

CANTERBURY DISTRICT HEALTH BOARD

EATING DISORDERS SERVICE REVIEW SUMMARY REPORT MARCH 2010

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Appendices

1. International guidelines for the treatment of eating disorders
2. International survey on age-mixing and service provision

Abbreviation Key:

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| CAFMHS/CAF | Child Adolescent and Family Mental Health Service |
| CFIU | Child and Family Inpatient Unit |
| SIEDS | South Island Eating Disorders Service |
| UNCROC | United Nations Convention on the Rights of the Child |
| YIU | Youth Inpatient Unit |

Compliance with the Ministry of Health’s broad interpretation United Nations’ Convention on the Rights of the Child (UNCROC)

Article 37(c) of UNCROC requires that “every child (age 17 and below) deprived of liberty be separated from adults unless it is considered in the child’s best interest to do so.” This guideline highlights the applicability of this provision to children and youth who are mandatorily detained under the Mental Health Act (Compulsory Assessment and Treatment Act 1992) and the Intellectual Disability (Compulsory Care and Rehabilitation Act 2003). The guideline then extends the relevance to all in-patient and residential settings and states that it should be applied to voluntary patients also.

Current status: Individuals <14 years with eating disorders are admitted to the Child and Family Inpatient Unit (CFIU). Those 14 and over are admitted to the South Island Eating Disorders Service (SIEDS). The average age of patients on the SIEDS is 23 years (range 14-46). Adolescents < 18 years comprise ~33% of inpatient admissions (~2 beds).

Treatment guidelines: As seen in Appendix 2, each of the specialist treatment guidelines underscores the importance of a multidisciplinary team in the treatment of eating disorders.

International survey: As seen in Appendix 3, other countries that are UNCROC signatories do not apply the age-mixing provision to the treatment of eating disorders. Most programs have mixed programming or joint programming. Only large metropolitan areas with independent children’s hospital facilities have the luxury of parallel adult and child eating disorders services.

South Island Options Considered:

Four options were considered by the SIREN plan to address the UNCROC provision:

- 1. Status quo with services for the group aged 13 and under remaining with CFIU and those aged 14 and over in the Eating Disorders Service.*
- 2. Status quo as above, with additional adolescent clinical input for those patients aged 14– 18.*
- 3. Child and youth services (0 – 17 years of age inclusive) provided by Child and Family Service (CAF) and adult services (18 years of age and over) provided by the Eating Disorders Service.*
- 4. All patients in the Eating Disorders Service with an integrated pod for child and youth patients.*

Guiding considerations:

1. Guidelines for Compliance document states:

Age-mixing “practice of placing a child (under 18 year old) into an adult unit or an adult (18 years or older) into a youth unit. There are special circumstances under which this may be in the child’s best interest.

Comment: Arguably, eating disorders represent special circumstances. The series of guidelines presented in Appendix 2 indicate that specialist multidisciplinary treatment is of paramount importance in treating individuals with eating disorders. In terms of outcome and mortality, multidisciplinary specialist care for eating disorders overrides other considerations.

2. UNCROC principles

2.1 The child’s best interests (article 3(1))

Comment: The best interest of the child is protected by delivering evidence-based interventions in an age-appropriate manner. As such the SIEDS has already taken enormous strides to provide such a service. Rather than dismantling their efforts, they should be supported and extended.

One alternative solution to address UNCROC provisions was having youth (ages 16-18) with eating disorders housed on the Youth Inpatient Unit (YIU). The YIU is an eight bed facility for the assessment and treatment of youth aged 16 up to the 18th birthday, or older if they are still at school, who have a psychiatric disorder (including but not limited to depressive, psychotic, anxiety disorders, substance abuse with co-morbidity etc.), and who cannot be effectively treated or managed in other mental health or youth services. This is a mixed-gender acute unit.

In short, the recommendation to house eating disorders patients on the YIU is unacceptable for both clinical and safety reasons.

2.2 Facilities designed specifically for children and adolescents, with distinct child-centred staff, personnel, policies and practices.

Comment: CFIU is specifically outfitted for care of children and is in compliance.

