Promoting equity in engagement, access, and quality of mental health care for Veterans facing barriers to care, especially rural Veterans

South Central MIRECC

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Research to Practice

Effects of Co-Occurring Depression on Treatment for Anxiety Disorders: Analysis of Outcomes from a Large Primary Care Effectiveness Trial

Summary by Kathy L. Henderson, M.D. and Patricia Dubbert, Ph.D.

**Editor's Note: With this issue of the Communiqué we introduce a new feature, Research to Practice, to highlight a recently published article describing a research study that is relevant to the practice of many VA providers working in mental health and primary care.*

Our first article is by Dr. Laura Campbell-Sills of the Department of Psychiatry at the University of California-San Diego and a group of investigators including former MIRECC Director Dr. Greer Sullivan. Their study used data from the recently completed CALM (Coordinated Anxiety Learning and Management) clinical trial to address the question of whether patients with an

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Recovery Corner

Shared Decision-Making: Providers and Consumers as Dance Partners?

By J. Glen White, Ph.D.
Central Arkansas Veterans Healthcare System

"You can sail on a ship by yourself
Take a nap or a nip by yourself
You can get into debt on your own
There are lots of thing you can do on your own
*But it takes two to tango, two to tango..."**

*Takes Two to Tango, written and composed in 1952 by Al Hoffman and Dick Manning.

Here's what Wikipedia says about the tango as a dance, as well as the common phrase ("It takes two to tango") arising from the song quoted above:

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PRACTICE (continued from page 1)

anxiety disorder and co-occurring Major Depressive Disorder (MDD) experienced similar improvements as patients without co-occurring MDD when receiving evidence-based treatments for their anxiety. Participating patients were recruited from primary care clinics and met diagnostic criteria for generalized anxiety disorder, panic disorder, posttraumatic stress disorder, and/or social anxiety disorder. They were randomly assigned to treatment for 3 to 12 months with either the experimental treatment (computer assisted cognitive-behavioral therapy, medication management, or both) or with usual care treatment in the clinic.

Almost two-thirds of the participants met criteria for MDD as well as one or more of the anxiety disorders and these patients had higher anxiety symptoms both at baseline and follow-up. Notably, however, the presence of MDD did not compromise the benefits of the CALM treatment compared with usual care. The clinical improvement of patients with MDD was substantial and even larger in magnitude than that observed in nondepressed patients.

Points of interest for clinicians and researchers:

- CALM included more than 1000 men and women from 17 different clinical sites with a range of education, income, marital and employment situations and medical conditions
- Patients were allowed to choose the computer-assisted psychotherapy, medication, or combination
- Results suggest that patients with anxiety disorders who also have MDD can benefit significantly from evidence-based care focused on their anxiety symptoms and should be offered this kind of treatment

If you are interested in reviewing the article, visit http://www.ncbi.nlm.nih.gov/pubmed/23290323.

Citation: Campbell-Sills, L., Sherbourne, C. D., Roy-Byrne, P., Craske, M. G., Sullivan, G., Bystritsky, A., Lang, A. J., Chavira, D. A., Rose, R. D., Welch, S. S., Stein, M. B. (2012). Effects of co-occurring depression on treatment for anxiety disorders: Analysis of outcomes from a large primary care effectiveness trial. Journal of Clinical Psychiatry, 73(12), 1509-1516. ♦

CBOC Mental Health Rounds

2nd Wednesdays Monthly
8:00-9:00 AM CT
1-800-767-1750; 26461#

Sponsored by the South Central MIRECC

VISN 6, 7, 11, 16, 17, and 23 mental health providers are invited to attend the next SC MIRECC CBOC Mental Health Rounds session titled “Integrated Mental Health Care in CBOCs: A Conversation" on Wednesday, April 10, 2013 at 8:00-9:00 a.m. (CT). This LiveMeeting session will be presented by Laura Wray, Ph.D. and Andrew Pomerantz, M.D. At the conclusion of this educational program, learners will be able to:

1. Articulate the necessary components of Primary Care-Mental Health Integration (PC-MHI) in VA;
2. Describe the challenges of implementing PC-MHI in CBOC settings; and
3. Discuss strategies to adapt the model to meet the needs of individual CBOCs

Call 1-800-767-1750 and use access code 26461# to participate. Contact Ashley McDaniel at Ashley.McDaniel@va.gov or (501) 257-1223 for registration and continuing education credit information.

