WA Eating Disorders Outreach & Consultation Service (WAEDOCS)

Eating Disorders: the Management of Youth and Adults - a Quick Reference Guide

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Introduction

WAEDOCS provides a consultation service for clinicians throughout Western Australia (WA), to build capacity in the identification, assessment and best-practice management of youth (aged ≥16) and adults presenting with an eating disorder.

In the absence of specialist eating disorder beds or day programme in the public sector in WA, WAEDOCS has created this Quick Reference Guide to provide health professionals with a guide to manage the needs of youth and adults presenting with an eating disorder.

Uses and limitations of WAEDOCS clinical guidelines

Evidence based guidelines are not a substitute for professional knowledge and should always be used in conjunction with good clinical judgement.

Guidelines can be limited in their applicability by a number of different factors: the lack of high quality research and the generalisability of research findings, and the uniqueness of individual patients.

These guidelines are designed predominantly for those eating disorders associated with severe malnutrition most typically Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Eating Disorders Not otherwise Specified (EDNOS. For support relating to Binge Eating Disorder (BED) or for further information regarding the management of eating disorders please contact WAEDOCS on: 1300 620 208 or emailing: waedocs@health.wa.gov.au

Background

Increasingly eating disorders are understood as neurobiological disorders, whose aetiology and treatment sit at the interface of physical and mental health care. Emerging evidence suggests early intervention, including assertive nutritional rehabilitation and structured psychological support with a multidisciplinary plan for relapse prevention are crucial for improving prognosis.

Severe malnutrition and “starvation syndrome” (1) can be experienced in people at any weight, resulting in physical and cognitive effects including poor insight regarding nutritional and medical risk. Severely malnourished individuals are unlikely to be able to reverse starvation on their own.

People with high risk medical complications or recurrent presentations may require inpatient admission to enable nutritional rehabilitation/weight gain to a level sufficient for brain recovery from malnutrition. Otherwise this will continue to drive eating disorder cognitions and impair engagement with psychological treatments, perpetuating the cycle of weight loss and readmission. **“Discharge from hospital should only occur when the person is medically stabilised, has had enough nutrition to reverse any cognitive effects of starvation so that she or he can benefit from outpatient or day patient psychotherapy (often several weeks of nutrition are required to achieve this)”** (RANZCP; 2). Access in Perth to public psychological services and the private day program for people with eating disorders requires an individual to safely sustain a BMI >16 kg/m^2, and BMI ≥17kg/m^2 is associated with improved ability to benefit from outpatient treatment (3).

Treating Eating Disorders / Disordered Eating: The Big Picture

This Quick Reference Guide is relevant for the treatment of eating disorders in any setting, addressing both the medical and psychological components of the illness.

The following steps are relevant in all settings:

1. **Identification of the illness and assessment of risk**
   It is important to conduct a thorough assessment of the medical and psychological factors that may be affecting the person.

2. **Medical monitoring and multi-disciplinary team (MDT) management**
   This is to ensure safety and contain compensatory behaviours.

3. **Reversing starvation (physical and psychological effects)**
   Starvation results in impaired insight and decision-making related to self-assessment of risk (see page 9 and 14)

4. **Normalising eating**
   The normalisation of eating requires support and repeated exposure to normal adequate eating, sufficient to improve and maintain nutrition.

5. **Psychological support**
   Providing the person with psychoeducation helps them understand the risks associated with their illness and validates their distress. Psychotherapy helps them develop healthier strategies for managing stress and resist future urges to engage in disordered behaviours.

6. **Discharge/transfer planning and relapse prevention**
   Collaborative multi-disciplinary planning recognises the need for developing strategies to manage the eating disorder outside of structured care and assertive facilitation of early readmission to reduce time spent in starvation.

1. Identification of Illness & Assessment of Risk

Medical complications can be due to both the amount and rapidity of the weight loss and the compensatory behaviours used (e.g., vomiting, laxative and diuretic abuse, and driven exercise).

Psychiatric co-morbidities include severe anxiety, obsessive compulsive disorder, depression, deliberate self-harm and suicidal ideation.

