The Commission on
Women, Children, Seniors, Equity & Opportunity

CWCSEO

Connecticut General Assembly

Disordered Eating:
A Behavioral Health Issue;
Acknowledgement, Prevention, and Reform

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The Commission on Women, Children, Seniors, Equity and Opportunity

Content

WHAT ARE EATING DISORDERS (ED)?

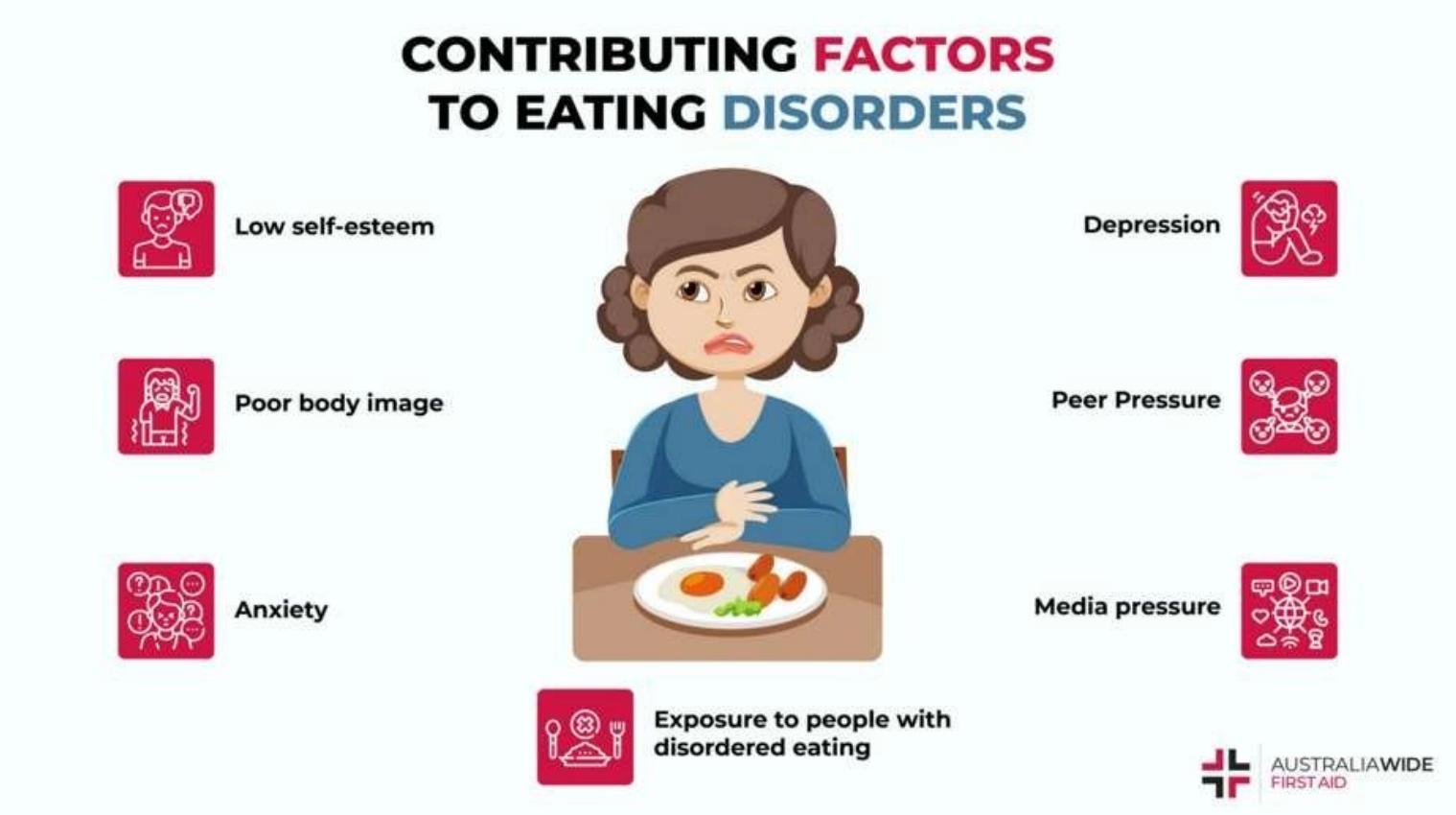
PREVALENCE AND SIGNIFICANCE OF EDs

CWCSEO LEGISLATIVE RECOMMENDATIONS

What Are Eating Disorders?

