

MINDVIEW

VOL. 4 | ISSUE 3 | AUGUST 2011 IMPROVING THE QUALITY OF LIFE FOR VETERANS WITH PSYCHOSIS

UPCOMING EVENTS

INTEGRATED BEHAVIORAL
COUPLES THERAPY WORKSHOP
August 29 – September 1, 2011
Location: Long Beach, CA
Contact: sglynn@ucla.edu

MIRECC TRAINING RETREAT
September 14-15, 2011
Location: Long Beach, CA
Contact: noosha.niv@va.gov

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GUIDE TO VA MENTAL HEALTH SERVICES FOR VETERANS & FAMILIES

Noosha Niv, Ph.D.

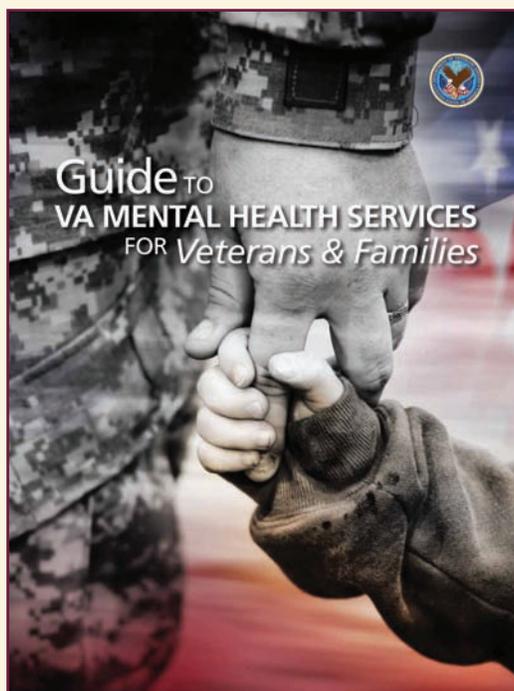
In 2008, the VA introduced the Uniform Mental Health Services Handbook which established minimum clinical requirements for VHA Mental Health Services. The handbook described the essential components of mental health services that were to be implemented nationally and specified exactly which services must be provided to veterans and their families at each VA Medical Center and each Community-Based Outpatient Clinic (CBOC). Incorporating the new standard requirements for VHA mental health services nationwide, the handbook was issued to ensure that all veterans have access to needed mental health services, no matter where in VHA they obtain care.

The VISN 16 MIRECC Consumer Guide Workgroup has developed an excellent guide that is a shorter, simplified version of the handbook intended for the general public. Developed specifically for veterans, family members, or anyone

else interested in VA mental health care, this 20-page guide provides a great overview of the mental health services that VA facilities offer to veterans. The guide covers many important topics, such as the guid-

The guide provides information about the types of evidence-based treatments available for the most common mental health problems experienced by veterans, including depression, anxiety, posttraumatic stress disorder, substance abuse, and severe mental illness (i.e., schizophrenia, schizoaffective disorder, and bipolar disorder). Special programs for veteran populations with special needs are also covered. Specifically, the guide provides an overview of VA programs for women veterans, veterans just returning from deployment, homeless veterans, older veterans, and veterans involved with the criminal justice system. Suicide prevention services and military sexual trauma services are also discussed.

The appendix section describes the mental health services VA medical centers and clinics are required to provide depending on their size and type. It also provides a glossary of common VA mental health terms.



ing principles of mental health care, how to find mental health care, and the various treatment settings in which the VA offers care (e.g., hospitals, clinics, and through telemedicine).

To download the guide, please visit:

http://www.mirecc.va.gov/visn16/docs/guide_to_va_mental_health_srvc_final12-20-10.pdf



LETTER FROM THE DIRECTOR

Stephen R. Marder, MD



One of the most important principles of recovery is that individuals with serious mental disorders should be empowered to take greater control over the management of their illnesses. For this to happen, these individuals need to have a greater knowledge of their own illnesses as well as their treatment options. In addition, when consumers of care are better informed, they can be effective agents for improving systems of care.

This issue of MindView documents innovative approaches for informing VA mental health patients about important services. The VISN 16 guide to services for patients and family members summarizes important infor-

mation from the Uniform Mental Health Services Handbook. This Handbook, originally developed for clinical managers and clinicians, documents services that should be available to every veteran who needs mental health care. The VISN 16 guide adapts a consumer's view and can help an individual learn about his or her illness, the treatments that have been found to be effective for the illness, and how to access those treatments.

