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“Closing the efficacy-effectiveness gap”

Health Care for Homeless Veterans (HCHV): A History of Collaboration and Community Linkages, Part I

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On any given day, as many as 200,000 veterans are living on the streets, or in shelters, and perhaps twice as many experience homelessness at some point during the course of a year. Many other veterans are considered near homeless or at risk because of poverty, lack of support from family and friends, and dismal living conditions in cheap hotels or in overcrowded or substandard housing. Most homeless veterans are male, single and from poor, disadvantaged backgrounds. They tend to be older and better educated than non-veteran homeless individuals. But similar to the general population of homeless adult males, about 45% of homeless veterans suffer from mental illness and slightly more than 70% suffer from alcohol or other drug abuse problems (with considerable overlap). Roughly, 56% are African American or Hispanic.

Central Arkansas HCHV History and Program Components

This year marks the 20th Anniversary of VA Homeless Programs. Notably, the HCHV Program in Little Rock is one of 43 original Homeless Chronically Mentally Ill (HCMI) Programs implemented by the VA in 1987. Since its inception, they have grown from two employees, to eighteen employees, and offer a range of services to address physical, social, vocational, and psychological problems that plague veterans who are homeless. In 1995, the HCHV Program in Little Rock was named one of seven, Comprehensive Homeless Centers (CHC) because of its broad array of services. The primary mission of the CHC in Little Rock is to expedite the transition of homeless veterans from a state of instability to one of physical, mental, vocational, and social constancy. Strategies for achieving this mission include street, shelter, and prison outreach; case management; specialty services for mental health, substance abuse and physical disabilities; referrals for acute and residential treatment; permanent supportive housing; and supported aftercare with in-home follow-up. In 1997, their innovative approaches to achieving this vision earned them the distinction of being named one of six “Clinical Programs of Excellence” for treatment of homeless veterans in the VA system.

The CHC in Little Rock is composed of HCHV, Residential Rehabilitation Treatment (Domiciliary), and Compensated Work Therapy-Therapeutic Residency (CWT-TR) Programs. The HCHV Programs include Homeless Veterans Outreach, Housing and Urban Development-VA Supported Housing (HUD-VASH), HCMI Permanent Supported Housing, HCMI Community Residential Contract Treatment, Grant and Per Diem, VA Benefits Linkage, Special Needs-Chronically Mentally Ill, and Drop-In Day Treatment Center Programs. The Special Needs-Critical Time Intervention Program, the newest component of the CAVHS Homeless Programs, is a collaborative program with St. Francis House, which houses the Chronically Mentally Ill Treatment and the Vet-to-Vet components of the Program. The HCHV Program is also a participant in the HUD Continuum of Care, where they participate as a member of the Interagency

Council on Homelessness and the Central Arkansas Team Care for the Homeless (CATCH) Coalition. They are also members of the Jericho Coalition, which grants access to permanent housing for formerly incarcerated veterans, who would otherwise have problems gaining access to housing. HCHV staff work irregular tours Monday through Thursday, extending their hours of outreach and providing after-hours access to services. HCHV staff also provide aftercare follow-up to veterans who have been placed in permanent housing.

In 2005, the HCHV Program joined with the Veterans Benefits Administration and Veteran Service Organizations to implement the Central Arkansas Dignity Memorial Homeless Veterans Burial Program, a program created by veterans for veterans. This was a significant addition to the program for veterans with no family and no resources for burial.

The HCHV program was recognized as a GlaxoSmithKline Circle of Excellence Award winner in 2001. They received an Exemplary Program Award in 2003 from the Homeless Programs Branch of the SAMHSA Center for Mental Health Services. They became one of the first VA Homeless Programs accredited by CARF in 2002. They were designated "Exemplary" based on Employment and Community Service Standards in 2002 and again received this three year "Exemplary" designation for 2005-2008.

Moving Care to the Community: Drop-In Day Treatment

To improve access to services for homeless veterans, the HCHV Program relocated from the North Little Rock campus to a community location in downtown Little Rock in 1996. This accessible location is a place that homeless veterans can call "home." This relocation has increased convenience for both customers and staff and has allowed HCHV staff to expand the level of services that are readily available to homeless veterans. The facility operates Monday through Friday during the hours when the shelters are closed. At this location, veterans can receive psychosocial and health assessments, participate in therapeutic groups, obtain food and clothing, receive personal hygiene items, and use laundry and shower facilities.

The Drop-In Day Treatment Center in Little Rock operates as a Social Treatment Model. It is a Person Centered Program that focuses on the strengths of veterans and strives to meet them where they are and allow them to define their own reality. During its 11 years of operation in a community setting, the center has consistently provided services of exceptional quality that adhere to the highest standards of clinical care, patient satisfaction, resource utilization, teaching, and research.

