Royal College of Psychiatrists
Consultation Response

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RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS, WELSH DIVISION

RESPONSE TO: Technical Consultation on Eating Disorders: Pathway for Wales

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and the Republic of Ireland and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation was prepared by the Royal College of Psychiatrists, Welsh Division

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Response to technical consultation on Eating Disorders: Pathway for Wales

As members of The Royal College of Psychiatrists we encounter patients with moderate and severe forms of eating disorders in our clinical practice and are well aware of their unmet needs. We were pleased that the strategy aimed to embrace eating disorders as opposed to purely anorexia and bulimia nervosa. We are very encouraged with the landmark perspective of developing community-based services for eating disorders in Wales and would like to support it fully.

1. **The challenges to the implementation of the Pathway nationally and locally**

The proposed Pathway needs to engage and support professionals in order to be successfully implemented. Involving professionals with expertise in eating disorders gained locally and nationally could turn the guidelines into reality. In particular proposed tier 3 services need to be close to tier two and work with local teams.

Implementing tier 3 services can be brought to the foremost attention of Trusts if it was included as a performance indicator for Trust Chief Executives.

In order to form and execute standards across the country it would help to form a strategic structure of health bodies. Key roles for the national structure could include:

1) Engagement of key professionals, public health and stakeholders.
2) To ensure that the allocated funds are well invested and deliver real improvements to patients. Employing new members of staff delivering care and therapy will be a key from the patients point of view.
3) To work well with Tier 4 commissioners and providers. Local funding panels developed jointly with Health Commission Wales have already made inroads into understanding of local needs and commissioning right treatments for the right patients.
4) To Develop **single** standard **clinical** care process defined for Wales, i.e not left to districts **Adequate Dedicated** resources i.e staff of all appropriate professions and protected time with teams.
5) Consistent **all-Wales training** in assessment and managements of eating Disorders including medical aspects, whether this is from a single or multiple educational providers.

Competency and Attitude

Nationally it will present a challenge to improve the skills of the whole medical workforce including medical students from Welsh Universities, junior doctors of all specialties such as general practice, medicine, gynaecology, and psychiatry dealing with eating disorders as well as senior practitioners. We cannot afford to miss early presentations of this often chronic illness.

> Many services (both general and specialist) prefer to work with highly motivated intelligent anorectic patients, and will abandon those that are not. In a way this is understandable from the professional's standpoint, because it avoids the pain and frustration of being responsible for a patient that does not want to change, and could die as a result. From the public's and sufferer's viewpoints this attitude is absurd. Services need to be focused more on working within the cycle of change, and using motivational techniques as a primary intervention that underpins later work. They also need to be confident in the potential need to enforce treatment using the Mental Health Act. Not working with poorly motivated patients cannot be an option with this group of patients.
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> Severe cases often can frighten professionals. They feel powerless and vulnerable, and do not want to be responsible for a patient's death. Generic Adult Mental Health Services may well hide behind the need to create specialist tertiary eating disorder services as a pre-requisite to involvement with these cases.
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> Whilst there is a lot that could be done without specialist eating disorder teams, generic services must feel that they have support from more specialist, confident and competent professionals.
> In summary, the successful implementation requires the design and delivery of a medical staff competency framework for Tiers 1 – 4.

Locally it will present different challenges to different localities. In some Trusts it maybe the case of starting an enormous task of identifying local champions and employing new staff. In other Trusts it may be the case of improving on already evidence based services. Managing these different needs may be exacerbated by some of the proposed regions. We would not like to witness the Trusts loosing out or concentrating their efforts on negotiations with other Trusts. That problem appears to affect South East Wales. Some proposed regions are however well matched to local trusts. Based on the expertise in the other regions of the UK it appears that a regional service should cover an area of up to 1 million population, even less population in a rural area. The proposed South east region has a population far in excess of that.

