South Central MIRECC

Promoting equity in engagement, access, and quality of mental health care for Veterans facing barriers to care, especially rural Veterans

www.mirecc.va.gov/visn16

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Communiqué

In This Issue

New Year, New Opportunities

By Ashley McDaniel

After 15 years of distinguished service as the Director of the SC MIRECC, Dr. Greer Sullivan is stepping down this month and starting a new chapter of her life working with the University of Arkansas for Medical Sciences (UAMS) Translational Research Institute (TRI), which reports to the UAMS Chancellor's Office. She will serve as Co-Principal Investigator of the TRI Clinical Translational Science Award (CTSA) grant and will lead its renewal effort. Dr. Sullivan will also create a new center for community translational research. She will continue to be a Professor in the UAMS Department of Psychiatry and an Affiliate Investigator with the SC MIRECC. She has two ongoing VA projects, Provider Decision-Making and the VA-Clergy Partnership Project.

Since 1998, Dr. Sullivan has led the SC MIRECC as it evolved from "closing the gap" in mental health clinical areas to having a greater emphasis on mental health services research and implementation science and improving quality of and access to mental health care by rural and other Veterans facing barriers to

See OPPORTUNITIES on page 2

Meet the new SC MIRECC Associate Director for Improving Clinical Care: Kathy L. Henderson, M.D.

In November 2012, the SC MIRECC welcomed Dr. Kathy L. Henderson as its new Associate Director for Improving Clinical Care. Dr. Henderson replaces Dr. Patricia Dubbert, who is now serving as the Associate Co-Director for Research Training. This month, Dr. Henderson tells us about her new role and past experiences.

Q. *Dr. Henderson, you spent many years as the manager of the VISN 16 Mental Health Product Line (MHPL). How did your previous position prepare you for your new position as the SC MIRECC Associate Director for Improving Clinical Care?*

I have been with the VA almost 29 years and spent over 13 years in the role of Manager of the VISN 16 Mental Health Product Line. During those years, I worked daily with the Chiefs of Mental Health at every facility, and travelled multiple times to every hospital and the majority of the community-based

See CLINICAL on page 4

OPPORTUNITIES (continued from page 1)

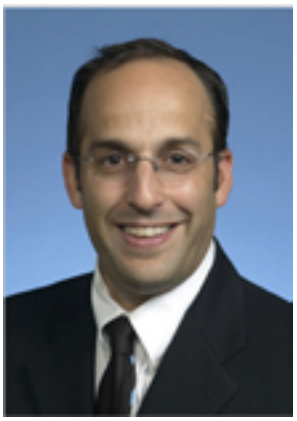
care. She leaves behind a rich legacy and although it was a difficult choice to step down, Dr. Sullivan is excited about this new opportunity. "Leading the MIRECC has been the most rewarding experience of my career. I'm very grateful to have had that experience and I'm very grateful to all wonderful people that I've met and had the opportunity to work with," said Sullivan.

Dr. Sullivan will be remembered by SC MIRECC staff and investigators who have worked with her over the years. Michael Kauth, the SC MIRECC Co-Director and Associate Director for Education, has very fond memories of his time working with her. "I remember first meeting Greer in Little Rock where we had convened to practice our MIRECC proposal presentation to Office of Mental Health leaders," said Kauth. "Tom Horvath was leading VA Mental Health at that time. We were expected to look as if all of us had always worked together. It was a very awkward and anxiety-provoking meeting, but we managed to pull it off. Before the MIRECC came along, I was bored and thinking about leaving the VA. Greer offered me a part-time MIRECC job leading Education efforts, and everything changed! She had a vision for what kinds of educational programs we should offer, but she gave me the freedom to figure out how to make it work. Within a short time, our MIRECC was known for its educational activities, and I was given a national role coordinating collaborative education among the MIRECCs."

With Dr. Sullivan's support, Dr. Kauth eventually took on more leadership roles in the MIRECC and VA. "What Greer has always done best is to inspire people and provide them opportunities to grow. Greer really made my VA career, as she made the careers of many others who were involved in the MIRECC. If not for Greer and the MIRECC, I would not be in the regional and national leadership roles that I have today."

