Eating Disorders
Integrated Care Pathway

NHS Lanarkshire Child and Adolescent Mental Health Service
Welcome

Welcome to the NHS Lanarkshire Child and Adolescent Mental Health Service Integrated Care Pathway for Eating Disorders. For the purposes of this document (and in line with current research and practice), formal diagnostic categories of eating disorders are divided into –

- Anorexia Nervosa (commonly referred to as “AN”)
- Bulimia Nervosa (commonly referred to as “BN”)
- Eating Disorder, Not Otherwise Specified (commonly referred to as “EDNOS”)

Where it is not necessary to specify particular formal diagnostic categories, the generic term “Eating disorders” (“ED”) will be used.

This document is designed to provide guidance to practitioners encountering, or likely to encounter, a young person (0-18yrs) affected by an eating disorder living in the area covered by NHS Lanarkshire.

This document is

- compiled using guidance from the most recent evidence prepared by a variety of researchers
- compliant with Scottish Government standards covering the development of Integrated Care Pathways
- applicable to any professional working with young people affected by an eating disorder
- liable to be updated in the light of new developments in the field.

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NHS Lanarkshire CAMHS Eating Disorders Integrated Care Pathway
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- FACECARAS Risk Assessment tools: Eating Disorders – Guide for patients, families, clinicians:
  Laboratory test recommendations / requirements: CAMHS ED ICP Guide For First Response Practitioners (P42): PHQ-9: SCOFF: REFEEDING SYNDROME (P44)
1.1 Introduction
Eating Disorders are a group of conditions related to body image disturbance and abnormal eating behaviour. These include anorexia nervosa, bulimia nervosa and atypical eating disorders. The International Classification of Diseases (ICD 10) definitions of eating disorders are included in Appendix 1.
In eating disorders there is not just a disturbance of eating behaviour, but also an abnormal thinking pattern characterised by an extreme preoccupation with body shape and weight, and body disparagement.
An important distinction is between those disorders that occur in people of at least normal body weight, and those that occur in people with low body weight. Other conditions, including depression, anxiety, often co-exist alongside eating disorders.
People frequently move between the different categories of eating disorders. For some people compulsive activity is even more important than food restriction. Treatment therefore has to consider the meaning of exercise, as well as of eating and of body image in people’s lives. At low weight, it can be psychologically as well as physically damaging to overexercise.
Eating disorders are serious and may be enduring mental disorders. They have the highest mortality rate of any psychiatric disorder.
Early identification and appropriate intervention improves the clinical outcome for many people who have an eating disorder.
The annual incidence of anorexia nervosa is 8.1 per 100,000 and of bulimia nervosa it is 11.4 per 100,000 (approximately 0.45% of the population) and with about half of this annual incidence falling in the age range for which NHS Lanarkshire CAMHS is currently responsible, in each year we might expect to see more than 50 new referrals for Eating Disorders.
1.2 Rational for Developing the ICP

NHS Quality Improvement Scotland (QIS) (an organisation which helps the NHS in Scotland to improve the quality of care and treatment they provide) is helping health boards to develop Integrated Care Pathways (ICPs) for mental health services. An Integrated Care Pathway is a tool that allows for a

“comparison of planned care with care actually given”
(Standards for Integrated Care Pathways for Mental Health, NHS QIS, 2007)

For the service user, this means the right care and interventions at the right time, in the right place. ICPs are much more than a document of care given; they also embody a system of care planning, organisation, co-ordination and governance. To achieve this NHS QIS has published standards for the development of ICPs detailing:

♦ how ICPs should be developed;
♦ how ICPs should be monitored.

In Lanarkshire these standards have been incorporated into the development of this ICP by consulting with a variety of stakeholders consisting of NHS staff, representatives of service users and carers, local authorities, voluntary organisations and the independent sector.

1.3 How to use the Lanarkshire CAMHS ED ICP

The Lanarkshire CAMHS ED ICP will automatically be used for people accessing CAMHS services in Lanarkshire where an eating disorder is suspected. This will therefore include all young people residing in Lanarkshire from birth to their 18th Birthday who are experiencing difficulties suggestive of an eating disorder. It is expected that many of the referrals initially managed by NHS Lanarkshire CAMHS may be appropriately jointly managed with the Lanarkshire specialist tier three eating disorder service (TESS) according to the young person’s age, and the nature of their presentation. The Lanarkshire CAMHS ED ICP is based on a stepped model of care as described in the Lanarkshire Mental Health Strategy. The focus is on the patient journey across various service elements taking into account the different care and treatment needs the service user may have at different times and how these needs can best be met by health and partner agency services. The ICP documents this journey of care across all of the
service elements, forming part of the care record. Staff involved in delivering each episode of care will contribute to completing the ICP documentation.

This model should place the emphasis on the whole person, rather than just their symptoms and view the service user as the ‘expert’ in their experience (Rights, Relationships and Recovery, the Report of the National Review of Mental Health Nursing in Scotland. Scottish Executive April 2006). The ICP encompasses a culture and values which aim to enable person-centred recovery and strengths-based focus with a move towards positive management of individual risk, maximising choice and access to evidence-based interventions (see Appendix 2 for guidance and policy base).

The ICP is intended to provide a standard model of good care based on the current evidence base and expert opinion. It is important to note that the ICP is a guide to good care but it should never replace sound professional judgement. The professionals’ assessment and judgement will always override the advice of the tool where this is necessary. The ICP is part of the patient record and as with all such records, it will be private and confidential with access governed by the usual rules of confidentiality.

By using this ICP we will be able to produce data about the care and interventions provided to young people in Lanarkshire with eating disorders. This information (variance data), will allow us to compare the actual care and interventions given with those planned in the ICP and enable us to identify areas where the ICP should be modified to improve the quality of care provided. The variance information will also identify resource issues, gaps in service availability and future staff training and supervision requirements.
### 1.4 Tiered Model

The Tiered Model illustrates the matched approach to care across the various levels or tiers of service. This means that the interventions and services provided match the level of need of the service user. **Table 1** shows the services provided in each tier.

#### TABLE 1 Description of Tiers

<table>
<thead>
<tr>
<th>Tier</th>
<th>Description</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 0 – Community Health and Wellbeing</td>
<td>Generic services providing education, health improvement and preventative approaches</td>
<td>Voluntary services, public health services, local authority education and leisure services, education</td>
</tr>
<tr>
<td>Tier 1 – Primary Care and Mental Health Services</td>
<td>Entry level for care where professionals will seek to address issues before they may require referral on to more specialised and focused services</td>
<td>General practitioner, public health nurse, school nurses, community paediatricians, allied health professionals, e.g. dietetics, physiotherapy, occupational therapy</td>
</tr>
<tr>
<td>Tier 2 – CAMHS Primary Mental Health Team and Youth Counselling Service</td>
<td>Specialist community and inpatient based structured treatment service accessed by referral from Tier 1</td>
<td>NHS Lanarkshire CAMHS Primary Mental Health Team and Youth Counselling Service, Psychology Liaison Team</td>
</tr>
<tr>
<td>Tier 3 – CAMHS Locality Teams</td>
<td>NHS Lanarkshire CAMHS patch teams, TESS</td>
<td>Motherwell/Wishaw, Hamilton, East Kilbride, Clydesdale, Bellshill/Coatbridge, Airdrie/Cumbernauld</td>
</tr>
<tr>
<td>Tier 4 – Specialist CAMHS</td>
<td>Intensive community support. Inpatient treatment</td>
<td>NHS Lanarkshire CAMHS Intensive Home Treatment Team, Skye House Inpatient Adolescent Unit, Other inpatient units</td>
</tr>
</tbody>
</table>

All available services are included within the CAMHS ED ICP, but will be used as required by each individual service user. Once a person has been assessed by a health professional and a mental health need identified, a decision in collaboration with the young person and their family will be reached on the most appropriate care and interventions. This will inform which pathway the service user will follow.
2. Tier 0 Services

2.1 Introduction

Mental health is a term used to describe emotional and psychological wellbeing. For individuals, mental health is how a person thinks, feels, and acts when faced with different situations. It is affected by factors that promote or demote peoples' sense of wellbeing either individually or at population level. Mental health improvement is an inclusive term that may include action to promote mental health and wellbeing, to prevent mental health problems and to improve quality of life for people with a diagnosed mental health problem.

2.2 Mental Health and Wellbeing Services

In Lanarkshire the services available at Tier 0 to promote or improve a person’s mental health and well being are referred to as ‘Gateway Services’ illustrated here.

Examples of Gateway Services

- Befriending, Cove
- Black/Ethnic Minority Services
- Carers Organisations
- Childcare Facilities
- Counselling Services
- Education – teaching and guidance staff
- Educational Psychology
- Housing, Homelessness and Tenancy Support
- Lanarkshire Association for Mental Health
- Leisure and Sports Facilities
- NHS Lanarkshire PMHT team
- Rape Crisis/Victim Support
- Social Networks
- Student Services
- Social Work Reception Services
- Volunteer Services
- Websites
- YMCA
2.3 Healthy Reading Programme

The Lanarkshire Healthy Reading Programme launched in 2010, makes it easier for people to access mental health and well-being leaflets, books, CDs, DVDs and web-based support, through visiting the library or referral from GPs and other services in the community. All 50 libraries across Lanarkshire now have resources aimed at helping people get the most from life such as living life to the full, sleeping better and becoming more confident and assertive. Healthy reading can be helpful for people to overcome and cope with mental health problems such as anxiety, depression, stress, dementia, eating disorders, bereavement and panic. There are also resources for all ages including supporting young people, adults and older people as well as items on positive parenting.

