

MINDVIEW

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IMPROVING THE QUALITY OF LIFE FOR VETERANS WITH PSYCHOSIS

UPCOMING EVENTS

MIRECC INITIATIVE ON ANTIPSYCHOTIC MANAGEMENT IMPROVEMENT (MIAMI) CONFERENCE
May 18, 2010
Location: Washington D.C.
Contact: noosha.niv@va.gov

MOTIVATIONAL INTERVIEWING WORKSHOP
June 24 - 25, 2010
Location: Los Angeles, CA
Contact: noosha.niv@va.gov

CPT GROUP TRAINING WORKSHOPS
July 16, 2010 and September 10, 2010
Location: San Diego, CA
Contact: deborah.jackson2@va.gov

4TH ANNUAL VA MENTAL HEALTH CONFERENCE
July 27- 29, 2010
Location: Baltimore, MD

COUPLES THERAPY WORKSHOP
August 2 - 5, 2010
Location: TBD
Contact: noosha.niv@va.gov

BEHAVIORAL FAMILY THERAPY WORKSHOP
September 14 - 16, 2010
Location: Seattle, WA
Contact: sglynn@ucla.edu

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MEASURING OUTCOMES TO IMPROVE CARE FOR SCHIZOPHRENIA

Noosha Niv, Ph.D. and Alexander S. Young, MD, MSHS

Healthcare organizations have succeeded in improving the care they provide by making use of quality improvement efforts that include routine collection of outcome data. The routine and systematic collection of data allows for identification of unmet treatment needs and redesign of services to improve access to effective practices and improve outcomes. There have been fewer successes with this approach in schizophrenia than in other chronic medical disorders. Although appropriate medication and psychosocial treatments improve outcomes in schizophrenia, key evidence-based treatments have not been widely disseminated.

A major barrier to improving care for schizophrenia has been a lack of routinely collected outcomes data that identifies patients who are failing to improve clinically or who are not receiving effective treatments. The lack of such data to some degree reflects uncertainty regarding which outcome domains to monitor and how to feasibly collect routine

outcomes data in large populations of patients. In response to this gap in knowledge, the Department of Veterans Affairs Mental Health Quality Enhancement Research Initiative (QUERI) convened a Schizophrenia Outcomes Workgroup. This Workgroup used literature review, expert interviews, and a national expert panel to increase consensus regarding routine outcomes monitoring instruments and strategies that support quality improvement efforts in schizophrenia.

The Workgroup concluded that the most feasible strategies for obtaining routine outcomes data are the use of administrative or billing data, and self-administered assessments. Self-report should be supplemented, where helpful, by clinician documentation and administrative data. Self-administered, patient assessments have the advantage of taking less time from busy clinicians and not requiring repeated training of clinical staff. Methods of self-assessment vary and can be determined by the needs of

specific projects and healthcare organizations. Newer assessment methods include the use of electronic self-entry devices and internet access by patients. Electronic devices at clinics can include dedicated kiosks or tablet computers with touch-screen and audio interfaces.

The Workgroup developed good consensus regarding outcome measures in the domains of psychotic symptoms, medication side-effects, drug and alcohol use, depression, family and caregivers, vocational functioning, community tenure, and housing. A review of the recommended measures as well as downloadable files of many of these assessment instruments can be found on the MIRECC website at www.mirecc.va.gov/visn22/assessment.asp. In most of the domains listed above, there are well developed, validated, self-report outcomes assessment instruments. However, it was not possible to develop consensus in other domains, such as negative symptoms, cognitive symptoms, and use of peer support interventions, because efficacy research is not sufficiently developed in

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"Efforts to systematically monitor outcomes have substantial potential to improve access to effective treatments and improve care and outcomes in populations with schizophrenia."



LETTER FROM THE DIRECTOR

Stephen R. Marder, MD



TRAINING IN EVIDENCE-BASED PSYCHOTHERAPIES

The VA's Uniform Mental Health Handbook emphasizes the importance of evidence-based, psychosocial treatments for serious mental illnesses. There are a number of challenges facing VA facilities that are attempting to implement these treatments. First, it is important to develop a cadre of VA clinicians who are trained in each of these treatments. In addition, it is important to give these clinicians the resources and the time they need to deliver these treatments. Finally, it is also essential that VA clinicians refer appropriate patients for these treatments.

