It’s exciting to prepare my presentation for the American Dietetic Association’s (ADA) 2008 Food & Nutrition Conference & Expo (FNCE) this fall in Chicago, IL entitled, “From Addiction to Recovery: The Role of the Dietitian.” Substance abuse touches many lives. My own sister-in-law died at the age of 44 from complications of alcohol abuse. What began as a teenage right-of-passage slowly took away her health and ended in her untimely death. According to a 2004 Health and Human Services (HHS) report, nearly one-fourth of all U.S. hospital stays for patients 18 and older involve a mental health or substance use related disorder (1). Beyond hospital walls, a 2006 HHS report states that an estimated 22.6 million persons were classified with substance dependence or abuse (2). Clearly, these staggering statistics suggest that most dietitians will encounter such clients in daily practice. How can we help?

From my experience working in alcohol and drug rehabilitation programs, I’ve identified several key issues I hope to explore with you in October:

- The effects of alcohol and substance abuse on nutrition and health
- The use of vitamin/mineral/herbal supplements in recovery
- Cross-addiction: substituting a legal chemical for an illegal one or a non-intoxicating beverage for alcohol
- Components of successful nutrition intervention and education

Whether you are currently working in an alcohol and drug rehabilitation program, a behavioral or community healthcare setting, or would like to expand your services to this population, patients will benefit from nutrition intervention on their road to recovery.

And I hope you will plan to join me at FNCE to learn more about this important area of practice. Also, I need your help to compile current data regarding the role of medical nutrition therapy and nutrition education in addiction treatment programs. If you or someone you know work in this area, please complete the questionnaire I plan to post on the Behavioral Health Nutrition (BHN) and Nutrition Entrepreneurs (NE) dietetic practice groups list-serves. In the interim, please don’t hesitate to contact me at Theresa@theresastahl.us to share your thoughts or questions.

Citations:

A lifelong promoter of healthy living, Theresa Yosuico Stahl, RD, LDN, has over 20 years’ experience as a Registered Dietitian in a wide variety of settings. She recently spent 6 years as a Medical Nutrition Therapist at a behavioral health hospital and adult and adolescent alcohol and drug rehab programs where she taught monthly nutrition education groups for recovery program participants. Theresa is Clinical Dietitian Specialist with an outpatient dialysis center and authors the weekly e-newsletter column, “Ask the Nutritionist” for health and nutrition website “Nubella.com”. She hosts a “Balanced Eating” blog on Nubella.com and QualityHealth.com and is a Medical Advisor for Nubella.

Theresa served on the nutrition faculty at Potomac State College of West Virginia University. Committed to advancing wellness, she is a certified alternative yoga instructor (PraiseMoves) and enjoys encouraging others to live healthy, balanced lives.
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Articles about successful programs, research interventions, evaluations and treatment strategies, meeting announcements and information about educational programs are welcome and should be sent to the editor by the next deadline.

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FROM THE CHAIR
PAULA KERR, MS, RD, CD

Learning and Communicating
Our Behavioral Health Nutrition (BHN) Dietetics Practice Group (DPG) Vision Statement tells us that we as members of BHN are “the most valued source of food and nutrition services for persons with addictions, mental illnesses, intellectual and developmental disabilities, and eating disorders.” Our members are the experts. Do you feel like an expert? I hope so. Your portfolio of achievements in education, training and practice experience make you uniquely qualified to assess, diagnose, treat, and monitor nutritional concerns commonly found in persons experiencing behavioral health challenges.

Our BHN Mission statement tells us that we are “Leading the future of dietetics practice in the care of persons with eating disorders, mental illnesses, intellectual and developmental disabilities, and addictions.” To lead the future of practice, we must continue to actively learn about our profession, and then broadly communicate that which we learn. Learning and communicating.

Learning: This year we built on work done by previous DPG leadership teams. We joined with Research DPG to develop for you tools for conducting your own outcomes research. We solicited and presented to you up-to-date teaching from leaders in all BHN areas of practice. We conversed and learned from your professional “e-conversations” on our BHN Listserv.

Communicating: This year we modernized our system of communication for greater efficiency, effectiveness, and “member-friendliness.” We updated the newsletter and published 2 electronic issues. We redesigned our website to make it easier and more comfortable for you to use. We sent you electronic surveys to include you in BHN decision-making. We sent our Public Policy Chair to Washington D.C. to converse with lawmakers and lobbyists involved in pressing nutrition legislation.

If you don’t already, I encourage you to recognize yourself as the expert that you are. Other BHN members are waiting to hear about your research, your ideas, and your experiences. They are most valued. Make a new commitment to learn together, to communicate with each other, and together we can reset the standards for nutritional care of persons with Behavioral Health concerns.

My admiration and thanks go to all who participated in the work of BHN this past year. It has been my privilege and pleasure to serve with you.

Paula D. Kerr MS, RD, CD

Thank you Paula Kerr for your leadership and dedication to the advancement of BHN!
It was pure luck in 1988 that I happened to sit next to a gentleman on the Washington DC Metro train who suggested I contact a geneticist at Bethesda Naval Hospital after listening to me vent about our daughter’s challenges in life. A few months later, we had our answer! After 12 long years, genetic tests confirmed that our firstborn Amy, inherited the full mutation of Fragile X syndrome from me, her mom, who has the pre-mutation. Even, you, the reader of this article could be a carrier and not know it!

You may ask, “What is Fragile X syndrome?” Simply stated, Fragile X syndrome is the leading genetic cause of mental impairment in the world, ranging from subtle learning disabilities and a normal IQ to severe cognitive or intellectual challenges, including autism or autistic-like behavior. Symptoms often include physical characteristics, behavioral deficits and delays in speech/language development. It only takes one parent to pass this genetic condition to their children. Fathers will pass the pre-mutation to all of their daughters, but to none of their sons, while mothers have a 50% chance with each pregnancy of passing either the pre- or full mutation to either their sons or daughters. Lucky for us, Amy’s younger sister, Genevieve, born six years later, did not inherit Fragile X syndrome, nor is she even a premutation carrier like me, her mom. Current statistics estimate that the number of premutation carriers is 1/250 in women and 1/800 in men worldwide among all nationalities.

At birth, Amy’s only noticeable abnormalities were crossing of her eyes (strabismus), difficulty nursing due to oral motor sensitivities, a high palate, larger than average head circumference and sensitivity to noises, lights and crowds. Since she was our first child, I thought it was normal for a newborn to take 2-3 days to learn how to breastfeed. Once she learned, she wanted to nurse every 1 ½ hours instead of the usual 3-4 hours. She continued to nurse for a full year supplemented by foods I made myself. Her height/weight was at the 95% level on the growth chart for the next 5 years.

