Introducción

Historia y Visión del Programa

El Programa de Trastornos de Alimentación del Hospital Infantil de Colorado (EDU) inició en 1988 con un pequeño grupo de profesionales comprometidos que incluía a un médico adolescente, una trabajadora social y una enfermera psiquiátrica, quienes se organizaron alrededor de una observación común: los pacientes con trastornos de la alimentación necesitan cuidado recíproco, multidisciplinario. Desde entonces, el programa de EDU ha crecido de manera significativa y proporciona servicios en un área especializada en el edificio de salud mental del Hospital Infantil de Colorado.

El tratamiento en el EDU se proporciona por profesionales con experiencia extensa en el tratamiento de trastornos de la alimentación en niños. El equipo de liderazgo multidisciplinario del tratamiento está compuesto por un Director Médico (psiquiatría), un Director de Programa Clínico (psicólogo), Medicina Adolescentes, Gerente Clínico (enfermera) y un Senior de Salud Mental (trabajo social). El equipo de tratamiento se compone de psiquiatría infantil, psicología clínica, medicina adolescente, trabajo social, enfermería, terapeutas de artes creativas, consejeros de salud mental y dietistas.

EDU proporciona tratamiento en un continuo de cuidado que va desde la hospitalización médica, programa de ingreso, tratamiento de día extendido, tratamiento de día corto, tratamiento de día intermitente, tratamiento ambulatorio intensivo y tratamiento ambulatorio. Todos los programas (excepto el ambulatorio) incluyen evaluación médica, psiquiátrica y psicológica, terapia individual, grupo y familiar, apoyo nutricional y educación para los pacientes y familias y otros terapias experienciales diseñadas para enseñar habilidades y construir confianza para que los pacientes puedan mejorar su recuperación no solo del trastorno alimentario, sino también de otras dificultades emocionales.

El tiempo promedio de permanencia en programa (en todos los niveles de cuidado) es 35 días, o alrededor de 5 semanas.

Filosofía del Programa

El tratamiento en el EDU se basa en tres principios básicos que guían nuestro programa de tratamiento:

1. Familias son un recurso esencial en la recuperación
2. El cambio es un proceso y cada paciente/familia tiene su motivación para el cambio en algún punto de la continuidad del cambio en el continuo de Transformación. Todos tienen la capacidad de recuperarse y por lo tanto, las estrategias de Motivación de la Transformación son el núcleo de todos nuestros tratamientos. 
We attempt to match interventions as well as aim to enhance motivational incentives for every individual patient and family.

3. The ideal setting for children and adolescents with eating disorders to challenge and change self-destructive behavior is a structured, predictable, and nurturing environment.

We understand the toll eating disorders can take on a sufferer and his/her family. Our aim is to support families as an entire system through the acute phase of recovery and provide recommendations and ongoing support and guidance through aftercare as this is a critical component to ensure a successful transition while maintaining recovery. To this end, our program has embraced a family supported recovery model which seeks to involve, educate and empower families throughout the entire continuum of care.

**Family Supported Recovery Program (FSRP)**

*Background on using family-based approach to treatment*

Family Based Treatment (FBT) teaches us that the family is the child/adolescent’s greatest resource in recovery. Having empowered parents will allow the child the best chance for ongoing recovery. This is based on the most current literature in treatment of eating disorders for children and adolescents stating that involving the family in treatment/recovery can be an effective approach.

Evidence supports the use of Family Based Treatment (FBT) for adolescents and children with eating disorders. In practice, however, some families do not feel ready or able to confidently navigate outpatient FBT treatment. Our Family Supported Recovery Program (FSRP) serves as an FBT “primer” and upon successful completion, most families should be ready and able to successfully engage in outpatient FBT as either late Phase I or beginning Phase II.

**Referrals, Evaluation and Assessment**

**Intake initial call**

When an interested family is referred to our program, they are scheduled for a 10-15 minute initial phone screen with the program’s intake coordinator. In this call families are educated about the family involvement component in our program and asked to consider and evaluate if this is a commitment they are able to make. They are then given some initial information about our process and asked for a brief history of the eating disorder concern. When possible, the intake coordinator is able to obtain medical records prior to the initial evaluation. The primary goal of the phone call is to establish potential appropriateness of the referral and to schedule an initial evaluation.
Evaluation

The Eating Disorder Program evaluations occur 3-4 days mornings per week by a team consisting of an eating disorder clinician and an adolescent medicine provider. The evaluations typically take 90 minutes and include a clinical interview to obtain medical and psychiatric history from both the patient and family perspective. The adolescent medicine provider will conduct a physical exam and obtain relevant history as well. Following the interview(s), the treatment team will confer and recommend a level of care. If a level of care (other than outpatient) is recommended, the clinician will provide a detailed explanation of the treatment program and provide the family with next steps for admission. If patients are recommended inpatient (either EDU or acute medical) they are asked to get labs drawn on site and wait in the area while our case managers obtain insurance authorization. If day treatment is recommended they are asked to go home and wait for a call to verify start date (which is typically the following day) pending insurance approval.

