South Central MIRECC

Reducing mental health disparities among rural veterans

Communiqué

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The next issue of the *South Central MIRECC Communiqué* will be published April 3, 2009. Deadline for submission of items to the April newsletter is March 24th. 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

TULSA, OKLAHOMA OFFERS DRUG TREATMENT COURT FOR VETERANS

Elise M. Taylor, Ph.D.
Clinical Psychologist
Substance Use Disorder Program Supervisor
Tulsa VA Behavioral Medicine
and Carrie Edlund, MS

Veterans who are arrested in Tulsa County for non-violent alcohol/drug-related felony charges now have the option of requesting placement in the new Veterans Treatment Court (VTC), thanks to the hard work and collaboration of individuals from the Jack C. Montgomery VAMC, Tulsa Behavioral Medicine Service Substance Use Disorder Program, Tulsa County 14th Judicial District Court, the Tulsa County Drug Court Program, and the Tulsa Mayor's office.

Once placed in the VTC, Veterans can be sentenced to treatment for substance abuse. Treatment can also uncover other issues such as PTSD, Traumatic Brain Injury, or the adjustment stress of returning to civilian life after combat. VTC immediately connects them with substance use disorder treatment, benefits coordination, and support services available through the VA. Even Veterans who are not eligible for VA benefits can use the Treatment Court services and are referred to community treatment organizations that work with the Tulsa County Drug Court system. Veterans must complete the treatment requirements or face penalties in the criminal justice system.

Veteran Mentors Make the Difference. An important component of VTC will be the mentorship it provides. Each Veteran seen in the court will be assigned a mentor, also a Veteran, and usually one of similar age, service branch, and experience. This allows both the Veteran needing help and the mentor to tap into the strong allegiance Veterans have for their service branch or war service experience. Most importantly, the mentor serves as a good role model, and can be available during and after assignment to the court. Volunteers from Veteran Service Organizations have helped fill this important role.

It was this allegiance to fellow Veterans that prompted John "Gunny" Bennett, a transitional patient advocate and Veteran who works closely with Nanette Waller, OEF, OIF coordinator for the Jack C. Montgomery VAMC in Muskogee, OK, to try to help the Veterans he was seeing pass through the criminal justice system.

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Drug Treatment Court for Veterans continued…

In October 2008, 158 Veterans were arrested in Tulsa County. Bennett contacted Matt Stiner, the Veterans coordinator for Tulsa Mayor Kathy Taylor's office, and a planning group was convened, spearheaded by VA Medical Center Director Adam Walmus. The planning team, consisting of Dr. Elise Taylor, Tulsa VA Substance Use Disorder Supervisor; Dowanna Wright, VA's VTC Liaison/Addiction Therapist; Judge Sarah Day Smith; Rose Ewing, Tulsa County Drug Court Coordinator; and her team, visited the Veterans Court in Buffalo, N.Y., to learn how they might initiate and run a similar program in Oklahoma.

The Veterans Treatment Court sees only Veterans, so someone presenting at VTC for the first time to make a plea will encounter other Veterans moving through the system, and will see them interact with their mentors and either promote due to their adherence to VTC requirements, or be sanctioned (including possible jail time) because they did not. Veterans new to VTC will be carefully monitored by a dedicated VTC team that includes VTC Liaison Wright, the Tulsa County Drug Court team, Veteran mentors, Service Officers, and Judge Smith, who presides over the VTC. Weekly treatment team meetings allow Wright and the VTC treatment team to review the Veteran's progress, including jobs, volunteer work, community service, drug tests, or family issues, and to make recommendations for either promotions or sanctions.

Finding Veterans who slip through the cracks. Finding ways to identify Veterans in the criminal justice system so they can take advantage of the VTC demonstrates the level of coordination needed to establish a VTC program. The VTC team discovered that some Veterans, particularly those who did not identify themselves as Veterans because they had never served in combat, slipped through the cracks at arrest due to answering in the negative when asked if they were Veterans. Through good communication with the VA and the legal system, all arrestees are now asked if they have ever served in the military.

