



**Third Annual VA Mental Health Conference *Meeting the Diverse Needs of Veterans: Implementing the Uniform Services Handbook* - Michael R. Kauth, PhD (co-chair of the conference)**



“Big,” “energizing,” “inspiring,” “transforming” are words that describe the July meeting. Nearly 1300 VA clinicians, managers, researchers, and educators packed the conference in Baltimore. There were more than 20 plenary sessions, 84 concurrent presentations, and 106 poster presentations. Topics included national and field efforts to implement the Uniform Mental Health Services Handbook, as well as other research-informed practices across VA. The MIRECCs and MH CoEs were well represented. Researchers, educators, and trainees gave presentations and contributed significantly to the planning and functioning of the conference.

*Meeting continued on page 4*

## Science in the Spotlight

### Focus on Traumatic Brain Injury

Traumatic brain injury (TBI) has been termed a “signature injury” of the current conflicts. Several MIRECCs and MH COEs are deeply involved in efforts to improve diagnosis and clinical care for Veterans with TBI.

#### Practice Recommendations for the Treatment of Veterans with Comorbid PTSD, mild TBI, and Pain: Results from the June 2009 Consensus Conference

This plenary session was presented by Matthew Friedman (National Center for PTSD) and Robin Hurley (VISN 6 MIRECC). It began with an overview and summary of our present understanding. Key points included:

- Studies indicate that a substantial minority of OEF/OIF Veterans report episodes during deployment consistent with having experienced a concussion (mild TBI).
- The majority included exposure to explosions (blast).
- Other conditions, including PTSD and chronic pain, are much more common in Veterans who report mild TBIs.
- PTSD and mild TBI have considerable symptom overlap, including sleep disturbances, irritability, and difficulty with concentration.

The VA has clinical practice guidelines (CPGs) for each of these conditions when they occur alone. The recent Evidence Synthesis concluded that there are no definitive studies yet to guide clinical treatment when mild TBI and PTSD are present together. One purpose of the Consensus Conference was to provide guidance to clinicians.

*TBI continued on page 5*

## Veteran's View

### Consumer Panel Faith Barrow, Jeffrey Tarr, & William Rosenberg (VA New Jersey Health Care System)

We went to Baltimore for the Mental Health Conference, excited but concerned. We were presenting on the Lyons House, our drop-in center. It is mostly staffed with Veteran CWT workers and Veteran Volunteers with staff there to support. None of the staff are working fulltime in the Lyons House and we were concerned. Would staff really listen to us? Would they even talk to us? Would we be deserted?

We checked into the hotel and started exploring. Our staff person started introducing us to everyone. We had a ten minute conversation with Dr. Ira Katz about the role of Veterans in Recovery. He listened. Dr. Bob Gresen came up to us and thanked us for coming and being part of the conference. He said that he and the staff were very lucky to have us there to teach them. We met with so many people from across the country. One of our favorite presentations was by a doctor from Iraq, Michael McBride, who talked about the traumatic brain injuries from Iraq. While he was speaking, a Veteran in the audience talked about the Veterans coming back and their needs.

Wednesday was the scary day. It was the day of our presentation. Michelle [Smith] and Dr. [Leon] Green kept saying that they knew we would do a good job and they considered us a success by just being there. It was time for

*Veteran's View continued on page 6*

### Inside this issue:

Services OEF/OIF	2
PC-MH, Recovery Conf	2
Substance Use Disorder	3
EBT, Incarcerated Vets	3
Implementation	4
Suicide Prevention	5
EQUIP	5
Brief CBT	6
Editorial Board	7
Center Directors	7
Education Activities	7
eSCID, Posters	8

### Fellows Pre-Meeting Conference & Update

*The VA Advanced Fellowship Program in Mental Illness Research and Treatment* is the new name for the MIRECC Fellowship program. Launched in 2001, this mental health research program has successfully trained over a hundred psychiatrists and psychologists. Most have gone on to academic clinical research careers within the VA and academic institutions nationwide. This success has led to the recent expansion of the program to include more than 21 sites, including the National Center for PTSD and multiple MH COEs and MIRECCs.

A **Pre-Meeting Conference - First Annual Fellows' Research Institute** - was held from Friday to Monday. It was attended by 21 of our Fellows. A key aspect was the opportunity for Fellows to present their research to and get feedback from expert faculty on Day 1, which they incorporated into their Day 2 presentations. This proved to be a very valuable experience. It helped Fellows in developing their current research ideas and provided

*Fellows continued on page 6*

## Services for OEF/OIF Veterans

### Gender Specific Mental Health Finding Among OEF/OIF Veterans Seeking VA Care (VISN 6 MIRECC & VA Environmental Epidemiology)

Twelve percent of OEF/OIF Veterans are women. Very little is presently known about how their care needs might differ from male Veterans. Preliminary findings from more than 54,000 female and 398,000 male OEF/OIF Veterans indicate that compared to males, female Veterans are:

- Less likely to report PTSD symptoms.
- Less likely to report non-dependent abuse of substances, alcohol dependence or drug dependence.
- More likely to report depression and anxiety disorders.

