

Gloucestershire Health Authority (GHA) - Guidelines for the Management of Out of County Referrals for People with an Eating Disorder

Introduction

People with a severe eating disorder can sometimes require in-patient clinical management. These guidelines are to be used when specialist in-patient management is required and is not available within Gloucestershire. The guidelines explain the process of referral to an out of county unit and set standards for liaison and discharge. They are intended to aid Consultant Psychiatrists to secure appropriate and effective in-patient management, utilising the available resources judiciously. This paper is divided into two parts:

Part 1 describes the referral process, standards and responsibilities relating to out of county in-patient admissions.

Part 2 provides background information regarding the reasons for developing the guidelines and the role of in-patient clinical management in the care of people with a severe eating disorder.

13/03/98

**Sam Clark-Stone
Clinical Co-ordinator
Eating Disorders**

01452 891142

Part 1

Referral process for out of county admissions (see Appendix A)

The Clinical Co-ordinator will be available for consultation regarding any aspect of clinical management and the management of potential referrals to out of county units.

1. When the patient is not in contact with local mental health services, health professionals (e.g. General Practitioners and Consultant Physicians) should seek assessment and advice from the appropriate Community Mental Health Team (CMHT) in the first instance.
2. Referrals to out of county units are only to be made by the relevant local NHS Consultant Psychiatrist, after assessment of the patient's needs, following initial clinical management by an appropriate member(s) of the mental health team.
3. Admission to a local NHS paediatric, medical or psychiatric ward might sometimes be necessary to deal with an immediate physical or psychiatric crisis and to provide adequate time to consider any plans for an out of county admission.
4. If Health Authority approval for funding is not required, a copy of the referral letter is to be sent to the Clinical Co-ordinator for monitoring purposes.
5. When Health Authority approval for funding is required, the Clinical Co-ordinator should be contacted as early as possible to discuss the case.
6. Decisions resulting from discussion with the Clinical Co-ordinator will be documented in a letter to the local Consultant Psychiatrist.
7. When required, confirmation of Health Authority approval for funding will be included in the above letter and copied to the relevant out of county unit.
8. A copy of the referral letter and subsequent correspondence is to be sent to the Clinical Co-ordinator.
9. Referrals to Priory Hospital, Bristol should be addressed to the Admissions Officer.

Liaison (see Appendix B)

When a patient has to go out of county for treatment, regular liaison becomes particularly important if the treatment goals are to be achieved and relapse on discharge avoided.

1. An initial review date, not longer than 6 weeks hence, should be set at admission.
2. Whenever possible, the local mental health team key worker or Consultant Psychiatrist should attend the review meeting (admission to a unit a long distance away might make liaison meetings impractical).
3. When attendance at the review meeting is not possible, the key worker should telephone the unit prior to the review date to liaise regarding progress and future plans.
4. The results of the meeting or telephone call to be documented in the local mental health team case-notes.
5. Further reviews will depend on the length of the admission, but should take place at intervals of no longer than 6-8 weeks.

Discharge

1. A pre-discharge review date to be set at the prior review meeting or at least 4 weeks in advance.
2. Whenever possible, the local mental health team key worker will attend the pre-discharge review meeting.
3. When attendance at the pre-discharge meeting is not possible, the key worker will telephone the unit prior to the review date to liaise regarding progress and future plans.
4. The results of the meeting or telephone call to be documented in the local mental health team case-notes.

Follow up

1. Follow up arrangements should be agreed at the pre-discharge meeting.
2. Generally, follow up should be the responsibility of the local mental health team, except in circumstances when there are particular reasons for time limited follow up by the out of county team. In such circumstances, arrangements for shared care should be agreed, documented and regularly reviewed.

