

MINDVIEW

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LESSONS FROM HIGH ACHIEVING INDIVIDUALS WITH SCHIZOPHRENIA

Amy N. Cohen, PhD, Alison B. Hamilton, PhD, MPH, Elyn Saks, JD, PhD, and Stephen Marder, MD

A substantial number of individuals with schizophrenia live remarkably productive lives with rich interpersonal relationships, despite enduring active symptoms of their illness. Many in the mental health community consider this positive turn of events to be “recovery” from severe mental illness. The President’s New Freedom Commission states, “Recovery...is the process in which people are able to live, work, learn, and participate fully in their communities.” Our goal is to understand what recovery means for individuals with mental illnesses, and how those individuals go about recovery.

Most research on schizophrenia has focused on those who are most impaired rather than those who are high-achieving, so very little is known about the latter group. With funding from the Larsen Foundation and the Greenwall Foundation, we conducted

in terms of occupational status, and 2) to understand the strategies that high-achieving individuals have used to reach their current functioning level, and strategies they use to negotiate their daily living. Although “high-achieving” can be defined in a number of ways, this study defined it as “individuals who have a life history of effectively negotiating developmental and life tasks and continuing to balance multiple daily demands, regardless of whether they have a psychiatric illness.” For someone with schizophrenia, pursuing developmental and life tasks often runs alongside a constellation of chronic symptoms that could range from suspicious ideas to a lack of motivation to hearing voices. There is a wealth of information to be gained from those individuals who are able to achieve success in one or more domains of their lives (e.g., academic, social, occupational) in spite of their illness.

The study sample was comprised equally of men and women with an average age of 40 years. In terms of education, the sample included 2 MDs, 1 PhD, 1 JD, 5 with master’s degrees, 7 with Bachelor’s degrees (of which 3 were currently completing a master’s

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“There is a wealth of information to be gained from those individuals who are able to achieve success in one or more domains of their lives (e.g., academic, social, occupational) in spite of their illness.”

a qualitative, exploratory study of a small sample (n = 20) of high-achieving individuals with schizophrenia. The goals of this study were: 1) to understand the characteristics of individuals with schizophrenia who could be considered “high-achieving”



LETTER FROM THE DIRECTOR

Stephen R. Marder, MD



Readers may be surprised by the individuals described in the article by Amy Cohen and others in this issue of *MindView*. That is, despite having to live with serious psychotic symptoms, these people have been able to live full lives with success in their work and family relationships. These individuals

seem very different from the patients that clinicians see during their work at VA and other clinics. This can be a clinical problem that can interfere with recovery since it could lead providers to convey a pessimism that is not justified.

The tendency to underestimate patients has been called the “the clinician’s illusion.” People who work with patients tend to spend much more of

their time with individuals who are doing poorly, and these people have the greatest influence on the clinician’s expectations. In addition, patients who are treated in VA and other public mental health settings often are seen at those setting because of disabilities that are associated with low incomes. The individuals who do very well are seen elsewhere, and they tend to not disclose their illnesses because of the stigma associated with schizophrenia and other illnesses.

In my view, there are important lessons from this article. First, some individuals learn to live with their symptoms. For them, the symptoms are a burden, but they do not define what that person is capable of achieving. Second, clinicians should explore whether their overly pessimistic views about the course of psychotic illnesses may be interfering with an individual’s recovery plan.

SCHIZOPHRENIA *cont. from page 1*

degree), and 4 with a high school diploma (of which 1 was completing a bachelor’s degree). Three participants held professional jobs, 7 held technical jobs, 5 held managerial jobs, 4 were full-time students, and 1 was a caretaker of elderly parents.

Intensive, person-centered interviews (approximately 5 hours each over two sessions) were conducted examining the life history of each individual. These interviews provided an opportunity for participants to describe an array of compensatory strategies that have been effective in lessening the impact of psychotic thought processes during developmental and life tasks. Several compensatory mechanisms were identified as helpful, including cognitive techniques, exercise, control of their environment (including noise and light), and confirming (or disconfirming) their thoughts and beliefs as they occur with close others. Other important aspects of self-care were medication adherence, staying physically healthy, engaging spirituality, and, for some, engaging in the mental health recovery movement. Across the sample, common avoidances included illicit drugs and alcohol, travel, crowds, and isolation. It was clear that there were many common elements between their stories and the recovery literature, including the importance of hope, a focus on strengths (as opposed to deficits), the importance of redefining self, participating in meaningful activities, building a feeling of empowerment,

assuming control over one’s illness, and overcoming stigma.