Medical Instability: Why BMI should never be the sole determinant

- Many people with severe malnutrition/purging present in a compensated state and may not exhibit the full extent of their medical instability at the point of initial presentation. With increased caloric intake and increase in weight/BMI they may become more unstable in the first days/weeks of an admission.
- Some people may present in the “healthy” weight range but be severely medically compromised if they have fasted for a long period and/or lost a large amount of weight within a short time. They may exhibit other cognitive features of eating disorders, including distorted body image and fear of weight gain.
- Because of the intense fear of weight regain, patients may modify their weight/height measurement, which can result in an artificially high BMI.
- Malnourished people may be fearful about engaging in treatment and may be inaccurate in their self-reporting. Risk assessment and treatment decisions should be informed by medical parameters and not solely on the patient’s account. Family members/carers and the patient’s GP/psychologist may provide a more objective picture of symptoms and behaviours.
- The biggest risk is unintentional death due to starvation or purging. The patient **can feel fine and have normal bloods just before sudden death** due to arrhythmia.

Assessing Risk in a Person with an Eating Disorder

- It is useful to ask questions which may reveal current behaviours and cognitions associated with disordered eating, as well as physical symptoms and psychiatric concerns.
- It is important to recognise, however, that people with eating disorders tend to have both an impaired ability to self-assess risk and an intense fear of losing control/ gaining weight. This can result in ambivalence about seeking care. Education from health professionals about the health risks of eating disorders can challenge patients’ cognitive distortions and facilitate engagement with care.
- It is important to screen for restrictive eating and recent weight loss at all weights, since even a 5% weight loss, combined with cognitive concerns, may reflect a clinically significant eating disorder (3).
- Family members/carers should be involved at assessment when possible. Careful listening to them may offer vital information/history that the patient has not disclosed, or that provides a perspective different from that which the patient has given.

A comprehensive patient assessment should include:

Weight: Current BMI: formally measured (not self-reported) height and weight (patient should be weighed in gown); highest and lowest weight since the age of 16 and weight trajectory.

Weight loss: Duration, amount, means (dietary restriction, vomiting, laxative and diuretic abuse, excessive exercise).

Recent nutritional intake: Ask in detail for intake over the past two weeks.

History of presenting illness: And any precipitants, including previous eating disorder history.

Cognitive features: Fear of weight gain, body image distortion, denial of the seriousness of the condition, rigid rules about food/eating.

Hormone functioning: In females, age at menarche and any amenorrhoea; in males, sexual desire and performance

Co-morbid conditions: Medical, psychiatric including suicidal ideation or deliberate self-harm.

Family functioning: Support systems (or lack thereof).

Physical and health assessment: see indicators below to determine need for admission.

Indicators for Admission – if patient meets any of the following criteria:

Criteria below are adapted from the RANZCP (2014) and NSW (2014) Guidelines (4,5).

Note: RANZCP guidelines specify criteria for settings of care. WAEDOCS has decided to identify these indicators as general criteria for admission, given the potential for inaccuracy of weight at initial admission, risk of clinical deterioration on refeeding and the variability of medical support to mental health settings across WA.

Patients who are not as unwell as indicated here may still require admission ***If in doubt, consider liaison with WAEDOCS regarding appropriate setting of care.***

Rapid weight loss, low weight	• Loss of >1 kg/week over several weeks **OR** • Grossly inadequate nutritional intake (<1000kcal daily) for > 2 days **OR** • BMI < 14kg/m^2 (*for ages 16-18: admit if <75%-85% ideal body weight, i.e., approximately BMI 16 kg/m^2 for a 16 year old)*
Purging	Daily (uncontrolled; sufficient to cause distress and/or medical instability)
Blood pressure	< 90mmHg systolic or postural blood pressure >10 mmHg drop (lying to standing)
Heart rate	≤40 bpm (adolescents <50 bpm) or >120 bpm or postural tachycardia >20 bpm (increase in >20 bpm from lying to standing)
ECG	Any arrhythmia including QTc prolongation, nonspecific ST or T-wave changes including inversion or biphasic waves
Blood sugar	Below normal range / < 3.5mmol/L
Sodium	<130mmol/L
Potassium	Below normal range*
Magnesium	Below normal range*
Phosphate	Below normal range*
Albumin	Below normal range*
Liver enzymes	Mildly elevated
Neutrophils	<1.5 × 10^9/L
Temperature	<35.5^{o}C or cold/blue extremities
Psychiatric concerns	Significant psychiatric risk such as deliberate self-harm or suicidal ideation. Moderate-high agitation and/or distress.

