Ten Years: 1998 - 2008
South Central MIRECC
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"

A Far, Far Better Thing than We Have Ever Done

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(Editor's note: This article is written by the former Chief of Staff of the Houston VAMC, who recently retired from the VA after 9 years. Prior to his Chief of Staff position in Houston, Dr. Horvath was Chief of the Mental Health Strategic Health Group in VA Central Office. In this article Dr. Horvath shares his views and reflections on his many years as a mental health practitioner, administrator, and leader in the VA.)

"It is the best of times, it is the worst of times; it is the age of wisdom, it is the age of foolishness....it is the spring of hope, it is the winter of despair."

In the pre 9/11 days, an insightful and brave Commission reported on New Freedoms to a new President, who endorsed these novel, recovery based approaches to mental health. The recommendations, if properly implemented, had the potential of changing practices and power relationships around the mentally ill. In VHA, dozens of professionals and scores of veterans then crafted a detailed Strategic Plan for Mental Health (MHSP) and earned the moral and financial support of VACO and the National Leadership Board. Money was found, sent to the field, and so far is being spent as intended; a truly precedent setting behavior in our system. Most recently, the tactical implementation of the MHSP – the Uniform Mental Health Services Package (UMHSP) – was published with an invitation to apply for funds to cross the gap from current realities and these generous promises.

To take advantage of this first fortuitous alignment of stars, we have a Congress interested in "binding the wounds of war," and a Secretary for Veterans Affairs, Jim Peake, who has earned a West Point commission, two Purple Hearts, a Silver Star, and a medical degree in the Army, and the respect of his comrades in four decades of service as a hard charging, warmly caring "soldiers' soldier."

A second set of research-related stars rose in the Phoenix-like resurrection of the Office of Research and Development. First in HSR&D and in COOP studies, then in the Basic Biomedical office, then among its top leadership, and now in Clinical and in Rehabilitation research, the consensus grew that

research into mental illness was necessary, that it deserved more respect and more support, and that the field was ready for more investment and was willing to give back good returns.

It seems obvious now that the decade old investment in MIRECCs, their expansion and the recent addition of Mental Health Centers of Excellence has paid off. We have enhanced our research capacity and achievements, engaged in all three forms of Translations (T1: bench to bedside, T2: efficacy to effectiveness, T3: implementation to clinical practice) and strengthened our ability to support the New Freedom Commission Report and the recent Institute of Medicine recommendations for a dramatic transformation of our Mental Health system.

All the MIRECCs that have operated long enough to undergo their 5 year reviews have achieved better than the targeted 1:4 leveraging of their core funding, have published hundreds of articles, held dozens of educational sessions, and initiated significant model clinical programs. All the sites work with the National Center for PTSD, have collaborated with the two relevant QUERIs, and most have good relationships with neighboring HSR&D Centers of Excellence (COEs), PADRECCs, and GRECCs.

VISN 16 is fortunate in hosting both the Mental Health and the Substance Use Disorder QUERIs; these in turn have tight relationships with the Little Rock and Houston HSR&D COEs. If this alone did not put VISN 16 into the cockpit of policy change in mental health, then the new mission of our VISN 16 MIRECC surely will! This MIRECC already successfully specialized in T2, "bridging" translations, and due to its excellent relationship with our Network, was forging ahead in T3 implementation activities. Our new task is to study the T1, T2, and T3 activities in rural health, and to bring physiologically relevant, evidence-based, efficacious and effective care to rural veterans. If successful, this will be a remarkable achievement, as the culture of psychiatry and psychology is widely perceived as an urban, bicoastal elitist affectation, and rural life is (incorrectly) seen as a bucolic antidote to the stresses of modern life.

The "worst of times" of a prolonged war of occupation now exists side-by-side with the "best of times" of the Decade of the Brain. Because our nation is "at the Mall and not at War," the sacrifice falls disproportionately on the patriotic small towns and rural communities, the very places with poor access to the fruits of the Decade of the Brain. Even in the VA, we are not always cognizant of the wounds of war, especially those unseen results of the unholy trinity of post traumatic stress disorder, traumatic brain injury, and substance use disorder (PTSD/TBI/SUD). Those veterans who are condemned to suffer their impact in culturally and physically isolated rural communities may truly experience the worst of times.

