

MINDVIEW

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IMPROVING THE QUALITY OF LIFE FOR VETERANS WITH PSYCHOSIS

UPCOMING EVENTS

SOCIAL SKILLS TRAINING

September 17-18, 2009
Santa Monica, CA
Contact: Shirley Glynn at
sglynn@ucla.edu

MIRECC SCIENTIFIC RETREAT

September 21-22, 2009
Long Beach, CA
Contact: Noosha Niv at
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VISN 22 WELCOMES DR. PETER HAUSER AS NEW MENTAL HEALTH SERVICES LEAD

Noosha Niv, Ph.D.

Peter Hauser, MD, moved from Portland, Oregon in June 2009 to become the new mental health services lead for VISN 22. Dr. Hauser intends to help facilitate communication and interaction between VISN 22 mental health leadership and facility leadership in order to develop a VISN-level mental health program that shares best practices and innovations among facilities. His vision for clinical, education, and research services for VISN 22 is "to be the best care for veterans in the nation." One way to achieve this goal is "to bring all mental health care providers to a similar level of excellence in regard to utilizing best clinical practices to treat our veterans." With a particular focus on implementation of VHA's Uniform Mental Health Services Handbook as well as priorities set by central office, his primary goal is to identify local best practices and innovations within VISN 22 Mental Health programs and implement them throughout the network in order to serve the needs of our veterans. Another clinical priority he highlights is meeting the needs of returning OEF/OIF service person-

nel to improve their reintegration into work, family and community. Dr. Hauser also identifies education and research as important missions of the VA stating, "I think it will be important for us to develop novel and innovative research studies that may help to inform our clinicians how to better serve our veterans with psychiatric illness and to utilize educational services to translate

His vision for clinical, education, and research services for VISN 22 is "to be the best care for veterans in the nation."

research findings into clinical practice. I think we have a vehicle through the MIRECC to do that."

Dr. Hauser attended the University of Virginia where he majored in German literature. He attended the School of Medicine at the University of Virginia and completed his internship at the University of Utah Medical Center. He began his psychiatry residency at the University of Toronto's Clarke Institute of Psychiatry and completed his last year of residency at Georgetown University in



Washington, DC. Dr. Hauser worked at the National Institutes of Health until joining VA in 1994. Since then, he has served as the Chief of Psychiatry at the Baltimore and Portland VA Medical Centers. He has conducted research in a number of areas including risk and protective factors in schizophrenia, the behavioral manifestation of thyroid disease, imaging in bipolar disorder, and psychiatric and substance use disorder comorbidities in veterans with hepatitis C.



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LETTER FROM THE DIRECTOR

Stephen R. Marder, MD



DUAL DISORDERS

Individuals with schizophrenia and other serious mental illnesses often suffer from substance use disorders (SUDs). As noted in the article by Dr. Noosha Niv, the lifetime prevalence of SUD in individuals with schizophrenia is 40-60%. The presence of substance abuse is associated with greater likelihood of non-adherence with treatment and greater long-term functional impairment. Epidemiological studies suggest that the use of cannabis may be a risk factor for developing schizophrenia.

Until recently, patients with psychotic illnesses and SUD were frequently treated at the same time in separate mental health and substance abuse programs. These individuals often fared poorly in substance abuse programs as some programs discouraged the use of medications that patients needed. In addition, psychotic patients with severe cognitive impairments, poor social skills, or suspiciousness may have had difficulty integrating into the complex social milieu of these programs. More recently, the VA has addressed this problem by developing specialized programs that provide integrated treatment for this difficult population. These programs are commonly housed in mental health settings and include staff mem-

bers with skills in managing both disorders.

This issue describes some of the interesting MIRECC research programs that are addressing important issues in these integrated programs. Dr. Joe Pierre is studying use of clozapine in patients who abuse cannabis. Even though cannabis clearly has a negative effect on the long-term outcome of schizophrenia, many patients persist in using it regularly. A number of studies have suggested that clozapine has unique effects on other types of substance use including smoking and alcohol abuse. The large multisite study will evaluate clozapine in comparison to other antipsychotics.

