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The next issue of the *South Central MIRECC Communiqué* will be published December 2, 2008. Deadline for submission of items to the December newsletter is November 21st. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Mary Sue Farmer, at Mary.Farmer2@va.gov

South Central MIRECC Internet site: www.va.gov/scmirecc

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

MEET THE MIRECC RESEARCHERS: JEFFERSON PARKER

Interview with
Jefferson D. Parker, Ph.D.
Team Leader, Addictive Disorders Treatment Program/Assistant Professor
Department of Psychiatry & Human Behavior
University of Mississippi Medical Center

What is your area of research?

My research has been marked by a diversity of interests, but unified by the population of interest – veterans with substance use disorders – and an interest in enhancing exposure to effective treatments. I've enjoyed examining access to treatment, the psychometrics of assessment instruments utilized during treatment, the effects of co-occurring disorders, and ways to enhance retention in continuing care following acute treatment.

What active studies do you have going?

Most of my research

time over the past two years has been spent on a multi-site VA HSR&D-funded experimental study examining the efficacy of an intervention aimed at enhancing both continuing care retention and treatment outcome following an intensive substance abuse rehabilitation program (IIR 03-267-3). The Co-PI's of this grant are Steve Lash, Ph.D. and Jennifer Burden, Ph.D., both at the VAMC in Salem, Virginia. I am a Co-Investigator and the site PI in Jackson. We completed recruitment this past April and are working on our 6- and 12-month follow-ups. This study is exciting because it uses several

elements shown to work in other contexts: goal-setting (contracting), use of prompts, reminders, and feedback on progress toward goals, and social reinforcement. I'm pleased that we were able to integrate the intervention with the standard continuing care services offered by our program.

In addition to this study, I have ongoing research on contingency management interventions, and a newly approved study that will look at acute changes in measures of emotional regulation across the early weeks of abstinence from drugs and alcohol.

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Meet the MIRECC Researchers continued...

What are the implications or potential benefits of your research?

The most efficacious of treatments is limited by our ability to expose the right individuals to it, at the right time and in the right dose. So, whether I'm looking at how to reduce attrition among those awaiting treatment, trying to enhance contextual interpretation of psychometric assessment, trying to understand the impact of co-occurring disorders, or trying to enhance involvement in continuing care; what I'm fundamentally attempting is to improve exposure to effective interventions. My hope is that by focusing on these issues, I help in some small way to reduce suffering and enhance quality of life for veterans and their families.

How did you get started in this area of research?

My exposure to Motivational Interviewing (MI) many years ago was seminal. MI opened my eyes to the whole family of brief interventions and provided a

framework within which to understand motivation, ambivalence, and the process of change. My work was encouraged by key persons – Pat Dubbert, Ph.D., and Greer Sullivan, M.D., in particular – and by an important organization – the South Central MIRECC. The South Central VA Health Care Network Mental Health Product line was instrumental in developing my interests in contingency management through its funding of a small grant back in 2001.

What person or experience had the most influence on your research career?

I'm afraid to get started with names for fear I'll leave someone important out! I am well aware that my work has benefited by contact with a series of incredibly smart, talented, and motivated predoctoral psychology residents and postdoctoral fellows over the years. I believe I have learned as much or more than I've taught. The energy they've brought to research has helped keep my own

energy from being swallowed up completely by what seems to be ever-increasing administrative and clinical demands.

What advice would you give to junior investigators and to people who are new to research?

You cannot wait for the right time to do research! If you are going to be a researcher you have to aggressively carve out the time to do it. Second, you must be a team player: find good people and play well with them! Science is a community enterprise. Finally, my own experience says to let the heart lead – I believe one's work will be of higher quality and one's energy will be more focused if there's passion in the mix.

How can people get in touch with you if they have questions about your work?

My VA email address is Jefferson.parker@va.gov and my phone number is 601-364-1440.



