**NNSWLHD C&A Eating Disorder Service Model of Care – September 2021**

**Northern NSW Local Health District (NNSWLHD) Specialist Service for Children and Adolescents with Eating Disorders**



**Acknowledgements**

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# **Introduction to the Model of Care**

Eating disorders are complex mental illnesses that result in significant physical impairment and have high rates of mortality and low rates of early detection and intervention. People with eating disorders experience higher rates of comorbid mental health problems than the general population including depression and anxiety disorders, substance misuse and personality disorders. They can also experience significant physical comorbidities, such as higher levels of cardiovascular disease and neurological symptoms, and are likely to experience stigma and discrimination as a result of their disorder. Treatment for an eating disorder requires not only responses to the underlying pathology but also integrated responses to relevant mental and physical health comorbidities.

Of the services available, there is a notable absence of eating disorder expertise among various health practitioners in rural areas thereby leading to barriers in timely assessment, diagnosis and treatment which may result in an increased likelihood of hospitalisation, illness chronicity or, even worse, premature death. The conservative estimated prevalence of eating disorders is 4% of the population[[1]](#footnote-1). As such, it is estimated that 14,900 people residing in NNSW LHD are living with an eating disorder[[2]](#footnote-2). The Northern NSW LHD has the largest number of people with eating disorders of all the rural LHDs outside of Hunter New England, which is arguably more closely reflective of a metro LHD (it has approximate numbers equivalent to Northern Sydney, South Eastern Sydney, South Western Sydney and Western Sydney LHDs). Reference data

In response to *The NSW Service Plan for People with Eating Disorders 2013-2015* (1) *The Northern NSW Local Health District (NNSWLHD) Eating Disorders Service and Workforce Development Plan June 2016-June 2021* (2) was developed, and provides strategic direction to ensure people with eating disorders in the NNSWLHD receive consistent, timely, and appropriate interventions regardless of their age, area of residence, and severity of illness. Clinical services and the delivery of evidence-based treatment have improved significantly over recent years as a result of a coordinated response by the LHD. The identification, cultivation, and active participation of clinical leaders across the disciplines of Paediatrics, Nursing, Dietetics, Community Mental Health, and Inpatient Mental Health has occurred and the provision of high-quality eating disorder service delivery has begun to develop – through staff training and clinical supervision, the development of local policies and guidelines, and a dedicated service coordination role.

Phase Two of the NSW Service Plan has recently been developed. *The NSW Service Plan for People with Eating Disorders 2020-2024*, (reference here) was developed by the InsideOut Institute (Australia’s national research and clinical excellence institute for people with eating disorders) following consultation with NSW Health Districts, key stakeholders, and the Mental Health Branch of The Ministry of Health. This plan builds on the achievements of the *NSW Service Plan for People with Eating Disorders (2013-2018).*

Over the same period, the rates of eating disorder admissions in NNSW LHD both inpatient and community have increased exponentially. Capacity has been an issue. Despite increasing demand for services, until now, there has been no accompanying increase in resources to meet demand, and significant service gaps exist. The absence of an integrated outpatient eating disorder clinic, or of a step up/step down intensive community Model of Care provided through the public health system, in addition to limited eating disorder expertise available through primary care, has likely contributed to increased severity of illness on presentation, repeat emergency department presentations, longer lengths of stay, increased re-admission rates, and waitlists for inpatient and community health treatment. In addition to the economic costs and service burden this represents, the significant distress experienced by patients and their families increases, related to difficulty accessing care, difficulty coping with transition periods (e.g. from hospital to home), re-presenting to emergency departments where there is significant wait, as well as readmission. This Model of Care, outlining a District-Wide Specialist Eating Disorder Service for children and adolescents aims to address these gaps and improve service delivery.

**1.1 Background**

NNSWLHD has always had a high proportion of Youth and Family Mental Health (YAF) clients and paediatric admissions with eating disorders. However, while numbers have been increasing significantly over the last five years across all age rages and areas of the health, until now, there has been no increase in resources or clinical positions to meet the increasing demand for services. Of inpatients with an F50 diagnosis data from 2015/2016 to 2019/2020 reflect a **47% increase** in hospital admissions across all age groups, and a **35% increase** in the 0-17 age group. Community Mental Health data from 2016/2017 to 2019/2020 show a **41% increase** in eating disorder community referrals for this same client group (note: data for 2015/16 not included in community result due to transition to eMR resulting incomplete data for that time period). At the time of writing of the MoC, quarterly data from InforMH (21-Q2) indicate that during this quarter community treatment in the under 16 age group has **increased** by **31%** with a **75% increase** in the 16-17 year old age range. As a result of increase in referrals, service gaps exist and community teams in particular are experiencing difficulty meeting the demand, which is likely due to a lack of ability to access intensive community care, and may contribute to repeat hospital re-admissions.

In response to this demand, NNSW LHD has developed a specialist child and adolescent eating disorder service. The purpose of this MoC is to facilitate the provision of district-wide, consistent, evidence-based multidisciplinary eating disorder service in a timely manner, create strong links between existing service providers and ensure smooth transition between services.

