

# MINDVIEW

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IMPROVING THE QUALITY OF LIFE FOR VETERANS WITH PSYCHOSIS

## UPCOMING EVENTS

MOTIVATIONAL INTERVIEWING WORKSHOP FOR OEF/OIF TRANSITION CASE MANAGERS  
November 9-10, 2009  
Long Beach, CA  
Contact: Noosha Niv at noosha.niv@va.gov

MOTIVATIONAL INTERVIEWING WORKSHOP FOR PSYCHOLOGISTS  
January 8, 2010  
Los Angeles, CA  
Contact: Noosha Niv at noosha.niv@va.gov

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## MIAMI: MIRECC INITIATIVE ON ANTIPSYCHOTIC MANAGEMENT IMPROVEMENT

Noosha Niv, Ph.D.

While significant advances have been made in the pharmacological management of psychosis, gains are being offset by the increased weight gain liability associated with newer 2<sup>nd</sup> generation antipsychotic medications. Weight gain, obesity, and resultant medical problems, such as diabetes, hyperlipidemia and hypertension, are increasingly recognized as critical side-effects and pervasive problems in the treatment of psychotic disorders. Compared to the general population, individuals with schizophrenia are more likely to be overweight or obese (42% vs. 27%). Obesity increases the risk for diabetes, cardiovascular morbidity, impaired quality of life, and death. The prevalence of diabetes is particularly high in schizophrenia (16% – 25%) compared to the general population (4%), and there is evidence that this prevalence has increased since the introduction of 2<sup>nd</sup> generation antipsychotic medications.

In 2007, the VA Office of Inspector General (OIG) evaluated the effectiveness of diabetes screening, monitoring, and treatment for mental health patients who received

atypical antipsychotic medications at VHA facilities. They concluded that although guidelines for monitoring weight, fasting blood glucose, blood pressure, and lipids were being met for the most part, there were inconsistencies in the documentation of these risk factors and in the implementation of interventions (including medication, diet, exercise, and specialty referral) for patients

clinical issues discussed in the VA OIG Report. These recommendations included: (1) assuring that clinicians in primary care and mental health have facilitated access to guidance documents; (2) improving the coordination of care between primary care and mental health for patients treated with antipsychotic medication; (3) improving the referral of identified patients with

*Weight gain, obesity, and resultant medical problems, such as diabetes, hyperlipidemia and hypertension, are increasingly recognized as critical side-effects and pervasive problems in the treatment of psychotic disorders.*

with abnormal clinical values. In 2008, the Workgroup on Atypical Antipsychotic Medications and Diabetes Screening and Management was appointed by Ira Katz, M.D., Ph.D., Deputy Chief of Patient Care Services for Mental Health. The purpose of the Workgroup was to evaluate the OIG report and to make recommendations that would improve the documentation of risk factors and implementation of interventions for abnormal values. The Workgroup recommended a number of strategies for addressing the

metabolic risk factors, such as obesity, hyperlipidemia, insulin resistance, and diabetes to MOVE! or other lifestyle programs; and (4) ensuring that mental health clinics are able to monitor metabolic risk factors.

The MIAMI Project (MIRECC Initiative on Antipsychotic Management Improvement) will be administered collaboratively

*cont'd on page 2*



# LETTER FROM THE DIRECTOR

Stephen R. Marder, MD



## WELLNESS IN SERIOUS MENTAL ILLNESS

Stereotyping of individuals with serious mental illnesses, such as schizophrenia and bipolar disorder, can result in a tendency among healthcare providers to view these individuals as being disinterested in rehabilitation activities that can improve their physical health and the quality of their lives. The reality is that the seriously mentally ill (SMI) form a diverse population, and many are excellent candidates when programs are welcoming and appropriate for their needs.

This view of the SMI is apparent in the area of work. Although clinicians may believe that most veterans who receive benefits are disinterested in finding a job, this assumption is often not based on asking them. Studies suggest that a substantial proportion of clients, in some cases more than 60%, would like to work. Moreover, studies using supported employment indicate that a majority of these patients can find a job

if they are given the proper services, and those individuals who do find work experience an improvement in the quality of their lives.

