



Promoting equity in engagement, access, and quality of mental health care for Veterans facing barriers to care, especially rural Veterans

October 2013 Vol 15, Issue 10

www.mirecc.va.gov/visn16

Communiqué

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RESEARCH TO PRACTICE

Taking Issue with FDA's Warning on Citalopram

Summary by Kathy L. Henderson, M.D.

An article by Karin Zivin, et al., in the June 2013 *American Journal of Psychiatry* raises more questions than it answers about whether citalopram (marketed as Celexa) is safe to use at higher dosages. The FDA issued a drug safety warning in August 2011 informing health care providers that citalopram should no longer be prescribed at dosages above 40 mg/day because of potential cardiac arrhythmias (e.g. QT prolongation, torsade de pointes). This warning was subsequently revised in March 2012 recommending that dosages > 20 mg/day not be used in adults older than 60 years of age.



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Striking Methodologic Gold: MIDAS's Methods Consultations Are a Valued Resource for SC MIRECC Affiliates – New and Experienced

By Ellen Fischer, Ph.D., MIDAS Director

In 2008, the South Central MIRECC created MIDAS (MIRECC Implementation, Design and Analysis Support), a team of methodological consultants, to provide short-term methodological support – at no cost – to VISN 16 affiliates. The MIDAS team includes biostatisticians, epidemiologists, measurement specialists, qualitative methods experts, data analysts and programmers, and primary and secondary data collection experts, among other methodological experts.

MIDAS is probably best known for working with pilot awardees and new investigators who are developing proposals for external grant support. It does that and much more – working with senior investigators as well as on organizational projects consistent with SC MIRECC's mission.

MIDAS's recent work with a VISN 16 Be a Hero, Save a Hero Suicide Elimination Initiative workgroup is a good example of the latter. The

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RESEARCH (continued from page 1)

This current study sought to evaluate if there are dose-dependent negative health outcomes associated with citalopram. They used data from the VHA National Registry for Depression and the National Death Index from 2004 through 2009, and identified 618,450 Veterans who received a prescription for citalopram. A cohort of 365,898 Veterans prescribed sertraline was identified for comparison (sertraline has no FDA warning).

Study highlights for clinicians:

- Citalopram daily doses > 40 mg were associated with LOWER risks of ventricular arrhythmia, all-cause mortality, AND non-cardiac mortality compared with daily doses of 1-20 mg. No elevation in risks of cardiac death was found.
- Citalopram daily doses of 21-40 mg were also associated with LOWER risk of ventricular arrhythmia compared with doses of 1-20 mg, but no significant difference in risk of any cause of mortality.
- The sertraline analyses were very similar (lower risk of ventricular arrhythmia with doses > 100 mg/day).
- Outcomes for Veterans prescribed citalopram with non-VHA utilization were the same.

When these warnings were published, the VISN 16 Mental Health Product Line worked closely with the Regional Data Warehouse and Network and facility pharmacy services to identify patients on higher dosages and > 60 years old so that these recommendations could be

implemented quickly. VISN data from June 2012 to June 2013 show that the number of Veterans prescribed > 40 mg/day of citalopram has decreased by 51% and Veterans on > 20 mg/day of citalopram and age > 60 years has decreased by 27%.

Although all medications have some risks, have patient outcomes (e.g. increased depression, suicidal events) been negatively impacted by this recommended dosage change? Hopefully, someone will address that question. In the meantime, we have been asked to follow the National Pharmacy Benefit Management (PBM) bulletin recommendations, recognizing that some patients may require higher doses (off label). This article gives us a little reassurance that Veterans may not be at as high a risk of cardiac sequelae as first thought.

The PBM bulletin can be viewed at <http://www.pbm.va.gov/vacenterformedicationsafety/nationalpbmbulletin/CitalopramandDoseDependentQTIntervalProlongationUP-DATENATIONALPBMBULLETIN041712FINAL.pdf>. The article may be viewed at www.ncbi.nlm.nih.gov/pubmed/23640689.

Citations

VHA Pharmacy Benefits Management Services, Medical Advisory Panel, & Center for Medication Safety (2012). Citalopram hydrobromide (Celexa) and dose-dependent QT interval prolongation. Department of Veterans Affairs: Washington, DC.

Zivin, K., Pfeiffer, P. N., Bohnert, A. S., Ganoczy, D., Blow, F. C., Nallamothu, B. K., & Kales, H. C. (2013). Evaluation of the FDA warning against prescribing citalopram at doses exceeding 40 mg. *American Journal of Psychiatry*, 170(6), 642-650.