What Are Eating Disorders?

- Psychiatric illnesses characterized by **disturbances in eating behaviors and related thoughts or emotions.**
- EDs Affect **people of all ages, genders, and body sizes.**
- Can be **ego-syntonic** or **ego-dystonic.**
- Often rooted in a complex interaction of **biological, psychological, and sociocultural factors.**



This presentation includes both **diagnosed disorders** and **subclinical patterns** (e.g., chronic undereating, overeating) that signal risk or distress.

https://www.australiawidefirstaid.com.au/resources/mental-health-first-aid-for-people-with-eating-disorders

Prevalence and Significance of Eating Disorders

Prevalence and Public Health Impact

9%, or 28.8 million of the U.S. population will have an eating disorder in their lifetime. (Harvard STRIPED)

9%, or 314,495 of Connecticut residents will have an ED in their lifetime. (Harvard STRIPED)

Global Increase in Prevalence

- The global prevalence of eating disorders nearly **doubled** from **3.5% in 2000 to 7.8% in 2018**. **(**The American journal of clinical nutrition**)**
- Most EDs **begin between ages 12–25**, with a **peak onset in mid-adolescence**. (Johns Hopkins Medicine)

Prevalence and Public Health Impact

- EDs have **one of the highest mortality rates** among mental illnesses. (JAMA Psychiatry)

10,200 deaths per year as a direct result of an eating disorder

= 1 death every 52 minutes

- Other than **severe physical consequences, suicide** is also one of the leading causes of death for those diagnosed with an ED.
  - **31%** of individuals with AN, **23%** with BN, and **23%** with BED have attempted suicide. (BMC Medicine)

Additional Connecticut Data

- **Inpatient Pediatric Admissions:**

YNHCH Eating Disorders

	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025
Discharges	21	31	61	52	46	34	45
% Δ YoY		*48%*	*97%*	*-15%*	*-12%*	*-26%*	*32%*
ALOS	10.9	12.1	15.8	14.5	19.2	11.1	9.5

- **Outpatient Ambulatory Clinic:**

Pediatric Specialty Center Visits

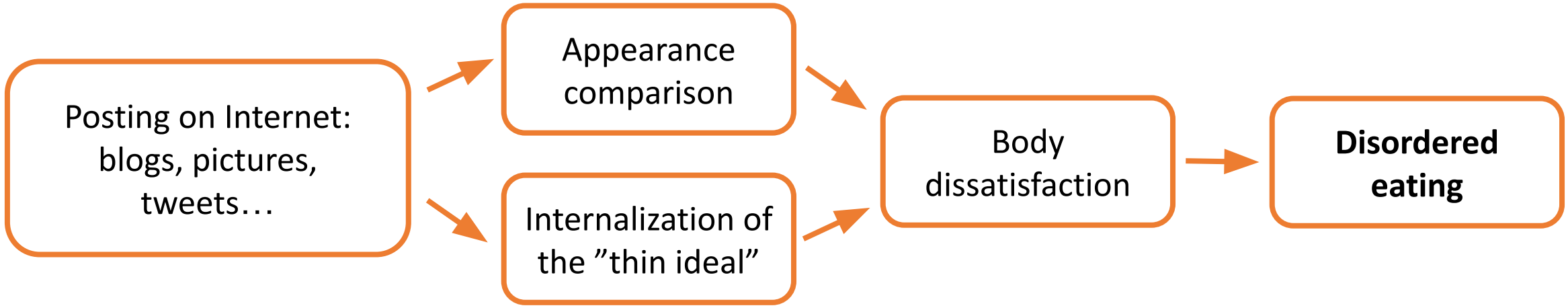
Patients with Eating Disorder (primary or secondary dx)

	FY2023	FY2024	FY2025
Unique Patients	222	253	247
Total Visits	482	577	527
Visits per Patient	2.17	2.28	2.13

(Yale Health System)

