STARVING FOR SUPPORT: THE SEVERE LACK OF CARE AVAILABLE FOR IDAHO EATING DISORDER PATIENTS

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ABSTRACT

Eating Disorders (EDs) have one of the highest if not the highest mortality rates of all mental disorders, yet patients seeking treatment face obstacles in every direction they turn. EDs remain a very misunderstood, stigmatized, and underrepresented area of mental and behavioral health nationally, and particularly in Idaho.

This Comment first dives into the background of EDs including a case example, diagnostics, treatment, economic and social costs. Next, this Comment addresses the steps Federal and State legislatures have taken to address these pernicious disorders. While various state legislatures—like Missouri and Virginia—have begun to consider and pass legislation providing education and support systems for ED patients and those at risk of developing EDs, Idaho remains behind the curve. This Comment inquiries into the various resources that states, such as Virginia and Missouri have begun to implement and the benefits as well as possible harms that may arise because of said programs.

This Comment then makes various recommendations. The first recommendation relates to the American Counseling Code of Ethics, and how it fails to consider the nuances of support that ED patients need daily to complete simple tasks such as going to the grocery store or eating lunch. These nuances of needed care place ED providers in precarious ethical positions which the ACA Code fails to address. In turn, forcing counselors to have to choose between strict compliance with ethical codes or potentially violating said codes to ensure that their patients receive care that is in their best interest.

Subsequently this Comment addresses specific recommendations for Idaho, including enactment of various bills to increase awareness and education about EDs; the establishment of a higher level of care treatment center so that patients and families are not obligated to leave the state to obtain care; and creating incentives for counselors to obtain their certification in treating EDs so that patients have better long-term care in Idaho.
I. INTRODUCTION

This Comment begins by providing a case example of an Idaho resident who is still recovering from an eating disorder. For the sake of anonymity, she will be referred to as Jane Doe.

A. Jane Doe Case Example
In 2013, at the age of fourteen, Jane first explicitly stated her dissatisfaction with her body. Jane expressed this to her mother, who soon after took her to a nutritionist. The nutritionist noted that Jane could probably afford to lose a few pounds and provided various dietary and exercise recommendations to do so. From this point forward, Jane began a slow and steady mental and physical decline, which ultimately led to the loss of her menstrual cycle, abnormally low blood pressure and heart rate, and her hair falling out. She also began to distance from her family and friends, and she began tracking every calorie she consumed religiously.

Over a period of two years, Jane continually lost weight, ultimately losing approximately 20% of her body weight. Despite these seemingly dramatic symptoms, no one suspected anything was wrong with Jane, not even her doctors. Indeed, many even complimented Jane for her attempts to slim down. Jane was a top student at her high school, a starter on her volleyball team, and widely liked. Internally however, Jane was convinced that she was dumb, chubby, and annoying. During this time, Jane sporadically visited her pediatrician for annual physicals, the flu, and a broken arm. At each of these visits her pediatrician noted Jane’s weight loss, expressed no concern, and even applauded Jane’s efforts to “stay fit.” Said pediatrician even explicitly rejected Jane’s mother’s concerns when she inquired about the weight loss.

Nearly two years into this behavior, Jane’s mother began to suspect Jane might have an ED when she noted Jane’s most recent weight on the family scale, and Jane had various fainting spells. Jane’s mother was also clued in about the possibility of an ED due to a family friend who was knowledgeable about the subject because her own daughter struggled with an ED. Jane’s mother initially tried to take the matter into her own hands, trying to compel Jane to eat more and gain some of the weight back. When Jane was extremely reluctant to do so and demonstrated high levels of anxiety when unable to control her food intake, the family friend recommended Jane be evaluated by Dr. O’Toole, at St. Luke’s. Dr. O’Toole, who owns and operates the Kartini Clinic in Portland, Oregon, made monthly visits Boise to evaluate potential ED patients.

1. Interview with Jane Doe, in Boise, Idaho (Nov. 12, 2022) [hereinafter Doe].
2. Doe, supra note 1.
3. Doe, supra note 1.
5. Doe, supra note 1.
After a physical and mental assessment, Dr. O’Toole diagnosed Jane with Anorexia Nervosa, restricting type. Subsequently, Dr. O’Toole explained Jane’s treatment options. Jane could either stay in Boise and attempt extensive outpatient care with counselors, doctors, and dieticians or she could travel out of the state to Oregon to receive treatment at the Kartini Clinic or at Monte Nido treatment center where she would obtain either partial hospitalization or residential treatment. While Jane’s condition was severe, it was not yet life threatening to the point of needing acute medical stabilization.

While staying in Idaho was a treatment option, Dr. O’Toole noted the significantly reduced possibility of improvement for Jane due to the lack of treatment availability, there being no in state options for partial hospitalization or residential treatment in Idaho at the time. Staying in Idaho meant that Jane’s parents would have to be heavily involved in Jane’s treatment by prepping all her meals, sharing every meal with her, doing bathroom checks to ensure Jane was not purging, prohibiting her from exercising until her vitals improved, and removing Jane’s access to mirrors. EDs are resistant to correction and forcing parents to be treatment enforcers often places significant strain on family relationships and oftentimes simply reinforces rather than treats the illness. Accordingly, Dr. O’Toole strongly recommended Jane leave Idaho to obtain necessary treatment to return to a healthy mental and physical state.

Forty-eight hours after the appointment with Dr. O’Toole, Jane and her mother left their Boise home and started the journey to Portland, Oregon where they would spend the next ten weeks living at the Ronald McDonald House Charity and going to Kartini clinic daily for Jane’s partial hospitalization treatment. Jane would see her father and younger brother only once during this time, and only for a weekend. Furthermore, Jane’s mother was forced to quit her job to be available for all of Jane’s appointments and to keep a vigilant eye on Jane when she wasn’t in treatment to ensure she was not engaging in ED behaviors.

7. Doe, supra note 1.
8. Acute medical stabilization is used to treat patients “experiencing severe, uncomfortable and life-threatening medical complications” as a result of their ED. Hospital-Based Medical Stabilization for Eating Disorders, ACUTE CTR. FOR EATING DISORDERS & SEVERE MALNUTRITION, https://www.acute.org/treatment/medical-stabilization (last visited Feb. 25, 2023).
10. Doe, supra note 1.
Initially, Jane was very resistant to treatment both physically and mentally. Physically, as is typical of many ED patients, Jane’s body was initially very resistant to weight gain despite a significant calorie surplus. And mentally, Jane could recognize that her fellow patients were ill, but she could not see and did not believe she herself had a disorder. Rather, she merely thought that she was very intentional about the food she ate, had a lot of self-control when it came to food, and was better at managing her weight than most people.\(^1\)

As treatment progressed, however, Jane began to recognize that she was in fact not well. She became more aware of the extreme levels of anxiety she experienced surrounding food now that she could not totally control of what she ate, and was angry for being forced to eat more food than was “normal” for her. Furthermore, Jane was petrified of the idea of having to gain back the weight she had lost.\(^2\) But the more aware that Jane became about her illness, and how much it controlled her, the more she began to come to terms with her diagnosis and genuinely want to improve.

