Eastern Health CYMHS Eating Disorders Clinician Pack

Developed by the Eating Disorders Sub-committee within CYMHS

with

Acknowledgement to the Victorian Centre of Excellence in Eating Disorders

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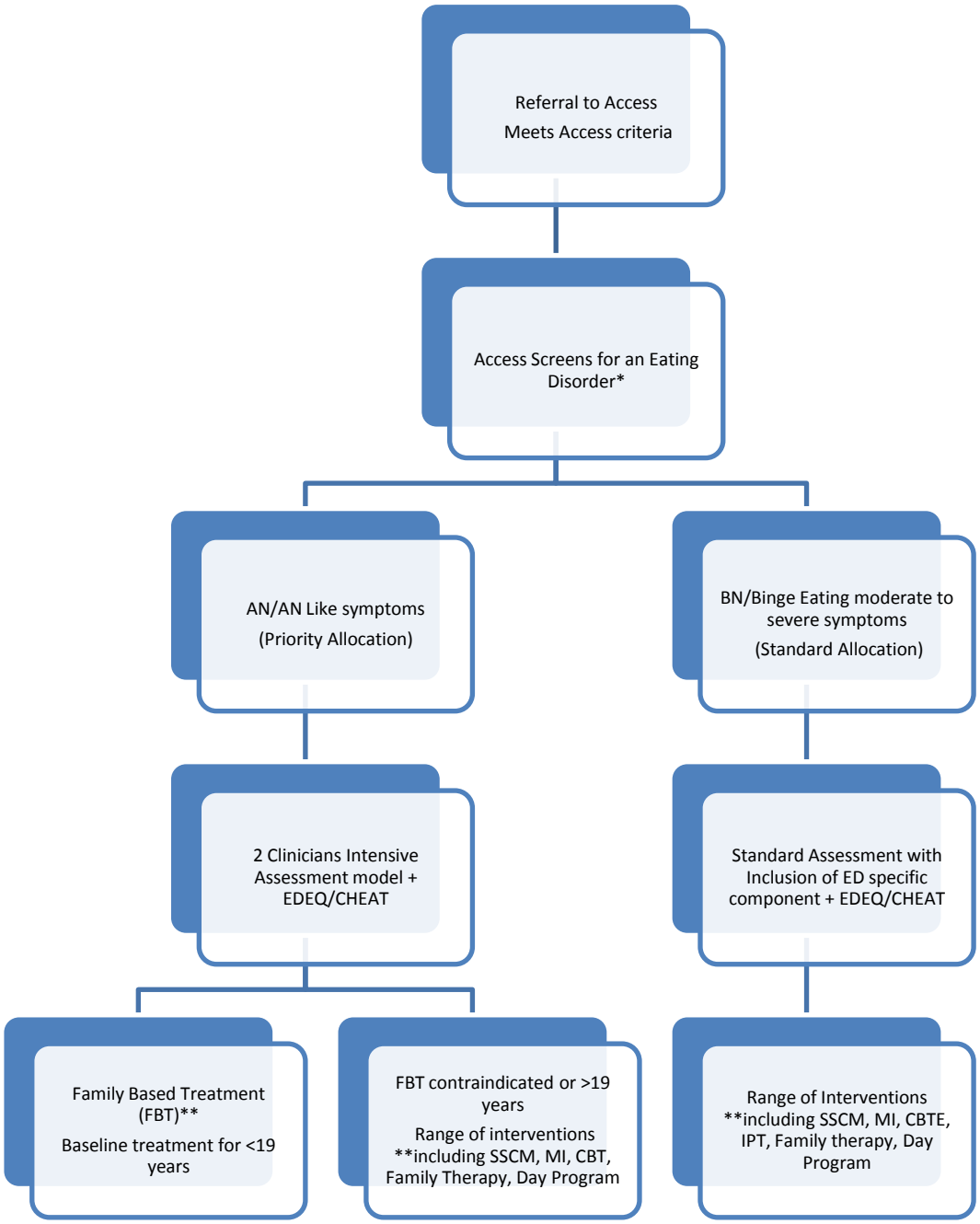
Clinical Pathway Category	Eating Disorders Clinical Pathway
Aims Anticipated outcomes	To provide consistent, timely and effective evidence-based screening, assessment and treatment for 0 -25 year old clients referred with symptoms of disturbed eating and who meet the criteria for an Eating Disorder; Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder or EDNOS. To ensure clients presented with symptoms of disturbed eating are referred for medical assessment via GP, Paediatrician or where acute medical concern to the Emergency Dept of local Hospital.
Target Population Eligibility/ineligibility	Children and youth, 0 -25 years who meet the criteria for assessment and treatment of an Eating Disorder as per Access guidelines. See Attachment 1: Eligibility Criteria for young people with an ED.
Resources Location, clinicians, skills	• Access clinicians with skills in screening children and youth for the presence of an Eating disorder. • Community team clinicians with access to specialised training, supervision and consultation in providing assessment, specialised therapeutic intervention and case management to clients and their family's presenting with symptoms of an eating disorder. • Access to outpatient medical monitoring and review using shared care pathways with Paediatric Hospital Outpatient Department, GPs and/or Paediatricians. Currently clients under 18years generally monitored by MMC, Austin Hospital, Box Hill Hospital or privately. Box Hill Hospital, Paediatric Outpatient Department does not have an ED Clinic and have limited capacity to provide the required regular medical monitoring and review required. Over 18 year olds are generally monitored via GP's. • Access to specialised ED Dieticians for clinical input and consultation, via Paediatric Hospital Outpatient Department/Community Health, private practitioners. • Acute Medical Care: Access to acute medical inpatient care in the event of medical compromise due to disordered eating. For over 18 year olds this generally occurs via local public hospital and for clients under 18 years with the Austin Hospital, Monash Medical Centre or Box Hill Hospital Paediatric Unit. Box Hill Hospital currently has no dedicated eating disordered beds. Acute Psychiatric Care: Access for acute admissions to psychiatric units where there is acute suicidality or significant immediate psychiatric risk is via: <12yrs Austin <18yrs AIPU >18yrs Upton House IPU 1 & 2 (Maroondah) Specialised Eating Disorder beds through BETRS (Body Image and Eating disorders Treatment & recovery Service) . • Continuation of the ED Subcommittee within CYMHS with representation from each of the Community teams, Groupworx, AIPU, Access. Subcommittee to continue to refine, evaluate and ensure delivery of E D Clinical Pathway, overview specialised training for clinicians, coordinate appropriate supervision and consultation, and develop protocols with partnership services/practitioners e.g., Acute Health systems, GP's, Dietetics.

Clinical Pathway

- Whole Clinical Pathway (consider flowchart)
- Assessment
- Treatment
- Review and Review Frequency
- Discharge/ Re-entry



***Screening:**

See Attachment 1: CYMHS Eligibility Criteria for young people with an ED

Those with a diagnosis of Anorexia Nervosa or symptoms suggestive of the development of Anorexia Nervosa would be appropriate for priority allocation to CYMHS; those with a diagnosis of Bulimia Nervosa of a moderate to severe level would be appropriate for CYMHS, standard allocation.