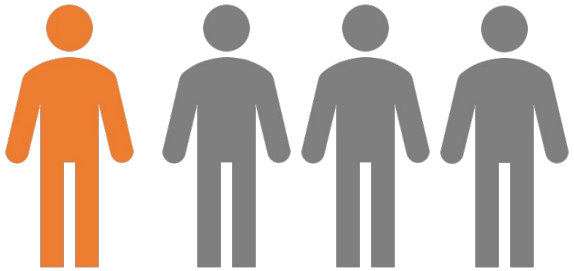
Surge in Eating Disorders

- **COVID-19 Impact**
  - **ED–related hospital admissions rose by 188%** since the pandemic onset (2.9× more than pre-COVID). (International Journal of Eating Disorders, 2022).
- **Social Media Impact**
  - Online content has been increasingly linked to **body dissatisfaction** and the **normalization of disordered eating behaviors**, especially among adolescents. (Frontiers in Psychology)
- **GLP-1 Drug Impact**
  - Psychologists have seen an increase in patients with eating disorders who are taking weight loss drugs. (NBC News)



Gender Disparities

- **Women** are about **2–3 times more likely** than men to develop an eating disorder.
- However, **males** represent up to **25% of ED cases,** and the rates are **increasing faster** than the rates for females**.** (Child and Adolescent Psychiatric Clinics of North America)



1 in 4 of those diagnosed with eating disorders are **males**

- Cases in males are frequently underdiagnosed due to **stereotypes** and **stigma**.
- **LGBTQ+ youth** are **three times more likely to have an ED** when compared to their straight peers. (Journal of Eating Disorders)

Racial Disparities

Equal or Higher Risk, Yet Lower Treatment Access

- Black, Hispanic, Asian, and Indigenous populations have **equal or elevated risk** of eating disorders.
- However, they receive **< 50% of the treatment access** of their White peers. (International Journal of Eating Disorders).

Clinician Bias in Diagnosis

- When clinicians were given the same case description of an eating disorder, diagnosis rates differed sharply by the patient's **race** (Behavior Therapy).
  - **White patient:** 44% correctly identified
  - **Hispanic patient:** 41%
  - **Black patient:** 17%

Additional Disparities

Military Populations

- **Under-reported Cases (2017-2021)**
  - In active duty, **5–8% of women and 0.1% of men** have a diagnosed ED (Military Health System).
  - Stigma, inadequate screening, and military norms that prioritize endurance and discipline contribute to widespread underrecognition and delayed treatment.
- **Broader Symptom Prevalence**
  - Up to **18.5% of women** and **8.5% of men** in a national veteran sample **screened positive** for an eating disorder (Psychological Assessment, 2021).

Socioeconomic Status

- Individuals from **lower socioeconomic backgrounds** often face:
  - Greater barriers to accessing timely and effective treatment
  - Higher risks of delayed diagnosis and more severe outcomes
  - Many families cannot afford care, especially in states **lacking insurance parity laws.**

Eating Disorders and Insurance Coverage

- **HUSKY Medicaid pays far less than private insurance**
  - CT's Medicaid program (HUSKY) reimburses behavioral-health providers **as little as 47%** of commercial plan rates. (OHS, 2024)
  - Low rates drive provider non-participation, limiting access to care.
- **Behavioral health providers undercut across the board**
  - Major commercial insurers (Anthem, Cigna, ConnectiCare, UnitedHealthcare) also pay psychiatrists, therapists, and dietitians **below other medical specialties**, disincentivizing ED care. (OHS, 2024)

Case: Denied coverage for Medical Nutrition Therapy (MNT)

- **MNT is critical** for weight restoration and medical monitoring in ED treatment.
- Despite parity laws, insurers have:
  - Denied MNT by labeling it "not a covered benefit."
  - Cap sessions (e.g., 3–6/year) even with medical-necessity documentation.
- *In contrast, conditions like diabetes often receive* ***unlimited nutritional counseling.***

H.R.1's Effect on Eating Disorders

Sections 10101–10106: SNAP Eligibility & Benefit Changes
Restricts access to SNAP benefits, increasing food insecurity, a known risk factor for disordered eating behaviors.

- **Implication:**
- Likely to increase ED vulnerability among low-income population. CT policy should build upon food insecurity screening, and formally integrate disordered eating risk questions into screening tools used in pediatric care, SBHCs, and social services (e.g., 211). Follow-up systems should ensure access to behavioral health care when risk is identified.

Section 10107: Elimination of SNAP-Ed
Ends funding for evidence-based school/community nutrition education.

- **Implication:**
- Removes a federal prevention platform, creating a messaging and education gap. CT has an opportunity to build its own ED-informed, developmentally appropriate school curriculum, emphasizing weight-neutral education and early behavioral health promotion.

Section 71120: Medicaid Cost-Sharing Exemption for MH/SUD
Exempts mental health and substance use services from required cost-sharing.

