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“Closing the efficacy-effectiveness gap”

Editor’s note: This is the last in a three part series on homelessness among veterans in Arkansas. This third article describes some of the contributing factors to homelessness nationally and in Little Rock, various intervention efforts in the VA, and a personal connection to homelessness.

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

Estella L. Morris, PhD, LCSW, H. Lynn Hemphill, LCSW, and Debra Hollis, BS
Central Arkansas Veterans Health Care System, Little Rock, AR

As we enter the 21st Century, we face the reality that in a country teeming with human and natural resources we are plagued by homelessness. It is easy for us to blame this problem on moral decay and the character defects of those who suffer most. However, this is not an issue that will allow us to place blame on a single entity. Although we cannot absolve individuals, neither can we absolve institutions and society in general for this state of affairs. We must acknowledge that externally based societal factors, as well as internally based micro factors are contributors to this problem.

A number of things occurred at the national level in the 1970s and 1980s that played into where we are today. We faced the abolition of the draft and a question of how to build a military comprised of an all volunteer force. We saw a subsequent decrease in support for the post-secondary education system, and benefits for higher education were attached to military service more so than to educational institutions. The cut-off age for beneficiaries receiving Social Security benefits dropped from 21 to 18, and there was no safety net for children aging out of the foster care system. We experienced the Iran Crisis and the Nicaraguan-Contra Affair and, ultimately, we saw the explosion of crack-cocaine on the scene as a dominant part of the American landscape.

In the 1970s in Little Rock, the most significant occurrence was the construction of a 7.4 mile stretch of highway known as Interstate 630, the Wilbur D. Mills Freeway. When this stretch of highway was completed in the late 1980s, and I-630 abutted I-30, east and west came together, forming the heart of the business community on the north and south sides of the river. Although more affluent citizens could now by-pass poor neighborhoods, the city was faced with poverty at its worse. By this time, the faces of homeless individuals, many of whom were veterans, had changed and were visible in the downtown area.

Now in 2007, Little Rock is faced with seeing people who are homeless on a daily basis. As the homeless become part of the greater universal community anchored by the Clinton Library and the 50 year legacy of Little Rock Central High School, it is evident that homelessness in Central Arkansas mirrors that in every other metropolitan area in this country. Homelessness in this rural state, in this city of less than 200,000, is no longer something that can be denied; nor can we be passive in our response. Just as Little Rock became an open window to the world in 1957, it is again in that same position, having been named one of the Top

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Five “Meanest” Cities to homeless people. In spite of efforts by the provider community and the faith-based community, the problem continues to grow. Addressing this challenge is no longer a problem that can be contained or managed by relegating the task to a dedicated few. Homelessness is an issue that affects all of us.

A Comprehensive Approach

There is a need to address issues related to mental illness, substance abuse, incarceration, transportation, education, foster care, and unemployment. All of these issues have the potential for feeding into homelessness. It is, therefore, important to be comprehensive in our endeavors, when it comes to meeting the needs of homeless individuals. It is also a necessity that we address prevention as well as intervention. More importantly, it is necessary to give equal attention to structural factors and consider individual concerns. This requires input from the community of health care systems; businesses; human service providers; civic leaders; educators; local, state and federal governments; faith-based entities; concerned citizens; and those who are now or who have individually or collectively been affected by this concern.

In 2005, city mayors across the nation were challenged by the federal government to develop a “Ten Year Plan to End Chronic Homelessness.” Several cities in Central Arkansas including the two largest cities, Little Rock and North Little Rock, joined forces to develop an initiative to address homelessness. Estella Morris, LCSW, PhD, served as co-chair for this project. Dr. Morris is the Program Manager for the Comprehensive Homeless Center of Excellence at the Central Arkansas Veterans Healthcare System. She was instrumental in developing an integrated approach to ending chronic homelessness and coined the term, “Comprehensive Services, Policy Enactment, and Resource (CPR) Development,” as an approach to addressing the challenges of homelessness. This integrated approach reflects an intimate understanding of the nature of homelessness and of the seriousness and urgency with which this issue must be addressed. Within the realm of social concerns, homelessness represents the apex of social dysfunction and like the threat of a heart

attack within the spectrum of biological urgencies, within the social arena, homelessness can signal the end of life due to pathological factors that are exacerbated by its throes or by the dangers and threats to life represented by the act of being homeless. These dangers contribute to the need to address this issue in a holistic and comprehensive manner. In addition to addressing the clinical needs of this population, homeless providers, advocates, and legislators must also be aware of policies governing homelessness and of structural barriers that present challenges to meeting identified needs. Addressing substance abuse, mental illness, or medical problems will be of little help without also addressing the need for housing and employment or disability income. The CPR approach takes a systems perspective and considers both micro and macro factors that contribute to homelessness.