A study by Drs. Shirley Glynn and Noosha Niv will focus on a family intervention for patients with dual disorders. Studies have found that the family can be a powerful healing force for patients with serious mental illnesses. For example, patients with supportive families are more likely to succeed in rehabilitation programs. In addition, there is strong evidence supporting the effectiveness of family psychotherapeutic interventions. There is good reason to believe that these interventions may be particularly effective in individuals with comorbid serious mental illness and substance use problems.

It is interesting to note that integrated dual diagnosis programs have evolved in the VA because patients and clinicians appreciated that these individuals were not being adequately treated. It is surprising that the research supporting these programs is rather weak. Hopefully, these MIRECC programs will help to further improve the care of this complex and difficult population.

SOCIAL SKILLS TRAINING

Shirley Glynn, Ph.D.

Many people with serious psychiatric illnesses identify strengthening or expanding their social relationships as one of their primary recovery goals. These goals might include, for example, "getting a girlfriend" or "making more friends." However, poor social functioning, which can greatly impede meeting these social goals, is a core feature of illnesses such as schizophrenia, chronic depression, and some forms of bipolar illness. Social skills training is an evidenced-based psychosocial intervention which has been found to improve knowledge and use of social skills in clinical settings. An important study conducted by Dr. Stephen Marder found that providing a support person in the community to prompt use of social skills significantly improved generalization of skills in the community. Thus, participation in social skills training to meet social goals can be a core feature of many recovery plans.

In recognition of the importance of social skills in recovery, the VA has mandated that every medical center offer social skills training to veterans with serious psychiatric illnesses as part of the Uniform Mental Health Services Plan. As part of the evidence-based clinical initiative, the MIRECCs in VISN 5 and VISN 22 were awarded a 3-year contract funding the development and implementation of a program of training and ongoing consultation to assure that VA clinicians throughout the country have the requisite skills to provide social skills training. An expert panel was first convened to outline the goals and content of the training, and then a detailed training manual was developed. The plan calls for two trainings a year on both the east coast (Baltimore) and west coast (Los Angeles/Long Beach). Clinicians who attend the training receive six months of expert consultation while they conduct their

first social skills groups. In order to achieve high levels of mastery, the consultation program is intensive and includes weekly, individualized feedback sessions.

To date, 172 mental health clinicians have attended the trainings, and most have gone on to conduct social skills training groups at their own sites. Evaluations of the training have been very positive with over 95% of participants saying they completely agree with the statement that they are satisfied with the training experience. The next west coast training is scheduled for September 17-18, 2009 in Santa Monica and is targeted to VA mental health clinicians who work with veterans with serious and persisting psychiatric disorders. For more information on the program, contact Shirley Glynn at sglynn@ucla.edu.



DUAL DISORDERS:

Severe Mental Illness and Substance Use Disorders

Noosha Niv, Ph.D.

There is abundant evidence that individuals with severe mental illness (SMI) are at high risk for comorbid substance use disorders (SUD) compared to the general population. Epidemiological surveys indicate that the lifetime prevalence of comorbid SUD is between 40% and 60%, with current SUD present in 25% to 40% of clients. Comorbidity has been shown to be associated with serious clinical and psychosocial complications. Among the many consequences are high rates of relapse and re-hospitalization, treatment non-compliance, family burden, financial problems, legal problems, risky behaviors and infectious diseases, violence, suicide, and increased service utilization and service costs. Ultimately, SUD in persons with SMI takes a heavy toll on clients, their families, and society at large.

Integration of mental health and SUD treatment services in recent years has led to improvements in the outcomes of dually diagnosed clients. Despite this progress, SUD in SMI remains persistent over many years for most clients, with fewer than 15% achieving stable abstinence per year in integrated treatment. Clearly, there is much room for further progress. In fact, comprehensive reviews of the dual disorder research literature conclude that there is little evidence supporting the effectiveness of any specific individual or group interventions at this time. To fill this gap in the evidence, the Desert Pacific MIRECC is currently conducting three treatment studies with dually diagnosed patients.

