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The next issue of the *South Central MIRECC Communiqué* will be published November 3, 2009. Deadline for submission of items to the November newsletter is October 23, 2009. 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](mailto:Mary.Farmer2@va.gov)

South Central MIRECC Internet site: [www.va.gov/scmirecc](http://www.va.gov/scmirecc)

National MIRECC Internet site: [www.mirecc.va.gov](http://www.mirecc.va.gov)

## ENGAGING TRAINEES IN WRITING MANUSCRIPTS

**MARK E. KUNIK, MD, MPH**

Associate Director for Research Training, SC MIRECC  
Michael E. DeBakey VA Medical Center & Baylor College of Medicine

Few staff appreciate the rewards, efficiencies and practicalities of engaging trainees to write manuscripts. Almost all of us have students training in or near our facilities in clinical fields such as medicine, psychology, social work, nursing, or nutrition and in non-clinical disciplines such as health administration, economics, epidemiology, and statistics. Accessing students who train at your site is relatively easy, and finding students outside your facility might be as easy as placing a call to the respective departments at local undergraduate or graduate schools. Most welcome elective or volunteer opportunities for students to do research or write scientific manuscripts. It is important to set up volunteer or elective experiences that require a minimum of 200 hours (e.g., 15-20 hours a week for a semester, 4-6 hours a week for a year, 40 hours a week for a month). Efforts below these levels are not likely to result in any scientific products.

skill and effort level of the trainee requires an assessment of his/her writing skills. Most trainees have little training in evidence-based practices or research, but great variability exists in writing skills. At the very least, elicit a self-assessment, but a one-paragraph writing assignment better tells the story. It is much easier to teach the scientific skills necessary to write a paper than to teach a student how to write. If a student has never written a scientific manuscript, the best initial papers are systematic reviews, book chapters, or articles for discipline-specific newspapers (e.g., *Psychiatric Times*). Most students have heard some of the terms in evidence-based practice, but few have the skills to perform the steps necessary for a systematic review (see table). Two web-based references on performing systematic reviews are available at <http://ssrc.tums.ac.ir/SystematicReview/> and <http://www.york.ac.uk/inst/crd/SysRev3.htm>.

Choosing a project appropriate to the

*(continued on page 2)*

## *Engaging Trainees in Writing Manuscripts continued...*

Writing a paper with a student does require some effort, but the work is modest compared with the work done by the student and rewards exist for both student and staff. On average, the experience will require 1 hour of in-person meetings a week and an additional 1-2 hours a week to prepare materials and review manuscript drafts. It is critical to establish and monitor calendar deadlines for writing. Most trainees are fearful of submitting “not-ready” drafts and too often hold on to drafts too long. Setting deadlines and providing reassurances that getting feedback will help to improve and move the paper forward are helpful.

There are great rewards for student and staff in jointly writing manuscripts. It is rare to see joy as great as that of a student getting his or her first published piece. Trainees love to see their names in print, send it to friends and family, and document it in their resumes. In addition, if coauthors are involved, they have the opportunity to make nice professional contacts. A successful experience is likely to lead to future willingness to write papers and possibly pursue academic careers. The greatest rewards for staff are the joys inherent in teaching students, seeing students succeed in publishing, and occasionally inspiring them to pursue careers in academics, mental health, and/or the VHA. Other rewards include the efficiencies gained in disseminating scientific advances, increasing manuscript productivity, and working as a team.

Steps in Preparing a Systematic Review:

1. Frame the question.

2. Identify relevant publications.
3. Assess study quality.
4. Summarize the evidence.
5. Interpret the findings.

Examples of Projects in Which Students Collaborated as Authors:

- A second-year psychiatry resident wrote two papers, both related to dementia, one on comorbidity and one on nonpharmacologic treatment of insomnia.
- A chief resident in psychiatry wrote one paper reporting results of a small sub-study of 10 patients of a larger study and finished another paper that had stalled when the first author had transferred to another research post.
- A fourth-year medical student completed a systematic review and a chart-review paper documenting one aspect of data gathered in a larger study.
- A new college graduate headed to medical school (who had received a summer grant through a national program to encourage students to participate in research) did a chart-review paper.
- A medical school student spent a month during summer vacation between her first and second years writing an article targeted at primary care physicians on one aspect of dealing with persons with dementia.

All these individuals came away with their first (and some with their second) publications.

## **RURAL HEALTH RESOURCES UPDATE**

### **OFFICE OF RURAL HEALTH POLICY ADDS NEW RURAL HEALTH POLICY ANALYSIS INITIATIVES**

New Rural Health Policy Analysis Initiatives will produce policy relevant research to help decision makers better understand the problems that rural communities face in accessing quality, affordable health care and leading healthier lives.