The article by Leigh Messinides, Ph.D., in this issue of MindView provides an overview of activities taking place in our Network for implementing these treatments. Adding Evidence-Based

Psychotherapy Coordinators to each facilities workforce will facilitate training and other activities. Educating clinic managers and frontline clinicians is an essential, and also rather challenging, component of implementation. In contrast to pharmacotherapy which is relatively easy to disseminate in a clinic, psychosocial treatments – particularly those that are group-based and those that include family members – require substantial administrative support.

It is also important to assure that providers receive the best possible training. The VISN 22 MIRECC is providing national and VISN-wide implementation of a number of psychosocial treatments including social skills training (in collaboration with the VISN 5 MIRECC), cognitive behavior therapy, motivational interviewing, and family-based interventions. When possible, training is followed by a consultation period. For example, the social skills training program includes a requirement for participants to participate in follow-up consultation, which includes the review of taped treatment sessions. This assures that the training experience is adapted to the realities of every day clinical care.

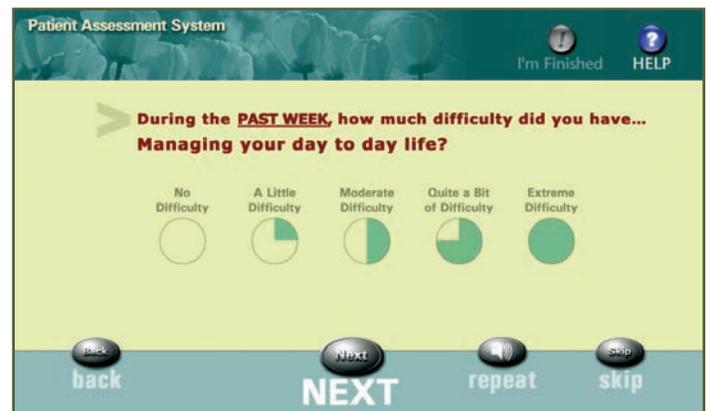
MEASURING OUTCOMES CONT'D FROM PAGE 1

these areas. National treatment guidelines offer limited guidance regarding treatments that should be provided to patients and, therefore, outcomes to be monitored. Hence, these areas would benefit from further research on treatment efficacy and outcome measurement.

For quality improvement, it is useful to know which patients would benefit from specific treatments, and which of these patients have not been receiving those treatments. The Workgroup did not review methods for monitoring the utilization or appropriateness of services that patients receive. However, there was agreement that, in addition to monitoring outcomes, it will also be important to monitor the provision of effective care. For psychosocial treatments in particular, it is important to monitor the extent to which treatments demonstrate fidelity to practices that are known to improve outcomes.

Efforts to systematically monitor outcomes have substantial potential to improve access to effective treatments and improve care and outcomes in populations with schizophrenia. Electronic, self-entry devices provide one way of collecting and synthesizing such data. MIRECC investigators have developed the Patient Assessment System (PAS), an internet-based system designed to assess outcomes in patients with severe and persistent mental illness. The PAS is an audio, computer-assisted, self-interviewing aid that is completed by patients in the provider's office before a scheduled appointment. Survey questions are designed to assess a broad set of psychiatric vital signs, including the patient's current functioning, interpersonal problems, psychosis, substance abuse, medication compliance, side effects, and pre-existing conditions. The computer application and interface are designed to make it as easy as possible for pa-

tients to complete the survey. Clear instructions on how to use the system are provided to the patient at the computer. Survey questions appear one at a time, and questions are read aloud by a recorded voice and then again after 60 seconds of inactivity. Potential answers appear as buttons on the screen that patients "push" to answer the question. Where appropriate, graphical images and other visual cues are used to assist the patient in answering questions. After patients complete the assessment, a one-page summary is printed for the patient to give to the psychiatrist. Information from the assessment summary helps the provider to understand key issues about the patient's condition and guides patient-provider communication during the visit. Research has shown that the PAS can generate reliable and valid data, is well accepted by patients with schizophrenia, and is feasible to implement in clinic settings.