The CPR approach necessitates the development of partnerships between federal, state, and municipal governments and local non-profit or for profit agencies and business leaders. The approach has led the Central Arkansas Veterans Healthcare System (CAVHS) to work closely with local government and community leaders. In addition, the mayors of North Little Rock and Little Rock appointed Dr. Morris to the Central Arkansas Homeless Commission, charged with implementation of the “Ten Year Plan.” The commission is taking steps to develop a Comprehensive Services Network that will utilize partnerships between businesses and local homeless coalitions and the homeless provider network. The Arkansas State Legislature has established a Legislative Task Force on Homelessness that is expected to develop policies that will create an infrastructure for addressing homeless issues, including a housing and homeless trust fund. This is the first effort by the state to be actively involved in homeless issues. At the last legislative session, Dr. Morris and Dr. Greer Sullivan, Director of the South Central (VISN 16) MIRECC, presented. As a result, a recommendation was made to include a veteran representative on the Task Force. Mr. Terry Williams, a member of the Governor’s Commission on Veterans Affairs and the VISN 16 MIRECC Consumer Advisory Board, was appointed to the Task Force. Mr. Williams is retired military (Army). He is also a member of the Arkansas Veteran’s Coalition.

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The CAVHS has recently hired a full-time Homeless Coordinator who is responsible for development of a Day Resource Center. The Center will be modeled after the VA Drop-In Day Treatment Center. The community has been made aware of this center through participation in quarterly Community Homeless Assessment Local Education Networking Group (CHALENG) meetings. CHALENG is a nationwide initiative in which VA medical center and regional office directors work with federal, state, and local agencies and nonprofit organizations to assess the needs of homeless veterans, develop action plans to meet identified needs, and develop directories that contain local community resources to be used by homeless veterans. More than 10,000 representatives from non-VA organizations have participated in CHALENG initiatives, which include holding conferences at VA medical centers to raise awareness of the needs of homeless veterans, creating new partnerships in the fight against homelessness, and developing new strategies for future action.

The Little Rock CHALENG meetings are held on a quarterly basis and are a mechanism for the VA to inform the community of services that are available for homeless veterans. These meetings also provide a way for the VA to maintain an awareness of community resources and maintain

contacts for ease of access to services. Over the past year, CHALENG meetings have included presentations on topics such as the Ten-Year Plan to end homelessness in Little Rock, PTSD among OIF/OEF veterans, the Homeless Court program, and awareness about and prevention of communicable diseases.

A Personal Connection

In closing, we wish to stress that homelessness is a problem that touches us all, although there is hope. Dr. Morris has noted the personal connection for her. She has a younger brother who completed the VA Homeless program in San Diego 12 years. He was one of the first graduates of that program and has now been stable and in permanent housing since that time. He is currently completing a two-year associate degree computer training program. Dr. Morris also has a younger sister who became homeless and moved into a shelter as a result of a co-dependent relationship. She received assistance from the VA Homeless program in Atlanta. She has maintained full-time employment and has been in stable housing for about 4 years. Dr. Morris states, “I deeply appreciate the VA clinicians who helped my brother and sister. Their progress and the progress of homeless veterans seen at the Central Arkansas Comprehensive Homeless Center are vivid examples of the value of directly addressing the needs of homeless veterans.”



Meet the MIRECC Researchers: Dr. Cully

Interview with

Jeffrey A. Cully, PhD

Clinical Psychologist and Health Services Researcher

Michael E. Debakey VA Medical Center and Baylor College of Medicine, Houston TX

Editor: *What is your area of research?*

Dr. Cully: I am a clinical and health services researcher with a focus on improving the quality of mental health care, especially for veterans with chronic medical conditions. A specific focus of my work pertains to the application of psychotherapy for medically ill patients with heart and lung conditions. My research team is in the process of

adapting traditional psychotherapy to better meet the needs of medically ill patients to increase access and improve both physical and mental health outcomes. Our interventions focus on increasing patient choice (e.g., goal setting and treatment focus), reducing session length and overall duration of treatment, using telephone-based sessions, and

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focusing on the overlap between mental and physical health symptoms.

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

Dr. Cully: I have two ongoing programs of research. The first is a series of studies (several of which were funded by the SC MIRECC) designed to adapt psychotherapy for the medically ill. At present, we are collecting pilot data for a psychosocial intervention (Adjusting to Chronic Conditions using Education and Support - ACCES). This project has been especially exciting and rewarding as we have been able to conduct high quality research but, more importantly, we have provided services to individuals who often do not receive mental health care. Despite the severity of their medical conditions, a large percentage of patients (80% or more) are completing our intervention and over 75% of those completing the intervention are no longer symptomatic for depression/anxiety at the conclusion of the trial.

