ASSESSMENT OF SUSPECTED EATING DISORDERS

AT RISK GROUPS
In psychiatric populations, a screen for eating disorder pathology should form part of the standard assessment. An individual’s risk may increase if they are:

- Female
- Aged 12 to 20
- An elite athlete, sportsperson or dancer
- On a restrictive diet for medical reasons
- A member of a family with a history of eating disorders
- Sufferers of sexual abuse and trauma

WARNING SIGNS

- Dieting behaviours (especially when kept private)
- Extreme dieting (fasting) or disordered eating habits
- Skipping meals
- Purging (such as vomiting or use of laxatives) or signs of purging (enlarged parotid glands, calluses on knuckles, cracked/split lips)
- Frequent bathroom visits especially after meals
- Excessive exercise behaviours (especially when solitary or secretive)
- Body dissatisfaction
- Weight loss or failure to reach expected gains

ASSESSMENT PARAMETERS

Weight and calculation of BMI centile
If eating disorder pathology is suspected it is essential to weigh the patient, measure their height and calculate a BMI centile. Any individual whose body weight is reduced, less than expected, or has experienced a sudden or chronic loss of weight, should be assessed for the presence of an eating disorder. Note: Weight is an unreliable measure and has to be used in the context of previous weight, weight controlling behaviours and medical stability, amongst other things.

24-hour recall
Take a 24-hour recall of the patient’s food and fluid intake, ask if the last 24 hours is typical, and assess whether it meets minimum daily requirements for age. Purging or excessive exercise may be present if the individual is bingeing or significantly over-eating but remains at a healthy or low weight.

Blood chemistry and ECG as required

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1 See section titled “Assessing Growth and Determining Healthy Weight Range” for more information.
EATING DISORDER ASSESSMENT

KEY POINTS
- Complete a thorough, individualised assessment of the young person and their situation (allowing clear and appropriate decisions about treatment).
- Aim to assess risk (medical and psychological).
- Be patient- and family-centred.
- A comprehensive assessment is generally achieved by involvement of the multidisciplinary team.
- Appropriately trained mental health staff should carry out the majority of the family and individual assessment.
- Questioning should be searching, detailed and sensitive. Aim to validate the young person’s experience and demonstrate that you have heard what has been said by all family members.
- Attempt to gain some understanding of how the young person views their illness and what they feel will help or hinder their recovery.
- The interview will be difficult for many young people and will depend, in part, on their level of insight to the illness as well as their medical and psychological status at the time. Parent or carer input is required to validate or supplement some of the interview findings.
- Involve the patient and family in assessment, treatment and discharge planning.
- Adolescents are still growing and developing. Physical consequences of the eating disorder may be irreversible, though may be treatable if intervention is timely.
- See Appendix 5 for examples of psychometric assessment tools.

THE INDIVIDUAL INTERVIEW
The key aspects of the individual interview include consideration of the history of the presenting illness, the past and co-morbid psychiatric history, as well as social and family history.

HISTORY OF THE PRESENTING ILLNESS
1. Patient’s perception of the problem and perceived impact on the patient and the family
2. Duration of illness
3. Description of the eating disorder symptoms (include onset, potential triggers and maintaining factors)
4. Weight controlling behaviours (restricting eating, vomiting, exercise, laxative use, and other substance misuse)
5. Current patterns of eating (including mealtime description, feelings associated with eating and binge eating episodes)
6. Presence of excessive exercise behaviours
7. Premorbid weight and growth
8. Degree of body image distortion; impact of potential weight gain
9. Insight into illness and motivation for change
10. Effects on school (e.g., academic progress, peer and teacher relationships, achievements, difficulties)

PAST AND CO-MORBID PSYCHIATRIC HISTORY
1. Past psychiatric history and treatment
2. Co-morbid conditions (mood and anxiety disorders are common)
3. Other psychological history including neglect, trauma, depression, self-harm, suicidal thoughts and bullying
4. Personality traits (e.g., perfectionism, obsessiveness)
SOCIAL AND FAMILY HISTORY

1. Personal interests (e.g., hobbies, sport, recreations) and strengths
2. History and details of family eating and dieting behaviours
3. Family history (e.g., mental illness)
4. Degree parents are working together consistently to care for the child
5. Relationships between family members
6. General atmosphere of the family (e.g., warmth, tension, closed)
7. Affective responses and communication processes between family members
8. Family strengths and weaknesses
9. Areas for consideration such as cohesion, adaptability, flexibility, hardiness, and problem solving
10. Cooperation, or willingness, of the family to work with the treating team

Note: HEEADSSS assessment is a useful tool in biopsychosocial assessment, although training is required (see Appendix 5).

