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The next issue of the *South Central MIRECC Communiqué* will be published January 2, 2008. Deadline for submission of items to the January newsletter is December 26th. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Mary Sue Farmer, at [Mary.Farmer2@va.gov](mailto:Mary.Farmer2@va.gov)

South Central MIRECC Internet site: [www.va.gov/scmirecc](http://www.va.gov/scmirecc)

National MIRECC Internet site: [www.mirecc.va.gov](http://www.mirecc.va.gov)

## MEET THE MIRECC RESEARCHERS: JUDITH LYONS, PHD

Interview with  
Judith Lyons, Ph.D.

Clinical psychologist and acting Trauma Recovery Program team leader,  
G.V. ("Sonny") Montgomery VAMC, Jackson, MS  
Associate professor, Psychiatry and Human Behavior,  
University of Mississippi Medical Center

### What is your area of research?

My career has focused on the assessment and treatment of posttraumatic stress disorder (PTSD) to promote posttraumatic growth and relieve suffering.

### What active studies do you have going?

I am collaborating with Dr. Karen Quigley and her colleagues in NJ on a VA/DoD study of troops pre- and post-deployment. That study aims to identify psychological and biological predictors of postwar unexplained medical illness (e.g., "Gulf War syndrome"). Dr. Kevin Del Ben and I have a MIRECC-funded project examining an interoceptive intervention to increase treatment engagement. We are continuing unfunded efforts to refine treatment protocols/matching for veterans with PTSD and their partners.

### What are the implications or potential benefits of your research?

I have always viewed exposure therapy as key in treating PTSD. Many patients who have aversive,



intrusive re-experiencing of one or more specific events can benefit quickly and significantly from therapeutic exposure to details of their trauma.

However, individuals who have only occasional negative thoughts or dreams about their events, whose distress is about diffuse issues rather than discrete events, or who spend a lot of time voluntarily reminiscing about their military time as their "glory days" often are misdiagnosed as having PTSD and referred for exposure therapy.

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## *Meet the MIRECC Researchers continued...*

Stirring up memories that are not producing clinically-significant symptoms or reinforcing excessive voluntary ruminations about the past is apt to be counterproductive, so accurate assessment is extremely important. Our work to develop assessment protocols, demonstrate potential for faking on popular measures, and establish diagnostic cut-offs and profiles during the 1980's-1990's was targeted at ensuring the right treatments are offered to the right patients.

From the early 1990's to today, much of my work has focused on how to increase access and supplement the core treatment of imaginal exposure to trauma-related cues. Interoceptive cues are internal sensations such as sweating or pounding heart rate that are associated with the trauma memory. When, in 1994, I began giving conference presentations about physical exertion as a PTSD treatment component to provide in vivo exposure to interoceptive cues, I was often challenged by audiences who argued that physiological arousal is a response rather than a stimulus/cue. Now interoceptive exposure is a widely accepted treatment component. Family services still lag behind direct services to veterans, but our MIRECC-supported research on distress and caregiver burden among partners of veterans with PTSD has helped place this need on VA's agenda nationally. My writings and presentations on coordinating disaster/school shooting response have helped shape school and American Red Cross policies, particularly regarding the role of local clergy in the response effort. It is exciting to see an idea take off and bloom on a larger stage in ways that benefit trauma survivors and their families and to know my work was one of the seeds in that process.

### *How did you get started in this area of research?*

As therapist to the daughter of two Holocaust concentration camp survivors during my graduate training at Concordia University, I was introduced to the depth of moral dilemmas many trauma survivors have to navigate and the resilience many show. I was fascinated that posttraumatic growth and severe PTSD co-exist. When Dr. Danny Kaloupek joined the faculty at Concordia, bringing his experience working with Vietnam veterans at Jackson VA, I became sold on PTSD as a career focus. I came to Jackson to intern with Dr. Terry Keane and Dr. John Fairbank in 1984. When

Terry left to start the Boston division of the National Center for PTSD, I followed him to serve as the founding clinical director there in 1985. In that capacity, I had the opportunity to publish some of the first how-to papers on PTSD assessment and exposure therapy for PTSD.