Some early indicators of success. Although the first Tulsa County Veterans Treatment Court convened just over two months ago in December 2008, VTC is already seeing some success. Some VTC Veterans are progressing through VA's substance use disorder intensive outpatient program (IOP), one level of treatment available to VTC Veterans. Two of these VTC Veterans, in particular, are relying on each other for support, finding that their similar situations allow them to assist each other in complying with the program. They have already completed the IOP program and are progressing through VTC. Both have been equally successful in their treatment and they have used each other as good supports to stay sober. Both have reunited with their families. They are getting their lives back. Reaching these young Veterans earlier in their lives is an important goal of the Veterans Treatment Court. If we can assist these Veterans early on, there is a better chance they will not be estranged from their families and support systems, and they will have jobs they can go back to.

Investment in helping people change. The Veterans court team in Buffalo, N.Y., inspired the Tulsa VTC with its clear investment in seeing Veterans change their lives for the better. That team showed a caring, rather than a punitive, approach to Veterans moving through the court system that gave Veterans hope. This attitude of support, which the Tulsa system emulates, does not excuse non-compliance, nor does it mean Veterans do not suffer consequences for their behaviors. But it does mean that they get the best opportunity available for making the changes they need to make so they can avoid incarceration and keep their families and jobs intact.

It is a need that has gained growing awareness. For example, some Veterans from Iraq or Afghanistan are entering the criminal justice systems because of domestic violence, driving under the influence, and drug-related charges. Veterans struggling with these problems who are referred to VTC can maintain their positive identity of having served their country. Being able to see themselves not just as an individual with a drug or alcohol problem, but as a Veteran, helps them progress. Being with other Veterans who understand and have overcome similar problems gives them both hope and a very practical resource. The VTC may also be identifying and treating individuals who otherwise would not seek treatment unless mandated by the courts.

KEEPING UP WITH MIRECC RESEARCH

PARTNERS IN DEMENTIA CARE – MARK KUNIK, MD, MPH

Partners in Dementia Care (PDC) is a study funded by the VA, Houston Alzheimer's Association (AA), and Robert Wood Johnson Foundation that examines the effects of dementia care coordination and education on Veterans with memory-related illnesses and/or dementia and their caregivers. PDC represents an innovative partnership between the VA and AA. The intervention, being investigated at five VA medical centers and involving approximately 600 Veterans over 65, provides guidelines and educational support for providers on the diagnosis and management of dementia in VA primary care settings.

PDC relies on the joint efforts of VA and AA care coordinators to allow patients and their caregivers to take full advantage of both VA and community services to resolve medical, psychological, safety, legal, financial, and other problems. After an initial telephone assessment with the VA care coordinator covering medical issues, a referral brings in the services of an AA care coordinator to assist the patient and caregiver with issues that would benefit from available community services. Each patient/caregiver pair works with both a VA and AA care coordinator, and care coordinators talk weekly by telephone to help resolve issues. The program provides much-needed support to caregivers, who often do not receive the help they need to deal with the problems and stresses they face in their everyday tasks.

"The goal of the project is to think 'outside the box' and take full advantage of all available community resources to help Veterans and their caregivers improve their quality of life," said Mark E. Kunik, MD, MPH, principal investigator of the project and associate PI of the Houston Center for Quality of Care & Utilization Studies, a VA Center of Excellence. "It offers a comprehensive approach to provision of services in the hope that these patients and those caring for them will be able to close the gaps in assistance that sometimes keep them from having an optimal experience. It is extremely important because of the increasing numbers of Veterans we expect in the next few years who will fall into this age group." Dr. Kunik is also the MIRECC Associate Director for Research Training. For more information about PDC, contact Brian Murry at 713-794-8668 (murry@bcm.tmc.edu).