MEDICAL INFORMATION

Collect information on pre-existing medical conditions, allergies, medications (including vitamins, minerals and complementary medicines), bowel function and a detailed menstrual history. The menstrual history should include age of menarche (if reached), regularity of menstrual periods, length of menstrual cycle, absence of any menstrual periods and date of last menstrual period.

PHYSICAL ASSESSMENT

Try to ensure that the physical examination is carried out sensitively. The patient will be exposing their body (a disliked aspect of themselves) to an unfamiliar person.

- **Weight and height.** Weigh without heavy clothing or shoes using calibrated scales (ideally those that will be used for future weigh). Measure height using a stadiometer.
- **Calculate BMI** (weight kg/height m²).
- **Chart weight, height and BMI** using age appropriate percentile charts. Include any other available measures to help assess progress. Rapid weight changes even within the normal percentile range can cause severe symptoms.
- **Pulse, blood pressure (lying and standing) and temperature**
- **Assess for dehydration** (sunken eyes, dry lips and tongue, poor skin turgor, slow capillary return).
- **Skin inspection:** acrocyanosis (blue discoloration), jaundice, carotenaemia (orange skin), dry skin, lanugo hair (soft downy hair on back and arms), callused knuckles (repeated induced vomiting), skin infections and lesions from self-harm.
- **Oral examination:** dental erosions, pharyngeal redness and parotid enlargement may all occur with recurrent vomiting.
- **General systems examination** is required for all patients to assess any pre-existing illness. Other findings in patients with an eating disorder may include cardiac flow murmurs, oedema, evidence of significant constipation and hepatomegaly with rapid weight change.
- **Pubertal status** should be assessed using Tanner Stages.
- **Urinalysis** may show high specific gravity and ketones in fasting patients.

INVESTIGATIONS

- **ECG** is useful in all patients (provides a more accurate resting pulse and assesses for arrhythmias especially prolonged QTc which is common with severe weight loss).
- **Blood tests** - full blood count (FBC), electrolytes (UEC), liver function tests (LFTs), glucose, calcium, magnesium, and phosphate are mandatory in acute assessment especially if rehydration or refeeding is planned. These may all be normal even in very unwell patients. Thyroid stimulating hormone (TSH), Tri-iodothyronine (T3), Serum Thyroxine (T4), Follicle stimulating hormone (FSH), Luteinising Hormone (LH) and oestradiol should also be measured.
- **Bone densitometry** if available and amenorrhoea persists > 6-12 months.
- **Further investigations** to exclude other diagnoses & assess nutritional status may include: erythrocyte sedimentation rate (ESR), thyroid function, Ferritin, B12, folate, Anti-transglutaminase Antibodies, stool microscopy.
- **Pelvic ultrasound and bone age** may be considered.
RISK ASSESSMENT AND MANAGEMENT

Assessment and management of risk is an ongoing process, not a single event.

DEFINITION OF RISK
Risk is defined as the probability of a negative consequence or the likelihood that a particular adverse event will recur.

Risk assessment enables…
the earliest identification and management of factors that may threaten or adversely affect the safety and well being of the young person with an eating disorder, staff or others.

Risk Management incorporates the following functions:
1. Identification of all potential risk exposures.
2. Rating the nature and severity of the risk.
3. Examination of possible solutions or remedies.
4. Selection of the most appropriate solution or remedy.
5. Implementation of the selected solution.
6. Monitoring of the solution to ensure effectiveness.
7. Reviewing and choosing an alternative solution or changing protocol if first approach not effective or if risk status has changed.

KEY PRINCIPLES
- Early identification facilitates appropriate management.
- Risk assessment is an ongoing process that should be carried out by all staff.
- Risk assessment is one part in the provision of care and should be used to inform the treatment plan as it develops.
- Risk assessment must occur within the context of risk management.
- The overall goal during admission is to provide care, not just to avoid risk.
- Risk assessment and risk management do not remove all risk.
- Risk assessment assumes that the assessment will be acted upon.
OTHER CONSIDERATIONS

- Mental health risk management has the specific concern of reducing harm to self, harm to others and disruption and destruction of the treatment setting. Avoiding the treatment setting by absconding and resisting treatment essential to survival are included in this definition.

- Risk management aims to reduce and contain threats whenever possible. Risk assessment and management are based on protection and provision of basic emotional and physical needs in the treatment setting.

- In some cases risk assessment may result in the transfer of a patient to a more secure or appropriate setting.

- Sometimes there is a need for patients at higher risk (e.g., of self harm) to be held in a more secure environment – this is consistent with the Mental Health Act (see Guidebook, 2003) and the requirement for provision of the least restrictive environment in which the “best possible care and treatment … can be effectively given”.

- The level of risk to the patient’s mental and physical health should be monitored as treatment progresses because it may increase, e.g., for those with anorexia nervosa, this may occur as weight increases or at times of transition such as moving between services.

