



## **ACADEMY FOR EATING DISORDERS**

# **CLINICAL PRACTICE RECOMMENDATIONS FOR RESIDENTIAL AND INPATIENT EATING DISORDER PROGRAMS**

*Release date: November 2012*

The purpose of these guidelines is to promote high quality residential and inpatient treatment for eating disorders. Specifically they are intended to (a) contribute to safeguarding patients and families who seek eating disorder residential and inpatient treatment; (b) review and improve the quality of care offered by residential and inpatient treatment programs; and (c) provide a quality of care benchmark for third party payers to consider as they collaborate with health care providers in the development of comprehensive models of care and its reimbursement, where applicable.

The guidelines were developed for programs that offer treatment to patients with eating disorders 24-hours per day, 7 days per week under the supervision of a licensed health care professional who has access to a licensed physician. The majority of recommendations apply to eating disorder residential and inpatient programs across the globe. Those that apply specifically to programs in the USA are italicized in the document. Non-US providers should substitute reasonable local procedures for these sections.

The recommendations are intended for use in clinical governance and quality assurance and as a guide for credentialing of treatment programs and/or the development of key performance indicators. They may be used by eating disorder residential and inpatient treatment programs,

insurers, government health officials, and accrediting organizations willing to integrate these recommendations into a program of accreditation. Additionally, these recommendations can be helpful in providing information about recommended standards for care to patients and families as they consider possible treatment program options.

The guidelines are clinical practice recommendations based on empirical data and expert consensus that would have general relevance to standards of care for patients with an eating disorder. The standards are intended as a minimal standard of care, to inform clinical practice and consumers, but should be applied with clinical judgment. These recommendations may not be sufficient to ensure appropriate or adequate care of some patients and are not intended as a substitute for medical advice from a clinician who is able to evaluate the entire relevant clinical context, patient history, individual care needs, treatment and goals. Recommendations specific to children and adolescent have been integrated into the recommendations.

Users of these guidelines should understand that health care delivery practices and laws may vary from region to region, including across states in the US and across national health systems. Moreover, as scientific studies and clinical practice advance the field, standards and recommendations may change.

The guidelines were developed by the Academy for Eating Disorders (AED) in collaboration with the National Eating Disorders Association (NEDA) and the International Association of Eating Disorder Professionals (IAEDP). The Task Force work groups comprised more than 50 individuals including professional experts in the eating disorders and related fields, individuals in recovery, and family members, supported by external facilitators. Work group members were asked to review existing guidance, including the National Institute for Clinical Excellence (NICE) Guidelines for Eating Disorders (2004)<sup>1</sup>, American Psychiatric Association Practice Guidelines for the Treatment of Eating Disorders (2006)<sup>2</sup>, and Australian and New Zealand Clinical for the Treatment of Anorexia Nervosa (2005)<sup>3</sup>, as well as the American Academy of Pediatrics Policy Statement on Identifying and Treating Eating Disorders (2003)<sup>4</sup> in preparation for their work on these clinical practice recommendations for residential and inpatient eating disorder programs.

Consensus regarding recommendations was reached through extensive intra- and inter-work group discussion. The guidelines were then put out for consultation to stakeholder groups including the membership of the AED, NEDA, and IAEDP; program directors; insurer groups in the USA; and recovered individuals and family members.

The full list of the AED Task Force members, consultants, and work group chairs and members is given in Appendix A. Expert consultation from colleagues in countries outside the USA, including Australia, Canada, and the United Kingdom, was obtained during the development and review of these guidelines. They have also been reviewed by the Scientific Committee and Board of Directors of the Academy for Eating Disorders.

The contents of this document are copyrighted to the authors and the Academy for Eating Disorders.

AED Task Force Chair: Mary Tantillo, PhD PMHCNS-BC FAED, USA

Task Force Work Group Chairs:

- I. Assessment and Treatment Planning: Joel Jahraus, MD, FAED, USA and Benita Quakenbush-Roberts, PhD, USA
- II. Treatment Delivery: Jillian Lampert, PhD, MPH, RD, LD, FAED, USA and Craig Johnson PhD, FAED, USA
- III. Quality Improvement and Outcome Measurement: Pauline Powers, MD, FAED, USA and Jim Mitchell, MD, FAED, USA

Work Groups IV (Accreditation Work plan: Co-chairs Doug Bunnell, PhD, FAED, USA and Ovidio Bermudez, MD, FAED, USA) and V (Specialized Protocols: Co-chairs William Davis, PhD, FAED, USA and Mae Sokol, MD, USA) addressed dissemination of these standards and specific protocols for implementation once the implementation of these standards has begun.

## **WORK GROUP I RECOMMENDATIONS FOR ASSESSMENT AND TREATMENT PLANNING STANDARDS**

**Work group focus:** Development of recommendations for credentialing guidelines for an eating disorder treatment residential facility intake and treatment planning process.

**Work group co-chairs:** Joel Jahraus, MD, FAED, USA; Benita Quakenbush-Roberts, PhD, USA

**Work group members:** Barton Blinder, MD, PhD, FAED, USA; Carolyn Costin, MA, MEd, MFT, FAED, USA, Luke Einerson, USA; Rich Levine, MD, FAED, USA; Connie Roberts, RN, USA; Janet Treasure, FRCP, UK; Joel Yager, MD, USA.

**Background and Overview Paragraph:** The initial assessment in this case is the first contact with the facility, where evaluation will determine whether the facility can provide safe and effective care for the level of medical and psychiatric need of the patient. The patient's first contact with a treatment facility is often a highly emotional and often overwhelming experience. It is essential that this initial process maximize engagement and support while minimizing confusion.

### **Standard 1: Initial Assessment**

Initial assessment should be done promptly and effectively.

#### **Rationale:**

As eating disorders are complex biopsychosocial disorders, it is essential to conduct a thorough and timely initial assessment to obtain information to ensure that the patient is medically stable and that the facility can provide appropriate medical and psychological care.

#### **Elements of Performance:**

In order to determine suitability for admission, an initial assessment can be done on site or remotely by telephone/videolink (subject to legal limitations regarding the communication of confidential health information) to gather information from the referrer and from the patient and their family, as

indicated, that assists in determining the appropriateness of the individual for the facility and program. It is important for outpatient providers to expect to interface closely with the inpatient team and for patients/families to know that their team will facilitate the referral. A clinician knowledgeable about eating disorders should conduct the initial assessment, under the overall responsibility of the manager of the facility.

