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The next issue of the *South Central MIRECC Communiqué* will be published June 3, 2011. Deadline for submission of items to the June newsletter is May 27, 2011. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Ashley McDaniel, at Ashley.McDaniel@va.gov

South Central MIRECC
Internet site:
www.mirecc.va.gov/visn16

National MIRECC Internet
site: www.mirecc.va.gov

SOUTH CENTRAL MIRECC 2011 ADVISORY COUNCIL MEETING

By Greer Sullivan, M.D., MSPH

Director, SC MIRECC

Professor, Department of Psychiatry

University of Arkansas for Medical Sciences

On February 4, 2011, the SC MIRECC held what was probably the first MIRECC Advisory Council meeting conducted entirely by distance technology! Our meeting was originally scheduled as a face-to-face meeting in Houston, but inclement weather (a freak snowstorm in Texas) prevented travel to Houston for most MIRECCers and Advisory Council members. Thanks to the efforts of Ashley McDaniel, Tom Teasdale and Michael Kauth, we were able to proceed with the Advisory Council meeting nonetheless. We distributed an "electronic agenda" that was configured such that participants need only click on each presentation to see the slides for that presentation on their computer. It was, in its own way, a technical feat (especially to those of us who are not technology geeks!) accomplished on very short notice -- and certainly very appropriate for a rural center that emphasizes telemedicine and distance technology. And we are very grateful to Ashley, Tom and Michael for pulling this off!

Our presentations to the Advisory Council consisted of a presentation on clinical issues in VISN 16 by Kathy



Pictured: Greer Sullivan, MD, MSPH

Henderson, M.D. and overviews of research (led by John Fortney, Ph.D.), education (led by Michael Kauth, Ph.D.), community outreach efforts (led by Pat Dubbert, Ph.D.), and training and recruitment (led by Mark Kunik, M.D., M.P.H.). We were eager to let our Advisory Council see just how much we have been doing to improve rural mental health care and we packed a great deal into a very short time frame.

(continued on next page)

SC MIRECC 2011 Advisory Council Meeting continued...

Included in the agenda were descriptions of telemedicine research (Dr. Fortney), innovations in cognitive behavioral therapy (CBT) (Ellen Teng, Ph.D., and Melinda Stanley, Ph.D.), our new “Community of Practice” professional networking site (Tom Teasdale, Dr.P.H.), modifications to the Support and Family Education (SAFE) program for community based outpatient clinics (CBOCs) (Michelle Sherman, Ph.D.), and outreach to community colleges (Justin Hunt, M.D.). We also heard about new recruits to the MIRECC and an update on the fellowship program from Dr. Kunik.

The Advisory Council meeting was attended by Sonja Batten, Ph.D., from the VA Office of Mental Health Services and Gregg Parker, M.D., the VISN 16 Chief Medical Officer; and chaired by Grayson Norquist, M.D., MSPH, Chair of the Department of Psychiatry at the University of Mississippi. Other members of the Advisory Council present included Terry Keane, Ph.D.;

John Fairbank , Ph.D.; Bruce Levine, M.D.; Thomas Berger, Ph.D.; Jay Shore, M.D., M.P.H.; Lisa Rubenstein, M.D., MSPH; and Ken Weingardt, Ph.D. We received uniformly positive feedback from the Council. It was obvious to everyone that we have come a very, very long way in the few years since we adopted the rural theme.

Of course, our work is not done. The Advisory Council also challenged us to think about how to sustain and grow our partnership with an ever-expanding group of CBOCs. We may need to take a strategic approach and focus on a smaller subset of CBOCs initially, later rolling innovations out to a larger group. In particular, the Advisory Council challenged us to think about how to assure functional integration of primary care and mental health services in the CBOCs. We will continue on our mission to improve mental health care for Veterans living in rural areas. ■

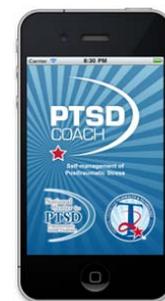
MENTAL HEALTH RESOURCES UPDATE

Mobile App: PTSD Coach

The VA National Center for PTSD and the Department of Defense National Center for Telehealth and Technology have created the PTSD iPhone app to help Veterans and their families learn about and manage symptoms that commonly occur after trauma. Features include:

- Reliable information on PTSD and treatments that work
- Tools for screening and tracking your symptoms
- Convenient, easy-to-use skills to help you handle stress symptoms
- Direct links to support and help
- Always with you when you need it

For more information, visit
<http://www.ptsd.va.gov/public/pages/PTSDcoach.asp>.



