



*A decade of bridging
the gap between research
and clinical care*

Communiqué

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2008 National Mental Health Conference

“Continuing the Transformation of VA Mental Health Services: Bridging the Gaps”

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South Central Mental Illness Research, Education, and Clinical Center

The Department of Veterans Affairs Employee Education System and the Office of Mental Health Services VA Central Office sponsored the annual conference on July 21-24 at the Hyatt Regency Crystal City in Arlington, VA. The conference provided the opportunity for key leaders, providers, researchers and educators to come together, in order to enhance learning, address implementation and evaluation aspects of the Uniform Mental Health Services handbook in VA Medical Centers and Clinics, and to identify strategies to improve and offer innovative care across the continuum of VHA Mental Health Services.

Almost 1,000 participants attended representing the VISN Mental Health Liaisons, Mental Illness Research, Education and Clinical Centers (MIRECC), Northeast Program Evaluation Center (NEPEC), Serious Mental Illness Treatment Research and Evaluation Center (SMITREC), Program Evaluation Resource Center (PERC), Mental Health (MH) and Substance Use Disorder (SUD) Quality Enhancement Research Initiative (QUERI), National Center for Post-traumatic Stress Disorder (NCPTSD), Center of Excellence for Substance Abuse Treatment & Education (CESATE), and VISN 2 Center for Integrated Care and the Centers of Excellence at San Diego, Canandaigua and Waco. Participants included physicians, psychologists, nurses, social workers, counselors, and healthcare executives.

Participants increased their awareness of the diverse clinical, research and educational initiatives related to VHA's Uniform Mental Health Services in VA medical centers and clinics, and how the initiatives can be best implemented and monitored in their networks and local medical centers. The conference focused on increasing recovery oriented services, integrating care, promoting a national model for suicide risk identification and prevention, addressing the needs of returning soldiers and their families, preventing homelessness among veterans, increasing safety and access, and implementing evidence based treatments particularly as they related to PTSD. Additionally, the conference stressed enhanced collaboration with Vet Centers and other community partners in the promotion of family psycho-education models and increased utilization of peer-to-peer support services. The conference emphasized the need to foster collaboration among researchers, clinicians and educators, thus increasing the opportunities for new VA research while enhancing opportunities for psychiatry and psychology fellows.

VISN16 and the SCMIRECC was an important part of the conference from its inception. Michael Kauth, PhD, served on the planning committee; presenters included Greer Sullivan, MD, Michael Kauth, PhD, Richard Owen, MD, JoAnn Kirchner, MD, Kathy Henderson, MD, Lawrence Daily, LSSW, Kim

Kalupa, PhD, Jay Otero, MD and John Fortney, PhD; and posters presentations included Vince Roca, PhD, Gabriel Tan, PhD, John Thornby, PhD, Quang Nguyen, PhD, Tam Dao, PhD, Lisa Martone, APN, Andra Teten, PhD, Paul Sloan, PhD, Laura Tolpin, PhD, Ali Asgar-Ali, Steve Balsis, Mary Farmer, PhD (ABD), and Dean Blevins, PhD.

The conference allowed a wonderful opportunity to create new connections with other mental health providers and hear from VA leaders such as James Peake, MD, Secretary Department of Veterans Affairs. Slides from the conference are available at:

http://vaww.sites.lrn.va.gov/vacatalog/cu_detail.asp?id=24031



Resources for Rural Researchers

Geographic Access to Veterans Health Administration Services

Full details at: http://vaww.pssg.med.va.gov/PSSG/pssg_geographic_access.htm.

In 2007, the FY 2006 Geographic Access to Veterans Health Administration Services information was gathered from the FY 2006 Geocoded Enrollment File. This newly developed annual report provides decision makers with detailed information about geographic access to primary, acute, and tertiary care VHA facilities. Information is further provided based on whether the facility is located in an urban, rural, or highly rural area and whether the veteran lives in an urban, rural, or highly rural area. In addition, the data is broken down by Veterans Integrated Service Network (VISN), market, and veteran status (i.e., whether the veteran is an enrollee or patient). Where possible, these results are compared to the guidelines used in the CARES analysis.