After age one, other behaviors included arm flapping, toe walking, repetitive rocking, sensitivity to touch, attention deficit disorder and lack of eye contact. It was difficult to find shoes to fit her since her feet were unusually wide and flat. Amy was easily distracted and had difficulty with socialization. Nevertheless, despite her shyness and anxiety, she exuded this beautiful smile especially when swinging on her favorite swing or dancing to the Muppet’s music.

When we moved to Champaign, Illinois, I enrolled Amy in the
Child Development preschool at the University of Illinois. It was at that time that she was identified as autistic-like and transferred to a preschool for the emotionally disturbed, our only option at that time. When she started imitating the inappropriate behaviors of her classmates, we removed her and placed her in the local university speech/hearing clinic where she received both individual and group therapy for her delayed, disfluent, perseverative speech. Whether her speech delay occurred because of her constant ear infections with fluid in the middle ear or because of her Fragile X will never be known simply because most of her doctors, therapists and educators were not aware of its existence.

Fragile X does affect the connective tissue in the body which could explain why her Eustachian tube was often filled with fluid. Whether the ear infections could be related to dietary issues such as food intolerances is just speculation at this time. I often wonder why Amy's ear infections started after she stopped breast feeding. Could it be that she developed gluten or casein sensitivity? This may be a question you may wish to ask your clients.

After Amy entered puberty at age 11, she showed classic physical signs of Fragile X such as an elongated face, large ears, and hyperextensible finger joints. Some, but not all, males and females tend to have these features to varying degrees. More recently at age 27 she suffered her first grand mal seizure which was first attributed to her daytime sleep disorder, but after several more seizures, the diagnosis was changed to epilepsy. It is more common for young children with Fragile X to develop a seizure disorder which they usually outgrow by adulthood.

Over the course of my husband's Marine Corps career, Amy attended 10 schools and graduated with her high school diploma at age 21. That alone taught us that the right educational program can make all the difference in the world. Her best year ever was when a master's level special education teacher, with experience working with children with autism, became her 3rd grade regular education teacher. Amy developed better socialization skills from her classmates while enjoying the benefits of what her teacher had to offer. For the first time in her life, she had real friends.

Amy also was a highly visual, hands-on student. Helping me prepare meals at home helped her understand math, science, food history, & develop reading skills. This type of “nutrition integration” is recommended for those of you who work with young children, including preschoolers. This is crucial for those who like our daughter who have difficulties with executive-function thinking skills (the ability to take facts and reach a conclusion).

Amy has been living independently for 10 years in a duplex we remodeled, has learned to drive her own car, work in the community, attend college, and she taught herself sign language so she could communicate with a young boy who is hearing impaired. Because she has excellent imitative skills, acting and sign language came easy to her. Reading food labels, preparing her own meals, and evaluating her diet on mypyramid.com are her other strengths.

Amy’s diet is pretty balanced. Some other children with Fragile X do have a subphenotype of Prader-Willi Syndrome and resulting obesity issues. Others may experience just the opposite: cessation of growth from ages 2-3 and/or limited food choices (picky eaters).

Compromise for others has led her to advocate for those with special needs including becoming a global messenger for Montana Special Olympics. Our local newspaper often prints “Letters to the Editor”, helping our community better understand people in her position. She is often quoted as saying “focus on the positive and throw the negative out the door”. She is definitely our sunshine!

Currently, Dr. Randi Hagerman, MD, Medical Director of the University of California Davis M.I.N.D. Institute is making an effort to increase awareness of not only the mental retardation/autism link in Fragile X, but also links to anxiety, a variety of psychological, behavioral and learning disorders.

More recently two medical conditions, Fragile X Tremor/Ataxia Syndrome (FXTAS) and Primary Ovarian Insufficiency (POI) were discovered in pre-mutation carriers giving geneticists another portal into understanding how the Fragile X gene works and an additional way to diagnose Fragile X in a family. FXTAS, which can show up in 30% of male carriers as early as age 50, is characterized by an early hand tremor, difficulty with walking/balance, short term memory and eventual loss of independence.

Other children with Fragile X do have a subphenotype of Prader-Willi Syndrome

POI may be the reason why it took my husband and me several years to give birth to our second child, Genevieve, when I was 36 years old. Twenty percent of female premutation carriers are estimated to develop POI under age 40. Early menopause may carry increased risks of cardiovascular disease, osteoporosis, and other chronic diseases of aging. Female carriers also have hypoestrogenism and osteopenia rates significantly higher than in the general population.

Presently, our “miracle daughter”, Genevieve, is enrolled at the University of Nevada’s Behavior Analysis graduate program working towards her PhD. She found
**ASDA Gives Back to the Community through Food Donations, Education, and Sponsorship**

By Dr. Lisa McAulsey, PhD, RD

The Appalachian Student Dietetic Association (ASDA) has been actively involved in two community service projects. For the past two years, ASDA has been cultivating a variety of vegetables on a plot of land at the Boone Community Garden in Boone County, North Carolina. The purpose of this project is to provide a local food shelter, Hunger Coalition, with fresh produce for those in need in our community. Subsequently, members learn about gardening basics and gain enhanced appreciation for locally grown produce. One focus of the project is to grow nutrient specific vegetables, such as spinach which is rich in folate, to increase intake of certain nutrients from whole foods which people may not consume as a routine part of their diet.

Many women of child-bearing age are unaware of the importance of folic acid before and during pregnancy...

A second project that ASDA has been involved with for three years is the Western North Carolina Folic Acid Campaign. Folate is a B vitamin critical in brain and spinal cord development of unborn babies. Requirement for this vitamin increases weeks before conception, in preparation for the rapid growth and development of the fetus which follows soon after conception. Given that many pregnancies are unplanned and the fact that many women of child-bearing age are unaware of the importance of folic acid before and during pregnancy, the goal of the campaign is to educate women of child-bearing age in the western part of North Carolina about the importance of folic acid in the prevention of neural tube defects (NTDs) which result in incomplete closure of the spine and/or poor brain development. North Carolina was previously identified as having one of the highest incidence rates of NTDs in the nation, and it has been estimated that nearly 50-70% of NTD cases could be prevented by adequate folic acid intake prior to and during pregnancy. ASDA members have been presenting education sessions to groups at ASU and in the community using materials provided by the NC Folic Acid Council. In return, ASDA receives $30 from the Council for each education session presented. The students dedicate the majority of those funds to programs designed to promote the health and well-being of children living in Boone. ASDA allocated $600 earned from the Folic Acid Council to sponsor two adolescent participants for the AdFit program in Boone this past summer. This program is a multi-disciplinary effort between Appalachian Regional Healthcare System, ASU, and local physicians which encourages total body wellness and fitness for overweight young people 10-14 years of age. Because of their continued involvement in community nutrition education, commitment to the Folic Acid Campaign, and strong desire to promote the health and well-being of our local adolescent population, ASDA has already raised enough money this year to provide tuition for four AdFit participants.

The Folic Acid project serves as a model program which provides students the opportunity to educate members of the community about an important nutrition-related topic, receive money for their hard work, and in turn donate this money to other nutrition-related causes.