Treatment recommendation(s) triage for level of care

There are 3 primary aspects of health in recovery from an eating disorder - medical/physical, behavioral and psychological/emotional. Each aspect is equally important and essential for recovery. However, in order to determine where to start or which aspect to emphasize first, it is as if a spotlight is shining on all aspects and rotating where it lands depending on medical stability, severity of behaviors and psychological and emotional stability. As such, the focus of treatment will shift as patients work through recovery. During the initial assessment, the team will carefully evaluate patients and families from these 3 categories of health to determine appropriate treatment recommendations. As the “spotlight” shifts through treatment, the EDU program treatment team continues to assess patients and families and recommend transitions accordingly.
Three Areas of Focus for Recovery:

**Medical/Physical Health** – including achieving normal body weight, normal heart rates, resolution of physical symptoms including (but not limited to): return of menses, electrolyte imbalances, cold intolerance, lanugo, and brittle hair.

Physical and Medical Stabilization are the number one treatment priority when patients are medically fragile, instable or compromised. Overall medical presentation is the primary factor in determining level of care. Factors such as amount of weight lost, rapidness of weight loss, risk for re-feeding syndrome, severe bradycardia and orthostatic instability are medical indicators for inpatient hospitalization.

**Primary Interventions:**

1. Acute hospitalization on medical unit with trained nursing staff and specialized weight restoration protocol
   - Adolescent medicine attending
   - Monitor heart rate 24 hour per day
   - Monitor for re-feeding syndrome in acute weight restoration phase
   - Bed rest only
   - Daily weights and vitals

2. Inpatient hospitalization on Eating Disorder Unit (specialty psychiatric service) to provide 24/7 care
- Adolescent medicine provider providing 2x per week exams
- 24/7 hour nursing support
- Nightly cardiac monitoring
- Modified bed rest
- Daily weights and vitals

When patients have reached a level of medical stabilization including (but not always limited to) improved heart rate, positive weight trend, eliminated risk of re-feeding they are recommended to step down to extended day treatment. Behavioral factors are also taken into consideration to determine this transition (will be discussed in more detail in behavioral section). While medical and physical stability is still being closely monitored, the focus of intervention shifts to more of the behavioral components.

**Additional Intervention:**

3. Extended day program:
   - Adolescent medicine provider providing 1x per week exam
   - Daily weights and vitals
   - Restricted activity (unit activities of daily living)

4. Regular day program –
   - Adolescent medicine provider as needed
   - 3x per week weights and vitals
   - Restricted activity (introduce “normal” life activities such as going school, the store, etc)

5. Intensive outpatient/Outpatient
   - Adolescent medicine provider OR transition to local PCP 2x per month or monthly
   - 1x per week weight checks/ vitals as needed
   - Supervised and monitored re-integration of normal activities/sports, etc.

**Behavioral Health:** including reduction of food avoidance behaviors/compensatory behaviors including purging, compulsive exercise, food rituals, etc.

**Primary interventions:**

- **Meal Support - Parent Supported Nutrition (PSN)®, Meal Coaching, Ease of Eating, Nutrition levels**

  1. **Meal planning**
A central tenant of Family Based Treatment is parent/family empowerment to refeed the child. Children/teens need to learn to trust their parents to re-establish a functional family system that will support recovery as well as proper adolescent development.

Parents sometimes feel overwhelmed by the amount of nutrition information their children have, and feel ill prepared for the task of refeeding. We have found meal planning to be a very helpful, in some cases essential tool, in helping empower parents to feed their children appropriate amounts of food to facilitate weight restoration and/or weight maintenance. Meal planning with a trained dietitian gives them the support and confidence they need to begin to shift the trust the child has toward the ED to trusting their parent with nutrition decisions.

Parents begin meal planning for their children as soon as they enter our program –regardless of level of care. Our dietitians meet with families as often as needed to teach essential nutrition information individualized for their child. They give them meal planning guidelines and nutritional exchange information. Dietitians also teach families how to adapt meal planning information to food the family would normally eat at home, how to read and translate labels and store-bought/packaged food and how to estimate portion sizes without measuring. They also provide detailed information about how to add appropriate amounts of additional nutrition to take additional activity into account as patients transition back to their normal activities.

2. Meal coaching

Meal times are often very anxiety-producing and can be quite stressful for children who struggle with eating disorders as well as the families, friends and caregivers who try to offer support. It may appear that patients are t being irrational and/or oppositional when they are unable to eat food normally. To a person with an eating disorder, however, certain foods and/or meal-time situations can trigger intense anxiety and panic feelings. Empirical evidence teaches that high emotional reactivity is negatively correlated to outcome. Therefore, it is an essential component of our program to teach caregivers how to reduce emotional expression/reactivity. Caregivers are encouraged to learn to stay calm and be supportive during meals. Parents are educated to avoid judgmental or critical comments as this type of interaction can actually make the eating disorder behavior more intense.

Eating Disorder Unit staff members provide meal coaching for every meal/snack. In addition, once a week dietitians take groups of 2-3 patients who have been referred by the treatment team on an Advanced Lunch outing to a restaurant. Patients are encouraged to pick based on preference/taste and dietitians will adjust meal plans. Patients are encouraged to have dessert and other challenging food items to enhance “normalized” eating goals. Patients picked for advanced lunch are most often, but not always, Nutrition level 3 and/or in Stage 3 or above in treatment.
• Families/caregivers are also given extensive opportunities to learn, observe, and practice meal support throughout the week.
• Parent only skills groups (2x per week). These groups provide essential psychoeducation and training in meal coaching skills as well as general skills.
• Family days – opportunities to eat snacks, lunch with patients and support provided by milieu staff, therapist and/or nutrition
• Evening meals – parents are encouraged to eat all dinners with patients while they are in higher levels of care – supported by milieu/nursing staff

Families are asked to initially allow trained staff to provide all meal coaching during the first days of orienting to the program. Families are then put on “Family Re-focus” where trained staff eats with them to provide guidance on implementing the most effective meal coaching strategies specific to the individual patient. Once a family has completed 4 eating episodes with staff, they are encouraged to practice meal coaching on their own.

