



*Reducing
mental health
disparities
among
rural veterans*

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

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

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

RURAL-URBAN DIFFERENCES IN MENTAL HEALTH AND MENTAL HEALTHCARE: PART II

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Increasing Interest in Rural Healthcare

There are several reasons for increasing national interest in the challenges of rural healthcare delivery. Wars in Iraq and Afghanistan have focused the public's attention on health care for returning Veterans, and Veterans are more likely to live in rural areas than non-Veterans.^{1,2} Nearly half of all U.S. military recruits now come from rural areas, and nearly one-third of soldiers who have died in Iraq are from small towns and communities across the nation. To better serve rural Veterans, it is critical to understand rural-urban differences in the mental health, and rural-urban differences in access to and quality of mental health services.

Rural-Urban Differences in Prevalence

The National Comorbidity Study replication found no significant rural-urban differences in the 12-month prevalence of psychiatric disorders,³ and the National Health Interview Survey found the 12-month prevalence of major depressive disorder to be significantly but not

substantially higher in rural areas.⁴ For Veterans, the prevalence of mental health disorders is significantly lower in rural areas than in urban areas.⁵

Rural-Urban Differences in Severity

It is often hypothesized that rural individuals delay seeking care longer than urban individuals, resulting in greater severity of illness. However, data do not support this hypothesis. For Veterans, the severity of mental health disorders is significantly, but not substantially, worse in rural areas than in urban areas.^{2,5} Rural Veterans' self-reported health status is poor compared to that of their urban counterparts.⁶ For Veterans diagnosed with post-traumatic disorder (PTSD) at an outpatient PTSD clinic, there were no significant rural-urban differences in PTSD severity or comorbidity.⁷ Likewise, Fischer et al. found no significant rural-urban differences in severity or functioning for Veterans hospitalized with schizophrenia,⁸ and Fortney et al. found no significant rural-urban differences in severity for Veterans presenting for emergency psychiatric care.⁹

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Rural-Urban Differences continued...

Rural-Urban Differences in Service Utilization

Larson found no rural-urban differences in any outpatient health service use in the general population.¹⁰ However, rural residents with a mental health disorder are less likely to have any (formal or informal) mental health treatment, and much less likely to receive specialty mental health care, than urban residents.¹¹ Rural residents with depression are more likely to receive pharmacotherapy and less likely to receive psychotherapy.¹² For elderly Veterans, those living in rural areas have similar numbers of primary care visits compared to urban Veterans, but substantially fewer specialty mental health visits.¹³

Rural-Urban Differences in Quality and Outcomes of Care

Only one-third of patients with depression or anxiety disorders receive minimally adequate care,¹⁴ despite the fact that receipt of minimally adequate care is associated with better outcomes for depression.¹⁵ Patients are more likely to receive minimally adequate care from a specialty mental health setting than a primary care setting,¹⁴ where most rural patients receive care for their mental health problems. Likewise, patients with longer travel times to their provider are less likely to receive minimally adequate care.¹⁶ There are currently no data available about rural-urban differences in the clinical outcomes of mental health treatments among Veterans.

Summary

Researchers and policy makers are focusing on rural healthcare because of some intriguing questions about access to and quality of health care for people in rural communities. Rural residents have similar prevalence rates and levels of severity of psychiatric disorders as their urban counterparts, but they don't receive the same levels of care. More research is needed to better understand the causal mechanisms that explain these findings.

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THE SOUTH CENTRAL MIRECC CONSUMER ADVISORY BOARD (CAB) VETERAN PROFILE: ESTELLA MORRIS, PH.D., LCSW

Interviewed By Carrie Edlund, M.S.

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. This month we profile past CAB Chairperson Estella Morris, Ph.D., LCSW, who also serves as program manager for the CAVHS Comprehensive Homeless Center in Little Rock.

You've just completed your tenure as CAB Chairperson. How did you get involved in the CAB, and how long did you serve as Chairperson?