Contact information:

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## **NEW CLINICAL EDUCATOR PRODUCT: MAPS: A GUIDE TO MANAGING ADULT PSYCHIATRIC SYMPTOMS FOR FAMILY MEMBERS AND FRIENDS**

Kristin Sorroco, Ph.D.  
Oklahoma City VA Medical Center

The number of family members providing health care assistance to Veterans is rapidly increasing due to demographic changes, increased reliance on outpatient services, and large numbers of soldiers returning from active combat. Although caregivers are sometimes provided with information to assist with medication regimens, information concerning the psychosocial issues that both the Veteran and the family will experience as a result of mental health diagnosis is not typically provided, and if it is provided, it is done in a support group format. A number of effective support groups for family members of Veterans suffering with a serious mental illness have been created for diagnoses such as PTSD, dementia, and other psychiatric illnesses. However, only family members who are able to attend support group sessions have access to this invaluable information on managing caregiver stress.

Many family members are not able to attend these support groups due to reasons such as time of day, work schedules, family responsibilities, or distance. For example, the Support And Family Education program (SAFE) program at the Oklahoma City VA has served only approximately 200 family members of Veterans

with a serious mental illness, yet last year the mental health units in the OKC VA served 8,609 veterans with a mental health diagnosis. Additionally, there are no tools specifically for Veterans that are easily accessible to providers to give to family members.

*MAPS: A Guide to Managing Adult Psychiatric Symptoms for Family Members and Friends* is an educational take-home packet designed for family members and friends of Veterans dealing with a mental illness who may not attend a support group at the facility. *MAPS* provides information about how to support someone with a mental illness and how to take care of themselves. It is designed to stress the important role family members and close friends can play in the successful management of a mental health disorder. The educational packet contains information on mental health diagnoses, tips on how to care for someone with a mental health problem, suggestions on how to care for yourself and your family, and where and how to get help. For more information about this product or to request a copy, contact Michael Kauth, SC MIRECC Associate Director for Education at [Michael.Kauth@va.gov](mailto:Michael.Kauth@va.gov).

### **OCTOBER CONFERENCE CALLS**

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

		ACCESS CODE
12	MIRECC Site Leaders, 9:00 AM CT, <i>CANCELLED DUE TO HOLIDAY</i>	27761#
13	MIRECC Leadership Council, 3:30 PM CT	19356#
20	VISN 16 Mental Disaster Team, 11AM CT	76670#
21	MIRECC Program Assistants, 2PM Central	43593#
22	National MIRECC & COE Education Implementation Science Group, 1:00 PM CT	28791#
26	MIRECC Education Core, 3:00 PM CT	16821#
27	MIRECC Leadership Council, 3:30 PM CT	19356#

## RECOVERY CORNER

### VETERANS ACHIEVING RECOVERY THROUGH EMPLOYMENT

By Wanda Shull, M.S., CRC

Vocational Rehabilitation Specialist

Veterans Healthcare System of the Ozarks, Fayetteville, AR

In light of the VHA and South Central MIRECC's commitment to a recovery-oriented model of care, it is appropriate to discuss an important tool that facilitates the process of recovery: employment. Work is an important life role for all persons, providing not only a source of income, but social identity, social integration, and personal achievement (Binnie, 2008). From the research, we know that people with severe mental illness (SMI) are massively unemployed, with some estimates as high as 90% (Bond, Becker, Drake et al., 2001; Mak, Tsang, & Cheung, 2006), yet the majority of persons with SMI want to be competitively employed. Consider also the stress of unemployment, which can result in decreased general well being, negative psychological symptoms, and decrease in skills which can lead to greater difficulty securing employment (Binnie, 2008), not to mention the financial constraints imposed by loss of income.

VHA Directive 2007-005 has called on the implementation of Supported Employment Programs in VA Medical Centers. Accordingly, the Individual Placement and Supports (IPS) model (Becker & Drake, 2003) has been used as the standardized evidenced-based practice for supported employment. Under the IPS model of Supported Employment, employment specialists adhere to specific principles such as integration with mental health treatment teams, rapid job search, zero exclusion, individualized job search, and continuous follow along supports to assist persons with severe mental illness to secure and maintain employment. Positive outcomes for those served under the IPS model include: fewer hospitalizations, reduction in psychiatric symptoms, employment in integrated settings, and improved quality of life (Salyers, Becker, Drake, Torrey, & Wyzik, 2004).

The IPS model parallels many, if not all, of the core recovery principles. Veterans participating in Supported Employment can be assured of *respect* in interactions with Employment Specialists and other staff at the VA.