* Clinicians should refer to their individual organisation's reference values

2. Medical monitoring & Multi-Disciplinary Team (MDT) management

Medical monitoring

The goals of medical management aim for medical stabilisation via:

- Prevention and treatment of re-feeding syndrome
- Safe nutritional and weight restoration
- Reversal of acute cognitive effects of starvation

DAILY OBSERVATIONS

- **U+E / Mg^{+2} / PO_4 / Ca^{+2} / FBP / LFT**
- **Vitamin B12 / Folate / Vitamin D (initial presentation)**
- Other investigations as indicated by clinical findings
- **QID observations of:**
  - Temperature,
  - Respiration Rate,
  - Lying and standing Heart Rate, AND Blood Pressure – lying and standing, if safe to do so
- **Daily ECG**
- **Blood Sugar Levels (BSLs) QID** (2 hrs. post prandial irrespective of feeding route) and 0200 (management of hypoglycaemia as per local hospital diabetic management policy)
- **Bowel openings**
- **Fluid intake / urine output**

DAILY SUPPLEMENTATION

- 300mg Thiamine OD
- 1 Complete Multivitamin and Mineral Supplement OD
- 1 B Complex Supplement OD
- 500mg Phosphate Sandoz BD (500mg Phosphate Phebra BD)
- **Replace abnormal electrolytes as clinically indicated**

NOTIFY RMO IF:

- *Pulse* is below 50bpm,
- Systolic BP below 90mmHg **or:**
- Significant Postural Drop of more than 10mmHg **or:**
- Postural Tachycardia >20 bpm
- Temp below 35.5^{o}C
- QTC interval >450ms
- BSL<4mmol/L

Initial Nursing Management

- On admission (preferably with patient consent) search belongings for laxatives, diuretics, chewing gum, sweeteners, etc. Repeat on return from any ward leave.
- Create Individualised Behavioural Management Plans (IBMP) outlining activity, level of observation, bathroom access, meal support, leave, etc.)
- Consideration should be given as to the benefit of 1:1 nursing supervision aimed at providing structure, reducing anxiety and opportunities for eating disorder compensatory behaviours as there is the potential for increase distress with refeeding
- Initially no off ward leave due to medical risk.
- As per Daily Observations (see page 6)
- Daily observations (see previous page)
- Bed rest

Monitor and contain eating disorder behaviours

NUTRITION: Only food authorised by the dietitian is to be consumed.

- Record all offered food and fluids / NGT feeds.
- Request family members/carers support with adherence to the IBMP by not supplying foods from outside or medications or allowing patient to exercise.
- NGT Feeding – Lock pump, tube visible and sealed with tape at the join. Observe for potential tampering.
- Monitor fluid intake for ↑ or ↓ consumption and record specific gravity daily if there is suspicion of water loading (excessive intake of fluids to falsify weight).
- Ensure bowel openings daily – if not consider use of appropriate aperients

MEAL SUPPORT: through boundary setting and role modelling.

- Attend to toilet needs prior to meals.
- No vomiting, chewing, spitting – ideally 1:1 supervision during meals to contain anxiety and provide support strategies during meals (30 mins) and at snack time (15 mins). Post meal supervision (60 minutes for main meals and 30 minutes for snacks) is recommended to contain any potential compensatory behaviours.

ACTIVITY/EXERCISE: Current national exercise and activity guidelines are being reviewed. Contact WAEDOCS for further advice and support

WEIGHT: (In underwear or gown. Non-negotiable, Patient may be told BMI band at team's discretion, but not weight as even small changes can increase the drive for engagement in high risk behaviours). Record at 6.30am after voiding, repeat as per IBMP using same scales for each weight measure.

- Do not discuss weight or weight goals at point of initial admission, given the potential for inaccuracy of weight at admission.

Multi-Disciplinary Team (MDT) management

It is important that a weekly MDT meeting takes place. This is an opportunity for the entire treating team to meet with the patient to evaluate progress and plan the next phase of care. Patients should be asked to invite any important people they wish to be involved in their care.

A weekly MDT meeting facilitates consistency of care and clarity, in that all parties have the same information regarding treatment planning. It also reduces the chances of team members miscommunicating and "splitting" (where one or more team members unwittingly undermine treatment goals). For additional information regarding the therapeutic rationale for "non-negotiables" and team consistency, contact WAEDOCS for the Neurobiology of Eating Disorders information sheet.