As part of this programme Elament (Lanarkshire’s Mental Health and Well-being Website) has also been re-launched, with a full range of self-help materials for everyone to use. It also includes an improved service directory with maps built in to help people access services more easily. Specific information and advice about eating disorders can be found at http://www.elament.org.uk/mental-health-topics/eating-disorders.aspx?letter=E.

2.4 Other Internet resources

In addition, there is a wealth of material available on the internet from a variety of organisations. The “Young Minds” website (http://www.youngminds.org.uk/search?q=Eating+Disorders) has a wealth of information about young people’s experiences of eating disorders, together with considerable advice for commissioning services regarding establishment and management of services for young people, and links to the views of a variety of professionals and agencies.

A specialist charity working within the field of eating disorders, B-EAT (http://www.b-eat.co.uk/) has developed a very high quality website with many excellent articles which help to demystify eating disorders, and also provides guidance for young people, parents / carers, and professionals.

However, parents / carers and young people should be advised to exercise caution when using the internet to find out about eating disorders. Much of the information available on the internet is helpful and carefully presented, but there are also sites which contain unhelpful and occasionally dangerous information, or which “promote” eating disorders, offering encouragement to lose weight or praise for doing so.
2.5 Access to Services

These services can generally be accessed by individuals without going through a GP first, (although people may be referred to them from primary care and specialist mental health services) and include services provided by health, local authorities, voluntary organisations and independent providers. In the context of eating disorders, however, a significant proportion of initial contacts with helping agencies will be focused on questions about physical health (for example unexplained weight loss, sudden unexplained fainting / collapse etc) and the involvement of general practitioners or similarly qualified personnel is recommended.
3. Tier 1 Services

3.1 Introduction

Whilst approximately 90% of mental health problems are identified, assessed and managed within tier 1 services, it is unlikely that young people with eating disorders will be successfully managed without accessing specialist services, and evidence is growing for the important positive effect on outcomes facilitated by early interventions by specialist or semi-specialist services. These services cover the mental health needs of young people from birth, and it should be remembered that there are occasionally presentations of very young people with eating disorders. Scottish Government policy is that mental health assessments should be delivered in a manner that is person centred, with a socially inclusive focus where care planning and care delivery are based on recovery, and where required outcomes are identified by the service user rather than on the availability of services and treatments.

3.2 Primary Care Services

Services provided at Tier 1 in primary care are based on assessment and diagnosis made using clinical judgement and may include the use of standardised assessment tools. Services include:

- Assessment and diagnosis where weight loss of unclear mechanism is observed, with the use of standardised assessment tools and questionnaires (see appendices)
- Risk assessment, with particular attention paid to risks presented by both physical considerations and psychological / psychiatric considerations.
- Primary Care Treatment, such as the use of approved emergency feeding plans (see appendices).
- Information and advice
- Onward referral to specialist mental health services, local authority services and other agencies.
3.3 Access to Services

The most usual method of accessing these services is through the GP practice. As with Tier 0 services we record the use of Tier 1 care and intervention in relation to the Generic CAMHS ICP or when these services are used in conjunction with treatment given at different Tiers of the service as part of other condition specific ICPs. (See the Generic CAMHS ICP and other condition specific ICPs.)
4. Tier 2 Services

4.1 Introduction

The model of CAMHS Tier 2 services is currently developing with considerable expansion planned. As with Tier 1 services, it is unlikely that a young person with an eating disorder would not need specialist interventions provided by tier 3 and possibly tier 4 services. Tier 2 interventions should focus on assessment and establishing provisional diagnosis which can be made using clinical judgement and may include the use of standardised assessment tools. Services include:

- Assessment and diagnosis where weight loss of unclear mechanism is observed, with the use of standardised assessment tools and questionnaires (see appendices)
- Assessment of disordered dietary / nutritional behaviour.
- Risk assessment, with particular attention paid to risks presented by both physical considerations and psychological / psychiatric considerations.
- Primary Care Treatment, such as the use of approved emergency feeding plans (see appendices).
- Information and advice
- Onward referral to specialist mental health services, local authority services and other agencies.

4.2 Additional Functions Provided by Tier 2

1. Giving advice on the management of mental health problems by other professionals, in particular advice to colleagues in primary care, and a triage and assessment function enabling appropriate referral and intervention matched to need (“Gatekeeping”).
2. Providing care and interventions for those people with time limited disorders who can benefit from specialist interventions, such as early presentations of eating disorders where there is an immediate positive response to initial assessments and interventions.
3. Managing the transitions to tier 3 services through liaison, discussion and participation in ongoing therapeutic work where this is thought to be helpful.
5. Tier 3 Services

5.1 Introduction

♦ People are referred to Tier 3 services Lanarkshire when specialist and high intensity care and interventions are required due to the severity and/or complexity of their condition. The majority of young people with eating disorders will access these services.

5.2 Access to Tier 3 CAMHS

Referrals to these services can be made by any relevant professionals with concerns, although as with all referrals to CAMHS the involvement of the General Practitioner for the young person involved is vital. As things stand, about 65% of referrals to CAMHS come from GPs.

5.3 CAMHS Tier 3 services

The overall management of health and social care services is developing. A key part of these developments is locality based health and social work community mental health services working in partnership with other statutory and voluntary service providers to deliver a variety of services for the residents of Lanarkshire. Currently, NHS Lanarkshire Child and Adolescent Mental Health Services (CAMHS) functions as a multi-tier, locality and functional team based system. Client patients, and their families, have care and treatment delivered via either tier two Primary Mental Health and Youth Counselling (PMHT and YC), or by tier three locality based teams (of which there are seven covering North and South Lanarkshire), the Paediatric Psychology Liaison team, or by functional teams such as the CAMHS Learning Disability team, the “Reach Out” team (a service for young people who are affected by their parents serious and enduring mental ill-health) or the CAMH service for Accommodated Young People (CAYP) which provides a service for young people “Looked After” or “Accommodated” by local authority provision. In addition, NHS Lanarkshire CAMHS operates an intensive treatment team (CITT) whose aim is to support young people with serious mental ill-health at home thus reducing hospitalisation. It is likely that eating disorders may feature in any one of these clinical environments, but the majority of ED treatment and engagement will occur in tier three locality teams and the CITT service.
5.4 Referral

- All referrals must be discussed with the service user and carer (as appropriate) by the referrer before a referral is made.

- The referrer must identify whether the referral meets the criteria for routine consideration by the locality CAMHS and should be made to a single point of access to the service. Referral to the locality CAMHS team where an eating disorder is suspected should include the details listed below.

<table>
<thead>
<tr>
<th>Physical considerations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Weight</td>
</tr>
<tr>
<td>Current Height</td>
</tr>
<tr>
<td>Calculated BMI (inc % BMI for age/gender)</td>
</tr>
<tr>
<td>Weight loss (known or estimated)</td>
</tr>
<tr>
<td>Rate of known or estimated weight loss</td>
</tr>
<tr>
<td>Current Blood pressure</td>
</tr>
<tr>
<td>Current heart rate / rhythm</td>
</tr>
<tr>
<td>Current temperature</td>
</tr>
<tr>
<td>Status of circulation</td>
</tr>
<tr>
<td>Status of fluid balance</td>
</tr>
<tr>
<td>Bloods obtained for investigation, (results of investigations where available) to include at least FBC, TFT, LFT, U&amp;Es (See appendices for more detail)</td>
</tr>
<tr>
<td>ECG esp if bradycardia present</td>
</tr>
<tr>
<td>Presence of vomiting</td>
</tr>
<tr>
<td>Presence of sustained, driven, intense, compelled exercising</td>
</tr>
<tr>
<td>Poor muscle tone / weakness etc</td>
</tr>
<tr>
<td>Presence of Oesophageal tears</td>
</tr>
<tr>
<td>Physical signs of severe malnutrition (ie lunago, skin changes, nails, hair etc)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health Considerations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal thinking / intent / planning</td>
</tr>
<tr>
<td>Deliberate Self Harm</td>
</tr>
<tr>
<td>Depression / anxiety / agitation or other comorbidity.</td>
</tr>
<tr>
<td>Delusional thinking esp concerning dietary intake, body size, shape, weight etc.</td>
</tr>
<tr>
<td>Other disordered thinking</td>
</tr>
<tr>
<td>Evidence of cognitive impairment</td>
</tr>
<tr>
<td>Denial of symptoms / evidence of impairment / physical deterioration / weight loss</td>
</tr>
<tr>
<td>Evidence of compulsion esp. exercise levels</td>
</tr>
<tr>
<td>Duration of psychological disorder</td>
</tr>
</tbody>
</table>

- Referrals are screened initially on receipt by NHS Lanarkshire CAMHS duty staff.

  i. Not appropriate – the rationale for this decision will be communicated to the referrer, client and client’s family.

  ii. Insufficient information to correctly prioritise the referral – in which case the referrer will be asked to complete the details required.

  iii. Accepted for assessment – in which case the family will be invited to “opt-in” for the next available appointment. Assessment appointments generally occur on at least a daily basis, and in line with Scottish Government directives, NHS Lanarkshire CAMHS intends to meet national “Referral to Treatment” targets which from April 2014 will be 18 weeks.