2. Views on the recommendations for specialist tertiary eating disorder teams

In our view there is a very clear need to develop a source of expertise in eating disorders that can only be delivered by specialist teams. Specialist Teams should be tasked with predominantly delivering care, therapy and managing risk in order to reduce waiting time and bring recovery or in the most severe cases alleviate illness and manage it safely. Specialist Teams would cascade their skills interacting with local mental health services, acute medicine and primary care engaging them all in care plans.

The four tier model has some strengths, but we are concerned that it may become a rather arbitrary dogma – everything will be fitted into the four tier model. Essentially there need to be non-specialist services (Tier 1), general specialist services (Tier 2) and super-specialist services (Tier 3 & 4).

There is a great danger in assuming that Tier 2 is functioning fine (or, worse still, simply expect it to be OK) and put all efforts into Tiers 1 & 3/4. It may be seen that Tier 1 (essentially primary care) is grossly under-resourced and under-skilled for primary prevention, screening, basic advice and health care etc, and that there is no Tier 3/4 service available for NHS Wales, and put all energies into these areas. The risk is that putting resources into these new areas (which are currently missing) and not into services they believe that they are already funding (but which are not providing effective ED services).

We need better Tier 1 services for all MH problems including EDs. We do need a specialist service for Wales (Tiers 3/4); this should provide sufficient resource for outpatient and inpatient assessment and treatment for all ages and both sexes (not just young women, for example, with the new unit in Bridgend) – and provide clinical leadership and **training/quality assurance**.

However, we believe that we need to strengthen Tier 2 services equally. Tier 2 adult MH services are not only under-resourced (doing everything and more within one service) but also under-skilled. There is widely varying practice because there is no one single service model for all of Wales. Some clinicians have brought in skills they have developed elsewhere and are committed to using these regardless of other pressures, but this is not universal; and many areas do not have a hospital-wide protocol for EDs.

Tier 2 is vital to any ED service. If more people with EDs are identified and assessed at Tier 1 more will require referral to Tier 2. Tier 2 will need to screen those who need Tiers 3/4. Tiers 3/4 will not function effectively unless Tier 2 can assess and treat ED patients effectively.

The consultation document is focused on mental health services. What about local physicians and dieticians, for example? Should trusts providing Tier 2 services be required to have specialist medical care available either integrated into an ED pathway or available to those working in it? What about specialist dieticians who would not traditionally be managed within MH directorates?

Should all ED admissions be to regional super-specialist units? What would be the role of local MH or medical units in managing weight loss/re-feeding? If they had a role what skills and protocols would need to be developed to manage this safely and effectively?

Interfaces

The interface between CAMHS and adult MH services needs to very carefully considered. There is dissatisfaction among colleagues about the quality of communication at the CAMHS/adult boundary. We realise that CAMHS services have extensive experience and expertise in treatment of EDs. If these skills could be shared this would be of benefit to adult MH services – this could be by either continuing to provide expertise to young adults who would traditionally "graduate" and/or by providing some training to their local services so that they could eventually assume care of these "graduates", and other adult patients. There is increasing recognition of the high rate of eating disorders in people with Learning Disabilities and developmental disorders. There is only a very limited skill base available within specialist Learning Disability Services.

Specific Recommendations for Specialist Tertiary Eating Disorder Teams.

1. Once established these teams must link intimately with inpatient services for the following reasons:
    a. It is important for transitions into and back out of inpatient care.
    b. It helps keep inpatient care timely, focused and reasonably short.
    c. In the absence of specialist inpatient care, specialist teams must drive the inpatient programme of care and provide training and supervision for the non-specialist inpatient nursing teams for these cases.
    d. The community and inpatient treatment tasks are very different with differing priorities and models of care. It is vital that the specialist tier-3 teams recognize this difference and can work within it. For example, community care (for adults) necessarily incorporates a large degree of disease management and focuses on keeping patients out of hospital. Inpatient teams, conversely, need to focus more on the re-nourishment and physical safety tasks and somewhat less on disease management or indeed, psychological treatment packages (though these are clearly

important) because of the starvation induced cognitive impairment present. In the case of first admissions for adolescent inpatients, and the initial year's community care, it is important for both teams to aim for cure (which is different again).

