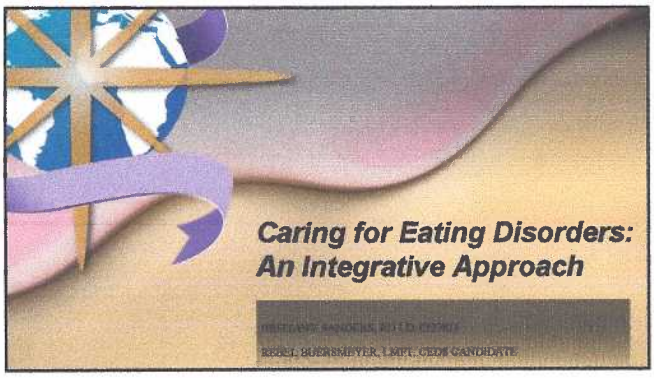


Objectives

- Participants will learn the importance of a collaborative treatment approach.
- Participants will learn about each providers role, differing levels of care, and best practices for step-down care.
- Participants will learn how to effectively implement communication throughout the entire treatment process, along the continuum of care and transitionary periods.

Eating Disorders Overview

ED's are a mental illness

- The defining characteristic of mental illness is that the person has "lost perspective"....
- They are seeing, thinking, hearing, and feeling things that may not have much basis in reality.
- ED patients are having distorted thoughts regarding their size and shape, food, fat, exercise, self and others.

Because these patients are so successful, it is hard to see them as having mental illnesses

The tendency is to want to see their illness as a "disorder of choice" and their struggles as issues of "will and discipline"

Eating Disorders Overview

Anorexia Nervosa (AN): Anorexia nervosa (AN): Restriction of energy intake relative to an individual's requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory and health status. Disturbance of body image, an intense fear of gaining weight, lack of recognition of the seriousness of the illness and/or behaviors that interfere with weight gain are also present.

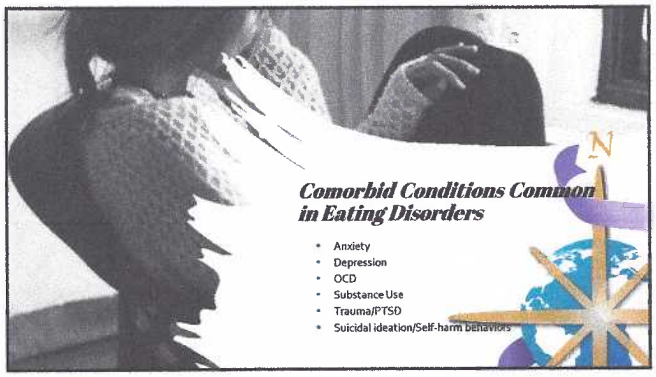
Bulimia Nervosa (BN): Binge eating(eating a large amount of food in a relatively short period of time with a concomitant sense of loss of control) with purging/compensatory behavior (e.g. self-induced vomiting, laxative or diuretic abuse, insulin misuse, excessive exercise, diet pills) once a week or more for at least 3 months. Disturbance of body image, an intense fear of gaining weight and lack of recognition of the seriousness of the illness may also be present.

Eating Disorders Overview

Binge Eating Disorder (BED)	Binge eating, in the absence of compensatory behavior, once a week for at least 3 months. Binge eating episodes are associated with eating: rapidly, when not hungry, until extreme full- ness, and/or associated with depression, shame or guilt.
Other Specified Feeding and Eating Disorder (OSFED)	An ED that does not meet full criteria for one of the above categories, but has specific disordered eating behaviors such as restricting intake, purging and/or binge eating as key features.
Avoidant/Restrictive Food Intake Disorder (ARFID)	Significant weight loss, nutritional deficiency, dependence on nutritional supplement or marked interference with psychosocial functioning due to caloric and/or nutrient restriction, but without weight or shape concerns.

Why we are passionate about treatment of eating disorders

- Eating Disorders do NOT discriminate
- Affects ALL ages
- Affects BOTH genders
- Eating disorders have the highest mortality rate of ALL mental illnesses
- Only 1 in 10 with ED seek treatment
- In the US, 20 million women and 10 million men suffer from an ED at some time in their life
- By age 6, girls especially start to express concerns about their own weight or shape. 40-60% of elementary school girls are concerned about their weight or becoming too fat. In the year 2000, 31% of 5th grade girls dieted, this rate is likely doubled.
- For females 15-24 years old who suffer from AN, the mortality rate associated with illness is 12x higher than the death rate of all other causes of death.



