



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

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Communiqué

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RESEARCH TO PRACTICE

Suicide Risk Assessments Prior to Suicide

Summary by Kathy L. Henderson, M.D.

An article by Eric Smith, et al., in the March 2013 *Journal of Clinical Psychiatry* examines the quality of suicide risk assessments administered to Veterans with a history of depression who died by suicide. This is the first study that has not only looked at rates of suicide assessments just prior to suicide deaths, but also used matched comparisons (Veterans who did not die by suicide) and comparisons between mental health and non-mental health providers completing the assessments.



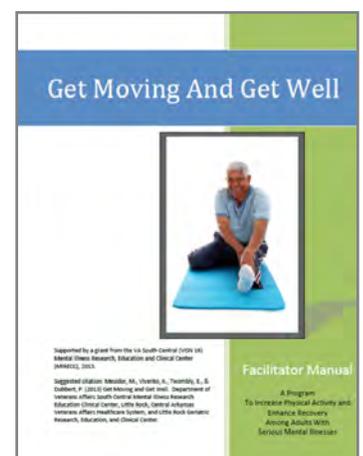
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New SC MIRECC Clinical Education Product Available: Get Moving and Get Well Facilitator Manual

Marie Mesidor, Ph.D., Kristen Viverito, Psy.D., Eric Twombly, L.P.N., Certified Peer Specialist, and Patricia Dubbert, Ph.D.

It is important for mental health and rehabilitation programs to promote physical activity among people with serious mental illness. Individuals living with serious mental illness experience higher rates of chronic disease and premature death. They tend to be more socially isolated and have a sedentary life style. In addition, the symptoms and consequences of living with mental illness often decrease a person's motivation to engage in physical activity, despite the fact that physical activity is beneficial.

The *Get Moving and Get Well* program was developed to help Veterans living with psychotic disorders, major depression, bipolar



Pictured: *Get Moving and Get Well* Manual Cover

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PRACTICE (continued from page 1)

This study used the VHA's National Registry for Depression and the National Death Index to identify Veterans who died by suicide from 1999-2004, and who had either received two diagnoses of depression or had a depression diagnosis plus an antidepressant prescription. Exclusions and stratification resulted in 244 matched pairs of Veterans whose charts were reviewed for analysis.

Study highlights for clinicians:

- Veterans who died by suicide were more likely to receive mental health care, have a mental health inpatient stay, or be diagnosed with a mental health condition at their final visit;
- Veterans who died by suicide were more likely than comparison patients to receive a suicide risk assessment within the last year (74% vs. 60%);
- Seventy percent (70%) of Veterans who died by suicide **did not** have a suicide risk assessment documented in the chart at their final visit;
- Safety planning at final visit occurred infrequently for both groups (5% for patients dying by suicide; 1% for comparison);
- Suicidal ideation was assessed much more frequently by mental health providers at final visit (60%) versus only 13% by primary care providers and 10% by other non-mental health providers;
- **Major Finding.** 85% of patients who died by suicide denied suicidal ideation at their final visit. Of those Veterans assessed within 7 days of suicide, 73% denied suicidal ideation.

There are several limitations of this study. The data

utilized was prior to 2007 when VHA enacted multiple strategies for suicide prevention, including safety planning, means restriction, and the 24-hour Veterans Crisis Line. VHA has also mandated record flagging of Veterans considered to be at high risk for suicide, and that patients discharged from a mental health inpatient unit are monitored more closely. In VISN 16, there is currently a tremendous effort underway to eliminate suicide through the *Be a Hero~Save a Hero* project. If this analysis was done today, the results might look quite different.

So what are the take home messages from this study? Everyone can do a better job assessing Veterans for suicide, especially patients who have a current or recent diagnosis of depression. More education of our mental health and non-mental health providers is needed regarding the importance of completing suicide risk assessments and safety planning and ensuring that restricting access to weapons is discussed. Providers in primary care and other non-mental health clinical areas should provide a 'warm handoff' of any Veteran in which suicidal concerns exist to their Primary Care/Mental Health Integration colleagues. And DO NOT RELY on denial of suicide ideation as the sole assessment tool; this appears to have limited value. Augmentation of screening, including an increased emphasis on addressing chronic risk factors, should be a part of any suicide risk assessment.

This article may be viewed at <http://www.ncbi.nlm.nih.gov/pubmed/23561227>.