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Dr. Lisa McAulsey, PhD, RD is Associate Professor and Director of the Didactic Program in Dietetics at Appalachian State University (ASU) in Boone, North Carolina. She earned her Bachelor of Science degree in Food Science and Human Nutrition from the University of Florida, her Master of Science in Foods and Nutrition at Texas Tech University in Lubbock, Texas and her PhD from Auburn University Auburn, Alabama. Dr. McAulsey teaches Advanced Nutrition I, Diet and Public Health, Nutrition for the Elderly, and Current Issues in Nutrition at ASU. Her research focus is antioxidant supplementation and oxidative damage associated with optimal health, exercise, and diets. Dr. McAulsey can be contacted at lmcaulsey@appstate.edu.
 PubMed, the National Library of Medicine’s portal to its MEDLINE database, is a wonderful resource that is freely available on the Internet at http://pubmed.gov. With its Google-like simplicity, it is easy for anyone to enter keywords in the search box and produce results. However, my experience in working at an academic health sciences library is that many health professionals under-utilize its capabilities.

**Tips and Tricks for Getting the Most Out of PubMed**

By Susan Arnold, MS, NLSP, AHIP, RD

**Refining Search Results**

Many users get discouraged when they perform a keyword search and produce hundreds or thousands of results. There are three key ways to refine a search and make your results more relevant:

- **Use Limits effectively.** The “Limits” tab is located just underneath the search box and to the left. Many options are available, including limiting to certain age groups, gender, publication date, and publication type (such as meta-analyses), but the limit that may be the most helpful is the last one, which is Tag Terms. Here, one can choose “Title” or “Title/Abstract” so that the keyword term(s) for which you are searching must appear in the title and/or the abstract of the article. This alone can pare a large results list down to a manageable number and give you much better citations.

- **Use the Related Articles link,** which can be found to the right of every citation. If the user comes across a particularly good citation, choosing the “Related Articles” link can produce several more articles that were indexed using the same terms. These results will be ranked from most to least relevant. Another way to see Related Articles is to choose a particular citation by clicking on the hyperlink under the authors’ names in the results list, and setting the display to AbstractPlus. The top five related links will display to the right of the original citation/abstract.

Alternatively, the Display can be set to **AbstractPlus** to view Related Articles.
Use MeSH Terms. Articles in PubMed are indexed using Medical Subject Headings (MeSH), which are the National Library of Medicine's controlled vocabulary. Often, a user will uncover different relevant articles by using MeSH terms to search rather than keywords. MeSH terms used to index a particular article can be found by displaying the article in the Citation format and looking below the abstract. Terms with asterisks are considered major indexing terms. Often, locating these terms for a relevant article can help to refine a search by showing the user search terms they might not have thought to use. If one chooses to use the MeSH Database on the PubMed sidebar to locate MeSH terms, it should be remembered that “Diet Therapy” is one of the available subheadings for all appropriate terms. It is also helpful to check the box to “Restrict Search to Major Topic headings only.” Use of MeSH terms with subheadings is an excellent way to focus a search to get exactly what you are seeking.
Automatic Search Updates

A particularly helpful feature of PubMed is My NCBI, which can store searches and provide automatic e-mail updates for specific search topics. It is located in the upper right-hand corner of the main PubMed page. You must first register for My NCBI by creating an account and choosing a username and password. Once you have registered, sign in to My NCBI before performing a search. After you have run the search, click on the “Save Search” link to the right of the search box. To set up an email alert service for the search, check “yes” when asked whether or not you want updates. This will expand the window to allow you to customize the update to arrive daily, weekly, or monthly. You can also specify whether you want the citations with or without abstracts, and whether you would prefer text or HTML formatting. My NCBI will also save the search, which can be retrieved by selecting the My NCBI hyperlink. A chart will display all saved searches and allow the user to see what is new for a selected search since the last time it was either run or produced an email update.

An alternative to setting up an email update is to create an RSS feed. RSS (Really Simple Syndication) is an XML-based format used to send new items or information to recipients who use RSS feed readers such as Bloglines or iGoogle. PubMed RSS feeds include the latest biomedical articles for a specific search with links back to the citations and abstracts in PubMed in the AbstractPlus format. These are easy to set up and are updated daily. You can choose to have 5-100 citations sent at a time. Here are the steps to get started with setting up a feed:
• Once you have run a search, select “RSS feed” in the Send to drop-down menu
• On the next screen, name your search update and click “Create Feed”
Click the orange XML icon that appears on the next screen
In the new window, copy the URL in the browser Address box and paste it into your RSS reader

Clinical Queries
Another often overlooked feature of PubMed is the Clinical Queries link because it is hidden among several other features over on the blue sidebar. However, this section can make it much easier to find articles that report results of applied clinical research. There are three options in this section that the nutrition researcher may find beneficial.
- The first is to choose to Search by Clinical Study Category. Once a search term is entered into the box provided, the search can be filtered to find articles relating to its etiology, diagnosis, therapy, or prognosis. In addition, the user can specify whether the search should be narrow and specific or broad and sensitive.
- The second option is to Find Systematic Reviews. This is most helpful in finding information dealing with evidence-based practice. Searching through this search box will uncover not only systematic reviews, but also meta-analyses, reviews of clinical trials, consensus development conferences, and guidelines.
- The last option is to select Medical Genetics Searches. This search finds citations and abstracts related to various topics in medical genetics. There are several filter categories provided, which can be used either individually or grouped together.

PubMed can be a most helpful tool to the dietetics professional if one is aware of its many useful features. Hopefully, this brief article has provided some new ideas for using PubMed to its full capacity. Further assistance can be found in the sidebar under “Entrez PubMed” with the Overview, FAQ, Help and Tutorials links. This writer would welcome questions and/or comments at susan.arnold@mail.wvu.edu

Susan Arnold, MS, MLIS, AHIP, RD is the Director of the Health Sciences Library at West Virginia University, a position she has held since 2004. Prior to joining the library faculty in 2001, she served as Clinical Nutrition Manager/Dietetic Internship Director at West Virginia University Hospitals for thirteen years. Susan holds Master’s degrees in Human Nutrition & Foods from Virginia Tech and Library & Information Science from the University of South Carolina. She has been active both in the West Virginia Dietetic Association and the Mid-Atlantic Chapter of the Medical Library Association. In 2007, Susan achieved senior membership in the Academy of Health Information Professionals.
Comorbidities

by Ruth Leyse-Wallace PhD, RD

A Review of Selected Literature

Schizophrenia is a disorder whose defining feature is the presence of psychotic symptoms. “Psychotic is narrowly defined as restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature. Some definitions include prominent hallucinations that the individual realizes are hallucinatory experiences.” The term may also include disorganized speech, disorganized catatonic behavior, or being delusional.