DECISION (continued from page 1)

> The tango is a dance which requires two partners moving in relation to each other, sometimes in tandem, sometimes in opposition. The meaning of this expression has been extended to include any situation in which the two partners are by definition understood to be essential... It takes two to tango is a common idiomatic expression which suggests something in which more than one person or other entity are paired in an inextricably-related and active manner.... The phrase originated in a song ... popularized by singer Pearl Bailey's 1952 recording.

So how does this relate to recovery practices in healthcare? In 1997, Charles, Gafni and Whelan described a clear model for shared decision-making (SDM), seeing it as an emerging practice whose time had come. One key reason for using SDM was that physicians and patients were increasingly confronting chronic or life-threatening illnesses that had several treatment options, all with varying benefits and risks to weigh. Given these difficult and ambiguous clinical options, working together toward a consensus decision was seen as most sensible.

As our healthcare system is increasingly moving toward recovery-friendly services for consumers, SDM offers one good model for how providers and the persons for whom they provide healthcare services can work together to reach consensus on the person's care plan. Learning the steps of this new "dance" is important for providers because research has shown that SDM can result in improved adherence and patient satisfaction, and decreased costs (Barry, et al, 2012; Lee & Emanual, 2013). SDM also shows respect for the consumer's role in his or her healthcare.

The development of SDM as a collaborative approach to medical decision-making marked a critical change in what had previously been a more paternalistic model. Previously the physician, an expert in diseases and treatment, made decisions determined by the physician to be in the patient's best interests. The patient assumed a more acquiescent role in following "doctor's orders." Patients who did not go along with the recommendation sometimes risked being deemed non-compliant, which created problems for their subsequent interactions with the healthcare system.

Wise practitioners understand that it takes more than an insistence on compliance to help patients benefit from provider expertise. For some more clear-cut medical situations (e.g., acute appendicitis, fractures, etc.), it makes sense for the physician to call the shots, but for many chronic illnesses, including serious mental disorders, SDM is now being seen as a desirable approach to treatment planning. As early as 2001, the Institute of Medicine advocated more emphasis on shared decision-making, and the recently passed Affordable Care Act of 2010 specifically advocates increased use of SDM in healthcare. Thus, in today's healthcare environment, SDM and other person-centered approaches are becoming more common, both in clinical practice and in physician training (SAMHSA, 2010). With the influence of recovery-oriented care, the mental health field especially has been an enthusiastic adopter of SDM.

With SDM, the provider supplies expertise about the condition being faced, including important treatment and side-effect considerations, while the patient, now considered under the broader term "consumer" is the expert about her or his desired goals and outcomes, preferences about side effects, and the personal far-reaching impacts of treatment decisions. Like the tango, the "dance" of negotiation that takes place between the provider and consumer is a complex one that requires each partner to exercise some push and pull on the other. When both find the steps that work together, it can be a win-win. It really does take two to tango!

Utilizing decision aids can help the consumer learn the steps of this dance, and several such aids are available from a variety of sources. Among available aids are documents that help consumers learn how to effectively talk with their prescribing provider about medication decisions. Some persons may wish to avoid certain side effects because to them they outweigh the medication's positive effect on symptoms. Although their prior experience with providers may not have prepared consumers to do so, they need to be able to have this conversation with their prescriber.

One example is the consumer who finds a medication's interference with sexual functioning to be especially problematic in a relationship, and would thus prefer another medication with fewer such side effects. Another example is the individual diagnosed with schizophrenia who is willing to tolerate hearing some voices in return for a reduced dosage of antipsychotic medication and greater alertness and ability to function on a daily basis in important activities. That individual can in turn utilize other coping skills such as mindfulness or cognitive-behavioral techniques to deal with the remaining symptoms.

