

MINDVIEW

VOL. 3 | ISSUE 1 | FEB. 2010

IMPROVING THE QUALITY OF LIFE FOR VETERANS WITH PSYCHOSIS

UPCOMING EVENTS

PTSD LUNCH AND LEARN TRAINING SERIES

1st Tuesday of the month; noon-1

Location: At your desktop

To register, go to:

<https://vaww.trace.lrn.va.gov/registration/>

Default.asp?CourseID=4009

CPT GROUP TRAINING WORKSHOPS

January 29, 2010; March 19, 2010; May 7, 2010; July 16, 2010; and September 10, 2010
San Diego, CA

Contact: Deborah Jackson at
deborah.jackson2@va.gov

MOTIVATIONAL INTERVIEWING WORKSHOP FOR LONG BEACH MENTAL HEALTH STAFF

March 23-24, 2010

Long Beach, CA

Contact: Noosha Niv at noosha.niv@va.gov

SOCIAL SKILLS TRAINING WORKSHOP

April 22-23, 2010

Santa Monica, CA

Contact: Matthew Wiley at
matthew.wiley@va.gov

MIRECC INITIATIVE ON ANTIPSYCHOTIC MANAGEMENT IMPROVEMENT (MIAMI) CONFERENCE

May 18, 2010

Washington D.C.

Contact: noosha.niv@va.gov

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MOTIVATIONAL INTERVIEWING: PROMOTING BEHAVIOR CHANGE AND ENHANCING HEALTH

Noosha Niv, Ph.D.

Consider how many people engage in self-destructive patterns of behavior despite negative consequences and how difficult it is to make a change despite our best intentions. Lack of change in clients who would clearly benefit from it is a source of common frustration among healthcare profes-

sionals. One approach clinicians can use to facilitate positive behavior change is Motivational Interviewing (MI). MI is "a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence." This method is increasingly being used to help individuals mobilize their

commitment to change and their personal resources to address a wide range of mental and physical health concerns.

Although MI was originally developed to address substance use disorders, it has since been used to reduce a wide range of maladaptive behaviors (e.g., HIV risk behaviors, gambling) and to promote adaptive behavior change (e.g., diet, exercise, treatment adherence). The impact of MI varies depending on the target behavior addressed. In general, clinical trials of MI yield significant effect sizes that are considered small (0.3) to medium (0.5). In comparison to control groups, the effects of MI emerge relatively quickly (first few months of treatment) and tend to diminish over time as the control/comparison group "catches up." The exception to this is when MI is added to another active treatment. When

cont'd on page 2



VISN 22 psychologists at MI workshop, January 2010

"Motivational Interviewing is a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence."



MIRECC
Mental Illness Research,
Education and Clinical Center

LETTER FROM THE DIRECTOR

Stephen R. Marder, MD



PEER SUPPORT

The MindView article by Chinman, Cohen and Shoai focuses on the implementation of peer support services in the VA. Peer support can be potent for addressing some of the important obstacles to recovery. One of these obstacles is the stigma associated with psychiatric disorders, particularly the psychotic disorders. There is a well documented tendency of many mental health providers to underestimate the ability of patients to improve their lives. Clinicians often focus on managing a patient's symptoms and neglect asking them about their personal goals and the quality of their lives. Such clinician attitudes can lead patients to take on the attitudes of their providers and to believe that goals such as working, returning to school, or living independently are unrealistic. Peer support technicians can address these concerns in ways that most traditional providers cannot.

The most obvious tool of the peer providers is their own story. Each of these individuals has found that they can succeed despite the added burden of their illness. Moreover, their personal life experiences are likely to have provided them with skills and knowledge that are unavailable from traditional providers. Peer support providers may also have advantages for enlisting the trust of individuals who have become suspicious of the mental health care system in the VA. As a result, these providers may serve as a bridge between the suspicious or non-adherent patient and the mental health treatment team. Finally, as noted in the article, these individuals are trained to provide direct services to patients. These services can include facilitating support groups or assisting patients who are interested in rehabilitation, education, or housing.