Comorbid Conditions Common in Eating Disorders

- Anxiety
- Depression
- OCD
- Substance Use
- Trauma/PTSD
- Suicidal ideation/Self-harm behaviors

People do not choose to have eating disorders

- -Genetic predisposition
- -Gender
- -Ethnicity
- -GI Disorders/ Early childhood feeding issues
- -Increased weight/shape concerns
- -Negative self-evaluation
- -Feelings of inadequacy or lack of control in life
- -Abuse/trauma history- with or without the involvement of food
- -General psychiatric morbidity
- -Family Dynamic: Can influence stress levels
- -Temperament
- -Function: Begins to help with emotional regulation

Commonly Used Screening Tools for Eating Disorders

- Eat-26
  - Measurement of a general eating disorder
  - 20/26 cut off identifies problematic attitudes with eating.
- Scoff Screening Tool
  - Do you make yourself Sick because you feel uncomfortably full?
  - Do you worry that you have lost Control over how much you eat?
  - Have you recently lost more than One stone (14 lb) in a 3-month period?
  - Do you believe yourself to be Fat when others say you are too thin?
  - Would you say that food controls your life?
  - "Yes" Answers of 2 or more screen positive for sensitivity for an ED

Appropriate language if Eating Disorder is Suspected

Talk about diets(past, current, future)	Appetite	Comments about weight/body shape/size
• "Diet/self help book really helped me" • Calories Counting	• Discussion about own appetite • Discussion about own food preferences	• Yourself or the client • Atypical Anorexia outcomes poor

Referrals

It is important for patients to have an adequate treatment team with training in the field of eating disorders.

If you do not feel adequately trained in the philosophy and methods of treating Eating Disorders, referrals are important.

Oklahoma Eating Disorders Association has a list of treatment providers in the State of Oklahoma

- http://okeatingdisorders.org/find-treatment/

National Eating Disorder Association for nation wide list

- https://www.nationaleatingdisorders.org/find-treatment/treatment-and-support-groups

Treatment Team

Treatment Team

Because of the seriousness and complexity of these disorders a multidisciplinary team is necessary

Psychiatrist	• Med management and treatment of co-occuring psychiatric conditions
Primary Care Physician	• Management of medical conditions • Specialist referrals
Registered Dietitian	• Will discuss
Therapist	• Will Discuss
Family (when appropriate)	• Adolescents and adults with healthy and supportive family members.

Role of the Registered Dietitian

- Assess client's nutritional needs
- Create and implement individualized meal plans to meet client's caloric needs for weight restoration or weight maintenance
- Provide nutrition counseling to help normalize eating and exercise behaviors
- Collaborate with multidisciplinary team and family, when appropriate

Nutrition Rehabilitation Improves Therapeutic Outcomes

- **MEDICAL:**
  - Inappropriate nutrition-related labs
  - Cardiovascular abnormalities
  - Dizziness or fatigue
  - Amenorrhea
  - GI complaints (constipation/diarrhea/bloating)
  - Bone density loss (stress fractures)
  - Electrolyte imbalance
  - Dental erosion
  - Protein-calorie malnutrition
  - *It is important to note that laboratory studies may be normal even with significant malnutrition
- **BEHAVIORAL:**
  - Increased talk or preoccupation with food and/or body size
  - Secretive eating
  - Excessive fear of eating in public
  - Withdrawal from social situations in general
  - Loss of interest in hobbies
  - Increased depression or anxiety
  - Inability to be in touch with reality of disease and impact on life
  - Because these patients are bright, attractive, and generally successful, it is hard to see them as having mental illnesses.

Basic Nutrition Counseling

- Focuses on the development of a collaborative relationship with patients that must be maintained for delivery of information and interventions.
- Specialized approach focused on correcting ED behaviors and beliefs in areas of:
  - Food
  - Exercise

Basic Nutrition Counseling

- Illuminates antecedents of food behaviors and beliefs in the areas of food and exercise
- Provides nutrition information
- Supports experimentation with new behaviors
- Assesses outcomes
- Major aim is to replace disordered unhealthy eating patterns.
  - Also, rightfully aims on weight(nutritional restoration) and monitoring.