In sum, there are a number of strategies used by individuals with schizophrenia to function and achieve even in the face of active symptoms. Although some of these strategies might be idiosyncratic to this sample, they may still be of use to other individuals who are working to manage their symptoms. In-depth information about people’s experiences can strengthen our understanding of what it means to “recover” from serious mental illness. We are grateful to the individuals who chose to share their life stories with us.



NATIONAL VETERANS SUMMMER SPORTS CLINIC

Analisa Enoch

For the 4th year in a row, the VA San Diego Healthcare System hosted the annual National Veterans Summer Sports Clinic (NVSSC). The NVSSC is a week long, life changing experience for more than 100 disabled Veterans from across the country. NVSSC promotes rehabilitation for Veterans diagnosed with traumatic brain and spinal cord injuries, amputations, visual impairments, and neurological challenges, by



encouraging and involving them and their families in summer sports activities.

The goal of the Clinic is to heal the whole person – body, mind and spirit - through adaptive surfing, kayaking, sailing, track and field events, rowing and cycling. The NVSSC reinforces the hard work and motivation of participants' on-going rehabilitation while renewing old skills and building new abilities.

These events are not only about overcoming physical challenges; they are also emotionally healing for the families. Family members get to witness the life spring back into their loved ones and get the opportunity to meet other families who are going through similar experiences.

Whether it's surfing, kayaking, or biking, participants come together with their coaches and Team Leaders as teams and begin the journey. First time participant and recent amputee, Navy Veteran John Grimm, wasted no time getting into the cool water along La Jolla Shores surfing venue. Grimm was able to get up on his knees on the first try. He summed

up a day of surfing with his team, Phoenix, by simply stating, "If you didn't have fun today out there, you are crazy!" His participation has given him the confidence to compete in next year's National Veterans Golden Age Games, and he is looking forward to coming back next year as a second time participant.



Closing ceremonies wrapped up the week's events with an awards reception and dinner. All participants were presented with a medal that signifies their tremendous efforts. While watching the closing video of the week's events, participant Brenda Trussler, a Navy Veteran and first time participant from North Carolina, leaned over and whispered to me "I don't want to go home." Moments such as this is why I volunteer as a Team Leader every year – it offers me a chance to become personally involved and maybe make a difference in a few of our Nation's Wounded Warriors.



THE 5TH ANNUAL VA MENTAL HEALTH CONFERENCE

Noosha Niv, Ph.D.

The 5th Annual VA Mental Health conference, Improving Veterans Mental Health Care for the 21st Century, took place in Baltimore, MD in August 2011. The conference venue, the Marriott Waterfront, was briefly evacuated on the first day of the conference after a 5.8 magnitude earthquake struck at 1:51 p.m. The quake, which was centered 35 miles northwest of Richmond, was felt from Georgia to Canada and was one of the strongest ever felt in Maryland. This is the second year in a row that the Marriott Waterfront has been evacuated during the VA Mental Health conference. The disruption in 2010 was due to a water pipe rupture that caused significant flooding and water damage. The following six presentations/workshops from VISN 22 MIRECC investigators were included in this year's program.

Getting Veterans with Schizophrenia to Supported Employment and Back to Work: Improving Care Quality

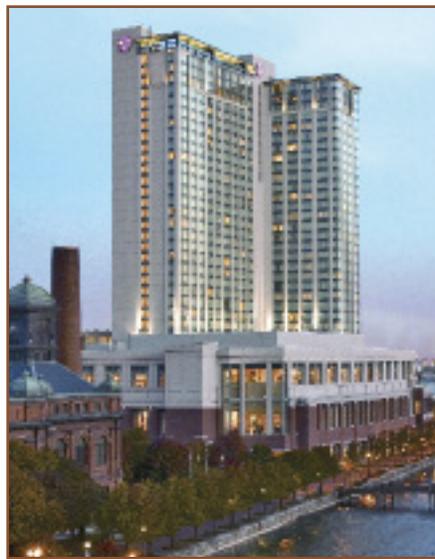
Amy N. Cohen, PhD, Alison Hamilton, PhD, Anna Teague, MD, Deborah Mullins, PhD, Eran Chemerinski, MD, Max Schubert, MD, Avila Steele, PhD, Kirk McNagny, MD, Christopher Reist, MD, MBA, Fiona Whelan, MS, Nikki Armstrong, PhD, Alexander S. Young, MD, MSHS

