

# LETTERS

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## A False Dilemma and an Unfair Characterization of Veterans

**To the Editor:** In a commentary in the January issue, Frueh (1) contended that Department of Veterans Affairs (VA) policies provide an incentive for secondary gain and illness behavior, resulting in a high number of disability claims for mental disorders and poor treatment response among veterans with posttraumatic stress disorder (PTSD). Further, he implied that there are two types of veterans with PTSD: those who respond favorably to treatment because they are not receiving disability compensation and those who do not respond favorably to treatment because they are receiving disability compensation. This false dichotomy unfairly characterizes veterans and fails to recognize that evidence-based treatments for PTSD do not work equally for everyone, even among veterans who are not receiving disability compensation for PTSD (2). Frueh's position may only serve to stigmatize the many veterans who genuinely work hard to ameliorate their PTSD with limited success.

Among other factors, veterans' treatment response may be contingent upon initial symptom severity and

other general medical comorbidities. Therefore, evidence-based treatments, even when they result in substantial symptom improvements, may not be adequate to achieve full symptom remission or eliminate disability among veterans with severe PTSD. Naturally, we would expect PTSD symptom levels to be strongly associated with disability levels, with the most symptomatic and disabled veterans more likely to receive disability compensation.

Other research not cited by Frueh has found that disability compensation for PTSD does not affect veterans' clinical outcomes or treatment dropout rates. One study even found that veterans who had been awarded service-connected PTSD disability status maintained or increased their utilization of mental health services after receiving their disability rating (3). Murdoch and colleagues (4) found that after six years of ongoing benefits, veterans who had service-connected PTSD disability status experienced clinically important reductions in PTSD symptoms and less poverty and homelessness, compared with applicants whose disability claims had been denied. Two clinical trials, which found that veterans with PTSD can benefit from the two evidence-based treatments being disseminated within the VA, demonstrated that PTSD compensation status did not affect treatment response (5,6). Admittedly, however, more research is needed.

Frueh suggested that the VA faces a "dilemma of logic" in which it is not reasonable to simultaneously provide treatment and disability compensation to veterans with PTSD that is related to their military service. This false dilemma fails to recognize symptom severity and legitimately limited treatment response and could lend support to depriving veterans of well-deserved financial assistance while they make sincere and repeated attempts to reduce the burden of mental illness with standard or emerging treatments for PTSD.

Unquestionably, it is productive to maintain an open dialogue on the

VA's disability compensation system and efforts to disseminate and implement evidence-based treatment for PTSD as long as that dialogue includes a thorough examination of all the available empirical evidence. In contrast, it is counterproductive to disparage VA disability policies and treatment efforts without clear supporting evidence. We do a great disservice to disabled veterans by assuming that anyone who does not respond favorably to treatment must not be motivated to change. Rather, unless shown or told otherwise, we should assume that our veterans remain interested in treatment, and we should continue to provide them with the best care possible.

**Brian P. Marx, Ph.D.**

**Stacey Pollack, Ph.D.**

*Dr. Marx is affiliated with the VA National Center for Posttraumatic Stress Disorder of the VA Boston Healthcare System, and Boston University School of Medicine. Dr. Pollack is with the U.S. Department of Veterans Affairs, Washington, D.C.*

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**In Reply:** Marx and Pollack take issue with the concern I raised about ineffective mental health care provided

to veterans with PTSD through the VA. Unfortunately, they set up a straw-man argument that does not address the most important aspects of my commentary and instead suggest that I unfairly stigmatize veterans. My criticism is entirely of the VA as a system, not of veterans.

Although Marx and Pollack cite several studies that purportedly contradict narrow aspects of the concerns I raised, they mischaracterize the findings of these studies. None of these studies were designed to evaluate the effectiveness or appropriateness of VA's disability policies, address the question of whether there is a meaningful secondary gain effect, or answer the question of whether there are better service models for veterans. In contrast, Marx and Pollack sidestep the ample number of reasons for concern about the effectiveness of VA's current treatment and disability services (1–5).

In my very brief commentary, I asked that the VA reflect on its policies and review the available evidence regarding the effectiveness of the mental health care provided to veterans. The VA could start by examining data from the PTSD symptom checklists that veterans with PTSD diagnosis are asked to complete every 90 days. These data have been collected for several years at the national level, and if aggregated, they would demonstrate a trajectory of clinical symptoms during the course of VA treatment. To the best of my knowledge, these data have not been published or disseminated.

