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The next issue of the *South Central MIRECC Communiqué* will be published January 4, 2010. Deadline for submission of items to the January newsletter is December 24, 2009. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Mary Sue Farmer, at [Mary.Farmer2@va.gov](mailto:Mary.Farmer2@va.gov)

South Central MIRECC  
Internet site:

[www.mirecc.va.gov/visn16](http://www.mirecc.va.gov/visn16)

National MIRECC Internet  
site: [www.mirecc.va.gov](http://www.mirecc.va.gov)

## EFFICACY OF BEHAVIORAL WEIGHT LOSS INTERVENTIONS IN MANAGING WEIGHT GAIN AND METABOLIC RISK ASSOCIATED WITH ATYPICAL ANTIPSYCHOTICS

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Individuals with schizophrenia are a medically vulnerable population. These individuals are at increased risk for cardiovascular disease and diabetes and have a 20% shorter lifespan than the general population (Newcomer, 2007a). Atypical antipsychotics, now widely used in the treatment of schizophrenia, are associated with substantial weight gain as well as disturbances in lipid and glucose metabolism (Newcomer, 2007b). These side effects increase risk for both cardiovascular disease and morbidity in this already vulnerable population and may have negative effects on medication compliance.

We conducted a systematic review of research on the effectiveness of behavioral weight loss interventions for the treatment and prevention of weight gain and metabolic risk

associated with atypical antipsychotics (Gabriele, Dubbert, & Reeves, 2009). From a computer search of Pubmed and Psycinfo, we identified 16 studies. Interventions ranged in duration from 10 weeks to 18 months. The number of participants in studies ranged from 11 to 130 (*Median* = 52 participants) and the number of participants in intervention groups ranged from 8 to 59 (*Median* = 30 participants).

Interventions ranged in duration from 10 weeks to 18 months. Interventions contained individual sessions, group sessions, and a combination of individual and group sessions. Sessions were led by a variety of personnel including psychologists, nurses, dietitians, and behavioral counselors.

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## *Efficacy of Behavioral Weight Loss Interventions continued...*

Intervention components were typically tailored to the patient and included education on healthy eating and exercise, calorie restriction/portion size, goal setting, self monitoring, stimulus control, stress management, social support and rewards/contingency management. Thus, these studies used intervention components similar to those found in the VA's MOVE program.

Three studies were randomized controlled trials (RCT) that assessed whether a behavioral intervention could decrease weight gain in individuals initiating treatment with an atypical antipsychotic. At 12 to 16-weeks, all three reported significant between-group differences. Individuals in behavioral weight loss intervention conditions gained 2.89 to 4.00 kg less than individuals in control conditions (*Mean* group difference = 3.46 kg). Two of these studies also assessed 6-month weight change and found significant between-group differences favoring the behavioral weight loss intervention conditions (*Mean* group difference = 6.25 kg). No additional weight gain was observed between 12 to 16-weeks and six months in individuals who received the behavioral weight loss intervention. These results indicate that behavioral interventions can attenuate weight gain in individuals initiating treatment with atypical antipsychotics.

Thirteen studies assessed the effects of behavioral weight loss interventions on weight loss in patients already taking atypical antipsychotics. All reported significant reductions in weight for intervention patients. Five additional studies reported descriptive information on weight change. In 10 studies reporting weight change in the behavioral intervention group following 10- to 16-weeks of intervention, mean weight loss ranged from 1.40 to 3.94 kg (*Mean* = 2.63 kg). In four studies reporting 6-month weight change, weight losses ranged from 3.50 to 6.00 kg (*Mean* = 4.24 kg). Only two studies had an intervention longer than 6 months. One reported a 3.00 kg weight loss following a 12-month intervention and the other reported a 3.10 kg weight loss following an 18-month intervention.

Ten studies compared behavioral weight loss intervention conditions to control conditions. Six reported significant between-group differences for

weight loss. Group differences at 10 to 16 weeks ranged from 1.20 to 5.60 kg (*Mean* = 2.86 kg) and group differences at 6 months ranged from 4.30 kg to 5.20 kg (*Mean* = 4.75 kg). In the two studies longer than 6 months, one reported a 6.20 kg difference at 12 months and the other reported a 6.70 kg difference at 18 months.

Five studies assessed the effects of a behavioral weight loss intervention on insulin sensitivity or HbA1c. Four reported that behavioral weight loss interventions significantly improved these outcomes. In addition, three of four studies that assessed blood pressure and three of five studies that assessed triglycerides reported that behavioral weight loss interventions were associated with significant improvements in these outcomes. Furthermore, three studies assessed quality of life outcomes, two of which reported significant improvements in quality of life following participation in a behavioral weight loss intervention.