Symptoms of schizophrenia may be categorized as positive, negative or cognitive. Positive symptoms can be dramatic and capture the attention of clinicians and laypeople. Positive symptoms include psychosis, hallucinations, delusions, secondary agitation and thought disorders. Command auditory or visual hallucinations may tell the individual to do or not do something. The action may be trivial but also may be harmful to the individual experiencing the hallucination or to others. This was memorably portrayed in the movie “A Beautiful Mind.” Positive symptoms may wax and wane over time and usually become less severe as people age.

Negative symptoms of schizophrenia imply the absence of something. Negative symptoms may include a lack of social contacts (social isolation), lack of initiative, socially awkward behavior, loss of energy or motivation, as well as decreased emotional displays (social withdrawal), social withdrawal, lack of initiative, socially awkward behavior, loss of energy or motivation, as well as decreased emotional displays (emotional withdrawal), emotional withdrawal. Negative symptoms tend to become more prominent over time.

Cognitive symptoms of schizophrenia involve deficits in memory, decision making and problem solving, although these symptoms are not as severe as those seen in persons with Alzheimer’s dementia. Together, negative and cognitive symptoms are associated with the persistent disability commonly seen in individuals with schizophrenia.

Schizophrenia occurs in approximately 1% of the population nationally and around the world. According to the National Institutes of Mental Health, approximately 2.2 million American adults have schizophrenia in a given year. Symptoms commonly begin to appear in men during their late teens and early twenties and appear in women in their twenties or early thirties. Diagnostic criteria for schizophrenia include demonstrating at least two active symptoms for a significant portion of a one-month period.

Comorbidities

Research shows that psychiatric patients are at high risk of developing obesity, hypertension, hyperlipidemia, and diabetes. Recently more attention has been given to screening and treating psychiatric patients for these health factors, as studies have shown that 40-90% of afflicted patients were not being treated for comorbidities.

Studies regarding schizophrenia have investigated whether the risk of comorbidities is related to quality of diet, specific nutrients and their metabolites, weight status, psychotropic medications, or metabolic factors linked to genetic factors. Lifestyle choices such as smoking, exercise, and use of alcohol and drugs have also been investigated due to clinical observations.

C. P. Carney and colleagues conducted a retrospective analysis of inpatient and outpatient insurance claims data in the state of Iowa to determine comorbidities of patients with schizophrenia (n=1074) vs. controls (n=726,262). Subjects with schizophrenia were more likely than controls to have chronic conditions such as hypertension, chronic obstructive pulmonary disease, diabetes with complications, hepatitis C, fluid/electrolyte disorders, and nicotine abuse/dependence.

Quality of Diet

D. C. Henderson et al reported a cross-sectional study in 2006, evaluating the dietary intake of patients with schizophrenia or schizoaffective disorder and who were being treated with atypical antipsychotic agents. Dietary intakes of patients (n=88) from an urban community mental health clinic were measured using a four-day dietary record. Nutritional variables included total intake of energy, fat, protein, carbohydrate, cholesterol, fiber, sucrose, folate, calcium, sodium, zinc, alcohol and caffeine. Data were compared to the general population using data matched for age, gender, and ethnicity from the National Health and Nutrition Examination Survey (NHANES), 1999-2000. The Body Mass Index (BMI) of the schizophrenia group (M=31.3, SD=12.67) was significantly greater than the NHANES group (M=28.3, SD=6.62) (p = 0.001). The schizophrenia group reported consuming significantly fewer calories, carbohydrates, proteins, total fat, saturated fats, monounsaturated fatty acids (MUFA), polyunsaturated fatty acids (PUFA), significantly less fiber, folate, sodium and alcohol and significantly more caffeine than the NHANES group. The authors concluded that findings may suggest that obesity in schizophrenia patients is not solely related to food consumption, but perhaps related to other factors including medication side effects and reduced physical activity.

Authors recommended that education and interventions for the schizophrenia population focus on overall lifestyle factors such as physical activity and healthy food choices.

Resting Energy Expenditure

Jenny-Kay Sharpe and colleagues measured the Resting Energy Expenditure (REE) and compared data to calorie needs predicted by five energy-prediction equations. Subjects included eight males diagnosed with chronic paranoid schizophrenia that had been treated with Clozapine for at least six months. Exclusion criteria includ-
ed any medical condition known to affect REE. BMI for the group averaged 29.8 ± 6.8; percentage of body fat was 30.0 ± 9.5. The authors concluded that professionals using the Harris-Benedict and Schofield equations to determine energy needs in persons being treated with Clozapine should reduce the resulting estimated REE by 280 kcal/day. Systematic bias and greater variability when using other formulas for predicting energy needs led the authors to comment that these factors "make the equations unsuitable for this population."

**Essential Fatty Acids and Antioxidants**

R. F. Kemperman et al assessed essential fatty acids (EFA), B-vitamin status (folate, B-6, B-12), homocysteine status and the response to planned supplementation in a group of patients with schizophrenia (n=61). Patients who reported not taking vitamins were found to have low serum B-12 and high homocysteine levels. Alcohol consumption predicted low PUFAs. Absence of fish consumption and being male predicted hyperhomocysteinemia. Two patients exhibited EFA deficiency, seven patients had marginal docosahexaenoic acid (DHA) levels, and four patients exhibited moderate hyperhomocysteinaemia. Although no patients were predicted by clinicians to have poor diets, the authors concluded that patient response to supplementation with B-vitamins, soybean and fish oils confirmed that a dietary lack was causative.

Brain phospholipids are rich in polyunsaturated fatty acids (PUFA). Essential PUFA include alpha-linolenic acid 18:3 (Omega-3) (ALA), eicosapentaenoic acid 20:5 (Omega-3) (EPA), docosa- hexaenoic acid 22:6 (Omega-3) (DHA) and arachidonic acid 20:4 (Omega-6) (AA). PUFA are very sensitive to oxidative stress. Decreased EFA content has been observed in cell membranes of various types of tissue of patients with schizophrenia, including neural cell membranes.

To investigate the assumption that patients with schizophrenia make poor dietary choices, Martin Strassnig and colleagues utilized a 24-hour diet recall to elicit nutritional information in 146 outpatients with schizophrenia. Intake of fatty acids and antioxidants including vitamins A, C, and E was compared to U.S. population standards according to the National Health and Nutrition Examination Survey Cycle III (NHANES III) results. Investigators found that saturated and PUFAs intake was significantly higher in patients with schizophrenia than in controls (p≤0.05; p≤0.005, respectively).

No differences were found with regard to dietary intake of gamma-linolenic acid 18:3 (Omega-3), EPA or DHA. Antioxidant intake was not different between schizophrenia patients and controls. Investigators concluded that the observed cell membrane deficits in PUFA and EFA content do not appear to derive from decreased dietary supply and that intrinsic membrane phospholipid metabolism abnormalities may be causative.

