



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

# Communiqué

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## *“Improving access to mental health care for rural and other underserved veterans”*

### **Improving Mental Health and Substance Abuse Outcomes for Rural Veterans**

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According to the National Comorbidity Study Replication, Americans with mental health and substance use disorders who live in rural areas are significantly less likely to receive any type of treatment for their mental health and substance use problems compared to Americans living in urban and suburban areas (Wang et. al, 2005). Among those receiving any treatment, individuals living in rural areas are significantly less likely than their urban counterparts to receive specialty mental health care (Wang et. al, 2005) but more likely to receive general medical care only or human services only (e.g., pastoral counseling) (Wang et. al, 2006). Unfortunately (for individuals with poor geographic access to specialty mental health services), the likelihood of receiving minimally adequate mental health care in the general medical sector and human services sector is substantially lower (12.7% and 21.6%, respectively) than in the specialty mental health sector (45.4%) (Wang et. al., 2005). Moreover, the longer travel distances faced by rural patients further reduce their likelihood of receiving minimally adequate care (Fortney, 1999).

Although these data are not specific to veterans, these trends are likely to generalize to patients treated in the VA health care system. Compared to urban and suburban veterans who use the VA system, rural veterans suffer from significantly worse mental health (Weeks et. al, 2004). Veterans with mental health disorders who face long travel distances to VA providers substitute Medicare mental health services for VA mental health services (Carey et. al, 2008). Likewise, veterans using Community Based Outpatient Clinics (CBOCs) are less reliant on the VA system than veterans using VA medical centers. Thus, compared to urban veterans, rural veterans with mental health disorders are less likely to receive all their mental health care from the VA. In addition, to having different patterns of service use, rural veterans come from cultures with different beliefs about self reliance, stigma, anonymity, and treatment effectiveness. Beliefs among rural veterans may also limit the acceptability of clinical services designed for urban veterans in urban settings. Clearly, observational studies are needed to examine rural veterans' health beliefs, treatment preferences, and patterns of service utilization prior to designing programs to improve outcomes for rural veterans.

Due to rural-urban differences in preferences for and patterns of care, interventions designed for rural veterans will need to be different from those designed for urban veterans. Specifically, best practices proven to be effective in urban settings will need to be refined and reevaluated for rural settings. For example, the *type of clinician* delivering the intervention may need to be adapted to better match the

capacity of clinical personnel available in rural settings and preferred by rural veterans. Because rural individuals are more likely to be treated by a general medical provider or informal caregiver, interventions are needed that can be delivered effectively by these types of providers, either alone or in collaboration with off-site mental health specialists. Novel distance education programs, medical informatics applications, and decision support systems will need to be developed to support non-specialty providers. Internet-based applications may be a particularly effective way to train and support rural providers. Alternatively, the *mode* of delivering the intervention might need to be expanded beyond face-to-face encounters to include interactive video encounters in CBOCs and home-based telephone encounters. Likewise, Internet-based applications (e.g., My HealthVet) and telemonitoring devices (e.g., Health Buddy<sup>®</sup>) have the potential to improve outcomes via patient self-management activities such as education, health promotion, and better communication with providers. When best practices designed for urban settings are refined for rural veterans and their providers, it will often be necessary to reevaluate their effectiveness with respect to patient outcomes.

When interventions are found to be effective for rural veterans, implementation strategies will need to be designed and tested to disseminate these “rural best practices” in rural settings. The culture, capacity, and climate for quality improvement in small rural CBOCs (sometimes private clinics contracting with VA) may be very different than in large urban VA medical centers. Thus, the facilitators and barriers to implementing best practices in rural settings may be different than those in urban areas, and implementation strategies found to be effective in VA medical centers may not be successful in CBOCs. Thus, implementation strategies used effectively in urban areas will need to be tailored for rural areas.

The VA is making great strides in improving mental health and substance treatment services. To minimize rural-urban health disparities, research is needed to ensure that rural veterans benefit from these ongoing quality improvement efforts. To improve outcomes among rural veterans, researchers need to be conducting research in three phases. Rural *observational* studies are needed to better understand veterans’ beliefs, preferences, and patterns of care. Rural *intervention* studies are needed to evaluate the effectiveness of clinical programs tailored for rural veterans’ preferences and service settings. Finally, rural *implementation* studies are needed to promote the adoption of rural best practices in service settings that serve rural veterans.

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## MIRECC Annual Retreat

Investigators and leaders of the South Central MIRECC will meet April 16-18 in Little Rock, AR for the Annual Retreat. The Retreat will focus on implementing the new MIRECC theme (“**Improving access to mental health care for rural and other underserved veterans**”). In addition, attendees will celebrate 10 years of funding as a MIRECC. The South Central MIRECC was established in 1998.

