rejects our contention that poverty and other factors play an important role in the social problems experienced by persons with serious mental illness. He argues that mental illness is the root of social problems experienced by persons with mental illness and that treatment for the illness will ameliorate these social problems. On the other hand, Ms. Severson and Dr. Lieberman contend that our arguments are old, and they imply that these arguments are so widely accepted in the mental health community that they deserve little additional comment. The authors argue that action, rather than continued reflection, is needed.

The central thesis of our paper is that poverty has a profound impact on homelessness, employment, and involvement in the criminal justice system independent of the presence of a mental illness. We do not ignore mental illness as an important factor in the experience of poverty, but we note that focusing on aggressive treatment of the illness will not bring persons with serious mental illness out of poverty. Continued impoverishment is what keeps them at high risk of experiencing the aforementioned social problems.

Thinking about policy or program interventions is not an academic sidebar; it is at the center of action. We would argue that this approach is not reinventing the wheel but that understanding the contemporary social and political contexts in which mental health services are embedded is essential to understanding where the mental health wheel fits, and what it can and cannot do. Vigilance is required in understanding changing contexts and changing times. Ideas for new interventions do not exist in the context of early 20th century Europe, which is the context for the historic Penrose study (published in 1939) mentioned by Ms. Severson and Dr. Lieberman, but in the contemporary U.S. context in which the rate of adult incarceration is currently more than four times the 1975 rate (4).

Perhaps it is discomforting when the implications suggested by our analysis seem at odds with our conceptions of our roles as mental health professionals, whether we are social workers, psychologists, nurses, or psychiatrists. Perhaps that discomfort is a starting point from which to face the challenge of developing truly new directions and new ideas.

We hope that readers of the journal will examine the literature we cited in our paper along with related studies and that they will apply our basic criticism to their reading. The comparisons that would most validly support connections between serious mental illness and these social problems are rarely made. For example, in both commentaries on our paper, the authors note that most people with mental illness who are in jails are there for misdemeanors, which they assert supports the criminalization hypothesis. They offer no evidence that this is any different than for the general jail population. The number of misdemeanors among the jail population with mental illness might seem high, but high compared with what? Do these differences remain after the proper controls are used? (5). Even if people with mental illness are more likely to be arrested for misdemeanors, such a simple comparison may not take into account the factors that typically explain arrest.

We hope this conversation continues, and we join in proposing and encouraging more action—but action based on reflection. Actions based on a misunderstanding of the problem can be ineffective at best—leading to misallocation of resources—and may even have an adverse effect. Painstaking effort to understand the work of mental health professionals and its impact, especially when the impact is complicated, is ultimately in the best interest of our clients.

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Mark Salzer, Ph.D.
Dennis Culhane, Ph.D.
Trevor Hadley, Ph.D.

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To the Editor: Nelson's response (1) to the article in the May issue by Draine and his colleagues (2) illustrates the stubborn persistence of clinical illusions about the relation-

ship between mental illness and crime, unemployment, and poverty. Nelson states that the article "does not succeed in showing that untreated mental illness is not substantially associated with these conditions." Draine and colleagues' extensive documentation that the effects of mental illness are considerably smaller than have been implied in the psychiatric services literature would cause most readers to turn Nelson's response on its head: "Psychiatrists have not succeeded in showing that untreated mental illness per se is substantially associated with these conditions."

Perhaps because of their clinical roles, psychiatrists more easily identify the proximal causes of these conditions. Thus Nelson points to "the paranoia often associated with homelessness." Indeed, mental illness may appear to be the dominant factor at the point of entry into homelessness, unemployment, or prison. However, a scientific approach necessitates that we ask questions about distal causes (3). For example, what is it about persons with mental illness that make them more likely to become homeless? The article by Draine and colleagues provides evidence that factors such as poverty, unavailability of low-cost housing, and the inaccessibility of services more strongly explain why a mentally ill person shows up at the shelter door than does his or her psychosis.

Despite the excellence of the article by Draine and his colleagues, they have relied primarily on one conceptual model, whereas a multitiered approach must be considered. The effects of the relationship between poverty (P) and mental illness (M) on outcomes (O) such as homelessness, unemployment, or criminality can be understood by at least three different models, which are not mutually exclusive (4). The first model postulates that the relationship is additive: P + M=O. Thus M may have an independent effect on O, and then P further increases the likelihood of O. However, this model also allows for P to modify the effects of M. In other words, if there is a correlation between the two, adding P to the analysis would diminish the original effect of M on O.

The Draine article focused primarily on the implications related to this model. However, a second model proposes that the relationship may also be interactive: P × M=O. Hence, the likelihood of O increases appreciably as the level of P or M increases, and conversely, if the level of either P or M is low, the risk of O is much less.

