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Building Collaborative Connections: Creating an Eating Disorder Task Force

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**Elisa Hernandez, Ph.D.
Kevin Thomas, Psy.D.**

Monsour Counseling and Psychological Services



Overview

- **Introduction**
- **Eating Disorders on Campus**
- **Complex Issue**
- **Treatment Team Model**
- **Working with our Limitations**
- **Task Force Model**
- **Two components of Model**
- **How to create task force at your University**



Eating Disorders on Campus

- Students eating a special diet to increase weight loss increased from 4.2% in 1995 to 22% in 2008 (White, 2011).
- **4% of females and 1% of males reported vomiting or taking laxatives to lose weight in the previous 30 days (American College Health Association, 2007).**
- Data from one college over a 13 year period shows disordered eating behaviors increasing from 23 to 32% among females and from 7.9 to 25% among males (White, 2011).



Eating Disorders on Campus

- **It is estimated that clinical eating disorders affect 10 to 20% of female university students and 4 to 10% of male university students (Hoerr et al, 2002).**
- **According to a study done by colleagues at the American Journal of Psychiatry (2009), crude mortality rates were:**
 - **4% for anorexia nervosa**
 - **3.9% for bulimia nervosa**
 - **5.2% for eating disorder not otherwise specified**



Eating Disorders at The Claremont Colleges

- **Last year, 12% Of the clients seen at Monsour Counseling & Psychological Services were Diagnosed with an Eating Disorder:**
 - **6% EDNOS**
 - **4% Bulimia**
 - **2% Anorexia**



And yet We Know that . . .

Early detection, intervention and treatment is extremely important and gives an individual the best chance of recovery (Arcelus, 2011).



This is a complex issue:

- **Reluctant to seek treatment**
- **Many different professionals need to be involved with the treatment**
- **Treatment can be lengthy**
- **Not all students may want to seek treatment**
- **Splitting between providers**
- **Rates of Substance use, Trauma, and Self-Injurious Behaviors within the eating disorder populations.**

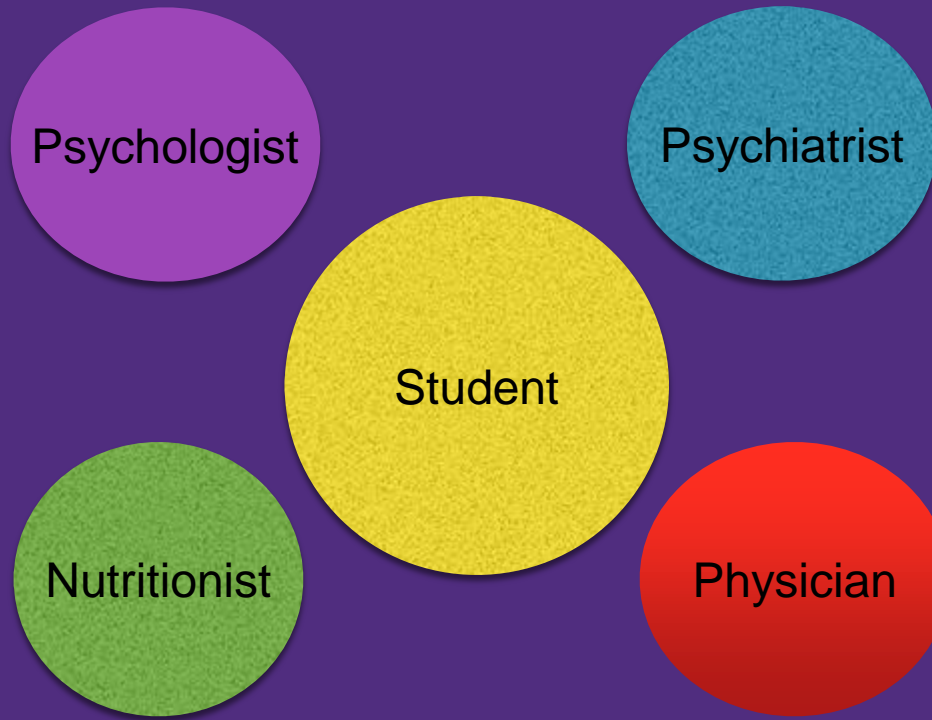


Method for Selecting/Creating a Model

- **Recognized the need on campus**
- **Looked at current Gold Standard**
- **Analyzed available resources to students on campus**
- **Reviewed the limitations that we faced on campus**
- **Found a way to work with limitations and still gain multidisciplinary communication**