- **Implication:**
- CT should first establish a clear and consistent classification of ED care as behavioral health. This designation is a critical foundation for ensuring parity, coverage, and exemption from cost-sharing under HUSKY. Once defined, this alignment creates a pathway to expand coverage, strengthen provider access, and fill current gaps in ED treatment reimbursement.

Limited Support Services in Connecticut

Treatment Infrastructure including, but not limited to:

- **Walden Behavioral Care (Middletown, CT)**: State's only acute medical unit for eating disorders
- **Center for Discovery (Fairfield, CT)**: Leading adolescent residential program (ages 10-17)

Research Development

- **UConn EMPOWER Lab**: Emerging research initiatives
- **POWER at Yale:** Treatment studies for eating disorders

See supplemental table for additional treatment providers, telehealth services, and community-based ED support resources across Connecticut.

Behavioral Health Coverage Across States

State	Case management services	Mental health screening services	Outpatient mental health services	Partial hospitalization or day treatment services	Assertive community treatment	Psychosocial rehabilitation services	Residential services	Inpatient psychiatric treatment	Peer support	Supported employment	Skills training and development	Crisis stabilization services		
												Emergency crisis services, crisis intervention, or crisis stabilization	Mobile crisis services	Residential crisis services
Total	**46**	**51**	**51**	**44**	**41**	**43**	**28**	**51**	**42**	**25**	**34**	**46**	**35**	**29**
Alabama	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	No	No	No
Alaska	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Arizona	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Arkansas	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
California*	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No	No	Yes	No	Yes
Colorado	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Connecticut	**Yes**	**Yes**	**Yes**	**Yes**	**No**	**No**	**No**	**Yes**	**No**	**No**	**No**	**Yes**	**Yes**	**Yes**
Delaware	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No

***Source**: MACPAC, "State Coverage Policies of Mental Health Services for Adults" (2021)*

Connecticut (HUSKY): Strong outpatient and inpatient coverage, but lacks full coverage for **residential, peer-support, and rehabilitative services**.

What Can We Do in Connecticut?

- No ED-specific legislation currently exists at the state level.
- No statewide commission or working group.
- No comprehensive adolescent preventative educational programming.
- No statewide data or surveillance system.
- Limited infrastructure for clinical and community-based pre-clinical services.

CWCSEO Legislative Recommendations

A Continuum of Care for Eating Disorders

AWARENESS

PREVENTION

SCREENING / DIAGNOSIS

INTERVENTION

RECOVERY

Recommendation 1:
Expansion of Screening and Follow-up Protocol

- **Require school-based health centers** to offer an **evidence-based screening tool** to support early identification of disordered eating behaviors, and ensure **timely follow-up**. (ED)
  - Student participation on the screening would be on a voluntary basis.
  - Consider professional development and allocation of state resources.
- Strongly encourage the utilization of **evidence-based screening tools** during **annual physician visits**. Suggested amendment to Sec.19a-914, or creating a new section similar this. (PH)

Recommendation 1: Suggested Screening Guidelines

Screening Foundations

- Designed upon **validated instruments,** such as Eating Disorder Examination Questionnaire (EDE-Q).
  - Conduct in **confidential stigma-free** environments.
    - i.e., school-based health centers, annual pediatric visits.

Integration into Existing Systems

- Embed ED screening alongside other behavioral health screenings (e.g., depression [PHQ-9]).

Two-Step Screening Model

- **Step 1:** *Brief pre-screen questions* (e.g., 3-item trigger screen) → Identifies potential risk.
- **Step 2:** *Full evidence-based assessment* (e.g., EDE-Q, SCOFF) → When pre-screen indicates concern.

Follow-Up and Referral

- **Establish clear referral protocols** for at-risk youth, ensuring connection to:
  - Behavioral health specialists, trained dietitians, community-based support resources.

