

Eating Disorders on Campus:

Integrated Treatment and
Challenges

Identifying at Risk Students

- Review incoming medical records
- Invite families to share information
- Educate residential staff- reports from maintenance and dining hall workers
- Student Advocacy/ Peer Counseling
- Self-screening online
- Involve PCPs

Challenges

- Stigma
- Assessment
- Readiness for Treatment
- Higher Levels of Care
- Why Now?
- Leaves of Absence and Return

Evaluations

- Follow path of least resistance: PCP, nutrition
- Low BMI students- Guidelines: BMI under 18 encourage medical follow up and possible MH referral
- Outreach and Education to Vulnerable Groups: Athletes, Dancers, Theatre

Impediments to Academic Success

- Stress 32.4%
- Cold/Flu 25.6%
- Sleep Problems 24.6%
- Depression 15.3%
- Internet Use/ Games 13.4%

The Treatment Team

- Individual therapist: “captain” of team, responsible for coordinating care
- PCP: initial medical intake; ongoing monitoring weight, VS, labs as needed
- Nutritionist: works with patient to normalize eating, using individualized strategies
- Psychiatrist: prescribes medication if indicated; supports team efforts

Treatment Team

- Counseling Separate from Student Health on many campuses
- Psychiatry Role
- "The Heavy"

Coordination of Care: Communication

- Need to Know: MH Record Firewall
- Sharing Information with Primary Care, Nutrition and Counseling
- What if Student Refuses Communication with PCP or Care Outside of Health Service
- ? Residential Staff, Administration

Referral and Support: Don't worry alone

- Identified ED Team: Assigning Students to Clinicians
- Mandatory Assessments from residence
- PRN Case Conferences
- Review Meetings for High Risk Students:

Treatment Modalities

- Group, individual, Nutrition
- DBT- mindfulness, distress tolerance
- Skills based treatment
- Balanced focus on normalized eating and addressing underlying issues
- Treatment manuals

Resource Challenges

- Resource limitations: Caring for whole community: frequency of therapy
- ED expertise of Staff- training
- Insurance and Outside Providers
- Staffing: 1/1000, 1500 UHS 1/800

Groups

- Hard Sell- Shame, Denial, and Embarrassment
- Huge Relief- often most helpful treatment
- Mix of Students- Anorexic, Bulimic, Binge Eaters, Males, Grads and Undergrads
- Stage of Recovery and Resistance
- Structure and Balanced Participation

Groups

- Different Points in Recovery
- Different Issues
- Self Care is a Primary Focus
- Structure: CBT, DBT, Dynamic
- Contact Outside of Group
- Email, Same Dorm, Department, Lab, Section

Legal Issues

- Content of Handbook re: Hospitalization, Notification
- 2 Reasons for Involuntary Leave:
 - A. Medical Safety Concerns
 - B. Significant Disruption to Community
- Contracts

Contracts

- What are the expectations: treatment compliance
- Who writes the contracts?
- What are the consequences?

Leaves of Absence/ Hospital

- Voluntary/ Involuntary
- Clear Role Definition and Decision Tree
- College Makes Decisions with Clinical Input
- Content of Leave Letters (must be in therapy, maintain BMI)
- Health-Safety Key Factors

Readmission Expectations

- Guidelines set at time of Leave
- Check in 6-8 weeks before planned return
- Information needed- written and verbal contact with care provider
- Work requirement
- Contract

Recovery Process

- Make Health # 1 Priority
- How to Keep the College off your Back and Stay in School
- Normalize Eating- 2 Steps Forward 1 Back
- Distress Tolerance: Temporary States
- Identify Needs/Express Feelings, including Anger
- Challenge Self-Defeating Behaviors
- Accept Support and Reduce Isolation