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The next issue of the *South Central MIRECC Communiqué* will be published February 3, 2009. Deadline for submission of items to the February newsletter is January 23rd.

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: GREER SULLIVAN, MD, MSPH

Interview with
Greer Sullivan, MD, MSPH

Director, SC MIRECC

Professor, Department of Psychiatry,
University of Arkansas for Medical Sciences

Adjunct Senior Scientist, RAND



What is your area of research?

I have done research in a number of areas, an approach that I do not recommend for a successful academic career! (One is better off “branding” oneself by sticking to one area.) In my case, I have tended to take advantage of opportunities to collaborate with interesting people from whom I could learn and to work in areas that seemed important in advancing the field of

mental health services research. Early in my career I was very interested in the seriously mentally ill (SMI) population, especially issues of rehabilitation. I was involved in research related to the public sector systems that served – or, in some cases did not serve – this population. I studied predictors of rehospitalization, described SMI populations living in rural areas, and examined the factors related to being incarcerated in local jails. Most of my time at RAND was spent on research related to homelessness, mental illness, and the associated public sector costs. I also studied seriously mentally ill persons who were HIV positive. Because much

of this work involved interviewing large numbers of people, sometimes in the dead of night, I became involved in developing measures appropriate to this, especially measures of functioning, and so learned a lot about psychometrics and survey design.

More recently I have been working on a national study of approaches to improving the treatment of anxiety disorders in primary care settings. Anxiety disorders are more common than depression but have received far less attention. Finally, through my experience in the MIRECC, I have become interested in implementation and training issues.

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Meet the MIRECC Researchers continued...

And, as further evidence of my being “all over the map,” I have just submitted an application to study stigma of mental illness among providers.

What active studies do you have going?

We completed data collection on a study related to Hurricane Katrina and I am now writing up the results of those studies. I have an NIMH-funded project called Coordinated Anxiety Learning and Management (CALM), a randomized controlled trial which is still in the data collection phase. I have been fortunate to work with colleagues at UCLA, UCSD, University of Washington, and RAND on this national project which tests a model of service delivery called “collaborative care.” There are 12 clinics involved in this study nationally, including 3 primary care clinics in the Little Rock area. Some of the technology developed by Michelle Craske, PhD, for this study is so exciting that I hope to test its cost effectiveness as a mode to deliver CBT in rural areas.

What are the implications or potential benefits of your research?

We had some interesting findings in our work with homeless people. We thought that we would find that providing housing to homeless people would decrease overall public sector costs. In fact, we found just the opposite. Many homeless people do not even “touch” health systems, benefits

services, or the criminal justice system. So, allowing them to stay homeless actually “saves” money. Jails are, in fact, much cheaper than hospitals. Giving people what they really need would involve a significant increase in public sector costs. Also, our descriptive work on HIV positive seriously mentally ill persons was groundbreaking. We knew this problem existed because of working with homeless populations but the first application we sent to NIMH was sent back with a critique saying that this was not a significant problem! Two years later we were called and asked to resubmit. Finally, I am enjoying the work I have been doing with Michael Kauth on issues around implementation. Michael has been leading an effort to examine the effect of ‘external facilitation’ on the success of implementation. All of this was prompted by our experience in VISN-wide MIRECC-sponsored training in evidence-based practices. We hope that this work will provide guidance to improve implementation of programs and practices in the VA.

How did you get started in this area of research?

I was initially interested in public sector systems of care because experiences in my clinical practice, both internal and external to the VA, led me to believe that treatment could not improve unless service systems improved. The best research comes, I think, out of observations in clinical, or sometimes administrative, settings.

After that, the areas that I chose probably had more to do with the people I wanted to work with and the relative importance of the work rather than the content of the work itself.