After ten weeks of partial hospitalization treatment, Jane began to gain weight at a normal rate and her menstrual cycle returned to a semi-normal schedule. At this point, Jane was deemed medically stable enough to return to Boise and to full time school. Upon discharge from partial hospitalization treatment, Jane demonstrated significant fear in returning to school.\(^3\) Now that she had realized her thoughts and behaviors around food had in fact been an illness and not merely a desire to lose weight, Jane feared being thrown back into all the initial stressors and triggers of school and life that prompted her restrictive eating in the first place.

Despite returning to her regular life in Boise, monthly visits to Portland would remain in effect so that Dr. O’Toole would be able to monitor Jane to ensure she was not backsliding into old food restriction and exercise habits. These visits also allowed Dr. O’Toole to check Jane’s bloodwork to ensure it showed increasingly healthy hormone levels.

While Portland would continue to be home base for Jane’s medical treatment, Jane would also need psychiatric support in Boise.\(^4\) While Jane’s weight had been restored, she still needed to do a lot of mental work to understand why she tends to use food as a coping mechanism and find alternative healthy outlets for her anxiety. That being said, counseling was necessary to ensure Jane continued a trajectory toward healing rather than backsliding toward a relapse. Jane needed to

\(^{11}\) Doe, supra note 1.
\(^{12}\) Doe, supra note 1.
\(^{13}\) Id.
\(^{14}\) Id.
find a counselor, specifically one educated and knowledgeable about EDs, a Certified Eating Disorder Specialist (CEDS). Currently, Boise has a total of about eight CEDS who help treat all the ED patients in the state, with seven of them located in Boise. Fortunately for Jane, she was a priority patient since she had recently been discharged from partial hospitalization treatment and was able to start therapy sessions right away. While Jane was fortunate to get on a CEDS regular calendar, her situation is an unusual one due to the fact that the demand for CEDS in Idaho is not met by the supply, as it is impossible for 7 CEDS to treat all ED patients within 300 miles of Boise.

Now, nearly ten years later, Jane is still on the road to recovery. She sees her CEDS counselor on a bi-weekly basis as new stages of life present new stressors, oftentimes still triggering food anxiety and body dysmorphia. While having been medically stable for a long time, Jane still has mental work to do to counteract her body dysmorphia and needs to be challenged to expand her palate, to try new foods with different people, at different places and at different intervals.

While Jane has been a model patient in terms of desire and effort to improve, her journey has been an uphill one. Jane was one of the lucky few patients whose familial and financial situation allowed her to obtain treatment in Oregon, which spearheaded a path to remission for her disorder. For many, the path Jane took is merely not doable, and those patients need care to be more accessible and affordable. Because of individuals like Jane, and the many other individuals and their families who cannot manage to leave the state to get the care they need, the Idaho legislature can and should act to better protect those struggling with EDs.

Roughly 58,000 Idahoans—like Jane—suffer from an ED. Approximately every fifty-two minutes someone dies because of an eating disorder, accounting for over 10,000 deaths annually. EDs are among the deadliest mental illnesses, coming in second behind opioid overdoses, with most deaths occurring either by organ failure or suicide.

15. Id.
16. Interview with Kristi Shohet, MS, LCPC, CEDS, in Boise, Idaho (Nov. 12, 2022) [hereinafter Shohet].
17. Doe, supra note 1.
18. Shohet, supra note 16.
22. Id.
EDs amongst children have steadily increased since the 1950s with the result being that today around nine percent of the U.S. population will have an ED during their lifetime. Moreover, this percentage has increased in recent years as a result of the COVID-19 pandemic, with one study finding that during 2020, medical admissions for adolescents with EDs more than doubled. For those ages twelve to fifteen, ED diagnoses have increased approximately twenty-five percent since the beginning of the pandemic. Experts attribute this increase to loss of regular routines with friends and family, food insecurity in the home, increased time on social media, and less opportunity to participate in team sports or other physical activities.

Because EDs relate to behaviors, habits, or actions that impact mental and physical health, they are traditionally considered behavioral health disorders rather than mental health disorders. EDs are especially pernicious behavioral disorders because they often co-exist with other psychiatric and physical co-morbidities. Psychiatric co-morbidities can include major depressive disorder, obsessive compulsive disorder, social anxiety disorder, and post-traumatic stress disorder. Physical co-morbidities connected to or resulting from EDs include higher incidence of type 1 and 2 diabetes, osteopenia and osteoporosis, polycystic ovarian

23. Id.
27. Id.
30. Id.
31. Osteoporosis is a condition whereby bones become less dense and more likely to fracture. ED patients, particularly females, with extremely low body weight oftentimes produce low levels of estrogen which contributes to loss in bone density, thereby leading to osteoporosis. What People with
syndrome (PCOS), gastrointestinal problems, menstrual irregularities, and headaches and migraines.32 Due to the commonality of Jane’s situation across all of Idaho, the Idaho legislature needs to act now to protect individuals from the dangers of EDs. Without legislative action, the concerns addressed above will continue to persist.

II. BACKGROUND

This Comment next addresses some essential background information relating to EDs, including the current recognized diagnosis; treatment options and recovery statistics; social and economic costs of EDs; and the inadequate education that healthcare providers receive about these disorders.

A. Diagnostics

EDs are often difficult to identify by family and friends because symptoms can often be excused as “picky” eating. Broadly speaking, warning signs of EDs are any sort of attitudes or behavior that indicate excessive concern and control of food, weight, and dieting.33 More specific emotional and behavioral warning signs or symptoms can include: anxiety eating around others, rigid food rituals, skipping meals or eating very small portions at mealtimes, withdrawal from usual friends and activities, excessive exercising, habitually checking the nutrition facts on foods, calorie tracking, or constantly checking one’s reflection in mirrors and when passing reflective windows, and more.34 Physical symptoms can include menstrual irregularities, dizziness, fainting, osteopenia and/or osteoporosis, tooth decay, cuts and calluses on fingers as a result of induced vomiting, gastrointestinal problems, hormonal imbalances, and more.35

Currently, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) recognizes seven different types of EDs including Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Other Specific Feeding or Eating Disorder (OSFED),

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32. Co-Occurring Conditions, supra note 29.
34. Id.
35. Id.
Avoidant Restrictive Food Intake Disorder (ARFID), Pica, and Rumination Disorder. \textsuperscript{36} Diagnostic criteria for each of these categories is included below:

<table>
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<th>ED</th>
<th>Diagnostic criteria</th>
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| AN     | • Restriction of energy intake leading to a significantly low body weight and a fear of weight gain  
      | • Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain  
      | • Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body shape of weight on self-evaluation, or shape is experienced, undue influence of body shape or weight on self-evaluation or persistent lack of recognition of the seriousness of current low body weight |
| BN     | • Recurrent episodes of binge-eating and compensatory behavior (purging) to prevent weight gain  
      | • Recurrent inappropriate compensatory behavior to prevent weight gain  
      | • The binging and inappropriate behavior both occur, on average, at least once a week for three months  
      | • The disturbance does not occur exclusively during episodes of AN |
| BED    | • Recurrent episodes of binge-eating and these episodes are not associated with a concurrent diagnosis of AN or BN  
      | • Marked distress regarding binging is present  
      | • The binging occurs, on average, at least once a week for three weeks |
| ARFID  | • An eating or feeding disturbance as manifested by persistent failure to meet appropriate nutritional and/or energy needs.  
      | • Eating behavior is not explained by lack of available food or cultural practices  
      | • The ED is not attributable to another medical condition |
| Pica   | • Persistent eating of non-nutritive, non-food substances over a period of at least 1 month  
      | • Eating behavior is not part of culturally supported or socially normative practice |
| Rumination disorder | • Repeated regurgitation of food over a period of at least 1 month  
      | • Repeated regurgitation is not due to another medical condition – mental or physical |
| OSFED  | • A clinically significant disturbance of eating behavior the symptoms of which do not fulfill the criteria for other EDs |


B. Treatment

EDs are not only difficult to identify and diagnose, but they are also difficult to treat as they require an interdisciplinary approach involving psychological, behavioral, medical, and nutritional components of care. Even when treatment is obtained, remission is a long and arduous journey with approximately 31.4% of anorexia patients and 68.2% of bulimia patients recovering after a nine-year follow up. After a twenty-two-year follow up, more significant improvements can be seen with 62.8% of participants with anorexia nervosa and 68.2% of participants with bulimia nervosa considered fully recovered.