SIEDS already has considerable experience and expertise working with youth and families. To be wholly compliant with the broadened UNCROC guidelines, this can be improved. Options here include greater consultation and education by youth staff to the eating disorders service; increased opportunities for eating disorders staff to undertake youth-specific training including adolescent mental health papers, developmental psychology papers; increased care coordination and participation by SIEDS staff on CFIU and vice versa enabling more seamless transition between services as patients age-out of the CFIU service.

2.3 A precautionary plan in age-mixing situations must include awareness of the young person’s potential physical, emotional, and sexual vulnerability (level of supervision, visiting policies and smoking or other drug use policies may need modification).

Comment: The situation in eating disorders is unique in that the risk is lower on the age-mixed unit than on the age-equivalent generalist unit. Given that patients with eating disorders of all ages tend to be female and physically challenged by emaciation, this does not represent a high-risk environment for victimization at all.

2.4 The young person will have access to appropriate therapeutic and recreational activities and their educational needs will be met.

Comment: The SIEDS already provides age-appropriate therapeutic and recreational activities. Program materials should be reviewed to determine whether separate youth and adult materials are needed.

3. Available resources

The terms of reference of this review suggests that solutions be found that do not request additional funds. The proposal to house <14 on the CFU, 15-18 on the YIU, and >18 on the SIEDS proposes creating three redundant parallel services. This is a non-viable solution financially, and represents an artificial division based on age rather than developmental stage of the patient. New Zealand would be the only country in the world to have three parallel redundant services based on arbitrary age divisions.

4. Acknowledging the possibility that major changes in facilities planning may occur, which would impact the location of the SIEDS

Opinions varied on the likelihood and timing of development of the Christchurch Public site and whether the SIEDS would be likely to move there. A comprehensive eating disorders service is best suited to a medical campus with ready access to paediatrics, general medicine, gynaecology, cardiology, and other medical specialities that are often required during the course of treatment of eating disorders. If this occurs, then careful planning should be conducted so that the new facilities would be in compliance with the broadened UNCROC directive.

Recommendations:

1. The SIEDS should be retained, expanded, and empowered to guide and deliver treatment for eating disorders in the South Island across the life span, in both sexes, and across cultures in the South Island.
2. Rather than fragmenting care across the CFU, the YIU, and the SIEDS, in the second stage, all care of eating disorders patients [i.e., inpatient, intensive outpatient (if feasible and appropriate), and outpatient]] should be centrally located under the SIEDS umbrella. In the first stage (prior to physical reconfiguration and staff recruitment), patients <14 should continue to be admitted to the CFU for inpatient treatment with increased input from SIEDS staff and >=14 should be admitted to the SIEDS for inpatient treatment when required. Ultimately, all eating disorders treatment should be consolidated on the SIEDS in a manner that enables compliance with the broadened interpretation of UNCROC. If relocation to the Christchurch Public site occurs, complete consolidation of services with available medical specialties would be ideal.
3. Distribute available FTEs to ensure both adult and child/adolescent consultant time, adequate afterhours medical coverage, increased child/adolescent trained family therapy clinician time, and clinical positions that will focus on enhancing consultation via the hub and spoke model

both with adult mental health services and Child Adolescent and Family Mental Health Service (CAMHS) services throughout the districts and within Canterbury including rural Canterbury.

4. To remain compliant with broadened UNCROC guidelines and maintain best practices, the consolidation of service provision across the life span will require shared services, shared resources, and cooperation between Adult Specialty Services and Child Adolescent and Family Services
5. Staff reconfiguration and recruitment should be undertaken to ensure that age-appropriate services are delivered by staff with training and experience in their patient's target age range.
6. Staff reconfiguration and recruitment should be undertaken to ensure adequate 24/7 medical coverage for medically compromised patients with eating disorders.
7. Physical reconfiguration of the eating disorders inpatient unit should be considered to provide a flexible pod area for child and adolescent patients (<18) while retaining space to allow for joint programming that is in the best interest of the child and adolescent patients, developmentally appropriate for child, adolescent, and adult patients, and is staff-intensive to the point where duplicate staff would be unaffordable and unreasonable (e.g., some groups, mealtime support, and post-meal observation).
8. All decisions about appropriate programming and housing should be made by the team on the basis of developmental particulars of the individual patient, not based on arbitrary age cut-offs.