The conversation required now concerns how to best ensure that veterans with posttraumatic conditions receive the most effective services possible in order to maximize quality of life and reintegration with society. Our entire society has a stake in this goal. Unfortunately, as far as I know there is virtually no convincing administrative data to indicate that VA is effectively treating veterans with combat-related PTSD. This is cause for concern. How can we as a society justify maintaining the status quo of

a VA system that cannot show that it is helping veterans with PTSD?

**B. Christopher Frueh, Ph.D.**

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### Self-Assessed Fidelity: Proceed With Caution

**To the Editor:** In the March issue, the study of fidelity ratings of assertive community treatment (ACT) programs by McGrew and colleagues (1) compared agreement between ratings obtained from self-report and from phone interviews under conditions favoring high reliability. The investigators enlisted a volunteer sample of team leaders who were well versed in ACT fidelity to complete a detailed self-report protocol. Over the years, these teams had undergone multiple annual onsite fidelity reviews, and meeting ACT standards qualified them for generous Medicaid reimbursement rates. Knowing that researchers would be conducting follow-up interviews, respondents may have been especially scrupulous.

I doubt that findings from this one-time assessment provide realistic benchmarks for performance by ACT team leaders in routine practice.

I am even more skeptical that self-assessment can serve as a practical substitute for site visits by independent assessors, except under extraordinary conditions. The teams required an average of about seven hours to complete the study's self-assessment protocol (2), a substantial time commitment for busy team leaders. Compliance with a self-assessment protocol would depend on the specific circumstances; however, self-report procedures might devolve over time into hurriedly completed assessments (with missing data, as occurred in the study), especially when teams do not have access to technical assistance. If researchers must monitor and advise team leaders to ensure accurate assessments, I see no advantage of self-assessment over telephone-based assessment. Moreover, the authors' suggestion to use self-report as a screen to decide whether programs need more stringent assessments seems to invite self-assessors to give their programs favorable ratings in order to avoid closer review.

My broader concern is the message that this study sends the mental health field. State mental health administrators and program leaders in underresourced service systems may overinterpret and misapply the findings, despite the authors' caveats. Although the authors stress that self-reported fidelity is most appropriate for "stable, existing teams with good prior fidelity," this study might be used as justification for wholesale adoption of self-assessment as an expedient alternative to independent fidelity reviews. The self-report approach might be extended to other evidence-based practices, even those with less precise fidelity scales. Most worrisome are self-report assessments conducted by practitioners, researchers, and others who have no direct experience with a model and who lack training in its fidelity scale. Unfortunately, misapplication of fidelity scales by unqualified users is already widespread. The research literature is filled with evaluations of purportedly "high-fidelity" programs that bear little resemblance to the original models. Inaccurate self-labeling of

programs was widespread decades ago before dissemination of fidelity scales, and, unfortunately, this remains true today.

Unlike the authors, I endorse the use of self-assessment for quality improvement purposes. But self-assessment should be in addition to independent fidelity reviews, not a replacement. Self-monitoring of key fidelity indicators is invaluable in supervision, and this form of self-assessment should be completed frequently between independent fidelity reviews.

Finally, I note that the findings provide a foundation for a critical next step in fidelity measurement. By greatly reducing ambiguity in scale definitions, this study suggests the feasibility of automated scoring of selected fidelity items from electronic records, thereby increasing accuracy, decreasing duplication of reporting, facilitating rapid access, and enhancing supervision.

**Gary R. Bond, Ph.D.**

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**In Reply:** We appreciate the opportunity to respond to Bond's thoughtful commentary on our brief report. It is important to contextualize this discussion. The evidence-based practice "movement" is sweeping public mental health. Proponents largely agree that these practices should be widely disseminated, that fidelity assessment is needed to ensure high-quality implementation, and that assessments are most valid when conducted by independent assessors. But there is a problem. The "need" for independent assessment far outstrips the capacity

to provide it. This problem is exacerbated by increases in the numbers of interventions classified as evidence-based practices (now exceeding 100 [1]) and of sites implementing them and is particularly acute for onsite assessment, which requires up to three days of assessor time. Thus there is a need to identify alternate, less burdensome, yet valid assessment methods, such as self-report.