RURAL HEALTH RESOURCES UPDATE

REPORTS EXAMINING THE ALLIED HEALTH CLINICAL DOCTORATE

These reports examine how the transition to clinical doctorates in allied health impacts rural communities by using the Doctor of Physical Therapy (DPT) degree as an example of the effect on the supply and quality of rural physical therapy care.

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Electronic copies of these reports can be found here:

What Does the Allied Health Clinical Doctorate Mean for Rural Areas? (Findings Brief)
http://www.shepscenter.unc.edu/research_programs/rural_program/pubs/finding_brief/FB86.pdf

The Trend Toward the Clinical Doctorate in Allied Health: Implications for Rural Communities (Final Report)
http://www.shepscenter.unc.edu/research_programs/rural_program/pubs/report/FR94.pdf

RECENT MIRECC PUBLICATIONS

ANXIETY IN DEMENTIA: A CRITICAL REVIEW

Seignourel PJ, **Kunik ME**, Snow L, Wilson N, **Stanley M**

Clinical Psychology Review, 2008, 28(7), 1071-1082.

Until recently, little attention has been paid to anxiety symptoms in dementia. However, anxiety is common in this population, and associated with poor outcome and quality of life. The current review examines the existing literature around three major themes: the definition of anxiety in dementia, the properties of available instruments for assessment, and the clinical characteristics of anxiety in this population. Defining anxiety in individuals with dementia is complicated by the overlap between symptoms of anxiety, depression and dementia, and by the influence of the source of information.

Several instruments are available to assess anxiety in this population, including general neuropsychiatric instruments and two scales designed specifically for this purpose. The reliability of these instruments is acceptable, but their validity has not been sufficiently examined, and they may discriminate poorly between anxiety and depression. Anxiety may be higher in vascular dementia than in Alzheimer's Disease, and it decreases in the severe stages of dementia. It is associated with poor quality of life and behavioral disturbances, even after controlling for depression. Little is known, however, about its social and environmental correlates. Limitations of the existing literature and key directions for future research are discussed.

KEY FACTORS INVOLVED IN ENGAGING SIGNIFICANT OTHERS IN THE TREATMENT OF VIETNAM VETERANS WITH PTSD

Sherman MD, **Blevins D**, **Kirchner J, Ridener LC**, Jackson T

Professional Psychology: Research and Practice, 2008, 39 (4), 443-45.

In an effort to be responsive to the often complicated, multilayered family issues of people living with posttraumatic stress disorder (PTSD), many well-intentioned therapists create a variety of family-based services—only to be discouraged when participation is very low. This project involved separate semi-structured interviews with ten Vietnam Veterans with PTSD who were active in a stress recovery program and with their live-in female partners. Interviews explored each couple's perceptions about family participation in mental health treatment, including potential benefits and barriers. Findings revealed nine key themes that elucidate many of the key issues in family engagement. Seven recommendations are made about how clinicians can overcome some of the possible obstacles to involving families in care.

BELIEFS ABOUT DEPRESSION AND DEPRESSION TREATMENT AMONG DEPRESSED VETERANS

Edlund MJ, **Fortney JC**, Reaves CM, **Pyne JM, Mittal D**

Medical Care, 2008, 46(6):581-589.

Because of the misunderstanding and stigmatization of mental health disorders and treatment, health beliefs may be important in treatment seeking for depression. It is important to understand patients' beliefs about mental health disorders and mental health treatment to improve systems of care. We studied beliefs about depression and depression treatment among patients in a randomized trial of a chronic care intervention to improve depression treatment in the Veterans Administration healthcare system (n = 395).

The Depression Beliefs Inventory was used to assess beliefs regarding: (1) perceived need for depression treatment, (2) the

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efficacy of depression treatment, and (3) treatment barriers, including stigma, at baseline and 6 months.