Recommendation 1:
Potential 3-Question Framework for Pre-Screen

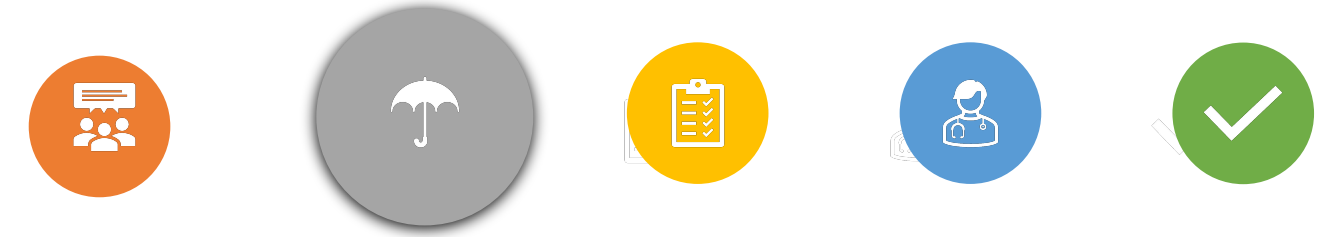
Behavioral (Action):
“Have you been skipping meals or eating much less than usual because of worries about your weight or shape?”

Cognitive (Thought):
“Do thoughts about food, weight, or body shape ever make it hard to focus on school, friends, or things you enjoy?”

Emotional (Feeling):
“In the past month, how often have you felt unhappy with your body or afraid of gaining weight?”

Recommendation 2: Youth Access to Over-The-Counter Diet Pills and Muscle-Building Supplements

Adopt modified version of the model legislation which prohibits the **retail and online sale** of over-the-counter diet pills and muscle-building supplements marketed for weight loss or muscle gain to individuals **under age 18**. (PH)



Recommendation 2:
Suggested Programming Guidelines

Ban youth sales	• **Prohibit any distribution or sales of** OTC diet pills and dietary supplements marketed for weight loss or muscle-building to individuals **under the age of 18**, including retail, online, and mail-order sales.
Limit in-store access	• Require **ID checks** when age cannot reasonably be determined before completing an in-store purchase.
Strengthen online safeguards:	• Require third-party electronic **age verification** at checkout for online sales.
Existing Model:	• Can be modeled based on STRIPED's *Out of Kids' Hands* model legislation, New York S.5863/A.5610D (effective 2024).

Recommendation 3:
School-Based Eating Disorders Prevention

Create developmentally appropriate, evidence-based **educational programming** on disordered eating behaviors as a component of middle and high school curricula. (ED)

Recommendation 3:
Suggested School-based Programming Guidelines

For Students

- Integrate eating disorder preventative education into existing health, physical education, and may be considered as part of an advisory curricula.
- **Core content areas may include:**

1. **<u>Nutrition and mental health education</u>**

2. **<u>Body image and media literacy modules</u>**
    - Based on Health at Every Size approach.
    - The course can be modeled on existing programs like *<u>The Body Project</u>*.
        - ***The Body Project*** *is an evidence-based prevention program that helps adolescents challenge unrealistic appearance ideals, reduce body dissatisfaction, and build resilience against eating disorders through interactive, peer-led discussions.*

For Educators

- Encourage **teacher and counselor training** to support early identification and destigmatized discussion

Recommendation 4:
Protections For People With An Eating Disorder

- Prohibit health insurance companies and State Medicaid from using **Body Mass Index (BMI)** to **deny or limit** eating disorder treatment coverage, and establish baseline medical necessity criteria.
  - Weight metrics may still be consider to **authorize** care, ensuring access for Anorexia Nervosa (AN) and Atypical Anorexia (AAN).
- Example legislation provided below: [SB23-176 Protections For People With An Eating Disorder | Colorado General Assembly](#) (PH)

Recommendation 4:
Proposed Evidenced-Based Criteria

- **Medical necessity** refers to the health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition in order to **attain or maintain the individual's achievable health and independent functioning**. (Section 17b-295b)

Criteria for **medical necessity and coverage** should be determined based on the individual's:

- **Eating Behaviors:** The individual's specific behavioral patterns.
- **Need for Support:** The need for supervised meals and support interventions.
- **Lab Results:** Including (but not limited to) heart rate, blood pressure, renal/cardiovascular activity.
- **Recovery Environment:** The safety and support level of the patient's living situation.
- **Co-occurring Disorders:** Any additional mental or physical health diagnoses.
- **Weight History, Suppression, and Stability**: The evaluation of weight trends over time, such as weight suppression (loss from highest historical weight), rapid fluctuations, or chronic cycling on metabolic health, irrespective of BMI.

