Reducing Mental Health Disparities Among Rural Veterans

South Central MIRECC

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Communiqué

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Social Skills Training for Schizophrenia

By SST Master Trainers Delores Hendrix-Giles, LCSW & Sarah V. Smith, OTR/L, CPRP

If you pass by a social skills training (SST) class in progress, you may hear laughter, clapping, and cheering. However, participants are practicing complex, new behaviors. The ability to express our feelings, appropriately interact with others in varied contexts, and be attuned to complex verbal and non-verbal responses are skills that many of us take for granted. People experiencing psychotic symptoms (e.g. schizophrenia) demonstrate and report great difficulty being successful in social situations. According to Bellack, Mueser, Gingerich and Agresta (2004), social dysfunction results when necessary behaviors are not part of a person's social repertoire, are not used at the appropriate time, or are performed inappropriately in social situations. Gaining proficiency in the skills to overcome these deficits requires practice. Social skills training provides essential tools and ample practice to increase social competency for consumers.

Solidly grounded in years of research, SST, which evolved from Lehman's skills training, is an evidence-based practice approach that uses a behavioral model to assess and treat social skills deficits in people with schizophrenia. Lehman's skills training recommended that people

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Keeping up with SCMIRECC Research

Arkansas Counselor Practice-Based Research Network

by Angie Waliski, Ph.D., JoAnn Kirchner, M.D. & Patti Bokony, Ph.D.

Research indicates that one in every four or five Veterans will return from war with a serious mental illness, most commonly depression (14%), PTSD (14%), or traumatic brain injury (19%). Often, substance abuse complicates these illnesses. Many of these Veterans return to rural areas with limited access to mental health and social services. Additionally, more than half of the two million service men and women who have experienced recent combat deployment have children. According to the VA National Center for PTSD, 16.7% of the 300,000 children of deployed parents have been diagnosed with a mental illness.

Mental health providers and researchers have acknowledged the importance of using community resources to support returning Veterans and their families,

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with schizophrenia should be taught the key elements of behavioral-based instruction through modeling, corrective feedback, contingent social reinforcement and homework assignments (Lehman, et al., 2004). Social skills training builds on these elements and is recognized as a credible and effective evidence-based practice intervention for people with mental illness.

Veterans in VISN 16 who have participated in SST groups report improved communication with friends and family, development of new friendships, increased ability to advocate for themselves with providers, improved satisfaction with medical care, and increased ability to clarify the expectations of caregivers and others. Recently, a Veteran shared his success using the "Requesting a Change in your Medication Dosage" skill during a psychiatry appointment where he used the health maintenance skill worksheet from the SST class. The psychiatrist promptly documented the Veteran's assertive self-advocacy! We have also received positive feedback from other Veterans who have participated in SST, such as:

"This is fun; now I know what to say!"

"This is so much easier when we practice, now I can speak up for myself."

"When I tried this at home I fell right into the pattern of how to say it; it really made my wife happy!"

Preferably, SST groups are conducted in closed-group format and are typically delivered at least twice per week. Each session lasts 45 minutes. Individual sessions prior to the establishment of a social skills training group are essential for engagement, orientation, and personalized goal setting. The social skills training curriculum includes the following major categories:

- Basic Skills (e.g. Listening to Others);
- Conversation Skills;
- Assertiveness Skills;
- Conflict Management Skills;
- Communal Living Skills;
- Friendship and Dating Skills;
- Health Maintenance Skills;
- Vocational Skills;
- Coping Skills for Drug & Alcohol Use.

A typical class session ends with the assignment of homework for reinforcement and generalization of learning. An emphasis on role-play and positive, corrective feedback increases proficiency and integration of skills into daily life (Bellack, 2009).

Providers trained in SST will learn how to deliver group services. Trainees learn the elemental skills of modeling, role playing, positive reinforcement, providing feedback and behavior shaping. They are also versed in the concepts and application of overlearning and generalization of learning (Bellack, 2009). This experience puts trainees in the unique position of simultaneously being a member of and facilitating a SST group. The experience of being on both sides of the table creates an empathic and collaborative foundation for facilitators that can translate to an enhanced experience for group participants.

The VA recovery transformation initiated by the President's New Freedom Commission of 2003 and the subsequent VA Action agenda set the stage for recovery-oriented care in VA mental health services. Recovery and SST share attributes to empower Veterans; both approaches focus on behavior rather than symptoms, increase independence, provide choice, foster hope by assuming that change is possible, foster self-efficacy, and are founded in respect. The assumption is that failures are the result of skill deficits and/or environment, not personal faults such as "low motivation" (Bellack, et al. 2004).

Dissemination of SST in mental health care throughout the region is fully supported by Veterans Integrated Service Network (VISN) 16 leadership. The Uniform Mental Health Services Handbook (2008) stipulates that recovery and rehabilitation-oriented services must be made available to seriously mentally ill Veterans. To date, 24 clinicians, including two master trainers, have been trained to provide SST groups in the VISN. Social skills groups are being delivered to inpatients and outpatients in multiple settings within the network. Social skills training is made possible by the VA Office of Mental Health Services through the VA Psychosocial Rehabilitation Program to increase availability of evidence-based practices to Veterans. Group leaders are generally licensed providers of mental health services; however, peer specialists have also been trained as successful co-facilitators. The Master Trainers in VISN 16 have trained staff to teach SST in Little Rock, Houston and Oklahoma City.