Fortunately, the VA has mandated that all veterans with mental illnesses have access to peer support services. The work of Chinman and his colleagues will guide the VA and other systems in the best way for assuring that these providers are effective.

MOTIVATIONAL INTERVIEWING CONT'D FROM PAGE 1

added to another active treatment, the effectiveness of MI appears to be amplified, showing a sizeable effect (0.6) that holds up over time. MI therefore serves as a useful clinical tool that can be integrated with other evidence-based treatments for veterans who are ambivalent about change.

Process studies of MI have shown that training in MI improves not only clinician MI skills, but also increases clinician empathy and change talk among their clients. In 2009, the Desert Pacific MIRECC began an MI training program that focuses on the basic microskills used in MI (O.A.R.S: open-ended questions, affirmations, reflective listening and summaries) as well as other core MI skills such as raising the importance of behavior change, enhancing the client's confidence, resolving ambivalence, solidifying commitment to change, and negotiating a change plan. Thus far, three training workshops have been completed with 94 mental health clinicians and 25 OEF/OIF transition case managers from across the network having participated. Five more workshops are currently being planned for Spring and Summer 2010 for both mental health and primary care clinicians.

The Desert Pacific MIRECC is also involved in research examining MI in persons with severe mental illness. These studies include "Motivational Interviewing to Improve Work Outcomes in Schizophrenia" and "The Effectiveness of Family Member Provider Outreach in Improving Quality of Care for Persons with SMI." Please see related articles for more information about these studies including contact information for referrals.



MI Trainers: Shirley Glynn, Ph.D. (left) and Noosha Niv, Ph.D. (right)

MOTIVATIONAL INTERVIEWING TO IMPROVE WORK OUTCOMES IN SCHIZOPHRENIA

Shirley Glynn, Ph.D.

Individual Placement and Support (IPS), a form of supported employment, is the most empirically-validated intervention to assist individuals with serious and persisting psychiatric illnesses return to the work force. The overarching goal of IPS is to help a client obtain and sustain competitive employment through the provision of unlimited-duration, community-based support. IPS is based on a place-train model that emphasizes rapidly finding a job that is well-matched to the client's preferences and strengths. Seven randomized trials demonstrate that, in comparison to control conditions such as referrals to traditional vocational rehabilitation services, IPS participants were three to four more times more likely to obtain a job during the study, and twice as likely to be competitively employed at any point in the study, with no apparent worsening of symptoms.

In spite of its clear benefits, IPS has many limitations. Among those engaged in IPS, most participants are not competitively employed at any point in time, it takes an average of about four months to obtain a first job, a typical job lasts only approximately 20-25 weeks, and employment rates across the sample asymptote at about month 8 or 9 of participation in the trials. Obtaining a first job seems to be an insurmountable impediment for approximately 35%-40% of participants. Motivational deficits may play a prominent role in explaining the limited benefits of IPS in persons with serious and persisting psychiatric illnesses, especially in those with schizophrenia. Building a successful work life requires sustained effort over months and years. However, many persons with schizophrenia experience high degrees of negative symptoms, demoralization, and ambivalence, which likely all interfere with the persistent efforts required to initiate and maintain successful vocational adjustment. Enhancing already validated vocational rehabilitation programs, such as IPS, with specific techniques to address motivational deficits, may be essential to increasing employment rates among persons with schizophrenia.