The article by Niv and Bonet describes PTSD Coach, an application for mobile phones that can help individuals with Post Traumatic Stress Disorder. As noted in the article, it can help these individuals learn about their symptoms and manage them through methods such as muscle relaxation and deep breathing. In addition, it can help individuals connect with VA services that are provided at VA facilities and the National PTSD hotline.

VA LAUNCHES NEW PERSONALIZED VETERANS HEALTH BENEFITS HANDBOOK

The Department of Veterans Affairs (VA) is currently piloting a new, personalized Veterans Health Benefits Handbooks. The handbooks are tailored to provide enrolled Veterans with the most relevant health benefits information based on their own specific eligibility. In essence, each handbook will be written for the individual Veteran.

"These handbooks will give Veterans everything they need to know and leave out everything that doesn't apply to them," said Secretary of Veterans Affairs Eric K. Shinseki. "Our Veterans will now have a comprehensive, easy to understand roadmap to the medical benefits they earned with their service."

In addition to highlighting each Veteran's specific health benefits, the handbook also provides contact information for the Veteran's preferred local facility, ways to schedule personal appointments, guidelines for communicating treatment needs and an explanation of the Veteran's responsibilities, such as copayments when applicable.

"Enhancing access isn't just about expanding the kinds of services VA provides. It also includes making sure we do everything we can to ensure Veterans have a clear understanding of the benefits available to them so they can make full use of the services they have earned," Shinseki said.

The new handbook is currently available only to certain Veterans in Cleveland and Washington, D.C. areas. Following the pilot phase, full implementation across the country is scheduled to begin in the Fall of 2011.



THE INTERFACE BETWEEN PERCEPTION AND ATTENTION: CLARIFYING THE TIMELINE OF COGNITIVE IMPAIRMENT IN VETERANS WITH SCHIZOPHRENIA

Kristopher I. Mathis, Ph.D.

Among the many challenges faced by veterans living with schizophrenia is a wide array of cognitive impairments. The mental processes impacted by these impairments range from the most fundamental, such as perceiving basic geometric shapes or letters, to the highly complex, such as interpreting ambiguous social situations. Most of these impairments are resistant to current interventions, and many are related to community functioning. The Treatment Unit of the VISN 22 MIRECC, in collaboration with the Clinical Neuroscience and Genomics Unit, has endeavored to specify the nature of these cognitive impairments and to identify the brain mechanisms underlying them. These efforts have had as their ultimate goal the development of treatment programs that would address the cognitive impairments directly and ameliorate their impact on community functioning.

Several studies conducted recently within the unit have focused on differentiating impairments occurring at various stages of processing basic visual stimuli. The motivation to conduct these studies was to improve our understanding of how early processing stages associated with perception interact with later processing stages associated with attention. Previous research has shown that veterans with schizophrenia exhibit impairment at both the early and later visual processing stages, and there is ongoing debate regarding how the observed deficits in these stages interact. Resolving this debate could help focus treatment development on addressing the early deficits, the later deficits, or on the interaction between the two classes of deficits.

A recent publication authored by members of the Treatment Unit describes a study in which the interaction between early and later stages of visual processing was

directly assessed in large samples of veterans with schizophrenia and healthy comparison participants. This study employed a paradigm known as the Attentional Blink, in which the participants are asked to identify visual targets embedded within a rapidly presented stream of visual distractors. This paradigm was designed to assess the interface between perception and attention and to evaluate visual processing at the level of milliseconds. The results of this study indicate that patients experience two types of impairment: 1) at the interface between the early, perceptual stages and the later, attentional stages of processing and 2) a later, attentional deficit present throughout the processing timeline.

To clarify the findings of this study, we have conducted a follow-up study using electroencephalography (EEG) to allow us to tease apart the observed attentional deficit from the deficits at the interface between the perceptual/attentional interface. Our analyses of the EEG data suggest that after attempting to control for the general attentional deficit, two distinct impairments remained: 1) a basic perceptual deficit and 2) a higher order deficit that is specific to later attentional processes and relatively independent from deficits occurring earlier in the processing timeline. These findings will aid us in disentangling the mechanisms in the brain associated with the observed deficits as we continue this line of research.

The ongoing research being conducted in the Treatment Unit has helped to extend our understanding of cognitive impairments by identifying the specific stages of processing at which deficits occur for veterans living with schizophrenia and has contributed to increasing awareness of the importance of studying and eventually treating these impairments.



VETERANS ADMINISTRATION CELEBRATES 81ST ANNIVERSARY: A BRIEF HISTORY

Noosha Niv, Ph.D.

July 21st was the 81st Anniversary of the creation of the "Veterans Administration." The VA was established in 1930 when Congress authorized the president to "consolidate and coordinate Government activities affecting war veterans." President Hoover signed the bill creating the VA on July 21, 1930.