The results of this review suggest that behavioral weight loss interventions can reduce weight and metabolic risk in individuals taking atypical antipsychotics. These interventions may be most beneficial when started near the initiation of treatment with atypical antipsychotics because they can prevent the weight gain and metabolic side effects associated with these medications.

Most of the behavioral intervention programs reported in this review utilized behavioral weight loss strategies that are familiar components of the VA's MOVE program. Thus, within the VA setting, there are resources in place, that, if utilized by patients taking atypical antipsychotics, may help to decrease the metabolic side effects associated with these medications. The challenge is to get patients taking atypical antipsychotics to participate in these already established services. Where feasible, it may be useful to offer an additional MOVE group or some other behavioral weight loss program just for individuals in this population.

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Mental health providers can motivate and assist their patients in participating in this type of program by 1) educating patients taking atypical antipsychotics on the weight and metabolic side effects associated with these medications, 2) providing information on how behavioral weight loss strategies can reduce these side effects, 3) assessing patients' motivation for participation in a behavioral weight loss program, and 4) referring motivated patients to a behavioral weight loss program such as the VA's MOVE program.

In patients who report not being interested in a behavioral weight loss program, motivational interviewing techniques may be beneficial in increasing motivation. Providers should continue to evaluate motivation in these individuals who initially report no interest in participating in this program so they can quickly respond to any changes in motivational readiness.

Future research should assess both weight loss and diabetes outcomes; assess mental health outcomes; attempt to implement programs at the organizational level; assess whether continued on-going follow-up and support is needed for weight maintenance; and assess the reach, adoption, implementation, and maintenance of these interventions.

#### References

1. Allison, D.B., Mentore, J.L., Heo, M., Chandler, L.P., Cappelleri, J.C., Infante, M.C., Weiden, P.J. (1999). Antipsychotic-induced weight gain: a comprehensive research synthesis. *American Journal of Psychiatry*, 156, 1686-1696.
2. Gabriele, J.M., Dubbert, P., & Reeves, R. (2009). Efficacy of behavioral interventions in managing atypical antipsychotic weight gain. *Obesity Reviews*, 10 (4), 442-455.
3. Newcomer, J. (2007a). Metabolic syndrome and mental illness. *American Journal of Managed Care*, 13(7 Suppl), S170-177.
4. Newcomer, J. (2007b). Antipsychotic medications: metabolic and cardiovascular risk. *Journal of Clinical Psychiatry*, 68(Suppl 4), 8-13.

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## SOUTH CENTRAL MIRECC UNIFORM MENTAL HEALTH SERVICES HANDBOOK EDUCATION INITIATIVE

**KIMBERLY ARLINGHAUS, M.D., KATHARINE HEAD, M.A. AND CAYLA TEAL, PH.D. WITH CONSULTATION  
FROM THE VISN 16 MENTAL HEALTH PRODUCT LINE ADVISORY COUNCIL**

Developed and funded by the SC MIRECC and the VISN 16 Mental Health Product Line, the Uniform Mental Health Services Handbook (UMHSH) Education Initiative is dedicated to informing mental health providers practicing in VISN 16 about the VA's Uniform Mental Health Services Handbook. The Initiative provides an education tool that highlights the major sections of the UMHS Handbook in 9 brief (10-20 minute) video modules. The modules provide details about requirements and recommendations for mental health services in the VHA system, and tie key aspects of the Handbook to requirements corresponding to facility size. The modules also present additional education opportunities about evidence-based treatments and other helpful resources available through the SC MIRECC or the VHA.

To view a module or access the additional resources associated with a module, visit:

<http://www.mirecc.va.gov/VISN16/umhshs/umhshEducation.asp> and click on the relevant link. The video link will open up a WMV file (Windows Media Video file) and begin playing on your screen using Windows Media Player. The video modules are designed to be viewed in order, but we understand that some providers might want to view particular modules before others. We hope you will view all the video modules, as there are important elements in each one about which all mental health providers should be aware.

Educational videos linked from this page are available only to individuals using the VA Intranet. General Internet connections will not reach these videos. If you have any trouble with viewing the modules or with accessing the additional information and resources, please contact Michael Kauth, SC MIRECC Director of Education at [Michael.Kauth@va.gov](mailto:Michael.Kauth@va.gov).