Evidence indicates that outpatient treatment should be the first line of treatment for children and adolescents with an eating disorder (reference here). In conjunction with General Practitioners (GPs), the Youth and Family Mental Health Service and Child and Family Community Health Service (YAF and C&F) are the key services for children and adolescents with an eating disorder residing in the NNSWLHD. Mid 2021, the LHD transitioned from a YAF to a Child and Adolescent Mental Health (CAMHS) service, the rest of this document will refer to the service as such.

# **1.2 Aim**

The Youth Eating Disorder Service will provide specialist multidisciplinary care incorporating both virtual and face to face services including:

* Step up/step down model of care incorporating an intensive outpatient service utilising a combination of face to face treatment with evidence based virtual models of care and video therapy service delivery.
* The creation of a “virtual team” using multidisciplinary team clinicians (psychiatry, allied health, dietetics and nursing). This team will offer outreach and virtual intensive outpatient support via in person and telemedicine (meal support, e-therapy, case management and/or home visits post discharge from hospital) to provide intensive outpatient follow up and lower readmission rates.

# **1.3 Target Population**

The target population for the Youth eating disorder service is children, and adolescents, and their families living in NNSWLHD who meet the criteria for assessment and/or treatment of an eating disorder according to the DSM 5. The patient group for this service is children and adolescents with moderate to severe eating disorders including Anorexia Nervosa (AN), Bulimia Nervosa (BN), Avoidant/Restrictive Food Intake Disorder (ARFID) and Binge Eating Disorder (BED).

*Inclusion criteria:*

* Children and young people aged 8-17years. New referrals aged 18 and over will not be accepted. Adolescents diagnosed before the age of 18 and receiving care from CAMHS service may continue to receive services after their 18th birthday if clinically indicated. Those diagnosed with an eating disorder/referred to Community Mental Health (CMH) services after their 18th birthday, will be referred to the adult CMH team for treatment
* There will be some flexibility with consideration of developmental factors. Chronological age is not the only factor in determining treatment, and will include consideration of social, emotional and psychological maturity.
* Diagnosable eating disorder according to the Diagnostic and Statistical Manual of Mental Disorders version 5 (DSM-5).
* Residing within NNSWLHD catchment area.
* Failure to progress in treatment with CAMHS or C&F eating disorder treatment in community and it is deemed by the Youth Eating Disorder Service that more intensive therapy (i.e. more than once per week with community team) is required.
* Children and young people experiencing first presentation to inpatient treatment, and requiring psychoeducation/in reach prior to discharge to community services

*Exclusion criteria:*

* Young people with a first diagnosis of an eating disorder past their 18th birthday (referral to adult services appropriate).
* First presentation to community services without assessment and treatment provided by local CAMHS/C&FH team in the first instance.
* Families where there are significant Mental Health, Drug and Alcohol, or child protection issues which would impact the family’s ability to successfully engage with the treatment program.
* Each case will be evaluated on its own circumstances and it may be deemed that this service is not suitable for a client at a particular point in time.
* Situations where there are complex and significant issues that may impact treatment such as violence, aggression and substance use in the young person or family, alternative or modified treatment options may be explored, and safety planning undertaken in consultation with the ED service and current service providers.

# **Development of the Specialist Eating Disorder Model of Care (MoC)**

This MoC was developed in consultation with CAMHS and C&F managers and clinicians, paediatricians, psychiatrists, dietitians, people with a lived experience and their parents or carers, and other NNSWLHD service providers in addition to external stakeholders. Bi-monthly Eating Disorder Child and Adolescent Working Party Meetings and Quarterly Eating Disorder Implementation Committee (EDIC) meetings provided governance and oversight to guide the development and implementation of the model.

* 1. **Service Description**

The service involves a virtual “Hub and Spokes” Model, with the Hub being based at the Nexus Centre in Ballina.

The service is managed by the CAMHS Service Manager, with operational support from the NNSW LHD Eating Disorders Coordinator. The CAMHS clinical director provides clinical governance oversight, and the team is led by a Clinical Lead.

The service operates outpatient clinics, flexible intensive community based services, incorporating a mix of face to face services, and telehealth services. Existing resources such as inpatient consultation liaison, community mental health clinicians, medical and psychiatry staff and dietetics continue to be involved in order to ensure seamless transfer between services. The creation of a “virtual team” allows for the provision of home/site visits in person or via video link as clinically necessary and when safe to do so (i.e. not high complexity or high reactivity.)

* + 1. **Service Arms**

The service involves three separate, though interconnected service arms:

**Intensive Community Based Support:**

* Allows for intensive service delivery through a combination of face to face and virtual support, with a focus on intensive family-based support.
* Flexible model dependent on individual client needs, phase of treatment and frequency of support required. May include intensive FBT, meal support, case management or home visits (in person or virtual) as required post discharge from hospital to provide intensive outpatient follow up and lower re-admission rates
* Utilises evidence-based models of service delivery via digital modules, and video therapy in client’s homes.

