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How Many Authors Is Too Many?

To the Editor: A brief report in the January 2012 issue has 20 authors (1). To put this number of researchers and scribes in perspective, the text of the report is composed of 20 paragraphs, and thus we could conclude that each author wrote a single paragraph. Further, the list of authors and the paragraph that presents their affiliations account for more than 10% of the total space of the four-page report.

Psychiatric Services specifies the maximum number of words and number of references each type of submission can have. How about also specifying the maximum number of authors?

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Dr. Geller is professor of psychiatry and director of public-sector psychiatry at the University of Massachusetts Medical School, Worcester.

Reference

1. Schennach R, Obermeier M, Meyer S, et al: Predictors of relapse in the year after hospital discharge among patients with schizophrenia. *Psychiatric Services* 63:87–90, 2012

In Reply: Thank you for giving me the opportunity to clarify the journal's

policy on authorship. While 20 authors is quite a crowd for a regular article or a brief report, multiple authorship has become the rule for research journals, reflecting the complex collaborative work required to advance scholarship. We limit the number of authors for some items—Taking Issue and other brief commentaries, letters to the editor, and Frontline Reports—although we occasionally relax these limits, as we do word limits for some submissions.

However, for regular articles and brief reports, we do not impose a limit on the number of authors. Like most scholarly journals, *Psychiatric Services*' authorship criteria follow those set forth by the International Committee of Medical Journal Editors (www.icmje.org/ethical_1author.html). The journal requires each author to have participated sufficiently in the work to *take public responsibility for the content*. For this reason, we send an attestation of authorship form to each author upon acceptance of the manuscript.

Each author is required to sign this form certifying that he or she

1. made a significant contribution to the conception and design of experimental studies or the analysis and interpretation of data,
2. participated in drafting the manuscript or reviewing and/or revising it for intellectual content, and
3. approved the final version of the manuscript.

Each author must also certify that his or her role as author was not limited solely to

1. the acquisition of funding for the research or
2. his or her position as chair or director of a relevant department, division, or research group.

In our view, if authors are willing to put their reputations behind the published material by signing the form, then a byline seems the least we can do to honor their commitment to the research.

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

Dr. Goldman is editor of Psychiatric Services.

Shortage or Maldistribution?

To The Editor: In their December 2011 brief report on the national distribution of psychiatric mental health—advanced practice registered nurses (PMH-APRNs), Ghosh and colleagues (1) articulate several questionable conclusions. The authors present a map of the United States that visually demonstrates an asymmetric national distribution of PMH-APRNs, with clustering in urban coastal counties and sparse representation in rural inland counties. The authors recommend increasing the number of PMH-APRNs to correct what they conclude is a “shortage.”

Although the authors' data demonstrate a scarcity in rural areas compared with urban areas, their conclusion that this scarcity of PMH-APRNs equals a shortage is unsupported. On the basis of their data, an equally plausible (although empirically unlikely) conclusion is that affluent urban regions are oversupplied with PMH-APRNs.

The authors' proposal to increase the supply of PMH-APRNs would likely exacerbate their maldistribution and do little to improve access to mental health services in rural areas. In medically underserved areas where recruitment and retention of mental health practitioners is a challenge, provision of training to existing primary care practitioners, consultation via telemedicine, and introduction of incentives for mental health specialists of all backgrounds would be far more effective.

Michael Bernstein, M.D.

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References

1. Ghosh D, Sterns AA, Drew BL, et al: Geospatial study of psychiatric mental health—advanced practice registered nurses (PMH-APRNs) in the United States. *Psychiatric Services* 62:1506–1509, 2011

In Reply: We appreciate Dr. Bernstein's insightful comments on our article, “Geospatial Study of Psychiatric

Mental Health—Advanced Practice Registered Nurses (PMH-APRNs) in the United States.”

