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 Outdated beliefs about what is possible undermine the therapeutic relationships that are necessary to promote recovery, and they inhibit access to effective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.

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References

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.

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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 Y87.0). (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≤.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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