The complete FY 2006 Geographic Access to Veterans Health Administration Services (VHA) report results are available on the PSSG VA Intranet Website at:

http://vaww.pssg.med.va.gov/PSSG/pssg_geographic_access.htm.

The results of the survey are displayed in four (4) chapters: Travel Time Access to Primary Care, Acute Care and Tertiary Care Services; Travel Time Access for Urban, Rural and Highly Urban Patients and Enrollees to Urban, Rural and Highly Rural VHA Sites; Comparison of travel times to CARES guidelines for Primary, Acute and Tertiary Care; and VISN facilities used in the geocoding process.

Questions about the survey report may be directed to the Joe Marburger, Deputy Director, Planning Systems Support Group (PSSG) at 352-374-6080 or Karen Lentz, Deputy Director, Healthcare Analysis & Information Group (HAIG) at 414-384-2000 ext. 42365.

Meet the MIRECC Researchers: Thomas A. Teasdale, Dr.P.H.

Interview with

Thomas A. Teasdale, Dr.P.H.

Core Investigator, South Central MIRECC & Statistician, Oklahoma City VAMC, OK;
Associate Professor, Reynolds Department of Geriatric Medicine,
College of Medicine, University of Oklahoma Health Sciences Center, OKC

What is your area of research?

I am an educator with a research methodology background. My primary interest is in “rolling out” education to various audiences of learners, but primarily to healthcare providers of veterans and older persons in general. To me, “roll out” can-and-does include (a) development of education products that are (b) tested for effectiveness, and finally (c) distributed to learners. Under this model, education research can be an exciting blend of observation, intervention, and implementation. That is, the pipeline includes identification of a specific educational need, development, packaging and testing of materials to suit those needs, and evaluation of the implementation process and outcomes. There is something for everyone here.

What active studies do you have going?

I am currently involved in five projects, two of which are MIRECC based. I am a co-investigator on both MIRECC projects that provide complementary evaluations of a formal “roll-out” of cognitive behavioral therapy (CBT) to selected therapists within the South Central Network. My role is to facilitate the therapists’ efforts to implement CBT after they return to their respective clinical settings. This work has the potential to improve the extent to which therapists are able to utilize newly offered therapies in the care of veterans. Regarding my university research, I am PI on the Oklahoma Geriatric Education Center (OkGEC), one of 48 federally funded centers that provide geriatrics education and skills to frontline healthcare providers throughout the United States (link at bottom). The education formats range from brief in-services at rural LTC settings, to State-wide conferences, to distance learning products. An exciting aspect of this work is that we reach a large number of clinical disciplines. VA

facilities and clinicians are often included, but not exclusively. My MIRECC affiliation has resulted in a new OkGEC goal to create a mental health curriculum within the OkGEC for providers of older veterans who do not use VA facilities. I am also PI on a nearly finished project to update ten online educational modules that I created almost ten years ago for medicine residents. Clinicians author the content which I shape into online products, accessible to all via Internet and CD-ROM. A conversation with a physician-geneticist led to a federally funded study to examine the issues associated with Neurofibromatosis 1 in old age. Our goal is to suggest a research agenda and interim clinical guidelines. My specific role is to conduct focus groups to characterize the older NF1 experience and to develop educational materials for health care providers.

What are the implications or potential benefits of your research?