Yet it is from these areas that the majority of our service men and women hail from. The best and brightest from these communities join up for all the good patriotic reasons, but for practical considerations as well: to advance themselves, learn skills, earn educational credits and, yes, to see the world. Most of them achieve these goals and more and prove themselves as brave citizen soldiers and good leaders. But too many also bring home visible and invisible wounds. For many of these wounded warriors, it is the "winter of despair" and for their families, distinctly the "worst of times."

Can the new "age of wisdom" in Mental Health overcome these heartbreaking results and meet the needs of soldiers? The traditional remedies do not seem entirely adequate to the task. Our professions have experimented with "brainless psychotherapy" and then with "mindless psychopharmacology" for the past 75 years. We have attempted deinstitutionalization only to end up with homeless veterans on the streets and mentally ill veterans incarcerated in unprecedented numbers. Our society reinvented Bedlam and put some mentally ill back in chains. These are hardly the proper venues for the wounded of the proud, best trained army in history.

Yet if we remember history, we may see some emerging answers. During the last years of the Great War, Ferenczi in his cavalry uniform, and his students of psychoanalysis, began to combine the clinical experience of empathy with the animal observational studies on attachment, and introduced brief, analytic psychotherapy as the treatment of choice for soldiers with traumatic war neurosis. (By contrast, the French were shooting soldiers for cowardice; the British labeled them as having a Lack of Moral Fiber; the Austrians gave them painful electric shocks; and the Americans gave them hot food and baths "within the sound of artillery" and then sent them back into the trenches). Now we know much more about the sociobiological roots of empathy, the developmental psychobiology of attachments and the phenomenological philosophy of "personhood" and have begun to craft and test therapies based on the

emerging foundational concept of "mentalization" that combines these approaches. These developments promise to provide a central meaning to the bio-psycho-social-existential approach to PERSONS. And veterans, more perhaps than anyone else, need to be approached as PERSONS, not as ciphers, patients, clients, consumers, or victims of brain or cognitive/emotional dysfunctions.

Military training and combat experience changes soldiers but their warrior identification often builds a stronger identity, and their journey through war shows them not only cruelty and despair but the depths of empathy, compassion, and sacrifice. As proud PERSONS in their own earned rights, they will not stand for being studied and handled as objects, tested for their brain or cognitive functions, behaviorally manipulated or pharmacologically dulled. But they will engage with us, if we approach them respectfully, manifesting ourselves as often wounded healers. We can then embark together on a journey of enquiry into the heights and depths of human experience, exploring not only vulnerabilities and psychopathologies but resiliences and virtues hammered through fire. We can then work with them for Recovery even though there may be wounds that do not heal. If we have the wisdom to try these new developments in science, I believe that this science can contribute to caring and will inspire the courage to care for these veterans, no matter how difficult; and if we also speak "truth to power" on their behalf, then it will be, as Charles Dickens says, "…a far, far better thing that I do now than I've ever done."

Resources for Rural Researchers

Rural Health Research Gateway

The Office of Rural Health Policy funds research activities at eight rural health research centers, as well as research conducted by individual investigators at other institutions. They provide a website with summaries of current and completed research projects and related publications. The site allows searches by topic, research center or researcher. They also have a listserv for research updates on rural issues. You may sign up on the website: www.ruralhealthresearch.org

VHA Office of Rural Health

The newly established Office of Rural Health (ORH) was created to improve access and quality of care for enrolled rural veterans by developing evidence-based policies and innovative practices to support the unique needs of veterans in geographically rural areas. The strategic direction is to work closely with internal VA offices and field units and external rural health experts, leveraging expertise and resources to build on current programs, and to develop new methods to provide the best solutions to the challenges that rural veterans face.

The ORH has many initiatives under development which include the development of a National Advisory Board, creation of VISN Rural Consultants (VRC), and the development of Rural Health Resource Centers program (RHRC). Currently, the website for the ORH is being developed, but the office is available for information by contacting:

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Tel: (202) 461-7121

Meet the MIRECC Researchers: Dr. Cayla Teal

Interview with
Cayla Teal, PhD
Investigator, Health Communication and Decision-Making Division,
Houston Center for Quality of Care and Utilization Studies, MEDVAMC

What is your area of research?