**Process Measures:**

1. From the time of initial contact with the individual (and family as indicated) requesting admission, the initial assessment and decision-making should be accomplished within 48 hours after all necessary data have been obtained. Patients, when clinical severity is greater (e.g., who have serious medical compromise or suicidal risk), may require initial evaluation in an emergency room and/or by their own physician for safety and appropriate interventions while completion of this process is pending
2. Initial assessment consists of:
  - a. An evaluation of medical stability as determined by a history and physical examination provided by a medical clinician, laboratory testing, and electrocardiogram (EKG). Medical history, laboratory, and EKG findings may be obtained directly from the patient or provided in a timely manner from an evaluating medical clinician where applicable. This information should be coded on Axis III of the Diagnostic and Statistical Manual of Mental Disorders (DSM) if using the DSM classification system.
  - b. Mental health screening and multi-axial diagnosis using the DSM or ICD classification of Mental Disorders, including for personality disorder, substance abuse, suicidal and violence risk.
  - c. Details of past and current treatment including current provider contact information
  - d. Nutritional screening for eating disorder behaviors, and nutritional status.
  - e. Special needs including, but not limited to, disabilities, language barriers, and communicable disease requiring isolation.
  - f. Assessment of impact of illness on patient and family in relation to role impairment, quality of life, and burden of care.

For children and adolescents specifically:

- g. Information from the parents/guardians regarding the patient's history of present illness and the facility's ability to provide for the patient's age and developmental level.

3. The treatment facility informs applicants of the treatment that will be offered or if not, of the appropriate alternative treatment and/or facilities. In accordance with good clinical practice the facility will advise that outcomes of care are assessed by structured surveys that may include self-report, as well as clinician-completed measures. In the USA and other insurance-based health care systems, informed financial consent is obtained (as indicated), and patients and family are informed of:

- a. Whether the facility is considered in-network for the member's insurance company
- b. An estimated range of expenses for services provided
- c. The means and timing of payment
- d. The consequences of non-payment

4. Each patient, whether voluntary or involuntary, and family (as indicated) is engaged in the process preparing them for admission:

- h. Is appropriately prepared for admission.
- i. Is assisted in understanding the reasons for admission.
- j. Is notified of all available options.
- k. Receives a pre-placement visit to the residential or inpatient treatment center, when feasible.

**Outcome Measures:**

Facility provides initial assessment procedures and adequate documentation demonstrating compliance with the standard. Appropriate staff could also be surveyed as a means of assessing standards.

**Standard 2: Admission Process**

The admission should comprise a comprehensive, interdisciplinary clinical process and form the basis for individualized treatment planning and delivery.

**Rationale:**

A thorough assessment of an individual's biopsychosocial functioning and family system/support network ensures a more accurate understanding of predisposing, precipitating, and perpetuating factors related to the eating disorder and assesses the individual's specific medical, psychological, and nutritional needs. This allows for refinement of the diagnostic summary, and the development and coordination of a comprehensive and effective treatment plan. An interdisciplinary team of medical/nursing, nutritional, psychological, psychiatric, and/or other professionals makes admission decisions, using the organization's own assessments, medical necessity criteria, and materials from specialty organizations such as the American Psychiatric Association (APA) Guidelines for Treatment of Eating Disorders and NICE Guidelines for Eating Disorders. Timely and thorough assessment by an interdisciplinary team is also imperative given the high risk for concurrent conditions.

**Elements of Performance:**

Assessments are done as soon as the patient is admitted to ensure that appropriate interventions are implemented as necessary for patient safety, comfort, and to advance therapeutic goals. The patient's family (including, but not limited to, family of origin, spouse, children, significant other or close friends) are included in the admission and assessment process because the patient's and family's participation in treatment planning improves the probability of treatment compliance. Corroborating data from family members and other clinicians is collected as indicated in relation to eating disorder symptoms and severity as well as co-morbid conditions.

**Process Measures:**

1. Consent for treatment, contracts, releases of information, and emergency contact information as well as all other applicable program documentation are completed during the assessment. For a minor, informed consent for admission is obtained from parents if necessary, in line with the appropriate legal framework for the country or state and depending on the young person's development stage and capacity.

2. The patient and, if applicable, the family are oriented to the program and its policies and procedures including expectations and rationale for family communication, clinical involvement, and visitation.
3. The facility establishes a policy for providing assessments and written evaluations provided by duly licensed and qualified health professionals within a biopsychosocial framework, in the following areas:
  - a. Medical
  - b. Nursing
  - c. Psychiatric
  - d. Psychological
  - e. Nutritional
4. The facility gathers information from outpatient providers and/or other treatment programs the patient has participated in within their lifetime, if available.
5. Each patient receives:
  - a. An assessment of environmental, religious, and cultural factors.
  - b. An assessment of the family when appropriate by direct involvement of pertinent family members.
  - c. An educational and/or vocational assessment, as needed.
  - d. Additional psychological testing (e.g. intelligence, personality) during the diagnostic process or later in treatment, as needed.
  - e. Substance abuse assessment.

For children and adolescents:

- f. Developmental, educational and cognitive assessments, as needed.
6. A comprehensive medical assessment, multi-axial diagnostic assessment, psychiatric evaluation, and nutritional assessment will be completed within 72 hours of admission, and all assessments will be completed within one week of admission or sooner. Some aspects of care, such as stability or risk, may require a shorter time frame in order to institute immediate therapeutic or safety measures. Psychological testing will be completed as clinically indicated. If

an assessment cannot be completed within the recommended time frame, justification for delay must be documented in the medical record. The facility staff will:

- a. Conduct regular and ongoing assessments of each patient and his/her family system to determine the continued necessity for residential or inpatient care or whether the patient is ready to be stepped down to a less restrictive and/or intense level of care.
  - b. Document and justify the continued need for current level of care in the case record.
7. If substance abuse is indicated by history and/or evaluation, treatment or referral will be provided.
  8. The facility identifies, assesses, treats, and/or refers victims and perpetrators of abuse and neglect for treatment, in compliance with mandatory reporting laws, and for safeguarding in the case of minors at ongoing risk.
  9. The patient sets goals for treatment and discharge expectations with treatment team members. The parents/guardians of child and adolescent patients participate in setting goals for treatment.

**Outcome Measures:**

The facility provides documentation of assessment being performed within a biopsychosocial framework, in compliance with Standard 2, #3 a-d and appropriate staff surveyed.

**Standard 3: Treatment Planning**

The clinical staff complete and regularly review a comprehensive treatment plan for each patient.

**Rationale:**

Comprehensive treatment and continuity of care are initiated as soon as possible to promote successful treatment.