A study by M. Arvindakshan and colleagues investigated the effects of four months of oral supplementation with EPA and DHA (180:120 mg) and antioxidants (400 IU vitamin E, 500 mg vitamin C) morning and evening. Thirty-three patients with schizophrenia were tested pre-treatment and post-treatment for 1) red cell membrane fatty acid level, 2) plasma lipid peroxides, and 3) clinical measures. Fatty acid and lipid peroxide levels were also compared with 45 control subjects without schizophrenia.

After four months of treatment, red cell membranes of subjects with schizophrenia were significantly higher than pre-treatment levels in essential PUFA without increase in plasma peroxides. After supplementation essential PUFA levels were higher than levels of normal control subjects as well. Subjects with schizophrenia had reduced symptomology based on the brief psychiatric rating scale (BPRS) and positive and negative syndrome scales (PANSS), general psychopathology-PANSS and an increase in Henrich’s Qualify of Life (QOL) scale. After a four month washout, the essential PUFA levels returned to pre-treatment levels, but the clinical improvement was retained.

A 2001 study by Wayne S. Fenton and colleagues looked at treating residual symptoms remaining after beginning treatment with neuroleptic drugs. Residual symptoms were treated with a trial of Omega-3 fatty acids. A 16-week, double-blind study was conducted in which 3 gm EPA/day or a placebo was provided to 87 patients with schizophrenia or schizoaffective disorder. Investigators found no difference between subjects receiving Omega-3 fatty acids and controls receiving a placebo in terms of negative or positive symptoms, mood, cognition or global impressions.

**Medications**

Jonathan M. Meyers MD reported on a consensus paper from the American Diabetes Association and American Psychiatric Association discussing the weight gain response to certain antipsychotics. Prospective data shows that during the first year of therapy patients taking Clozapine gained 11.7 to 13.9 pounds. Olanzapine was associated with a gain of 15.0 to 26.0 pounds. Patients taking Risperidone and Quetiapine showed an average gain of 4.4 to 5.1 pounds and 6.1 to 12.3 pounds, respectively. Ziprasidone and Aripiprazole showed gains of less than 2 pounds. However, it is noted that the correlation between obesity and schizophrenia antedates the availability of atypical antipsychotics. In a report on the Clinical Antipsychotic Trials for Interventions Effectiveness (CATIE) it was stated that Clozapine was found to be the most effective treatment for patients chronically ill with schizophrenia. John M. Kane MD discussed many findings and questions associated with the complexity of treating schizophrenia. It was noted that Olanzapine and Clozapine have similar molecular structures, that both are effective and that both may alter lipid and carbohydrate metabolism.

**Weight Management**

Weight management programs for people newly diagnosed with schizophrenia, as well as for those who have been on medication over longer periods of time have proven effective. Reported programs include combinations of behavioral therapy, cognitive therapy, nutrition counseling, and exercise.
Interventions such as stepped interventions, self-monitoring of body weight, short terms of 8 weeks and long term group meetings over a year have been effective. Weight gain can be prevented or reversed with weight management programs. A weight gain of 7% of baseline weight is considered a clinically meaningful weight gain. Screening programs recommend referral for weight management if a weight gain of 5% above baseline weight is observed.

Genetic Mechanisms

It is recognized that schizophrenia is familial, suggesting a genetic etiology. A number of genes have been identified that are likely to predispose to schizophrenia. A. Sharma and colleagues reported work in the area of phospholipid methylation and the implications for schizophrenia. A comparison of phospholipid methylation in lymphocytes showed a four-fold lower activity level in subjects with schizophrenia when compared to controls. Authors commented that this reveals a novel mechanism by which dopamine 4 receptors (D4R) can regulate membrane composition. Methylation (addition of a -CH3 radical) often involves folic acid as the donor.

It was noted by B. Regland that subjects who have schizophrenia seems to have disturbed single-carbon metabolism. A case-controlled study indicated elevated methionine and homocysteine (Hcy) in cerebrospinal fluid. Regland notes that this is encouraging due to the fact it can potentially be modified by natural means: vitamins and antioxidants.

A 2003 investigation by J.W. Muntjewerff compared the prevalence of the 677C > T mutation in the methylene-tetrahydrofolate reductase (MTHFR) gene in 35 subjects who had schizophrenia with 104 unrelated controls. Muntjewerff also compared plasma and red blood cell levels of folate, vitamin B-6, vitamin B-12 and homocysteine. Plasma folate levels below the 10th percentile of control subjects were associated with a 4-7-fold risk of having schizophrenia, a significant relationship between plasma folate concentrations and risk for schizophrenia. Elevated levels of Hcy were not associated with increased risk for schizophrenia, leading to the suggestion by the authors that folate metabolism is disturbed in persons with schizophrenia independently of Hcy.

Vitamins and Minerals

In one report of 20 individuals institutionalized with schizophrenia, 5 were found to be deficient in magnesium (Mg). Reduced magnesium levels were found to coincide with extrapyramidal symptoms. Long term neuroleptic use may be a factor contributing to the development of extrapyramidal symptoms. Supplementation with 600 mg MgCl did not appear to normalize plasma Mg levels. J. Daniel Kanofsky, MD suggested possible abnormal absorption as the mechanism. He discussed the functions of Mg and how hypomagnesemia possibly affects metabolism related to mental function. Mg is essential for enzymes systems using Vitamin B-1 (a cofactor in serotonin synthesis) and B-6 (a cofactor in serotonin and gamma aminobutyric acid (GABA) synthesis): a lack of Mg may result in impaired neurotransmitter function. Dr. Kanofsky commented that Mg inhibits the release of acetylcholine and that decreased 5-hydroxy tryptamine (5HT) function is a biochemical marker for negative symptoms of schizophrenia. Magnesium-deficient patients may display depression, agitation, confusion and disorientation. Psychiatric behavior including auditory and visual hallucinations has been reported in 50% of subjects with hypomagnesemia.

M. Nechifor et al investigated the influence of treatment with Haloperidol and Risperidone on plasma and erythrocyte Mg and on plasma levels of zinc, calcium and copper in 56 hospitalized patients diagnosed with paranoid schizophrenia. They found a decrease of erythrocyte magnesium levels in these patients when compared to subjects in a control group (4.82 +/- 3.1 mg/L vs. 59.2 +/- 1.1 mg/L in control group, p < 0.01). The plasma level of magnesium was unchanged (18.9 +/- 2.17 mg/L in schizophrenic patients vs. 18.26 +/- 1.9 mg/L in control group). They concluded plasma Cu(2+)/Zn(2+) ratios are two important biological markers of acute paranoid schizophrenia.

A case study of a patient with schizophrenia and Wernicke's encephalopathy (WE) was reported by R.A. Harrison, T. Vu and A.J. Hunter. The 51-year old male did not have a history of alcohol use, but presented with delirium, ophthalmoplegia and seizures. He had a rapid response to administration of magnesium.

