How could a scheduled 30-minute interview turn into a 90-minute chat? Easily, when you are hearing that Shirley Ekvall, PhD, FAAMD, FACN, RD accepted a recent invitation to conduct an international workshop in Rei, Saudi Arabia for 600 hundred Registered Dietitians (RDs), nurses and physicians, and how and why she became involved with childhood obesity in Spain, and with Pediatric Nutrition in India, and with Autism Spectrum Disorder in Cincinnati.

Shirley Ekvall’s initial interest in dietetics began in high school when a dietitian in her hometown talked with Shirley about the profession - not just mentioning the profession, “but really talking up the opportunities” which eventually led her to research, pediatrics, and authorship. Shirley has been an everyday example of caring and sharing about the dietetics field for many including her daughter, who is also an RD.

Shirley is a Charter Member of BHN - thirty-three years, and a fifty-year member of ADA. Here is part of our conversation:

“Get involved on teams and committees. Sometimes you have to maneuver and position yourself, even without being asked.” This brought to mind the time Shirley started attending rounds on the Cerebral Palsy unit and was told kindly there was no need for her services, and that she didn’t need to be there. No matter – Shirley continued to attend and offered relevant input as often as she could. Soon she was a valued part of the team.

“Interdisciplinary networking develops a greater depth of understanding.” The exchange of ideas and findings leads to greater understanding of problems and their solutions.” Perhaps you could join the Disability Committee to share perspectives.”

“Write and publish your knowledge and findings. Start early in your career and continue.” If you wait until you are retired it takes longer since you are then involved in many more projects that need your time and energy.


Shirley’s current interest in disease prevention has led her to membership in The National Environmental Task Force, and Content Advisor for ADA position paper “Dietary Guidance for Healthy Children Ages 2–11 Years.” Both projects are examples of opportunities available to other dietitians too. “Pediatrics is a long-term investment and a focus on disabilities compounds health issues. Children need our help...prevention is health and it is cost effective for everyone.”
FROM THE CHAIR

I am thrilled with all the work that BHN has accomplished this summer. Until now it has been behind the scenes, but at FNCE we will be showing off the fruits of our work . . . the pre-FNCE workshop, the Nutrition and Addictions session, the Nutrition and Addictions book, the Intellectual & Developmental Disabilities CD, our first-ever BHN excellence in practice awards, our Eating Disorders Standards of Practice workgroup . . . the list goes on and on. I hope you will get your BHN membership ribbon to place on your badge so that we can meet and greet each other as we participate in all the events. I hope to see you there! And as always, I am happy to hear from you by phone or email.

Jessica Setnick, MS, RD, CSSD
BHN Chair
BHN 2008 EXCELLENCE IN PRACTICE AWARDS
The Behavioral Health Nutrition Excellence in Practice Awards recognize members who have been nominated by peers and colleagues for their achievements and contributions to clinical practice in behavioral health nutrition. Recognized members have also demonstrated leadership related to the promotion of nutrition and health in populations served within the four BHN practice areas. Their award-winning leadership is demonstrated through involvement in legislation, research, management, education, publication and/or professional activities at the district, state or national level.

The awards will be presented at the BHN member meeting and awards presentation held in conjunction with FNCE 2008 in Chicago. Don’t miss the opportunity to meet and congratulate these acclaimed dietitians!

Excellence in Practice - Intellectual and Developmental Disabilities:
Betty L. Lucas, MPH, RD, CD
By Julie Griffith, RD

Betty Lucas was selected for the IDD Excellence in Practice Award for her leadership and commitment to teaching students, professionals and parents about the unique nutritional needs of individuals with intellectual and developmental disabilities. Betty is a true role model and a wealth of information for dietitians and students pursuing a career in this field.

Betty currently holds three positions. First, as Nutritionist for the Center on Human Development and at the University of Washington in Seattle, Washington. Second, as lecturer on Family and Child Nursing at the University of Washington School of Nursing. Third, as Project Director of the Nutrition Training Contract for Children with Special Health Care Needs Program at the Washington State Department of Health. Betty has held these positions since 1970.

In her work Betty combines her love for pediatrics with her expertise in understanding of the unique nutritional needs of persons with intellectual and developmental disabilities. She has assisted in the creation of 54 publications and volunteered her time for numerous talks to community and parent groups. Two of her most notable accomplishments were as editor of Children with Special Health Care Needs: Nutrition Care Handbook and as co-author for ADA Position Paper: Nutrition in Comprehensive Program Planning for Persons with Developmental Disabilities.

Most recently, BHN was honored to co-sponsor Betty’s April 18, 2008 presentation “Alternative Therapies and Feeding in Autism Spectrum Disorders” at the Annual Conference of the Kansas Dietetic Association.

Betty has been a member of the American Dietetic Association for 40 years and a member of this practice group since its inception (serving as chair in 1982-1983.) Betty believes that “this field will only continue to grow . . . It needs qualified dietitians to work at the local, state and national levels to ensure that nutrition education and training are being done for the health and nutritional wellbeing of individuals with disabilities, Early Intervention Programs, state and federal public health departments and tertiary and community facilities all need dietitians to play a role in the care of people with special needs” This is sound advice from one RD who is “Excellent” in her practice.

Congratulations Betty and thank you for all that you have accomplished and continue to accomplish for our profession!

Excellence in Practice - Mental Illness:
Zaneta M. Pronsky, MS, RD, LDN, FADA

BHN is pleased to name Zaneta Pronsky as the recipient of its 2008 Excellence in Practice-Mental Health Award. Zaneta exhibits excellence for her ongoing commitment to teaching dietitians to recognize and plan for the unique nutritional needs of persons with mental illness.

Zaneta is best known to BHN members as author of the text Food Medication Interactions, now in its 15th edition of publication. She is co-author of the HIV Medications - Food Interactions and the Food-Drug Interactions chapter of Mahan K and Escott-Stump S. Food, Nutrition and Diet Therapy, 11th edition, 2004 and 12th edition, 2007. Many of us know Zaneta as co-author, along with Sr. Jeanne Crowe, PharmD, RPh, of our often-requested newsletter article “Psychotropic Drugs, Nutritional and Weight Management Considerations” (Summer 2005.)