Although we agree with Bond's cautions concerning self-assessment for fidelity ratings as usually conducted, we believe that these concerns are most relevant for self-rated fidelity and that carefully collected self-reported data can be a valid and sole source for independent fidelity raters. Moreover, because all fidelity assessment methods use some self-reported data, differences are a matter of degree. Our approach assumes that the chief source of self-report invalidity is subjectivity in defining items and data needed to make ratings and that most people will report accurately when asked directly and clearly. To establish more objective procedures, we created a detailed protocol to gather data to score scale items, piloting and revising it over several years. For example, instead of asking, "Do you provide 24-hour coverage?" we ask, "What percentage of clients in crisis directly talk to staff after hours?" Instead of asking, "Are you involved with 95% of admissions?" we ask, "Describe team involvement with the past ten admissions." In addition, we use independent raters to score the self-reported data and do not permit self-scoring of items. We believe that self-presentation biases are most problematic when self-scoring is used. In our study, for example, self-reported fidelity generally produced lower scores than phone fidelity.

As detailed in our report, self-report can be reliable and valid when this approach is used. Moreover, in contrast to Bond's generalizability concerns, preliminary results from an ongoing study support the validity of our self-report approach for teams naïve to fidelity assessment and for those with moderate experience. Also, we disagree with and are confused by

Bond's assertion that we endorse replacing onsite assessment with self-reported assessment. In fact, we proposed a stepped approach in which phone and self-reported assessment complement and supplement onsite assessment. Nevertheless, we agree that self-report should be reserved for evidence-based practices with well-articulated fidelity scales, that auditing procedures are needed to ensure accuracy, and that, to date, the advantage of self-reported over phone assessment appears minimal (2). We also agree that integrating self-report fidelity data into electronic records is a useful next step. However, the current state of the science is preliminary, and further research is needed to more carefully examine each of these important questions.

**John H. McGrew, Ph.D.  
Laura M. White, M.S.  
Laura G. Stull, Ph.D.**

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## Closing the Knowing-Doing Gap

**To the Editor:** I was pleased to read Dr. Goldfinger's discussion of the "knowing-doing gap" in the December issue (1). It has long been clear to me that although we do not know as much as we would like to about mental illnesses and their treatment, the people we care for would experience significantly better outcomes if we implemented all that we do know. Dr. Goldfinger noted the lack of use of evidence-based practices concerning medications, housing for homeless individuals, case management, and adherence strategies. I would add limited availability of supported employment



services, psychoeducation for families, integrated treatment for individuals with comorbid substance use disorders and general medical disorders, mental health and drug courts, and peer support in both formal mental health treatment settings and complementary services.

The reasons for the limited availability are multiple and complex and include policy and funding restrictions and the existence of too few evidence-based approaches for implementing effective methodologies. My experience is that the vast majority of mental health providers are hard working and committed to delivering the best care, so I would not join Dr. Goldfinger in suggesting that laziness or burnout might contribute to this dilemma. On the other hand, I am increasingly concerned that unidentified and unaddressed professional stigma plays a role in impeding acknowledgment that people with mental illnesses can and do recover and can fully participate in community life (2). Outdated beliefs about what is possible undermine the therapeutic relationships that are necessary to promote recovery, and they inhibit access to effective interventions.

Even so, clinicians can play only a limited role in addressing this multifaceted problem. I support Dr. Goldfinger in his call for research focused on identifying evidence-based methodologies that support clinicians, managers, policy makers, families, people with mental illnesses, and advocates in ensuring that the best possible treatments are available and offered to those who need them.

**Robert Surber, M.S.S.W.**

*Mr. Surber is a behavioral health consultant in Kaaau, Hawaii.*

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## Psychiatrists' Knowledge of Their Patients' Job Functioning

**To the Editor:** Conservative estimates suggest that 23 million working-age Americans have chronic health and mental health problems that diminish their ability to work (1). Mental health symptoms impair functioning and functional status, which in turn inhibits improvement in mental health status. Mental health clinicians know how to assess and manage symptom reduction and interpersonal functioning. But even though clinicians have long recognized the importance of work in their patients' lives, they may know less about how to assess work functioning and employment status. Clinicians may also assume that work functioning will simply improve with symptom improvement and may therefore not prioritize a detailed occupational assessment (2). An evolving literature has demonstrated that symptom reduction alone does not improve job performance and satisfaction (3,4). Clinicians need to understand the details of their patients' jobs to intervene directly regarding work performance.

