**The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred), and no references, tables, or figures. Send material to Francine Cournos, M.D., at the New York State Psychiatric Institute (fc15@columbia.edu) or Stephen M. Goldfinger, M.D., at SUNY Downstate Medical Center (steve007ny@aol.com).**

## Evaluation of CBT Training of Clinicians in Routine Clinical Practice

There is a consensus that cognitive-behavioral therapy (CBT) constitutes an effective and evidenced-based psychological treatment. Clinical practice guidelines consistently recommend CBT as an adjunctive intervention for schizophrenia and other psychiatric disorders, but mental health services often do not provide CBT to most of their consumers. Barriers to service provision often include a lack of suitably qualified practitioners to provide training, insufficient training programs, a lack of support from managers to implement training programs, financial constraints, limited time availability for training, and even a change-averse culture.

Peninsula Health Psychiatric Service (in Australia) has over the past three years implemented a 40-session, one-hour weekly CBT training program, which is available to all inpatient and community mental health clinicians in its service. Participants have included psychiatric nurses, occupational therapists, psychiatric trainees, and social workers. The training consists of a combination of didactic lectures, experiential training, and group supervision. Formal CBT is taught throughout the course and includes CBT for psychosis as well as depression and anxiety, which are often highly comorbid with psychotic disorders.

To address potential barriers, the facilitators, both experienced in teaching CBT, advocated for the implementation of the training program. Ongoing consultation occurred with management and other stakeholders, and although no additional funds were required for the program, management committed to invest in the training and ongoing supervision through allocation of resources. Information related to the need for change was disseminated throughout the service and included reviews of evidence-based practice and professional development discussion groups. Interviews conducted with participants before the training began indicated a genuine desire to provide a more effective treatment to their consumers.

The initial results indicated that the training program was effective in bringing about a relative change in practice for most of the participants. The immediate effectiveness of the training was assessed with a set of eight questions administered before and after the course to all participants. The results indicated that the course was successful in increasing participant's knowledge and confidence in implementing CBT for symptoms of psychosis, depression, and anxiety. In addition, participants reported an average increase of approximately 40% in the number of sessions spent using CBT. Audits were conducted 12 months and 24 months later on the files of the first two years of CBT-trained clinicians, and 88% had documented evidence of using CBT. Of these, 38% had implemented structured CBT interventions that showed progressive change for the consumer, and 50% showed evidence of teaching clients brief CBT strategies in a more opportunistic but effective manner. In addition, informal interviews were conducted with the clinicians to obtain qualitative data regarding the effectiveness of the training and the change in treatment approach.

Many clinicians highlighted the importance of ongoing supervision and periodic education sessions to the success of the training program. Further, some clinicians reported difficulty with providing a more psychotherapeutic approach within a case management model of care. As a result of the evaluation, a greater commitment from managers and administrators of the service has been given to imbed the training and supervision program within a broader strategic service plan. This has resulted in the development of clinical pathways to ensure that consumers have greater access to evidence-based psychological treatment as part of the service. Further study is required to more formally evaluate adherence to treatment models by clinicians who are trained in CBT and the effect of the interventions on the consumers.

To conclude, this training initiative indicates that a change to more evidence-based practice can be relatively easily implemented through the identification of specific individuals who will diligently advocate for change, identify and address barriers, promote a commitment from service administrators, ensure appropriate training, and assist with incorporating the change into routine practice within the context of broader strategic service planning. The result is better access to evidence-based therapy, which increases the ability of the service to address the charges of clinical governance: that the service meets the relevant needs of the population with a range of safe and effective therapies that reflect best practices for psychiatry.