THE OFFICE OF RURAL HEALTH POLICY (HEALTH RESOURCES & SERVICES ADMINISTRATION) FUNDS SIX RURAL HEALTH CENTERS

The Office of Rural Health Policy, with a section of the U.S. Department of Health and Human Services, announced the funding of six Rural Health Research and Policy Centers for 2008-2012. These centers integrate research and analysis in an effort to help policymakers and others understand and take actions to strengthen the access to health care by individuals in rural communities.

The Rural Health Research and Policy Centers for 2008-2012 are:

- Maine Rural Health Research Center
(<http://muskie.usm.maine.edu/ihp/ruralhealth/>)
- North Carolina Rural Health Research & Policy Analysis Center
(http://www.shepscenter.unc.edu/research_programs/rural_program/)
- South Carolina Rural Health Research Center
(<http://rhr.sph.sc.edu/index.php>)
- Upper Midwest Rural Health Research Center – University of MN & University of ND
(<http://www.uppermidwestrhrc.org/>)
- West Virginia Rural Health Research Center
(<http://www.hsc.wvu.edu/wvhealthpolicy/index.html>)
- WWAMI Rural Health Research Center
(<http://depts.washington.edu/uwrhrc/>)



To download a printable flyer with detailed information about the Rural Health Research and Policy Centers, including contacts and the areas of emphasis, visit http://www.ruralhealthresearch.org/pdf/Gateway_Flyer_HighRes.

NEW RESOURCES FOR RURAL HEALTH RESEARCHERS: PSYCHEXTRA

In 2007, the American Psychological Association (APA) unveiled the PsychExtra database as a resource for researchers. PsychExtra is a bibliographical and full-text companion to the scholarly PsychInfo database that covers a gamut of literature related to psychology and the behavioral sciences.

PsychExtra includes technical, annual and government reports, conference papers,

newsletters, magazines, consumer reports, and much more. Additionally, it contains more than 120,000 records that are not indexed in any other APA database.

For more information about PsychExtra or other library research resources, please contact the VISN 16 network librarian, Edward Poletti at Edward.Poletti@va.gov.

THE SOUTH CENTRAL MIRECC CONSUMER ADVISORY BOARD (CAB) VETERAN PROFILE: MARC SHOFF

By Carrie Edlund, MS

To ensure that the SC MIRECC is responsive to consumers of VA mental health services, and in keeping with the direction of the President's New Freedom Commission recommendations, the SC MIRECC and the VISN 16 Mental Health Product Line established the network Consumer Advisory Board in 2002. The CAB includes patients, consumer advocates, administrators, public health experts, and clinicians. These consumers of VA mental health services advise the Mental Health Product Line and the SC MIRECC regarding needed improvements in VA mental health services and review education and clinical services materials developed by the SC MIRECC. This month we profile Marc Shoff, an OEF/OIF veteran and new CAB member.

You're a newcomer to the Consumer Advisory Board. How do you see your role?

This is all new to me. If I can provide real world Intel from an OIF Veteran with PTSD, then that is the role I will play.

How did you become interested in serving other veterans in this capacity?

I have seen the frustration of Vets who have a need for mental health care. They seem to expect results right away or they are still in the denial stage. I try to have the attitude just like if they were my troops in Iraq. Anything I can do, even if it helps just one, then it is worth my time.

What other veteran's organizations are you involved in, and what kinds of things do you do for them?

I am a life member of DAV and there is a group called Harmony House in our area that is starting up to help OIF/OEF vets and their families re-adjust to being back in the world. My wife, Rhonda and I are on the Board of Directors.

Will you tell us a little about your military service?

I retired as a Master Sergeant in May 05 with almost 24 years total service in the Army. I was deployed in January 1991 for Desert Shield/Desert Storm and again in February 2004 for Iraqi Freedom. I was an Ammunition Inspector and worked as an Operations Sergeant for the Support Operations Section at the Battalion level.

What inspires you?

My wife, Rhonda and my children. Life and all the small things that most people overlook.



How do the people who know you best describe you?

