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The next issue of the *South Central MIRECC Communiqué* will be published December 3, 2010. Deadline for submission of items to the December newsletter is November 29, 2010. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Ashley McDaniel, at [Ashley.McDaniel@va.gov](mailto:Ashley.McDaniel@va.gov)

South Central MIRECC  
Internet site:  
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## HOW MENTAL HEALTH CLINICIANS AT CBOCs COLLABORATE WITH THEIR VA MEDICAL CENTER COLLEAGUES

By Maurilio Garcia-Maldonado, M.D.  
Beaumont VA Outpatient Clinic Care Line Executive

*Dr. Maurilio Garcia-Maldonado, BOPC Care Line Executive, describes how mental health clinicians in one CBOC interact with their colleagues in other clinical areas at the CBOC and at their parent VAMC.*

The Beaumont, Texas VA Outpatient Clinic (BOPC) is located 90 miles from Houston's Michael E. DeBakey VA Medical Center (MEDVAMC). Like most Community-Based Outpatient Clinics, it serves Veterans who live too far from the larger VA Medical Center to receive convenient, regular health care at the VAMC. Beaumont's six mental health providers — 1 psychiatrist, 2 physician assistants, 1 nurse practitioner, 1 social worker, 1 psychologist, 1 nurse, and 1 clerk — serve over 11,000 patients. In addition, Beaumont offers Primary Care, Laboratory, Radiology, Pharmacy, Audiology, Social Work, Dietitian, Podiatry, Tele Mental

Health, Tele Retina Imaging, and Optometry services, as well as Care Coordination Services for Home Tele Health, Home-Based Primary care, and Supported Housing services.

Local collaboration and communication among Beaumont mental health and primary care clinicians, and distance collaboration and communication among Beaumont mental health clinicians and their peers at the MEDVAMC are essential for delivering quality, evidence-based care. Mental health care providers at BOPC and the Houston VAMC communicate in a frequent, open manner, as needed. The mode of communication depends on the situation.

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## *CBOC MH Collaboration With VAMC Colleagues Continued...*

*In-person communication at the BOPC.* Locally, at BOPC, there is a great deal of collaboration between Primary Care and Mental Health staff, who communicate by e-mail, by phone and in person. There are impromptu conversations and consultations where the primary care physician (PCP) may phone or walk to the Mental Health clinical area to discuss a patient's needs. Often, the primary care provider asks a mental health provider for guidance on medication choice or dose or whether to refer a patient to specialty mental health care.

More formally, there is Patient-Centered Mental Health Integration, in which a patient may be transferred to the mental health staff member assigned to that role. In cases where a PCP requires more than a quick phone call or hallway consultation, the PCP contacts primary care mental health for a just-in-time brief consultation. For long-term follow up, the patient is then seen in the mental health clinic.

*Communication between BOPC and MEDVAMC.* Mental Health clinicians at BOPC and MEDVAMC maintain active communication that occurs at various levels, directions, times, locations and formats. Much of the communication occurs at the time that it is needed, with clinicians sharing information by email, phone, formal consultations, and informal hallway meetings. In addition, formal avenues of communication include regular reports and peer reviews.

Clinicians interact with discipline-peers. For example, the CBOC psychologist talks with psychologists at MEDVAMC regarding available resources, educational materials, or approaches to implement new programs. Communication among peers at MEDVAMC and BOPC provides an important avenue for professionals to remain up to date on the discipline-specific content, regulations and programs.

On occasion, BOPC mental health clinicians may drive to MEDVAMC in Houston for a meeting or program, but this seldom happens as it takes essentially a workday to drive to Houston and back to participate in a typical meeting. More commonly, participation in meetings with Houston or other VISN sites takes place virtually.

*Email.* The most common mode of individual, peer-to-peer communication is e-mail as it is readily available, participants do not have to be available simultaneously, and it is ready to read, retrieve, and reply. Also, e-mail can reach one or many recipients, as needed. Typically, e-mail communications focus on a few recipient(s), rather than the entire group of mental health clinicians at both facilities. In addition, dissemination and guidance of information on mental health guidelines, new programs and initiatives comes from the MEDVAMC to BOPC, typically by e-mail, and those communications are followed by phone calls for clarification and additional information.

