NSW Eating Disorders Forum 2016

Setting up a treatment team for eating disorders in the community:
Requirements and considerations

Cathy Anderson
Senior Psychologist
Illawarra Eating Disorders Service
Illawarra Shoalhaven LHD

Megan Lorimer
Dietitian
Shoalhaven Eating Behaviour Service
South Eastern Sydney LHD

Emma Kerr
Clinical Psychologist
START, Adult Community Mental Health
South Eastern Sydney LHD

NSW Health | NSW Health Illawarra Shoalhaven Local Health District | cedd centre for eating & dieting disorders

Why set up a team?

'Appropriate support and treatment ***reduces*** suffering, illness duration and burden on families and carers, as well as morbidity and ***mortality***'.
(NSW Service Plan for People with Eating Disorders 2013-2018)

A team approach is the recommended model of care

- psychological and medical risk
- clinician confidence
- prevents clients falling through the gaps
- clinician anxiety
- resistance to treatment

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Challenges in working with EDs across the spectrum

- Secrecy aids the ED – building trust
- ED's are functional – why would they want to give up something that is helping to meet their needs?
- Medical risk – but wait I'm just a community-based clinician!
- Changing intensity of treatment – what do you mean there are no beds?!
- Length of time to treat – no we cant get this done in 6 sessions
- Co-morbid diagnoses – isn't this just a "straight eating disorder"?
- Families – they aren't all the same…
- Age range – I thought this was just a teenage thing?!
- Cognitive capacity – but she is an intelligent girl!

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What clients are we talking about?

pre-diagnostic 'disordered eating' body image concerns — **clinically diagnosable eating disorder** — **severe and enduring**

Eating disorders are not just anorexia nervosa (also BED, BN, + others)

- often not under-weight (screen *anyone* you have concerns about eating!)
- co-morbidity is usually the rule not the exception
- males and females
- individual and family therapy
- all ages

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Setting Up a Team

Picture credit: vator.tv

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Identify Team Members

Basic core community team
at a minimum mental health and medical input is required

- GP
- psychologist
- case coordinator (not always necessarily psych– may be a nurse, mental health clinician,etc)

Although not essential, from our experience, inclusion of a dietitian as part of the core team significantly enhances the effectiveness of treatment.

Commonly required extended team clinicians
dietitian, psychiatrist, paediatrician, ED coordinator

Possible extensions of team
emergency department, Consult Liaison Psychiatry, inpatient staff, social worker, guardianship tribunal, tertiary/outreach services

Peripheral team that needs to have awareness of policies/protocols/patient group
clinicians at *access* points to treatment (e.g. SMHTAL staff, ACT, triage staff)

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Other points to Consider…

When incorporating eating disorder clients into a caseload, take into account

- the significant role that the 'primary clinician' will play
- the time required for care planning and coordination
- which therapies will be provided (individual, family therapy, group)
- referral/wait list management
- what are the different roles of each of the team members
- who will weigh the client

Photo credit: clo

Essential components for delivery of treatment

Develop strong relationships

- within team and with client

Ensure that everyone is on the same page

- clear understanding of role in team
- establishment of non-negotiables
- good communication

Identify training needs

- who needs what

Establish supervision

- consider different options

Regular clinical review

Setting Up Service Processes

Photo credit: evoasys.biz

Therapy modalities

Determined by staff experience, training/willingness and support at a service level

- individual Tx (supportive psychotherapy, case coordination, motivational interviewing, specialist treatment – CBT-E, FBT)
- Maudsley FBT
- treatment groups (binge-eating/bulimia)
- carer's groups
- CBT - guided self help

Therapy practicalities/requirements

- scales, stadiometer, family meals, FBT counselling room

Referral and Triage Process

Define appropriate treatment setting

- community treatment – is it right for them?
- proximity to other state services

Identify access points

- How would they come into your service
- how they would be referred to you

Be mindful that the treatment process starts with the referral.
The majority of clients are ambivalent about treatment (average 4 years from symptom onset to presentation to treatment if at all) and so need to be treated sensitively at every step of process.

Initial triage/ first point of contact

- weight
- recent weight changes
- recent significant change in oral intake
- current fluid intake
- GP involvement

A qualitative analysis (Leavey et al. 2011) looking at psychosocial *barriers to engaging* with an eating disorders service suggested:

Quicker appointments and personal contact may assist in diminishing the barriers established through previous negative experiences (mistrust, fear of abandonment).

