

The Mercy Safety Model:

Outcomes for Weight Restoration
and
Potential Impact on Secure Familial
Attachment

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Program History

- 1988: Jackson Brook Institute, now Spring Harbor Hospital
- Inpatient treatment model
- ALOS 40 days
- Minimal focus on family therapy
- Developmental rationale: “A growing adolescent needs independence and control over her life”

History (cont.)

- 1996: Partial Hospitalization as primary treatment environment
- Format: 12 hours/day, 5 days/wk, ALOS 15 days
- Family involvement: informational
- “do’s and don’t’s”
- Patients maintained control over all aspects of treatment and parents continued to be secondary resources

Outcomes: Pre Safety Model

- Patients were not meeting recovery expectations on the weekends
- Only highly motivated patients made progress in treatment
- Harm reduction expectation vs elimination of behaviors
- Staff felt ineffective

Mercy Safety Model

**Rationale: Safety first, then
independence based on
demonstrated readiness**

**Assumption: The child is perfectly
capable of handling distress within a
safe environment**

Attachment Theory

- Infants instinctively motivated to seek and maintain proximity to mother
- When needs are met, child develops secure and stable base
- Healthy self can develop

Theory: This can occur at any age

Components of Safety Model

1. The Support Plan

- The patient is supervised 100% of the time by parents or other informed adults
- The meal plan is non-negotiable

Adolescents: Expectation is full compliance

Adults: Recommendation only.
Greater compliance increases

Components of Safety Model

2. Multi-Family Group

- Detailed report of weekend events
- Expectations:
 - Full compliance with mealplan
 - No forced compliance by parents
 - Patient aware of natural consequences
 - Sharing on successes and struggles
 - Alignment with other families

Components of Safety Model

3. Self-Evaluation Group

- 2 hour daily group
 - Multiple staff avoids splitting
 - Focus on personal accountability
 - Personal goals and development within established environment of safety
 - Principles of Change: Johari's Window

Outcomes: Safety Model

- Patients gain confidence by demonstrating ability, first in a highly-structured environment, then on their own
- Immediate normalization of meal plan
- Empowering parents to be parents
- Change the identified patient's environment to one that supports success
- Increase the patient's personal accountability

Effectiveness of Treatment

Pre Safety Model

Admission Weight	Weekend 1	Weekend 2	Weekend 3	Discharge Weight	Delta
89	96-93	96-92	96-95	95	+6
111	111-111	112-111	112-112	111	0
114	114-112	116-114	115-113	116	+2
104	105-106	106-105	106-105	105	+1
89	95-93	97-95	99-98	103	+14
86	89-88	92-90	92-93	93	+7
124	125-124	126-124	125-124	126	+2
118	119-118	118-118	119-119	119	+1
111	114-114	114-115	114-114	114	+3
112	118-115	116-114	116-113	113	+1

Post Safety Model

Admission Weight	Weekend 1	Weekend 2	Weekend 3	Discharge Weight	Delta
87	88-89	90-91	94-97	98	+11
130	131-132	133-134	135-139	141	+11
101	101-102	104-105	106-108	115	+14
89	90-89	90-92	92-93	102	+13
103	104-105	106-109	109-110	114	+11
89	89-92	94-95	96-98	103	+14
99	103-106	104-104	105-108	112	+13
108	108-113	113-113	113-115	122	+14
96	99-100	101-103	104-106	105	+9
98	101-103	102-107	105-108	112	+14

Attachment theory: Link to intensity of eating disorder symptoms

- Armstrong and Roth, 1989
- Kenny and Hart, 1992
- Orzolek-Kronner, 2002

- Our study goals: Can brief, intensive intervention increase secure attachment?
- Data to come