Studies are needed to explore factors that might underlie these differences.

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### Family and Veteran OEF/OIF Enhanced Outreach (VISN 4 MIRECC & VISN 6 MIRECC)

This collaborative project is designed to reach recently returned OEF/OIF Veterans by way of family members concerned about their Veteran. The program name, “Families - At Ease,” was selected to represent the key role of concerned family members in prompting the Veteran to seek care. Project goals include:

- Develop evocative outreach materials to motivate family members of OEF/OIF Veterans to call the VA for information.
- Determine which public education/outreach methods are most effective.
- Develop effective methods for coaching family members to support help-seeking by troubled Veterans.
- Develop family call centers to attend to informational needs of Veterans and their family members.

Our group has worked with OEF/OIF Program Managers and others at the Philadelphia VA and Durham VA to extend their outreach efforts as part of this project.

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### Experiential Avoidance and Mental Health Over Time (VISN 16 MIRECC)

Key components of Acceptance and Commitment Therapy (ACT) are experiential avoidance and mindfulness. The influence of these therapeutic elements on mental health outcomes of OEF/OIF Veterans was evaluated.

- Those back in the US longer (>300 days) show few symptoms of PTSD, depression, or generalized anxiety disorders despite more exposure to combat, being more rural, and being single.
- Coping skills were a powerful predictor of positive mental health outcomes; time since returning was not.
- Key elements of ACT were consistent and powerful predictors of a variety of mental health outcomes.

These results support benefits of ACT in promoting successful readjustment of OEF/OIF Veterans. Further testing of such interventions is warranted.

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## Primary Care-Mental Health Integration Workshop: Field Perspective and Effective PC-MH Practice in 30 Minutes (VISN 2 CIH & DOD Behavioral Health)

Improving treatment access and quality of care for common mental health (MH) conditions is a VA priority. One evidence-based strategy is to integrate MH treatment within primary care (PC) settings. Two approaches to this were presented.

The first was a sequence designed for a 30 minute PC appointment:

- Introduce the role of the MH provider in PC (1-2 min).
- Identify/clarify the consultation problem (1 min).
- Conduct functional analysis of the problem (12-15 min).
- Summarize your understanding of the problem (1-2 min).
- List possible change plan options (“selling it”) (1-2 min).
- Start a behavioral change plan (5-10 min).

The second was the “5 A’s” to insure that all points are addressed:

- Assess-Risk factors, behaviors, symptoms, and attitudes.
- Advise-Specific, personalized treatment options to improve quality of health.
- Agree-Collaboratively select goals based on the Veteran’s interest and motivation to change.
- Assist-Provide information and teach skills to problem solve.
- Arrange – Make specific plans for follow up.

These evidence-based strategies can help PC providers optimize use of their time with Veterans and insure that they leave the office with a concrete plan of action.

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### Pre-Meeting Conference for Local Recovery Coordinators (VISN 5 MIRECC)

Amy Drapalski (VISN 5 MIRECC) gave an overview of the social skills training (SST) model and the evidence-base for its use. SST is a psychosocial treatment for individuals with serious mental illness. This training can be used to assist Veterans in making progress towards their recovery goals. It is one of the VA Evidence-Based Practice dissemination initiatives supported by the Office of Mental Health Services. The program is directed by the VISN 5 MIRECC and co-facilitated by the VISN 22 MIRECC. Efforts include both training and ongoing consultation of VA staff offered through the program and through designated Master Trainers who serve as expert trainers and consultants for their VISN.

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## Substance Use Disorder

### Treatment Outcomes from a Primary Care-Based Intervention Study: Telephone Care Management for At-Risk Drinking (VISN 4 MIRECC)

The goal of our study was to develop an evidence-based treatment algorithm for patients with at-risk drinking. Participants were randomly assigned to receive either Usual Care or Telephone Care Management (TCM), a brief intervention for at-risk drinking. Results indicated:

- Both groups reduced their drinking.
- There were no significant differences between TCM and Usual Care. Our results indicated that additional treatment is not always beneficial. The surprising outcome may relate to the level of care already provided by the primary care provider and the behavioral health laboratory staff. Moreover, participants could only be included if they did not have concurrent mental health problems.