The concept that government should care for its Veterans was not a new one. The English colonies in North America provided pensions to disabled veterans who had defended the colonies against Indians. The first of these laws was established in Plymouth in 1636. In 1776, the Continental Congress passes the nation's first pension law. Payments were left to the states, however, as the Congress did not actually have the authority or the money to make pension payments. The

first federal pension legislation wasn't passed until 1789 when the first Congress assumed the responsibility of paying veteran benefits following the ratification of the U.S. Constitution. The establishment of Naval Home in Philadelphia in 1812 was the first national effort to provide medical care to disabled veterans. In 1833, Congress authorized the creation of the Bureau of Pensions, the first administrative office dedicated solely to the aid of veterans.

The Veterans Bureau was established in 1921, consolidating programs previously managed by three agencies: the Bureau of War Risk Insurance, Public Health Service and the Federal Board of Vocation Education. At this time, the various Veteran benefits were administered by three different federal agencies: the Veterans Bureau, the Bureau of Pensions

of the Interior Department, and the National Home for Disabled Volunteer Soldiers. The 1930 Executive Order, signed by President Hoover, consolidated these three agencies to form the new Veterans Administration. Brigadier General Frank T. Hines, who directed the Veterans Bureau for seven years, was named as the first Administrator of the Veterans Administration, a job he held until 1945.

In 1944, Congress passed the Servicemen's Readjustment Act, the "GI Bill of Rights." Signed by President Roosevelt, the bill significantly transformed the concept of veterans' benefits with three key provisions: 1) up to four years of education and training, 2) federally guaranteed home, farm and business loans with no down payment, and 3) unemployment compensation. The Veterans' Preference Act of 1944 also gave veterans hiring preference where federal funds were spent.

President Reagan signed legislation in 1988 to elevate

the VA to Cabinet status. Proponents of this change argued that the agency should have direct access to the president given that about one-third of the U.S. population was eligible for veterans' benefits and that the VA was second only to the Department of Defense in the number of employees it hired. On March 15, 1989, the Veterans Administration became the Department of Veterans Affairs, and Edward J. Derwinski, was appointed the first Secretary of Veterans Affairs.

In 1930, the VA had an operating budget of \$786 million and served 4.6 million veterans. Today, the VA has a budget of over \$120 billion, provides care to more than 5.6 million unique patients, and hires approximately 280,000 employees. VA maintains the largest integrated health care system in America and is dedicated to fulfill President Abraham Lincoln's call "To care for him who shall have borne the battle and for his widow, and his orphan."

The VA is dedicated to fulfilling President Abraham Lincoln's call "To care for him who shall have borne the battle and for his widow, and his orphan."



President Herbert Hoover, General Hines and staff, following the signing of Executive Order 5398 creating the Veterans Administration.

MILITARY SEXUAL TRAUMA DIRECTIVE

Noosha Niv, Ph.D.

In July 2010, the VA issued a policy directive regarding clinical care, monitoring, staff education, and informational outreach related to military sexual trauma (MST) services. The directive defined MST as “psychological trauma, which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or active duty for training.” Sexual harassment was further defined as “repeated, unsolicited verbal or physical contact of a sexual nature, which is threatening in character.” Public Law 103-452 removed limits on the duration of the care provided related to MST and specified that treat-

ment must be available to both male and female survivors of MST.

Veterans and eligible individuals who experienced MST while on active duty or active duty for training do not need to file a disability claim, be service connected, or provide evidence of the sexual trauma to receive MST-related care. They may receive MST-related care even if they are not determined to be eligible for other VA health care benefits. All MST-related health care, including medications, is provided free of charge. All veterans and potentially eligible individuals must be screened for MST experiences using the MST Clinical Reminder in CPRS, and all VA facilities must have appropriate physical and mental health care available for MST-related

conditions.

Every facility now has a designated MST Coordinator whose responsibilities include monitoring and helping to ensure national and VISN-level policies related to MST screening, treatment and informational outreach to veterans are implemented at the facility and associated CBOCs. MST Coordinators serve as a point of contact, source of information, and problem solver for MST-related issues. MST Coordinators are also responsible for staff education related to MST. Training may include topics such as: sensitivity and confidentiality; treatment options; importance of, and rationale for, screening; potential impact of an MST history on provision of care; and background information on MST. A mandatory training for all

VA providers will soon be rolled out.

Each VISN now also has a designated MST VISN-level Point of Contact (POC). It is the responsibility of the POC to provide support to the MST Coordinators within the VISN, to communicate with national, VISN, and facility-level leadership and other stakeholders, and to monitor and help ensure that national and VISN-level policies related to MST are implemented at VISN medical centers and CBOCs.