*Telephone and videoconferencing.* MEDVAMC-sponsored meetings, courses, and presentations that may be of interest to BOPC staff are conducted in a format where BOPC staff can actively participate via phone conference or videoconferencing.

*Tele Mental Health.* MEDVAMC clinicians provide support for Tele Mental Health for BOPC patients. This is coordinated between both sites, as patient rooms and equipment need to be available at BOPC, and the mental health care provider needs to be available in Houston. This requires more complex scheduling than a typical local clinic appointment that involves only one patient and one provider.

*Website.* The new VISN 16 Mental Health Providers Community of Practice website will provide new channels for communication not only locally but also throughout VISN 16, allowing updates on new topics, discussion of challenging patients, new guidelines, and networking with peers. This is open to large medical centers and small CBOCs alike. It also offers clinicians the opportunity to participate in forums and group discussions. Some features such as "ask the expert" are likely to invite participation and trigger follow up and discussion.

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*Administrative Communications.* BOPC staff occasionally consults MEDVAMC administrative staff, for example, when developing a new clinic with all its attendant parameters such as stop codes, count-non count, and other administrative and procedural details. These consultations usually occur by a combination of phone and email communications. VISN guidance and visits are channeled through the mental health leadership at the MEDVAMC. BOPC also has in-person visits from

MEDVAMC and VISN leadership on occasion, as needed. ■

Visit the Ask the Expert section of the VISN 16 Mental Health Providers Community of Practice website from a VA computer at <http://vawww.visn16.portal.va.gov/SiteDirectory/mhp/AsktheExpert/default.aspx> to submit your questions to Dr. Garcia-Maldonado or participate in the article discussion group.

## MEET THE SC MIRECC FELLOWS

The Little Rock, Arkansas and Houston, Texas SC MIRECC sites have a two-year special fellowship training program in advanced psychiatry and psychology. This interdisciplinary program aims to train psychiatrists, psychologists, and associated health professionals to become outstanding clinical or health services researchers in high priority areas of mental health. In concert with the theme of the SC MIRECC, the fellowship emphasizes mental health services research while offering clinical research opportunities. Little Rock focus areas include rural mental health or telemedicine, mental health in primary care, implementation science, PTSD, cognitive impairment and neuropsychology, and substance abuse. Houston focus areas include medical psychology/behavioral medicine, geropsychology, PTSD, anxiety and substance use disorders, health services and outcomes research, and implementation science. At both sites, individualized, mentored research and clinical training are combined with a state-of-the-art curriculum that emphasizes research methods, statistics, epidemiology, mental health systems, quality improvement methods, education, and service delivery.

Didactic research training is coordinated through a fellowship hub site located at the Palo Alto VAMC while research mentors are located at the training site. Fellows devote 75% of their time to research and education activities and 25% to clinical training. In collaboration with their mentors, fellows will develop and implement a research project, publish and present findings, participate in grant writing, and utilize the latest technology for educational activities and clinical service delivery. Please welcome our new and returning fellows:

**Crystal Clark, M.D.** is a first-year SC MIRECC fellow in Houston. She completed her B.A. in psychology at Northwestern University. She obtained her medical doctorate from University of Louisville School of Medicine. There she also completed a program in clinical and research sciences. Dr. Clark completed her adult Psychiatry residency at Johns Hopkins Hospital. Her research interests are focused on women's mental health. She has specific interests in the overlap of mood disorders and women's reproductive health (i.e., premenstrual dysphoric disorder, postpartum depression and psychosis, PTSD and traumatic births, and treatment of mood disorders in pregnancy). Her interests also include PTSD in women who are victims of sexual assault and domestic violence. She ultimately hopes to

help implement better screening and treatment of women with mood disorders, particularly women Veterans.

