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The next issue of the *South Central MIRECC Communiqué* will be published July 2, 2009. Deadline for submission of items to the July newsletter is June 26, 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)

## REFLECTING ON THE 2009 SC MIRECC RETREAT

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**“Addressing the Mental Health Needs of Rural OEF/OIF Returning Veterans”** was the theme of the South Central MIRECC’s annual retreat, held in Houston from April 22 – 24. We were fortunate to hear two excellent keynote speakers: Terry Keane, Ph.D., Director of the VA’s National Center for PTSD, Behavioral Sciences Division and Terri Tanielian, M.A., Co-Director of the Center for Military Health at RAND. Other highlights included a panel discussion with clinicians from a range of network community-based outpatient clinics (CBOCs) and an overview of the literature on rural mental health care presented by John Fortney, Ph.D., SC MIRECC Associate Director for Research.

Dr. Keane provided information about new treatments for PTSD, many developed by investigators at the National Center for PTSD. Dr. Keane stressed that delivery of optimal treatment to Veterans will require change and innovation within the VA. While acknowledging the many challenges of transformation, he urged providers and the VA system as a whole to adopt and use practices that are evidence-based. Dr.

Keane noted that we need to think outside the traditional box of face-to-face, one-on-one psychotherapy, especially as we attempt to meet treatment needs of Veterans living in rural areas. Dr. Keane’s thinking was very much in line with our MIRECC’s perspective which emphasizes the need for distance delivery of therapy via various modes of telemedicine and the need for training in, and focused implementation of, evidence-based psychotherapy practices in VISN 16. Having our perspectives confirmed by individuals not directly involved in our MIRECC – and particularly by national leaders such as Dr. Keane – lets us know that we are moving in the right direction.

Ms. Tanielian gave an excellent overview of what is known about service members returning from Iraq and Afghanistan and their families. According to the recent RAND report, “Invisible Wounds of War,” nearly 20% of returning Veterans have either depression (5%), PTSD (5%), or both (9%) and exposure to combat trauma is the best predictor of having a mental health problem.

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## *Reflecting on the 2009 SC MIRECC Retreat continued...*

Although the Army Reserve has proposed a five phase model of homecoming (pre-entry, reunion, disruption, communication, and normalization), Ms. Tanielian noted that the challenges of reintegration are poorly understood. We do know that having more relationship problems within the family is known to affect recovery from and resistance to PTSD in the service member but little empirical evidence exists about the impact of OEF-OIF on families, and particularly on children within these families. Further, although being “resilient” is seen to be beneficial, the exact definition of resilience and its measurement are still vague. Ms. Tanielian’s presentation underscored the great need for additional research in all these areas, especially relative to rural Veterans and their families.

A highlight of this year’s retreat was a panel of mental health clinicians from VISN 16 CBOC’s, including Julie Arseneau, Ph.D., Jo Walker Hines, LCSW, Valorie King, Ph.D., Scott Mayers, M.D., Donna Miller-Brown, Psy.D., Pamela Norwood, LMSW, Theresa Rozum, LCSW, Lahoma Schultz, Ph.D., Russell Smith, Ph.D., and Teresa Timmons, M.D. We in the SC MIRECC are becoming more familiar with CBOC mental health practitioners through our CBOC Partnership Project, a program funded by the Office of Rural Health and headed by Mary Sue Farmer, Ph.D.-C, Cayla Teal, Ph.D., and Kim Arlinghaus, M.D. Although we have visited each of the CBOCs in our VISN, there is nothing comparable to hearing directly from a group of CBOC-based providers about their experiences in community clinic settings! This panel was a highlight of the retreat as the hard work and dedication of these clinicians was apparent to all. They described the rewards and

challenges of their rural practices where they sometimes work in relative isolation. Once our CBOC needs assessment is completed, we in the SC MIRECC expect to have a better idea of how we can work and communicate with CBOC clinicians on an ongoing basis, not just at our annual retreat.

Emphasizing that nearly half of military recruits now come from rural areas, John Fortney, Ph.D., urged us to think of “rural” as a multi-dimensional concept, including not only issues related to population density but also to other constructs such as social networks, culture, and access to care. Dr. Fortney told us that rural populations differ in that they are older, poorer, and have less education. He noted that rural Veterans with mental health disorders are less likely to receive any mental health treatment and, if they do seek treatment, are less likely to see a mental health specialist. He identified distance to care, stigma, and, potentially, rural culture (which highly values independence and self-reliance) as some of the potential barriers to mental health treatment. Finally, Dr. Fortney identified research opportunities in terms of observational, intervention, and implementation studies. Rarely have we heard such a comprehensive and thoughtful review of the rural mental health literature as it pertains to Veterans.

