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1 VA/DoD Clinical Practice Guideline Summary: Management of Major Depressive Disorder

Summary by Sonora Hudson, MA

As its title indicates, this clinical practice guideline (CPG) is designed for use by providers treating active military personnel and Veterans with major depressive disorder (MDD). It does not cover any other depressive disorders. The documented prevalence of MDD in Veterans treated at VHA was 6.5% in 2015, compared with the overall documented prevalence of any depression at 19.8% (CPG, p. 3).

See GUIDELINE on page 2

Q&A with a VISN 16 Clinical Provider: Birgit Smart, PhD

Interview by Dr. Jennifer Bryan

This month we are starting a new series of interviews with community providers and stakeholders in VISNs 16 and 17. Our first interview is with Dr. Birgit Smart of the Alexandria VA Medical Center in Louisiana.

Q. What is your career background and how long have you served at VA?

I have a PhD in counseling psychology, and two master’s degrees in industrial/organizational psychology.

See Q&A on page 4
GUIDELINE (continued from page 1)

The guideline is formatted as one algorithm with 33 evidence-based recommendations. It is available in several formats: 173-page full text; a 28-page clinical summary; a 13-page “pocket card” displaying the algorithm and assorted measures and helpful information; and a five-page patient guide. All this information can be accessed at http://www.healthquality.va.gov/guidelines/MH/mdd/.

The recommendations are displayed in tables organized into sections for identification, assessment and triage, treatment setting and management, and other treatment considerations. Recommendation categories in this CPG (2016) were adapted from those used by the National Institute for Health and Care Excellence (NICE, UK). For those wanting a quick update on changes from the last CPG, a glance at the last column in the recommendations table in the clinician summary provides information as to what has been changed, added and updated.

Among recommendations with strong evidence that have been reviewed and either added or replaced are the following:

- Patients with complex MDD (severe, chronic or recurrent) should be offered specialty care by providers with mental health expertise.
- The collaborative-care model should be used for treating MDD within the primary care setting.
- First-line treatment for uncomplicated mild-to-moderate MDD should be either an evidence-based psychotherapy (EBP) (acceptance and commitment therapy, behavioral therapy/behavioral activation, cognitive-behavioral therapy, interpersonal therapy, mindfulness-based cognitive therapy or problem-solving therapy, or evidence-based pharmacotherapy (selective serotonin reuptake inhibitors [except fluvoxamine], serotonin-norepinephrine reuptake inhibitors, mirtazapine, or bupropion).
- Patients with only partial or no response to initial pharmacotherapy monotherapy (maximized) after 4 to 6 weeks should be switched to another monotherapy

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(either EBP or medication) or augmented with a second therapy.

- Patients who achieve remission with antidepressant medication should stay on a therapeutic dose for at least 6 months.

- Patients at high risk for recurrent episodes treated with pharmacotherapy should be continued on medication for at least 12 months/indefinitely.

- The first-line treatment for pregnant or breastfeeding women with mild-to-moderate MDD should be one of the recommended EBPs.

- The first-line treatment for adults over 65 years with mild-to-moderate MDD should be one of the recommended EBPs.

- The first-line treatment for patients with treatment-resistant MDD who have at least two adequate pharmacotherapy trials should be monoamine oxidase inhibitors or tricyclic antidepressants along with patient education about safety and side-effects.

Recommendations with strong evidence against that are new or replaced include the following:

- Ketamine should not be used to treat MDD outside a research setting.

- Vagus nerve stimulation and deep brain stimulation should not be used to treat MDD outside a research setting.

There is not room here to summarize additional changes, but a plethora of useful information is also included, such as measures and scoring tools, so at least a cursory read would benefit anyone not already familiar with this latest version.

Dr. Elizabeth Conti Discusses SC MIRECC-Funded Safety Planning Manual on Rocky Mountain MIRECC Podcast

In this podcast, Adam Hoffberg of the Rocky Mountain MIRECC talks with Dr. Elizabeth Conti, a clinical psychologist and postdoctoral research fellow with the VA HSR&D Center for Innovation in Houston, Texas. With funds from a SC MIRECC Clinical Educator Grant, Dr. Conti, along with four of her colleagues at the Michael E. DeBakey VAMC, published the “Collaborative Safety Planning for Older Adults” manual and wallet card (http://www.mirecc.va.gov/VISN16/new_and_featured_products.asp).