**Teri Davis, Ph.D.** Dr. Davis is a second-year fellow in Little Rock. She completed her master's studies at the Universities of Minnesota (Educational Psychology) and Oklahoma (Counseling) and received her Ph.D. in Clinical Psychology from Jackson State University. In 2009, she completed her clinical residency at Indiana University School of Medicine.

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Dr. Davis' dissertation, titled "HIV-risk Behaviors among African-American Survivors of the Hurricane Katrina Disaster," evaluated post disaster factors (i.e. depression, PTSD, coping self-efficacy) contributing to HIV-risk behavior. As a SC MIRECC fellow, she is pursuing a similar research direction with secondary data among Gulf Coast Veterans exposed to the disaster. Dr. Davis' primary interest involves conceptualizing the factors that contribute to mental health treatment seeking for depression and anxiety conditions among African-Americans, particularly women. Her work will take the direction of building a help-seeking model, guided by those existing models, which may be applicable to diverse cultures of women. She is also interested in investigating the factors that contribute to the scarcity of mental health providers of color in the VA system and/or other clinical settings. After the completion of her fellowship, she hopes to pursue a research career in an academic medical environment, as well as build a small clinical practice specializing in depression in women.



**Tiffany Haynes, Ph.D.** is a first-year fellow in Little Rock. She received her PhD in Clinical Psychology from the University of Michigan in Ann Arbor. Her current research interests focus on understanding patterns of mental health service utilization among rural minorities, with a particular interest in understanding the role of religion and spirituality in the decision to initiate mental health treatment.

**Juliette Mott, Ph.D.** Dr. Mott is a first-year fellow in Houston. She received her Ph.D. in clinical psychology from the University of Missouri-St. Louis in August 2010 and completed her predoctoral internship at the Michael E. DeBakey VAMC. Dr. Mott's primary research interest is in improving current psychotherapies for PTSD. She has been involved in several NIH-funded treatment trials examining the effectiveness of Cognitive Processing Therapy and more recently served as a co-investigator on a study evaluating the feasibility of an exposure-based group therapy for Veterans with combat-related PTSD. Her current research focuses on increasing Veterans' engagement in evidence-based treatments for PTSD through patient education and patient choice.

**Angie Waliski, Ph.D.** is a second-year poly-trauma fellow under the direction of the SC MIRECC in Little Rock. Dr. Waliski received her bachelor and master's degree from Southeastern Louisiana University and her Ph.D. from the University of Arkansas, Fayetteville in 2001. Following her degree program, she worked at a community mental health agency where she provided services in a therapeutic day treatment program and in local schools, to children aged 2-5 and their families. Dr. Waliski decided to treat preschool aged children after spending five years working with adolescents and adults seeking treatment due to sexual victimization and substance abuse. She believes that early interventions and treatment for abuse can prevent later mental health and addiction problems. After working with preschoolers for 5 years, she decided that more research was needed to determine evidence-based practices for this population and this fellowship gives her the opportunity to do that. Dr. Waliski's current research focus is on the needs of young children in OIF/OEF families.

## NOVEMBER CONFERENCE CALLS

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

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

## RECENT SC MIRECC PUBLICATIONS

*Male to female sexual aggression among Iraq, Afghanistan, Vietnam Veterans: Co-occurring substance abuse and intimate partner aggression (Journal of Traumatic Stress. 2009:22; 307-311)*

Andra Teten Tharp, Ph.D., Julie Schumacher, Ph.D., Sara (Su) Bailey, Ph.D., and Thomas Kent, M.D.

Introduction by Andra Teten Tharp, Ph.D.

Self-directed violence and non-sexual violence perpetrated toward an intimate partner have been extensively studied in military and Veteran samples. The associations between these forms of violence and specific disorders, such as PTSD, have been well established and provide avenues for prevention and treatment. However, research on the perpetration of other forms of violence, such as sexual violence, among the military and Veterans is needed. Sexual violence involves using force or coercion to obtain sexual contact. In the US, approximately 1 in 6 women and 1 in 33 men have experienced forced sex during their lifetimes (Tjaden & Thoennes, 2000). Although many processes are underway to document and respond to sexual victimization during military service, relatively little work has examined sexual violence perpetration or its correlates.