Zaneta’s professional portfolio reveals her roots in nutrition research, renal nutrition, and long term care for persons with intellectual and developmental disabilities. While she continues in her work as consultant dietitian, Zaneta’s career has grown into writing, publishing, speaking, and leadership roles in the Pennsylvania Dietetic Association, American Dietetic Association, the Philadelphia Dietetic Association, and Pennsylvania Consultant Dietitians in Health Care Facilities (PA CDHCF.)

Zaneta chose to share the following messages with our readers. “When assessing and planning nutrition care for someone with a mental illness: always include interview with the mentally ill patient as part of the assessment process; involve that person in the plan as much as possible; be willing to look up medication/food interactions for psychotropic and other drugs; get to know the field and to understand the diagnoses; honor the dignity and privacy due all patients; while employers may want to rush you, insist on having enough time to complete a thoughtful assessment.”

Thank you, Zaneta for your commitment to the thoughtful nutrition assessment and care of persons with mental illness. Congratulations on your BHN Excellence in Practice Award!

continued on page 4
Excellence in Practice - 
Eating Disorders:
Molly Kellogg, MS, RD, LCSW
By Ruth Leyse-Wallace PhD, RD

Molly Kellogg is one of the few RDs who is credentialed as a Licensed Clinical Social Worker as well as a Registered Dietitian. In addition to providing brief and long-term therapy for a full range of diagnoses to individuals and couples, she also offers nutrition counseling for women with eating disorders, leads a psychoeducational group for overeaters, serves as administrator for a three-state weight management program, and provides clinical supervision for dietitians. She has served as an adjunct faculty member of Drexel University and is certified in Adult Weight Management and as a Gestalt Therapist.

Molly’s professional activities, in addition to clinical practice, include serving as President of the Philadelphia Dietetic Association, as accredited provider of professional education with the CDR and as a member on the Board of Directors at the Center for Mindful Eating. Molly practiced as an RD for fifteen years. Realizing she needed more than workshops in counseling, she returned to school for training and licensure in social work. After a time of working in this new area, she increasingly integrated nutrition into her practice and presently has a patient population of many individuals with eating disorders.

A good proportion of Molly’s time is spent writing and speaking. Molly has published Counseling Tips for Nutrition Therapists: Practice Workbook (2006) and Toolbox for Nutrition Counseling Education (2007). Her Toolbox for Nutrition Counseling Education is mainly designed for educators; her books, workshops, and the free monthly counseling tips available on her Web site are designed for any practitioner who has client contact. Her Web site may be accessed at www.mollykellogg.com.

Molly says a combination of skills in counseling, reflective listening, and awareness of the therapeutic use of self, increases effectiveness not only for RD’s who treat eating disorders, but in any clinical position or positions which involve supervision of employees. She notes that professional supervision by an experienced RD, either in person or by telephone, can be helpful for processing issues of professional boundaries, and a practitioner’s own reactions to clients while providing nutritional counseling or medical nutrition therapy. She believes training in topics such as professional boundaries, ethics, and behavioral cognitive therapy are as useful for dietitians as they are for mental health professionals. A joint presence in training groups with mental health professionals would also help others realize the value and contribution RD’s make while providing nutritional care to their mutual patients.

Molly concluded our interview with: “I am proud to be associated with the RD’s who integrate nutrition into psychiatric patient care and honored to receive this award from the wonderful members of BHN.”

Congratulations on your award, Molly, and thank you for your “Excellence in Practice!”

Excellence in Practice - 
Substance Abuse:
Renée Hoffinger, MHSE, RD, LD
By Charlene DuBois, MPA, RD

Renée has been a leader in the profession. Renée was inspired to become an RD while working as a medical assistant for an internist. Seeing the physician hand all of his multi-ethnic elderly patients the same tear-off-pad sheet for an 1800 kcal diabetic diet sparked Renée’s insight for motivating life-saving diet changes requiring a higher level of specialized intervention.

Renée has helped clients in the mental health and substance abuse populations achieve their goals since 1993. She is most proud of her work in integrating nutrition into the rehabilitation programs at North Florida/South Georgia Veterans Health System in Gainesville, Florida. Beginning with a one-hour class on diet and recovery, the program grew to include interdisciplinary instruction in menu planning, and consumer skills training in grocery shopping and food preparation.

In addition to giving recovering alcoholics and addicts the skills to support their recovery with good nutrition on their own, Renée also works with patients infected with HIV/AIDS. She has shown leadership by researching and developing practice guidelines at a time when little guidance for this diagnosis was available.

When asked about her personal vision for the profession, Renée easily identified a goal of increasing networking among RDs who are working with similar populations. The exchange of ideas and mutual support is needed with the growing complexity of patient needs. “The key to working effectively with behavioral health populations (indeed, with everyone),” says Renée, “is to see the spark of the divine in each person and treat them as such.”

Congratulations Renée! We look forward to congratulating you in person at FNCE Chicago
A recent (2008) review by Dieleman et al (published in the Dutch language) found 9 randomized controlled trials for medications in pediatric anxiety disorders. Of these, 3 trials had subjects with a diagnosis of generalized anxiety disorder (GAD) (1 each for fluoxetine, fluvoxamine and sertraline). There were no head-to-head comparative trials between selective serotonin re-uptake inhibitors (SSRIs) found. Only one trial had GAD subjects exclusively (sertraline). An additional article reporting on a pooled analysis of two trials using venlafaxine in pediatric GAD which was published in 2007 and not referenced in the Dieleman article was also analyzed.

[Note: The studies with fluoxetine, fluvoxamine and sertraline were done prior to the controversy regarding SSRIs and suicidality becoming apparent in 2004, and thus this issue was specifically addressed. In the studies, a CGI-I value of 3 = improved, a value of 2 = much improved, and a value of 1 = no symptoms present.]

**Fluoxetine (level 1b – Grade B)**

Birmaher et al (2003) evaluated 74 American youths aged 7-17 with various anxiety disorders. Of the 74 subjects in the trial, 47 met criteria for GAD. Concurrent anxiety disorders are common, and children with more than a single anxiety disorder were admitted to the study. Subjects were randomized to receive 12 weeks of either fluoxetine 20 mg/day (10 mg/day during the first week) or placebo. Baseline demographics were comparable, with average age of 11.75 years, 54% females, 95% Caucasian background.

GAD subjects randomized to fluoxetine (n = 24) also had a significantly better clinical response (CGI-I ≤ 2) at 12 weeks than those treated with placebo (n = 22) (67% versus 36%; _2 = 4.22, p = .04, ES = 0.30). In the placebo group, 84% completed the 12 week study, compared to 76% in the fluoxetine group.