Background: Schizophrenia is the most common serious mental illness and, when poorly treated, results in substantial functional impairment including chronic unemployment. Evidence-based practices for schizophrenia, including Supported Employment (SE), improve outcomes and facilitate independence. The SE model is based on the concept of "individualized placement and support," the only eligibility criterion is a desire to work and the goal is paid, competitive employment. The VA offers SE services, but it is unclear which veterans want to work. The goal of this study was to improve quality by investigating the organizational structure around SE, identifying barriers and facilitators to utilization, and assessing impact.

Methods & Results: EQUIP (Enhancing Quality-of-care In Psychosis) was a site-level, controlled trial. Within 4 VISNs, pairs of sites were assigned to intervention or usual care. Assessment of organizational readiness informed implementation, which included marketing, opinion leaders, provider and patient education, continual feedback to staff,

and routine patient assessment. Kiosks were placed in waiting rooms. At each clinic visit, patients responded to questions about desire to work, referral to and appointments in SE, and employment details. These data were used throughout implementation to identify referrals and to monitor quality. Patients and clinicians were interviewed at baseline and 15 months.

801 adults with schizophrenia and 171 clinicians enrolled. At baseline, 15% of patients were working, and 53% wanted to work. Across all sites, the probability of veterans using SE services during the study was examined using a logistic model. A forward stepwise selection method was used. The model predicted utilization of SE services based on group status (intervention/control) while controlling for baseline utilization and



The Baltimore Marriott Waterfront

desire to work. Results indicated that individuals at intervention sites were 2.2 (95% CI: 1.1 - 4.3) times more likely to utilize SE services during the study as compared to individuals at control sites. When examining site level differences, chi-square results indicated that two intervention sites (Sites B and C) had significant increases in utilization compared to their VISN control. Across all sites, the probability that veterans were employed at follow-up was examined. None of the variables met significance criteria to enter the model. When examining site level differences, chi-square results indicated that one intervention site (Site C) showed significant increases in employment ($p = .004$). Site C

had a SE fidelity rating of 70, indicating good model fidelity. Such high ratings of fidelity were not evident at the other sites. Formative evaluation results indicated an overall increase in SE capacity, including one site adding a SE worker, another site training other clinicians as SE workers, and several sites discharging patients who were not progressing through SE.

Conclusions: Consistent with the literature, only 15% of patients with schizophrenia in this large sample were working. Unknown until this study, 53% of patients in treatment for schizophrenia wanted to work. Implementation efforts addressed the large gap in evidence-based, recovery-oriented care, and increased service utilization and capacity. Employment rates, a more distal outcome, were only increased at one site. Employment outcomes may have been limited by poor model fidelity at other sites and limited intervention time.

Utilizing Quality Improvement Teams to Address Gaps in Care: Techniques and Tools

Amy N. Cohen, PhD, Matthew Chinman, PhD, Jeffrey Smith

Background: Quality of care is often impeded by organizational structure and process issues (e.g., limited utilization of evidence-based practices, provider attitudes and behaviors, communication between staff). Accordingly, improvement in services and their delivery has been the focus of the Uniform Mental Health Service Package and several recent implementation trials in VA mental health.

Problem to be Solved: Externally-driven (top-down) efforts to improve quality have typically resulted in modest or no improvement in treatment quality. Quality improvement necessitates local buy-in and involvement of those who are expected to deliver quality services.