**However it is likely that most referrals featuring concerns about eating disorders will be prioritised as “Urgent” (in line with NHS**

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Lanarkshire CAMHS current Operational Policy) and will be seen within two weeks from the point of referral, or on the next working day in the event of an emergency referral.

- If the referral is considered to be routine, an “Opt-in” letter is sent to the service user inviting them to contact the clinic’s admin staff in order to choose from available appointments. In the event that an appointment is arranged, this will be confirmed with an appointment pack which includes a Patient Service Information Leaflet. If the referral is considered to be urgent, the family will be offered an appointment within two weeks. The speed of this response means that flexibility about the timing of these appointments is limited.

- If the person does not attend where the referral is considered to be urgent, contact should be made with the referring practitioner in order to establish the next step, which may include contacting the family directly. Where a routinely arranged appointment is not kept, the referring practitioner and family GP should be notified and a further “Opt-in” letter should be send with a two week deadline.

ICP Standard 9a: There is an agreed decision-making system to support referrals into mental health services.

ICP Standard 9b: Service care providers have an agreed system on how referrals are managed within their mental health services, including: initial screening, triage assessment and signposting to required service according to complexity of need.

5.5 Assessment

- A Core Mental Health Assessment and Multi-agency Risk Assessment as per the Generic CAMHS ICP documentation are carried out. This will include completion of the FACECARAS suite (see Appendices). Specific assessment of thoughts, feeling and behaviour related to eating disorders utilising various questionnaires and assessment tools (see Appendices) are useful.

Standard 11a: There is a record of the service user’s vulnerabilities and risks, including: self harm; suicide; harm to others; finance; occupation; social vulnerability; sexual vulnerability; abuse; neglect, and informal carer risk assessment, where relevant.

- The outcome of this initial assessment is:
i. No further intervention required by locality mental health service. A No Further Intervention Letter is sent to the referrer and service user.

ii. Further intervention required.

Case allocation then takes place and a named case manager assumes responsibility for the care and intervention package. Referrers and other appropriate agencies are involved in this process. Further assessments may be required.

**ICP Standard 10a:** A holistic assessment is carried out with the service user and identifies: current and past mental health problems (including the informal carer’s perspective); current and past interventions for these problems (including outcomes, adverse reactions and side-effects); personal, family and social circumstances; strengths and aspirations; physical health problems; functioning (e.g. life skills assessment); service user needs assessment (e.g. Avon) and where appropriate, informal carer needs assessment; capacity to consent to care and treatment, and drug and alcohol use and misuse.

**ICP Standard 10b:** A target time for completion of the holistic assessment is recorded.

**ICP Standard 11b:** The risk assessment leads to the generation of a risk management plan that is: developed with the service user; communicated to all those involved and identifies roles and responsibilities; reviewed at regular intervals, and amended as necessary.

**ICP Standard 12a:** There is a record of a risk assessment and management plan for women of childbearing age which includes: advice and explanation of risks of becoming pregnant during treatment; access to contraceptive advice; the considered involvement of a partner; previous history of puerperal psychosis; suitability of current medication while pregnant and in the postnatal period; the effects of medication on the foetus and on the woman, and the risk of relapse if medication needs to be withdrawn or changed.

**ICP Standard 13b:** The care record shows information on the management of physical health needs, including: information on who is responsible for the physical health assessment (primary care or specialist services); evidence that results have been shared; evidence that results have been acted upon, and evidence that information and/or advice on promoting a healthy lifestyle has been provided.

**ICP Standard 21a:** The care record includes a needs assessment scale which is rated by service users and informal carers, e.g. Avon Mental Health Measure.
ICP Standard 21b: The care record includes a professionally rated assessment tool which is validated for the relevant client group to monitor outcome.

ICP Standard 14a: The care record shows: the diagnosis or diagnoses; information on how the diagnosis or diagnoses was reached following evidence based guidelines or established diagnostic criteria, where available confirmation that the diagnosis or diagnoses has been explained to the service user and informal carer, and post-diagnosis support is offered.

ICP Standard 16a: The care record shows that care is planned and agreed with the service user and informal carer in a format that is accessible and takes into account personal values and beliefs.

ICP Standard 16b: The care record shows that advice has been provided to the service user and their informal carer on sources of further information and support, for example voluntary organisations and advocacy services.

ICP Standard 17a: The single care plan records a nominated co-ordinator who has been identified and agreed with the involvement of the service user.

ICP Standard 17b: The single care plan operates across all service care providers and: is based on the assessment of needs, strengths and past experience; identifies goals and aspirations; specifies tasks, treatment and interventions (including risk management); records roles and responsibilities of all individuals and agencies involved; includes a record of service user desired outcome (self-directed outcome); includes a system to record disagreement; records that service users are invited to hold a copy of the care plan, and records unmet needs since the last assessment.

• An initial Single Care Plan/Formulation is agreed with the service user and relevant others, the referrer informed and discharge planning commenced (including condition-specific ICP requirements).
5.6 Management of a young person with an Eating Disorder in the community

There is growing evidence that the most successful method of working with young people with eating disorders (especially anorexia nervosa) follows what has become known as a “Family-Based Treatment” approach.

This approach mobilises the family of a young person with an eating disorder to (in the case of the parents) take control of the young person’s diet and nutrition, and (in the case of the siblings) to become supporters of the recovering young person.

The approach is in three phases. The first phase facilitates parental control of diet and nutrition. Once this is restored, and appropriate dietary intake is maintained with a resultant improvement in all areas of functioning, phase two emphasises a gradual return to the young person in question exercising the appropriate level of control over diet and nutrition. The third phase provides support for the young person and their family to look at rebuilding family relationships in the absence of the eating disorder, and helps establish prodromal awareness and monitoring.

Family Based Treatment

- Is agnostic as to the “cause” of eating disorders
- Seeks to empower parents to take control of the crisis
- Aims for the restoration of health eating
- Seeks to separate the illness from the young person
- Places the therapist in the role as consultant advisor

Family Based Treatment

Phase 1 – Weight Restoration

Session 1

- Engagement
- History and effect of eating disorder on family
- Preliminary view of family functioning
Session 2

- Continuing assessment of family functioning
- Family meal in clinic (or at home if clinic attendance is not indicated)
- Assessment of family strengths in particular with regard to mealtime management

Subsequent sessions

- Maintenance of family focus on eating disorder
- Empowering of parents
- Mobilizing of siblings to offer support to patient

Phase 2 – Transitioning of control back to recovering young person

- Maintaining parental control until evidence of recovery develops
- Eventual return of control of diet / nutrition to the young person
- Exploration of relationship between adolescent development and eating disorder

Phase 3 – Adolescent Issues and termination

- Confirmation that eating disorder no longer has a role in family life
- Review of adolescent development issues, modelling problem solving, developing prodromal monitoring stratagems
- Ending of treatment.

Since the idea behind an Integrated Care Pathway is to provide a suggested structure of treatment, and never replaces the opinion of experienced professional judgement, not all young people with eating disorders will necessarily be treated using this model. Other methods of supporting young people with eating disorders have proven outcomes. The ICP is then used to record variances from this model and the rationale for using different approaches.

However, all young people with a suspected eating disorder should be assessed using the guidance contained in Section 5.4 of this document. This initial assessment should be continued during (in particular) the early
phases of treatment, with the frequency, scope and content of these assessments being adjusted to suit changes in presentation.

The delivery of Psychological Therapies in Lanarkshire is based on the principle of matched care, whereby individuals referred into the service are matched to the appropriate level of treatment for the level of complexity of their difficulties (NHS Lanarkshire Psychological Therapies Strategy, August 2009). In addition the recently published Matrix document from the Scottish executive provides health boards with a comprehensive review of the evidence base for psychological therapies and guidance as to how these should be delivered (i.e. level of training required to deliver therapy, amount of supervision required).

Before any psychological or psychosocial therapy is undertaken a comprehensive psychological assessment and formulation should be carried out by an appropriately trained professional and recorded as per agreed recording procedures. Where needs have been identified a selection can be made from a Comprehensive List of Therapies/Interventions based on service user need and preferences. This is recorded via the multidisciplinary team as per agreed recording procedures. These therapies/ interventions will be delivered within agreed timescales, and outcomes reviewed periodically dependant on progress.

Psychological Therapies with some evidence of efficacy for the treatment of eating disorders in children and young people (ie “C or C+” in the context of the Psychological Therapies Matrix) include:

- Cognitive Behavioural Therapy CBT, (with specialist applications known as CBT-E shown to be beneficial, for AN and EDNOS)
- Cognitive Restructuring Therapy (for BN)
- Interpersonal Psychotherapy (IPT) (for BN, especially where binge/purge cycles are present)
- Psychodynamic Therapy, (for BN)
- Cognitive Analytic Therapy (CAT), (for BN)
- Motivational Enhancement Therapy. (for AN, BN, EDNOS)

Psychological Therapies with good evidence of efficacy or the treatment of eating disorders in children and young people (ie “B” or better in the context of the Psychological Therapies Matrix) include:

**Behavioural Interventions**

NHS Lanarkshire CAMHS Eating Disorders Integrated Care Pathway
Family Work focussed on eating behaviour (for AN, EDNOS)
Family Therapy (separate from eating disorders tasks in families with high expressed emotion / stress levels etc) (for AN, EDNOS)

♦ For service users who also have substance misuse issues, appropriate care is offered.

