Eating Recovery Center

GUIDANCE ON LEVELS OF CARE FOR EATING DISORDER TREATMENT

How & When to Refer

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The Facts & Figures on Eating Disorders

Eating disorders affect more than 30 million Americans. Despite their prevalence and the reality that they have one of the highest mortality rates of all psychiatric illnesses, access to treatment remains challenging. Only one in three individuals with anorexia nervosa receives mental care, and for bulimia nervosa the numbers are much lower at approximately 6%. As a society, we still seem locked into the stereotype of who has an eating disorder, i.e., an adolescent, white, upper-middle-class female. And yet that stereotype is no longer valid. Eating disorders impact individuals of all ages, genders, races, sexual orientations and socioeconomic levels. More middle-aged individuals are requiring hospitalization than ever before and more men are being identified, with numbers now thought to be as high as 4 in 10 individuals with an eating disorder being male, compared to the historical statistic of 1 in 10.

In addition to the high mortality rate, eating disorders have a profound impact on the lives of individuals struggling with these illnesses. Without treatment, individuals can experience negative impact on their interpersonal relationships, lower rates of marriage and fertility, and inability to reach their potential. Despite these adverse consequences, individuals with eating disorders are frequently ambivalent at best about treatment as the eating disorder may play a role in their life, serving as a coping mechanism or even as an identity. Subsequently, they may be more reluctant to disclose their symptoms and less forthcoming with their medical provider, choosing to not reveal their behaviors.

Another factor is that eating disorders develop gradually. A person slowly begins to engage in these behaviors, and so the consequences develop over time and may not be recognized by family, friends and even providers. On top of this, many healthcare professionals are not trained to recognize, much less treat, eating disorders. The result is that many individuals miss out on the opportunity to access treatment. And yet, surveys have revealed that when asked directly by a healthcare provider about disordered eating, individuals tend to be open about their behaviors.

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Dr. Steven Crawford is Managing Director, Medical at Eating Recovery Center and Assistant Chief of Psychiatry at University of Maryland St. Joseph Medical Center. Dr. Crawford attended University of Maryland School of Medicine and trained in psychiatry there. He received fellowship training in eating disorders at the Center for Eating Disorders and has worked continuously in the field for over 25 years, including as Co-Director of the Center for Eating Disorders. Dr. Crawford is a past-president of the Maryland Psychiatric Society and chairs the Scientific Council of Med-Chi, the Maryland State Medical Society. He serves on the Multidisciplinary Peer Review Committee at University of Maryland St. Joseph Medical Center and heads Schwartz Center Rounds to bring doctors, nurses and other caregivers together to discuss the human side of healthcare. Dr. Crawford is consistently listed as a Top Doctor in local and national professional surveys.

Multiple studies have demonstrated that the earlier an individual enters treatment, the better the outcome. Our hope is that as the public awareness surrounding eating disorders increases, access to treatment will become more common and normalized.

Identifying a multidisciplinary treatment team with specialized knowledge and experience in evidence-based treatment, along with access to a comprehensive continuum of care, is critical in providing effective care. The continuum of care, ranging from **Inpatient Program (IP), Residential Program (RES),Partial Hospitalization Program (PHP)**, **Intensive Outpatient Program (IOP)** to outpatient treatment, allows for individuals to get the right amount of support, structure and autonomy that promotes recovery.

> All research indicates that the earlier the intervention, the better the outcome.

Several factors contribute to determining what level of care is optimal for a patient at a particular time. These factors include:

1. **Structure:** Individuals with eating disorders benefit from structure and support to not act on their disordered eating impulses. When the intensity of the behavior is beyond what the individual along with their support network, family and friends can manage, then a higher level of care is indicated.
2. **Medical complications:** Eating disorders adversely impact all organ systems in the body, and individuals may require intensive monitoring to ensure medical stability. When a patient is medically unstable, higher levels of care can ensure stability while allowing the patient to participate in psychiatric treatment.
3. **Therapy:** Based on severity of symptoms, patients may require daily intervention and opportunities to learn and practice coping skills to effectively manage the eating disorder. Higher levels of care offer patients multiple group therapies coupled with individual and family therapy, nutritional counseling and meetings with their psychiatrist to provide comprehensive treatment.
4. **Safety:** At times individuals with eating disorders may experience worsening depression and even suicidal ideation. When this occurs, higher levels of care can provide increased support and observation to ensure the safety of the individual.