Solution / Innovative Approach: Site-based, locally-driven quality improvement (QI) teams can help to reduce the gap between research and practice by identifying and addressing local gaps in care with a collaborative process. Ideally comprised of staff from several different organizational levels and disciplines, QI teams gather data about clinical concerns, plan and implement feasible changes, and evaluate their change efforts (e.g., in a Plan-Do-Study-Act cycle). Teams conducting clinical quality improvement can foster a sense of mutual engagement in change processes, which may

be critical for QI sustainability.

Dr. Cohen began the workshop with an overview of QI concepts and methods including: 1) strategies for formulating, developing, and supporting QI teams; 2) tools for identifying gaps in care; 3) measures for assessing organizational change; and 4) data analysis techniques for QI team studies. This introduction provided detailed how-to steps on how to build and utilize QI teams in local clinics.

The workshop also described recent examples from typical clinics to further elucidate these methods. 1) Dr. Cohen described QI teams built and utilized in 4 VA specialty mental health clinics to improve care for veterans with schizophrenia. Each QI team worked differently and had different goals providing a rich example of how QI teams can vary but still be effective. Targeted gaps in care included inpatient-outpatient communication, transformation to recovery-oriented treatment plans, engaging homeless veterans in VA services, and reducing the number of clinic no-shows. 2) Dr. Chinman described QI teams built and utilized in 3 VA homelessness programs to improve care for homeless veterans. This project used staff training and ongoing technical assistance to assist teams in developing goals, adopting evidence based practices, planning for change, and self-evaluation. 3) Mr. Smith described a QI team built and utilized in a VA specialty mental health clinic in order to support improvement in antipsychotic medication management for patients with schizophrenia. The work attempted to move the medical center from non-compliance to compliance with VISN-level performance measures.

Evaluation / Lessons Learned: Locally-driven QI teams can improve care, particularly when the teams are empowered to address local concerns. By utilizing established QI strategies and tools, local teams can generate important and real-time findings that contribute to organizational change.

Conclusions: If we are to meet the charge to implement the Uniform Mental Health Service Package and end homelessness in 5 years, we need to address organizational change, systems redesign, and gaps in care. QI teams can support and augment efforts to improve quality of healthcare services.

Veterans with Serious Psychiatric Illness and Their Families: How to Engage Them in Treatment and Effectively Provide Support

Shirley M. Glynn, PhD, Amy Cohen, PhD, Lisa Dixon, MD, Barbara Dausch, PhD

Background: Family involvement in mental

health care can have many benefits for persons with serious psychiatric illnesses and their relatives. The VA has mounted an extraordinary effort to improve family support for veterans with serious psychiatric illnesses through the provision of a continuum of services, including: 1) family friendly agencies, 2) illness education (the provision of factual information in programs such as Support and Family Education (SAFE) or NAMI's Family-to-Family (FTF) program), 3) family consultation (brief, targeted interventions to resolve specific problems) and 4) family psychoeducation (evidence-based interventions to enhance coping and problem-solving skills to improve illness outcomes). All VA medical centers and large CBOCs are mandated to offer family consultation and either education or family psychoeducation in the Uniform Mental Health Services Package (UMHSP). This series of presentations highlighted innovative and effective strategies to address common challenges in implementing family services consistent with the UMSHP in VA.

Methods & Results: Results from three projects were presented along with comments from the Office of Mental Health Services (OMHS). The projects demonstrate methods to address common challenges/questions in the field, including how to engage families, optimal ways to educate families, and how to implement family psychoeducation programs in typical VA settings. The comments from OMHS summarized the national efforts to disseminate family interventions in VA.

First, Dr. Cohen explained an innovative and successful strategy to activate veterans to invite their family to be involved in their treatment. The approach is centered around the veteran's recovery goals and offers a brief intervention to link the veteran's family with the treatment team. Results from a two site RCT with over 200 veterans were presented. Dr. Dixon presented data from an RCT demonstrating that relatives' participation in the NAMI FTF program leads to significantly increased coping, problem solving, empowerment and knowledge. Dr. Dausch described a clinical demonstration project supporting the effectiveness of Family Focus Therapy in reducing relapse and rehospitalization in veterans with bipolar illness or schizophrenia. Lastly, Dr. Glynn detailed OMHS's efforts to disseminate evidence-based, family psychoeducational programs throughout VA, including overall penetration, successes and lessons learned.