My broad research agenda focuses on the cultural influences that contribute to health and mental health disparities, particularly through the interaction between consumers and providers and the resulting health practices and decisions. My work has two current parallel tracks: a) the development of enhanced means for measuring patient-level cultural influences on health behavior, and b) the improvement of cross-cultural communication between providers and patients to enhance patient outcomes. We tend to associate "culture" with aspects of race or ethnicity, but my interests also specifically include cultural aspects of rural and urban living.

What active studies do you have going?

I am currently completing data collection on questions we designed to measure patient-level cultural attitudes about communication, the desired role of the provider, family involvement in healthcare, etc. We are just beginning to test these questions and develop others for use specifically around mental health care and with rural patients. I also have a project that is exploring how providers can be more adaptable in their communication with patients, particularly with diverse patients. And then finally, I've just begun working with a team of MIRECC folks to learn more about the VISN 16 Community Based Outpatient Clinics – their organization, structure, needs, etc. – so that we might partner with them in research studies focusing on rural veterans.

What are the implications or potential benefits of your research?

We all know that a patient's culture plays a part in how they seek and utilize health or mental health care. Health care systems and provider training programs have tried to insure that providers have an understanding of patient culture, so the treatment we deliver can be flexible enough to accommodate those cultural differences. However, what we know about culture is based on anthropological studies of cultural groups. Usually these are racial groups or ethnicities, or sometimes, people who congregate in one geographic area. With so much mobility in the United States, all members of one race or geographic area may not be "the same" with respect to their cultural background. Our healthcare system needs to be responsive to cultural differences, without assuming that every member of a specific group has the same cultural beliefs or attitudes. I hope that my research will help us to get a better understanding of how culture really is manifested at the individual level, and how we can better train providers to adapt to cultural differences.

How did you get started in this area of research?

I got interested in this area based on conversations I had with community persons seeking care with less than optimal results. These were usually individuals who were underserved in one way or another – limited access to care, immigrants whose language skills were challenged, members of disadvantaged groups who experienced stereotyping or discrimination, or people who just felt that they couldn't develop a good working relationship with their provider. I heard from most of them about their feelings of not being understood. The more I listened, the more it seemed that there were cultural differences in what they wanted from care and what were we were offering. Things took off from there.

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

I grew up in a rural community of about 500 mostly blue-collar folks, and there was an observable

divide between the races. My father was a minister, and people were always in our home that needed help – a doctor, counseling, a job, a meal. Mom and Dad helped if they could, and race or ability to pay my folks back just didn't matter. I internalized that, I guess. When I began to be interested in research, all my research questions were about how differences in race or income or education can contribute to how we seek out or receive care.

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

Find a mentor you trust who shares your interest. Enjoy asking questions, because there will always be more questions than answers. Collaborate; it makes the research better and it is much more fun!

How can people get in touch with you if they have questions about your work?
Email is best - cteal@bcm.edu or cayla.teal@va.gov.

New MIRECC Education Product: Preparing Veterans for Group Therapy DVD

Pamela C. Fischer, Ph.D.
Oklahoma City VAMC

Entering any kind of mental health treatment for the first time is anxiety-provoking for patients. However, sending them for treatment they know little about often results in patients entering therapy skeptically or deciding not to come at all. This is particularly true with a referral for group therapy. Since most individuals who decide to undergo mental health treatment expect individual therapy, a referral for group therapy may be perceived as a referral for "second rate" treatment. This perception, along with discomfort being around and sharing information with others, often makes veterans particularly reluctant to enter group treatment.

The DVD, *Preparing Veterans for Group Therapy*, provides a way to educate veterans about group therapy and prepare them for what a group experience is like. Who better to explain group therapy to veterans than other veterans? This 25 minute DVD includes actual veterans talking about their own experiences in participating in group therapy. They explain their initial reluctance to enter a group and what it was like to learn to open up and trust others. They talk about their relief in learning others have similar problems and feelings. They speak about learning to tolerate different ideas from their own and developing more compassion and tolerance for others. While no mental health treatment guarantees 100% happiness on the part of the recipient, these veterans encourage others to give group therapy a try and remind them that "the help is here. All you have to do is come."