Recent SC MIRECC Publications

EFFECTIVENESS OF COLLABORATIVE CARE FOR DEPRESSION IN HUMAN IMMUNODEFICIENCY VIRUS CLINICS

Pyne JM, Fortney JC, Curran GM, Tripathi S, Atkinson JH, Kilbourne AM, Hagedorn HJ, Rimland D, Rodriguez-Barradas MC, Monson T, Bottonari KA, Asch SM, Gifford AL.

Arch Intern Med, 2011, 10; 171(1):23-31

Depression is common among persons with the human immunodeficiency virus (HIV) and is associated with unfavorable outcomes. A single-blind randomized controlled effectiveness trial at three Veterans Affairs HIV clinics (HIV Translating Initiatives for Depression Into Effective Solutions [HITIDES]) was implemented to improve these outcomes. The HITIDES intervention consisted of an off-site HIV depression care team (a registered nurse depression care manager, pharmacist, and psychiatrist) that delivered up to 12 months of collaborative care backed by a Web-based decision support system. Participants who completed the baseline telephone interview were 249 HIV-infected patients with depression, of whom 123 were randomized to the intervention and 126 to usual care. Participant interview data were collected at baseline and at the 6- and 12-month follow-up visits. The primary outcome was depression severity measured using the 20-item Hopkins Symptom Checklist (SCL-20) and reported as treatment response ($\geq 50\%$ decrease in SCL-20 item score), remission (mean SCL-20 item score, < 0.5), and depression-free days. Secondary outcomes were health-related quality of life, health status, HIV symptom severity, and antidepressant or HIV medication regimen adherence.

Intervention participants were more likely to report treatment response (33.3% vs. 17.5%) (odds ratio, 2.50; 95% confidence interval [CI], 1.37-4.56) and remission (22.0% vs. 11.9%) (2.25; 1.11-4.54) at 6 months but not 12 months. Intervention participants reported more depression-free days during the 12 months ($\beta = 19.3$; 95% CI, 10.9-27.6; $P < .001$). Significant intervention effects were observed for lowering HIV symptom severity at 6 months ($\beta = -2.6$; 95% CI, -3.5 to -1.8; $P < .001$) and 12 months ($\beta = -0.82$; -1.6 to -0.07; $P =$

.03). Intervention effects were not significant for other secondary outcomes. The HITIDES intervention improved depression and HIV symptom outcomes and may serve as a model for collaborative care interventions in HIV and other specialty physical health care settings where patients find their "medical home."

OLDER ADULTS' PREFERENCES FOR RELIGION/SPIRITUALITY IN TREATMENT FOR ANXIETY AND DEPRESSION

Stanley MA, Bush AL, Camp ME, Jameson JP, Phillips LL, Barber CR, Zeno D, Lomax JW, Cully JA.

Aging Ment Health, 2011; 15(3):334-43.

The objective of this study is to examine patient preferences for incorporating religion and/or spirituality into therapy for anxiety or depression and examine the relationships between patient preferences and religious and spiritual coping styles, beliefs and behaviors. Participants (66 adults, 55 years or older, from earlier studies of cognitive-behavioral therapy for late-life anxiety and/or depression in primary care) completed these measures by telephone or in-person: Geriatric Anxiety Inventory, Client Attitudes Toward Spirituality in Therapy, Patient Interview, Brief Religious Coping, Religious Problem Solving Scale, Santa Clara Strength of Religious Faith, and Brief Multidimensional Measure of Religiousness and Spirituality. Spearman's rank-order correlations and ordinal logistic regression examined religious/spiritual variables as predictors of preferences for inclusion of religion or spirituality into counseling.

Most participants (77-83%) preferred including religion and/or spirituality in therapy for anxiety and depression. Participants who thought it was important to include religion or spirituality in therapy reported more positive religious-based coping, greater strength of religious faith, and greater collaborative and less self-directed problem-solving styles than participants who did not think it was important. The study found that for individuals like most participants in this study (Christians), incorporating spirituality/religion into counseling for anxiety and depression was desirable. ■

New SC MIRECC Clinical Educator Product

The Team Up to Facilitate Functioning (TUFF) Series: Interactive Brochures for Treatment of Postconcussive Symptoms in Returning Veterans with History of Traumatic Brain Injury

Nicholas J. Pastorek, Ph.D., Carol Gustafson Holdaway, M.S., Jared Benge, Ph.D., and Jane Booth, Ph.D.

A series of interactive brochures titled **Team Up to Facilitate Functioning (TUFF)** has been developed for Veterans and clinicians to address functional problems related to postconcussive symptoms. While treatments for postconcussive symptoms are typically available through specialized programs staffed by brain injury rehabilitation specialists in the national Polytrauma System of Care, Veterans residing in rural areas may have difficulty accessing these programs. The goal of the current project was to develop a set of interactive brochures, appropriate for use by clinicians without specialized training in traumatic brain injury rehabilitation, detailing empirically supported interventions to help Veterans effectively manage the most common postconcussive symptoms.