ATTRIBUTION: ACKNOWLEDGEMENT OF MIRECC RESEARCH SUPPORT/EMPLOYMENT

SC MIRECC researchers and educators have a responsibility to ensure that the SC MIRECC receives proper credit for SC MIRECC-supported studies or projects in articles, presentations, interviews, and other professional activities in which the results of those projects are publicized or recognized. All investigators should credit the SC MIRECC if they receive either direct or indirect support from the SC MIRECC. For example, "This work was supported in part by the VA South Central (VISN 16) Mental Illness Research, Education, and Clinical Center." If you receive salary support from the SC MIRECC, you should list the SC MIRECC as an affiliation.

SC MIRECC Welcomes New and Returning Fellows

Kathleen Grubbs, Ph.D. is a second-year fellow in Little Rock. She received her Ph.D. in Clinical Psychology from the University of Hawaii, Manoa in August 2011 and completed her clinical internship and postdoctoral fellowship training at the Michael E. DeBakey VAMC in Houston. Dr. Grubbs' VA research interests have developed over the past 4 years. Dr. Grubbs worked with Dr. Leslie Morland on treatments delivered to Veterans living on remote pacific islands using telemedicine. During her internship and fellowship she gained experience adapting and delivering innovative treatments for panic disorder (brief intensive treatment, combined treatments) while working with Dr. Ellen Teng. These experiences as well as excellent mentoring have shaped her long-term research goals of developing and testing innovative strategies to implement evidence-based treatments for rural Veterans with PTSD.

Joe Mignogna, Ph.D. is a second-year fellow in Houston. He received his doctoral degree in Clinical Psychology from Oklahoma State University in 2010. He completed his predoctoral internship at the Michael E. DeBakey VAMC. Dr. Mignogna's primary research interest focuses on improving the efficiency and effectiveness of mental health services in primary care, particularly in enhancing the coordination and continuity of care in this setting.

Christopher Rodgman, M.D. is a first-year fellow from Tulane University Department of Psychiatry and Behavioral Sciences where he served as Chief Resident. Dr. Rodgman has previously been mentored by Dr. Daniel K. Winstead and comes to us to work under Dr. Thomas Newton. Drs. Rodgman and Newton's research interests involve the study of potential pharmacological treatments for addiction and PTSD. Currently Dr. Rodgman's main focus is a human laboratory study involving the use of doxazosin XL in the treatment of PTSD in Veterans exposed to virtual reality sessions.

Terri Barrera, Ph.D. is a first-year fellow in Houston. She received her Ph.D. in Clinical Psychology from the University of Houston and completed her clinical internship at Baylor College of Medicine with an emphasis in geropsychology. Dr. Barrera has a strong background in the delivery of evidence-based treatments for anxiety disorders. She has been involved in several clinical trials of innovative delivery methods of cognitive behavioral therapy (CBT) for anxiety disorders, including

transdiagnostic group CBT, and modular CBT for late-life anxiety with attention to religion/spirituality. Her primary research interests are focused on increasing engagement in psychotherapy for anxiety by addressing the spiritual needs of Veterans. Currently, Dr. Barrera is working with her mentor, Dr. Stanley, to develop an integrated mental health and spiritual intervention for Veterans with anxiety.

Shannon Miles, Ph.D. is a first-year fellow in Houston. She received her Ph.D. in Clinical Psychology from the University of Tulsa in 2013. Dr. Miles completed her predoctoral internship at the Michael E. DeBakey VAMC. Dr. Miles' previous research focused on personality and emotion systems, and her goal is to apply that knowledge to improve treatment outcomes for Veterans with PTSD. Her long-term research goals include developing and providing brief emotion-focused treatments to Veterans prior to the Veterans' participating in more traditional PTSD treatments. Brief emotion-focused treatments can reduce Veterans' general negative affect and stress and prepare them for trauma specific treatments. ♦

Congratulations to Drs. Juliette Mott and Natalie Hundt for completing the Houston MIRECC fellowship program. They have joined the MIRECC as junior faculty. We also congratulate Drs. Thomas Waltz and Claudia Drossel for completing their on-site fellowship experience in Little Rock.