ED treatment is generally categorized into six different levels of care, with patients typically moving up or down a level of care as needed. From the least intensive to the most intensive treatment, the spectrum of care includes:

1. Outpatient treatment
2. Intensive Outpatient Treatment (IOP)
3. Partial Hospitalization (PHP)
4. Residential Treatment
5. Inpatient Treatment
6. Acute Medical Stabilization.

Outpatient treatment involves the patient living at home, attending weekly or bi-weekly sessions with providers (whether counselors, dietitians, physicians). IOP treatment typically involves attendance of programming two to three times per week for a minimum of three hours each time. PHP involves treatment five days per week for around eight hours daily, where services occur in a single location to reduce ED behaviors and facilitate physical and mental recovery. Residential treatment places the individual under twenty-four hour supervision for those who

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39. Id.
41. Id.
42. Id.
43. Id.
44. Id.
continue to engage in ED behaviors.\textsuperscript{45} Inpatient treatment is best suited for those who are not responsive to treatment, require a high level of care, and require structured twenty-four hour care.\textsuperscript{46} Finally, acute medical stabilization may be necessary when individuals are medically unstable and it aims to stabilize the patient until they can transition to a lower level of care.\textsuperscript{47}

C. Social and Economic Costs of EDs

It is estimated that the annual economic costs of EDs in the United States are approximately $64.7 billion dollars, with $48.6 billion resulting from productivity losses.\textsuperscript{48} While such costs are extreme, they can successfully be curbed. Deloitte, in its 2020 report addressing the social and economic costs of EDs, recommends a better integrated care model which they characterize as “the comprehensive delivery of health services, designed according to the multidimensional needs of the population and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care.”\textsuperscript{49} The findings suggest that this integrated care model will provide cost-effective treatment by offering care via multiple disciplines (e.g. medicine, nutrition, psychology/social work, and psychiatry) to support each patient’s individual needs based on their symptoms.\textsuperscript{50} Other findings suggested that partial hospitalization programs, described above, may offer substantial cost savings when compared to inpatient care.\textsuperscript{51} Further cost savings might also be possible through screening, which might identify people with emerging or early EDs and allow for earlier treatment, thus avoiding more intensive and expensive care later.\textsuperscript{52}

Currently, up to 80\% of EDs go undiagnosed or never receive treatment.\textsuperscript{53} At face value, this would appear economically concerning. If 80\% of EDs go

\textsuperscript{45} Types of Eating Disorder Treatment, supra note 40.
\textsuperscript{46} Id.
\textsuperscript{47} Id.
\textsuperscript{49} Id. at vii.
\textsuperscript{50} Id.
\textsuperscript{51} Id.
\textsuperscript{52} Id. at viii.
undiagnosed and economic costs of existing EDs are calculated to be nearly $65 billion, how much will the economic burden increase if we diagnose even 50% of all EDs? This question creates a paradox where individuals who do not receive treatment specifically for their ED end up incurring higher health service costs for their physical symptoms than individuals who do not have an ED. Thus, if patients are properly diagnosed and treated for the ED initially rather than merely being treated for the physical symptoms stemming from the disorder, the economic burden EDs impose can be diminished.

D. Inadequacy in Education

Another problem in the ED field is the inadequate training health care providers receive when it comes to assessing and treating EDs. Nurses, dentists, medical doctors, and licensed clinical professional counselors (LCPC) typically receive little to no education about these disorders and thus frequently fail to identify them. Indeed, up to 92% of frontline clinicians have in hindsight admitted to potentially missing an ED diagnosis. What is more, even if providers are aware of these illnesses and can correctly identify them, they usually still lack awareness about applicable interventions and techniques to treat EDs.

Despite this lack of education, many providers, especially counselors, continue to try and treat ED patients anyways. Counselors may either try to ignore the ED and treat the patient for their co-occurring symptoms, such as anxiety and depression, or the counselor may try to treat the ED head on despite their lack of specified training in these illnesses. But treating EDs without understanding what causes them and what types of therapeutic techniques are beneficial to ED patients, may end up causing more harm than good. Counseling without background education in what methods are effective to treat EDs may result in “iatrogenesis” (i.e., adverse conditions resulting from treatment). These adverse conditions, such as worsening symptoms, may largely be attributed to providers’ poor

54. DELOITTE, supra note 48, at viii.
56. Shohet, supra note 16.
58. Id.
59. Id.
understanding of EDs. If this occurs in a counseling relationship, an inadequate therapeutic relationship may exist and can result in reinforcement and maintenance of the disorder rather than healing.\textsuperscript{61} This reinforcement of the disorder prolongs care and may even worsen the disorder such that higher level of care is subsequently required. This inadequate care thus poses a substantial expense, potentially requiring care both for a longer period of time as well as more intensive care. Thus, providers need to be better educated in these disorders to be able to identify them and then give appropriate referrals to providers who are specifically educated in these disorders to reduce the longevity and intensity of care required.\textsuperscript{62}

i. International Association of Eating Disorders Professionals Foundation Certification

Although most doctors and counselors lack an understanding of EDs, a small subset of them—CEDS-Medical and CEDS—are specifically trained to treat EDs and are certified by the International Association of Eating Disorders Professionals Foundation (IAEDPA).\textsuperscript{63} While obtaining certification by the IAEDPA is not a prerequisite to treating EDs, those in the field recognize the importance of this certification.\textsuperscript{64} As stated above, most providers are not provided with substantial education about EDs, and thus frequently fail to identify a disorder. Moreover, even if able to identify an ED, said providers are ill-equipped in the treatment techniques of EDs and thus may end up reinforcing the illness rather than treating it if they attempt to provide services without certification by the IAEDPA. It is to these IAEDPA certified providers that general providers need to refer clients if they suspect or identify a patient who may be struggling with or engaging in ED behavior.

III. FEDERAL BILLS AND STATUTES

This Comment next addresses the role of federal and state legislation in increasing education and accessibility to care for ED patients. We address which statutes have been enacted as well as proposed legislation that could have a significant effect in helping ED patients receive the care they desperately need and

\textsuperscript{61} Id.
\textsuperscript{64} Shohet, supra note 16.
deserve. Recently there has been an uptick in both federal and state legislation which increases awareness about EDs, educates the public and health care providers about EDs, and improves insurance coverage for these disorders. Despite this positive upward trend, there is still a lot of room to statutorily provide more support for these patients.