Recommendation 4:
Suggested Programming Guidelines

Ban weight-based coverage denials:	Adopt standardized medical-necessity criteria	Transparency & Accountability	Existing Model:
• Prohibit using BMI or weight standards to **deny or limit** treatment coverage.	• Mandate that determinations adhere to **generally accepted standards of care**, including the clinical criteria defined in statute.	• Require insurers to make their criteria **publicly available** and share them with patients and providers upon request. • Consider the establishment of a **monitoring mechanism** to ensure compliance with the mandate.	• Can be modeled based on **Colorado Senate Bill 23-176 (2023)**

Recommendation 5: Allocation of State Resources

- State funding to establish **community-based, non-clinical support networks** that connect awareness, early engagement, and recovery.
  - i.e., school-based support groups (UConn S.H.A.P.E.), family support groups.
- Allocate funding to support administration of school-based screening. (PH/ED)

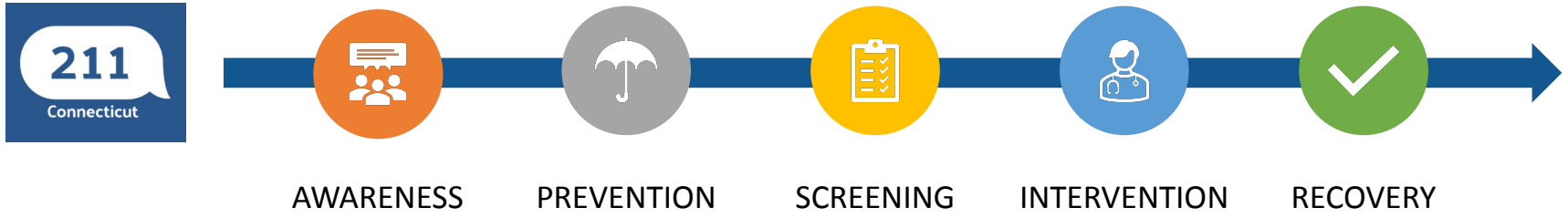
Recommendation 5:
Examples of Community-based Programs

- Serve a broad network of individuals who are **concerned** or **experiencing** disordered eating, those **in or post-recovery**, and the **caregivers, families, and educators** who supports them.
- Programs should be **low-barrier**, **inclusive**, and **welcoming**, creating environments where participants can seek connection, information, and community.
- They may include:

School-based workshops	• *e.g.,* body image, media literacy, awareness, prevention, and wellness programs
Peer-facilitated support groups	• *e.g.,* student-led wellness circles, identity-based support groups, recovery-support groups
Community drop-in spaces	• *e.g.,* public libraries, youth centers, culturally inclusive wellness hours
Referrals pathways to resources	• e.*g.,* connecting individuals toward appropriate next steps, resources, and services

Recommendation 6:
Supporting the Core Function of CT's 2-1-1 System

- Support Connecticut's 2-1-1 system, expanding access to **accurate information**, **timely referrals**, and **early identification** for eating-disorder-related concerns.
  - *Improve Categorization and Searchability*
  - *Integrate Screening in Consultations*



