Guide to Eating Disorder Recovery/Treatment Care Team Planning

- *For clinicians working with clients with Anorexia Nervosa and other severe eating disorder presentations*
- *To be used after assessment and discussion with client and/or family about their view of what will help and available treatment options*
- *Treatment is client-centred, outcome focussed, evidence-based*

- **Recovery/Treatment requires both mental health & medical treatment provided by a care team working collaboratively**
- **Out-patient treatment is the primary context for eating disorder recovery, with in-patient admission used primarily for medical emergency resuscitation and at times, for weight restoration and behaviour change.**
- **Therapeutic alliance and client/family involvement in care team planning are important**

1. Indicate Client's Recovery/Treatment requirements:

- ☐ Regular medical monitoring
- ☐ Structured eating disorder treatment intervention
- ☐ Care co-ordination & general support
- ☐ Care team leadership
- ☐ Medical in-patient admission criteria & plan
- ☐ Criteria for psychiatric in-patient admission & plan
- ☐ Risk & safety plan
- ☐ Help with other problems eg: BPD, school refusal, self-harm
- ☐ Medication support & review
- ☐ Family / carer / partner involvement
- ☐ Systemic interventions & support e.g: school, employment, social connection
- ☐ Other

2. Build the Care Team – *with parsimony – make team as small as possible to do what needs doing. Consider who has/will have the primary therapeutic alliance with the client. The simplest team is mental health worker and GP.*

Mental Health		
Treatment	**Clinician/Service**	**Contact**
Medical		
Treatment	**Clinician/Service**	**Contact**

Note: - Medical safety management in the community
GP Role:

- Provides regular medical monitoring (vital signs, hydration, weight, Δ weight, electrolytes, cardiac function) (frequency of review dependent on clinical presentation).
- Communicates with client, carer & team re medical status. Recommends & arranges for assessment at Emergency Department and/or medical inpatient admission if indicated

Client / carer / non-medical team member role in community medical management:
Client will attend GP appointments and medical reviews as recommended by GP
If client or others observe:

- Dizziness & fainting
- Weakness eg inability to rise from a sitting or lying position
- Minimal food intake for >3 – 5 days
- Minimal fluid intake> 48hrs
- Escalation of other eating disorder behaviours (vomiting / laxative use / physical activity)

Client will seek medical review on the same day, either from the (regular) GP or at Emergency Department. Team members may need to ensure client's compliance with this, including arranging urgent transport via family, ambulance, CAT team assessment or police

3. Build a communication plan - *A meeting of the care team (preferably at least one initial meeting face to face) and then ongoing communication about progress is needed to achieve a shared view of the client's situation and a shared plan. Email trees work well. Client and family are part of the care team, though there may be meetings of the clinicians without client and family as necessary. It is necessary to have a care team leader who facilitates communication, monitors progress, calls meetings etc. The care team leader helps the team develop a* ***hopeful, purposeful and specific view of how treatment/recovery will work*** *over the next time period, team roles, and a review date. The care team leader will usually be the mental health worker.*

Care team Leadership & Coordination	Facilitate communication; ensure clear plan & review; monitor progress. Help engender a hopeful & purposeful team view & plan Call crisis meetings if needed	*Who?*
First meeting	Develop shared view, plan & review date including client & family	*When? Where? Who?*
Ongoing communications	Facilitate communication; ensure clear shared plan & regular review	*How?*

4. Build a one-page shared care plan:

- **based on client outcomes**
- **with clear actions and care team roles**
- **and a review date.**

Preferably developed at, and circulated after, the first care team meeting.

Services have their own treatment planning forms, often complex and not easily navigated by clinicians outside the service or by clients and families. A useful care team tool is a short, basic recovery/treatment plan in inclusive language which is shared by all team members. For example:

Summary of Care Team Meeting and Plan for:
Name:
Date
Place

Present:

Current situation:
Brief summary of team's shared view of client's current situation

Aims:
Brief summary of team's shared view of what to address over the next time period (eg: 3 months)

Plan:
What will we do and who will do it? A list of actions and who will do them. May include in-patient admission criteria.

Review Date:

5. Build an admission plan, if indicated

Admission may be in:

- ***Acute Medical Unit:*** *Goal – medical stabilisation. (See clinical indicators for medical admissions – Adults & Child / Youth, below)*

- ***Eating Disorder Specialist bed*** *– Goals developed by in-patient team, preferably in consultation with out-patient team. May include: weight restoration, reduction in eating disorder behaviours eg: dietary restriction, binge-eating, purging (laxative misuse & / or self-induced vomiting), and excessive/compulsive exercise. Goals for inpatient admissions may also include review of medication and diagnostic clarification in complex cases. Specialist wards provide a containing, structured, intensive meal support environment and often offer group work eg: psycho-education, goals, emotional self-management. An admission to an eating disorder specialist bed can be a planned and agreed component of treatment where a more intense level of treatment is needed.*

- ***Acute Psychiatric Unit****- Goals developed by in-patient team preferably in consultation with out-patient team. They may include those above. Often clients have other psychiatric problems and/risks. Psychiatric wards vary widely in their accessibility for, and role with clients with eating disorders.*

Admission Plan for Eating Disorders

Problem / risk:

Medical risk – specify:

Eg: Client experiences food and fluid restriction behaviour, underweight/malnutrition, ongoing weight loss, self-induced vomiting, laxative misuse & risky exercise behaviours as symptoms of an eating disorder. These behaviours can result in medical instability and electrolyte disturbance which require inpatient medical treatment to manage and resolve.