## MIRECC DVD on Resilience Wins Award

The MIRECC DVD “**Resilience to Trauma**” developed by Wright Williams, PhD (Houston VA), won two bronze awards for Film Editing and Low Budget Film in the 29<sup>th</sup> Annual Telly Award competition. The 56-minute DVD features World War II ex-Prisoners of War describing their internment experiences and their life after captivity. The program is intended to help to show other individuals who have experienced trauma how to thrive in spite of their experiences. Development of the DVD was supported by a Clinical Educator grant from the South Central MIRECC. To request a copy, contact [Michael.kauth@va.gov](mailto:Michael.kauth@va.gov)

Since 1978, the Telly Awards has recognized outstanding local, regional, and cable TV commercials and programs, as well as the finest video and film productions. The Telly Awards is a respected national and international competition. More than 14,000 entries are received annually from all 50 states and many foreign countries.

## Recovery Corner

### Recovery-Oriented Services: Translating Recovery Values into Practice

VISN 16 Local Recovery Coordinators

In the last Recovery Corner, we reviewed the ten fundamental characteristics or values of recovery identified in The National Consensus Statement on Mental Health Recovery (HHS, 2005). In this issue, we discuss how recovery values and concepts can be translated into clinical practice.

#### Components of Recovery

1. Self-Direction
2. Individualized and Person-Centered
3. Empowerment
4. Holistic
5. Non-Linear
6. Strengths-Based
7. Peer Support
8. Respect
9. Responsibility
10. Hope

To move these mental health recovery values and concepts beyond the aspirational or inspirational level, they need to be attached to established clinical practices or theories that have been empirically validated. Operationalizing these values allows the concepts to be studied and taught more effectively (Anthony, 2005). For instance, Maier and Seligman’s (1976) work on learned helplessness demonstrated that when viable

productive choices are not present in the environment the individual can become hopeless and lose initiative, underscoring the importance of hope and empowerment. Maslow’s (1970) hierarchy of needs proposed that more basic physiological needs must be met before higher level needs can be addressed. Thus, meeting basic needs such as shelter, food, physical and economic security, and safety are prerequisites for the development of a satisfying social, spiritual, and emotional life.

Early in the history of psychotherapy, Freud (1913) noted the therapeutic value of the analyst’s “serious and empathetic” understanding of the patient and that this positive attachment with the patient could serve as the basis for change and empowerment. More recent psychotherapy researchers such as Luborsky have emphasized the value of developing an alliance with the patient “in a shared struggle against the patient’s illness” (Horvath & Luborsky, 1993). These writers and others (e.g. Diorio, 2001) emphasize that a collaborative therapeutic relationship with individuals who are struggling with mental illness can help to promote hope, self-empowerment, self-direction, and respect.

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Work by Prochaska and colleagues (Prochaska & DiClemente, 1994) show that change, like recovery, is not a discrete event. The Transtheoretical Model of change begins with *precontemplation* (“I don’t need to change” or “I can’t change”) and moves through *contemplation* (“I’m thinking about what I need to do differently”), *preparation* (“I’m going to a self-help group this week”), *action* (“I meet or talk with my friend once a week”), and *maintenance* (“I don’t worry about becoming isolated and lonely”). These researchers have also identified and tested various strategies for assisting people in moving through the change process and adopting new behaviors. One person-centered approach, Motivational Interviewing, directs individuals toward exploring and resolving their ambivalence about changing their behavior (Rollnick & Miller, 1995). This type of counseling relies on the collaborative and respectful interaction between provider and individual to resolve ambivalence for change, acknowledging that this is a non-linear process.

Active listening is a clinical practice that demonstrates respect for the individual. This technique communicates an understanding of the individual’s experience through nonverbal communication, reflection, open-ended questions, and expressions of empathy (Rogers, 1961). Active listening reflects a person-centered, empowering relationship.

Miller and Rollnick (1991) also describe a conceptual model, FRAMES, for delivering brief interventions that has utility as a recovery-oriented strategy. In this model, *F*, represents providing objective feedback to the individual. *R* stands for promoting personal responsibility for recovery. *A* denotes advising positive change. *M* stands for developing a menu of options with the individual. *E* reminds the provider to develop empathy with the individual. Finally, *S* highlights the importance of self-efficacy and remaining positive. This model embraces personal responsibility, self-direction, as well as many other recovery values and concepts.

These established clinical practices and others can be employed to promote mental health recovery values and concepts in clinical practice. One of the important roles of Local Recovery Coordinators (LRC) is to assist clinicians and staff in the development, education, and implementation

of recovery oriented practice guidelines, strategies, and techniques that support the values of recovery. Although many recovery values are not new, the philosophy of the recovery movement combined with recovery practice principles represents uncharted territory for many mental health professionals. LRCs are the VA’s central resource in charting this new territory.

### Meet the LRCs

Below the VISN 16 LRCs continue to introduce themselves and describe some of their recovery activities.

#### *Biloxi VA Medical Center*

**Leigh Ann Johnson, MSW**, received a Masters of Social Work from St. Louis University in St. Louis, MO, where she also received a Bachelor of Arts in Psychology and a Bachelor of Science in Social Work. She is completing paperwork for licensure as a clinical social worker. Ms. Johnson is new to the VA, after many years working for the Florida Department of Health (DOH) in Ft. Lauderdale as a Social Work Consultant for the Broward County Health Department. She provided staff training and consultation on behavioral health issues to public health staff, behavioral health counseling to clinic patients, participated in numerous hurricane deployments throughout Florida and provided psychological first aid training to public health staff and community partners. As Chair of the Outreach Planning Group, she worked with staff, community health partners, civic groups, and faith based organizations on strategies to promote community health. She also Co-Chaired the School Board of Broward County’s Teen Parent Advisory Group. Ms. Johnson initially joined DOH to work in the Healthy Start Program where she provided brief cognitive therapy in the community to high risk pregnant and post-partum females and their families. Prior to working for DOH, she worked in Miami with Florida’s Child Welfare System.