Screenshot of Patient Assessment System

THE EVIDENCE-BASED PSYCHOTHERAPY INITIATIVE ACROSS VA HEALTH CARE

Leigh Messinides, Ph.D.

In parallel to the movement in healthcare for evidence-based practice (Institute of Medicine, 2001), VHA in recent years has placed an increased emphasis on training providers in evidence-based psychotherapies. Initiating a broad-based programmatic change in such a large healthcare system as VA is obviously a major undertaking with many challenging aspects (for a review of issues involved in both VA and non-VA settings, see McHugh and Barlow, 2010). As an offshoot of the requirements of the Uniform Mental Health Handbook, each VA Medical Center has been asked to provide veterans access to certain treatments chosen for their record of efficacy and their applicability to areas of priority in mental health care for veterans. In support of these goals, each VHA Medical Center has added a new position to their staff, the Local Evidence-Based Psychotherapy (EBP) Coordinator. A part-time position for a licensed mental health provider, the Local EBP Coordinator has multiple roles. A major emphasis is on the support of staff who will be training in some of these identified evidence-based psychotherapies. Staff who have an interest in a training program and who will be able to utilize the treatment in their day-to-day clinical assignment are encouraged to apply to participate in these intensive training workshops and follow-up consultation which lead to VA certification in a particular treatment modality. The trainings that have been offered so far include Cognitive-Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT) for depression, Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) for PTSD, and Social Skills Training (SST) for serious mental illness. Newly added workshops in family interventions, Multiple Family Group Therapy and Behavioral Family Therapy, were added this spring. Plans for workshops in couples therapy, Interpersonal Therapy and other modalities are being developed and/or considered.

In addition to coordinating information about trainings and assisting in the staff application process, the EBP Coordinator can also provide support and consultation to the therapists upon their return from the training, and advocate for additional support the clinician will need from the local healthcare system as they weave these treatments into their usual clinical responsibilities. One of the other goals of the EBP Coordinator position is to educate medical center leadership and providers outside of mental health on efficacy of these treatment approaches, and to help raise the awareness of veterans of different treatment options if they so choose. As these treatments are implemented, the EBP Coordinator can serve as a local resource for information, awareness, and to help problem-solve on the implementation of this initiative.

Many VISN 22 clinicians have taken advantage of the trainings offered, and enthusiasm and interest spreads to other clinicians as they observe the benefits to our veterans. Veterans have begun to discuss their treatment gains from these approaches with their peers, and staff notes that this is a very powerful way to overcome the doubts or stigma associated with seeking help. Staff have entered into lively debate both formally and in peer consultation, tackling important questions including the merits and limits of the still emerging knowledge base on psychotherapy interventions, what other treatments approaches should be added to the existing offerings, what local resources can help in implementing these treatments, and how to balance the demands of more intensive and structured treatment with other clinical activities and approaches. This type of dialogue reflects the complexity of implementing this type of initiative but also the commitment that VA mental health staff have in providing excellent care to our veterans.

MEET YOUR LOCAL EVIDENCE-BASED PSYCHOTHERAPY (EBP) COORDINATORS

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THE DOMICILIARY RESIDENTIAL REHABILITATION TREATMENT PROGRAM

Mona N. Lam, Ph.D.

The Domiciliary Residential Rehabilitation Treatment Program (DRRTP) at the West Los Angeles VA campus has been in existence since 1888. Historically, the DRRTP is the oldest of the VA's health care programs, previously known as an "Old Soldiers Home," and has evolved into a residential program providing biopsychosocial rehabilitation services. Today, the DRRTP offers evidence-based treatment to male and female veterans who suffer from substance dependence, mental health concerns (including trauma), vocational limitations, and/or homelessness.