Eating Disorder Behaviours – specify:

Eg: Client's eating disorder behaviours are escalating and exposing client to risk not manageable in the community; client & team are seeking intensive support & containment for escalating eating disorder behaviours

Eg: Client is unable to eat enough to gain weight as specified in treatment/recovery plan; client & team seeking more intensive support for weight restoration

Psychiatric risk - specify

Eg: Clients level of risk (of eg DSH, suicide) is considered too high to be managed in the community

Criteria for admission

Specify the medical, eating behaviour or psychiatric risk parameters which will trigger assessment for admission

Contact

Site for admission and contact details

Communication

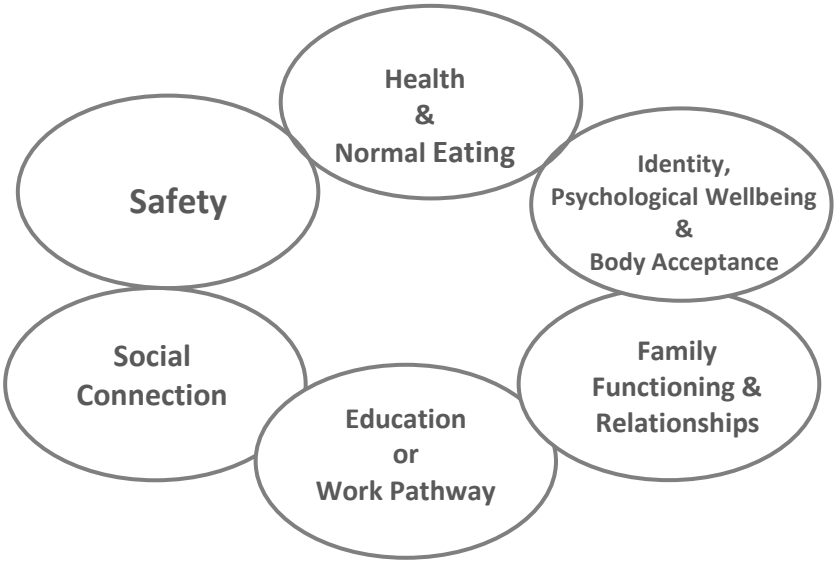
Copy of plan lodged with Emergency department / ED psych liaison etc

Agreement from all services & service elements involved

Broad Guide to Evidence-based Structured Eating Disorder Interventions	
Client with ED	**Recommended Structured Eating Disorder Treatment**
< 18 years	• Family-Based Treatment (FBT)(Maudsley model); in exceptional circumstances consider individual therapy or a day program
> 18 years	• Cognitive Behavioural Therapy for Eating Disorders (CBT-E) or other intervention which targets the eating behaviour directly eg: Specialist Supportive Clinical Management (SSCM) • Motivational interviewing is often a component of treatment • Interpersonal models, ACT, DBT also used • Day programs used to increase treatment intensity.
	• Guided self-help an option for Bulimia and Binge Eating Disorder
> 8 – 10years chronicity of disorder & several previous treatment/ recovery attempts	• Psychosocial support for quality of life and harm minimisation and may be the client's choice • If active treatment is the client's choice, as above

Example Eating Disorders Recovery Goals & Tasks

Eating Disorders – Recovery Domains



Restore Safety
- Medical monitoring
- Develop Crisis plan (medical & psychiatric) & service pathway
- Psycho-education

Restore Health & Normal Eating
- Weight gain or stabilisation, growth
- Normalise variety, pattern & social elements of eating
- Normalise physical activity

Restore Identity & Body Acceptance
- Explore the meaning & function of the ED
- Explore & validate the person's concerns & worries about weight & shape
- Help the person see themselves as separate from the ED
- Encourage body acceptance & strengthen other domains of the 'self'
- Provide emotional regulation & expression skills
- Address any other traumas or interpersonal issues that help maintain the eating disorder

Restore Family Functioning & Relationships
- Explore impact of the ED on Family members
- Explore family and friends capacity as a resource for treatment
- In adolescents - empower the parent's to re-feed their child as per the FBT approach
- Strengthen family relationships
- Psycho-education

Restore Education & Work Path
- Work with school / workplace

Restore Social Connection
- Create & foster a social network to support the person during recovery
- Support long term social connection
- Strengthen existing or create new recreational interests