ICP Standard 19a: When substance misuse is identified in a service user with a mental illness, there is a record that matched care appropriate to each person’s level of need is offered.

NHS Lanarkshire CAMHS have a number of standards in relation to record keeping and contact with referrers and other agencies, published elsewhere.

ICP Standard 17c: The single care plan is reviewed regularly.
ICP Standard 13a: The care record shows that physical health needs are assessed at least annually using the following features: the completion of a physical health assessment; the provision of health promotion advice, and service users receiving medication should have side-effects and physical health assessed and managed according to the appropriate algorithm for that medication.
ICP Standard 17d: The single care plan includes: a record of the service user’s named person, where applicable; the offer of an advance statement; a crisis plan drawn up by the service user and care team, and a staying-well plan.
ICP Standard 18a: The care record shows the decision-making process, including when to initiate, change, maintain or end medication.

If needs cannot be met by the locality mental health team, referral to other services/agencies should be considered. The CAMHS Intensive Treatment Team (CITT) can be asked to engage with young people and their families should his be clinically indicated and agreed upon by the Multi Disciplinary Team lead by the case manager and Consultant Child and Adolescent Psychiatrist, although consideration should be given to the possible impact of direct interventions whilst FBT is being delivered.
6.0 Secondary Care

6.1 Management in Secondary Care Inpatient Services

Young people in Lanarkshire with Eating Disorders may be admitted to hospital in two specific situations.

A. In the even of immediate clinical risk as a result of the medical consequences of prolonged dietary restriction and/or intensely driven excessive exercise (see GP advice sheet in Appendices), admission to local paediatric or general medical (depending on the age of the young person) wards may be necessary to perform detailed physical condition monitoring and intensive medical support as required. Young people in this situation can be viewed as being high dependency patients, and their inpatient care plans should be amended to reflect this. The close supervision implied by High Dependency status is generally an appropriate level of supervision, and beyond the normal provision of meals with appropriate encouragement to maintain a healthy dietary intake and fluid balance, there is no expectation that staff will be required to resolve the symptoms of the eating disorder, although consideration should be given to the possibility of underlying mental illness and the resultant effect on risk management.

B. Subsequent to initial treatment, and in the light of either little or no progress, worsening of presentation, or refusal to engage in treatment, an admission to a specialist (and therefore Tier 4 service) may be considered. The use of relevant sections of the Mental Health (Care and Treatment) (Scotland) Act 2003 may be necessary. There are a total of 72 specialist NHS Adolescent Mental health beds, and 18 beds for children up to the age of 12, in Scotland as a whole, spread across facilities in Glasgow, Edinburgh and the Lothians, Dundee and Aberdeen. Referrals would initially be directed to Skye House, on the Stobhill Hospital Campus in Glasgow, with other resources being referred to if there is no availability at Skye House. There are also a small number of beds in private facilities.
The need for Psychological Therapies is assessed, offered, and delivered by trained staff within nationally agreed timescales as per the NHS Lanarkshire Psychological Therapies Strategy Implementation.

**ICP Standard 15a:** Psychological therapies are delivered by appropriately trained and accredited staff under practice supervision.

**ICP Standard 15b:** The assessed need for psychological and/or psychosocial interventions is recorded.

**ICP Standard 15d:** Where needs have been identified, there is a record that the service user has been offered a range of therapies, including educational, social and lifestyle advice as well as psychological and/or psychosocial therapies.

**ICP Standard 15d:** There are systems for the provision of psychological and/or psychosocial therapies, including: delivery within 3 months of referral; review of individual service user progress, and recording of outcome.

**ICP Standard 20a:** When a service user is admitted to hospital, the care record shows: the reasons for inpatient admission; any alternative options considered; the aims of admission, in accordance with the recommendations of Bateman & Tyrer and Fagin for the borderline personality disorder client group; the expected and actual length of the inpatient stay; the plan for discharge.
7. ICP Monitoring

- **Recording Variance**

<table>
<thead>
<tr>
<th>Patient CHI (affix patient label)</th>
<th>Date</th>
<th>What Happened?</th>
<th>Why did this happen?</th>
<th>What did you do?</th>
<th>What was the outcome?</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**Notes:**
- This form should be used whenever there is a variance from the ED ICP pathway – for example if FBT is not being considered and other treatment modalities are utilised.

NHS Lanarkshire CAMHS Eating Disorders Integrated Care Pathway
• If there is not enough space to explain rationale, it is appropriate to make a note to “refer to casenotes” providing there is a clear indication of the date and signatory of the casenote included on this form so that the explanation(s) can be easily located.

• The complete form should be included in the casenote file, with an electronic version stored in the patient folder on the NHSL shared drive. More than one variance can be recorded on this form, as required.

• Staff, Service User and Carer Surveys

NHS CAMHS use a variety of tools such as

• SDQ
  (http://www.sdqinfo.org/py/sdqinfo/b3.py?language=Englishqz(UK))

• CGAS (www.rcpsych.ac.uk/docs/CGAS%20tool.doc)

There is at present no specific client satisfaction tool in mandatory use in NHS Lanarkshire CAMHS although it is likely this will change in due course.
Included below in the appendices are various tools such as relevant FACECARAS tools for young people with eating disorders, who may be at risk of self-harming behaviour, who are vulnerable, or who are being managed in a hospital setting either open or secure. There is also information for patient clients and their families which can be copied and pasted into a separate document for delivery to patient clients and their families.

Also included is detailed information about the medical requirements for assessment, analysis and treatment of young people with ED, a quick medical assessment tool for first responders when an ED presentation is suspected (CAMHS Eating Disorder Pathway Guidance), ideal for General Practitioners etc. This tool can be used in conjunction with the overall assessment of a young person with unexplained weight loss in order to determine the correct response. Those wishing to use the tool should double click on the electronic version, which opens a pdf file for easy printing and viewing.
### Historical risk factors

#### Potential lethality of previous self-harm episodes

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not present, n/k = Not present</td>
</tr>
<tr>
<td>1</td>
<td>Low: Previous self-harm highly unlikely to have resulted in death or disability.</td>
</tr>
<tr>
<td>2</td>
<td>Moderate: Previous self-harm associated with significant probability of death or disability (1-10%) (e.g. significant undisclosed paracetamol OD).</td>
</tr>
<tr>
<td>3</td>
<td>High: Previous self-harm was associated with a high (&gt;10%) probability of death or lasting disability (e.g. attempted hanging).</td>
</tr>
</tbody>
</table>

#### Previous planning and concealment of self-harm attempts

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not present, n/k = Not present</td>
</tr>
<tr>
<td>1</td>
<td>Mild: No active attempts to conceal act. Some ambivalent help-seeking behaviour evident (texting friend, delayed disclosure etc.).</td>
</tr>
<tr>
<td>2</td>
<td>Moderate: May be some planning of act evident but this was in conjunction with help-seeking immediately after event OR little or no planning of act but no active help-seeking reported.</td>
</tr>
<tr>
<td>3</td>
<td>Severe: Evidence of active planning or concealment. Little or no evidence of help-seeking in aftermath (e.g. waiting until parents away before significant OD, &quot;suicide note&quot; left).</td>
</tr>
</tbody>
</table>

#### Previous triggers

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not present, n/k = Not present</td>
</tr>
<tr>
<td>1</td>
<td>Mild: Only mild trigger (e.g. argument with family member, poor report from school, etc.).</td>
</tr>
<tr>
<td>2</td>
<td>Moderate: Moderate triggering event associated with previous act such as parental separation, break-up of significant relationship.</td>
</tr>
<tr>
<td>3</td>
<td>Severe: Previous self-harm within three months of and associated with earlier serious trauma (e.g. serious sexual assault or major loss event).</td>
</tr>
</tbody>
</table>

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**FACE CASH (Child & Adolescent Self-Harm Schedule)**

**Confidential**

<table>
<thead>
<tr>
<th>Name:</th>
<th>CHI Number:</th>
<th>Completed by:</th>
</tr>
</thead>
</table>

**Assessment details**

<table>
<thead>
<tr>
<th>Location of assessment:</th>
<th>Date of assessment:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Assessment type:</th>
<th>Initial</th>
<th>Repeat</th>
<th>Discharge</th>
</tr>
</thead>
</table>

**Information sources available/accessed in completing risk schedule**

- Person assessed
- Case notes
- Family/carer
- Social work
- Education/school
- Other (specify)

---

**Details:**
### FEDS (FACE Eating Disorder Schedule: Children and Adolescents)

<table>
<thead>
<tr>
<th>Information sources available/accessed in completing risk schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person assessed</td>
</tr>
<tr>
<td>Social work</td>
</tr>
</tbody>
</table>

#### Physical risk symptoms

*(Based on MARSIPAN Jr Guidance produced by the Royal College of Psychiatrists MARSIPAN Jr Working Group, 2012)*