MIDAS (continued from page 1)

workgroup, comprised of Su Bailey, Ph.D. (Houston), Barbara Masters, M.D. (Oklahoma City) and John Baye, D.Min. (New Orleans), was responsible for surveying VISN 16 mental health and primary care providers about their experiences with VA's procedures following a patient suicide. Provider Post-Suicide Survey results will guide development and implementation of a plan that will promote employee well-being and psychological safety.

Over a 5-month period, MIDAS and Workgroup members collaborated to take the workgroup's charge from idea to completed survey. As part of the collaboration:

- MIDAS qualitative methods expert, Karen Drummond, Ph.D., advised on development of an interview guide and analysis of interview data to assure the final survey would cover all major domains of the providers' post-suicide experience
- MIDAS psychometric and survey methods experts, Adam Kelly, Ph.D. and Ellen Fischer, Ph.D., advised on the content and format for survey questions and responses
- MIDAS electronic survey "guru," Adam Kelly, Ph.D., translated the questionnaire into Survey Monkey format and managed the survey while it was open
- MIDAS biostatistical and qualitative methods experts, Nancy Petersen, Ph.D. and Karen Drummond, Ph.D., analyzed the quantitative and qualitative data received from over 700 survey respondents

When asked how MIDAS services might be improved, a workgroup member responded: "Honestly, I can't think of a thing - it was TERRIFIC!"

The Provider Post-Suicide Project was unusual in its complexity, in the breadth of expertise involved, and in the intensity of activities required by the short timeframe. Modesty aside, however, workgroup feedback was pretty typical.

Senior investigators who have used MIDAS services on other projects have been similarly laudatory, as the next two examples demonstrate:

- Little Rock-based Jeff Pyne, M.D., received psychometric consultation from Adam Kelly in development of the proposal for a CREATE sub-project, "Development and Validation of a Perceived Access Instrument." When asked whether he would use MIDAS's services again, Dr. Pyne replied, "Absolutely! I think with Dr. Kelly's help, this HSR&D IIR will be funded." Dr. Pyne was correct; the project was subsequently funded.
- Oklahoma City-based Michelle Sherman, Ph.D., received consultation from MIDAS Director, Ellen Fischer, on development of survey instruments for a MIRECC clinical education grant application, "Ensuring VA Care is Caring for All Veterans: Exploring Lesbian/Gay/Bisexual (LG) Veterans' Experiences at the VA and VA Providers' Practices and Attitudes about LGB Issues." Asked to evaluate MIDAS's services, Dr. Sherman said, "I found Dr. Fischer's help to be invaluable. She provided detailed feedback even sending me a book chapter that provided even more guidance" and "Continue to get the word out about MIDAS's services! It's awesome!"

["...it was *TERRIFIC!*"]

As illustrated in the comments below, relatively new investigators have benefitted from the experience of working in close collaboration with MIDAS methodologists to design, conduct and analyze data from methodologically rigorous research projects:

- Then post-doctoral fellow, Teri Davis, Ph.D., worked with Teresa Hudson, PharmD, on Dr. Davis's project "Racial differences in frequency and type of VA mental health service use among returning women veterans suffering from depression." Evaluating her experience, Dr. Davis noted, "As an aspiring independent investigator, I often need assistance with the methodological issues of my research projects. I found the MIDAS service to be very accommodating in that it encouraged me to think more critically about these issues while designing studies and writing papers."

How does MIDAS work and how can an investigator get in touch with MIDAS?

MIDAS services range from brief consultation to hands-on assistance and span the research process. For

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example, during the initial proposal-development phase, MIDAS consultants are available to assist with such things as pre-proposal review, quantitative and qualitative study design, sampling design, and budget preparation. During the planning, implementation and data collection phases, MIDAS consultants can assist with instrument design and piloting, secondary data abstraction processes, quantitative and qualitative data collection methodologies, interviewer

“Continue to get the word out about MIDAS’s services! It’s awesome!”

training, subject recruitment, and project management. In the later phases of a project, MIDAS consultants can assist with database construction, biostatistical and qualitative data analysis, manuscript preparation, and other dissemination activities.

Wherever you are in your research, however experienced or new you are to research, no matter where you are based in VISN 16, MIDAS has the methodological expertise you need for your projects. For more information or to request assistance from MIDAS consultants, contact Ellen Fischer, Ph.D., at FischerEllenP@uams.edu. You can also read more about MIDAS by visiting <http://www.mirecc.va.gov/VISN16/research.asp>. ♦

New SC MIRECC Clinical Education Product: Problem Gambling: Assessing for and Making Plans for Reduction

Developed by Joseph Vanderveen, Ph.D. and Daniel Williams, Ph.D.