Vocationally-oriented motivational interviewing (VOMI), a novel strategy designed to improve motivation for positive behavior change in persons with schizophrenia is being tested in a randomized controlled trial funded by VA HSR&D (PI: Shirley Glynn, Ph.D.). Outpatients with schizophrenia or schizoaffective disorder were randomly assigned to one of two conditions: 18 month of IPS alone or IPS with the addition of VOMI. It was hypothesized that patients with schizophrenia who participate in IPS+VOMI will have better vocational outcomes (including a greater likelihood of obtaining a first job, more weeks worked, more total hours employed, and more wages) than those participating in traditional IPS. Data analysis is currently underway for this trial. If found to be effective, VOMI may be another tool that can be used to address unemployment among individuals with schizophrenia and other psychotic disorders.



THE EFFECTIVENESS OF FAMILY MEMBER PROVIDER OUTREACH IN IMPROVING QUALITY OF CARE FOR PERSONS WITH SMI

Shirley Glynn, Ph.D.

The VHA is engaged in a major initiative aimed at implementing the recommendations of the President's New Freedom Commission for the care of persons with mental illness and substance use disorders. The Secretary's Mental Health Strategic Plan recommends "implementing veteran and family centered care programs at all VAMCs." Previous research consistently demonstrates that individuals with SMI have improved outcomes when families are active participants in their clinical care. Numerous controlled trials show that when family involvement in clinical care achieves the level of intensity of family psychoeducation (FPE), relapse rates are cut in half, and treatment adherence, clinical symptoms, and patient functioning are improved. Accordingly, the goal of this research proposal is to test a patient-centered strategy designed to enhance family/caregiver involvement in care.

Despite the demonstrated benefits of family and caregiver involvement, rates of even minimal family-clinician contact in VA are unacceptably low, barely occurring in one third of SMI patients, with lower rates than in non-VA systems of care. At present, the minimal participation of caregivers in the clinical care of persons with SMI in the VA represents a large gap between what we know ("evidence") and what we do ("practice"). The program tested in

this study, Family Member Provider Outreach (FMPO), is designed to help close this gap (PI: Lisa Dixon, M.D.; Site PIs: Amy Cohen, Ph.D., and Shirley Glynn, Ph.D.). FMPO, a structured, manualized, family engagement intervention is patient centered, recovery based, and grounded in many of the principles and techniques of motivational interviewing. FMPO aims to increase the likelihood that families and caregivers of veterans with SMI become constructive partners in the veterans' regular ongoing mental health care. In the FMPO model, a trained outreach person (a "Family Member Provider [FMP]"), who has a relative with a serious psychiatric illness, first works with the veteran to clarify the benefits of family involvement in their recovery and the veteran's feelings about such involvement. The goal is to collaboratively resolve veteran-based barriers to family involvement and to enhance the extent to which veteran consumers feel empowered to encourage their families to be involved in their treatment and to encourage their regular care providers to involve their families in appropriate ways. In the second phase of the intervention, with the patient's permission and if the family is amenable, the FMP engages in education and support with the relatives to strengthen their ability to support the veteran and interact effectively with the treatment team.

HELPING HOMELESS VETERANS

Betty Zamost, LCSW, MPA and John Nakashima, Ph.D., MSW

In November 2009, Secretary of Veterans Affairs Eric K. Shinseki gave marching orders to the field to end homelessness among this nation's Veterans within the next five years. The Secretary wants to ensure that no Veteran, no matter when he or she has served, is homeless on the streets of America. The VA Desert Pacific Healthcare Network was actively engaged in ending homelessness among Veterans prior to this call to arms and is well-positioned to participate in the National VA Strategy to end homelessness. Nationally, the VA has identified a multi-front approach to ending homelessness including outreach, education, treatment, prevention, housing and supportive services, income, employment and benefits services, and community partnerships.