The Psychopathology Committee of the Group for Advancement of Psychiatry (GAP) undertook an Internet survey of 1,700 psychiatrists to assess the degree to which they were knowledgeable about their employed patients' work functioning. For the survey, they were asked to select two of their employed patients (anonymously) and, using a Likert scale, to answer ten work-related questions about each patient and four statements about the importance of their knowledge about patients' work functioning. [A list of the GAP committee members and more information about the survey are available online as a data supplement to this letter.]

A total of 136 psychiatrists answered work-related questions for 269 patients. The low response rate (8%), which is unfortunately common with Internet surveys (nonresponse bias) (5), limited our ability to draw solid conclusions. However, the respondents claimed to know more about their patients' work functioning

than prior qualitative interviewing undertaken by the committee suggested. It may be that those who responded knew more about their patients' work functioning than those who did not respond; that respondents made socially desirable responses; or that respondents overestimated their knowledge of patients' work functioning, much as parents believe that they know what their children perceive and believe. The poor response rate may have several implications. It could reflect the generally low response to Internet surveys or a lack of interest in the topic.

Although we cannot answer these questions, it is time for our field to identify what we need to know to maximize our patients' participation in the labor market and function effectively on the job in spite of current or ongoing psychiatric difficulties. The importance of clinicians' attention to the domain of work has been highlighted by the impact of the current economy on all working adults and particularly on those with psychiatric symptoms. Symptom reduction must be addressed, but addressing symptoms is insufficient to help patients do well occupationally. Work is intimately connected to life satisfaction, and clinicians should strengthen their ability to help patients attain positive work-related outcomes. To this end, clinicians should become more knowledgeable about their patients' work functioning. Training programs should emphasize the importance of exploring patients' functioning. Finally, further research is needed to test collaborative care strategies to better enable patients with psychiatric disorders to be productive and engaged in work.

**David Adler, M.D., and the GAP Psychopathology Committee**

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## Acknowledgments and disclosures

The authors report no competing interests.

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## An Update on Perfect Depression Care

**To the Editor:** Suicide is an important public health issue and the cause of much personal suffering (1). In 2006, an article in this journal described our quality improvement initiative, the Perfect Depression Care program, which received the American Psychiatric Association's Gold Significant Achievement Award for that year. The initiative was associated with a dramatic reduction in annual suicide rates among members of our large health maintenance organization (HMO) network, who were receiving mental health care from the Division of Behavioral Health Services of the Henry Ford Health System in Detroit, Michigan (2). More recent data suggest that these improvements may have been sustained (3). Although promising, these clinical results were preliminary because they had not been compared with official U.S. mortality data.

To address this issue, we cross-referenced clinical suicide data from the first 11 years (1999–2009) of our ongoing initiative with the most recent finalized State of Michigan mortality records for any member of

our HMO network who died by suicide (defined by the State of Michigan with *ICD-10* codes X60–X84 and Y.87.0). (Because of a two-year lag, 2009 is the most recent year for which state information is available. Pre-1999 data were recorded by the State of Michigan with a different coding system.) HMO member records were matched to State of Michigan mortality data with a two-step process: first by Social Security Number and then by first and last name, date of birth, address, and sex.

The matched State of Michigan mortality records indicated 27 completed suicide deaths among our patients; however, the match missed four suicides that our internal clinical surveillance system had previously identified. Two of these individuals were not residents of Michigan and thus were not listed in the Michigan records. For the other two, the cause of death was listed as other than suicide (“unintentional self-poisoning”) even though our internal surveillance process clearly identified both deaths as suicides.

On the basis of the combined total of 31 suicides for the 11-year observation period, the rate of suicide among our patients was 97 per 100,000 ( $N=13$ ) for the two baseline years (the average rate for 1999 and 2000). This rate is similar to that reported for a clinical population (4). For the start-up year (2001), the rate of suicide was 41 per 100,000 ( $N=3$ ). For the follow-up interval (the average for 2002–2009), the rate was 19 per 100,000 ( $N=15$ ). Poisson regression analysis showed a statistically significant decrease of 82% in the suicide death rate between the baseline (1999–2000) and intervention (2002–2009) years (rate ratio=.20; 95% confidence interval=.16–.24,  $p\leq .001$ ).

This analysis used official mortality statistics to extend findings reported

in the 2006 description of our program. Furthermore, our experience suggests that suicide data obtained from a clinical surveillance system may be useful in driving quality improvement. Although these results also suggest that our Perfect Depression Care program may be associated with a reduction in suicide, this finding remains preliminary given the small number of suicides in our sample and other methodological challenges inherent in suicide research (5) and quality improvement work.

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The authors report no competing interests.

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