When individual side effects were examined at any week, only abdominal pain differed between the two groups (fluoxetine, 44% versus placebo, 22%; _2 = 4.31, p = .04). Subjects tolerated the fluoxetine well; a few subjects experienced mild, transient headaches and gastrointestinal symptoms. Five subjects randomized to fluoxetine were excluded from the study because of significant agitation. However, there were no differences in the number of mild to moderate agitation/disinhibition episodes observed during the study between fluoxetine and placebo. These findings suggest that not all the episodes of disinhibition, in particular if they are mild and transient, are due to the SSRIs.

**Fluvoxamine (level 1b – Grade B)**

The Research Unit on Pediatric Psychopharmacology (RUPP) anxiety study group (2001) conducted a trial of 128 American youths aged 6-17 years with various anxiety disorders. Of 128 subjects, 73 met criteria for GAD. Children with more than a single anxiety disorder were admitted to the study. Subjects were randomized to receive 8 weeks of either fluvoxamine 250 mg/day (children under 12) or 300 mg/day (children 12 and over). Fluvoxamine was titrated upwards in 50 mg/day steps at weekly intervals. Titration was interrupted in subjects with adverse effects or remission of their anxiety disorder. Baseline demographics were comparable, with 74% of subjects in the age group 6-12 years old, 51% male subjects, 63% of subjects were Caucasian and 19% of subjects were Hispanic.

Subjects randomized to fluvoxamine had a significantly better clinical response (CGI-I ≤ 3) at 8 weeks than those treated with placebo (76% vs. 29% (P<0.001).

Increased motor activity and abdominal discomfort occurred at a significantly higher rate in the fluvoxamine group, compared to the placebo group.

In the placebo group, 79% completed the study, compared to 84% in the fluvoxamine group. The reasons for withdrawal from the fluvoxamine group were failure to return to the clinic (two children), inability to swallow medication (three children), and adverse events (sedation, somatic discomfort, or hyperactivity; five children). The reasons for withdrawal from the placebo group were irritability and insomnia (one child), failure to return (eight children), and lack of efficacy (five children).

**Sertraline (level 1b – Grade B)**

Rynn et al (2001) conducted a trial of 22 American youth aged 5-17 with all subjects meeting the criteria for GAD (on the Anxiety Disorders Interview Schedule for Children-Revised and who had a Hamilton Anxiety Rating Scale score ≥ 16). Subjects were randomized to 9 weeks of treatment with either sertraline at doses up to 50 mg/day (except for 25 mg/day in the first week) or placebo. A 2-week evaluation period prior to randomization and commencement of randomized treatment was employed, and 7 of 37 subjects entering the screening period had improvement, and no longer met inclusion criteria.

No significant differences in demographics at baseline were identified. Mean age of subjects was 11.3 years, 67% were males, and 86% were Caucasian.

Primary outcome measures looked at reduction in HAM-A score, CGI-S and CGI-I (score ≤ 2 considered to be clinically improved). At 9 weeks, 10 of 11 subjects (91%) receiving sertraline were considered significantly improved, compared to 1 of 11 subjects (9%) receiving placebo (mean CGI-I score 2.1 in sertraline group, continued on page 6
of CGI-I score ≤ 2, compared to 40% of the placebo group (p=0.004). In study 2, 73% of subjects receiving venlafaxine had a response as defined by CGI-I score ≤ 2, compared to 53% of the placebo group (p=0.008).

Overall, response rates according to CGI-I score were 69% and 48% for the extended-release venlafaxine and placebo groups, respectively (p=0.004).

Columbia K-SADS scores: Subjects in the venlafaxine group had an adjusted mean decrease of 17.4 points on their score on the nine delineated items of the Columbia K-SADS, compared with 12.7 points for the placebo group (p<0.001).

Loss of appetite occurred more often in the venlafaxine group (13%) than the placebo group (3%), while headache was reported more commonly in the placebo group (34%) than the venlafaxine group (24%). Two participants in each treatment group (1%) had serious adverse events. Two participants, both from study 1, had suicidal ideation or made a suicide attempt, in both cases resulting in withdrawal from the study: a 10-year-old boy in the extended-release venlafaxine group withdrew on day 19 because of suicidal ideation, which occurred 2 days after the last full dose of extended-release venlafaxine, and a 17-year-old girl in the placebo group withdrew because of a suicide attempt on day 15. In study 2, a case of withdrawal syndrome with agitation and confusion and a case of mononucleosis were reported. (Though these studies were conducted in 2000 and 2001 prior to the controversy re: SSRIs and suicidality becoming apparent, this article was published in 2007, and suicidality needed to be addressed. It does raise questions about what rate of suicidality would have been detected in the studies with other SSRIs. −DE]

The primary outcome measure was the composite score of nine delineated items from the Columbia K-SADS generalized anxiety disorder section, which was administered at each visit. CGI-S, CGI-I, HAM-A, SCARED, and PARS rating scales were also assessed. Response was defined as a decrease from baseline by ≥ 50% on the nine delineated items of the Columbia K-SADS, PARS rating scale, or a CGI-I ≤ 2).

No significant differences in baseline characteristics were found, with mean age 11.3 years, 57.5% were male, and 76% were Caucasian. In study 1, 63% of subjects receiving venlafaxine had a response as defined by CGI-I score ≤ 2, compared to 40% of the placebo group (p<0.001)).

Mean HAM-A scores were reduced from a baseline of 20.6 to 7.8 at 9 weeks in the sertraline group, compared to a change from a mean score of 23.3 at baseline to a score of 21 at 9 weeks in the placebo group (P<0.001). The CGI-S score also showed significant improvement from baseline. Scores were significantly different between groups starting at week 4. The authors noted that they used the adult Hamilton anxiety scale successfully, yet formal validity and reliability data for use of this instrument with children are not available. The authors noted a relatively low placebo response rate (only 1/11 subjects (9%) considered clinically improved in placebo group) and low dropout rate (91% of subjects receiving sertraline completed the study, compared to 82% in the placebo group.)

Though not well documented in this trial, it was reported that there were no differences between the placebo and sertraline groups in side effects reported.