**Elements of Performance:**

Treatment planning is conducted in a timely and responsive manner and provides enough information to the patient, family, and treatment team so they can proceed with treatment. In order to make

appropriate modifications, it is imperative to regularly re-evaluate the individual's progress or lack of progress.

**Process Measures:**

1. An initial treatment plan is developed within 72 hours of admission, and a comprehensive treatment plan within 7 days to provide efficient, safe, and continuous care.
2. The treatment plan is developed with the participation of the patient, the parent/guardian (if the patient is a minor), the facility and:
  - a. Helps the patient understand the options, benefits and consequences of different treatment alternatives.
  - b. Helps the patient understand the ways the facility can support the achievement of his/her desired outcomes.
  - c. Informs each patient in advance about the benefits, risks, and alternatives to planned treatments.
3. The written treatment plan specifies a diagnosis according to criteria in the current DSM and/or ICD International Classification of Diseases and the treatment plan consists of:
  - a. Patient identification on each page of the document
  - b. Description of problems
  - c. Symptoms
  - d. Patient treatment goals/expected outcomes
  - e. Expected date of goal completion
  - f. Measurable objectives to complete goals
  - g. Therapeutic interventions and responsible staff
  - h. Assets/strengths of the patient and family (as indicated) that will assist them in achieving treatment goals
  - i. Date specifying when objectives will be reviewed with patient and family (as indicated)
  - j. Signatures of patient (and parent/guardian for minors) and representatives of the treatment team

4. The facility provides procedures and documentation demonstrating Standard 3 #3 a-j.
5. The treatment team reviews (including critiques, updates and revises the plan in interactive discussion) treatment plans at least every 7 days for appropriateness, effectiveness, or when individual needs dictate.

**Outcome Measures:**

The facility provides the procedures listed above and adequate documentation demonstrating compliance. Appropriate staff will also be surveyed.

**Standard 4: Continuity of Care**

Continuity of care is provided by sharing pertinent information with appropriate individuals invested in the patient's care and well-being.

**Rationale:**

Continuity of care is essential to the provision of best-practice care and transition to step down services or the community after discharge. Continuity of care is accomplished through disseminating information to treating clinicians that then standardizes care and allows the clinicians to work in tandem. This is particularly essential in working with patients with eating disorders who have complex presentations and whose motivation for recovery may vary at different times, creating the possibility for staff splitting.

**Elements of Performance:**

Internal continuity of care is provided by sharing applicable information promptly and disseminating it to appropriate staff. External continuity of care is ensured by providing verbal and/or written communication to step-down providers (including the patient's primary care provider and receiving mental health therapist or program) within 48 hours of a treatment determination regarding next level of care or at the time of discharge. Written consent by the patient (or parent/guardian if a minor) must be given prior to any information exchange with outside providers. *In the USA the latter is required to*

*maintain compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) but may be overridden if required by law and the patient is at substantial risk of harm to self or others.*

**Outcome Measures:**

The facility provides assessment policies, procedures, and documentation demonstrating compliance.

**Standard 5: Discharge Planning**

The facility assists the patient in developing an after-care plan and works to assure follow-up after discharge. The facility staff provides the patient, family (as indicated) and after-care team with the appropriate information to ensure continuity of care.

**Rationale:**

The discharge plan should adequately inform the patient, the family, and the receiving team the level of care recommended for the patient.

**Elements of Performance:**

Discharge planning begins upon admission and is further developed with the patient and family/support network throughout treatment culminating in a comprehensive plan. An assessment of the prognostic features (e.g., dietary restraint, motivation for treatment, and quality of family support) and response to residential or inpatient care is conducted to determine the need for further treatment, and type of treatment. Access to appropriate step-down care can be problematic in certain areas around the world. The treatment team will make every effort to link the patient and family with appropriate providers who are located in or near the community to which the patient is discharged.

**Process Measures:**

1. The discharge plan developed during the patient's treatment consists of:
  - a. Level of care recommended, based on current risk assessment.
  - b. Specific recommendations for follow-up treatment.
  - c. Medication education.

d. Providers' names and contact information for follow-up appointments.

For children and adolescents:

e. Parents/guardians are involved in discharge planning, where school follow up is addressed.

2. After-care providers will be given a copy of the discharge summary upon written consent of patient within a timely manner after discharge.

**Outcome Measures:**

The facility follows procedures to create after-care discharge plan with the patient and family (as indicated), the discharge plan is effectively communicated to the client, and the facility can demonstrate compliance with guidelines.

## **WORK GROUP II**

### **RECOMMENDATIONS FOR TREATMENT DELIVERY STANDARDS**

**Work group focus:** Treatment delivery characteristics available for review by prospective patients, families, and relevant providers.

**Work group co-chairs:** Jillian Lampert, PhD, RD, MPH, FAED, USA, and Craig Johnson, PhD, FAED, USA

**Work group members:** Pamela Carlton, MD, USA; Carol Cochraine, MA, LMFT, USA; Bryan Gusdal, MA, Canada; Phillipa Hay, DPhil, Australia; Susan Ice, MD, USA; Marsha Marcus, PhD, FAED USA; Wendy Oliver-Pyatt; MD, FAED, USA

**Background and Overview Paragraph:** Work group findings and recommendations related to treatment delivery are presented in this document. Recommended treatment delivery characteristics are described. Such characteristics should be readily available for review by prospective patients, families, and referring providers.

#### **Standard 1: Licensure Adequately Described**

In countries requiring licensure, treatment facilities should accurately state licensure on patient information materials, including websites, brochures, and information sheets about the facility, display licensure and provide details of licensure upon request. As licensure will vary widely by location and program description, there is no specific type of licensure recommended. At a minimum, a treatment facility must be licensed in the state or region in which it is located as a mental health treatment facility or program, if such licensure for the level of care is available.

#### **Rationale:**

Licensure should be adequate, legally proper, and fitting of treatment center service delivery.

#### **Elements of Performance:**

Licensure should be adequately described. Documentation of such licensure should be displayed and details of licensure made available upon request.

**Process Measures:**

Licensure status should be clearly stated on information available to patients, families (as indicated), and outside providers and documentation provided upon request.

**Outcome Measures:**

Patients and families report they received adequate information regarding facility licensure.

**Standard 2: Program Accurately Described**

An accurate description of program setting, components, and population served should be readily provided to consumers including prospective patients, families, and referring providers.

**Rationale:**

Program settings/components will vary widely by facility and population served. Consumers should be adequately informed regarding treatment techniques and modalities used at the facility. Regardless of type of treatment offered, evidence of core staff competencies should be documented and available upon request.