3. Behavioral Nutrition Levels & Ease of Eating Scale
The Ease of Eating Scale © was developed in an attempt to operationalize “normal” eating and give staff a way to objectively describe behavioral goals for patients to learn to eat more normally. The scale was initially developed by observing common food avoidance behaviors (“FAB’s”). Initial analyses indicate the criteria for what is considered an FAB is objective enough to establish good inter-rater reliability. Our trained staff score meals and snacks with the patients and give them direct and immediate feedback on behaviors to work on. Parents are also educated on the Ease of Eating system and given the opportunity to score meals eaten with their child.

Nutrition levels (1, 2, 3 & Re-focus) are determined by patients Ease of Eating© scores each day. The numerical level is inversely related to the amount of food avoidance behaviors recorded (i.e. Nutrition level 1 indicates high food avoidance whereas Nutrition level 3 indicates more normalized eating). The levels thus correspond directly with how much support, re-direction and structure patients are requiring in order to complete meals. With a daily nutrition level rating, patients are able to set specific goals to improve their rating in order to work toward normalizing their eating. Parents also have objective indicators to help them determine how much supervision, support and guidance they will need to provide their child at home. The behavioral emphasis of treatment is aimed at helping patients achieve Nutrition level 3 consistently in program as well as meals eaten at home.

When patients are unable to finish the food presented to them within the allotted time limits (30 minutes for meals; 15 minutes for snacks) they are given a nutritional supplement at either 100% or 150% of total calories they were unable to complete. Patients who are regularly
requiring supplement will be on “Refocus” nutrition level. These patients will eat 1-1 with a staff member to get more individualized attention, support and coaching.

If a patient refuses or is otherwise unable to eat and/or supplement for 3 meals or snacks, an NG tube is placed to ensure adequate nutrition and support the physical goal of weight restoration. Someone on NG feeds is automatically on Re-focus nutrition. The therapy and nutrition team will work with patients behaviorally to encourage re-introduction to oral intake.

4. Bathroom observation
Every patient in the program is on bathroom observation status throughout the time he/she is in program. This means that a staff member must observe all bathroom use by standing by the door and maintaining visual and auditory contact. The rationale for this is to minimize the ability for patients to engage in purging, exercising, drinking excess water while using the bathroom or any other potential eating disorder driven behavior. In the hour immediately following a meal or snack, patients needing to use the bathroom are on “eyes-on” status for bathroom observation since the urge to purge might be greatest during this time frame.

Meal Support Overview

1. Nutrition Levels
   - **Refocus**: Patient is having extremely severe eating disorder behavior, is frequently unable to complete meals. Is unable to ask for support. Patient eats with staff on a 1:1 basis away from the general milieu so that appropriate support can be given.
   - **Level 1**: Ease of Eating score of 7 points and above. Patient is demonstrating severe eating disorder behavior, is having difficulty completing meals on a consistent basis, and has difficulty asking for support. Patient will have staff in close proximity during meals to provide support and close supervision.
   - **Level 2**: Ease of Eating score between 2 and 6 points. Patient is demonstrating moderate eating disorder behavior, is more able to ask for support. Patient is supervised by having staff at the table.

2. **Level 3**: Ease of Eating score or less than 2 points. Patient is eating well and independently. Patient is able to ask for support if needed.

3. Time parameters for meals
   - 30 minutes for meals
   - 15 minutes for snacks

4. How and when supplements are used:
   - In lieu of meal complete – Boost Plus only at 150% of uneaten calories (or 100% if directed by treatment team)
   - Time limit for completion of supplements is 15 minutes

5. Other Guidelines
   - After all meals and snacks, staff checks the patients’ trays to make sure all food is finished.
• All patients at a given table wait for everyone else at the table to finish before tossing the garbage from the meal/snack.
• Patients are instructed to remove all hoodies, sweatshirts and other tops with pockets or hoods to reduce the opportunity to hide food. If patients do not have an appropriate shirt underneath, staff may ask them to wear scrubs or gown during the meal/snack.