The quality of information and level of interaction made the 2009 SC MIRECC retreat truly a success. Meetings such as this allow us to learn more about rural mental health issues and to re-focus participants in the South Central MIRECC on our new rural theme.

### **JUNE CONFERENCE CALLS**

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

|    |  | ACCESS<br>CODE |
|----|--|----------------|
| 3  | MIRECC Site Leaders, 9:00 AM CT  | 27761#         |
| 9  | MIRECC Leadership Council, 3:30 PM CT                                    | 19356#         |
| 15 | MIRECC Education Core, 3:00 PM CT  | 16821#         |
| 16 | VISN 16 Mental Disaster Team, 11AM CT                                    | 76670#         |
| 17 | MIRECC Program Assistants, 2PM Central                                   | 43593#         |
| 23 | MIRECC Leadership Council, 3:30 PM CT                                    | 19356#         |
| 25 | National MIRECC & COE Education Implementation Science Group, 1:00 PM CT | 28791#         |

## RECOGNITION OF EXCELLENCE IN THE SC MIRECC

The South Central MIRECC recognized the substantial contributions of several individuals at the annual retreat, April 22-24, 2009, in Houston. Please join us in congratulating the following awardees:

Department of Veterans Affairs  
South Central MIRECC

***Major Contributor Award***

Presented to

**John Fortney, Ph.D.**

Department of Veterans Affairs  
South Central MIRECC

***Clinical Care Award***

Presented to

**Elise Taylor, Ph.D.**

Department of Veterans Affairs  
South Central MIRECC

***Excellence in Education Award***

Presented to

**Wright Williams, Ph.D., ABPP**

Department of Veterans Affairs  
South Central MIRECC

***Best Publication by a Senior Investigator***

Presented to

**Melinda Stanley, Ph.D.**

Department of Veterans Affairs  
South Central MIRECC

***Excellence in Research***

Presented to

**Jeffrey Pyne, M.D.**

Department of Veterans Affairs  
South Central MIRECC

***Best Publication by a Junior Investigator***

Presented to

**Ellen Teng, Ph.D.**

Department of Veterans Affairs  
South Central MIRECC

***Excellence in Research Education***

Presented to

**Melinda Stanley, Ph.D.**

Department of Veterans Affairs  
South Central MIRECC

***Special Contribution Award***

Presented to

**Michelle Sherman, Ph.D.**

Department of Veterans Affairs  
South Central MIRECC

***Clinical Leadership Award***

Presented to

**Madhusudan Koduri, M.D.**

## **THIRD ANNUAL VA MENTAL HEALTH CONFERENCE, JULY 21-23:**

### **MEETING THE DIVERSE MENTAL HEALTH NEEDS OF VETERANS: IMPLEMENTING THE UNIFORM SERVICES HANDBOOK**

VISN 16 Presenters include --

**Kim Arlinghaus, M.D.\*, Katharine Head, M.A.\*, Mary Sue Farmer, Ph.D.-C\*, Teresa Simmons, M.D.\*, Kathy Henderson, MD\* & Cayla Teal, PhD\***

“Rural Roads To Recovery”: Bringing the Uniform Mental Health Services Handbook to VA CBOCs

**Dean Blevins, Ph.D.\* & J. Vincent Roca, Ph.D.\***  
Experiential Avoidance and the Mental Health of OIF/OEF Veterans Over Time

**Christina Gamez-Galka, Ph.D.**  
Measuring Recovery: The Promise of goal attainment scaling

**Kathy Henderson, M.D., Catina McClain, M.D. & Loretta Cohan, LCSW**  
Network-wide Approach to Inpatient Psychiatry Environment of Care Safety

**Michael Kauth, Ph.D.\*, Dean Blevins, Ph.D.\*, Greer Sullivan, M.D.\* Jeff Cully, Ph.D.\*, & Reid Landis, Ph.D. \***  
Factors Related to Implementing Brief Cognitive Behavioral Therapy in VA Clinics: A Pilot Study

**Thomas Kosten, M.D. & JoAnn Kirchner, M.D.\***  
From Screening to Treatment: Implementing the UMHS for Veterans with Alcohol Use Disorders

**Stephen Marder, M.D., Rick Owen, M.D. & Teresa Hudson, Pharm.D.**  
Metabolic Side-effects of Antipsychotic Medications: Improving care

**Salah Qureshi, M.D.\***  
Is There an Association Between PTSD & Dementia? From Systematic Review to Retrospective Study

**Edward Post, M.D. & JoAnn Kirchner, M.D.\***  
Primary Care – Mental Health Integration: Implementation, Evaluation, and Field Perspectives

**Kevin Reeder, Ph.D.**  
Implementing Prolonged Exposure Therapy in a Variety of VA Environments

**Qayyim Said, Ph.D.\***  
Facilitation in Implementing CBT among Veterans: Analysis of Therapist Time in Facilitation and CBT Provision

**William Schmitz Jr., Psy.D.**  
Scaling Questions – How to implement daily ratings to assist in treatment planning and monitor suicide risk.

