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).

Metabolic Screening and Treatment Preferences of Hispanic Inpatients

To the Editor: Hispanics with severe mental illness have a higher prevalence of metabolic syndrome than persons with schizophrenia in general or Hispanics in the general population, which suggests additive risk (1,2). Despite national guideline recommendations, metabolic screening and treatment rates are low among persons with severe mental illness (3). Little is known about rates among Hispanics in this population. We determined screening and treatment rates for metabolic abnormalities in an urban sample of predominantly Hispanic inpatients with severe mental illness. We hypothesized that we would find low rates and that these inpatients would prefer pharmacological treatments over behavioral interventions for metabolic abnormalities.

After the study received approval from the Columbia University Institutional Review Board, we recruited persons with severe mental illness from a New York City community service inpatient unit. Psychiatrically stable inpatients taking an antipsychotic were eligible. After patients gave informed consent, charts were reviewed for screening data, and patients completed a survey about preferred interventions. Most inpatients approached agreed to participate (64%, 49 of 77). The sample was predominantly Hispanic (N=35, 71%) and of Dominican American origin (N=29, 59%). [Data on sample characteristics are available in an online supplement to this letter at ps.psychiatryonline.org.] The largest non-Hispanic subgroup was African American (N=10, 20%), another high-risk group.

Metabolic screening fell short of national recommendations. For example, although weight and height were recorded for 98% of the inpatients (N=48), waist circumference was not measured for any, and body-mass index (BMI) was recorded for only three (6%). Lack of BMI documentation raises the possibility that even though nursing staff collect weight data, treating physicians may not review these notes. Blood pressure was assessed for all patients, fasting glucose for 35 (71%), and fasting lipids for 42 (86%). These rates are higher than previously reported (4), which likely reflects easy laboratory access on an inpatient unit.

Metabolic abnormalities were prevalent in the screened sample: 67% of patients whose weight was recorded (32 of 48) were overweight, and 40% (19 of 48) were obese; 55% (23 of 42) had lipid abnormalities, 51% (25 of 49) were hypertensive, 31% (11 of 35) had high fasting glucose, and 35% (12 of 34) met criteria for metabolic syndrome. Sixty-three percent of the overweight sample (20 of 32) were not treated. Dyslipidemia was treated among only half of the patients (52%, 12 of 23). In contrast, 72% with hypertension (18 of 25) were treated, as were 64% (seven of 11) with high fasting glucose.

Hispanic inpatients preferred behavioral interventions (such as diet and exercise) over pharmacological interventions (such as medication switching) (Mann-Whitney $U=1,691$, $z=-2.57$, $p<.05$), and Spanish-speaking Hispanics voiced this preference even more strongly (Mann-Whitney $U=1,168$, $z=-5.05$, $p<.001$). [Figures illustrating treatment preferences are available in an online supplement at ps.psychiatryonline.org.]

To our knowledge, this is the first study to assess metabolic screening and treatment of a predominantly Hispanic population with severe mental illness. Most were not treated for weight problems, which is concerning given the high prevalence of obesity in this population. Although switching antipsychotics to those with lower metabolic risk has been proven effective for weight loss (5), clinicians should consider behavioral interventions for high-risk Hispanic populations because these findings suggest that they prefer them.

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Percentage of Hazardous Drinkers Who Might Be Treated in Primary Care

To the Editor: Treatment of hazardous drinking can occur in the primary care or specialty alcohol treatment sector, depending on severity. Guidelines from the World Health Organization (WHO) (1) and the National Institute on Alcohol Abuse and Alcoholism (2) suggest that individuals with less severe disorders are appropriate candidates for primary care treatment with evidence-based interventions, including screening and brief interventions.

We estimated the percentage of individuals with hazardous drinking who might be treated in primary care, using data from the second wave of the Healthcare for Communities survey (HCC2), conducted in 2000–2001 (3). HCC2 data are nationally representative, and the survey includes the AUDIT (Alcohol Use Disorders Identification Test) (1), developed by WHO to screen for hazardous drinking and to determine treatment setting. Estimates of the percentages of the population with hazardous drinking who can be treated in primary care and who require specialty care are vital for triage to the appropriate sector and allocation of scarce resources.

Our analysis was based on 7,893 respondents and was weighted to be representative of the adult U.S. population. (Percentages reported are weighted, and counts are unweighted.) WHO recommends that individuals with AUDIT scores between 8 and 15 receive simple advice in primary care to reduce hazardous drinking, those with scores from 16 to 19 should receive brief counseling and continued monitoring in primary care, and those with scores of 20 or greater should receive specialty treatment (1).