Development of care pathways

The SIEDS is delivering treatment that is in line with international standards of best-practice. However, due to the siloed nature of service delivery and resource allocation, currently there is no integrated treatment pathway that can accommodate patients with eating disorders across the life-span.

It is proposed that there is a shared service pathway in which the SIEDS is supported by funding from both adult speciality and the CAF services in order to provide integrated services across the age spectrum. It will require further development of the SIEDS regional consultation services to include consultation and liaison with district CAMHS. The proposed model would be in compliance with the broadened UNCROC guidelines by providing an adolescent pod , would allow for an integrated patient journey throughout the system regardless of age, and would no longer lead to patients ageing-out of one service and having to adapt to a completely different provider team simply based on arbitrary age cut-offs. If the further development of the Christchurch Public site

occurs, positioning the SIEDS service near other medical specialties commonly required in the treatment of eating disorders would enable complete integration of multidisciplinary services necessary for comprehensive treatment of eating disorders.

1. Workforce needs for all pathways

In order to transition child and adolescent care to the SIEDS and enhance regional services for children and adolescents, mindful distribution of available FTEs is required. In order to transfer the care of children/youth to the SIEDS, staff must be put in place to attend to patients who are currently treated on the CFIU. FTE distribution should address:

- child consultant (inpatient and outpatient duties);
- after hours medical coverage;
- child/family therapist (inpatient and outpatient duties);
- full time regional coordination for SIEDS for both adult and child patients (up from current 0.4);
- additional nursing support for child admissions and intensive outpatient;
- additional occupational therapist, dietitian, and teacher time for youth

2. Immediate and Short-Term Pathways

A two-stage process is recommended. Immediately, patients <14 should continue to be admitted to the CFIU. Following reconfiguration of the SIEDS and recruitment of staff (short-term), all admissions across the age-span should be to the SIEDS. Long-term planning should consider the possibility of the SIEDS relocating to the Christchurch Public Site according to current proposed plans. As child/adolescent patients are transitioned to the SIEDS, all materials should be reviewed for age-appropriateness. When necessary, separate youth/adult documents should be created and labelled.

3. The suitability and safety of admitting medically compromised patients into a psychiatric unit rather than a medical ward

In most programs around the world, transitions to medical units are brief stabilizations, and patients are then returned to the eating disorders service. That being said, adequate medical cover is essential for this practice to succeed. A portion of the available FTEs should be directed towards ensuring adequate 24/7 medical coverage for patients on the SIEDS.

4. The viability of continuing with only one consultant psychiatrist

Having a single consultant psychiatrist is not advisable for an eating disorders service. This is a difficult population with which to work and medical and psychiatric demands on the consultant are high. Given the recommendation to expand the SIEDS to include child/adolescent patients, the inclusion of an additional child consultant will also alleviate this concern.

5. The possible expansion of the consult / liaison function of the service

The most innovative and effective feature of the SIEDS is the hub and spoke model. If there is expansion of treatment to children/adolescence, this model needs to be strengthened even further. In addition, the consultation and liaison services that have been provided to the regions also need to be extended to generalist services in Canterbury. For this reason, it is recommended that a full FTE be devoted to regional coordination. The consult/liaison role can be enhanced with increased use of telemedicine, on-site multi family groups followed up by internet consults, and liaison with both adult and CAMH services in the regions and in Canterbury.

6. The level of consultation / liaison function required from general medicine and paediatrics.

Clear guidelines for medical admissions must be established for youth under 15 (paediatrics) for youth 15-18 (general medicine), and for adults (general medicine). Communication between the SIEDS and these medicine teams during admissions is essential. Medical staff are often at a loss as to how to treat eating disorders. Nursing staff are ill-equipped to deal with eating disorders whilst attending to their regular nursing duties. The guideline should be sufficiently clear to provide them with direction within the bounds of their capability. The SIEDS should monitor progress of patients admitted medically daily and be available for consultation at all times.

7. The philosophy and model of service delivery and its position within the wider context of health (not limited to mental health) and independent of current practice

The philosophy of the service is sound. It is recommended that a strategic planning session to assist the SIEDS team with developing their mission statement, their five year plan, their service delivery priorities, and exploring ways for staff to become accountable for their time. With few adolescent medicine specialists, a paediatrics department that has to limit care to those under 15 due to space and resources, and a difficult-to-comprehend age structure dictating care across the CFIU and YIU, adolescents are in great danger of falling through the health and mental health cracks. Service planning for the future should carefully consider how best to serve adolescent patients.