Dedicated, selfless, giving, humble, happy and carefree. Life is so different now. I know what a bad day is and, therefore, just haven't had a bad day since I have been home. People take things way too seriously and seem to

think it is "life and death" if they don't get their way or what they want. They don't know what "life and death" is.

What do you think people most need to know about mental health?

That we are not "crazy". That we can learn to get better and control the demons that live in our minds. That it is OK for us to be different and to not like being in crowds or that some things will trigger a response from us that is not "normal" for others. We also want things to be the way they were but know they will never be the same. We want to be the same as we were but know we will never be the same. Just love us for who we are.

What do you think people most need to know about the needs and experiences of returning OIF/OEF veterans?

Regardless of cost, we need care, long-term health and mental care. For those with the physical wounds, they have more complex, long term needs.

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We all have different experiences, and we're in different places and had different jobs.

We all need to feel the appreciation for doing what our country has asked. If you want to know something, ask. Some of us will answer, some will not. If you really care about the question, I will know. Be ready for the truth and let ME tell the story till the end. Don't take me down that road and leave me by asking me to stop. You will go there with me and you need to be ready for any emotional release.

Would you like to tell us a little bit about your family and hobbies and interests?

Rhonda and I have been married for 31 years. We have 2 children, Tara, 25, and Joseph, 23. We love to camp and boat during most of the year. We have a 1969 Chevelle that I tinker with, and we take on cruises. I am very content and at peace with my life.

Anything else you'd like to mention?

I will continue to give my time and efforts to anything that may help other OIF/OEF veterans.

SOUTH CENTRAL NETWORK IMPLEMENTS UNIFORM MENTAL HEALTH SERVICES PLAN

By Kathy Henderson, MD

Manager, VISN 16 MHPL
and Carrie Edlund, MS

The June 2008 release of the *Veterans Health Administration's Uniform Mental Health Services in VA Medical Centers and Clinics handbook* details new standard requirements for mental health services that must be made available to all enrolled veterans, regardless of where they seek service. The plan, based on the principles that "mental health care is an essential component of overall health care," that "services addressing substance use –related conditions must be integrated or coordinated with other components of mental health care," and that "mental health services must be integrated or coordinated with other components of overall health care," focuses VA efforts on mental health care from the patient's perspective. The 40-page handbook specifies minimum requirements for the whole range of mental health care delivery, from how quickly an established patient should be able to obtain an outpatient appointment (less than 30 days from the desired date of appointment), to meeting the unique needs of women veterans, and evidence-based psychotherapies for specific diagnoses. The plan should further the VA's vision of access to comprehensive, evidence-based care for all veterans. In particular, the plan emphasizes enhanced access, evidence-based care, and recovery or rehabilitation.

Implementing many of these requirements will mean additional staffing needs for the South Central Network and, in some cases, a reorganization of the way the ten network facilities manage their mental health care delivery. This may require a paradigm shift for facilities, as they restructure services and reorganize to meet gaps. Not every staff member is going to be doing next year what he or she is doing right now.

As an example, Dr. Henderson cites the success of the network's program to deliver mental health care services in primary care, which reduced referrals to specialty mental health by over 40% this year. The resulting capacity in general mental health allows some shift of resources from general mental health to primary care.

The South Central Network, with its emphasis on translating evidence-based care to everyday practice, was already working on many of the provisions the Uniform Mental Health Services Handbook (UMHSH) mandates. The network has made significant investments to expand mental health in community-based outpatient clinics (CBOCs) in recent years, and plans to add 16-18 new CBOCs in the upcoming year.

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The Network has consulted with the SC MIRECC about how to engage and educate clinicians in the CBOCs to improve the quality of services provided. The MIRECC is currently conducting site visits of the CBOCs in an effort to develop a research “practice network”.

Still, some gaps remain between the current level of services that facilities are able to offer and the services mandated by the UMHS. For example, many facilities don’t provide out-patient detoxification services or pharmacotherapy for addictive disorders. And some lack psychosocial rehabilitation centers—the new model of day treatment. Some gaps also remain in offering primary care mental health services. To help network facilities implement the plan, Dr. Henderson requested prioritized action items from all ten facilities in the network. Facilities identified and prioritized resources they need to be able to offer mental health care services at the levels specified by the uniform services plan, and the network requested funding to address these gaps, in accordance with facilities’ most pressing needs.