**Intensive Outreach Support:**

* Team provides consultation and outreach support to existing community and inpatient teams via telemedicine and/ or face to face when clinically indicated.
* Team provides consultation and in-reach into hospitals to assist with assessments and the provision of psychoeducation to families.
* Provision of outreach support into hospital settings where in/out bolus may be required and lack of specialist services on-site. **(in development)**

**Multi-Family Intensive Program:**

MFT was developed at the Maudsley Hospital London and is now a key intervention offered by the Children’s Hospital at Westmead. MFT targets families not progressing in outpatient care, or who present with some other complexity. It aims to boost empathy and understanding between parent and young person, reduce isolation, develop solidarity, improve parent-child communication and facilitate enhancing and sharing of skills. MFT builds upon the core constructs of family based treatment for anorexia nervosa, whilst adding the unique experience of solidarity for young people and their families through the group context. The content of MFT is experiential, involving activities and specific debriefing techniques to help families develop ways to work together against anorexia, increase attunement to their child’s needs and feel more agency around the process of recovery[[3]](#footnote-3).

MFT has been established at The Eating Disorder Service at The Children’s Hospital at Westmead (CHW) where it has been well received. Feedback from the program has included families feeling less alone, learning from each other, and often connecting and creating their own community that may continue past the group program as a source of support for one another. As it is an intensive program, families often progress at a faster rate than with standard weekly FBT.

NNSWLHD Child and Adolescent Eating Disorder Service (EDS) will provide MFT to families who require intensive treatment, with the aim of averting more serious or long-term illness. The local service will provide equity of access, care closer to home allowing more affordable and greater access for rural and regional families. The outline of the program will be delineated further in this document.

Families can be referred to the MFT program alone, whilst continuing to be managed solely by the CAMHS service. In these families, MFT can be seen as an adjunct and complementary treatment to the standard FBT delivered by their community CAMHS clinician.

* + 1. **Staffing Profile**

Clinical Lead (Clinical Psychologist) or level 4 Social Worker 1.0 FTE

Mental Health Clinician (Multidisciplinary) Allied Health Level 3 (Psychology, Social Work, Occupational Therapy) and/or CNC 2 2x 0.8 FTE

Dietetics (Level 3) 0.4 FTE

Psychiatry 0.2 FTE

Administrative Staff: 0.2 FTE

* + 1. **Roles and Responsibilities of the MDT**

**Team Leader:** The team leader is responsible for coordinating the eating disorder service and assisting with the day to day running and organisation of the service. The team leader organises and supports the outreach service and liaises with services across the LHD requiring support. The team leader is responsible for allocation of resources, identification of education needs of staff and communication amongst the team. The team leader will liaise closely with the NNSW Eating Disorders Coordinator around ongoing service development, clinical consultation and supervision, and workforce development needs. The team leader will also perform a clinical role, and provide evidence-based psychotherapies to clients and families.

**Allied Health/Nursing(Therapy team):** The role of theallied health/nursing clinicians is to provide evidence based psychological therapies for the treatment of eating disorders, in addition to case management where required. These clinicians will run, and co-facilitated the MFT program once per quarter. The clinicians will also be involved in co-ordinating case conferences and intensive family based interventions.

**Psychiatrist:** The consultant psychiatrist provides psychiatric assessment and supervision of behavioural, psychological and psychopharmacological treatment of all clients. The consultant psychiatrist works in collaboration with the treating therapist to ensure consistent service delivery.

**Dietitian:** The Dietitian provides comprehensive nutrition assessment and ongoing management. They further have a role in providing nutrition education to the family, and to explain strategies to support healthy eating. It is the expectation that for families undergoing FBT, and/or MFT that the Dietitian meets with the family only (not the young person) where there are issues with feeding and nutrition such as coeliac or allergies, whereby the family requires additional support to ensure adequate nutrition. The Dietitian may also provide outreach consultation to CAMHS and C&F clinicians who are providing FBT treatment in the community.

**The Eating Disorder Coordinator:** The Eating Disorder Coordinator is not a member of the Specialist Team per se, though provides ongoing support. The Coordinator is responsible for the development of LHD wide protocols and service development, providing clinical consultation and support to clinicians and coordinating external supervision and training.

**1.6.4 Family Based Therapy for Eating Disorders**

Family-Based Therapy for eating disorders (FBT) is an evidence-based treatment that has been shown internationally to be effective for children and adolescents with anorexia nervosa when provided by specialist eating disorders services, and is considered frontline treatment (9). There is also some evidence for the use of an adapted FBT model in young people with bulimia nervosa (10, 11) and avoidant restrictive food intake disorder (ARFID) (reference here). There are three distinct treatment phases: 1) weight restoration, 2) transitioning control of eating to the young person or as developmentally appropriate with younger children and 3) focus on child and adolescent issues. FBT involves approximately 9-18 months of therapy delivered over 20 plus sessions, which are held weekly, fortnightly or monthly depending on the treatment phase.

FBT utilises the family as the primary resource to renourish the young person. It is the role of the parents to take responsibility for refeeding their child and manage the eating disorder symptoms (while showing respect for the young person’s point of view and experience) until weight is stabilised and the young person is able to take control of their own eating appropriate to age and stage of development. Therapy is centred on supporting the parents to feed the young person to promote weight restoration. General child/adolescent and family issues are deferred until the eating disorder behaviour is well controlled. There is a strong focus on Anorexia Nervosa in FBT. The principles can be translated to symptom management in other eating disorders.