**Temperature (degrees centigrade)**

<table>
<thead>
<tr>
<th>Level</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Within normal range</td>
</tr>
<tr>
<td>1</td>
<td>Moderate risk: &lt;36.0°C</td>
</tr>
<tr>
<td>2</td>
<td>High: &lt;35.5°C tympanic, &lt;35°C axillary</td>
</tr>
</tbody>
</table>

**Systolic blood pressure (requires centiles for age and gender)**

<table>
<thead>
<tr>
<th>Level</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Within normal range for age and gender</td>
</tr>
<tr>
<td>1</td>
<td>&lt;2nd centile: 98-105mmHg</td>
</tr>
<tr>
<td>2</td>
<td>&lt;0.4th centile: 84-98mmHg</td>
</tr>
</tbody>
</table>

**Diastolic blood pressure (requires centiles for age and gender)**

<table>
<thead>
<tr>
<th>Level</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>Within normal range for age and gender</td>
</tr>
<tr>
<td>1</td>
<td>&lt;0.4th centile: 35-40mmHg</td>
</tr>
</tbody>
</table>
**FACE VAS (Vulnerability Assessment Schedule)**

<table>
<thead>
<tr>
<th>Family name:</th>
<th>Given name:</th>
<th>Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred name:</td>
<td>Date of birth:</td>
<td></td>
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</table>

**Assessment details**

<table>
<thead>
<tr>
<th>Location of assessment:</th>
<th>Date of assessment:</th>
</tr>
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</table>

**Assessment type:**

<table>
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<th>Initial</th>
<th>Repeat</th>
<th>Discharge</th>
</tr>
</thead>
</table>

**Information sources available/accessed in completing risk schedule:**

<table>
<thead>
<tr>
<th>Person assessed</th>
<th>Case notes</th>
<th>Family/carer</th>
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</thead>
<tbody>
<tr>
<td>Social work</td>
<td>Education/school</td>
<td>Other (specify):</td>
</tr>
</tbody>
</table>

**Child/adolescent factors**

0 = Not present, n/k = Not known

### Presence of intellectual or developmental disability (ICD-10 “Mental Retardation”)

<table>
<thead>
<tr>
<th>Level</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Low</td>
<td>Young person is of low intellectual ability or borderline learning disability. Some minor impact on ability to manage self care and daily activities. May result in being easily led by others at times into inappropriate behaviour.</td>
</tr>
<tr>
<td>2 = Moderate</td>
<td>Confirmed or suspected borderline or mild learning disability. Only a moderate impact on ability to manage self care and daily activities compared to age-related peers.</td>
</tr>
<tr>
<td>3 = High</td>
<td>Confirmed or suspected learning disability at least mild degree. Much support required from carers, statutory and non-statutory agencies to engage in daily activities and self care.</td>
</tr>
</tbody>
</table>

**Presence of physical impairment**

(excludes problems impacting only on communication)

<table>
<thead>
<tr>
<th>Level</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Low</td>
<td>Some mild impairment of physical health or well-being. Requires medical or practical intervention in order to prevent problems impacting on function and/or future health.</td>
</tr>
<tr>
<td>2 = Moderate</td>
<td>Physical problems resulting in some significant impairment in ability to perform activities of daily living. Requires considerable support from carer(s) in this respect.</td>
</tr>
<tr>
<td>3 = High</td>
<td>Significant physical problems resulting in marked degree of disability and impairment of ability to perform activities of daily living. Requires almost constant presence of a carer.</td>
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</table>

**Presence of communication impairment**

(include non-organic impairment, e.g. selective mutism)

<table>
<thead>
<tr>
<th>Level</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Low</td>
<td>Some mild impairment of communication ability. Generally understood by close family members but not always understood by those outside family. May choose to communicate little in certain settings.</td>
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</table>

NHS Lanarkshire CAMHS Eating Disorders Integrated Care Pathway
**FACE Ward Assessment (Open)**

<table>
<thead>
<tr>
<th>Family name:</th>
<th>Given name:</th>
<th>Title:</th>
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<table>
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<tr>
<th>Preferred name:</th>
<th>Date of birth:</th>
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</table>

**Assessment details**

- **Location of assessment:**
- **Date of assessment:**

<table>
<thead>
<tr>
<th>Assessment type:</th>
<th>Initial</th>
<th>Repeat</th>
<th>Discharge</th>
</tr>
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<tbody>
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</table>

**Information sources available/accessed in completing risk schedule** *(indicate all sources used):*

- **Person assessed:**
- **Case notes:**
- **Family/carer:**
- **Social work:**
- **Education/school:**
- **Other (specify):**

<table>
<thead>
<tr>
<th>Legal status</th>
<th>None</th>
<th>Informal inpatient</th>
<th>Detained inpatient</th>
<th>Section</th>
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<th>Details:</th>
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**1. Ward assessment – Inpatient** *(five screening questions)*

<table>
<thead>
<tr>
<th>Risk to self</th>
<th>Level</th>
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</table>

- **1 = Low**
  Occasional indications; signs (minor cuts, bruises); plans of self-harm (thoughts, ideas, behaviours); or suicide ideation. *(Once every two weeks).*

- **2 = Moderate**
  Clear or regular indications (ambivalent about suicide or self-harm); signs (cuts, burns); verbalised plans of self-harm or suicide ideation (thoughts of death and suicide). *(Once per week).*

- **3 = Severe**
  Consistent self-harm attempts. Intense suicide planning and attempts. Disappointed to be alive. *(Daily).*

**Details:**

- Consider FACE CASH

**Risk to others**

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<tr>
<th>Level</th>
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- **1 = Low**
  Less than two harm incidents/threats in preceding two weeks. Significant provocation (i.e. physical assault). Aggression with minor injuries not requiring medical attention (i.e. bruises; verbal insults).

- **2 = Moderate**
  Regular harm incidents and threats (three or more per week). Minor provocation (i.e. teasing). Aggression with significant injuries requiring medical attention (i.e. broken bone).

- **3 = Severe**
  Significant harm to others and threats (most days). Trivial provocation (real or perceived). Aggression with serious injury (i.e. multiple injuries, death).

**Details:**

NHS Lanarkshire CAMHS Eating Disorders Integrated Care Pathway

- Consider FACE CRAY; FACE SCRAP; FACE SHARP *(if sexually inappropriate behaviour)*

**Absconsion**

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<tr>
<th>Level</th>
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### NAME: CHI Number: Completed by:

<table>
<thead>
<tr>
<th>FACE Ward Assessment (Secure)</th>
<th>Confidential</th>
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</thead>
<tbody>
<tr>
<td><strong>Family name</strong>:</td>
<td><strong>Given name</strong>:</td>
</tr>
<tr>
<td><strong>Preferred name</strong>:</td>
<td><strong>Date of birth</strong>:</td>
</tr>
</tbody>
</table>

#### Assessment details

<table>
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<th>Date of assessment:</th>
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</thead>
<tbody>
<tr>
<td><strong>Assessment type</strong>:</td>
<td><strong>Initial</strong></td>
</tr>
</tbody>
</table>

#### Information sources available/accessed in completing risk schedule

*indicate all sources used):

- Person assessed
- Case notes
- Family/carer
- Education/school
- Other *(specify)*

#### Legal status

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>LAC</td>
<td>Other</td>
<td></td>
<td>Details:</td>
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</table>

#### 1. Ward assessment – Inpatient *(five screening questions)*

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<th><strong>Risk to self</strong></th>
<th><strong>Level</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Low</td>
<td>Occasional indications; signs (minor cuts, bruises); plans of self-harm (thoughts, ideas, behaviours); or suicide ideation. <em>(Once every two weeks).</em></td>
</tr>
<tr>
<td>2 = Moderate</td>
<td>Clear or regular indications (ambivalent about suicide or self-harm); signs (cuts, burns); verbalised plans of self-harm or suicide ideation (thoughts of death and suicide). <em>(Once per week).</em></td>
</tr>
<tr>
<td>3 = Severe</td>
<td>Consistent self-harm attempts. Intense suicide planning and attempts. Disappointed to be alive. <em>(Daily).</em></td>
</tr>
</tbody>
</table>

#### Details:

* Consider FACE CASH

#### 2. Risk to others

<table>
<thead>
<tr>
<th><strong>Level</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Low</td>
</tr>
<tr>
<td>2 = Moderate</td>
</tr>
<tr>
<td>3 = Severe</td>
</tr>
</tbody>
</table>

#### Details:

- NHS Lanarkshire CAMHS Eating Disorders Integrated Care Pathway

* Consider FACE CRAY; FACE SCRAP; FACE SHARP *(if sexually inappropriate behaviour)*

#### Absconision

| **Level** |
Eating Disorders – A Brief Guide for Young People and their Families

How Common is Anorexia Nervosa?

- Roughly 0.5% of the general population have Anorexia Nervosa.
- About 1% of teenage girls suffer from it.
- Around 1 in 10 cases of Anorexia Nervosa occur in men.
- It usually starts in adolescence, but it can start at any age.

What are the Common Symptoms of Anorexia Nervosa?