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

I was very fortunate to be a Robert Wood Johnson Clinical Scholar at UCLA. This fellowship program was certainly the most important experience of my career and served as the foundation for everything I have done since then. For anyone interested in health policy or services there is simply no better training. (Talk to me if you know residents who might be interested in this program!) I went into psychiatry because of the great respect I had for Jim Williams, MD, now deceased, who taught me in medical school in Mississippi. Robert Liberman at UCLA and the West LA VAMC, who was far ahead of his time in developing rehabilitation programs for persons with SMI, and Al Williams, an economist at RAND, gave me a great deal of early encouragement. But, my research career has been most influenced by my Clinical Scholars mentor, Ken Wells at UCLA/RAND, who has continued to be a generous advisor. Both Ken and Bob Brook modeled vision, dedication, and generosity for me. I “grew up” in research wanting to be like them – a tall order!

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

Research can be extremely rewarding. Three things I would recommend are: (1) If you are serious about being successful at research then you need to get some serious research training. For physicians, residencies simply do not provide the kind of training that is needed. Try to do a fellowship or obtain some kind of

formal research training, and do it at the best place you can, preferably in a setting where there's lots of exciting research going on. (2) Find a mentor who truly wants to help you build your career. Look for people who are secure in their own skills and competence so that they can not only tolerate but fully support your success. It helps if your mentor is willing to challenge you and provoke your thinking by asking tough questions. (3) Finally, I would advise people to work on projects that excite and engage

them. As Dr. Howard Thurman, educator and civil rights leader, said (and I am paraphrasing), "Don't aim to change the world. Instead aim to do what makes you come alive. Because what the world really needs are people who have come alive."

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

Email is the best way to reach me: gsullivan@uams.edu

MIRECC EDUCATIONAL PRODUCT LINE UPDATE:

MIRECC EDUCATORS DEVELOP THE COURAGE GROUP MANUAL

DANA FOLEY, PHD

The MIRECC is pleased to announce the release of the Courage Group Manual, developed by Dana Foley, PhD, with the assistance of Michelle Sherman, PhD. The Courage Group Manual was created to help therapists run outpatient groups for veterans with sexual trauma. The manual describes a program at the Oklahoma City VAMC that has been running for 13 years.

Treatment of sexual trauma, specifically military sexual trauma, has been increasingly recognized as an area of need for veterans for many years. This treatment program is a 12 week, closed group for clients who have experienced sexual trauma either as a child or adult,

including military sexual trauma. This treatment program includes aspects of several evidence-based treatment programs, including exposure, cognitive processing, and dialectical behavioral therapy. The program is presented in a provider and patient friendly format. Because treating sexual trauma can be very challenging, this manual was designed to make treatment easier to implement, and more readily available to veterans. This program resource is available through the South Central MIRECC to all therapists.

For a copy of the manual or more information, please contact Dr. Michael Kauth at Michael.Kauth@va.gov.

MIRECC EDUCATIONAL PRODUCT LINE UPDATE:

POST DEPLOYMENT CONNECTION FOR VISN 16 RETURNING VETERANS

GRANT RECIPIENTS: DELEENE MENELEE, PHD, JANINE SHAW, PHD, SU BAILEY, PHD, & FERN TAYLOR AND TONI BROWN OF THE OEF/OIF PROGRAM AT MEDVAMC

The OEF/OIF Post Deployment Connection web page and newsletter series were developed to educate returning veterans about essential VA information utilizing a culturally relevant delivery medium, the internet. Focus groups conducted by the OEF/OIF team in Houston's rural and urban communities yielded a wealth of guiding information for the content of the webpage and newsletter.

The OEF/OIF web page provides useful information addressing questions, such as, "Why register with the VA?" and "Why a mental health appointment?" Direct links to each hospital's OEF/OIF program are listed on the web page as well as in the newsletter. The web page is hosted on the MIRECC website.

The first quarterly newsletter provided informational topics, such as Suicide Prevention, My HealthVet, Resources for Family, Friends, and Teachers (e.g. Sesame Street: Deployments, Homecomings, Changes and VA Kids) and Returning from War. Each VISN 16 OEF/OIF team received 1350 magnets that provide the website address, and also hard copies of the newsletter for distribution at Reserve, National Guard, and other military events for returning veterans.

To access the website visit:

<http://www1.va.gov/scmirecc/page.cfm?pg=71>.