When Dr. Fairbank left Jackson, I returned to fill his position in Jackson in 1987. At that time, PTSD services were provided within the general psychology consult service. Through a series of grants and VA special program proposals, I had the opportunity to launch a multidisciplinary PTSD outpatient clinical team in 1989 and add a residential unit in 1992. We conducted VA-funded studies on psychophysiological aspects of PTSD and treatment effectiveness. VA also funded our project proposal to conduct educational workshops on PTSD at community mental health centers throughout the state to address capacity issues and the needs of rural veterans prior to the existence of VA CBOCs. As one of the first PTSD clinical research programs, our Trauma Recovery Program's work was profiled in VA's PTSD Research Quarterly in 1993 and in the Association for Advancement of Behavior Therapy trauma interest group newsletter in 1995.

### *What person or experience had the most influence on your research career?*

Dr. Kaloupek, Dr. Keane, Dr. Fairbank and many others helped me arrive at where I am now. At this phase of my career, Dr. Charles Figley is a role model for generativity (to borrow Erikson's term). Dr. Figley has a phenomenal track record for launching projects (organizations, journals, collaborative texts), ensuring that a mechanism for continuity is in place under the direction of others, then moving on to a new idea. As my clinical and administrative loads expand to crowd out research time, I am grateful for Dr. Figley's example that one can influence the field by letting others run with your research ideas, mentoring junior colleagues, etc. I take pride in contributing to the next generation of trauma researchers who can take the field to an even greater level.

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What advice would you give to junior investigators and to people who are new to research?

I was recently discussing this question with colleagues at a conference. Each of us had encountered talented young researchers who seemed oblivious to the fact they were undermining their own careers by claiming undue credit for projects/ideas. Young researchers do not always recognize the amount of political capital senior researchers and administrators expend to support their project. Similarly, in their enthusiasm for the project, junior investigators sometimes forget that the idea they are testing was not their own or they fail to notice the extent to which peers contributed. As a result, they lose the support of potentially valuable mentors and peers shy away from them when seeking future collaborators for a

grant, symposium, book, etc. Be proud of your role in the team but always value the team as a whole...not just in listing names on a paper, but in how you think about the project on a daily basis.

Make quality a priority. Select topics and colleagues that truly energize you. It will make those long hours a joyful journey.

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

E-mail [Judith.Lyons@va.gov](mailto:Judith.Lyons@va.gov) or call 601-364-1224



## MIRECC EDUCATIONAL PRODUCT LINE UPDATE:

### MIRECC RESEARCHERS DEVELOP BRIEF CBT MANUAL

#### JEFF CULLY, PHD AND ANDRA TETEN, PHD

Jeff Cully, PhD and Andra Teten, PhD, are pleased to announce that their MIRECC sponsored clinician educator grant entitled “Development of Clinician and Patient Treatment Manuals for the Training and Dissemination of Brief Cognitive Behavioral Therapy” is now complete. The researchers sought to generate materials to support training and the use of brief cognitive behavioral therapy (CBT) in primary care clinics. The materials are intended to support existing training and supervision in CBT.

Copies of the CBT manual are now available through the MIRECC educational product line. The manual has already been used at a VISN 16 mental health in primary care training workshop in June 2008.

Over 25 therapists participated in the CBT workshop over a period of two days. The developed manual served as the foundational materials for this workshop. This training and dissemination occurred as part of an ongoing MIRECC facilitation intervention study, directed by Michael Kauth, PhD, which will allow Drs. Cully and Teten to obtain data related to the effectiveness of the training and CBT manual and future training and implementation efforts.

For a copy of the CBT manual (in print or PDF format) or more information about the project, please contact Dr. Kauth at (713) 794-8637 or [Michal.Kauth@va.gov](mailto:Michal.Kauth@va.gov).