**Venlafaxine: (level 1b – Grade B)**

Rynn et al (2007) published a prospectively-defined pooled analysis of two multicenter trials of identical design involving a total of 320 American youths aged 6-17 years, with all subjects meeting the DSM-IV criteria for GAD. Subjects were randomized to 8 weeks of treatment with venlafaxine extended release capsules (ER), at variable dosage (venlafaxine dosage range was 37.5-225 mg/day, with maximum dose based on body weight or placebo.)

The primary outcome measure was the composite score of nine delineated items from the Columbia-K-SADS generalized anxiety disorder section, which was administered at each visit. CGI-S, CGI-I, HAM-A, SCARED, and PARS rating scales were also assessed. Response was defined as a decrease from baseline by ≥ 50% on the nine delineated items of the Columbia-K-SADS, PARS rating scale, or a CGI-I ≤ 2).

No significant differences in baseline characteristics were found, with mean age 11.3 years, 57.5% were male, and 76% were Caucasian. In study 1, 63% of subjects receiving venlafaxine had a response as defined by CGI-I score ≤ 2, compared to 40% of the placebo group (p=0.004). In study 2, 73% of subjects receiving venlafaxine had a response as defined by CGI-I score ≤ 2, compared to 53% of the placebo group (p=0.008). Overall, response rates according to CGI-I score were 69% and 48% for the extended-release venlafaxine and placebo groups, respectively (p=0.004).

Columbia K-SADS scores: Subjects in the venlafaxine group had an adjusted mean decrease of 17.4 points on their score on the nine delineated items of the Columbia K-SADS, compared with 12.7 points for the placebo group (p<0.001).

Loss of appetite occurred more often in the venlafaxine group (13%) than the placebo group (3%), while headache was reported more commonly in the placebo group (34%) than the venlafaxine group (24%). Two participants in each treatment group (1%) had serious adverse events. Two participants, both from study 1, had suicidal ideation or made a suicide attempt, in both cases resulting in withdrawal from the study: a 10-year-old boy in the extended-release venlafaxine group withdrew on day 19 because of suicidal ideation, which occurred 2 days after the last full dose of extended-release venlafaxine, and a 17-year-old girl in the placebo group withdrew because of a suicide attempt on day 15. In study 2, a case of withdrawal syndrome with agitation and confusion and a case of mononucleosis were reported. (Though these studies were conducted in 2000 and 2001 prior to the controversy re: SSRIs and suicidality becoming apparent, this article was published in 2007, and suicidality needed to be addressed. It does raise questions about what rate of suicidality would have been detected in the studies with other SSRIs. −DE]

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**Analysis:**

There was a higher apparent response rate in the fluvoxamine trial and sertraline trials compared to the fluoxetine trial and venlafaxine trials. The fluvoxamine trial had a lower standard to meet for a treatment response to be deemed significant (CGI-I ≤ 3 = improved or better) whereas the other trials had a standard of CGI-I ≤ 2 = much improved or better). Fluvoxamine dosing was allowed to span the full range of medication dosing, whereas the fluoxetine and sertraline trials used maximum doses of 20 mg/day and 50 mg/day respectively. Venlafaxine dosing was variable, and ranged as high as 225 mg/day.

Though there were a low number of subjects, all subjects in the sertraline trial had a diagnosis of GAD, compared to the mixed compositions of diagnoses in the fluoxetine and fluvoxamine trials. The sertraline trial had a low placebo response rate (9%, compared to 36% and 29% in the fluoxetine and fluvoxamine trials), though 7/37 subjects screen were excluded prior to randomization. This process did not occur in the fluvoxamine or fluoxetine trials, and may serve to explain the differences observed in the placebo response rate.

Though tempting to make comparisons, variability in study design, population, and criteria for response do not allow differentiation of one SSRI from another in terms of efficacy for pediatric GAD without availability of a head-to-head randomized trial. All trials constitute level 1b evidence/Grade B recommendations (though two trials conducted separately, the venlafaxine trial was prospectively designed to be pooled, and given a common author group, constitutes a single trial).

**Suicidality risks of SSRIs**

The recent review of SSRI use and suicidality by Bridge et al (2007) looked at variable rates of response and suicidality with SSRi treatment, and a sub-analysis was done for trials involving GAD. Unpublished data on file was included in the analysis (total of 6 trials entered into the analysis). No completed suicides were found in the trial (n=4751). The definition of suicidality used in the review was as follows:

**Suicidal ideation**

Passive thoughts about wanting to be dead or active thoughts about killing oneself, not accompanied by preparatory behavior

**Suicide attempt**

Self-injurious behavior associated with some intent to die. Intent can be stated or inferred by rater. No injury needed

continued on page 7
**Preparatory actions toward imminent suicidal behavior**
Person takes steps to injure self but is stopped by self or other (e.g., a person tries to hang self but is prevented from doing so by family members). Intent to die is either stated or inferred.

**Suicidal ideation/suicide attempt**
Occurrence of suicidal ideation, suicide attempt, or preparatory actions toward imminent suicidal behavior

While excess suicidality was found in the SSRI treatment group compared to placebo treated subjects, the absolute risk increase was small, and translated into an NNH of 143. With a corresponding NNT of 3 to cause one extra treatment response in anxiety disorders, the ratio of NNT to NNH for anxiety disorders is considerably lower than that observed for Major Depressive Disorder (MDD) and is also less than seen for OCD (Obsessive-Compulsive Disorder).

**Conclusion:**
All 4 SSRIs reviewed in this article appear to be reasonable options for the treatment of pediatric GAD. Risks of suicidality with SSRI use in a meta-analysis, while still elevated compared to placebo, appear to be lower in GAD than for treatment of Major Depressive Disorder (MDD).