The program is intended to break the pattern of hopelessness and powerlessness through a holistic, therapeutic, community program aimed toward promoting positive life changes, maintaining sobriety, and improving skills for interdependent living. The focus is a mind-body wellness ap-

proach at the DRRTP, encouraging physical wellness through the in-house gym, yoga, pilates, golf, and meditation groups, in addition to mental health wellness with psychoeducation, cognitive-behavioral and coping skills interventions. Veterans have an opportunity to work with an interdisciplinary treatment team comprised of medical staff, psychiatrists, psychologists, social workers, addiction therapists, recreation therapists, vocational rehabilitation therapists, and social science technicians, to develop an individualized treatment program. This 296 bed, residential facility has an average length of stay of 90-120 days. Veterans must be able to provide self care and not have significant cognitive impairment that would limit their ability to actively engage in treatment. Veterans are expected to participate in a minimum of 4 hours of therapeutic program-

ming each day, 7 days a week.

A separate Women's Program has been developed recently to address the specific needs of female veterans. The goal of the program is to decrease distress, maintain sobriety, and help the women create healthier living patterns. As the numbers of recent returning veterans increase, specific programming is offered for OEF/OIF veterans. Currently, there is an average of 27-30 OEF/OIF veterans in the pro-

gram.

Arzenia Redcross, Chief of the DRRTP, concluded, "Our goal is to make our Dom the model Dom." For those who are interested in the DRRTP treatment, clinicians can submit a Domiciliary consult, or refer veterans to the Comprehensive Homeless Program at GLA where the Domiciliary liaison can review and submit a consult. If you have questions, please contact (310) 478-3711 x 43105.



CLINICAL TRIAL ANNOUNCEMENT: PRAZOSIN AND COMBAT TRAUMA PTSD (PACT)

The VA Cooperative Studies Program recently initiated "Prazosin and Combat Trauma PTSD (PACT)" – a nationwide project to investigate the therapeutic efficacy of prazosin for veterans with combat-related posttraumatic stress disorder. This 26 week, randomized, double-blind, placebo-controlled study is designed to demonstrate both short term efficacy and long term effec-

tiveness of prazosin for PTSD. The research design encompasses a shorter-term, more tightly controlled efficacy component and a longer-term, more real world, effectiveness component. Primary outcomes include trauma nightmares, sleep disturbance, and global clinical status; secondary outcomes include total PTSD symptoms, comorbid depres-

sion, quality of life, and physical functioning. The Long Beach and Loma Linda Healthcare Centers are currently seeking veterans who are interesting in participating in this 26 week trial. One need not be a prescriber to make a referral to the study. For more information or to make a referral, please contact your local research staff.

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LOMA LINDA VA MEDICAL CENTER

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AGE-RELATED CHANGES IN PSYCHOSIS AND BIPOLAR DISORDER

Lisa Eyler, Ph.D.

The number of older veterans with mental illness is growing rapidly due to demographic trends that are contributing to the “graying” of America. Older veterans with psychosis and affective disorders may face unique treatment issues, such as the appropriateness of certain medications and treatments, the interplay of mental and physical health issues, and decreased ability to function due to combined effects of the illness and cognitive declines associated with aging. As a Clinical Research Psychologist at the San Diego VA Healthcare System and a faculty member of the VISN 22 MIRECC, my research has focused on better understanding the aging process in serious mental illness, particularly from the standpoint of cognition and the brain. Our previous research has shown that older individuals with schizophrenia

have an abnormal brain response during cognitive tasks, even under conditions when they perform normally. In addition, we found that older patients with schizophrenia lack some of the typical changes in brain function that accompany aging, which could point to the existence of compensatory mechanisms that might help preserve cognitive function in some schizophrenia patients.



Our research group also showed that a pro-cognitive drug that targets the acetylcholine neurotransmitter system led to normalizing effects on brain function among patients with schizophrenia even though it had little effect on cognitive performance.

We have now turned our attention to bipolar disorder and have recently been funded by NIMH to examine age-re-

lated changes in the brain of veterans with bipolar disorder and healthy comparison participants. Using magnetic resonance imaging (MRI), the study will measure brain structure and function in 85 patients with bipolar disorder ranging in age from 30-79 years and will compare these indices to a similar group of healthy individuals. We expect to find evidence for accelerated brain aging in bipolar disorder that would help explain why cognitive declines appear to be worse in this group. Results from this study will help to guide future investigations in which the same individuals will be followed over time with imaging measures in order to better understand the process of brain aging in bipolar disorder and what factors might minimize cognitive losses and improve functional outcomes for older veterans.