- In anorexia nervosa, although weight and BMI\(^6\) are important indicators, they should not be considered the sole indicators of physical risk.

- Attention should be paid to careful and adequate documentation, including assessment of risk, communication with other clinicians, decision-making process, and rationale for the treatment.

- Responses must be proactive, effective in meeting patient needs at the time, and satisfy ethical/regulatory requirements.

- Whenever possible patients should be engaged and treated before reaching severe emaciation. This requires both early identification and intervention.

- The plan should document strategic directions for immediate response in patient management in times of increased risk, and serve as a communication tool.

- The plan should document longer-term responses or a hierarchy of responses depending on level of risk.

- Psychoeducation with the patient, their family and clinicians should include discussion of the risks and any uncertainties regarding treatment and outcomes. Due attention should be given to confidentiality issues with respect to psycho-education.

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\(^6\) For children & adolescents use BMI Centile charts. See section “Assessing Growth and Determining Healthy Weight Range”.

Eating Disorders Toolkit - Assessment and Treatment Planning 19
ASSESSING GROWTH AND DETERMINING HEALTHY WEIGHT RANGE

Growth is influenced by many factors including ethnicity, family genetics, timing of puberty, chronic disease, psychosocial environment and nutrition. These factors should be considered as part of a comprehensive history and examination. If an organic growth disorder is suspected, a paediatrician should assess the patient. In some cases referral to a specialist paediatric endocrinologist may be indicated.

METHODS TO ASSESS GROWTH

For adolescents with an eating disorder the most important growth assessment methods are:

- Accurately measuring height and weight and plotting on growth charts.
- Obtaining previous height and weight measurements; plotting on growth charts.
- Using growth charts to determine the growth trajectory.
- Calculating BMI and interpreting using BMI-for-age percentile charts.
- Other methods may be used to assess growth but require specialist training and facilities.

MEASURING WEIGHT AND HEIGHT

**Weight**

- Scales should be calibrated regularly and weight should be measured consecutively on the same scales.
- Patients should wear minimal clothing, empty their pockets and remove shoes.
- Where possible, weigh patients early in the morning, before breakfast and after urination.
- Limit weighing to once or twice weekly; frequent weighs can overemphasize its importance.
- Patients may manipulate their weight by water loading or concealing heavy objects. If this is suspected consider random or "surprise" weight measurement.

**Height**

- Height should be measured as accurately as possible, ideally with a stadiometer, on admission and subsequently at three monthly intervals.

OBTAINING PREVIOUS HEIGHT AND WEIGHT MEASUREMENTS

- Plotting and interpreting one-off measurements is not as useful as a series so obtain as many previous height and weight measurements as possible.
- The Personal Health Record or "blue book" can provide useful information on weight and length measurements in infancy and early childhood.
- Check previous medical records and seek previous measures from the parents or GP.

USING GROWTH CHARTS TO DETERMINE GROWTH TRAJECTORY

- The National Health and Medical Research Council (NH&MRC) has recommended that the American Centre for Disease Control (CDC) growth charts be used in Australia. Copies of these charts are included in Appendix 2. For additional charts and information visit [www.cdc.gov/growthcharts](http://www.cdc.gov/growthcharts)
- Plot the accurate height and weight measurements on growth charts to obtain a pattern of growth or growth trajectory.
MID PARENTAL HEIGHT

Mid parental height (MPH) is a calculation that estimates the expected adult height of an individual based on their parents’ heights. This measurement may be helpful if there are inadequate data to determine growth trajectory.

**HOW TO CALCULATE MID PARENTAL HEIGHT**

Girls  \[ \text{MPH} = \frac{[\text{Dad’s height} - 13 + \text{Mum’s height}]}{2} \]

Boys  \[ \text{MPH} = \frac{[\text{Mum’s height} + 13 + \text{Dad’s height}]}{2} \]

For example, if mum is 165cm and dad is 176cm, their daughter’s MPH would be:

\[ \text{MPH} = \frac{[176-13]+165}{2} = \frac{163+165}{2} = 328/2 = 164cm \]

And their son’s MPH would be:

\[ \text{MPH} = \frac{[165+13]+176}{2} = \frac{178+176}{2} = 354/2 = 177cm \]

In our example the expected adult height (or MPH) of 164cm for the daughter is at the 50th percentile (pictured). It would be expected that this girl’s height would track along the 50th percentile throughout her childhood and adolescence. If it is significantly above or below the 50th percentile, a referral to a paediatrician or paediatric endocrinologist for a more thorough growth assessment is indicated.

