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The next issue of the *South Central MIRECC Communiqué* will be published August 3, 2010. Deadline for submission of items to the August newsletter is July 27, 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

DIRECTOR'S REPORT: THE 2010 SC MIRECC LEADERSHIP RETREAT

By: Greer Sullivan, M.D., MSPH
Director, SC MIRECC

Professor, Department of Psychiatry
University of Arkansas for Medical Sciences



Greer Sullivan welcomes attendees to the 2010 SC MIRECC leadership retreat.

The SC MIRECC held a Leadership Retreat in Little Rock in April 2010 to discuss further development of MIRECC research. This was an unusual meeting for the SC MIRECC in many respects. Our relatively small group of attendees primarily included our associate directors, site leaders, and a few younger investigators who we hope to engage in SC MIRECC research.

Our focus was narrow; we reviewed our current research portfolio and assessed the extent to which our research is now aligned with the SC MIRECC's rural mission. We also engaged in several brainstorming activities that allowed us to collectively identify areas of opportunity for SC MIRECC research.

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2010 SC MIRECC Leadership Retreat continued...

This meeting was very helpful in allowing us to gauge the extent to which we have adequately responded to the recommendations of our 2007 national advisory board and to prepare us for an upcoming national advisory board meeting in early 2011. By all accounts, we are doing well in turning our virtual center toward its mission to improve care for rural and other underserved populations. We estimate that about 49% of our research portfolio is either focused on or relevant to three, often overlapping, populations: rural Veterans, vulnerable elderly Veterans, or OEF-OIF Veterans. We identified three potential areas in which we want to “grow” our research: (1) use of technology, (2) understanding rural help-seeking, and (3) novel applications of cognitive behavioral therapy (CBT).

First, we all agreed that increased use of technology is central to our rural mission. We decided to form a technology working group so that we could move toward this agenda in concert with key individuals in the Office of Mental Health Services and elsewhere in the VA who share our goal of optimizing the use of technology in our research and education efforts. We have taken a first step in this direction by including Dr. Irmgard Willcockson, an expert in using technology for teaching and training, as a MIDAS consultant. Second, Dr. Ellen Fischer is leading the development of a large study on rural culture and its relationship to help-seeking -- a study with the potential to inform our efforts to better engage rural Veterans in mental health care. Dr. Fischer has already brought together SC MIRECC investigators from several sites and outside



Attendees review retreat materials.

consultants to assist in conceptualizing and designing the study. Third, within the MIRECC we have a number of individual researchers who have been studying the effectiveness of CBT in several different forms for several different populations. We plan to form a working group to assess the status of our CBT research within the SC MIRECC and to identify areas where we might want to collectively expand this research.

We are excited about the potential of creating research projects that not only are innovative and inform mental health care delivery but also span across SC MIRECC sites. Research in the SC MIRECC is alive and growing! ■

JULY CONFERENCE CALLS

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

	ACCESS CODE
8 National MIRECC & COE Education Group, 1:00 PM CT	28791#
12 MIRECC Site Leaders, 11:00 AM CT	27761#
13 MIRECC Leadership Council, 3:30 PM CT	19356#
20 VISN 16 Mental Disaster Team, 11AM CT	76670#
21 MIRECC Program Assistants, 2PM Central	43593#
22 National MIRECC & COE Implementation Science discussion, 2:00 PM CT	59066#
26 MIRECC Education Core, 3:00 PM CT - <i>cancelled</i>	16821#
27 MIRECC Leadership Council, 3:30 PM CT	19356#

RECOGNITION OF EXCELLENCE IN THE SC MIRECC

The South Central MIRECC recognized the substantial contributions of several individuals at the leadership retreat, April 28-29, 2010, in Little Rock, Arkansas. Please join us in congratulating the following awardees:

Department of Veterans Affairs
South Central MIRECC

Major Contributor Award

Presented to

Michael Kauth, Ph.D.

Department of Veterans Affairs
South Central MIRECC

Special Contribution Award

Presented to

Kristin Ward, M.S.