Cannabis and Schizophrenia: Effects of Clozapine. A NIDA-funded study is being conducted examining the effect of clozapine on cannabis use

among individuals with schizophrenia (PI: Alan Green, M.D.). The West Los Angeles VA is serving as one of the sites for this multicenter trial (Site PI: Joseph Pierre, M.D.). The 12-week, randomized clinical trial compares the effect of clozapine to usual antipsychotic treatment in decreasing cannabis and other substance use.

Family Interventions for Dual Disorders (FIDD). Family intervention for dual disorders is a promising but neglected treatment modality. Most dually diagnosed patients continue to have contact with their families, and substance abuse contributes to increased family burden and stress. Aggression in patients with dual disorder is most likely to be directed at family members, and the loss of family support is a major cause of housing instability and homelessness. Finally, there is ample support for the effects of family collaboration in the treatment of SMI and primary substance use disorders, but little research has addressed its effects on dual disorders. Drs. Shirley Glynn and Noosha Niv are collaborating with Dr. Kim Mueser at Dartmouth University to conduct a pilot study to evaluate the feasibility and acceptance of the Family Intervention for Dual Disorders (FIDD) program for individuals with dual disorders. The secondary objective of the study is to assess the impact of participation in reducing substance use, psychiatric symptoms, and family burden. Treatment will consist of 20-30 sessions of conjoint family treatment offered over one year. The behaviorally-oriented program consists of seven modules: engagement, illness education, communication skills training, motivational enhancement, substance

use relapse prevention, contingency management for families, and termination.

Cognitive-Behavioral Therapy for Dual Disorders (CBT-DD). The Matrix Model, a substance use disorder treatment package which includes individual and group CBT, family education groups, social support groups, and weekly urine testing, is a treatment model frequently utilized in outpatient substance abuse programs. Dr. Noosha Niv conducted focus groups at two VA substance abuse clinics that utilize the group CBT portion of this program to better understand the needs of clients with dual disorders and of clinicians who work with them. The major themes that emerged from these focus groups included: 1) clinicians agreed that their dual diagnosis clients seemed less aware of their substance use problems and lacked the motivation to change substance using behaviors; 2) clients and clinicians noted their lack of knowledge about dual disorders (i.e., the nature of each disorder and their interactions) and emphasized the need for educational material concerning SUD and SMI; 3) session components which required abstract thinking were identified as too difficult for patients with cognitive deficits; 4) clients and clinicians reported that the intervention asked for a number of behavioral changes to be made; however, concrete ways to learn the skills taught were not addressed; and 5) clinicians indicated that their patients were unable to learn some of the more challenging skills in one session and could benefit from greater repetition.

To address the themes that emerged from the focus groups, the following modifications were made to the Matrix intervention: 1) sessions

were restructured so that lead-in sessions would be used to develop motivation for working on SUD, and several motivational enhancement sessions were added throughout the intervention to help maintain motivation; 2) a psychoeducational component regarding SMI was added; 3) to accommodate cognitive deficits, session length was shortened, the amount of material covered was reduced, content which required abstract thinking was removed and replaced with concrete information, key concepts were repeated throughout the treatment, and the use of multi-modal presentation of materials was incorporated to improve learning; and 4) the emphasis of the intervention was shifted from cognitive to behavioral, incorporating social skills and problem-solving training to a greater extent. Standardized manuals were developed for both clients and clinicians, and a pilot study of the intervention has been completed at the West Los Angeles VA with the assistance of Susan Rosenbluth, Ph.D., Peter Graves, Ph.D., and Donna Cobbah, MSW.



COLLABORATION BETWEEN VA AND COLLEGE THEATER GROUP BRINGS AWARENESS OF WAR TRAUMA

Leigh Messinides, Ph.D.

One could tell this would be a different kind of Grand Rounds presentation when the preparations involved a dress rehearsal and last-minute efforts to fix the footlights. "The Wall," a short, one-act play on the topic of war trauma was presented on June 2, 2009 at the VA Medical Center in Long Beach before an audience of staff, veterans and their families. The aim was to utilize a creative medium to help illustrate issues of military trauma and facilitate open discussion. The dialogue between a young, married couple sensitively portrayed the withdrawal caused by trauma and the impact of withdrawal on the couple's relationship. The story of this presentation began when Rod Doran, a Navy veteran, returned to Orange Coast College pursuing his dream of writing. The play was originally presented at Orange Coast College this past spring, and the student troupe (writer Rod Doran, director David Salai and cast members Teresa Rios and Elliott Glasser) was very willing to assist when asked if they could present the production at the VA.

