The New York Times | http://nyti.ms/22gbnmD

HEALTH

Centers to Treat Eating Disorders Are Growing, and Raising Concerns

By **ERICA GOODE** MARCH 14, 2016

Their websites show peaceful scenes — young women relaxing by the ocean or caring for horses in emerald pastures — and boast of their chefs and other amenities.

One center sends out invitations to a reception with cocktails and hors d'oeuvres. Another offers doctors and therapists all-expense-paid trips to visit and experience their offerings, including yoga classes. Several employ staff who call mental health professionals, saying they would love to have lunch.

The marketing efforts by these for-profit residential care centers are aimed at patients with eating disorders and the clinicians who treat them. The programs have proliferated in recent years, with some companies expanding across the country.

The rapid growth of the industry — there are more than 75 centers, compared with 22 a decade ago, according to one count — has been propelled by the Affordable Care Act and other changes in health insurance laws that have increased coverage for mental disorders, as well as by investments from private equity firms.

The residential programs, their directors say, fill a dire need, serving patients from areas where no adequate treatment is available. "Only 15 to 30 percent of people have access to specialized care for eating disorders, which means there are a lot of people out there who have zippo," said Doug Bunnell, the chief clinical officer for Monte Nido, a program that began in Malibu, Calif., and now operates centers in five states.

But the advertising and the profusion of centers, which typically cost $1,000 a day but can run much higher, is raising concerns among some eating disorders experts, who worry that some programs may be taking advantage of vulnerable patients and their families.

In the companies' rush to expand, they argue, quality of treatment may be sacrificed for profit. And they question whether the spalike atmosphere of some programs is so comfortable that it fosters dependency.

"For the most part, the people who are running and working in these programs believe they're doing the right thing," said Dr. Angela Guarda, the director of the eating disorders program at the Johns Hopkins Hospital in Baltimore.

"But it's a slippery slope," she said. "Money can cloud your view."

Many eating disorders specialists agree that some patients require the supervision of residential programs and benefit from the treatment. But studies showing the programs' effectiveness are scant, Dr. Guarda and other experts said. The methods of the handful of studies that exist have been criticized.

The quality and form of treatment varies widely across centers, and in some cases includes approaches — equine therapy, for example, or "faith-based" treatment — with little or no scientific evidence behind them. Some programs have full-time psychiatrists and medical doctors on staff, but others lack the expertise to handle emergencies or treat patients with coexisting medical or psychiatric problems.

The perks offered to outside clinicians who might refer patients, the experts say, include free trips, restaurant meals, educational seminars and small gifts like pens and key chains dispensed at professional meetings. Critics liken them to pharmaceutical industry tactics that led to laws and policies requiring financial disclosure, though on a smaller scale. Studies had shown that even small gifts from drug companies, like free medication samples, affected doctors' prescription practices.

In an article to be published Monday in the journal Psychiatric Services, Dr. Evelyn Attia, a professor of psychiatry and director of the eating disorders program

at Columbia University Medical Center, and four colleagues called for more transparency about the financial relationships between residential centers and the professionals who send them patients, and urged clinicians to be mindful of efforts to influence their recommended treatment.

"The effect of these clinician inducements, which are aimed at building a program's patient referral base, may not be fully recognized by the professionals they target," wrote Dr. Attia and her colleagues, who included Dr. Guarda.

Several industry representatives said that while they had not seen the journal article, they agreed that more data on patient outcomes and stricter standards were needed. But, they said, the trips and seminars offered to clinicians were primarily educational. "I don't think anyone in the eating disorders world is giving out swimming pools and trips to Europe and things like that," Dr. Bunnell said.

Jillian Lampert, president of the Residential Eating Disorders Consortium, a group that represents about 85 percent of the centers, said, "Health care's always been a business," adding that quality and profit were not mutually exclusive. If there are concerns, she said, "we are incredibly open to having those conversations."

A Deadly Mental Illness

Eating disorders are among the most difficult mental illnesses to treat.

Anorexia, in particular, has stymied many of psychiatry's best treatment efforts. The illness has the highest mortality rate of any mental disorder, with patients dying from the medical complications of starvation or from suicide. And patients often resist treatments that make them feel uncomfortable.

The most severely ill patients — the prognosis is grimmer the longer someone has anorexia, studies suggest — require hospital treatment just to stay alive. But even after being stabilized, many patients need continual supervision for a time to regain weight and learn new behavior. The length of stay in residential centers ranges from two weeks to a year. A 2006 study found that the average stay was 83 days.