CONSIDER MHU TRANSFER IF MEDICALLY STABLE FOR 72 HOURS AS PER:

- Systolic BP 90mmHg or above
- (>80mmHg if reviewed and agreed in conjunction with psychiatrist in charge of the mental health ward / unit).
- Heart rate >50 and <100 bpm
- No significant postural tachycardia or hypotension
- Normal ECG
- Normal electrolytes

CONSIDER DISCHARGE TO COMMUNITY IF AS ABOVE, PLUS:

- Consuming regular adequate nutrition on and off the ward
- Returns from 48 hrs leave medically stable and eating adequately
- Cognitive effects of starvation reduced sufficiently to be able to engage in outpatient psychotherapy (3)
- Clear plan for collaborative MDT community care (including mental health governance)

See Pages 14-17 for further information on discharge planning and transfer of care.

3. Reversing Starvation

Starvation is not always evident upon initial examination. Whilst many starved people appear emaciated, starvation and/or malnutrition can affect anyone who has lost a large amount of weight in a short time and/or has not eaten much for several days. People who are not underweight may also be malnourished. Patients of average weight may present as extremely medically unstable and undernourished, so **weight/BMI should never be the sole determinant of the appropriate level of care.**

Semi-starvation commonly leads to medical instability. When the body is in a state of semi-starvation, the brain is also affected, which affects people's emotional and cognitive functioning and often their insight related to the need for treatment. Renourishment of both the individual's body and their brain is a priority. See the handout: https://www.cci.health.wa.gov.au/Resources/For-Clinicians/Eating-Disorders

Patients may be fearful and unable to engage in healthy eating on their own and may require treatment in the form of an inpatient admission or structured evidence-based outpatient therapy.

It is helpful to provide family members/carers with full information regarding the need reverse starvation as they can provide essential support for the patient.

Refeeding Syndrome

Refeeding syndrome is the potentially fatal shift in fluids and electrolytes that can occur following re-introduction of nutrition in patients who are malnourished. This syndrome may not occur in every starved patient, however due to the potential seriousness and its unpredictability, clinicians should be aware that every malnourished patient may be at risk.

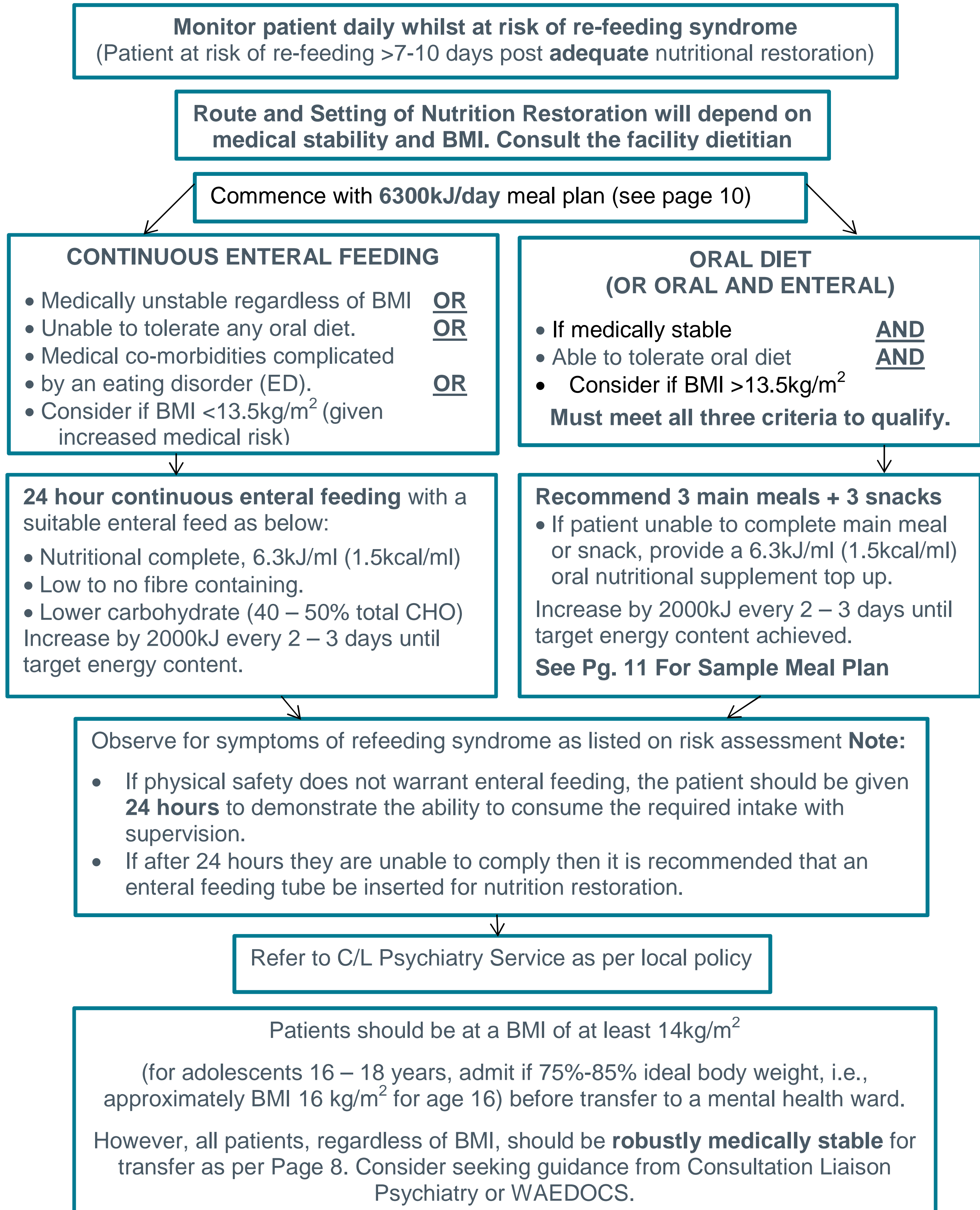
What are the risk factors for refeeding syndrome?