NEW RESOURCES FOR RURAL HEALTH RESEARCHERS: SocINDEX

SocINDEX with Full Text is the world's most comprehensive and highest quality sociology research database. The database features more than 1,986,000 records with subject headings from a 19,600+ term sociological thesaurus designed by subject experts and expert lexicographers.

SocINDEX with Full Text contains full text for 708 journals dating back to 1908. This database

also includes full text for more than 780 books and monographs, and full text for 9,333 conference papers.

For more information about SocIndex 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: DICK HILLS

Interviewed 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 SC MIRECC's Consumer Advisory Board (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 CAB member Dick Hills, a long time advocate for people with mental illness and their families.

How did you become involved in mental illness advocacy?

I've been around for a long time. In 1968, when I first got out of the Air Force, I worked at the Bangor state hospital in Maine. I also had a close family member with mental illness, and experienced what it was like to try to get good treatment and support. After graduate school I became interested enough to found a psychiatric hospital in South Carolina. I'm one of the people who first founded NAMI (the National Alliance on Mental Illness), the nation's largest grassroots organization for people with mental illness and their families, in 1979. South Carolina has a large military population. I'm a veteran myself, and had friends in the military, so I kept talking to NAMI about taking care of veterans. I got very involved in 1984 when the government started restricting mental health care coverage in CHAMPUS, the Civilian Health & Medical Program of the Uniformed Services. I got NAMI members involved and became co-chair of the veterans committee. I was also a founding member of the Severely/Chronically Mentally Ill Veterans (SMI) committee, and I worked with Tom Horvath, who was chief consultant for psychiatry in the VA and who wanted to start the MIRECC. He asked me to be on the MIRECC review board, and I've been involved with the MIRECC ever since. The MIRECCs represent something I've always believed in with the way they

bring researchers and clinicians and consumers together to solve problems.

At the time, the SMI committee was unique because it brought together clinicians of varying disciplines,



veterans services organizations, advocates, all to the same table, and believe it or not we'd come to a consensus eventually. The SMI committee needed an advisory committee, so we formed consumer advocacy groups, then pushed them down the organization so there was a vehicle to know the problems at the level where the tire hits the road and to get that information back up through the organization. A lot of credit has to go to people with vision who worked with the VA, and they get together and all the politics melt away and they really focus on the needs of the vets.

You've been at this work a long time. Which issues have your attention now?

I'm particularly interested in Parkinson's disease. Research within the VA found that a major problem keeping people with Parkinson's from being able to function is the anxiety and depression, because Parkinson's affects dopamine.

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Much of my current work revolves around trying to get people with Parkinson's tied in to the psychiatric units and to get all the units—primary care, geriatrics, and psychiatry, working together on this problem.

So your work involves educating patients, clinicians, researchers, and the public?

Yes, and also lobbying. In this case, I'm lobbying to get Federal nursing home standards to allow people with Parkinson's to receive medication to reduce their anxiety and depression. We've also seen recent legislation to help families of veterans with their mental health care needs.

Why is it important for veterans' families to receive mental health care?

With modern warfare, the concept of "veteran" needs to be extended to include the families. Children of soldiers are being affected like they never were before, because modern communications bring the war into the living room, kids live on base, and their parents are seeing more and more and longer and longer deployments.

Whole families are starting to become part of the casualties—if we don't take care of those families, we won't have the next generation of soldiers.

Would you like to tell us something about your family and hobbies?

My wife and I are happily married, with 3 kids and a niece who's like a daughter to us, and 5 grandkids and my niece's two children. I guess if you scratch us, we're sort of red, white, and blue. I trace my roots back to Bill Conant, who started Paul Revere on his famous ride, and there have been generations of soldiers in the family since then. My passion is this work I do for the VA. Others do it for the same reason. It's like soldiers—a soldier doesn't fight for himself, he fights for the fellow next to him.

What do you think people need to understand about mental illness?

Mental illness is not just schizophrenia. PTSD is clearly as big a problem and a bigger problem in the VA.

Is it getting easier to advocate for the mentally ill?

Somewhat. Clearly people listen. The VA isn't frightened of consumer advocates. We're there to help.