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<table>
<thead>
<tr>
<th>Behaviors</th>
<th>What it could look like</th>
</tr>
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<tbody>
<tr>
<td>Cutting into small pieces</td>
<td>Cutting food into small pieces or taking small bites.</td>
</tr>
<tr>
<td>Refusal of menu food item</td>
<td>Leaving items on the plate/tray, requesting a substitute or supplement for an item.</td>
</tr>
<tr>
<td>Unusual food combinations</td>
<td>Mixing all food together, putting mustard on pancakes, etc. Combinations with the goal of making food not food or uneatable. There can be varying opinions related to what is unusual. Something may be “normal” at home that is not considered normal on the EDU.</td>
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<tr>
<td>Hiding food</td>
<td>Dropping food on the floor on purpose, throwing away food, putting food in a napkin, etc.</td>
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<td>(Also counts as food refusal because not 100%</td>
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<td>complete.)</td>
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<td>&gt; 5 min to prep meals</td>
<td>Slow to prepare the meal to delay eating it.</td>
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<tr>
<td>&gt; 5 min to initiate the meal</td>
<td>Sitting at the table without starting.</td>
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<tr>
<td>&gt; 30 sec between bites</td>
<td>Slow pace and/or a long time in-between each bite.</td>
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<tr>
<td>Leaving food on plate/crumbling/smearing</td>
<td>Leaving food, or leaving crumbs of food around the tray/plate, or smearing food around the tray/plate. For example, there might be cracker crumbs on the chair and table, or peanut butter smeared on the napkin or other places.</td>
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<tr>
<td>(Also counts as food refusal because not 100%</td>
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<tr>
<td>Other</td>
<td>Examples include:</td>
</tr>
<tr>
<td></td>
<td>• Foods, muffins and other foods that are traditionally eaten by hand such as sandwiches are to be cut into no more than 5 pieces and eating by hand  o Bite sizes must be reasonable</td>
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<td>• Beverages are to be drunk in a traditional manner not by the spoonful</td>
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<td></td>
<td>• Use the appropriate utensil (e.g., cereal with a fork)</td>
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<td></td>
<td>• Excessive use of microwave</td>
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<td></td>
<td>• Food rituals (e.g., eating in a circle)</td>
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</tbody>
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- 0 = Did not observe the behavior
- 1 = Observed the behavior, but patient is able to redirect it
- 2 = Observed the behavior and it continued throughout; was not able to re-direct
**Emotional health**: improving body image, self-esteem, more coping resources to deal with emotions and stress, improved ability to communicate, improved quality of family and social relationships.

**Primary Interventions**

**Assessment**

Each patient and family entering program will be asked to fill out several self-report measures upon admission. The measures provide data about severity of eating disorder symptoms, perception of family functioning, personality features and co-morbid clinical concerns. The data are transferred into a clinical report within the first 3-5 days of admission and given to the primary treatment team. The report is designed to give providers a snapshot of areas of the most clinical concern as a way to help individualize and structure interventions.

The measures are repeated at the 4-week mark in treatment and clinical feedback is provided to the family and treatment team as an objective marker of treatment progress as well as for help defining after-care needs.

**Therapy**

- **Individual therapy**
  Patients are assigned a primary therapist with specialized training in eating disorders who will facilitate treatment throughout the entire continuum of care. Therapists provide both individual and family therapy (2-3 hours per week). Primary therapists also serve as the liaison to the rest of the treatment team in coordinating aspects of care and guiding families through the treatment stages. In addition, the primary therapist will coordinate care with community/outside providers and schools as indicated.

- **Psychiatric evaluation & monitoring**
  Each patient is assigned a psychiatrist who will provide psychiatric evaluation and ongoing management of any associated symptoms including (but not limited to) depression, anxiety, obsessive-compulsive disorder, post-traumatic stress disorder, and sleep concerns. Psychiatrists meet with patients 1-3 times per week and provide additional therapeutic support for patients. Patients will be evaluated for medication recommendations which will be discussed with families. Patients taking medication are closely monitored by the psychiatry team.

- **Family therapy**
  Family therapy occurs 1-2 times per week with the primary therapist. Family therapy has 3 primary goals: enhance parent empowerment to make decisions about managing the eating disorder in the home without accommodating to the illness; decrease isolation and guilt associated with the illness; and to reduce emotional expression/reactivity and criticism by improving communication and empathy within the family.
• **Group therapy**
  There are 2 kinds of group therapies offered in program – experiential “process” groups and skills/psychoeducation groups.
  
  o **Experiential groups** are most often facilitated by therapists and allow patients a chance to process personal issues in a supportive, non-judgmental environment. These groups most often include smaller groups of patients who are farther along the stage of change/motivational continuum and/or are ready to transition to spending more time at home.
  
  o **Skills groups** are mostly facilitated by trained mental health counselors and typically involve all patients in higher levels of care. These groups are designed to teach skills and apply skills and include skills-based learning models from cognitive behavioral therapy, dialectical behavioral therapy and acceptance and commitment therapy.

• **Creative Arts therapy**
  Patients on the EDU have the opportunity to participate in 4 different modalities of creative arts therapies throughout the week – dance/movement therapy, art therapy, yoga therapy and music therapy. These additional therapeutic modalities allow for experiential expression of feelings beyond more traditional verbal modes of therapy.

**Intensive Family Programming**

In addition to 1-2 times per week family therapy, the Family Supported Recovery Program includes 2 multi-family intensive days per week. At least one family member is required to attend both family days each week their child is in treatment. Family program days include a coached snack, multi-family group therapy, a coached lunch, and a caregiver-only skills and/or support group. Additionally, parents must attend a multi-family goal-setting/check-out group each day; and, for patients arriving after breakfast, families must attend a multi-family Monday morning check-in group. The aim of the intensive family program is to provide on-going education and support to families in a non-judgmental and supportive environment to reduce feelings of guilt and blame, increase feelings of hope and empowerment in working together toward recovery, and improve skills-based knowledge for improving communication and finding new ways of empathizing and supporting their child.

**Passes and family recreational time**

Only patients in inpatient program are allowed “passes.” Passes typically occur as patients are becoming more medically stable and are beginning to prepare for the transition to day treatment. Patients in day treatment do not get passes but instead prepare for transitions by structurally increasing the amount of time they spend out of program.
Visiting time is daily after the evening meal. Families not going home or on pass are invited to spend time together in common areas or in patient rooms. They are welcome to stay with their child as long as they like providing the interactions remain supportive, safe and appropriate.

Each weekend, families are encouraged to participate in family recreation time which includes opportunities to play games, work on crafts, or otherwise engage in benign activities. The intention behind this time is to allow families to build positive experiences interacting in ways outside the stress of meal times or intensive family therapy activities.