A panel with diverse backgrounds in the fine arts, the military and mental health was invited to participate in a dis-

ussion after the play. Kevin Vejar, RN, the VALB PTSD Team Nurse Case Manager, spoke on the military experience, VA treatment resources, as well as his own Navy experience. Dalia Sanchez, a counselor at the Orange County Vet Center with extensive military experience and a recent tour in Iraq, spoke about her work with veterans and their families. Professor Joanne Gordon,

Chair of the Theater Arts Department at California State University, Long Beach and Director of Cal Rep Theater, spoke about the role of the arts in communicating the human cost of war.

The play coordinators, Stacey Maruska, LCSW, and Leigh Messinides, Ph.D., were struck by the generosity of the Orange Coast College students in sharing their talents and

time with our VA community and the enthusiasm and openness of veterans and staff to this non-traditional presentation. Since the presentation, VA staff members have asked about the possibility of using a play to heighten awareness of other mental health issues, and a project is underway to develop a similar presentation for Suicide Awareness Month this September.



Students Elliott Glasser, Rod Doran, and Teresa Rios and Dr. Larry Albers

MULTIPLE FAMILY GROUP TREATMENT

Shirley Glynn, Ph.D.

Participation in family psychoeducational programs which emphasize illness education, training in communication and problem-solving skills, and the development of realistic expectations for the recovery period have been found to dramatically reduce relapse rates in schizophrenia and bipolar illness, often by as much as 50%. In recognition of the benefits of family involvement in care, the VA Office of Mental Health Services embarked on a clinical initiative

three years ago to provide training in two kinds of family psychoeducation - individually based behavioral family therapy and multiple family groups. Dr. Shirley Glynn, a MIRECC investigator, is the VA national behavioral family therapy consultant and trainer and serves as a point person for the Office of Mental Health Services as it develops a broader array of services to assist families in helping veterans recover from serious psychiatric illnesses. In addi-

tion to family psychoeducation, these services include family consultation and family education, as described in the Uniform Mental Health Services Package.

The Desert Pacific MIRECC hosted a 4-day, national training on Multiple Family Group Treatment in June 2009. The program was attended by 27 clinicians from throughout the country. Clinicians received training in multiple family group treatment, family consultation, and family education. Dr. Susan Mc-

Cutcheon, Director of Family Services, Women's Mental Health and Military Sexual Trauma, represented the Office of Mental Health Services. Participating clinicians will now receive 6 months of ongoing consultation as they begin developing multiple family group interventions at their home VAs. The overall goal of the family psychoeducation training program is to develop a cadre of VA clinicians with expertise in helping families support veterans in their recovery.

THE 3RD ANNUAL VA MENTAL HEALTH CONFERENCE

The 3rd Annual VA Mental Health conference, *Meeting the Diverse Mental Health Needs of Veterans: Implementing the Uniform Services Handbook*, took place in Baltimore, MD in July 2009. The Desert Pacific MIRECC presented the following six projects at this meeting.

EVALUATING ORGANIZATIONAL READINESS TO IMPROVE CARE AT FOUR VA HEALTHCARE CENTERS

Amy N. Cohen, PhD, Alexander S. Young, MD, MSHS, Alison Hamilton, PhD, Matthew Chinman, PhD, and the EQUIP-2 project team in VISNs 3, 16, 17, and 22

BACKGROUND: The VHA Uniform Mental Health Services Package stipulates that recovery and rehabilitation-oriented programs must be available for all seriously mentally ill (SMI) patients. This includes services such as wellness programming, supported employment, family services, and peer support. Many patients with SMI have not been receiving these services and outcomes in routine care are worse than outcomes under state-of-the-art care. This problem is not confined to VA. It is important to maximize the potential for clinician acceptance and adoption of evidence-based, recovery-oriented services. To help managers and policymakers plan for successful roll-out and uptake of these services, it will be important to understand the organizational context where change is to be implemented.