ANOTHER KIND OF VALOR

Stacey Maruska, LCSW and Noosha Niv, Ph.D.

The Los Angeles County Department of Mental Health, VA Greater Los Angeles Healthcare System, and VA Desert Pacific MIRECC sponsored an integrated learning experience and town hall meeting in March 2010 at the Brentwood Theatre on the West Los Angeles VA campus. Another Kind of Valor Conference was the first collaboration between LA DMH and the VA to raise greater awareness and understanding of the mental health and psychosocial difficulties faced by many returning veterans and their families and to promote better coordinated and responsive community partnerships among agencies to better serve our veterans. The 189 attendees included veterans and their families, mental health, substance abuse, and physical health pro-

fessionals, law enforcement, judges, emergency responders, clergy, armed forces representatives, and local, state and national elected officials.

Utilizing a DVD “Another Kind Of Valor” by Executive Producer-Director, Dan E. Weisburd, the audience was transported through vignettes that illustrate experiences that may have occurred with returning soldiers on the battlefield and at home. The vignettes served to prompt dialogue between the attendees regarding effective tools and strategies to better serve returning veterans and to foster interagency collaborations to address the issues facing veterans during reintegration into their families and communities. Some of the preliminary ideas generated by this discussion are cross training for

DMH and VA clinicians in skills such as CBT for PTSD and suicide assessment, identification of resources for veterans and their families in the

community, and development of women-specific and veteran-focused violence prevention programs, to name just a few.



Jon Sherin, M.D., Carl McKnight, Ph.D., Roderick Shaner, M.D., Andrew Shaner, M.D.

MAY IS MENTAL HEALTH AWARENESS MONTH

Stacey Maruska, LCSW

Mental health awareness has been celebrated every year in May since 1949. Mental Health Awareness Month is just one more opportunity to raise awareness about mental health issues and resources. Similar to diseases like breast cancer and diabetes, mental illness is a disease that many Americans face every year. According to NIMH, "an estimated 26.2 percent of Americans ages 18 and older,

about one in four adults, suffer from a diagnosable mental disorder in a given year. In addition, mental disorders are the leading cause of disability in the U.S. and Canada for ages 15-44." Awareness campaigns help bring the issues to light for many Americans. National and local organizations make efforts to educate people about the realities of mental illness and attempt to dispel misconceptions people may have

about others living with mental illnesses. It is also a great opportunity for many organizations to garner support for mental health legislation, such as the Mental Health Parity Law.

At the VA Long Beach Healthcare Center, the Mental Health Department hosts an annual fair to educate veterans, their family members, VA staff, and the community about mental health issues and re-

sources. This year's event will include booths featuring information about specific mental illnesses, medications, health and wellness, suicide prevention, resources for veterans and caregivers, and the latest VA research on mental illness. This event will take place at the Pantages Theatre in the Long Beach Medical Center on Friday, May 14, 2010 from 11:00 am - 1:00 pm.

MEET YOUR CBOC: EAST LOS ANGELES VA COMMUNITY CLINIC

Noosha Niv, Ph.D.

The East Los Angeles Mental Health CBOC is managed by Dr. Deborah R. Owens and Retha Robinson, LCSW. It houses a Psychosocial Rehabilitation and Recovery Center (PRRC), an evidence-based PTSD program, and a General Mental Health Clinic. The clinic was developed in response to a grass roots initiative in the Los Angeles community to provide a neighborhood clinic that addressed the mental health and psychosocial needs of Latino veterans. The Clinic was originally located on Bonnie Brae in Los Angeles and moved to its current location in East Los Angeles in the late 1980's. At that time, medical services also were added to meet the needs of the East LA veteran community.