The National Institute for Health and Care Excellence (NICE) guidelines indicate that if patients display the following criteria they are at a high risk of refeeding syndrome:	
≥ 1 of:	• BMI less than 16kg/m^2. • Unintentional weight loss greater than 15% within 3 – 6 months. • Little to no nutritional intake for more than 10 days. • Low levels of potassium, phosphate or magnesium prior to feeding.
≥ 2 of:	• BMI less than 18.5kg/m^2. • Unintentional weight loss greater than 10% within 3 – 6 months. • Little to no nutritional intake for more than 5 days. • A history of alcohol abuse or drugs including insulin, chemotherapy, antacids or diuretics.

Nutritional Management

Relevant for medical, nursing and dietetic staff.

TO MINIMISE THE RISK OF RE-FEEDING SYNDROME IT IS RECOMMENDED THAT YOUR TEAM COMMENCE THESE INSTRUCTIONS IMMEDIATELY



6300 kJ/day Meal Plans

Solid Oral Diet - can be started prior to review by your facility dietitian:

Breakfast:	1 Portion Pack Cereal (Cornflakes™ or Rice Bubbles™) + 150ml Hilo Milk + 1 Portion Pack Tinned Fruit in Natural Juice
Morning Tea:	200ml UHT Flavoured Milk **+** 1 Piece Fresh Fruit
Lunch:	Hot Main Meal (standard portion / serve size). Must include carbohydrate e.g., potato / rice / couscous / pasta
Afternoon Tea:	200ml UHT flavoured milk
Dinner:	Hot Main Meal (standard portion / serve size). Must include carbohydrate e.g., potato / rice / couscous / pasta
Supper:	200ml UHT flavoured milk

Liquid Oral Diet (if unable to tolerate solid oral diet):

Breakfast / Lunch / Dinner:	200ml Fortisip (no fibre) **OR** 200ml Ensure Plus (tetrapack)
Morning Tea / Afternoon Tea:	100ml Fortisip (no fibre) **OR** 100ml Ensure Plus (tetrapack)
Supper:	200ml Fortisip (no fibre) **OR** 200ml Ensure Plus (tetrapack)

Nutritional Management in Community Settings

The priority for outpatient treatment for eating disorders is to reverse starvation (if present) and to facilitate the consumption of sufficient energy to maintain current health and improve health status.

A dietitian can be useful in providing specialist input. Where there is no dietitian available, the Centre for Clinical Interventions (CCI) has a number of dietetic handouts created in collaboration with a specialist eating disorders dietitian: https://www.cci.health.wa.gov.au/Resources/For-Clinicians/Eating-Disorders

All evidence-based psychological treatments prioritise the swift restoration of adequate nutrition and the normalisation of eating (see below).

4. Normalising Eating

Eating disorders are mental illnesses. By definition, people with eating disorders have problems related to eating in a controlled, healthy, balanced way. These eating problems may include: severe restriction of intake or fasting, binge eating and engaging in compensatory behaviours in an effort to rid their bodies of calories (e.g., vomiting, laxative and diuretic abuse, driven exercise).