For more information: [dave.oslin@va.gov](mailto:dave.oslin@va.gov)

### Contracts, Prompts, and Reinforcement (CPR): Strategies for Improving Adherence to SUD Continuing Care (Salem VAMC & VISN 6 MIRECC)

The goal of CPR is to improve care adherence and abstinence in Veterans completing residential substance abuse treatment. This workshop emphasized the rationale behind the intervention, including:

- A brief contract is completed by the therapist with the patient using a motivational enhancement style.
- Prompts include reminders for regular appointment as well as immediately following any missed therapy sessions.
- Rewards (reinforcers) are provided for both attendance and ongoing abstinence.
- Contingency Management (CM) principles are used, so reinforcers are social rather than monetary.

This is a promising and cost-effective approach, making it practical in clinical settings. CPR is now undergoing review for possible inclusion in the National Registry of Evidence-Based Programs and Practices. For more information: [jennifer.burden@va.gov](mailto:jennifer.burden@va.gov)

### Covariates of Sleep Quality in Alcohol Dependent Veterans (VISN 4 MIRECC)

Sleep quality in recovering alcohol dependent subjects has been associated with mood disturbance, anxiety, severity of the alcohol dependence, alcohol-related problems, and self-rated health status. There is, however, no prior data on the sleep quality in actively drinking alcohol dependent Veterans. The aims of this investigation were the following:

- Assess sleep quality across a spectrum of alcohol use disorders, as compared to Veterans without pathological alcohol use.
- Assess the covariates of sleep quality in actively drinking alcohol dependent Veterans.

Cross-sectional data over 4 months indicated the following:

- Sleep quality deteriorated with increasing severity of the alcohol use disorder.
- Covariates of sleep quality in the prediction model were the presence of any mood disorder and the presence of any anxiety disorder. The severity of alcohol dependence and the indices of alcohol use were not associated with the sleep quality.

The sleep quality in actively drinking alcohol dependent veterans thus may be a manifestation of their underlying mood and anxiety disorders. For more information: [subhajit.chakravorty@va.gov](mailto:subhajit.chakravorty@va.gov)

## Updates on Evidence-Based Treatments for PTSD (VISN 22 CESAMH)

Ours is one of several groups within the VA training clinicians all over the nation on evidence-based treatment of PTSD. Methods known to be effective include Prolonged Exposure (PE) therapy and Cognitive Processing Therapy (CPT). Researchers from the National Center for PTSD reported that nearly 500 mental health providers have been trained to provide PE therapy. Since this report in July an additional 200 have received training, with a further 400 to be trained in 2010. Continuing development and refinement of treatments for PTSD is also a high priority for the VA. A group that has adapted PE therapy for delivery using video telehealth methods reported very promising results in rural Veterans. This may be a very effective method for outreach. CPT has now been adapted for use in residential PTSD programs. It was reported to be more effective than trauma-focused group therapy in that setting. The effectiveness of CBT for traumas other than combat exposure has also been demonstrated.



### Serving Justice Involved Veterans: Clinical and Research Challenges (VISN 19 MIRECC)

A systematic review of the literature related to suicide among incarcerated Veterans was presented. Both Veterans and jail/prison inmates face an increased risk of suicide, yet little is known about suicide risk in Veterans who are incarcerated. Among the most striking results:

- There is so little data available on suicide among incarcerated Veterans that there is no meaningful way to estimate the suicide rate.
- There is concern that the population of incarcerated Veterans may be increasing and that some may also have mental illness and/or traumatic brain injury.
- Characteristics most useful in identifying potential suicide victims were age greater than 40, one prior incarceration, homelessness, history of psychiatric care, history of drug abuse, and a violent offense.
- Periods of life transition seem to increase risk.

It is clear that studies are needed to provide a more complete picture. Of particular importance are practice changes that promote routinely inquiring about Veteran status, suicide risk factors, and incarceration history as well as systems changes to promote intervention when Veterans and returning soldiers face difficult transitions.

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## Challenges in Implementing Services: Identifying and Overcoming Barriers

Implementing recovery and rehabilitation-oriented programs is an important area of emphasis for Veterans with serious mental illness. These include wellness, supported employment, family services, and peer support.

### Implementing Recovery-Oriented Care: The Importance of Clinicians' Knowledge, Attitudes, and Beliefs (VISN 22 MIRECC)

One barrier to adoption of recovery-oriented and evidence-based clinical practices is clinician acceptance. This is influenced by clinicians' knowledge, attitudes, and beliefs about Veterans' needs for services. We queried clinicians at four VA medical centers, asking them to describe the "top three" needs of Veterans with schizophrenia.

