RECOMMENDATIONS FOR THE EVALUATION, TREATMENT, AND MONITORING OF HEALTHCARE PROFESSIONALS WITH CO-OCCURRING EATING AND SUBSTANCE USE DISORDERS

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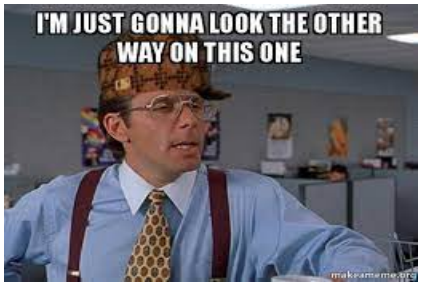
PROBLEMS PROGRAMS FACE

- Substance use disorders and eating disorders are common at about ~35%
- Generally, no specific protocol
- ED poses concerns for those occupying safety sensitive positions
- Viewed as out of scope but impacts SUD recovery



EATING DISORDERS REFRESHER

- Anorexia Nervosa
  - Restricting Subtype
  - Binge/Purge Subtype
- Bulimia Nervosa
- Binge Eating Disorder
- Obesity?
- Food addiction?
- Other Specified Feeding or Eating Disorder
- Avoidant/Restrictive Food Intake Disorder
- Severe and Enduring Eating Disorders

CO-MORBID PRESENTATION

- Characteristics (Gregowski et al, 2013)
  - Greater severity of substance use
  - Longer time to recovery
  - Poorer outcomes in general functioning
  - Higher relapse rates
  - Higher incidence of sexual abuse
  - Higher incidence of BPD
- Binge/purge variants are more common
- Combination is lethal, increasing mortality rate 2x in those with AN and an SUD (Tabri et al., 2019)

POTENTIAL IMPACTS OF EATING DISORDERS ON PATIENT CARE

- Bringing own biases related to weight into the room
- High rates of cognitive impairment compared to HC (Aloi et al., 2015)
  - Executive functioning deficits in BED that are above what is found in obese individuals, suggesting association with the disorder itself (Blume et al. 2018)
  - Significant cognitive deficits in AN compared to healthy controls (Rania et al., 2021)
    - Particularly with memory, inhibition, and visuospatial abilities
    - Effect of both age (longer duration of illness) and BMI
    - Negative effect of education for memory and set shifting
- Medical complications that are often sudden and unpredictable

MEDICAL ASSESSMENT

- Weight
- Orthostatic vitals
- ECG
- DEXA with amenorrhea
- Labs
  - Phosphorous
  - Magnesium
  - Amylase
  - CMP
  - CBC
  - Thyroid
- **Patients with significant alcohol intake are at increased risk for the development of Wernicke's**
  - Thiamine
  - Folate
- Refeeding syndrome risks:
  - BMI <15
  - Rapid weight loss (greater than 10-15% in 3-6 months)
  - Little to no energy intake for more than 10 days
  - Post bariatric patients with significant weight loss
  - Electrolyte abnormalities

FULL ASSESSMENT

- Rate/amount of weight loss/change in past six months or longer
- Level of weight suppression: highest recent body weight-current body weight
- Nutritional history
- Compensatory behaviors and frequency
- Exercise frequency, duration, and intensity
- Menstrual history
- Family history
- Trauma and psychiatric history

NEUROPSYCHOLOGICAL ASSESSMENT ADDITIONS

- EDI: assesses psychopathology of EDs
- BES: to measure binge eating severity
- For AN: Profile tends to skew towards more cognitive rigidity and detail oriented processing (Aloi et al., 2015, Raina et al., 2021)
  - Trail Making Test
  - Perseverative Responses Condition of the Wisconsin Card Sorting Test
  - Block Design Test from Wechsler Adult Intelligence Scale
  - Rey Complex Figure Test
  - Central Coherence Index
- For BN: Profile tends to skew towards lack of attention and difficulty adapting to changes (Aloi et al., 2015)
- ADHD assessments
- Focus more on process scores as many measures normed for brain injuries not psychiatric conditions

WHERE CAN THE EATING DISORDER BE MANAGED?

Before Completion of Treatment

- Medical instability
- Body weight at or below 85%
- Unwilling or unable to seek out support to manage binging and purging (not expecting total abstinence)
- Denial of eating disorder or engagement in symptoms despite contrary evidence
- Increasing use of eating disorder behaviors despite intervention
- Unable to fulfill treatment agreement as laid out by treatment team

More Focused Interventions Post-SUD Tx

- Obsessions or behaviors continue to be present
- ED thoughts and urges increase in tx despite previous remission status
- Success with interventions in treatment but need for continued support
- Long previous history of an eating disorder
- Red flags for further assessment
  - Significant changes in weight or exercise pattern while in treatment
  - Voicing feeling like they are becoming "addicted to sweets"

	Level 1: Outpatient	Level 2: Intensive Outpatient	Level 3: Partial Hospitalization (Full-Day Outpatient Care)[a]	Level 4: Residential Treatment Center	Level 5: Inpatient Hospitalization
Medical status	Medically stable to the extent that more extensive medical monitoring, as defined in levels 4 and 5, is not required			Medically stable to the extent that intravenous fluids, nasogastric tube feedings, or multiple daily laboratory tests are not needed	*For adults:* Heart rate <40 bpm; blood pressure <90/60 mmHg; glucose <60 mg/dl; potassium <3 mEq/L; electrolyte imbalance; temperature <97.0°F; dehydration; hepatic, renal, or cardiovascular organ compromise requiring acute treatment; poorly controlled diabetes *For children and adolescents:* Heart rate near 40 bpm, orthostatic blood pressure changes (>20 bpm increase in heart rate or >10 mmHg to 20 mmHg drop), blood pressure <80/50 mmHg, hypokalemia,[b] hypophosphatemia, or hypomagnesemia
Suicidality[c]	If suicidality is present, inpatient monitoring and treatment may be needed depending on the estimated level of risk				Specific plan with high lethality or intent; admission may also be indicated in patient with suicidal ideas or after a suicide attempt or aborted attempt, depending on the presence or absence of other factors modulating suicide risk
Weight as percentage of healthy body weight[d]	Generally >85%	Generally >80%	Generally >80%	Generally <85%	Generally <85%; acute weight decline with food refusal even if not <85% of healthy body weight