- An intense, overwhelming “fear” or “dread” of fatness, and as a consequence,
- An intense drive to be thin.
- A person suffering from an eating disorder might only be able to see themselves as fat when everyone else sees them as very thin.
- They may be driven to do things to make themselves thin:
- They are likely to restrict what they eat and avoiding certain foods, often in a very secretive way
- They are likely to exercise to extraordinary excess, often in secret
- They may make themselves sick
- They may take laxatives, diuretics or ‘diet’ pills excessively
- They are likely to feel very down, listless and unhappy most of the time.
- They may be feeling anxious, tense or panicky.
- They may have thoughts that come into their head over and over and feel “driven” to do things in a particular way eg: eating.
- They may have periods of intense, furious rage where they are often particularly vicious to those they love.

These symptoms will tend to get worse as more weight is lost. Success in losing weight can give a sense of achievement and control. This can be important for someone when they feel under pressure or out of control in other ways. Controlling their food intake and weight can start to seem more and more important and begin to take over their life.
Am I Doing my Body any Harm?

Young people and their families need to know what prolonged starvation is doing to the young person.

Physical

- In Anorexia, the body enters a state of starvation because it doesn’t have enough energy to function normally.
- Many things in the body will slow up, and some things stop working altogether.
- The heart tends to slow, giving a slow pulse and low blood pressure.
- The stomach shrinks and empties more slowly, leading to a feeling of fullness or bloatedness after eating.
- The gut slows down, causing constipation.
- The ovaries and uterus shrink and periods stop, with the knock-on effect that the bones become weaker because of a lack of the hormone oestrogen.
- Skin becomes dry and thin, and nails and hair brittle.
- They will tend to lack energy and feel cold.
- Although there can be many physical consequences of Anorexia, the vast majority of physical problems get better when a person’s weight gets back into the normal range. Unfortunately, in those who do not manage to regain weight and become very low in weight, there is a risk of death.

Cognitive (thinking, feeling, emotions)

- They might become increasingly obsessive / compulsive, often about food and diet (calorie counting) or about the size, shape or appearance of their body or parts of their body.
- They might become increasingly cognitively impaired – so that thinking, reacting, problem solving, tolerating and understanding become progressively harder.
- They may seem to become another, sometimes very unpleasant person.
- They may become very secretive.
- They may tell lies, especially about food, eating and nutrition.
- They may be prone to rages and may reject family members in hurtful and distressing ways.

What Causes Anorexia?

There is no single or simple answer to this question. Finding the “cause” is not the priority in treatment. Having a person with an eating disorder in a family often has a major impact on family relationships and families affected might need some support.
help to rebuild these relationships, but people who work with eating disorders don’t need to focus on the cause so much as what to do about the illness. Having said that, there is some thought that a failure of the normal bodily functions of hunger and satiety (involving fluctuation in levels of hormones called leptin and ghrelin) might contribute to the development of eating disorders. In addition, the Western cultural ideal of a thin female body shape creates strong social pressure. The rewards of a sense of achievement and control, or the approval or concern of other people, can make it hard to give up restricting dietary intake once started. Often, during adolescence, young people feel driven to exercise control in their lives but are limited by normal societal standards and conventions. Being able to control to such an extraordinary degree one’s weight often temporarily restores a young person’s sense of competence and ability where they otherwise might feel as though they have no control in their lives. Young people with eating disorders are often already high achieving perfectionists for whom measurable achievement is a high priority. The simple fact of starvation is, in itself, one of the causes of many of symptoms a young person with an eating disorder will experience both physically and cognitively. Upon restoration of a healthy eating pattern, the majority of these symptoms will usually ease,

Will I Ever get Better?

♦ Studies of patients with Anorexia have found recovery rates of between 50% and 75%. New models of treatment are improving these results.
♦ The sooner a young person gets help, the better the outcome. However, even people who have been ill for 10 years or more can go on to recover.
♦ Most young people will have periods of rapid progress towards recovery, with periods of difficulty in between.

Will my General Health be Okay Once I get Better?

♦ For most people who recover from Anorexia, their physical health will return to normal once their weight is back within the healthy range (BMI 19 – 25), or 95%+ expected weight for age and gender.
♦ Problems with kidneys or the bowels may continue for a few people, but the risk of this can be reduced if the sufferer has kept themselves well hydrated whilst they were underweight.
♦ Although it takes time, the bones will gradually strengthen. Part of the longer term follow up would keep an eye on this
♦ The ability to become pregnant is probably not reduced. However, it may be that the risk of complications in pregnancy is increased amongst ex-sufferers of Anorexia Nervosa.
What is the Worst that Could Happen?

- People die because of Anorexia
- It has the highest mortality rate of any psychiatric illness – in the past as much as 10% of all people diagnosed with eating disorders did not recover, but new methods of working with eating disorders are aiming to improve this.
- It could become chronic and continue to dominate your life.

What is the Best that Could Happen?

- You can get better!
- People who recover find their self-esteem increases and their mood stabilises. They have no greater risk of having psychological or physical problems than other people their age.
- Ex-sufferers have every chance of a normal social life, fulfilling relationships and good careers; all things that are usually seriously affected whilst they are ill.
- Many report a great sense of liberation once they are no longer driven by anorexic thinking
- You can be a happier, healthier individual with a full and exciting life just like other young people.

What is Bulimia Nervosa?

Bulimia nervosa is an eating disorder characterized by frequent episodes of binge eating, followed by frantic efforts to avoid gaining weight. It affects women and men of all ages.

When you’re struggling with bulimia, life is a constant battle between the desire to lose weight or stay thin and the overwhelming compulsion to binge eat.

You don’t want to binge—you know you’ll feel guilty and ashamed afterwards—but time and again you give in. During an average binge, you may consume from 3,000 to 5,000 calories in one short hour.

After it ends, panic sets in and you turn to drastic measures to “undo” the binge, such as taking ex-lax, inducing vomiting, or going for a ten-mile run. And all the while, you feel increasingly out of control.
It’s important to note that bulimia doesn’t necessarily involve purging—physically eliminating the food from your body by throwing up or using laxatives, enemas, or diuretics. If you make up for your binges by fasting, exercising to excess, or going on crash diets, this also qualifies as bulimia.

If you are wondering if you might have bulimia nervosa, it might be helpful to ask yourself the following questions. The more “yes” answers, the more likely you are suffering from bulimia or another eating disorder.

- Are you obsessed with your body and your weight?
- Does food and dieting dominate your life?
- Are you afraid that when you start eating, you won’t be able to stop?
- Do you ever eat until you feel sick?
- Do you feel guilty, ashamed, or depressed after you eat?
- Do you vomit or take laxatives to control your weight?

These factors affecting your life might lead to strong and often irresistible urges to “do something” to put the feelings right. Often this involves doing something for short term relief which had drastic consequences further down the line.

For example, in order to do something about feelings of being out of control, people sometimes become incredibly expert at controlling their dietary intake by restricting or purging. The cycle of dietary restriction or purging is ironically very likely to make obsessive thought about food and eating even more powerful – as a kind of survival mechanism for the body, which makes you unable to concentrate on anything else other than food / eating if you are malnourished.

**Things to look out for.**

- Lack of control over eating – Inability to stop eating. Eating until the point of physical discomfort and pain.
- Secrecy surrounding eating – Going to the kitchen after everyone else has gone to bed. Going out alone on unexpected food runs. Wanting to eat in privacy.
- Eating unusually large amounts of food with no obvious change in weight.
- Disappearance of food, numerous empty wrappers or food containers in the bin, or hidden stashes of junk food.
- Alternating between overeating and fasting – Rarely eats normal meals. It’s all-or-nothing when it comes to food.
Going to the bathroom after meals – Frequently disappears after meals or takes a trip to the bathroom to throw up. May run the water to disguise sounds of vomiting.

Using laxatives, diuretics, or enemas after eating. May also take diet pills to curb appetite or use the sauna to “sweat out” water weight.

Smell of vomit – The bathroom or the person may smell like vomit. They may try to cover up the smell with mouthwash, perfume, air freshener, gum, or mints.

Excessive exercising – Works out strenuously, especially after eating. Typical activities include high-intensity calorie burners such as running or aerobics.

Calluses or scars on the knuckles or hands from sticking fingers down the throat to induce vomiting.

Puffy “chipmunk” cheeks caused by repeated vomiting.

Discoloured teeth from exposure to stomach acid when throwing up. May look yellow, ragged, or clear.

Not underweight – Men and women with bulimia are usually normal weight or slightly overweight. Being underweight while purging might indicate a purging type of anorexia.

Frequent fluctuations in weight – Weight may fluctuate by 10 pounds or more due to alternating episodes of bingeing and purging.

Bulimia nervosa, like anorexia nervosa, is a thinking / perceiving and feeling disorder which is reinforced by the mechanisms the body uses to ensure health and well-being. Getting better from bulimia nervosa will come about when how a person thinks about his or her situation, circumstances, and how they understand their position changes. We know this because whenever a change is achieved in a person’s thinking behaviour, a change in how they perceive things and how they feel about things will follow.

Most of the treatments that have been proven to be successful will feature a cognitive element.

“CBT” (Cognitive Behavioural Therapy) has been repeatedly shown to be effective. CBT involves working with a therapist who will help a person with bulimia to recognise the destructive, harmful or counter-productive habitual thinking that is causing their difficulties, and helps to design thinking strategies to address these unhelpful thoughtsd.

CBT-E is the abbreviation for “enhanced cognitive therapy”, and it refers to a “transdiagnostic” personalised psychological treatment for eating disorders. It was developed as an outpatient treatment for adults but is an intensive version
for day patient and inpatient settings (Dalle Grave, 2012), and a version for younger people. A detailed treatment guide is available (Fairburn, 2008).

