

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

South Central MIRECC

COMMUNIQUE

December 2016 Volume 18 Issue 12

IN THIS ISSUE

- 1 VA/DoD Clinical Practice Guideline: Assessment and Management of Patients at Risk for Suicide
- 1 Summary of the SC MIRECC Summer 2016 Motivational Interviewing Training
- 4 Announcements
- 7 Publications
- 8 December CBOC MH Rounds: Resources for Successfully Treating Insomnia and PTSD

VA/DoD Clinical Practice Guideline: Assessment and Management of Patients at Risk for Suicide

Summary by Sonora Hudson, MA

The Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide provides evidence-based suggestions for managing Veterans at risk for suicidal behavior. The guideline is available in several formats (full guideline, 190 pages; pocket-guide card; and summary, 64 pages; plus a separate patient safety plan worksheet) at <http://www.healthquality.va.gov> or <https://www.qmo.amedd.army.mil>. It includes

See SUICIDE on page 2

Summary of the SC MIRECC Summer 2016 Motivational Interviewing Training

The SC MIRECC Education Core hosted an online motivational interviewing (MI) training for select VISN 16 mental health providers in late August 2016. Presented by Dr. LaDonna Saxon, this interactive full-day training was delivered via Adobe Connect with small-group breakout sessions via the VANTS teleconference network.

Dr. Saxon is a staff psychologist, health behavior coordinator, and tobacco cessation lead clinician at VA North Texas Health Care System. She is also a

See MI on page 6

**South Central MIRECC
Communique**

December 2016

Ashley McDaniel, MA
Editor

www.mirecc.va.gov/visn16

Leadership

Mark E. Kunik, MD, MPH
Director
Houston, TX

Michael R. Kauth, PhD
Co-Director
Houston, TX

Jeffrey M. Pyne, MD
Associate Director
for Research
Little Rock, AR

Ellen P. Fischer, PhD
Assistant Director
for Research
Little Rock, AR

Ali Abbas Asghar-Ali, MD
Associate Director for
Education
Houston, TX

Geri Adler, PhD
Assistant Director for
Education
Houston, TX

Michael A. Cucciare, PhD
Associate Director
for Research Training
Little Rock, AR

Tracey L. Smith, PhD
Associate Director
for Improving Clinical Care
Houston, TX

SUICIDE (continued from page 1)

three clinical algorithms and modules, with annotations, dealing with assessment and management of risk for suicide in primary care, evaluation and management of risk for suicide by behavioral health providers and management of the patient at high acute risk.

The guideline emphasizes that distinguishing between nonsuicidal and suicidal self-directed violence is important. An act of ambiguous intent should be considered as having suicidal intent until determined otherwise. Initial assessment should evaluate the intensity and duration of suicidal ideation or thoughts, intent or plan and preparatory behavior or previous attempt. It is also important to gather data on warning signs, and risk and protective factors, including determination of level of risk and appropriate setting for care. The person at high-to-intermediate acute risk should be put under direct observation and transferred with escort to an emergency care setting to evaluate the need for hospitalization. A behavioral health provider should then complete a psychosocial evaluation to determine whether the patient should be admitted or whether he/she can be managed in a less restrictive environment. Although mental disorders increase risk of suicide, the level of ideation, intent or preparatory behavior should guide initial risk stratification in determining level of care required.

Warning signs, or indications for urgent/immediate action, include suicidal communication and seeking access to or recent use of lethal means and preparations. Initial assessment should inquire about other warning signs, including substance abuse, hopelessness, purposelessness, anger, recklessness, feeling trapped, social withdrawal, anxiety, mood changes, sleep disturbances and guilt or shame and information about risk factors sufficient to inform further assessment if conditions change. Risk should be reassessed as needed. Intentional overdose is the most common method of attempted suicide, so overdoses require consideration as intentional acts.

(SUICIDE continued on page 3)

(SUICIDE continued from page 2)

Assessment of risk for suicide should not be based on any single instrument, and no specific measurement scale has been shown to determine risk. In primary care, the provider should be alert to somatic complaints, such as insomnia, fatigue, pain and memory loss, which indicate need for screening for depression, anxiety, substance use and presence of acute stressors. A complete clinical assessment of patients at risk includes a medical history to rule out relevant conditions, psychiatric history, suicidal-behavior history, substance-use history, psychosocial history (including history of life stressors, impulsivity, aggression and relationships), family psychiatric history (including history of suicide), physical examination, mental status examination, relevant lab tests and drug inventory.