We calculated descriptive statistics on patients' baseline beliefs, and used multiple regression to investigate the extent to which beliefs changed in intervention and treatment as usual patients between baseline and 6-month assessments. We used logistic regression to investigate the relationship between beliefs and antidepressant initiation, adherence and clinical response. At baseline, 73% of our sample believed that they had depression, and 66% believed that taking antidepressants would be helpful for their depression. However, the depression intervention had few effects on beliefs, and individual beliefs were generally not associated with taking medication or clinical response. However, a summary measure of beliefs was found to have predictive validity with respect to initiating and adhering to antidepressant treatment. Our results highlight the potential difficulty in modifying individuals' attitudes regarding depression and depression treatment in chronic care models for depression interventions.

MARCH CONFERENCE CALLS

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

		ACCESS CODE
10	MIRECC Leadership Council, 3:30 PM CT	19356#
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	National MIRECC & COE Education Implementation Science Group, 1:00 PM CT	28791#

REMINDER: THIRD ANNUAL VA MENTAL HEALTH CONFERENCE PROPOSALS DUE MARCH 13, 2009

The 3rd Annual VA Mental Health conference, **Meeting the Diverse Mental Health Needs of Veterans: Implementing the Uniform Services Handbook**, **will be held** July 21- 23, 2009 in the Washington DC metro area. This meeting will allow for two and a half days of information sharing among mental health professionals and administrators on the current state of implementation of the Uniform Mental Health Services Handbook, the utilization of enhancement funding, research-informed practices, as well as best practices identified by clinicians in the field. Submission of abstracts for oral presentations, posters, and interactive workshops at the conference are invited.

Please submit a one-page abstract describing your proposal to Jan Kemp, Center of Excellence in Canandaigua, at Jan.kemp@va.gov by COB **March 13, 2009**. Please indicate whether you wish your abstract to be considered as an oral presentation, a poster, or a workshop presentation. Abstracts will be reviewed by the planning committee and other selected experts. Applicants will be notified of acceptance by **May 5, 2009.** For a copy of the application, please contact Mary Farmer at Mary.Farmer2@va.gov.

MEET YOUR HARRISON CBOC

PARENT FACILITY: FAYETTEVILLE, VAMC

By Mary Farmer & Kristin Ward

The SCMIRECC team visited Lynn Outlaw from the Harrison CBOC in October, 2009. Harrison, the county seat of Boone County, is located in northwest Arkansas in the beautiful Ozark Mountains, 29 miles south of the Missouri border, in the middle of picturesque Ozark Vacation land situated on U.S. 62-412 and U.S. 65 highways.

Today over 12, 500 people call Harrison Home. Harrison's history has been one of constant growth and improvement in civic facilities, industrial expansion, agriculture, education and recreation. Harrison's economic base is built on manufacturing, retail, wholesale sales, agriculture, and tourism.

The “hometown atmosphere” of Harrison offers simple, relaxing, family-oriented living. Harrison is included in the "100 Best Small Towns in America", with a 2000 estimated population of 13,000 and estimated county population of 34,000. The downtown district boasts many historical buildings dating as far back as 1876.

Harrison's economy is strong and the unemployment is low thanks to the diverse segments of business that are anchored by a large manufacturing community. Wood products, medical services, manufacturing, telecommunications, trucking, electronics, warehousing and tourism all play a large part in Harrison's success.

The Harrison CBOC is affiliated with the Fayetteville VAMC, and is housed in the Main Street Medical Clinic of Dr. Klepper and Dr. Chitsey. Mental health care, as well as primary health, radiology, and laboratory services are provided at the Harrison CBOC. The primary care providers screen for depression and conduct PTSD screening and refer Veterans to specialty mental health care when necessary. Lynn Outlaw is the VA-employed Psychiatric APN who provides mental health services (individual therapy, medication management, smoking cessation, crisis management, and marriage counseling) to the Veterans in the clinic. Additionally, individual treatment is offered with Fayetteville mental health providers using video teleconferencing (V.Tel) technology.

Left: Arlene Johnson, APN – Branson CBOC
Right: Lynn Outlaw, Psychiatric APN – Harrison CBOC

At the present time, Lynn is also traveling to the new Branson, MO CBOC. The new clinic is up and running and fully staffed, so she will soon return to providing services only in Harrison.