



INSIDE THIS ISSUE

The Direction of the SC MIRECC in 2010	Pg. 1
Recent SC MIRECC Publications	Pg. 3
MIDAS Profile	Pg. 4
Recovery Corner	Pg. 5
Upcoming Conference Calls	Pg. 6

The next issue of the *South Central MIRECC Communiqué* will be published April 2, 2010. Deadline for submission of items to the April newsletter is March 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

LOOKING AHEAD: THE DIRECTION OF THE SC MIRECC IN 2010

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The South Central MIRECC is now almost twelve years old! From the outset, our most important goal has been to improve mental health care for Veterans. We have approached this goal from many angles.

In education, the South Central MIRECC has been a leader. Since our inception, we have supported clinician education by providing dozens of continuing education programs on a wide range of topics. We have also offered intensive skills-based clinical training in psychosocial rehabilitation, group therapy, brief cognitive behavioral therapy, dialectical behavior therapy, and mental health disaster response.

As part of our efforts to improve mental health delivered in primary care and to assure implementation of the Uniform Mental Health Services Handbook we have conducted training with primary care providers in every VA medical center in our VISN, and in several community-based outpatient clinics (CBOCs). Most recently, we created an innovative program to train clinicians in skills needed to work with couples. Further, we have moved from simply providing workshops and clinical training toward testing innovative techniques in implementing



newly acquired skills in VA clinical care. In all of these educational efforts, we have partnered with the Mental Health Product Line Advisory Council, which has identified training needs in our VISN. We estimate that we have provided skill-based training in mental health treatments to over 285 clinicians and informational programs to more than 5,000 clinicians in our 12-year history. We have also supported creative educational ideas of clinicians by funding more than 74 clinical education projects. These projects have produced 33 products to date.

(continued on page 2)

The Direction of the SC MIRECC in 2010 continued...

These educational products are used widely across the US, both within and external to the VA.

In research, we have served as a vehicle to pull together talented investigators across VISN 16. Altogether, we have provided pilot funding to 71 investigators across our network – funding that has often facilitated their being able to get their innovative ideas off the ground. We have built a centralized program, called MIDAS (MIRECC Implementation, Design and Analysis Support), to assist investigators seeking research funding. The MIDAS team has expertise in key research areas such as design and statistics. Through obtaining grant funding from the VA and other sources, MIRECC investigators have created innovative interventions related to a number of key clinical issues including, but not limited to, distance delivery of mental health care (telemedicine), psychotherapy for geriatric populations, quality improvement for mental health treatment in primary care, family psycho-education, and couples therapy. In addition, MIRECC investigators have conducted key observational studies of risk factors for poor outcomes for Veterans suffering from both combat-related PTSD and natural disasters, specifically Hurricane Katrina, which has had a powerful impact in our network. Over this past year, for every MIRECC dollar we received, MIRECC investigators obtained about \$10 in grant funding, allowing us to build a collective research portfolio of more than \$21,000,000.

We are also very proud of our record in research training. Our Houston-based research fellowship is widely acknowledged as one of the best MIRECC fellowships nationally, having “graduated” 18 researchers, psychologists and psychiatrists, to date. Our fellowship has been especially successful in attracting physicians to research training. More than half of these graduates have gone on to academic careers. These young investigators are now contributing not only in our VISN, but in various academic and research settings across the US. Through our Training Residents in Psychiatric Scholarship (TRIPS) program, we have continued to partner with seven academically-affiliated departments of psychiatry in our region to encourage young psychiatrists to enter research. We continue to provide training in grant-writing skills for researchers. All these efforts have served as “seeds” in strengthening the research capacity in mental health in this geographic area.

Clearly, we have accomplished a great deal. Where do we go from here? In 2008, we adopted the mission of improving care for rural and other underserved Veterans. We are using several approaches to better align our program with this mission. One approach involves building a partnership with our now more than 40 network CBOCs. We expect to move forward in the next year to reduce the geographic, clinical, and academic isolation of CBOC-based mental health clinicians by linking them to each other and to us through distance technology, using a social networking approach. We will also begin to utilize distance technology in our educational efforts for clinicians so that all clinicians in the network can more readily benefit. We are eager to examine the outcomes and costs of these training approaches. In addition, we are also excited about starting our second South Central MIRECC research fellowship in Little Rock.