Veterans can get off the streets very quickly thanks to the VA Medical Centers and

Clinics providing both medical and mental health care supporting the homeless programs. Given the large variety of programs within the network, a Veteran can literally go from being homeless to owning a home. Two major programs to assist homeless Veterans are the Grant & Per Diem (GPD) transitional housing programs and the HUD-VA Supported Housing (HUD-VASH) program. The GPD program is funded through a competitive grant process to private, non-profit agencies to provide transitional housing. Within these programs, Veterans can receive substance abuse treatment, employment assistance, income assistance, and other services designed to help Veterans leave homelessness. The HUD-VASH program helps formerly homeless Veterans maintain independent housing in the community. HUD (Department of Housing and Urban Develop-

ment) provides the housing vouchers while the VA provides supportive services through case management. Fortunately, GPD and HUD-VASH are expected to grow so as to provide more housing opportunities for Veterans.

VISN 22 has a long history with both the Grant & Per Diem and HUD-VASH programs. HUD-VASH was implemented in the early 90's, and the first Grant & Per Diem homeless transitional housing programs were funded in 1995. VISN 22 currently has 17% of all the GPD beds (2123 current operational beds with an additional 50+ in the pipeline) and 20% (2270) of the HUD-VASH permanent housing vouchers. This program was revitalized when the VA looked at national data collected by its Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) process. Project CHALENG is an ongoing

needs assessment of homeless Veteran services with thousands of VA staff, community providers, and consumers surveyed annually (11,711 respondents in the FY 2008 survey). Each participant completed a self-administered survey by ranking 42 pre-identified homeless Veteran need categories (e.g., housing, food, substance abuse treatment, legal assistance) on a Likert Scale of 1 (need unmet) to 5 (need met). For several years, housing (especially transitional and permanent, long-term housing) has been the highest unmet need identified. The VA has responded nationally utilizing both CHALENG data and data gathered by the North East Program Evaluation Center (NEPEC) on the original HUD-VASH program to support its efforts in expanding the partnership with HUD, increasing the VASH program and providing more affordable housing for homeless veterans.

NATIONAL CALL CENTER FOR HOMELESS VETERANS IS COMING

The Department of Veterans Affairs has developed a Five-Year Plan with the goal of ending homelessness among our Nation's Veterans. To achieve this goal, VA plans to enhance existing services and add new initiatives. One of the new initiatives in this plan is the creation of a National Call Center for Homeless Veterans. The National Call Center will be very similar in operation to that of the Suicide Prevention Hotline. The primary purpose of the call center is to connect homeless Veterans and referral services to VA services. Veterans and others in the community will be provided with an 800 number that connects them with a

trained VA staff member 24 hours a day, seven days a week. The Call Center staff will conduct a brief screen to determine the severity of the need, and if it is an emergency, it will be handled immediately by the Homeless Call Center staff, with the closest VA facility subsequently notified of the call and intervention. More routine calls will be routed to the nearest VA facility who will make contact with that homeless Veteran, or whoever has made the call on the Veteran's behalf, within 24 business hours, and document the interaction on a template form. Stay tuned for more information.



THE ROLE OF COMMUNITY-BASED OUTPATIENT CLINICS (CBOCs)

John Fortney, Ph.D.

Many rural Veterans face particular challenges accessing health care because they live far from VA Medical Centers. Community-Based Outpatient Clinics (CBOCs) provide basic clinical services and a local “front door” to VA health services for many rural Veterans. As of September 2008, there were 754 CBOCs nationwide, 29 of which are in VISN 22. CBOCs provide local services and an access point for off-site specialty care as needed for Veterans who find it difficult to travel to a VA Medical Center. The establishment and growth of CBOCs reflects the VA’s transition from a hospital-based system of care in the early ‘90s, when the first CBOC was created in Amarillo, Texas, to one focused on primary and ambulatory care. While specific services available vary from CBOC to CBOC, in general these clinics provide local primary care and mental health services, with access to specialty care available through telemedicine or contracts with local specialists. CBOCs were established to provide health care for Veterans by meeting the following goals: 1) improve convenience of VA care for current users; 2) improve equity of access to Veterans by targeting underserved areas; 3) improve efficiency and effectiveness of care; and 4) improve access to care for all eligible Veterans.

