



*Reducing
mental health
disparities
among
rural veterans*

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The next issue of the *South Central MIRECC Communiqué* will be published February 3, 2010. Deadline for submission of items to the February newsletter is January 26, 2010. 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.mirecc.va.gov/visn16

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

JOANN KIRCHNER, M.D. NAMED MENTAL HEALTH QUERI DIRECTOR KIMBERLY ARLINGHAUS, M.D. NAMED INTERIM SOUTH CENTRAL MIRECC ASSOCIATE DIRECTOR FOR IMPROVING CLINICAL CARE

By Carrie Edlund, M.S.

Dr. JoAnn Kirchner was recently named Director of the VA Health Services Research and Development (HSR&D) Mental Health Quality Enhancement Research Initiative (MH QUERI). Dr. Kimberly Arlinghaus was named SC MIRECC Interim Associate Director for Improving Clinical Care.



From left: JoAnn Kirchner, M.D. and Kimberly Arlinghaus, M.D.

Dr. Kirchner, Associate Professor in the Departments of Psychiatry and Behavioral Sciences, University of Arkansas for Medical Sciences (UAMS) College of Medicine, and Maternal and Child Health, UAMS College of Public Health, served as the SC MIRECC Associate Director for Improving Clinical Care from 2003 to 2009. Her research focuses on the implementation of evidence-based practices into routine clinical settings, emphasizing primary care mental

health, quality improvement, depression, alcohol use disorders, OEF/OIF Veterans, and rural health.

Dr. Arlinghaus is the Medical Director for the Traumatic Brain Injury Center of Excellence, the Mental Health Care Line Deputy Executive, and Senior Consultant for Psychiatry at the Michael E. DeBakey VA Medical Center in Houston. She is Associate Professor of Psychiatry and Associate Professor of Physical

Medicine and Rehabilitation at Baylor College of Medicine. Her clinical interests include the neuropsychiatry of traumatic brain injury, psychiatric problems in the medically ill, and women's mental health. Her research focuses on traumatic brain injury. Dr. Arlinghaus has been an affiliate educator with the SC MIRECC since 2000.

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New Directors continued...

Mental Health QUERI

The MH QUERI, housed in North Little Rock at the Central Arkansas Veterans Health System (CAVHS), is one of nine QUERI sites nationwide that work to improve the quality of healthcare for Veterans by implementing research findings into routine clinical practice. Mental Health QUERI's mission is to improve quality of care, outcomes, and health-related quality of life for Veterans with depression and schizophrenia by promoting research to close gaps in knowledge and implementing evidence-based practices.

Q—Dr. Kirchner, how did your previous position with the SC MIRECC prepare you for your new position directing the MH QUERI?

*A—*In many ways, leading MH QUERI is my dream job, because implementation research has been the focus of all of my research for the past ten years, so to be able to lead an organization that is focused on implementation research is both an honor and a nice fit with my research interests. The mission of the MH QUERI and the previous SC MIRECC mission are very consistent. The SC MIRECC was charged with facilitating translation--the implementation of evidence-based practices into clinical care. The MH QUERI is charged with conducting implementation research, and so we are able to develop and evaluate implementation strategies.

Q—What new directions or initiatives will you be considering for the MH QUERI?

*A—*Our recent Executive Committee meeting focused on strategic planning and reviewed recommendations from our annual review and from the VA Central Office. The MH QUERI has traditionally focused on depression and schizophrenia. We now see an emerging focus on PTSD, women's health, psychological trauma, and health disparities. We're working on getting a better understanding of these areas and reevaluating our current goals. And the national implementation of guidelines from the *Uniform Mental Health Services Handbook* offers additional impetus to do some strategic planning around having a very clear clinical mandate for a center charged with implementation.

Q—Was it hard to leave the SC MIRECC?

*A—*It was very hard to leave. The SC MIRECC position allowed me to grow immensely, and I think that growth will serve me well in my new position. It allowed me to see intimately the workings of the clinical service line.

Q—What was the most important thing you accomplished in your position with the SC MIRECC?