The third model hypothesizes that the relationship between P and M are dialectical so that they are mutually transforming. Thus P alters M so that the mentally ill person who becomes poor is more vulnerable to O, or conversely, a poor person who becomes mentally ill is more vulnerable to O.

Although I agree with Severson and Lieberman (5) that it is time to put money into solving these problems, they minimize the necessity of combining theoretical research with practice as well as the role research plays in refuting those who neglect the social concomitants of mental illness in favor of biomedical solutions. The wheel keeps being reinvented because scientific research is not a dispassionate enterprise. Too often, the questions posed and whether results are acted upon depend on sociopolitical forces.

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Pastors' Perceptions of Mental Disorders

To the Editor: Churches have long been considered community resources offering support to persons in need. Clergy are readily available in times of crisis and enjoy high levels of public trust (1). Their relationships with individuals and families are often long term, and many pastors can mobilize sizable numbers of volunteers. Collaborative activities between mental health programs and churches, especially social clubs, integrate social resources and increase the community support available to persons with mental disorders (2). However, we know little about clergy members' knowledge of and attitudes toward mental disorders and formal treatment services, especially psychotropic medications. To what extent are their views consistent with current biomedical knowledge, or instead based on religious interpretations?

At our initiative, three conference offices of the United Methodist Church distributed surveys about the causes of mental disorders, perceptions of people with mental disorders, and views of medications and other treatments to 1,718 pastors in Indiana and Virginia. A total of 1,031 surveys (60 percent) were completed.

Results indicated that most pastors have mainstream, up-to-date views about the causes of mental disorders. Three causes of mental disorders that are based in biology—chemical imbalance, excessive use of drugs or alcohol, and inherited genes—were all perceived as more important than three psychosocial causes—inconsistent parenting, social pressure, and spiritual poverty. Each of these six biopsychosocial variables was seen as a very important or somewhat important cause of mental disorders by more than half of the sample (54 to 94 percent). All remaining causes, which included explicit religious interpretations and "fate or luck," were seen by more than half the sample (from 60 to 83 percent) as not important in causing mental disorders.

Most of the pastors (from 53 to 86 percent) agreed or strongly agreed that

medication helps people control symptoms, deal with day-to-day stresses, manage relationships, and feel better about themselves and that "mental illness is like any other illness." Most pastors (76 percent or more) were neutral about or disagreed with statements that prayer and counseling are more important than medication in treating mental disorders. Eighty to 90 percent also disagreed that people with mental illnesses cause their own problems or can control their behavior and symptoms and that no one can really do anything to solve a patient's problems.

Interestingly, 484 respondents (47 percent) disagreed with the statement "Mental patients are no more dangerous than an average citizen," while only 243 (24 percent) agreed. That is, almost half of the pastors perceived that people with mental disorders are more dangerous than the average citizen, which may reflect negative stereotyping of individuals with mental disorders.

In summary, most pastors in this large, mainline Protestant denomination appear to have an informed, scientifically based understanding of the causes of mental disorders and of the importance of medications in effective treatment, which suggests a promising basis for useful communication and collaboration with psychiatrists and other professionals.

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High-Bandwidth Interactive Telepsychiatry

To the Editor: In response to a review of research on telepsychiatry (1), Werner (2) focused on a number of important issues in the development and implementation of telepsychiatry for delivery of care. He emphasized the cost of an organizational structure and the need for high utilization to justify a telepsychiatry system. Given his impression that high-bandwidth interactive telepsychiatry is not economically feasible, he suggested alternative approaches to interactive telepsychiatry. These alternatives included the provision of services by nurses, psychiatric physician assistants, and trained primary care physicians, followed by a telephone call to a psychiatrist and the review of videotaped structured interviews by a psychiatrist, followed by a telephone call to the treating clinician. However, Werner rightly concluded that maybe the most difficult questions are related to "the quality of human interaction and the importance of personal contact with a caregiver."

I have been involved with a telepsychiatry project between the department of psychiatry at the University of Michigan and Hiawatha Community Mental Health in the Upper Peninsula of Michigan. The purpose of the project was to determine the feasibility of adolescent telepsychiatry. After some clinical experience with high-bandwidth (384 kB) interactive telepsychiatry for evaluation and treatment I think it worthy of further development, but I question whether the use of other professionals or videotapes augmented by telephone contact with a psychiatrist would suffice in providing adequate care to children and adolescents with serious psychiatric disorders. These patients have constituted some of the most difficult and unstable cases in the local mental health system because of two factors—numerous comorbid conditions, some of which had not been previously identified, and the use of multiple medications. The management of such complex cases is difficult even in face-to-face encounters. The care of these patients involved case management, reviews of cases with parents, provision of services by support system personnel, and, ultimately, seeing a patient face-to-face.