Dr. Conti gives a wonderful overview of safety planning and leads the audience through creating one. Clinicians will gain a deeper appreciation of the safety plan and be able to learn skills for their everyday practice. Visit http://go.usa.gov/x9MCG to listen to the podcast.
Q&A (continued from page 1)

(Louisiana Tech University) and psychology (Cameron University). I was a practicum student at the Alexandria VA Medical Center (VAMC) in 2007, and, after a clinical internship at another VA, I started working at the Alexandria VAMC in 2009.

Q. **What is your community like?**

The Alexandria VAMC is located in Pineville, Louisiana. Alexandria and Pineville are two medium-sized cities, almost built together but separated by the Red River. It is a very family-oriented area and most social contact is within one’s family or people they have grown up with. Church and faith play a major part in this culture and many “newcomers” will hear the question “have you found a church yet” at least once. The setting is mostly rural.

Q. **What do you enjoy about working with Veterans?**

Working with Veterans has been one of the most satisfying employment opportunities for me. I like serving these men and women because they gave so much, physically and emotionally, in order for all of us to enjoy our freedom. My main Veteran population at this time is in Home-Based Primary Care (HBPC). I enjoy seeing patients in their homes because I can observe their entire environment, such as housing and physical setting of the neighborhood. Visiting Veterans in their homes also provides me with the opportunity to meet some of their support system, caretakers, as well as their pets. While many of our homebound patients have at least a limited support system, many patients on my HBPC list have very few visitors, have never participated in psychological treatment during their earlier years, and use this for the first time to discuss long-buried psychological issues and to work on overall life improvements.

Q. **You recently finished a quality-improvement project with the Geriatric Scholars Program about your work with HBPC patients. What was this experience like and what did your team learn about your patient population?**

For this project, we developed a written protocol that all HBPC staff can use to screen potential HBPC patients over the phone. We developed interview questions for asking Veterans about their homebound status, health issues, and overall living and support situation to determine if they meet criteria for our program. We also provided education about our program so that potential patients could make an informed decision on using our services, which helps us reduce confusion of our services with other programs like home (continued on page 5)
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health or hospice.

Q. What was your experience with the Geriatric Scholars program?

I had very little knowledge about that program at that time and I am very excited that this opportunity was presented to me. The training in Palo Alto was simply amazing and a wonderful educational experience for my professional and personal growth.

Note: The Geriatrics Scholars Program is administered at the VA Greater Los Angeles Healthcare System GRECC and is directed by Dr. B. Josea Kramer. This longitudinal workforce development program is designed to integrate geriatrics into clinical practices of VHA primary care providers and associated health professions that support primary care teams. For more information about the program, providers can email Dr. Kramer at Josea.Kramer@va.gov or the program administrator, Luis Melendez at Luis.Melendez2@va.gov.

Recommendations for VISN 16 or 17 clinical providers who can be profiled in this series can be submitted to Jennifer.Bryan1@va.gov.

Announcement

Drs. Lilian Dindo and Natalie Hundt Speak at TexVet Symposium

SC MIRECC Houston Anchor Site investigators Drs. Lilian Dindo and Natalie Hundt presented at the TexVet symposium, "Research on the Road 2017," in February. TexVet supports scientific research applied for public benefit, especially in the field of Veterans' mental health. TexVet is an Initiative of the Texas A&M University Health Science Center and The Texas Department of Health and Human Services.

The TexVet annual "Research Meets The Road" symposium provides a platform for respected cutting-edge researchers and Veteran service providers to share knowledge to everyone's benefit. Dr. Dindo presented on the development of novel treatments to address the needs of Operation Enduring Freedom/Operation Iraqi Freedom Veterans. She described her current and potential VA treatment trials and hopes to reach Veterans and to get them into treatment by partnering with community organizations that serve them.

Dr. Hundt presented on engaging Veterans in PTSD care. She discussed her qualitative data on reasons Veterans do not initiate PTSD therapy and made recommendations to the community audience on things they can do to help. Visit http://www.texvet.org/rotr-2017-01 to learn more about the conference.
Recent SC MIRECC Publications

**Overcoming Barriers to Sustained Engagement in Mental Healthcare: Perspectives of Rural Veterans and Providers**


*Journal of Rural Health, 2016, 32(4), 429-438*

**Problem Addressed by Study**

Nearly 40% of Veterans enrolled in the VA healthcare system live in rural areas. Historically, Veterans living in rural areas have used fewer mental health services than those living in urban areas. VA is aggressively addressing structural barriers to access to healthcare (including mental healthcare) through CBOCs, telemedicine and the Choice Act. While this has reduced the rural/urban differences in utilization, it has not eliminated them. Several studies suggest that rural/urban differences in attitudes may lead to different patterns of help-seeking and service, yet there is little empirical evidence regarding the attitudes that influence initiation and sustained service use among rural residents in the United States in general or in the rural Veteran population specifically. This manuscript presents findings from the initial, qualitative, component of a mixed methods study designed to better understand the ways in which attitudinal characteristics influence treatment-seeking and sustained mental health service use among rural Veterans.