METHODS: Data are from the VA HSR&D QUERI project, "EQUIP-2" (Enhancing Quality of care In Psychosis). EQUIP-2 is evaluating, in a controlled trial, facilitation and evidence-based quality improvement to improve care for schizophrenia. In EQUIP-2, four VISNs (3, 16, 17, and 22) selected two evidence-based practices for care improvement. All those practices to increase competitive employment and reduce weight. The project began with a context analysis of the mental health care line by having ad-

ministrators and clinicians complete the TCU Organizational Readiness for Change Scale (which focuses on organizational traits that predict program change, $n = 28$ administrators and $n = 119$ clinicians) and then interviewing a subset of key stakeholders ($n = 10$ administrators and $n = 28$ clinicians).

RESULTS: At sites A and B, data indicated good clinic structure and functioning with strikingly consistent responses across clinicians. Nothing extraordinary was done at these sites to specifically ready them for the implementation of the evidence-based practices. At site C, data indicated structure issues including training needs and program needs and functional issues including a relatively poor understanding of the clinic's mission and relatively low sense of autonomy amongst clinicians. We addressed these through educational programs about the practices to be implemented, marketing a consistent message regarding the purpose of the changes, and allowing clinicians to determine how the new practices would be designed and implemented. At site D, data indicated structure issues including relatively less adaptable clinicians and functional issues including a relatively poor understanding of the clinic's mission, relatively low level of cohesion amongst clinicians, and relatively low sense of autonomy amongst clinicians. We addressed these by getting key staff on board early, using testimonials of early adopters, marketing a consistent message regarding the purpose of the changes, building teams within the clinic to work together on change goals, and allowing clinicians to determine how the new practices would be designed and implemented.

IMPLICATIONS: Systematic evaluation of organizational context is a critical first step in efforts to improve care. This evaluation allows for an understanding of the structure and functioning of sites prior to implementation of change. The survey used in EQUIP only

takes 15 minutes to complete and provides a wealth of information on areas of weakness and strength. The organizational evaluation in this study shaped training, implementation, and communication efforts to meet each site's needs and state of readiness, thereby increasing the likelihood that system redesign and quality improvement efforts were successful.

MEASURING RECOVERY: THE PROMISE OF GOAL ATTAINMENT SCALING

Cristy Gamez-Galka, PhD, Sue Mirch-Kretschmann, PhD and Amy N. Cohen, PhD

BACKGROUND: The VHA Uniform Mental Health Services Package provides clear guidance on the practice of recovery, which includes consumer-centered care and enhanced access to evidence-based and recovery-oriented services. Use of recovery-oriented services should reflect the veteran's unique goals and values. In collaboration with consumers, we need to work together to set goals and understand progress towards those goals, and for accountability to those we serve, we need to be able to measure goal attainment. The issue for many committed to facilitating the implementation of recovery is how this can be accomplished given the vastly different organizational structures, services, and needs of the veterans. Goal Attainment Scaling (GAS) is one method applicable to various services; it is trans-theoretical, and recovery-oriented. GAS is a "systematic procedure for defining rehabilitation goals and measuring progress toward these goals... the advantages of GAS are the ability to transform subjective desires into measurable goals and the ability to rate progress toward goals using a variety of methods such as rating scales, functional criteria, and objective measures." GAS emphasizes collaboration, the unique goals of the veteran, and graded specific behavioral indicators used to assess individual outcomes. GAS is, in itself, a treatment intervention since it stimulates

both therapists and patient to set and evaluate progress toward concrete, realistic goals." GAS has a demonstrated a record of usefulness in community mental health, day treatment centers, drug and alcohol treatment, family therapy, and rehabilitation. GAS can also be used for consumer (or other concerned parties) for audits of care. GAS has applicability in quality assurance (QA) at six levels: the client, the service provider, the treatment, the program, relevant policy, and QA of mechanisms employed to assure quality at the first five levels. There is an evidence-base for its use including demonstrated reliability, validity, and sensitivity of GAS with working age and older adults.

