



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

August 2015 Vol 17, Issue 8

www.mirecc.va.gov/visn16

Communiqué

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RESEARCH TO PRACTICE

Identification and Understanding of Suicide Risks (Part 2)

By Kathy L. Henderson, M.D.

Editor's Note: This article is the second in a two part series about new research on suicide risks.

Last month's column reviewed results from two recent large population studies that compared suicide rates in Veterans to non-Veterans, as well as suicide risk factors in Veterans deployed versus not deployed (<http://www.mirecc.va.gov/VISN16/docs/CommuniqueVol17No7Jul2015.pdf>). The article reviewed in this current issue is a very significant study that will likely impact the way we identify high-risk Veterans and target suicide prevention efforts in the future.



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MEET THE SC MIRECC RESEARCHER

Interview with Jessica Larsen, Ph.D.

Q. Please tell us a bit about your background.

I am an Oklahoma City MIRECC affiliate and a postdoctoral fellow at the University of Oklahoma Health Sciences Center (OUHSC) and Oklahoma City VA Health Care System (OKC VAHCS). In September, I will transition into my new role as a staff psychologist in the Home Based Primary Care program at the OKC VAHCS and an Assistant Clinical Professor at OUHSC. Broadly, I'm interested in program evaluation and systems-based interventions for Veterans. I also have an interest in

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RESEARCH (continued from page 1)

The article, by John McCarthy, et al, in the *American Journal of Public Health*, June 2015 (published online ahead of print), examined data from all Veteran patients who died from suicide between October 2008 and September 2011 and a random 1% of living VA patients, all of whom had received VHA services in the previous 2 years of the study dates. Suicide data came from the National Death Index. They also used data of all Veteran patients alive on September 30, 2011 to evaluate predictions of suicide risk over 1 year. Predictors were taken from VHA clinical records and included 381 measures. Using data from these three samples, the authors developed and validated a predictive model that can identify certain strata or groups of patients with substantial increase risk for suicide.

Study highlights for clinicians:

- Veterans who completed suicide were more likely than Veterans who did not complete suicide to:
 - be young, male, and unmarried
 - live in a rural area
 - have a history of or be at risk for homelessness
 - have no service-connected disabilities
 - have been diagnosed with mental health conditions, pain, sleep disorders, or traumatic brain injury
 - have used VHA mental health services
 - have had psychiatric hospitalizations
 - have received mental health residential care, emergency department, or urgent care

- have used psychotropic medication
- have previously attempted suicide
- Suicide rates were 60 times **greater** for the group who had been predicted to be at highest risk in the next 12 months (the top .01% validation sample) than for the overall sample.
- Suicide rates were 12 times **greater** in the top 1% of the predicted risk group.
- The 5% group accounted for 24% of VHA suicides over 1 year.
- Only 31% of Veterans in the top .01% group had a high-risk flag in the medical record.
- Only 8.8% of Veterans in the top 1% group had been identified as high risk for suicide.

This study clearly demonstrates that predictive modeling can be used to identify Veterans who are at a high risk for suicide. The authors also showed that using a statistical model has the potential to identify high-risk patients who had not been identified by clinical assessment (as shown by high risk flags in the medical record). This finding should not be interpreted that good clinical judgement is not vital to the identification of suicide risk. This modeling is just a potential tool that, in the future, may be useful for clinicians to enhance services for our high-risk Veterans.

Caitlin Thompson, Ph.D., Deputy Director for Suicide Prevention in Mental Health Services, describes this study as “groundbreaking.” She believes this study will help identify those Veterans that may not be readily evident even to the best clinicians to be at high risk for suicide. And this predictive modeling has the potential to allow suicide

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Attribution: Acknowledgement of MIRECC Research Support/Employment

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prevention coordinators and clinicians to target clinical and preventive interventions to those high risk Veterans. Hopefully, this will lead to a dashboard that will allow real-time identification of Veterans at risk. Exciting potential for the future!

This article may be viewed at <http://www.ncbi.nlm.nih.gov/pubmed/?term=26066914>.