**BODY MASS INDEX (BMI)**

- BMI is an anthropometric index of weight and height. It is not a diagnostic tool.
- BMI is calculated as follows: \[ \text{BMI} = \frac{\text{weight (kg)}}{\text{height (m)}^2} \]

‘BMI FOR AGE’ IS USED FOR CHILDREN AND ADOLESCENTS

- Because body composition changes throughout childhood, BMI cannot be interpreted for children and adolescents in the same way as it is for adults. Instead, ‘BMI-for-age’ is used.
- BMI is plotted on gender-specific BMI percentile charts. Copies of the American Centre for Disease Control (CDC) BMI charts are included in Appendix 2. For additional charts and information visit [www.cdc.gov/growthcharts](http://www.cdc.gov/growthcharts)
- The BMI-for-age charts contain a series of curved lines indicating specific percentiles. The following cut-off points have been used to identify underweight and overweight in children and adolescents.

<table>
<thead>
<tr>
<th>BMI-for-age</th>
<th>&lt; 5th percentile</th>
<th>Underweight</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI-for-age</td>
<td>5th percentile to &lt;85th percentile</td>
<td>Normal</td>
</tr>
<tr>
<td>BMI-for-age</td>
<td>85th percentile to &lt;95th percentile</td>
<td>At Risk of Overweight</td>
</tr>
<tr>
<td>BMI-for-age</td>
<td>&gt; 95th percentile</td>
<td>Overweight</td>
</tr>
</tbody>
</table>

**DETERMINING A HEALTHY WEIGHT RANGE**

- Determining a healthy weight range helps patients, their family and the treating team plan management and assess progress.
- A healthy weight range (HWR) rather than a specific target weight should be set.
- It is important to avoid long discussions or negotiations about HWR as this may ‘collude’ with the eating disorder and encourage a focus on weight rather than physical health as an outcome.
- The HWR is not necessarily the discharge weight. Patients may be discharged from hospital below the HWR and before full physical recovery depending on medical and/or psychological stability.
- Normal vital signs are indicators of physical recovery. However these can return to normal below a HWR or, if weight loss has been rapid, they can be abnormal within a HWR.
- For girls, return or commencement of menses is an indicator of physical recovery. Menses may take some time to return after weight restoration, or may sometimes return at a low weight.

Physical recovery is the best indicator of healthy weight; hence HWR will be unique to each individual

APPROXIMATING THE HEALTHY WEIGHT RANGE

- Assess previous growth trajectory and set a HWR. HWR must allow for continued growth along the individual patient’s growth trajectory.
- Using BMI-for age, an estimation of a HWR can be made.
- A normal BMI is 5th percentile to <85th percentile. The 5th percentile is often too low for physical recovery to occur for patients with eating disorders.
- A BMI between the 25th and 85th percentiles is recommended, as this is more likely to correlate with physical recovery.
- BMI for 25th and 85th percentiles (ages 12 -18) are listed below.

<table>
<thead>
<tr>
<th>Age</th>
<th>Male HWR BMI = 25th %ile</th>
<th>Male HWR BMI = 85th %ile</th>
<th>Female HWR BMI = 25th %ile</th>
<th>Female HWR BMI = 85th %ile</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.0</td>
<td>16.4</td>
<td>21.0</td>
<td>16.5</td>
<td>21.7</td>
</tr>
<tr>
<td>12.5</td>
<td>16.7</td>
<td>21.4</td>
<td>16.8</td>
<td>22.2</td>
</tr>
<tr>
<td>13.0</td>
<td>17.0</td>
<td>21.8</td>
<td>17.0</td>
<td>22.5</td>
</tr>
<tr>
<td>13.5</td>
<td>17.3</td>
<td>22.2</td>
<td>17.4</td>
<td>23.0</td>
</tr>
<tr>
<td>14.0</td>
<td>17.6</td>
<td>22.6</td>
<td>17.6</td>
<td>23.3</td>
</tr>
<tr>
<td>14.5</td>
<td>17.9</td>
<td>23.0</td>
<td>17.9</td>
<td>23.7</td>
</tr>
<tr>
<td>15.0</td>
<td>18.2</td>
<td>23.4</td>
<td>18.2</td>
<td>24.0</td>
</tr>
<tr>
<td>15.5</td>
<td>18.6</td>
<td>23.8</td>
<td>18.4</td>
<td>24.3</td>
</tr>
<tr>
<td>16.0</td>
<td>18.9</td>
<td>24.2</td>
<td>18.6</td>
<td>24.6</td>
</tr>
<tr>
<td>16.5</td>
<td>19.2</td>
<td>24.6</td>
<td>18.9</td>
<td>24.9</td>
</tr>
<tr>
<td>17.0</td>
<td>19.5</td>
<td>24.9</td>
<td>19.1</td>
<td>25.2</td>
</tr>
<tr>
<td>17.5</td>
<td>19.8</td>
<td>25.2</td>
<td>19.3</td>
<td>25.4</td>
</tr>
<tr>
<td>18.0</td>
<td>20.0</td>
<td>25.6</td>
<td>19.4</td>
<td>25.6</td>
</tr>
</tbody>
</table>