Roles and responsibilities

Clinical Co-ordinator

1. Offers consultation and supervision regarding the clinical management of people with an eating disorder, including attendance at clinical review meetings
2. Authorises initial and on-going Health Authority approval of funding, following consultation with the responsible Consultant Psychiatrist
3. Monitors the use, cost and effectiveness of out of county admissions
4. Provides information regarding the clinical management programmes available at each out of county unit
5. After consultation with local mental health services and Gloucestershire Health Authority, sets and reviews quality standards relating to out of county units
6. Advises the Health Authority on the clinical eating disorder component of contracts with out of county units
7. Raises any issues of concern with the Health Authority and the relevant clinicians

Consultant Psychiatrist

1. Provides consultation to the relevant CMHT regarding the assessment of physical and psychiatric risk and appropriate clinical management
2. Consults with the Clinical Co-ordinator regarding patients requiring Health Authority approval for out of county clinical management
3. Makes the referral to the appropriate out of county unit
4. Provides the Clinical Co-ordinator with a copy of all referral letters to out of county treatment teams

5. Maintains the lead clinical responsibility for the local mental health team's contribution to in-patient clinical management goal planning, liaison, discharge planning and follow up arrangements.
6. Raises any issues of concern with the Clinical Co-ordinator

Health Authority out of area treatment (OATs) and contracts managers

1. Negotiates contracts on behalf of the Health Authority with out of county in-patient units
2. Monitors the contract or OAT activity
3. Provides copies of invoices or contract monitoring information to the Clinical Co-ordinator
4. Raises any issues of concern with the Clinical Co-ordinator

SCS/03/98

Part 2

A Background to the development of these guidelines

In 1995, GHA established a project group to consider the development of services for people with an eating disorder. A Clinical Co-ordinator was appointed to undertake a health needs assessment and to make recommendations for future service development. Issues relating to out of county admissions were identified as an area of concern. Discussion with local clinicians and a case note audit of people who spent time as patients out of county during the financial year 1996-97, revealed the following difficulties:

- No evidence that in-patient care is more effective than out-patient care in the long term. Little evidence regarding which patients are likely to benefit from which treatments.
- Lack of knowledge regarding the clinical management available at each out of county unit.
- Late referral to mental health services resulting in urgent admissions unknown to mental health services.
- First choice out of county unit often full.
- Communication from out of county units infrequent or insufficient.
- Difficulties with direct liaison leading to discontinuity of care.
- Lack of statistical and clinical information regarding the use of out of county units.
- Unclear or unrealistic treatment aims.
- Local mental health services not involved in the care of some referrals.
- Lack of clarity regarding responsibilities.
- No local outcome data available.

B Evidence of effectiveness of in-patient treatment for Anorexia Nervosa

- Lack of evidence from randomised controlled trials.
- Specialist in-patient treatment is effective at restoring weight, but short term improvement does not predict long-term outcome (Wilson & Fairburn 1997).
- Relapse after in-patient treatment is common (40-50%) (Treasure et al 1995).
- No evidence that in-patient care is more effective than out-patient care. One study comparing in-patient treatment with out-patient treatment showed no advantage for in-patient treatment at one year follow up (Crisp et al 1991).

C General treatment aims

The overall aim of treatment is to help the person to be able to replace their eating disorder with healthier ways of coping and relating, taking personal responsibility (appropriate to their age) for improving their own nutritional, mental and physical health.

Specific goals will apply in each individual's case, but they will probably include:

- establishing a healthy eating pattern
- gradual restoration of weight to a normal range
- cessation of purging behaviour
- improving self esteem
- using healthier coping strategies
- developing relationship and communication skills.

Recovery involves a collaborative effort between the person with the eating disorder and their helpers. It requires a combination of sufficient motivation to change and adequate support and guidance. Children and young adolescents have particular needs and collaborative work with their families will be especially important.

An out-patient psychotherapeutic approach addressing the above treatment aims is the accepted first approach to treatment. The role of hospital in-patient treatment is open to debate and is usually reserved for patients with especially severe disorders (Royal College of Psychiatrists 1992).