The national MST Support Team was established under the direction of Amy Street, Ph.D. and Margaret Bell, Ph.D. Networking and training have been a priority with monthly MST calls that feature talks relevant to the topic of MST and to the work of the MST Coordinators.

VISN 22 MILITARY SEXUAL TRAUMA COORDINATORS



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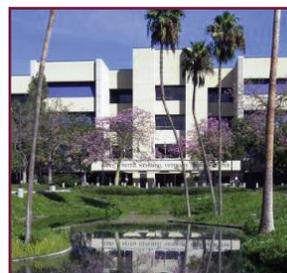
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TRAUMA SUPPORT GOES MOBILE

Noosha Niv, Ph.D. and Vanessa Bonet, BA

Got PTSD? There's an app for that. There is now mobile help for those suffering from Post Traumatic Stress Disorder (PTSD). A new mobile application, PTSD Coach, has been created by the VA National Center for PTSD and the Defense Department's National Center for Telehealth and Technology to help individuals dealing with symptoms of PTSD cope with the challenges of readjustment and obtain assistance anonymously. The "PTSD Coach" is one of the first in a series of free smartphone applications developed by the DVA and DOD.

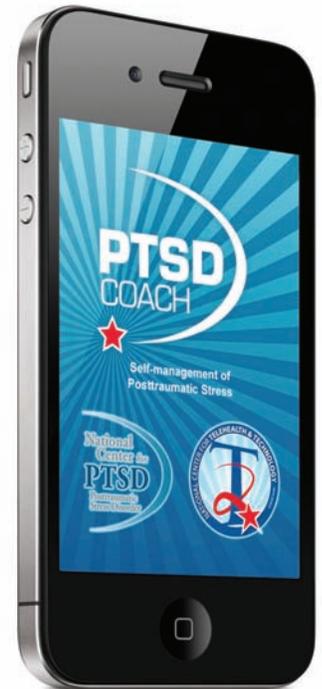
Although the app was designed to work in conjunction with traditional therapy, it can be helpful for those who are considering treatment or who would simply like to learn

more about PTSD. The app was specifically developed for veterans and features tools for tracking PTSD symptoms, information about PTSD, tools to manage and cope with symptoms, and direct links to support and help. The symptom tracker allows for self-assessment and even suggests that users should get professional help when symptoms increase. The app addresses frequently asked questions regarding PTSD and provides information on coping skills designed to help with various symptoms. For example, it provides step-by-step instructions in muscle relaxation and deep breathing and integrates personal photos and music that can be utilized during stressful periods. The app includes multiple links to vari-

ous treatment and support centers, including the National Suicide Prevention Hotline. Users can set up their own personalized support network as well.

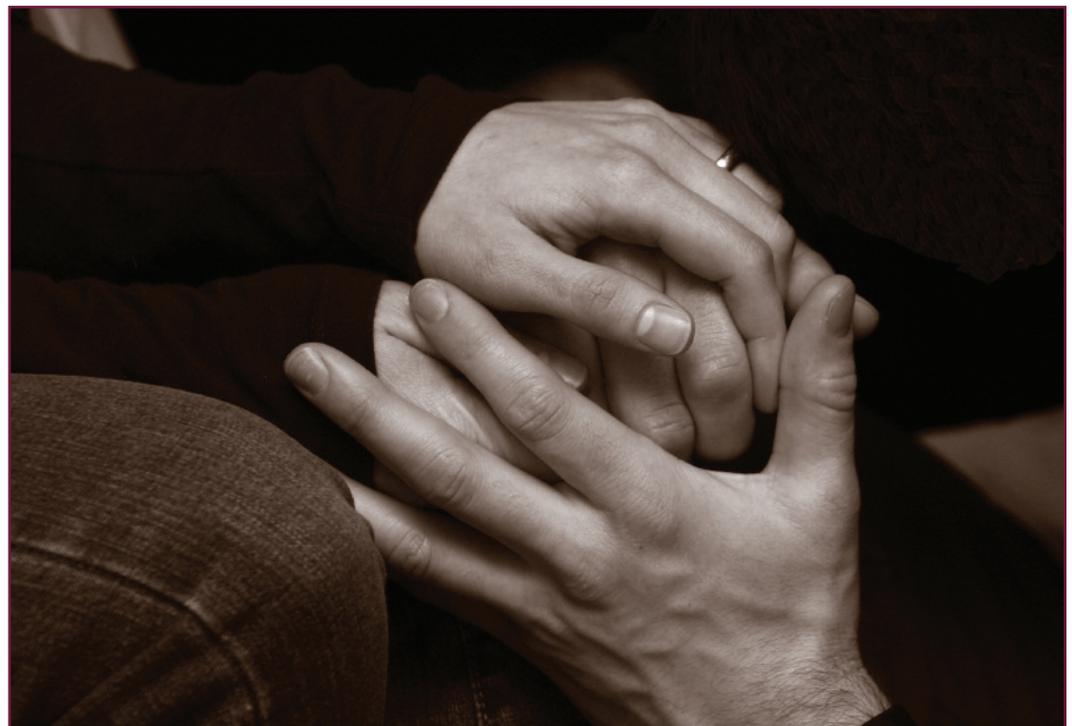
"This is about giving Veterans and Servicemembers the help they earned when and where they need it," said Secretary of Veterans Affairs Eric K. Shinseki. "We hope they, their families and friends, download this free app. Understanding PTSD and those who live with it is too important to ignore."