The goal of treatment in any care setting is to prepare the patient, once medically stable, to take initial steps towards the ultimate goal of being able to eat flexibly, with appropriate quantity and variety, without guilt/anxiety and without the need to engage in compensatory behaviours.

Inpatient Settings and Day Programmes - Supportive Meal Therapy

Supportive Meal Therapy (SMT) is a critical component in the management of eating disorders. During SMT, patients have an opportunity to consume and retain the prescribed amount of nutrition which supports the treatment and discharge goals.

Patients will generally be prescribed 3 main meals and 3 snacks by the dietitian – all of which may require one-on-one SMT. SMT is essentially provided in two phases – during the meal and post meal. Support during the meal assists with managing anxiety and post meal for containing compensatory behaviours. Main meals should be consumed within 30 minutes and snacks within 15 minutes. Post meal supervision should be for 60 minutes post meals and 30 minutes post snacks.

Where 1:1 supervised snack/meal and post-snack/meal supervision is not available, it is recommended that patients consume their meal seated in the sight of nursing staff (e.g., outside the nursing station) or a supportive family member or friend who has received guidance in the principles of SMT.

Community Settings – Regular Eating

Regular eating is a central goal of all evidence-based psychological therapies. Eating in the early stage of recovery will usually need to be "by the clock" until patients are eating more intuitively and appropriately.

The Centre for Clinical Interventions (CCI) website has a set of useful handouts. https://www.cci.health.wa.gov.au/Resources/For-Clinicians/Eating-Disorders Their handout on regular eating can help patients structure their eating patterns:

Cognitive Behaviour Therapy (CBT) uses self-monitoring to support patients towards developing healthy eating patterns. CCI has self-monitoring worksheets which patients can download: https://www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Disordered-Eating

There are also free phone "apps" to support monitoring food and emotions:

- Recovery Record: https://www.recoveryrecord.com
- RiseUp: https://www.recoverywarriors.com/app/.

Family Based Treatment (FBT) utilises parents to facilitate regular eating as the means of achieving required intake of nutrition to result in appropriate weight regain.

5. Psychological Support

All clinicians play an important role in supporting people with eating disorders, whatever the setting, whether or not there is access to mental health clinicians.

People with eating disorders should always be treated with a balance of ***compassion*** and ***firmness**,* to support their well-being and dignity. It is important to remember that there are always two sides to the person: the part that wants to get well and live a richer life, and the part that fears change and "letting go" of their eating disorder. It is important to offer a full rationale for all aspects of treatment, with clear non-negotiables (to ensure their safety and facilitate steps to recovery).

Validate the patient's distress. Show them that you appreciate how much they are struggling with being in hospital/ refeeding. Patients with a history of complex trauma or severe co-occurring emotional dysregulation may require an individualised approach to management. WAEDOCS is available to discuss the care of people with more complex needs.

Help patients manage their distress. Behaviours such as restricting and purging may have emerged as a means of regulating or "numbing" unpleasant emotions. Nutritional rehabilitation often exacerbates patients' distress as they are faced with managing feelings and behaviours related to their fear of weight gain, restoration of normal eating and giving up their disordered eating behaviours. Validation of their distress and offering strategies for managing distress can help with engagement.

Help patients understand their disorder, by providing psychoeducation. People in a malnourished state may be intensely fearful and not receptive to or able to benefit from psychological treatment. Showing concern and providing a context and a rationale for nutritional restoration helps engage the patient. Psychoeducation should always be available as a first step, especially regarding Starvation Syndrome: https://www.cci.health.wa.gov.au/Resources/For-Clinicians/Eating-Disorders

Support the family/carers, especially if they are new to dealing with an eating disorder. They may not have understood the severity / complexity of the mental and physical features of the illness. Provide psychoeducation, especially regarding starvation. Involve them in all aspects of care, treatment and discharge planning. For further carer resources see the WAEDOCS intranet page.

Evidence-based psychological treatments are recommended (6). In the absence of specialist psychological resources, CCI has online self-help workbooks which can guide treatment, if the patient is cognitively able and interested: https://www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Disordered-Eating
Treatment is also available at Community Mental Health Services in the patient's catchment area, and should be initiated by the GP.