In HCC2, 5.1% of the sample (N=427) had an AUDIT score of 8 or greater, and thus by WHO criteria should receive an alcohol intervention. Most met criteria for intervention in primary care (344 respondents, or 4.4%, with scores of 8 to 15, and 44 respondents, or .5%, with scores of 16 to 19). Only 39 (.3%) had scores indicating a need for specialty treatment. Thus, among individuals requiring an alcohol intervention, only one in 20 (.3%/5.1%) may initially require specialty treatment, according to WHO criteria.

The AUDIT manual does not discuss how comorbidity affects the treatment sector decision. One approach is to treat patients with comorbid disorders in specialty care. In the HCC2 sample, 1.7% (N=172) had an AUDIT score of 8 or greater and a comorbid mental disorder or problem drug use. Using this criterion, about one in three individuals (1.7%/5.1%) who require an intervention may initially require specialty treatment.

Although services for alcohol use disorders are often narrowly viewed as specialty treatment, by WHO guidelines most individuals with hazardous drinking are appropriate for primary care, at least initially, reserving specialty care for those with more severe alcohol problems, those with comorbid mental health or drug use problems, and those who do not appear to benefit from brief interventions. However, despite the evidence base for primary care treatment of hazardous drinking (4,5), barriers to implementing such interventions remain, including absence of insurance reimbursement, lack of trained personnel, and multiple demands placed on busy primary care practices. Sustained translational efforts are needed to overcome these barriers. Finally, we should note that the validity of the AUDIT recommendations has not been well studied.

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Recovery Knowledge and Recovery-Oriented Services in Hong Kong

To the Editor: In the past decade, recovery has been a guiding principle in mental health care in the United States and other Western countries. The recovery model goes beyond relapse prevention and medication management to emphasize the importance of living a meaningful life and achieving one's potential (1). In Hong Kong recovery is a relatively new model, compared with the traditional psychiatric rehabilitation and medical models. Adoption of a recovery orientation requires system transformation, staff training, and reorganization of services (2). A staff survey was conducted at the New Life Psychiatric Rehabilitation Association, the largest nongovernmental organization serving mental health consumers in Hong Kong. The survey evaluated recovery knowledge and perceptions of recovery-oriented practices.

The anonymous survey was distributed to all staff who had direct contact with consumers from April to May 2009. A total of 660 staff returned the survey (94% response rate), and 644 returned surveys had complete data for analysis. The sample included 261 males (41%). The mean±SD age was 40.58±10.15 years, and respondents had worked for the association for a mean of 6.82±5.98 years. Most (N=400, 62%) were frontline staff (hostel managers and workshop instructors), 99 (15%) were professional staff (social workers and nurses), 66 (10%) were supporting staff (office workers), and 34 (5%) were managers (officers in charge and service supervisors). The remaining staff (N=45) did not report their job rank.

The survey included the Recovery Knowledge Inventory (3). Possible scores range from 1 to 5, with higher scores indicating greater knowledge. Among the 644 staff, the mean score was 3.53±.26 on roles of self-definition and peers in recovery, 3.36±.98 on roles and responsibilities in recovery, 2.53±.59 on nonlinearity of the recovery process, and 2.67±.62 on expectations regarding recovery. Professional staff and managers had higher scores than frontline and supporting staff on roles and responsibilities, nonlinearity, and expectations ($p<.01$). Professional staff had the highest scores of all staff on roles of self-definition and peers ($p<.05$). Gender and working experience were not related to scores; however, older staff tended to have poorer understanding of recovery concepts (range of $r=-.13$ to $-.26$, $p<.01$).

The Recovery Self-Assessment–Revised (4), which assesses perceptions of the implementation of recovery principles, is scored similarly. Respondents' ratings in three areas—treatment options (3.84±.55), choices (3.76±.50), and life goals of consumers (3.84±.47)—were significantly lower than their ratings of individualized care (4.00±.51) and inviting environment for consumers (4.09±.55). Professional staff had higher ratings than frontline staff for inviting environment ($p<.01$). Among demographic characteristics, age was weakly associated with inviting environment ($r=.15$) and individualized care ($r=.11$), and working experience was related to inviting environment ($r=.08$) ($p<.05$).

Findings showed a need for staff training on recovery and improvement of recovery-oriented services. In particular, nonlinearity and consumer choice should be emphasized. Using a mix of experiential and didactic approaches, training should attempt to address myths and concerns and should be tailored for various types of staff on the basis of their knowledge and service provision needs. Consumers and family members should be involved in training and in the transformation process. Training for all stakeholders is essential to ensure that mental health care is recovery oriented.

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