Since 1987, at least one piece of legislation relating to EDs has been introduced in either the United States House or Senate every year.65 Despite this

65. 100th Congress – A joint resolution designating the week of April 24, 1988, through April 30, 1988, as “National Eating Disorders Awareness Week”, S.J. Res. 259 and H.R.J. Res. 272, 100th Cong. (1988).


110th Congress – Encouraging increased public awareness of eating disorders and expanded research for treatment and cures, H.R. Res. 13, 110th Cong. (2007); Eating
frequency of introduction and substantial co-sponsorship across partisan lines on many of the proposals, very few of these bills have been voted on and passed into law. To date, the only federal legislation specifically addressing EDs include the 21st Century Cures Act, the Serve Act, and the Anna Westin Act through the Cures Act.66


115th Congress – Expressing support for the designation of “National Eating Disorders Awareness Week” and supporting the goals and ideals to raise awareness and understanding of eating disorders H.R. Res. 428, 115th Cong. (2017); A resolution designating the week of February 26 through March 4, 2018 as “National Eating Disorders Awareness Week” and supporting the goals and ideals of raising awareness and understanding of eating disorders, S. Res. 419, 115th Cong. (2018); LIVE Well Act, H.R. 7136, 115th Cong. (2018).


While discouraging that so many of these proposals seemingly never gain enough momentum to pass a vote, there is hope to be garnered from the fact that legislators are aware of the danger that EDs pose and have at least been attempting to pass legislation that could make a real difference. Below this Comment explores some of the historic legislation that led to where the law stands today, the legislation that has been successfully codified, as well as several bills that are in the pipeline and could bring about some much-needed reform when it comes to education, research, and treatment of EDs.

A. Mental Health Parity Law

In 2008, Congress passed the Mental Health Parity and Addiction Equality Act (MHPAEA) which amended the Public Health Service Act. The MHPAEA was a significant national victory for individuals struggling with mental health disorders. Historically, lack of insurance transparency meant that treatment methods for mental health patients would often be excluded from coverage. Furthermore, even if mental health treatment was covered under the policy, it would often require more stringent prior authorization than coverage for other medical conditions. Enacted to remedy the unequal treatment of mental health patients and to lessen the financial burden of treatment, the Mental Health Parity Act establishes patient’s legal right to “equal access and coverage for mental health and substance use disorder (MH/SUD) treatment services as they would any other medical service.”

Initially, the MHPAEA’s goal of lessening financial burdens on patients seemed like a considerable means of getting more ED patients the treatment they needed. Prior to passage of the MHPAEA, obtaining treatment was nearly impossible for most ED patients since residential care facilities cost an average of $1,200 per day, with an average stay of ten weeks. For those patients who did seek this treatment, they would usually have to pay out of pocket. Despite the admirable goal of

68. Id.
mental health parity and the hopes of ED advocates that it would facilitate treatment for more patients, enforcement of the MHPAEA with respect to EDs was far from clear cut. Insurance companies frequently deny coverage despite clear medical necessity through loopholes or rule ambiguities.\textsuperscript{71}

Between 2011 and 2015, there was significant litigation regarding insurance coverage for ED treatment. During those four years, five circuit court of appeals and twenty-seven federal district courts issued decisions in disputes concerning whether insurance policies covered certain ED treatment.\textsuperscript{72} The claims largely examined whether under state mental health parity laws insurers had to cover residential treatment for allegedly medically necessary ED claims.\textsuperscript{73} Litigation resulted in disparate findings on the circuit court level.\textsuperscript{74} While the 9th Circuit was one of the 32 courts to issue decisions on cases, Idaho state courts did not reach this issue.

B. 21st Century Cures Act

While the MHPAEA required parity for mental health treatment and other medical services, it did not explicitly enumerate EDs as a mental illness requiring parity, thus it oftentimes resulted in no insurance coverage for ED treatment. This changed in 2016 with the passage of the 21st Century Cures Act, the first piece of legislation written specifically to help ED patients.\textsuperscript{75} The 21st Century Act was designed to help “accelerate medical product development and bring new


\textsuperscript{72} Mike Daly et. al., Learning the Language, Eating Disorders Pose Multiple Challenges Under Health Insurance Policies, 57 LIFE, HEALTH, & DISABILITY 45 (Dec. 2015).

\textsuperscript{73} Id.

\textsuperscript{74} Compare Harlick v. Blue Shield of Cal., 686 F.3d 699, 710–712 (9th Cir. 2012) (finding California’s Mental Health Parity Act did require coverage for residential treatment for eating disorders when medically necessary), with Douglas S. v. Altius Health Plans, Inc., 409 F. App’x 219, 225–26 (10th Cir. 2010) (finding Utah’s Catastrophic Mental Health Coverage did not require coverage for eating disorder residential treatment).

innovations and advances to patients who need them faster and more efficiently."

The Cures Act also clarified that ED coverage, including residential care, is subject to parity per the MHPAEA. Title XIII of the Cures Act deals with information and awareness, as well as education and training on EDs. In pertinent part, §13005 of the act provides that


78. 42 U.S.C. 282a(a)(1) § 13005. Information and awareness on eating disorders.

(a) Information
The Secretary of Health and Human Services, acting through the Director of the Office on Women’s Health, may—

(1) Update information, related fact sheets, and resource lists related to eating disorders that are available on the public Internet website of the National Women’s Health Information Center sponsored by the Office on Women’s Health, to include—

(A) Updated findings and current research related to eating disorders, as appropriate; and

(B) Information about eating disorders, including information related to males and females;

(2) Incorporate, as appropriate, and in coordination with the Secretary of Education, information from publicly available resources into appropriate obesity prevention programs developed by the Office on Women’s Health; and

(3) Make publicly available (through a public Internet website or other method) information, related fact sheets, and resource lists, as updated under paragraph (1), and the information incorporated into appropriate obesity prevention programs under paragraph (2).

(b) Awareness
The Secretary of Health and Human Services may advance public awareness on—

(1) the types of eating disorders;

(2) the seriousness of eating disorders, including prevalence, comorbidities, and physical and mental health consequences;

(3) methods to identify, intervene, refer for treatment, and prevent behaviors that may lead to the development of eating disorders;
the Director of the Office on Women’s Health provide information and resources related to EDs, increase awareness about the severity of EDs and how to identify them, and facilitate education and training for health professionals in strategies to identify, prevent, and treat EDs.\textsuperscript{79} §13006 of the Cures Act tasks the Secretary of Health and Human Services with advancing public awareness on the types of EDs, their severity, signs and symptoms, and the effects of media on body image.\textsuperscript{80} Finally, §13007 of the Cures Act clarified that if a group health plan or insurance issuer selects to offer coverage for eating disorders, including residential treatment, benefits have to be consistent with parity laws.\textsuperscript{81} Passage of the Cures Act largely put an end to ED health insurance coverage litigation.\textsuperscript{82} While this inclusion provided greater access to ED services based on better insurance coverage of

\begin{enumerate}
\item discrimination and bullying based on body size;
\item the effects of media on self-esteem and body image; and
\item the signs and symptoms of eating disorders.
\end{enumerate}

\textsuperscript{79} Id.
\textsuperscript{80} Id.
\textsuperscript{81} Id.
treatment, concerns remain about regulating compliance by insurance providers as well as regulating the quality of care provided to these patients.83