The Gulf Coast Veterans Health Care System is a very large health care system headquartered in Biloxi and serves veterans from urban and rural communities in South Mississippi, Lower Alabama, and Northwest Florida. Ms. Johnson is eager to use her experience in population based interventions to promote recovery for

(continued on page 5)

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veterans and their families along the Gulf Coast. Ms. Johnson can be contacted at [Leigh.Johnson2@va.gov](mailto:Leigh.Johnson2@va.gov) or at 228-523-4997.

*G. V. (Sonny) Montgomery VA Medical Center, Jackson*

**Brenda C. Price, MD**, received her medical degree from Louisiana State Health Science Center in Shreveport, LA, where she also completed her psychiatric residency. Dr. Price, a certified Diplomate of the American Board of Psychiatry and Neurology, also trained at the Overton Brooks VA Medical Center in Shreveport while in medical school and residency. Prior to medical school, Brenda was a registered pharmacist and Director of Pharmacy at a private psychiatric and chemical dependency hospital. She earned a B.S. with a double major in psychology and chemistry from Millsaps College and a B.S.Ph. from the University of Mississippi, where her clinical training included a psychiatric pharmacy externship at the Jackson VAMC.

Since completing her psychiatric residency, Dr. Price has worked for the Louisiana Department of Mental Health in Central LA as a staff psychiatrist leading treatment teams to partner with seriously mentally ill patients for recovery oriented care and, most recently, was in private practice in Brandon, MS. Throughout her past experiences in patient care, Dr. Price has been committed to partnering with patients and their family members, emphasizing many of the 10 fundamental values of recovery. She also has been involved in identifying evidence-based practices that have been shown to facilitate symptom remission and recovery, having served on the Louisiana Mental Health committee charged with developing clinical pathways of treatment for adult schizoaffective disorder.

As one of only four psychiatrists in the VA's national LRC group, Dr. Price believes that she can play a unique role in assisting the VA's transformation to a recovery-centered approach in mental health care. Traditionally, physicians have operated from the medical model for treatment purposes; however this model is not really

“recovery friendly”. In all of her patient care, medication management, and supportive psychotherapy sessions, Dr. Price has initiated patient education regarding recovery concepts. Dr. Price can be contacted at [Brenda.Price@va.gov](mailto:Brenda.Price@va.gov) or 601-362-4471 ext.1416.

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## Best Doctors in America 2007-2008 includes MIRECC MDs

The **Best Doctors in America** database announced the honorees for 2007-2008. The Best Doctors in America are identified through an exhaustive peer-review survey of thousands of physicians. Those who earn consensus support are included in the database. Approximately 40,000 physicians are profiled in the database. MIRECC physician investigators and educators who made The Best Doctors in America list include:

**Kimberly A. Arlinghaus, MD**, Michael E. DeBakey VA Medical Center; Baylor College of Medicine

**JoAnn E. Kirchner, MD**, Central Arkansas VA Health Care System, Little Rock; University of Arkansas for Medical Sciences

**Thomas R. Kosten, MD**, Michael E. DeBakey VA Medical Center; Baylor College of Medicine

**Mark Kunik, MD, MPH**, Michael E. DeBakey VA Medical Center, Houston; Baylor College of Medicine

**Richard R. Owen, MD**, Central Arkansas VA Health Care System, Little Rock; University of Arkansas for Medical Sciences

**Jeffrey Pyne, MD**, Central Arkansas VA Health Care System, Little Rock; University of Arkansas for Medical Sciences

**John Spollen III, MD**, Central Arkansas VA Health Care System, Little Rock; University of Arkansas for Medical Sciences

**J. Greer Sullivan, MD, MSPH**, Central Arkansas VA Health Care System, Little Rock; University of Arkansas for Medical Sciences



### April Conference Calls 1-800-767-1750

- 8—MIRECC Leadership Council, 3:30 PM CT, access code 19356#
- 8—VISN 16 Mental Disaster Team, noon PM CT, access code 76670#
- 16—Program Assistants, 2:00 PM CT, *cancelled due to Retreat*
- 22—MIRECC Leadership Council, 3:30 PM CT, access code 19356#
- 24—National Education Recovery Interest Group, noon CT, *cancelled*
- 24—National Education Implementation Science Group, 1:00 PM CT, access code 28791#
- 28—Education Core, 3:00 PM CT, *cancelled due to Retreat*

The next issue of the *South Central MIRECC Communiqué* will be published May 5, 2008. Deadline for submission of items to the May newsletter is April 28. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Michael R. Kauth, Ph.D., at [Michael.Kauth@med.va.gov](mailto:Michael.Kauth@med.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)