Advanced Nutrition Counseling

- Additional education required to handle the complex issues of even the most difficult patients.
- Familiarity with psychological treatment approaches to facilitate teamwork with mental health professionals.
- Diagnosing and treating psychological symptoms are the psychotherapist's domain- dietitians who treat eating disorder patients should be familiar with an understanding of psychological treatment theories and techniques.
- Dietitians who are familiar with counseling approaches are better equipped to apply research findings to clinical practice.

Advanced Nutrition Counseling

- Conduct very specialized types of behavioral counseling.
- Extinguish problematic behaviors and reinforce positive behaviors.
- Define the ED as a behavioral problem (essential).
- Assist clients in experimenting with new behaviors, setting goals, and assessing outcomes.
- Concentrate on the patient's thoughts, understandings, and behaviors that maintain the eating disorder.
- NOT on the cause of the ED. –This is domain of psychotherapist. Counseling sessions that discuss psychological issues dilute the nutrition treatment and impact psychotherapy relationship.

Advanced Nutrition Counseling

- Cognitive Behavioral Therapy
  - Focuses on thoughts, beliefs, and values that maintain an Eating Disorder
  - Includes educational components, normalizing eating patterns by prescription of meal plan, weight monitoring, and written self observation. Cognitive restructuring of the problematic thoughts that negatively influence food behaviors.

Advanced Nutrition Counseling

- Dialectical Behavioral Therapy
  - Define dysfunctional patterns of behavior and problem solving. Balance of acceptance of behavioral problems and work to help change behaviors.
  - Concentrate on behaviors that influence quality of life.
  - Acknowledge that patients are doing best they can, but they can do better.
  - Understand why they behaved the way they did, but then "How can we do this differently next time?"
  - Constant cheerleading
  - Wise mind- what is true and what they "feel" or believe" to be true regarding food and their ED behaviors.

Role of the Therapist

- Screen and assess for eating disorders
- Assess for comorbid psychological conditions
- Assess for cultural, social, or interpersonal factors that may be impacting eating disorder behaviors and thoughts.
- Work with patients to identify eating disorder triggers and work with patients to develop appropriate coping skills to manage eating disorder thoughts and behaviors, as well as, other stressors.
- Work with patients to identify other skill deficits and improve these skills.

Role of the Therapist

- Work with patients to identify and process underlying factors that have been causing eating disorders to be used as coping mechanisms..
- work with patients and their family and/ or support system to address:
  - underlying family issues
  - helpful and unhelpful family patterns
  - acknowledge the impact of eating disorders on others
  - increase understanding and support around eating disorders.

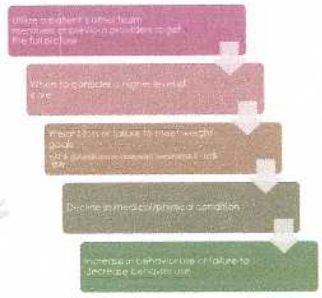
Therapy improves Nutrition Outcomes

- Skills training
- Coping skills while learning to stop nutrition related behaviors
- Improved outcomes with management of emotions while eating

Shared Roles

- Normal and Abnormal Eating
  - Healthy Relationship with Food
  - Sensory and Somatic Sensations
  - Emotional Eating
  - Risk Taking
- Relationships
  - Meet needs in other ways than their eating disorder
- Body Image
  - Shared role in reminding patients that while body shape and size are unalterable, it is the aspect of personality that imparts value into one's life.
  - Therapist works on the origins of the poor body image
  - Dietitian works on accurate feedback about body weight education and healthy weight range as determined by genetics and providing information on negative consequences of weight-loss behaviors.

Collaboration with Team Benefits



Sharing Critical Information

The mental health provider-nutritionist collaboration is a primary partnership in the treatment of eating disorders, and its integrity is important for good patient care.

Treating a person with an eating disorder can take many years and many cycles of care before recovery occurs. Research suggests that the course of illness for anorexia nervosa may be 7 to 10 years and possibly less for bulimia nervosa. As professionals, we often see patients who have received treatment, but for whom the continuum of care has been broken, leaving us without access to critical information.