Our Goal was/is Collaboration:





- **A treatment team is the recommended model of care (Yager, 2006):**
 - **Psychiatrists, physicians, mental health professionals, dietitians**
- **In outpatient care, communication is essential to monitoring progress, making adjustments, and clarifying roles (APA Treatment Guidelines for ED, 2012).**



Outpatient Level of Care (APA Treatment Guidelines for ED, 2012)

Medical Status	Medically stable to the extent that more extensive medical monitoring is not required (e.g. re-feeding, multiple daily lab tests)
Suicidality	If suicidality is present, depends on estimated level of risk
Weight as % of healthy body weight	Generally >85%
Motivation	Fair-to-food motivation
Co-occurring disorders	Presence of co-morbid condition can influence level of care
Structure needed for eating/gaining weight	Self-sufficient
Ability to control compulsive exercising	Can manage compulsive exercising through self-control
Purging behavior	Can greatly reduce incidents of purging in an unstructured setting; no significant medical complications
Environmental Stress	Others able to provide adequate emotional and practical support and structure
Geographic availability of treatment program	Patient lives near treatment setting



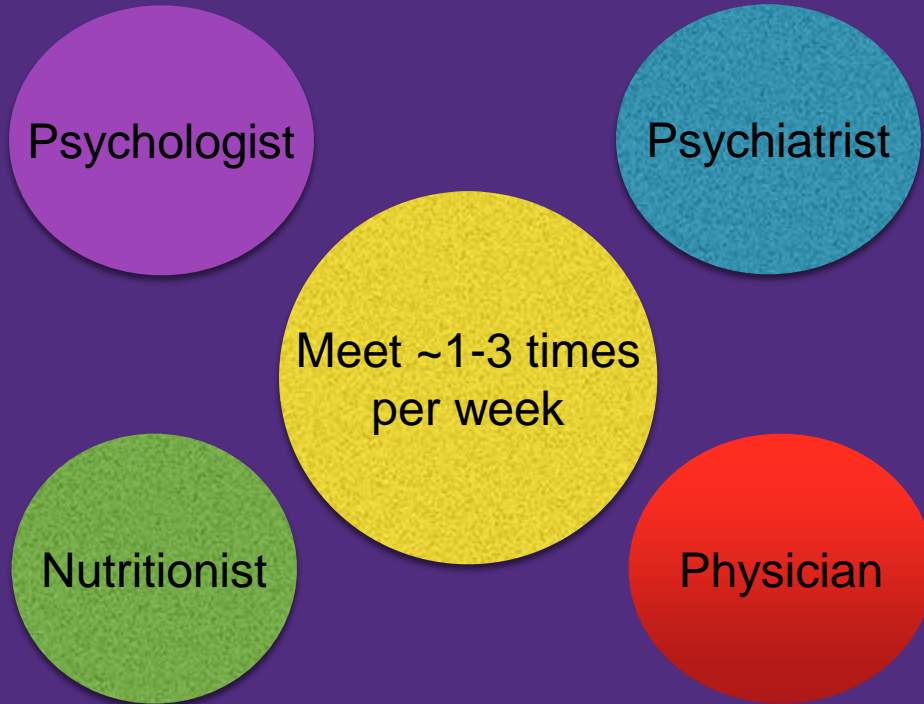
We wanted to do so much and yet there were limitations

- **Small College Campus**
 - **No hospital**
 - **Session limits for counseling**
 - **Session limits for nutritional education**
 - **Limits on medical services**