C. The Anna Westin Legacy Act

Another success for ED advocates was the enactment of the Anna Westin Legacy Act as part of the 21st Century Cures Act.84 Because millions of Americans will struggle with EDs during their lifetime, Senator Klobuchar introduced and sponsored, S.3686—The Anna Westin Legacy Act.85 The Act was also introduced into the House by Representative Doris Matsui (H.R. 7249) on March 28, 2022.86

The Anna Westin Act aims to improve the “identification of, interventions for, and treatment of eating disorders in a manner that is culturally and linguistically appropriate,” by establishing the Center for Excellence for Eating Disorders.87 In so doing, the Act extends the objectives enumerated in §13006 of the Cures Act by providing better education of frontline healthcare workers so they can more effectively intervene, screen, and refer patients to appropriate services. The Center for Excellence for Eating Disorders, administered by the University of North Carolina at Chapel Hill and Funded by the Substance Abuse and Mental Health Services Administration under the U.S. Department of Health and Human Services,88 offers training on evidence-based interventions for EDs for Continued Education (CE) credits for providers.89

D. Serve Act

Finally, and most recently, the Serve Act was passed into law through the 2022 Fiscal Year. The Serve Act helps United States Military servicemembers and their spouses and children struggling with EDs by allowing individuals to receive higher levels of care for EDs when necessary.90 The Department of Defense is also required to disseminate guidance and regulations relating to identifying, treating, and

83. Shields, supra note 77.
87. Id.
90. Accomplishments, supra note 75.
rehabilitating servicemembers or their family members suffering from EDs.\textsuperscript{91} Oftentimes, being in highly stressful environments like the military, or having a family member in the military, can often trigger an ED.\textsuperscript{92} That being said, the Serve Act is a momentous achievement for ED advocates in providing necessary care for servicemembers and their spouses or children struggling with an ED, but that support is limited exclusively to that demographic.

\textsuperscript{91} Id.; See also 10 U.S.C.A §1079.

(a) To assure that medical care is available for dependents, as described in subparagraphs (A), (D), and (I) of section 1072(2) of this title, of members of the uniformed services who are on active duty for a period of more than 30 days, the Secretary of Defense, after consulting with the other administering Secretaries, shall contract, under the authority of this section, for medical care for those persons under such insurance, medical service, or health plans as he considers appropriate. The types of health care authorized under this section shall be the same as those provided under section 1076 of this title, except as follows:

(18) Treatment for eating disorders may be provided in accordance with subsection (r).

(r)(1) The provision of health care services for an eating disorder under subsection (a)(18) may include the following services:

(A) Outpatient services for in-person or telehealth care, including partial hospitalization services and intensive outpatient services.

(B) Inpatient services, which shall include residential services only if medically indicated for treatment of a primary diagnosis of an eating disorder.

(2) A dependent provided health care services for an eating disorder under subsection (a)(18) shall be provided such services without regard to--

(A) the age of the dependent, except with respect to residential services under paragraph (1)(B), which may be provided only to a dependent who is not eligible for hospital insurance benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.); and

(B) except as otherwise specified in paragraph (1)(B), whether the eating disorder is the primary or secondary diagnosis of the dependent.

(3) In this section, the term ‘eating disorder’ has the meaning given the term ‘feeding and eating disorders’ in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (or successor edition), published by the American Psychiatric Association.

\textsuperscript{92} Danielle A. Touma, et al., Eating Disorders in U.S. Active Duty Military Member and Veterans: A Systematic Review, 188 MIL. MED. 1637, 1637 (2023).
E. H.R. 5526/S.2930 Improving Mental Health and Wellness in Schools Act

Another piece of legislation that has not yet been enacted but would provide broader education about and screening for EDs in schools is the Improving Mental Health and Wellness in Schools Act. In 2021 Representative Kathy Manning of North Carolina introduced H.R. 5526 – Improving Mental Health and Wellness in Schools Act.93 The bill was referred to the Committee on Education and Labor.94 A summary of the bill reads as follows:

This bill requires local educational agencies (LEAs) participating in the school lunch or breakfast programs to include in their local school wellness policies (1) goals for mental health promotion and education, and (2) nutrition guidelines for reducing childhood eating disorders. Such LEAs must also include registered dietitians and school-based mental health services providers in the development, implementation, and periodic review of such policies.

The bill also requires the Department of Agriculture to provide information and technical assistance to school health professionals (including school-based mental health services providers) for use in establishing healthy school environments. Such technical assistance must promote mental health, encourage mental health assessments, and establish resilient school environments.95

At the same time, on the Senate’s side, Senator Amy Klobuchar of Minnesota sponsored S.2930, also titled the Improving Mental Health and Wellness in Schools Act, and similarly seeking to amend the Richard B. Russell School Lunch Act to increase access to mental health resources.96 The bill was referred to the Committee on Agriculture, Nutrition, and Forestry, but ultimately has not passed.97

F. US Preventative Services Task Force Findings

Given the frequency and severity of EDs, a popular proposal has been to increase the frequency of ED screenings. While potentially an effective means of identifying EDs early on, it seems unlikely that the federal government will pass
legislation on this anytime soon given the recommendation statement published in March of 2022 by the U.S. Preventive Services Task Force.98 The Task Force commissioned a review to consider the potential harms and benefits of screening individuals from adolescents to adults with a normal to high BMI for EDs.99 Ultimately, the task force found no studies directly assessing the benefits and harms of screening for EDs.100 The task force opined that there is currently insufficient evidence to determine the benefits and harms of ED screenings amongst adolescents and children over the age of ten who have no signs or symptoms of an ED.101 The recommendation statement does address some of the potential harms of screening questionaries, including, “false-positive screening results that lead to unnecessary referrals, treatment, labeling, anxiety, and stigma. Pharmacologic treatments may result in adverse events such as dry mouth, headache, insomnia, nausea, and tremor.”102 While these are certainly relevant concerns, they should not overshadow the adverse effects of letting an ED go undiagnosed, namely loss of organ functioning and even death at its worst. However, given the insufficient findings, any sort of legislation mandating screening would be inappropriate at this time. Rather, further research should be done to understand the benefits and harms of more widespread screening as well as inquiring into the impact of screening not only average to high range BMI individuals, but those on the lower range as well.

Ultimately, while much progress has been made in legislation on the federal level and more is still needed to combat the harms of EDs, especially given the increased frequency of EDs that we have seen amidst the COVID-19 pandemic.

IV. STATE STATUTORY FRAMEWORKS

While the federal government has slowly but surely attempted to address the growing problem that EDs pose to our society, true change will likely be more effective if done at a state level. Because states vary drastically on their level of

100. U.S. Preventive Services Task Force, supra note 37.
education and access to resources for their ED patient citizens,\textsuperscript{103} we explore what some of the most patient friendly states have done to address these pernicious disorders.