The PRRC program is housed jointly at the ELA clinic and the Los Angeles Ambulatory Care Clinic (LAACC) in Downtown Los Angeles. Veterans are referred to either the LAACC or ELA program based on their needs and preferences. The mission of the PRRC

"is to stimulate hope and to promote mental health recovery by offering support, education, and opportunities so that individuals can successfully achieve their goals in the community." The day to day operations of the ELA PRRC are primarily overseen by Retha Robinson, LCSW, and Dr. Owens. The PRRC program at ELA currently serves 38 veterans; however, the two clinics often plan joint activities, and veterans can move between the programs readily. Through the General Mental Health Clinic, psychologist, Stephen Strack, Ph.D., provides assessment and individual psychotherapy. Psychiatrist, Ali Aziz, MD, splits his time between the General Mental Health Clinic and the PTSD program. Although the East LA Mental Health Clinic does not provide primary care services directly, the VA has contracted with Valor Healthcare to provide primary care services in the same location.

The PTSD program at ELA serves approximately 750 veterans and offers

assessment and individual and group therapy. Carolyn Feigel, Ph.D, the PTSD program coordinator, describes the PTSD program as "very near and dear to the patients. They're very protective of it." Individual and group Cognitive Processing Therapy and PTSD psychoeducation groups are run by Dr. Feigel and psychology interns. The PTSD program also has two social workers, Robert Wymss, LCSW, and Candace Lyles, LCSW, who conduct individual therapy and lead support groups, 12-step PTSD Anonymous groups, stress and anger management groups, and combat PTSD groups for World War II and Korean War veterans. Mr. Wymss also runs an OEF/OIF re-adjustment to civilian life support group in collaboration with the Veteran Center next door. Highlighting the assistance they provide in education, work, and housing, Dr. Feigel states that "social workers are so critical, especially with the OEF/OIF population." Psychiatric services are provided by Drs. Ali

Aziz and Thomas Grieder.

The ELA PTSD program aims to provide veterans with quick access to evidence-based PTSD treatment. Once a consult is placed, the clinic will make an intake appointment within 14 days. Clinic staff will conduct a phone screening to confirm interest in treatment and an initial confirmation of combat-related PTSD. During the screening interview, veterans will complete questionnaires to confirm their combat experience and to determine if they meet the severity cutoff for PTSD. They will then complete a diagnostic evaluation and meet with the psychiatrist at least once for a medication evaluation prior to starting treatment.

Thanks to all of the ELA staff for showing us around the clinic and informing us of the services they provide. For more information about the East Los Angeles Mental Health Clinic, call the clinic at (323) 725-7557 or contact Dr. Deborah Owens at deborah.owens@va.gov.



Rachel Stone, Thomas Grieder, M.D., Robert Wymss, LCSW, Candace Lyles, LCSW, and Carolyn Feigel, Ph.D.



Salvador Villar, Retha Robinson, LCSW, Rosie Dominguez, LCSW

VISN 22 METABOLIC TASK FORCE

Charles Nguyen, MD

Veterans with serious and persistent mental illness such as schizophrenia and bipolar disorder often suffer from metabolic disturbances that greatly increase their risks for diabetes, obesity, and cardiovascular disease. Second generation antipsychotic medications further increase the risks of metabolic disturbances. The American Diabetic Association (ADA), the American Psychiatric Association, and the North American Association for the Study of Obesity, in conjunction with the Consensus Development Conference on antipsychotic drugs, diabetes and obesity, published recommendations in 2004 for

metabolic monitoring. Despite these guidelines, only about 20% of clinicians actually monitor the patients on second generation antipsychotics (SGAs). Recognizing the potential problems, the mental health leadership at VISN 22 charged the creation of a metabolic task force to address this serious health concern. Hence, representatives from Loma Linda, Greater Los Angeles, Long Beach, San Diego, Las Vegas and the Desert Pacific MIRECC consisting of nurses, nurse practitioners, pharmacists, psychiatrists, and primary care physicians have met to address the metabolic issues associated with SGAs. After several tele-conferences, the

metabolic task force made the following recommendations:

1. Implement CPRS clinical reminders for metabolic monitoring across VISN 22.
2. Modify the vital sign package to include waist circumference as part of the field.
3. Ensure that all outpatient mental health clinics have digital scales, pressure cuffs and tape measures.
4. Dedicate a staff member stationed in outpatient psychiatry to obtain and record vital signs in CPRS.
5. Consider using a template progress note.

6. Increase the utilization of the Home TeleHealth Program for monitoring of high risk patients.

7. Work with the Academic Detailers to address metabolic monitoring of antipsychotics through development and implementation of teaching and patient care tools, data reporting, education, and patient follow up.