I served as Chairperson for the CAB for approximately four years. I became involved even before the CAB was established, through my acquaintance with Dr. Greer Sullivan. We shared a common interest in issues regarding homelessness and homeless Veterans. I worked with her from an ancillary perspective as she sought to obtain funding for the SC MIRECC. Once the SC MIRECC was approved, I became involved in the developmental stages and was later named a member of the initial consumer advisory board.

What changes have you noticed in the CAB from its beginning until today?

Early on, CAB members insisted that we did not want to be seen as members of the CAB in name only. We wanted to be effective in our efforts to contribute to the research and educational goals of the MIRECC. If we were going to be successful in that capacity, we wanted to be given the opportunity for input and we had to be able to witness positive responses to that input. After the first few meetings people realized CAB members had a considerable amount to offer. CAB members brought broad backgrounds and functional and cultural diversity to the team and the group was able to recognize this and benefit from members' input on projects.

What did your tenure on the CAB teach you about Veterans and mental illness?

The important thing I've learned about mental illness has also been integrated into the system at large. It's the importance of evidence-based practice and the importance of incorporating consumer input. The New Freedom Commission and the Uniform Mental Health

Services Handbook emphasize the importance of input from consumers, and highlight how that input can contribute to our overall understanding of mental illness. The CAB's diversity of people reflects what is going on at the field and consumer levels, in contrast to past efforts to understand mental illness, which were largely restricted to knowledge gained at the academic level, with limited attention to input from consumers.

What are you working on now that you're not chairing the CAB?

I'm no longer chairing the CAB but I'm still a member. I bring to the CAB the clinical perspective on mentally ill clients in general, and I continue to represent the needs of homeless Veterans. Although that's not currently one of the SC MIRECC's target areas, I hope at some point it will be identified as an area valuable for study. Because the homeless population experiences a range of mental health issues, a lot may be missed by not targeting the homeless population for research, even if you look just at the mere survival skills in that group. I serve as the program manager for the CAVHS comprehensive homeless center in Little Rock, one of only seven comprehensive VA homeless centers in the nation.

Are you a Veteran yourself?

Yes, I'm a service-connected Veteran. My time was spent primarily as a combat medic for seven years in the Army National Guard and a corpsman for three years in the Navy Reserve. I was activated in the Gulf War but was never mobilized.

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What are your hobbies?

I like making jewelry with semi-precious stones and silver. I never sell it. I just give it as gifts to friends. I also enjoy jazz and tap dancing. I've been doing that for about 15 years. And I love to travel. I've been to Jamaica, Asia, Africa, and all over the North American continent. My favorite places to visit were Seoul, South Korea and Hong Kong. Witnessing the differences in culture was a real learning experience. My most eye-opening travel was to Ghana, in West Africa. Outside of Mexico, I had never seen the level of poverty and lack of basic infrastructure that we take for granted here in the US. When I think about it, being in Africa was like being at home in southeast Arkansas as a child in the early 1950's.

What do you wish the general public understood better about mental illness?

I wish the general public understood better the value of individuality when it comes to mental illness. Sometimes people have a tendency to dump everything all in one pot, maybe because of fear. There is great value in looking at the individuals rather than the illness. It's very important to educate the public so they can better understand people with mental illness. I would

specifically like to see more understanding in the court systems, especially Veteran's courts, homeless courts and family courts. I see many people with mental illness who end up with felony charges because they are ill and unmedicated. These individuals often end up in situations where they are not able to secure housing or jobs. Most of these issues get addressed earlier with the Veteran population than with the general population. For example, just a year ago VA solved the issue of Veterans not being able to qualify for HUD-VA Supported Housing, if they had a felony charge. Now, Veterans who are stable are able to get that much needed permanent housing assistance as long as they do not have a sexual offender history.

It sounds like real progress is being made

Yes it is. Evidence-based programs are so valuable. Within Mental Health at the national level for instance, the VA has been monitoring the quality of its Homeless Programs for the last 22 years. We have the opportunity to view outcomes on an ongoing basis. This allows programs to operate in a perpetual manner where we can focus on continuously improving the quality of services, while at the same time insuring that those services are efficacious. This has allowed us to grow and become more comprehensive in our focus and to witness a true decrease in the level of homelessness among Veterans.