Executive Committee Announces Election Results

It gives me great pleasure to announce Behavioral Health Nutrition 2008-2009 election results for the year beginning June 1, 2008. BHN Chair-Elect will be Andrea Shorron, MS, RD, LDN of Magnolia, Texas; Secretary will be Karen Jircitano, RD, LDN of Jamestown, New York; Nominating Committee Chair will be Mary Tholking, MEd, RD, ID of Loveland, Ohio; Nominating Committee Members will be Janice Scott, MS, RD, CSP, LD, of Irving, Texas, and Carin B. Kreutzer, RD, MPH, of Los Angeles, California.

Welcome new officers, and “Thank you” to all who participated in the election process!
Population Study of Dietary Patterns

Projects showed a positive response.

Skin flush test, while 15 of 20 control subjects showed a positive response to the niacin skin flush test that demonstrates impaired arachidonic acid-related signal transduction in schizophrenia. Response to a topical application of niacin is recognized as a niacin skin flush test.

Researchers have discussed a niacin skin flush test that demonstrates impaired arachidonic acid-related signal transduction in schizophrenia. Response to a topical application of niacin is recognized as a niacin skin flush test.

The dietary predictors of outcomes of schizophrenia were similar to those that predict illness as coronary heart disease and diabetes. Level of alcohol consumption was a weak but significant positive predictor of overall best outcome. The best dietary predictor of depression was consumption of sugar (high sugar: higher prevalence of depression). The author noted that association does not equal causation and that diet could be a proxy for other variables. He also noted that national apparent food consumption is based on inexact data sets and does not necessarily reflect the food intake patterns of individuals. It is interesting that such a report mirrors to some degree conclusions based on less global data. It is interesting that such a report mirrors to some degree conclusions based on less global data.

Individuals with schizophrenia often develop obesity, hyperlipidemia, and hyperglycemia. Individuals with schizophrenia have been found to have decrease in REE, along with altered biochemistries related to essential fatty acids, antioxidants, and some vitamins/minerals, which may respond to nutritional supplementation. Responses to nutritional interventions have included improved physical measures and lessening of psychiatric symptoms. Hypotheses on the relationship between nutrition and schizophrenia now include genetic alterations that impact nutrient metabolism, effects of nutrients on neurotransmitters, changes in metabolism secondary to psychotropic medications, and nutritional deficiencies related to poor dietary intake and other lifestyle choices.

Recommendations

Nutritional assessment of individuals with schizophrenia should include assessment of diet as well as supplemental intake of essential fatty acids, vitamins (especially folic acid and vitamins B1, C and D), minerals, adjusted energy needs, and weight history. Nutrition assessments should note which antipsychotic medications are used in treatment so that patients can be counseled on reduced energy needs for the prevention or delayed onset of obesity, hypertension, cardiovascular disease, and diabetes.

Biochemical assessment of serum lipids and glucose should be monitored over time. Lipid levels of membrane EPUFA might also be useful.

People being treated with first and second generation antipsychotics should be referred to a weight management program if weight gains of 5-7% of baseline weight occur.

Weight management programs that have included nutrition counseling, behavioral change counseling, cognitive behavioral therapy, exercise, and that include follow-up contacts have been shown to be effective in preventing weight gain and decreasing previously gained weight.
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Steiming M, Bear JS, Ganzetti B. Dietary fatty acid and arachidonic intake in community dwelling patients suffering from schizophrenia. Schizophr Res. 2005:76:345-351.

Arvindakshan M, Ghazi M, Ranjekar PK, Evatt DR, Makalip S. Supplementation with a combination of omega-3 fatty acids and antioxidants (vitamin E and C) improves the outcome of schizophrenia. Schizophr Res. 2006;1251-204.


Girls with ADHD more likely to develop eating disorders: study

Researchers at the University of Virginia found that girls with attention deficit hyperactive disorder (ADHD) were more likely to develop eating disorders such as bulimia nervosa. Amori Yee Milami, the lead author, said in a CBC News press release on March 13, 2008, that “Girls with ADHD may be more at risk of developing eating problems as adolescents because they already have impulse behaviors that can set them apart from their peers.” The study involved 228 girls, 140 who had been diagnosed with ADHD. Milami also indicated that girls with ADHD may be more likely to use their medications to achieve weight loss. Stimulant medications used to treat ADHD have a side-effect of appetite suppression. The study is published in the February issue of the Journal of Abnormal Psychology.
The Role and Impact of Accurate Diagnosis: Seizure Disorders

By Dr. Adadot Hayes, M.D.,

Medical treatment is based on diagnoses. The more accurate a diagnosis is, the more likely it is that treatment will be successful. Successful treatment leads to improved health and better quality of life for the patient and to responsible utilization of available resources.

Accurate diagnosis is essential to proper treatment. A prime example from my practice with persons with Intellectual and Developmental Disorders (IDD) is the diagnosis of seizure disorders. Many of my patients have the diagnosis “seizures.” In the neurological arena, this non-specific diagnosis is not helpful because there are different types of seizure disorders and each type is responsive to different types of treatment. Generalized epilepsy usually involves a loss of consciousness with what is referred to as tonic clonic movements (which are usually observed by the lay person as shaking of the limbs) and is generally followed by a period of apparent sleepiness. Someone with a diagnosis of generalized epilepsy requires different treatment than someone diagnosed with absence seizures. Absence seizures may appear as chewing motions, staring, or in some cases, only forgetfulness. The most common type of seizure found in the IDD population is partial seizures with generalizations. This type of seizure disorder may look like both absence seizures and generalized seizures but medication treatment for partial seizures with generalizations may be different than treatments for either generalized epilepsy or partial seizures as a stand-alone diagnosis.

Neurologists base their treatment of seizures on the diagnosis which in turn is based on the presentation of the seizures, or how they look. A patient’s actual seizures are rarely observed by the doctor in the office. The doctor instead relies on those who have observed the patient’s seizures. It is important that persons witnessing the patient’s seizures understand that their detailed observations of the patient’s actual seizures can contribute to accurate diagnosis and optimal treatment of the patient’s seizure disorder. Understanding seizure disorder diagnosis and learning to accurately report characteristics of the patient’s seizure pattern is critical to optimal treatment selection and responsible utilization of available resources.

Dr. Adadot Hayes, M.D. is Medical Director and Director of Clinical Unit for the Department of Mental Retardation Services, Nashville, Tennessee.