D Considerations regarding intensive clinical management (in-patient or day care)

Sometimes people with eating disorders are not able to make changes despite their best efforts. They may deny the severity of their illness or have complex co-morbidity requiring treatment in its own right. At these times, more intensive clinical management might be required. The choice of setting will be determined by several factors. These might include:

- Risk to physical health
- Mental state
- Patient compliance
- Patient choice
- Available resources

Intensive clinical management can be successfully undertaken in a day-care setting providing there is no immediate risk to health, the patient is able to comply with treatment and adequate resources are available. In these circumstances, day care is often preferred and the negative consequences of hospital admission can be avoided.

In-patient clinical management is usually indicated in the following circumstances:

- Body Mass Index below 13.5 kg/m^2 (below 65% average expected weight) or a rapid, continuing rate of weight loss, above 20% decrease in 6 months.
- Circulatory failure (pulse rate < 60 , blood pressure $< 90/60$, unable to sleep flat, breathless at night).
- Syncope (fainting).

- Proximal myopathy (muscle weakness - inability to stand from a squat without help)
- Hypoglycaemia (low blood sugar causing faint, confusion or coma).
- Electrolyte imbalance. Potassium < 2.5mmol/l, low sodium or phosphate (body salt disturbance causing weakness, dizziness, confusion).
- Petechial rash and platelet suppression (poor blood clotting with measles like rash).
- Other physical complications.
- Severe behavioural disturbance.
- Risk of suicide.
- Intolerable family situation?
- Extreme social isolation?
- Failure of out-patient treatment? (Particularly relevant when a child is failing to make expected weight and height increases and puberty is delayed).

(Treasure et al 1995)

There are 5 options available for in-patient clinical management. They are:

- A child or adolescent psychiatric unit
- A paediatric medical ward
- A general adult psychiatric ward
- An adult medical ward
- A specialist eating disorder unit

The relative merits of admission to one of these settings should be considered bearing in mind the purpose of the admission and the quality of care available to meet the individual's needs. The Eating Disorders Association (EDA 1995) recommend that as a minimum, in-patient clinical management should provide:

- A quiet and safe environment.
- Continuity of care from staff with an understanding of eating disorders.
- Staffing levels that enable support to be given during and after eating.
- Expert nutritional management and appropriate food.

E In-patient clinical management goals

In-patient clinical management goals need to take account of the varying factors that can influence the possible outcome e.g.

- Severity of risk
- Severity and chronicity of the disorder
- Co-morbidity and social complexity (for prognostic indicators see Appendix C)
- Patient and family motivation to change
- Available clinical management programmes

In-patient clinical management plans and goals need to be agreed by all the parties involved, prior to admission (Patient, carers, local and out of county treatment teams).

The goals should reflect the minimum in-patient clinical management required to allow effective clinical management to continue in the community. Treatment approaches that are available locally will not normally be provided out of county, except when they constitute an integral part of the agreed in-patient treatment plan.

Admission may only need to be relatively short term to diffuse a crisis or initiate change; e.g. re-feeding to a “safe” weight (above 70% of average expected weight) might be more appropriate than a lengthy hospital admission, particularly for people with chronic anorexia nervosa. The average length of an in-patient admission (if day care is not available) would normally be 3 months. Admission needs to be long enough to restore weight to a healthier range and establish regular eating, but short enough to avoid the negative effects of hospitalisation (Treasure et al 1995).

The costs and benefits of continuing in-patient care should be regularly reviewed. Continuity of care is important, so that the transition between settings is managed as smoothly as possible.

Occasionally, patients are so ill that they are unable to comply with treatment despite immediate danger to their health. The usual provisions under the Mental Health Act (MHA) 1983 apply. Detention under Section Three of the MHA enables essential life saving measures to be taken. Re-feeding against the patients will is legal using Section 63 of the MHA. The treatment team should insist that safety is restored, but be prepared to negotiate the finer details of care (Mental Health Act Commission 1997).

F Factors for consideration prior to referral out of county

It is common for clinicians to feel pressured into seeking specialist in-patient treatment by a combination of powerful factors e.g.