** Attachment 2: Treatment Definitions

Assessment **Summary** (Core and Advanced functions) (Referral to other agencies)	**Assessment (of clients presenting with AN symptoms):** Allocation of 2 clinicians (Case Manager and additional clinician) to conduct a standard CYMHS Assessment (over 1 -2 extended sessions only) with additional specialised assessment of ED symptoms and administration of EDEQ. Development of a Mental Health Care Team, to include CM, Co-therapist and access to Consultant Psychiatrist. Development of a Care team which includes integrated collaborative care with defined roles for Mental Health Care Team, Medical Team and Dietetics, an identified communication strategy and a shared understanding and agreement re ideal body weight, parameters for acute hospital admission etc. **Assessment (of clients presenting with Binge Eating/BN symptoms):** Standard CYMHS assessment with additional specialised assessment of ED symptoms, readiness for change and EDEQ. Development of a Care team which includes integrated collaborative care with defined roles for Mental Health, Medical and Dietetics, an identified communication strategy and a shared understanding and agreement re ideal body weight, parameters for acute hospital admission etc.

Treatment Summary (Core and Advanced functions) (Group, Individual) (Referral to other agencies)	**Treatment (of clients presenting with AN symptoms):** Provision of specialised eating disordered psychotherapeutic interventions with Family Based Treatment (FBT) as the baseline treatment for 19 years and under. For clients over 19 years or where FBT is contra indicated: motivational enhancement work, Mindfulness; SSCM, CBTE, IPT, Psychodynamic Psychotherapy, Pharmacological, Day Program as indicated by assessment and formulation. Refer to Attachment 2: Treatment Definitions. Maintenance of Care team utilising a shared care model with medical monitoring via outpatient hospital department/ GP/Private Paediatrician; and may include Dietetics via outpatient hospital, private dietician, community health. Development of agreed health parameters between CYMHS and Acute Medical Care Team such as IBW range and parameters re medical admission e.g. medical instability with unstable vitals, <75% IBW. Ongoing psychiatric risk assessment provided by Case Manager with access to Team Consultant Psychiatrist and liaison with Psychiatric Triage/ Crisis Assessment and Treatment Team as indicated. Admission to acute psychiatric inpatient unit to be considered for management of acute suicidality or acute psychiatric risk. Treatment is likely to be 12 months to 2years of therapeutic sessions (individual and family as clinically indicated) commencing at a minimum of 1 hour per week with graduated reduction in therapeutic contact as IBW and restoration of psychosocial development is achieved. Post discharge from acute medical unit is likely to require twice weekly sessions for several weeks. Outpatient medical monitoring is likely to be required initially on a weekly basis. Timeframe and frequency dependent on severity of physical compromise and response to treatment intervention. **Treatment (of clients presenting with Binge Eating/BN symptoms):** As indicated by assessment and formulation. May include SSCM M.I, CBT, IPT, APT, FBT, Mindfulness, Motivational enhancement, Pharmacological, Day Program – refer to Attachment 2 for Treatment definitions. Development of agreed health parameters between CYMHS and Acute Medical Care Team such as IBW range and parameters re medical admission e.g. medical instability with unstable vitals, <75% IBW. Ongoing psychiatric risk assessment provided by Case Manager with access to Team Consultant Psychiatrist and liaison with Psychiatric Triage/ Crisis Assessment and Treatment Team as indicated. Admission to acute psychiatric inpatient unit to be considered for management of acute suicidality or acute psychiatric risk.
Evaluation How is service delivery evaluated (consider measurable outcomes)? Are you implementing or aware of any formal evaluation tools (non DOH prescribed)? Please list	Evaluation to include the following areas: • Identification of clients presenting with Eating Disorders using population statistics to approximately evaluate efficacy of identification. • Medical stabilisation, e.g. BP, potassium levels, attainment and maintenance of normal weight range. i.e. >95% IBW • Client's ability to function across psychosocial domains and in a developmentally appropriate manner. • Client/family satisfaction To be measured by: Routine use of outcome measurement tools of HONOSCA and SDQ EDEQ to be administered alongside standard OM tools on admission, review and discharge. Baseline of effectiveness of current and past intervention with ED clients is currently being established through retrospective examination of HONOSCA

Supporting Evidence Evidence base underpinning clinical pathway including Policies, Legislation, Guidelines Briefly list primary publications that govern and/or guide service delivery. Refer to Appendix 2 of the 'Because Mental Health Matters' document for a comprehensive list of Victorian policy contexts	Because Mental Health Matters, Consultation Paper May 2008 Clinical Mental Health Service Responses for People with Eating Disorders in Victoria – Department of Human Services, Victorian Government 2007. Eating Disorders: The Way Forward. The Australian National Framework (national Eating Disorders Collaboration) 2010 Eating Disorders Resource for Health Professionals (2005), Centre of Excellence in for Eating Disorders Eisler et al (2000) *5yr FU Eisler et al (2007)* Eisler & LeGrange. Child Adol Psychiatr Clin N Am 2008 Hill, L. S., Reid, F., Morgan, J, F. & Lacey, J.H. (2009), SCOFF, the development of an Eating Disorder Screening Questionnaire. *International Journal of Eating Disorders, 00*:000-000. Lock et al (2005) *4yr FU Lock et al (2006)* Lock, Le Grange etc Randomized Clinical Trial Comparing Family-Based Treatment with Adolescent-Focused Individual Therapy for Adolescents with Anorexia Nervosa, Arch Gen Psychiatry, Vol 67 (10) October 2010. Luck, A. J., Morgan, J. F., Reid, F., O'Brien, A., Brunton, J., Price, C., Perry, L., & Lacey, J.H. (2002), 'The SCOFF questionnaire and clinical interview for eating disorders in general practice; comparative study', *British Medical Journal, 325,* 7367, 755-756. Next Steps in Mental Health Care Reform for Children, Young People and their Families Department of Health 2011-08-24 Robin et al (1994) *1yr FU Robin et al (1999)* Russell et al (1987) *5yr FU Eisler et al (1997)* Royal Australian and New Zealand College of Psychiatrists (2009) Anorexia Nervosa; a treatment guide for consumers and carers. Smith, A. Eating Disorders Program Integrated Mental Health Service RCH, 2007 Le Grange, Eisler. ,Dare, C., & Russell, G.F (1992), International Journal of Eating Diosrders 12:347-358 (This is not an exhaustive list. It represents just some of the key literature)

Attachment 1

ACCESS CRITERIA

CYMHS eligibility criteria for young people with an Eating Disorder.

NB. The most effective screening device probably remains the (health professional) thinking about the possibility of an eating disorder (National Collaborating Centre for Mental Health 2004a page 74).

General Principle: Eligibility occurs following:

STEP 1 IDENTIFY WHETHER CHILD/YOUNG PERSON HAS A LIKELIHOOD OF AN EATING DISORDER (refer to following page for information regarding diagnostic criteria/screening questions)

NB. Co morbid presentation of depressive or anxiety symptoms including social withdrawal, irritability, mood lability, obsessive behaviours etc are likely.

STEP 2 IDENTIFY TYPE OF EATING DISORDER i.e. anorexia nervosa, bulimia nervosa, binge eating or EDNOS

N.B Check whether any immediate physical concerns - If access clinician is concerned:

Recommend that client proceed to be seen by G.P. or medical treating team in a timely manner.

If physical status is compromised significantly direct client to be seen in ED immediately.

