Research to Practice: Driving and Dementia: Clinical Update for Mental Health Professionals

Summary by Sonora Hudson, MA

A recent article by Charlotte L. Allan, Sophie Behrman, Nina Baruch and Klaus P. Ebmeier in Evidence-Based Mental Health summarizes current evidence and guidelines for use by mental health professionals in addressing individuals who drive and have dementia. Although the authors are based in the United Kingdom, much of the information, See RESEARCH on page 2

Q&A with a SC MIRECC Affiliate

Interview with Amanda Raines, PhD, New Orleans Anchor Site

Tell us a bit about your educational and career background.

My interest in human behavior and mental processes began at Florida State University (FSU) as an undergraduate student when I selected Psychology as my major. After graduation, I received a full-time research assistant position with the Anxiety and Behavioral Health Clinic at FSU working under the supervision of Dr. Brad Schmidt. This opportunity
RESEARCH (continued from page 1)

especially regarding use of cognitive tests and driving assessments, is useful for mental health professionals in the United States.

While some in the early stages of dementia can continue to drive safely, those with moderate-severe dementia are unlikely to be able to continue. Factors that put an individual with dementia at risk include a caregiver’s report of unsafe driving, a history of offenses and crashes, driving less than 60 miles per week and avoidance of challenging situations. The type of dementia suggests specific risks (for example, frontotemporal dementia is associated with lack of critical insight and Lewy body dementia is associated with fluctuating consciousness and visual hallucinations). However, further research is needed.

On-road driving tests are more reliable than clinician assessment, but a combination of on-road tests plus clinical and neuropsychological (e.g., trail making, visual construction and maze tasks) assessment is most effective. Although screening tools such as the Mini-Mental State Examination and Montreal Cognitive Examination do not correlate well with driving ability, they are useful in determining whether a clinician should consider recommending a driving evaluation. An individual with a score of 24 or less on the former would be a good candidate for a driving evaluation; and a score of 18 or less on the latter should suggest increased likelihood of significantly increased driving risk. The authors suggest relying on a broad range of risk factors, including type of dementia, cognitive status, age and severity of comorbidity, as independent risk factors associated with fitness to drive in individuals with dementia.

Common factors influencing the decision to stop driving include cognitive changes that impair driving ability, such as reduced concentration, slowed reaction times and problems finding directions. Noncognitive changes such as frailty, visual impairment, daytime sleepiness, mobility and head-turning ability may also influence the individual to quit. However, for many people the cognitive, physical and emotional factors have to be weighed against the benefits of driving in terms of convenience, independence and self-
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esteem. In the absence of immediate safety concerns, the authors recommend helping individuals to reflect on the benefits and risks of driving, enabling them to make their own decisions when possible.

On the negative side, driving cessation tends to increase depressive symptoms and is associated with a decline in overall physical health, increased risk of entry to long-term care facilities and increased 3-year mortality.

When an individual with dementia is determined to be fit to drive, annual review of risks associated with driving is suggested. In addition, for people who decide to stop driving or who have to stop, discussion about practical alternatives and the impact of driving cessation on them and their family is important.

Visit http://ebmh.bmj.com/content/19/4/110.full to access this article.


PACERS Dementia Training Courses Now Available in VHA TRAIN for Community Providers

The Program for Advancing Cognitive disorders Education for Rural Staff (PACERS) has released its "Dementia and Delirium" and "Dementia and Driving" e-learning modules on the VHA TRAIN platform for community providers. The dementia and delirium module describes two of the most common neurocognitive disorders that occur among elderly Veterans. The driving module presents practical information that can be used to address diminished driving skills and decision-making.

Each module is accredited for one free hour of continuing education for physicians, nurses, psychologists, social workers and counselors. VA providers can access the modules in VA TMS (TMS IDs 28776 and 29817).

VHA TRAIN (http://vha.train.org/) is a part of TRAIN National, a free service of the Public Health Foundation that provides a comprehensive catalog of public health learning products. VHA TRAIN is supported by the VHA Employee Education System (EES). TRAIN learning programs developed by EES support the professional development needs of public health and health care providers, with a focus on Veteran patient care.