Photo credit: pixabay.com

Eating Disorders Specific Triage

1. Ensure that the treatment that your community setting is delivering is the treatment that they are looking for, and the most appropriate treatment option for their state of physical and mental health.
2. Ensure that the client is safe for treatment in the community setting:
   - suicide and self harm risk assessment.
   - BMI and weight history.
   - ensure that they are receiving regular medical monitoring, including monitoring of physical indicators for hospital admission.
3. Recommending alternative options as indicated (eg. public/private clinicians, Headspace, Day Program, inpatient) Be aware of what other services available in you area!

Waiting List Management

"In some countries it is not uncommon for patients to have to wait a considerable time before starting treatment."
Fairburn, Cognitive Behaviour Therapy and Eating Disorders

And this is where the "team" kicks into gear

- GP (medical management)
- psychiatry (medication management, and co-morbidities)
- private treatment providers (psychological/dietetics)

Managing risk
Psychiatric *and* medical parameters

1. Mental health – DSH, suicidality (same as normal – assess and monitor). Be aware of high suicide risk in this population.
2. Medical risk – for normal and underweight patients

   Initial assessment (to determine laxative use, purging frequency, risk of re-feeding, rapid weight loss)
   - **Initial GP assessment and ongoing medical monitoring**
   - Staff are trained to understand warning signs + risk around re-feeding syndrome
   - Discuss escalation/emergency plan (i.e. present to Emergency Department if needed)

Create clear protocols for staff to follow.

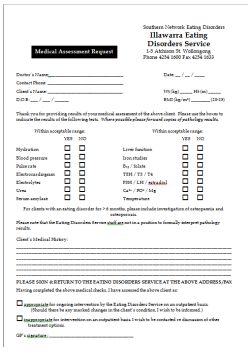
Mandatory GP monitoring

- at commencement of treatment and regular ongoing
  - frequency determined by GP
  - when acutely indicated
- send GP a medical assessment request and consent proforma
- provide link/s re management of ED's
- establish a communication plan with GP
  eg. 13 weekly reviews, and request they let you know if concerning results
- there are further GP and medico-specific guidelines available on the CEDD website (e.g. QLD GP guidelines)

http://cedd.org.au/health-professionals/test-health-professionals-clinical-resources-tools/developing-services/policy-protocol-guidelines/

"Well, yes, we could fix it in Photoshop, but your arm would still be broken."

An example of one of our GP proformas



Southern Network Eating Disorders
Illawarra Eating Disorders Service
1-5 Addison St Wollongong
Phone 4254 1650 Fax 4254 1653

Medical Assessment Request

Doctor's Name:_____ Date: __ / __ / ____
Contact Phone: _____
Client's Name: _____ Wt (kg) _____ Ht (m) _____
D.O.B: __ / __ / ____ BMI (kg/m²) _____ (19-24)

Thank you for providing results of your medical assessment of the above client. Please use the boxes to indicate the results of the following tests. Where possible please forward copies of pathology results.

	Within acceptable range YES	NO		Within acceptable range YES	NO
Hydration	☐	☐	Liver function	☐	☐
Blood pressure	☐	☐	Iron studies	☐	☐
Pulse rate	☐	☐	B_{12} / folate	☐	☐
Electrocardiogram	☐	☐	TSH / T3 / T4	☐	☐
Electrolytes	☐	☐	FSH / LH / oestradiol	☐	☐
Urea	☐	☐	Ca^{++} / PO^{-} / Mg	☐	☐
Serum amylase	☐	☐	Temperature	☐	☐

For clients with an eating disorder for > 6 months, please include investigation of osteopenia and osteoporosis.

Please note that the Eating Disorders Service shall not be in a position to formally interpret pathology results.

Client's Medical History:

_____
_____
_____
_____

PLEASE SIGN & RETURN TO THE EATING DISORDERS SERVICE AT THE ABOVE ADDRESS/FAX
Having completed the above medical checks, I have assessed the above client as:

☐ appropriate for ongoing intervention by the Eating Disorders Service on an outpatient basis. (Should there be any marked changes in the client's condition, I wish to be informed.)

☐ inappropriate for intervention on an outpatient basis. I wish to be contacted re discussion of other treatment options.

GP's signature: _____

Treatment structure at Illawarra Shoalhaven LHD

SMHTAL triage

↓

ED specific triage by service → Referred elsewhere

↓

Assessment and Care Plan/Goals

↓

Commence treatment

↓

13 week reviews with client

Clinical review

- Illawarra Shoalhaven LHD have established a 30 minute weekly clinical review session by teleconference between team members including psychiatrist
- discussion re cases and treatment plans
  - post client 'pathways' appointment/triage
  - at 13 week review
  - at discharge
  - (optional) as required for clinical issue

Treatment transition – local inpatient admission

Admission to a general medical ward is

- often due to low BMI, poor intake, and risk of refeeding syndrome
- for the purpose of medical stabilisation and regain of weight to a safe range to continue community treatment
- not for the purpose of treating the eating disorder
- an expectation of the NSW State Plan for Eating Disorders

Often there is limited experience with and knowledge regarding ED treatment on the ward.