- **If Anorexia Nervosa or EDNOS with AN like symptoms referral accepted for priority allocation given:**

1. Identify medical management – GP, Paediatrician, Outpatient ED Clinic
2. Nil other Mental Health Professionals providing treatment

- **If Bulimia Nervosa, Binge Eating or EDNOS with BN like symptoms referral accepted for wait list allocation**

CORE DIAGNOSTIC CRITERIA FOR ANOREXIA NERVOSA:

Weight loss leading to body weight less than 85% expected for age and height, or in adolescent loss of around 5% of body weight in a 3 month period, failure to make expected weight gain
Cessation of menses
Intense fear of gaining weight or becoming 'fat' (may see change in clothing style, wearing baggy clothes, excessive/fluctuating exercise motivated by desire to lose weight)
Restriction of quantity and quality of food intake (e.g. development of multiple 'food rules', obsessive rituals re food, frequent excuses not to eat, change of eating patterns)

CORE DIAGNOSTIC CRITERIA FOR BULIMIA NERVOSA:

Recurrent episodes of binge eating
Loss of control over amount of intake during meal
Inappropriate compensatory behaviours to prevent weight gain, vomiting, laxative misuse, other med, fasting, excessive exercise
Binge eating and compensatory behaviours to have occurred min 2 per week for 3 month duration
Self evaluation based on weight and body shape
SCOFF SCREENING TOOL - to assist in identifying possible presence of an ED (not diagnostic) **in adults** with an eating disorder (Morgan et al, 1999). If possible administer SCOFF screening tool (for use with 18 years and over) directly with young person:

1. Do you make yourself Sick because you feel uncomfortably full?
2. Do you worry you have lost Control over how much you eat?
3. Have you recently lost more than 6.35 kg or one stone) in a three-month period?
4. Do you believe yourself to be fat when others say you are too thin?
5. Would you say food dominates your life?

A further two questions have been shown to indicate high sensitivity and specificity for BN:

1. Are you satisfied with your eating patterns?
2. Do you ever eat in secret?

Attachment 2

Therapy Definitions:

Family Based Therapy (FBT)

"FBT" is interchangeable with "Maudsley approach", and is the term used by many researchers and some outside the research field. In the Maudsley approach, the eating disorder is not seen as an expression of family dysfunction. On the contrary, the eating disorder is seen as an illness and the family is seen as the solution to the problem. The Maudsley approach only deals with problematic family patterns inasmuch as these patterns interfere with the elimination of the eating disordered symptoms and the reestablishment of normal developmental stages. The Maudsley approach necessarily involves a Paediatrician or medical specialist working in conjunction with the therapist. This is particularly true in the case of individuals with anorexia nervosa. Eating disorders are life-threatening, so a Paediatrician or Doctor can help to monitor the client's health, provide nutritional information if needed, decide when it is appropriate to return to normal activities (e.g., work, exercise), and help to determine a healthy body weight.

References:

Lock, J., Le Grange, D., Agras, W.S., Dare, C. (2002). Treatment Manual for Anorexia Nervosa: A Family-Based Approach. The Guilford Press: New York.

http://www.maudsleyparents.org/uofchicagoadvice.html

Interpersonal Therapy (IPT)

Interpersonal Psychotherapy (IPT) is a time-limited psychotherapy that focuses on the interpersonal context and on building interpersonal skills. IPT is based on the belief that interpersonal factors may contribute heavily to psychological problems. It is commonly distinguished from other forms of therapy in its emphasis on interpersonal processes rather than intra-psychic processes. IPT aims to change the person's interpersonal behaviour by fostering adaptation to current interpersonal roles and situations.

References

Swartz, H. (1999). Interpersonal therapy. In M. Hersen and A. S. Bellack (Eds). *Handbook of Comparative Interventions for Adult Disorders*, 2nd ed. (pp. 139 – 159). New York: John Wiley & Sons, Inc.

Weissman, M. M, Markowitz, J. C., & Klerman, G. L. (2007). *Clinician's quick guide to interpersonal psychotherapy*. New York: Oxford University Press.

CBT-E

CBT-E is an outpatient-based, manualised, psychotherapy for eating disorders directed at factors that maintain the eating disorder: dietary restraint, binge eating and compensatory behaviours; the dysfunctional system for evaluating self-worth (that are typically largely or exclusively in terms of eating habits, shape and weight & their ability to control them); tendency to extreme self-criticism and perfectionism and response to adverse mood states.

Key strategies in CBT-E involve psycho-education, behavioural experiments to foster both behaviour change (particularly around eating, body checking, avoidance of social experiences) and cognitive restructuring, and distress tolerance.

The treatment involves 20 sessions over 5 months for BN for which evidence is good, and 40 sessions over 12 months for AN.

Motivational Interviewing (including Readiness and Motivational Interview)

Ambivalence to change is a major stumbling block for individuals who develop an eating disorder, consequently therapeutic approaches that assess and address motivation for change have been utilised in effective treatment of Eating Disorders. Geller's Readiness and Motivational Interview (1999; 2004) can be used to assess client readiness and is frequently cited as an inadvertent clinical intervention that may assist clients with eating difficulties to engage in a therapeutic process of change.

A better understanding of how clients come to the decision to change their eating disordered behaviour would facilitate therapy. The Trans-theoretical Model of Change (TTM) (Prochaska, 1994) has been extensively researched, and explains the process of behavioural change. There are three basic constructs of the model. First, there are the Stages of Change that individuals pass through on their way to behavioural change: 1. In Pre-contemplation, individuals are unaware about the problem, and do not intend to change; 2. In Contemplation, they are thinking about change but not yet ready to make a firm commitment; 3. In Preparation, they are intending to change in the near future; 4. In Action, they are actively involved in making changes; 5. In Maintenance, clients are working towards maintaining the changes made; and 6. In Termination, the identified behaviours are no longer a problem.

References:

Blake W, Turnball S, Treasure J. Stages and processes of change in eating disorders: implications for therapy. *Clinical Psychology and Psychotherapy.* 1997;**43**:186–191.

Geller J, Drab DL. The readiness and motivation interview: a symptom-specific measure of readiness for change in the Eating Disorders. *European Eating Disorders Review.* 1999;**7**:259–278.

Geller J, Drab-Hudson DL, Whisenhunt BL, et al. Readiness to change dietary restriction predicts outcomes in the eating disorders*. Eating Disorders: The Journal of Treatment and Prevention* 2004; 12:209.

Gusella, J.,Bird, D & Butler, G. (2003). Tipping the Scales: Is Decision Making Related to Readiness to Change in Girls With Eating Disorders? *Canadian Child and Adolescent Psychiatry Review*. 2003 November; 12(4): 110–112.

Prochaska JO, Velicer WF, Rossi JS, et al. Stages of Change and Decisional Balance for 12 Problem Behaviours. *Health Psychology.* 1994;**13**:39–46.

Treasure JL, Katzman M, Schmidt U, et al. Engagement and outcome in the treatment of bulimia nervosa: first phase of a sequential design comparing motivation enhancement therapy and cognitive behavioural therapy. *Behaviour Research and Therapy.* 1999;**37**:405–418.

Vansteenkiste M, Soenens B, Vandereycken W. Motivation to change in eating disorder patients: A conceptual clarification on the basis of self-determination theory. *International Journal of Eating Disorders,* 2005; 37:207.

Vitousek K, Watson S, Wilson GT. Enhancing motivation for change in treatment-resistant eating disorders. *Clinical Psychology Review* 1998; 18:391.

Specialist Supportive Clinical Management for Anorexia Nervosa (SSCM)

This approach was originally developed as part of a trial for anorexia nervosa, in particular as a comparison treatment to CBT and IPT. It is an outpatient treatment that could be offered to individuals with AN in usual clinical practice by a professional trained in eating disorders. It combines features of clinical management, supportive psychotherapy. For individuals with AN, treatment emphasises the resumption of normal eating and restoration of weight.