Without question, other health professionals could not have delivered the same quality of care, because they are not trained to identify important clinical phenomena and to ask specific questions when these phenomena need clarification. The use of videotaped structured interviews also would not have resulted in the same high-quality care, because it does not allow a clinician to pursue clinical areas that need clarification within the time frame of the direct contact. The detection of some clinical phenomena requires more than simply hearing a voice over the telephone. Only during eye-to-eye, face-to-face contact can a clinician discern certain diagnoses and explore the subtleties of various diagnoses and the response of these conditions to multiple medications. High-bandwidth interactive telepsychiatry allows clinicians to have such an experience with patients.

Telepsychiatry is an area that needs further investigation and clarification. It is easy to rush into the use of a new technology without a thorough investigation of important factors. It is just as easy to dismiss the value of a new technology. Nevertheless, unless systems of high-bandwidth interactive telepsychiatry are developed, some patients will never receive adequate care under any circumstances. Their conditions will go unrecognized or, worse, the patients will receive poor-quality psychiatric care under the name of adequate care. From my perspective, the development of high-bandwidth interactive telepsychiatry is a viable alternative.

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In Reply: I agree with Dr. Alessi's proposition that telepsychiatry should be explored as a means of providing care to a difficult-to-treat patient population in an underserved rural area that lacks psychiatric specialists. I also sense that he agrees with me that proper study of such treatment efforts needs to be undertaken. In fact, in my letter I raised a series of research questions that might be considered after I suggested that any study of telepsychiatry should include the costs per contact of the service provided. These were research questions, not an opinion about what services should be used. The issue of cost was addressed in an earlier paper (1); because of advances in technology, costs now should be lower than what we estimated in 1998.

A strong case can be made for using an expensive technology when alternatives are not available. Because of the interactive nature of telepsychiatry, one of its most promising aspects is its use as a teaching medium. For example, after conducting a number of consultations with a psychiatric nurse practitioner for a particular problem, one would expect an improvement in the nurse's ability to handle similar problems. It strikes me that expanding the capabilities of professionals in rural mental health centers is critical unless we either provide distant consultation indefinitely or decide to move to the Upper Peninsula of Michigan ourselves.

I hope Dr. Alessi will share his data with us, including the numbers of telepsychiatry contacts per year, the types of contacts—new patients, medication management sessions, emergency evaluations—and the cost per contact, as well as any data on outcomes as they compare with outcomes in similar populations treated in other ways.

Arnold Werner, M.D.

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Incorporating School Mental Health Programs in SCHIP Plans

To the Editor: Awareness is increasing that many children and adolescents who need mental health care do not receive it. Community mental health centers have provided services to some, but many youths who are uninsured or lack access to these centers have gone without needed treatment.

Expanded school mental health (ESMH) programs offer comprehensive mental health care for youths in general and special education in schools and reach youths who might not otherwise receive care. The State Children's Health Insurance Program, or SCHIP, provides insurance for youths from low-income families. Involvement of school-based mental health programs in SCHIP is important, because clinicians in schools frequently work with the population that SCHIP was designed to serve.

To better understand how to enhance connections between SCHIP and ESMH programs, we conducted a national survey of leaders who were involved in or knowledgeable about the development of SCHIP plans in their state or the role of mental health programs in schools (1).

Forty-nine respondents, including ten state health department officials, 12 state CHIP directors, 13 directors and four clinicians from ESMH programs, and ten administrators from state Mental Health Association offices and the Maternal Child Health Bureau, completed 30-minute telephone interviews. Questions addressed ideas for involving ESMH programs in SCHIP plans as well as ideas for overcoming the challenges inherent in this effort. The interviews were transcribed and then reviewed by two of the authors to uncover key themes.

Most respondents had highly favorable views about incorporating ESMH programs into SCHIP plans, typically because children from low-income families have better access to mental health services in schools than in community agencies. Unfortunately, several obstacles, such as lack of billing infrastructures and difficulty completing credentialing processes, may hinder the involvement of ESMH programs in SCHIP. Respondents made several suggestions for overcoming barriers. For instance, ESMH programs could work together, or with other community mental health agencies, to form an umbrella organization, which would serve as a billing infrastructure for all of the agencies. Additionally, representatives from each of the ESMH and community programs could develop a "service package" to present to the administrators of managed care organizations. Having a service package would simplify and organize the core services provided by all programs, making the negotiation process more efficient.

Including ESMH programs in SCHIP plans will assist states in reaching and providing needed mental health care to underserved youths. Funding opportunities through SCHIP will help stabilize and increase expenditures for mental health programs in schools. Challenges such as those involved in contracting between mental health programs and managed care organizations can be overcome, but explicit and sustained efforts will be needed to bring leaders of ESMH and funders together in a planning process that keeps the educational and mental health needs of children and adolescents in the foreground.

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