All of my work aims to improve the care of veterans and older persons. There is a danger in overestimating potential benefits, but I prefer to be ambitious. As just noted, findings from the MIRECC-related projects will inform the VA on how to best design large-scale implementation of new therapeutic modalities. Specifically, the premise is that giving additional support during an implementation process will result in frontline providers being more successful at utilizing a new therapy. When therapists (and patients) are successful in treatment, a variety of relevant outcomes can improve. Findings and insight from evaluation of our OkGEC activities will be used to improve subsequent State-wide education efforts. I certainly hope that my goal of establishing a mental health curriculum for non-VA affiliated providers of veterans results in improved knowledge and skills in those

clinicians, which could generate improved veteran health status. As a board member of the National Association of Geriatric Education Centers, I can advocate for certain education approaches or activities that meet criteria for being evidence-based.

How did you get started in this area of research?

My interest in program evaluation started with a public health training. Early opportunities at the Houston VAMC focused my attention on geriatric medicine. Large, multi-patient wards were still in use at that time and patient-centered care had yet to surface. The discipline of geriatrics was taking root in the US, and the educational need was great. One of my first projects was to support a study measuring the prevalence of dementia in our older patient population. At 9% it was a little below the national estimates of that time, but still surprisingly high to many clinicians. My role of turning research findings into educational materials was launched. It was an easy next step to assume responsibility for training fellows and junior faculty in research methods. My education and my research responsibilities eventually blended into an occupation.

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

I was lucky to have what is called a “triple threat” as a mentor; someone recognized for their research, teaching, and clinical prowess. Dr. Luchi (Chief of Medicine and ACOS, Extended Care at the Houston VAMC) encouraged being obsessive to reach highly rigorous standards of research, and that modality fit me. However, a second person influenced me in ways that altered

my career path. In 1999, Dr. Mark Kunik introduced me to the SC MIRECC. That simple invitation to explore an opportunity redirected my career toward mental health and toward working with some of the finest colleagues I’ve ever met.

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

Having a narrow focus and having a good mentor are always mentioned as important. However, I think that these points are misunderstood. To me, having a narrow focus doesn’t mean that my only interest is a particular enzyme or even a particular clinical therapy. Instead, my focus might be broadly on reducing the burden of dementia, yet my research will need to go in whatever direction is most fruitful, including enzymatic influences and therapeutic trials, if necessary. The point is to be nimble in your immediate choices while keeping the larger goals in sight. Mentors are crucial, but you don’t choose them, they choose you. A mentor who does not purposefully teach you, train you, and invite you to be nearby for those “osmotic” learning experiences, isn’t serving you well. Finding a mentor who will give you attention and knowledge is not easy, but is worth the pursuit.

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

Email is best: thomas-teasdale@ouhsc.edu or thomas.teasdale@va.gov.

I can also be found on the following websites that I manage: www.va.gov/scmirecc, www.ouhsc.edu/okgec, and www.ouhsc.edu/geriatricmedicine.

Training in *Seeking Safety* Coming Soon!

The Substance Use Disorders (SUD) QUERI and the VISN 16 MIRECC are co-sponsoring a series of trainings in Seeking Safety therapy at several locations in VISN 16. Seeking Safety is an evidence-based treatment for dually diagnosed individuals with PTSD and substance abuse, developed by Lisa Najavits, PhD. Seeking Safety is based on cognitive behavioral principles.

The one-day workshop will be held at several locations across VISN 16, beginning in September. Dates and exact locations have not yet been finalized. There are likely to be at least 7 training sites in VISN 16. Some close facilities will be combined into a single training site. The target audience includes all treatment-providing VA clinicians who work with veterans with substance abuse, PTSD, or are dual diagnosed. Clinicians in general mental health clinics and in all community based outpatient clinics (CBOCs) are eligible to participate.

Training in *Seeking Safety* Coming Soon! (cont.)

This training is offered as part of a research study. Tom Kosten, MD, is the principal investigator in this project with the SUD QUERI and MIRECC. Dr. Najavits is a co-investigator. Sites will be randomly assigned to receive additional contact from study personnel to facilitate training implementation. The study will evaluate whether this additional contact enhances adoption of Seeking Safety.