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Decision aids can help such consumers negotiate with their providers about the best choice of medicines. Other consumer decision aids include tips on how to start a difficult conversation with a provider, such as when a consumer wishes to change therapists. SAMHSA's website provides SDM aids (http://www.samhsa.gov/ConsumerSurvivor/shared.asp), as does the Informed Medical Conditions Foundation (http://informedmedicaldecisions.org/shared-decision-making-in-practice/decision-aids).

Mental Health Advance Directives (MHAD), which establish the consumer's preferences in advance regarding mental health treatment, are also considered to be SDM aids. When a consumer is hospitalized for an acute mental illness episode that renders him or her incapable of making good treatment decisions, the MHAD can inform providers about preferred medications, side effects to avoid, preferred hospital visitors, best approaches for calming when the patient is under acute distress, or who should be contacted to take care of pets, plants and bills while the consumer is hospitalized. In the VA, mental health preferences are documented by including them in the Veteran's Advance Directive, using the document in CPRS's IMED Consent tool.

Ultimately, SDM is about a respectful approach to negotiating a treatment plan that takes into account both the provider's expertise and recommendations and the consumer's specific preferences and goals.

Feel inspired to dance, now? Check out Pearl Bailey's version of Takes Two to Tango on YouTube: http://www.youtube.com/watch?v=8UmCS6cW33c .

References

Barry, M., & Edgman-Levitan, S. (2012). Shared decision making – The pinnacle of patient-centered care. *New England Journal of Medicine, 366*, 780-781.

Charles, C., Gafni, A., & Whelan, T. (1997). Shared decision-making in the medical encounter: What does it mean? (or it takes at least two to tango). *Social Science & Medicine, 44* (5), 681-692.

Lee, E., & Emanuel, E. (2013). Shared decision making to improve care and reduce costs. *New England Journal of Medicine, 368,* 6-8.

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2010). *Shared decision-making in mental health care: Practice, research, and future directions.* Rockville, MD: HHS Publication No. SMA-09-4371. ♦

Upcoming CBOC Mental Health Rounds
Second Wednesdays Monthly
8:00-9:00 am CT
1 (800) 767-1750; 26461#

April 10, 2013
Integrated Mental Health Care in CBOCs

May 8, 2013
Dialectical Behavioral Therapy

June 12, 2013
Competency & Decision Making in Health Care

July 10, 2013
Caregiver Support

ATTRIBUTION: ACKNOWLEDGEMENT OF MIRECC RESEARCH SUPPORT/EMPLOYMENT

SC MIRECC researchers and educators have a responsibility to ensure that the SC MIRECC receives proper credit for SC MIRECC-supported studies or projects in articles, presentations, interviews, and other professional activities in which the results of those projects are publicized or recognized. All investigators should credit the SC MIRECC if they receive either direct or indirect support from the SC MIRECC. For example, "This work was supported in part by the VA South Central (VISN 16) Mental Illness Research, Education, and Clinical Center." If you receive salary support from the SC MIRECC, you should list the SC MIRECC as an affiliation.

New SC MIRECC Clinical Education Product Available: Multi-Setting Peaceful Mind

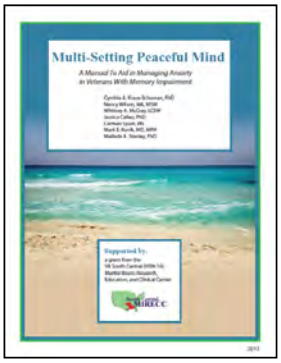
Cynthia Kraus-Shuman, Ph.D., Nancy Wilson, M.A., M.S.W., Whitney A. McCray, LCSW, Jessica Calleo, Ph.D., Carmen Spain, R.N., Mark E. Kunik, M.D., M.P.H., and Melinda A. Stanley, Ph.D.

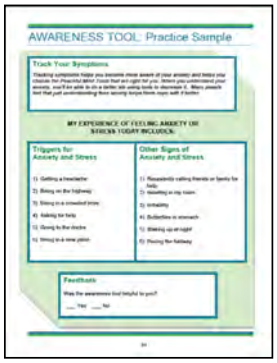
Anxiety symptoms occur in up to 71% of patients with dementia (Seignourel et al., 2008). However, despite the additional impairment anxiety contributes for individuals with dementia, there are relatively few treatments to guide clinical care.