The assumption that most patients with illnesses such as schizophrenia are disinterested in improving their health through improved diet, physical activity, and smoking cessation is also incorrect. A number of researchers both in and out of the VA have found that programs aimed at weight reduction can be highly successful – even when patients are taking medications that promote weight gain. Unfortunately, many VAs do not have specialized programs for the SMI. Also, a recent report from the VA Inspector General found that psychiatric patients with metabolic syndrome were seldom referred to available programs. VA research has also found that these same groups can benefit from smoking cessation programs.

This issue of MindView highlights VISN 22 programs that are available for addressing these problems. In addition, Dr. Peter Hauser has just appointed a task force that will aim at improving the monitoring and the management of metabolic syndrome in our Network. The success of all these efforts depends on a willingness of mental health treatment teams to encourage patients to take advantage of these resources.

## MIAMI CONT'D

by the VISN 22 and VISN 16 Mental Illness Research, Education and Clinical Centers (MIRECCs) and the Mental Health QUERI. MIAMI is a two-year national program designed to implement the recommendations made by the Atypical Antipsychotic Medication Workgroup. To achieve this goal, the MIAMI Project will offer a number of educational resources nationally. First, a national workshop will be held in March 2010 for representatives from each network's primary care and mental health services, who would then provide further training in their networks. Second, a technical assistance center will be established to offer clinical consultation on the metabolic effects of antipsychotics, advice about effective implementation strategies, and assistance in implementing clinical reminders and performance monitoring/feedback. Lastly, VA clinicians and administrators will readily have access to educational materials, guidance documents and implementation tools via the intranet (<http://vaww.mirecc.va.gov/miamiproject/>).

In addition to assisting all VISN sites with implementation of the Workgroup recommendations,

MIAMI will also monitor the implementation of those recommendations at several VA sites. Opinion leaders from these selected sites will have regular contact with MIAMI personnel to discuss implementation strategies and obstacles. MIAMI personnel will evaluate the effectiveness of academic detailing at these sites with the experiences at those sites informing a potential national roll-out of enhanced implementation strategies to improve metabolic monitoring. If your site is interested in participating in this aspect of the project, please contact Noosha Niv at [noosha.niv@va.gov](mailto:noosha.niv@va.gov).



# SMOKING CESSATION IN SCHIZOPHRENIA

Mark Myers, Ph.D.

Public health efforts aimed at limiting the health problems from cigarette smoking have resulted in significant reductions in the U.S. smoking prevalence over the past 40 years. However, patients with schizophrenia continue to smoke at high rates. A large study of patients with schizophrenia found that 68% of participants smoked cigarettes, which is three times the overall rate of smoking in the U.S. In addition, studies have shown that the smoking prevalence in patients with schizophrenia is two times greater than for other mental disorders. Given the high rates of smoking, it is not surprising that patients with schizophrenia are at significantly greater risk for tobacco-related diseases.

In addition to the high smoking prevalence, patients with schizophrenia inhale more deeply than those without schizophrenia, thereby taking in more nicotine and other chemicals contained in cigarette smoke. As a result, patients with schizophrenia have great difficulty quitting smoking. Despite these challenges, many of them are interested in smoking cessation. To address the needs of this population, the V.A. San Diego Healthcare System initiated a specialty smoking cessation clinic for patients with schizophrenia and other serious mental disorders. The program offers groups that meet weekly on an ongoing basis, so that patients can participate for as long as they find it helpful. This open-

ended format allows for a longer course of treatment, permits patients to progress toward smoking cessation at their own pace, and provides exposure to peers who have successfully quit smoking. Once patients feel prepared and motivated to stop smoking, they are asked to set a quit date and select a medication to assist them. Patients are encouraged to continue attending group meetings after quitting to obtain ongoing support for their cessation, encouragement and problem solving as they encounter difficulties, and an opportunity to share their experiences with other group members. Participants in these groups typically attend for several months, and some attend for years. The group meets every Tuesday from 10 – 11 am at the VA San Diego Medical Center in La Jolla, second floor North, Room 2436. These are walk-in groups, so no appointment is needed. Anyone interested in participating in this group can contact the VASDHS Mental Health Tobacco Cessation Program at (858) 642-3436.