*A—*The thing I'm most proud of is creating ways for the SC MIRECC to reach out and work with some of the non-affiliated VA medical

centers and leverage some of the SC MIRECC resources to ensure that those VAMCs were able to compete for research expertise, opportunities, and funds despite the fact that they weren't affiliated with a major research University. The SC MIRECC helped individual sites to identify evidence-based practices, write the funding requests, and be awarded the monies for that.

I also anticipate that our work with the Mental Health Product Line to implement primary care-mental health in the network will have long-lasting and very positive implications for how Veterans receive mental health care services in our network, and in other networks looking to follow our model.

Q—What research projects are you personally working on now? My current research takes a facilitation model using multiple implementation strategies facilitated by both an internal (clinical service line) and an external (knowledgeable in implementation strategies and evidence-based practices) facilitator. I'm also working on a program, supported by the VA Office of Rural Health, that works with first responders such as clergy, rural two-year colleges and universities, and the criminal justice system, to improve access to care for returning OIF/OEF Veterans.

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Q—Dr. Arlinghaus, how do you feel about your new position as SC MIRECC Associate Director for Improving Clinical Care?

*A—I'm very honored to have the opportunity to expand my collaboration with the educators, clinicians, and investigators in the SC MIRECC, working in concert with the VISN 16 Mental Health Product Line leadership to provide "the best care anywhere" to our Veterans. In my new role I hope to lend my experience in mental health/primary care integration, as well as traumatic brain injury, to facilitate the full implementation of the *Uniform Mental Health Services Handbook* initiatives.*

This is a challenging time for the VA as we focus our attention on aging Veterans from WW II, Vietnam, and Korea while adapting our system to meet the needs of our more contemporary heroes--men and women who served in Desert Storm, OIF, OEF, and other areas. We must contend with an unprecedented level of neuropsychiatric comorbidity in our newer Veterans suffering from PTSD, substance abuse, traumatic brain injury, depression, and

chronic pain, underscoring the need for coordinated care and evidence-based treatment. I believe the MIRECC is uniquely equipped to combat these challenges through education initiatives and translational research.

I also look forward to working with the SC MIRECC's Consumer Advisory Board (CAB) to better design our mental health care delivery. I am excited about broadening the diversity of the CAB to include family members of OIF/OEF Veterans and others who will bring important cultural perspectives. The CAB's "personal touch" will continue to enrich our network's provision of clinical care, inform research protocols, and enhance education products such as a new Consumer Guide our MIRECC is creating to highlight the key elements of the *Uniform Mental Health Services Handbook*.

I never dreamed that my early experiences in Rehabilitation Medicine would pave the way for me to better serve our nation's warriors.

JANUARY CONFERENCE CALLS

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

		ACCESS CODE
11	MIRECC Site Leaders, 9:00 AM CT	27761#
12	MIRECC Leadership Council, 3:30 PM CT	19356#
19	VISN 16 Mental Disaster Team, 11AM CT	76670#
20	MIRECC Program Assistants, 2PM Central	43593#
25	MIRECC Education Core, 3:00 PM CT	16821#
26	MIRECC Leadership Council, 3:30 PM CT	19356#
28	National MIRECC & COE Education Group, 1:00 PM CT	28791#

RURAL HEALTH RESOURCES UPDATE

RURAL RESIDENTS LAG IN PREVENTIVE SERVICES USE; LAG INCREASES WITH SERVICE COMPLEXITY

This research brief describes the receipt of preventive services among rural adults and explores the factors that are related to disparities in utilization. For an electronic copy of the brief, visit: <http://rhr.sph.sc.edu/News/Final%20-%20Preventive%20Services%20Policy%20Brief.pdf>.