Admission Planning for Eating Disorders

Risk state / behaviour:	Context / treatment setting	Possible admission treatment goals
Medical risk		
Medical instability related to underweight & protein-energy malnutrition (dietary restriction; dietary restriction + excessive physical activity other ED behaviours)	Acute medical admission Or integrated medical-psychiatric bed	Medical resuscitation & nutrition rehabilitation (partial weight restoration); Prevention & management of risk of re-feeding syndrome
Electrolyte disturbance related to purging behaviours (specify si vomiting; laxative misuse)	Acute medical admission Or integrated medical-psychiatric bed	Stabilisation / Normalisation of electrolytes
Eating disorder behaviours /maintaining factors		
Underweight / malnutrition & dietary restriction	Specialist eating disorder bed or Day program or Acute psychiatric unit Or integrated medical-psychiatric bed	Planned program to restore weight & health & reduce cognitive / psychological impact of starvation
ED behaviours (specify – restriction, binge-eating, si vomiting, laxative misuse; excess/compulsive exercise, other) – client & team seeking planned admission for intense support to reduce	Specialist eating disorder bed or Day Program or Acute psychiatric unit	Planned intensive, supportive exposure & response prevention program targeting specific ED behaviours
Risky Escalation in ED behaviours (specify – restriction, binge-eating, si vomiting, laxative misuse; excess/compulsive exercise, other) requiring acute containment	Specialist eating disorder bed or Acute psychiatric unit	Intensive containment of eating disorder behaviours to interrupt cycle of escalation in behaviours
Psychiatric risk		
Suicidal behaviour, DSH requiring acute containment	Acute psychiatric unit	
Severe psychiatric symptoms requiring inpatient assessment / review	Acute psychiatric unit	

Clinical indicators for inpatient medical treatment: Adult (from Nice guidelines 2004)

Clinical parameter	Medical admission indicated
Systolic BP	<80 mmHg
Postural BP	>20 mmHg drop with standing
Heart rate	≤40 bpm or > 120 bpm or postural tachycardia > 20/min
Temp	<35^{0}C or cold/blue extremities
Weight	BMI <13 or ongoing weight loss > 1kg / wk for several weeks
12-lead ECG	Any arrhythmia, including QTc prolongation, non-specific ST or T-wave changes including inversion or biphasic waves
Blood sugar	< 2.5 mmol/L
Sodium	<125 mmol/L
Potassium	<3.0 mmol/L
Magnesium	Below normal range
Phosphate	Below normal range
eGFR	<60ml/min/1.73m2 or rapidly dropping (25% drop within a week)
Albumin	<30 g/L
Liver enzymes	Markedly elevated (AST or ALD >500)*
Neutrophils	<1.0 x 109/L

Clinical indicators for inpatient medical treatment: Child/Youth

Clinical parameter	Medical Admission Indicated
Heart rate	< 50bpm Postural changes > 30 bpm
Postural BP changes	Orthostatic change in systolic pressure > 20mmHg between lying & standing
Core body temperature	< 35.5^{0}C
ECG	QT changes arrhythmias
biochemistry	K^+ < 3.0mmol/l
Hydration, perfusion	Dehydration Poor peripheral perfusion
Weight & BMI	prior weight loss + ongoing weight loss > 0.5kg for ≥ 2 weeks % median BMI (mBMI) <70%; >15% loss of body weight Ongoing weight loss & < 3rd percentile BMI

Easy to Find Case Management Resources		
Identification of eating disorders	**Screening information & screening tools**	• MHFA: eating disorders first aid: https://www.mhfa.com.au/cms/wp-content/uploads/2013/08/MHFA_eatdis_guidelines_A4_2013.pdf • SCOFF
Assessment & treatment planning	**Assessment tools** **Assessment checklists** **Treatment planning templates**	• Victorian Centre of Excellence in Eating Disorders: http://ceed.org.au/clinical-resources/
Medical risk management	**Medical risk assessment & management guides** **Medical risk indication guide for mental health clinicians** **Medical crisis plan template**	• Victorian Centre of Excellence in Eating Disorders: http://ceed.org.au/clinical-resources/ • http://www.health.nsw.gov.au/mhdao/publications/Publications/service-plan-eating-disorders-2013-2018.pdf
Resources for GPs	**GP guides**	• http://eda.org.au/wp-content/uploads/Complete-GP-Information-Kit-2013.pdf
Treatment tools & resources	**Weight monitoring chart (suitable for CBT-E & FBT)** **Nutrition guide for weight recovery in AN**	• Victorian Centre of Excellence in Eating Disorders: http://ceed.org.au/clinical-resources/
Professional development	**CEED Online training** **CEED advanced eating disorders training: CBT-E & FBT**	• http://ceed.org.au/training/eating-disorders-online-learning-program-for-health-professionals/ • http://ceed.org.au/training/cbt-e-cognitive-behaviour-therapy-eating-disorders-3/ • http://ceed.org.au/training/family-based-treatment-adolescents-anorexia-nervosa-2/