It is recognised that in some instances FBT will not be possible, however, this is usually the exception, and other treatment modalities will be considered through the clinical governance process. Examples of other treatment modalities include Enhanced Cognitive Behaviour Therapy (CBT-E) and conjoint treatment including both individual and family work. While fidelity to the core principles of FBT is important, it should be noted that the therapeutic approach is not rigid. Engagement with the young person and family is crucial and treatment should be tailored to the needs of the young person and family during care planning.

**2.0 Referral, Assessment and Treatment**

Referrals to the Specialist Eating Disorder service are made via existing pathways (CAMHS teams, C&F counselling and inpatient medical and mental health services). No direct referrals are to be accepted from external services (e.g. GPs or private clinicians) however, consultation may be provided. **Referrals to the Eating Disorder Service should be a joint decision with the multidisciplinary team members including both the CAMHS teams and paediatric team involved in a young person’s care.**

***It is not the expectation that the eating disorder service is intended for all families within the LHD who present with an eating disorder, rather the service is designed to provide a more intensive service that cannot be provided by treatment as usual.***

**2.1 Referrals**

Referrals to the EDS can be made via the eating disorder service intake email: NNSWLHDEatingDisorderIntake@... Each week, during the weekly Eating Disorder Team Intake Meeting, the Eating Disorder Team will review all new referrals. Referring clinicians are invited to dial in, or attend in person to provide a handover/rationale for referral to specialist service. If agreed upon by the MDT, and if admission criteria met, the EDS will arrange a multidisciplinary assessment to determine suitability for the service, and the level and intensity of treatment and services required. In some circumstances where it is clinically indicated there may be a shared care arrangement with the referring CAMHS or C&F provider. In circumstances where young people and families are not allocated to the Eating Disorder Service, support will be provided to the referrers by the Eating Disorder Team, to identify appropriate alternative services.

The following information is required from the referring team prior to an assessment being conducted:

* A completed Eating Disorder Examination Questionnaire (EDE-Q) assessment tool, soon to be included as a form on eMR (see appendix).
* Collaborative information from other stakeholders, such as GPs, schools, and other care providers, if available
* A comprehensive medical assessment. A medical assessment should be completed by a GP or a Paediatrician if involved, or the young person is an inpatient prior to assessment by the eating disorder team. Based on the medical assessment, the GP may refer to the local emergency department. The GP should be sent a copy of the LHD inpatient procedures including medical indicators for admission depending on age:

[NNSW-LHD-PRO-0530-19-inpatient-management-of-children-and-adolescents-with-eating-disorders-v-003.pdf](file:///\\lis-itt-sfp04\Data\UsrData\Deanna.Bowen\EatingDisorders\NNSW%20Procedures%20and%20Guidelines\NNSW-LHD-PRO-0530-19-inpatient-management-of-children-and-adolescents-with-eating-disorders-v-003.pdf)

[NNSW-LHD-PRO-0860-21-inpatient-management-of-adults-with-eating-disorders-v-002.pdf](file:///\\lis-itt-sfp04\Data\UsrData\Deanna.Bowen\EatingDisorders\NNSW%20Procedures%20and%20Guidelines\NNSW-LHD-PRO-0860-21-inpatient-management-of-adults-with-eating-disorders-v-002.pdf)

**2.1.2 Initial Assessment**

The Multidisciplinary team will undertake a comprehensive assessment including the following:

* The client/patient’s current treatment setting (community or inpatient) and treatment history/therapeutic modality employed to date
* Obstacles to treatment/issues impeding success of CAMHS/C&FH treatment as usual, and complexities arising
* Family assessment including exploration of safety and suitability of treatment
* Assessment of co-occurring mental health issues and treatments provided/impact on eating disorder treatment
* If deemed appropriate for service, a comprehensive assessment of multidisciplinary services required (intensive family based support, in-home support, telehealth, meal support, liaison with hospital/emergency services for NG support, consultation/outreach to existing clinical teams etc.)
* Willingness of family to engage in, and participate in ongoing treatment
* Current height, weight, and weight history.
* Comprehensive dietetic assessment

**2.1.3 Assessment and Treatment Planning**

As part of the assessment and treatment planning process, the eating disorder team will:

Provide psychoeducational material and resources. Handouts from the InsideOut Institute and the Centre for Clinical Interventions may be provided.

* Set up treatment, psychoeducation and engagement
* Clarify the role of the Specialist Eating Disorder Service and the CAMHS/C&FH service, as depending on circumstances there may be scope for shared care\*
* Commencement of FBT or alternative therapy if FBT is contraindicated
* Care planning and case conference
* 4-6 week clinical review
* Regular weight measured as per therapy guidelines. Note: Initial presentation to eating disorder service should have a weight conducted on the scales within the service irrespective of weights recorded in hospital or with GP to establish a baseline weight for future weights taken within the service.
* Initial height measurements should also be updated as growth progresses (e.g. every 3-4 months

***\*NB: The Eating Disorder Service supports existing treating teams in two main ways:***

***1. As a consultancy service and;***

***2. A step-up clinical service providing active treatment. In cases where young people and their families are receiving active treatment with the Eating Disorders Service, they will need to be discharged from their existing CAMHS team, but may be engaged in a shared care arrangement if clinically indicated.***

If at any time there is significant concern about a patient’s medical stability or suicide risk/co-occurring psychiatric condition that potentially requires an inpatient admission, clinical processes to identify the most appropriate intervention within the LHD must be followed. This may include escalation to the Emergency Department for medical concerns, or Kamala Mental Health Inpatient Unit for mental health treatment (conditional on medical stability).