**Elements of Performance:**

Program setting/components should be adequately and accurately described in program materials. Pertinent information regarding availability of and/or transfer to alternative setting of care, if necessary, such as acute hospital, psychiatric facility, etc. should be clearly communicated to patients and families.

Population and age group served by program should be adequately described in program materials. Pertinent information regarding availability of treatment based on particular population characteristic should be clearly communicated to patients and families (e.g. only one half of available beds are open

to adolescents; only females are served by program; patients must treat chemical dependency issues prior to entering program, etc.).

Program materials should contain a description of the treatment team (i.e. members of multidisciplinary team) providing services. Pertinent information regarding availability and frequency of contact should be clearly communicated to patients and families (e.g. full-time availability or available a limited number of times a week; level of medical care available when and where, etc.). Description of methods of communication (e.g. rounds, care plans, emergency calls, etc.) used among the care team should be adequately described, as well as a clear outline of established psychiatric emergency protocols.

**Process Measures:**

Documentation of typical pattern of transfer to alternative setting of care, description of typical population served, description of care team members, methods of communication among team, and education of team members should be available to patients, families, and outside providers upon request.

**Outcome Measures:**

The program's description of the services provided is adequately and accurately documented and the patients, families and referring providers indicate that they are adequately informed. In addition, the information provided is consistent with the consumer's report on whether or not the services were available at time of treatment.

**Standard 3: Core Treatment Components**

Treatment programs should offer all of the 4 core components of eating disorder treatment: medical/nursing, nutritional, psychological and psychiatric care services.

**Rationale:**

Expert clinical consensus supports inclusion of 4 core care components of any treatment program: medical/nursing, nutritional, psychological, and psychiatric care as well as milieu therapy (i.e., day to day milieu management and support). The staff providing milieu care may vary by site and may include any multiple disciplines, such as nursing, psychiatric technicians (in USA), mental health counselors, etc.

**Elements of Performance:**

Facilities are expected to provide care delivered by appropriately skilled, licensed professionals in each of the 4 core care areas including medical/nursing, nutritional, psychological, and psychiatric. At a minimum, core care components for adult patients should include, but not limited to, weekly individual therapy, group therapy, family therapy (as applicable), medical monitoring, medication monitoring (as applicable), and nutritional counseling. Some but not necessarily all of these elements will also be applicable to children and adolescents. Facilities will demonstrate that in addition to providing services based on expert clinical consensus, they also offer therapies informed by empirically-based treatments when appropriate to the individual's needs. Current evidence supports the use of cognitive-behavioral treatment (CBT) and interpersonal therapy (IPT) for adults with bulimia nervosa and family-based treatment for adolescents (<19 years of age with less than three years duration of illness) with anorexia nervosa and bulimia nervosa, as well as use of the principles of CBT and Supportive Specialist Clinical Management (SSCM) for adults with AN.

Pertinent information regarding availability and frequency of all available particular treatment modalities should be clearly documented and communicated to patients and families, including, but not limited to, the core treatment components. A description of why particular services are offered is considered ideal (e.g. evidence-based therapies implemented, rationale for therapies offered, offerings integrate with overarching program focus, etc.). Additional information regarding specific aspects of the program should be readily available as well, such as, but not limited to, staff to patient ratio, milieu philosophy, meal supervision protocols, re-feeding protocols including whether or not tube feeding is an option, school services available, typical daily schedule, free time offered and options for free time,

recreational opportunities and facilities available, policies regarding phones, privileges, passes, visitors, etc.

For children and adolescents there will specifically be:

1. Developmentally appropriate psychotherapy, psychoeducation, schooling, group therapy, active involvement of families in the treatment (as indicated), nutrition, and appropriate supervision of treatment geared to the patient's age-specific, cognitive, and developmental needs and abilities, delivered by professionals trained in the treatment of children and adolescents.
  - a. Psychotherapeutic groups are appropriate for age, developmental and cognitive level.
  - b. Education:
    - i. Treatment interrupts schooling as minimally as possible.
    - ii. There is appropriate educational programming by appropriately licensed teachers.
    - iii. Ideally, on-site schooling is available. An off-site school is acceptable for medically stable patients.
    - iv. Special educational needs of individuals are addressed, such as learning disabilities and hearing problems.
2. Medical care provided by a professional practicing within his or her scope of practice. Physical health care should be provided by a physician licensed and board-certified or eligible in the field of medicine most appropriate to the patient's age and level of care (e.g. pediatrics, adolescent medicine, internal medicine, or family practice) where possible. In some regions psychiatrists may also provide physical health care.
3. Psychiatric care provided by a professional practicing within his or her scope of practice. For patients less than 18 years of age it is recommended that the psychiatrist be a licensed, board certified or board eligible child and/or adolescent psychiatrist as is developmentally appropriate to the age of the patient. If a child and/or adolescent psychiatrist is not available, then a general psychiatrist with training and experience in treating eating disorders is an acceptable alternative. In the USA, when an advanced practice nurse (APN) is providing

psychiatric care, s/he is doing so within the context of a collaborative practice agreement with a physician according to state law.

4. Appropriate nutritional guidelines to promote growth and development in this age group. A Registered Dietician (RD) is available to provide for patients' nutritional needs. The RD will be specifically trained and experienced in eating disorders in this age group. The RD assesses, educates, and counsels patients, parents/guardians and staff on food and nutrition-related issues. A physician prescribes the diet. The RD designs, implements, and manages safe and effective nutrition-related strategies that enhance growth, development, recovery from disordered eating, address disturbances in body image, and promote lifelong health.
5. All facility staff members will have appropriate expertise in the spectrum of normal physical and psychological growth and development in this age group. They will have documented training and credentials and experience with eating disorders in this age group and work within their scope of practice.
6. A safe physical setting:
  - a. If adults are treated in the same facility, they are assigned separate sleeping quarters. If children or adolescents are housed in rooms with adults, the reason is clearly documented and follows state guidelines.
  - b. Rooms are shared with patients of the same sex and where possible, with patients of similar age and developmental level.
  - c. Minors are only permitted to leave the facility under the supervision of an appropriate adult (staff, parent, guardian, or designee of parent/guardian or staff).
  - d. Parents or guardians must give consent for visitors and for passes with visitors or peers.
  - e. The television, movies, computers, books, toys, and other equipment are appropriate for age and developmental level. Staff supervise the use of equipment, and make sure that equipment for adults only is not available to child or adolescent patients.
7. Families are involved in treatment (as indicated). If a family does not engage with the facility's efforts to involve them in treatment, staff makes ongoing attempts to explore and resolve the basis for this.