This year we are supporting two research mini-retreats as a means to “seed” externally funded large-scale MIRECC rural research projects, one involving using technology to gather self-report clinical data from Veterans, and a second involving a large-scale survey of health behaviors of rural Veterans. Further, we are looking across our VISN to identify additional recently recruited investigators and clinicians who can contribute to the MIRECC mission and we are actively recruiting from outside our region. Finally, we know that many Veterans in rural areas do not use mental health care even when needed. We are, therefore, identifying and partnering with key community groups (clergy, community colleges, and the criminal justice system) who are in the position to be “first responders” for these Veterans. We hope that we can “grow” these first responder projects across our VISN over the next few years and thereby assure that more Veterans in need will receive mental health care.

What accounts for our success? I believe it has been the creation of a culture that places value on inclusiveness and collaboration; our commitment to work with clinicians and mental health leadership; the support we receive from our network; and our genuine concern for the welfare of Veterans. Most of all, we have been fortunate to attract so many excellent investigators and outstanding leaders to the South Central MIRECC, both in our “virtual” Associate Director positions and at local MIRECC anchor sites. As a group, we remain committed to developing and implementing innovative educational, clinical, and research initiatives that improve mental health care for Veterans.

RECENT SC MIRECC PUBLICATIONS

INAPPROPRIATE PSYCHIATRIC ADMISSION OF ELDERLY PATIENTS WITH UNRECOGNIZED DELIRIUM

**Reeves RR, Parker JD, Burke RS,
Hart RH.**

South Med J. 2010, 103(2):111-5.

Our objective was to explore factors that might contribute to misattribution of mental status changes to psychiatric illness when an elderly patient actually has a delirium (mental status changes due to a medical condition). Records of 900 elderly patients referred to a Veterans Affairs psychiatric inpatient unit and 413 to an inpatient psychiatric team at a public hospital from 2001 to 2007 were reviewed. Cases referred because of symptoms secondary to an unrecognized delirium underwent further analysis of preadmission assessments.

Comparisons were made to elderly patients with delirium appropriately admitted to medical units. Thirty (2.3%) of the patients referred to psychiatric units were found to have a physical disorder requiring medical intervention within twelve hours. Compared to 30 delirious patients admitted to medical units, those inappropriately referred to psychiatric units had significantly lower rates of adequate medical histories, physical examinations, cognitive assessments, and laboratory/radiological studies. Among patients with delirium referred to psychiatric units, 66.7% had a history of mental illness, versus 26.7% of comparable admissions to medical units ($\chi^2(7) = 60.00, P < 0.001$). Our findings suggest that elderly patients with delirium admitted to psychiatric units are less likely to undergo

complete diagnostic assessments than delirious elderly patients admitted to medical units. Symptoms of delirium appear more likely to be incorrectly attributed to psychiatric illness in patients with a history of mental illness than in patients without such a history. Possible explanations for these findings and suggestions for addressing these issues are offered.

A NEW ENGAGEMENT STRATEGY IN A VA-BASED FAMILY PSYCHOEDUCATION PROGRAM

**Sherman MD, Fischer E, Bowling
UB, Dixon L, Ridener L, Harrison D.**
Psychiatr Serv. 2009, 254-7.

This brief report describes the engagement strategy used in the Reaching out to Educate and Assist Caring, Healthy Families (REACH) program, a nine-month family psychoeducation program for Veterans with serious mental illness or PTSD. A motivational interviewing-based strategy was created and implemented in a Veterans Affairs hospital to engage providers and Veterans and their families in the intervention.

Of the 1,539 Veterans told about the program, 41% had a family member living nearby and were willing to meet with a provider to learn more. REACH providers met with 505 Veterans for a motivational-interviewing session to explore family participation. Of the 436 Veterans who were eligible to participate in REACH, 28% of Veterans with PTSD, 34% of Veterans with an affective disorder, and 25% of Veterans with a schizophrenia spectrum disorder went on to participate in at least one session of the REACH program with a family

member; these rates compare favorably with those for programs requiring a much shorter commitment. This engagement strategy shows promise as an effective tool in recruiting Veterans and their families into family psychoeducation.