The VA classifies CBOCs according to these categories: 1) Owned – VA owned and staffed by VA; 2) Leased – space is leased but CBOC is staffed by VA; 3) Contracted – VA contracts with a provider, often a Healthcare Management Organization (HMO), to provide services; 4) Shared – one location is shared by clinics and/or parent facilities; and 5) Not Operational – approved by Congress but has not begun operations yet. CBOCs are also categorized by size, with the CBOC’s size determining which services it is required to

provide and which services are suggested according to VA guidelines. Very large CBOCs serve more than 10,000 unique Veterans each year. Large CBOCs serve 5000-10,000 unique Veterans each year. Mid-sized CBOCs serve 1,500-5,000 unique Veterans each year, and small CBOCs serve fewer than 1,500 unique Veterans each year.

Because CBOCs are particularly vulnerable to provider shortages in rural areas, they have to be creative about how to offer services. CBOCs offer services through telemedicine and contracts with local providers in addition to their own clinical providers. Guidelines for required and suggested mental health services are specified in the Uniform Mental Health Services Handbook. All CBOCs offer primary care and most offer mental health services (often provided via telemental health). In addition, the very large CBOCs offer some or all of the following: pharmacists, social workers, dietitians, radiology, prosthetics, lab, dental, optometry, substance abuse services, PTSD services, anger management, smoking cessation, vocational rehabilitation, etc.

In a national sample of CBOC users, the average distance to the closest VA Medical Center for CBOC users was 60 miles while the average distance to the CBOC was 15 miles. Compared to matched VA Medical Center users, CBOC users have a similar number of primary care encounters, but fewer specialty care visits and fewer specialty mental health visits. Compared to VA Medical Center users, CBOCs have lower total VA health care costs. The lower total VA health care costs may be due to the fact that CBOC users have more Medicare-funded encounters than VA Medical Center users. Mental health services were provided via real-time clinical videoconferencing at 300 VA CBOCs.

VISN 22 CBOCs

Medical Centers	Affiliated CBOCs
Las Vegas, NV	Henderson (<i>large</i>)
	Las Vegas (<i>small</i>)
	Pahrump (<i>mid-sized</i>)
Loma Linda, CA	Corona (<i>mid-sized</i>)
	Palm Desert (<i>mid-sized</i>)
	Rancho Cucamonga (<i>mid-sized</i>)
	Sun City (<i>large</i>)
	Victorville (<i>small</i>)
Long Beach, CA	Anaheim (<i>mid-sized</i>)
	Cabrillo (<i>small</i>)
	Laguna Hills (<i>mid-sized</i>)
	Santa Ana (<i>mid-sized</i>)
	Whittier/Santa Fe Springs (<i>mid-sized</i>)
Los Angeles, CA	Antelope Valley (<i>mid-sized</i>)
	Bakersfield (<i>large</i>)
	East Los Angeles (<i>mid-sized</i>)
	Gardena (<i>mid-sized</i>)
	Los Angeles (<i>very large</i>)
	Oxnard (<i>large</i>)
	Pasadena (<i>small</i>)
	San Luis Obispo (<i>mid-sized</i>)
	Santa Barbara (<i>large</i>)
	Santa Maria (<i>large</i>)
Sepulveda (<i>very large</i>)	
San Diego, CA	Chula Vista (<i>large</i>)
	Escondido (<i>large</i>)
	Imperial Valley (<i>small</i>)
	Mission Valley (<i>very large</i>)
	Vista (<i>large</i>)