## SAN DIEGO'S WELLNESS AND VOCATIONAL ENRICHMENT (WAVE) CLINIC

*Rebecca E. Williams, Ph.D., Sabrina Castaneda, M.S., Robert Scinta, R.N.C., M.N., Rita Osterman, M.S.N., Craig Dike, Psy.D., and Joan Danford, O.T.R., R.P.R.P.*

The San Diego VA's Wellness and Vocational Enrichment (WAVE) Clinic provides targeted vocational, wellness, and psychological services to a wide variety of veterans including those with severe mental illness. The WAVE Clinic was established in 1998 and has received the highest level of accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) through 2011. A multidisciplinary staff of providers uses a team approach to address the diverse needs of veterans seeking assistance in returning to work, improving psychological functioning, and improving lifestyle choices.

The WAVE Clinic currently receives over 70 referrals each month and each consult is individually reviewed. Wellness activities are available to all eligible veterans including those with severe mental illness. Exercise classes (upper body strength training and aerobic cardio pace-walking) are offered to promote general physical conditioning and reinforce exercise self-efficacy. These veterans also have the opportunity to participate in a healthy lifestyle group to discuss wellness related topics.

Several pathways to becoming competitively employed are offered to meet the diverse needs of the veterans. Vocational services provided include vocational readiness activities, Incentive Therapy and Compensated Work therapy programs, Supported Employment, access to an 11-week vocational seminar (that introduces veterans to community em-

ployers, guest speakers, community resources, educational benefits and opportunities, peer graduates, and financial literacy), and assistance with the job search process. All veterans in the program have access to the job lab and the computer lab. The Supported Employment Access (SEA) program provides services for severely mentally ill veterans who wish to return to work. The SEA program is managed by Sabrina Castaneda, M.S. and was implemented in September 2008 to provide evidence-based rapid engagement and employment services. In that short time period, 27% of the SEA participants been competitively hired. A successful outcome includes a veteran with schizophrenia who was unemployed for 19 years and is now working at the local airport 30 hours each week. He says he looks forward to working every day and making his own money. Strong collaboration exists with other clinical providers throughout the VA system especially the Mental Health Intensive Case Management (MHICM) Team and the Substance Abuse Mental Illness (SAMI) Program.

Four Interdisciplinary Psychosocial Psychology Rehabilitation (PSR) Fellows who specialize in delivering evidence and recovery-based psychosocial interventions for individuals with severe mental illness work closely with WAVE Clinic staff. Services provided by PSR Fellows include individual psychotherapy, supported employment (IPS model), social skills training, staff and provider consultation and recovery-oriented education. The Wellness and Vocational Enrichment Clinic program continues to improve and is one of the many services of choice for veterans who are in recovery from severe mental illness.

## LAS VEGAS PSYCHOSOCIAL REHABILITATION AND RECOVERY CENTER

Stacey Maruska, LCSW

Separated from the main medical center on Arville Avenue, one can find the newly designed Las Vegas Psychosocial Rehabilitation and Recovery Center (PRRC), formerly known as the "Arville House." Both staff and veterans praise the transition from the old Day Treatment model to a more individualized and holistic program which includes a comprehensive, veteran-centered, wellness program. The program includes individualized recovery plans, individual and group therapy sessions, coaching sessions, skills classes, peer support and meditation. Groups at the center focus on mind, body and spirit. One group, titled "Relax, Release, Let Go," is a mindfulness group led by Carol

Gobel, MSW. Carol emphasizes "living in the moment" to those attending her class. She teaches veterans how to recognize the signs that they are experiencing stress and how to manage their stress using techniques such as breathing and grounding. "Holistic Wellness," led by Julie Lee, RN, teaches healthy habits to veterans and incorporates daily exercise, meditation, and question and answer sessions with the pharmacist. Julie explains that they also aim to involve the community by bringing in community speakers. For example, they had an instructor from Le Cordon Bleu speak to veterans about healthy cooking preparation.

Veterans report enjoying and receiving benefits

from the program. Al, a Vietnam veteran, states that the program has helped improve his depression and has taught him to eat healthier foods. Al recently moved into a new condo and is now living independently. Lennox, also a Vietnam veteran states he enjoys the program, "I've lost weight. I'm not as anxious and angry. My depression and my relationship with my wife have improved." Ricky, another veteran in the program, has begun volunteering at the library two times a week and has finished two college courses toward his Bachelors degree. Ricky credits recovery coaches with helping him stick to his goals, "I choose what I want to do; they don't tell me what I want to do.