McIntosh, V, Jordan, J, Luty, S, Carter, F, McKenzie,J, Bulik, C, Joyce, P, (2006), Specialist Supportive Clinical Management for Anorexia Nervosa in International Journal of Eating Disorders, 398, 625-632

Eating Disorder Assessment Addendum to Standard CYMHS Assessment

Health & Eating Behaviour			
Details of typical pattern of eating & drinking:			
Breakfast:	Lunch:	Tea:	W/E:
MT:	AT:	S:	
Usual Shopping & Cooking arrangements:			
Details of any therapeutic diet:			
Food rules / aversions:			

Eating & Weight Control Behaviours: (See following prompt page)

Restriction:

Bingeing:

Vomiting:

Laxatives:

Diuretics / other substances (used for wt control):

Exercise & physical activity:

Medical and Physical Health:

Anthropometry: (body measurements)

Height:	m	Weight:	kg
BMI:	kg/m^2	Healthy Weight Range (*BMI: 20 –25 in adults):*	

Weight Hx Timeline:

_____

Birth

Now

Weight since onset of ED: Lowest wt:: Highest wt::

Usual wt:: Client preferred wt:

Menstrual Cycle

PROMPTS FOR FURTHER CLINICAL EXPLORATION OF EATING DISORDER SYMPTOMS AND BEHAVIOURS

NB: To assist in the Assessment of clients with ED symptoms. May be adapted for use as clinically indicated for individual Assessment or as a guide to Assessment with families.

Weight and shape dissatisfaction / body image concerns

- What words would you use to describe your body image (e.g. overweight, healthy weight, thin, slim)?
- What do you think of your current weight?
- What is your ideal weight or clothing size?
- Are there specific parts of your body that you don't like?
- Are there specific parts of your body that you are satisfied with?
- How do you feel about gaining weight?
- How do you feel about losing weight?
- Does your weight and/or body shape have an impact on how you feel about yourself?
- How much of the day do you spend thinking/checking about your weight or shape?
- Does worry about your weight/shape make you avoid situations eg: PE, shopping, looking in the mirror?
- How much of your day would be spent checking?
- Does thinking about your weight or shape interfere with your day to day activities?
- Have others expressed concerns that you have lost weight or are too thin? How do you feel about that? (to be asked if the person appears underweight)

Dieting

- Many people seem to characterise food as 'good' and 'bad' or 'healthy' and 'unhealthy'. Is that something you ever do?
- What are 'good' foods?
- What are 'bad' foods?
- Are there foods or food groups you try to avoid or are allergic to?
- How do you feel if you eat these foods?

Food Intake

- Obtain details of an example of a typical day pattern of eating and drinking?
    - Breakfast
    - Lunch
    - Dinner
    - Snacks
    - Fluid Intake

Binge Eating

- Some people describe eating large amounts of food quite quickly. Have you ever experienced that kind of thing?
- Do you ever have the feeling that you cannot stop eating or control what or how much you are eating?
- How often does this happen?
- How long has this been happening?
- What sorts of things do you eat during these episodes?
- What happens after these episodes?

Self-induced vomiting

- Sometimes people make themselves vomit after eating. Is that something you have ever done?
- For what reasons do you make yourself vomit?
    - To prevent weight gain after binge eating?
    - To control your weight/shape or lose weight?
    - After small amounts of food?
- How often do you make yourself vomit?

Exercise

- Do you exercise?
- What sort of exercise do you do? (e.g. jogging, swimming, aerobics, weights)
- How long do you do each form of exercise? (e.g. daily, 3 times a week)
- Do you exercise to control your weight, lose weight, or to prevent weight gain?
- Do you feel this amount/duration of exercise is excessive? Have others ever commented on it?

Laxatives

- Do you take laxatives?
- How often do you do this?
- How long have you been doing this?
- Can you describe how it feels after you take them? (i.e. some people who abuse laxatives report feeling 'lighter' or 'cleaner')

Fasting

- Do you skip meals or go for a long time without eating?
- Could you give me an example of when this last happened?
- How often do you do this?
- How long have you been doing this?

Diet pills, appetite control pills and diuretics

- Do you/have you ever taken diet pills or diuretics?
- For what reasons do you take these pills?
- How often do you do this?
- How long have you been doing this?
- Have you ever tried to stop taking them?

Other eating and weight related issues

- Do you know your weight?
- Do you weigh yourself? How often would you do that?
- Have you ever avoided weighing yourself?
- Do you/have you ever felt guilty after eating?
- Do you/have you ever avoided eating with other people?
- Do you/have you ever eaten in secret or tried to hide what you eat?
- Do you try to avoid other people seeing your body?

General medical problems/screening of physical symptoms (appropriate general information for mental health professionals to cover

- When was your last period?
- Have missed at least 3 consecutive menstrual cycles? (not including those missed during pregnancy)
- Are you on the oral contraceptive pill?
- What are your energy levels like?
- Have you noticed any weakness in your muscles?
- What about climbing stairs or brushing your hair?
- Are you more sensitive to the cold than others?
- Have you had times when you have fainted or had dizzy spells?
- Have you had problems with your teeth (hot/cold sensitivity etc)?
- Have you had any problems with your digestive system?

Therapist Question / Dialogue Prompts for Family Based Treatment

Rhodes P. & Wallis A. The Maudsley Model of Family Therapy for Anorexia Nervosa in Interventions for Body Image and Eating Disorders (2009) IP Communications, Melbourne Pg 58-74

Session 1: Developing Empathy & the Task of Re-feeding

- **Mapping the effects of the illness on the family – Circular Questions:**
  - If I asked your wife to tell me about the effects that the illness has had on her so far, what do you think she would say?
  - What do you think she would tell me has been the most distressing?
  - How does what your husband has been saying fit with you?
  - If I asked your sister (the client) what effects the illness has had on her so far, what do you think she would say?
  - What do you think she would tell me has been the most distressing?
  - How does what your brother is saying fit with you?

- **Exploring Guilt – Metaphor example:**

  Imagine if your daughter was in a ship and it started to sink. Our own perspective, based on bitter perspective, is that exploring the cause of the illness with parents can be like diving in the water, swimming to the boat, taking the engine out and taking it apart to see what went wrong. At the moment it's like we need you to dive in and save her from drowning.

- **Externalising the Illness:**
  - When things are at their worst, would you say your daughter has more control over the anorexia or the anorexia has more control over her?
  - On a scale of 1 – 10, 1 being the most control by your daughter and 10 being the most control by the anorexia, where would you say things are right now?
  - What kind of things does the anorexia have her do when it is in maximum control?

- **Seriousness of Illness:**
  - If anorexia maintained 10 out of 10 control for two more years what do you think could be happening for your daughter?
  - How much do you know about the potential physical consequences?
  - What would be the worst possible thing that could happen?
  - What would be your greatest fear?