Services are *individualized & person-centered*, as called for in the principles of the IPS model. Veterans' dreams, interests, and abilities are considered in plan development and service provision. Services in Supported Employment are *non-linear*. Setbacks can and do occur, and are used as learning experiences. The Veteran has support from the Employment Specialist through these setbacks, not to mention his or her entire mental health treatment team. The *strengths-based* approach utilized in Supported Employment distinguishes it from other employment services, where functional limitations are focused on and must be overcome, or fixed, in order for employment to occur. Often for the first time, Veterans are asked to discuss their strengths, and areas of real interest instead of sitting down and stating all that is "wrong" with them. It can be startling to see the number of Veterans who do not believe at first there are strengths present, because for so many years they have never been asked. Veterans experience *empowerment* in choosing how their program will function, not to mention a huge sense of empowerment once employed and able to realize their dreams in a job setting. Through employment, Veterans are able to foster *hope* of continued recovery, because such a large accomplishment has already occurred, as well as the sense of *responsibility* that comes with managing a job, new people in their lives, and additional financial resources.

The following quotes illustrate the recovery aspect of employment in veteran's lives:

*"All of my family works, why can't I?"*

*"I've always done better mentally when I've worked."*

*"I feel like someone is handing me a dream."*

*(continued on page 5)*

(continued from page 4)

"Before I was referred to Supported Employment, I thought I had to watch TV for hours a day and just take medication."

"Nobody has ever made me even think that going back to work was possible."

"This job is who I am. When I go to work, I know that people depend on me."

"Before I worked, I couldn't pursue my hobbies, because I didn't have the money."

"Now people rely on me instead of me relying on everyone else."

"I want people to know what I am capable of, not what my problems are."

"If I go to work, I can take my wife on the honeymoon we never had."

Certainly there is abundant research in the literature to attest to the fact that persons with SMI can and do

benefit from working. However, the above quotes really make a larger impact on a human level, showing us that what we are doing is making a difference for Veterans, and employment is such a powerful vehicle for helping Veterans move toward their recovery goals.

#### References

1. Becker, D.R., & Drake, R.E. (2003). *A Working Life for People with Severe Mental Illnesses*. Oxford University Press.
2. Binnie, J. (2008). Cognitive behavioural therapy in vocational rehabilitation with the severely mentally ill: Review, design, and implementation. *Journal of Mental Health, 17*(1), 105-117.
3. Bond, G.R., Becker, D.R., Drake, R.E., Rapp, C.A., Meisler, N., Lehmann, A.F., Bell, M.D., & Blyler, C.R. (2001). Implementing supported employment services as an evidence-based practice. *Psychiatric Services, 52*, 313-322.
4. Mak, D.S., Tsang, H.H., & Cheung, L.C. (2006). Job termination among individuals with severe mental illness participating in a supported employment program. *Psychiatry, (69)*3, 239-248.
5. Salyers, M.P., Becker, D.R., Drake, R.E., Torrey, W.C., & Wyzik, M.A. (2004). A ten -year follow-up of a Supported Employment Program. *Psychiatric Services, 55*(3), 302-308.
6. Veterans Administration (2007). *Compensated Work Therapy Supported Employment Services Implementation Plan*. Veterans Health Administration, Washington DC.

## RURAL HEALTH RESOURCES UPDATE

### POTENTIALLY PREVENTABLE READMISSIONS IN RURAL HOSPITALS

A hospital's potentially preventable readmission rate is a quality indicator receiving considerable attention from policymakers and payers. Using 3-M algorithm software and Medicare inpatient claims data from five states, this report examines potentially preventable readmission rates for rural and urban hospitals, and discusses the rural implications of policy initiatives to reduce readmission rates.

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## RECENT MIRECC PUBLICATIONS

### EMPATHIC DEFICITS AND ALEXITHYMIA IN TRAUMA- RELATED IMPULSIVE AGGRESSION

Teten AL, Miller LA, Bailey SD,  
Dunn NJ, Kent TA.

*Behav Sci Law* 26(6):823-832.

Our long term interest is to develop a developmental model of impulsive aggression based on a confluence of social, psychological and biological features. This approach incorporates neurobiological research, which has identified language processing deficits as a unique characteristic of impulsive aggressors and extends it to include emotional deficits. As an initial test of this hypothesis, we examined whether empathy and alexithymia were associated with impulsive aggression. Regressions were performed to explore the associations among impaired empathy, alexithymia, impulsive aggression, and verbal and physical general aggression. Among impulsive aggressive Veterans (n=38) recruited from a VA trauma clinic, alexithymia predicted impulsive aggression and empathic deficits predicted verbal aggression. Neither emotional awareness deficit predicted general physical aggression in this middle-aged sample. Results suggested that empathic deficits were associated with general verbal aggression, but alexithymia was

uniquely associated with impulsive aggression. Consideration of alexithymia in impulsive aggression has implications for its etiology, prevention and treatment.

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### MALE-TO-FEMALE SEXUAL AGGRESSION AMONG IRAQ, AFGHANISTAN, VIETNAM VETERANS: CO-OCCURRING SUBSTANCE ABUSE AND INTIMATE PARTNER AGGRESSION

Teten AL, Schumacher JA, Bailey SD,  
Kent TA.