### Table 1. SSRI and placebo response rates in pediatric GAD trials***

<table>
<thead>
<tr>
<th></th>
<th>Fluoxetine (Prozac®)</th>
<th>Fluvoxamine (Luvox®)</th>
<th>Sertraline (Zoloft®)</th>
<th>Venlafaxine (Effexor®)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lead author/year</strong></td>
<td>Birmaher 2003</td>
<td>RUPP 2001</td>
<td>Rynn 2001</td>
<td>Rynn 2007</td>
</tr>
<tr>
<td><strong>Dose used</strong></td>
<td>20 mg/day</td>
<td>50-300 mg/day</td>
<td>50 mg/day</td>
<td>37.5-225 mg/day</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>12 weeks</td>
<td>8 weeks</td>
<td>9 weeks</td>
<td>8 weeks</td>
</tr>
<tr>
<td><strong>SSRI response rate</strong>*</td>
<td>67%</td>
<td>76%</td>
<td>91%</td>
<td>69%</td>
</tr>
<tr>
<td><strong>Placebo response rate</strong>*</td>
<td>36%</td>
<td>29%</td>
<td>9%**</td>
<td>48%</td>
</tr>
</tbody>
</table>

* Response defined as CGI-I ≤ 2, except fluvoxamine trial where response defined as CGI-I ≤ 3
** Low placebo response rate reported, likely due to exclusion of responders following 2-week run-in period
*** Analysis described on patients with GAD diagnosis only in trials including subjects with multiple anxiety diagnoses

### Table 2. Rate of pooled response and suicidality in published SSRI trials

<table>
<thead>
<tr>
<th></th>
<th>MDD (13 trials, n=2910)</th>
<th>OCD (6 trials, n=705)</th>
<th>Anxiety (non-OCD) (6 trials, n=1136)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRI Response rate</td>
<td>61%</td>
<td>52%</td>
<td>69%</td>
</tr>
<tr>
<td>Placebo Response rate</td>
<td>50%</td>
<td>32%</td>
<td>39%</td>
</tr>
<tr>
<td><strong>Number Needed to Treat (NNT)</strong></td>
<td>10</td>
<td>6</td>
<td>3%</td>
</tr>
<tr>
<td>SSRI Suicidality rate</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Placebo Suicidality rate</td>
<td>2%</td>
<td>0.3%</td>
<td>0.2%</td>
</tr>
<tr>
<td><strong>Number Needed to Harm (NNH)</strong></td>
<td>112</td>
<td>200</td>
<td>143</td>
</tr>
</tbody>
</table>

* Number Needed to Treat: Number of subjects needed to treat to cause one extra response, when compared to placebo group
** Number Needed to Harm: Number of subjects needed to treat to cause one extra case of suicidality, compared to placebo group
Pre-FNCE Workshop

“What Dietitians Need to Know About Psychiatric Medications Including Weight Gain, Nutrient Interactions, and Pediatric Issues” Register at www.eatright.org/bhnprefnce

Review of SSRI Pharmacotherapy of Pediatric Generalized Anxiety Disorder (GAD)

by Linda L. Venning, MS, RD

Implications of this Study for the Pediatric Behavioral Health Nutrition Professional

This recent 2008 review by Dieleman suggests that the following Selective Serotonin Reuptake Inhibitors are reasonable treatment options for the treatment of pediatric generalized anxiety disorders. It was noted that children with more than a single anxiety disorder were included in this review. This study was completed prior to the controversy of SSRIs and suicidality, therefore this issue was not specifically addressed. All trials constituted Level 1b Evidence/Grade B recommendations. The SSRIs reviewed were: fluoxetine (Prozac), fluvoxamine (Luvox), sertraline (Zoloft) and venlafaxine (Effexor)

Nutrition Care Process for Dietitians in Behavioral Health Care

As dietitians providing nutrition care, nutrition goals are the same for children and adolescents, with or without Generalized Anxiety Disorders. The goal is to meet calorie and nutrient needs that promote optimal growth and development of the individual client. Nutrition Screen can begin the process to help identify the child who may be at a nutrition risk and for those who may require a more comprehensive assessment or specific nutrition interventions. Nutrition Assessment is the basis for developing the Nutrition Care Plan with specific interventions to meet nutrition goals. Components of the assessment can include the client’s diet history, identification of food allergies or intolerances, cultural and environmental influences, medical tests/procedures, physical examination findings, BMI’s greater than the 85%/age, SMR (sexual maturity rating-Tanner stage of development), laboratory data, medications, food-medication interactions and relevant data from other disciplines (i.e., psychiatrist, psychologist, pediatrician, nurse, social worker, health care provider).

Summarizing the results of these findings will allow the dietitian to determine the client’s energy, protein and other nutrient requirements that will promote optimal growth and development. After thoughtful nutrition assessment, the dietitian can proceed through the remaining steps of the nutrition care process: Nutrition Diagnoses, Nutrition Intervention, and Nutrition Monitoring as outlined in ADA Standard of Practice for Dietitians in Behavioral Health Care (1).

Dean’s article is an opportunity for dietitians to focus on nutrition interventions that promote healthier lifestyle choices with specific diet guidelines and recommendations for follow up in the care of children and adolescents, with Generalized Anxiety Disorders.

The Latest News on SSRI’s

According to the July issue of Archives of General Psychiatry, one of the JAMA/Archives journals, the class of antidepressants known as selective serotonin reuptake inhibitors (SSRIS) appears to be associated with bleeding in the upper gastrointestinal tract. An association between SSRIs and GI bleeding has been reported since the early 1990s. Research at the Spanish Agency for Medicines and Healthcare Products and the Spanish Centre for Pharmacoepidemiologic Research found that individuals with upper GI bleeding were significantly more likely than controls to be taking SSRIs. The risk of bleeding appeared to increase among those taking both SSRIs and other drugs known to be harmful to the GI tract and decreased in those taking acid-suppressing agents.

References:

We’re More Alike Than Different

By Joan Guthrie Medlen, RD, LD

I entered the world of disability not by choice, but by circumstance: the birth of my second child, who has Down syndrome. Nine years later we would learn he also has an autism spectrum disorder; 16 years later, celiac disease; and in his 19 years, he has uttered just one word, “Yah.” I entered the profession of dietetics for people with intellectual and developmental disabilities (IDD) by choice when my son was about six years old. I made this choice because I was distraught by the lack of useful information available to parents to promote healthy living for children and adults with developmental disabilities. I wanted to make a difference for my son and his peers through my profession.

Over the years, my son and his peers – children and adults with IDD from around the world – have influenced me far more than I believe I have influenced them or my fellow dietitians. The following is a sampling of lessons we have experienced together.

Motivational Interviewing and Coaching

In the recent past, dietitians have been encouraged to hone skills defined by a process called motivational interviewing. The key point to motivational interviewing is learning what most interests the person you are working with in their quest for change. Using this method dietitians ask questions to understand how best to lead someone to success rather than offering a pre-planned method that has no flexibility. Recently, the focus has been on a similar process, called coaching. Coaching is a process of asking probing questions that help the person you are working with make decisions about how to move forward or tackle tough barriers. Both of these methods are current best practice, are very effective, and are popular with dietitians and other health care professionals. What they have in common is that they employ client-centered methods that hinge on respectful communication.