Citation

McCarthy, J. F., Bossarte, R. M., Katz, I. R., Thompson, C., Kemp, J., Hannemann, C. M., Nielson, C., & Schoenbaum, M. (2015). Predictive modeling and concentration of the risk of suicide: Implications for preventive interventions in the US Department of Veterans Affairs. *American Journal of Public Health*. Advance online publication. ♦

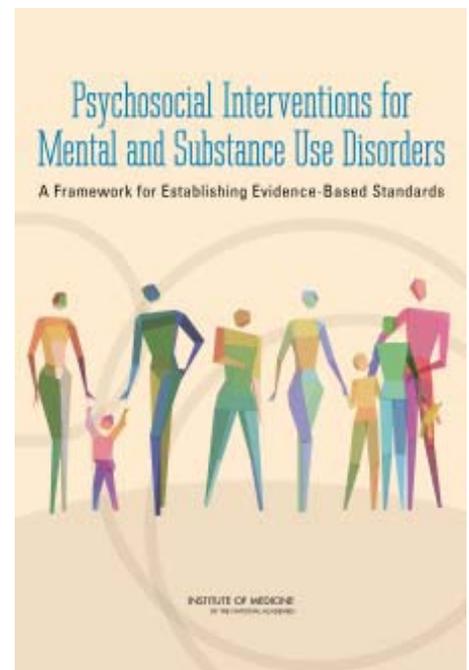
What We Have Learned

- ☆ Overall, Veteran suicide rates are increasing
- ☆ Veteran suicide rates are decreasing for Veterans utilizing VHA services
- ☆ Deployed Veterans have a lower suicide risk than nondeployed Veterans
- ☆ Suicide rate is highest during the first 3 years after military discharge
- ☆ Suicide risk is greater for female Veterans than male Veterans
- ☆ Predictive modeling can be used to identify high-risk Veterans not identified by clinical assessment

New Institute of Medicine Report: Psychosocial Interventions for Mental and Substance Use Disorders: A Framework for Establishing Evidence-Based Standards

Mental health and substance use disorders are a serious public health problem, affecting approximately 20 percent of Americans. The two often occur together and result in significant morbidity and mortality. The Patient Protection and Affordable Care Act (ACA), passed in 2010, and the Mental Health Parity and Addiction Equity Act, passed in 2008, aim to improve the delivery of and access to treatments for mental health and substance use disorders. In this context, the Institute of Medicine (IOM) convened an expert committee to identify key steps to ensure that evidence-based, high-quality care is provided to individuals receiving mental health and substance use services.

The resulting report, *Psychosocial Interventions for Mental and Substance Use Disorders*, details the reasons for the gap between what is known to be effective and what is currently practiced, and it offers recommendations for how best to address this gap by proposing a framework that can be used to establish standards for psychosocial interventions. To access the report, visit <http://iom.us8.list-manage.com/track/click?u=ab74d126b7d2db12591de5c2c&id=d1e4c827e7&e=24bb6ebe5d>.



MEET (continued from page 1)

technology and using technological solutions to expand mental health services to Veterans. My primary mentor, Kristen Sorocco, Ph.D., at OUHSC was involved in a larger implementation project examining Clinical Video Telehealth into the Home (CVTHM) and suggested that the project might be a good fit for me.

Q. Please give us an overview of the CVTHM project. How does this project affect patients and providers in rural communities?

The project is a part of a larger scale implementation project aimed at examining the use of a facilitation strategy to expand CVTHM services across two VA sites, Oklahoma City and Houston. As part of the larger CVTHM implementation project, we learned that a major barrier to implementing CVTHM in our sites was having licensed mental health clinicians navigate the certification process and gain the necessary competencies to become CVTHM providers. The certification process includes several online trainings and a skills assessment completed with a member of the telehealth staff. Part of the difficulty is that the requirements change frequently, the trainings can be difficult to locate as new resources are added, and this is not always effectively communicated to the field. Now that many resources are available online, we sought to create a one-stop-shopping product that mental health clinicians could use to access materials and training to get up and running on CVTHM in just a few hours. We collaborated with CVTHM providers, Facility Telehealth Coordinators, Telehealth Clinical Technicians, and VHA Office of Telehealth Services to create a draft version of a toolkit for providers. We then proceeded with a rigorous process of testing and refining our toolkit with providers at both our OKC and Houston sites. What resulted was a thirty-page document packed with information about CVTHM certification, practice, and technology, including various VA and non-VA resources and clinical materials.

CVTHM is particularly well suited for rural communities as it fosters immediate, regular contact with specialists for Veterans from the comfort of their own home. Veterans in rural areas may otherwise be forced to travel to a CBOC or many miles to their VA medical center to gain access to specialists. This makes regularly scheduled visits, such as specialized psychotherapy treatment, difficult for Veterans to access. CVTHM allows for these individuals to gain access to evidenced base therapies without having to travel physically to a VA location. Further, for many of our older



Jessica Larsen, Ph.D.

adult and chronically ill patients, mobility is a major barrier to accessing care. CVTHM is a major development for these Veterans in particular as it facilitates their accessing specialized and frequent care without having to leave their homes.