- Most clinicians identified medication management as the top need.
- Only a minority identified recovery-oriented services as a top need.

Improving workforce knowledge, attitudes and beliefs may be essential to successful quality improvement initiatives. One likely approach is assertive, tailored education strategies focused on both clinicians and Veterans.

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### Implementation of the Family Services Component of the USP: Lessons from the Field (VISN 22 MIRECC)

The session began with an overview of family treatment policy at the VA, emphasizing that involvement of family members in treatment should be addressed in every treatment plan. VA clinicians should discuss family involvement with their clients at least annually and at discharge. In addition, every VA should offer family services:

- Consultation (1-5 sessions to resolve a specific issue)
- Education (e.g., SAFE Program or NAMI's Family-to-Family Program)
- Psychoeducation (e.g., behavioral family therapy, multifamily groups).

Several sites presented examples of family-focused approaches.

### Implementing Evidence-Based Supported Employment: Lessons from a National Dissemination (VISN 1 MIRECC)

Implementation projects require careful planning and support to be successful. Supported Employment (SE), VA's program to assist Veterans in obtaining and maintaining employment, involves national training (conference, print materials, conference calls, email) for Mentors on the required skill sets and ongoing supervision. Topics include the principles of SE, conducting a fidelity assessment, establishing collaborative relationships with local VA leadership and clinicians, and providing constructive and critical feedback to local SE programs. Mentors provide training and ongoing technical assistance to SE programs in their VISNs. The presenters reported that all 21 sites have received 5 fidelity visits over the 3-year implementation period. Nine sites have achieved full implementation (> 65 on the SE Fidelity Scale). The mean score for all sites is 64.9.

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### Evaluating Organizational Readiness to Improve Care at Four VA Healthcare Centers (VISN 22 MIRECC)

The organizational context where change is to be implemented will influence success. Administrators and clinicians at four VA mental health clinics completed a measure focusing on organizational traits that predict achieving program change.

- Two sites reported good clinic structure and functioning. These were ready for implementation of evidence-based practices.
- Two sites reported traits (e.g., poor understanding of the clinic's mission, low sense of cohesion and/or autonomy among clinicians) indicating a need for further training. Educational efforts included training on the practices to be implemented, building teams to work together on change goals, and tailoring new practices to the setting.

The organizational evaluation shaped training, implementation, and communication efforts to meet each site's needs and state of readiness. A tailored approach increases the likelihood that implementation and quality improvement efforts will be successful.

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*Meeting continued from page 1*

Dr. Ira Katz (Deputy Chief of Patient Care Services for Mental Health) opened the conference. He reported on a year of progress in making VA mental health care more patient-centered, evidence-based, and accessible.

Throughout the meeting, program leaders in the Office of Mental Health Services gave updates about current and future national activities.



Highlights of the conference included a report from the recent VA-DoD consensus conference on treatment of Veterans with both PTSD and TBI and a panel of consumer advocates from four national organizations. The panel emphasized the transformation they see in VA and their growing partnership with VA. Lastly, Deputy Secretary W. Scott Gould gave a warm and personal address in which he thanked VA staff for their service to Veterans. Deputy Secretary Gould also outlined his and Secretary Shinseki's priorities for VA mental health – to provide effective, timely, and Veteran-centered care.

I was inspired myself by the progress and enthusiasm that I heard for implementing accessible, research-informed practices in VA! In my 17 years as a VA employee, I have not seen such a rapid, systemic, positive transformation in VA mental health services. I am excited to be involved in this transformation and look forward to learning at next year's conference what we have accomplished.


**Science in the Spotlight** *TBI continued from page 1*

Key recommendations, based on the preliminary results of initial clinical trials and expert opinion:

- **Assessment** – Perform a careful, comprehensive evaluation to identify all symptoms. It is important to differentiate a history of TBI from the present symptoms, as most people experiencing a concussion recover fully. Identification of other conditions, such as PTSD or chronic pain, is essential.
- **Education** – Promote recovery expectations for the Veteran/ family. Demystify the condition and the process.
- **Treatment** – A comprehensive plan is required that includes all co-occurring conditions. Encourage concurrent, collaborative treatment. Follow existing CPGs, with adjustment based on individual response.