Hospitalization is usually recommended for suicidal patients unable to be maintained in less restrictive settings. Discharge planning is critical and should include a written safety plan to assist the patient with restricting access to means for completing suicide, problem-solving and coping strategies, enhancing social supports and identifying a network of emergency contacts and ways to enhance motivation. There is no evidence for the effectiveness of using “no harm” or “no-suicide” contracts. Patients discharged from acute care should be followed-up within seven days of discharge and monitored for 12 weeks since this is a time of elevated risk. Patients at high acute risk should be followed closely (e.g., weekly for the first month). Patients surviving a suicide attempt or identified as high acute risk should be monitored for a least one year.

In treating nonpsychotic patients at high risk for suicide, cognitive therapy should be considered for those at high risk or who have survived a recent attempt. Problem-solving therapy directly addressing the risk for suicide-related behaviors should be considered for those with more than one previous attempt. If the self-directed violent behavior or suicide risk is attributable to a psychiatric illness, that illness should be identified and treated and the treatment plan modified to specifically address risk of suicide. Inconsistent evidence supports the efficacy of psychotherapy in reducing the risk for repetition of self-directed violence in patients with co-occurring disorders. Specific psychotherapies may be considered in the context of different disorders. Patients with a history of suicide attempt or behavior should continue to be regularly evaluated for risk of relapse.

Attribution: Acknowledgement of SC MIRECC Research Support/ Employment

SC MIRECC researchers and educators have a responsibility to ensure 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 SC MIRECC if they receive either direct or indirect SC MIRECC support.

For example, "This work was supported in part by the VA South Central Mental Illness Research, Education and Clinical Center." If you receive salary support from SC MIRECC, you should list SC MIRECC as an affiliation.

Announcements

Dr. Mark Kunik Receives VA Office of Rural Health Funding for Dementia Caregiving Tele-Health Alliance Project

Please join us in congratulating Dr. Mark Kunik, the SC MIRECC Director, on his receipt of funding from the VA Office of Rural Health for the project, "The Dementia Caregiving Tele-Health Alliance." This multidisciplinary initiative is sponsored by national program directors for the Offices of Geriatrics and Extended Care and Caregiver Support. The mission and primary objective of the project is to develop an enterprise-wide initiative that integrates and implements a judiciously compiled set of complementary evidence-based technology innovations for Veteran-caregiver dyads living with dementia that span the continuum of care, transcend geographic constraints and, ultimately, improve access to the full and comprehensive spectrum of quality healthcare services for all Veterans and their caregivers.



The alliance is comprised of VA providers, researchers and caregiving leaders from across the US and includes representatives from VA Central Office committees and program offices, in addition to Veterans, caregivers and other key stakeholders who will serve on the national advisory board. Project sites include the VHA Veteran Rural Health Resource Center in Togus, Maine (project lead); Atlanta, Georgia (clinical project lead); Gainesville, Florida; Houston, Texas; and Salt Lake City, Utah. Dr. Kunik is the Houston site-lead.

SC MIRECC Off-Cycle SC MIRECC Clinical Educator Grants Applications due December 16

SC MIRECC is now accepting off-cycle applications for the fiscal year 2017 SC MIRECC Clinical Educator Grants program. **Applications are due December 16, 2016 and projects will be selected in early January 2017.** Project funds are only available for one fiscal year; off-cycle grants require that applicants work faster than usual to spend or obligate project funds before the end of the fiscal year (early September).

These grants (up to \$10,000 for multi-site projects) are available to VISN 16 and VISN 17 clinicians to develop innovative clinical education tools that benefit the mental healthcare of rural and other underserved Veterans. We are especially interested in funding projects that involve collaborations between medical centers and community-based outpatient clinics. View our free inventory at <http://www.mirecc.va.gov/VISN16/clinicalEducationProducts.asp> for examples of past products. Contact Dr. Geri Adler at Geri.Adler@va.gov with questions about the Clinical Educator Grants program or to submit your application. **Download the application at www.mirecc.va.gov/visn16/education.asp.**

(ANNOUNCEMENTS continued on page 5)

(ANNOUNCEMENTS continued from page 4)

VA Awards \$219.2 Million to Increase Rural Veterans' Access to Health Care and Services

The 2.9 million rural Veterans who rely on the VA for health care will benefit from a recent award of \$219.2 million in health care programs and services by VA's Office of Rural Health (ORH).