- Pressure from the patient and /or their family
- Anxiety regarding physical health and prognosis
- A sense of failure and responsibility for the patient’s recovery

Clinical supervision and consultation play an important role in establishing what part in-patient treatment might play in the patient’s clinical management.

References

Crisp A.H., Norton K., Gowers S., Halek C., Bowyer C., Yeldham D., Levett G., & Bhat A. (1991) A controlled study of the effect of therapies aimed at adolescent and family psychopathology in anorexia nervosa. *British Journal of Psychiatry*, 159, 325-333.

Eating Disorders Association (1995) Eating disorders: A guide to purchasing and providing services.

Hsu L.K.G. (1995) Outcome of Bulimia Nervosa. In: *Eating Disorders and Obesity: A Comprehensive Handbook*. Edited by K. Brownell and C. Fairburn. Guilford Press. New York.

Mental Health Act Commission (1997) Guidance on the treatment of Anorexia Nervosa under the Mental Health Act 1983. Guidance Note 3.

Royal College of Psychiatrists (1992) Eating Disorders: Council Report CR14

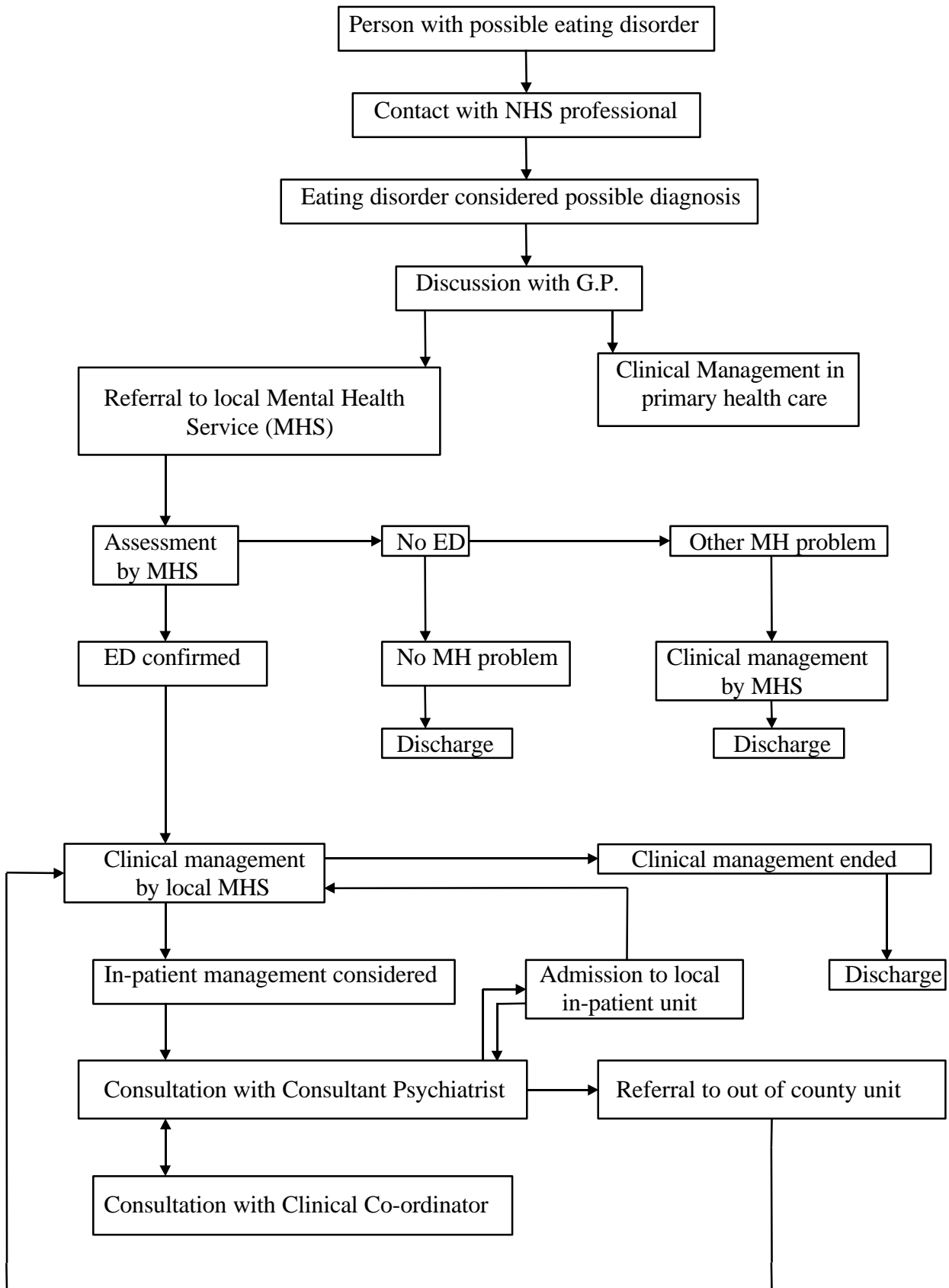
Steinhausen H.C. (1995) The Course and Outcome of Anorexia Nervosa. In: *Eating Disorders and Obesity: A Comprehensive Handbook*. Edited by K. Brownell and C. Fairburn. Guilford Press. New York.