Contact information:

Jan Probst, PhD, South Carolina Rural Health Research Center, Phone: 803-251-6317, jprobst@mailbox.sc.edu

SOUTH CENTRAL MIRECC UNIFORM MENTAL HEALTH SERVICES HANDBOOK EDUCATION INITIATIVE

**KIMBERLY ARLINGHAUS, M.D., KATHARINE HEAD, M.A. AND CAYLA TEAL, PH.D. WITH CONSULTATION
FROM THE VISN 16 MENTAL HEALTH PRODUCT LINE ADVISORY COUNCIL**

Developed and funded by the SC MIRECC and the VISN 16 Mental Health Product Line, the Uniform Mental Health Services Handbook (UMHSH) Education Initiative is dedicated to informing mental health providers practicing in VISN 16 about the VA's Uniform Mental Health Services Handbook. The Initiative provides an education tool that highlights the major sections of the UMHS Handbook in 9 brief (10-20 minute) video modules. The modules provide details about requirements and recommendations for mental health services in the VHA system, and tie key aspects of the Handbook to requirements corresponding to facility size. The modules also present additional education opportunities about evidence-based treatments and other helpful resources available through the SC MIRECC or the VHA. The 9 modules are:

1. History and Purpose
2. Foundations of Care
3. Integrating Primary Care and Mental Health
4. Substance Use Disorders
5. PTSD
6. Serious Mental Illness
7. Homeless and Incarcerated Veterans
8. Suicide Prevention
9. Mental Health Care Delivery

Recommendations for Use with Staff:

- **If possible, view the modules in order.** Though they are designed to be viewed independently of one another, earlier modules have some foundational ideas that can be useful in reviewing and discussing subsequent modules.
- **Be prepared** for the modules to trigger staff **questions** and concerns about implementation of the UMHS Handbook's directives.
- **View the modules as a team** for provoking the most uptake and meaningful discussion. Each module is short enough to view and discuss in a regular staff meeting. As opposed to staff viewing the modules individually and later having a discussion, **viewing the modules as a team is more likely to:**
 - Enhance the team members' focus on the UMHS Handbook priorities.
 - Facilitate application of the module information to the staff member's or team's particular work setting.
 - Help staff crystallize the relevance of the information to their specific CBOC or VAMC.
 - Offer leadership an opportunity to focus the team's attention to specific details and content.
 - Create an opportunity for solution-focused dialogue between CBOCs and VAMCs.

To view a module or access the additional resources associated with a module, visit:

<http://www.mirecc.va.gov/VISN16/umhshs/umhshEducation.asp> and click on the relevant link. The video link will open up a WMV file (Windows Media Video file) and begin playing on your screen using Windows Media Player. The video modules are designed to be viewed in order, but we understand that some providers might want to view particular modules before others. We hope you will view all the video modules, as there are important elements in each one about which all mental health providers should be aware.

Educational videos linked from this page are available only to individuals using the VA Intranet. General Internet connections will not reach these videos. If you have any trouble with viewing the modules or with accessing the additional information and resources, or would like to request the modules on a DVD, please contact Michael Kauth, SC MIRECC Director of Education at Michael.Kauth@va.gov.

RECENT SC MIRECC PUBLICATIONS

COGNITIVE BEHAVIOR THERAPY FOR GENERALIZED ANXIETY DISORDER AMONG OLDER ADULTS IN PRIMARY CARE: A RANDOMIZED CLINICAL TRIAL

Stanley MA, Wilson NL, Novy DM, Rhoades HM, Wagener PD, Greisinger AJ, Cully JA, Kunik ME
JAMA 301(14):1460-1467, April 2009

Cognitive behavior therapy (CBT) can be effective for late-life generalized anxiety disorder (GAD), but only pilot studies have been conducted in primary care, where older adults most often seek treatment. Our objective was to examine effects of CBT relative to enhanced usual care (EUC) in older adults with GAD in primary care. This was a randomized clinical trial recruiting 134 older adults (mean age, 66.9 years) from March 2004 to August 2006 in 2 primary care settings.

Treatment was provided for 3 months; assessments were conducted at baseline, post-treatment (3 months), and over 12 months of follow-up, with assessments at 6, 9, 12, and 15 months. Cognitive behavior therapy (n = 70) was conducted in the primary care clinics. Treatment included education and awareness, motivational interviewing, relaxation training, cognitive therapy, exposure, problem-

solving skills training, and behavioral sleep management. Patients assigned to receive EUC (n = 64) received biweekly telephone calls to ensure patient safety and provide minimal support. The primary outcomes included worry severity (Penn State Worry Questionnaire) and GAD severity (GAD Severity Scale). Secondary outcomes included anxiety ratings (Hamilton Anxiety Rating Scale, Beck Anxiety Inventory), coexistent depressive symptoms (Beck Depression Inventory II), and physical/mental health quality of life (12-Item Short Form Health Survey).