RURAL HEALTH RESOURCES UPDATE

THE KEY ROLE OF SOLE COMMUNITY PHARMACISTS IN THEIR LOCAL HEALTHCARE DELIVERY SYSTEMS

This brief presents findings from a 2008 survey of 401 community pharmacists that are the only retail provider in their community to document their extended relationships with other health care providers and the additional health care services these pharmacists provide to their patients.

Pharmacist-owners in independent pharmacies located at least 10 miles from the next closest retail pharmacy were interviewed to determine the presence in their community of other types of health care organizations that require pharmaceutical support (such as hospitals, long-term care facilities, hospice providers, home health agencies and community health centers), their level of involvement with those

facilities, and the types of clinical services (other than dispensing and counseling) the pharmacists offered to their own patients.

An electronic copy of the policy brief can be found here: <http://www.unmc.edu/ruprihealth/Pubs/b2009-3%20Loss%20of%20Comm%20Pharms.pdf>.

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RECOVERY CORNER

CONSISTENCY OF CLIENT DIRECTED OUTCOME INFORMED PRACTICE WITH RECOVERY-ORIENTED SERVICES

By Jennifer Halter, LICSW, QCSW, DCSW
Social Worker/Local Recovery Coordinator
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The Veterans Health Administration continues the journey it started several years ago toward recovery-oriented mental health services. Deputy Under Secretary for Health Operations and Management (ION) directed the Recovery Coordinators in a December 8, 2006 memorandum to “ensure Veterans have consumer-focused services and support necessary to live, work, learn, and participate fully in the community.” Thus began the struggle to find the most useful means to operationalize recovery-oriented services in the Department of Veterans Affairs.

Recovery has been described as “a deeply personal process of changing one’s attitudes, values, feelings, goals, skills, and/or roles” (Anthony, 1993) that imbues hope that the people with whom we work are more than their symptoms; that they can learn to live with their symptoms and challenges. Some ongoing research over the course of years and outside the auspice of recovery-oriented services finds common ground with the recovery movement. This body of research suggests that therapists and other helpers can facilitate change by focusing on what clients *can* do rather than focus on their problems (Snyder et al, 1999); soliciting the client’s perception of the problem, determining whom the client assigns responsibility for change; and obtaining client feedback and input on the therapeutic process (Maione & Chenail, 1999). Maione and Chenail (1999) observe that clients want to be active in the therapeutic process and like to provide feedback. These research findings provide a foundation for Client Directed Outcome Informed (CDOI) practice and are consistent with recovery-oriented practice.

CDOI practice developed, in part, from a review of the research results above and an additional 40-50 years of outcome studies. The Outcome Rating Scale and the Session Rating Scale are key components of CDOI practice that focus the clinician on the client’s

perceptions of personal well-being and effectiveness of the care rendered. CDOI is not a treatment modality; rather it is a useful adjunct to various interventions because it focuses on measuring the client’s perception of how he is doing and how well the therapist meets his needs. It does not preclude the use of modality-specific or other measures.

The Outcome Rating Scale (ORS) is a four-factor scale the client completes at each visit or once a week for clients receiving intensive services. The therapist introduces the tool as a means for the client and the therapist to track how the client is progressing. The introduction includes the expectation that clients will get better, and they can expect to get better sooner rather than later in therapy. After the introduction of this tool, it takes most clients less than a minute to complete the ORS. It serves to start a discussion from the client’s perspective about what’s working well in his or her life and where the client is having difficulty (Miller, Duncan, Sorrell, and Brown, 2005). The client’s ability to tell his or her story and assign responsibility has been found to be healing for the client (Tallman & Bohart, 1999). The therapist is free to use whatever interventions were agreed upon by the therapist and the client to facilitate the client’s recovery.