For providers, it is important to be knowledgeable about the medical complications, levels of care and referral guidelines for patients struggling with an eating disorder. To effectively assess patients, achieve optimal outcomes and help foster the continuum of care, our multidisciplinary team at **Eating Recovery Center (ERC)** collaborates with referring providers before, during and after treatment.

An Overview of the Medical Complications of Eating Disorders

While eating disorders are genetic, dieting and body image dissatisfaction are major risk factors for developing an eating disorder. A significant percentage of dieters move on to disordered eating behaviors and eventually an eating disorder. We know that adolescents who diet are five times more likely to develop an eating disorder and extreme restriction increases the likelihood by 18 fold.

The specific eating disorders defined in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5) include anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED) and avoidant restrictive food intake disorder (ARFID). In addition, individuals engaging in disordered eating but not fully meeting the criteria for one of these diagnoses tend to be at comparable risk for adverse consequences.

As noted, eating disorders can have major medical complications adversely impacting an individual's, growth and development, as well as their overall physical health. According to the American Psychiatric Association, medical comorbidities include:

- **Cardiovascular** – Most commonly, bradycardia, orthostatic hypotension, weak irregular pulse, acrocyanosis
- **Central nervous system** – Cognitive impairment, anxiety, depression, irritable mood; seizures and peripheral neuropathy in severe cases
- **Gastrointestinal** – Abdominal distention with meals, abnormal bowel sounds, acute gastric distention (rare); in purging patients, benign parotid hyperplasia, caries, gingivitis; in patients with vitamin deficiencies, angular stomatitis, glossitis, diarrhea
- **Muscular** – Muscle wasting in severe cases
- **Neurological** – Difficulty sleeping and concentrating, seizures and muscle cramps, dizziness and fainting, sleep apnea
- **Endocrine** – Hypothermia
- **Pulmonary** – Wasting of respiratory muscles in severe cases
- **Reproductive** – Loss of menses or primary amenorrhea, arrested sexual development or regression of secondary sex characteristics, fertility problems, higher rates of pregnancy complications and neonatal complications; deficiencies in the mother can result in deficiencies in the fetus
- **Skeletal** – Point tenderness, short stature and arrested skeletal growth in severe cases, osteopenia or osteoporosis
- **Other health consequences** – Dry skin, brittle hair, kidney failure, anemia, decreased white blood cells and increased risk of infection

A Breakdown of Levels of Care for Eating Disorder Treatment

The earlier the intervention, the better the outcome. Untreated individuals can become entrenched in their behaviors. The more entrenched, the more "hard-wired" the eating disorder becomes in the brain and the more difficult it is to effect change. That being said, studies have demonstrated that even after 20 years, people can change and can experience recovery. There is always hope and recovery is always possible.

> Due to the severe complications of eating disorders, admitting a patient to the appropriate level of care is critical.

As complex illnesses, eating disorders require access to a continuum of care. An individual's ability to manage and control their symptoms affects the necessary level of care, and they should be able to move between programs as treatment needs and goals change.

The least intensive level of care, the **Intensive Outpatient Program (IOP)**, is recommended when working closely with an individual and their family (or other support networks) to assist them in implementing structure to combat disordered eating behaviors. If patients can implement that structure with their support network and use it to support coping skills that prevent acting on those behaviors, a lower level of care is appropriate. The IOP level of care facilitates the individual's remaining in the community and continuing to go to school or work while receiving substantial support. It also serves as a step down from higher levels of care to facilitate a smooth transition back into the community. ERC offers IOP treatment for 3 hours per day, 3 days a week, which typically includes individual therapy, group therapy, dietary sessions, meal support and medication management, as well as family therapy and support.

A **Partial Hospitalization Program (PHP)** is recommended when the patient continues to act on disordered behaviors at a lower level of care. ERC offers PHP 10 hours a day, 7 days a week in an outpatient setting. Patients spend nights at their home or in nearby accommodations, allowing them to practice their skills in a non-treatment setting at night. Patients receive daily meals, snacks and group therapy, as well as regular meetings with a therapist, dietitian and psychiatrist.

A **Residential Program (RES)** is recommended for patients who have not made significant progress in IOP or PHP or for those whose symptoms upon presentation are at a level for which the lower levels of care cannot provide adequate management and support. They typically are struggling with motivation to change and require a highly structured treatment model. In residential treatment, patients are admitted full time into a non-hospital-based treatment setting where they receive meal support and multidisciplinary treatment, including individual and group therapy, as well as family therapy and support.