They meet with me and ask me how I am doing on my goals."

Celia Maher, LCSW, the PRRC program coordinator, states, "we strive to make this a respectful environment for the veterans, focusing on recovery and wellness." Veterans are asked to fill out satisfaction surveys when they first enter the program and monthly thereafter. Although they do not have any data to report yet, Celia hopes that the surveys will show a reduction in symptoms and improved satisfaction with all areas of life. Celia's hope for the future is that they can formalize their peer program with paid peer providers and continue the success they are having assisting veterans on their journey in recovery.

## SUICIDE ALERT!

*New VHA Findings on Risk Factors for Suicide in OEF/OIF Veterans: Specific Importance of Major Depression*

OEF/OIF veterans with mental health conditions are at increased risk for suicide. VHA patients who served in OEF/OIF and have Major Depression are at particularly high risk for death by suicide compared to OEF/OIF patients without a diagnosis of major depression or veterans of prior eras with a diagnosis. Specifically, in OEF/OIF veterans who received VHA services, those with Major Depression have a 9.1- fold in-

creased risk of suicide compared to those without major depression. In veterans from previous eras treated in VHA, major depression is associated with a 3.2 - fold increased risk. Special attention should be paid to identifying, evaluating, and intervening with veterans with depressive symptoms, especially for those found to have Major Depression and those returning from deployment to Iraq or Afghanistan.



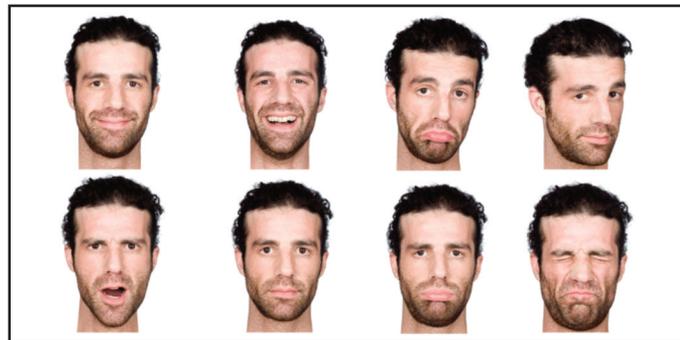
# SOCIAL COGNITION TRAINING FOR PEOPLE WITH SEVERE MENTAL ILLNESS

William P. Horan, Ph.D.

Many veterans with severe mental illnesses (SMI) experience difficulties across multiple domains of daily life functioning. Dysfunction in the social domain is particularly debilitating and has far reaching consequences, contributing to fractured family relationships, conflict with peers and coworkers, and social isolation. Further improvements in social functioning are unlikely to occur through gains in psychotic symptom management alone because psychotic symptoms are typically not closely related to functional adaptation in community-dwelling outpatients. Instead, new treatments that directly address the key determinants of poor social functioning are needed. Rapidly growing evidence indicates that impairments in social cognition are unique, important determinants of functional outcome, and are promising targets for psychosocial treatments that facilitate functional recovery.

Social cognition refers to the mental operations underlying social interactions, which include perceiving, interpreting, and flexibly generating responses to the intentions, dispositions, and behaviors of others. Simply put, social cognition is a set of skills that people use to understand and effectively interact with others. Problems in social cognition, such as misperceptions and unexpected reactions, can therefore be expected to impact peer, romantic, and family relationships as well as work and school behavior. Research on social cognition in SMI has focused on four areas: (1) *emotion perception*, such as perceiving facial

and vocal expressions of emotion in others; (2) *social perception*, including the ability to judge social cues from contextual information and nonverbal communicative gestures; (3) *attributional style*, which refers to biases in how individuals characteristically explain the causes of negative interpersonal events (e.g., blaming others rather than uncontrollable circumstances, “jumping to conclusions” that others have harmful motives); and (4) *mentalizing or “Theory of Mind”*, the ability to understand that others have mental states that differ from one’s own and to make cor-



rect inferences about the content of those mental states (e.g., detecting sarcasm or empathically relating to others’ feelings). People with SMI have been found to show substantial difficulties in each of these areas. There is now a general consensus that social cognition is distinct from, though related to, basic neurocognition (memory, attention) and other clinical features of schizophrenia. Furthermore, social cognition shows unique relationships to functional outcome, above and beyond basic neurocognition, and thus appears to have “added value” in explaining community functioning. These findings have generated a great deal of interest

in the possibility of enhancing social cognitive abilities as a means to ultimately improve real-world functioning.

