MENTAL HEALTH GROUP

Eating Disorders | Learning Disability | Mental Illness

THE BRITISH DIETETIC ASSOCIATION

Dietitians working with patients with Eating Disorders

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Position Statement

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Introduction

Eating disorders are complex physiological and psychological illnesses, with specific symptoms that are classified using strict diagnostic criteria, as outlined by the Diagnostic and Statistical Manual for Mental Disorders (American Psychiatric Association 1994). Management of an eating disorder requires consideration from a physiological, psychological and behavioural perspective. Nutritional interventions form an important part of the care package, and a dietitian is ideally placed to lead on the nutritional part of the treatment plan (American Dietetic Association 2006 ; Quality Improvement Scotland 2006).

This paper aims to inform and support all dietitians who have contact at any level with patients with eating disorders. It provides guidance to ensure safe, effective and efficient dietetic practice. It does not address the specifics of dietetic treatment which are covered in the Mental Health Group Guide to Clinical Dietetic Practice in Eating disorders due for launch in 2010. However, it does clearly depict the roles and responsibilities of the specialist eating disorders dietitian, and how non-specialist dietitians can gain further training, support and supervision to either become a specialist dietitian or continue to provide dietetic input to patients with an eating disorder safely. The following areas will be covered:

- Roles and responsibilities
- Knowledge, skills and training
- Clinical supervision
- Caseload management
- Recommendations

Roles and Responsibilities

Eating disordered behaviours arise from psychological difficulties and are a way of coping with and communicating distress. Making dietary changes may exacerbate difficult thoughts and/or feelings, and increase the likelihood of other risk taking behaviours e.g. self-harm, substance abuse etc. Dietitians should therefore avoid situations where they are lone working and carrying inappropriate responsibility for patients with eating disorders, particularly individuals of a high physical and/or psychological risk (Appendix 1). A collaborative team of professionals is required to best manage individuals with an eating disorder (Mehler and Anderson 1999), each contributing their own unique skills and expertise. The specialist dietitian is an important member of the multi-disciplinary team (MDT); with the expert skills needed to address these complex disorders involving food, weight and appetite.

As highlighted by the National Institute for Health and Clinical Excellence (NICE) (2004), dietary counselling should not be provided as the sole treatment for anorexia nervosa. Managing medical risk is not the sole responsibility of the dietitian, although the nutritional assessment is a key aspect of the medical risk assessment, especially during the process of refeeding and in the management of refeeding syndrome. The dietitian should ensure that other team members are also share responsibility for managing physical risk e.g. General Practitioner (GP), or Psychiatrist. Nutritional counselling is required to guide an individual back to normalised eating patterns and behaviours, but it is not a substitute for psychotherapy (Beumont, Russell and Touyz 1993). Another team member is required to treat the underlying psychopathology e.g. eating disorders

psychologist, therapist, specially trained counsellor. Other health professionals also offer important roles in the management of patients with an eating disorder (Appendix 2). It is best practice for patients to have a designated care co-ordinator for the dietitian to work alongside to assess and manage clinical risk. Treatment may be provided within primary, secondary or tertiary services depending on the patients' needs and local service availability. An example referral pathway for individuals with an eating disorder is outlined in appendix 3.

The dietitian needs to have a clear understanding of their own limitations, and seek support from the other members of the team when appropriate. Individuals with an eating disorder do struggle to disentangle their emotions from issues related to food, and so, dietitians may be faced with complex psychological issues. However, it is important that professional boundaries are kept at all times, and that the dietitian maintains a focus on food-related problems (American Dietetic Association 2006).

A non-specialist Dietitian can offer assessment, sign-positing and short-term education for individuals with an eating disorder, providing they liaise with the other health professional(s) involved in the patients care (i.e. health professionals managing both the medical and psychological aspects of the patients care). Non – specialist dietitians should seek guidance and support from an experienced/specialist eating disorder dietitian for the duration of the short-term work, and recognise their own limitations. Longer-term treatment or treatment of severe or complex needs patient's needs to be addressed by a specialist service that includes a Dietitian with specialist knowledge of eating disorders. The MARSIPAN report by the Royal Collage (2010) recommends that In-patient medical team's must contain a specialist Dietitian preferably within a Nutrition support team, and that any hospital that admits patients with anorexia Nervosa must have a Dietitian trained to provide care to such patients.

The specialist eating disorders dietitian (skills and knowledge described below) has a role in assessment, treatment, monitoring, support and education. The role in assessment is to determine nutritional status, eating patterns and behaviour, knowledge, food rules and beliefs, meal planning, shopping and cooking skills, motivation to change, and how underlying psychopathology impacts on eating behaviours and behaviour change. Dietitians are able to accurately assess habitual dietary intakes in people with an eating disorder (Hadigan, Anderson and Miller 2000). The dietitian develops the nutrition section of the treatment plan in consultation with the patient, and then supports the patient and the rest of the MDT throughout implementation. This includes intensive one to one work, but also group work. The development of a good therapeutic relationship is essential (Dresser 1984), as well as enhanced communication skills to support nutritional rehabilitation.