**Process Measures:**

Documentation of delivery of core treatment components and all other available treatment components including rationale for use, frequency, and methods of communication among team members across modality should be available to patients, families, and outside providers upon request.

**Outcome Measures:**

1. Patient/family reports they received/participated in the 4 core care components a minimum of one time per week. Patient/family reports they received adequate information regarding type, frequency of, and rationale for treatment modalities available through program.
2. Documentation of each core care component and the patient's and family's involvement will be in each patient chart e.g., in progress notes and treatment plans). For children and adolescents, there will be ongoing evaluation and documentation of progress in education, and developmental and cognitive appropriateness of treatment.

**Standard 4: Guidelines for Nutritional Rehabilitation**

Nutritional rehabilitation is a key component to successful eating disorder treatment.

**Rationale:**

Expert clinical consensus supports nutritional rehabilitation goals to include one or more of the following: weight restoration, weight stabilization, and symptom reduction.

**Elements of Performance:**

Programs are expected to provide sufficient nutritional rehabilitation to support a regular and consistent weight gain and/or measurable improvement in symptomatic eating behavior and/or urges (i.e. restricting, binge eating, purging, etc.). Such programs will provide adequate documentation of such measurable goals in their treatment plan and/or medical record.

**Process Measures:**

Documentation of nutritional rehabilitation guidelines and specific nutritional rehabilitation goals and/or goals pertaining to symptomatic eating behavior should be available to patients, families, and outside providers upon request (where appropriate).

**Outcome Measures:**

Improvement in nutritional status in line with expectations appropriate for age and developmental stage.

**Standard 5: Treatment Team Providers**

The core care treatment providers will be the therapist, dietitian, nurse(s), primary care physician and psychiatrist, in addition to and varied team members participating in care delivery based on program components offered.

**Rationale:**

Program will describe training, licensure, and continuing education credit attainment by all staff.

**Elements of Performance:**

Adequate and accurate description of core care team composition, frequency of delivery of care components, outline of care standards, and continuing education of staff should be readily available to prospective patients, families, and referring providers. Clear job descriptions with performance based competencies and line of supervision will be available for review.

In addition, description of training and licensure of treatment providers should be clear and readily available. Level of staff experience should be easily accessible. Staff should demonstrate completion of regular continuing education credits or similar ongoing education specific to eating disorders. Staff working with children or adolescents have documented training, credentials, and experience with eating disorders in this age group and work within their scope of practice.

**Process Measures:**

Adequate and accurate documentation of training, qualifications, and on-going education of treatment providers should be available to patients, families, and outside providers and prominently displayed.

**Outcome Measures:**

All licensed staff will annually complete discipline – specific required amounts of continuing education, including at least six hours per year of continuing education specific to eating disorders. Programs will be able to show documentation of licensed staff annual completion of continuing education hours as well as documentation of continuing education for unlicensed staff. Continuing education may include activities such as in-service education, local, state or national conferences, or certified on-line educational offerings.

**Standard 6: Financial Issues**

Financial information is of great importance to prospective patients, families, and referring providers and should be readily available. *(This information is particularly important to patients and families in the USA and other countries where private insurers reimburse health care.)*

**Rationale:**

Cost across programs may vary widely and may play a large part in the decision that prospective patients, families, and other interested parties (e.g. third-party payers) make regarding care.

**Elements of Performance:**

A description of cost and insurance coverage accepted by the facility should be readily available, as well as the possibility of any sort of financial assistance available. *A USA-based facility informs the patient and family (if applicable) to the best of its ability whether or not the facility is considered in-network for the patient's insurance company.*

**Process Measures:**

Description of typical costs associated with a typical stay and usual program components should be available upon request.

**Outcome Measures:**

Adequate and accurate information regarding costs of the program and other financial matters is accessible for patients, families, and other interested parties.

**Standard 7: Utilization Review and Insurance Appeals**

Information regarding utilization review and insurance appeals should be readily available and adequately outlined for prospective patients and families. *This information is especially relevant for patients and families from the USA, many of whom use private insurance to pay for their health care.*

**Rationale:**

It is understood that patients may have external constraints on their length of stay due to life circumstance, insurance coverage, or financial issues.

**Elements of Performance:**

Policies regarding utilization review and insurance appeals should be discussed with patients and families (if applicable).

**Process Measures:**

Adequate description of utilization review and insurance appeals should be available to patients, families, and outside providers upon request.

**Outcome Measures:**

Patients and families (if applicable) report they received adequate information about the process of utilization review and insurance appeals.

**WORK GROUP III**  
**RECOMMENDATIONS FOR QUALITY IMPROVEMENT**  
**AND OUTCOME MEASUREMENT**

Work Group III-a (Quality Improvement) focus: This workgroup focused on guidelines for quality improvement measurements conducted by a program.

Work group III-a co-chairs: Pauline Powers MD, FAED, USA

Work group III-a members: Camela Balcomb, USA; Michael Berrett, PhD, USA; Melissa Cottrell, MS APRN-CNS, USA; Amy Hanson-Akins MSW, LISW-S, USA; Nicole Hawkins PhD, USA; Whitney Matson, MA, USA; Tony Jaffa, BM, BS, FRCPSych,UK; Christina Scribner, MS, RD, USA

Work Group III-b (Outcomes Measurement) focus: This workgroup focused on outcomes measurement guidelines to describe patient progress post-discharge.

Work group III-b chair: James Mitchell,MD, FAED, USA .

Work group III-b members: Mark Chavez.PhD, USA; Mary Hales, PhD, USA; Christine Hartline, MA, USA; Steven Prinze, MD, USA; Maria Rago, PhD, USA; Kitty Westin, MA, USA; Judith Weyl, USA

**Background and Overview Paragraph:** Treatment centers should have specified guidelines for assessing clinical performance, methods of providing feedback to the staff, and a system to determine if improvement has been made in a timely fashion. This process is often referred to as Quality Improvement (QI). The specifics of the process for measuring and reporting on clinical performance will vary at different facilities according to the type of patients treated (including their age, severity of illness) and resources of the program. There should be evidence that the program described is actually being provided and that the quality of the program elements is regularly evaluated. Measurement of patient/family satisfaction and outcome of treatment are expected to be integral parts of the quality improvement program. There should be evidence of supervision for all members of the staff both

outside the facility and within the facility. It is expected that the director of the program will have had significant experience in the treatment of eating disorder patients

These standards are not meant to assess the safety and quality features of a program that are for example, *typically evaluated in state licensure within the USA* and/or certification/accreditation by other organizations (*e.g., in the USA, The Joint Commission or CARF*). Rather, these standards reflect quality improvement and outcome measurement issues specifically related to eating disorders. Conforming to these standards does not obviate the need to *consider state licensure in the USA* or accreditation by other organizations.