How and Why Residential Programs Are Critical to Support Patients In Need of Intensive Care

The need for residential care is often most evident when, after a provider has reviewed, revised and refined what worked and did not work in a patient's care plan, the illness remains active. I have told patients: "It's not that this is a failure on your part, it's that at this point in time the illness is at such a level of intensity that you need additional support. We need more help for you than what you're able to put together outside of a higher level of care." Framing the progression of illness to a level warranting a higher level of care can be likened to the progression of medical illnesses that result in hospitalization. As many individuals with eating disorders struggle with perfectionism, it can be helpful to frame the need for higher levels of care within the context of the illness's severity rather than a failure of the patient.

Eating disorders have an extremely high rate of comorbidities and for many the eating disorder has served as a coping skill – sometimes for years – for comorbid disorders such as anxiety and depression. When the eating disorder is removed, the co-occurring symptoms can worsen. Patients with eating disorders can experience hopelessness and may engage in self-injurious behaviors or have suicidal ideation. As the individual in the process of trying to recover may feel worse, it can be difficult to resist going back to behaviors that, while unhealthy, provide relief. A key element of higher-level care is to provide a safe environment while managing these exacerbated behaviors. Ultimately, the individual is assisted in developing alternative coping skills that are more constructive.

Our centers are designed with colors and artwork that support healing and tranquility.

A patient's length of stay in eating disorder treatment is based on the individual symptoms and their severities, any co-occurring disorders, medical complications and the ability to have a cohesive and structured support network.

An extended length of stay in an RES solidifies nutritional progress for patients who have not responded to hospitalization, PHP or IOP. It can additionally provide extended respite from home if that environment is particularly chaotic. Because residential programming is part of a continuum of care, it is important to shift patients to a lower level of care as they improve.

When to Refer Patients to a Different or Higher Level of Care

Due to the severe complications of eating disorders, admitting a patient to the appropriate level of care is critical. The following is a brief overview of referral guidelines.

When to refer to Intensive Inpatient:	• There are many factors to consider at this level, including the consideration of age (adult, or child/adolescent). Overall, these patients are not medically stable. • The patient is experiencing acute medical complications of malnutrition including dehydration, cardiovascular complications and hypothermia. • The patient is experiencing acute food refusal and requires tube feeding.
When to refer to Residential:	• The patient is medically stable and does not require intensive medical intervention. • The patient is psychiatrically impaired and unable to respond to partial hospitalization or outpatient treatment, or has relapsed after several inpatient hospitalizations.

When to refer to Partial Hospitalization:	• **Distinctions from Inpatient:**
	  ○ The patient is medically stable, sometimes approaching a past weight at which point they became medically unstable.
	  ○ The patient does not engage in eating disorder behavior overnight or has established support structures to facilitate this goal.
	  ○ The patient no longer requires the intensity of a higher level of care but is unable to manage in outpatient care without daily contact and substantial meal support.
	• **Similarities to Inpatient:**
	  ○ The patient experiences social, educational and/or vocational setting impairments.
	  ○ The patient requires daily assessment of physiological and mental status.
	  ○ The patient engages in daily eating disorder behaviors.

When to refer to Intensive Outpatient:	• **Distinctions from PHP**
	  ○ The patient has not responded to outpatient care, but symptoms are not at the intensity or frequency to warrant PHP.
	  ○ The patient no longer requires intensity of a higher level of care but is unable to manage in outpatient care without frequent contact and meal support.
	  ○ The patient can function in their social, educational or vocational environment while in treatment.
	• **Similarities to PHP**
	  ○ The patient is medically stable.

The newly opened Residential Program at **Eating Recovery Center Baltimore** is a welcome addition to the community, allowing people to more easily access the appropriate level of care closer to home. Families are a critical component of treatment; the ability to have support nearby while a loved one is in treatment is a valuable marker of recovery. Because RES is onsite with PHP and IOP, patients can transition between levels of care efficiently and effectively. ERC can meet specific patient needs and goals – and respond to them with the appropriate level of care.

Sources:

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3) Guideline Watch (August 2012). Practice Guideline for the Treatment of Patients With Eating Disorders, 3rd Edition, January 2014, FOCUS The Journal of Lifelong Learning in Psychiatry 12(4):416-431, DOI:10.1176/appi.focus.120404. Retrieved from psychiatryonline.org