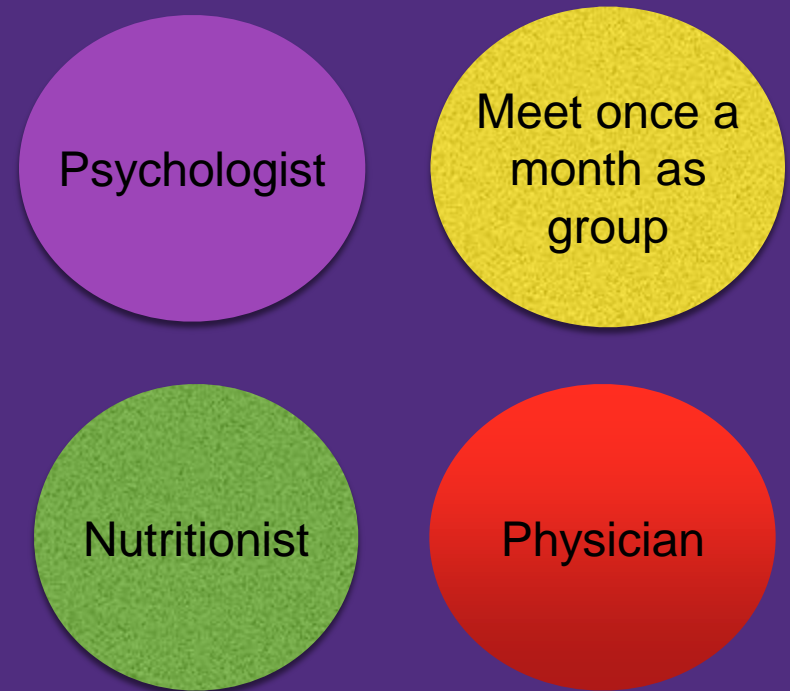


Treatment Team vs. Task Force

Treatment Team



ED Task Force





Clinical Providers

- ◆ **Counseling Center**
 - ◆ **Psychologists & Psychiatrists**
- ◆ **Student Health Center**
 - ◆ **Physicians and Nurse Practitioners**
- ◆ **Student Health Education Center**
 - ◆ **Registered Dietician**

Additional Team Members (Staff/Faculty)

- ◆ **Athletic Trainers**
- ◆ **Health and Wellness Coordinators**

Student Participation

- ◆ **Partner with Student Organizations**



What We Do

Direct Services

- **Brief Individual Therapy (8 sessions)**
- **Group Therapy**
- **Medical Monitoring (1x/wk)**
- **Nutritional Assessments (2-4 sessions)**
- **Clinical consultation and collaboration**
- **Evaluations/Assessments**
- **Treatment Recommendations**
- **Referrals - including low cost/pro bono referrals**

Outreach and Programming

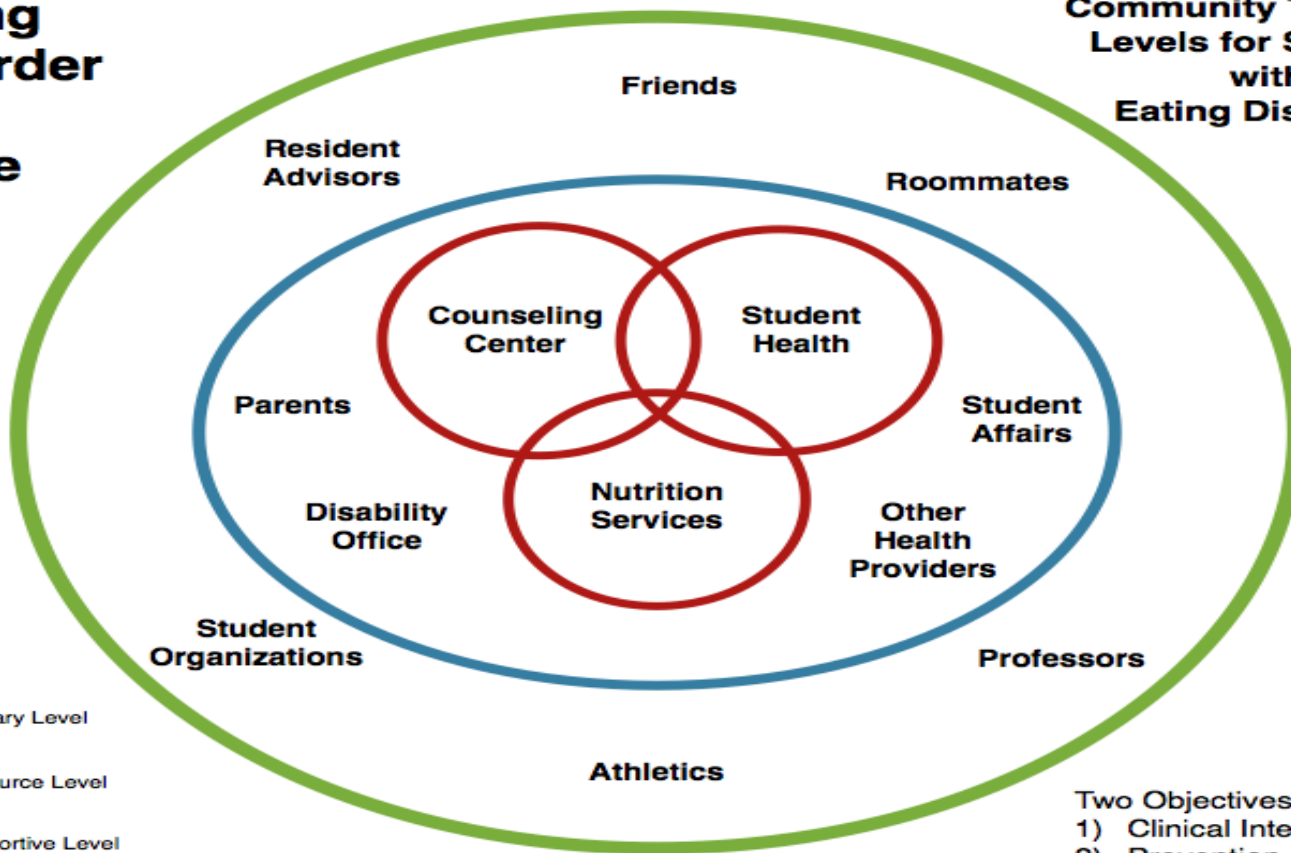
- **Prevention Programs**
- **Screening**
- **Policies and Procedures**
- **Consultation**
- **Education**