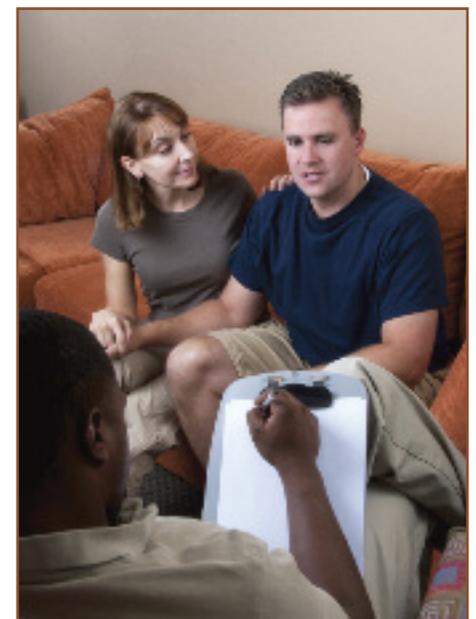
Conclusions: The results of these three studies demonstrate that families can be successfully engaged in VA services, families

can benefit from participation in NAMI's FTF program, and that family psychoeducation programs designed for civilian populations also show benefits in veterans and can be implemented in typical VA clinics. However, discussion from OMHS indicates that penetration of family interventions in VA is still limited despite these successes. Recommendations emanating from these series of presentations include: 1) teaching VA clinicians more effective engagement strategies for families, 2) helping clinicians learn to make more effective referrals to community resources such as FTF, and 3) continuing the effort to teach clinicians how to use evidence-based family interventions. Implementing family services in VA has been extremely challenging, but these studies and the efforts and support of OMHS provide renewed hope that providing support for these veterans and their families is possible, and can be effective, in VA.

Cognitive-Behavioral and Motivational Enhancement Therapy for Comorbid Affective and Substance Use Disorders

Noosha Niv, PhD, Peter Graves, JD, PhD, Donna Cobbah, MSW, Susan Rosenbluth, PhD

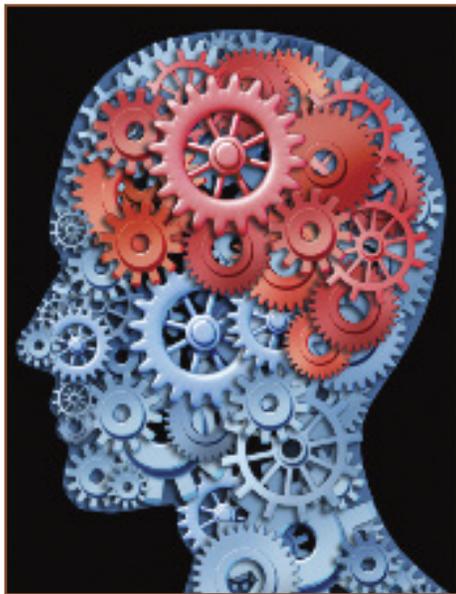
Background: There is little evidence supporting the effectiveness of any specific intervention for comorbid affective and substance use disorders. The Matrix Model is an evidence-based, cognitive-behavioral treatment for substance use disorders. The goals of this study were: 1) to modify the Matrix Model to better fit the needs of individuals with dual disorders based on feedback received from veterans and clinicians, and 2) to conduct a pilot study of



VA CONFERENCE *cont.*

the modified intervention to determine the feasibility of implementation in a VA setting and to measure several outcomes including substance abuse relapse, psychiatric symptom severity, and psychosocial outcomes.

Methods: Focus groups were held with veterans with dual disorders who participated in the Matrix substance abuse program and clinicians who led these programs to better understand the needs of patients with comorbid disorders. Modifications were made to the intervention based on the themes that emerged from the focus groups, and treatment manuals standardizing the 16-week intervention were developed. A pilot study of the experimental intervention was conducted at the West Los Angeles VA. Participants were 12 veterans with a current substance use disorder and major depressive or bipolar



disorder. The SCID-IV was used to confirm diagnoses. The Brief Symptom Inventory and the Addiction Severity Index, which assesses problem severity in seven areas (alcohol use, drug use, employment, family and social relationships, legal, medical status, and mental health), were completed at baseline and at 4 months. Data on treatment utilization and substance use relapse were also collected.