In FY 06, the HCHV program staff, operating from the Drop-In Day Treatment Center, completed 463 intakes and made 11,811 visits to 962 separate individuals. Most (97%) of these veterans were male. Sixty-five percent were African Americans, 33% were Caucasians, and 0.4% were Hispanic. Most (73%) reported a history of alcohol abuse, 68% reported a history of drug abuse, 46% reported symptoms of mental illness, and 68% reported having a medical illness. Gulf War veterans comprised 11% of contacts, Vietnam era veterans were 43%, post-Vietnam veterans were 42%, veterans serving between Korea and Vietnam were 4%, Korean era veterans were 1%, and 0.5% were World War II veterans. Seventeen percent of these reported combat exposure. Maritally, 46% were divorced, 14% were separated, 4% were widowed, 6% were married, and 30% were never married. Forty-three percent had been homeless for more than one year, compared to the national average of 27%. This demonstrates that veterans are more likely to experience chronic homelessness.

In addition, 84% of homeless veterans in Arkansas report hospitalization for psychiatric or substance abuse problems compared to 73% for all other sites. A population-based study by Rosenheck and others (1989) also found that VISN 16 had the second highest number of veterans with incomes below \$10,000. Despite the fact that our veterans are sicker, more chronically homeless, and experience greater poverty, clinical outcome measures from VA's Northeast Program Evaluation Center (NEPEC) show that veterans discharged from residential treatment in Little Rock were consistently above the VA national average in improvements for all diagnostic categories. NEPEC data demonstrates that in 2006, 88% of veterans discharged from the HCHV program at Little Rock showed improvements regarding alcohol abuse compared to 61% nationally. In the social/vocational arena, 95% of Little Rock veterans showed improvement compared to the national average of 54%, and 90% showed improvement in medical problems compared to 53% nationally.

The next installment in this series on homelessness will focus on the role that collaboration and community linkages play in serving and achieving successful outcomes.

Rosenheck RA, Leda CL, Gallup P, et al. Initial assessment data from a 43-site program for homeless chronically mentally ill veterans. *Hospital and Community Psychiatry* 40:937-942, September 1989.



Meet the MIRECC Researchers: Dr. Mark Kunik

Interview with
Mark E. Kunik, MD, MPH
Associate Director for Research Training, SCMIRECC
Associate Director, Houston Center for Quality of Care and Utilization Studies (HCQCUS)
Professor, Menninger Dept of Psychiatry and Behavioral Sciences, Houston, TX

Editor: *What is your area of research?*

Dr. Kunik: I am a geropsychiatrist and health service researcher. My primary area of research is in finding better ways to assess and treat psychological problems in persons with medical and neurological illnesses in non-mental health settings. I am most attracted to research with older adults within the primary care setting. More than half of my research efforts and products have focused on dementia. Within dementia research, most of my work has been on developing better approaches to the behavioral and psychological problems that occur in persons with dementia.

Editor: *What active studies do you have going?*

Dr. Kunik: I am the principal investigator on two grants funded by VA HSR&D (Health Services Research & Development). “Causes and Consequences of Aggression in Dementia” is an epidemiologic cohort study where we have been following 225 newly diagnosed persons with dementia and their caregivers for two years, looking for incidences, potential mutable causes, and the consequences of aggression. Our preliminary findings show a 40% annual incidence of aggression that is predicted by pain, depression, psychosis, caregiver burden, and caregiver-patient relationship problems. A more recently funded study, “Partners in Dementia Care,” is a controlled trial that examines whether a collaborative care approach improves patient and caregiver outcomes

in the primary care setting. This multi-site study also receives funding from SCMIRECC and the Robert Wood Johnson Foundation and is occurring in Houston, Oklahoma City, Providence, and Boston. Finally, I am a co-investigator on funded projects led by Drs. Melinda Stanley and Lauren Marangell.

Editor: *What are the implications or potential benefits of your research?*

Dr. Kunik: I hope that my research helps to lead to finding potentially treatable causes of aggression in persons with dementia and that such findings will lead to a prevention approach. Currently, antipsychotic medications are the mainstay for treating behavioral problems, despite their limited efficacy and substantial morbidity. I also hope that my research helps to improve the assessment and treatment of dementia in the primary care setting.

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

Dr. Kunik: As a practicing geropsychiatrist, I was upset by the limited efficacy and overuse of tranquilizing medications to manage behavioral problems in persons with dementia. I was also surprised by the lack of empirical data about the causes of aggression and other behavioral problems. It remains a puzzle to me to this day why

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pharmaceutical companies and the National Institutes of Health (NIH) continue to fund so many clinical pharmacologic trials with so little data on potential causes. My public health training shifted my research focus to prevention and on treatment in non-Mental Health settings, which is where most people with mental health problems are seen.