Peer Support

'Peer support' refers to the support provided by someone who has been through a similar experience. Trained peer support workers are an effective adjunct to the treatment of eating disorders, because of their in-depth knowledge and understanding of the eating disorder process and what it takes to recover.

Essentially, a well-trained peer support worker acts as a ‘recovery coach’ for patients. By providing a role model for life after the eating disorder, s/he can urge

patients to engage with treatment and resist the distorted thoughts associated with the illness, focussing on other strategies to improve well-being. WAEDOCS has a Peer Support Co-ordinator who can assist with training and offer guidance to local non-specialist peer workers.

6. Discharge/Transfer Plans & Relapse Prevention

Discharge planning should be considered at the point of admission into any care setting. This may entail transfer from one level of care to another (“step down” or “step up”) or may signify the end of a treatment phase.

Discharge planning for someone with an eating disorder aims to:

- Maintain gains
- Make further progress, with respect to: a) normalising eating and improving nutrition, and b) working on any psychiatric comorbidities
- Prevent/minimise relapse by developing a plan for facilitated rapid readmission if required.

Involvement of family members/carers

Collaborating with and involving parents/family members/carers in the development of transfer, discharge and relapse prevention plans will enable family/carers to provide their loved one with necessary support upon discharge. It is important to upskill families/carers on strategies such as meal support, physical activity monitoring, psychosocial support and risk management. This is particularly relevant when a patient is young, but even adults will usually require encouragement, validation and support from partners, family, carers or people close to them.

Transfer to a Different Level of Care from Hospital (Step Down)

People with eating disorders are fearful of weight gain, and those who are sufficiently unwell to require admission will typically have rigid cognitions as a result of semi-starvation. If discharged before receiving sufficient nutrition to reverse the severe cognitive effects of starvation, such patients are at high risk of relapse, as they are likely to return to restrictive eating.

Patients who meet criteria for discharge from a medical inpatient setting may still require continued inpatient treatment via transfer to a mental health unit (MHU) or may be suitable for discharge into a coordinated and collaborative multidisciplinary plan within the community setting. See Pages 5 and 8 to determine medical stability criteria and discharge recommendations and Pages 15-16 for a Collaborative Care Plan (CCP) to assist in co-ordination between providers.

High risk patients who meet criteria for discharge into the community may require a Community Treatment Order (CTO) to ensure they continue to receive appropriate care. See Page 17 for more information on the 2014 Mental Health Act (MHA).

Transfer to a Higher Level of Care from the Community (Step Up)

Patients may need to be discharged / transferred to a higher level of care if their mental and/or physical condition deteriorates. In WA there are currently no specialist day programs, comprehensive multi-disciplinary outpatient services or inpatient beds. Therefore if someone in the community needs a higher level of care, this will necessitate facilitated admission to either a medical ward or MHU (ideally following initial Emergency Department Assessment), and may need assertive community mental health service outreach and/or Emergency Department Liaison Psychiatry input.

General Practitioner
Initial weekly visits. Once stable, fortnightly to monthly.

Monitor:
- Weight - ↑0.5 – 1 kg/week (restoring) or maintain weight (if at ideal BMI.
- Blood profile (U+E/ PO4/Mg /LFT/ FBC).
- Lying to standing BP (>10mmHg) / HR (deficit <20bpm).
- Random BSL.
- Urine specific gravity / ECG.

Note: weighing done in light clothing, empty pockets, no shoes. If concerned then weight in hospital gown.

Causes for concern (admission required):
- Postural tachycardia >20 bpm
- Weight loss >1kg per week for 3 weeks or BMI below agreed value.
- BSL <4mmol/L
- Uncontrolled purging or laxative misuse or diuretic misuse.
- Unable to maintain adequate oral intake

Community Mental Health Service
- CTO / voluntary with ?CMHS.
- Dr ? (Psychiatrist).
- Dr ? (Registrar).
- Provide support and back up for GP / CCI / Private Dietitian / Private Psychologist.
- Weekly weight.
- Facilitate admission to ED if required (+/- MHA).
- Access to OT for functional re-training.

Private Dietitian
- Weekly appointments initially.
- Provide nutrition support for either ongoing restoration (if target BMI not reached) or weight maintenance (if within ideal BMI range).
- Liaise with GP and Private Psychologist about ongoing management.

Causes for concern
- Not attending appointments
- Re-emergence of rigid cognition resulting in inability to maintain adequate oral intake.
- Weight loss to BMI below agreed value requiring admission for inpatient restoration.