LESSONS LEARNED FROM AN HIV ADHERENCE PILOT STUDY IN THE DEEP SOUTH

**Konkle-Parker DJ, Erlen JA, Dubbert
PM.**

Patient Educ Couns. 2010, 78(1):91-6.

Adherence to treatment for chronic illnesses, including HIV disease, is a complex process, and needs practical interventions in poorly resourced clinic settings. This study tested the feasibility of an adherence intervention in 73 HIV-infected individuals in a Deep South public clinic based on Fisher & Fisher's Information-Motivation-Behavioral Skills Model.

There was high baseline adherence and unexpectedly high clinic attrition, and 27% of the intervention group received less than one-quarter of the planned intervention contacts. Refill rate was the adherence measure that correlated best with HIV viral load and CD4 count, and there was poor use of electronic adherence monitoring (MEMS). Interviewed individuals expressed positive feelings about audio-supported computer-assisted survey instruments (ACASI) and the intervention support.

This process evaluation showed feasible study components in this population and setting.

(continued on page 4)

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Lessons learned included: (1) clinic retention is an important part of adherence; (2) telephone interventions may need to add additional technology

and flexibility to maximize dose; (3) ongoing fidelity monitoring is important with motivational interviewing; (4) refill rate was the most accurate adherence assessment; (5) MEMS was not well-accepted; (6)

ACASI was easily used in this population; and (7) individuals appreciated adherence support from a consistent caring individual.

MIRECC IMPLEMENTATION, DESIGN AND ANALYSIS SUPPORT (MIDAS) PROFILE: P. ADAM KELLY, PH.D., MBA

Interviewed by Ashley McDaniel

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. This month we profile MIDAS member P. Adam Kelly, Ph.D., MBA.



What is your area of research?

My research focus is measurement of patient-provider communication in the clinical setting. Communication has been shown to be a huge factor in patients' compliance and outcomes, yet we still know relatively few specifics about how to improve communication in those

critical, short periods of face-to-face interaction. I'm working to identify those specifics and teach them to doctors and patients.

What is your role on the MIDAS team?

I am a psychometrician/measurement specialist.

How does your expertise in psychometrics impact your work with MIDAS?

I bring to MIDAS a wealth of experiences (good and bad!) with measurement instruments and techniques, technologies, and analysis approaches. I've seen what works and what doesn't in psychometrics in the VA, and I can and do share that with my MIDAS colleagues and clients.

What do you like best about your service on MIDAS?

I have the opportunity to work on a broad range of interesting research topics, helping South Central

MIRECC investigators find or develop the best measures to strengthen their VA research proposals.

What advice would you give to researchers who are new to using MIDAS?

Measurement is a more complex issue than investigators often realize. Sometimes, particularly if an investigator is in a hurry, she or he may just "whip up" a survey or find one from a published article and submit it in the proposal, on the grounds that it's good enough for a first application. But my experience is that's not how merit reviewers see things. It pays to make the effort from the start to find and/or develop, and then include in your proposal, sound, justifiable measures for your research questions. And we are here to help! Our goal is to support your research proposals, and we only succeed to the extent you do, so contact us as early as possible in the grant submission cycle and let's work together to get you funded!

How can people get in touch with you if they have questions about your work or MIDAS?

My personal VA homepage is

<http://www.hsrh.houston.med.va.gov/health-decision/kelly.htm>. You may contact me at

adam.kelly@va.gov for details about my research or other questions.

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

RECOVERY CORNER

THE VAC: INSPIRING FORCE MULTIPLIER FOR VA MISSION

Paul Moitoso LICSW, BCD
LRC/Recovery Services Consultant
Overton Brooks VAMC

E lane McDade never imagined that she could be an advocate for Veterans, never mind have the opportunity to lead a Veteran's Advocacy Council (VAC). She was always uncomfortable standing in front of an audience to share her beliefs and concerns. Her years of dealing with addiction, illness and homelessness had not helped her self-confidence, either. But in October 2009, she overcame her fears and represented the Shreveport VA facility on a VISN 16 VAC video teleconference hosted by Houston. During that meeting she shared her vision for the VAC with more than 25 attendees at 11 different facilities, and collaborated with them about future educational activities and informational materials that could help Veterans. She also requested assistance with recruiting techniques and information on the most popular VA programs.