Treasure J., Todd G. & Szukler G. (1995) The in-patient treatment of anorexia nervosa. In *Handbook of eating disorders: Theory, treatment and research*. Edited by G.Szukler, C.Dare & J.Treasure. Wiley. Chichester.

Wilson G. & Fairburn C. (1997) Treatment of eating disorders. In *Psychotherapies and drugs that work: A review of the outcome studies*. Edited by P.Nathan & J.Gorman. Oxford University Press.

Appendix A

Management of Eating Disorder (ED) referrals to out of county specialist units



Appendix B

Specification for Eating Disorders Services Provided by Out of County Units

1. The out of county unit is to have a written protocol for the in patient clinical management of someone with an eating disorder.
2. The protocol should state the aims of admission and the physical and psychiatric, assessment and management procedures that will be routinely utilised with eating disorder patients, paying special attention to the management of continued food refusal.
3. Goals for the admission to be agreed with the patient, their family and the local mental health team (including plans for liaison from the local team) and documented in the assessment letter from the out of county unit.
4. The out of county unit to invite the referrer to a review no later than 6 weeks into the admission and pre-discharge. The date for the first review to be provisionally booked at admission. Extra reviews (6-8 weekly) might need to be arranged for admissions lasting longer than 3-4 months.
5. Written reports to be sent to the referring mental health team (copy to the Clinical Co-ordinator) after assessments and reviews. The content to include a standardised set of information reporting on all aspects of the eating disorder and its affects, management and therapy (including family involvement) and other changes in the patient's psychiatric, social and educational functioning, as well as agreed plans of action.
6. Discharge letters to be standardised in terms of the information included, summarising progress in the above areas.
7. The key worker at the out of county unit to telephone the key worker within the local CMHT once each 2-3 weeks to discuss progress and developments. The relevant information should be documented in the notes at the unit and the local CMHT. Alternatively, a brief standardised form could be sent from the unit to follow up the 'phone call, summarising the key issues.
8. Standardised measures of outcome (e.g. Child and Adolescent or Adult Health of the Nation Outcome Scales) to be administered at admission and discharge, the results being reported to the referrer in the discharge letter.

Appendix C

Prognostic factors

Anorexia Nervosa - poor outcome

- bulimia
- vomiting
- longer duration of illness
- lower minimum weight
- pre-morbid personality and social difficulties
- disturbed relationship with family
- previous treatment

Anorexia Nervosa - good outcome

- early onset (adolescents and adults)
- hysterical personality
- conflict-free parent/child relationship
- short duration between onset and treatment

(Steinhausen 1995)

Bulimia Nervosa - poor outcome

- personality disorder
- low self-esteem

(Wilson and Fairburn 1997)

Bulimia Nervosa - good outcome

- shorter duration of illness
- absence of personality disorder
- family history of alcoholism

(Hsu 1995)