FIRST STUDY OF ENVIRONMENT-TRIGGERED GENETIC CHANGES IN SCHIZOPHRENIA

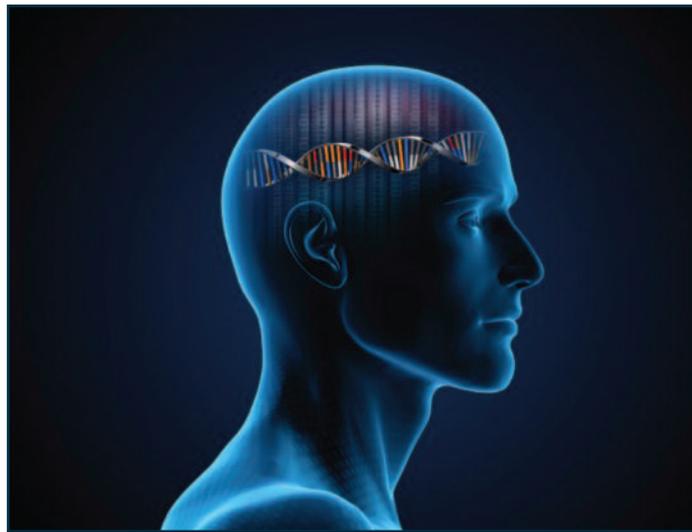
Source: NARSAD

MIRECC Investigator David Braff, M.D., of the University of California, San Diego, who received a NARSAD Distinguished Investigator Award in 2007, and Raquel Gur, M.D., Ph.D., of the University of Pennsylvania, a 1999 NARSAD Distinguished Investigator, are participating in the first study of its kind to pinpoint environmentally induced genetic changes that may affect the onset of schizophrenia. Launched with \$9.8 million from the National Institute of Mental Health (NIMH), the study is being conducted at five sites, also including Johns Hopkins University, the University of Pittsburgh and the University of Alabama.

Aging and other environmental influences, such as diet and chemicals, can induce so-called epigenetic changes, events that influence how genes are regulated -- how they turn on and off. Schizophrenia is estimated to be 80 to 90 percent heritable, but studies of identical twins have shown that if one twin develops the illness, the other will be affected only about half the time.

Evidence suggests that epigenetic changes may be responsible for the discrepancy. Such mechanisms have been observed in the epigenomes - the affected genomes - of patients with cancer and of experimentally stressed animals that develop depression-like behaviors.

changes ebb and flow over the lifecycle, with members of families often sharing a similar pattern. Such changing gene expression could hold keys to major mysteries of schizophrenia, such as delayed onset in the late teens and early 20s - how a genetically-rooted illness process that likely begins



In a recently reported study, researchers have turned up clues as to how such epigenetic changes might affect brain development. Epigenetic

before birth spares the brain through childhood, only to erupt in psychotic breakdowns and profound disability at the cusp of productive life.

Using newly available technology, the researchers will mount a genome-wide association study of a key type of epigenetic mark created when a molecule called a methyl group attaches to certain parts of DNA. Drawing from the NIMH Genetics Repository, the research team will comb nearly 10,000 sites in the epigenomes of several thousand people with schizophrenia as well as healthy participants for signs of such methylation - and then subject 50 suspect sites to closer scrutiny.

They will also examine illness-implicated areas in nearly 300 postmortem brain samples from affected and unaffected individuals. The epigenetic findings will then be compared with results from conventional genetic studies in the same people in hopes of implicating specific gene activity in the illness.

Editor's Note: Andrew Feinberg, MD, MPH, King Fahd Professor of Molecular Medicine at John Hopkins University, is the Principal Investigator of this study.

VISN 22 PEER STUDY DELIVERS TRAINING TO PEER SUPPORT TECHNICIANS

Matthew Chinman, Ph.D., Amy Cohen, Ph.D., and Rebecca Shoai, MPH

Following guidelines in the VA's Mental Health Strategic Plan, VA began in 2005 to fund a number of new positions for peer support technicians (PSTs) - individuals with personal experience of serious mental illness (SMI) who provide support services to others with SMI, typically as clinical team members. In 2008, the VA further codified PST services in the Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics, stating that "all veterans with SMI must have access to peer