*J Trauma Stress* 22(4); 307-311.

The current study examined the frequency and correlates of coercive sexual behaviors by male Iraq, Afghanistan, and/or Vietnam veterans recruited from a Veterans Affairs trauma recovery clinic (n = 92) toward their female partners. Men who reported sexual aggression in the past year (n = 37) compared to men who did not report sexual aggression in the past year (n = 55) more frequently reported impulsive aggression, dominating/isolating, and physically assaulting their partner, and were more likely to have a substance abuse diagnosis. Sexually aggressive men were significantly less likely than nonsexually aggressive men to have a

diagnosis of depression. Posttraumatic stress disorder, an established risk factor for nonsexual partner aggression among Veterans, was not associated with sexual aggression.

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### LANGUAGE AND THE MODULATION OF IMPULSIVE AGGRESSION

Miller LA, Collins RC, Kent TA.

*J Neuropsychiatry Clin Neurosci*  
20(3):261-273.

The current conceptualization of the functional anatomy of impulsive aggression relies on data largely derived from studies of animal models of defensive rage. However, animal models cannot account for the replicable findings of verbal impairments and abnormalities in the language processing regions of the brain, described in more recent studies of impulsive aggression in humans. The authors present an updated model of impulsive aggression that preserves the core defensive rage functional anatomy while implicating the brain regions associated directly and indirectly with language processing and their relationship to executive function as integral to the etiology, modulation, and treatment of impulsive aggression.

## MIDAS – MIRECC IMPLEMENTATION, DESIGN, AND ANALYSIS SUPPORT

MIDAS is a service arm of the South Central MIRECC created to assist VISN 16 investigators who are seeking intramural or extramural funding or conducting pilot studies. The MIDAS team offers design, methods, and analytic support for all phases of project development, implementation, analysis, and/or dissemination. Team members have expertise in biostatistics, epidemiology, psychometrics, qualitative methods, information technology in healthcare, and project implementation and management. To apply for MIDAS services or to learn more about MIDAS, please contact Melonie Shelton ([Melonie.Shelton@va.gov](mailto:Melonie.Shelton@va.gov)) or Dr. Ellen Fischer ([fischerellenp@uams.edu](mailto:fischerellenp@uams.edu)).

## MEET YOUR CBOC: PENSACOLA, FL

### PARENT FACILITY: BILOXI VAMC

By Ashley McDaniel

Last fall the CBOC Partnership Project team visited the Pensacola Community Based Outpatient Clinic (CBOC) in Florida. With over 450 years of history, Pensacola, North America's first European settlement, is located along the Gulf Coast between Orange Beach, Alabama and Walton Beach, Florida. Nicknamed the "City of the Five Flags," Pensacola has been ruled by Spain, France, England, the Confederacy, and the United States.

Also known as the "Cradle of Naval Aviation," Pensacola is home to the Fort Pickens, Fort Barrancas and the Advanced Redoubt historic military installations, the National Museum of Naval Aviation, and the Naval Air Station. Not only is Pensacola rich in arts and culture, it has a unique military history.



*Staff of the Pensacola CBOC. Pictured from left: Audrey Michal, Mary Valera, Sue Ann Garrison, and Mary Valera.*

The Pensacola Outpatient Clinic, affiliated with the Gulf Coast Veterans Health Care System in Biloxi, Mississippi, offers primary and mental health care to surrounding Veterans. The CBOC mental health team that we met with includes VA Psychiatrist Audrey Michal, VA psychologists Storne Shively and Sue Ann Garrison, and addiction therapist Mary Valera. Together, they work with other mental health providers to offer

individual/group therapy; chronic pain management; services for PTSD; sleep disorder therapy; and multi-systemic therapy.

Thanks to the wonderful staff at the Pensacola clinic for making us feel welcome!

## SECOND FUNDING DEADLINE FOR CLINICAL EDUCATION GRANTS

The next deadline for submission of South Central MIRECC Clinical Educator grants is 4:00 pm November 13, 2009. These grants of up to \$7,000 are designed to encourage frontline clinicians and educators to develop innovative educational tools or programs that target under-served or hard-to-reach Veterans and/or their families and address their mental health needs,

especially in rural settings. These grants have been used in a number of ways: to develop new educational tools, develop new educational programs and modify existing materials or put them in a new format. We strongly recommend that anyone who is interested in applying for a grant first talk to someone in the MIRECC about your idea and get feedback about whether your

project is unique, doable, and fundable. We strongly encourage proposals from clinicians at community-based outpatient clinics (CBOCs) and collaborative proposals involving medical centers and CBOCs.

Contact Dr. Randy Burke ([randy.burke@va.gov](mailto:randy.burke@va.gov)) for an application and sample proposals.