Starting January 12, Dr. Mark Kunik will serve as the Acting SC MIRECC Director while a national search begins to find Dr. Sullivan's replacement. Dr. Kunik is a psychiatrist whose research focuses on examining the determinants of behavioral disturbances in patients with dementia, and how these behavioral disturbances affect health service use. Dr. Kunik is also interested in developing cost-effective interventions to treat anxiety and depression in older patients with chronic medical illnesses in the primary care setting. Dr. Kunik has served as the SC MIRECC Associate Director for Research Training for many years, in addition to his duties as a Professor in the Baylor College of Medicine Department of Psychiatry & Behavioral Sciences and as Associate Director of the Houston VA Health Services Research & Development Center for Quality of Care & Utilization Studies.

Greer Sullivan, MD, MSPH



Mark Kunik, MD, MPH

"Like mine, Mark Kunik's career really took off with the MIRECC. Mark is a solid health services researcher, respected expert, and a very capable leader. He understands our MIRECC mission and knows all the players. The MIRECC is in very good hands with Mark Kunik as Acting Director. Mark Kunik is probably the easiest guy to get along with in the VA! At the same time, he knows what he wants and he makes it clear what he expects from others," added Kauth.

The SC MIRECC wishes Drs. Sullivan and Kunik good luck in their new roles. We are excited to see what opportunities await us all in the New Year. ♦

ATTRIBUTION: ACKNOWLEDGEMENT OF MIRECC RESEARCH SUPPORT/EMPLOYMENT

SC MIRECC researchers and educators have a responsibility to ensure that the SC MIRECC receives proper credit for SC MIRECC-supported studies or projects in articles, presentations, interviews, and other professional activities in which the results of those projects are publicized or recognized. All investigators should credit the SC MIRECC if they receive either direct or indirect support from the SC MIRECC. For example, "This work was supported in part by the VA South Central (VISN 16) Mental Illness Research, Education, and Clinical Center." If you receive salary support from the SC MIRECC, you should list the SC MIRECC as an affiliation.

SC MIRECC Education Bulletin Board

Pictured: SC MIRECC Clinical Education Products Cover

The SC MIRECC catalog of Clinical Education Products has been updated. The products in this catalog were developed through the Clinical Education Grants Program, which supports the development of unique clinical education tools by frontline clinicians and investigators at VA parent facilities and community-based outpatient clinics. Program administrators work closely with frontline clinicians to develop their ideas into fundable projects which can extend or complement research and demonstration projects through the development of clinical tools, intervention materials, training programs, and evidence-based treatment manuals. The products developed through this program are offered to mental health providers and consumers by download or request at no charge.. Download the catalog at http://www.mirecc.va.gov/VISN16/docs/SCMIRECC_Clinical_Education_Products_Catalog.pdf.

Featured Product

Pictured: Working with Couples Module

Working with Couples Training Modules - These modules were developed by Drs. Michelle Sherman and Michael Kauth based on live training content created by Drs. Michelle Sherman, Ursula Bowling, and Dutch Doerman. The six modules provide an overview of essential content and skills for treating the Veteran and his or her partner or spouse who struggle with communication problems, anger and conflict, mental illness, trauma, and reintegration into the family after deployment. This training targets VA clinicians but may be helpful to non-VA providers who work with Veterans. Additional training and supervision are required to become competent in providing couples therapy. Visit the Working with Couples Web site at http://www.vacouplestherapy.org/. ♦

CBOC Mental Health Rounds

2nd Wednesdays Monthly
8:00-9:00 AM CT
1-800-767-1750; 26461#

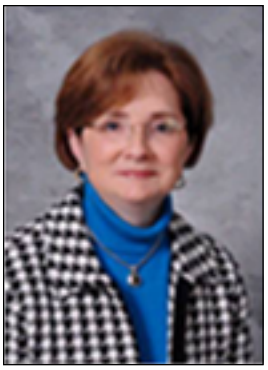
Sponsored by the South Central MIRECC

VISN 6, 16, and 23 mental health providers are invited to attend the next SC MIRECC CBOC Mental Health Rounds session titled “Mild Cognitive Impairment" on Wednesday, January 9, 2013 at 8:00-9:00 a.m. (CT). This LiveMeeting session will be presented by Jared Benge, Ph.D. At the conclusion of this educational program, learners will be able to:

1. Make a conceptual distinction between normal aging, mild cognitive impairment, and dementia;
2. Discuss the theoretical importance and limitations of this concept, and
3. Outline a screening strategy for monitoring cognitive complaints in busy clinical practices.