First-time TRAIN users will need to create an account to access the modules. Visit http://coscorm.train.org/Page%202/how_to_create_a_user_account.html to watch a short video on how to create an account. Opt-in to TRAIN emails to receive important messages and updates. Use the keyword "PACERS" or ID numbers 1068283 and 1068629 to access the trainings. Contact the help desk at VHATRAIN@va.gov for assistance.
allowed me to further my research experiences by orchestrating the day-to-day operations on a large-scale multi-site National Institute of Mental Health grant. This treatment trial focused on anxiety risk factors relevant to the development of adverse mental and medical health outcomes. In my doctoral program, I continued to work with Dr. Schmidt exploring the relationships between various anxiety relevant risk factors and anxiety and mood pathology. Further, I assisted with the development of two brief computerized interventions for use with military populations. Both of these interventions targeted well-known malleable risk factors that have been shown to be relevant to the development of anxiety and suicide.

Q. **What do you like about doing research with Veterans?**
Veterans are always so open to participating in research. They understand that their involvement helps lead to medical discoveries and improved care for current and future service members.

Q. **How will you use your SC MIRECC affiliation to grow your research career?**
My career goal is to become an independent, funded clinical scientist within the Department of Veterans Affairs. Within this capacity, I want to continue my program of research focused on identifying and evaluating novel treatment protocols. My affiliation with the SC MIRECC has enhanced my ability to achieve this goal in a number of ways. First, my involvement with the SC MIRECC has already allowed me to network and partner with other established VA researchers. I hope that this type of interdisciplinary collaboration will lead to innovative, groundbreaking discoveries and improved mental health outcomes for Veterans and civilians, alike. Second, the SC MIRECC provides a variety of informal and formal training opportunities. This education helps me to stay current with the latest developments, skills, and technologies required to grow as a clinical scientist. Third, the SC MIRECC provides funds necessary to carry out the work that researchers do in its catchment area. As a scientist, my job is completely dependent upon this type of grant funding. With all the efforts to cut federal budgets, it’s nice to have an organization that invests in scientific research and development particularly for our Veterans.

Q. **What would your dream research study be if funding weren’t an issue?**
I would love to follow a large cohort of Veterans over time while collecting various data points.
levels of information ranging from basic self-report to genetic/biological data. This type of information would help uncover a great deal of information about the mental health disease process, which could ultimately lead to better prevention and intervention efforts for Veterans.

Q. Is there anything that I haven’t asked that you would like our readers to know about you or your work and how can people get in touch with you if they have questions?

Much of what we benefit from as a society stems from basic research just like mine. Consider volunteering as a research participant. Through your involvement, you can help yourself and future generations! People can feel free to email me at Amanda.Raines@va.gov if they have any questions about my work.

Announcement

SC MIRECC Pilot Study Research Program Application Deadline April 3

VISN 16 or 17 researchers interested in pilot funding for research that can be used to develop clinical policy or programs that improve access, quality and outcomes of mental health and substance abuse treatment services for rural and underserved Veterans are invited to submit an application to the SC MIRECC Pilot Study Research Program. This program is intended to increase both the quantity and quality of federally funded research that will help better understand the experiences of rural/underserved Veterans and to support the development and dissemination of evidence-based practices that can make a real difference in their lives.

Visit http://www.mirecc.va.gov/VISN16/research.asp to review examples of funded research projects and download the request for applications (RFA) to apply. The next deadline to submit a RFA is April 3, 2017. Important details to note:

- The maximum duration of projects is 1 year, although it is possible to request a waiver to submit a proposal for a longer period.

- The maximum budget request is $55,000; again, it is possible to request a waiver to submit a proposal with a larger budget.

- The maximum length of the proposal narrative is 5 pages to give applicants more room to provide methodologic detail.

- Fellows who are applying must include a plan describing how the project will be completed if the fellowship ends before project-completion and must identify a doctoral-level faculty co-investigator who will assume responsibility for completing the project, if necessary. An additional 1/2 page may be added to the usual maximum of 5 pages to allow Fellows to describe the plan.

- Medical students, interns and residents are not eligible to apply for pilot awards unless they request and receive a waiver prior to submission.
Providers’ Personal and Professional Contact With Persons With Mental Illness: Relationship to Clinical Expectations

Mittal, D, Ounpraseuth, ST, Reaves, C, Chekuri, L, Han, X, Corrigan, P, & Sullivan, G
Psychiatric Services, 2016, 67(1), 55-61

Problem Addressed by Study
Studies have indicated that providers share many stigmatizing attitudes towards persons with serious mental illness, such as schizophrenia, with the general public. Recent evidence suggests that providers' stigmatizing attitudes may have a negative influence on clinical care in that providers with more stigmatizing attitudes are less likely to refer individuals with serious mental illness for specialty care and expect that these individuals are less likely to refill their prescriptions. Such attitudes may also discourage recovery, vocational advancement or help seeking.