Marjorie Geiser, RD, NSCA-CPT, President of MEG Enterprises and chair of the Coaches Specialty Group for the Nutrition Entrepreneurs Practice Group says that coaching is “effective because the client is the person in charge of what to do with their life.” Coaching a person means we, as dietitians, are no longer “the expert of them. They are.”

Motivational interviewing and coaching allow an infusion of value-based methods into evidence-based work. These methods balance what is important to the client (value) from what is important for the client (evidence). Both put the client in the driver’s seat and the dietitian in the role of supporting health and safety. In other words, dietitians no longer dictate what will happen, when it will happen, and how it will happen. We have learned we are more effective when we listen, instruct, and support people’s decisions as they make choices toward their vision of a healthy life.

According to Smull and Allen of TLC, “What is important to a person includes only what they are saying with their words and their behavior.” When there is a difference between what people say and what they do, rely on the behavior as the message.

Smull and Allen define what is important for people with IDD as only "those things we need to keep in mind for people regarding issues of health or safety and what others see as important to help the person be a valued member of the community.” The balance of these two concepts is essential in person-centered work. When “health and safety” dictate a person’s life, then what is important to them, the things they value, are minimized or forgotten, reducing self-esteem. When “choice” dictates life with no responsibility, then health and safety are minimized and forgotten, thus opening the door for illness or abuse. The two are not exclusive of each other. Rather, they are inextricably linked.

Just as with coaching, described above, using a person-centered method is more effective because we, as dietitians, are no longer the experts of the person, they are. With people who have IDD, dietitians may need to do more work teaching as a part of this process. However, generally speaking, when people with IDD feel the power of being the person in charge of their lives, the balance between “important to” and “important for” is easier to achieve.

Applying value-based methods such as person-centered thinking to evidence-based work with people who have IDD may take some time. It requires moving away from traditional models of providing service in this area of practice to successfully put the person, or client, in the center of our work. The good news is that it is in-line with the current best practice trends in dietetics.

continued on page 10
Best Practices in Communication

Best practices are methods to guide us as dietitians. Each area of specialty within dietetics has a set of best practices that is unique to the people served. Use of communication-based best practices often sets the tone with your colleagues and clients. In the field of IDD, the use of person-first language is essential. **Person-first language** showcases putting the person first and the disability label second (or third or fourth). Here are a few examples:

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<thead>
<tr>
<th>Say…</th>
<th>Instead of…</th>
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<tr>
<td>“Person (or client) with intellectual disability”</td>
<td>“MR Client”</td>
</tr>
<tr>
<td>“Emily has Down syndrome”</td>
<td>“Emily is Down’s” or “my Down’s client, Emily.”</td>
</tr>
<tr>
<td>“Person who uses a communication device”</td>
<td>“nonverbal client.”</td>
</tr>
<tr>
<td>“Young man with CP”</td>
<td>“CP boy.”</td>
</tr>
</tbody>
</table>

There are always differences within disability groups. Again, use best practices methods regarding cultural diversity as a guide. If unsure, ask the person their preference or use person-first language. Clients will respect the effort. Remember it is important to keep the person with a disability as the focus when providing education or counseling. The conversation is with that person, rather than the direct support person or family member who has come with them.

Use Appropriate Educational Materials

When teaching people with disabilities, it is sometimes important to make changes to educational materials or lessons. A first step is to use low literacy guidelines available for health literacy when deciding on materials. Ask other professionals for ideas. Educational materials do not need to be flashy to be useful. However, remember to apply best practices to your selection. For example, it is **never** appropriate to use children’s materials for adults with disabilities. Even if the reading level is appropriate, the person you are working with knows that you just provided them with something designed for a child. Additionally, nutrition recommendations for children are different from adults. If a direct support provider refers to the handout later, the information is inaccurate.

**Conclusion**

When looking at the leading trends in dietetics and supporting people with IDD, it’s easy to see that in the end, we are more alike than different. Regardless of whether you have had the time to read journal articles or complete continuing education modules about working with people who have disabilities, if you remember the Golden Rule and use methods that you want and value in your own life, you are on your way. Given that people with intellectual disabilities are an often forgotten and vulnerable population, the rewards of empowerment are amazing – for both the person you serve and you as their support professional.

Creating solutions for quality lives requires a community vision.

Welcome to our community.

**References**


**About the Author:** Joan Guthrie Medlen, RD, LD, focuses her diverse work on supporting people with intellectual disabilities and their families. She is the Clinical Director for Health Literacy and Communications for Special Olympics, Healthy Athletes Program. She is President of Phronesis Publishing and JEM Communications as well as author of e-books, chapters, and books including The Down Syndrome Nutrition Handbook, the first book published promoting healthy living for people with Down syndrome. Joan is the mother of two grown men, one of whom has Down syndrome, autism, celiac disease and is nonverbal. For more information, www.Downsyndromenutrition.com

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**Coding & Coverage Committee’s Passion for Payment**

If you’ve ever wondered what the American Dietetic Association (ADA) is doing about reimbursement or coverage for nutrition services (and the problematic lack of), know that some of the most business savvy RDs in the association are working hard to develop strategies for increasing RD recognition and coverage.

To learn more about the Coding & Coverage Committee and to view member coding and coverage resources go to www.eatright.org/mnt.
Heard and Overheard on the BHN Listserv

If you are not on the BHN listserv, you’re missing out on one of your free member benefits! To join in or read the conversations, log on to www.bhndpg.org Member Only.

Q: I am a dietitian who is new to this group and new to addictions work. I am hoping to attend the pre-FNCE workshop but my responsibilities have already begun. Any recommendations on best resources or reading?

A1: When I started in drug rehab I read a couple articles from Dr. Anne Hatcher called “Links Between Substance Abuse Disorders and Nutrition”. Another resource I use is “Nutrition and Recovery” (www.camh.net) from the Centre for Addiction and Mental Health in Canada.