WORKSHOP: The 90 minute workshop will begin with an overview of the strong evidence for the reliability, validity and sensitivity of GAS. We will then present how-to use GAS clinically as both a process (setting and reaching for goals) and as an outcome (goal achievement) measure in a wide range of VA settings. This presentation will be accompanied by handouts and examples. We will also discuss how the GAS itself can be a recovery-oriented, consumer-centered intervention. Dr. Gamez-Galka will present data from the Houston VA PRRC, where GAS was used as part of individual therapy and within a group setting with veterans diagnosed with SMI. Dr. Cohen will present data from the West Los Angeles MIRECC where GAS was used as part of an intervention as well as an outcome measure for consumers with schizophrenia. Dr. Mirch-Kretschmann from the VA Palo Alto will present data from a study using GAS to set and measure goal attainment for veterans with SMI attending an aging group. Individuals will leave the workshop with a strong understanding of the measure and skills to implement it at their VA.

METABOLIC SIDE-EFFECTS OF ANTIPSYCHOTIC MEDICATIONS: IMPROVING CARE

Stephen R. Marder, MD, Alexander Young, MD, and Richard Owen, MD

BACKGROUND: Individuals with

Richard Owen, MD

BACKGROUND: Individuals with serious mental illnesses such as schizophrenia and bipolar disorder have a higher risk for cardiovascular disease than the general population. This risk is, in part, related to metabolic factors such as elevated lipids, obesity, and an increased prevalence of Type II diabetes mellitus. Unfortunately, some of the antipsychotic medications that are used to treat these illnesses have the potential for worsening these metabolic effects. Recent guidelines from the VA and other sources have suggested strategies addressing these metabolic risks through improved clinical monitoring followed by treatment interventions.

WORKSHOP: This workshop will review the recommendations of a work group appointed by the VA Office of Mental Health Services to address this issue. It will then review recent strategies that have been developed to implement the work group recommendations. The workshop will be highly interactive and will focus on developing a consensus regarding implementation strategies that are most likely to be effective. Stephen Marder, the workshop chair and the chair of the work group will provide a background on risk factors associated with the metabolic syndrome, guideline recommendations for management, and research focused on addressing metabolic risk factors. He will also review the work group recommendations. Alexander Young will provide an example of an implementation strategy that used group-based wellness interventions and observations regarding their effectiveness. Richard Owen will present the approach and findings from the ASSIST (A Study of Strategies to Improve Schizophrenia Treatment) trial. This study focused on improving the dosing and monitoring of antipsychotic side effects. Data from these trials will be used to help formulate a consensus on implementation strategies for VA facilities.

IMPLEMENTATION OF A PSYCHOSOCIAL WEIGHT LOSS PROGRAM IN SCHIZOPHRENIA

Noosha Niv, PhD, Amy N. Cohen, PhD, Alison Brown,

PhD, Kirk McNagny, MD, Chris Kessler, MD, and Alexander S. Young, MD, MSHS

BACKGROUND: While significant advances have been made in the pharmacological management of psychosis, gains are being offset by the increased weight gain associated with newer antipsychotic medications. Excess weight, obesity and resultant medical problems (e.g., diabetes and cardiovascular morbidity) are increasingly recognized as pervasive problems in populations with psychotic disorders. VHA is establishing *MOVE!*, a weight management program, at all VA clinics as a national initiative to control weight. *MOVE!*, however, was not designed for people with the cognitive deficits that many individuals with psychosis exhibit. National treatment guidelines for schizophrenia and systematic literature reviews of weight loss practices have identified individual and group, evidence-based, weight management programs that are effective in this population. These programs are similar to *MOVE!*, but they are more intensive, designed for specialty mental health clinics, and not broadly available at VA. A better understanding is needed of whether these programs can be implemented at VA clinics and whether they would be as effective in VA practice as they have been in clinical trials.