The ***Preparing Veterans for Group Therapy*** DVD was supported by a Clinical Educator grant from the South Central MIRECC. To request a copy of this manual, contact Michael.kauth@va.gov

Recovery Corner

Instrumental Approach: VISN 16 Takes Avant-Garde Approach to Local Recovery Coordinator Strategic Planning Retreat

Paul Moitoso LICSW, BCD
Social Worker/Local recovery Coordinator
Overton Brooks Veterans Administration Medical Center
Erin B. Williams, PhD, HSPP
Psychologist/Local Recovery Coordinator
Central Arkansas Veterans Healthcare System

The Shreveport VA Medical Center Local Recovery Coordinator (LRC) and Retreat Coordinator, Paul Moitoso LCSW, BCD, along with eight other VISN 16 LRCs, took an avant-garde approach to their inaugural Strategic Planning Retreat April 22- 24 in Shreveport, Louisiana. The goal of the retreat was to specifically define what a LRC needs to accomplish to successfully meet performance criteria and implement viable recovery-oriented services at their facility. The group's use of a systematic approach to achieve these ambitious objectives was accomplished by learning and applying industry best practices for Project Management.

The result to utilizing this forward-thinking approach was remarkably successful. As part of the process in creating a three year standardized plan to implement recovery oriented services across VISN 16, the retreat provided the first opportunity for all of the LRCs in the network to gather together, thoroughly discuss and agree upon practical methods for achieving these common goals. The event also provided the LRCs with invaluable training on current technology that will allow them to more effectively accomplish their clarified mission.

During the first day of the retreat, the team learned and practiced fundamental project management techniques. These techniques were then used throughout the rest of the conference to help attendees begin designing multi-year strategies to implement. A Project Management professional for a major telecom company volunteered personal time and served as the lead instructor for the first day of the week long retreat. The LRCs quickly benefited from the intensive workshop about how to use MS Project 2007 as a comprehensive planning and scheduling tool. This training proved to be an essential part of the VISN 16's goal to implement a common tool to manage project resources and project scheduling.

The following days of strategic planning allowed the LRCs to establish a shared language and mutual goals imperative to making programs operational and successful. By standardizing the methodology and technology, any personnel changes will not so adversely affect efforts towards reaching the targeted goals. For example, two of ten LRCs in VISN 16 are yet to be hired and the use of a common framework will allow them to more promptly get up to speed and accomplish the mission for their facility, as well as work more effectively with the rest of the LRCs in the network. As VISN wide templates are created, they will include concise instructions, timelines and realistic examples to assist with the development of recovery-oriented services. By the end of the planning retreat, a project plan was developed which included a work breakdown structure consisting of over 294 deliverables. This strategic plan is broad enough to meet VISN requirements, yet

flexible enough to accommodate the needs of each local facility. Additionally, the plan will allow for true web-based working collaboration, with documents and capabilities easily transferable during weekly phone and email meetings. The VISN 16 LRCs will be able to specifically track their progress through the MS Project plan and make accommodation through ongoing formative appraisal.

The next LRC retreat is planned for September 08 in Little Rock, Arkansas. In addition to enhancing the established strategic plan conceived at the inaugural retreat, attendees of the upcoming meeting will explore the use of additional web-based tools, such as Windows SharePoint and MS Project Server, which will further advance information sharing and change management, as well as promote collaborative capability. The upcoming meeting will be used to address a standardized approach to Knowledge Management. The intellectual capital of the VISN 16 LRCs is increased by leveraging the knowledge and experience of each individual, sharing the information through practical and effective means, reutilizing proven program resources, mentoring new recovery coordinators, and facilitating the ongoing, professional development of Local Recovery Coordinators as proficient agents of change.

June Conference Calls
1-800-767-1750

10—MIRECC Leadership Council, 3:30 PM CT, access code 19356#
17—VISN 16 Mental Disaster Team, noon PM CT, access code 76670#
18—MIRECC Program Assistants, *Cancelled*
24—MIRECC Leadership Council, 3:30 PM CT, access code 19356#
26—National MIRECC & COE Education Recovery Interest Group, noon CT, access code 22233#
26—National MIRECC & COE Education Implementation Science Group, 1:00 PM CT, access code 28791#
30—MIRECC Education Core, 3:00 PM CT, access code 28791#

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

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