This training is accredited by the VA Employee Education System for psychiatrists, psychologists, social workers, and nurses. When training dates and locations have been confirmed, instructions for registration will be announced. Space is limited. Due to space constraints, registrants who consent to participate in the research study will have priority over those who just wish to receive the training alone. The first 200 registrants who also participate in the research study will be eligible to receive a free copy of the Seeking Safety manual (a \$45 value) upon completion of the training.



Recovery Corner

Consumer Councils: Concept to Reality across VISN 16

Erin B. Williams, PhD, HSPP
Psychologist/Local Recovery Coordinator
Central Arkansas Veterans Healthcare System

Michael W. Roach, MSW, LCSW
Social Worker/Local Recovery Coordinator
Alexandria VA Medical Center

Nora Jacobson, Ph.D. and Dianne Greenly, M.S.W., J.D. (2001) suggested that both internal and external conditions impact a person's journey of recovery. Internal conditions include the individual's personal attitudes, experiences, and process of change. Positive internal conditions include a sense of hope, healing, empowerment and connection. External conditions that promote recovery include circumstances, events, policies and practices within a cultural milieu of healing. The tangible outcomes of both internal and external conditions can reciprocally enhance these very conditions; thus, it is imperative that both consumers and providers of care successfully partner together.

In 1996, the 104th Congress enacted Public Law 104-262 to amend Title 38 and established the Committee on Care of Severely Chronically Mentally Ill Veterans which included "employees of the Department with expertise in the care of the chronically mentally ill to serve on the committee". With the full support of the National VHA Mental Health Consumer Liaison Council, a recommendation was issued to pilot mental health consumer councils within five service networks (i.e., VISNs 3, 5, 7, 10 & 16). The outcome of the project underscored the need for having consumer councils at the facility level because mental health policies had been enhanced and an effective feedback loop was created regarding quality of services.

Nearly five years later, the President formed the New Freedom Commission on Mental Health which identified a need for recovery-oriented approaches when working with the mental health population. Among many outcomes, their report became a catalyst for the Deputy Under Secretary for Health of the VHA to develop a task force to address a comprehensive strategic plan for mental health services. This plan included over 240 recommendations, including the eventual creation of the Uniform Services Handbook for

VA Mental Health Services, which was issued on June 11, 2008. The Handbook outlines how all veterans will receive quality mental health services, defines acceptable provision options, as well as emphasizes that veterans must have a voice in their care. Moreover, “facilities are strongly encouraged to promote a local mental health Consumer-Advocate Liaison Council to facilitate input from stakeholders on the structure and operations of mental health services.”

In June 2008, the VA held its first Mental Health Consumer Advocate Councils Conference in Atlanta. The conference was designed to assist facilities in developing new councils and to provide further guidance to existing councils. Of particular attention to both new and older councils was the potential applicability of the Federal Advisory Committee Act (FACA). This legislation became Public Law 92-463 in October, 1972 to regulate operations, provide oversight, and “ensure that advice by the various advisory committees formed over the years is objective and accessible to the public” (US General Service Administration). Until recently, there had been limited awareness of the possible application of this law to consumer councils at local VA facilities. Councils could be potentially impacted by restrictions originally intended to provide oversight of programs within the Executive Branch of the Federal Government. If not wanting to face detailed restrictions, councils would need to avoid including VA employees, even those that are veterans, among its voting members. Per E. Philip Riggins, Committee Management Officer, Voluntary Service National Advisory Committee and presenter at the June conference, this would help to diminish FACA applicability and perception of the council as being “managed or controlled by” the federal government. Certain non-VA federal employees and reservists might still serve on a council, but Riggins strongly recommended careful examination on a case by case basis to make certain that such membership is essential to the business of the council.