**Additional interventions:**

**Family Treatment planning rounds:**

Family treatment planning meetings occur weekly with every family. These 30 minute meetings include every member of the treatment team including family members and patients. These meetings give families the opportunity to meet with all the team members at one time and ask any questions they might have. The meeting is an opportunity to review progress to goals and establish next steps in treatment and define goals to meet those steps. The meeting is structured such that families meet with the team (without the patient) for the first 15-20 minutes and review any sensitive topics and discuss concerns and how to approach them. The patient fills out a treatment planning form where they are expected to self-assess their motivational stage of change, progress to goals and set goals for the upcoming week. They are then invited to join the meeting where they review their form and discuss any questions or concerns with the team. Decisions about passes, time away from program and upcoming transitions are made in this meeting as well.

**Communication**

We provide every family with a Back and Forth book. The book is a way for parents to record behavioral progress as well as observations and concerns to communicate with program staff. Staff members review the books each morning and relay relevant questions, comments and concerns to Primary therapist and/or other members of the treatment team. They also use the comments to structure the morning check-in with patients to make sure patients are setting goals that are relevant to struggles they are experiencing at home.

In addition, parents are encouraged to talk to nursing staff at any point should they want more information about their child’s progress. They are informed that they can inquire about any aspect of the child’s treatment at any time and do not need to wait for scheduled appointment times to get information about Nutrition levels, weights, vitals, or program participation.
Safety

Maintaining patient safety is an essential component of sustaining a therapeutic environment. The Eating Disorder Unit is an unlocked unit and therefore our staff members are trained to take precautions to ensure the safety of all patients. Patients are asked on a daily basis to assess their distress level on a scale from 1-10. If they rate their overall distress level higher than 4, they are asked to assess their level of suicidal ideation (SI) as well as urge to engage in non-suicidal self-injury (NSSI) on a scale from 1-5. If patients rate higher than 1 on either of those measures, they are evaluated for safety by a licensed clinician, or a trainee under direct supervision. Any patient with a history of suicidal ideation or a history of NSSI is automatically placed on Support Zone when they admit to program. Patients with passive SI or history with no current ideation or intention will be on Low Level Support Zone. These patients receive extra 15 minute checks by mental health or nursing staff. Patients whose safety is in question will be placed on High Level Support Zone. These patients will be asked to change from their clothes into scrubs to minimize access to items they could use to self-harm. They are to stay in staff line of sight at all times and are not able to leave the unit.

Patients who go home in the evenings for day treatment will be given the SI/SIB assessment measures again before they leave for the day. If they are still experiencing high distress levels and/or suicidal thinking or urge to engage in NSSI they will be assessed prior to leaving with their parent. If their level of risk is assessed to be manageable in the home and they are able to engage in safety planning with their family, they will go home on “wrap around” which means that they are given a designated time to call into the unit and a nurse will conduct another safety assessment. If they are not able to safety plan or the parents otherwise feel unsafe bringing their child home, they are instructed to go to the emergency department to be evaluated further.

Behavioral expectations

The primary behavioral interventions revolve around reducing food avoidance behavior. However, how a patient behaves in program tends to correlate with how successful they are transitioning home. Furthermore, in a group milieu setting, it is important to maintain behavioral expectations in order to facilitate optimal growth and recovery. The EDU program includes a behavioral level system as a way to reflect to patients how they are interacting in groups and with peers. The level system consists of Green, yellow and red levels. The levels are determined by daily point averages and points are gained from participating and using skills. Green level indicates that patients are actively participating in groups by making meaningful contributions and appearing engaged and focused. They are observed to be trying to use skills to manage distressing situations either in therapy, groups, and/or meals. Yellow level indicates patients are making some effort to participate but requiring more encouragement from staff or
providing surface-level observations or comments. Skill use might be minimal, or happening only with large amount of effort and encouragement from staff, peers, or family. Red level indicates patients are presenting as largely disengaged or disinterested and do not appear to be making effort to use skills or find applicability of group topics and discussions.

Because the EDU program day is structured with meals, snacks and therapeutic groups, there are few behavior-based incentives that are built into the program. Patients who are on Green level are awarded a “green award” which they can use to trade for a small Worry Stone (which are ceramic stones glazed with inspirational messages). Instead of focusing on in-program rewards, we think about what the levels might predict for at-home behavior. Participation and willingness to use skills in program tend to correlate with a higher likelihood that patients will use skills outside of program. Patients regularly achieving Green level suggest indicates a higher chance that he/she can handle privileges responsibly and will not take advantage of opportunities he/she is given. Parents are educated on what the levels indicate and work with their primary therapist to design rewards and consequences for time they spend at home (such as spending time with friends, using technology) as these at-home privileges tend to be more reinforcing for patients.

If a patient engages in aggressive and/or oppositional behavior either in program or at home, they are placed immediately on Stop Zone. These behaviors can include hitting, kicking, throwing objects, running away, complete food/supplement refusal, or verbal aggression toward others. Stop Zone is a behavioral intervention giving the patient time and space to encourage self-reflection in the hopes patients can begin to determine how he/she can gain mastery over intense emotions and exhibit more appropriate behavioral control. Patients are removed from the milieu group setting and given therapeutic assignments aimed at helping them process the situation that triggered the outburst and finding different solutions for the next time the situation might arise.