Citation

Smith, E. G., Kim, H. M., Ganoczy, D., Stano, C., Pfeiffer, P. N., & Valenstein, M. (2013). Suicide risk assessment received prior to suicide death by Veterans Health Administration patients with a history of depression. *Journal of Clinical Psychiatry*, 74(3), 226-232. ♦

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.

GMGW (continued from page 1)

disorder, and severe PTSD who have difficulty identifying and making use of opportunities for physical activity. The program was implemented at the Central Arkansas Veterans Healthcare System (CAVHS) Psychosocial Rehabilitation and Recovery Center, and focuses on wellness rather than weight management.

The *Get Moving and Get Well* program is designed to be delivered in 60-minute classes scheduled twice a week for 12 weeks. Participants engage in walking, dancing, and stretching activities. Classes follow a similar format each week and include time for casual conversation, setting the day's objectives, educational information, activities, and participant feedback and goal setting. Class topics include benefits of physical activity, neighborhood walkability, physical pain, the relationship between physical activity and mood, using pedometers, and safety tips. Topics are usually introduced during the first class of the week and then reinforced during the second class of the week before moving on. A 12-week follow-up cycle of the class focuses on community integration.

The program is intended to be used by VA mental health providers who work with Veterans with serious

mental illness in Psychosocial Rehabilitation and Recovery Centers. At the time this manual was developed, no other handbook of this nature had been published for Veterans served by these centers. However, the program may also be useful in other settings where small groups of adults with serious mental illness can meet to engage in light-to-moderate physical activity. *Get Moving and Get Well* can be offered as part of regular Psychosocial Rehabilitation and Recovery Center programming or another mental health program. It can also be a special class or clinic designed for participants living with serious mental illness at facilities without a Psychosocial Rehabilitation and Recovery Center. To download the manual, visit http://www.mirecc.va.gov/visn16/docs/Get_Moving_and_Get_Well_Manual.pdf.

Acknowledgements: The developers thank the *Get Moving and Get Well* project team for their hard work. They also thank Dr. Tina McClain, Associate Chief of Staff of the CAVHS Mental Health Service and Ms. Lisa Martone, CAVHS Chief of Patient Care Services for their support. Additionally, they thank the CAVHS Psychosocial Rehabilitation and Recovery Center staff members for supporting the program. ♦

New Program Site Assistant at the SC MIRECC Oklahoma City Anchor Site

We welcome Wendelyn "Wendy" Caldwell, M.A., as the new program site assistant at our Oklahoma City anchor site. Originally from New York, she has a bachelor's degree in Communications from St. John's University and two associate degrees in Business and Interdisciplinary Studies from Cameron University. She received a master's degree from Cameron University in Behavioral Science in 2010. She served in the U.S. Army Reserves from 2002-2010. She is currently working toward certification in Licensed Professional Counseling.

After graduating from St. John's University, she worked in the television, cable and internet industry in the traffic and media departments. She was responsible for ensuring that all programs and commercials were compliant with local and federal guidelines, supervised a traffic support team, and developed buying strategies for marketing clients.

In 2005, Caldwell moved to Oklahoma and continued her studies at Cameron University. In 2007, she joined the Oklahoma City VA Medical Center Ward Administration Section of Medical Administration Service. In her current

position with the SC MIRECC, Caldwell is responsible for everything from budgets and administrative tasks to maintaining communication with local site affiliates.

Caldwell describes herself as trustworthy, ethical and discreet, and diplomatic and tactful with professionals and non-professionals at all levels. She loves to laugh and always has a smile on her face. Her hobbies include reading, dancing and writing short stories. She also loves photography and surrounding herself with pictures of cherished memories. ♦

Upcoming CBOC Mental Health Rounds Second Wednesdays Monthly

8:00-9:00 am CT; (800) 767-1750; 26461#

July 10, 2013

Caregiver Support

August 14, 2013

Safety Planning App

ANNOUNCEMENTS

Eliminating Veteran Suicide in VISN 16: Be a Hero ~ Save a Hero

The South Central VA Health Care Network (VISN 16) has a new initiative to eliminate Veteran suicide. *Be a Hero ~ Save a Hero* will be rolling out to all VISN 16 facilities soon. One of the goals is to teach providers how to recognize the signs of despair in Veterans and provide them resources to help. They want to make sure providers have the necessary tools and support to achieve their ultimate goal of eliminating Veteran suicide by 2016.