# MIRECC EDUCATIONAL PRODUCT LINE UPDATE:

## RECOVERY: A JOURNEY OF HEALING AND TRANSFORMATION

CHARLIE NGUYEN, PHD

The treatment of individuals with mental illness has advanced significantly over the years, both in the areas of pharmacological and psychosocial interventions. The traditional model of treatment, however, focused primarily on management of symptoms and maintenance of current functioning, and not necessarily rehabilitation. This emphasis was based on the belief that serious mental disorders, such as schizophrenia, had a degenerative and deteriorating course with little hope for improvement, particularly in the long-term. Over the past several decades, however, longitudinal and qualitative studies, as well as consumer testimonials, have severely challenged the idea that the only outcome possible for individuals with schizophrenia and other serious mental illnesses is a negative one. Research findings indicate that approximately half to two-thirds of patients with schizophrenia evidence recovery and significant improvement over the long-term. Recovery outcomes include regaining functioning and satisfaction in valued life roles, increased self-esteem and self-efficacy, improved ability to manage symptoms, enhanced feelings of wellbeing, and others. The President's New Freedom Commission Report in 2003 urged our mental health system to adopt a recovery-oriented model of care. The Department of Veterans Affairs responded to the Commission's call for a sea change in the way mental health services are delivered in the United States with its Action Agenda, which pledges commitment to providing recovery-based mental health care for veterans with mental illness.

The video, entitled *Recovery: A Journey of Healing and Transformation*, was developed as an educational resource for veterans with mental illness, family members and significant others, and medical and mental health providers with funding from the South Central MIRECC. The purpose of the video is to introduce viewers to the Recovery Model, psychosocial rehabilitation, the importance and benefits of implementing recovery-based services, fundamental recovery components, and core system elements needed for implementation of recovery-based services. This 48-minute video contains didactic presentations, veteran

consumer testimonials, and a simulated community meeting for instructive purposes that contains actual veterans, family members, and providers.

This project involved a multi-site effort, with participation from VA facilities in Houston (coordinating site), Dallas, Little Rock, and Biloxi. This video could not have been made without the dedication and enthusiasm of numerous individuals, both in front of the camera and behind the scenes. On behalf of the project Planning Committee, I wish to thank all those individuals who generously gave their time and energy to this project. I want to thank the MIRECC for funding this project and for providing consultation throughout the process. I particularly wish to thank the veterans who shared their inspiring stories of recovery with us.

### Planning Committee

**Houston:** Rayan Al Jurdi, MD; Oliver Avery, III; Robert Black; Agenda Burnett; Delores Hendrix-Giles, LCSW; Deborah Lundin, LCSW; Quang (Charlie) X. Nguyen, PhD; Steven Olson; Thomas Pilch; Susan Rawson; Paul Sloan, PhD; Anna Teague, MD; Jack Washburn; Bobby Wilkerson; George Zurenda.

**Biloxi:** Scott Cardin, PhD; Clarence Hawthorne; Rayford Keen.

**Dallas:** James Daniels; Curtis Diggles; Kathy Dohoney, PsyD, CPRP.

**Little Rock:** Richard Howard; Sarah Jones; Lisa Martone, APN, CPRP.

### Acknowledgements

Wayne Alley; Matthew Chinman, PhD; Teresia Dupins, RN, MSN, CPRP; Kay Edwards, MA, VRS; F.W. "Arch" Ethun; Fisher House (Houston); Joseph DeVance Hamilton, MD; Brian House; David Howard; Sonora Hudson, MA; Jane Kang, MD; Michael R. Kauth, PhD; Eric Maaya; Medical Media (Houston, Biloxi, Little Rock); Mental Health Consumer and Advocacy Council (Dallas); Mental Health Consumer Council (Houston); MIRECC (South Central, VISN 16); Anita Plummer; Recovery Committee (South Central, VISN 16); Brenda Schubert; Michael Spratt; Fred Verser, RN; Lauri Warren; Belinda Wilson; Raymond Wodynski.