**Example:** a 12yr old girl who is 150cm tall would need to be 37-47kg to achieve a BMI of 16 to 21. If her growth has always previously been around the 25-50th percentiles her HWR may be set as 37-41kg.
# EATING DISORDER CLINICAL SUMMARY

<table>
<thead>
<tr>
<th>Name/MRN</th>
<th>Case Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date</td>
<td>Primary Nurse</td>
</tr>
<tr>
<td>Expected Discharge Date</td>
<td>Consultant</td>
</tr>
<tr>
<td>Carers</td>
<td>General Practitioner</td>
</tr>
</tbody>
</table>

**Diagnoses:**

- ...
- ...

**Medical History** (Including menstrual history):

**Social History** (Living situation, family or carer support, education, etc…):

- ...
- ...
- ...
- ...
- ...
- ...

**Medications:**

- ...
- ...
- ...

**Considerations (re: Meds):**

- Weight Gain
- Weight Loss
- Fluid
- TGs/BGLs
- Other

<table>
<thead>
<tr>
<th>Height: ............... (m) ( / / ) %ile ..........</th>
<th>Lowest Past Weight</th>
<th>Healthy Weight Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight: ............... (kg) ( / / ) %ile ..........</td>
<td>Highest Past Weight</td>
<td>Goal Wt Gain/Week</td>
</tr>
<tr>
<td>BMI: ...............(kg/ m²) ( / / )%ile..........</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Most Recent:**

<table>
<thead>
<tr>
<th>Temperature</th>
<th>Blood Pressure</th>
<th>Pulse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Date</td>
<td>Date</td>
</tr>
<tr>
<td>Date</td>
<td>Date</td>
<td>Date</td>
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<td>Date</td>
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<td>Date</td>
<td>Date</td>
<td>Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bone Densitometry</th>
<th>Pelvic Ultrasound</th>
<th>ECG -QTc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Result</td>
<td>Date</td>
</tr>
<tr>
<td>Date</td>
<td>Result</td>
<td>Date</td>
</tr>
<tr>
<td>Date</td>
<td>Result</td>
<td>Date</td>
</tr>
</tbody>
</table>

**Estimated Nutrition Requirements:**

<table>
<thead>
<tr>
<th>Energy</th>
<th>Protein</th>
<th>Fluid</th>
</tr>
</thead>
</table>
**Eating Behaviour:**

**Description of eating (restrictive patterns, dietary “rules”…)**

**Weight Controlling Behaviour (frequency, intensity, duration):**

- **Dieting/ fasting**
- **Vomiting**
- **Exercise**
  - (Type, intensity, duration, frequency, solitary, secretive, compulsive)
- **Substance misuse**
  - (Laxatives, emetics, diuretics, alcohol, cocaine, amphetamines)
- **Other (e.g., spitting food)**

**Binge Eating Behaviour:**

<table>
<thead>
<tr>
<th>Frequency of binge eating over past 3 months (circle)</th>
<th>&lt; Once fortnight</th>
<th>&lt; Once week</th>
<th>1-5 x week</th>
<th>Once a day</th>
<th>&gt; 2 x day</th>
<th>5-10 x day</th>
<th>&gt; 10 x day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typical times and settings for binge eating</td>
<td>☐ Morning ☐ Middle of Day ☐ Evening ☐ Alone ☐ Planned ☐ At home ☐ Other place (Circle)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood before, during and after episodes</td>
<td>Before</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>During</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>After</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Experience loss of control?</td>
<td>☐ Yes ☐ No ☐ Not sure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Attitudes Towards Weight and Shape:**

- **Level of self criticism**
  - Whole body & specific regions
- **Perceptions of shape**
- **Frequency of weighing, weight preoccupations and intrusive thoughts, response to weighing**
- **Perception of others’ attitudes about patient’s weight**
Physical Signs and Symptoms Checklist:

<table>
<thead>
<tr>
<th>Signs and Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agitation</td>
</tr>
<tr>
<td>Irritability</td>
</tr>
<tr>
<td>Amenorrhoea</td>
</tr>
<tr>
<td>Oligomenorrhea</td>
</tr>
<tr>
<td>Constipation</td>
</tr>
<tr>
<td>Abdominal pain</td>
</tr>
<tr>
<td>Abdominal bloating</td>
</tr>
<tr>
<td>Cold intolerance</td>
</tr>
</tbody>
</table>

Biochemistry:

<table>
<thead>
<tr>
<th>Date</th>
<th>Na</th>
<th>K+</th>
<th>Chloride</th>
<th>PO4-</th>
<th>Mg2+</th>
<th>Urea</th>
<th>Cr</th>
<th>Ferr.</th>
<th>B12</th>
<th>Folate</th>
<th>Bicarb</th>
</tr>
</thead>
</table>

Please note: This form is not approved for official use within the Area Health Service – this is a guide only.
FORMULATION OF A TREATMENT PLAN

KEY PRINCIPLES
- Bring together and make sense of all assessment information to develop a meaningful treatment plan.
- Obtain a detailed understanding of the young person’s presenting problems (i.e., eating disorder).
- Identify variables that are functionally related to these difficulties.
- Define admission goals.