2. Specialist tier-3 eating disorders teams must have a full range of skills in the assessment and treatment of eating disorders. In particular:
   a. They must understand the re-feeding task, and be competent in helping their patients to increase their oral intake. This fundamentally underpins competent care, and yet it is probably not well understood by most professionals. This is often considered to be a task for a dietician, but this severely underestimates the necessary level of understanding of the many barriers to successful community re-nourishment that are required to be held in mind. Many services, including specialist services in my view, focus too much on starting psychological therapies, and too little on achieving satisfactory nutrition. Without this, psychological input can be wasteful and ineffective (because of the cognitive impairment that comes along with starvation. Concentration, memory and emotional IQ are all affected).
   b. The team must have excellent specialist knowledge of the physical complications (and causes) of eating disorders in mind at all times. It is not sufficient to rely on external expertise that may be several days away. It is a mistake to consider that any general physician, paediatrician or gastroenterologist will necessarily be experienced in the medical management of eating disorders. These skills come with experience and practice through treating many cases (and this is a niche role for most medics). It makes sense for the team to have an exclusive relationship with a single physician that meets regularly with the team (and not just with the patients). This way the physician can learn from the team, and have the benefit of a regular flow of patients, and be properly supported. Finally, the medical consequences (both for physical and mental health) are one of the most powerful motivating factors for patients. Patients have much confusion about, and hold fast to many myths about, the effects of dietary restriction on their bodies. Many of these can be dispelled by clinicians having good medical knowledge. It cannot only be external physicians that hold this expertise as it is required within the daily work with all patients.
   c. As pointed out in the framework, psychiatric comorbidity is common. Specialist teams have to have sufficient senior psychiatric skills within the teams. The need for high levels of additional medical knowledge (see b. above) make the psychiatrist (who is medically trained as well as psychiatrically

trained) the ideal professional to lead the team. There must be sufficient psychiatry available to input at least 5-days a week.

d. Once the re-nourishment task, and medical safety, has been taken care of the team must have competencies in a range of relevant psychological therapies.
e. The team must function as a team. This work is onerous and stressful. Burnout and other stress-related phenomena are to be expected, and the teams must pay close attention to their own mental health. This means working in a supportive way with regular team meetings and supervision. It means managing caseloads to include a mixture of severities of illness (not just the tough stuff). It also means taking opportunities to joint work cases.

Any other specific comments

1. Whilst it is widely understood that severely malnourished patients are at severe medical risk, there is a common misconception that, therefore, severely malnourished patients are best treated on medical or paediatric wards. There is also, probably, an under-recognition of death by medical misadventure, which perhaps more often occurs in the specialist medical setting (see point 3b above) than in the psychiatric one. Clearly there are some circumstances (such as severe dehydration, severe hypokalaemia, pneumonia, or a serious cardiac arrhythmia) that mandate brief medical ward (or even intensive care) treatment, but against this must be balanced the supervision and psychiatric needs of the patients too. Ultimately it is the re-nourishment that will improve the medical condition, and this must take primacy. Re-feeding syndrome does kill patients, but it is much more frequently caused by parenteral nutrition, or rapid tube feeding. Oral feeding is always to be preferred, and the proper setting for this is the psychiatric ward where intensive supervision can be provided. Only about 5% of admission cases should require tube feeding if treated by a skilful nursing team, but this can only be realistically achieved in the psychiatric setting. Wherever re-feeding takes place, specialist dietetic and medical advice must be present. If you are not eating on a medical ward, you are more likely to be offered a tube, with all its dangers. On a psychiatric ward, you are more likely to be offered food, and a staff member to support you to eat it.