Department of Veterans Affairs
South Central MIRECC

Excellence in Research

Presented to

Mark Kunik, M.D., M.P.H.

Department of Veterans Affairs
South Central MIRECC/MHPL

Clinical Leadership Award

Presented to

Lawrence C. Daily, LMSW

Department of Veterans Affairs
South Central MIRECC

Excellence in Research Training

Presented to

Geoff Curran, Ph.D.

Department of Veterans Affairs
South Central MIRECC/MHPL

Clinical Care Award

Presented to

David Germany, M.A.

Department of Veterans Affairs
South Central MIRECC

Best Publication by a Senior Investigator

Presented to

Jeff Pyne, M.D.

Department of Veterans Affairs
South Central MIRECC/MHPL

Clinical Care Award

Presented to

**Overton Brooks VA Medical Center
Psychosocial Rehabilitation
and Recovery Center (PRRC)**

RECENT SC MIRECC PUBLICATIONS

ANTIPSYCHOTIC ADHERENCE INTERVENTION FOR VETERANS OVER 40 WITH SCHIZOPHRENIA: RESULTS OF A PILOT STUDY

Mittal, D., Owen, R.R., Lacro, J.P., Landes, R.D., Edlund, M., Valenstein, M., Jeste, D.V.

Clin Schizophr Relat Psychoses, 2009, 24(Suppl. 1), S1171.

This pilot study tested the feasibility, acceptability, and effect-sizes of a multimodal, individual intervention designed to optimize antipsychotic medication use in patients ≥ 40 years of age with schizophrenia or schizoaffective disorder. We randomized 40 patients into two groups: usual care (UC) or a nine-session, manualized, antipsychotic adherence intervention (AAI). The AAI attempted to improve adherence by combining three psychosocial techniques: a) education, b) skills training, and c) alliance building. Sessions employed a semi-structured format to facilitate open communication. The primary outcome was antipsychotic adherence at study end. We obtained qualitative data regarding patient preferences for the duration and modality for receiving the adherence intervention. Compared to the UC group, a greater proportion of the AAI group was adherent post-intervention (65% vs. 55.6%; OR=1.49), a difference that was statistically not significant. The entire

AAI group reported that they intended to take medications, and 75% were satisfied with the intervention. The AAI was feasible and acceptable. Preliminary data on its effectiveness warrant a larger study. Qualitative data shows that patients prefer brief adherence interventions and accept telephone strategies.

EFFECT OF A MOTIVATION ENHANCEMENT INTERVENTION ON VETERANS' ENGAGEMENT IN PTSD TREATMENT

Murphy, R.T., Thompson, K.E., Murray, M., Rainey, Q., Uddo, M. M. *Psychological Services*, 2009, 6(4), 264-278.

This study is the first randomized controlled trial of the PTSD motivation enhancement (PME) Group, a brief intervention based on Motivational Interviewing and designed to enhance combat Veterans' engagement in PTSD treatment by increasing awareness of the need to change PTSD-related problems. Outpatients in a year-long, group- and cognitive-behavioral therapy (CBT)-oriented Veterans Affairs PTSD treatment program were randomly assigned to 4 sessions of the PME Group (n = 60) or a Psychoeducation Group (n = 54) in the 2nd month of treatment. Hypotheses about the proposed impact of the PME Group on PTSD treatment engagement (i.e., readiness to change, perceived

treatment relevance, and PTSD program attendance) were all supported, although predicted differences were not found on all measures. These results support the need to address readiness to change in combat-related PTSD treatment.