**Results of the Study**

In-depth, semi-structured interviews with 25 rural Veterans and 11 rural mental healthcare providers in 4 states identified 3 main attitudinal barriers to both initial help-seeking and sustained engagement in mental healthcare: (1) the importance given by Veterans to self-reliance, (2) their emphasis on stoicism, and (3) concerns about stigma. Also important in impeding initial treatment-seeking was a lack of trust in the VA system. Perceived need for care and the support of other Veterans were critical to overcoming attitudinal barriers to initial treatment-seeking. Critical facilitators of ongoing service use included "warm handoffs" from medical to mental healthcare providers, perceived respect and caring from providers, and provider accessibility and continuity.

**Implications and Impact of the Study**

The study presents strong evidence for the importance of attitudinal influences on patterns of mental health service use among rural Veterans. It also reinforces the importance of system support for programs and for provider behaviors (e.g., those that generate trust and demonstrate caring) that help rural Veterans overcome attitudinal barriers to treatment-seeking and sustained engagement in needed mental health services.

**Single Session Emotion Regulation Skills Training to Reduce Aggression in Combat Veterans: A Clinical Innovation Case Study**

Miles, SR, Thompson, KE, Stanley, M, & Kent, TA

*Psychological Services, 2016, 13(2), 170-177*

**Problem Addressed by Study**

PTSD is common among returning Veterans, and aggression frequently co-occurs with (continued on page 7)
PTSD. Veterans with PTSD most commonly engage in impulsive aggression, or aggression that is emotionally charged, unplanned, and uncontrolled, rather than premeditated aggression, which is planned and controlled. Previous research demonstrated a variety of emotions can result in aggression, rather than the traditional conceptualization that only anger leads to aggression. In a Veteran sample, deficiencies in the ability to regulate emotions (emotion dysregulation) mediated the relationship between PTSD and impulsive aggression. We presented two cases of combat Veterans with PTSD who completed a single-session training that taught them how to regulate their emotions with the goal of reducing aggression.

Results of the Study
The two Veterans differed in how frequently they practiced the emotion regulation skills and their reductions in emotion dysregulation and aggression. One Veteran was attentive in group and practiced the skills for homework. This Veteran saw reductions in both his emotion dysregulation and aggression. The second Veteran did not practice the skills regularly and did not see any changes in his symptoms.

Implications and Impact of the Study
Case studies allow one to begin to examine if a new treatment is worthy of additional research. Teaching Veterans how to regulate their emotions in a condensed time frame may be beneficial for certain Veterans and reduce provider burden. One case presented here suggested that some Veterans with PTSD and impulsive aggression may benefit from learning emotion regulation skills. The use of emotion regulation skills in the Veteran’s daily life and emotional engagement during the group intervention appeared to be related to decreases in aggression. Further research is warranted on this brief treatment. Currently, the authors are conducting a larger open trial that builds upon this study.

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

Saving Veterans Lives with VA Opioid Overdose Education and Naloxone Distribution (OEND)

Elizabeth Oliva, PhD

Wednesday, March 8 at 8:00-9:00 am CT or Thursday, March 9 at 11:00-12:00 pm CT

This month's topic includes continuing education credit for pharmacists and pharmacy technicians. Register online in TMS through March 7. Be sure to click “REGISTER NOW.” Clicking “assign to me” will not register you for continuing education credit.

VA Providers (including Pharmacists):

Click here to register in TMS

VA Pharmacy Technicians

Click here to register in TMS

About the Topic: At the conclusion of this webinar, learners will be able to explain the need for Opioid Overdose Education and Naloxone Distribution (OEND), access available VA resources to support OEND implementation, and discuss how OEND and other actions can be implemented in community-based outpatient clinics.

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

Visual: Join Microsoft Lync through VA TMS

Contact: Ashley.McDaniel@va.gov

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