**Technology Policy**

The EDU is a “technology free” zone. Patients are not allowed to have any personal electronic devices while in program. If they need the use of personal computers for schoolwork, parents may bring personal laptops during family visits as long as they are able to supervise their work to ensure patients are not using the device inappropriately. Patients are allowed to make phone calls using the unit phone in the case of emergency or during evening free time. We encourage parents to follow program behavioral guidelines (daily behavior level) guidance in determining access to electronic devices once patients are going home at night in day treatment.
**Education**

**Academic Education**

There is no formal education program through the eating disorder program. However, primary therapists will work with each family to collaborate with the school to develop an education plan that fits the individual needs of the patient. In addition, Children's Hospital Colorado occupational therapy department provides an educational tutor for 1 hour each day. There are flexible blocks of time each day that can be devoted to completing school work while in longer day/inpatient program and once patients transition to the short day treatment and intermittent day program, they are encouraged to work on school assignments in the afternoons, evenings and weekends. Transitions back to school are coordinated on an individual basis and are generally arranged with the school and family and primary therapist to facilitate these transitions.

**Psychoeducation**

As previously discussed in the group therapy section, the daily milieu program offers several skills groups as part of the curriculum. The curriculum is organized around 5 different weekly themes – with each theme having unique associated skills and interventions. The weekly themes are designed to help patients address a wide range of psychological and social issues and provide necessary skills to manage these issues more effectively. Our themes are:

- **Self-awareness** (e.g. improving self-esteem and self-confidence by practicing affirmations, non-judgmental stance)

- **Emotional regulation and anxiety management** (e.g. distraction, self-soothing, deep breathing, progressive muscle relaxation, DBT – IMPROVE the moment, CBT – challenge thought distortions)

- **Communication and interpersonal effectiveness** (e.g. DBT – DEARMAN, GIVE, FAST; reflective listening skills, communication styles).

- **Motivation enhancement and Values** (e.g. Stage of Change; ACT – value driven behavior)

- **Media and Societal influences** (CBT – gather evidence, challenge core beliefs, becoming a critical media viewer, body image)

Most patients who complete the approximately 5 week treatment will have the opportunity to participate in all the weekly themes and will acquire at least 15-25 skills designed to not only manage eating disorder behaviors, but that are instrumental in leading a productive and fulfilling life beyond eating disorder treatment.
The complete milieu curriculum and suggested group ideas are described in supplementary material.

**Three Phase Model of Care**

In an effort to provide providers and families a predictable and structured approach to this comprehensive care model, we have developed a Three Phase Program including 5 distinctive stages of treatment, which can be achieved in an average of 5 weeks. This is also supported by research which suggests change is most likely to occur in a predictable and sequential progression. The phases are designed to help guide families through the entire recovery process beyond the time spent in program.

The 3 phases in progressive order are **Orientation, Adaptation, and Transition**. Each phase has 1-2 stages which are designed to help organize and orient families to the treatment process. The stages each have delineated specific treatment goals and expected therapeutic expectations. Going through each stage and completing the associated goals/assignments prepares the family for the subsequent step in the treatment process. There are defined treatment goals for patients (primarily around symptom expression and participation in treatment) and concurrent family goals, which are related to improving the family dynamics associated with best prognosis.

**Target Behaviors for Treatment:**

**Attitude** – overall cooperation and observance of rules and respectful behavior

**Participation** – effort to be involved and learn from therapy, groups, family activities

**Skills/Safety** – using skills that suggest patients are attempting to find healing and recovery. These include using skills/communicating instead of engaging in maladaptive behaviors (such as food refusal, self-harm)

**Honesty & Personal Responsibility** - Making an effort to be honest in treatment with team and family. Accept feedback from others. Recognize responsibility for managing triggers and urges. Participate in expectations without being reminded – take initiative for managing situations that might be challenging by identifying skills and supports needed for success.
Phase 1: Orientation

Stage 1: Orientation and Adjustment

Entering treatment can be extremely overwhelming for families. Not only is a life-threatening diagnosis either given or confirmed, but families are asked to essentially put their lives on “hold” while they participate fully in a 5-6 week intensive treatment process.

The emphasis of Stage 1 is to understand what it means to be in program. Typically, the proverbial “spotlight” is on the physical health with behavioral next and emotional more dimly lit at this point. The primary targets for Stage 1 are Attitude and Participation.

For families and patients this translates to meeting the treatment team, learning the program schedule, completing initial assessments and admission paperwork, meal orientation, learning about Food Avoidance Behaviors and assessing motivation for recovery.

Additional goals for families include signing up for the treatment planning meeting, attending an orientation meeting and making plans to work out the logistics of being present at all family therapy sessions, treatment planning meetings, meal planning meetings, and family intensive day programming. Parents should know how to meal plan by the end of Stage 1. Another family Stage 1 goal is to buy resource materials and begin reading the parent workbook and familiarizing themselves with eating disorder treatment terminology. This stage typically lasts from 3-7 days.

Stage 2: Doing and Tolerating

Stage 2 is best described as “going through the motions.” It might still feel overwhelming and patients in particular might not have accepted the treatment program as “reality” yet; but, they are participating in what is expected and doing the best they can to manage one day at a time.
Attitude continues to be a primary emphasis, while patients in Stage 2 are also working on Participation goals. Patients are likely to practice “distraction” as a skill to get them through each challenge without engaging in abstract or big picture thinking. Goals for treatment are to learn about different skills, and maybe start to apply them at times, trying to participate more in groups and therapy, asking questions of treatment team and setting some preliminary treatment goals. Families are working on tolerating their child’s distress without becoming overly reactive and/or protective, learning and beginning to apply skills and strategies for meal support, meal planning independently, and setting limits especially around food avoidance behaviors.