IMAGERY RESCRIPTING IN THE TREATMENT OF POSTTRAUMATIC STRESS DISORDER

Long, M.E.; Quevillon, R. *Journal of Cognitive Psychotherapy*, 2009, 23(1), 67-76

The use of imagery in psychotherapy has received surprisingly little attention from researchers despite its long history in psychology and the significance of imagery in a number of psychological disorders. One procedure warranting increased attention is imagery rescripting, an imagery technique in which an image is modified in some way to decrease distress. Imagery rescripting is relatively new with a small but growing empirical base. This article briefly reviews hypothesized mechanisms for therapeutic change via imagery techniques, emphasizing imagery rescripting, and how they might be relevant in the treatment of PTSD. We review studies employing imagery rescripting as a component of treatment, followed by recommendations for future directions. ■

SC MIRECC ACCEPTING CLINICAL EDUCATOR GRANTS PROPOSALS FOR FY11

The South Central MIRECC **is accepting** proposals for Clinical Educator grants. These small grants of up to \$7,000 are designed for mental health clinicians to develop unique, exportable clinical education tools to enhance the delivery of care. The SC MIRECC is especially interested in funding projects that focus on the delivery of care in rural settings and that involve collaborations between medical centers and community based clinics.

Past projects include a CD-ROM compendium of pain management information and tools for clinicians who treat Veterans with substance abuse, a manual to conduct psychoeducational workshops for returning Iraq and Afghanistan Veterans and their families about readjustment issues, and a DVD of ex-POWs telling their story about internment and their struggle

with PTSD symptoms and how they have managed to survive and thrive in their lives. The Clinical Educator grants program has resulted in more than 30 excellent clinical education products that the SC MIRECC makes available to clinicians at no cost.

If you have a great idea for an educational tool to improve care delivery, this may be the opportunity that you are looking for! The deadline for submitting a proposal is August 16. For more information about the Clinical Educator grants, contact Dr. Randy Burke (Randy.burke@va.gov) or Dr. Michael Kauth (Michael.kauth@va.gov).

FY10 SC MIRECC CLINICAL EDUCATOR GRANTS AWARDEES

Michelle Sherman, Ph.D.

Parenting Toolkit: New Challenges and New Opportunities for our Veterans, Families, and Mental Health Providers.

Kevin Connolly, Ph.D.

Smoking Cessation Program Audio Recording.

Jeffrey Cully, Ph.D.

Development of an Internet-Based Cognitive Behavioral Therapy Training Program.

Nicholas Pastorek, Ph.D., ABPP

Interventional Brochures for Treatment of Post-concussive Symptoms in Returning Veterans with a History of Traumatic Brain Injury.

MIRECC IMPLEMENTATION, DESIGN AND ANALYSIS SUPPORT (MIDAS) PROFILE: DANA M. PERRY, M.A.

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, Dana M. Perry, M.A., a primary data collection methodologist.

Share a little information with us about who you are.

I've worked in Mental Health Services Research and Program Evaluation for the past 21 years. The first 10 years I worked for the RAND Corporation, which is how I met the Director of the SC MIRECC, Greer Sullivan, which is how I ended up working with the SC MIRECC for the past 11 years, and MIDAS since its inception. I've been Co-Investigator on some large-scale health services and health policy studies, Program Evaluator on some smaller scale qualitative studies; directed several large scale studies, and have provided consultation, like I do for MIDAS, to lots of researchers.

What is your role in MIDAS?

During the proposal development phase, my role is to work with researchers to help them select the most rigorous data collection method(s) and sampling strategy(s) possible. Once their study is funded, they may request my help to guide them through the process to finalize and pretest their instrument, train interviewers, determine what data collection tools they need, develop overall project management issues and structure, implement the sampling strategy, and design and implement a system to monitor attrition rates and data quality. During the data collection phase I may help them analyze project enrollment and attrition rates and, when warranted, work with them to develop strategies to reduce attrition.

What is your area of expertise and how does it impact your work with MIDAS?

I've worked on many large-scale, methodologically complex studies and many smaller, relatively straight forward studies conducted in California, South Dakota, Texas, Indonesia, Maryland, Oregon, and all of the SC MIRECC states. I've been involved in all study phases from proposal development and study design through implementation to data collection, cleaning, analyses and dissemination. I've collaborated in overall study design, development, pretesting and validation of numerous diagnostic screeners and survey instruments. I have also

contributed to the design, training and implementation of all modes of quantitative and qualitative data collection methods, including the collection of biological samples and anthropometric data, and layperson physical health examinations of the homeless, focus groups, key informant and in-depth interviews, and field observations. I have designed, implemented and monitored sampling strategies of all sorts of populations including the most difficult to reach populations. I've been called in to analyze and address issues with sample attrition and other data collection challenges on some very large scale studies both within the U.S. and in Indonesia.