**Janine Shaw, Ph.D.**  
GUI Fileman Application for Suicidal Behavior Follow-Up

**Paul Sloan, Ph.D.**  
Predicting Veteran Satisfaction on Inpatient Psychiatric Units Employing Recovery-oriented Programming

**Gabriel Tan, Ph.D., ABPP\***  
Autonomic Dysregulation Among Veterans of Operation Enduring and Iraqi Freedom: A Pilot Study

**Cayla Teal, Ph.D.\*, Katharine Head, M.A.\*, Mary Sue Farmer, Ph.D.-C\*, Kristin Ward, M.S.\* & Greer Sullivan, M.D.\***  
Assessing the Educational Needs of CBOC Mental Health Providers: Implications for Training and Development

**Su Bailey, Ph.D.\* & Andra Teten, Ph.D.\***  
A Special Issue in Providing Services to Veterans, Couples, and Families: Male-to-Female Sexual Aggression among Iraq, Afghanistan, and Vietnam Veterans and Co-Occurring Substance Abuse and Intimate Partner Aggression

\*SC MIRECC Presenter

## RECOVERY CORNER

# MENTAL HEALTH ADVANCED DIRECTIVES: A COLLABORATIVE JOURNEY

Erin B. Williams, Ph.D., CPRP

Psychologist/ Local Recovery Coordinator

Central Arkansas Veterans Healthcare System (CAVHS)

The Local Recovery Coordinator's role as champion for system transformation is only possible through intensive collaboration with Veterans, their families, policy makers, administrators, healthcare providers, researchers, support staff and community partners. The very foundation of any Recovery approach is empowering relationships and the following are but a few examples of the necessity of such collaboration.

In 2007, I learned of an online presentation by the National Resource Center on Psychiatric Advanced Directives featuring Mary Blake, CRE, Public Health Advisor for the Center for Mental Health Services/SAMHSA. My interest was immediately piqued as she described her personal experience of navigating the mental health care system as a consumer and how she went about creating a Psychiatric Advanced Directive (PAD). A PAD is a legal document that allows mental health consumers to establish treatment preferences and have some say in their future psychiatric care should they become incapacitated due to lack of competency or inability to communicate. Like standard medical advance directives, the PAD document allows an individual to refuse or give consent for specific treatments and/or authorizes a designee to make decisions when the person is unable to do so.

Ms. Blake (2007) underscored that PADS are "vehicles for promoting consumer's voice, self-directed care and self determination" through partnering with care providers in the treatment planning process. She described key objectives for her first PAD, including when it would become effective, signs of distress and duration, allowance for stabilization through self-identified interventions, transferring decision making authority to a designee, and setting specific time limits for automatic review. It soon became apparent that the document would need ongoing revisions, including detailing preferences along with justifications to assist

the healthcare team. For example, she described the need to focus and relax by being allowed to pace in a quiet environment when hearing voices or feeling distressed. Due to a history of trauma involving unwanted touch, Mary also specified in her PAD that healthcare staff ask permission to touch her, give reason for touching and provide her extra personal body space when she became distraught. Other preferences included history of medication effectiveness, person to be identified in the event of admission, a contact for pet care, and people prohibited from visiting while she was hospitalized.

Since a PAD seemed to be such a logical and practical recovery tool, I began working with a VA psychiatrist and the local medical school to arrange for Ms. Blake to present for Psychiatric Grand Rounds. The response by attendees was overwhelmingly positive and prompted an ongoing Recovery Series where experts are invited regularly to central Arkansas to address both professionals and laypersons in a variety of local venues. Four months later, I listened to the VHA National Ethics Teleconference on Advance Directives for Mental Health. The National Ethics Committee (NEC) was quite thorough in their review and referencing their February 2008 report, they reiterated,

**"In our view current VA policy, which folds Mental Health Advanced Directives (MHADs) into advance care health planning overall, appropriately meets the needs of patients with chronic, severe mental illness. We find many of the provisions in state statutes pertaining to MHADs to be unnecessary for VHA or even ethically problematic insofar as they make exceptions for patients completing MHADs that do not apply to patients completing general advance directives or may have the effect of limiting the rights of patients with mental illness relative to other patients."**