Among the general public, interventions involving direct contact with a person with serious mental illness have been shown to be effective in reducing stigmatizing attitudes. No previous studies have investigated whether contact with persons with mental illness influences health care provider attitudes. In this study, we examined the relationships between provider contact (personal or professional) with persons with mental illness and provider stigmatizing attitudes and clinical expectations toward persons with mental illness. We hypothesized that provider contact (both professional and personal) with persons with mental illness would be associated with clinical expectations and that this relationship would be mediated by provider stigmatizing attitudes.

Results of the Study
We found that providers with greater professional contact with patients with mental illness in their clinical practice and greater personal contact with individuals with mental illness exhibited significantly lower stigmatizing attitudes toward the patient with schizophrenia in the vignette and were more likely to expect the vignette patient with serious mental illness to have better treatment adherence, a better understanding of educational material, and higher social and vocational functioning.

Implications and Impact of the Study
Greater personal and professional contact with persons with mental illness was associated with lower provider stigma and higher expectations of patient adherence, increased ability to understand educational material, and higher social and vocational functioning. It is possible that interventions involving contact with persons with mental illness, especially those who have achieved substantial degree of recovery, could reduce providers’ stigma.

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Understanding Barriers to Mental Health Care for Recent War Veterans Through Photovoice.

True, G, Rigg, KK, & Butler, A

Qualitative Health Research, 2015, 25(10), 1443-1455

Problem Addressed by Study
Many Veterans returning from deployments to Iraq and Afghanistan do not access needed mental health care or drop out prior to completing an adequate course of treatment. Improving access to and engagement in mental health services requires understanding and addressing barriers to care and, in particular, the role of the Veterans’ negative perceptions of mental health care. We used a community-based participatory research approach called Photovoice to engage OEF/OIF Veterans in identifying barriers to accessing mental health services and generating patient-centered suggestions for improving engagement in post-deployment mental health care. Photovoice empowers individuals to convey their experiences, perspectives, and needs through visual images and first person narratives.

Results of the Study
Veterans described how aspects of military identity and experiences during deployment can deter help-seeking behavior and hinder recovery. Veterans’ photo-narratives highlighted how mental health symptoms and self-coping strategies operate as barriers to care. Many Veterans revealed how negative health care encounters can be re-traumatizing, contributing to avoidance and abandonment of treatment.

Implications and Impact of the Study
Visual methods—such as Photovoice—are a powerful tool for engaging recent war Veterans in research. In particular, community-based participatory research approaches, which have rarely been used with Veterans, hold great promise for informing effective interventions to improve access and enhance provision of patient-centered care for Veterans.

Attribution: Acknowledgement of SC MIRECC Research Support/ Employment
SC MIRECC researchers and educators have a responsibility to ensure 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 SC MIRECC if they receive either direct or indirect SC MIRECC support.

For example, "This work was supported in part by the VA South Central Mental Illness Research, Education and Clinical Center." If you receive salary support from SC MIRECC, you should list SC MIRECC as an affiliation.
CBOC Mental Health Rounds

In the Moment: Using Mindfulness-Based Intervention in Clinical Practice

VA mental health providers are invited to attend the next CBOC Mental Health Rounds session titled "In the Moment: Using Mindfulness-Based Intervention in Clinical Practice," on Wednesday, February 8 or Thursday, February 9. This Microsoft Lync session will be presented by Dr. Xuan V. Nguyen. At the conclusion of this educational program, learners will be able to:

1. Define mindfulness
2. Describe the benefits of mindfulness-based interventions
3. Discuss opportunities to use mindfulness-based interventions in clinical practice

Date and Time: Wednesday, February 8 at 8:00-9:00 am CT or Thursday, February 9 at 11:00-12:00 pm CT

Registration: Free; CLICK HERE TO REGISTER NOW

Deadline: Registration closes on February 7, 2017

Audio: Call 1-800-767-1750 and use access code 37009#

Visual: Join Microsoft Lync through VA TMS

Obtain CEU: You have up to 30 days after the training to complete the program evaluation in TMS. After you complete the evaluation, obtain your certificate from the "completed work" section. Hover your mouse over the title of the program and select "view details" and then select the appropriate accreditation certificate for your discipline.

Contact: Ashley.McDaniel@va.gov

Learn more about SC MIRECC by visiting http://www.mirecc.va.gov/visn16/index.asp