A. Missouri

Missouri is one of the leading states in enacting legislation, providing education and access to mental and physical care for ED patients. Between 2010 and now, Missouri has passed one bill and considered another which have direct impacts on EDs including: \textsc{Mo. Ann. Stat.} §630.575 and \textsc{S.B. 922}.\textsuperscript{104}

ii. The Missouri Eating Disorder Council

In 2010, Missouri enacted \textsc{S.B. 754} establishing the “Missouri Eating Disorder Council”—codified in \textsc{Mo. Ann. Stat.} §630.575—to help the over 250,000 individuals in Missouri fighting an ED.\textsuperscript{105} The Council exists within Missouri’s Department of Mental Health.\textsuperscript{106} Members of the council are appointed by the director of the department of mental health, who also determines the total number of council members.\textsuperscript{107} Council members are appointed for four year terms and the council must include designees from the department of Mental Health as well as ED researchers, clinicians, patient advocacy groups, and members of the general

\textsuperscript{103} Compare H.R. Res. 3, 65th Leg., 1st Reg. Sess. (Idaho 2019) (Idaho’s first and only legislation on eating disorders was the recognition of the last week of February as Eating Disorder Awareness Week), with \textsc{Mo. Ann. Stat.} §630.575 (West 2010), and \textsc{Mo. Ann. Stat.} § 630.580 (West 2010) (Missouri establishing a council within the State’s Department of Mental Health to increase education and awareness about eating disorders).

\textsuperscript{104} \textsc{Mo. Ann. Stat.} §630.575 (West 2010); \textsc{S. 922}, 101st Gen. Assemb., 2d Reg. Sess. (Mo. 2022).

\textsuperscript{105} \textsc{Mo. Ann. Stat.} §630.575 (West 2010).


\textsuperscript{107} \textit{Id.}
The Council works in conjunction with various state agencies to develop and implement programs to educate and raise awareness about EDs.

The Council is tasked with implementing education and awareness programs relating to EDs for: health care professionals, elementary and secondary and higher education professionals, and general ED education and awareness programs. For health care professionals specifically, programs may include identification of individuals who may be at-risk and conducting individual and familial health risk assessments. Education programs include distribution of educational material to both public and private middle and high school students, and development of a

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1. There is hereby established within the department of mental health the “Missouri Eating Disorder Council” which shall consist of the following persons to be selected by and the number of members to be determined by the director of the department of mental health:

   (1) Director’s designees from the department of mental health;
   (2) Eating disorder researchers, clinicians, and patient advocacy groups; and
   (3) The general public.

2. The council shall:

   (1) Oversee the eating disorder education and awareness programs established in section 630.580;
   (2) Identify whether adequate treatment and diagnostic services are available in the state; and
   (3) Assist the department of mental health in identifying eating disorder research projects.

3. Members of the council shall serve four-year terms, with the initial terms of the members staggered as two-year, three-year, and four-year terms. The members of the council may be reappointed. The members of the council shall not receive compensation for their service on the council, but may, subject to appropriation, be reimbursed for their actual and necessary expenses incurred as members of the council.

4. The council shall conduct an organizational meeting at the call of the director of the department of mental health. At such meeting, the council shall select a chair and vice chair of the council. Subsequent meetings of the council shall be called as necessary by the chair of the council or the director of the department of mental health.

109. Id.

110. Id.

school curriculum in identifying signs and symptoms of EDs and encouraging healthy and positive body image.\footnote{112}

iii. S.B. 922 Regulating the Sale of Dietary Supplements to Minors

Another bill considered in Missouri was S.B. 922 Regulating the Sale of Dietary Supplements, prohibiting the sale of “over-the-counter diet pills or dietary supplements for weight loss or muscle building to any person under eighteen years of age.”\footnote{113} Under the bill, retail establishments found to violate this provision constitutes an unlawful practice under state Merchandising Practices law and are punished by a maximum fine of $2,000.\footnote{114} While not explicitly suggested for the sake of preventing EDs, the bill would likely nevertheless have this positive impact.\footnote{115} SB 922 follows the recent trend of social media platforms (Instagram and Facebook) and states regulating the sale of diet pills to minors.\footnote{116} Ultimately however, the bill died in the Insurance and Banking committee.\footnote{117}

B. Virginia

Another state that has adopted legislation to help increase awareness and disseminate information about EDs is Virginia. In 2013, Virginia passed HB 1406, codified as VA Code Ann. § 22.1-273.2. Parent information regarding eating disorders.\footnote{118} The statute states that, “[e]ach school board shall annually provide parent educational information regarding eating disorders for pupils in grades five through twelve. Such information shall be consistent with guidelines set forth by the Department of Education.”\footnote{119} Scholarship on this provision suggests an inverse association between parental education and harmful mental outlooks that may lead to mental disorders.\footnote{120} Thus, the more educated parents are about these

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\begin{itemize}
\item \footnote{112} id.
\item \footnote{113} S.B. 922, 101st Gen. Assemb., 2nd Reg. Sess. (Mo. 2022).
\item \footnote{114} id.
\item \footnote{115} Amy Roeder, A Gateway to Eating Disorders, \textit{THE HARV. GAZETTE}, (Nov. 21, 2019), https://news.harvard.edu/gazette/story/2019/11/diet-pills-linked-with-eating-disorder-diagnosis/ (finding higher rates of diagnoses of eating disorders amongst individuals who used diet pills or laxatives compared with those who did not use these products).
\item \footnote{117} Mo. S. B. 922.
\item \footnote{118} VA. CODE ANN. § 22.1-273.2.
\item \footnote{119} id.
\item \footnote{120} Sean P. Byrne & Garrett Hooe, \textit{Health Care Law}, 49 U. RICH. L. REV. 103, 124 (2014).
\end{itemize}
disorders, the less likely their children are to engage in disordered behaviors leading to a potential disorder. 121

Guidelines released by the Virginia Department of Education in 2020 noted school communities’ unique position to help with ED prevention efforts and recommended that these educational materials should include the following. 122

- A description of eating disorders and associated health consequences;
- A description of how eating disorders are identified (i.e., warning signs and symptoms);
- A statement describing why it is important to screen for eating disorders (early detection and treatment);
- A description of eating disorders screening;
- Information on referral for assessment, diagnosis, and treatment; and
- A description of prevention efforts and potential treatment. 123

These resources are to be shared with parents and guardians using ordinary methods of communication in schools such as via the student handbook, sending letters home with report cards or through email correspondence. 124 Alongside mandatory dissemination of educational material to parents/guardians, as part of section 22.1-273.2, the Virginia Department of Education created an optional screening program that schools have discretion on whether or not to implement. 125 Should schools choose to provide this screening program, there must be proper training relating to the screening tool selected as well as a procedure for parents/guardians of the pupil to opt-out of the screening if desired. 126 Policy wise, §22.1-273.2 strikes a fair balance of providing education about these severely misunderstood disorders to a wider populace of parents who are uniquely positioned to help prevent EDs, while also providing opt-out procedures should families be uncomfortable with their children being screened for an ED.

121. Id. at 124–25.
123. Id.
124. Id.
125. Id. at 3.
126. Id.
While §22.1-273.2 is a major piece of legislation for ED advocates, the Virginia legislature seems eager to adopt even more legislation to help address the severe problems that EDs pose to our society. In January of 2022, Senate Joint Resolution No. 11 was filed and calls for further research into EDs in the Commonwealth of Virginia.\textsuperscript{127} The Joint Commission on Health Care would be commissioned to further investigate the incidence of EDs in Virginia, the adequacy of ED training provided to educators, strategies to increase awareness, and much more.\textsuperscript{128}

C. Idaho

In 2019 the Idaho legislature passed Concurrent Resolution No. 3 which established the last week of February each year as Eating Disorder Awareness Week.\textsuperscript{129} Although this is a step in the right direction, many legislators recognize that more needs to be done. For example, in response to Senator Lee’s inquiry as to why the resolution was limited to a single week, Representative McCrostie noted that he hopes more legislation will be adopted moving forward, but nothing has been recommended as of yet.\textsuperscript{130} The Eating Disorder Awareness Week resolution provides hope to ED patients, but as recognized by Senator Lee, more should be done. Senator Lee’s commentary is hopeful however, as it demonstrates the willingness of the legislature to act in this area.