In the past, health insurance companies placed strict limits on coverage for eating disorders, treating them differently from other medical illnesses. Few insurers were willing to pay for 24-hour care after a patient was out of immediate danger.

But the passage of the Mental Health Parity and Addiction Equity Act in 2008 and the Affordable Care Act two years later mandated equal treatment. Lawsuits brought by the families of patients who were denied coverage added to the pressure on insurers. In 2012, a federal appeals court ruled that health plans must cover residential treatment for anorexia under California's parity law. The higher reimbursement rates offered some relief to families, who had often mortgaged their houses or drained their savings to pay for critically needed care.

They also attracted the attention of Wall Street investors, who saw profits in providing treatment for so-called behavioral health problems like eating disorders, alcoholism and drug abuse. "The number of covered lives is growing faster than the availability of services to treat them, creating compelling investment opportunities," the accounting and consulting firm BDO noted last year in an article on its website, referring to the effects of the legal changes.

As the industry has expanded, larger centers have acquired smaller ones and some programs, flush with private equity investments, have expanded across the country.

For example, Monte Nido, a treatment program founded by Carolyn Costin, a former teacher who recovered from an eating disorder, began with a center in Malibu.

But in 2012, with financing from Centre Partners, a middle-market equity firm, Monte Nido began opening new residential centers and day-treatment programs. The company now has centers in Oregon, Massachusetts, Pennsylvania and New York, including one in a renovated mansion in Westchester County.

Last year, noting that the investment had "tripled the company's facility footprint during our ownership period," Centre Partners sold Monte Nido to another investment firm, Levine Leichtman Capital Partners, for an undisclosed sum.

"I believe that the Monte Nido's [sic] approach to eating disorder treatment is what you and others like you have been waiting for," Ms. Costin wrote in a letter to potential patients on the company's website, which includes images of beaches, mountains and the Boston skyline on its home page.

With a need to fill more beds, marketers for some centers make cold calls to psychiatrists, psychotherapists, medical doctors and others who treat eating disorders, offering to inform them about a program's advantages and inviting them to visit.

The Denver-based Eating Recovery Center has a call center and employs 20 "professional relations liaisons" who contact clinicians across the country. The author and motivational speaker Jenni Schaefer, who recovered from an eating disorder, recently joined the program's outreach team. On its website, the company, which began with a single center, bills itself as "the only national health care system devoted to serious eating disorders at all levels of care."

Craig Johnson, a well-known eating disorders specialist, joined the company in 2010 and has seen it through its expansion to 24 treatment programs in seven states, including three residential centers. He said when therapists visit, the focus is education, not entertainment. "We're delivering lectures," Dr. Johnson said.

Some therapists see the offer of free trips as a chance to view the facilities that they might recommend to patients.

Ann Jacob Smith, a family therapist in Chevy Chase, Md., said that last year, she accepted an invitation to visit the Oliver-Pyatt eating disorders center in Miami. (The center is now part of Monte Nido).

"It was absolutely promotional," she said, "But it was actually really educational. They took us in depth into what they did."

Her later referrals were not influenced by the visit, she added. "I'm not impressed by being romanced."

But Adrian Brown, a psychiatrist in Virginia, said that therapists who had not gone through the "battle phase" with drug companies might not even realize they were being swayed by financial interests.

Dr. Brown recalled being offered a "V.I.P." trip to a treatment center, with the representative telling her, "We will pay your way, put you up in a really nice hotel, all expenses paid, yoga and whatever."

Dr. Brown responded, "No, that's not ethical."

The representative replied, "What do you mean?" Another invitation arrived the next year.

Mixed Results

Prospective patients or family members searching for a treatment program sometimes turn to edtreatmentreview.com, where former patients describe their experiences at different centers, evaluating the staff, critiquing the food and noting whether cellphones are allowed.

Many reviewers have spent time in more than one residential center and the opinions on any particular program vary widely, a range reflected in interviews with former patients over the last several months.

Tina Klaus, a 51-year-old artist who has struggled with bulimia since she was 10, said residential care was initially useful.

"Residential treatment is vital when you are at your ultimate rock bottom" she said. But once home, her illness worsened because "you're going back into your life, you're going back into all the emotions you used your eating disorder to hide from."

Melissa R., 28, who asked that her last name not be used for reasons of privacy, said after several hospitalizations for anorexia, beginning when she was 21, she found a residential center in the Southwest on the Internet and spent six weeks there. The center, which she described as "more like a resort," was "somewhat helpful," she said, but not worth the time and money.