## **OVERVIEW OF THE COMMUNITY BASED OUTPATIENT CLINIC (CBOC) PARTNERSHIP FOR IMPROVING RURAL MENTAL HEALTH CARE**

Cayla R. Teal, Ph.D., Houston VA HSR&D, Baylor College of Medicine

Carrie Edlund, MS

In October, the SC MIRECC began a new project called the *Community Based Outpatient Clinic (CBOC) Partnership for Improving Rural Mental Health Care*. Funded by the VA Office of Rural Health through the SC MIRECC, this project's purpose is to provide educational interventions and materials related to mental health treatment for CBOCs and to create a "practice network" of CBOCs that are interested in participating in research on rural mental health care. Dr. Teal, a co-investigator for the project, described it in a recent interview. Also see the "Meet Your CBOC" column in this newsletter to learn more about the Ft. Smith CBOC.

### *What are the CBOC Partnership's main goals?*

The first goal is to build relationships between the SC MIRECC and VISN 16 CBOCs. This program aims to develop connections among mental health researchers and CBOC personnel, primarily around the challenges of providing more rural mental health care. In many cases, some connections among these folk already exist, but they occurred serendipitously, and reflect the goals of those particular individuals. The CBOC partnership will make such connections more deliberate and explicit.

Second, we'll conduct a needs assessment to evaluate what mental health education and training needs the CBOCs have that the MIRECC can fulfill. In addition to asking about specific education or training needs, we'll document the organization of mental health services at each CBOC, provider structure and function, offered and provided services, methods of service delivery, and how services are accessed by veterans. That information will help us understand why some education and training needs exist, and should also inform how we can best help meet those needs. And we'll also determine which CBOCs would be interested in participating in rural mental health research (clinical, educational, etc.) in VISN 16, and to what extent. The needs assessment will include methods for identifying these interests – both the degree of interest as well as the types of research or roles in research a CBOC might have interests in. This data will be used to match CBOCs with VISN 16 investigators, and be part of the formation of a research practice network that includes interested CBOCs and their personnel.

Finally, we will document the processes that we use to form these partnerships, creating a toolkit that other MIRECCs can use for similar endeavors.

### *What activities will take place to meet these goals?*

MIRECC researchers have already begun visits to meet CBOCs, start a needs assessment, and let the CBOC personnel get to know some of the MIRECC researchers. These site visits acquaint the CBOC MH providers and other personnel with MIRECC researchers and personnel, and also permit MIRECC to become more familiar with the CBOCs in terms of size, organizational culture, and work processes. These in-person site visits will be followed up with a written needs assessment CBOCs will complete to indicate what mental health training and education needs exist, in what organizational context, and how MIRECC can help with meeting those needs. For example, some CBOCs may be particularly interested in additional training for CBT and other evidence-based treatments, based on the mental health needs of the veterans they serve and what's currently available to the providers. MIRECC personnel plan to survey at least three people from each CBOC—for example, a mental health provider or maybe two (depending on the size of the CBOC), a primary care provider, and maybe a nurse or physician assistant. Ultimately, we just want to collect information from those folks who can best help us understand the experience of providing mental health care in their CBOC and how we can help meet any education or training needs.

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*Why has the MIRECC chosen to send people out to visit CBOCs, instead of using distance technologies like conference calls and email to accomplish this task?*

We feel it's important to interact with people in ways that respect their culture. Rural southern culture has traditionally been one of personal relationships and face to face interactions, and we recognize how important those personal meetings are as the basis of our forming good working relationships with the CBOCs and their personnel. Many of us at MIRECC, including myself, come from more rural backgrounds, so meeting face-to-face is important to us as well.

*Who is leading this effort?*

Mary Sue Farmer, the Principal Investigator, coordinates all aspects of the project, tracking progress, coordinating meetings, and identifying and resolving barriers to progress. She is also the heart and soul of this project, because she truly wants to help meet veterans' mental health needs, and the needs of those who provide mental health services. And she is especially attune to the differences that are possible between urban and rural environments; that familiarity and experience is helping facilitate relationships between the CBOCs and those of us at MIRECC with less experience in more rural settings.

Kim Arlinghaus, MD, chairs the Partnership Advisory Committee comprised of key stakeholders whose input and advice guides the CBOC partnership team. While her primary work will be in forming and guiding this Advisory Committee, and facilitating the MIRECC's interactions with the Advisory Committee to improve our efforts and outcomes, Dr. Arlinghaus will participate in other ways as well. She will assist in the interpretation of the needs assessment data, participate in development of tools to meet the needs expressed by the CBOCs; and assist in the development of the toolkit. Dr.