Phase 1
Session 1: First Face to Face Meeting
Directly Observed Competencies

Name of Therapist: _____
Date:_____

Task	Comments	Areas to Improve
Review the hypothesis regarding family structure prior to the session		
Greet the family in a sincere but grave manner • engage with each family member regarding their work/school/interest • maintain a grave and warm demeanour		
Find out what effects "the anorexia" has had on each family member • Use circular questions starting with the parents and then with children from oldest to youngest		
Assess and challenge feelings of guilt • Explain that guilt is one of "the anorexia's" methods of deception" • Ask the adolescent who is most likely to have been targeted/who next likely • Check with these people • Ask who is most likely to disagree • Ask this person to argue against "the anorexia" in this respect		
Separate the illness from the patient • Ask one of the parents how much they feel "the anorexia" has been in charge of adolescent and how much the adolescent has been in charge of it • Utilise a rating scale 1-10 • Assess the anorexia's tricks • Challenge any views held that she has been more in charge of it		
Orchestrate an intense scene concerning the seriousness of the		

illness and the difficulty of recovery • Ask the parents what they would tell you about the adolescent if you met them in one year and " the anorexia had continued to take charge of her • Ask them about their worst fears • Explore all of the medical complications listed in the (Maudsley model manual • Tell them about mortality rates • Maintain an intense and foreboding tone		
Charge the parents with the task of refeeding • Summarise your findings from the interview (this interview?) • Emphasise the family's essential role in preventing medical complications/death • Emphasise that hospitalisation cannot defeat anorexia • Explain why the family are the best resource for refeeding • Emphasise the need for the adolescent not to attend school for two weeks and for the parent's to take leave		
Prepare for next sessions family meal • Ask the parents to bring enough food to feed a starving child		

Session 2: Family Meal
Encouraging parents to reconsider any decisions that may have been influenced by the anorexia.

Imagine that you had 10 out of 10 control over the anorexia, what kind of food would you be giving your daughter for dinner?
How much do you think your daughter's involvement in cooking is her own personal choice as opposed to a tactic of the anorexia?

Coaching Role Tips:

1. Ask parents questions that encourage them to take charge:

- What do you think the both of you could do or say to convince your daughter that you will never give up on her until she eats what you have brought?
- If I asked your daughter if she thinks you will persist until you succeed at this task, what do you think she would say?

2. Encourage small instances of interactions that may work:

- Did you notice how calm your husband was when he was speaking to your daughter then? He's really got what it takes
- OK if you repeat that 1000 more times, it just might work
- Wow, I thought you said you weren't tough on the anorexia? Keeping doing that, that's really impressive.

3. Use seating to gradually enhance the intensity of the session:

It can be useful for the therapist to gradually move their own chair and that of the parents and siblings closer to the patient as the session proceeds. This is likely to be experienced negatively by the patient, especially given that her parents are consistently asking her to eat food that she finds challenging. However, the presence and comfort of the siblings and the physical proximity of the family can also create a simultaneous atmosphere of love and concern.

4. Manage your doubts:

It is possible that after 20 minutes or 30 minutes of coaching with little success, the therapist may entertain doubts that the patient will eat. It is important for the therapist to learn to manage these doubts, letting them come and go, but not interfere with their persistent faith in the capacity of the family and persistent emphasis on the task.

Phase 1
Session 2: The Family Meal
Directly Observed Competencies

Name of Therapist: _____ Date:_____

Task	Comments	Areas to Improve
Weigh the patient and engage with her		
Explain the purpose of the meeting, to get the patient to eat one more mouthful than the anorexia wants her to		
Ask the family to commence the meal		
Review ground that anorexia has taken regarding who cooks, type of foods, who is present at meal times		
Ask the parents to consult their parental instincts regarding making changes to above		
Make direct recommendations if required		
Observe the family in their attempt to convince their daughter to eat at least one mouthful more than she is prepared to		
Help the parents convince their daughter to eat at least one mouthful more than she is prepared to: • Instruct them to take charge • Direct comments to them only. Ask them to sit either side of their daughter • Ask them to fill her plate rather than negotiate • Physically stand behind them to prompt them		

• Prompt them to be a monotonous force on their daughter • Oppose family structures that disrupt parental authority • Oppose and confront inconsistency in parenting • Make repeated and insistent suggestions about how they can act uniformly • Praise all appropriate attempts • Use a paradoxical injunction if the adolescent complies to easily		
Align the patient with her siblings for support • Ask them to check with her to see if she is distressed • Ask them to sympathise if she is distressed		
Closing the session • summarise your findings from the family meal • provide feedback in a hopeful and optimistic tone • include words of caution if the adolescent's weight has decreased • reinvigorate the parents to take prompt and persistent action if they have not been successful during the family meal		

Phase 1 – Session 3 Onwards:
Core themes to consider & address ongoing sessions of Phase 1

- Is the parent team consistent?
- Are siblings providing emotional support to the patient?
- Do parents become critical or personal in their efforts to stand up to the patient?
- Are parents waning in the level of intensity that informs their approach to the anorexia?

Tips for the Therapist:

1. Persist until the family starts to succeed

"Therapists should manage their own frustration, maintain their faith in the family and work persistently on the behavioural and structural demands of the model until weight gain commences."

2. Empathise first, Challenge second

"Take care to develop empathy with a family member before challenging them to make a difficult change in behaviour. The greater the connection that can be achieved the more forthright the therapist can be. Challenges will be more successful if questions are used rather than statements, and if these questions help family members to come to conclusions about change themselves."

Phase 1
Sessions 3 +
Directly Observed Competencies

Name of Therapist: _____
Date:_____

Task	Comments	Areas to Improve
Engage with the adolescent during weighing asking if she has any issues she wants discussed		
Use externalising and empathy non critically if the adolescent uses hidden weights		
Plot the weight chart in front of the whole family		
Refrain from setting a target weight • use the phrase "the weight you know is right for a healthy body" • target the return of menses and healthy skin, hair, and bones		
Review progress with re-feeding • track exactly what happened during specific meal times, including difficult ones • use circular questions to gather more information • linger over discrepancies until the picture is clear • carefully select steps to reinforce and steps to discourage		
Discuss, support, and help the parenting • check consistency with extreme vigilance • assist parents to agree on foods and re-feeding strategies before meal time • do not take over their role by over-controlling or over-directing them • allow them to make the decisions and work		

out strategies • make some suggestions especially regarding not counting calories or having detailed negotiations with the adolescent • access the parent's expertise on creating high density meals • keep reminding them that their daughter's illness is still dangerous • emphasise urgency if they relax with early successes • create a second intense scene if weight plateaus due to uncertainty, loss, or nostalgia in the adolescent • target other anorexic behaviours including exercising, laxatives • guide the parents to supervise her by engaging in joint activities if she exercises after meal-times • guide parents to liaise with the pharmacist to prevent access to laxatives		
Discuss, support, and help the family to evaluate efforts of siblings to support their affected sister • encourage and reinforce attempts by siblings to support sister who may be upset by parents' tough stance or scared at the prospect of weight gain • encourage or reinforce verbal support, listening, or in the case of younger siblings, hugs • promote the adolescent spending time with peers if she has no siblings • promote time with peers at home if the adolescent is too unwell to go out		
Continue to modify parental and sibling criticism that may be due to feelings of guilt • correct criticism at every point if it occurs in the session or is reported to have occurred at home • explore specific examples without being critical of the parents or sibling • assist the parents or sibling to find alternative ways that interactions could be handled • continue to externalise the illness		

• use the “venn diagram” strategy • educate the parents or sibling regarding the effects of “the anorexia” on thoughts and behaviour • encourage one parent to support another who may be critical because they are over-burdened in the re-feeding process • compliment the parents or sibling on their successes		
Develop a strategy to deal with any parental psychopathology that might serve as a restraint to the re-feeding process refer a parent if they are clinically depressed, anxious, etc encourage the other parent to provide support to alleviate this restraint		
Review the grandparents role if a parent is exhausted or cannot take more time off work • invite grandparent/s to sessions to assess their understanding of the illness • include them in one more session to assist in the re-feeding process iftheir understanding is good		
Provide feedback to medical colleagues regarding weight and progress after each session		