***J. Richard Newton, F.R.A.N.Z.C.P.***
***Priscilla G. Yardley, D.Psych.***

*Dr. Newton is associate professor and director of psychiatry at Peninsula Health Psychiatric Service, Frankston Hospital, and Monash University, P.O. Box 52, Frankston, Victoria, Australia 3199 (e-mail: rnewton@phcn.vic.gov.au). Dr. Yardley is senior psychologist at Peninsula Health Psychiatric Service.*

## Behavioral Weight Loss Classes for Patients With Severe Mental Illness

There is much skepticism and stigma about whether patients with severe mental illness can participate in, understand, and benefit from a behavioral approach to weight loss. Many fitness programs, even those provided by medical facilities to their outpatient population, exclude patients with severe mental illness. This leaves this population without a source of information or support for weight loss, and obesity is a problem often caused by such psychiatric medications as second-generation antipsychotics. The purpose of our study was to adapt the behavioral weight loss program that was used in the Diabetes Prevention Program for use in a population with mental illness. Our three pilot studies found that patients with severe mental illness not only have the capacity to learn from such programs but also have the commitment to benefit from them.

We prescribed a diet and exercise program to achieve 7% weight loss by following the Diabetes Prevention Program recommendations. The program is carried out through weekly classes and individual case management. The materials for implementation are available at www.bsc.gwu.edu/dpp. The goal is to help patients achieve a 500-calorie deficit per day that will result in roughly one pound of weight loss per week. Patients are asked to exercise 30 minutes per day for at least five days per week, with a weekly group walking session being held immediately after class. Each patient is provided with a pedometer as a reward and a reminder to walk. Personal fat-intake goals are given to each patient, ranging from 33 to 55 grams per day. Patients are asked to keep a daily diary of food intake and exercise performed.

Patients attend 16 Lifestyle Balance sessions, based largely on the Lifestyle Balance classes used in the Diabetes Prevention Program (which come with an extensive training manual, available at www.bsc.gwu.edu/dpp/lifestyle/dppdcor.html). These sessions take approximately eight weeks to complete, with an average of two sessions being taught per week. On completion of the weekly classes, patients attend classes monthly for the remainder of the 12 months of the program to review important concepts and address any problems that might arise. Because of possible motivational problems and knowledge deficits in a population with severe mental illness, some participants may require additional time to complete the classes. In order to facilitate patient adherence, instructors are urged to offer flexible class schedules that can be performed at the patients' convenience.

Each patient is assigned a case manager who provides individualized nutritional counseling. The model we use in our treatment of patients is intensive case management with a minimum of biweekly contact for each patient, plus continual contact with his or her treating physician. For example, several patients are housed at nearby board-and-care homes, and it is not uncommon for case managers to make house calls to assist patients who inadvertently missed appointments.

Case managers work together as a team to help patients. For example, if patients are having difficulty with losing weight, they may be asked to allow a case manager to attend their meals for a few days to assist them in making healthy choices. In general we have found that one-on-one assistance with skills training is particularly beneficial.

Dietary adherence depends, in part, on environmental and caregiver influences. Many of our patients have little choice over the food that is fed to them in board-and-care homes. Accordingly, we assess patients' involvement in food preparation and their willingness to involve their caregivers in helping to make necessary dietary changes. In our program a professional chef and a nutritionist act as liaisons to patients' caregiver families and board-and-care operators and provide on-site nutritional and cooking education. They also assist care providers in understanding the dietary needs of our patients. In some cases we have recommended meal replacements, such as Slim-Fast, when patients are having difficulty with portion control. We also organize monthly field trips to local grocers to help patients learn how to purchase healthier foods while staying within their financial budgets.

Our patients responded well to consistent positive reinforcement for every step forward. We tempered our expectations to each patient's individual needs and applauded any and all positive change. With this approach, we slowly saw changes in the patients' attitudes, behaviors, and ability to maintain weight loss. A more formal assessment of our behavioral weight loss program is ongoing.

***Lisa H. Guzik, B.A.***
***Donna A. Wirshing, M.D.***

*Ms. Guzik and Dr. Wirshing are affiliated with the Department of Psychiatry, Veterans Affairs Greater Los Angeles Healthcare Center, 11301 Wilshire Blvd., Bldg. 210, Los Angeles, CA 90073 (e-mail: lisa.guzik@gmail.com). Dr. Wirshing is also an associate clinical professor in the Department of Psychiatry at the University of California, Los Angeles, School of Medicine.*