Recommendations

1. Develop pathways of care that are developmentally appropriate for children (<14), adolescents (14-18), and adults within the SIEDS.
2. Without reducing the amount of direct patient care provided by the SIEDS, expand the consult and liaison functions of the SIEDS to assist clinicians in Canterbury (adult and child services) and the regions (adult and child services) with the ongoing management of eating disorders both prior to referral to the SIEDS and after discharge.
3. Enhance training of adult and child/adolescent community workforce for delivery of outpatient care for eating disorders in children and adolescents using efficient models (e.g. yearly training symposia, internet- or telemedicine-based supervision etc.).
4. Enhance current hub and spoke model with more sophisticated use of internet, chat bridges, teleconferencing, videoconferencing, telemedicine, etc.
5. Together with paediatrics (for under 15s) and medicine (for over 15s) develop clear clinical pathways to guide medical admissions to Christchurch Public. These should include in-hospital management, coordination of care, communication, and discharge planning.
6. Creative approaches should be developed or extended for dealing with long-term severe cases of anorexia nervosa. If the population could support this model, one option would be to develop an intensive outpatient program that includes a designated number of meals and snacks, post-meal observations, group participation, and weekly individual therapy. Joining ongoing inpatient meals and groups consolidates staff. Alternatively, continue to make use of services already in place in a disease management model (e.g., support for GPs over medical management, support for families and caregivers, counselling in the community, provision of community support workers, occupational therapy for improvement of quality of life, and intermittent admissions to prevent clinical deterioration).

Appendix 1: Eating Disorder Practice Guidelines for Eating Disorders

| SOURCE | NICE | APA | AAP | RANZCP | SAM |
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| Domain | <i>NICE, Eating Disorders, Core Interventions in the Treatment and management of AN, BN, and related eating disorders, © 2004</i> | <i>APA Steering Committee on Practice Guidelines, Practice Guidelines for the Treatment of Patients with Eating Disorders, © 2006</i> | <i>AAP Policy Statement, Identifying and Treating Eating Disorders, © 2003</i> | <i>Royal Australian and NZ College of Psychiatrists, Clinical Practice Guidelines for the Treatment of AN, © 2004</i> | <i>Society for Adolescent Medicine, Position Paper, Eating Disorders in Adolescents. Journal of Adolescent Health, 2003, 33, 496-503</i> |
| Importance of multidisciplinary treatment | Not specifically addressed | A team approach is the recommended model of care. | Other than the most severely affected patients, most children and adolescents with eating disorders will be managed in an outpatient setting by a multidisciplinary team coordinated by a paediatrician or subspecialist with appropriate expertise in the care of children and adolescents with eating disorders. | A multidisciplinary team is indicated for optimal treatment of AN. | Eating disorders best addressed by an interdisciplinary team of medical, nutritional, mental health and nursing professionals who are experienced in the treatment of eating disorders and who have expertise in adolescent health. |
| Importance of treatment by a specialized team | Healthcare professionals without specialist experience of eating disorders, or in situations of uncertainty, should consider seeking advice from an appropriate specialist when contemplating a compulsory admission for a patient with anorexia nervosa, regardless of the age of the patient. | There is evidence to suggest that patients with eating disorders have better outcomes when treated on inpatient units specializing in the treatment of these disorders than when treated in general inpatient settings where staff lack expertise and experience in treating eating disorders. In treatment settings where staff do not have the training or experience to deal with patients with eating disorders, the provision of education, supervision, and leadership by a qualified psychiatrist can be crucial to the success of | Many general paediatricians do not feel comfortable treating patients with eating disorders and prefer to refer patients with anorexia or bulimia nervosa for care by those with special expertise. More severe cases require the involvement of a multidisciplinary specialty team working in outpatient, inpatient, or day program settings. | Not specifically addressed. | Eating disorders best addressed by an interdisciplinary team of medical, nutritional, mental health and nursing professionals who are experienced in the treatment of eating disorders and who have expertise in adolescent health. Treatment should be provided by health care providers who have expertise in managing adolescents with eating disorders and who are knowledgeable about normal adolescent physical and psychological growth and development. |