Interpersonal therapy (IPT), originally developed to treat depression, is used in treatment of eating disorders, including bulimia, but most research shows it's less effective at eradicating eating disorder symptoms than the more common method of cognitive behavioral therapy (CBT).

Family Therapy has proven to be an important element in the treatment of patients with eating disorders. For adolescent patients, getting the family involved with therapy is considered essential, and family therapy can be equally important for adults. Family sessions for adults can include family of origin, current family, or members of a close support network.

Through therapy, families come to discover how changes in the way they communicate, manage conflict, or tolerate negative emotions can aid in their loved one’s recovery. Specifically for children and adolescents, family therapy emphasizes a strong parental alliance, resolution of family difficulties and support for the adolescent’s developing independence. Family therapy also helps support people understand the role the eating disorder has played within their family, what factors may be maintaining the disorder, and how to differentiate between their family member and their family member’s illness.
# Guide to Common Laboratory Tests for Eating Disorder Patients

<table>
<thead>
<tr>
<th>Test</th>
<th>Measure</th>
<th>Description</th>
<th>Reference Range*</th>
<th>Abnormal High</th>
<th>Abnormal Low</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Blood Count (CBC)</td>
<td>See below</td>
<td>Levels of multiple blood components</td>
<td>See individual counts</td>
<td>Infected inflammation, trauma to tissue, high physical or emotional stress, anemia</td>
<td>Malnutrition can lead to decreases in one or more of these types of cells. Decrease is not typically correlated with increased risk of infection.</td>
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<tr>
<td>White Blood Cell (WBC) Count</td>
<td>Measures immune system functioning (includes basophils, eosinophils, lymphocytes, monocytes, neutrophils)</td>
<td>4,000-10,000 WBCs/mL</td>
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<tr>
<td>Red Blood Cell (RBC) Count</td>
<td>Count of the actual number of red blood cells per volume of blood. RBCs deliver oxygen throughout the body.</td>
<td>4.3-5.7</td>
<td>Fluid loss due to diarrhea or dehydration</td>
<td>Anemia</td>
<td></td>
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<tr>
<td>Hemoglobin (HGB)</td>
<td>Protein used by red blood cells to distribute oxygen to other tissues and cells in the body.</td>
<td>13.2-16.9</td>
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<tr>
<td>Hematocrit (HCT)</td>
<td>Percent of blood that is occupied by red blood cells.</td>
<td>38.5-49%</td>
<td></td>
<td>Anemia</td>
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<tr>
<td>Mean Corpuscular Volume (MCV)</td>
<td>Measures the size of red blood cells.</td>
<td>80-97</td>
<td></td>
<td>Anemia</td>
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</tr>
<tr>
<td>Platelet</td>
<td>Create clots or erect to prevent or stop bleeding.</td>
<td>150,000-450,000 platelets per sec</td>
<td></td>
<td>Malnutrition; Vitamin B6 deficiency</td>
<td></td>
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</tr>
<tr>
<td>Comprehensive Metabolic Panel</td>
<td>See below</td>
<td>Assesses current status of kidneys, liver, and electrolyte and acid/base balance as well as blood sugar and blood proteins</td>
<td>See individual counts</td>
<td></td>
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</tr>
<tr>
<td>Glucose</td>
<td>Blood sugar level at time of testing</td>
<td>70-115 mg/dL</td>
<td>Diabetes, excessive food intake, use of diuretics</td>
<td>Hypoglycemia; starvation</td>
<td>A sudden drop in glucose (&lt;70 mg/dL) can have serious medical complications</td>
<td></td>
</tr>
<tr>
<td>Total Protein</td>
<td>Total protein level in blood fluid</td>
<td>6.0-8.3</td>
<td>Unusual with eating disorders</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Albumin</td>
<td>Small protein produced in liver</td>
<td>3.4-5.4 g/dL</td>
<td>Dehydration</td>
<td>Malnutrition</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NHS Lanarkshire CAMHS Eating Disorders Integrated Care Pathway
NHS Lanarkshire CAMHS Eating Disorders Integrated Care Pathway
Patient Health Questionnaire—PHQ-9

Name: ___________________________ Date of Birth: ___________ Today’s Date: ___________

Fill in the boxes with pen or pencil to mark your answers.

A. Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>3. Trouble falling/staying asleep, sleeping too much</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>4. Feeling tired or having little energy</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Total Score = ___ + ___ + ___ + ___

B. If you have been bothered by **any** of the 9 problems listed above, please answer the following:

How **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat Difficult Very Difficult Extremely Difficult
The SCOFF questions
Do you make yourself Sick because you feel uncomfortably full?
Do you worry you have lost Control over how much you eat?
Have you recently lost more than One stone in a 3 month period?
Do you believe yourself to be Fat when others say you are too thin?
Would you say that Food dominates your life?
Re-Feeding Syndrome

The physical consequences of eating disorders seriously threaten the health of our patients. Every system of the body is eventually at risk of deterioration as a result of measures taken in an attempt to maintain a reduced body weight.

The mortality rate for severe anorexia nervosa is higher than any other functional psychiatric illness and is higher amongst those with the most severe degree of weight loss (15 – fold greater if weight < 35kg).

Definition of Refeeding Syndrome

Severe fluid and electrolyte shifts and related metabolic complications in malnourished patients undergoing refeeding.

Potential consequences

- Hypophosphataemia
- Hypokalaemia
- Hypomagnesaemia
- Altered glucose metabolism
- Fluid balance abnormalities
- Vitamin deficiency

The table overleaf details the consequences of electrolyte shifts.
Table 1: Clinical sequelae of altered electrolytes in refeeding syndrome

<table>
<thead>
<tr>
<th>Electrolytes</th>
<th>Cardiac</th>
<th>Respiratory</th>
<th>Hepatic</th>
<th>Renal</th>
<th>GI</th>
<th>Neuro-muscular</th>
<th>Haematologic</th>
<th>Metabolic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low phosphorus</td>
<td>Altered myocardial function</td>
<td>Acute ventilatory failure</td>
<td>Liver dysfunction</td>
<td>Acute Renal Failure</td>
<td>Anorexia</td>
<td>Lethargy</td>
<td>Haemolytic anaemia</td>
<td>Reduced oxygen</td>
</tr>
<tr>
<td></td>
<td>Arrhythmia</td>
<td></td>
<td></td>
<td></td>
<td>Nausea</td>
<td>Weakness / paralysis</td>
<td>WBC dysfunction</td>
<td>Release to tissues from haemoglobin</td>
</tr>
<tr>
<td></td>
<td>Congestive heart failure</td>
<td></td>
<td></td>
<td></td>
<td>Bicarboate and glucose wasting</td>
<td>Confusion</td>
<td>Thrombocytopenia</td>
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<td></td>
<td></td>
<td>Coma</td>
<td>Haemorrhage</td>
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<td></td>
<td></td>
<td></td>
<td>Diaphragm weakness</td>
<td>Red cell 2, 3 disphosphoglycerate deficiency</td>
<td></td>
</tr>
<tr>
<td>Low potassium</td>
<td>Arrhythmia</td>
<td>Respiratory depression</td>
<td>Exacerbation of hepatic encephalopathy</td>
<td>Decreased urinary concentrating ability</td>
<td>Constipation</td>
<td>Paralysis</td>
<td>Glucose intolerance</td>
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<tr>
<td></td>
<td>Cardiac arrest</td>
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<td>Rhabdomyolysis</td>
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<td>ECG Changes</td>
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<tr>
<td>Low magnesium</td>
<td>Arrhythmia</td>
<td>Respiratory depression</td>
<td>Increased potassium loss</td>
<td>Abdo pain</td>
<td>Ataxia</td>
<td>Glucose intolerance</td>
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<tr>
<td></td>
<td>Tachycardia</td>
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<td></td>
<td></td>
<td>Anorexia</td>
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<td>Diarrhoea</td>
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<td>Constipation</td>
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<tr>
<td>Fluid / glucose</td>
<td>Heart failure</td>
<td>Pulmonary oedema</td>
<td>Fatty Liver</td>
<td>Hyperosmotic non-ketotic coma</td>
<td>Hyperglycaemia</td>
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<td></td>
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<td>Respiratory depression</td>
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NHS Lanarkshire CAMHS Eating Disorders Integrated Care Pathway
Pathophysiology of Refeeding Syndrome

During starvation, adaptations take place to reduce cellular activity and organ function in order to save energy. The changes included down-regulation of metabolic pumping and synthetic activities with consequences that include:

- Decreased insulin and increased glucagon secretion, with a switch from glucose to ketone bodies as a source of energy
- Deficiency of vitamins and trace elements
- Whole body depletion of potassium, magnesium and phosphate
- Increased intracellular and whole body sodium and water
- Impaired cardiac, intestinal and renal reserve, leading to reduced ability to excrete excess sodium and water
- Abnormal liver function

During refeeding

- Increased insulin release leads to increased uptake of glucose, phosphate and potassium into cells. Magnesium is used as a co-factor for cellular pump activity
- Reactivation of the Na/K membrane pump leads to further movement of K into cells with a simultaneous movement of sodium and fluid out of cells
- Reduced phosphate is associated with increased urinary magnesium excretion
- Stimulation of protein synthesis leads to increased anabolic tissue growth which in turn leads to increased cellular demand for phosphate, potassium, glucose and water
- Reduced sodium and water excretion
- Increased cellular thiamine utilisation due to its role as a co-factor for carbohydrate metabolism
Criteria for determining people at risk/high risk of developing refeeding problems

The criteria for determining young people at risk/high risk of developing refeeding syndrome cannot be based on those used for adults due to the differing BMI ranges.
The following guidelines are based on several sources. Clinical judgement, however, and close monitoring are very important.