DCE and the Journal Join Forces for a Successful Collaboration

By Carl Scott, ADA Practice Coordinator

The publication of the April 2008 Journal of the American Dietetic Association will mark the release of “Emerging Trends in Diabetes Prevention & Control: Applications to Practice,” a 72-page supplement to the Journal co-developed by the Diabetes Care and Education Dietetic Practice Group (DCE DPG). The supplement, funded by Takeda Pharmaceuticals and compiled by guest editor Judith Wylie-Rosett, EdD, RD, features a dozen original articles written by leading dietetics experts on a wide range of issues within diabetes care, including cost effectiveness, genetic and environmental interaction, weight-loss surgery, dietary supplements, and much more. In addition, the funding from Takeda provides for a mailing to the membership of the American Association of Diabetes Educators. A special thanks to DCE’s leaders and members for their efforts in securing funding and soliciting manuscripts for the supplement, becoming the first DPG to collaborate with the Journal to develop and publish a supplemental issue on their area of interest. Supplements like this one highlight the specialized expertise of ADA’s DPGs and emphasize the depth of knowledge food and nutrition professionals possess.

It is BHN Awards Time!

Time to spotlight those among us who have shown “Excellence in Practice” and to celebrate one BHN member as recipient of our “Distinguished Member Award.” Please use the forms posted on BHN Web site Home Page to nominate members you know to be deserving of these awards. www.bnhdp.org

Application deadline is June 1, 2008.
Practice Tips from the Behavioral Health Nutrition (BHN) Listserv

Q: Does anyone deal with phenylketonuria (PKU)? An adult moving to one of our homes requires a "strict PKU diet, no protein, and receives Phenylaid."

A1: Adults with PKU and caregivers require on-going training, regular follow-up and monitoring as well as close and regular monitoring of diet and urine and tyrosine levels with the physician and RD in the genetics clinic. The RD in the clinic is an excellent resource in providing updated information on dietary guidelines and product information. Other good resources are the Ross publication “Nutrition support protocol for previously untreated adults with PKU” and www.pku.com.

A2: Visit the website for the California PKU Late Treatment Project at http://www.pkulatex.com and http://www.lanterman.org/news/HealthViews/WhatPKU.asp to learn more about PKU. The California Department of Developmental Services program advisory “Improving Care for Adults with Untreated PKU” is very helpful. The new tablets available help liberalize the diet.

Q: Do you find that food preferences of group home residents change as a normal part of growing up, as a challenge to parental preferences, or as adapting to the preferences of new peers?

A1: All three and more. Parents will have found what works, and what their child will eat for them. That’s where you start. Almost all children typically have changes in food preferences as they grow up. Certainly seeing peers eat something can broaden an eating experience. Sometimes it is just expectations. Parents often have more emotion invested in providing food, mealtimes and eating. Cooking styles or skills vary and the way food is prepared changes or defines a person’s food preference.

A2: Think of it as motivational interviewing or person-centered thinking. We’re all affected by our environment — by the people around us, the way things are done, etc. Everything about the new environment will affect food preferences all the way down to who is sitting at the table. It’s impossible to rule out sensory issues (noise, lighting, busy-ness, temperature) when considering successful eating and development of food preferences. When at home, the person with Intellectual and Developmental Disabilities models the expectations and preferences of the family’s culture. When they move to a different living environment — whether their own apartment in supported living arrangement or a group home — they will be influenced by the people in that environment. It’s a way of fitting in — of making friends — of being a part of that micro-community. Consider working with the communication specialist to learn about the person’s preferences first-hand. Work through what they like and don’t like using all sorts of tools including photos, objects, and even just the moment itself.

Q: I am looking for any information regarding use of peanut butter in residential facilities/group homes that addresses the issue of peanut butter in relation to choking. Some individuals would like to see peanut butter removed from the facility all together because they feel it is a choking risk. I am in need of some information to bring to the table to address this.

A1: I encountered this problem a number of years ago and was asked to remove peanut butter from the menu but had numerous individuals who looked forward to receiving it. The request was in response to an incident that happened at another facility in the state. Peanut butter is identified as one of those high risk foods for choking. I established a policy that the only way that peanut butter can be served in my homes in the traditional sense i.e. sandwiches or on crackers is if it is blended (in a food processor) with equal amounts of peanut butter and equal amounts of jelly. We have a recipe. It cannot be mixed with a spoon. It turns out very good, especially with black raspberry jelly! Delicious!! The color is a problem for some consumers so therefore use of apple jelly maintains the color and then more grape jelly can be used to make the “traditional” sandwich if desired. Sugar free jelly can be used. We actually use this on our pureed diets with no problem. If you prepare this and show the item to those concerned I think all will agree it is very easy to eat and no longer a problem.

A2: I have mixed it with silken tofu, which improves the texture for some individuals for whom the texture is too thick and sticky.

Q: I have mixed it with silken tofu, which improves the texture for some individuals for whom the texture is too thick and sticky.

A1: Here is a recipe we worked on at our facility: Peanut Butter Applesauce Dip
1 Tablespoon peanut butter (smooth)
2 Tablespoons applesauce
Mix thoroughly until smooth. Serve as a dip for fresh veggies on cracker or bread.

A2: We mix PB with applesauce or extra jelly (no sugar added or regular). There are a few people in our population of 120 that we don’t serve it to.

To join in or read the conversations, sign up for BHN listserv: log on to our Website at www.bhndpg.org and click “FORUMS”

Peanut Butter Applesauce Dip
2 Tablespoons applesauce
1 Tablespoon peanut butter (smooth)
Mix thoroughly until smooth. Serve as a dip for fresh veggies on cracker or bread.

Mix thoroughly until smooth. Serve as a dip for fresh veggies on cracker or bread.
Eating Disorders were front and center in the debate leading to yesterday’s passage of mental health parity in the U.S. House of Representatives. The House passed the parity bill by a vote of 268 to 148.

The House version of a national mental health parity bill includes broad definitions of mental illness that would include eating disorders. A Senate bill passed last year offers fewer protections but is likely to become the final version that Congress will send for the president’s signature. The Eating Disorders Coalition has supported both House and Senate versions, but prefers the House bill.

Yesterday’s action in the House marks the first time in 12 years that mental health parity has been brought to a vote. House Speaker Nancy Pelosi agreed to schedule a vote, reversing the long-held opposition of former House Speaker Dennis Hastert. The EDC was in the front row during yesterday’s rally at the Capitol. Speakers included House Speaker Nancy Pelosi, House Majority Leader Steny Hoyer, Rep. Jim Ramstad, Rep. Patrick Kennedy, former first lady Rosalynn Carter, and David Wellstone. The audience included singer-songwriter Carole King and U.S. Senate candidate Al Franken.

Since the beginning of the 110th Congress, the Eating Disorders Coalition and other mental health advocates have had numerous opportunities to bring the issue to the attention of congressional committees. EDC President Kitty Westin testified in Congress and spoke at a parity rally with Speaker Pelosi in 2007, recalling the loss of her daughter after the family’s insurance company denied treatment for Anna Westin’s eating disorder.

EDC Executive Director Marc Lerro says, “We made our points so often that members of Congress started making our points for us. In committee meetings, Republicans and Democrats alike described how parity could affect people with eating disorders.”