"Our mission is to improve the health and well-being of rural Veterans by increasing their access to care and services," said Gina Capra, ORH Director. "To do this in a more uniform manner nationwide, we shifted our focus from local pilot programs to spread what we refer to as enterprise-wide initiatives – or proven solutions designed to bring care and services closer to home for rural Veterans."



In fact, this funding translates to more than 40 enterprise-wide initiatives at 400 VA medical centers and community based outpatient clinic sites in more than 45 states across the US, with more sites expected throughout fiscal year 2017.

The initiatives reach 75 percent of the 167 VA medical centers across the nation. ORH estimates these initiatives will impact more than 570,000 rural Veterans.

ORH's fiscal year 2017 enterprise-wide initiatives are grouped into five categories, listed below with corresponding funding amounts:

- Primary care services – \$61.7 million
- Mental health services – \$22.5 million
- Specialty care services – \$57.4 million
- Workforce training and education services – \$10.7 million
- Ancillary support services – \$66.9 million (comprised mostly of transportation-related programs)

"This year and beyond, we will continue to develop programs that address rural Veteran health care needs and deliver high-quality care across the VA system," said Capra.

Examples include free transportation for rural Veterans to or from medical appointments, physical rehabilitation at home, training for rural providers and support for caregivers of Veterans.

To view a full list and learn more about ORH's enterprise-wide initiatives, visit <http://www.ruralhealth.va.gov/providers/collaborativeaccess.asp>. For more information about the VA Office of Rural Health, visit www.ruralhealth.va.gov.

MI (continued from page 1)

national trainer and consultant with the VHA Office of Mental Health Services for the cognitive behavioral therapy for chronic pain, motivational interviewing, and motivational enhancement therapy evidence-based initiatives. She has been a member of the international motivational interviewing network of trainers since 2013 and trains providers locally and nationwide. She is also an assistant professor at the University of Texas Southwestern Medical School Department of Psychiatry.

The training highlighted key processes of MI and skills used by clinicians, including the fundamental spirit and principles of MI, practical guidelines for use of MI, and the counseling micro-skills essential to proficient MI practice. The training also emphasized the brief nature of MI encounters, which are applicable to a wide variety of care settings and can enhance treatment engagement for a broad variety of presenting concerns.

About 30 learners participated in the training. SC MIRECC worked with the VISN 16 Mental Health Product Line and Mental Health Service Chiefs for participant recommendations and selections. Learners participated in four VANTS breakout sessions throughout the day. Breakout groups were assigned by each learner's VISN 16 VA parent facility, including Biloxi, Fayetteville, Houston, Jackson, Little Rock, New Orleans, and Shreveport. Additionally, seven VA providers served as facilitators for the breakout sessions. They are:

- Mirella Auchus (Jackson, Mississippi)
- Eleanora Baltz (Little Rock, Arkansas)
- Daniel Broderick (Little Rock, Arkansas)

- Caroline Chartier (Shreveport, Louisiana)
- Krista Crowe (based in Dallas, Texas; served as facilitator for New Orleans, Louisiana)
- Daniel DeBrule (Houston, Texas)
- Marie Mesidor (Little Rock, Arkansas)

The training was well received by learners. Key results from the program evaluation show:

- 96% of respondents were satisfied with the training
- 78% of respondents learned new knowledge and skills
- 91% of respondents felt they will be able to apply the knowledge and skills they learned in their jobs
- 83% of respondents found the Adobe Connect and VANTS training environment effective for learning

SC MIRECC network-wide training like the August MI event is determined by an annual needs assessment survey distributed to VISN 16, and for fiscal year 2017 and beyond, VISN 17, mental health providers. Survey results are narrowed down to the top 3 training needs and reported to the network Mental Health Product Line and Mental Health Service Chiefs, who select the training for the upcoming fiscal year. Though these trainings are limited to selected network providers, SC MIRECC offers other opportunities for training and mental health resources to providers nationwide, including our monthly accredited CBOC Mental Health Rounds and our clinical education products. For more information about SC MIRECC education, visit <http://www.mirecc.va.gov/VISN16/education.asp>.