**2.1.4 Appropriateness of FBT for the client and family**

In most cases, FBT would be the treatment of choice, however FBT may not be appropriate in certain situations and an alternative treatment approach should be considered and discussed. Examples may include but are not limited to:

* Child protection issues
* Older adolescents who are living an independent lifestyle
* Those with inadequate family support or acute parental mental health issues
* Those in out of home care

**2.1.5 Assessment and Management while on Inpatient Ward**

Where there is an inpatient being treated in a medical or psychiatric inpatient setting that is deemed appropriate for referral to the eating disorder service, a representative from the eating disorder service should be invited to video in to the relevant MDT meeting where the family and treatment management is discussed. There is no expectation of attendance at every MDT, but only in the case where referral is being considered and discharge planning is in progress. The assessment phase, psychoeducation, and setting up treatment may be completed whilst the patient is in hospital prior to discharge in consultation with the inpatient treating team. Current weekly LHD MDT meetings occur at the following times:\*

The Tweed Hospital Paediatric MDT: Mondays at 13:00

Lismore Base Hospital Adult MDT (for patients 17 and up): Tuesdays at 10:00

Lismore Base Hospital Paediatric MDT: Tuesdays at 11:30

Grafton Base Hospital Paediatric MDT: Thursdays at 10:00

Kamala Child and Adolescent Mental Health Unit MDT: Fridays at 9:30

\**While these meetings are consistent at time of writing, dates/times may be subject to change in future.*

**3.0 Treatment**

**3.1 Care Planning and Case Conference**

Once the assessment process has been completed, the Multidisciplinary Eating Disorder Care Plan is drafted in consultation with the young person and family. The care plan clearly outlines the management plan for the young person and family including treatment plan, roles of the Eating Disorder Service (EDS) team members and responsibilities and commitment of family members to engage in treatment. Within the EDS Team, a care coordinator is to be identified for each new referral to the service, and is responsible for identifying members of the treating team external to the eating disorder service such as the client/families, CAMHS and C&F clinicians, GP, Paediatrician, school, NGOs, or any other relevant stakeholders. Due to the part-time status of clinicians, each client/family will be assigned a primary and a secondary care coordinator, to ensure relevant communications on days where the primary clinician is not at work, can take place in a timely fashion.

A case conference is arranged with the treating team to discuss the draft care plan. Copies of the care plan are saved in the patient record in eMR and sent to key stakeholders. A copy of the care plan is given to the client and their parent/carer.

**Actions that should occur during the Assessment and Treatment Planning Phase**

* **Liaison with relevant CAMHS or C&F clinician if involved**
* Whole of Family Assessment including Medical assessment
* Provision of resources to young person and family
* Ensure diagnosis is recorded in eMR
* Eating disorder and co-occurring mental health assessment
* GP liaison
* School liaison where appropriate
* Setting up treatment, psychoeducation and engagement
* Care planning and MDT case conference
  1. **Treatment: Delivery of Services**

**3.2.1 Stepped Care Approach**

The National Eating Disorder Collaboration (NEDC) has recently published a briefing paper *The stepped system of care for eating disorders (ref 11 on TEDS paper).* Stepped Care is defined as “an evidence-based staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to a person’s needs. Within a stepped care approach, a person is supported to transition up to higher-intensity services or transition down to lower intensity services as their needs change” (ref 12 TEDS paper). The NNSW LHD Eating Disorder Service stepped care approach takes inspiration from both the NEDC position paper and the Tasmanian Eating Disorder Service Review.

The Eating Disorder Service (EDS) will be a service “hub” and will be a point of contact for clinical consultation, and capacity building. Not all referrals to the service will involve face to face client contact, rather many functions will be performed on an outreach/ telehealth basis.

**Stepped Care Treatment Model**

**Community Based Treatment**

Evidence-based treatment delivered in community/outpatient for EDs

Includes: CAMHS, C&FH, and some private and dietetic service providers.

**Initial Referral/Response**

Comprised of assessment and referral to services depending on medical, nutritional and psychological needs

Includes: Primary Health,

Mental Health and Dietetic services in community (public and private) and Headspace

**Intensive Community Based Eating Disorder Service**

Evidenced-based intensive community treatment delivered by EDS for young people and families who require more intensive intervention

Outreach and clinical support to other services (both community and hospital –private services not eligible for this service).

Includes Intensive Community-Based support, intensive outreach support, and multifamily intensive program

Consultation liaison, education, and capacity building

Telehealth and online self-help

**Inpatient Treatment**

Hospital admission for people who require medical and or psychiatric admission locally, or referral to tertiary services.