Another area for the development of policies and programs to help the Idaho ED population is via the Idaho Behavioral Health Council. Established in 2020, the Idaho Behavioral Health Council’s (IBHC) vision is that “adults, children, and their families who live with mental illness and addiction receive the behavioral health care services they need when they need them.”\textsuperscript{131} Should it choose to do so, the IBHC could prove to be a powerful platform off which ED education and treatment programs may be launched. We discuss this possibility in more detail below.

\textsuperscript{127} S. J. Res. 11, 117th Cong. (2022).
\textsuperscript{129} Minutes Senate Health & Welfare Committee, HCR 038 Eating Disorder Awareness Week, Senate Health & Welfare Comm., 2018 Leg., 64 (Idaho 2018).
\textsuperscript{130} Id.
V. RECOMMENDATIONS

Given the many obstacles the ED patients face in obtaining adequate care for their needs, a variety of recommendations are in order. From increased education about EDs to earlier diagnosis, more availability of care, and better follow-up care to ensure remission rather than relapses, there is a lot that can and ought to be done for this population of patients who have gone under cared for, for far too long. This Comment includes five recommendations. The first recommendation is national in scope whereas the remaining four are all specific to Idaho.

First, this Comment recommends an amendment to the American Counseling Association Code of Ethics relating to boundaries and changes in the counselor-client relationship specifically for ED patients. Subsequently, this Comment recommends that Idaho (1) increase education about EDs in school via the adoption of a bill similar to VA Code Ann. Section 22.1–273.2, (2) establish an ED workgroup as part of the Idaho Behavioral Health Council, (3) establish a level 4 or 5 care facility in Boise, and (4) provide greater access to education for providers and incentives for Idaho counselors to obtain their CEDS.

A. An Amendment to the ACA Code of Ethics

CEDS, like all counselors, are required to comply with the American Counseling Association (“ACA”) Code of Ethics (“Code”) in their practice. Part of this Code is maintaining counseling boundaries as well as potential changes in the professional (counselor-client) relationship. The Code subscribes to six ethical principles as the basis for ethical behavior and decision-making to ensure the relationship is one of healing rather than harm. These principles include (1) autonomy—fostering the right to control the direction of one’s life; (2) nonmaleficence—avoiding actions that cause harm; (3) beneficence—working for the good of the individual and society, (4) justice—treating individuals fairly and fostering equality, (5) fidelity—fulfilling one’s responsibilities and honoring commitments of the professional relationship, and (6) veracity—dealing truthfully with those whom counselors come into professional contact with. ACA Section A.6.b governs the extension of counseling boundaries beyond what are considered

132. See generally ACA CODE OF ETHICS (AM. COUN. ASS‘N 2014); See also id. § A.6.b.
133. See id. pmbl.
134. Id.
“conventional parameters” (i.e. in a counselor’s office or via telehealth).\footnote{135}{\textit{Id.} § A.6.b. [Extending Counseling Boundaries].} Falling largely within the nonmaleficence ethical principle of the Code, Section A.6.b forces counselors to consider the benefits and harms of extending the counseling relationship beyond said “conventional parameters.”\footnote{136}{\textit{Id.}} As it stands, Section A.6.b contains various examples of when extending the boundary might occur, such as attending a client’s wedding or visiting a client’s sick family member in the hospital. Yet, there are no examples of how this extension might be appropriate for ED patients or any other treatment of a mental disorder.\footnote{137}{\textit{Id.}} The provision goes on to include that should a counselor choose to extend the typical counseling boundaries, they must comply with professional precautions including informed consent, supervision, and documentation of the extension to ensure no harm occurs.\footnote{138}{\textit{Id.}} Generally, these precautions are important to ensure that the therapeutic relationship promotes healing rather than harm. When it comes to treating ED patients however, these precautions all but preclude therapists from extending the traditional counseling boundary, and may cause them to fear reports of ethical violations and revocation of licensure, even when the extension would be in the individual’s best interest.

This comment submits that a separate and additional provision (A.6.b.i) be drafted and incorporated into the Code whereby the ACA goes into further detail of the specific illnesses and circumstances under which extension of the traditional counseling boundary might be appropriate, and even necessary, to truly care for the patient. Because Section A.6.b is applicable to counselors treating all sorts of mental illnesses and emotional disturbances—not only CEDS treating ED patients—the broad provision of A.6.b relating to maintaining traditional counselor boundaries should not, and likely cannot, include carveouts for every mental illness that may benefit from an extension of the traditional counseling boundaries. EDs, however, are a prime example of where such a carveout could substantially promote, rather than hinder, the ethical principles the Code subscribes to by
working toward the beneficence of the individual. Indeed, such a provision could facilitate counselors in achieving the Code’s ultimate goal—to provide what the patient needs to heal.

Substantively, § A.6.b.i ought to include exceptions allowing counselors treating ED patients to share meals with them, to go grocery shopping with them, and to go clothes shopping with them. For ED patients, eating meals, grocery shopping, and buying clothes can often be activities fraught with anxiety. Skipping meals is a frequent symptom of an ED, and patients who have little support often get away with this behavior.139 Amending the Code to allow counselors to share meals with patients forces patients not to skip said meals, but also provides them with the comfort and support of their counselor during these anxious times. ED patients also frequently struggle when buying groceries or clothes.140 While at the grocery store, patients may feel paralyzed by the abundance of choices and compulsively check every food label.141 When clothes shopping, patients are typically forced to look in the mirror, often causing body dysmorphia and triggering feelings of needing to restrict their food intake or increase their exercise to an unhealthy degree.142 Allowing counselors to be present at everyday activities like these, where ED frequently rears its ugly head, provides much needed support to patients and is a reasonable extension of the counselor-client relationship.143 Rather than forcing patients to relive their shame of having skipped various meals throughout the week or relive the anxiety of seeing their distorted reflection of themselves in the mirror whenever their next therapy session is, counselors can observe and assist their patients while anxiety levels are high or while surrounded by triggering stimuli.144 Thus, an amendment to the Code § A.6.b as advocated for above would give counselors a proximate role to be able to nip ED behaviors in the bud and provide encouragement and support for everyday activities that are uniquely difficult for ED patients.

To summarize, while the Code is intended as a jumpstart for ethical decision-making for practitioners, in effect it often works as a severe impediment to those treating ED patients. Fearing reports of ethical violations, many counselors trained in EDs choose not to participate in everyday activities, such as going out to lunch with their clients, despite recognition of the treatment and healing possibilities

139. Doe, supra note 1.
140. Id.
141. Id.
142. Id.
143. Id.
144. Doe, supra note 1.
these everyday activities provide and the acute stress that patients experience when they must complete these activities alone. Furthermore, while the Code is intended to protect the best interest of the patient, these standards are not suited to address the unique challenges ED patients face. These standards severely limit the location and methods by which counselors can provide support in order to conform with counseling boundaries and the professional relationship. In the interest of patients, an amendment to section A.6.b of the Code needs to be adopted to help counselors better care for ED patients as well as other mental illnesses. Although possible to complete these everyday activities of eating and shopping with family and/or friends, counselors are uniquely acquainted with the patients’ disordered behaviors and any possible symptoms they may express that are not so keenly noted by the untrained eye.