**Resources:** <http://www.healthquality.va.gov/index.asp>  
<http://www.hsrd.research.va.gov/publications/esp/>

**Meeting the Needs of Those with Co-Occurring Mild Traumatic Brain Injury and PTSD (Tampa VAMC & VISN 19 MIRECC)**

The substantial overlap in symptoms between mild TBI and PTSD can make it difficult to determine the origin of particular symptoms in Veterans with both conditions. However, from a practical clinical perspective, what is important is appropriately treating the symptoms regardless of origin. A sequential or stepwise approach is recommended, starting with conditions known to affect many domains of functioning:

- Provide education that supports the expectation of recovery and address any mental health issues such as depression.
- Address physical complaints such as headaches and sleep difficulties. An important part of this step is to support improved self-care routines including proper sleep hygiene.
- Once these approaches have been fully implemented, any remaining cognitive symptoms should be addressed.

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**Mild Traumatic Brain Injury Workshop: Assessment and Treatment of Cognitive Impairment (VISN 6 MIRECC & Hefner VAMC, VISN 22 CESAMH & San Diego VAMC, Phoenix VAMC)**

Three programs from across the VHA healthcare system that have established new programs to assess and treat Veterans with mild TBI and cognitive deficits were presented.

- **CogSMART** (Cognitive Symptom Management & Rehabilitation Therapy)– A 12-week program, with individual/group sessions 1-2 hours per week. For more information, including manuals: [elizabeth.twamley@va.gov](mailto:elizabeth.twamley@va.gov)
- **Brain Boosters** – A 10-session program designed to assist Veterans in learning how to help themselves to retrain the brain to function more efficiently. For more information, including manuals: [mary.bushnell@va.gov](mailto:mary.bushnell@va.gov)
- **FACT** (Functional Adaptation & Cognitive retraining) – A multi-disciplinary 6-week program, with individual/group sessions 6 hours per week. For more information, including manuals: [david.butler@va.gov](mailto:david.butler@va.gov)

All three programs emphasize teaching compensatory strategies, use of adaptive aids, and education on key topics. Preliminary results are very encouraging. The importance of addressing co-occurring conditions, especially PTSD and sleep disturbances, was emphasized. It was noted that each cohort in a program is unique, so flexibility is important. In addition, many Veterans are working or in school, so scheduling can be a challenge.

**Suicide Prevention (VISN 2 COE)**

Prevention of suicide is a core goal for the VA, and developing new approaches is a major focus for the Canandaigua CoE.

- Operation S.A.V.E. is a suicide awareness program that has been distributed to VA's Suicide Prevention Coordinators across the country. The target audience is front line staff. Initial analysis of post-training evaluation revealed that learning had occurred and that participants felt that their attitudes had changed. They were specifically more ready to accept that suicide awareness and getting people appropriate help was part of their job.
- Initial findings from an on-going study designed to look at who is calling the Hotline and why revealed that mental health concerns, substance abuse, homeless concerns, physical health problems and relationship issues all play a significant role in hotline use.
- The VA is developing a system for reporting and monitoring suicidal behaviors. Suicide prevention coordinators have been reporting known attempts and completions for over a year. Preliminary review indicates that about 29% of those who completed suicide had a history of a prior attempt. Variations in data across facilities and VISNs may indicate differences in reporting strategies and communication patterns concerning suicidal behaviors.

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**Implementation of a Psychosocial Weight Loss Program in Schizophrenia (VISN 22 MIRECC)**

Although second generation antipsychotic medications are effective at managing symptoms, they are also associated with weight gain. To address this problem, our researchers have developed the EQUIP Wellness Toolkit, a psychoeducational weight management program. The EQUIP Wellness program includes 16 group sessions as well as individual therapy. The program was designed specifically for people with severe mental illness. For example, the program uses handouts with large fonts, frequent summaries and knowledge quizzes, concrete examples, food models and fast food guides. The EQUIP study found a significant need for weight management services. Out of 146 veterans with schizophrenia or schizoaffective disorder, 75% of them were overweight or obese. Only half of these veterans chose to participate in the weight loss program, and those who did participate attended the sessions infrequently. Strategies to increase use of the weight program need to be developed. For further information: [noosha.niv@va.gov](mailto:noosha.niv@va.gov)

**Veteran's View** *continued from page 1*

the presentation and we dropped the bomb, a military term. Attendance at our presentation was good. Our Network Director and other VISN Staff were there to give us support. You could tell that they were impressed as we were speaking. We gave our presentation about Lyons House, a clubhouse with a recovery theme. At the end of the presentation, we called to the Lyons House so that the other team leaders could hear the applause because everyone belongs to the Lyons House and worked hard at making it a success. We had questions from the audience so people were interested and listened.