Phase 2

Helping the Adolescent Eat on Their Own: Approximately 2- 6 Sessions

Directly Observed Competencies

Name of Therapist: _____ Date:_____

Task	Comments	Areas to Improve
Commence phase only if following criteria are met • weight is at 90-95% of ideal • patient eats without cajoling by parents/struggle • parents feel empowered in refeeding process/relieved that they can take charge		
Fade to fortnightly or three weekly sessions		
Demonstrate a less grave and sombre mood		
Maintain parental management of eating by: • reviewing eating events using circular questions to explore discrepancies • select strategies to reinforce and interactions to modify • consolidate parental trust in their own ability rather than direct coaching		
Continue to modify criticism and encourage sibling support during the re-feeding process		
Maintain parental control until the patient no longer doubts their ability to take charge		
Carefully negotiate a trial period of fading parental management to see if the adolescent can cope • develop a mutually agreed handing over process that includes the patient's input • include issues such as letting the patient serve her own meals, increasing her choice of foods, letting her eat alone for 1 to 2 meals per day while parents supervise main meal		

Explore the divergence between anorexic thinking and adolescent thinking in the patient		
Encourage the adolescent to restart engagement with the outside world (eg: peers, dating)		
Assist parents to plan any gradual return to exercise including their thoughts about increasing calories and managing injuries/ risks to bones		
Focus on "what is in it for them" as they take more control of the anorexia themselves (ie: getting teenage life back)		
Encourage the parents and adolescent to problem solve a plan regarding eating out with friends including where and exactly which foods		
Create a new intense scene in the family if the adolescent resists parental efforts as she approaches a critical weight/menses and plateaus • □inform the parents about medical complications of persistent amenorrhea to reinvigorate them in their re-feeding responsibilities		
Reinvigorate Phase 1 if the adolescent's weight slides as she is given more autonomy		

Phase 3
Adolescent Issues Approximately 3- 4 Sessions
Directly Observed Competencies

Name of Therapist: _____ Date:_____

Task	Comments	Areas to Improve
Commence only if the following criteria are met • 95-100% of ideal body weight • therapist and parents convinced anorexia will not return if it is not the focus of discussion		
Fade to sessions every 4 to 6 weeks		
Conduct session in an optimistic, hopeful, anticipatory mood		
Discontinue insistence on weighing at every session		
Review progress so far with the family		
Identify a list of adolescent issues to be the focus of Phase III		
Assist the parents and adolescent to problem solve each issue • Flesh out each issue in detail using circular questions • Authorise and empower the parents to approach each of the issues • Facilitate discussion between the parents and the adolescent to resolve each issue • Maintain a focus that conceptualises each issue as a normal part of adolescent development		
Check how much the parents are doing as a couple • Ask them how much time they spend together, what they do, what they would like		

to do • If marital problems were significant before the onset of anorexia and ifthey have not been resolved indirectly by Phases I-III refer for relationship counselling		
Plan for future issues • Help the family predict future adolescent issues that may occur • Make some brief suggestions about how these might be resolved		
Facilitate the termination of therapy • Review each family member's individual experience of the therapy from start to finish while demarcating each phase and issue • Confer sincere confidence that they can proceed with likely success if future problems arise • Say goodbye to each person • Mirror the momentous and careful greeting in the first meeting by praising each one for their work with genuine warmth and optimism • Give each person an opportunity to say goodbye to you		

Calculating Body Mass Index (BMI) and Ideal Body Weight (IBW)

formula to calculate BMI is as follows:
The

$$\textbf{BMI} = \frac{\textbf{Weight (in kg)}}{\textbf{Height (in m)}^2}$$

For example, for a height of 1.60m and weight of 40kg, the BMI is:

$$\frac{\textbf{Weight (in kg)}}{\textbf{Height (in m)}^2} = \frac{\textbf{40kg}}{\textbf{1.6mx1.6m}} = \frac{\textbf{40}}{\textbf{2.56}} = \textbf{15.6}$$

In drawing up the weight chart, it can be helpful to know 100% Ideal Body Weight (a guide to expected healthy BMI for age where BMI is at 50th%ile), 90% IBW (> Phase 2), 85% IBW (< Dx Anorexia Nervosa) and 75% IBW (> suit FBT).

We need to use the BMI Ready Reckoner chart for GIRLS (A26) and BOYS (A27) to get the calculated BMI at each of these levels for the young person's age. Use this BMI in the calculation below to work out the weight at each of these % levels:

Weight = BMI (from the Ready Reckoner) x height (in m)^2
For example, for a 15 year old girl with a height of 1.60m, the Ready Reckoner says that her BMI at 100% IBW is 19.9. So we use the above formula to calculate this weight:
Weight = 19.9 (BMI) x 1.6m x 1.6m
= 50.9kg
Therefore, 50.9kg would be her weight at 100% Ideal Body Weight. This can be used for 90%, 85% and 75% in the same way, just use the table to get the BMI at that %.

Body Mass Index (BMI)* Percentiles in Diagnosis & Family-Based Treatment of AN
GIRLS (7 - 18 yr)

(calculated from CDC growth charts 2000)

Age	BMI at 50th percentile for age (used to define Ideal Body Weight (IBW)** in FBT)	BMI indicative of AN (≤ 85% IBW)	BMI above which FBT is most suitable (≥75% IBW)	BMI above which phase II FBT indicated / menses likely to return (≥ 90% IBW)
7	15.4	13.1	11.5	13.9
7.5	15.6	13.3	11.7	14.0
8	15.8	13.4	11.8	14.2
8.5	16.0	13.6	12.0	14.4
9	16.3	13.9	12.2	14.7
9.5	16.6	14.1	12.4	14.9
10	16.8	14.3	12.6	15.1
10.5	17.2	14.6	12.9	15.5
11	17.4	14.8	13.0	15.7
11.5	17.8	15.1	13.3	16.0
12	18.0	15.3	13.5	16.2
12.5	18.4	15.6	13.8	16.6
13	18.7	15.9	14.0	16.8
13.5	19.0	16.1	14.2	17.1
14	19.4	16.5	14.6	17.5
14.5	19.6	16.7	14.7	17.6
15	19.9	16.9	14.9	17.9
15.5	20.2	17.2	15.1	18.2
16	20.4	17.3	15.3	18.4
16.5	20.6	17.5	15.4	18.5
17	20.9	17.8	15.7	18.8
17.5	21.1	17.9	15.8	19.0
18	21.2	18.0	15.9	19.1

(*) BMI = weight (kg) ÷ height $(m)^2$

(**) **BMI at 50th percentile** is used in Family-Based Treatment for AN to define a client's **'Ideal Body Weight' (IBW)**, and provides a general guide to expected healthy BMI for age. Healthy BMI for age for very slight or robust framed individuals may range above or below this figure. Assessment by a Paediatrician will provide a more comprehensive guide to an individual's healthy weight and growth status.