Beginning in September, training will be offered through group sessions led by a facilitator using an interactive video. The video uses scenarios in which providers can participate. Additional videos and educational information will be made available to providers, along with a community resource guide and provider support toolbox. Soon, mental health providers in primary care areas will have a new screening tool at their disposal. Lastly, VISN 16 is working on a plan to let providers know that they are not alone in dealing with a suicidal Veteran. ♦



Pictured: VISN 16 Eliminate Veteran Suicide: Be a Hero ~ Save a Hero Logo

VHA Diagnostic and Statistical Manual of Mental Disorders (5th Edition) Conversion

The American Psychiatric Association's fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was issued in May 2013. VHA's transition to the new DSM-5 criteria will occur on approximately October 1, 2013. Prior to the transition, clinicians should continue to use the DSM-4. Download the following documents for an overview of the VHA DSM-5 conversion and highlights of differences between the two editions.

- http://www.mirecc.va.gov/MIRECC/VISN16/docs/DSM_5_Conversion.pdf
- http://www.mirecc.va.gov/MIRECC/VISN16/docs/APA_DSM_4_to_5_Changes.pdf

CBOC Mental Health Rounds

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

Sponsored by the South Central MIRECC

VA Mental health providers are invited to attend the next SC MIRECC CBOC Mental Health Rounds session titled "Caregiver Support Programs: Comprehensive Assistance for Family Caregivers" on Wednesday, July 10, 2013 at 8:00-9:00 a.m. (CT). This Microsoft Lync session will be presented by Carolyn Blackstone, MSW, LCSW and Veronica Castro, LCSW, C-ASWCM. At the conclusion of this educational program, learners will be able to:

1. Describe the Comprehensive Assistance for Family Caregivers application and eligibility process;
2. Participate in providing feedback as it relates to identifying care needs of Veterans; and
3. Educate Veterans/Caregivers and VA staff on the application process and other services available to Caregivers.

Call 1-800-767-1750 and use access code 26461# to participate. Contact Ashley McDaniel at Ashley.McDaniel@va.gov or (501) 257-1223 for registration and continuing education credit information.

RECOVERY CORNER

Overton Brooks VAMC Deploys Innovative Peer-Led Class Approach to Attract OEF/OIF/OND Veterans to Reintegration/Readjustment Group

By Christopher Shea Wilkes, LCSW
Local Recovery Coordinator
Overton Brooks VA Medical Center
Shreveport, LA

Establishing communication with our newest group of combat Veterans can sometimes be a moving target. Engaging them in group interactions can be a challenge, as many avoid crowds and noises and keep their backs to the door. To address these issues, I joined forces with the Overton Brooks VA Medical Center Operating Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn (OEF/OIF/OND) Team to create a program to determine the effectiveness of utilizing a classroom format to improve outcomes for combat Veterans readjusting to civilian life. Laura Campbell, LCSW, and I direct the program. I'm a licensed clinical social worker and the Local Recovery Coordinator at Overton Brooks VAMC. I'm also a Captain in the Army Reserve who has been deployed to Afghanistan. Ms. Campbell is the Manager of OEF/OIF/OND Program. Prior to coming to the VA, she worked in the private sector where she taught mental health professionals about treating patients with PTSD.

The reintegration program engages ten to twelve Veterans in a small group setting over four weekly classes, providing them with information to assist in coping with stress they commonly experience. The first phase of the pilot program involved sending invitations to OEF/OIF/OND Veterans diagnosed with PTSD but not engaged in treatment to participate in the reintegration class. As a fellow combat Veteran and peer who has experienced the impact of war and the difficulties Veterans face when returning home to their everyday lives, I led the class.

Twenty-one Veterans attended the first reintegration class. Many expressed their discomfort at being in a group setting at the first meeting, but said that they attended because they were invited by a fellow combat Veteran. As the weekly sessions progressed, Ms. Campbell took the lead on presenting the material. I stayed involved by translating the material into military terminology the group was familiar with and discussing my own experiences in military life, combat, and returning home to help engage the Veterans in the group and treatment. In the first class conversations were brief and there were cold stares from the group, but by the second class, the Veterans were communicating without prompting, as they would if surrounded by each other on a

Forward Operating Base or in a transition tent on the way home from Iraq or Afghanistan.