Arlinghaus is also widely known for her skills as a clinical educator. We hope that she will also develop educational interventions that will address the needs identified by our CBOC needs assessments.

I'm a Co-Investigator on the project, and have primary responsibility for designing the data collection methods for the CBOC needs assessments (that is, the survey questions and any follow-up interview questions that we want to ask). I'll also analyze the data to identify educational and training needs and methods for meeting those needs, to guide our efforts to develop tools to fulfill those needs. Some of my analysis will also focus on how research partnerships might be generated and of course, generation of reports, etc.

*What is your timeline? When will CBOCs start to see MIRECC visitors?*

CBOC site visits have begun in Little Rock and should finish at all sites by end of January. We hope to complete the needs assessment (surveys and some follow-up interviews) by end of February or so.

*What difference do you expect the partnership to make in the way CBOCs deliver mental health care to rural veterans?*

To our knowledge, this will be the first VISN-level partnership of its kind, between researchers and clinicians, formed for the specific purpose of improving mental health care for rural veterans who use CBOCs. We view the partnership as a "two-way street" in that the SC MIRECC will provide educational or training products, based in part on needs identified by CBOCs, and CBOCs may elect to participate in research, which helps our researchers develop and test more effective interventions that address local clinical needs. Ultimately, this pairing of perspectives and resources should improve care for rural veterans with mental illness.

## RECOVERY CORNER

### SERVICES FOR FAMILIES OF VETERANS: WHAT FITS BEST?

By Leigh Ann Johnson, LCSW

Local Recovery Coordinator/Consultant

VA Gulf Coast Veterans Healthcare System

The VA has embarked on various innovative programs to address the needs of Veterans diagnosed with a serious mental illness (SMI) and their families. Through partnerships with the National Alliance on Mental Illness (NAMI) and development of new programs, the VA is offering more recovery-oriented care to those diagnosed with an SMI.

The National Alliance for the Mentally Ill (NAMI) sponsors the NAMI Family to Family program. This program is taught by trained peer facilitators who have a family member with mental illness, and uses a scripted curriculum that is recovery-oriented. The curriculum consists of 12 modules and is cohort based. It is especially beneficial to family members who have limited social support and are able to attend on a consistent basis. The NAMI Family to Family program has a strong evidence base of helping families of persons diagnosed with Schizophrenia. It also provides information helpful to families of persons diagnosed with Schizoaffective Disorder, Mood Disorders, and Severe Depression. The modules include information about these and other disorders, brain research, and medications. They are designed to help family members develop greater empathy for the emotional struggles of persons diagnosed with mental illness. Modules also assist family members with skill building in the areas of communication, setting boundaries, self-care, problem solving and advocacy. Recently NAMI added “A Supplemental Take-Home Module for the NAMI Family to Family Education Program: Understanding and Coping with PTSD”. This 27 page module was prepared by the Veterans Health Care Administration, National Center for PTSD. NAMI has recently developed an outreach brochure “Understanding Posttraumatic Stress Disorder and Recovery: What You Need to Know about This Mental Illness”. NAMI is eager to expand its programs to serve veterans and their families, and NAMI chapters in each state are partnering with the VA to expand the availability of NAMI Family to Family

classes through a recent memo of understanding. This new initiative has been especially helpful for VAs located in rural areas with limited community resources. For more information about NAMI go to [www.nami.org](http://www.nami.org).