Includes: Emergency Departments, Medical and psychiatric units (Kamala)

Tertiary eating disorder units or residential programs

Young people and their families will move through and across the stepped levels of care, and remain at the level that is deemed by the EDS for a period deemed clinically necessary. For example, if a family is participating in FBT with a CAMHS clinician and the CAMHS service, in consultation with the EDS deems that the family is not responding to treatment as usual, the decision may be made to refer to the EDS for increased intensity of the service. This may include such things as providing meal support, in-home support, or increasing the number of family sessions to several times per week. The levels are not mutually exclusive, so the CAMHS clinician may continue to be involved if clinically indicated.

**3.2.2 Intensive community-based support**

The level of community based support is scalable, and families can participate in the number of days they need support, which is expected to change over time. For example, when young people are discharged from hospital and it is deemed that more intensive support is required than would be possible at home, families may be scheduled for several support sessions in the weeks following discharge. Such contact may include intensive psychoeducation, intensive FBT sessions, several sessions of meal support (which may include in-home support) etc. As the family and young person progresses in treatment, contact may be scaled back from several contacts per week, down to one or two as clinically indicated.

**Therapy Services:**

The main mode of therapy provided by the EDS will be FBT in line with best practice guidelines. In cases where FBT is not indicated, or possible, a move to a more individual approach may be indicated. Therapeutic approaches including FBT, MFBT and individual approaches (AFT or CBT-E) are provided by the allied health EDS team members (excluding dietetics). Allied health clinicians will be in regular consultation with the wider MDT to review practice approaches. Therapeutic services may be provided in person at the Nexus Building in Ballina where the service is based, or may be provided by telehealth to families where travel or finances are an issue. In home services may also be provided dependent on need. Therapy services may also be a combination of in person or telehealth.

Family Based Treatment:FBT will form the key therapeutic modality. This may occur either by increasing the intensity of existing FBT therapy approaches in the community (e.g. the EDS increasing the frequency of sessions), or by the EDS providing intensive support to the parents with respect to skill development (meal support, in-home support). Where families require an additional level of support and despite FBT delivery in the community, treatment is not progressing, they may be considered for inclusion in the Multifamily Intensive Program.

Multi-Family Program: The MFT program will provide the opportunity for 5-7 families (5-7 young people with their parents and siblings) to work together for a 4-day intensive treatment workshop, with 6 follow up days over the next 6 months provided through the eating disorder service. The MFT program will be run once per quarter. Establishing the program would require eating disorder team members to travel to Sydney to shadow the Intensive Program at Westmead, with a view to adapting the program locally using existing resources and services. The goal of this program is to provide early, intensive treatment to families who require more intensive support, aimed at averting more serious illness or chronicity. Families may be referred to the program post hospital admission, or from community treatment where it is deemed more intensive therapy is required. The program will be designed to enhance standard outpatient treatment through group learning. Many families undergoing FBT in the community may find benefit from participation in the MFT as an adjunct to the standard FBT delivered by their community CAMHS clinician.

*Structure of the Program:*

The program centres on group learning led by two lead facilitators (allied health from eating disorders service) and two support facilitators (drawn from CAMHS community clinicians across the LHD) Activities include:

* Psychoeducation and support groups where all families are present, and separate parent, young person, and sibling groups.
* Individual family unit activities with support from facilitators.
* Meal support: Families must bring in the food required for three meals/day and receive support and coaching from the facilitators. Opportunities to challenge feared foods/amounts are supported.

Individual Therapies: Whilst FBT will be the main form of therapy offered by the EDS, CBT-E and AFT may also be offered dependent on clinical need. *Note, it is the expectation that regardless of whether FBT is the therapy provided, families and/or carers must always be involved in their young person’s treatment in some capacity.* The EDS will utilise both face to face, and evidence-based virtual models of service delivery via video therapy in client’s homes.

**Family Consultation Services:**

Dietetics: Provides nutritional advice to parents and other care providers involved in a young person’s care. In cases where the family is undergoing FBT, the dietitian provides consultation to the family only (not the young person). The Dietitian may also provide outreach consultation to CAMHS and C&F clinicians who are providing FBT treatment in the community. In addition, Dietitian may provide consultation to other services where there may be a risk of refeeding Syndrome.

Psychiatry: Provide Initial psychiatric assessment and ongoing psychiatric reviews (minimum 4-6 weekly).

**3.2.3 Outreach/In-Reach Services**

Outreach and Consultation:

The team will have a regular consultation and support role with community and inpatient teams. It is the goal of the EDS to increase the capacity and expertise of local teams to look after young people and their families by consultation liaison, capacity building, training and education. The team will offer a weekly telehealth case consultation time, whereby teams from across the LHD (Tweed/Byron, Clarence and Richmond – including all remote sites, both medical and mental health) can book a consult time. Similar to the outreach model currently provided by the Children’s hospital at Westmead, clinical teams can request a case conference. The intention is to provide consultation and support to allow existing services to continue to treat clients locally, whilst at the same time flagging cases whereby a referral to the EDS may be indicated and an assessment deemed necessary.

In-Reach to Hospital and Emergency Services**\***:

The EDS has a role in providing consultation and liaison with hospital and Emergency Departments. The team (on a pre-planned basis) will provide consultation and in-reach to hospitals to assist with assessments and the provision of psychoeducation to families. In addition, the team will provide telehealth support into hospital settings, and liaise with service providers where in/out bolus may be required and there is a lack of specialist services on site. Note: it is not the expectation that all inpatient admissions would require specialist consult from the EDS. Referral decisions would be made by the respective MDTs based on complexity and individual client/family need and capacity of the treatment setting to provide specialist care.