KEY CONSIDERATIONS
Treatment plans should be implemented based upon short, medium or long-term admissions. Treatment plans must be tailored to the needs of each individual and to the diagnosis.
- Therapeutic alliance - developing an empathic, supportive and trusting relationship is crucial in reducing resistance and in facilitating change. This should be considered from the first point of contact with the patient.
- Patients will not leave hospital “cured” of their eating disorder, although they should be “health” restored sufficiently to promote ongoing treatment in the community. It is essential to consider realistic expectations for the admission.
- The focus of admission should not be solely based on weight alone and should consider a holistic approach to the individual.
- A detailed management plan is required including treatment targets and suggested time frames.
- Involve the young person, family and members of the team in the development and implementation of the treatment plan.

Parental input and commitment to treatment is an integral component of care. This should be seen as an ongoing process throughout treatment.

- A multi-disciplinary approach to eating disorders must be recognised.
- CAMHS should be part of the treating team throughout all treatment phases.
- Establish “non-negotiable” elements of the plan. Choice may be offered in certain areas of the plan; however, other aspects would be considered essential for safety and wellbeing, and not able to be negotiated, at least not until a later stage in treatment or recovery. The use of non-negotiables, and a focus on safety aspects of treatment (physical, psychological and nutritional), can be particularly helpful when managing patients who are having difficulty adhering to treatment, are refusing to eat, or are in a pre-contemplative stage of change.
- Clearly document treatment plans and ensure access to all staff.

Examples of Non-Negotiables

Physical/medical safety, e.g., in the case of dehydration there can be no negotiation around the amount of fluid given to the young person to rehydrate them.

Nutrition, e.g., if the young person needs to gain weight, as indicated by medical or physical assessment, there can be no negotiation of the amount of energy (or food) that is required. Similarly, there can be no negotiation around healthy nutrition whether the young person needs to gain weight or not.

Leave from the ward, e.g., if the young person is deemed unsafe to leave the ward for medical or other safety reasons this decision is non-negotiable.
TREATMENT PLAN

Define the goals of admission, including timeframes and strategies. These may be based upon:

1. Physical and psychiatric stabilisation
2. Family psychoeducation, support and involvement
3. Weight and health restoration
4. Development of healthy eating behaviours
5. Enhancement of motivation to change
6. Improvement in core maladaptive thoughts, attitudes and feelings about food, weight and body image
7. Treatment of associated psychiatric conditions including depression and anxiety
8. Reduction of compensatory behaviours (e.g., vomiting, laxatives, over-exercise)
9. Facilitation of normal socialisation

Note: The use of harsh and punitive behavioural programs can make the development of a therapeutic alliance with the young person (and their family or carers) extremely difficult. See section titled “Working with the young person” for further information.
THE ROLES OF THE MULTIDISCIPLINARY TEAM MEMBERS ON THE WARD

Teamwork and collaboration are central to good working relationships and service delivery. Effective teamwork and collaboration is supported by key elements including agreed goals, an agreed treatment approach, effective communication styles, established ground rules, clear team roles and competent leadership.

The availability of and access to multidisciplinary team members will vary in regional and rural areas. Involvement may also depend on the expertise and interest of the clinician. Potential key roles for members of the multidisciplinary team are summarized below (in alphabetical order)

- **Care Manager**
  - Coordination of care and overall management of admission
  - Responsible for ensuring tasks are followed through and completed
  - Assist with the smooth transition from admission, to discharge and follow-up

- **CAMHS**
  - CAMHS have the potential to provide treatment and may form an integral part of the community shared care team
  - The CAMHS team should be contacted at the commencement of the young person’s admission and remain involved during treatment and discharge planning

- **Clinical Psychologist / Psychologist**
  - Psychological assessment and treatment planning
  - Family assessment and therapy
  - Individual therapy
  - Behaviour programmes
  - Motivational enhancement
  - Group work

- **Dietician**
  - Comprehensive nutrition assessment and ongoing management
  - Provision of adequate nutrition to optimise nutritional status and growth
  - Establish meal plans and refeeding regimes
  - Facilitate the development of healthy eating behaviours
  - Provision of nutrition education

- **General Practitioner**
  - Early detection and establishment of the seriousness of the condition
  - Triage and referral to appropriate services
  - Ongoing community medical care