We are currently in the process of forming a committee to implement the recommendations for VISN 22. We hope to educate the psychiatrists of the recommendations to improve the metabolic monitoring for our veterans on second generation antipsychotics.

RECENT MIRECC PUBLICATIONS

Brown, G.G. & Thompson, W.K. (In press). **Functional brain imaging in schizophrenia: Selected results and methods.** In Neal R. Swerdlow (Ed.). *Behavioral Neurobiology of Schizophrenia and Its Treatment.*

Bystritsky, A., Kerwin, L., Niv, N., Natoli, J.L., Abrahami, N., Klap, R., Wells, K., & Young, A.S. (2010). **Clinical and subthreshold panic disorder.** *Depression and Anxiety*, 27, 381-389.

Chinman, M.J., Shoai, R., Cohen, A.N. (2010). **Using organizational change strategies to guide Peer Support Technician implementation in the Veterans Administration.** *Psychiatric Rehabilitation Journal*, 33, 269-277.

Cohen, A.N., Glynn, S.M., Hamilton, A.B., & Young,

A.S. (2010). **Implementation of a family intervention for individuals with schizophrenia.** *Journal of General Internal Medicine*, 25 (Supplement 1), 32-37.

Gresack, J.E., Risbrough, V.B., Scott, C.N., Coste, S., Stenzel-Poore, M., Geyer, M.A., & Powell, S.B. (2010). **Isolation rearing induced deficits in contextual fear learning do not require CRF2 receptors.** *Behavioural Brain Research*, 209, 80-84.

Hamilton, A.B., Cohen, A.N. & Young, A.S. (2010). **Organizational readiness in specialty mental health care.** *Journal of General Internal Medicine*, 25 Supplement 1, 27-31.

Henderson, C., Jackson, C., Slade, M., Young, A.S. & Strauss, J.L. (2010). **How should we implement psychiatric advance directives? Views of**

consumers, care givers, mental health providers and researchers. *Administration and Policy in Mental Health.* Epub ahead of print.

Hilti, C.C., Delko, T., Orosz, A.T., Thomann, K., Ludwig, S., Geyer, M.A., Vollenweider, F.X., Feldon, J., & Cattapan-Ludewig, K. (2010). **Sustained attention and planning deficits but intact attentional set-shifting in first-episode neuroleptic-naive schizophrenia patients.** *Neuropsychobiology*, 61, 79-86.

Kremen, W.S., O'Brien, R.C., Panizzon, M.S., Prom-Wormley, E., Eaves, L.J., Eisen, S.A., Eyer, L.T., et al. (2010). **Salivary cortisol and prefrontal cortical thickness in middle-aged men: A twin study.** *Neuroimage.* Epub ahead of print.

Kremen, W.S., Prom-Wormley, E., Panizzon, M.S., Eyer, L.T., Fischl, B., et al. (2010). **Genetic and environmental influences on the size of specific brain regions in midlife: The VETSA MRI study.** *Neuroimage*, 49(2), 1213-23.

Rimol, L.M., Panizzon, M.S., Fennema-Notestine, C., Eyer, L.T., Fischl, B., et al. (2009). **Cortical thickness is influenced by regionally specific genetic factors.** *Biological Psychiatry*, 67(5), 493-9.

Schweinsburg, A.D., McQueeney, T., Nagel, B.J., Eyer, L.T. & Tapert, S.F. (2010). **A preliminary study of functional magnetic resonance imaging response during verbal encoding among adolescent binge drinkers.** *Alcohol*, 44(1), 111-7.

NEW GRANTS

"Applying Rapid Assessment Process to Health Outreach to OIF/OEF Veterans"

Principal Investigator: Patrick Link, M.D.

Funded by VA QUERI

NEW AWARDS

Congratulations to Dr. Alison Hamilton for being awarded a VA-sponsored slot as a 2010-2011 Implementation Research Institute Fellow, in affiliation with the Center for Mental Health Services Research within the George Warren Brown School of Social Work at Washington University in St. Louis.



MENTAL ILLNESS RESEARCH, EDUCATION AND CLINICAL CENTER

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