Examining perpetration is critical for three reasons: 1) Acts of sexual violence can only be reliably prevented by intervening with potential perpetrators; 2) Risk reduction strategies that address the victim's role in the assault (e.g., self defense classes) are of limited utility and can have the secondary effect of blaming the victim; and 3) victim characteristics provide little consistent information by which to develop prevention programs.

For these reasons and to address these gaps, my colleagues and I examined the prevalence and correlates of sexual violence among a diverse sample of Veterans recruited from an outpatient VA PTSD clinic ( $N = 92$ ). Results demonstrated that 40% of the men in the sample reported some form of sexual violence against an adult woman in the past year and 6% had perpetrated rape in

the past year. Men who reported sexual violence were more likely to report other forms of partner violence, were more likely to have a diagnosis of a substance abuse disorder, and were more likely to report impulsive (vs. premeditated) aggression. While the results of this study are preliminary, they begin to suggest that sexual violence is not a low base rate event among Veterans. The rates of violence we identified were consistent with rates of perpetration reported in civilian samples.

As VA services expand to include Veterans' partners and families, sexual violence, as with other forms of partner violence and child maltreatment, should be assessed by clinicians. Clinicians should also be aware of signs and symptoms that suggest violence may occur and integrate preventive approaches with response and treatment efforts. The presence of violence, in general, and sexual violence, in particular, in Veteran families and relationships threatens the health and wellbeing of the family and complicates and may undermine treatment efforts.

Tjaden & Thoennes (2000). *Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey*. Research Report, Washington, DC: U.S. Department of Justice, National Institute of Justice, 2000, NCJ 183781.

Andra Teten Tharp completed this work while she was an SC MIRECC post-doctoral fellow (2006-2008). She is currently a health scientist in the Division of Violence Prevention at the Centers for Disease Control and Prevention. She may be contacted at [ateten@cdc.gov](mailto:ateten@cdc.gov) or 770-488-3936.

## RECOVERY CORNER

### PROMOTING RECOVERY PHILOSOPHY THROUGH TRAINEE EDUCATION AND SUPERVISION

J. Glen White, Ph.D., CPRP - Clinical Psychologist

Director of Training, Psychology Postdoctoral & PSR Fellowships; Local Recovery Coordinator  
Central Arkansas Veterans Healthcare System/Mental Health Service

How does one convert an entire system of care's paradigm? Well, "one" doesn't, but through the efforts of many people and gradual education, influence and system redesign, it can happen over time. The call of the 2008 Uniform Mental Health Services handbook to convert the VA healthcare system to a recovery-oriented system of care included requirements for a "Local Recovery Coordinator" (LRC) for each facility, who was given primary responsibility for effecting this change. Facilitating this conversion is a daunting task, and potential approaches are many. With wide latitude for accomplishing such a significant system transformation, LRCs across the country have focused on a variety of ways to accomplish their charge. One approach used at the Central Arkansas Veterans Healthcare System (CAVHS) is incorporating training and supervision in recovery-based services into traineeships within the facility. Specifically, interns and fellows in psychology, social work, and rehabilitation counseling (in the future, we hope to expand this effort to other disciplines) are being provided an introduction to the recovery approach through didactic training and supervised practice in various facility programs. This focus on training budding healthcare professionals in recovery approaches catches them early and helps them incorporate recovery philosophy into their practice and professional worldview. During the training year, placements within existing programs in their facility expose those programs and their staff to recovery-based ways of thinking and practicing, while providing the fellow or intern with valuable experience. Ideally, this exposure serves as "recovery training by proxy" and helps augment the efforts of the LRC.