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

Dr. Kunik: I have had the benefit of many great influences on my academic career since medical school. However, if I was to limit the list to two persons, it would be Drs. Carol Ashton and Greer Sullivan, who were the co-mentors for my VA Career Development Award. Prior to meeting them in 1998, I was a clinician-educator; I had never had a grant and did not even know about health services research. Neither one of them knew me, but they were willing to take a chance on me by being my mentor. The funding of my Career Development Award led to my initial participation and current leadership in the SCMIRECC and the VA Houston Center for Quality of Care and Utilization Studies (HCQCUS).

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

Dr. Kunik: Find a mentor who has a career similar to the one that you are aiming for. Make sure that the mentor has a good track record of mentoring as well. A good track record can be measured by the number and successes of their mentees. You can also ask these mentees, and others in the field, for their advice on good mentors.

Also, associating yourself with a research center is also a key to success as a junior researcher. Research centers have resources important to success, such as research mentors, methodologists, pilot funding, and other research infrastructure. Examples of research centers include MIRECC, GRECC (Geriatric Research, Education and Clinical Center), PADRECC (Parkinson's Disease Research, Education and Clinical Center), CTSA (Clinical and Translational Science Awards) programs, and other NIH funded research centers.

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

Dr. Kunik: The best way to reach me is by email: mkunik@bcm.edu or kunik.marke@va.gov



2007 Psychopharmacology Update

Baylor College of Medicine and the South Central MIRECC will hold the **2007 Psychopharmacology Update** on Friday and Saturday, November 2-3, 2007, in Houston, TX. The complete program is forthcoming. This meeting is approved for CME.

Space is limited! To register, go to www.baylorcme.org/1377/ or call Baylor College of Medicine, Office of Continuing Medical Education at 713-798-8237 for a registration form. **South Central MIRECC Affiliates can have their registration fees covered by the MIRECC. To inquire about registering as a MIRECC Affiliate, contact Ms. Brenda Schubert at Brenda.schubert@med.va.gov. The deadline for registration is October 15, 2007.**

The Houstonian Hotel is located at 111 North Post Oak Lane, Houston, TX 77024. The special group rate is \$185 per night. For reservations, call 800-231-2759.

For more information, email the Baylor Office of Continuing Medical Education at cme@bcm.tmc.edu.

Implementing Dialectical Behavior Therapy at the Little Rock VA

Stephen McCandless, PsyD; Grace Aikman, PhD; Erica Hiatt, MD;
Irving Kuo, MD; and John Milwee, PsyD
Central Arkansas Veterans Healthcare System, Little Rock

The past two editions of the *South Central MIRECC Communiqué* featured articles from clinicians at the Gulf Coast and Houston VA's in which they described implementing Dialectical Behavior Therapy (DBT) programs at their facilities. The Houston VA provided a rationale for developing these programs within VA systems as well as the theoretical underpinnings of the treatment approach. The Gulf Coast VA elaborated on the MIRECC supported training experiences and instituting their program. In this third and last installment in the series, the Little Rock VA hopes to build on the reader's understanding by demonstrating how we present this treatment to clients. We will also describe our experiences in implementing the program.

Explaining DBT to Patients: In order to establish a collaborative relationship with patients, we begin therapy with an overview of the treatment approach. What follows is a general description about DBT provided to patients in the first session. For more information see Linehan (1994).

DBT was developed in the 1980's to treat individuals who have problems regulating their emotions. While all of us are emotional to some extent, people with emotion regulation problems tend to have frequent and dramatic emotional changes. Not only does it take less to make these individuals happy, sad, angry, fearful, or even confused, but they tend to experience these emotions more intensely and for longer periods of time. These problems often develop from a combination of biological traits inherited from family members and from learning as a child. We think that victims of abuse or neglect are particularly vulnerable to these problems as they have not been given appropriate feedback regarding emotions. Difficulty with emotion regulation creates lots of turmoil not only within the individual but also with those closest to them. Often people attempt to regulate their emotions by self-harming or by attempting suicide. These behaviors can also be a way of eliciting support from other individuals to help regulate emotion. DBT teaches people better and more effective alternative behaviors and a way to have a "life worth living."

