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Employment Outcomes for SSA Beneficiaries

To the Editor: In the article entitled "Can SSDI and SSI Beneficiaries With Mental Illness Benefit From Evidence-Based Supported Employment?" in the November 2007 issue, Bond and colleagues (1) concluded by stating that persons with severe mental illness who receive Social Security Administration (SSA) benefits have "excellent potential to return to competitive employment." Sadly, the data the authors present do not support this conclusion. In their study, during a 78-week follow-up period, Supplemental Security Income (SSI) recipients who received individual placement and support services worked an average of 18 weeks and persons who received Social Security Disability Insurance (SSDI) worked an average of 21 weeks. If the periods of employment were scattered over the 78-week follow-up period, this rate of employment hardly demonstrates that the services they received were able to overcome the disincentives for employment in the SSA disability system.

On the other hand, if further analysis of the data revealed that study participants receiving individual placement and support services had a significantly higher rate of employment in the final 26 weeks of the follow-up period, this would provide evidence that the interventions launched many SSA recipients into a long-term trajectory of competitive employment. I look forward to further research efforts along these lines.

Finally, as a practicing social worker, I've found that any employment interventions for persons with severe mental illnesses should involve very specific counseling about how SSI and SSDI affect future employment prospects. For persons who do not receive SSA benefits, the study's findings that nonbeneficiaries had nearly double the rate of employment might suggest that avoiding SSI or SSDI benefits can make the objective of competitive employment more achievable.

Clinicians should inform SSI recipients that they can retain their Medicaid coverage in most states even if they are employed full-time at a modest wage. In addition, clinicians should inform SSDI recipients that they can earn a significant amount each month (\$940 in 2007) without any impact on their benefits or Medicare coverage. For SSDI recipients, part-time employment is often the wisest objective. However, for SSI recipients, part-time employment is not nearly as advantageous.

Joel Kanter, M.S.W., L.C.S.W.-C.

Mr. Kanter is in private practice in Silver Spring, Maryland.

Reference

1. Bond GR, Xie H, Drake RE: Can SSDI and SSI beneficiaries with mental illness benefit from evidence-based supported employment? *Psychiatric Services* 58:1412-1420, 2007

To the Editor: In the article "Can SSDI and SSI Beneficiaries With Mental Illness Benefit From Evidence-Based Supported Employment?" in the November issue, Bond

and colleagues concluded that "supported employment . . . extends optimism that SSA beneficiaries with severe mental illness have excellent potential to return to competitive employment." Although there is little doubt that compared with customary rehabilitation supported employment enables significantly more persons with psychiatric disabilities—both SSA beneficiaries and nonbeneficiaries—to return to competitive employment, the clinical significance of this outcome should not lull practitioners and administrators into viewing the intervention as strong enough to overcome disincentives to entering the workforce for SSA beneficiaries.

In the study by Bond and colleagues, the mean number of weeks worked for SSDI beneficiaries ranged between 18.5% and 22.8% of the 18-month study period. Thus very few persons in the sample exhausted the SSA's nine-month trial work period after which they would "fall off the cliff" and lose their pensions. The nine-month trial work period permits individuals to be employed full-time for 39 weeks, a duration which far exceeds the means of 14.5 to 21.3 weeks worked half-time among SSDI recipients in the study. Similarly, the SSI recipients worked half-time, for a mean of 17.8 weeks over the 18-month study period, an amount that would not threaten their SSI benefits.

Although Bond and colleagues clearly acknowledged that the benefits of supported employment will be limited unless disincentives inherent in SSA policies are reduced, it is important for stakeholders to grasp the realistic constraints of supported employment in promoting sustained employment. Individual placement and support, the evidence-based practice for vocational rehabilitation, generally is successful in recruiting not much more than 50% of persons with serious mental illness in the total population of disabled persons (1). Thus it is not clear that this evidence-based practice can overcome reluctance to join the workforce, deficits in social skills, and neurocognitive impairments that militate against enduring employment

(2–4). Even with systematic efforts to disseminate individual placement and support, mobilizing sufficient administrative, service system, and clinical supports for this evidence-based practice is often difficult (5).

Notwithstanding these qualifications, supported employment that follows individual placement and support procedures remains the best model of vocational rehabilitation for persons with psychiatric disabilities. There is every reason to anticipate that this model will stimulate the design of the next generation of interventions for giving this stigmatized population even greater opportunities to achieve durable working lives.

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In Reply: We thank Mr. Kanter and Professor Liberman for their thoughtful letters. We agree with most of their comments, but we provide a few clarifications.