Collaborative Care Plan
WA Eating Disorders Outreach and Consultation Service

ED
Complete comprehensive medical assessment.
Readmission to hospital if >1kg weight loss per week for 3 weeks.

General Medical setting of care indicated if patient is medically unstable and BMI below agreed value..
MHU setting of care indicated if patient is medically stable and BMI below agreed value.

Medical Management for ED, Gen. Med. and MHU
The following observations should be completed DAILY:
- Lying to standing BP/HR QID + 0200
- Blood profile (U+E/PO_4/ Mg/LFT/FBC) & supplement if low.
- QID BSL 2 hours post prandial + 0200
- ECG / blinded weight / height (once off measured accurately).
- Provide safe nutrition restoration in accordance with medical stability / BMI / refeeding syndrome risk.
- Supplementation multivitamin OD / B complex OD / Thiamine 300mg OD / Phosphate Phebra 500mg BD

NOTE: In a compensated state the blood profile/ ECG/ Postural BP & HR may appear within acceptable range until adequate nutrition has been safely provided.

General Medicine
For Advice on Medical Management, see Medical Management for ED, General Practitioner and MHU box.

Mental Health Unit
- Movement to MHU to in order to address anxiety, secondary mental health complication and continue to normalise eating behaviours.
- For Advice on Medical Management, see Medical Management for ED, Gen. Med. and MHU box.

Psychology (CCI / Private)
Weekly evidence based psychological treatment and weekly weighing.
- Regular communication with patient's GP and Community Mental Health Services (CMHS) regarding patient's progress and attendance for appointments.

Cause for concern:
- Not attending appointments.
- Re-emergence of rigid cognition resulting in inability to maintain adequate oral intake.

Contact Information for Collaborative Care

Service Type	Contact Name	Service Name	Phone Number	Email	Appointment Scheduled?	If Yes, list next 3 Appointments
General Practitioner						
Dietitian						
Psychology						
Community MH Service						
Other:						
Other:						

For general guidance for health professionals around management of eating disorders - WA Eating Disorders & Outreach Consultation Service (WAEDOCS) Tel: 1300 620 208

Use of the 2014 Mental Health Act (7)

Malnutrition, starvation syndrome and eating disorder cognitions can occur at any weight and can impair insight and judgement with respect to safe decision-making regarding **consistent** engagement with treatment. Ambivalence in the face of nutritional rehabilitation is a key feature of eating disorders, and use of the mental health act may be required. To be considered for involuntary treatment in WA a person must meet all of the following criteria:

1. **The person is experiencing a mental illness for which the person is in need of treatment.** All eating disorders are listed as mental illnesses in DSM-5

2. **Because of the mental illness there is a significant risk to health and safety / or a significant risk of harm to the person.** Eating disorders have an overall mortality of up to 20%, predominantly as a result of malnutrition and suicide.

3. **The person does not demonstrate that they have the capacity to make treatment decisions.**
   a. The Minnesota Semi-starvation Study demonstrated that loss of 25% of body weight led to profound cognitive changes (including obsessive preoccupation with food/eating and **loss of perspective and insight**), which were only reversed with weight restoration.
   b. An eating disorder can impact upon accurate self-perception and judgement regarding severity of malnutrition, medical risk and the need for treatment.
   c. The WA Department of Health Consent Policy (2011) defines capacity as 'the extent to which a person is able to make reasonable judgements about their treatment / personal welfare". Capacity comprises the following four features: the ability to communicate a choice; to understand relevant information; to reason about treatment options; and appreciate the situation and its consequences. Patients with eating disorders may appear to comprehend factual information but fail to realistically evaluate and emotionally appreciate the relevance for them in terms of implications for their future. (8).

4. **There is no less restrictive way to provide the treatment that the person needs**
   a. People with eating disorders exhibit cognitive distortions regarding self-perception of body image and nutrition, which can drive intense ambivalence regarding engagement with nutritional rehabilitation and psychotherapy.
   b. Patients may acknowledge a need for treatment but struggle to engage consistently or engage in use of compensatory measures.
   c. Assessment of decision-making with respect to setting and restriction of care should take into account an individual's ability or lack thereof, to engage safely with treatment in that setting.
   d. This may also be relevant with respect to use of community treatment orders (CTOs) following a period of nutritional restoration.

Guidance can be sought from the WAEDOCS Psychiatrist around application of the MHA (2014) in the care of people with Eating Disorders

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