***\*****The EDS is* ***not*** *an emergency service, and only operates within business hours. Hospitals and emergency departments may contact the EDS during business hours for guidance around where to locate LHD policies and procedures, and/or provide ad hoc support.*

**Clinical Reviews and Clinical Governance**

## **4.1 Clinical Reviews**

Regular clinical reviews are a key clinical governance feature throughout treatment.

**4.1.2 Six-week Progress Review**

An EDS Team progress review should occur at the first 6 week interval or as indicated by clinical need which may earlier. It is the responsibility of the key clinician to set up and arrange the progress review. This review is designed to evaluate client progress, make decisions about treatment and review the care plan. The review may also assist in establishing whether there may be any difficulties in progressing to ongoing treatment, or whether the type of therapy needs to be modified. The review acts as a key clinical governance point to determine whether more intensive treatment is indicated. More intensive treatment options may include offering additional sessions, in-home support, or provision of extra telehealth and e-health supports. Outcome to be documented in eMR. (MDT template in appendix)

**4.1.3 Ongoing Mental Health Reviews**

Ongoing clinical reviews should take place every 13 weeks or in line with current CAMHS procedures for the duration of treatment.

The 13-week mental health review acts as key clinical governance checkpoint to identify treatment progression, or whether a different treatment approach or intensive treatment option is needed (e.g. increasing the frequency or intensity of sessions). Other available treatment options may be consultation with the Sydney Children’s Hospital Network (SCHN) for the Regional and Rural Telemedicine Outreach Program with a view to consultation and support via case conference, to refer for a specialist Eating Disorder Inpatient admission. See [SCHN Regional & Rural Telemedicine Outreach Program](file:///T:\Outreach\EDIPA%20Regional%20and%20Rural%20Telemedicine%20Outreach%20Service%20flyer%2001_10_16%20(2).pdf). [SCHN Eating Disorder Service Rural & Regional Telemedicine Outreach Program](file:///T:\EatingDisorders\Outreach\EDIPA%20Regional%20and%20Rural%20Telemedicine%20Outreach%20Service%20flyer%2001_10_16%20(2).pdf) In addition, families may be referred to the Eating Disorder Intensive Program for adolescents (EDIPA) which includes the Two Week intensive Program. Please see link to [EDIPA Referral Package](file:///C:\Users\60055292\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\Outreach\EDIPA%20referral%20package%2010-16.pdf) here: [EDIPA Referral Package](file:///T:\EatingDisorders\Outreach\EDIPA%20referral%20package%2010-16.pdf).

**4.1.4 Weekly/Monthly Team Meeting and supervision**

The team leader is the only 1 FTE position, with the other EDS roles being part time (from 0.3 -0.8). It is therefore essential that one day per week all team members are present. On this day, a regular meeting will be held, where new allocations and reviews will be raised, and the team can engage in case consultation and peer supervision. One half-day per month the entire team will meet for a planning and service development meeting. The Eating Disorder Coordinator and Clinical Director may be invited to attend these meetings.

**5.0 Clinical Governance**

Clinicians who play a key role in the clinical governance of the specialist eating disorder service MoC are listed below. For further information regarding the roles of team members, please refer to Appendix ?.

* + 1. NNSW LHD CAMHS Service Manager
    2. NNSW LHD Clinical Director
    3. NNSW LHD Eating Disorders Coordinator
    4. Team Leader, Specialist Eating Disorder Service
    5. CAMHS Eating Disorder Clinical Leads
    6. Psychiatric and Medical Clinical Leads
    7. Sydney Children’s Hospital Network

# **Discharge Planning**

Discharge will be considered based on the following criteria being met:

* In any case where the eating disorder has resolved, and there is no or minimal evidence of eating disorder cognitions and/or compensatory behaviours. ***Note: resolution of the eating disorder is not a requirement for discharge from service.***
* The service provided by the EDS (e.g. intensive family based support, in-home support or MFT) has been completed and the EDS (in conjunction with the family and referring team) EDS Team agree that the intensity of service has been sufficient to address the presenting issues, and the family can be transferred back to the treating team.
* The EDS, despite intensive interventions deems that further intervention by the service is unlikely to be effective if continued, and further services are required (e.g. referral to local inpatient mental health or medical facilities, or residential care with tertiary services).
* Parents are well informed and aware that eating disorder symptoms need to be monitored for relapse
* A documented, clear maintenance, relapse prevention, and re-admission plan is in place, agreed upon by the treating team, client and family
* Ongoing supports in place for illness self-management and relapse management

A discharge review meeting with all stakeholders, including psychiatry should be completed before progressing to discharge.

The discharge plan should include documentation of the following:

* Plan for regular follow up with the young person’s GP
* Identification of impediments and triggers for relapse
* Identification of warning signs for relapse and development of a plan for responding
* Liaison with other support services if appropriate

Recommended communication at the point of discharge includes:

* Communication of the discharge letter and/or plan with active stakeholders which may include GP, Paediatrician, Dietitian and school.