Midway to the end of the session, the therapist uses the Session Rating Scale (SRS) to obtain feedback from the client about how well the therapist demonstrated respect and understanding, the extent to which the session focused on what was important to the client, the client’s perception if the therapist’s approach was useful, and the client’s overall rating of the session (Duncan et al, 2003).

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Once the client provides this feedback, the therapist discusses with the client the behavior the therapist engaged in that was/was not helpful. Many therapists are hesitant to request this type of feedback from clients because therapists have their own evaluation anxiety, have paternalistic ideas about providing services, and/or worry the feedback will be used to their detriment by their supervisor. For therapists who overcome their concerns with regard to obtaining client feedback, client goal attainment is more likely. When therapists are tuned into the client's perspective and seek to understand the client, clients are likely to rate the therapeutic alliance high. This is consistent with reviewed research findings that therapists who ask for feedback about the therapeutic process have satisfied clients (Tallman & Bohart, 1999). Satisfied clients tend to keep their appointments and reach their goals. There are times when clients do not rate therapists well and the therapeutic alliance appears to be at risk. Therapists who follow-up lower alliance ratings with conversations with the client about what the therapist could do differently are correlated with better outcomes (Miller, Duncan, Brown, Sorrell, & Chalk, 2006). This increases the likelihood that clients return for services because their needs, beliefs, desires are respected – central tenets of recovery-oriented practice.

Of additional use is the database of normative responses for the ORS and SRS. Therapists who use electronic rather than paper/pencil ORS and SRS have the advantage of showing their clients the expected progression of wellness based on their baseline scores. The database plots the client's scores and shows the 25th, 50th, and 75th percentile ranges based on the baseline. Clients return for subsequent visits, complete the ORS, and compare the current ORS score to the normative sample range. Therapists discuss with the client follow-up scores as they compare to the percentile ranges. Clients who fall below the 25th percentile are at high risk for adverse therapeutic outcomes and attention must be directed to the client's therapeutic concerns. Addressing clients at risk for adverse outcomes places care providers in a better place to retain the client in care and achieve positive outcomes (Miller, Duncan, Sorrell, & Brown, 2005).

Over time, therapists using the database have the opportunity to determine their effectiveness as therapists. The database calculates the therapist

outcomes compared with other therapists using CDOI tools statistically demonstrating the most effective therapists. Statistically effective therapists are therapists from whom we can learn within our agencies. This also applies to program components in agencies where ORS and SRS use is institutionalized. Administrators and supervisors are able to review therapist and program effectiveness based on data that is stored and calculated at the moment clients complete the tools electronically (Miller et al, 2005). Numerous agencies providing mental health and substance abuse services with "difficult" populations have implemented these tools and found 50% reduction in therapy cancellations/no shows and up to 65% improved effectiveness within their agencies (Duncan, 2007). Improving effectiveness and efficiency such as those achieved by other agencies within the Department of Veterans Affairs mental health services is consistent with its recovery-oriented mission. Mental health resources are historically limited. Using research-based practice tools that keep therapists client-focused and improve our outcomes appears to be a logical component of recovery transformation efforts. It is also consistent with our goals of providing evidence-based interventions that respect the autonomy of our clients, focus on their strengths, create hope, and facilitate the highest possible functioning of the Veterans whom we serve.

Jennifer Halter, LICSW, QCSW, DCSW, is the Facility Recovery Coordinator at the VA Medical Center in Oklahoma City, OK. She is recently retired from the U.S. Air Force where she served as a clinical social worker in support of the Global War on Terrorism and Operation IRAQI FREEDOM. You can contact her at jennifer.halter@va.gov or 405-456-3991. More information about Client Directed Outcome Informed practice, including free downloadable copies of the ORS and SRS, can be found at www.talkingcure.com

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FY 2008 CLINICAL EDUCATION AWARD GRANTEE: WOMEN VETERANS HEALTH STRATEGIC HEALTH CARE GROUP