I've had numerous opportunities to observe the direct impact that decisions about data collection and sampling have on all phases of a study. I've come to appreciate just how important it is during the development of the proposal to understand the interaction between the measures you choose and the appropriateness of the data collection method selected, and the interaction between the study population and sampling strategies you've proposed. Also important is and the impact that these decisions have on the more mundane and often neglected components of the study, including the timeline, budget, and overall project management. For example, generally speaking, we know that the least expensive mode of collecting quantitative data is through a mail survey and the most expensive is an in-person, interviewer administered survey. We know that a mail survey must be simple and relatively short and the in-person interview can be much longer and far more complex. We know that the mail survey will usually yield the lowest response rate and the in-person survey will usually yield the highest. However, those are only a few pieces to the puzzle and they don't apply in every case. There is no cookie cutter solution and, believe me, I've been looking for one.

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What do you like best about your work with MIDAS?

I love the kinds of challenges that sampling populations and collecting data present. I've spent a lot of time thinking about the strengths and weaknesses and existing strategies and testing how to improve upon them. The MIDAS provides the perfect avenue for me to share what I know.

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

Take advantage of us! Guard against that voice that says, "Oh, I should know how to do this on my own." I've observed that the most successful researchers are the ones who know that conducting rigorous health services research is a collaborative and iterative effort. They focus on developing their own area of expertise while actively seeking out the expertise of others. Also, know

that there are challenges that will come up no matter what, but if you've used the expertise available to develop a strong proposal and thought through ways to avoid known pitfalls, you will have a lot more time and energy to address the issues that no one could have predicted. And you'll have a lot more fun.

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

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. The application process is simple, but if you have questions about MIDAS before requesting assistance, you can contact me at 541 420-4301 or Dr. Fischer. If I am not the right person to answer your questions or brainstorm about your needs, I will direct you to another MIDAS member. ■

RURAL HEALTH RESOURCES UPDATE

The Provision of Mental Health Services by Rural Health Clinics

The number of Rural Health Clinics (RHCs) providing specialty mental health services remains limited. This study examined changes in the delivery of mental health services by RHCs, their operational characteristics, barriers to the development of services, and policy options to encourage more RHCs to deliver mental health services.

Approximately 6% of independent and 2% of provider-based RHCs offer mental health services by doctoral-level psychologists and/or clinical social workers. Models used to provide mental health services include contracted and/or employed clinicians housed in the same facility as primary care providers. A key element in the development of mental health services is the presence of an internal champion (typically clinicians or senior administrators) who identify the need for and undertake implementation of services, help overcome internal barriers, and direct resources to the development of services. To download a copy of this publication, visit <http://muskie.usm.maine.edu/Publications/rural/WP43/Rural-Health-Clinics-Mental-Health-Services.pdf>.

Encouraging Rural Health Clinics to Provide Mental Health Services: What are the Options?

This study examined changes in the delivery of mental health services by Rural Health Clinics (RHCs), their operational characteristics, barriers to the development of services, and policy options to encourage more RHCs to deliver mental health services. Key Findings:

- Approximately 6% of independent and 2% of provider-based RHCs offer mental health services.
- 38% of study RHCs reported their mental health services were not profitable but continued to provide them in response to community and patient needs.
- An important factor in the development of RHC mental health services is the presence of a local champion who spearheads the development effort.

For download a copy of this publication, visit <http://muskie.usm.maine.edu/Publications/rural/pb/mental-health-services-Rural-Health-Clinics.pdf>. For more information about these publications contact John Gale, Maine Rural Health Research Center, Phone: 207-228-8246, email: jgale@usm.maine.edu.