support (pg. 28)". PSTs can reach out to patients that are difficult to engage, assist patients with tasks of daily living, offer a variety of rehabilitation (vocational, social, residential) services, facilitate support groups, be role models and offer hope for recovery. PEER (Peers Enhancing Recovery), a study funded by HSR&D in 2008, is evaluating the acceptability, implementation facilitators and barriers, and the impacts on patient outcomes of the deployment of PSTs on VA

case management teams. Mental Health Intensive Case Management (MHICM) teams in Los Angeles, Sepulveda, and Long Beach have recently received the PSTs and are being compared to control MHICM teams with no PSTs in Loma Linda, San Diego, and Las Vegas. PEER staff (Matthew Chinman - PI, Amy Cohen - Co-PI, and Rebecca Shoai - Project Coordinator), are providing intensive technical assistance consisting of help in hiring, training, and supervising

the PSTs.

One of the key components of this assistance is training. The first was a week-long PST "certification" training conducted in 2009 by the Peer-to-Peer Resource Center of the Depression and Bipolar Support Alliance. The Peer-to-Peer Resource Center developed their curriculum based on the highly successful "Georgia model," the first state in which the services delivered by trained PSTs were "certified" to be Medicaid-reimbursable. After completing the week-

PEER STUDY, CONT'D

long course, individuals needed to pass a written exam in order to receive certification. This training, the national standard for training PSTs and accepted by the VA, includes the following topics: role of peer support in recovery, orientation to psychosocial rehabilitation, environments that promote recovery, using your story as a recovery tool, facilitating mutual support groups, effective listening and asking questions, problem-solving with individuals, planning and accomplishing recovery goals,

dealing with ethical and workplace issues and mental illness overview.

The second training sponsored by PEER was a one-day training in Illness Management and Recovery (IMR) that was conducted on January 12, 2010 by the staff from the ACT Center of Indiana. IMR is a curriculum-based approach to helping patients set and achieve personal recovery goals and acquire the knowledge and skills to manage their illnesses independently. Developed as part of SAMHSA's National Implementing Evidence-Based Practices Project, the IMR package

manualizes five types of evidence-based techniques: psychoeducation, cognitive-behavioral approaches to medication adherence, relapse prevention, social skills training (e.g., to enhance social support), and coping skills training (e.g., for persistent symptoms). After training, PSTs will use IMR curriculum in both groups and in 1-on-1 sessions.

The PEER PSTs have been settling into their role on their teams, following an implementation protocol that includes shadowing current MHICM staff and weekly supervision by MHICM and PEER staff.

Baseline data collection on patient outcomes and the teams' recovery attitudes has already been completed for all six teams participating in PEER, and another round of data collection will take place after the PSTs' year-long stint. Permanent funding will be sought to support the PSTs judged to be successful by MHICM and PEER staff. Results from PEER will provide important information about how PSTs can be helpful to patients and what supports the PSTs and their teams for the PSTs to be successful.

RECENT MIRECC PUBLICATIONS

Brekke, J.S., Hoe, M., & Green, M.F. (2009). **Neurocognitive change, functional change, and service intensity during community-based psychosocial rehabilitation for schizophrenia.** *Psychological Medicine*, 39, 1637-1647.

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O'Hara, R., Cassidy-Eagle, E.L., Beaudreau, S.A., Eyler, L.T., Gray, H.L., et al. (2010). **Increasing the ranks of academic researchers in mental health: A multi-site approach to post-doctoral fellowship training** *Academic Medicine*, 85(1), 41-47.

Ozyurt, I.B. & Brown, G.G. (2009). **Knowledge discovery via machine learning for neurodegenerative disease researchers** *Methods Molecular Biology*, 569, 173-96.

Vaskinn, A., Sergi, M.J., & Green, M.F. (2009). **The challenges of ecological validity in the measurement of social perception in schizophrenia.** *Journal of Nervous and Mental Disease*, 197, 700-702.