The highlight of the conference was the session by Under Secretary Gould. He spoke about the needs of the Veterans and the responsibilities of the VA to take care of our Veterans. It was heartwarming to realize that to the higher ups, we aren't just a number or a patient but a Veteran with a history of our own. He spoke of his experiences in the Military and shared that while he did not know all of the problems that our Veterans were facing, he is committed to not only work on those problems but learn all he could. In the future, I would suggest more than 5 Veterans go to these conferences. VA staff want and need to hear from Veterans.


**Factors Related to Implementing Brief Cognitive Behavioral Therapy in VA Clinics: A Pilot Study (VISN 16 MIRECC)**

Changing clinician behavior is very difficult. We piloted a small study to test a strategy ("external facilitation") to promote adoption of brief cognitive behavioral therapy (CBT) training. Twenty-three therapists from 6 VA medical centers and 14 community-based outpatient clinics participated. Everyone received training in CBT plus 3 months of biweekly consultation. However, therapists at half the sites met at least monthly with a facilitator before the workshop and for 6 months after the workshop. The facilitator focused on trying CBT quickly and resolving barriers to CBT use. The facilitator employed several interventions to encourage CBT use. We looked at change in self-reported CBT usage from baseline.

- Therapists who got facilitation reported an average 19% increase in CBT use, supporting our prediction. This translates to about 28 additional hours of CBT per month.
- Therapists who did not get facilitation reported only a 4% increase in CBT.
- Facility type was not related to differences in CBT use.
- Barriers included the nature of the clinic (e.g., walk-ins only), patient issues (e.g., distance to clinic), lack of time to prepare for CBT, and the complexity of patient symptoms.

Although the small sample limits our conclusions, the results appear to support the usefulness of external facilitation to promote adoption of psychotherapy. For more information:

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**Fellows** *continued from page 1*

concrete suggestions on ways to continue to develop their expertise. Another exciting aspect was a mock grant review committee led by an NIMH Program Officer. Both Fellows and Faculty contributed grants for the committee to discuss. Other highlights of the individual talks and panels at the preconference included:

- VA and NIH Career Development Awards
- Establishing Empirically Supported Treatments within the VA Setting
- Networking within the VA
- Academic Career Trajectories within VA: A View from MIRECC Directors
- Creating an Effective Career Development CV
- Implementation: An Emerging Field and Its Effect on Dissemination in VA

As you can see, this has been an exciting year for the Fellowship program. We welcome our new Fellows and new sites who have recently joined us, and look forward to the academic year ahead of us. Fellows also presented posters on a range of topics highly relevant to VA mental health care initiatives during the main conference:

**Asgard GL, Young JW, Geyer M, Brown G, Eyer LT** *Translating an Animal Model of Attention and Inhibition into Human Imaging*

**Bahraini N, et al** *The Colorado Violent Death Reporting System: Exploring Factors Associated with Suicide in VA and Non-VA Utilizing Vets*

**Barber J, Rao S, Luther J, Haas GL** *Development and Implementation of Primary Care Integration in VACHS-West Haven*

**Bhat R** *Depression in the Bereaved vs. Those with Other Losses: A look at Functionality, Coping and Personality*

**Calmes C, Lucksted A, et al** *Resisting Internalized Stigma: A Recovery-oriented Group Intervention for Veterans with Mental Illness*

**Dao TK, Nguyen C, et al** *Clinical Depression, Anxiety, & PTSD as Risk Factors for Morbidity following Coronary Artery Bypass Surgery*

**Eggleston AM, Guerra VS, Calhoun PS** *Alcohol and Other Substance Use among OEF/OIF Combat Veterans with and without PTSD*

**Gellis LA** *Predictors of Sleep Disturbances in OEF/OIF Veterans Reporting a Trauma*

**Gibbons CJ, DeRubeis RJ, Carroll K** *The Clinical Effectiveness of Cognitive Therapy for Depression in an Outpatient Clinic*

**Guerra VS, Calhoun PS** *PTSD and Suicidality in an OEF/OIF Sample*

**Jeong JY** *Interpersonal Stress and Suicidality: Targets for Intervention*

**Kuluva J** *IED Related TBI and it's Effects on Impulsivity*

**Long ME, Teng EJ, Stanley M** *Adapting an Existing Treatment for Combat Related Nightmares for Recently Deployed Rural Veterans*

**Matukaitis Broyles L, et al** *Buprenorphine and Methadone Opioid Agonist Therapy: Differences in Patient Characteristics*

**McCarthy E, Jane S, O'Brien E, et al** *Modified CPT-C for the Treatment of Veterans Diagnosed with PTSD and Alcohol Dependence*

**Moore SA, Zoellner LA** *Autobiographical Memory and PTSD: The Role of Contextual Information*

**Olson-Madden J, Brenner L, Harwood J, et al** *TBI in Veterans Seeking Substance Abuse Treatment: Findings and Clinical Implications*