Our Model:

Eating Disorder Task Force

Community Treatment Levels for Students with Eating Disorders



- Two Objectives:
- 1) Clinical Intervention
 - 2) Prevention Intervention



Vision

To ethically assess, evaluate, monitor, manage, and support students with identified eating disorders, disordered eating habits, and body image concerns through a collaborative multidisciplinary task force.



Mission

- 1. Support students with direct services and provide appropriate referrals to enhance their psychological well-being and physical health.**
- 2. Provide education, awareness, and outreach services to students, faculty, and staff at The Claremont Colleges.**



Values

Collaborative Care

Ethical Treatment and Best Practices

Enhance Professional Competence

Increase Awareness

Multiculturalism and Diversity

Strengthen Relationships

Develop and Implement Outreach

Programming

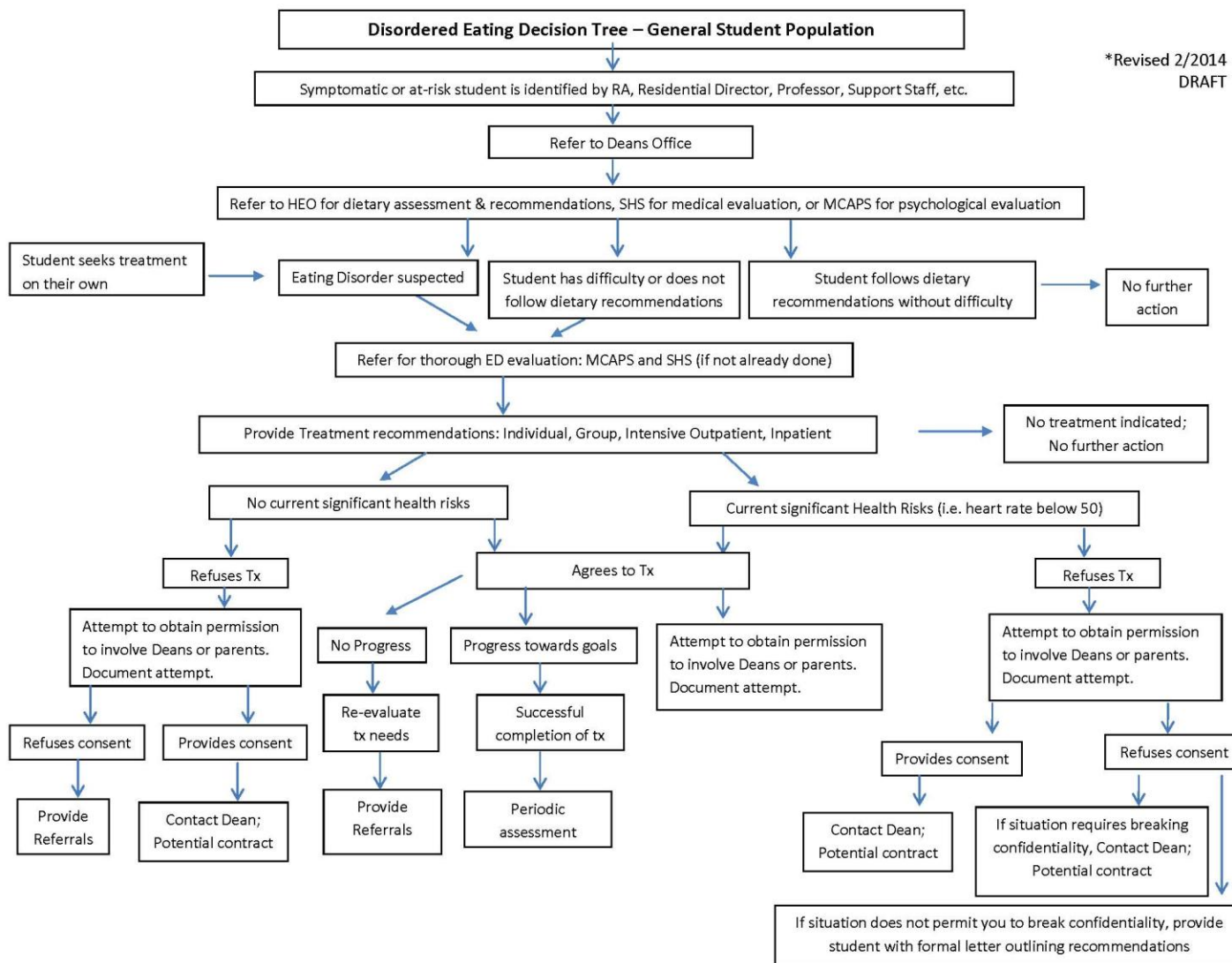


Referral Process

- **Student affairs staff, athletic coach/trainer, residence staff, etc. become aware of a student who may be experiencing pathology around eating or body image issues.**
- **They refer to one of the three departments in the Task Force**
- **Contact with one department will result in referrals to the other two departments**
- **MCAPS, in consultation with SHS and HEO, can determine appropriate level of care (inpatient, intensive outpatient, etc.) and make treatment recommendations.**



Referral Decision Tree





Prevention Efforts (NEDA, 2013)

- **Campus wide programming and screenings**
- **Education campaigns**
- **Staff training**
- **Trainings for RAs and Mentors**
- **Resident life programming for freshman**
- **Programs targeted at athletes**