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Young, J.W., Goey, A.K.L., Minassian, A., Perry, W., Paulus, M.P., & Geyer, M.A. (2010). **GBR 12909 administration as a mouse model of Bipolar Disorder mania: Mimicking quantitative assessment of manic behavior.** *Psychopharmacology*, 208, 443-454.

NEW GRANTS

"Functional MRI in Drug Discovery"

Principle Investigator: Greg Brown, Ph.D.
Funded by Roche Pharmaceutical

"Social Cognition and Functioning in Bipolar Disorder"

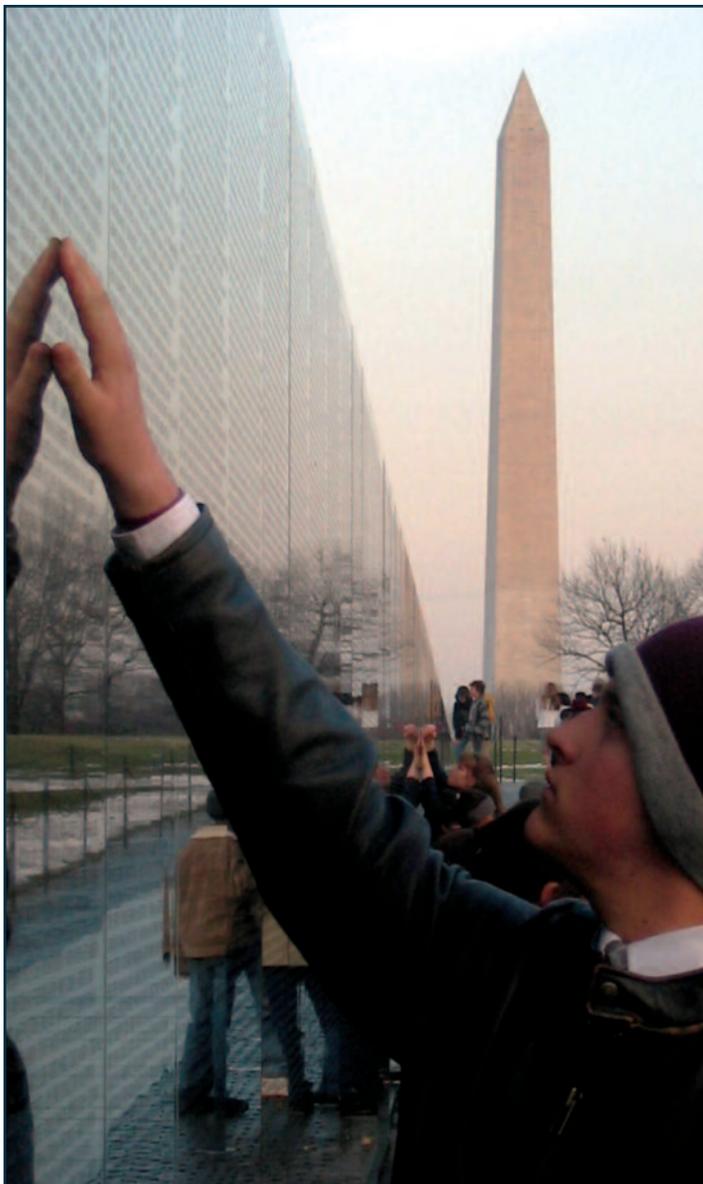
Principal Investigator: Michael Green, Ph.D.
Funded by the National Institute of Mental Health

"Clinical Kiosks for Patient Self-Assessment and Education"

Principal Investigator: Alexander Young, M.D., M.S.H.S.
Funded by Department of Veterans Affairs, Office of Information & Technology, Greenfield Innovations Program

"Web-Based Delivery of MOVE! to Veterans With Serious Mental Illness"

Principal Investigator: Alexander Young, M.D., M.S.H.S.
Funded by Department of Veterans Affairs HSR&D



MENTAL ILLNESS RESEARCH, EDUCATION AND CLINICAL CENTER

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