In 2008, it was estimated that approximately 300,000 Operation Enduring Freedom / Operation Iraqi Freedom (OEF/OIF) Veterans had suffered a combat related mild traumatic brain injury. Based on previous research, a small but significant minority of returning Veterans may experience cognitive, emotional, and somatic problems, called postconcussive syndrome. Given that 35% of OEF/OIF Veterans have sought care through Veterans Health Administration, it can reasonably be expected that most clinicians working within the VA healthcare system will provide care to a Veteran with a history of mild traumatic brain injury, including clinicians providing services in rural settings. The TUFF series was designed to enhance care for Veterans with a history of mild traumatic brain injury who have difficulty immediately accessing specialized rehabilitation services.

Each TUFF module includes an evidence-based interactive brochure with references for additional community resources, pre- and post-intervention symptom assessment, and a user manual. The six modules address the following needs: Academic Skills, Cognitive Skills, Managing Headaches, Healthy Sleeping, Stress Management, and Mood Management. Each interactive brochure contains several 'Team Up' sections designed specifically to encourage clinicians to personalize the administration of each brochure and

**Team Up to Facilitate Functioning (TUFF):
The Interactive Brochure Series**

General Description

- > The rate of comorbidity of psychological and somatic problems among OEF/OIF Veterans with histories of polytrauma is exceedingly high!
- > The Michael E. DeBakey VA Medical Center Polytrauma Team completed clinical reviews and surveys to identify the needs of returning Veterans
- > Based on the results of this process, a series of interactive brochures called the Team Up to Facilitate Functioning (TUFF) series was developed for Veterans and clinicians who do not have ready access to specialists in polytrauma, such as those Veterans living in rural areas
- > Each TUFF module includes an evidence-based interactive brochure with references for additional community resources, pre- and post-intervention symptom assessment, and a user manual. The 6 modules address the following:
 - Academic Skills
 - Managing Headaches
 - Stress Management
 - Cognitive Skills
 - Healthy Sleeping
 - Mood Management

Target Audience

- > The interactive brochures are intended to be used with returning Veterans whose symptoms or problems are interfering with their daily lives
- > The brief, low-intensity interactive brochures are not recommended for use when the identified problems are serious or debilitating

Selecting an Interactive Brochure

- > Clinicians are encouraged to focus on the most salient problem or symptom reported by the Veterans when deciding which interactive brochure to use
- > Although use of one brochure at a time is recommended to allow for simple discussion and re-presentation of newly learned skills, the administration of two brochures that are conceptually unrelated is acceptable

Team Up

- > Rapport building and validation are crucial elements of forming a therapeutic bond with the Veteran
- > The Team Up sections of each brochure are designed to encourage a sense of teamwork while providing an opportunity to practice newly learned skills
- > Clinicians are encouraged to personalize the administration of the brochures by collaborating with the Veterans to fill out each Team Up section (where specified)

Pre- and Post-Intervention Symptom Assessment and the Tracking Log

- > The symptom assessment is administered prior to the intervention and is re-administered 4 weeks following the intervention
- > This pre/post assessment helps to determine if the intervention was successful and whether further services or referrals may be needed

Administration Procedure Quick Reference

- > Ensure Veteran is part of target audience
- > Administer pre-intervention symptom assessment
- > Deliver the interactive brochure
- > Establish follow-up date
- > Document intervention including the symptom assessment results
- > Complete the post-intervention symptom assessment 4 weeks later
- > Determine if further intervention is needed

Reference

1. Lew et al. (2008). Prevalence of chronic pain, posttraumatic stress disorder, and persistent postconcussive symptoms in OEF/OIF veterans polytrauma clinical trial. *J Rehabil Res Dev*, 46, 697-702.

Development of this material was sponsored by a Clinical Educator Grant from the VISN 16 South Central MIRECC. For more information, contact: nicola.pastorek@hhs.gov

Part of the Team Up to Facilitate Functioning (TUFF) series by the Michael E. DeBakey VA Medical Center Polytrauma Team

practice new skills through collaboration with the Veteran. A pre- and post-symptom assessment is paired with each interactive brochure, allowing clinicians to determine the effectiveness of the intervention.

To download the brochures, visit :

<http://www.mirecc.va.gov/VISN16/providers/TUFF.asp>.