Results: Themes that emerged from the focus groups and resulting modifications to the Matrix Model were discussed. Half of the participants ($n = 6$) who participated in the pilot study completed all 16 weeks of treatment. Participants utilized an average of 2.2 of the 4 individual sessions and 21.3 of the 40 group sessions available to them. Five participants (41.7%) experienced a substance use relapse during the course of treatment. There was a

significant relationship between psychiatric diagnosis and relapse. All individuals with bipolar disorder ($n = 4$) relapsed, whereas only one out of the 8 individuals (12.5%) with major depressive disorder relapsed. Participants reported significant decreases in how bothered or troubled they were by their medical, work, alcohol, drug, and family problems. There were no significant changes in how bothered or troubled they were by their legal, social and psychiatric difficulties. Psychiatric symptoms did not show significant improvement.

Conclusions: Study results indicate that VA clinicians can effectively administer the experimental intervention in routine care and that veterans will attend a little over half of the treatment sessions. This is particularly true for individuals with depression, most of whom completed all 16 weeks of treatment. In regard to outcomes, the findings look promising for individuals with comorbid substance use and depression and warrant a clinical trial of the intervention. High rates of treatment dropout and relapse among those with bipolar disorder indicate that further modifications to the treatment are needed for this population.

Metabolic Monitoring of Antipsychotic Medications: Implementation Strategies, Tools, Barriers and Solutions

Noosha Niv, PhD, Teresa Hudson, PharmD, Melissa Christopher, PharmD, Amy Furman, PharmD

Background: While significant advances have been made in the pharmacological management of psychosis, gains are being offset by the increased liability of weight gain associated with atypical antipsychotics. The most common, serious side-effects that are seen in severe mental illness (SMI) are weight gain and related diabetes, hyperlipidemia, and hypertension. Treatment guidelines recommend that metabolic risk factors be addressed through improved clinical monitoring following initiation or change of antipsychotic medication.

Problem to be Solved: Both VA OIG's report on cardiometabolic monitoring for atypical antipsychotics and the Uniform Mental Health Services Handbook recommend that veterans prescribed atypical antipsychotics have side effects regularly monitored. Despite the provision of treatment guidelines, rates of metabolic monitoring remain low.

Solution / Innovative Approach: This workshop described two programs focused on improving the cardiometabolic monitoring and management of antipsychotics in the VA – the MIAMI (MIRECC Initiative for Antipsy-

chotic Management Improvement) Project and the Academic Detailing Service. Noosha Niv provided background on the metabolic risk factors associated with atypicals and recommendations for metabolic monitoring. Teresa Hudson described the MIAMI project, a national program designed to improve monitoring and management of metabolic problems in individuals on antipsychotic medication. MIAMI activities include dissemination of guidelines and education tools, provision of a technical assistance center, training of clinicians nationally and an assessment of implementation at some VA facilities. Melissa Christopher described the Academic Detailing pilot program in VISNs 21 and 22. This program is aimed at reducing non-evidence based use of antipsychotics and cardiometabolic risk factors through the development and distribution of data driven tools and educational outreach to mental health clinicians. The project includes not only classic educational outreach activities, but the design and implementation of clinical informatics tools for mental health providers. Amy Furman described the Mental Health Clinical Dashboard, one of the tools of the Academic Detailing Service. The Dashboard allows clinicians to quickly get a global view of their patients or drill to the individual patient level. Administrators and clinicians can generate reports with a simple computer click to display those patients that are not meeting the measure by clinic or by provider. The workshop ended with a discussion of lessons learned from the field regarding barriers to implementation of monitoring and management of metabolic side effects. Strategies to overcome veteran, treatment provider, and organizational barriers were discussed.

Evaluation / Lessons Learned: Administrators and clinicians have been receptive to the efforts of both the MIAMI Project and the Academic Detailing Service. Although most stakeholders report high interest in metabolic monitoring and management, the barriers to implementation vary significantly by site and need to be individually addressed. Common barriers to implementation include lack of resources (i.e., staff, equipment, weight programs for SMI), lack of leadership buy-in, and lack of agreement between mental health and primary care providers regarding who is responsible for monitoring and management.