Pitfalls

- **Treatment non-compliance**
- **Student refusal to sign release for parents, student affairs, or task force**
- **Not aware/denial of severity of current situation**
- **Lack of financial resources**
- **Lack of community referrals/resources**
- **Access issues for treatment**
- **American with Disabilities Act as Amended**
- **Overemphasis of academics (instead of student wellness)**



Benefits of EDTF

- **Support from colleagues**
- **Strengthened relationships**
- **Increased knowledge**
- **Collaborative assessment**
- **Multidisciplinary perspective**
- **Unified front for treatment recommendations**



Ways to Implement an Eating Disorder Program at Your School

- **Conduct a needs assessment**
- **Determine resources and limitations**
- **Develop a mission and vision that reflects your intentions**
- **Identify potential members**
- **Determine scope of services**
- **Establish referrals in community**



Elements of toolkit

- **Create release of information for task force to facilitate open communication**
- **Choose an assessment for gathering information**
- **Decide on referral procedure**
- **Create a written protocol**
- **Monitor quality control and evaluate outcomes**



Policy Implications/Future considerations

- **Student Code of Conduct**
- **Medical Leave of Absence**
- **Americans with Disabilities Act as Amended (ADAA)**
- **Quality Control**
- **Building Relationship/Establishing Presence**



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Thank You

Questions

Contact Information

Elisa Hernandez, Ph.D.

elisah@cuc.claremont.edu

Kevin Thomas, Psy.D.

kevint@cuc.claremont.edu



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