- **Nurse**
  - Implementing treatment plans on a daily basis
  - Assessment and maintenance of patient safety
  - Management and close monitoring of the patient’s physical and emotional status
  - Frequently nursing staff coordinate care for the young person

- **Occupational Therapist**
  - Assess functioning in self care, productivity (e.g., domestic, educational, vocational needs or skills), rest and leisure with particular emphasis on: initial stabilisation/early recovery and expected post discharge functioning
  - Provide individual, group and/or family interventions as required in relation to the above.
  - This may include coordination of a therapeutic (ward) program that also involves multidisciplinary input

- **Paediatric or Physician**
  - Must be involved in all admissions due to the potentially serious medical complications
  - Medical assessment & ongoing management
  - Will usually be the lead clinician

- **Physiotherapist**
  - Assessment of physical activity behaviours
  - Management of musculoskeletal issues associated with under-nutrition and/or over-exercise
  - Preparation and progression of a physical activity plan
  - Educating patients and families on healthy levels of physical activity and return to sports

- **Psychiatrist**
  - Should be involved in all admissions
  - Comprehensive assessment, diagnosis and ongoing management of psychiatric needs
  - May be the lead clinician in the treatment of the young person and their family

- **School Teacher**
  - Assessment of academic abilities
  - Management of behaviour and development of social skills in the classroom
  - Development and implementation of individual learning plans
  - Liaison with other agencies and schools

- **Social Worker**
  - Provide individual, group and family intervention
  - Links to external supports e.g., financial counselling, accommodation assistance
  - Liaison with primary supports in the young person’s social context, including indigenous or CALD services, and community groups
  - Child protection consultation
  - Management of psychosocial complexities

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Please also refer ‘Team Cohesion’ in section “Treatment on the Ward”.

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CARE (CASE) MANAGEMENT

The role of the care manager may vary depending upon the time, experience and background of the health professional, and the agreed role within each treating team. The regular tasks of a care manager also will vary depending on the needs of the patient and family, stage of recovery and focus of treatment. Key roles involve coordinating care, providing overall management and responsibility for ensuring tasks are followed through and completed, and assisting with the smooth transition from admission, to discharge and follow-up.

COMMON TASKS

- Before admission (if the care manager is nominated and aware of the admission in advance), informing other staff members of the pending admission.
- Work with the clinical team to establish goals of admission.
- Refer to clinicians, other professionals or groups (e.g., school) as necessary.
- Introduce new care providers to the family.
- Attend weekly ward rounds to discuss the patient’s progress and clarify or modify treatment and discharge plans.
- Communicate with parents/carers (ideally, at least once per week face to face and phone calls as necessary) and directly involving other relevant professionals in such meetings.
- Liaise with agencies such as Department of Community Services (DoCS), Department of Ageing, Disability and Home Care (DADHC), Centrelink and Department of Education and Training (DET) where necessary.
- Coordinate appointments for the patient and/or parents with the treating team.
- Coordinate discharge, such as arranging discharge prescriptions and medication supply, writing a discharge summary, informing parents, and ensuring community follow-up appointments are in place.
- Inform the patient and family if you will be away on leave and arranging for another person to care manage in your absence.
- Participate in regular supervision. This will allow the opportunity to debrief and reflect on practice.
- Seek assistance from other clinicians when required. It is important not to exceed your professional knowledge base or boundaries.
DISCHARGE FROM HOSPITAL

Discharge planning should commence at the beginning of the admission and should be a gradual transition process. Planning will include determining indications of discharge readiness, where the young person will be discharged to and involving the community team in discharge planning from early in the admission. Factors to consider in readiness for discharge include the level of functioning of the young person, anticipated progress in the community, the discharge environment and follow-up arrangements.

CURRENT LEVEL OF FUNCTIONING

Factors to consider:
- Medical status (including residual medical problems)
- Nutritional status (including ability to consume adequate nutrition orally)
- Psychological and behavioural assessment (including degree of disordered eating thinking and behaviours)
- Family functioning and management of conflicts

Note: research indicates better outcomes for children discharged at or above a minimum healthy weight, in terms of lower relapse rates and more rapid recovery

ANTICIPATED PROGRESS IN THE COMMUNITY

A main goal following discharge should be to maintain physical and psychological well being through a sustained, healthy approach to eating and physical activity with ongoing psychological, nutritional, and medical monitoring and support. Potential difficulties post discharge should be outlined in a discharge summary, e.g., distress around returning to school, ongoing family conflict or re-emergence of eating disordered thinking and behaviours.