Cognitive behavior therapy compared with EUC significantly improved worry severity (45.6 [95% confidence interval {CI}, 43.4-47.8] versus 54.4 [95% CI, 51.4-57.3], respectively; $P < .001$), depressive symptoms (10.2 [95% CI, 8.5-11.9] versus 12.8 [95% CI, 10.5-15.1], $P = .02$), and general mental health (49.6 [95% CI, 47.4-51.8] versus 45.3 [95% CI, 42.6-47.9], $P = .008$). There was no difference in GAD severity in patients receiving CBT versus those receiving EUC (8.6 [95% CI, 7.7-9.5] versus 9.9 [95% CI, 8.7-11.1], $P = .19$). In intention-to-treat analyses, response rates defined according to worry severity were higher following CBT compared with EUC at 3 months (40.0% [28/70] versus 21.9% [14/64], $P = .02$). Compared with EUC, CBT resulted in greater improvement in worry severity,

depressive symptoms, and general mental health for older patients with GAD in primary care. However, a measure of GAD severity did not indicate greater improvement with CBT.

INCORPORATING RELIGION AND SPIRITUALITY TO IMPROVE CARE FOR ANXIETY AND DEPRESSION IN OLDER ADULTS

Phillips LL, Paukert AL, Stanley MA, Kunik ME
Geriatrics 64(8):15-18, 2009.

Recent research has suggested that religion/spirituality may be linked to improved physical and emotional health, although the patient's motivation and method of using religious/spiritual beliefs appear to be a key factor in obtaining benefit. Studies have shown that there is a high level of religion/spirituality among older adults in the United States and significant patient-reported desire to include such beliefs in health care settings. This article provides a brief overview of the support for considering religion/spirituality in the health care of older adults and reviews potential drawbacks and methods for providers to assess and use patient beliefs to improve anxiety/depression.

RECOVERY CORNER

VISN 16 LRC STRATEGIC PLANNING MEETING

Leigh Ann Johnson, LCSW
LRC-Mental Health Recovery Coordinator
VA Gulf Coast Veterans Health Care System

The third annual VISN 16 Local Recovery Coordinator Strategic Planning Meeting was held at the Michael E. DeBakey Veterans Affairs Medical Center (MED VAMC) in Houston, TX on December 7-9, 2009. The purpose of the event was to provide VISN 16's facility-based Local Recovery Coordinators (LRCs) an opportunity to review and discuss implementation of the most critical areas of recovery-oriented practice within the Uniform Mental Health Services Handbook and to work on operational issues. Michael E. DeBakey Mental Health Care Line leadership met with the LRCs to review challenges and provide guidance regarding dissemination of recovery-oriented thought and care. The LRCs then reviewed their progress in meeting objectives from the 2009 Charter, and developed the 2010 Charter for submission to the VISN 16 Mental Health Product Manager and National Director of Recovery Services.

Review of the 2009 LRC Charter included discussion of facility status with maintaining consumer councils, staff training and recovery consultation, outreach efforts to promote mental health recovery, and development of family support services across the VISN. Many LRCs reported difficulty in engaging family members of Veterans with serious mental illness (SMI) in some of the programs being promoted nationally. LRCs have received reports from staff at their facilities that some Veterans with SMI diagnoses, such as schizophrenia, who have participated in VA mental health services for many years, may have less contact with family members, thus making it difficult to engage their families in family support services. Some VA mental health staff report that newer Veterans who have a diagnosis that includes PTSD or PTSD in combination with other issues such as TBI, depression, substance abuse, sleep problems, etc. may be interested in family support services, but indicate a preference to come as a couple to individual family counseling sessions with the therapist, as opposed to groups.

Recovery-oriented treatment planning was a key focus during the meeting. The group reviewed Joint Commission and Commission on Accreditation of Rehabilitation Facilities (CARF) guidelines and compared them with sample treatment plans currently being used in VISN 16 Mental Health Outpatient Clinics. The group also discussed the status of national LRC workgroups that have been addressing recovery-oriented treatment planning, information presented through the employee education system broadcast "Recovery Oriented Treatment Planning," and challenges faced by those VA programs that have attempted to use the standardized template developed by the national workgroup. It was agreed that the complexity and variation of VA programs precluded development of a standardized template for all mental health programs in VISN 16. As a result, the LRCs elected to begin work on an LRC toolkit to assist VA mental health staff in developing recovery-oriented treatment plans tailored to the needs of their respective programs.