A \$25,000 clinical education grant award for targeting the 28,000 women Veterans in the MEDVAMC catchment area was received by Project Leader **Deleene Menefee, Ph.D.**, Women's Inpatient Psychologist with the Michael E. DeBakey VA Medical Center, Rola El-Serag, M.D.,; W. Smitherman, M.D.,; B. Melton, M.D.,; A. Dawkins-Oliver, LCSW.,; M. Beckner, PhD.,; S. Gwynn, Ph.D., and A. LeMaire, Ph.D. Additionally, Margaret Nosek, Ph.D., Center for Research on Women with Disabilities and Tracey LeDoux, Ph.D., Clinical Nutrition and Research Center, both at Baylor College of Medicine, were collaborators. The grant will target the gap in women Veterans' knowledge of all VA services and the quality of care received.

ACKNOWLEDGING SC MIRECCERS

The SC MIRECC would like to recognize its educators and researchers for their contributions to the field.

Congratulations to **Alan ("Dutch") Doerman, Ph.D.** who has been selected to receive the Outstanding Clinician award from the American Psychological Association's Division 18 (Psychology in Public Service). This award will be presented at the APA convention in August 2009.

Congratulations to **Karen F. Wyche, Ph.D.**, for being chosen to receive the Sue Rosenberg Zalk Award for Distinguished Service to the Society for

the Psychology of Women, American Psychological Association. Dr. Wyche will be presented the award at the annual meeting of the American Psychological Association in Toronto, Ontario, Canada, in August 2009.

Cayla Teal, Ph.D. and **Richard Street, Ph.D.**, have the 12th hottest article in terms of number of downloads in *Social Science & Medicine* for the period January through March 2009. Please click on the link below to find the citation and the publication ranking:

<http://top25.sciencedirect.com/subject/social-sciences/23/journal/social-science-medicine/02779536/archive/21/>

MEET YOUR CBOC: MOUNTAIN HOME, AR

PARENT FACILITY: LITTLE ROCK, VAMC

By Mary Sue Farmer and Kristin Ward

In the fall of 2008, the SCMIRECC CBOC Partnership Project team visited the Mountain Home CBOC, which is housed in the Burnett-Croom-Lincoln-Aden-Williams Clinic. Mountain Home is located in the beautiful Ozark Mountains of Arkansas, and is one of the best vacation and retirement spots in the country. The Mountain Home area encompasses two massive lakes, three rivers, and beautiful mountain scenery, fulfilling Arkansas' motto as "The Natural State." For the second year in a row, Mountain Home was selected by Outdoor Life Magazine as one of the top places to live in the U.S. in 2009! In the June/July 2009 edition of, "Top 200 Affordable, Thriving, and perfectly Wild Towns in America" (for hunting, fishing and other outdoor activities) Mountain Home was ranked #19. This selection was based on affordable housing, low unemployment rates and the potential to earn a decent living...all within a short drive of first-rate hunting and fishing.

Our Veterans in this area enjoy quick and easy access to lakes, rivers and a National Forest. Incorporated in 1888, Mountain Home is the seat for Baxter County, Arkansas government. The city, with a population of 11,012 for the 2000 census, houses a hospital, a branch of Arkansas State University, Youth & Senior Centers, four City Parks, and a golf course. Additionally, our Veterans have many mental health services provided at the



Mountain Home CBOC by Jim Dorethy, a licensed clinical social worker. Mr. Dorethy provides services for individual and family therapy, couples counseling; substance abuse follow-up, posttraumatic stress disorder, depression, anxiety, grief, smoking cessation; hospice referrals, and elder care. Long-distance services are also available for Veterans through VA telemedicine.

Thanks to Jim and the Burnett-Croom-Lincoln-Aden-Williams Clinic for making us feel welcome during our visit to Mountain Home!

AUGUST CONFERENCE CALLS

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

		ACCESS CODE
5	MIRECC Site Leaders, 9:00 AM CT	27761#
11	MIRECC Leadership Council, 3:30 PM CT	19356#
18	VISN 16 Mental Disaster Team, 11AM CT	76670#
19	MIRECC Program Assistants, 2PM 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 Implementation Science Group, 1:00 PM CT	28791#