Network mental health leadership submitted a proposal for jump start money to begin hiring even before the FY09 budget would become available. That proposal was funded in September, with the stipulation that 85% of the funded positions must be filled within 120 days, and the network began hiring additional personnel. In mid-October, the VISN once again submitted a request for funding, again prompted by facilities’ resource needs, to fund the equivalent of an additional 148 full time employees. VISN leadership hopes for letters of support and funding in the next month. Because the network has identified these needs as essential to its

ability to implement the UMHS, any funding not supported by the VA central office must be supplied by the network.

While most South Central network CBOCs have been able to provide mental health services either on site or through telemedicine, new requirements regarding services for PTSD and substance abuse may require additional staffing. The new UMHS defines CBOCs by number of unique veterans served, and larger CBOCs are required to offer more comprehensive services.

The nationwide shortage of mental health clinicians and the rural nature of many areas of the South Central network make filling positions a challenge. Dr. Henderson acknowledges that recruiting mental health providers can be difficult, but cites the network’s recent success. From FY05-FY08 the network has filled 81% of its mental health positions. The network has just received \$6.6 million to start, which will allow funding for approximately 60 of the 148 FTEE requested. More money should be coming in January, but that amount is still undetermined. Dr. Henderson is confident the VISN will be able to continue to staff newly funded positions.

The UMHS aims to improve veterans’ access to mental health care, but its implementation will also benefit mental health care providers. Dr. Henderson notes that many mental health providers who were already working in the South Central network are moving into the new positions and programs. New programs and treatment modalities offer clinicians an opportunity to grow professionally, and get additional training, especially in evidence-based psychotherapy. These new tools empower providers to offer their patients the best treatments available.



NEW COLUMN BEGINS IN DECEMBER: MEET THE VISN 16 CBOCs

In October, the SC MIRECC began a new project called the *Community Based Outpatient Clinic (CBOC) Partnership for Improving Rural Mental Health Care*. This project aims to create a partnership program involving the South Central (VISN 16) Mental Illness Research, Education, and Clinical Center (MIRECC), VISN 16 Mental Health Product Line, and CBOCs in VISN 16. The purpose of the partnership will be to provide educational interventions and materials related to mental health treatment for CBOCs and to create a

“practice network” of CBOCs that are interested in participating in research on rural mental health care.

In December a regular column will begin that highlights the mental health providers and programs affiliated with each of the VISN 16 medical centers. Please take the opportunity to find out about our partners in mental health for VISN16 veterans.

For more information about this project contact Mary Farmer at mary.farmer2@va.gov.

Recovery Corner

TRANSFORMATIONAL CHANGE: THE LOCAL RECOVERY COORDINATOR'S ROLE AS AN INTERNAL CONSULTANT

By Baris B. Konur, Psy.D.

Psychologist/Local Recovery Coordinator

Southeast Louisiana Veterans Health Care System

Systems change in its simplest form can be thought of as any modification that is made to the workings of an organization or practice within an organization. The integration of recovery principles into how VHA provides mental health care represents a transformational shift from a predominantly medical or maintenance model to a recovery model. This edition of Recovery Corner will focus on the broad and sometimes uncomfortable topic of transformational change.

Before one can take part in making any modification, one needs to have a basic understanding of that system. Here, within VHA, this entails understanding not only your local facility's system, but also the larger, network level and national systems. Meeting with supervisors, listening to staff, and joining committees are effective methods for achieving this insight. With a new perspective on the big picture, LRCs are able to move into their role as an internal consultant.