METHODS: The present study utilizes data from the Enhancing Quality-of-care In Psychosis (EQUIP) study and describes findings from an in-person, evidence-based, weight loss intervention implemented at VA for persons with schizophrenia. Improving weight and wellness required assessment of the problem in each patient, the establishment of therapeutic groups, involvement of nutrition and recreational services, and help with referrals and follow-ups. Data were collected at the Long Beach and Sepulveda mental health clinics from 146 participants who met criteria for schizophrenia or schizoaffective disorder. All participants were interviewed at baseline and approximately 1 year later. Participants who chose to enter the weight program were weighed at each session.

RESULTS: Seventy-five percent of study participants were identified as overweight or obese, and 40% received in-person, weight services. Compared to those who did not receive weight services, those who received such services had significantly greater weight, had higher BMI scores, and were more likely to be obese. Those who enrolled in the weight program received an average of 6.6 sessions (range 1-23). Participation in the weight program resulted in an average weight loss of 2.4 pounds and an average BMI decrease of 0.3. There was a significant change in BMI categories from treatment initiation to termination; a significant proportion of participants moved from the obese category to the overweight category, and a significant proportion of participants moved from the overweight category to the normal category. Outcome data compared to a control group will also be reported. Qualitative analyses indicated shortcomings with clinician knowledge and attitudes regarding the efficacy of weight services ("teaching is really not successful") and service provision or referrals ("we do not offer any services that I am aware of").

IMPLICATIONS: VA specialty mental health clinics should implement evidence-based, psychosocial, weight management programs to assist overweight patients. Study results suggest that implementation of such programs is possible, and that these programs are effective in reducing weight and are well received by both patients and clinicians. The high prevalence of overweight and obese individuals in the sample highlights the importance of weight monitoring and management in this population. Improved awareness of the efficacy of psychosocial weight programs and training in administering these interventions is needed among mental health providers.

ASSESSING MOTIVATION TO WORK AMONG PSYCHIATRIC PATIENTS: SCALE DEVELOPMENT

Noosha Niv, PhD, Anna Lui, MSW, and Shirley Glynn, PhD

BACKGROUND: The role of work in a successful psychiatric rehabilitation program is becoming

increasingly recognized, and the majority of people with severe mental illnesses (SMI) report they would like paid employment. However, unemployment rates among persons with SMI are 3-5 times higher than the general population, and competitive employment rates for this group are 11-30%. To address these low work rates, VHA has adopted supported employment as an evidence-based practice for individuals with SMI. Despite the effectiveness of supported employment programs in assisting participants obtain jobs, these jobs are often short-lived, and at any given time, most participants in these programs are not competitively employed. Further, supported employment does not appear to increase job tenure. Motivational deficits may play a prominent role in explaining the limited benefits accruing from vocational rehabilitation in persons with SMI. Maintaining motivation may be particularly challenging for persons who have to cope with psychiatric symptoms in addition to practical impediments to work, such as a reduction in disability benefits and social services if one succeeds in one's job. Difficulties in motivation, rather than skill in obtaining or performing job tasks, may be a critical rate-limiting factor to employment. To date, there are no questionnaires available to measure what motivates an individual to get and maintain employment. There are also no instruments available that measure individuals' perceived obstacles to work. The goal of this study was to develop and evaluate the psychometric properties of the Motivators and Barriers to Employment Questionnaire (MBEQ) and to evaluate its factor structure.

METHODS: Veterans (n = 308) who were receiving treatment at the West Los Angeles mental health clinic participated in the initial scale development by completing the questionnaire. The questionnaire was shortened based on analysis of its factor structure. Twenty-six psychiatric patients completed the shortened questionnaire twice (1 week apart) to evaluate test-retest reliability.

RESULTS: The initial questionnaire consisted of four motivation scales including: increased

psychiatric patients completed the shortened questionnaire twice (1 week apart) to evaluate test-retest reliability.

RESULTS: The initial questionnaire consisted of four motivation scales including: increased money, increased self-esteem, improved social life and relationship with family members, and rewarding use of time. The initial questionnaire also consisted of five obstacle scales including: loss of benefits, loss of free time, fear of failing in the job, fear of relapse due to stress, and stigma. Factor analyses revealed a 5-factor solution for the scale. All items assessing motivators to work loaded on one factor. The other four factors consisted of varying barriers to employment. These four obstacle factors were: loss of benefits, loss of free time, fear of failing on the job or experiencing a relapse due to job stress, and stigma regarding mental illness. The questionnaire was reduced to 36 items based on these analyses. The shortened questionnaire was administered for test-retest reliability which will be reported.