For more information or training for your location, contact Sarah V. Smith (501) 257-1632, Sarah.Smith@va.gov or Delores Hendrix-Giles (713) 791-1414 Ext. 6712, Delores.Hendrix-Giles@va.gov.

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Lehman, A. F., Kreyenbuhl, J., Buchanan, R. W., Dickerson, F. B., Dixon, L. B., Goldberg, R., Green-Paden, L. D., Tenhula, W. N., Boerescu, D., Tek, C., Sandson, N., Steinwachs, D. M. (2004). The Schizophrenia Patient Outcomes Research Team (PORT): Updated Treatment Recommendations 2003. Schizophrenia Bulletin, 30(2), 193-217.

Uniform Mental Health Services Handbook. VHA Handbook No. 1160.01. VA Veterans Health Administration, Washington, DC, September 11, 2008. ♦

SCMIRECC IMPLEMENTATION, DESIGN AND ANALYSIS SUPPORT (MIDAS) WELCOMES NEW TEAM MEMBER

MIDAS is a service arm of the South Central MIRECC created to assist VISN 16 investigators who are seeking intramural or extramural funding or conducting pilot studies. The MIDAS team offers design, methods, and analytic support for all phases of project development, implementation, analysis, and/or dissemination. Team members have expertise in biostatistics, epidemiology, psychometrics, qualitative methods and project implementation and management. The SCMIRECC welcomes its new MIDAS team member, Karen Drummond, Ph.D.

Karen Drummond, Ph.D. – Dr. Drummond is an assistant professor in the Division of Health Services Research at the University of Arkansas for Medical Sciences (Department of Psychiatry, College of Medicine) and a Research Health Scientist at the Central Arkansas Veterans Healthcare System. She is a medical anthropologist whose research interests include provider decision making, patient-centered medical home models, opioid use disorders, PTSD treatment, palliative medicine, and integrative medicine.

Currently, Dr. Drummond serves as a co-investigator on two research studies focused on : 1) the adoption of evidence-based practices by rural Community Health Centers; and 2) timely monitoring and management of metabolic side effects of Veterans taking antipsychotic medicine. The findings from these projects will increase the knowledge base of evidence based medicine, continuous quality improvement, and participatory research, and prevent/reduce morbidity associated with overweight/obesity, diabetes, and hyperlipidemia for Veterans.

Dr. Drummond will bring qualitative expertise to the MIDAS team, providing methodological support to investigators in the South Central VA Healthcare Network who need assistance designing and implementing qualitative studies. She will consult with investigators and assist them as they develop their project, conduct their research, and analyze their data.

For all requests for assistance from MIDAS, please contact Dr. Ellen Fischer at FischerEllenP@uams.edu or Melonie Shelton at Melonie.Shelton@va.gov to fill out an application.♦

ATTRIBUTION: ACKNOWLEDGEMENT OF MIRECC RESEARCH SUPPORT/EMPLOYMENT

SC MIRECC researchers and educators have a responsibility to ensure that the SC MIRECC receives proper credit for SC MIRECC-supported studies or projects in articles, presentations, interviews, and other professional activities in which the results of those projects are publicized or recognized. All investigators should credit the SC MIRECC if they receive either direct or indirect support from the SC MIRECC. For example, "This work was supported in part by the VA South Central (VISN 16) Mental Illness Research, Education, and Clinical Center." If you receive salary support from the SC MIRECC, you should list the SC MIRECC as an affiliation.

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especially those who have not formally presented for VA care. The purpose of the Arkansas Counselor Practice-Based Research Network (ARC-PBRN) is to provide licensed counselors throughout Arkansas with necessary education and resources to better serve local Veterans and their families. Counselors will receive training to more effectively identify mental health issues in children and families and make appropriate referrals to services in their communities.

Drs. Waliski, Kirchner and Bokony conducted several pilot studies to determine the need for education and the feasibility of organizing a practice-based research network of counselors to improve outcomes:

Pilot Study 1: The SCMIRECC funded a two-day workshop, "Psychological Trauma of War: Impact on Returning Veterans, Their Families, Schools, and Communities," for school counselors. Survey results from participants (n=75; 91% from rural counties) revealed that children of deployed parents may be negatively impacted academically and/or socially in area schools. During group discussions with elementary and secondary counselors, participants felt that the availability of more education and resources would enable them to identify emotional and behavioral problems in children of military families more effectively, as well as allow them to provide better interventions and referrals to appropriate services.

Pilot Study 2: The University of Arkansas for Medical Sciences Department of Health Services Research funded focus groups on stress and mental health service use with active duty and National Guard families with preschool-aged children. Participants reported experiencing stress and conflict with partners due to perceived lack of familial support. Discussions indicated that it was common for military spouses to take medication for anxiety or depression and for children to experience behavioral and/or academic problems. Stigma and the possible effect on military careers prevented most of these families from seeking mental health services.