Including trainees in recovery services also results in these new professionals taking positions within the local facility after training. They carry the new recovery orientation into programs where they are hired, and others will be hired elsewhere in the VHA to provide other facilities a similar recovery-focused influence. Individuals completing their training who pursue careers

outside the VHA system will retain a more holistic view in their practice and will influence non-VHA systems as well. The strong influence of the VHA's training traditions on professional healthcare practice in this country has previously been noted (e.g., Baker, et al, 2010; O'Hara et al, 2010), so using trainees to propagate recovery philosophy promises to have a similarly significant impact for VA facilities and for the US healthcare system.

CAVHS, like most VAMCs, has several programs providing training and supervised experiences in various disciplines. One program provides post-graduate training and experience through one-year interdisciplinary fellowships that emphasize Psychosocial Rehabilitation (PSR). Implemented recently by VHA's Office of Academic Affairs and started in 2007 at CAVHS, the PSR fellowship is an interdisciplinary program utilizing a recovery-oriented approach to providing services and support for Veterans diagnosed with a serious mental illness, a historically underserved population. The vision was that after these PSR trainees completed their fellowship, many would then be hired as practitioners within the VHA. Given their preparation for recovery-oriented services, these new staff would serve as ambassadors for the recovery philosophy within the VHA and serve as role models for the PSR/recovery approach.

In keeping with that concept, CAVHS provides recovery-oriented training outside the Interdisciplinary PSR fellowship. Other trainees currently receiving recovery-oriented training include clinical psychology pre-doctoral interns, PTSD fellows, and research fellows. Psychology interns receive seminars in recovery-oriented approaches to clinical practice, and those interns who select certain rotations have the chance to gain intensive supervised practice in recovery-oriented services.

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VISN 16 MIRECC and HSRD programs sponsor the research-oriented, interdisciplinary fellowship. The two-year research fellowships include 25% time devoted to clinical experiences. The PTSD and research fellows' training includes exposure to the recovery approach during orientation, in subsequent seminars available to all trainees, and via a monthly recovery journal club. Through the PTSD and research fellows' clinical experiences at existing programs at CAVHS, they are able to integrate recovery principles into their clinical work. Initial efforts with our non-PSR trainees are encouraging, and additional development of this approach is ongoing.

Providing education and training in recovery-friendly services to facility programs is a particular challenge for the LRC. One approach we are using pairs trainees with the LRC or another recovery-friendly practitioner to help implement a group intervention in programs not yet exposed to recovery-oriented practices. The program provides a staff person to co-lead a group or class with the assistance of the trainee and recovery practitioner. Recovery-consistent practices and materials are included in the curriculum. This "free" help provides incentive to allow recovery components into the program. In the process, staff members become exposed to the recovery philosophy and how it can be incorporated and implemented within the context of their programming. Providing services within a program helps the LRC to appreciate the unique challenges each program encounters in moving toward more recovery-oriented

interventions. This approach holds promise for lowering barriers and increasing acceptance for recovery-consistent services through direct modeling. The excellent training and supervised experience for the fellow also provides the program staff with "free" help, and recovery-oriented practices are implemented. Everybody wins!

Facilities are encouraged to consider utilizing their existing training programs to contribute to transforming their system towards a recovery-friendly one. Opportunities for implementing new training programs, especially for a PSR fellowship, should be pursued. Training programs offer the LRC and facility a great tool to modernize treatment and training approaches within their facility through the assistance of these highly trained and motivated persons who represent the future of healthcare for the Veterans we serve.

#### References:

- Baker, Rodney R.; Pickren, Wade E.; *In: History of psychotherapy: Continuity and change* (2nd ed.). Norcross, John C. (Ed.); VandenBos, Gary R. (Ed.); Freedheim, Donald K. (Ed.); Washington, DC, US: American Psychological Association, 2010. pp. 673-683.
- O'Hara, Ruth; Cassidy-Eagle, Erin L.; Beaudreau, Sherry A.; Eyler, Lisa T.; Gray, Heather L.; Giese-Davis, Janine; Hubbard, Jeffrey; Yesavage, Jerome A.; *Academic Medicine*, Vol 85(1), Jan, 2010. pp. 41-47.