Multi-Setting Peaceful Mind (MSPM) aims to improve the access of evidence-based cognitive behavioral therapy (CBT) for Veterans with dementia or cognitive impairment. MSPM is an easy clinician reference manual with accompanying Veteran take home handouts on managing anxiety with CBT skills tailored to help individuals with mild to moderate dementia or cognitive impairment. These resources will equip providers with a basic understanding of CBT skills and ways to tailor CBT techniques to address the needs of Veterans with mild/moderate dementia.

The materials were designed for non-expert clinicians providing care to individuals with cognitive difficulties in various settings. MSPM is meant to be flexible. Skills can be used on their own or in collaboration with other skills presented in the manual. The manual also provides workbook materials that Veterans can take home with them to use independently or with other caregivers including loved ones. Take home materials may be especially helpful for those Veterans in rural areas who may not have access to expert dementia care providers.

The developers would like to thank the consultants from various backgrounds who contributed to the development of MSPM. To download a copy of Multi-Setting Peaceful Mind, visit http://www.mirecc.va.gov/MIRECC/VISN16/docs/Multi_Setting_Peaceful_Mind.pdf.





Pictured: Excerpts from the Multi-Setting Peaceful Mind Manual

Reference

Seignourel, P. J., Kunik, M. E., Snow, L., Wilson, N., & Stanley, M. (2008). Anxiety in dementia: A critical review. Clinical Psychology Review, 28(7), 1071-82. ♦

New National MIRECC Education Product Available: Substance Use and Traumatic Brain Injury: Risk Reduction and Prevention Video

The VISN 19 MIRECC recently released an educational video titled, "Substance Use and Traumatic Brain Injury: Risk Reduction and Prevention." This six-minute program provides information regarding the impact of using drugs and alcohol after a traumatic brain injury (TBI). The video guides the viewer through a discussion about how the brain works before and after a brain injury, and then demonstrates how drug and alcohol use can affect persons with a history of TBI. This tool was designed to help providers engage clients in a dialogue about substance use post-injury. It was made possible by funding from the Department of Defense, Congressionally Directed Medical Research Program. Jennifer Olson-Madden, Ph.D. (VISN 19 MIRECC) was Principal Investigator of the project. Collaborators included John Corrigan, Ph.D. (Ohio State University) and Lisa Brenner, Ph.D. (VISN 19 MIRECC). To view the video, visit http://www.mirecc.va.gov/visn19/images/videos/Substance_Use_Traumatic_Brain_Injury.asx. ♦

Associated Press Adds Entry on Mental Illness to AP Stylebook

In March, the Associated Press updated the AP Stylebook to include an entry on mental illness. The AP Stylebook is an industry-standard journalism reference manual. This AP Stylebook entry is intended to help journalists work through when information about mental illness is relevant to a story and how to discuss mental illness thoughtfully, accurately and fairly. The new guidelines include:

- Do not describe an individual as mentally ill unless it is clearly pertinent to a story and the diagnosis is properly sourced.
- Mental illness is a general condition. Specific disorders are types of mental illness and should be used whenever possible.
- Do not use derogatory terms, such as insane, crazy/crazed, nuts or deranged, unless they are part of a quotation that is essential to the story.
- Do not assume that mental illness is a factor in a violent crime, and verify statements to that effect. A past history of mental illness is not necessarily a reliable indicator. Studies have shown that the vast majority of people with mental illness are not violent, and experts say most people who are violent do not suffer from mental illness.
- Avoid unsubstantiated statements by witnesses or first responders attributing violence to mental illness.
- Avoid descriptions that connote pity, such as afflicted with, suffers from or victim of. Rather, he has obsessive-compulsive disorder.
- Double-check specific symptoms and diagnoses. Avoid interpreting behavior common to many people as symptoms of mental illness. Sadness, anger, exuberance and the occasional desire to be alone are normal emotions experienced by people who have mental illness as well as those who don't.
- Wherever possible, rely on people with mental illness to talk about their own diagnoses.
- Avoid using mental health terms to describe non-health issues. Don't say that an awards show, for example, was schizophrenic.

For more information about the AP Stylebook, visit www.ap.org. ♦

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