By then end of this first phase, families should be familiar with all program expectations for participating and nutrition and be regularly attending and participating in all aspects of treatment. The recovery spotlight remains on physical stabilization, however by the end of Phase 1 and into Phase 2 it makes a definitive shift to the Behavioral section.

**Phase 2: Awareness & Adaptation**

**Stage 3: Acceptance**

As the spotlight shifts onto Behavioral aspects of recovery, patients and families start to have an increased awareness of the detrimental effects the eating disorder has had on the patient’s life. Additionally, families begin to gain insight into how their own behaviors, expectations, and beliefs may have influenced the maintenance of the eating disorder behaviors. The target behavior category that is emphasized is Skills/Safety. Motivation to change tends to improve at this stage as families begin to envision life outside the program and how they might need to integrate aspects of treatment into their life at home. Goals for patients at this level are to achieve and maintain eating at Nutrition level 2 or 3 by completing meals and snacks with little or no food avoidance behaviors. Patients should be using skills regularly both in and out of
program time and using individual and family therapy as well as group therapy and check-ins to openly communicate about struggles. Families in Stage 3 have begun to visualize how aspects of treatment will map on to life at home. Specific goals are to maintain structure and limits at home, integrate the rest of the family (i.e. siblings, partners, etc) by discussing expectations, and actively applying skills to improve communication and family dynamics as families are increasing time out of program spent at home.

**Stage 4: Adapting to the Real World**

Skills/Safety remains the primary target area in this stage as patients and families continue to practice using skills and changing behaviors. By the end of Stage 4, Honesty and Responsibility should be a central focus as patients and families prepare for the final stages in treatment. By Stage 4, medical and physical health should be essentially established with the goal for the end of stage 4 being that Behavioral Health has either been mostly or fully restored, or if it is not, that families know how to successfully structure time at home to manage and contain the behaviors outside of program. Specific treatment goals are to practice coping with time out of program by using skills to manage emotions, improve communication and improve flexibility. Patients should be comfortable using therapy and groups to address on-going challenges they are facing as they integrate back into their home and social lives. Families are expected to be meal planning confidently and flexibly to adjust to a variety of situations (including parties, going out to eat, etc). Family therapy should be used to assess necessary treatment structures to implement at home and discuss on-going challenges in implementation.

**Phase 3: Transition**

**Stage 5: Problem-Solving and Fine Tuning**

In this final Phase/Stage, patients are now working on being more honest and taking responsibility for their recovery. The recovery spotlight remains on behavior but is now starting
to shine more directly on the psychological/emotional aspects as patients begin to demonstrate more insight and motivation to practice value-driven behaviors and focus on their goals outside the eating disorder. Patient goals around attitude are to lead by example and taking initiative. Patients will be pursing behaviors and strategies that promote health and show self-respect. Patients should take an active role in maintaining the safety of themselves and others and might show this by involving staff or other adult if they have concerns about their own thoughts/behaviors and/or urges, or if they have these concerns about other patients in the milieu. Patients and families in this stage can synthesize treatment gains and insights and have accepted and adapted to the recovery lifestyle as their “new normal.” They are continue to actively work on using and integrating skills and improved communication styles into their family and lifestyle. Specific goals are set around assessing what patient and families need to remain successful in preventing relapses as patients transition back to their regular life and re-gain developmentally appropriate responsibilities and independence.

**After-care**

Once a family discharges from the EDU program there are several options for appropriate next steps. These are largely individualized and recommendations are largely dependent on several factors including proximity to treatment center(s), available treatment, financial resources and level of need. The primary therapist along with the treatment team will help families assess these options throughout treatment and make appropriate recommendations and referrals prior to discharge from program.

The Eating Disorder Program at Children's Hospital Colorado houses an outpatient clinic with one full time eating disorder specialist therapist. EDU program primary therapists also have outpatient spots available as well for their own transitioning patients and can offer short-term/transition support to local families and families willing to travel for intermittent therapy sessions. The program also offers intensive outpatient treatment which is a 6 week program that meets 3 afternoons per week and runs approximately 4-5 times per year. Families travelling from other states or locations will need to secure community based treatment providers in their area. Therapists will help families identify appropriate providers and help facilitate those referrals. Families requiring long-term psychotherapy for concerns beyond the eating disorder (such as depression, anxiety, and complex family dynamics) will be referred to appropriate local treatment providers specializing in those areas.

**Young Child Program (12 and under) – “Delta” Program**

The number of children coming to treatment under the age of 12 has steadily increased since 2005. The “Delta” program is geared towards the specific developmental needs of these patients 12 and under.
Children commonly experience food preference “phases”, leading parents to consider initial changes in eating as “normal”. Because young children are smaller in stature and weight, smaller amounts of weight loss subsequent to food refusal can lead to sudden onset of eating disorder diagnoses. By the time parents become aware of the significance of weight loss and disordered eating symptoms, changes in behavior and attitude can be profound.

Most children with eating disorders have more atypical eating disorder symptoms. Presentations are often complex and patterns of food restriction are usually different from older patients. Common reasons for food refusal in children include fear of getting “fat” related to seeing other peers teased at school, fear of getting stomach aches or vomiting, choking, or aversion to tastes, smells and textures. Many children have pre-morbid anxiety symptoms which further impact their fears and disordered eating, while others may develop OCD-like behaviors which coincide with restriction and malnutrition. Children often present in behaviorally regressed states, displaying severe tantrums, physical aggression, screaming, and excess movement.