The types of clinical data that should be collected and reported are covered in greater detail in the Treatment Delivery section of this document, In general, the basic information to be reviewed as part of an accreditation process would include:

1. the length of time the facility has been open
2. whether or not it is affiliated with inpatient or day treatment/partial hospitalization or outpatient services
3. the number of patients accepted stratified by age and diagnosis
4. ratings on the severity of illness (including duration of illness, number of previous treatment episodes, and physiological and psychological co-morbidities).

**Rationale:**

The goal of QI program is to ensure that appropriate care is provided to patients with eating disorders and their families so that the likelihood of recovery is maximized. In order to evaluate this goal, outcome assessment is crucial.

**Elements of Performance**

1. Knowledge of consensus and evidence-based guidelines for treatment of patients with eating disorders (*e.g., the most recent versions of the APA Eating Disorder Treatment Guidelines and NICE recommendations*). There should be evidence that the treatment staff is familiar with the

latest versions of these standards and their recommendations regarding evidence-based treatment for eating disorders. The treatment center is required to provide clear rationale for their choice to provide alternative treatments.

2. Required professional qualifications for degree and licensure for all clinical personnel (as outlined in Standards 3 and 5 above).
3. Documentation of specialized training in the treatment of patients with eating disorders. This may include records of continuing education or internal training and supervision.
4. Attitude that fosters continued increase in knowledge and application of new information into the treatment protocols.
5. Documentation that the staff is continuously seeking out new information and acting on analysis of this information. This may include records of program training activities.
6. Documentation that all treatment personnel, including the director of the program, receive regularly scheduled supervision.
7. The center's QI program regularly assesses clinical performance, provides feedback to the appropriate personnel, and ensures that needed changes are made. There should be documentation of continuous self-review of both the individual practitioners and the treatment team as a whole.
8. Documentation that the program that is described is actually provided.
9. Assessment of outcomes including patient (and, if appropriate, family and other sources of support) satisfaction
10. Assessment of patient outcomes/progress at admission, during the course of the current admission, and discharge. (Though not required, certain assessments, as specified below in Table 1 should be repeated at 12-month follow-up after discharge.)
11. Documentation that information obtained from patient and family satisfaction surveys and patient outcome measurements are provided to the clinical team and, if changes are needed in the treatment regimen, these occur in a timely fashion.
12. Documentation that referring team has been contacted, appropriate follow-up care has been arranged, and whether care has been utilized by the patient.

**Examples of Process Measurement Tools:**

1. Concurrent chart audit form
2. Discharge checklist and outpatient needs assessment
3. Risk management and quality improvement measure

**Outcomes Measurements Rationale:**

Systematic collection of outcomes standardized across treatment centers are needed in order to demonstrate the effectiveness of inpatient and residential treatment. In addition, each facility should be assessing patient outcomes to inform their own audit and quality improvement, and the effectiveness of their own treatments.

There are two components of the required outcome measurement assessment. The first is a clinical portion (at admission a complete history and physical including height, weight, frequency of binge eating and purging, and eating disorder diagnostic symptoms regarding weight, shape and body image preoccupations; and at discharge, height, weight, frequency of binge eating and purging, and eating disorder diagnostic regarding weight, shape and body image preoccupations). If the Residential or Inpatient Treatment Center is conducting 12 month follow-ups, the treatment(s) since discharge should also be determined. The second portion of the outcomes measurement utilizes a set of standardized instruments. The Residential or Inpatient Treatment Center can determine which outcome measures it uses and should be able to provide the rationale for their use. However, instruments that have shown validity and reliability are strongly encouraged. There are several recommended outcome measures for assessing patients at admission, mid-treatment, at discharge, and at 12-month follow-up. For the purposes of pooling data across centers, it is recommended that, at minimum, the dataset must include:

- Eating Disorders Examination (EDE) or the Eating Disorders Examination-Questionnaire (EDE-Q)<sup>5-6</sup>

This measure is available for no charge. Age adjusted versions of the EDE<sup>7</sup> and EDE-Q<sup>8</sup> are available for use with younger patients.

It is recommended that the dataset also include reliable and valid measures, such as the following clinical and quality of life dimensions.

<b><u>Clinical Dimension</u></b>	<b><u>Recommended Measures</u></b>
Quality of Life Scale	Eating Disorders Quality of Life Scale (EDQOL) <sup>9</sup>
Mood and Depression	Beck Depression Inventory II (BDI)* <sup>10-11</sup>
Functional Health and Well-Being	SF-36 <sup>12-13</sup>
Eating Disorder Attitudes/Psychological Features	e.g. Eating Disorder Inventory (EDI-2, EDI-3) <sup>14</sup> , Eating Attitudes test (EAT) <sup>15</sup> , Multifactorial Assessment of Eating Disorder Symptoms (MAEDS) <sup>16</sup> , Stirling Eating Disorders Scale <sup>17</sup> , Body Shape Questionnaire (BSQ) <sup>18</sup>

\*If BDI II is used findings will be promptly reviewed in order to detect changes in level of depression and maintain patient safety.

In addition, patient and family satisfaction questionnaires should be obtained at discharge. There should be evidence that the treatment team has considered these questionnaires and revised the program accordingly and in a timely fashion.

There should be evidence that the treatment team has periodically evaluated both individual and aggregate outcomes from their treatment center and that treatment has been modified appropriately.

**Table 1: Outcome Measurement Assessment**

<u>Required and Recommended Outcome Measures</u>			
	<b>Admission</b>	<b>Discharge</b>	<b>1 yr. F/U</b>
General			
<b>History and Physical</b>	<b>+</b>		
<b>DSM-IV-TR ED</b>	<b>+</b>	<b>+</b>	<b>+</b>
<b>Freq. BE/P</b>	<b>+</b>	<b>+</b>	<b>+</b>
<b>Weight/height</b>	<b>+</b>	<b>+</b>	<b>+</b>
*Instruments			
<b>EDE-Q</b>	<b>+</b>	<b>+</b>	<b>+</b>
ED attitudes and related psychological features	<b>+</b>	<b>+</b>	<b>+</b>
BDI II	<b>+</b>	<b>+</b>	<b>+</b>
SF-36	<b>+</b>	<b>+</b>	<b>+</b>
EDQOL	<b>+</b>	<b>+</b>	<b>+</b>
Treatment since Discharge			<b>+</b>
<b>Satisfaction Questionnaire</b>		<b>+</b>	

\*Children and adolescents should be assessed using age and developmentally appropriate instruments e.g. CHEAT in place of EAT. The EDE-Q is not validated below age 12.