FOLLOW-UP ARRANGEMENTS

The discharge summary should outline the following:
- Clinical status on discharge and criteria for readmission
- Identification of the community care manager or coordinator (including roles and anticipated frequency of review)
- Identify multidisciplinary team members, their role and frequency of review (e.g., weekly for the first month, then reduce frequency as required). This may include the GP, psychologist, dietician and others as required
- Liaison with paediatrician, psychiatrist and others (e.g., school)
- Relapse prevention strategies

General practitioner shared care - a shared care approach may be possible between the GP and local mental health team through a GP initiated care plan. This may be especially useful when access to community paediatric care is limited

CRITERIA FOR RE-ADMISSION

The criteria for readmission should be specified and may include physical, psychological or social-emotional factors. A readmission weight may be specified.

Readmission may be required under the following circumstances:
- Failure to respond to community-based care in terms of ongoing weight gain or stabilisation, or other eating disorder symptoms (e.g., binge eating and purging)
- Significant medical complications (e.g., bradycardia)
- Acute/severe general psychopathology (e.g., major depressive disorder, obsessive compulsive disorder or substance dependence)
- Insufficient social support (e.g., severe family dysfunction or a lack of community-based services)

**RELAPSE PREVENTION**

Full recovery is a lengthy process and some patients will require several hospital admissions. For those with AN, for example, 20% of patients fully recover 5 years after discharge and 70% at 10 years post-discharge. The longer healthy eating behaviours and appropriate weight can be sustained post-discharge, the more likely the patient is to eventually attain full recovery. An estimated 30% of adolescents with AN relapse following discharge from hospital, with most relapsing within the first year. Assisting patients to continue their progress after discharge is crucial.

**In preparing for discharge, effective strategies may include:**

- Summarising the progress made during admission. Since the patient will continue to be symptomatic, it can be easy to lose sight of the gains that have been made (e.g., a greater awareness of the negative aspects of the disorder and a consequent willingness to at least consider recovery). Reviewing progress fosters a sense of accomplishment and increases confidence that change is possible.

- Acknowledging, validating and assisting with strategies to address any negative affect associated with discharge (e.g., anxiety about coping without the structure of the inpatient setting; terminating relationships with certain health professionals).

- Identifying impediments to continued recovery. A significant barrier to ongoing recovery in AN is the high value that patients may place on the anorexia symptoms and hence an ongoing sense of grief and/or failure at their loss (e.g., regretting the loss of their emaciated physique and the sense of control/achievement this provided). (See section on Motivation to Change).

- Identifying areas that require ongoing focus and developing a discharge plan regarding further treatment. Ongoing treatment post-discharge is necessary to maintain any weight restoration achieved during hospitalisation and to target ongoing problems (e.g., disordered eating, compensatory behaviours, dysfunctional attitudes regarding shape and weight, general psychopathology and relationship dysfunction). (See section on Psychological Interventions).

- Understanding the warning signs of relapse (e.g., rapid weight loss or gain; the emergence of binge eating or compensatory behaviours; an intensification of food/body preoccupations) and developing a plan for responding to any indications of relapse (including clarifying indications for readmission).

- Ensuring that the young person is linked in with key clinicians in the community for ongoing monitoring and support. Regular monitoring of eating disorder pathology, including weight status, post-discharge is essential.
IN視為VEMENT OF THE GENERAL PRACTITIONER
BEFORE AND AFTER A HOSPITAL ADMISSION

The GP’s role may be flexible and will depend on the level of expertise, the needs of the patient, the expectations of the team and the GP’s availability. The GP may be involved as a sole medical practitioner in the community, as part of a shared care model with community teams and/or as part of a GP initiated care plan for mental health. The GP should be kept informed of treatment progress throughout the admission and be involved in discharge planning.

PRE-ADMISSION
- The GP will ideally have engaged with the young person and their family and completed a medical assessment
- The GP should be notified of admission of the young person to hospital

DURING ADMISSION
- The GP should be kept informed of the progress of treatment and anticipated discharge plan
- For extended admissions the GP should be kept informed on a monthly basis
- The GP may wish to contact the patient or family during the admission where appropriate and within the confines of confidentiality
- If a GP has not been involved prior to admission, the young person and family may nominate a GP to work with post-discharge (preferably contact has already been initiated at admission)
- Prior to discharge ensure planning is in place for follow-up care with the GP for the young person and family. The initial appointment should be in place prior to discharge (for no longer than 2 weeks post-discharge)
- Timely notification of discharge is of vital importance to the GP

POST ADMISSION
- It is essential that the GP is involved in the management of the young person following discharge
- A person discharged from hospital with an eating disorder should be seeing a GP at least once per month (more often if rapid weight loss is a risk, if engaging in regular purging, or if any medical threat is present)
- Where possible, the GP should work as a part of a multidisciplinary team including at minimum a dietician, paediatrician and mental health clinician

OTHER USEFUL INFORMATION
GP shared care: A shared care approach may be possible between the GP and local mental health team through a GP initiated care plan. This may be especially useful when access to community paediatric care is limited.