Body Mass Index (BMI)* Percentiles in Diagnosis & Family-Based Treatment of AN
BOYS (7 - 18 yrs)

(Calculated from CDC growth charts 2000)

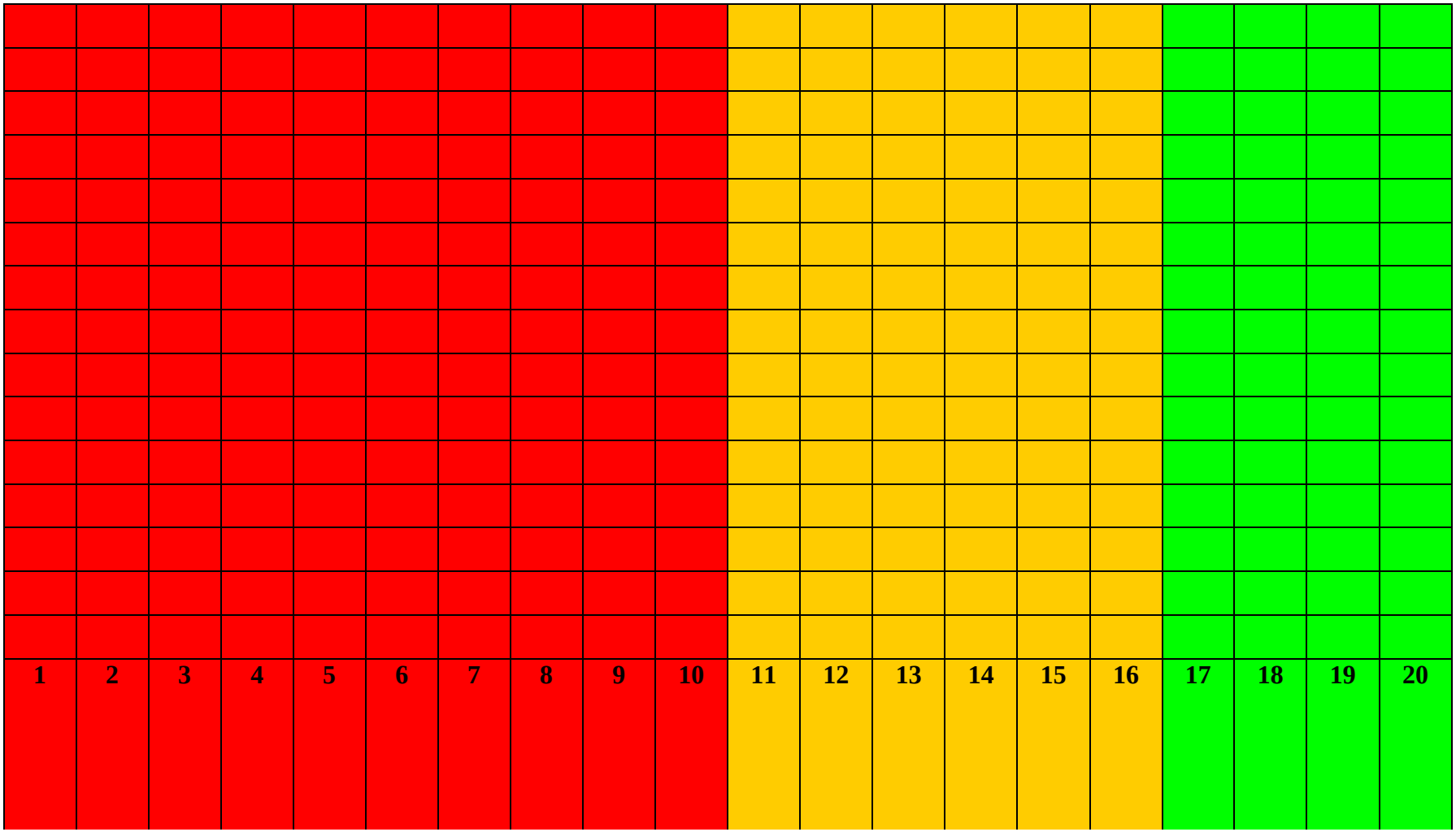
Age	BMI at 50th Percentile for age (used to define Ideal Body Weight (IBW)** in FBT	BMI indicative of AN (≤ 85% IBW)	BMI above which FBT is most suitable (≥ 75% IBW)	BMI above which Phase II FBT indicated (≥ 90% IBW)
7	15.5	13.2	11.6	13.9
7.5	15.6	13.3	11.7	14.0
8	15.8	13.4	11.8	14.2
8.5	16.0	13.6	12.0	14.4
9	16.2	13.8	12.1	14.6
9.5	16.4	13.9	12.3	14.8
10	16.6	14.1	12.4	14.9
10.5	16.9	14.4	12.7	15.2
11	17.2	14.6	12.9	15.5
11.5	17.5	14.9	13.1	15.7
12	17.8	15.1	13.3	16.0
12.5	18.1	15.4	13.6	16.3
13	18.4	15.6	13.8	16.6
13.5	18.8	16.0	14.1	16.9
14	19.2	16.3	14.4	17.3
14.5	19.5	16.6	14.6	17.5
15	19.8	16.8	14.8	17.8
15.5	20.2	17.2	15.1	18.2
16	20.6	17.5	15.4	18.5
16.5	20.9	17.8	15.7	18.8
17	21.2	18.0	15.9	19.1
17.5	21.6	18.4	16.2	19.4
18	21.9	18.6	16.4	19.7

(*) BMI = weight (kg) ÷ height $(m)^2$

(**) **BMI at 50th percentile** is used in Family-Based Treatment for AN to define a client's **'Ideal Body Weight' (IBW)**, and provides a general guide to expected healthy BMI for age. Healthy BMI for age for very slight or robust framed individuals may range above or below this figure. Assessment by a Paediatrician will provide a more comprehensive guide to an individual's healthy weight and growth status.

Family Based Treatment Weight Chart

Kgs



Session/Date

Name: **Starting Weight:** **Starting Height:** **DOB:**

Progress 1 Weight 1: **Progress Height 1:**

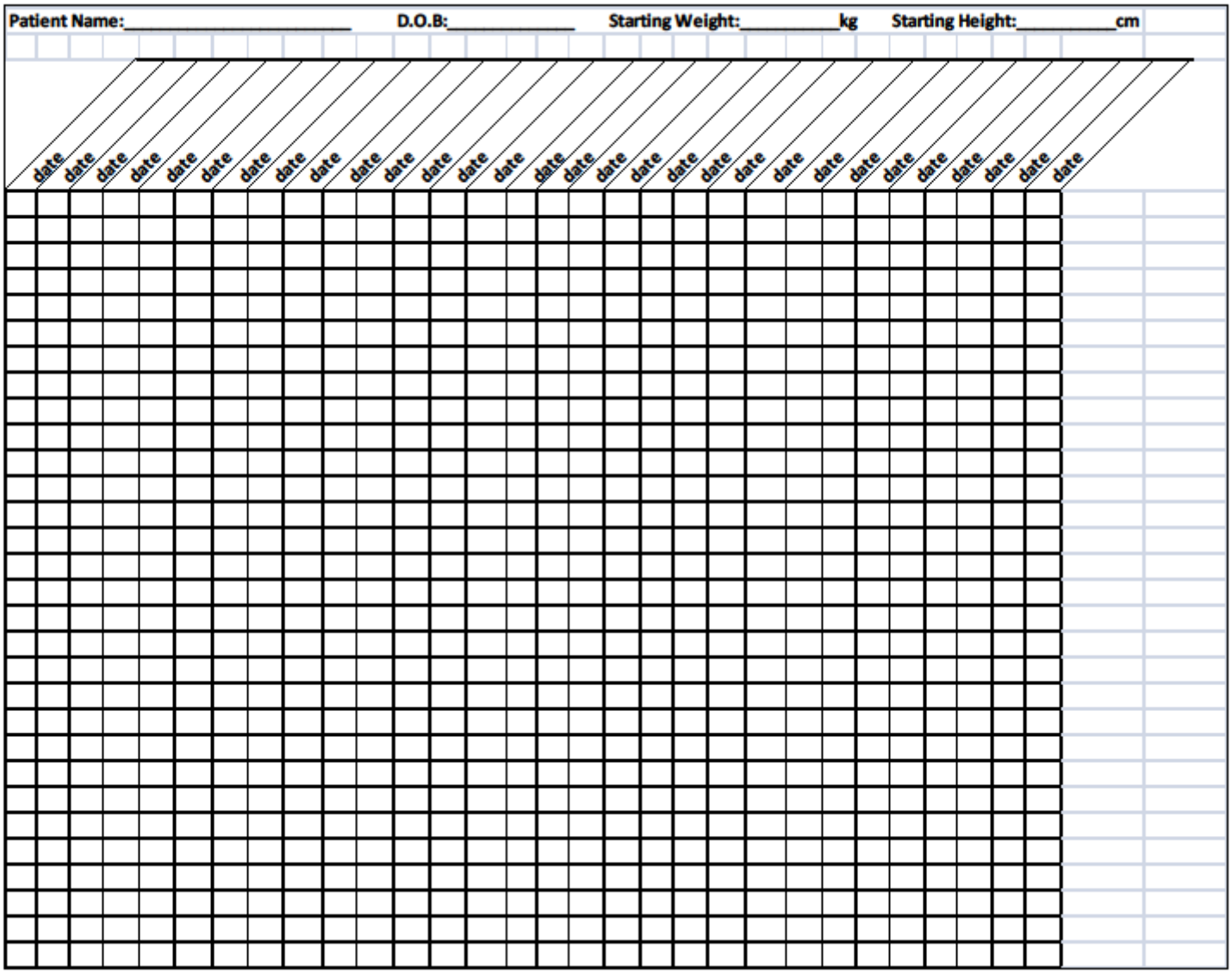
Family Based Treatment Clinician Information Sheet