Recommendation 6: Suggested Programming Details

Improve Categorization and Searchability

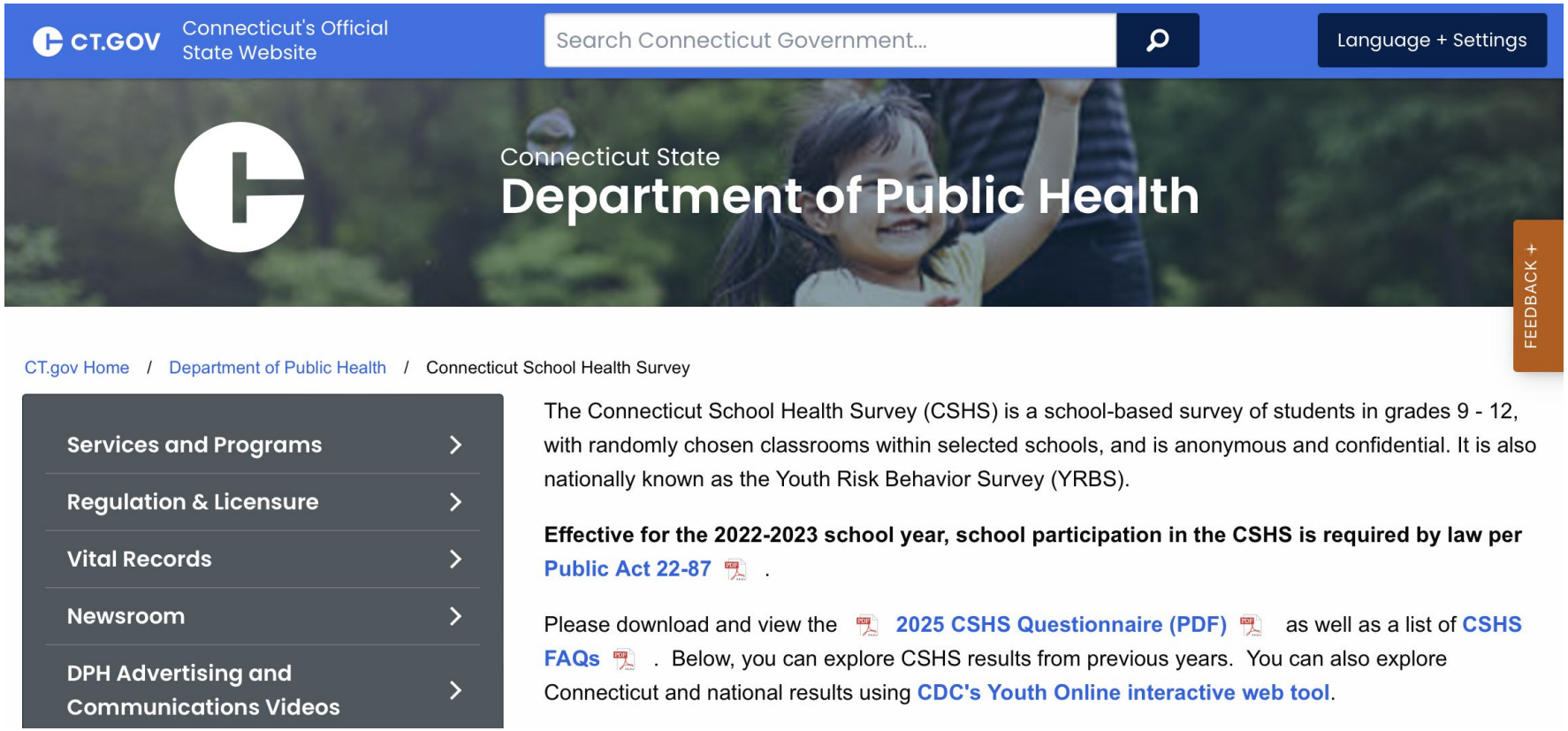
- Designate eating disorders as a recognized **behavioral health subcategory** within Connecticut's 211 directory.
- Integrate the **Statewide Eating Disorder Treatment Registry** into the 211 platform.
- Enhance discoverability by cross-listing ED under recognized subcategories like **"Mental Health" and "Youth"** for intuitive navigation.

Integrate Screening in Consultations

- Expand 211's **screening protocols** to include basic prompts or questions related to disordered eating behaviors.
- This could mirror current practices for suicide prevention or crisis risk assessments.

Recommendation 7: Inclusion in School Health Survey

- Incorporate **<u>at least one</u>** question on **disordered eating behaviors** into the behavioral health section of the **Connecticut School Health Survey (CSHS)**. (PH)



Recommendation 8: Establish a CWCSEO Eating Disorders and a Holistic Food Education Workgroup

- Establish an **Eating Disorders Workgroup** to develop a standardized approach for the early recognition, awareness, and treatment of eating disorders in children and adolescents.
  - Appointments to the workgroup not required, but recommendations are encouraged, and all meetings are open to the public.
    - Among various responsibilities this workgroup would create a **statewide eating-disorder treatment registry** and strongly consider facility standards. (PH)
- Establish a **Holistic Food Education Workgroup** to develop a statewide food education roadmap, a model school nutrition education policy, and model curricula/lesson plans. (ED/PH)

Recommendation 8:
Proposed Workgroup Responsibilities

Subcommittee responsibilities may include:

- **Identify** existing barriers to early detection, diagnosis, and treatment.
- **Develop** statewide recommendations and best-practice guidelines for early identification, coordinated treatment, and age-appropriate education of eating disorders.
- **Review** existing screening tools, education curricula, and district compliance.
- **Create** educational and outreach materials for schools, families, providers.
- **Promote** public awareness and prevention campaigns.
- **Explore** the development of a statewide eating-disorder treatment registry and facility standards, and work with children's hospitals and treatment centers in the state to maximize clinical capacity.
- **Facilitate** collaboration across behavioral-health coalitions and state agencies.

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Thank you, and we look forward to any questions and feedback!

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