Call 1-800-767-1750 and use access code 26461# to participate. For registration and continuing education credit information email Ashley.McDaniel@va.gov.

CLINICAL (continued from page 1)



Kathy L. Henderson, M.D.

outpatient clinics (CBOCs). This experience gave me the opportunity to truly understand what clinical opportunities and barriers exist across the Network. I have also worked very closely with the Office of Mental Health Operations, Mental Health Services, and other VISN Mental Health Leads and understand the national perspective of mental health in VHA. This has also assisted me in identifying best practices that could be implemented in VISN 16. Although some may not know this, I have been involved in the SC MIRECC from its inception, assisted in the development of the original proposal, and have continued to be very active in the Education Core. The transition to this new role seems like a natural for me at this point in my career.

Q. *What was the most important thing you accomplished in your position with the VISN 16 MHPL?*

During my tenure with the VISN 16 MHPL, mental health funding greatly increased, giving us the opportunity to develop, implement, and expand many new mental health programs across the network. Facilities that had very few mental health staff in 2005 had tripled and quadrupled the number of providers by the end of fiscal year 2012. But the most important accomplishment for me has been the implementation of telemental health services in VISN 16. This project was originally supported by a previous Network Director, Dr. Robert Lynch, and championed by myself and Dr. Dean Robinson, Chief of Mental Health in New Orleans. Dr. John Fortney also was instrumental in this effort. When this project started in 2002, only a few facilities across the country were using this technology to deliver mental health services to Veterans. With about $2 million, we were able to purchase 20 Clinical Video Teleconference (CVT) units and hire staff at the facilities to provide mental health services to Veterans in CBOCs.

It wasn't until much later that Central Office strongly encouraged and then ultimately mandated that CVT services be available to Veterans for easier access to services. By the end of FY12, VISN 16 provided 17,346 mental health encounters serving 6,458 Veterans, which was almost 90% of all CVT services provided by the network. I am very proud of the efforts we have made to provide needed mental health treatment to Veterans in rural areas.

Q. *What new directions or initiatives will you be considering for your new role in the SC MIRECC?*

Of course, there is so much more that can be done with telemental health services in CBOCs, home telehealth, and other health informatics tools. We have really only scratched the surface of what can we do with technology. The VISN 16 Network Director is concerned about the number of suicides in our Veteran population and the adequacy of evaluating Veterans at high risk for suicide. There will be a 'Mental Health Summit' in February to identify short and long term strategies that will focus on suicide reduction, the pursuit of perfect depression care, and seamless transitions in delivery of mental health care. The SC MIRECC will work closely with the Mental Health Product Line to develop and implement innovative concepts derived from that meeting. I personally have an interest in evaluating non-evidence-based psychopharmacologic prescribing practices and polypharmacy, and am hopeful that this role will give me an opportunity to expand our usage of the Corporate Data Warehouse in addressing those issues.

Q. *You will also spend half of your time working with the VA Mental Health Quality Enhancement Research Initiative (MH QUERI). What are the responsibilities of this position?*

I will also be serving as the Clinical Coordinator for MH QUERI. Although I do not currently know all of the responsibilities of this position, I do believe that my clinical and administrative experience in the field can greatly inform researchers as they design interventions that will take evidence-based treatments and implement them into everyday practice. Initially, I will be involved in the areas of Serious Mental Illness Health and Recovery.

Q. *Is there anything else our readers should know that I have not asked you?*

Well, I have been in the middle of planning my daughter's wedding that takes place January 5th. And, my husband and I are big sailors so I always love discussing that with folks.

continued on page 5

continued from page 4

Q. *Finally, how can people get in touch with you if they have questions about your work?*

I can always be reached on email at Henderson.Kathy@va.gov or at 501-257-1967. ♦

Recent SC MIRECC Publications

A DESCRIPTION OF TELEMENTAL HEALTH SERVICES PROVIDED BY THE VETERANS HEALTH ADMINISTRATION IN 2006-2010.