### **Summary of Quality Improvement Standards**

1. Performance Improvement Plan with policies and procedures to ensure appropriate change and feedback. Evidence of development of QI corrective action plan and its implementation when QI monitoring reveals problem areas and needed changes. Findings regarding QI indicators are shared with leadership and program staff.
2. Program description including elements of treatment for types of patients admitted.

3. Evidence that described program is provided and that quality and effectiveness are routinely evaluated.
4. Evidence that entire treatment staff know current evidence-based treatments for eating disorders.
5. Evidence that staff continue to learn and seek out new information.
6. All staff have appropriate training in their profession and specialized training in eating disorders.
7. All staff have ongoing documented continuing education and a minimum of 6 hours per year devoted to understanding and treating eating disorders.
8. All staff, including director, demonstrate competence in their scope of practice. All staff receive clinical supervision.
9. Established program for assessing the outcome of treatment at discharge and ideally, at twelve month follow-ups.
10. Outcomes Measurement Assessment are completed at admission, at discharge, and ideally, at one year follow-up. *Programs are encouraged to include empirical assessment of patient progress during their current admission to the treatment program.*
11. There is evidence of appropriate discharge and transfer planning.

## APPENDIX A

### ACADEMY FOR EATING DISORDERS CREDENTIALING TASK FORCE

#### Chairperson:

Mary Tantillo, PhD, PMHCNS-BC FAED, USA

#### Members:

Ovidio Bermudez, MD, FAED, USA

Douglas Bunnell, PhD, FAED, USA

Jillian Lampert, PhD, MPH, RD, LD, FAED, USA

Julie Holland MHS, CEDS, USA

Craig Johnson, PhD, FAED, USA

James Mitchell, MD, FAED, USA

Pauline Powers, MD, FAED, USA

Benita Quakenbush-Roberts PhD, USA

Janet Treasure, FRCP, FAED, UK

#### Consultants:

Marsha Marcus, PhD, FAED, USA

Joel Yager, MD, FAED, USA

### ACADEMY FOR EATING DISORDERS CREDENTIALING TASK FORCE WORK GROUPS

**Chairperson:** Mary Tantillo PhD PMHCNS-BC FAED, USA, *Director, Western New York Comprehensive Care Center for Eating Disorders and Associate Professor of Clinical Nursing, University of Rochester School of Nursing*

#### **Work Group I: Assessment and Treatment Planning**

Joel Jahraus MD, FAED, USA (Co-chair), *Medical Director, Oliver-Pyatt Centers*

Benita Quakenbush-Roberts PhD, USA (Co-chair), *Founder/Owner, Avalon Hills*

Barton Blinder, MD, PhD, FAED USA, *Clinical Professor at University of California Irvine*

Carolyn Costin, MA, MEd, MFT, FAED, USA, *Founder and Executive Director of Monte Nido and Affiliates*

Luke Einerson, USA, *Accreditation Project Manager, Avalon Hills*

Richard Levine, MD, FAED, USA, *Professor, Pediatrics & Psychiatry at Pennsylvania State University College of Medicine*

Connie Roberts, RN, USA, *Director of Nursing, Avalon Hills*

Janet Treasure FRCP, FAED, UK, *Professor, South London & Maudsley NHS Trust, Director Eating Disorder Unit and Professor Psychiatry Guys, Kings & St Thomas Medical School, London*

Joel Yager, MD, FAED USA, *Professor of Psychiatry, University of Colorado Health Sciences Center*

### **Work Group II: Treatment Delivery**

Jillian Lampert, PhD, MPH, RD, LD, FAED, USA (co-chair), *Senior Director Communications, Community Development, and Research, The Emily Program*

Craig Johnson, PhD, FAED, USA (co-chair), *Chief Clinical Officer, Eating Recovery Center*

Pamela Carlton, MD, USA, *Board certified pediatrician with sub-specialty training in adolescent medicine*

Carol Cochrane, MA, LMFT, USA, *Licensed Marriage and Family Therapist at Santa Cruz Family Therapy, PC*

Bryan Gusdal, MA, Canada, *Director at Westwind Eating Disorder Recovery Centre*

Phillipa Hay, DPhil, Australia, *Professor, Psychiatry at University of Western Sydney*

Susan Ice, MD, USA, *Vice President of Clinical Services at The Renfrew Center and Medical Director of The Renfrew Center of Philadelphia*

Marsha Marcus, PhD, FAED, USA, *Professor of Psychiatry and Psychology, Western Psychiatric Institute and Clinic, University of Pittsburgh Medical Center*

Wendy Oliver-Pyatt, MD, FAED, CEDS, USA, *Founder/Executive Director, Psychiatrist, Oliver-Pyatt Centers*

### **Work Group III: Quality Improvement and Outcome Measures**

Pauline Powers, MD, FAED, USA (co-chair), *Director, USF Hope House for Eating Disorders*

James Mitchell, MD, FAED, USA (co-chair), *President and Scientific Director, Neuropsychiatric Research Institute*

Amy Hanson-Akins, MSW, LISW, USA, *Mental Health Private Practice*

Camela Balcomb, USA, *Executive Director at Shades of Hope, LP*

Michael Berrett, PhD, USA, *Executive Director-Chief Executive Officer-Psychologist at Center for Change*

Mark Chavez, PhD, USA, *Program Chief, Eating Disorders Research Program, National Institution of Mental Health*

Melissa Cottrell, MS, APRN-CNS, USA, *Clinical Nurse Specialist at Laureate*

Mary Hales, PhD, USA, *Clinical Neuropsychologist and the director of NeuroDynamics, LLC*

Christine Hartline, MA, USA, *Deceased, Founder of EDreferral.com*

Nicole Hawkins PhD, USA, *Clinical Services Director-Psychologist, Center for Change*

Tony Jaffa, BM, BS, FRCPsych, *Clinical Director, Children's Services at Cambridgeshire and Peterborough NHS Foundation Trust*

Whitney Matson, MA, USA, *Quality Assurance Director, Avalon Hills*

Steven Prinze, MD, USA, *Medical Director at Linden Oaks Hospital, Eating Disorders Program*