Nicholas J. Pastorek, Ph.D., Carol Gustafson Holdaway, M.S., Jared Benge, Ph.D., and Jane Booth, Ph.D. would like to thank the VISN 16 South Central MIRECC for the Clinical Educator Grant that supported the development of these materials. We would also like to thank the Michael E. DeBakey VA Medical Center Polytrauma Team, Pamela Striplin, N.P., Stephanie Sneed, M.D., Jennifer Romesser, Psy.D., and Kimberly Arlinghaus, M.D., for their thoughtful reviews and insightful feedback. ■

RECOVERY CORNER

PARTNERSHIP

By Cristina Gamez-Galka, Ph.D.
LRC/Recovery Services Consultant
Michael E. DeBakey VA Medical Center



“In comradeship there are no demands on the self. This is part of its appeal and one of the reasons we miss it and seek to recreate it.” Chris Hedges, from War Is a Force That Gives Us Meaning

We are all looking for comrades. These are the people who accept us, understand us, and whom we trust. Many VA stakeholders, including Veterans, VA staff and the community, can build upon the concept of camaraderie to improve relationships with one another.

Comradeship is incredibly important to Veterans and many search for relationship connections in their civilian lives like those they experienced while in the military. For example, consider Vietnam Veterans who feel the country turned its back on them when they returned. Many of these Veterans have languished in isolation for decades. Alternatively, think about returning OEF/OIF Veterans who struggle to re-integrate into civilian life after experiencing events that changed how they view themselves and the world in which we live. Many of these Veterans are marginalized by homelessness, unemployment, mental health concerns, or entering the criminal justice system. Further, they often have difficulty establishing and/or maintaining healthy relationships.

Yet, there is hope. The VA is one place where Veterans can develop relationships with their military brothers and sisters. As Veterans help one another, recovery blossoms. The VHA Uniform Mental Health Services in VA Medical Centers and Clinics Handbook (2008) draws from the military values of honor, selfless service, commitment, and teamwork to move recovery forward through the provision of peer-support services. Veterans can help each other navigate the VA system and access services and resources that facilitate the recovery process through support programs like Vet-to-Vet or by working as Peer Specialists. Peer Specialists use group and one-on-one meetings to teach, advocate, liaison, and serve as role models to Veterans in need. Veterans can also use the VA to help each other informally by simply reaching out to another Veteran while in the hallway, waiting room, or lobby of the medical center.

Solidarity with the Veteran's goals, strengths, needs, abilities and preferences is a hallmark of recovery-oriented practice. Hence, recovery coordinators use the Veteran's vision for recovery as one way to foster *acceptance* and *respect* in the therapeutic relationship. These principals, which are strongly reinforced in the military, are commensurate with the espoused values and beliefs of Veterans. Building the therapeutic connection around what Veterans' desire to achieve can help foster a relationship that is mutually beneficial and gratifying and promotes treatment engagement.

Relationships among VA staff members are a critical component in carrying out the VA's recovery mission. In July 2010, Secretary Shinseki wrote, "leaders are responsible for two things – accomplishing their missions and taking care of their people." We are all leaders, whether formally or informally, and as such we must help people around us to develop and grow.

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These positive and healthy connections give VA staff opportunities for giving and receiving support to each other, which maximizes creativity and adaptability. These are also foundational elements of a healthy organization.

Partnerships between local VA medical centers and the surrounding community are another way to foster relationships and a sense of belonging for Veterans. This recovery tenet, called community integration, gives Veterans and their families increased access to resources and services available throughout the community and at the medical center.

Finally, fostering relationships between Veterans and the community can help mitigate the isolation and loss many Veterans experience as they transition back into civilian life. The loss of close companionship, mission focus, and a life driven by military values causes many Veterans to feel as if they do not belong anywhere except with other Veterans. Decreasing this sense of feeling left out can be especially difficult for Veterans

whose comrades are scattered across the country or did not come home. Relationships with other Veterans, VA staff and members of the community can make the transition easier for our Veterans.



On a personal level, belonging, acceptance and a meaningful existence are things for which we all strive. As we transition into the beauty of the springtime, I encourage you to take some time to consider the relationship between you and your comrades. How can this relationship be further

developed? Also, consider what you can do to enhance relationships between Veterans and their families, the VA, and the community.

References

Hedges, C. (2002). War is a force that gives us meaning. New York: Anchor.
 Shinseki, R. (2010, July 15). Announcement of VA ADVANCE.
 VHA Handbook 1160.01 (2008). Uniform Mental Health Services in VA Medical Centers and Clinics, http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1762 ■

MAY CONFERENCE CALLS		ACCESS
CALL-IN NUMBER: 1-800-767-1750		CODE
9	MIRECC Site Leaders, 11:00 AM CT	27761#
10	MIRECC Leadership Council, 3:30 PM CT	19356#
12	National MIRECC & CoE Education Group, 1:00 PM CT	28791#
17	VISN 16 Mental Disaster Team, 11AM CT	76670#
18	MIRECC Program Assistants, 2PM Central	43593#
23	MIRECC Education Core, 3:00 PM CT	16821#
24	MIRECC Leadership Council, 3:30 PM CT	19356#
26	MIRECC & CoE Implementation Science Discussion, 1:00 PM CT	28791#