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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Peer-Led Recovery International Groups for Mental Health Consumers

To the Editor: The Recovery International (RI) method is a peer-led, cognitive-behavioral program that teaches mental health care consumers how to identify and monitor negative thoughts and behaviors and change the way that they would typically respond to daily challenges. The premise of RI is that with the help and support of peers, anyone experiencing any type of psychiatric symptoms can learn to overcome self-defeating, illness-driven thoughts and reactions and replace them with self-enhancing, wellness-promoting thoughts and actions. Created in 1937 by Dr. Abraham Low and offered worldwide since 1952 by Abraham Low Self-Help Systems (ALSHS), RI is one of the largest peer-led programs for persons with mental illness.

Trained peer leaders deliver the RI method to participants via weekly groups that are held in three formats: in person, by phone, and online. Meetings last from 60 to 90 minutes and follow a structured format. The format includes discussing a reading from one of Dr. Low's books, giving "4-Part Examples," and offering mutual aid. The "4-Part Example" is a structured process for describing and responding to daily problems. Group members describe an everyday event that upset them, describe their physical reactions and thoughts, share RI tools (short statements participants use to identify a stressful thought or behavior and recognize that they have the power to choose how they will react) that they used to cope with the stressor, and describe how they would have reacted before their RI training. After giving examples, group members describe what they actually did, applaud or endorse themselves for making the effort to change, and receive feedback from their peers via RI tools.

From February 1, 2008, to January 31, 2011, we conducted a pilot study funded by ALSHS to examine RI program participation and benefits. A total of 126 newcomers—individuals who were new to RI and who had attended from one to five meetings—to RI groups nationwide enrolled in the study in response to information packets distributed at meetings by group leaders. Study participants completed four telephone interviews that assessed their RI attendance, psychiatric symptoms, and mental health recovery. Interviews were conducted at study enrollment and at three, six, and 12 months postenrollment. A total of 79 participants completed all four interviews. This study was approved by the University of Illinois at Chicago Institutional Review Board.

At 12 months, 50 participants (63%) were still attending RI groups, and 29 had stopped going to meetings. Generalized linear model analyses of mental health outcome data collected via standardized instruments used in the interviews indicated that compared with those who stopped attending meetings, RI attendees experienced significantly greater decreases in depressive symptoms and increases in confidence in their personal recovery and ability to achieve personal goals.

Our results are limited by a small sample that may not be representative of all RI groups. In addition, we did not assess RI group fidelity. However, these results suggest that RI may provide participants with the skills and support they need to cope with symptoms and sustain their personal recovery.

The availability and accessibility of peer-led programs are rapidly increasing. In an era of shrinking mental health service dollars, peer-led programs such as RI may provide adjunct recovery-promoting care. More rigorous studies are needed to further explore potential RI participation benefits.

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