This treatment will teach you skills based on dialectical principles. The term Dialectics comes from classic philosophy and refers to a synthesis of views that are seemingly incompatible. Zen principles of acceptance and mindful awareness are practiced to help patients develop a dialectical understanding of themselves and others. It is a way of thinking that promotes wellness by helping people become more at ease with themselves and the world around them. These skills are especially effective for people who view themselves, others, and the world in extremes rather than finding a middle ground. For example some people tend to experience the world as either "all good versus all bad," others as "loving versus hateful," and themselves as "virtuous versus shameful." Most importantly, dialectical thinking will help you fully accept yourself as you are, while at the same time recognizing a need for change.

Behavior Therapy focuses on things you can do to cope with difficult emotions. The treatment teaches you new skills, helps you practice these skills, and assists you in knowing when to use them. In other words, we hope that you not only learn new skills but that they become habits for you. This process of developing recently learned skills into long term behaviors (or habits) is termed Behavior Therapy.

In addition to individual psychotherapy to help you with your specific problems, skills groups are a part of the DBT program and consist of four sections: Mindfulness, Emotion Regulation, Distress Tolerance, and Interpersonal Effectiveness. Mindfulness techniques enable you to truly focus on what is happening in the present moment. We can better deal with situations (including our own thoughts and feelings) when we are able to see them clearly. The other three sections focus on techniques to help regulate emotions, better tolerate distressful feelings when they do occur, and deal more effectively with other people.

We expect at least six months to a year of therapy before seeing a significant reduction in self-harming behaviors and unrelenting crises. At that point, you may choose to continue therapy to address any trauma related issues that are getting in your way of leading an ideal life.

Implementation: Following the January 2007 DBT training, the Little Rock VA established a DBT clinic and housed it within the outpatient Mental Health Clinic. A main goal of our program was to reduce the utilization of the acute inpatient psychiatric ward; therefore, we did not limit our patient recruitment to one specific diagnosis. Our first patients were identified by searching through Quality Assurance data that recorded past parasuicidal acts; others were identified by Mental Health Clinic staff. We identified four categories of patients with repeated hospitalizations or chronic crises: 1) patients with parasuicidal behaviors and Cluster B personality traits (defined as long-standing interpersonal deficits and emotional dysregulation); 2) patients with Cluster B personality traits without recent parasuicidal behaviors; 3) returning OIF/OEF veterans with PTSD who have engaged in parasuicidal behaviors upon returning from combat; and 4) patients with primary drug/alcohol problems who repeatedly attempt suicide during acute intoxication.

Next, we negotiated with other Mental Health programs to create a protocol for assigning patients: 1) We determined that veterans returning from the war should receive services through the PTSD unit and be referred to our program only if that treatment approach fails to reduce parasuicidal behaviors. 2) Patients with primary drug/alcohol problems would first be treated by the dual diagnosis programs and receive a referral to DBT after a successful period of abstinence. 3) Patients with Cluster B traits and parasuicidal behaviors would receive the full DBT program (individual and group therapy). 4) Patients with Cluster B traits but no parasuicidal behaviors would receive only the group therapy component of DBT.

The final step in developing our DBT program was the implementation of individual psychotherapy and group psychotherapy. Our workload allowed for twelve patients to receive the full DBT treatment approach (individual and group psychotherapy). We also allowed for ten more patients that would attend the group only. We established three group psychotherapy cohorts and also began the weekly Team Consultation Meetings (providers only) that are a standard part of the treatment. We use this meeting time for consultation, support, and skills development. After running this program for several months, we returned to Northampton for the second half of DBT training where we received feedback on our program.

At this point we are planning for the future of the program. By collaborating with the Houston and Gulf Cost VA's, we hope to gather outcome data demonstrating the effectiveness of DBT. All three teams are also actively teaching DBT strategies to mental health professionals, and we have discussed plans for incorporating the program into the psychiatric resident and psychology internship training programs.

We would like to thank the South Central MIRECC for its support in helping us to develop this program.



There is no *Bringing Science to Practice* web-based presentation scheduled for October

Because of Monday holidays, the South Central MIRECC Research Rounds will not meet in October and November

October Conference Calls
1-800-767-1750

- 1—Education Core, 2:00 PM CT - *cancelled*
- 8—Research Rounds, 2:00 PM CT - *cancelled; Columbus Day*
- 9—Leadership Council, 3:30 PM CT, access code 19356#
- 11—PSR Group Call, noon PM CT, access code 85388#
- 17—Program Assistants, 2:00 PM CT, access code 43593#
- 23—Leadership Council, 3:30 PM CT, access code 19356#
- 25—National MIRECC Recovery Interest Group, noon CT, access code 22233#

The next issue of the *South Central MIRECC Communiqué* will be published November 5, 2007. Deadline for submission of items to the November newsletter is October 29. 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.

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

SC MIRECC intranet site: vaww.visn16.med.va.gov/mirecc/mirecc.htm

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