David Wellstone, founder of Wellstone Action, campaigned aggressively for the passage of the House bill. He often cited eating disorders as an example of mental health conditions that may not be fully covered under the weaker Senate bill. Wellstone was critical of the Senate bill and refused to allow the bill to be named in memory of his father, the late Senator Paul Wellstone.

Wellstone told National Public Radio’s Julie Rovner, “My dad always believed that you can’t leave people out. You can’t have people like Kitty Westin, who was his friend and my friend, whose daughter had an eating disorder and went in and was told ‘we have to figure out if this is a medical necessity.’”

During a national speaking tour in support of parity, members of Congress in several major cities appeared with speakers who had first-hand experience with eating disorders. In Washington, D.C., the EDC hosted educational briefings and sent mailings that also kept the issue before policymakers at the Capitol. Last week, the Coalition hosted a briefing in the House of Representatives titled “Eating Disorders: From Stigma to Science,” which drew a capacity bipartisan audience.

Next, negotiations between the House and Senate must close the gap between the two bills before a final piece of legislation can be sent to the president. Rep. Kennedy is willing to compromise. He told NPR, “I’m not an all-or-nothing person. I want something, and then I can add to it next year, and the year after, and the year after that. That’s the way Congress works. I’ve watched my father over the years. I’ve taken lessons.”

The Eating Disorders Coalition for Research, Policy & Action is working in Washington, D.C., to increase awareness, educate policymakers, and promote understanding about the disabling and life-threatening effects of eating disorders. Our mission is to advance the federal recognition of eating disorders as a public health priority.


Contact:
Eating Disorders Coalition
611 Pennsylvania Ave SE #423
Washington, District of Columbia 20003-4303
BHN in Washington D.C.
By Andrea Shotten, MS, RD
BHN Public Policy Chair

This February I joined several hundred of our American Dietetic Association (ADA) colleagues from around the United States in Washington, D.C. at ADA’s Public Policy Workshop (PPW). Held annually, the PPW provides participants with an understanding of the legislative and regulatory processes that are key to influencing ADA’s food, nutrition and health initiative priorities. One priority issue identified for the congressional session is the Farm Bill.

The Farm Bill hits on main food and nutrition issues and should be every ADA member’s opportunity to encourage healthy diets and promote health by reminding their respective congressman to support ADA’s endeavors. Both the House and the Senate passed the Farm Bill in 2007. In 2008 a conference committee between the two will attempt to draft a version to send to the President for approval. The negotiations between the House and the Senate provide an opportunity to make improvements in several areas that ADA supports such as investments in food and agriculture research, conservation, environment, food safety, and reforms in the commodity programs. The Senators’ version did include these ADA recommendations:

• New pilot program to help food stamp recipients choose foods consistent with the 2005 Dietary Guidelines for Americans. (Note: Eighty-nine percent of food stamp households contained an elderly person, a person with a disability, or a child, according to a statement of Senator Tom Harkin (D-IA) at the senate agriculture, nutrition and forestry committee hearing on “the role of federal food assistance programs in family economic security and nutrition”). This program includes a feature that promotes food banks and community kitchens to promote eating fresh fruits and vegetables.
• Reauthorization for the nation’s long-running nutrition monitoring system, which tracks Americans’ eating habits and health status, otherwise known as NHANES. (Also included in the House version)
• Improvements in school fresh fruit and vegetable programs (FFVP). The FFVP began as an immensely successful pilot program 5 years ago to encourage fresh fruit and vegetable consumption in elementary school children, particularly those in disadvantaged communities.
• Greater opportunities for farmers to sell directly to consumers.

The House version was closer to meeting ADA’s recommendations for research and included $600 million for food and agriculture research.

The farm bill is a big budget item and money concerns are a key factor in the conference negotiations. It is vital that ADA members contact their U.S. Senators and Representatives and ask them to support strong nutrition provisions in the farm bill.

While understanding the legislative priorities for ADA is critical, so is the implementation of the grassroots skills to deliver these important messages to Senators and Representatives. By going to ADA’s website, http://www.eatright.org and following the Advocacy and Professions tab to the Grassroots Manager link (make sure you are logged in as a member prior to pressing on the link), each ADA member can choose the “Take Action” tab and find the link marked “Farm Bill Conference Letter for House and Senate” that will allow quick and simple letters to be sent to perspective senators and representatives.

It is each member’s duty to contact your state’s local officials and congressmen to speak about ADA’s priority issues. For more information on ADA’s stance on the Farm Bill, please contact Jennifer Weber, Manager of National Nutrition Policy, at jweber@eatright.org.

Behavioral Health Nutrition (BHN) SUPPORTS RESEARCH TOOLKIT

The BHN Executive Committee has voted to support the development of an online Research Toolkit by the ADA Research Committee in collaboration with the Research Dietetic Practice Group (DPG). The Toolkit will be a resource for BHN members to practical, user-friendly, on-demand training that will help you to:
• read and interpret research articles more effectively,
• select the most appropriate research designs and analyses for research projects in practice areas, and
• identify related topics and resources.

Development of the toolkit will occur in stages, with the introduction of a major new topic area each year for several years. The focus of the first year will be how to use and interpret statistics in practice. ADA members will have an opportunity to earn free CPEU credits following successful completion of the online tutorials comprising the toolkit.

Empower members to research in practice

BHN incoming 2008-2009 Chair, Jessica Serruck, MS, RD, CSSD states, “We all know that research on outcomes in our four practice areas is essential to receiving reimbursement and respect for our work, in addition to research that will help us determine best practice. This research tool will help us (BHN members) implement research that can only be done by those of us who work in the field.”

The Executive Committee of BHN agrees that it is ideal to support a project that will empower members to research in practice and ultimately benefit all DPG members. Watch for additional information as this practice resource comes available.
Behavioral Health Nutrition (BHN)
(Formerly Dietetics in Developmental and Psychiatric Practice DDPD)
A Dietetics Practice Group of the American Dietetics Association (ADA)

Psychiatric Nutrition Therapy
A resource guide for dietetics professionals
Practicing in Behavioral Health Care.
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This resource guide is intended for anyone working in the 4 practice areas within Behavioral Health Nutrition: mental illness, eating disorders, addictions, and those with intellectual and developmental disabilities who also require psychiatric care. It contains formats for nutrition assessment, descriptions of neurochemistry driving brain processes and behavior, reproducible handouts and other tools for leading nutrition education groups, helps for training employees, and more. Content was created, compiled and donated by BHN Nutrition Professionals.

The resource guide is contained on one CD-ROM as a 170-page PDF file. You will be able to scan, search, view and print selected sections of the resource guide using your Adobe Acrobat. The CD also contains 5 power point presentations, plus a copy of the ADA Standards of Practice and Standards of Professional Performance for Dietitians in Behavioral Health Care.

Prices:  BHN members: $25.00 plus $3.00 shipping = $28.00
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Learn more about these and over 140 educational events that will be offered by visiting www.eatright.org/fnce2008.
Behavioral Health Nutrition (BHN) DPG
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