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| | | treatment. | | | |
| When to hospitalize | Inpatient treatment or day patient treatment should be considered for people with anorexia nervosa whose disorder has not improved with appropriate outpatient treatment, or for whom there is a significant risk of suicide or severe self-harm. Inpatient treatment should be considered for people with anorexia nervosa whose disorder is associated with high or moderate physical risk. | Factors suggesting that hospitalization may be appropriate include rapid or persistent decline in oral intake, a decline in weight despite maximally intensive outpatient or partial hospitalization interventions, the presence of additional stressors that may interfere with the patient's ability to eat, knowledge of the weight at which instability previously occurred in the patient, co-occurring psychiatric problems that merit hospitalization, and the degree of the patient's denial and resistance to participate in his or her own care in less intensively supervised settings. | Hospitalization may be required because of medical or psychiatric needs or because of failure of outpatient treatment to accomplish needed medical, nutritional, or psychiatric progress. See attached table 6 for specific criteria. | For patients with AN which is not so severe as to require inpatient treatment (e.g. where the risk of death from suicide or physical effects is high), outpatient or day-patient treatment may be suitable, but this decision will depend on availability of appropriate services. | See attached table for specific hospitalization criteria. Threshold for intervention should be lower in adolescents than adults. An eating disorder can still be present in the absence of established diagnostic criteria. Hospitalization of an adolescent with an eating disorder is necessary in the presence of severe malnutrition, physiologic instability, severe mental health disturbance or failure of outpatient treatment. Ongoing treatment should be provided until complete resolution. |
| Type of hospitalization | Patients with anorexia nervosa who require admission to a psychiatric unit should be admitted to a unit experienced in the treatment of eating disorders. | The decision about whether a patient should be hospitalized on a psychiatric versus a general medical or adolescent/paediatric unit should be made based on the patient's general medical and psychiatric status, the skills and abilities of local psychiatric and general medical staff, and the availability of suitable programs to care for the patient's general medical and psychiatric problems [1]. There is evidence to suggest that patients with eating disorders have better outcomes when treated on inpatient units | No specific statements about selecting type of hospitalization, but discuss IP, PHP, and IOP in general contexts. | Not specifically addressed. | Various levels of care should be available to adolescents with eating disorders (outpatient, intensive outpatient, partial hospitalization, inpatient hospitalization, or residential treatment centers). |

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| | | specializing in the treatment of these disorders than when treated in general inpatient settings where staff lack expertise and experience in treating eating disorders. | | | |
| Co-mingling of adults and adolescents | Admission of children and adolescents with anorexia nervosa should be to age-appropriate facilities (with the potential for separate children and adolescent services), which have the capacity to provide appropriate educational and related activities. | Not addressed | Not addressed | Not addressed | <p>“Expertise of the treatment team who work specifically with adolescents and their families is as important as the setting in which they work.”</p> <p>“General psychiatric wards may be less appropriate than an adolescent medical unit.”</p> |
| Recommended composition of the treatment team | Not specifically addressed; Implies psychological, medical, and nutritional treatment | Professionals from several disciplines may collaborate in the patient’s care. The specific role of each professional may vary with the organizational structure of the eating disorders program and the professional qualifications of those working within the program. The psychiatrist may assume the leadership role in the patient’s treatment program or the patient’s treatment team or work collaboratively on a team led by other health professionals, including other physicians or psychologists. Registered dietitians with specialized training in eating disorders often provide nutritional counselling. Therapists from a variety of professional fields may provide family, individual, | Paediatricians generally work with nursing, nutrition, and mental health colleagues in the provision of medical, nutrition, and mental health care required by these patients. | The team ideally would include a specialist in physical medicine (e.g. a general practitioner, physician or paediatrician, depending on the patient’s age), a dietitian, nurses and other allied health specialists such as psychologists, occupational therapists and physiotherapists. | Eating disorders best addressed by an interdisciplinary team of medical, nutritional, mental health and nursing professionals who are experienced in the treatment of eating disorders and who have expertise in adolescent health. |