**Qureshi SU, Kunik M, Schultz PE, et al** *Association of Trauma and PTSD with Dementia and Other Physical Illnesses in Older Veterans*

**Reed K** *Evaluation of the Quick Inventory of Depressive Symptomatology-Self Report (QIDS-SR) in a Spinal Cord Injury Population*

**Renner KA, Jacoby AM** *Measuring Patient Satisfaction as a Means for PTSD Clinical Team Program Development*

**Rosell DR** *Increased 5-HT<sub>2A</sub> Receptor Binding in the Orbitofrontal Cortex of Impulsively Aggressive Personality Disordered Patients*

**Wang L, Rhode K, Hart KL, Hoff DJ, Shofer JB, et al** *Prazosin for Treatment of Agitation and Aggression in Alzheimer's Disease*

**Youssef N, Marx C, et al** *Candidate Biomarkers for Suicidality in OEF/OIF Era Veterans: Relevance to Suicide Risk Reduction and Prevention*



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## National MIRECC Website

[www.mirecc.va.gov](http://www.mirecc.va.gov)

## MIRECC and MH COE Directors & Education Activities

### VISN 1 MIRECC

**Director:** Bruce Rounsaville, MD

**Focus:** Improve care for Veterans with mental illness and substance dependence.

**Activity:** The Peer Education Center offers monthly seminars and workshops for VA Peer Support Providers.

**Contact:** [patricia.sweeney@va.gov](mailto:patricia.sweeney@va.gov)

### VISN 16 MIRECC

**Director:** Greer Sullivan, MD,

**Focus:** Improve access to evidence-based practices in rural and other underserved populations.

**Activity:** Implementation meeting with CeMHOR-March 2010 (proposed); MIRECC Research Retreat-April 2010, Little Rock AK

**Contact:** [michael.kauth@va.gov](mailto:michael.kauth@va.gov)

### VISN 2 Center for Integrated Healthcare

**Director:** Stephen Maisto, PhD, ABPP

**Focus:** Improve care by integrating behavioral health services into the primary care setting.

**Activity:** Co-located Collaborative Care Staff Training, March 30-April 1 2010, and quarterly thereafter, Buffalo NY

**Contact:** [randy.allen@va.gov](mailto:randy.allen@va.gov)

### VISN 17 COE for Research on Returning War Veterans

**Director:** Suzy Gulliver, PhD

**Focus:** Identify the characteristics that mediate potential psychopathological response to war-related stress.

### VISN 2 COE at Canandaigua

**Director:** Kerry Knox, PhD

**Focus:** Improve access to care and the adaptation and evaluation of innovative approaches for at risk Veterans for suicide.

### VISN 19 MIRECC

**Director:** Lawrence E. Adler, MD

**Focus:** Study suicide with the goal of reducing suicidality in the Veteran population.

**Activity:** Peter M. Gutierrez, PhD - NYU Psychiatry Grand Rounds 3/26/10; Lisa A. Brenner, PhD - AAS Annual Conference Plenary Speaker 4/23/10

**Contact:** [lisa.brenner@va.gov](mailto:lisa.brenner@va.gov)

### VISN 3 MIRECC

**Director:** Larry Siever, MD

**Focus:** Investigate causes and treatments of serious mental illness to enhance recovery of Veterans.

### VISN 20 MIRECC

**Director:** Murray A. Raskind, MD

**Focus:** Investigate the genetics, neurobiology, and treatment of schizophrenia, PTSD, and dementia.

**Activity:** Bi-monthly 'MIRECC Presents' v-tel lecture series with upcoming lectures focusing on mild TBI, PTSD, Alzheimer's, Veterans in the Justice System

**Contact:** [lauren.stoner@va.gov](mailto:lauren.stoner@va.gov)

### VISN 4 MIRECC

**Director:** David Oslin, MD

**Focus:** Advance care for veterans with concurrent physical, mental, and/or substance use disorder.

**Activity:** Primary Care-Mental Health Integration training including the Behavioral Health Lab platform, care management, and implementation.