Problematic gambling, or gambling disorder, as it is now classified in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), is an often unreported and undiagnosed problem among Veterans. Research has shown that VA healthcare professionals feel “inadequately trained to identify, evaluate or provide care for or to refer their large number of mental health clients with co-morbid gambling” (Drebing et al., 2001, pg. 131). This can be viewed as a crucial piece of missing information when considering that problem gamblers often present with higher co-occurrence rates of substance use disorders (Petry et al., 2005), homelessness (Edens et al., 2012), and Axis I psychopathology (Cunningham-Williams et al., 1998). These patients also are more likely to have emergency room visits and inpatient hospitalizations (Morasco et al., 2006). As such, the development of a quick and accessible tool, like a brochure, is much needed in order to facilitate a greater understanding of this issue. This is especially the case when considering that a large proportion of Veterans may not have access to available group or individual gambling treatments within their VAMCs or CBOCs.

Using the simple framework of a brochure and utilizing findings from previous research, the goal of this educational product is to make information available regarding the description of gambling problems, how to briefly assess for gambling problems, and what steps can be



Pictured: Screenshot of the Problem Gambling brochure.

taken to curtail the further development and continuation of gambling problems. The brochure utilizes information from the Shortened South Oaks Gambling Screen as well as the DSM-5. This highly accessible and easily transportable information will not only allow providers to conduct quick, on-site assessments within any type of Veteran-utilized clinic, it will also help educate providers and Veterans alike about whether a gambling problem may exist. At the very least, this brochure will allow for an increase in communication regarding a Veteran’s gambling

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habits, while also providing an element of empirically supported brief treatment. Given the previous findings and conclusions from the literature (Petry et al., 2008; Slutske, 2006), any decrease in these types of behaviors can be viewed as the makings of success.

This product was designed for both VA mental healthcare providers (particularly providers working with addiction prone populations) and Veterans of all ages and backgrounds. The goal of the brochure is not to provide any formal diagnosis but to educate both the patient and provider about what problematic gambling is and how it is classified. This brochure may also serve as an enhancer of motivation to make changes or provide referral resources if the problem is severe. The brochure lists websites and phone numbers to which the Veteran can be directed. For the more tech savvy Veteran, this brochure also includes a QR code that can be scanned using most smartphones. Scanning this code on a smartphone will display the National Council on Problem Gambling website, which offers state-by-state gambling affiliates and other helpful information.

The developers would like to thank the MIRECC for the funding that allowed this product to be developed. They would also like to acknowledge Drs. Randy Burke and Jeff Parker for their contributions to the development of this product. Finally, they would like to thank the Meridian Mississippi VA Community Based Outpatient Clinic for

allowing them to pilot this brochure with their staff and patients. To view the brochure, visit http://www.mirecc.va.gov/VISN16/docs/Problem_Gambling_Brochure.pdf

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CBOC Mental Health Rounds

Sponsored by the South Central MIRECC

VA Mental health providers are invited to attend the next CBOC Mental Health Rounds session titled "Neuropsychiatric Effects of Medications: More Common Than We Think" on Wednesday, October 9 at 8:00-9:00 a.m. CT or Thursday, October 10 at 11:00-12:00 p.m. CT. This Microsoft Lync session will be presented by Marie DeWitt, M.D. and Lisa Miller, PharmD. At the conclusion of this educational program, learners will be able to:

1. Assess the relationship between the administration of a drug and the adverse reaction attributed to it;
2. List (or identify) the most commonly used medications implicated in producing neuropsychiatric effects; and
3. Describe strategies for managing and minimizing neuropsychiatric adverse effects once they occur.

Call 1-800-767-1750 and use access code 26461# to participate. Email Ashley.McDaniel@va.gov or call (501) 257-1223 for registration and continuing education credit information.

RECOVERY CORNER

The Use of Peers in Self-Management of Medical and Mental Health Conditions

By Angela Chelette, L.C.S.W.,
Local Recovery Coordinator, Alexandria VA Health Care System

Persons with serious mental illnesses have been found to have elevated rates of comorbid chronic medical conditions. Research has shown that these individuals benefit from interventions designed to support illness self-management. The role of peers in implementing these interventions is emerging.