Prior to seeing improvement, periods of behavioral regression are common, including refusal to eat solids necessitating a liquid supplement diet, complete refusal of food and supplement requiring NG tube feeding, increase in aggressive tantrums/outbursts, and increase in anxiety. Due to these issues, children often require longer stays in intensive treatment programs.

Parents vary in awareness of need for and readiness to receive treatment. Children typically do not recognize their symptoms as a problem and are often “precontemplative” about changing behaviors and participating in treatment. Given the necessity of parental involvement in treatment, while considering parents’ level of readiness and acceptance of treatment, evaluating teams should convey clinical information while developing rapport essential to facilitating acceptance of treatment recommendations. Encourage parents to elaborate on their concerns to improve rapport and increase motivation for change.

Parents must be prepared to prioritize the need to take control of all aspects of daily nutrition (planning, preparing, supervising meals and snacks). Families and patients should think of food as medicine or ‘fuel to run the body’. Just as medications are prescribed to be taken a certain number of times daily, nutrition “prescriptions” include eating a minimum of three meals and 2-3 snacks each day. This requires changes to home, work and school schedules.
Delta Program - Children's Hospital Colorado

Treatment of eating disorders in children 12 and under

The EDU Delta program shares the same fundamental principles of the general program, but it has separate programming with interventions aimed at the specific developmental needs of younger children.

The principle difference is emphasis on behavioral interventions and programming used with this young population. Children in this more concrete stage of cognitive development require more immediate and tangible behavioral incentives in order to establish a pattern of behavior change. The classroom/milieu environment has standards of expected behavior including: following directions, staying seated, completing meals within the time limit given, staying safe with hands and feet and completing assignments.

Rainbow Behavior Program

The behavior program includes a Rainbow chart with each color corresponding to behavioral readiness.

Green: Ready to Learn. This means patients are following classroom rules with little or no directives.

Blue: Above and Beyond. If patients are willing to go beyond this and try out new skills or push themselves beyond the minimum expectation.

Purple: Role Model behavior which implies a patient is taking an active leadership role in program.

Yellow: Having a hard time. When patients are having a difficult time following the rules or are requiring a lot of re-direction, encouragement and reminders they will be asked to place the clip on the yellow level.

Orange – Refocus. If patients continue to struggle and make poor choices they will be asked to place the clip on the Orange level which is considered a time to “re-focus.” They might be asked to do a different assignment or task in order to reflect on what they need to make better choices.

Red – Stop Zone. Any unacceptable behavior warrants the patient to move to Red Level or Stop Zone. These behaviors include (but are not limited to) physical aggression, verbal aggression, complete food/supplement refusal. Patients on Red/Stop Zone are separated from their peers and work on therapeutic assignments aimed at helping them reflect on what they need to do and/or ask for to stay in better behavioral control and participate more effectively in program.
Patients begin each day on Green level. If parents report that a patient has struggled in the morning with following at-home expectations, patients might be asked to immediately clip down to the appropriate level.

Patients can “clip” up or down throughout the day thus encouraging immediate redirection for negative behavior as well as immediate reinforcement for positive behavior.

Primary therapists work very closely with parents to understand the behavior program and to create individual behavior programs with more individually tailored behavioral goals that can map onto the Rainbow system used in program. This encourages parents to be empowered to create and maintain a useable system and structure for behavior change that they can readily use at home.

Parents are invited to attend the general support and skills groups and they are also offered additional parenting support for following behavior programs and understanding the developmental needs of their young child. They are allowed to attend most, if not all, multi-family groups as well and participate in the family intensive program with the general program.

**RAINBOW BEHAVIOR CHART**

**DELTA PROGRAM**

**ROLE MODEL**

- Follow classroom rules with no reminders
- Complete 100% of meals within time limit
- Volunteer to go above and beyond in groups
- Provide support to my peers

**ABOVE AND BEYOND**

- Follow classroom rules with no reminders
- Complete 100% of meals/supplement within time limit
- Participate in all groups by paying attention and raising my hand before speaking
- Use my skills to get through meals and supplements
- Communicating and asking for help when I feel overwhelmed or confused
READY TO LEARN

- Follow classroom rules with little or no reminders
- Complete 100% of meals/supplement within time limit
- Participate in all groups by paying attention and raising my hand before speaking
- Remaining safe (not hurting myself or others)
- Trying to use my coping skills
- Willing to accept support to work through hard moments

HAVING A HARD TIME

- Follow classroom rules but requiring more than 1 reminder to
- Participating in groups with staff encouragement
- Completing meals and supplements with redirection from staff
- Remaining safe (not hurting myself or others)
- I need reminders to use coping skills to manage my feelings
- I am willing to try to get past tough moments, but it is hard

REFOCUS – TIME TO MAKE A BETTER CHOICE

- Having some difficulty following classroom rules
- Not participating in groups
- Completing meals and supplements requiring redirection from staff
- Remaining safe (not hurting myself or others) with support
- Not willing to use my coping skills
- Struggling to figure out how to get past tough moments

Refocus Intervention
- Unable to participate in special activities (i.e. going outside or to the gym)
- Able to attend therapeutic groups and activities

STOP ZONE

- Unable to follow classroom rules
- Meal or supplement refusal
- Being unsafe toward myself or others
- Disrespectful of others

Stop Zone Intervention
- Unable to participate in activities
- Independently completing stop zone worksheets