A number of research groups throughout the world have started to examine whether psychosocial interventions can improve one or more aspects of social cognition. The initial results have been encouraging. For example, with funding provided by a MIRECC pilot study grant, our team developed an integrative 12-session social cognition skills training program for outpatients with SMI. This program is administered to

groups of 6-8 participants and targets the four aspects of social cognition described above. It combines successful elements from other programs with a variety of novel training exercises and materials designed to help participants become better “social detectives”. Sessions employ highly structured, skills training-based, psychiatric rehabilitation strategies, including: 1) breaking down complex social cognitive processes into their component skills, 2) initially teaching/training skills at the most fundamental level and gradually increasing complexity of skill acquisition, and 3) automating these skills through repetition and practice. Training

materials include a large collection of still photos of one of more individuals in various contexts, audio/visual clips of people interacting, and various interactive didactic and role-play exercises. For example, sessions that address social perception incorporate foreign language videos that require participants to deduce what is happening in various social situations from non-verbal cues.

In an initial randomized trial that included 31 veterans with SMI, those receiving social cognition training demonstrated significant improvements in facial affect perception that were not present in a control group that received the same number of sessions of traditional symptom management training. Furthermore, this improvement was independent of changes in basic neurocognitive functioning or symptoms. In an on-going randomized clinical trial funded by a MERIT award (“Improving Basic and Social Cognition in Schizophrenia”, M.F. Green, PI), we are evaluating the efficacy of an expanded 24-session version of our social cognition skills training program as compared to 24 sessions of either computerized basic neurocognitive remediation or traditional symptom management training. Although psychosocial treatments for social cognition are currently in their infancy, this area represents an exciting new approach to helping patients achieve a recovery that goes beyond the traditional focus on symptom management to include more effective and satisfying social functioning in daily life.

## WEST LOS ANGELES PSYCHOSOCIAL REHABILITATION AND RECOVERY CENTER (PRRC): THE SCHOOL FOR BETTER LIVING

Noosha Niv, Ph.D. and Stacey Maru

The newly formed Psychosocial Rehabilitation and Recovery Center (PRRC) at the West Los Angeles VA provides state of the art, evidenced-based treatments for people with severe mental illness. The center is also known as the “The School for Better Living,” a name given to the center by the veterans attending it. The PRRC uses an interdisciplinary and multimodal approach to wellness which incorporates eastern and western practices, such as yoga, tai chi, walking, golf, and mindfulness.

Metabolic monitoring is a key component of the program. Utilizing guidelines established by the American Diabetes Association, PRRC nurses regularly monitor vital signs and measure BMI and waist circumference, and PRRC doctors order appropriate lab tests and work with primary care to manage diabetes, hy-

perlipidemia, and other weight-related difficulties. MOVE-Day Treatment, a newly formed clinic in the PRRC, provides group classes titled “Food, Fun and Fitness” which are aimed at healthy eating. Aaron Flores, dietician, and Jim Ratsch, RN, provide individual health coaching in addition to running the groups. Other groups available through the PRRC are a “Personal and Group Health Goals 2009” class and a smoking cessation class. Family education is also provided through “Support and Family Education (SAFE),” an 18-week family psychoeducation program. Veterans also have access to a number of fitness opportunities, including yoga, tai chi, qi gong, pilates, walking groups, and golf.