Q. Are there any preliminary results from your project about CVT treatment or anecdotal information about how patients respond to this modality that you can share with our readers?

Anecdotally, we find that there are high levels of satisfaction among both Veterans and providers. Some of the providers we work with have initially been somewhat hesitant about adopting this model of care, but when they begin to use it and realize the benefits, including increased patient access, these folks generally become CVTHM's biggest advocates. Veterans appreciate that they do not have to travel to the VA location, deal with the logistics of navigating a hospital (especially parking), and waiting for their appointment. They get instant, confidential, private mental health services. In addition, for some mental health diagnoses, developing coping skills via CVTHM maybe a necessary preliminary step in order for the individual to be able to seek mental health care outside of their home.

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Q. How has this project impacted you? Have your beliefs about clinical video telehealth changed since becoming involved with this project?

I was initially open to the idea of telemental health, but wondered whether something would be lost in translation, so to speak, over such a technology. After all, as psychotherapists, we are trained to be good listeners, as well as good interpreters of non-verbal information, including body language and facial expressions. I wondered whether those nuances would be lost with a video camera and computer screen between me and my patients. I found that while, initially, CVTHM felt a bit awkward to me, my psychotherapy training quickly took over and the technology faded in the background. I was amazed that I could continue to get accurate non-verbal information over CVTHM even though I was not sharing the same physical space with my patients.

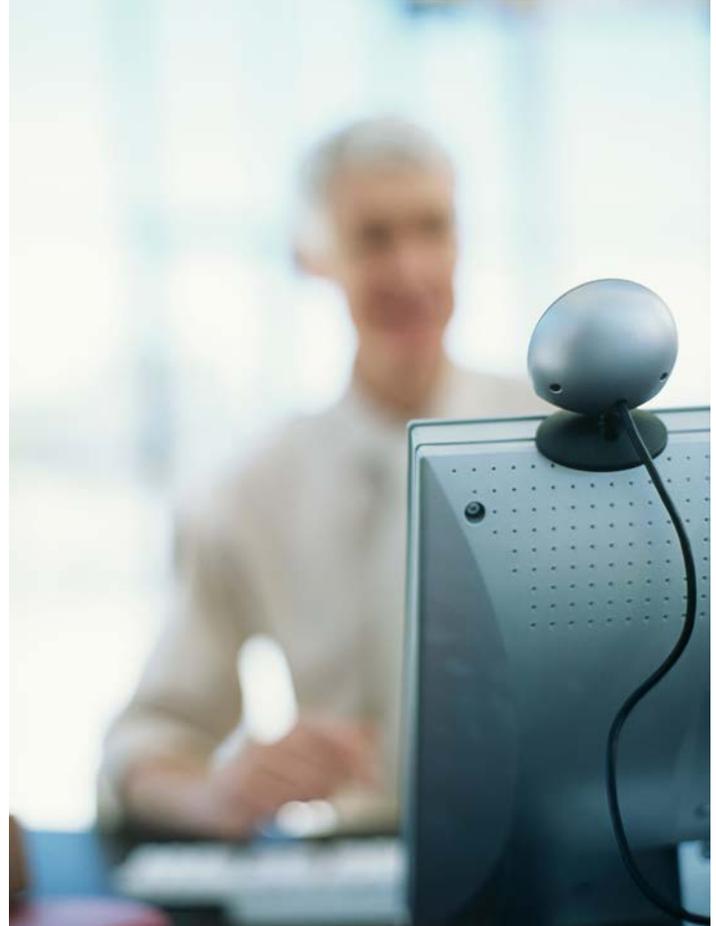
Q. How has the knowledge you gained from this project informed your research?

I've just returned from presenting our results from the user toolkit at the HSR&D Conference in Philadelphia this month. It was a great experience to learn about the VA's new research initiatives and different directions we can take this and other research projects we have ongoing here in Oklahoma City.

I would say that I am absolutely more open to telemental health as a means of reaching patients who would otherwise be marginalized from accessing care. I still appreciate face-to-face interactions, but I believe that as diagnosis and standardized treatments become more focused, we will rely more heavily on specialists trained in evidence based practices to provide care. It would be possible to imagine that in just a few years, Veterans with particular presenting issues may see specialist mental health therapists in another state for treatment, just as now is being done in other medical professions. The possibilities are endless for patients and providers alike. I think it's exciting and the new frontier of therapy provision. I hope to continue to integrate telemental health into my research and examine how these technologies are both improving patient care and saving valuable resources.