A major element already in the toolkit is a document developed by one of the national LRC workgroups titled "Key Aspects to Recovery Oriented Treatment Planning" (This document is available through the LRCs or by download from the National LRC SharePoint site http://vaww.mentalhealth.va.gov/Forums_Discussions_Documents.asp).

The LRCs will continue working on the toolkit and use it for staff training and recovery consultation at their respective facilities. The VISN 16 toolkit will also include worksheets and resources to help staff promote recovery readiness, such as various Veteran self-assessments concerning values, interests, goals, and life satisfaction, a summary of Joint Commission and CARF requirements, PowerPoint Presentations, and other documents.

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Development of the 2010 LRC Charter included discussion of strategies for ongoing LRC collaborative support. The group agreed to update the resource list for new LRCs and develop a process for mentoring of new LRCs. The VISN 16 LRC SharePoint site being developed will assist in these efforts. A new aspect of the 2010 Charter will be a VISN 16 LRC service project designed to continue to foster recovery transformation efforts. This will include development of strategies to promote recovery-based early intervention, access, and community integration across the network. This will include partnering with Military One Source to help them populate their database of local resources in rural areas.

Peer support is another area of recovery transformation that VISN 16 LRCs will focus on in 2010. The policy and procedure manual on peer support is still being developed by the VA Office of Mental Health Services. The national Director for Peer Support Services is currently working on a process for training and certifying VA Peer Support Technicians. Many rural

areas lack the level of community-based resources for peer support that are available in some VAs in urban communities. Consequently, some local VAs have concerns about how to best proceed with peer support. The LRCs will explore interim strategies for peer support consistent with facility needs.

VISN 16 Facilities represented by LRCs: Houston: Cristy Gamez-Galka, Ph. D.; Oklahoma City: Jennifer Halter, LICSW, DCSW; Muskogee: D. Jeff Johnson, Ph.D.; Biloxi: Leigh Ann Johnson, LCSW; New Orleans: Baris Konur, Psy.D.; Shreveport: Paul Moitoso, LICSW, BCD; Alexandria: Michael Roach, LCSW; Fayetteville: Wanda Shull, M.S., CRC; and Little Rock by proxy- Jerry G. White Ph D. (Jackson VA: not represented).

The next VISN 16 LRC Strategic Planning meeting is tentatively scheduled for December 2010. The venue will be the VA Gulf Coast (Biloxi or Pensacola).

References

1. <http://www.mentalhealth.va.gov/mentalhealthrecovery.asp>

RURAL HEALTH RESOURCES UPDATE

PERSISTENT PRIMARY CARE HEALTH PROFESSIONAL SHORTAGE AREAS (HPSAs) AND HEALTH CARE ACCESS IN RURAL AMERICA (POLICY BRIEF)

This study examined the degree to which persistence of primary care HPSA designation in rural counties was associated with lower population socioeconomic status and deficiencies in access to health care services. It used a 5-level classification of rural counties and their partial-vs. whole-county persistence of primary care HPSA designation to stratify rural populations by socioeconomic status, race/ethnicity, primary care supply, health insurance uptake and access to needed health care services.

Those U.S. rural counties that were persistently designated as whole-county HPSAs were found to have much lower socioeconomic status, and adults residing in these counties reported substantial financial obstacles to obtaining needed health care services. Rural counties that were persistently designated as whole-county HPSAs also faced severe provider shortages, and adults

residing in these locations were less likely to have a regular primary care provider. The ability to identify persistence and extent of HPSA designation may be a valuable tool in selecting counties with higher levels of need. This research was supported through the WWAMI Rural Health Research Center with funding from the federal Office of Rural Health Policy. To download this policy brief visit:

http://depts.washington.edu/uwrhrc/uploads/Persistent_HPSAs_PB.pdf .

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