At the beginning of the program, participants used a Subjective Unit of Distress Scale (SUDS) to measure their anxiety level from 1 to 10. They were able to see their anxiety decreasing as the class progressed. We used this as an example to teach participants how exposure works. They were encouraged to identify situations, or triggers, they automatically avoid and to take small steps to expose themselves to those situations or triggers. Then they rated those triggers using the SUDS scale. They learned that avoidance sustains symptoms and that overexposure may exacerbate them. Soon, they independently identified when they needed to raise their anxiety to a 4-6 level and then retreat from the triggering situation.

When avoidance situations were brought up, we asked the Veterans to describe how they were reminded of combat. For example, a common situation for participants was managing anger when working with civilians they felt didn't take their jobs seriously. Many returning Veterans report becoming enraged when co-workers appeared lazy or incompetent in their duties. We asked the class to describe outcomes of similar behavior in combat, such as accidents, injury and death. Through this process, participants were able to recognize that they were expecting civilians to act as if their work is a life or death situation, which isn't an experience for many civilians. Many participants have expressed that this perspective has given them a new way to frame triggers when dealing with frustrating people, including family members.

Another example is from a Veteran who talked about pushing a table through a wall. When asked what upset him, he said that he was trying to put a leaf in the table with several family members watching him but no one offered to help, leaving him feeling that he was all alone and on his own. When asked to relate the situation to combat, he quickly identified that if he was alone in combat, he was in greater danger. Other class members said they would have helped without being asked because that is what they did in the service; they jumped in to get the job done. Each noted

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that this was necessary to keep everyone safe. We used this example to help the Veterans understand that while decisions and duties may be life or death in combat, many decisions dealing with normal, everyday life issues have little to no consequences when they return home.

In class we also discussed neurobiological theories of PTSD to show how adrenaline responses are triggered by events. Understanding that this physical reaction is connected to basic survival helps Veterans normalize their symptoms. We showed them how to identify irrational thoughts that make normal events seem like life-or-death situations. We asked Veterans to challenge automatic thinking and to remind themselves that they are no longer in combat. An exercise for this class was to imagine an older woman in Wal-Mart using her cell phone, which is an anxiety trigger for many, and to challenge thoughts that insist the woman poses a threat to them.

The last session was spent reviewing evidence-based therapies available from the VA. We recommended therapies that emphasize treatment and recovery. Because the classes provide an opportunity to establish rapport with a combat Veteran and a therapist, most Veterans who completed the classes were motivated to start evidence-based therapy.

So far, we've held five reintegration classes and we always learn something new to add to discussions in subsequent classes. We are encouraged by the enthusiasm of the Veterans who have participated and their willingness to engage in further treatment utilizing evidence-based therapy. Unique problems require innovative solutions and the Overton Brooks team feels we have hit on a winning combination to provide the best care possible for our Veterans. For more information about the reintegration classes, email Christopher.Wilkes@va.gov. ♦

FY2014 Clinical Educator Grants Call for Applications

Don't miss your chance to submit a proposal for the FY2014 SC MIRECC Clinical Educator Grant program. These small grants (up to \$10,000 for multi-site projects) are designed to help clinicians develop innovative clinical education tools that benefit the mental health care of rural and other under-served Veterans. The SC MIRECC is especially interested in funding projects that involve collaborations between medical centers and community-based clinics.

Examples of past projects include a CD-ROM compendium of pain management information and tools for clinicians who treat Veterans with substance abuse, a manual to conduct psychoeducational workshops for returning Iraq and Afghanistan Veterans and their families about readjustment issues, and a DVD of ex-Prisoners of War telling their stories about internment and their struggle with PTSD symptoms and how they have managed to survive and thrive in their lives. The Clinical Educator Grants program has produced more than 30 excellent clinical education products that the SC MIRECC makes available to clinicians free of charge. Additional products can be found at <http://www.mirecc.va.gov/VISN16/clinicalEducationProducts.asp>.

If you have a great idea for an educational tool to improve care delivery, this may be the opportunity that you are looking for! **The deadline for submitting a proposal is August 1, 2013.** For more information about the Clinical Educator Grants, contact Dr. Geri Adler at Geri.Adler@va.gov or Dr. Michael Kauth at Michael.Kauth@va.gov.

- Download Application at http://www.mirecc.va.gov/VISN16/docs/CEG_Application.pdf.
- Download Example Application 1 at http://www.mirecc.va.gov/VISN16/docs/Sample_application_I.pdf.
- Download Example Application 2 at http://www.mirecc.va.gov/VISN16/docs/Sample_application_II.pdf. ♦

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