Q. Are there any products or resources you want to share with our readers?

Certainly the toolkit once it is finalized. There is also an



Office of Telehealth Services SharePoint website where you can access CVTHM forms including guidance documents, liability waivers, emergency procedures protocols, need assessments, operations manuals, and telehealth service agreements at <http://vaww.infoshare.va.gov/sites/telehealth/docs/Forms/cvthome.aspx>.

Q. Is there anything you want to say about your project that I have not asked you?

First, I would like to thank the SC MIRECC for recognizing the importance of CVTHM and funding this project. Also, I want to thank Drs. Sorocco, Henderson, Lindsay, and Martin for their collaboration. It's been a great experience to work with such talented researchers from across our VISN so early in my career. The ability to establish such collaborations is one of the major benefits of conducting research within the VA system. ♦

RECENT SC MIRECC PUBLICATIONS

IMPLEMENTATION OF VIDEO TELEHEALTH TO IMPROVE ACCESS TO EVIDENCE-BASED PSYCHOTHERAPY FOR POSTTRAUMATIC STRESS DISORDER

Lindsay, J. A., Kauth, M. R., Hudson, S., Martin, L. A., Ramsey, D. J., Daily, L., & Rader, J.

Telemedicine Journal & E-Health, 21(6), 467-472

Increasing access to psychotherapy for PTSD is a primary focus of the VA healthcare system. Delivery of treatment via video telehealth can expand availability of treatment and be equally effective as in-person treatment. Despite VA efforts, barriers to establishing telehealth services remain, including both provider acceptance and organizational obstacles. Thus, development of specific strategies is needed to implement video telehealth services in complex healthcare systems, like the VA. This project was guided by the Promoting Action on Research Implementation in Health Services framework and used external facilitation to increase access to psychotherapy via video telehealth. The project was conducted at five VA Medical Centers and their associated community clinics across six states in the South Central United States.

Over a 21-month period, 27 video telehealth clinics were established to provide greater access to evidence-based psychotherapies for PTSD. Examination of change scores showed that participating sites averaged a 3.2-fold increase in unique patients and a 6.5-fold increase in psychotherapy sessions via video telehealth for PTSD. Differences between participating and nonparticipating sites in both unique patients and encounters were significant ($p=0.041$ and $p=0.009$, respectively). Two groups emerged, separated by degree of engagement in the facilitation intervention. Facilitation was perceived as useful by providers. To our knowledge, this is the first prospective study of external

facilitation as an implementation strategy for telehealth. Our findings suggest that external facilitation is an effective and acceptable strategy to support providers as they establish clinics and make complex practice changes, such as implementing video telehealth to deliver psychotherapy.

EMOTION DYSREGULATION MEDIATES THE RELATIONSHIP BETWEEN TRAUMATIC EXPOSURE AND AGGRESSION IN HEALTHY YOUNG WOMEN

Miles, S. R., Tharp, A. T., Stanford, M., Sharp, C., Menefee, D., & Kent, T. A.

Personality and Individual Differences, 76, 222-227

Research has linked trauma-sequelae, such as PTSD, to aggression. However, not all who experience a trauma become violent, suggesting non-trauma factors, such as emotion dysregulation, influence aggression expression and if confirmed, may influence treatment approaches. Aggression can be considered a multifaceted construct with Impulsive Aggression (IA) as emotional, reactive, and uncontrolled and Premeditated Aggression (PA) as deliberate, planned, and instrumental. We hypothesized that parceling apart IA and PA may further refine predictors of aggression in the context of trauma exposure. We tested this hypothesis in undergraduate women ($N = 208$) who completed trauma, emotion, and aggression measures. Path analysis indicated that Borderline Features, including emotion dysregulation, mediated the relationship between trauma exposure and IA and PA. The finding extends clinical literature by providing evidence that emotion dysregulation influences both IA and PA in a non-clinical sample, while clinical sample research shows emotion dysregulation more specifically mediated the relationship between trauma and IA. Factors responsible for these differences are discussed.

Published by the South Central MIRECC
Editor: Ashley McDaniel, M.A.
Reviewer: Carrie Edlund, M.S., M.A.



U.S. Department of Veterans Affairs

Veterans Health Administration
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