ELECTRONIC HEALTH RECORDS ADOPTION: RURAL PROVIDERS' DECISION-MAKING PROCESS (POLICY BRIEF)

This policy brief reports findings of a study that examined the decision-making process that small rural physician clinics and hospitals use as they investigate and select an electronic health record (EHR) system, and to understand the rationale for their decision. Policy makers can use the study findings to understand the challenges that rural health care providers may face in the process of adopting EHRs and to develop incentives that promote the use of health information technology

in rural America.

For more information about the project the author, Li-Wu Chen, PhD, can be contacted at the Rural Policy Research Institute (RUPRI) Center for Rural Health Policy Analysis at 402-559-7113 or liwuchen@unmc.edu. An electronic copy of the policy brief can be found here:

<http://www.unmc.edu/ruprihealth/Pubs/pb2008-4.pdf>.

RECOVERY CORNER

A SAILOR'S SONG

Cristina Gamez-Galka, Ph.D.

LRC/Recovery Services Consultant

Michael E. DeBakey VAMC

In this first issue of the Recovery Corner for 2009, it seemed fitting to share a veteran's story as a reminder of those we serve and their journeys of recovery. I came to know Clifton Garrett through our mutual involvement in the Psychosocial Rehabilitation and Recovery Center (PRRC). After listening to the importance he placed on helping those who are experiencing issues of dual diagnosis, I approached him about telling his story. Mr. Garrett's courage to share the successes and challenges of his life is evidence to all that recovery from serious mental illness is a reality. Thank you, Clif.

Clifton Garrett hails from a prominent African-American family in West Texas. His father was in real estate and his mother in education, both staples of the community. He and his siblings followed in the high achieving footsteps of their parents by choosing careers in real estate, the ministry, psychiatry, and the military. Yet, his family's standing did not protect Mr. Garrett from the multiple forms of childhood abuse he experienced, which led to the regular consumption of alcohol by age 11. Clifton also sought other means to handle what he was experiencing and his love and gift for music provided a refuge from his pain. In 1965, he became the first African-American to make all-state in music, was awarded a music scholarship to Texas Tech, and joined the Lubbock symphony when he was just 17. Financial difficulties led to a break from his education, which also made him eligible for the draft and in February, 1970 his number came up and he entered the Navy. Clifton moved to Norfolk, Virginia where he worked as a staff member in the Naval School of Music for over five years. The stress of arranging and composing music there in 1973 coincided with the initiation of what he calls "thought insertion". These "messages from God" and other thoughts perceived to be not his own made it hard to function at work, so his

alcohol consumption increased. Yet, more was to come that year including sustaining a coma from a motor vehicle accident. He believes that his experience with paranoia likely began around the same time. The Navy tried multiple medications to address the unwanted thoughts, but with no success. In 1985, Clifton received a medical discharge for Schizoaffective Disorder and the worst years were to follow.

These "tumultuous" years (1985 - 1996) brought with them the highs of marriage, the birth of his two children, starting college, and working for the Santa Fe Railroad. The pressure of dealing with thought insertion, increased paranoia and the dissolution of his marriage eventually led to use of marijuana, alcohol, and crack cocaine. Momentary reprieves were produced through the use of cocaine, but the rebound effects were more intense and distressing. Nevertheless, the tide began to turn in 1996 with a trial of Paxil; finally, something that allowed him to begin to maintain focus. Work with Dr. Lawson at the dual diagnosis unit at the North Little Rock VA resulted in attempts to stabilize his mood with Valproic Acid and Tegretol. One medication produced excessive weight gain and the other was not effective in improving his mood. Eventually, Wellbutrin came on the market and within 6 months he was given a trial. Depression was no longer "body slamming" him without warning and he remains on the medication today.

The effectiveness of the medications brought relief and improved thinking which led to a decrease in self medicating. His music and creativity flourished and other successes followed. Clifton was able to maintain his independence by writing music and jingles. His self-employment, the flexibility of the music industry and his exceptional talent kept him off the streets, but the gradual decline in self-care and social withdrawal continued.