My second area of active research is to better understand the quality of psychotherapy being provided within medical care settings. This research has largely utilized VA databases to examine the number of patients receiving psychotherapy, time between diagnosis and psychotherapy treatment, and the total number of sessions provided to patients.

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

Dr. Cully: I hope that our research directly improves the mental health care provided within the VA. If our ACCES intervention continues to show positive results, we hope to disseminate this work within the primary care and medical care settings to increase access to mental health care for patients who need these services. My psychotherapy quality research will hopefully provide information that leads to increases in the number of patients who receive effective psychotherapy through improved resource allocation and/or improved evidence-based practices.

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

Dr. Cully: Almost all of my research is inspired by my clinical and applied research experiences and by

the patients I interact with. My focus on medically ill patients is founded in my geropsychology background and the numerous patients I have worked with in the primary care setting at the MEDVAMC.

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

Dr. Cully: The person who has been the most influential on my research career is my current primary mentor, Mark Kunik, MD, MPH. Dr. Kunik and I have worked with one another since 1998, and he has been my mentor and direct research supervisor since 2002. He is a selfless mentor with a passion for teaching and developing future clinicians and researchers. He has been instrumental in providing the knowledge and support that I have needed in the process of moving from postdoctoral fellowship, to an Associate Investigator Award (now CDA-1), and now to my current VA Career Development Award (CDA-2).

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

Dr. Cully: Passion, persistence, and colleagues are important parts of my work. I encourage the postdoctoral fellows and interns who I mentor to follow research and clinical issues that inspire them. It is passion that will carry you forward on those grey days when things are not going well. Passion is also closely related to purpose and happiness, which are vital for maintaining one's well-being.

Because research often involves delayed rewards, persistence is also very important. Whether it is trying to complete a manuscript or a grant, persistence is the key to your eventual success. Finally, your colleagues make a huge difference. Surround yourself with mentors and peers who inspire you to be your best, and remember to be active in shaping your work environment by creating a positive culture of teaching and collaboration.

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

Dr. Cully: I can be reached by email at jcully@bcm.edu or by phone at 713-794-8526.

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National Suicide Prevention Hotline (1-800-273-TALK) Has a Dedicated Line for Veterans

Loretta A. Coonan, LCSW, MEDVAMC Suicide Prevention Coordinator, Houston
Jan Kemp, RN, PhD, VA National Suicide Prevention Coordinator, Canandaigua, NY

Veterans experiencing emotional and suicidal crisis can now immediately access emergency counseling services from VA employees 24 hours per day/7 days per week via the **National Suicide Prevention Hotline (1-800-273-TALK)**. The 2004 VHA Mental Health Strategic Plan specified the development of a national hotline for veterans experiencing emotional crisis. VHA partnered with the established national hotline operated by the Suicide Prevention Lifeline Organization (a grantee of Substance Abuse and Mental Health Services Administration – SAMHSA), hired a group of experienced crisis counselors to respond to the calls of veterans and their concerned family members, and established a process for ensuring timely follow-up for the veteran at local VA facilities through the network of Suicide Prevention Coordinators. Some of the frequently asked questions about the National Suicide Prevention Hotline are answered below.

What happens when a veteran calls the National Suicide Prevention Hotline?

The caller immediately hears an instruction to enter the number “1” if he or she is a veteran or a concerned family member of a veteran. Once entered, the call is immediately transferred to the VA crisis call center located in Canandaigua, NY. The VA staff member receiving the call immediately assesses the urgency of the call, whether or not emergency rescue services are needed, provides counseling, and with the permission of the veteran, sends an electronic consult to the Suicide Prevention Coordinator in the veteran’s immediate area. The local Suicide Prevention Coordinator then contacts the veteran and works with the veteran to connect him or her to mental health services at the local VA facility, community based outpatient clinic, Vet Center, or community mental health center depending on the individual needs of the veteran.

How many veterans have used the National Suicide Prevention Hotline?

The National Suicide Hotline implemented the call line for veterans on July 23, 2007 and has processed 12,322 calls as of October 27. Of those calls, 3,868 have been identified veterans, 206 callers have been identified family and friends of veterans, 961 referrals have been made to Suicide Prevention Coordinators at individual facilities, 195 emergency rescues have been initiated from the Suicide Prevention Call Center, 667 “warm transfers” to community or VA services have been made by the Suicide Prevention Call Center, and 114 active duty military personnel have utilized the hotline.