In addition to treating veterans, the PRRC has been utilizing grand

rounds and mental health clinic lecture series to alert clinicians to the importance of monitoring and managing obesity and related metabolic changes associated with antipsychotic medications. Donna Ames, M.D., PRRC program leader, knows the importance of monitoring and managing weight and other metabolic indicators. Funded by a VA Merit Review grant, Dr. Ames has nearly completed a study which included 120 veterans with serious mental illness who participated in an evidence-based, weight loss program called the Diabetes Prevention Program. One of the key components of the intervention was to assure that veterans exercised as well as adjusted their eating habits. Veterans received small rewards if they attended exercise classes. Additionally, Julie Miller, the dietician for the research

program, went to board and care facilities to work with care providers on improving their menus. Many of the veterans in the PRRC participated in the study and achieved remarkable results. Dr. Ames described one success story, “A veteran recently reported to me he lost 30 pounds, stopped smoking (went from 4-5 packs per day to 1 pack per month), and lost 3 inches from his waist. It [the Diabetes Prevention Program] is an intensive lifestyle intervention program that has been proven to prevent diabetes in people without severe mental illness, and I believe the preliminary results from our study suggest that it works well in SMI veterans as well.” Dr. Ames recently received a new grant that will test the program at four VA clinics (West Los Angeles, Sepulveda, Los Angeles Ambulatory Care Center, and Long Beach).



# RECENT MIRECC PUBLICATIONS

- Brown, G.G., Delano-Wood, L., & Lazar, R. (2009). **Cerebrovascular Disease.** In I. Grant & K. Adams (Eds.). *Neuropsychological Assessment of Neuropsychiatric and Neuromedical Disorders (3rd Ed.)* (pp. 306-335). New York: Oxford University Press.
- Bystritsky, A., Niv, N., Kerwin, L., Natoli, J.L., Abrahami, N., et al. (In press). **Clinical and subthreshold panic disorder.** *Depression and Anxiety.*
- Chinman, M., Shoai, R., & Cohen, A.N. (In press). **Using organizational change strategies to guide peer support technician implementation in the VA.** *Psychiatric Rehabilitation Journal.*
- Citrome, L., Reist, C., Palmer, L., et al. (In press). **Impact of real-world ziprasidone dosing on treatment discontinuation rates in patients with schizophrenia or bipolar disorder.** *Schizophrenia Research.*
- Cohen, A.N., Glynn, S.M., Hamilton, A.B., & Young, A.S. (In press). **Implementation of a family intervention for individuals with schizophrenia.** *Journal of General Internal Medicine.*
- Depp, C.A., Mausbach, B.T., Eyler, L.T., Palmer, B.W., Cain, A.E., et al. (2009). **Performance-based and subjective measures of functioning in middle-aged and older adults with bipolar disorder.** *Journal of Nervous and Mental Disease, 197(7), 471-5.*
- Duvvuri, V., Risbrough, V.B., Kaye, W.H., & Geyer, M.A. (2009). **5-HT1A receptor-activation is necessary for 5-MeODMT-dependent potentiation of feeding inhibition.** *Pharmacology, Biochemistry, and Behavior, 93, 349-353.*
- Eyler, L.T. & Brown, G.G. (2009). **Geriatric Psychiatry: Neuroimaging.** In B.J. Sadock, V.A. Sadock, & P. Ruiz (Eds.). *Kaplan & Sadock's Comprehensive Textbook of Psychiatry (9th Ed.)* (pp. 3994 – 4002). Philadelphia: Lippincott, Williams, & Wilkins.
- Grella, C.E., Karno, M.P., Moore, A.A., Niv, N., & Warda, U.S. (2009). **Gender and comorbidity among individuals with opioid use disorders in the NESARC Study.** *Addictive Behaviors, 34, 498-504.*
- Grella, C.E., Karno, M.P., Warda, U.S., Niv, N., & Moore, A.A. (2009). **Perceptions of need and help received for alcohol or drug dependence in a national probability survey.** *Psychiatric Services, 60, 1068-1074.*
- Hamilton, A.B., Cohen, A.N., & Young, A.S. (In press). **Organizational readiness in specialty mental health care.** *Journal of General Internal Medicine.*
- Hamilton, A. & Goeders, N. (In press). **Violence perpetrated by women who use methamphetamine.** *Journal of Substance Use.*
- Henderson, C., Jackson, C., Slade, M., Young, A.S., & Strauss, J.L. (In press). **How should we implement psychiatric advance directives? A consensus study.** *Administration and Policy in Mental Health and Mental Health Services Research.*
- Horan, W. P., Wynn, J. K., Kring, A. M., Simons, R. F., & Green, M. F. (in press). **Electrophysiological correlates of emotional responding in schizophrenia.** *Journal of Abnormal Psychology.*
- Horan, W.P., Green, M.F., Gur, R.E., & Braff, D.L. (2009). **The use of neurocognitive endophenotypes in large-scale family genetic studies of schizophrenia.** M.S. Ritsner (Ed.), *Endophenotypes and Biomarkers for Neuropsychiatric Disorders.* (pp. 179-193). Springer.
- Hurford, I.M., Marder, S.R., Keefe, R.S., Reise, S.P., & Bilder, R.M. (In press). **A brief cognitive assessment tool for schizophrenia: Construction of a tool for clinicians.** *Schizophrenia Bulletin.*
- Kern, R.S., Glynn, S.M., Horan, W.P., & Marder, S.R. (2009). **Psychosocial treatments to promote functional recovery in schizophrenia.** *Schizophrenia Bulletin, 35(2), 347-61.*
- Kremen, W.S., Prom-Wormley, E., Panizzon, M.S., Eyler, L.T., Fischl, B., et al. (In press). **Genetic and environmental influences on the size of specific brain regions in midlife. The VETSA MRI study.** *Neuroimage.*
- Marder, S. (2009). **Both typical and atypical antipsychotic agents were associated with increased risk for sudden cardiac death.** *Annals of Internal Medicine, 151(4), Jc2-12.*
- Niv, N., Hamilton, A., & Hser, Y. (2009). **Impact of court-mandated substance abuse treatment on clinical decision-making.** *Journal of Behavioral Health Services & Research, 36, 505-516.*
- Niv, N., Pham, R., & Hser, Y. (2009). **Ethnic differences in substance abuse service needs, utilization, and outcomes in California.** *Psychiatric Services, 60, 1350-1356.*
- Niv, N., Shatkin, J.P., Hamilton, A.B., Unützer, J., Klap, R., & Young, A.S. (In press). **The use of herbal medications and dietary supplements by people with mental illness.** *Community Mental Health Journal.*
- Ozyurt, I.B. & Brown, G.G. (2009). **Knowledge discovery via machine learning for neurodegenerative disease researchers.** *Methods of Molecular Biology, 569, 173-96.*
- Powell, S.B., Zhou, X., & Geyer, M.A. (2009). **Prepulse inhibition and genetic mouse models of schizophrenia.** *Behavioral Brain Research, 204, 282-294.*
- Young, A.S. & Niv, N. (In press). **Mental Health Services for Adults.** In: B.L. Levin, J. Petrila, D. Hennessy (Eds.) *Mental Health Services: A Public Health Perspective (3rd Ed.)*. New York, NY: Oxford University Press.