Kanter questions our assertion that SSA beneficiaries with severe mental illness have “excellent potential to return to competitive employment.” He concludes that “this rate of employ-

ment hardly demonstrates that the services they received were able to overcome the disincentives for employment in the SSA disability system.” We offer these two clarifications: the goal of individual placement and support is competitive employment, not an exit from the disability rolls, and the most beneficial outcomes from this intervention are typically concentrated in a subset of persons enrolled in these services.

The main point of both letters concerns the huge barriers preventing SSA beneficiaries from leaving the disability rolls. We certainly agree on this point, as we tried to stress in our article. Kanter observes that avoidance of SSA benefits makes competitive employment more “achievable.” Clearly receipt of SSA benefits makes competitive employment less likely. Thus in our discussion we note the value of early intervention programs aimed at preventing individuals from ever entering the disability system as the best way to avoid the “benefits trap.” We also agree with Kanter on the importance of benefits counseling. Benefits counseling is a core principle of the individual placement and support model (1).

Both letters emphasize the fact that the actual gains from supported employment reported in the article are modest. To clarify our findings, we offer these supplemental statistics. First, the average time to first competitive job in individual placement and support studies is five months (1). Thus the follow-up period for judging job duration for our combined study sample is roughly 13 months. Probably the best way to characterize our findings is that a subgroup benefited most from individual placement and support by maintaining at least six months of competitive employment during the study period: 25.9% of SSI beneficiaries receiving the intervention compared with 5.5% of the SSI control group, and 34.5% of SSDI beneficiaries compared with 4.4% of the SSDI control group. Thus these comparisons suggest an approximately five- to sevenfold advantage for individual placement and support. On the basis of findings from long-term

follow-up studies that showed a sizeable proportion of individual placement and support clients with steady employment after a lifetime of sporadic employment (2), we speculate that this best-outcome group started a journey toward a lifelong pattern of employment. Long-term outcomes for individual placement and support clients are much better than the inert and dismal employment rates for most individuals who do not receive evidence-based vocational services.

Both letters point to the need for further improvements in the individual placement and support model, and we wholeheartedly agree (2). Among other things, we need more effective methods to reach persons who are disenchanted with the service system and not hopeful of ever working again, which probably includes a majority of persons currently receiving SSDI and SSI (3).

It is commonly believed that the barriers to implementing evidence-based supported employment preclude broad dissemination, but we are cautiously optimistic, even in the face of underfunded service systems and other intractable problems. Liberman cites a Dutch study of individual placement and support to illustrate implementation problems with the model. However, U.S. findings for implementation are more encouraging. A recent national study showed an 89% success rate in implementing high-fidelity supported employment in new sites, mostly within one year (4). The spread of supported employment through a learning collaborative in nine states and the District of Columbia (5) has shown that creativity can often overcome the systems barriers Liberman notes.

Most psychosocial interventions show modest improvements in this population. It is critical to recognize the significance of those that have large and tangible influences. Readers can draw their own conclusions as to whether the findings are clinically meaningful and warrant the promotion of supported employment.

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Predictors of Enduring PTSD After an Industrial Disaster

To the Editor: Only a few studies have examined the long-term effects (more than one year) of mass trauma on victimized communities (1,2). On September 21, 2001, a petrochemical plant exploded in the city of Toulouse, France. Victims were surveyed by using self-report questionnaires that assessed peritraumatic distress and dissociation and acute stress. A hierarchical multiple regression conducted with survey data gathered six months after the explosion indicated that all three constructs explained unique variance, accounting for 62% of the variance in symptoms of posttraumatic stress disorder (PTSD) (3). Here we report the results of a follow-up survey conducted 15 months after the explosion. The survey used the same predictors plus a measure of depression.

Five to ten weeks after the explosion, 892 potential study participants were sent self-report questionnaires to assess symptoms of acute stress (Stanford Acute Stress Reaction Questionnaire) and depression (Beck Depression Inventory). The 391 persons who responded were sent another self-report questionnaire six months after the explosion. The sec-

ond survey retrospectively assessed peritraumatic dissociation (Peritraumatic Dissociative Experiences Questionnaire) and distress (Peritraumatic Distress Inventory) as well as current PTSD symptoms (Posttraumatic Stress Disorder Checklist). Fifteen months after the explosion, the 200 participants who responded to the second survey were sent the same questionnaire assessing PTSD symptoms, and 129 persons responded to this third survey.