In some cases, if the program is not meeting the needs of the client and family, they may be discharged from the service after a discussion with the EDT and the young person and family regarding the most appropriate follow-on service.

# **Transition between services**

Transition is a high risk period for people with an eating disorder. Lack of attention and/or ease of this process can result in unsuccessful transitions for clients (and their families), increasing the risk of relapse, disengagement and isolation.

## **7.1 Inpatient and Community Services**

As per the NNSWLHD Inpatient Management of Children and Adolescents with Eating Disorders Procedure (include hyperlink), young people with an eating disorder can be admitted to a designated mental health inpatient unit (Kamala) or nominated Paediatric Ward should there be a deterioration in their mental health presentation and/ or eating disorder. A deterioration in medical stability would require a medical admission. It should be noted that step up to more intensive care via the eating disorder service should support the ongoing program of the outpatient community care.

Regular communication and collaboration is essential between the inpatient and community-based settings to ensure smooth transition between services. Discussions will need to occur at the beginning of the admission to ascertain the goals of treatment and treatment timeframe with confirmation of who will be the treating community clinicians. Communications will also need to be ongoing with the inpatient team updating the community team regarding client progress and expected discharge. Recommended communication includes:

* Information gained through the inpatient admission is shared with the relevant community team prior to discharge
* Regular communication between inpatient and community teams during admission, through MDTs
* Community clinician to have contact with the family during the hospital admission (such as via telehealth or utilisation of day leave to see community clinician)
* Community clinician and GP appointments to occur within one week of discharge from inpatient ward
* Multidisciplinary Team discussions between CAMHS team and Inpatient team as to whether referral to EDS is warranted post D/C

## It is recognised that in some settings (e.g. single clinician sites), it may not be feasible to communicate as frequently or within the timeframes suggested above. It is recommended that these sites attempt to align with the outlined communication within their capacity.

## **7.1 Adult Services**

For older adolescents who are transitioning to adult services, transition planning should commence prior to transfer of care within at least one month and/or a reasonable time frame dependent on client’s care needs.

**8.0 Training, Resources and Support**

Training, resources and ongoing supervision will be provided to clinicians to support the implementation of the model of care. A tiered training and support package will be delivered to clinicians as part of the Workforce Development Plan. This will include:

* + 1. The ‘Foundations’ Course e-learning provided by InsideOut is accessible to all NNSWLHD CAMHS clinicians. NSW health clinicians are also encouraged to enrol in the extensive (approximately 17 hours) ‘Essentials’ course e-learning provided by InsideOut (also free)
    2. Family based therapy for eating disorders training for nominated Treatment Providers provided by InsideOut Institute for Eating Disorders
    3. Ongoing Peer Supervision for Eating Disorders Treatment Providers for 1 hour per month
    4. With Phase Two of the NSW Service Plan further workforce development will be provided in FBT and other therapeutic modalities (e.g. CBT-E)

To support the Workforce Development Plan, Learning Pathways have been developed in My Health Learning. Please see Appendix ? for further information regarding training and support as well as useful resources.

# **9.0 Model of Care Review**

# As per policy, the MoC will be reviewed in one year from going live on the policy drive, then again in five years with input from all relevant service providers and stakeholders. A review can be established at any time outside of these parameters if circumstances change.

# **10.0 Key contacts**

Leanne Friis, Manager, Child and Adolescent Mental Health Service: 6620 7912

Deanna Bowen, Eating Disorders Coordinator: 6620 7587

## Appendix: Resources and Support

Training, resources and ongoing support will be provided to clinicians to support the implementation of the model of care.

Clinicians will receive ongoing support from:

* Team Champions
* Eating Disorder Coordinator

Key resources to support this Model of Care

* **A practical guide to helping your young person gain weight and eat normally: Sydney Children’s Hospital Network.** This resource provides practical advice regarding refeeding children and adolescents.
* [**InsideOut Institute**](https://insideoutinstitute.org.au/). National research and clinical excellence institute dedicated to improving the lives of people with eating disorders and those who care for them.
* [**The Butterfly Foundation**](https://thebutterflyfoundation.org.au/)**.** Provides support to people with eating disorders and body image issues, including education services, support groups, recovery and treatment programs.
* [**National Eating Disorders Collaboration**](https://www.nedc.com.au/)**.** Provides information regarding eating disorders, professional development opportunities for health professionals, research and resources and support and services for people with an eating disorder.
* [**Centre for Clinical Interventions**.](http://www.cci.health.wa.gov.au/resources/minipax.cfm?mini_ID=19) Provides handouts that may be useful during treatment for someone with an eating disorder

1. Hay, 2017 [↑](#footnote-ref-1)
2. NSW Service Plan [↑](#footnote-ref-2)
3. *Multiple family therapy for anorexia nervosa at the Eating Disorder Service, the Children's Hospital at Westmead*. Available from: <https://www.researchgate.net/publication/284560627_Multiple_family_therapy_for_anorexia_nervosa_at_the_Eating_Disorder_Service_the_Children's_Hospital_at_Westmead> [accessed Nov 07 2020]. [↑](#footnote-ref-3)