Pilot Study 3: Once the need for increased education and resources for counselors to assist OEF/OIF families was determined, investigators identified the feasibility of a counselor practice-based research network in Arkansas. Investigators collaborated with the Arkansas Department of Education Guidance and Counseling Unit to provide an educational training session to 15 educational cooperatives and counselors across the state. Through these activities, 315 counselors indicated interest in participating in the ARC-PBRN.

Investigators have submitted a grant proposal to continue the implementation phase of the project. Next steps include: 1) establishing the ARC-PBRN at the Harding University Department of Counseling; 2) recruiting Arkansas mental health and school counselors to participate in the ARC-PBRN; and 3) developing a website to host resources and tools to inform counselors about mental health referral resources and evidence-based practices and research, and to provide continuing education opportunities.

For more information about the ARC-PBRN, contact Dr. Waliski at ADWaliski@uams.edu. Dr. Waliski is a third-year poly-trauma fellow with the SC MIRECC in Little Rock, Arkansas. ♦

Resource for VA Clinicians and Providers

The National Center for PTSD has created a consultation resource for VA providers and clinicians. The VA PTSD Consultation Program gives VA staff members the opportunity to ask an expert any question they may have about PTSD in a one-on-one prompt consultation. The consultations are free and clinicians can speak with a staff psychiatrist or a clinical psychologist to help with treatment or assessment questions, clinical practice or programmatic issues, general PTSD questions, finding resources or improving patient care.

Request a consultation by calling 1-866-948-7880, visiting http://vaww.ptsd.va.gov/consultation/ptsd_consult_req.asp, or by sending an e-mail to ptsdconsult@va.gov. When requesting a consultation by phone, callers will be asked a few questions before being referred to a consultant who will generally return the call within 24 hours. Consultations last approximately 30 minutes and may include a follow-up depending on the nature of the call. For more information about the program, contact the PTSD Consultation Program Administrator, Cathy J. Lombardo, at Cathy.Lombardo@va.gov. ♦

Recent SCMIRECC Publications

EARLY RESPONSE TO PSYCHOTHERAPY AND LONG-TERM CHANGE IN WORRY SYMPTOMS IN OLDER ADULTS WITH GENERALIZED ANXIETY DISORDER.

Bradford A, Cully J, Rhoades H, Kunik M, Kraus-Schuman C, Wilson N, Stanley M.

Am J Geriatr Psychiatry, 2011, 19(4):347-356

The objective of this study was to determine the association of early and long-term reductions in worry symptoms after cognitive behavior therapy for generalized anxiety disorder in older adults. This study is a substudy of larger randomized controlled trial. The setting for the study was a family medicine clinic and large multi-specialty health organization in Houston, Texas, between March 2004 and August 2006. The participants were patients (N = 76) aged 60 years or older with a principal or co-principal diagnosis of general anxiety disorder, excluding those with significant cognitive impairment, bipolar disorder, psychosis, or active substance abuse.

The intervention consisted of up to 10 sessions of cognitive behavior therapy for 12 weeks, or enhanced usual care (regular, brief telephone calls, and referrals to primary care provider as needed). The Penn State Worry Questionnaire (PSWQ) was administered by telephone at baseline, 1 month (mid treatment), 3 months (posttreatment), and at 3-month intervals through 15 months (1-year follow-up). The authors used binary logistic regression analysis to determine the association between early (1 month) response and treatment responder status (reduction of more than 8.5 points on the PSWQ) at 3 and 15 months. The authors also used hierarchical linear modeling to determine the relationship of early response to the trajectory of score change after posttreatment. Results showed that reduction in PSWQ scores after the first month predicted treatment response at posttreatment and follow-up, controlling for treatment arm and baseline PSWQ score. The magnitude of early reduction also predicted the slope of score change from posttreatment through the 15-month assessment. The authors concluded that early symptom reduction is associated with long-term outcomes after psychotherapy in older adults with general anxiety disorder.

REALITY GRADED EXPOSURE THERAPY WITH PHYSIOLOGICAL MONITORING FOR THE TREATMENT OF COMBAT RELATED POST TRAUMATIC STRESS DISORDER: A PILOT STUDY.

Wood, D.P., Webb-Murphy, J., McLay, R.N., Wiederhold, B.K., Spira, J.L., Johnston, S., Koffman, R.L., Wiederhold, M.D., & Pyne, J.

Studies in Health Technology and Informatics, 2011, 163, 696-702.

A high percentage of Operation Iraqi Freedom and Operation Enduring Freedom combat Veterans have been diagnosed with PTSD during and following their respective combat tours. Virtual Reality (VR) treatment has been documented as an exceptional treatment for anxiety disorders and specifically for PTSD. An Office of Naval Research funded pilot study, completed by the Virtual Reality Medical Center and Naval Medical Center San Diego, investigated the use of Virtual Reality Graded Exposure Therapy (VR-GET) study with participants who had been diagnosed with PTSD following their combat deployments. A significant reduction in PTSD symptoms severity was noted. Implications for treatment with VR-GET and future research areas of investigation, including the use of VR-GET with smart phones and the internet, are suggested. ♦

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