PTSD Coach was launched in April 2011 and has been downloaded more than 14,000 times in 41 countries as of July 2011. PTSD Coach is available for download via iTunes and the Android Market.



2011 STAND DOWN FOR HOMELESS VETERANS

Stand Downs are one part of the Department of Veterans Affairs' efforts to provide services to homeless veterans. The 24th Annual Stand Down took place on July 15-17, 2011 at San Diego High School. Over two hundred VA employees volunteered for the event, which provided various services including medical, dental and legal affairs to former servicemen and women. Over a thousand Veterans utilized various services provided by the VA including dispensary needs, testing for HIV and Tuberculosis, skin and foot care, and mental health and substance abuse referral.



HONORING DR. GARY WOLFE

Nikki Frousakis, Ph.D. and Noosha Niv, Ph.D.

Each year the Association of VA Psychologist Leaders (AVAPL) presents a Professional Service Award to a psychologist in recognition of outstanding service and accomplishment in psychology in service to the VA. Gary Wolfe, Ph.D., has been named this year's recipient of the AVAPL Professional Service Award. He was honored for his service at this year's American Psychological Association Convention on August 5th in Washington, DC. Dr. Wolfe was also awarded the AVAPL Leadership Award in 2007.

Dr. Wolfe has worked at the VA for 35 years. During this time, he spent 11 years as the Training Director of the APA-approved Psychology Internship Training Program at the Downtown Los Angeles Outpatient Clinic (now called the Los Angeles Ambulatory Care Clinic or LAACC). Since 1998, he has been the Department Chair in Psychology for the VA Greater Los Angeles Healthcare System and Associate Chief of Mental Health for LAACC. Dr. Wolfe has made invaluable contributions to mental health for countless veterans and has served as a mentor to numerous clinicians who have moved on to leadership positions both at the VA and at other facilities.

Dr. Wolfe will retire in January 2012. He is an avid cyclist, and his plans for retirement include plenty of bicycling. Additionally, he plans on remaining involved in research as a consultant on study design and statistics.

Thank you, Dr. Wolfe, for your service to the VA. You will be missed!



RECENT MIRECC PUBLICATIONS



Harvey, P-O, Lee, J., Cohen, M.S., Engel, S.A., Glahn, D.C., et al. (2011). **Altered dynamic coupling of lateral occipital complex during visual perception in schizophrenia.** *NeuroImage*, 55, 1219-1226.

Harvey, P-O, Lee, J., Horan, W.P., Ochsner, K., & Green, M.F. (2011). **Do patients with schizophrenia benefit from a self-referential memory bias?** *Schizophrenia Research*, 127, 171-177.

Rassovsky, Y., Horan, W.P., Lee, J., Sergi, M.J., & Green, M.F. (2011). **Pathways between early visual processing and functional outcome in schizophrenia.** *Psychological Medicine*, 41, 487-497.

Sun, Y., Farzan, F., Barr, M.S., Kirihara, K., Fitzgerald, P.B., et al. (In press). **Gamma oscillations in schizophrenia: Mechanisms and clinical significance.** *Brain Research Reviews*.

NEW GRANTS

“Gating and Inhibition in Schizophrenia: Studies of Startle Plasticity in Schizophrenia Patients and Related Animal Models”

Principle Investigator: David Braff, M.D.
Funded by National Institute of Mental Health

NEW AWARDS

Congratulations to Dr. Alexander Young and the MIRECC Health Services Unit! Their talk, “Implementation of Evidence-Based Weight Practices in Specialty Mental Health,” was selected as the Best Abstract in Behavioral Health at the 2011 Academy Health National Conference.



MIRECC
Mental Illness Research,
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