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The NEC also emphasized the importance of comparing local policy to determine how commensurate it is to VHA policy. Discussion with my local Mental Health Administration and Ethics Committee resulted in interest about this unexplored topic. Subsequently, I began chairing a multi-disciplinary MHAD task force which included Sheri Ault, R.N., Nyasanu Barbee, Ph.D., Dorothy Dodak, LMSW, Monica Shotwell, M.D., Stephany Robinson, LMSW, and J. Glen White, Ph.D. This committee has met 16 times since October 2008 with the objectives of learning as much as possible about this topic and developing a useable document with accompanying education. Resources reviewed thus far include NRC-PADs.org, Bazelon Center for Mental Health Law, US Living Will Registry, UPENN Collaborative on Community Integration Advance Self-Advocacy Plan, National Empowerment Center, National Mental Health Association, Compassion and Support.org, Maryland Network of Care, local medical facilities directives, state and federal law, and a review of recent literature. This undertaking has been similar to exploring catacombs with each pathway dividing further, a reflection of the complexity of issues involved.

A brief overview of some of the information gleaned in the process includes learning that only 25 states have adopted formal PAD/MHAD statutes and three variations are being used in the United States (i.e., instructional, proxy, and a hybrid of the two) (Swartz & Blake, 2008; La Fond & Srebnik, 2002). While advanced directives have the potential to positively change acute mental healthcare, research indicates that providers are often uncertain about how to use them. There is a general lack of clear and consistent standards available about how to complete, activate, or revoke PADs (Srebnik & Kim, 2006). Some consumers are also reluctant to consider PADs, similar to the denial associated with creating a will. Furthermore, feelings of coercion may exist because of the inherent power differential in the provider-patient relationship, including consumers being told they should complete a MHAD, and the clinician ultimately being the one to determine competency (La Fond & Srebnik, 2002). "Liberation, as Paulo Freire put it, cannot be handed to the oppressed by the oppressor, but we must continue to work with service users to make greater freedom a possibility for them" (Thomas & Cahill, 2004).

Additional considerations in the use of MHADs include fluctuating decision-making capacity, issues of revocability, and the rights of individuals to not complete an advance directive as a condition of care. Also, the execution of these directives if not heeded by providers must include written notification of the decision and a rationale must be provided to the surrogate or family member, and, once he or she is competent, directly to the consumer. The notification must include whether the decision was institutional (not an accepted standard) or specific to the circumstance (e.g., not sufficient, unavailable, or might hinder emergency care) (Srebnik & Kim, 2006; Koyonagi, 2007; Swartz & Blake, 2008; The Patient Self Determination Act, 1994).

Veterans Health Administration (VHA) policies and procedures are outside the realm of state jurisdiction. The CAVHS task force learned while reviewing the literature that the VHA has been putting forth notable effort since 2003 to develop its own PAD document. Review of HSR& D studies conducted at the Durham VAMC and ongoing conversations with Dr. Jennifer Strauss, a Health Scientist at the Mid-Atlantic MIRECC, have proven beneficial. Randomized studies have demonstrated that Veterans with severe mental illnesses not only welcome, but can complete "clinically relevant" advance directives and are satisfied with them. However, existing barriers include lack of access, limited knowledge by providers, and poor communication between inpatient and outpatient staff. Consumers desire choice in who will partner with them in creating a MHAD and in what setting the effort should occur. Recommendations for future study include determining the role of provider education in prevalence of MHAD use (Henderson, 2009; Strauss 2007, 2008).

In review of this article, it is clear that collaboration is not only empowering, but a necessity. Such practices, like any recovery-oriented process, involve shared decision-making with emphasis placed on the value of consumer preference and provider education. If you would like to learn more, please contact me at [erin.williams3@va.gov](mailto:erin.williams3@va.gov).

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## CLINICAL EDUCATOR GRANTS AVAILABLE TO DEVELOP NEW TOOLS

The South Central MIRECC is requesting applications for **2010 Clinical Educator grants**. These grants are designed to encourage frontline clinicians and educators to develop innovative educational tools or programs that target under-served or hard-to-reach populations and/or their families, or improve the system of mental health care delivery, especially in rural settings. These grants have been used in a number of ways: to develop new, unique educational tools or innovative psychoeducational programs, and modify existing materials or put them in a new format.

Deadline for applications is 4:00 PM CT, July 17, 2009. Awards are between \$500 and \$7,000. VA personnel in VISN 16 who are affiliated or collaborating with local Mental Health staff are eligible to apply. Trainees are eligible to apply.

*Before you begin writing, please talk to consultants listed in the application or contact local MIRECC personnel for feedback on your idea. Many great ideas have already been done, or your project may be too ambitious. We want to help you develop your idea into a fundable project.*

Applications are reviewed by a committee. In many cases, applicants are asked to provide additional information or make modifications in their project. In past years, about 75% of applications have received funding. Funding announcements are expected by early November. A list of completed products to illustrate the range of funded projects and the application is attached. The application can also be accessed at:

<http://www1.va.gov/scmirecc/page.cfm?pg=18>.