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Motivation to recover, including cooperativeness, insight, and ability to control obsessive thoughts	Fair-to-good motivation	Fair motivation	Partial motivation; cooperative; patient preoccupied with intrusive, repetitive thoughts[c] >3 hours/day	Poor-to-fair motivation; patient preoccupied with intrusive repetitive thoughts[c] 4–6 hours a day; patient cooperative with highly structured treatment	Very poor to poor motivation; patient preoccupied with intrusive repetitive thoughts[c]; patient uncooperative with treatment or cooperative only in highly structured environment
Co-occurring disorders (substance use, depression, anxiety)	Presence of comorbid condition may influence choice of level of care				Any existing psychiatric disorder that would require hospitalization
Structure needed for eating/gaining weight	Self-sufficient	Self-sufficient	Needs some structure to gain weight	Needs supervision at all meals or will restrict eating	Needs supervision during and after all meals or nasogastric/special feeding modality
Ability to control compulsive exercising	Can manage compulsive exercising through self-control	Some degree of external structure beyond self-control required to prevent patient from compulsive exercising; rarely a sole indication for increasing the level of care			
Purging behavior (laxatives and diuretics)	Can greatly reduce incidents of purging in an unstructured setting; no significant medical complications, such as electrocardiographic or other abnormalities, suggesting the need for hospitalization			Can ask for and use support from others or use cognitive and behavioral skills to inhibit purging	Needs supervision during and after all meals and in bathrooms; unable to control multiple daily episodes of purging that are severe, persistent, and disabling, despite appropriate trials of outpatient care, even if routine laboratory test results reveal no obvious metabolic abnormalities

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Environmental stress	Others able to provide adequate emotional and practical support and structure		Others able to provide at least limited support and structure	Severe family conflict or problems or absence of family so patient is unable to receive structured treatment in home; patient lives alone without adequate support system	
Geographic availability of treatment program	Patient lives near treatment setting			Treatment program is too distant for patient to participate from home	

INCREASING EATING DISORDER SUPPORT IN PRIMARY SUD FACILITY

- Certified Eating Disorder Specialist on staff for evaluations and regular adjunct sessions
- Groups targeting body image, balanced eating and movement (not only for ED patients)
- Weekly sessions with dietitian, not just initial assessment
- Use of Recovery Record or similar food monitoring app or log to be shared daily with dietitian for more oversight into daily eating patterns and ability to enact changes discussed
- Bathroom buddies/monitoring after meals
- Weekly blind weights
- Setting a cap on frequency of exercise
- Regular attendance at free online support groups (National Alliance for Eating Disorders, ANAD, or EDA)
- Suicide assessments
- Specific neuropsychological assessments for impairments in AN
- Clear cut treatment agreement on when referral to ED specific treatment facility would need to occur

TREATMENT MODALITIES

- Anorexia Nervosa
  - CBT-E
  - ACT
  - RO-DBT
  - CRT
  - CREST
- Bulimia Nervosa and BED
  - IPT
  - DBT
  - CBT-E
  - ACT

DETERMINING APPROPRIATE AFTERCARE RECOMMENDATIONS

- Objective is a gradual reduction in symptoms and the patient being able to state needs surrounding support
- Anorexic attitude and continued body image disturbance despite behavioral cessation predicts relapse
- High risk of relapse when patient reaches 90% of EBW and within first year of recovery
- "Dry drunk" equivalent?
- Minimum assessment by a therapist AND a dietitian specializing in eating disorders (CEDS)
- Refer to LOC Guidelines

MONITORING AFTER DISCHARGE

- Regular visits with PCP to monitor weight trends, orthostatic vitals, or changes in lab work
- "Check ups" with therapist AND dietitian with reports on progress given from both
- Suicide assessments
- Regular administration of EDE-Q to check for resurgence of thoughts and behaviors in comparison with norms
  - Restraint
  - Eating Concern
  - Weight Concern
- Special attention to prescriptions related to weight loss including Ozempic and the like as well as use of Wellbutrin
- Monitoring cosmetic surgeries, would strongly caution against in early recovery period
- Bariatric surgery only after 1 year of no eating disorder behaviors, assessment and treatment by ED specialist with specialized training in addressing ED and preparing for success post surgery

OUTCOME

- Generally around 50% when individual receive evidence based outpatient interventions
- Suggestions of close to 80% when you look out to 20 years, argue against QOL interventions as goal (Eddy et al., 2017)
- Chances of spontaneous remission are low and early symptom change is the best predictor
- Poorer outcomes associated with
  - Binge eating and purging behaviors
  - Lower BMI
  - Early stage of change
  - Concurrent depressed mood
  - Concurrent substance use
  - Higher body image concerns
- Recovery from an ED at 22 years is associated with 5x greater decrease in likelihood not to have a SUD at 22 years compared to those who are not in recovery from ED (Tabri et al., 2019)

QUESTIONS?