Conclusions: This workshop described tools and strategies that can assist facilities in implementing metabolic monitoring into routine care. Educational services and products, clinical consultation, academic detailing and informatics tools may be utilized by clinicians to improve veteran outcomes.

EQUIP: Implementation of Evidence-Based Weight Practices in Specialty Mental Health

Alexander S. Young, MD, MSHS, Amy N. Cohen, PhD, Alison Hamilton, PhD, Fiona Whelan, MS, Nikki Armstrong, PhD, Kirk McNagny, MD, Anna Teague, MD, Christopher Reist, MD

Background: Obesity and related medical disorders are common in people with serious, persistent mental illness. This population dies about 20 years prematurely, most commonly because of cardiovascular disease. In people with mental illness, psychosocial weight loss practices have efficacy in clinical trials and are included in national treatment guidelines. However, these practices are rarely used, and it is not clear whether they can be implemented in routine care. Efforts to implement evidence-based services in specialty mental health have often shown little or no success. EQUIP was a clinic-level, controlled trial of implementation of evidence-based, recovery-oriented practices for schizophrenia. Support for the project was provided by the VA HSR&D Quality Enhancement Research Initiative (QUERI). EQUIP sought to improve clinical information by implementing routine kiosk-based patient assessment, and using this information to support evidence-based quality improvement, implementation science, and formative evaluation to improve care.

Methods and Results: Mixed methods were used to evaluate the implementation and effectiveness of a weight program for veterans with schizophrenia at medical centers in VISNs 3, 16, 17, and 22. Eight medical centers were assigned to implementation or to continue with usual care. 171 clinicians and 801 adults with schizophrenia enrolled. Computerized patient

self-assessment kiosks were integrated into care. Clinicians were trained to deliver a 16-week, group-based, weight management program. Social marketing promoted the program. Patients and staff were interviewed at baseline and 15 months. Assessment of organizational



readiness informed implementation. Implementation logs and minutes of meetings tracked barriers and facilitators.

At baseline, staff interviews revealed shortcomings with clinical competencies regarding weight management, and variation by site in readiness to improve care. 80% of patients (n = 635) were

overweight, 45% were obese (n = 356), and the mean Body Mass Index was 30 (obese). With facilitation, clinics engaged in implementation processes to improve utilization of appropriate services, including providing education and marketing to patients and clinicians. At implementation sites, use of weight services increased from 15% to 32% of overweight patients, and the average number of weight sessions attended increased from 2 to 11. At control sites, weight services were used by 26% of overweight patients, an average of 2 weight sessions were attended, and there were no changes over time. Controlling for pre-baseline and baseline weight, at implementation sites, patients' final weight was an average of 13 pounds less than at control sites (F = 4.8, p = .03).

Conclusions: In specialty mental health, overweight is a pervasive problem, but only a small proportion of patients receive appropriate practices for weight. Evidence-based quality improvement is possible, is supported by routine patient self-assessment, and can lead to substantial increases in the use of appropriate services and improved patient outcomes. However, challenges exist to implementing evidence-based psychosocial services. Patients are often ambivalent regarding their need for services and are disadvantaged, with limited transportation options. Clinician competencies are variable and often are poor. Medical records lack key automated clinical data regarding patients. Improving mental health care would benefit from kiosk-based patient assessment, systematic implementation, and development of psychosocial treatments that focus more on motivation and engagement and on being feasible in routine practice.

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MIRECC PUBLICATIONS *cont.*

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NEW GRANTS

“Affective Neuroscience of Schizophrenia and Bipolar Disorder”

Principal Investigator: William Horan, Ph.D.

Funded by National Institute of Mental Health

CORRECTION

The last issue of MindView incorrectly reported that the national Military Sexual Trauma Team was established under the direction of Amy Street, PhD and Margaret Bell, PhD. The national MST Support Team was actually established under the direction of Susan McCutcheon, RN, EdD. There are two divisions in the MST Support Team: the Education and Training Division, located in Boston, is under the direction of Amy Street, PhD, and the Monitoring Division, located in Palo Alto, is under the direction of Rachel Kimerling, PhD.



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