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| | | or group psychotherapy, including CBT. Other physician specialists and dentists may be consulted for management of acute and ongoing medical and dental complications. Often in the treatment of children and adolescents, school coaches, teachers, and school counsellors may be asked to collaborate in a patient's treatment. | | | |
| When acute medical treatment is needed versus inpatient/residential | Not addressed | Hospitalization should occur before the onset of medical instability as manifested by abnormalities in vital signs (e.g., marked orthostatic hypotension with an increase in pulse of 20 bpm or a drop in standing blood pressure of 20 mmHg, bradycardia <40 bpm, tachycardia >110 bpm, or an inability to sustain core body temperature), physical findings, or laboratory tests [I]. To avert potentially irreversible effects on physical growth and development, many children and adolescents require inpatient medical treatment, even when weight loss, although rapid, has not been as severe as that suggesting a need for hospitalization in adult patients [I]. Patients who are physiologically stabilized on acute medical units will still require specific inpatient treatment for eating disorders if they do not meet | Not addressed | Not addressed | Given potentially irreversible medical complications in adolescents, the importance of immediate medical management is underscored including ongoing monitoring and aggressive treatment by physicians who understand adolescent growth and development. Underscore importance of being discharged as close to normal body weight as possible. |

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| | | biopsychosocial criteria for less intensive levels of care and/or if no suitable less intensive levels of care are accessible because of geographic or other reasons. | | | |
| | NICE | APA | AAP | RANZCP | SAM |

Appendix 3. Global Service Provision Survey

Given that the terms of reference for the review of the SIEDS included an evaluation of current service delivery vis à vis international standards as well as a focus on the UNCROC issue of age-mixing, we conducted a global survey to provide a context for the review and evaluation.

We created a service provision survey to explore three primary issues in eating disorders programs around the world: 1) provisions for age-mixing; 2) provisions for gender-mixing; and 3) qualifications of program directors and clinical staff.

The survey was approved for distribution by the University of North Carolina Institutional Review Board.

We sent the survey via Survey Monkey to members of the Eating Disorders Research Society. This listserve was chosen in order to: 1) enhance international response as it is an international society; and 2) focus response on not-for-profit organizations. Many programs in the United States for example are run by for-profit companies and their responses would be less applicable to the terms of reference of this review.

We received prompt responses from 20 programs around the world which can be found on the following page.

In summary, programs vary greatly on their approaches to age- and gender-mixing. There is clearly no consensus approach to age-mixing. Those instances in which completely separate child facilities exist occur in large metropolitan areas that have independent large children's hospital facilities.

Survey Summary

Total Programs Responded: 20 (US, Netherlands, Spain, Mexico, Canada, United Kingdom)*

- All UNCRC signatories http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en

Programs with Inpatient Services: 14
Programs with Residential Services: 5
Programs with Partial Hospitalization Services: 14
Programs with Intensive Outpatient Services: 7
Programs with Outpatient Services: 15

Inpatient Programs

Sleeping Arrangements

Age: 4 programs with separate child/adult sleeping facilities
4 programs with age-mixed sleeping facilities

Gender: 1 program with separate male/female sleeping facilities
9 programs with mixed sleeping facilities

Programming

Age: 4 programs with completely separate child/adult programming
3 programs with some overlapping programming
2 programs with completely overlapping programming

Gender: 6 programs with some overlapping male/female programming
5 programs with completely overlapping programming

Residential Programs

Sleeping Arrangements

Age: 2 programs with separate child/adults sleeping facilities
2 programs with mixed sleeping facilities

Gender: 1 program with separate male/female sleeping facilities
2 programs with mixed sleeping facilities

Programming

Age: 3 programs with completely separate child/adult programming
1 programs with some overlapping programming
1 program with all programming together

Gender: 1 program with completely separate male/female programming
1 program with some overlapping programming
2 programs with completely overlapping programming

Program Staffing

Medical Director Qualifications

- Programs rely heavily on child and adolescent psychiatrists
- No programs made distinctions between child vs. adult medical directors
- Some references to pediatrician involvement with children, but co-directed with psychiatrist

Program Director Qualifications

- Varied qualifications for directors
- No distinction between child and adult directors
- One program has child program directed by LMFT
- Program Directors tend to be Psychology PhDs or MDs

Therapist Qualifications

- All therapist qualifications described as MD, PhD, master's level therapists, or licensed therapists
- Therapists qualified as eating disorder experienced
- No distinctions made between adult and child therapists