What feedback has been received from veterans about the Suicide Prevention Hotline?

Response to the Suicide Prevention Hotline has been very positive. Veterans who have utilized the hotline have frequently reported how helpful the service has been in resolving crises. Several new veterans have been enrolled into VA care since their call to the Hotline, and other veterans are now receiving additional services and support.

How can veterans and their family members access the hotline?

The National Suicide Prevention Hotline is available 24 hours per day and 7 days per week. Veterans and their concerned family members or friends can call the hotline at **1-800-273-TALK (8255)** and select number 1. Interpretation services are also available on the veteran option.





Library Tip: What's New on the Virtual Library— ACP PIER Plus from STAT!Ref

Marvett S. Burns, MLS
Gulf Coast Veterans Health Care System, Biloxi, MS



VHA Offices of Information and Patient Care Services and the VA Library Network (VALNET) are pleased to announce that all VHA staff now have access to **ACP PIER Plus** from STAT!Ref and the following point of care, evidence-based resources:

- **ACP PIER** (American College of Physicians-Physicians' Information and Education Resource) – An authoritative, evidence-based guide for improving clinical care.
- **AHFS DI Essentials** (American Hospital Formulary Service-Drug Information Essentials) – Designed for clinicians who don't have the time to look through complex drug monographs and need direct, accurate answers fast!
- **AAFP Conditions A to Z** (American Academy of Family Physicians-Conditions A to Z) – A resource for consumer health information.

Want to learn more about **ACP PIER Plus** from STAT!Ref? Checkout the **ACP PIER Plus** web page at http://vaww.vhaco.va.gov/VALNET/ACP_Pier.asp or login to [ACP PIER Plus](#).



Recent SC MIRECC Publications

Below is a partial list of publications (A-K) from South Central MIRECC core and affiliate investigators over the past year. MIRECC personnel are indicated in bold face. Please contact the lead author for further information about the study or paper.

Arredondo SA, **Latini DM**, Sadetsky N, Pasta DJ, Wallace KL, & Carroll, PR (2007). Quality of life after second treatment for prostate cancer: Data from CaPSURE™. *Journal of Urology*, 177: 273-279.

Balasubramanyam V, **Stanley MA**, **Kunik ME**. (2007). Cognitive behavioral therapy for anxiety in dementia. *Dementia* 6(2): 299-307.

Boake C, Noser EA, Ro T, Baraniuk S, Gaber M, Johnson R, Salmeron ET, Tram TM, Lai JM, Taub E, Moye LA, Grotta JC, **Levin HS**. (2007). Constraint-induced movement therapy in early stroke rehabilitation. *Neurorehabil Neural Repair*, 21:14-24.

Brailey K, **Vasterling JJ**, Proctor SP, **Constans JI**, & Friedman MJ. (2007). PTSD symptoms, life events, and unit cohesion in U.S. soldiers: Baseline findings from the Neurocognition Deployment Health Study. *Journal of Traumatic Stress*, 20: 1-8.

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Druss BG, **Henderson KL**, Rosenheck RA. (2007). Swept away: Use of general medical and mental health services among veterans displaced by Hurricane Katrina. *American Journal of Psychiatr.* 164 (1): 154-156.

Dunn NJ, Rehm LP, Schillaci J, Soucek J, Mehta P, Ashton C, Yanasak E, **Hamilton JD**. (2007). A randomized trial of self-management and psychoeducational group therapies for comorbid chronic posttraumatic stress disorder and depressive disorder. *J Traum Stress.*, 20:221-237.

Fabian RH, Perez-Polo RJ, **Kent TA**. (2007). A decoy oligonucleotide inhibiting NF- κ B binding to the IgG κ B consensus site reduces cerebral injury and apoptosis in neonatal hypoxic-ischemic encephalopathy. *J Neurosci Res.*, 85(7):1420-6.

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December Conference Calls 1-800-767-1750

- 3—Education Core, 2:00 PM CT, access code 16821#
- 10—Research Rounds, 2:00 PM CT – *cancelled*
- 11—MIRECC Leadership Council, 3:30 PM CT, access code 19356#
- 13—PSR Group Call, noon PM CT, access code 85388#
- 19—Program Assistants, 2:00 PM CT, access code 43593#
- 25—MIRECC Leadership Council, 3:30 PM CT, access code 19356# - *cancelled*
- 27—National MIRECC Recovery Interest Group, noon CT – *cancelled*

The next issue of the *South Central MIRECC Communiqué* will be published January 7, 2008. Deadline for submission of items to the January newsletter is December 31. 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

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