To analyze the relationship between predictors and PTSD symptoms at 15 months, we computed Pearson correlations. Strong correlations with PTSD symptoms were found for peritraumatic dissociation ($r=.50$, $p<.01$), peritraumatic distress ($r=.58$, $p<.01$), acute stress symptoms ($r=.71$, $p<.01$), and depression symptoms ($r=.61$, $p<.01$). We computed a hierarchical multiple linear regression with PTSD symptom score as the dependent variable. Peritraumatic dissociation was entered first, followed by peritraumatic distress in the second step, symptoms of acute stress in the third step, and symptoms of depression in the fourth step. The model accounted for 59% of the variance in PTSD symptoms. All of our predictors were strongly correlated with persistent PTSD symptoms 15 months after exposure.

The number of dropouts and retrospective ratings of the peritraumatic responses should be acknowledged as potentially limiting the generalizability of these results. However, the study found that peritraumatic dissociation and distress, acute stress, and depression were related to the development and persistence of PTSD symptoms after an industrial disaster. Loss of control and helplessness-anger, measured with the Peritraumatic Distress Inventory, were strong predictors of posttraumatic stress one year after the World Trade Center disaster (4).

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Ethnic Differences in Antidepressant Treatment Preceding Suicide in Sweden

To the Editor: In the October 2007 issue Ray and colleagues (1) observed that the odds of receiving treatments for mood disorders in the year preceding suicide were lower for African Americans. The study of racial-ethnic differences in drug utilization among individuals with severe mood disorders is important. We analyzed whether similar undertreatment is present in Sweden, a country of nine million inhabitants. However, because Sweden has a different racial-ethnic composition than the United States, we analyzed country of birth instead of race.

We analyzed all suicides and deaths from undetermined intent among persons aged 18 to 84 in 2006 ($N=1,255$, or about 95% of all suicides). We examined use of prescription drugs in the 180 days before death. Persons born in Sweden, Denmark, and Norway, representing the Scandinavian countries, were compared with persons born in all other countries.

We first looked at antidepressant prescriptions. Of the 776 Scandinavian men in the sample, 259 (32%) (age-adjusted 95% confidence interval [CI]=28.5–35.2) filled a prescription for antidepressants in the 180 days before death. The corresponding figures were 176 of the 333 Scandinavian women in the sample (52%) (CI=46.7–57.5), 32 of the 102 foreign-born men (31%) (CI=21.6–39.5), and 21 of the 44 foreign-born women (43%) (CI=28.7–58.1).

We also examined use of antipsychotic drugs. Among Scandinavian men, 100 (13%) (CI=10.1–14.5) filled a prescription for an antipsychotic in the 180 days before death. The corresponding figures were 81 of the Scandinavian women (24%) (CI=19.5–28.9), 19 of the foreign-born men (18%) (10.7–25.4), and 16 of the foreign-born women (32%) (CI=19.8–44.6). Use of lithium was 2% or less in all groups.

As a comparison we analyzed use of these drugs among persons aged 18 to 84 years in the Swedish population in 2006 by country of birth. Among Scandinavian men, 6.1% (CI=6.05–6.10) had at least one filled prescription for an antidepressant. The corresponding figure for foreign-born men was 6.5% (CI=6.43–6.59). Among Scandinavian women the figure was 11.7% (CI=11.68–11.76), compared with 11.1% (CI=11.02–11.20) for for-

eign-born women. We did not analyze differences in inpatient or outpatient admission before suicide, although we have previously commented on postdischarge suicides in Sweden (2).

We have some minor concerns about the study by Ray and colleagues (1). Data used in that study represented suicides in different periods—1986 to 2004. Over those years, at least in Sweden, policies in regard to inpatient care changed. We also suspect that use of antidepressants increased substantially in the United States since the early 1990s as a result of the introduction of selective serotonin reuptake inhibitors (SSRIs). The increase in use of SSRIs in Sweden was sixfold between 1990 and 2004. In the study by Ray and colleagues, the mean age of African Americans who committed suicide was also nearly ten years lower than that of whites, which may indicate socioeconomic or other differences in the underlying white and African-American populations from which the samples were drawn.

Although one might suspect relative undertreatment of psychiatric disorders in the non-Scandinavian population in Sweden, it could not be verified by our analyses because we studied only drug utilization without knowledge of the underlying disease prevalence. However, the rates of prescription were similar for Scandi-

navians and foreign-born persons in our sample who filled a prescription for an antidepressant in the months before they committed suicide—and who therefore could be said to have been suffering from a severe mood disorder. This, together with the observed similar rates of prescription in the general population, could indicate equal access to drug treatment. The study by Ray and colleagues highlights an important issue in research on socioeconomic inequalities in care. Racial-ethnic differences in the use of medications may result from differences in religious and cultural beliefs that can affect both health-seeking behavior and attitudes toward suicide.

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