A2: I recommend you purchase the BHN publication Psychiatric Nutrition Therapy. It has a lot of helpful information, along with handouts, for use with addictions patients. Dr. Anne Hatcher was a major contributor to this publication. She also wrote a book called, “Good Food for a Sober Life,” which I have found very useful over the years, but I believe is now out of print. The BHN practice group will soon publish another book by Dr. Anne Hatcher, which will be available soon. The company, National Health Videos, has excellent videos to use in a group education setting. I’ve used the “Alcohol and Nutrition” and “Substance Abuse and Nutrition” videos. http://www.nhv.com/index.cfm?fuseaction=browse&id=60204&pageid=55

Other Useful Websites:
National Clearinghouse for Alcohol and Drug Information (NCADI) www.healthfinder.gov
National Institute on Alcohol Abuse and Alcoholism http://www.niaaa.nih.gov
Substance Abuse and Mental Health Services Administration http://www.samhsa.gov

Don’t miss the BHN Priority Session “From Addiction to Recovery: The Role of the Dietitian”
Presenting: Kevin McCauley, MD and Theresa Stahl, MS, RD
Monday, Oct. 27 at 8:00 a.m., McCormick Place West, Rm. 470

The long-awaited “Nutrition and Addictions” manual is ready for purchase!

BHN is thrilled to claim Anne S. Hatcher, co-author of Good Food for Sober Living, as a long-time member and pioneer as a dietitian in the field of addictions. This 244-page manual includes information about addiction and drugs of abuse, including legal, illegal and pharmaceutical drugs, alcohol, nicotine, caffeine, and more. Essential for anyone working in a hospital, outpatient or recovery setting, Nutrition and Addictions will not stay on your bookshelf long, as you will refer to it often. Patient educational handouts on nutrition and recovery topics are also included.

Available for $24.95, discounted to $19.95 for BHN members. To order, visit the BHN website, www.bhndpg.org or order form link Download Order Form (PDF).
NEW! The Adult with Intellectual and Developmental Disabilities

A Resource Tool for Nutrition Professionals

This resource tool is designed to provide an overview of nutrition in individuals with intellectual and developmental disabilities. It contains descriptions of IDD Diagnoses, Inherited Metabolic Disorders, and Common Nutritional Concerns in IDD and information and guidelines on nutrition assessment, common medication actions, dysphagia and mealtime issues, and intervention approaches and practice tips. Content was created, compiled and donated by BHN Nutrition Professionals.

The resource guide is contained on one CD-ROM as a 209 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 a copy of ADA Standards of Practice and Standards of Professional Performance for Registered Dietitians (Generalist, Specialty, and Advanced) in Behavioral Health Care.

BHN Members Price: $25.00 plus $3.00 shipping = $28.00
BHN Non-member Price: $35.00 plus $3.00 = $38.00
Download Order Form (PDF) | View Table of Contents

Psychiatric Nutrition Therapy

A Resource Guide for Dietetics Professionals Practicing in Behavioral Healthcare

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.

BHN Member Price: $25.00 plus $3.00 shipping = $28.00
Non-Member Price: $35.00 plus $3.00 = $38.00
Download Order Form (PDF) | View Table of Contents

To order, visit the BHN website, www.bhndpg.org and click on Publications.
BHN

Represented at Leadership Institute

The ADA Leadership Institute took place over four action-packed days in June in Las Vegas. BHN was well-represented by Executive Committee members Andrea Shotton, Chair-Elect; Kathy Russell, Membership Chair; and Charlotte Caperton-Kilburn, Public Policy Chair. The Institute focused on improving professional skills, making a difference both locally and nationally, and networking with other DPG Board members, state affiliate representatives, House of Delegate members, and current and past ADA presidents.

From keynote speakers to breakout workshops, the Institute emphasized that every ADA member can be a leader, whether in their area of practice, or at affiliate, practice group, national or international levels. Professional development was encouraged, along with improving communication and bridging the generation gap. Participants were charged with encouraging other ADA members to make a difference - even if only by contributing one hour of their time every three months. If you are someone who would like to be involved in BHN, please contact our Chair, Jessica Setnick, at jessica@understandingnutrition.com.

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Winning the War Within: Nutrition Therapy for Clients with Eating Disorders


Book Review: By Jessica Setnick, MS, RD, CSSD

Reading *Winning the War Within*, by Eileen Stellefson Myers, turned out to have a dual purpose for me. In addition to reviewing it for this newsletter, I also was able to use the cognitive-behavioral techniques to analyze myself and get some clarity.

Let me explain. The first time I was introduced to Eileen, we were emailing back and forth to plan a three-way panel discussion at ADA in Denver in 1999. I was a dietitian cub presenting at FNCE for the very first time, and she was a seasoned professional and published author. The day of our presentation I was a nervous wreck, wondering why on earth anyone had let me leave the house, much less present at an international venue. Yet Eileen treated me as a colleague and even complimented me after my part of our talk. Fast forward to when Eileen asked me to review *Winning the War Within* for Developmental Issues, and I immediately time-traveled back into a nervous newbie intimidated by her accomplishments, just hoping I wouldn’t embarrass myself. I silently worried, once again, that I wouldn’t live up to expectations (mine, not hers), and yet Eileen graciously never gave up on me. While reading *Winning the War Within*, I gained some insight into my performance anxiety and was able to stop self-sabotaging (for the moment). What a great reminder that “disordered thinking” takes many forms.

*Winning the War Within* very comprehensively summarizes the current knowledge of what causes and what constitutes eating disorders, including physical symptomatology and treatment guidelines. But what makes *Winning the War Within* unique is the beautifully written synopsis of the cognitive-behavioral counseling tools that are part of the progression from “dietitian” to “nutrition therapist.” Eileen explains detailed motivational interviewing and cognitive-behavioral techniques and terminology by putting them into the context of nutrition counseling. Plus she offers sample dialogues to demonstrate how each method would actually play out during a session. For dietitians paralyzed by the fear of “making an eating disorder worse,” there are also examples of what not to say.

For dietitians new to the treatment of eating disorders, or anyone looking for more tools to use, there are sections to help with every aspect of counseling sessions, including forms, handouts and lesson plans. Just a few examples of resources included are thorough assessment forms with sample questions, examples of pitfalls to avoid, a contract to support patients in committing to treatment, sample food diaries, and guidelines for group sessions. Although many sections deserve more than one reading in order to more thoroughly absorb and implement the approach, *Winning the War Within* would also be a great crash-course for someone who wants to accelerate their counseling skills ASAP. And maybe gain a little self-knowledge in the process.

*Winning the War Within* is available at www.helmpublishing.com.

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The 18th Annual Renfrew Center Foundation Conference for Professionals, Feminist Perspectives and Beyond: The Power of Therapeutic Relationships in the Treatment of Eating Disorders.