*Our website has moved! Please visit the SC MIRECC at [www.mirecc.va.gov/visn16](http://www.mirecc.va.gov/visn16).*

## MIRECC IMPLEMENTATION, DESIGN AND ANALYSIS SUPPORT (MIDAS) PROFILE: IRMI WILLCOCKSON, PH.D.

Interviewed by Ashley McDaniel

MIDAS is a service arm of the South Central MIRECC created to assist VISN 16 investigators who are seeking intramural or extramural funding or conducting pilot studies. The MIDAS team offers design, methods, and analytic support for all phases of project development, implementation, analysis, and/or dissemination. Team members have expertise in biostatistics, epidemiology, psychometrics, qualitative methods and project implementation and management. This month we profile MIDAS member, Irmgard Willcockson, Ph.D.

### What is your role in MIDAS?

I just started working with MIDAS this month. I'm one of a group of consultants available to help researchers achieve their goals. My particular expertise lies in using technology for teaching and training.

This is not my first foray into mental health-related teaching. The first project I worked on with the School of Health Information Sciences was the LEARN Project, designed to interest high school students in a career in mental health research. We focused on learning and memory, and created a hands-on curriculum with and for high school teachers as well as web-based interactivities and biographies of scientists for students. Since then I've worked on a variety of projects using games to teach science content to elementary and middle school students, as well as teaching the use of emerging technologies to faculty.

### Your expertise is in the application of technology for teaching and learning in clinical interventions and research. How does this impact your work with MIDAS?

Whenever a researcher has a project, either developing a proposal or already funded, I am available to help with the technology and education/training needs. I can brainstorm which technologies to use and the scope of the project, point out resources to educate the researcher about what's available, make suggestions on the budget and write a section of narrative. After funding, I can assist with identifying the right team members, work on learning objectives, interactivities and assessments as well as suggest appropriate evaluation strategies.

### What do you like best about your work with MIDAS?

I love the variety of projects I can get involved in. From training providers to educating patients, from couples therapy to sexual health to Parkinson's disease screening, every project brings unique needs and opportunities. Another aspect I enjoy is the people involved in the projects. Everyone brings a different perspective, and seems eager to collaborate to make their project successful.

### What advice would you give to researchers who are new to using MIDAS?

Take advantage of the expertise we have to offer. Don't be shy about approaching us, even if you are in the early stages of trying to put your project together. Even an hour or two with an expert can increase your confidence and improve your project. We're not interested in 'taking over,' rather we want to help out. Speaking for myself, I enjoy working with researchers at different stages of their career and with different levels of prior knowledge. My job is to listen to what you want to do and then help you achieve success.

### How can people get in touch with you if they have questions about MIDAS?

To get help from MIDAS, contacting Melonie Shelton or Dr. Ellen Fischer and fill out a MIDAS request form. You may want to start there if you have a fairly good idea about what you need. You can also get in touch with me directly first, and we can define what you need together. Email works very well for the initial contact, [Irmgard.Willcockson@uth.tmc.edu](mailto:Irmgard.Willcockson@uth.tmc.edu). You should expect to hear from me within 48 hours. I am happy to meet with researchers located in Houston face-to-face, or use the teleconference system if you are outside of Houston.

## RECENT SC MIRECC PUBLICATIONS

### ETHNIC DISPARITIES IN THE TREATMENT OF DEMENTIA IN VETERANS

Kalkonde YV, Pinto-Patarroyo GP,  
Goldman T, Strutt AM, York MK,  
**Kunik ME**, Schulz PE

*Dement Geriatr Cogn Disord*  
28(2):145-152, 2009

Objective: To test for ethnic disparities in the evaluation and treatment of dementia. We reviewed 1,401 charts of patients from 4 Veteran clinics that routinely evaluate dementia patients. A total of 410 patients met criteria for dementia or mild cognitive impairment (MCI) and their charts were reviewed in detail. Regarding their evaluation, laboratory and imaging testing did not differ between ethnic groups ( $p > 0.05$ ). Depression screening was more common in African-American (AA) patients ( $p = 0.03$ ). Significantly more Caucasian patients underwent neuropsychologic testing ( $p = 0.001$ ). Regarding management, in a multivariate analysis, AA patients with Alzheimer's disease (AD) (odds ratio (OR) 0.09, 95% confidence interval (CI) 0.02-0.5) or 'all dementia types' (OR 0.6, 0.3-0.9) were significantly less likely to receive

acetylcholinesterase inhibitors (CHEIs). Other independent predictors of CHEI use were age  $\geq 71$  years (OR 5.2, 2.8-9.6), a diagnosis of AD (OR 3.1, 1.6-6.3) or MCI (OR 0.3, 0.1-0.7), and whether their evaluation included imaging (head CT or MRI; OR 1.9, 1.05-3.3). AA patients underwent comparable evaluations for dementia and the percentage of CHEI-responsive diagnoses rendered was similar across ethnic groups. However, dementia management differed significantly: AAs were prescribed CHEIs at considerably reduced rates. The reasons for this great disparity warrant further investigation because it may produce significantly greater cognitive impairment and hence suffering amongst AA patients.