Admissions are commonly to general medical wards.

Your LHD ED Coordinator can assist with supporting inpatient staff and is a point of contact for further information about referral pathways.

Setting Up Treatment

With
established parameters,
and having built a relationship that engenders
trust and confidence,
clinicians can follow-through
with tough but essential decisions.

Engaging Clients

Engaging Clients

- High degree of ambivalence
  - egosyntonic illness because patients experience their symptoms as congruent with their own values.
- Increasing the patient's knowledge of disease and therapy.
- History of traumatic experiences are common and will need to feel safe to return, therefore, professionals conducting the initial assessment must show genuine interest, trustworthiness and care.

Picture credit: Creativetherapyuk.com

Our experience in the community…

- aim to see the new clients within 3 weeks of referral for more detailed ED triage
- Increases engagement and return rate even when they have to wait for treatment

Treatment: general principles for all EDs

1. Person-centred informed decision-making
2. Involving family and significant others
3. Recovery-oriented practice
4. Least restrictive treatment context
5. Multi-disciplinary approach
6. Stepped and seamless care
7. A dimensional and culturally informed approach to diagnosis and treatment

Taken from the ANZCP Guidelines, 2014

Working collaboratively and transparently with clients & families

Consent and contacts

- obtain signed consent to liaise with any current or recent clinicians/treatment settings involved in treatment
- adults – obtain nominated emergency contact person

Treatment timeframes

- explain treatment processes and timeframes for review

Treatment goals

- collaboratively set treatment goals
- a useful tool to refer back to at 13 week review

A word on Communication

When a patient is managed by an interdisciplinary team in an outpatient setting, communication among the professionals is essential to monitoring the patient's progress, making necessary adjustments to the treatment plan, and delineating the specific roles and tasks of each team member.
(Yager et 2006)

Managing anxiety (clients and staff!)

Anxiety is a core feature of ED's.

Anxiety drives patient responses/behaviour
- rumination
- bargaining

Essentially exposure therapy becomes part of treatment – and clinicians need to be able to tolerate a significant amount of their clients' distress.

Clinicians will require skills in managing and tolerating distress, and in turn can teach these to the client, and/or serve as reminders to each other in the team.

Solution = Non-Negotiables (Josie Gellar)

- sound rationale : understanding the need for, and function of, NN's
- consistently implemented: can the team reasonably be expected to be able to follow through?
- Designed to not take the client by surprise
- collaborative and respectful and details what is expected of them
- maximise client autonomy : it provides opportunity for change

Delivery = collaborative rather than directive approach

Picture credit: Keepcalm-o-matic.co.uk

Supervision

- Risk
- Complexity
- Transference/countertransference
- Effective treatment
- Maintaining hope
- Clinician reflection
- Clinician wellbeing

Clinician survival

It is important to keep talking about these clients with other clinicians who understand the magnitude of what you are doing when you treat these clients (effort, time and worry).

Supervision is essential.

Picture credit: Novotorium.com

Knowing Your Resources

Clinicians

Your local LHD ED Clinical Coordinator
NSW Centre for Eating and Dieting Disorders (CEDD)
Australia and New Zealand Academy of Eating Disorders (ANZAED)
National Eating Disorders Collaboration (NEDC)
Centre for Clinical Innovations (CCI)
Dietitians Association of Australia (DAA)

Clients

Butterfly Foundation
Centre for Clinical Innovations (CCI)
Maudsley Parents

Useful websites

www.thebutterflyfoundation.org.au – The Butterfly Foundation
www.cedd.org.au - Centre for Eating and Dieting Disorders
www.nedc.com.au - National Collaboration for Eating Disorders

References

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* **Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders.** Phillipa Hay1,2,3, David Chinn1,4, David Forbes1,5, Sloane Madden1,6, Richard Newton1,7, Lois Sugenor1,8, Stephen Touyz1,9 and Warren Ward1,10 . *Australian & New Zealand Journal of Psychiatry* . 2014, Vol. 48(11) 1–62

* **National Collaborating Centre for Mental Health (NICE). (2004).** Eating disorders, core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders, London: National Institute for Clinical Excellence

* **Paying the Price: the economic and social impact of eating disorders in Australia (Deloitte Access Economics, 2012)**