November 13-16, 2008
Philadelphia Airport Marriott
Philadelphia, PA

The 18th Annual Renfrew Center Foundation Conference is a four-day seminar for behavioral health professionals and dietitians, 22.5 CEUs.

For more information, please visit the website: www.renfrew.org
Dates to Remember:

ADA's Food & Nutrition Conference & Expo
- 2008 -- Chicago, Illinois; October 25 to 28.
  Visit: http://www.eatright.org/fncest08
- 2009 -- Denver, Colorado; October 17 to 20
- 2010 -- Boston, Massachusetts; November 6 to 9
- 2011 -- San Diego, California; September 24 to 27

ADA Leader Nominations – Election 2009
- 2008 -- November 1;
  www.eatright.org/governance

ADA's Public Policy Workshop
- 2009 -- Washington, D.C.; February 8 to 10

28th American Overseas Dietetic Association Conference
- 2009 -- Kuala Lumpur, Malaysia; April 23 to 25.

18th Annual Renfrew Center Foundation Conference for Professionals, Feminist Perspectives and Beyond: The Power of Therapeutic Relationships in the Treatment of Eating Disorders. 22.5 CEUs
- 2008 -- Philadelphia, PA; November 13-16, 2008;
  Visit: www.renfrew.org

Pasadena Child Development Associates Conference, Pediatric Feeding: Assessment and Treatment.
- 2008 – Long Beach, CA; November 14th and 15th
  www.pasadenachilddevelopment.org

BHN 2008 FNCE Schedule of Events

Saturday, October 25
12:00-3:00 p.m.
Hyatt Regency Hotel on Wacker Drive
Columbus Room AB
Pre-FNCE Workshop
“What Dietitians Need to Know About Psychiatric Medications – Including Weight Gain, Nutrient Interactions, and Pediatric Issues”
Presenting: Zaneta Pronsky, MS, RD, LDN, FADA and Dean Elbe, BSc (Pharm), BCPP, authors of the indispensable “Food-Medication Interactions”.
After speaking to a packed house at last year’s FNCE, we have asked Zaneta and Dean to create an even more info-packed workshop to update you on the latest information about psych meds and nutrition. If you work in clinical or community nutrition, pediatrics, chemical dependency, behavioral health, and/or eating disorders treatment, you will find this workshop to be extremely beneficial. An afternoon snack is included!

Sunday, October 26
5:00 – 6:00 p.m.
Hyatt Regency Hotel on Wacker Drive
Wright Room
Member Reception and Awards Presentation
Join us for this valuable opportunity to network and build alliances with your peers and to applaud our recognized leaders in our areas of practice.

Monday, October 27
8:00 – 9:30 a.m.
McCormick Place West • Room 470
Priority Session
“From Addiction to Recovery: The Role of the Dietitian”
Presenting: Kevin McCauley, MD and Theresa Stahl, MS, RD
Discuss the misconceptions about addictions and the role of the dietitian. Identify the special nutrition needs of recovery. Explore techniques for group nutrition education for patients with addiction. Planned with Behavioral Health Nutrition Dietetic Practice Group

Monday, October 27
10:30 – 1:00 p.m.
McCormick Place West
Member Showcase
Stop by our display and see what your BHN Executive Committee has been up to! Bring along your friends and encourage them to join our dynamic practice group

Monday, October 27
1:00 – 2:00 p.m.
McCormick Place West
SOP Open Spaces Forum
Your View of Behavioral Health Care Practice Standards: Open Discussion
Does your work focus on meeting the nutritional needs of persons with eating disorders (ED), intellectual and developmental disabilities (IDD), addictions or mental illness? If so, then we need your opinions about practice standards for dietitians in Behavioral Health Care. Join us for an open discussion.

Nominations for Office – BHN Members
Interested in serving BHN in a new capacity this year? If you are a current BHN member and have the desire, now is the time to share your talents and ideas by volunteering with us. We have several positions waiting to be filled for 2009-2010. Chair elect, Treasurer, and Nominating Committee Members are open and ready for your leadership. We need you!
Please email marytholking@yahoo.com with your name, address, and phone number by November 17, 2008.
Thanks to Janice Scott, Cary Kreutzer, and Mary M Tholking, your BHN Nominating Committee
Behavioral Health Nutrition (BHN) DPG
Newsletter Advertising Policy and Order Form

We at BHN Newsletter team welcome your ad and look forward to working with you. Our newsletter is read by more than 1000 Nutrition Professionals. BHN Newsletter accepts paid advertisements in accordance with these guidelines:

- Ads are limited to products and services that are of interest to our members, consistent with the goals for the practice group, and promote the nutritional health of the people we serve.
- BHN reserves the right to evaluate all statements in ads and refuse any ad that does not meet guidelines established by the American Dietetic Association.
- This disclaimer will appear in each issue of BHN Newsletter where advertising appears: “The publication of an advertisement in BHN Newsletter should not be construed as an endorsement of the advertiser or product by the American Dietetic Association or BHN dietetic practice group.”
- Ads may be submitted any time and advertisers will receive notification of acceptance within 30 days of submission, at which time scheduling for placement will be arranged.

Artwork
- Send artwork files for ads to BHN Newsletter Editor on or before publication deadline.
- Artwork must be high resolution (300dpi) and in one of the following file formats:
  - EPS (preferred)
  - TIF
  - High resolution PDF files will be accepted. Please do not include any colors other than black in the file. Make sure that you are embedding the fonts and expect some pixilation if you send a low resolution file.
  - Ads that are text only (no artwork) must be at least 200 dpi if provided as an image file (EPS or TIF) or sent as a Microsoft Word file. PDF copies will not be accepted.
- BHN will not design original artwork or be involved in any design of the content of your advertisement.

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<th>RATES and METHOD OF PAYMENT</th>
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<td>BHN members receive 50% discount: your ADA member # __________</td>
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☐ BHN member prices: full page: $250  ½ page: $175  ¼ page: $125  ⅛ page: $62

☐ Check payable to: “American Dietetic Association DPG #12”
☐ Credit card payment
(All credit card payments processed in US Dollars)
☐ American Express  ☐ Discover
☐ MasterCard  ☐ VISA

Please pay total due
Total Amount: US $ ________________

Credit Card Number:
_______ - _______ - ________ - ________
Expiration date: _____ / ________
Daytime Telephone: ________________________

Signature

Please contact our BHN Newsletter Team to make plans for your ad now: Newsletter@bhndpg.org

Approved February 15, 2008