In response, local mental health consumer councils are now being developed or restructured to become more independent organizations, which might actually better represent the interests of veterans and their families. Throughout 2007, VISN 16 put forth concerted effort to develop consumer councils at facilities that had never had councils or those that had councils previously disbanded. The specific structure of each council within the network is individualized to the unique characteristics of the local facility. The membership consists of veterans who access mental health services, family members of veterans utilizing these services, representatives of veteran service organizations and health service organizations (e.g., National Alliance on Mental Illness), as well as community representatives with an investment in working with veterans. The mission, bylaws and identified projects are also varied across the network and determined by each local council. Per the Mental Health Uniform Service Handbook (2008), at least one VA mental health staff member has been selected to serve as a liaison between the council and the facility’s mental health leadership.

With increased opportunities come expected and unexpected challenges and so is true in the development and maintenance of these councils. Some barriers have included a lack of support, accountability, resources (e.g., fuel cost for travel), recruitment and retention issues, as well as need for an updated VA Consumer Council Handbook to better educate facilities. Another potential obstacle is how FACA will impact composition of councils as there are increasing numbers of veterans being hired as Peer Support Specialists in the VA and they will no longer be viable candidates for council leadership or membership. Local Recovery Coordinators (LRCs) remain willing to help local councils and facilities face the aforementioned challenges and are invested in making sure that veterans’ voices are heard within our VISN. For example, Dr. Christine Gamez Galka, the LRC at the Houston VAMC, helped to organize a Consumer Council V-Tel conference in October 2007 which linked councils across the VISN, allowing them to share information, generate ideas and forge collaborative relationships. Consumer councils across the network have been diligently working to improve mental health services for all veterans. The consumer council at the Alexandria VAMC will soon participate in a local NAMI Day Program focusing on anti-stigma, and the Central Arkansas consumer council has been working on satisfaction surveys, program review, and recovery education. These are just a few examples of the many exciting things that councils are doing across our VISN. Without a doubt, the impact of these councils will continue to positively change mental health policies and improve the quality of VA services. As Peggy M. Henderson Psy.D., Director of Consumer and Liaison Services in the Office of Mental Health Service (2008) so adequately expressed,

“Consumer Councils provide a unique vehicle for obtaining veteran, veteran family and stakeholder input into VA mental health services. It is exciting to be a part of the process of encouraging Consumer Councils and working in partnership with veterans. I am proud of the accomplishments of VA Consumer Councils and I anticipate that new Councils will continue to grow, to the benefit of veterans and VA.”

References

Henderson, Peggy M. (July, 2008). Personal email correspondence.

Jacobson N & Greenly D. (2001) What is recovery? A conceptual model and explication, *Psychiatric Services*, 52: 482-485.

Riggins, E. Philip (June, 2008). Presentation at the Implementing and Maintaining Mental Health Consumer Advocate Councils Conference, Atlanta, GA.

GPO Access: Public and Private Laws, <http://www.gpoaccess.gov/plaws/104publ.html>

Uniform Mental Health Service in VA Medical Centers and Clinics, VHA Handbook 1160.01, http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1703

US General Service Administration: The Federal Advisory Committee Act, http://www.gsa.gov/Portal/gsa/ep/contentView.do?contentType=GSA_BASIC&contentId=11635



August Conference Calls 1-800-767-1750

- 12—MIRECC Leadership Council, 3:30 PM CT, access code 19356#
- 19—VISN 16 Mental Disaster Team, 11AM CT, access code 76670#
- 20—MIRECC Program Assistants, 2PM Central, access code 43593#
- 25—MIRECC Education Core, 3:00 PM CT, access code 16821#
- 26— MIRECC Leadership Council, 3:30 PM CT, access code 19356#
- 28—National MIRECC & COE Education Recovery Interest Group, Noon CT, access code 22233#
- 28—National MIRECC & COE Education Implementation Science Group, 1:00 PM CT, access code 28791#

The next issue of the *South Central MIRECC Communiqué* will be published September 2, 2008. Deadline for submission of items to the August newsletter is July 25. 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

South Central MIRECC Internet site: www.va.gov/scmirecc

National MIRECC Internet site: www.mirecc.va.gov