## NEW GRANTS

**"Federated Database, Protocols and Tools for Arterial Spin Labeling CBF Measures"**

Site Principal Investigator:  
Greg Brown, Ph.D.  
Funded by the National  
Institute of Mental Health

**"Structural and Functional Brain Aging in Bipolar Disorder"**

Principal Investigator:  
Lisa Eyler, Ph.D.  
Funded by the National  
Institute of Mental Health

**"Social Cognition and Functioning in Bipolar Disorder"**

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

**"Developing Anesthesia as PTSD Treatment"**

Co-Investigator: Christo-  
pher Reist, M.D.  
Funded by the National  
Institute of Mental Health

**"Metabolic Side-Effects of Antipsychotic Medications: Improving Care"**

Co-Principal Investigator:  
Alexander Young, M.D.,  
M.S.H.S.  
Funded by the Depart-  
ment of Veterans Affairs  
Office of Mental Health

**"Barriers and Facilitators to Use of Wellness Services by Individuals with Schizophrenia"**

Principal Investigator:  
Alexander Young, M.D.,  
M.S.H.S.  
Funded by the Depart-  
ment of Veterans Affairs  
HSR&D and QUERI

**"Illness Management and Recovery Program: IMR-Web"**

Principal Investigator:  
Alexander Young, M.D.,  
M.S.H.S.  
Funded by the National  
Institute of Mental Health

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