Maria Rago, PhD, USA, *Clinical Director at Linden Oaks Hospital, Eating Disorders Programs*

Christina Scribner, MS, RD, CSSD, USA, *Registered Dietitian and Board Certified Specialist in Sports Dietetics at Encompass Nutrition*

Kitty Westin, MA, USA, *Advocacy Director, The Emily Program Foundation*

Judith Weyl, USA, *Case Manager at CIGNA*

#### **Work Group IV: Accreditation Work Plan**

Douglas Bunnell, PhD, FAED, USA (co-chair), *Clinical psychologist and Vice President of The Renfrew Center Foundation*

Ovidio Bermudez, MD, FAED, USA (co-chair), *Chief Medical Officer and Medical Director of Child and Adolescent Services at Eating Recovery Center*

Vicki Berkus, USA, *Medical Director of Eating Disorder Treatment at Fairwinds Treatment Center*

Dolly Bronzini, RN, MPH, CDE, USA, *American Diabetes Association*

Marian Eberly RN, MSW, LCSW, USA, *Vice President of Program Development and Clinical Advisor at Remuda Ranch*

Marty Goetz, USA, *Chief Executive, River Garden Hebrew Home*

Sam Menaged, JD USA, *Founder and President of The Renfrew Centers and The Renfrew Center Foundation*

Carol Schaefer, USA, *Co-founder, Puente de Vida*

Lynn Stark, APRN, MSN, COO - *Clinical Nurse Specialist - Program Director at McCallum Place*

Kenneth Weiner, MD, USA, *Founding Partner and Chief Executive Officer, Eating Recovery Center*

Adrian Worrall, MSc, UK, *Head of Centre for Quality Improvement, College Centre for Quality Improvement*

**Work Group V: Specialized Protocols**

William Davis, PhD, FAED, USA (co-chair), *Private Practice, Former Clinical Director of The Renfrew Center of Philadelphia*

Mae Sokol (co-chair), MD, USA. *Deceased, Former Director of the Eating Disorders Program at the Children's Hospital in Omaha*

Stephanie Gerkin, MS, RD, LD, CDE, USA, *Melrose Institute, Park Nicollet*

Neville Golden, MD, FAED, USA, *Director, Adolescent Medicine Fellowship Training Program, Stanford University School of Medicine*

Deborah Haller, PhD, USA, *Director Psychiatric Research, St. Luke's-Roosevelt Hospital*

John Levitt, PhD, USA, *Director of the Eating Disorders and Violence and Abuse Programs, Alexian Brothers Behavioral Health Hospital*

Kimberli McCallum, MD, USA, *CEO, Medical Director, & Founder of McCallum Place*

Mark Roloff LCSW, BCD, USA, *Consultant- Male Program, The Eating Disorders Treatment Center at River Oaks Hospital*

Ron Thompson, PhD, FAED, USA, *Co-Director and Developer of The Victory Program at McCallum Place*

## APPENDIX B

### References

1. American Psychiatric Association. (2006). *Practice guidelines for the treatment of patients with eating disorders*, 3<sup>rd</sup> edition, Washington, DC: APA.
2. National Institute for Clinical Excellence. (2004). Eating Disorders: Core interventions in the treatment and management of Anorexia Nervosa, Bulimia Nervosa, and related eating disorders, *Clinical Guideline 9*, London, NICE.
3. Beaumont et al. (2004). Australian and New Zealand clinical practice guidelines for the treatment of Anorexia Nervosa *Australian and New Zealand Journal of Psychiatry*, 38:659—670.
4. American Academy of Pediatrics.(2003). Identifying and treating eating disorders. *Pediatrics*, 111(1), 204-211
5. Fairburn, C. G. (2008). *Cognitive behavior therapy and eating disorders*, NY: Guilford Press.
6. Fairburn, C. G., & Beglin, S. J., (1994). The assessment of eating disorders: Assessment or self-report questionnaire? *International Journal of Eating Disorders*, 16, 363-370.
7. Bryant-Waugh, R., Cooper, P., Taylor, C., & Lask, B. (1996). The use of the Eating Disorder Examination with children: A pilot study. *International Journal of Eating Disorders*, 19, 391-397.
8. Goldschmidt A.B., Doyle A.C., Wilfley D.E. (2007) Assessment of binge eating in overweight youth using a questionnaire version of the Child Eating Disorder Examination with Instructions. *International Journal of Eating Disorders*, 40, 460-467.
9. Engel, S. G., Wittrock, D. A., Crosby, R. D., Wonderlich, S. A., Mitchell, J. E., & Kolotkin, R. L. (2006). Development and psychometric validation of an eating disorder-specific health-related quality of life instrument, *International Journal of Eating Disorders*, 39(1), 62-71.
10. Beck, A. T., Steer, R. E., & Brown, G. K. (1996). *Beck Depression Inventory II*. San Antonio, Texas: Pearson Education, Inc.
11. Beck, A. T., Steer, R. E., Ball, R., & Ranieri, W. F. (1996). Comparison of Beck Depression Inventories-IA and-II in psychiatric outpatients. *Journal of Personality Assessment*, 67(3), 588-597.

12. Ware JE, Sherbourne CD. The MOS 36-Item Short-Form Health Survey (SF-36®): I. conceptual framework and item selection. *Medical Care* 1992; 30(6):473-83.
13. Ware JE, Snow KK, Kosinski M, Gandek B. *SF-36® Health Survey Manual and Interpretation Guide*. Boston, MA: New England Medical Center, The Health Institute, 1993.
14. Garner, D. M. (2004). *Eating Disorder Inventory-3. Professional Manual*. Lutz, FL: *Psychological Assessment Resources, Inc*
15. Garner DM, Olmsted MP, Bohr Y, Garfinkel PE. (1982). The eating attitudes test: psychometric features and clinical correlates. *Psychol Med*. 12(4):871-8.
16. Anderson DA, Williamson DA, Duchmann EG, Gleaves DH, Barbin JM. (1999) Development and validation of a multifactorial treatment outcome measure for eating disorders. *Assessment*, 6(1):7-20.
17. Williams GJ, Power KG, Miller HR, Freeman CP, Yellowlees A, Dowds T, Walker M, Parry-Jones WL. (1994). Development and validation of the Stirling Eating Disorder Scales. *International Journal of Eating Disorders*. 16(1):35-43.
18. Cooper, P. J., Taylor, M. J., Cooper, Z. and Fairbum, C. G. (1987), The development and validation of the body shape questionnaire. *International Journal of Eating Disorders*, 6: 485–494.