**Risk factors**
- Very low weight for height. Below the 2nd centile (consistent with the Child Growth Foundation’s definition of ‘significant underweight’).
- Minimal or no nutritional intake for more than a few (3-4) days
- Weight loss of over 15% in the last 3 months
- Abnormal electrolytes prior to refeeding

In addition, the presence of purging behaviours, such as vomiting and/or laxative misuse, will significantly increase the risk of refeeding syndrome.

Remember patients with normal prefeeding levels of potassium, magnesium and phosphate can still be at risk of refeeding syndrome.

NHS Lanarkshire CAMHS Eating Disorders Integrated Care Pathway
Process of Nutrition Support:
Initial feeding (7-10 days) is aimed at weight and medical stabilisation, as opposed to weight gain, as well as building patient’s tolerance to a calorie intake that will eventually promote weight restoration.

Prior to commencing feeding:
- Ensure the most appropriate members of the MDT are involved
- Weigh patient (N), calculate BMI (N,D), plot centile charts (D) and complete the risk assessment (M, N) (see Table 1) to establish baseline measurements (MDT)
- Determine method of refeeding using Flow Chart 1 (MDT decision)
- Prescribe electrolyte, vitamin and mineral supplementation, as medically necessary (Table 3, 4). Medics will prescribe the relevant supplementation with consultation from the Dietitian.

Always consider consultation with Pharmacy and/or Biochemistry as appropriate.
Eating Disordered Clients Monitoring Chart

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<thead>
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<th>Date</th>
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<td>Weight</td>
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<td>Heart Rate</td>
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<td>Orthostatic changes</td>
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<td>Menstruation</td>
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<td>Hydration status</td>
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<td>SUSS test (squats)</td>
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<td>Uncontrolled exercise</td>
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NHS Lanarkshire CAMHS Eating Disorders Integrated Care Pathway
<table>
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<tr>
<th>Engagement</th>
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</thead>
<tbody>
<tr>
<td>Self-harm / Binge / Purge</td>
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<tr>
<td>Other mental health Dx</td>
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**Risk Assessment**

The medical risk of a seriously ill patient with anorexia nervosa should be assessed and baseline measurements obtained prior to any feeding. The table below may offer some guidance. Priority should be given to the overall physical examination of the patient as indicated clinically.

<table>
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<tr>
<th>Table 2 – A guide to the medical risk assessment for eating disorders (See also Community Practitioner Guide)</th>
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<td><strong>System</strong></td>
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Appendix 2 – Guidance and Policy to support Values

The Mental Health (Care and Treatment) (Scotland) Act 2003 is underpinned by the Milan principles of reciprocity, respect for equality and diversity in a non-discriminatory manner.

The 10 Essential Shared Capabilities for Mental Health promotes working in partnership, challenging inequalities (social inequality and exclusion), promoting recovery, providing service user centred care and making a difference.

The Scottish Recovery Indicator states the service should provide interventions designed specifically to promote participation in life’s roles, to self manage illness, and to enhance relationships with others.

NHS Lanarkshire’s Organisational Values which commit to quality, patient focused services; quality healthcare environment; continuous improvement; involvement; communication; respect, fairness and consistency; competence and continuous learning.

Better Health, Better Care, Scottish Government. This document sets out the 6 Dimensions of Quality which focus on providing safe, effective care that enhances the patient’s experience of our services:

1. Person centred: providing care that is responsive to individual personal preferences, needs and values and assuring that patient values guide all clinical decisions
2. Safe: avoiding injuries to patients from care that is intended to help them
3. Effective: providing services based on scientific knowledge
4. Efficient: avoiding waste, including waste of equipment, supplies, ideas and energy
5. Equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status
6. Timely: reducing waits and sometimes harmful delays for both those who receive care and those who give care.

Caring and Compassionate Practice is the work of a group from the Nursing, Midwifery and Allied Health Profession (NMAHP) Practice Development Centre in NHS Lanarkshire. It sets out a list of people’s expectations accompanied by statements that set the minimum practice standards for how nurses, midwives, allied health professionals and support workers must work on a day to day basis:

- To be valued as a person
- To feel and be safe
- To be cared for with dignity
- To see NMAHPs make the best possible effort
- To experience courtesy
- To be respected
- To receive kindness.
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NHS Lanarkshire CAMHS Eating Disorders Integrated Care Pathway

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<th>Glossary</th>
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<td><strong>AVON Mental Health Measure</strong></td>
<td>This is a descriptive instrument designed to enable self-assessment and help service users prepare for Care Programming and Care Management and to provide information to help plan better service responses. The questionnaire was developed in Avon by a working group of service users and carers, psychiatrists, psychologists, social workers and voluntary organisations. It describes options for physical health, social circumstances, behaviour, access and mental health. Service users select the description/s that are relevant and can provide further explanations if they wish to do so. They are asked if they need help to change things and are asked to identify what sort of help they need. The measure helps patients with mental health problems to build up a profile of themselves based on their abilities, needs, and aspirations.</td>
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<td><strong>Crisis Resolution and Home Treatment (CRHT)</strong></td>
<td>This is a part of the Community Mental Health Team which provides home based treatment for people who would otherwise require acute psychiatric care in a hospital ward. The main aim is to provide community based intervention during a time of crisis. However should admission become necessary, the use of this service may enable early discharge from hospital with intensive support.</td>
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<td><strong>Diagnostic and Statistical Manual of Mental Disorders (DSM IV)</strong></td>
<td>Psychiatric Diagnoses are categorized by the Diagnostic and Statistical Manual of Mental Disorders. The manual is published by the American Psychiatric Association and covers all mental health disorders for both children and adults. It also lists known causes of these disorders, statistics in terms of gender, age at onset, and prognosis as well as some research concerning the optimal treatment approaches.</td>
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<td><strong>Health of the Nation Outcomes Scale or HONOS 65+</strong></td>
<td>In 1993 the UK Department of Health commissioned the Royal College of Psychiatrists’ Research Unit to develop scales to measure the health and social functioning of people with severe mental illness. The initial aim was to provide a means of recording progress towards the Health of the Nation target ‘to improve significantly the health and social functioning of mentally ill people’. Development and testing over three years resulted in an instrument with 12 items measuring behaviour, impairment, symptoms and social functioning (Wing, Curtis &amp; Beevor, 1996). The scales are completed after routine clinical assessments in any setting and have a variety of uses for clinicians, researchers and administrators, in particular health care commissioners and providers. The scales were developed using stringent testing for acceptability, usability, sensitivity, reliability and validity.</td>
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<td><strong>International Classification of Diseases (ICD 10)</strong></td>
<td>This is the international standard diagnostic classification for all general epidemiological, many health management purposes and clinical use. It is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and health records. In addition to enabling the storage and retrieval of diagnostic information for clinical, epidemiological and quality purposes, these records also provide the basis for the compilation of national mortality and morbidity statistics by World Health Organisation Member States.</td>
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<td><strong>NHS Quality Improvement Scotland (QIS)</strong></td>
<td>NHS Quality Improvement Scotland was established as a Special Health Board by the Scottish Executive in 2003, in order to act as the lead organisation in improving the quality of healthcare delivered by NHS Scotland. By ‘improve’, they mean the improving of the experiences of patient/clients and the outcomes of their treatment while in the care of NHS Scotland. They work to achieve these goals through an analysis of scientific evidence, by listening to the needs and preferences of patient/clients and carers, as well as the experiences of healthcare professionals. Web address: <a href="http://www.nhshealthquality.org">www.nhshealthquality.org</a></td>
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<td><strong>National Institute for Clinical Excellence (NICE)</strong></td>
<td>NICE is part of the NHS. It is the independent organisation responsible for providing national guidance on treatments and care for those using the NHS in England and Wales. Its guidance is for healthcare professionals and patients and their carers, to help them make decisions about treatment and healthcare. NICE guidance and recommendations are prepared by independent groups that include healthcare professionals working in the NHS and people who are familiar with the issues affecting patients and carers. Website address: <a href="http://www.nice.org.uk">www.nice.org.uk</a></td>
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<td><strong>Scottish Intercollegiate Guidelines Network (SIGN)</strong></td>
<td>SIGN was established in 1993 by the Academy of Royal Colleges and Faculties in Scotland. Its objective is to improve the quality of healthcare for patients in Scotland by reducing variation in practice and outcome, through the dissemination of national clinical guidelines containing recommendations for effective practice based on current evidence. For further information contact: <a href="http://www.sign.ac.uk">www.sign.ac.uk</a></td>
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<td><strong>Variance</strong></td>
<td>A deviation from an activity set out in an ICP.</td>
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<td><strong>World Health Organisation (WHO)</strong></td>
<td>WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.</td>
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