

Welcome to MHPN's webinar on collaborative care for eating disorder presentations.

We will begin shortly

Webinar

An interdisciplinary panel discussion

Collaborative care for eating disorder
presentations

Wednesday 13th June 2012

“Working together. Working better.”

Supported by The Royal Australian College of General Practitioners, the Australian Psychological Society,
the Australian College of Mental Health Nurses and The Royal Australian and New Zealand College of Psychiatrists

This webinar is presented by



Panel

- o Dr Jan Orman (GP)
- o Mr Chris Thornton (psychologist)
- o Dr Andrew Court (psychiatrist)

Facilitator

- o Dr Michael Murray (GP)

Learning Objectives

At the end of the session participants will:

- Recognise the key issues in the assessment of eating disorders
- Recognise the key principles of intervention and the roles of different disciplines in treating, managing and supporting people with eating disorders
- Better understand the merits, challenges and opportunities in providing collaborative care to people with an eating disorder

GP perspective

Predisposing Factors:

- Genetic vulnerability (family history)
- Poor self esteem
- Anxiety (family and personal history)
- Depression
- Perfectionism
- Obsessionality
- Intensely competitive family social/sport/academic environment
- Previous trauma
- Environment with strong emphasis on appearance



Dr Jan Orman

GP perspective

Early clues

- Vegetarianism
- Development of food allergies
- **Fatigue**
- Irritability
- Disturbed sleep (hunger)
- Unexplained fainting
- Increased exercise
- Avoiding social eating
- Bowel disturbance esp. constipation
- (2 things conspicuously absent – amenorrhoea and deterioration of academic performance)



Dr Jan Orman

GP perspective

GPs Task with Jo

Initially:

- **Establish rapport**
- **Establish safety (physical and psychological)**
- **Exclude underlying physical illness**
- **Assess current physical and psychological state**
- **Refer appropriately**

Ongoing:

- **Co-ordinate care (treating team including family)**
- **Monitor medical and psychological state**



Dr Jan Orman

GP perspective

When is Hospital Admission Required?

- Patient is haemodynamically compromised:
 - Pulse <48-50 (<40/min indicates significant abnormality)
 - postural drop in blood pressure >20 mm Hg
- Significant electrolyte abnormality particularly low potassium
- ECG changes
- Low temperature (hypothermia)
- Dehydration
- Inter-current illness esp. infection (difficult to detect in the presence of poor immune response, no fever)

(How do you know if any of this is happening if they don't have someone monitoring their medical condition?)
- Suicidality and psychosis
- Failure of outpatient treatment



Dr Jan Orman

GP perspective

Basic Medical Monitoring:

- **Weight**
- **Pulse and blood pressure (lying and standing)**
- **Electrolytes (esp. if purging)**
- **Temperature**
- **(ECG)**



Dr Jan Orman

GP perspective

Perils of “going it alone”:

- Continuing unrecognised weight loss
- Misdiagnosis
- Missed diagnoses (underlying and co-morbid esp. medical decompensation and suicidality)
- Slipping through the cracks of care
- Withdrawal from “unsympathetic” care



Dr Jan Orman

GP perspective

What Jo needs:

- Firm and sympathetic engagement and an ongoing relationship
- Full medical assessment
- Referral to specialist services
- *A functional* treating team
- Ongoing physical and psychological monitoring



Dr Jan Orman

Psychologist perspective

Evidence Supported Treatment:

- For patients with an Early Onset (<18 years) and a Short History (< 3 years) a family based treatment is indicated.
 - NICE guidelines
- Maudsley Family Based Therapy would be the specific treatment of choice.
 - Manual - Lock, le Grange, Agras & Dare, 2001



Mr Chris Thornton

Psychologist perspective

Why MFBT

- **Developing Empirical Base indicates a consistent remission rate of about 75-80% with 12 month follow up.**
- **When compared to Individual therapy**
 - MFBT had more patients in full remission at follow up.
 - MFBT produces more rapid weight restoration
 - MFBT resulted in greater maintenance of treatment gains
- **MFBT disseminates from the research setting to the clinic room**
 - However, these studies were still done in specialist treatment centers.



Mr Chris Thornton

Psychologist perspective

Essential Ingredients of MFBT

- **Agnostic view of causation (PARENTS ARE NOT TO BLAME)**
- **Separation of the illness from the person with the illness (Externalization)**
- **Family/significant others seen as part of recovery and having skills to aid recovery**
 - Parental self efficacy in their ability to take control of their child's eating is consistently correlated with outcome
 - The focus of initial treatment is disruption of eating disorder maintaining behaviours with specific goals of weight restoration



Mr Chris Thornton

Psychologist perspective

Essential Ingredients of MFBT (continued)

Follows three phases of treatment:

- **Phase 1: parents/significant others in charge of refeeding with goal of full nutrition/weight restoration**
- **Phase 2: age-appropriate transfer back of control**
- **Phase 3: achieving healthy adolescent/young adult autonomy/discussing remaining issues**



Mr Chris Thornton

Psychologist perspective

Assessment Issues for MFBT

- **Diagnostic Interview (Session 1)**
- **Impact of the Eating Disorder on each member of the family (Session 2)**
 - Including worst fears for the patient
 - “Grave Scene”
- **Family Meal (Session 3) - assessment of family skills in intervening with the eating disorder**
 - Assessing structural Issues in the family



Mr Chris Thornton

Psychiatrist perspective

DIAGNOSIS:

- Not all AN patients are obsessive overachievers
- Boys increasing in frequency and often “exercisers” (like Jo)
- Younger patients (and “exercisers”) often seem to deny cognitions
- DSM V will take out cognitions as criteria
- Overall experience of ED clinic is that if LOW (to point of being underweight), unable to put it back on, no medical reason, likely AN



Dr Andrew Court

Psychiatrist perspective

RCH EXPERIENCE :

- Multidisciplinary team at assessment
- Admit only if medically unstable (HR < 50, even if “elite” athlete)
- FBT therapist (with family) takes over treatment
- Model of understanding AN (vulnerability + LOW leads to “illness”)
- Avoid inpatient treatment if possible
- Very changed roles for medical and psychiatric staff
- “Cure” approach vs. “chronic illness” approach



Dr Andrew Court

Psychiatrist perspective

FOCUS OF FBT:

- **Weight restoration using parents**
- **“Structural” form of family therapy**
- **Pushing through anxiety (not avoiding it)**
- **No individual work at time of FBT (may occur at end of treatment - after 6 months)**



Dr Andrew Court









Thank you for your participation



- Please complete the exit survey before you log out
- To continue the interdisciplinary discussion please go to the online forum on MHPN Online
- Each participant will be sent a link to online resources associated with this webinar within 24 hours
- The next MHPN webinar will be *'Working together, working better to support people with mental health and chronic pain issues'* on July 4 2012
- For more information about MHPN networks and online activities visit www.mhpn.org.au

Thank you for your contribution and participation

Artwork (slide 20 to 23) courtesy of Arts Project Australia and Q Art Studio

Miles HOWARD-WILKS

*Not titled (landscape with
waterfall, cross bridge and road)*
2009
MH09-0008

Sonja Kan

'Secret Garden Series' 2011
QAS

Steven Perrette

*In the bay, Port Philip Bay
that is*
SP00-0017

Ralph Dawson

'Stickmen with Yellow & Purple'
-for Calendar 2011 QAS