One of the well-known programs of chronic disease self-management is the Chronic Disease Self-Management Program (CDSMP). It was developed out of research completed at Stanford University in 1996. Subjects who participated in the initial study demonstrated significant improvements in exercise, cognitive symptom management, communication with physicians and self-reported general health. They also spent fewer days in the hospital and there was a trend toward fewer outpatient visits and hospitalizations.

CDSMP consists of workshops facilitated by two trained leaders, one or both of whom are non-health professionals who have chronic diseases themselves. Modifications of the CDSMP for persons with serious mental illness have been created and studied with positive results. In 2010, research on the Health and Recovery Peer Program, a manualized, six-session intervention delivered by mental health peer leaders, showed that after a six month follow-up, participants demonstrated significantly greater improvement in patient activation than those in usual care as well as reported increases in physical health related quality of life, physical activity, medication adherence, and though not statistically significant, had similar effect sizes as those seen for the CDSMP in general medical populations.

Living Well is another modified version of the CDSMP researched through the VISN 5 MIRECC. Participants received the 13-session, peer-facilitated *Living Well* intervention or usual care. Participants evaluated at baseline, at the end of the intervention, and at a two-month follow-up showed significant post-intervention improvements across a range of attitudinal, behavioral, and functional outcomes. Continued advantage was found in other areas, such as health-related locus of control and

reports of healthy eating and physical activity. Receipt of *Living Well* was associated with a notable decrease in use of the emergency room for medical care, although the between-group difference was not statistically significant.

A program involving peers in chronic disease self-management that is on its way to becoming an evidence-based practice is Peer Support Whole Health. Peer Support Whole Health and Resiliency (PSWHR) training was originally developed by Appalachian Consulting Group and the Georgia Mental Health Consumer Network as part of a Substance Abuse and Mental Health Services Administration-funded National Association of State Mental Health Program Directors Technology Transfer Initiative grant awarded to Georgia's Department of Behavioral Health and Developmental Disabilities. The PSWHR training is built on three beliefs.

1. People cannot be forced or coerced to change their unhealthy life-style habits or learn new skills; therefore participation in the PSWHR training needs to be on a voluntary basis and participants acknowledge that they have health and resiliency issues that they are thinking about dealing with.
2. People are more likely to create a healthier, more resilient life-style when you focus on their interests, strengths, supports and what they see as possible; therefore the PSWHR training helps people focus on what they want to create in their lives, not on what they may need to change.
3. People find it easier to create new habits than to change or stop old habits; therefore the PSWHR training focuses on creating new behaviors and skills on a weekly basis, monitoring how well they are doing and accepting support from their peers.

The PSWHR training is also built on a Person-Centered Planning (PCP) process that focuses on ten health life-style domains and five keys to success. The ten domains are:

1. Healthy Eating
2. Physical Activity

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3. Restful Sleep
4. Stress Management
5. Service to Others
6. Support Network
7. Optimism Based on Positive Expectations
8. Cognitive Skills to Avoid Negative Thinking
9. Meaning and Purpose
10. Spirituality

The five keys to success are:

1. A person-centered goal that uses the IMPACT (Improve, Measureable, Positively-Stated, Achievable, Call Forth Actions, Time limited) process to be written into a treatment plan
2. A weekly action plan that uses a confidence scale
3. A daily/weekly personal log
4. Peer accountability and support
5. Weekly Peer Support Whole Health Group

Another essential component of PSWH is the use of simple “Relaxation Response” exercises to counter the stress response. This is taken from the work of Dr. Herbert Benson, founder of the Benson – Henry Institute.

Peer Specialists attend a two-day training on the skills needed to help another peer set and keep a whole health/ resiliency goal from one or more of the ten domains. The program limits participant group size to 8 -10 people who meet weekly in a support group and in individual meetings with the peer specialist for up to twelve weeks. The first 2

-3 weeks include instruction on the domains and the five keys to success. The next eight weeks consist of weekly action plan accomplishments and action planning for the next week. The pilot study of this intervention showed promising results and peers are currently being trained across the country in delivering Peer Support Whole Health.

Evidence from the programs mentioned here highlights the possibilities for persons with shared conditions offering peer support through a range of existing or developing interventions including structured group sessions, individual coaching or potentially phone interventions. Adding mental health peers to self –management efforts aimed at reducing the morbidity and mortality of persons with serious mental illness may offer opportunities that do not exist elsewhere.

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Peer Support Whole Health: <http://www.gmhcn.org/ACG/>. ♦