VAC's are established and run by Veterans, without oversight of the VA, to give Veterans a direct voice in the care they receive during their recovery journey. Each VAC member promotes awareness of the mental health issues facing its community, as well as services available to help Veterans receiving care and their families. In addition, VAC's help combat the stigma associated with mental illness. Their work helps the VA become more responsive to Veteran and family needs.

Ms. McDade, now the Shreveport VAC Chair, had another opportunity to advocate for the Veterans when she presented at the monthly mental health staff meeting in November 2009. There she encouraged staff members to attend the council's weekly meetings and serve as advocates by providing fellow Veterans information on the VAC. "The VAC helped me to realize that I have great potential that other people can see that I couldn't see. And once I could see what I have, it hit me that I can show other Veterans what they have in themselves," McDade said.

When VAC members in the Shreveport area were asked if they felt the effort that they have put into the VAC has been worthwhile and effective, the council members agreed that the VAC has become a vehicle to reach out to

fellow Veterans, their beneficiaries, and VA staff. They explained how the VAC has empowered the council members to work outside of their comfort zones and take an active role in how care is provided in the VA.

For example, one afternoon in the middle of the 2009 Mental Health Wellness Week at the "Stand Down" event at the Shreveport Methodist Church, Ms. Jimmie Mitchell sat down with a Veteran living with addiction and talked with him for half an hour about the mission of the VAC. Through this outreach effort she successfully recruited Mr. Tony Villarreal to join the VAC where he serves as an advocate for Veterans and provides a voice in program development at the VA. For Mr. Villarreal, the VAC provides the opportunity to fulfill a life goal of giving back to the community by helping Veterans in need. "I'm part of something bigger," he explained. "I can share my experience with Veterans and help them."

Mr. Miko DeBerry and his fellow Shreveport VAC members agree that a key driver of their growth has been meeting with mental health service leadership not only to learn what services and resources are available through the VA, but also to share recommendations and concerns with those leaders. "The council offers Veterans a forum to constructively voice their concerns," he said, adding, "These Veterans have been through so much and they need somebody that can speak for them before they can speak for themselves. They need to be heard."

The VAC's voice was heard recently during a face-to-face meeting with the Chief of Mental Health Services to discuss high priority issues identified by the council. Several of the topics on the VAC's agenda were the lack of privacy when checking into care clinics, the elimination of "rapid fire" medication management approach to care, the need to implement a patient-centered approach to care and safety in an inpatient care milieu. Because the VAC members were able to clarify these issues for management, VA leaders have reprioritized their efforts.

(continued on page 6)

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By the nature of our jobs as VA mental health providers, we are always looking at deficits in our programs, constantly searching with a critical eye for opportunities to improve our service delivery and stretch our limited

resources. But we often miss opportunities to reflect back on the small but important successes that signify positive change within the VA. Veteran's Advocacy Council members across the country are reaching out in creative and inspiring ways, becoming a force multiplier for mental health services provided by the VA.

MIRECC IMPLEMENTATION, DESIGN AND ANALYSIS SUPPORT (MIDAS) TEAM "OPEN" CALL

MARCH 17, 2010

1:00 PM CST

1-800-767-1750, CODE: 49082

MIDAS is a methodologic consultation service offered by the SC MIRECC. It was created as a resource for investigators in VISN 16 who are conducting pilot studies or are seeking intramural or extramural research funding. The MIDAS team supports all phases of mental health research including:

- Project design and development
- Selection of appropriate technology(ies)
- Project implementation and monitoring
- Database design and management
- Data analysis and dissemination

The MIDAS team has expertise in such fields as biostatistics, epidemiology, psychometrics, qualitative methods, and appropriate technologies for research and education. Services are free of charge to MIRECC affiliates; you can become an affiliated investigator by completing a simple form.

This is your chance to meet the team, ask questions, and see whether our services could help you move your proposal or manuscript to the next level.

If you cannot make the call, additional information and a brochure are available from Melonie Shelton at melonie.shelton@va.gov.

MARCH CONFERENCE CALLS

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

ACCESS
CODE

8	MIRECC Site Leaders, 9:00 AM CT	27761#
9	MIRECC Leadership Council, 3:30 PM CT	19356#
11	National MIRECC & COE Education Group, 1:00 PM CT	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#
25	National MIRECC & COE Implementation Science discussion, 2:00 PM CT	59066#