### PSYCHOTHERAPY IN THE VETERANS HEALTH ADMINISTRATION: MISSED OPPORTUNITIES?

Cully JA, Henderson L, **Kunik ME**,  
Tolpin L, Jimenez D, Petersen LA  
*Psychol Serv* 5(4):320-331, 2008.

Informed by data on the dose-response effect, the authors assessed use of psychotherapy in the Veterans Health

Administration (VA). The authors identified 410,023 patients with newly-diagnosed depression, anxiety, or posttraumatic stress disorders using VA databases (October 2003 through September 2004). Psychotherapy encounters were identified by Current Procedural Terminology codes for the 12 months following patients' initial diagnosis. Psychotherapy was examined for session exposure received within the 12-month follow-up period and time (in days) between diagnosis and treatment. Of the cohort, 22% received at least one session of psychotherapy; 7.9% received four or more sessions; 4.2% received eight or more sessions; and 2.4% received 13 or more sessions. Delays between initial mental health diagnosis and initiation of care averaged 57 days. Patient variables including age, marital status, income, travel distances, psychiatric diagnosis, and medical-illness burden were significantly related to receipt of psychotherapy. Treatment delays and general underuse of psychotherapy services are potential missed opportunities for higher-quality psychotherapeutic care in integrated health care settings.

## DECEMBER CONFERENCE CALLS

CALL-IN NUMBER: 1-800-767-1750

ACCESS

CODE

8	MIRECC Leadership Council, 3:30 PM CT	19356#
10	National MIRECC & COE Education Group, 1:00 PM CT	28791#
10	National MIRECC & COE Implementation Science discussion, 2:00 PM CT	59066#
14	MIRECC Site Leaders, 9:00 AM CT	27761#
14	MIRECC Education Core, 3:00 PM CT	16821#
15	VISN 16 Mental Disaster Team, 11AM CT	76670#
16	MIRECC Program Assistants, 2PM Central	43593#
22	MIRECC Leadership Council, 3:30 PM CT	19356#

## MEET THE SC MIRECC FELLOWS

By Kristin Ward and Ashley McDaniel

In March 2009, the Little Rock, Arkansas SC MIRECC site was awarded a two-year Special Fellowship training program in Advanced Psychiatry and Psychology. Along with the Houston, Texas site, this interdisciplinary program aims to train psychiatrists, psychologists, and associated health professionals to become outstanding clinical or health services researchers in high priority areas of mental health. In concert with the theme of the SC MIRECC, the fellowship emphasizes mental health services research while offering clinical research opportunities. Little Rock focus areas include rural mental health or telemedicine, mental health in primary care, implementation science, PTSD, cognitive impairment and neuropsychology, and substance abuse. Houston focus areas include medical psychology/behavioral medicine, geropsychology, PTSD, anxiety and substance use disorders, health services and outcomes research, and implementation science. At both sites individualized, mentored research and clinical training is combined with a state-of-the-art curriculum that emphasizes research methods, statistics, epidemiology, mental health systems, quality improvement methods, education, and service delivery.

Didactic research training is coordinated through a Fellowship Hub Site located at the Palo Alto VAMC while research mentors are located at the training site. Fellows devote 75% of their time to research and education activities and 25% to clinical training. In collaboration with their mentors, Fellows will develop and implement a research project, publish and present findings, participate in grant writing, and utilize the latest technology for educational activities and clinical service delivery. Please welcome our new and returning Fellows:

**Teri Davis, Ph.D.** Dr. Davis is a first-year Fellow in Little Rock. She completed her master's studies at the Universities of Minnesota (Educational Psychology) and Oklahoma (Counseling) and received her Ph.D. in Clinical Psychology from Jackson State University. In 2009, she completed her clinical residency at Indiana University School of Medicine. Her dissertation, titled "HIV-risk Behaviors among African-American Survivors of the Hurricane Katrina Disaster," evaluated post disaster factors (i.e. depression, PTSD, coping self-efficacy) contributing to HIV-risk behavior. As a MIRECC Fellow, she will pursue a similar research direction with secondary data among Gulf Coast Veterans exposed to the disaster. Dr. Davis' primary interest involves conceptualizing the factors that contribute to mental health treatment seeking for depression and anxiety conditions among African-Americans; particularly women. Her work will take the direction of building a help-seeking model, guided by those existing models, which may be applicable to diverse cultures of women. She is also interested in investigating the factors that contribute to the scarcity of mental health providers of color in the VA system and/or other clinical settings. After the completion of her fellowship, she hopes to pursue a research career in an academic medical environment, as well as build a small clinical practice specializing in depression in women.