"People were nice, and the food was really good," she said. "I had fun, I enjoyed rock climbing and stuff, but that's not why I was there. I'm paying a lot of money to get well, not to rock climb."

Last year, she spent two months at Eating Recovery Center in Denver, moving from residential care to day treatment, and began to gain control of her illness. "E.R.C. was the best place I've been," she said about the center. "They were very individualized."

Ashley Bilkie, 29, had a different experience with E.R.C. When she returned home in February 2015 after about six months in the Denver program — her fourth stay in an inpatient program for treatment of anorexia and her second at E.R.C. — "I was getting sicker and sicker," she said. She lost the weight she had gained back at the center. "I had to buy children's clothing," she said.

She was evasive with her parents. At the recovery center, she said, "It was kind of like they set up a battle between myself and my parents." For their part, Ms. Bilkie's parents, who for years had watched their daughter's health decline, grew frantic. Ms. Bilkie would disappear, her father, Robert Bilkie, said, and he would find her wandering the aisles at Kroger or Target. Driving through the neighborhood, he half-expected to see her hanging from a tree.

"It's a parent's worst nightmare," he said.

It was also expensive. Mr. Bilkie, a financial adviser in Michigan, calculated that over three years, he paid at least $350,000 for unreimbursed inpatient care for his daughter. The Eating Recovery Center, he said, sent him bills for $30,000 each month. Mr. Bilkie paid willingly — he was desperate to see Ashley get well, he said — but no program seemed to produce lasting results.

"We spent an outrageous amount of money for what really amounted to ineffectual treatment," Mr. Bilkie said.

Last fall, Ms. Bilkie entered the eating disorder center at the Johns Hopkins Medical Center, a university affiliated program.

The staff there gradually weaned her off some drugs she had been taking taking at the center in Denver, including high doses of Xanax, a tranquilizer, and Adderall, an attention deficit drug and a stimulant.

In group therapy, other patients put pressure on her to change her behavior. It was a switch, she said, from previous groups, where patients talked about their problems. With the program's stress on weight restoration — studies show that it is the best predictor of how anorexic patients will do once they leave, rather than, say, elevated mood — her weight returned to normal.

She was discharged in November and continues to do well.

"I hated every single solitary second of it," she said of the experience. "But that's a good thing, because I was not comfortable, and it meant that something was working."

Dr. Ovidio Bermudez, the chief clinical officer of Eating Recovery Center, said that other patients have fared poorly at academic centers and then done well at E.R.C. Despite Ms. Bilkie's perception, he said, therapists at the program did not try to divide patients from their families. (Ms. Bilkie gave Eating Recovery Center permission to discuss her case.)

"We would have to filter this through 20/20 hindsight," Dr. Bermudez said. "It's really hard to know what somebody's frame of mind is and the degree of fragility they bring to any treatment experience."

Dr. Anne Marie O'Melia, a psychiatrist at the recovery center, said Ms. Bilkie was on Xanax when she arrived and was fearful of reducing the drug's dosage, though the center tried. She was switched to Adderall from another stimulant at E.R.C., Dr. O'Melia said, to treat "significant impulsivity."

Seeking Standards

Ms. Bilkie's history of ups and downs is not unusual for patients with eating disorders.

"In many cases, you see one step forward, two steps back," said Dr. Mark Friedlander, the chief medical officer for Aetna Behavioral Health.

His company, Dr. Friedlander said, considers residential care essential for treatment of some patients. But, he said, a lack of outcome studies, an absence of industry standards and a patchwork licensing system across states make it difficult for Aetna or other insurers to evaluate care.

"We would love to see greater consistency and higher standards," he said.

To that end, a group of eating disorder specialists from treatment centers, including Eating Recovery Center and Monte Nido, have developed a list of minimum requirements for accreditation of residential programs. The Joint Commission, an independent company that accredits health care facilities, has adopted the requirements, which go into effect July 1.

Dr. Lampert, president of the consortium, said the centers in the organization were also collecting data on patient outcomes, lengths of stay and other variables, with each center collecting data on 15 consecutive admissions of adults and adolescents.

In the meantime, many patients and families will continue to rely on word of mouth and any information they can find online.

"These are black boxes," Dr. Scott Hadland, an adolescent medicine specialist at Harvard Medical School, said of the residential centers. "People get the idea that these are places that can heal just based on what they see on a website or in the photos."

A version of this article appears in print on March 15, 2016, on page D1 of the New York edition with the headline: Recovery, at a Price.