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There were times when he “saw the need to buy and iron clothes”, but the addictions, lack of engagement in medical care, and a difficult marriage and divorce, culminated in repeated stays on mental health inpatient units for suicidal thoughts and attempts. He maintained no regular connection with a mental health professional. The light of recovery seemed to wane, but this was soon to change.

Clifton quit using cocaine due to the increasing paranoia he experienced with it. He found a support network through the Assertive Community Treatment (ACT) team in Houston. This team became acquainted with him - he was no longer without regular contact with people who truly understood him. Seroquel, Zyprexa, Halodol, Cymbalta, and Citalopram played a role in his ability to recovery at specific points, and a unique combination of medications provided him the chance to think more clearly, reason, concentrate, and become aware of his environment in ways he had long dreamed. Therapy provided him ways to understand his thoughts and overcome problematic reasoning. He felt mental health professionals were now focused on helping him learn how to cope, rather than only being a passive recipient of care. In 2005, the initiation of Geodon further improved his thought processes and speed, leading to an expansion of his creative activities. His poems and musical arrangements brought city wide recognition and invitations to organize events and

deliver speeches. Over a year of sobriety, repaired relationships, and getting to know his new self have produced a “tremendous” increase in quality of life. He remarked that at this stage “I’m at a constant level of gratitude” having known “the poverty, spiritual bankruptcy, and the torture of insanity”.

Not only is Mr. Garrett a gifted musician, but his poetry has earned him national awards and publication. He chose to share this excerpt from a piece he wrote entitled *Healers of the Mind*:

The thirst of my soul was insatiable,
What would fill this empty cup? Who would heal my
troubled mind?
In miserable endless tortured illusion I searched, with no
avail to find.
Yet deep in my heart I had this hope. That someday,
somewhere, the healers would appear.
Waiting. Darkness became my light, and life became
obscure.
Yes, We have waited many years in darkness, but Thank
God now we can say.
That the healers of our hope, the healers of our dignity,
our self-esteem, the people we thought we’d never see,
talk to, nor find.
Sat in this room before me. The healers of the mind.

JANUARY CONFERENCE CALLS

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

	ACCESS CODE
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 Recovery Interest Group, Noon CT	22233#
23 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#

MEET YOUR CBOC: MT. VERNON, MISSOURI

PARENT FACILITY: FAYETTEVILLE, VAMC

By Mary Farmer & Kristin Ward

Mt. Vernon, Missouri is a unique community that possesses, within its city boundaries, everything that is "small-town" America: from public gatherings on the lawn of the historic courthouse to friends and family gatherings at more than a half-dozen parks found throughout the town. Mt. Vernon even offers a 50-cent city taxi service.

The people of Mt. Vernon have always rallied around the concept of "growing together." At the same time they honor tradition, they are also embracing the future. The current population is 4,570, which represents over a twelve percent growth since 2000.

If the name "Mt. Vernon" sounds familiar to you, it might be due to the fact that the city was named in honor of George Washington's residence on the Potomac River.

Mt. Vernon lies at the start of the Ozark Mountain Parkway - scenic Route 265 leading to the Branson/Table Rock Lake tourist areas. It is a popular stopover for travelers on their way to Stockton Lake, Precious Moments Chapel, and Roaring River State Park, to name just a few of the numerous area attractions. Mt. Vernon is situated almost in the exact center of Lawrence County, and serves as the seat of Lawrence County government. The county's historic Carthage stone courthouse, built in 1901, lies in the center of the Mt. Vernon square. Mt. Vernon is home to the Missouri Rehabilitation Center, **Gene Taylor VA**



Outpatient Clinic, and the Missouri Veterans Home / Mt. Vernon.

The Gene Taylor VA Outpatient Clinic provides both primary care and mental health care services for veterans in the Mount Vernon metro area and surrounding communities. The Mental Health Clinic is currently staffed with three Psychiatrists, one Psychologist, two nurse practitioners, and six social workers. A wide variety of services are offered to veterans including: individual, group and family counseling, and programs focused on PTSD, substance abuse, sexual trauma, OIF/OEF, smoking cessation, and pain management.