**Gregory Foster, M.D., J.D.** Dr. Foster is a first-year Fellow in Houston. He received his M.D. from the Pennsylvania State University - College of Medicine and completed his residency training in psychiatry at Johns

Hopkins Hospital. He also holds a J.D. from the Loyola University of Chicago - School of Law. Dr. Foster's research interests include cognitive changes in Parkinson's Disease, time distortion in psychiatric illness, and deep brain stimulation for psychiatric illness.

**John P. Jameson, Ph.D.** Dr. Jameson is a first-year Fellow in Houston. He received his Ph.D. in psychology (clinical emphasis) from the University of Pennsylvania in August 2009. Broadly defined, his research interest is in improving the access and quality of mental health care for Veterans in rural areas. He is particularly interested in the role that the discipline of psychology can play in this process. Dr. Jameson has conducted studies examining the utilization of empirically supported treatments in rural community mental health centers, diagnostic and treatment practices of rural primary care providers, and rural psychology workforce issues. As a MIRECC Fellow, he hopes to build on this work through projects aimed at improving the efficiency and sustainability of telemental healthcare systems and designing co-located mental health-primary care models that meet the needs of our rural CBOCs.

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**Mary E. Long, M.S., Ph.D.** Dr. Long is a second-year Fellow in Houston. She received her M.S. in Counseling Psychology in 1995 from Northeastern University; and her M.A. and Ph.D. in Clinical Psychology from The University of South Dakota in 2005 and 2008 respectively. Dr. Long's research interests lie broadly within the study of anxiety disorders and related cognitive behavioral treatment interventions. In particular, she has been most interested in the assessment and treatment of individuals with traumatic event exposure and PTSD, and mechanisms behind the disorder's development.

**Salah Qureshi, M.D.** Dr. Qureshi, is a second-year Fellow in Houston. He completed his medical training at Dow Medical College in Karachi, Pakistan, and completed his residency in psychiatry from Jamaica Hospital Medical Center in New York. His research interests are neuropsychiatric disorders, particularly PTSD and dementia, and the use of health services associated with them. Currently he is working on a retrospective cohort study using the VISN 16 data

warehouse to examine the association between PTSD and dementia.

**Angie Waliski, Ph.D.** A Poly-Trauma Fellow under the direction of the SC MIRECC, Dr. Waliski received her bachelor and master's degree from Southeastern Louisiana University and her Ph.D. from the University of Arkansas, Fayetteville in 2001. Following her degree program, she worked at a community mental health agency where she provided services in a therapeutic day treatment program and in local schools, to children aged 2-5 and their families. Dr. Waliski decided to treat preschool aged children after spending five years working with adolescents and adults seeking treatment due to sexual victimization and substance abuse. She believes that early interventions and treatment for abuse can prevent later mental health and addiction problems. After working with preschoolers for 5 years, she decided that more research was needed to determine evidence-based practices for this population and this Fellowship gives her the opportunity to do that. Dr. Waliski's current research focus is on the needs of young children in OIF/OEF families.

## MEET YOUR CBOC: GREENVILLE, MS

PARENT FACILITY: JACKSON VAMC

By Ashley McDaniel

The CBOC Partnership Project had the opportunity to visit the Greenville, Mississippi CBOC, which is located in the heart of the Delta. Greenville has a population of approximately 37,800 and is one of the largest cities in Mississippi. Greenville boasts of several cultural activities, including the Delta Blues Festival, the American Kennel Club Dog Show, bass fishing tournaments, hunting, and fishing. It also maintains a strong military history with venues such as the Greenville Air Force Museum and the Robert T. Henry Congressional Medal of Honor Marker and Gravesite.

The Greenville CBOC is under the umbrella of the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi. During our visit, we met with Elizabeth Woods, a social worker in the clinic. The clinic provides individual, family and couples therapy, smoking cessation, therapy for alcohol abuse, PTSD, depression, anxiety, and readjustment issues and disorders.

We thank the Greenville CBOC for welcoming us with their special Delta brand of southern hospitality.