B. Increased Education and Availability of Screenings in School

The first recommendation this comment advocates specific to Idaho is that the legislature adopt the language of Virginia § 22.1-273.2 in full as it provides, “Each school board shall annually provide parent educational information regarding eating disorders for pupils in grades five through twelve. Such information shall be consistent with guidelines set forth by the Department of Education.”

Akin to Virginia, where implementation § 22.1-273.2 was assigned to their Department of Education, should such a provision be enacted in Idaho, the Idaho State Department of Education should be tasked with implementing it. To facilitate the rolling out of the program, Idaho can refer to the plethora of resources already developed by the Virginia Department of Education including a parent information sheet on EDs, a screening opt-out form, and even lesson plans for all grade levels.146 The statutory language of this provision is also optimal for Idaho as it allows the Idaho State Department of Education significant latitude in drafting guidelines for schools that are in accordance with particular needs and trends in Idaho.

As noted above, schools are uniquely positioned to both help identify children who might be developing or already struggling with an ED.147 Additionally, schools have access to a wide populace between students and parents, and thus are perfectly positioned to help disseminate educational materials relating to EDs. Thus, adopting an Idaho version of Virginia §22.1-273.2 could significantly increase Idaho’s awareness and education about these pernicious disorders as well as help

147. Eating Disorder Awareness in the Public School Setting, supra note 122.
identify people with emerging or early EDs, and allow for earlier treatment, avoiding more costly intensive care later.

C. Development of an ED Workgroup via the IBHC

The next recommendation this comment promotes is the development of an ED prevention workgroup within the IBHC. The IBHC has a variety of workgroups, including the Prevention-Early Intervention Workgroup, the Clinical Care Workgroup, as well as the Children & Youth Workgroup. While part of the IBHC’s goal is to decrease involvement in the criminal justice system, providing more and better access to care for ED patients still falls squarely within the council purpose and should be addressed. Currently, the Council is the best situated entity to further research EDs in Idaho and make further policy recommendations. At least one of the members of said workgroup should include an Idaho CEDS. While establishment of its own ED related workgroup would be preferrable, alternatively, we recommend that one or all the above mentioned IBCH workgroups address EDs in Idaho in their respective areas of expertise.

D. Establishment of a Residential Treatment and Inpatient Treatment Center

As stated in the introduction to this comment, roughly 58,000 Idahoans suffer from EDs. Despite this staggering number, there is almost nowhere for Idahoans to turn to receive necessary medical and psychiatric treatment within the state. Currently, other than hospitals that provide acute-medical stabilization, the Center for Change and Ashwood Recovery are the only facilities in the Boise area providing ED treatment for patients.

Ashwood Recovery, however, only offers ED treatment to patients who are not actively anorexic or bulimic unless they are under the care of a doctor specializing in EDs and have been deemed stable enough to be treated on an

149. See IDAHO BEHAV. HEALTH COUNCIL, supra note 131.
outpatient basis. Center for Change on the other hand, functions as a level 3 center of care in Boise, offering a Partial Hospitalization Program (PHP) and an evening Intensive Outpatient Program (IOP) for patients. However, neither Ashwood nor Center for Change offer residential care or inpatient treatment for ED patients. The result is that in Idaho, there is not a single higher level of care residential treatment (Level 4) or inpatient treatment (Level 5) facility available for ED patients.

The result of this absence of a higher level of care facility is that for those patients who need intensive treatment, they have no choice but to leave the state to obtain treatment, typically traveling to facilities in California, Utah, Oregon or Colorado. For some families however, traveling outside the state for treatment is not just difficult, but impossible.

Faced with either staying in state and receiving inadequate care given the severity of the disorder or traveling out of state for several months to receive recommended care, many families understandably choose to stay in Idaho. While understandable, this choice results in significant harms not only to the individual but to the Idaho health care system as a whole. ED patients who don’t receive sufficient treatment end up incurring higher health service costs for physical symptoms than had they obtained the requisite treatment. All this is to say that Idaho desperately needs to establish a residential and inpatient treatment facility for ED patients so they are not forced to leave the state to obtain treatment.

Seemingly the easiest solution and the one we recommend is that Center for Change expand its treatment facility to accommodate this need, particularly given the rise of EDs during the COVID-19 pandemic. However, should the Center for Change be unable to do so, the legislative groundwork for the establishment of a residential facility operated by the state is already established. Idaho Code §39-3304 provides that the state will foster the development of residential care or

152. Ashwood Recovery at Northpoint, supra 151.
153. Locations, supra note 151.
155. Kazdin, supra note 53.

The state will foster the development of, and provide incentives for, residential care or assisted living facilities serving specific mentally ill and developmentally or physically disabled populations which are small in size to provide for family and homelike arrangements. Small facilities of eight (8) beds or less for individuals with developmental or physical disabilities or dementia and fifteen (15) beds or less for individual with mental illness will provide residents with the opportunity for normalized and integrated living in typical homes in neighborhoods and communities.
assisted living facilities for specific mentally ill populations which are small in size.\textsuperscript{157}
EDs fit squarely within this demographic and thus a state funded facility could be jumpstarted via this provision. Additionally, Governor Little has expressed significant desire to expand the mental health services in Idaho, even recommending $15 million for psychiatric residential care facilities to bring children receiving treatment out of state back to Idaho.\textsuperscript{158} Thus, a state funded higher level of care facility for ED patients is a realistic objective given the Governor’s expressed desire.

E. Providing Incentives for Counselors to Obtain their CEDS

The final recommendation this Comment makes is to increase access to healthcare providers about EDs and provide incentives for Licensed Clinical Professional Counselors to obtain their CEDS certification via the International Association of Eating Disorder Professionals.

Currently Idaho has a total of eight CEDS throughout the entire state providing counseling to ED patients.\textsuperscript{159} CEDS are a necessary component to ED treatment as they can be helpful throughout the treatment and remission process of an ED patient. Furthermore, many ED patients who are not able to obtain high level of care alternatively see a CEDS on a regular basis. Finally, even for patients who did go to residential or outpatient treatment, sessions with CEDS continue to be an important part of a journey of remission. With only eight CEDS serving the entire Idaho ED population, those counselors are inundated with people seeking help, oftentimes with waitlists several months long.\textsuperscript{160}

VI. CONCLUSION

EDs are devastating illnesses. While there has been a significant increase in research and legislation dedicated to these disorders, Idaho remains behind the curve in providing treatment and resources to these patients. There is hope however, that the Idaho legislature is willing to remedy the plight that individuals in Idaho struggling with this illness face. Former representative McCrostie and Senator Lee’s commentary in 2018 suggest that there is at least some willingness

\textsuperscript{157} Id.
\textsuperscript{159} Shohet, supra note 16.
\textsuperscript{160} Id.
and desire to help this underserved population. Furthermore, the statutory framework of Idaho is ripe for legislation to assist these patients. We urge the legislature not to forget about this gap in care for ED patients but to seize the momentum and adopt provisions to help patients receive the care they need in Idaho rather than having to leave the state.