**Contact:** [jennifer.rego@va.gov](mailto:jennifer.rego@va.gov)

### VISN 21 MIRECC

**Director:** Jerome Yesavage, MD

**Focus:** Individualize treatments for Veterans with PTSD or with Alzheimer's Disease.

**MIRECC Fellowship Hub Site**

### VISN 5 MIRECC

**Director:** Alan S. Bellack, PhD, ABPP

**Focus:** Improve care for Veterans with schizophrenia and for their families.

**Activity:** VA Social Skills Training for Serious Mental Illness, March 2-3 2010, Baltimore MD

**Contact:** [matthew.wiley@va.gov](mailto:matthew.wiley@va.gov)

### VISN 22 MIRECC

**Director:** Stephen R. Marder, MD

**Focus:** Improve functional outcomes of Veterans with psychotic disorders.

**Activity:** Motivational Interviewing Workshop for Psychologists, January 8, 2010 in Los Angeles, CA

**Contact:** [noosha.niv@va.gov](mailto:noosha.niv@va.gov)

### VISN 6 MIRECC

**Director:** John A. Fairbank, PhD

**Focus:** Translational medicine center for assessment and treatment of post-deployment mental illness.

**Activity:** Post Deployment Mental Health Issues - monthly lectures presented by V-tel and audio

**Contact:** [mary.peoples1@va.gov](mailto:mary.peoples1@va.gov)

### VISN 22 COE for Stress and Mental Health

**Director:** James Lohr, MD

**Focus:** Understand prevent, and heal the effects of stress.

**Activity:** Lunch and Learn Series: Assessment and Treatment of PTSD, January-May 2010; VISN-22, VA San Diego Healthcare System, and v-tel

**Contact:** [carie.rodgers@va.gov](mailto:carie.rodgers@va.gov)

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### Use of the electronic Structured Clinical Interview for Psychiatric Diagnosis: Implementation in VA Research and Clinical Settings (VISN 6 MIRECC)

The Structured Clinical Interview for Axis I Disorders (SCID) is a clinician-administered diagnostic interview. Its reliability and validity have been well documented, and it is considered a 'gold standard' for assessment. The SCID has traditionally been administered in a paper and pencil format. We have worked with its creators and private industry to develop a workable electronic SCID (eSCID). Potential benefits of the eSCID include:

- Shorter interviewer training period as decision branching for diagnosis is semi-automatic
- Data entry is completed simultaneously during the participant interview resulting in an increase in cost effectiveness and decreased errors
- Item level data for symptoms is available for in depth analyses
- Implementation across study and clinical sites is enhanced through electronic availability.

The prototype has been implemented and a validation study is in progress. A VA use agreement via Central Office is underway. For more information: [kgreen@biac.duke.edu](mailto:kgreen@biac.duke.edu)



### MIRECC / MH COE Poster Presentations

- Appelt CJ, Rao S, Luther J, Haas GL** *Correlates of Awareness of Medical Conditions Among Veterans with Severe Mental Illness*  
**Beaudreau SA, Skultety K, Rideaux T, Kaci Fairchild J, Arian PA** *Problem Solving Therapy for Late Life Generalized Anxiety*  
**Bryan BC, Butler DL, Taber KH, et al** *Cognitive Rehabilitation of Mild TBI: Design and Outcomes of a Group-Based Model for Intervention*  
**Heyneman N** *Mindfulness-Based Cognitive Therapy for Posttraumatic Nightmares and Disturbed Sleep in Combat Veterans*  
**Kasckow J** *Treatment of Subsyndromal Depressive Symptoms in Middle-Age and Older Adults with Schizophrenia with Citalopram*  
**Kuhn E, Drescher K, Ruzek J, Rosen C** *Aggressive and Unsafe Driving in Male Veterans Receiving VA Residential PTSD Treatment*  
**Matukaitis Broyles L, et al** *Buprenorphine and Methadone Opioid Agonist Therapy: Differences in Patient Enrollment Characteristics*  
**Mavandadi S, et al** *The Quality of Social Interactions Among Veterans Screening Positive for Behavioral Health Conditions in Primary Care*  
**Morissette SB, et al** *Project SERVE : Research Aims and Clinical Mission in Support of the Uniform Mental Health Services Handbook*  
**Niv N, Lui A, Glynn S** *Assessing Motivation to Work Among Psychiatric Patients: Scale Development*  
**Raskind MA, Taylor F, Peskind ER** *Prazosin Effects on Objective Sleep Measures and Clinical Symptoms in Civilian Trauma PTSD*  
**Straits-Troster K, Kudler H, Marinkovich J** *Reaching OEF/OIF Veterans in Rural and Community Settings*  
**Strauss J, Weitlauf JC, et al** *Prevalence and Correlates of Trading Sex for Payment Among Male Veterans With Severe Mental Illness*  
**Suh JJ** *Poor Fronto-Limbic Connectivity: A Brain Endophenotype for Rapid Relapse to Cocaine?*  
**Wray LO, Tsukuda RA, Beaudreau SA** *Take My Poster-Please!: Tips on Getting Your Poster Accepted & Presenting at the MH Meeting*