Importance of Interdisciplinary Communication

- Between 20% and 30% of eating disorder patients drop out of treatment.
- **Due to denial and cognitive impairment secondary to malnutrition**, there are significant impediments, including denial of the severity of illness.
- Thus, patients may not fully understand the issues raised during previous treatments, while malnourished.
- The same ground must be therefore covered and re-covered, which may lead to prolonging the illness.

Collaboration and Synergy of Treatment

Collaboration across the continuum of care, improved communication, and synergy of treatment approaches improves recovery.

Collaboration and communication are enhanced when outpatient providers work together frequently as a team, and when inpatient and outpatient providers have established ties to one another.

Shared knowledge, trust and common language, and the responsiveness of self-identified colleagues all prove beneficial.

Team Improves Outcomes

Developing a Trustworthy Team

The first step in developing a team is finding professionals who are knowledgeable about eating disorders or who are willing to learn about them.

Here are some suggestions for those willing to learn: (1) Send them a copy of the *American Psychiatric Association Practice Guidelines*. (2) Suggest they join eating disorders associations, such as the Academy for Eating Disorders. (3) Recommend that they subscribe to relevant journals and attend relevant conferences. (4) Suggest that they host a monthly eating disorder consultation group with other professionals.

Strategies to Improve Communication

- Close communication is often difficult, given the busy schedules of many professionals.
- However, effective communication can be achieved with confidential voicemails and faxes.
- Teams should determine the information that is relevant to the group.
- Critical information may include:
  - changes in medical status, including weight changes,
  - problems with follow-up
  - missed appointments
  - changes in meal plans.
- Appropriate information releases must be secured at the beginning of treatment so providers can discuss important issues with other members of the team.
- When patients fail to cooperate, it may be a sign of therapy-interfering behavior. In such cases, the therapist and patient may need to negotiate a workable solution.
- Avoid "splitting"
  - Patient will try to play one staff member against another and confuse care by telling different versions of a story to different people. This often results in staff members taking sides against each other if not in complete collaboration and communication.

Management of "Splitting"

Conduct	Conduct brief weekly conferences to plan treatment and reach consensus about what to tell the patient. Make no changes in the plan unless the entire team is involved and informed.
Be	Patient needs to be told simply and truthfully what is being done.
Use	Use consistent team whenever possible. Don't ever encourage a client to leave a provider based on a story. Wait until you hear the whole story from the entire team before any recommendations are made.
Anticipate	Anticipate vacations/time off and prepare patient well in advance.
Be	Be aware of your own anger.
Say	Say, "I understand what you are asking for and because you deserve the best possible care, I am going to continue to pursue the plan dictated by the team's experience/judgment."
Do not try	Do not try to argue with the client. •Oftentimes, saying something like "Well, I know (insert provider), and that doesn't sound like something he/she would do, but let me discuss this with the team and get back to you."

Recognition of Higher LOC Needs

- Professionals recognize level of care needs according to the severity of illness.
- Treatment failures, including treating patients unsuccessfully for an extended time, may also indicate the need for a higher level of care in order to handle patient resistance and provider countertransference.
- If higher level of care criteria are met, a conference call is needed to plan for the transition. One team member can act as a point person for the team, the family, and the patient.

APA OVERVIEW Benefits with Collaboration

- HELPS TO DETERMINE IF CLIENT IS IN THE CORRECT LEVEL OF CARE — https://www.nationaleatingdisorders.org/toolkit/parent-toolkit/level-care-guideline-patients
- REQUIRES THAT INFORMATION FROM ALL MEMBERS OF THE TREATMENT TEAM IS ACCESSIBLE
- ASSISTS IN DOCUMENTATION TO BUILD A CASE FOR A HIGHER LEVEL OF CARE
- EDUCATE CLIENTS, FAMILIES, AND PROVIDERS ON TREATMENT NEEDED AND ETHICAL LEVEL OF CARE

Benefits of United Front when Recommending Higher Level of Care

- Outpatient providers have the major responsibility for coordinating the patient's care and for assessing their levels of care.
- To manage changes, outpatient providers must know that patients may need higher levels of care from professionals in their region.
- Therapeutic rapport can be pivotal when convincing a family or patient that a higher level is necessary.
- Transitional teleconferencing prior to and after a higher-level admission can ease concerns and build confidence.
- Outpatient providers have a great deal of influence with insurance companies, and recommendations from united teams are difficult to dispute.

