Addressing eating disorders and substance use: A call for inclusive clinical support for street–engaged youth and adults with eating disorders

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Abstract

Evidence points towards an interrelationship between eating disorders and substance use. However, individuals with concurrent substance abuse and eating disorders often experience significant barriers restricting access to treatment programs. One such barrier is that treatment programs often refuse or lack the expertise to treat individuals who suffer from both substance use disorders and eating disorders. Instead, the disorders are treated in an isolated manner that does not adequately address the nuances of concurrent disorders. As such, healthcare providers must adopt an approach that integrates and holistically addresses multiple factors, including homelessness and substance use, to benefit patients.

Eating disorders (EDs) do not occur in isolation, as they are nested in the contexts of the lives of those who experience them. Eating disorders are influenced by the intersection of complex social, political, cultural, and economic factors in life. In particular, substance use may be entangled with experiences of EDs.[1] However, available ED treatments typically exclude patients who abuse or use substances, while addiction programs generally exclude or do not effectively treat patients who suffer from disordered eating.[1,2] As such, patients with both ED and substance use disorders (SUDs) have more severe ED symptomatology and poorer outcomes compared to patients suffering from just disordered eating.[3] Ultimately, as a result of inadequate and inaccessible treatment, patients with both ED and SUD appear to fall through the cracks.[4]

In regards to the prevalence of concurrent SUDs and EDs, up to 50% of patients with ED will abuse alcohol or drugs and 35% of patients with SUD also present with an ED.[3] Participants have reported using substances such as caffeine, tobacco, and stimulants to aid in weight loss.[3] This can develop into a pattern of impulsive behavior, and ultimately, increase the susceptibility for addiction.[3] The experience of the interrelationship between SUDs and EDs are described by participants in Luongo's study—some consciously used substances to postpone hunger, reduce suffering, and to "numb the pain."[1]

For individuals who present with concurrent ED and substance use in Vancouver, there is a clear lack of resources that adequately and inclusively address both issues simultaneously.[1] The disorders are typically treated in an isolated manner that fails to effectively address the complexity and nuances of these concurrent disorders. For example, the non–profit, Looking Glass Foundation, in Vancouver offers a number of free community–based services to support individuals struggling with an ED, none of which accept clients "who are actively struggling with substance abuse."[4] These requirements present significant barriers to accessing treatment for populations that would benefit significantly from care but experience these issues concurrently.

As the disorders are generally perceived as independent of each other, individuals with ED and SUD are often forced to first undergo separate treatment for their SUD prior to accessing ED treatment.[2] Few clinicians have training in both SUD and ED treatment, and may be hesitant to treat the condition for which they are not trained, even if it is presenting concurrently.[5] As such, to access Vancouver Coastal Health's Eating Disorder Program, substance use cannot be the client's primary presenting concern.[6] Likewise, the Discovery Vista House, an intensive residential eating disorder treatment program run in collaboration with St. Paul's Hospital Eating Disorder Program and Vancouver Coastal Health, is typically unable to admit clients who struggle with both an ED and a SUD, "unless the client has already made significant steps" towards sobriety.[7]

This approach is problematic for three reasons:

1. This approach only serves to exacerbate the problems experienced by patients, as patients being treated for only SUD report an increase in severity of ED symptomatology.[2]

2. Denying access to healthcare based on these existing criteria may exclude those who need help most.[4]

3. Exclusion itself could deter those with sub–clinical substance use from accessing care. Thus, by limiting access to ED resources for those experiencing substance use and/or homelessness, overt and subtle messages are sent that exclude those who may need care most.

Therefore, there is a need for an inclusive approach towards treating EDs in the presence of substance use. Otherwise, these individuals will continue to be overlooked. The lack of available integrated treatment programs for patients with ED and SUD lead to severe ramifications such as higher rates of relapse, worsening of the untreated illness, and poor patient outcomes.[2] There is evidence that when comorbid diagnoses are treated concurrently and integrated on–site, treatment retention and patient outcomes improve significantly.[8] A comprehensive approach for patients with concurrent ED and SUD can improve treatment delivery, reduce time in treatment, improve patient outcomes, and lower overall treatment costs.[2]

Care providers should operate under the assumption that patients with substance abuse issues can benefit from integrated ED and substance use support. Research has shown healthcare professionals generally display a highly stigmatized attitude to patients with substance use and are subsequently less involved and less empathetic when treating patients with SUD.[9] It is clear that stigma surrounding substance use should not predispose clinicians to assumptions about the efficacy, or lack thereof, of ED treatment for those with SUD, especially when previous studies have proven the effectiveness of treating concurrent disorders in an integrated fashion.[2] Thus, it is important that clinicians are up–to–date with referral pathways and

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resources available to address EDs, and advocate for an integrated approach to ED and SUD treatment.

Compounding the issue, however, is the lack of research that addresses the economic feasibility of an integrated approach to concurrent ED and SUD treatment. Preliminary research has demonstrated that comprehensive support for patients with concurrent disorders reduces the total costs of treatment, as well as the cost of more intensive care among these patients.[10] However, more research is needed to determine the cost–effectiveness of integrated treatment. Studying the economic feasibility of comprehensive interventions is essential to providing effective support for patients with concurrent ED and SUD.

Eating disorder programs, rather than viewing substance use as an interference to treatment, should view EDs as issues entangled in the complexities of patient's lives, which can include substance use and housing issues. The adoption of a complementary treatment program that integrates and holistically addresses multiple factors, including substance use, would provide great benefits to patients and existing ED treatment programs themselves.

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