We agree with his point that the “scarcity” of PMH-APRNs, especially in rural areas, does not necessarily mean a “shortage.” To effectively quantify “shortage,” we would need additional information about the distribution of mental illness across the country. We mentioned this shortcoming of the study in the Discussion section. Nevertheless, whether it is a “scarcity” or a “shortage,” our finding of an uneven distribution of PMH-APRNs in the United States is important and critical for future educational and public policy.

We have no argument with Dr. Bernstein’s suggestions for increasing access by “provision of training to existing primary care practitioners, consultation via telemedicine, and introduction of incentives for mental health specialists.” In fact, we think that he is reinforcing our conclusion (although our focus only on PMH-APRNs may have been a bit narrow). We do make the point that recruitment and education of nurses who currently live in rural areas is one of the best strategies for increasing PMH-APRNs in underserved areas.

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Unexpectedly Low Cholesterol Levels Among New York State Inpatients

To the Editor: Independent of the use of antipsychotic medication, people with severe and persistent mental illness often have metabolic disarray, which increases cardiovascular risk (1). With use of antipsychotic medications, which are associated with weight gain and diabetes, the risk of metabolic abnormalities is even greater. For this reason the New York State Office of Mental Health (OMH) began an initiative in 2008 to summarize metabolic data from electronic patient records on a quarterly basis and provide the data to medical

directors of OMH-operated hospitals as part of a quality improvement effort (2). Surprisingly, as detailed below, we found that cholesterol values among inpatients were significantly lower than the national norm.

In 2008 OMH began aggregating data from its electronic record system to report to OMH-operated hospitals on patient weight, fasting cholesterol, and fasting blood glucose (weight is monitored every three months, and fasting cholesterol and fasting blood glucose are monitored on admission—and annually for long-stay patients). Laboratory values for fasting cholesterol reported here were from licensed laboratories that follow national standards for processing and chain of possession. As of April 1, 2010, the 25th, 50th, and 75th percentiles for length of stay for adults (excluding individuals with a forensic status) were 3.4, 12.4, and 57.3 months, respectively.

Of the 3,792 adult (age 18 and older) inpatients hospitalized between May 2010 and August 2010 for whom we had data, 17% (N=648) had a total cholesterol level (measured on admission or within the past year, whichever was more recent) of ≥ 200 , the cutoff for elevated cholesterol used by the National Cholesterol Education Program. The percentage of patients with elevated cholesterol ranged from 11% to 36% across the 17 OMH-operated hospitals. In contrast, U.S. national data indicate that among persons age 20 and older, from 40% to 51% have a cholesterol level of ≥ 200 , depending on ethnic background (3).

We had expected that cholesterol levels would be higher than the national average in this population of hospitalized psychiatric patients, given the large proportion taking antipsychotic medications. We were surprised to find that cholesterol values for inpatients were significantly lower than the national norm, and in most hospitals, rates were less than half that seen in the adult general population. We therefore commenced investigations to verify data accuracy, including verifying the chain of possession of blood samples

and confirming the accuracy of laboratory processes. In addition, we examined how patients’ cholesterol levels varied by age, because an inpatient population younger than the national average might account for the difference. However, we found no significant difference in cholesterol levels across inpatient age groups. Another possible reason for lower-than-expected cholesterol levels is exposure of these inpatients to interventions that may be more likely to occur in an inpatient setting than in the general population, including healthy diets, prescription of statins, and adherence to prescribed statins. Given the number of the hospitals involved and the geographic diversity of the patients, the results appear unlikely to stem from local variations in diet or prescribing practices. Rather, it appears that inpatient stays, many of which last several months or more, offer some protection from the elevated cholesterol so prevalent in the United States.

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Acknowledgments and disclosures

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The authors report no competing interests.

References

1. Mukherjee S, Decina P, Bocola V, et al: Diabetes mellitus in schizophrenic patients. *Comprehensive Psychiatry* 37:68–73, 1996
2. Mangurian C, Miller GA, Jackson CT, et al: Physical health screening in state mental health clinics: the New York health indicators initiative. *Psychiatric Services* 61:346–348, 2010