Deen TL, Godleski L, **Fortney JC**

Psychiatric Services, 2012, Nov, 63(11), 1131-1133

This is the first large-scale study to describe the types of telemental health services provided by the Veterans Health Administration (VHA). The authors compiled national-level VHA administrative data for fiscal years 2006-2010 (October 1, 2005, to September 30, 2010). Telemental health encounters were identified by VHA and U.S. Department of Veterans Affairs stop codes and categorized as medication management, individual psychotherapy with or without medication management, group psychotherapy, and diagnostic assessment. A total of 342,288 telemental health encounters were identified, and each type increased substantially across the five years. Telepsychotherapy with medication management was the fastest growing type of telemental health service. The use of videoconferencing technology has expanded beyond medication management alone to include telepsychotherapy services, including both individual and group psychotherapy, and diagnostic assessments. The increase in telemental health services is encouraging, given the large number of returning Veterans living in rural areas.

ANXIETY DISORDERS, PHYSICAL ILLNESSES, AND HEALTH CARE UTILIZATION IN OLDER MALE VETERANS WITH PARKINSON DISEASE AND COMORBID DEPRESSION.

Qureshi SU, Amspoker AB, **Calleo JS**, **Kunik ME**, **Marsh L**

Journal of Geriatric Psychiatry and Neurology, 2012, Nov 29 [Epub ahead of print]

This study examined the rates of anxiety and depressive disorders, physical illnesses, and health service use in male patients 55 years or older with a diagnosis of Parkinson disease who were seen at least twice at the 10 medical centers in the Veterans Affairs Healthcare Network of the South Central region of the United States. Of the 273 male patients diagnosed between October 1, 1997, and September 30, 2009, 62 (22.7%) had a depressive disorder. The overall prevalence of anxiety disorders was 12.8%; patients with comorbid depression had a 5-fold greater prevalence of anxiety disorders than those without depression (35.5% vs 6.2%, $P < .0001$). Patients with comorbid depression also had increased prevalence of all physical illnesses examined and more outpatient clinic and mental health visits. Patients with Parkinson disease and comorbid depression are more likely to have anxiety disorders and several physical illnesses, to be using antipsychotic and dementia medicines, and to have increased health service utilization than those without depression.

continued on page 6

continued from page 5

ADAPTING THE MULTIFAMILY GROUP MODEL FOR TREATING VETERANS WITH PTSD

Sherman MD, Perlick DA, Straits-Tröster K.

Psychological Services, 2012, Nov, 9(4), 349-360.

The Department of Veterans Affairs (VA) health care system's leadership has endorsed family involvement in Veterans' mental health care as an important component of treatment. Both Veterans and families describe family participation as highly desirable, and research has documented that having healthy social support is a strong protective factor for PTSD. Family psychoeducation has been shown to be effective in preventing relapse among the severely mentally ill, and preliminary evidence suggests that family interventions for PTSD may improve Veteran and family outcomes. The multifamily group (MFG) treatment model incorporates psychoeducation, communication training, and problem-solving skill building, and it increases social support through its group format. This article describes the rationale for further adaptation of the MFG model for PTSD, and it reviews issues related to its implementation as a promising adjunctive treatment as part of the continuum of PTSD services available in VA.

TOBACCO USE AND SUBSTANCE USE DISORDERS AS PREDICTORS OF POSTOPERATIVE WEIGHT LOSS TWO YEARS AFTER BARIATRIC SURGERY

Adams CE, **Gabriele JM**, Baillie LE, **Dubbert PM**

Journal of Behavioral Health Services and Research, 2012, Oct, 39(4), 462-71.

Although evaluations of tobacco and substance use disorders (SUDs) are required before bariatric surgery, the impact of these factors on postsurgical outcomes is unclear. This study describes (1) the prevalence of tobacco and SUDs in 61 Veterans undergoing bariatric surgery, (2) associations between presurgical tobacco use and postsurgical weight loss, and (3) relationships between presurgical SUDs and postsurgical weight loss. Height, weight, tobacco, and SUDs were assessed from medical charts at presurgery and 6, 12, and 24 months postsurgery. Thirty-three patients (55%) were former or recent tobacco users; eight (13%) had history of SUDs. All patients who quit smoking within 6 months before surgery resumed after surgery, which was associated with increased weight loss at 6 and 12 months. Presurgical SUDs were related to marginally worse weight loss at 12 and 24 months. Bariatric surgery candidates with history of smoking and/or SUDs might benefit from additional services to improve postsurgical outcomes. ♦

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