IMPLICATIONS: For individuals with SMI, the financial benefits from employment are limited, and job specialists must improve their ability to help clients identify and incorporate other intrinsic benefits of working in their job searches. Identification of such motivators and obstacles will be valuable to job specialists working

with patients with psychiatric disorders and might aid in improving employment rates. The MBEQ can serve as a tool for clinicians in identifying these motivators and obstacles to employment. Use of the MBEQ can also be valuable to researchers in identifying individuals who may benefit the most from vocation rehabilitation programs.

IMPLEMENTING RECOVERY-ORIENTED CARE: THE IMPORTANCE OF CLINICIANS' KNOWLEDGE, ATTITUDES, AND BELIEFS

Alexander S. Young, MD, MSHS, Alison Hamilton, PhD, Amy N. Cohen, PhD, and EQUIP investigators in VISNs 3, 16, 17, and 22

BACKGROUND: VHA is engaged in a major initiative to implement recovery-oriented, evidence-based services in mental health. These services go beyond symptom management to provide support for improved functional outcomes, wellness, and quality of life. To maximize clinician acceptance and adoption of recovery-oriented and evidence-based services, it is helpful to obtain a baseline understanding of clinicians' knowledge, attitudes, and beliefs (KAB) about patients' needs for services. Formative evaluation methods are ideally suited to assess KAB among clinicians. The HSR&D QUERI project, "Enhancing Quality of care In Psychosis" (EQUIP), is a

collaboration between researchers and policy makers in VISNs 3, 16, 17, and 22 with the goal of improving care for schizophrenia. EQUIP began by discussing, with mental health leadership in these VISNs, a list of evidence-based, recovery-oriented treatments to consider for implementation. All VISNs chose to implement treatments to improve patients' weight and work outcomes. To prepare for implementation at one medical center in each VISN, formative evaluations were conducted to assess clinicians' baseline KAB about patients' needs for services.

METHODS: Semi-structured interviews with 39 clinical staff were conducted at baseline. To evaluate KAB within a social cognitive theoretical framework, respondents were asked to describe the "top three" needs of patients with schizophrenia. They were then asked about their perceptions of supported employment and wellness because these services had been identified as priorities by the participating VISNs. Interview data were analyzed concurrently with field notes using Atlas.ti and the constant comparison method whereby data were compared within and across sites.

RESULTS: The VISN-identified priorities were not noted as high priority needs by clinicians. Instead, the top need, mentioned by 20 of the 39 respondents, was medication

management. Second to this, 14 clinicians noted patients' need for opportunities to engage socially in communities. Ten individuals noted a need for ongoing social support. Stable living situations and work opportunities were each mentioned by eight individuals. Other top needs mentioned by a minority were supported employment, exercise and nutrition education, and education around diagnosis and recovery. In EQUIP, these results were used to make adjustments to implementation so that clinicians would provide and sustain recovery-oriented services, and so that patients would request and use these services.

IMPLICATIONS: Consistent with the Uniform Mental Health Services Package, mental health leadership at the VISN and medical center levels identified recovery-oriented services as their highest priorities for implementation. However, only a minority of clinicians believed that recovery-oriented services were a top priority for patients. KAB of many clinicians appear to differ substantially from those required to meet policy objectives nationally and regionally. To increase the likelihood that system redesign and quality improvement efforts are successful, it may be necessary to improve workforce KAB using assertive, tailored education strategies focused on both clinicians and patients.



RECENT MIRECC PUBLICATIONS

Chinman, M., Tremain, B., Imm, P., & Wandersman, A. (In press). **Strengthening prevention performance using technology: A formative evaluation of interactive Getting To Outcomes™.** *The American Journal of Orthopsychiatry: Interdisciplinary Perspectives on Mental Health and Social Justice.*

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