A consultant, as defined by Peter Block, is, "a person in a position to have some influence over an individual, a group, or an organization, but who has no direct power to make changes or implement programs" (Block, 2000, pg.2). There are two main types of consultants, internal and external. As their names connote, internal consultants are employees of the organization they are working with and external consultants are brought in from outside the organization. Internal consultants differ from external consultants in a very important way; they are, at every moment, ingrained in some part of the hierarchy and current politics of the system. This means they have a number of "bosses" both formal and informal that they must satisfy whilst working towards their purpose of moving the system forward. In order to do this, the LRC will have to take on various roles.

The three roles played in organizational change are; Change Sponsor, Change Agent, and Change Target. The Change Sponsor is someone who is initiating change; this could be a directive being handed down by regional or local leadership, or a change being initiated by the LRC. A Change Agent is one who is implementing the change. In many respects this is the main role of the LRC, to be the change for which they strive. A Change Target is the focus of needed change. This could be the providers and staff, leadership, and at times the LRC themselves. Kotter, in *The Heart of Change* (2002), states, "People change what they do less because they are given analysis that shifts their thinking than because they are shown a truth that influences their feelings" (p. 1). As consultants, LRCs have three main goals to help change occur. The first and most closely related to the above quote is to establish collaborative relationships. Without an established relationship the LRC is going to have a much more difficult time moving the organization. Relationships that are collaborative will lead to identified champions of recovery that can then create more relationships with staff and veterans. This model of viral spread can be very effective for enacting change and moving the system from the bottom up. The second goal is to solve problems so they stay solved. This means incorporating your knowledge of the system and finding innovative methods for truly solving a problem versus providing a temporary patch. The third goal is to ensure attention is given to the technical, clinical, *and* administrative issues and the relationship between the people involved in those issues.

The LRC in many respects is the keeper of the vision of the future, the seer of the forest and not just the trees. A good vision serves three main purposes. 1) It clarifies the general direction for change. In other words, it provides the roadmap towards the goal. 2) It motivates others to take action in the right direction.

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With the roadmap in front of them, others are able to better navigate their way through the change. 3) It helps to coordinate the actions of others. Any large scale organizational change is going to entail individuals from many different areas. The vision provides each of these groups the necessary direction they need to fulfill their piece while still being able to see the whole.

Communication is key in sharing a vision and there are a variety of techniques useful for sharing that vision. First, ensure the vision is communicated using various languages and mediums, i.e. use examples, analogies, graphics, etc. Use as many different forums as possible to share this vision, become the broken record of recovery. Walk the talk, make sure your actions as observed by others reflect the principles you are trying to communicate. Also, address perceived inconsistencies. Failure to address these can lead to being dismissed or feelings that you are being hypocritical. Most importantly, listen and learn. Those

in the system that you are trying to facilitate movement in are the experts in how to go about making that change. Finally, keep in mind, none of this can occur without the consultant genuinely caring for the client, in this case your local facility or VA overall.

This month we leave you with, as Block (2000) puts it, “the heart of the matter.” Learn more than you teach. See learning as a social adventure. Know the struggle is part of the solution. Within moments of tension, resides insight. Focus on strengths rather than weaknesses. Take responsibility for one another’s learning. Most importantly, be authentic, in how you manage yourself, and in how you relate with others.

References

- Block, Peter (2000). *Flawless Consulting: Second Edition – A Guide to getting your expertise used*. San Francisco, California: Jossey-Bass Pfeiffer.
- Kotter, J. P. (2002). *The Heart of Change*. Boston: Harvard Business School Press.

NOVEMBER CONFERENCE CALLS

CALL-IN NUMBER: 1-800-767-1750

	ACCESS CODE
11 MIRECC Leadership Council, 3:30 PM CT, <i>cancelled</i>	19356#
18 VISN 16 Mental Disaster Team, 11:00 AM CT	76670#
19 MIRECC Program Assistants, 2:00 PM Central	43593#
24 MIRECC Education Core, 3:00 PM CT	16821#
25 MIRECC Leadership Council, 3:30 PM CT	19356#
27 National MIRECC & COE Education Recovery Interest Group, <i>cancelled</i>	22233#
27 National MIRECC & COE Education Implementation Science Group, <i>cancelled</i>	28791#