Support and Family Education (SAFE) was developed by Michelle Sherman, PhD, of the Oklahoma City VAMC, and is designed for people who care about someone living with mental illness or PTSD. SAFE consists of 18 structured sessions. It is recommended that classes be offered twice a month, with flyers distributed by the medical center listing topics for each date. Classes are open to any family member of a veteran who receives health care at a VA facility, even if that veteran has not yet enrolled in actual treatment for mental health issues. Many times family members recognize their loved one’s need for mental health treatment long before the veteran enters treatment. In the past, many veterans waited until they became estranged from family members before entering treatment and family members were not permitted to attend VA family programs until after obtaining the veteran’s consent. The SAFE format makes it easier for families to obtain support sooner, and may reduce pressures that lead to family breakup. NAMI Family to Family and SAFE cover some similar topics on mental illness and the needs of family members, however, SAFE also has a class on PTSD. A trained clinician delivers each SAFE module, and classes are highly interactive. Arrangements are also made for a psychiatrist, pharmacologist, or nurse to respond to questions about medication issues. It is also recommended that a representative from the local NAMI chapter attend the classes to provide information on local resources at the end of the session. For more details see link to SAFE curriculum: <http://w3.ouhsc.edu/safeprogram/>.

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Operation Enduring Families (OEF) is based on SAFE and modified to address the special needs of recently returning Veterans and their families. It includes 5 sessions and topics cover: Family Relationships, Communication & Intimacy, Anger, PTSD, and Depression. OEF is an excellent program to offer within a VA medical center as part of Mental Health in Primary Care, and can be marketed with help from OEF/OIF staff. For more information see link to OEF curriculum <http://w3.ouhsc.edu/oef>

In addition to family education and psycho-education, many VA Mental Health providers recognized the need to offer marriage and family counseling services to Veterans and their families. The VA Office of Mental Health has worked with congress to address limits to the VA's statutory authority to provide care. On October 10, 2008, Senate Bill 2162/ House Bill 4053, also known as the Veterans Mental Health and Other Care Improvement Act of 2008, became Public Law No: 110-387. This new law permits expansion of VA Mental Health services to include Marriage and Family Counseling. VA Office of Mental Health staff are developing guidance for implementation of this law. For complete text of the new law see: <http://www.govtrack.us/congress/bill.xpd?bill=s110-2162> Mental Health staff interested in developing Marriage and Family Counseling Programs may wish to learn more about Emotion Focused Therapy developed by Susan Johnson, PhD.

If you would like more information on Mental Health Initiatives related to recovery-oriented services, see you Local Recovery Coordinator.

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# MEET YOUR CBOC: FT. SMITH, ARKANSAS

## PARENT FACILITY: FAYETTEVILLE VAMC

By Mary Farmer & Kristin Ward

Fort Smith, Arkansas is famous for its hospitality. Blues, barbecue, Bach, broncos, belles and beautiful scenery all come together in Fort Smith. You can shop for antiques, attend a festival or symphony performance, see a show or enjoy the great outdoors. The total population is approximately 82,000. In the midst of this city, the Fort Smith Community-Based Outpatient Clinic (CBOC) is housed within the Sparks Regional Medical Facility. The South Central MIRECC team was the recipient of the Ft. Smith hospitality as they visited the Fort Smith CBOC twice during the month of October. The first visit was with Brian Tankersley, PA and Linda Bell, LCSW, who are



Linda Bell, LCSW and Brian Tankersley, PA

the mental health liaisons in primary care. The second visit was with the mental health staff during their department meeting. The mental health staff at the Ft. Smith CBOC includes two psychiatrists, one psychologist, three social workers, three psychiatric nurses, one physician's assistant, and three clerks. Behavioral Health services include individual, group and family counseling, depression and anger management groups, programs such as QuitSmart Smoking Cessation, and treatment for substance abuse, sexual trauma, and PTSD. The mental health staff is a highly professional group who are very dedicated to their veteran patients.

### DECEMBER CONFERENCE CALLS

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

		ACCESS CODE
9	MIRECC Leadership Council, 3:30 PM CT	19356#
16	VISN 16 Mental Disaster Team, 11AM CT	76670#
17	MIRECC Program Assistants, 2PM Central	43593#
22	MIRECC Education Core, 3:00 PM CT	16821#
23	MIRECC Leadership Council, 3:30 PM CT	19356#
25	National MIRECC & COE Education Recovery Interest Group, Noon CT, <i>cancelled</i>	22233#
26	National MIRECC & COE Education Implementation Science Group, 1:00 PM CT, <i>cancelled</i>	28791#