Face-to-face but not in the Same Place: A Pilot Study of iPhone Delivery of Prolonged Exposure

**Franklin, CL, Cuccurullo, L, Walton, JL, &
Arseneau, J**

Journal of Trauma and Dissociation, 1-15

This pilot study examined use of smartphone technology to deliver prolonged exposure (PE) therapy to patients with posttraumatic stress disorder (PTSD) with geographic limitations hindering in-person therapy. The primary goal was to examine the feasibility and acceptability of using video conferencing (i.e., computer-based and iPhone 4 streaming technology), with a secondary goal of examining clinical outcomes of PE delivered via teleconferencing compared with treatment as usual (TAU) on PTSD and depressive/anxious symptom reduction. Rural veterans (N = 27) were randomized to receive PE by computer teleconferencing at a Veterans Administration community clinic, PE by an iPhone issued for the duration of the study, or TAU provided by a referring clinician. To examine the research goals, we collected data on the number of referrals to the study, number of patients entering the study, and number completing psychotherapy and documented pragmatic and technical issues interfering with the ability to use teleconferencing to deliver PE; results are discussed. In addition, measures of symptom change examined clinical outcomes. Results indicated decreases in PTSD symptoms in veterans who completed PE therapy via teleconferencing; however, there was significantly more attrition in these groups than in the TAU group.

This article can be accessed at <http://www.tandfonline.com/doi/abs/10.1080/15299732.2016.1205704?af=R&journalCode=wjtd20>.

Other Publications

Barrera, TL, Smith, AH, & Norton, PJ (2016). **Motivational interviewing as an adjunct to cognitive behavioral therapy for anxiety.** *Journal of Clinical Psychology, 72(1), 5-14.*

Call, D, Pitcock, J, & Pyne, J (2015). **Longitudinal evaluation of the relationship between mindfulness, general distress, anxiety, and PTSD in a recently deployed National Guard sample.** *Mindfulness, 6(6), 1303-1312.*

Moriarty, H, Winter, L, Robinson, K, Piersol, CV, Vause-Earland, T, Lacovone, DB, Newhart, B, True, G, Fishman, D., Hodgson, N, & Gitlin, LN (2016). **A randomized controlled trial to evaluate the Veterans' In-Home Program for Military Veterans with Traumatic Brain Injury and Their Families: Report on impact for family members.** *PM&R, 8(6), 495-509.*

Stanley, MA, Wilson, N, Shrestha, S, Amspoker, AB, Armento, M, Cummings, JP, Evans-Hudnall, G, Wagener, P, & Kunik, ME (2016). **Calmer Life: A culturally tailored intervention for anxiety in underserved older adults.** *American Journal of Geriatric Psychiatry, 24(8), 648-658.*

CBOC Mental Health Rounds

Rest Assured: Resources for Successfully Treating Insomnia and PTSD

VA mental health providers are invited to attend the next CBOC Mental Health Rounds session titled "**Rest Assured: Resources for Successfully Treating Insomnia and PTSD**" on Wednesday, December 14 at 8:00-9:00 am CT or Thursday, December 15 at 11:00-12:00 pm CT. This Microsoft Lync session will be presented by Drs. Kenneth Major and Macgregor Montaña. At the conclusion of this educational program, learners will be able to:

1. Describe the epidemiology of PTSD sleep disturbance
2. Discuss the efficacy of pharmacologic and behavioral treatments of new insomnia guidelines
3. Explain strategies to improve cognitive behavioral therapy for insomnia outcomes in clients with a history of trauma

Call 1-800-767-1750 and use access code 37009# to participate. Email Ashley.McDaniel@va.gov or call (501) 257-1223 for registration and continuing education credit information.

**Upcoming CBOC
Mental Health Rounds
Second Wednesdays
(8:00-9:00 am CT)
and
Thursdays
(11:00-12:00 am CT)
Monthly
(800) 767-1750;
37009#**

January 11 & 12, 2017
Posttraumatic Growth

February 8 & 9, 2017
Mindfulness

Learn more about SC MIRECC by visiting www.mirecc.va.gov/visn16

VA



U.S. Department of Veterans Affairs

Veterans Health Administration
South Central MIRECC