Name		**Age/DOB**		**Date of Tx Onset**	
Starting Weight Kgs		**Starting Height cms**		**Optimal weight range kgs**	
Starting % IBW		**90% IBW Kgs**		**100% IBW kgs**	
Starting BMI		**90% IBW BMI**		**100% IBW BMI**	

Session No.	Date	Weight	+/-	% IBW kgs	BMI
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

Acknowledgment to RCA Centre of Excellence in Eating Disorders

Kg's ↓


Patient Name:_____ D.O.B:_____ Starting Weight:_____kg Starting Height:_____cm
date

Medical Consequences of Eating Disorders

Essentially, medical consequences of eating disorders are acute and longer-term effects of malnutrition and purging behaviours:

Long-term and potentially irreversible:

- Infertility
- Osteoporosis
- Gastrointestinal problems (after long term purging)
- Subtle brain changes
- Dental – enamel erosion, tooth loss
- Cardiac-heart muscle changes

Nb for clients with consequent obesity: lifestyle related health consequences: eg impaired glucose tolerance, raised blood fats, hypertension, joint problems, infertility.

Other medical consequences of eating disorders that inform mental health management:

- **Gastrointestinal:** delayed gastric emptying, early satiety, slow transit time & constipation, nausea, abdominal pain or bloating, diarrhoea & cramping, rebound constipation, rebound oedema, peptic ulcers
- **Metabolic:** decreased metabolic rate, hypothermia, cold intolerance, depressed immune function, altered thyroid function
- **Haematological:** anaemia, electrolyte, mineral and vitamin deficiencies
- **Cardiovascular:** abnormal ECG, dehydration, postural hypotension, slowed heart rate, cold & cyanosed extremities, oedema, CCF, cardiac arrest
- **Dermatological:** dry skin, hair loss, fine body hair (lanugo)
- **Endocrine:** amenorrhoea, low oestrogen, delayed menarche, growth & development. Low testosterone, sub-fertility
- **Oral health:** gum disease, infection, abscess
- **Skeletal:** fractures
- **Neurological:** enlarged cerebral ventricles and external cerebospinal fluid spaces (pseudo atrophy)

Physical Risk in Suspected Eating Disorders – Mental Health Clinician Response Guide

Response Required	Indication / Symptom / Behaviour
Arrange **urgent (on the same day) medical review** with medical practitioner or at emergency dept for decision re need for medical admission	• **Reported fainting / collapse / dizziness Cold blue extremities** • **Rapid (≥ 0.5kg/wk) / ongoing weight loss** • **BMI < 15 (adult); > 10% loss of body weight (child / adolescent)** • **Acute cessation of food intake over 3 – 5 days** • **Restriction of fluid intake (< 500ml / daily)** • **Increased fluid intake (> 3000ml / daily)** • **Self-induced vomiting ≥ 1 episode daily** • **Laxative / other medication use to control weight**
• Arrange **increase in frequency of medical monitoring**; or • Continue **weekly – fortnightly medical review**	• Ongoing weight loss • worsening dietary restriction (<1200kcal / 5000kJ daily) • Restriction of fluid intake (< 1000ml / daily) • Increase to purging / binge eating frequency • Self-induced vomiting ≥ 2 episode weekly • Laxative / other medication use to control weight
Medical monitoring as advised by medical practitioner / agreed by care team	• Ongoing mild to moderate eating disorder behaviours

Initial Report request from Paediatrician or GP / Shared Physical Data (key weight and growth information) for AN treatment Planning

Date:

Current medical status and risk:

Current medical treatment recommendations:

- Weight under which inpatient management is recommended:
- Indicators for medical stabilisation inpatient admission:

Next planned medical status review:

recommended frequency of review:

Report on growth and weight status (for outpatient AN treatment planning)

Current height: height %ile: MUAC:

Current weight: weight %ile:

BMI: BMI %ile:

Growth (physical development) history:

Current stage of Adolescent height growth spurt **(please circle):**

Pre early mid almost complete completed

I——————————————————————————————I

Pubertal Growth is **(please circle):**: on track delayed

Initial target weight (range), based on current height & age:

Recommended frequency of height review:
Next planned height review & review of target weight:

Predicted adult height:

Predicted adult weight range for predicted height & family build **(please circle):**

Healthy Weight Range:

Lower end middle upper end

I——————————————————————————I

Nb: Target weight (range) = 100% back on track for health & growth as determined by the paediatrician / team **(adult healthy weight range? / 100%IBW? / clinically determined)**

Prepared by Michelle Roberton Eating Disorders Senior Clinician Victorian Centre for Excellence in Eating Disorders

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Child & Youth
Mental Health Service (CYMHS)
Local Clinic:
_____

_____

TREATMENT UPDATE

DATE:
TO:
FROM: **PHONE:** **FAX:**
CLIENT: **DOB:**
DIAGNOSIS/DIAGNOSES:
GOAL WEIGHT RANGE: **IBW calculation—agreed by treating team**
DATE SEEN:
CURRENT CYMHS WEIGHT: **MOST RECENT MMC WEIGHT:**
MEDICATION:
KEY ISSUES:
RECOMMENDATION/PLAN:
NEXT SCHEDULED CYMHS APPOINTMENT:

Resource Tools and Contacts

Copies of the Clinician pack and a range of other recourses are available through the shared drive:

Eastern Health Intranet➔Mental Health Program➔CYMHS➔ED folder

Eating Disorder Coordinator Eastern Health CYMHS

Lynne Allison

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Education Services: 03 8387 2669

Fax: 038387 2667

ceed@mh.org.au

BETRS (Body Image Eating Disorders Treatment & Recovery Service)

Referrals: 9854 1700

16yrs +

Day Program & Specialised ED Beds (Austin Hospital)

104 Studley Park

Kew

Monash Medical Centre Eating Disorders Program

Michelle Coughey

Eating Disorders Victoria