Communication with Higher Levels of Care

- Because eating disorder patients are often reticent, a telephone call to gather information about the patient is essential for the inpatient providers before a treatment plan can be formulated.
- An agreement should be made between inpatient and outpatient providers regarding communication during the inpatient stay.

Collaboration with Patient in Residential Care

During longer lengths of stay, it is standard practice for outpatient therapists to disengage from therapy with their patients so that patients may switch to a new treatment setting and develop trust with the new treatment team.

→

However, it is optimal for inpatient and outpatient providers to communicate at least twice during the patient's stay, to keep outpatient providers abreast of patient progress and to help with interventions if the patient begins to talk about leaving inpatient treatment prematurely.

→

For shorter lengths of stay, good judgment will be needed to help both groups decide the outpatient provider's degree of disengagement.

Splitting at Higher Levels of Care

- Inpatients may say that the outpatient providers were not helpful to them. This may simply mean that such patients are displeased with the recommendation for a higher care level and the outpatient provider(s) who made it.

Stepping Down from Residential Treatment to Outpatient Treatment

- A teleconference prior to discharge is essential.
  - This conference should include the patient.
  - Treatment progress and issues to address in the lower level of care should be discussed and agreed upon.
- There may also be times when the inpatient team may need to communicate information to the outpatient treatment team that would not be said in the same way with the patient present.
- For patients with more severe illness or those who have been inpatients for a longer time, transitional care or "step-down" programs may be indicated for one to three months.
- These patients benefit from the structure of such programs, which enable them to practice new skills and to gain confidence while facing typical stressors of everyday life.
- Once patients are ready to return to outpatient care, inpatient/transitional providers should coordinate this hands-off with their outpatient colleagues by scheduling appointments for the patient during the first week following discharge.

Gathering Pertinent Information Before Seeing Clients

- All pertinent medical records should be forwarded to the appropriate outpatient providers, preferably prior to the first appointment with that provider.
- Inpatient treatment centers have a wealth of information available to the outpatient providers, often including psychological testing results and family therapy notes that are sometimes difficult to gather on an outpatient basis.
- According to surveys, most outpatient providers want clear and specific treatment recommendations from inpatient providers. They also believe that the discharge plan should contain specific criteria for readmission, such as body weight or other indicators of relapse.

Continuity of Inpatient Interventions and Goals

- Outpatient providers need to know the specific interventions and program content of the inpatient facility in order to continue with similar language, tools, and skill building.
- This helps the patient to internalize the inpatient experience.
- Inpatient and outpatient treatment goals should be discussed and aligned as much as possible.
- This also sends a congruent message to patients, and less time will be wasted on therapy-interfering behaviors such as splitting between providers.

Building Accountability During Transitions

- During inpatient discharge planning, it's helpful for the patient to create a relapse prevention plan to share with the follow-up treatment providers.
- In the manual, the patient writes down behaviors, events, and perceptions that might cause trouble in the future.
- These are often called Red Flag warnings.
- Involved families can also be alerted by the patient to these warning signs of relapse.
- Follow-up communication prior to discharge is an essential piece. Patients should be aware that collaboration exists and that outpatient providers expect their return on a specific date.

Failure to Follow up with Outpatient Team

- When patients fail to follow through with outpatient appointments, many healthcare professionals, inpatient and outpatient, do not try to bring patients back into treatment.
- Patients may need help with their motivation to change. We cannot assume that patients who reach a particular level of motivation at one point in treatment will maintain this level of motivation.
- The environment or relationships, along with fear, can affect patients, even those with the best intentions.
- **We urge providers to make a commitment to improve the recovery process for eating disorder patients and to try to go the extra mile when patients don't follow through. Preventing relapse and keeping patients in treatment can save lives.**

What Experiences and Difficulties Have you Experienced in Collaborating with Other Providers?

Brainstorming: How can we do better in the ED field with collaboration?

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