Boundaries are exceptionally important; the dietitian may feel pressure to compromise on issues related to the calorie content, or the actual foods consumed (Beumont, Russell and Touyz 1993). This is because recovery from an eating disorder can be very difficult, and often leads to the emergence of distressing feelings and increased anxiety that the individual would rather avoid. It can be useful to set the boundaries from the start of treatment, including what is negotiable, and what is non-negotiable.

Individuals with an eating disorder are believed to have a good comprehension of nutrition. However, Beaumont *et al*. (1981) show that individuals with an eating disorder have sound knowledge of the calorie content of foods, but a poor understanding of the basics of healthy eating, and how to meet their nutritional requirements. In addition, there is a tendency for those

with an eating disorder to have faulty ideas and beliefs towards food (Cockfield and Philpot, 2009). It is the responsibility of the dietitian to educate individuals in areas related to nutrition. A broader role in education extends to offering support and education to other health professionals, families, carers, non-specialist dietitians involved with patients with eating disorders, and the general public, through various mediums such as group work, presentations, the media etc. Thus, the specialist dietitian must have excellent communication skills and be a good negotiator, as well as have an up-to-date knowledge of the evidence base to support their advice.

There is a paucity of research in the area of dietetics and eating disorders. Although there is no clear evidence that a dietitian is an effective member of the MDT managing these complex disorders, some key papers are beginning to recognise the valuable role of the dietitian in this field (Royal College of Psychiatrists 2004). Dietitians need to produce outcome measures to evidence the effectiveness of their practice and support their continued role in eating disorders.

Knowledge, Skills and Training

Working with patients with eating disorders requires a comprehensive level of knowledge and skill mix to meet the complex needs and challenges of this client group.

Specialist Dietitians should have a sound knowledge of the development and maintenance of eating disorders in addition to an understanding of the physiological, psychological and medical aspects of a range of eating disorders. This needs to be underpinned by a broad understanding of mental health and psychological interventions and their application e.g. Motivational Enhancement Therapy, Cognitive Behavioural Therapy, Cognitive Analytical Therapy, Dialectical Behaviour Therapy, Interpersonal Therapy, and Psychodynamic/Psychoanalytic Psychotherapy. Enhanced communication, counselling and motivational interviewing skills are vital, especially since not all individuals with an eating disorder are motivated to change their behaviours, and ambivalence is a core condition in Anorexia Nervosa.

The Dietitian should therefore address their ongoing training needs via a personal development plan and an annual appraisal using the Knowledge and Skills Framework, to ensure that they are adequately skilled to work in this area. A list of recognised post graduate training and qualifications are given in appendix 4.

Clinical Supervision

Working with patients with eating disorders can be both personally and professionally demanding. Typically patients may present as distressed, anxious and/or depressed. As previously stated, patients may struggle to disentangle their emotional distress from more practical dietetic matters. Dietitians are, therefore, regularly confronted with challenging psychological issues. Furthermore, patients may evoke particular emotional responses in the professional, and at times this may influence the therapeutic process.

Access to regular and good quality clinical practice supervision from an experienced eating disorders dietitian and other MDT members is important. This will enable reflection on clinical practice and time to consider emotional and relationship issues, which may arise during consultations. Practice supervision can be available in a number of different ways, including one to one, group, face-to-face, or on the telephone. Since interpersonal issues may need to be

addressed, the supervisor will require skills in this area. Some practice supervision may therefore need to be provided from outside the dietetic profession, such as within psychological services. If this is the case, it is essential that the supervisor has a clear understanding of both professional and clinical dietetic issues as practice supervision can include caseload management and professional management (Practice supervision guidelines, 2008).

In addition to individual supervision, MDT supervision is needed, which allows an enhanced team approach and assists in maintaining clear professional boundaries. Working in a team can bring difficulties, such as differing priorities/ideas, splitting, issues with communication, and so on. The dietitian will need to overcome these challenges to be able to effectively collaborate with the team. MDT supervision is a medium to assist in this process.

Caseload Management

Caseload management is important due to the complex and challenging nature of this patient group, and should be managed at a level that reflects similar caseloads of other allied health professionals within the team, such as psychology and occupational therapy. Through consultation with specialist eating disorder dietitians who are members of the Mental Health Group of the British Dietetic Association (BDA), safe caseloads have been proposed as 0.5-1.0 whole time equivalent dietetic time for a 10-12 bedded inpatient unit specialising in the treatment of eating disorders. This range reflects the varying role of the dietitian within inpatient services. For example, some services will heavily rely on dietetic input in all areas related to nutrition within the unit, whereas some services may have other health professionals, such as nursing staff, with a special interest in nutrition and appropriate training, who are able to support the role of the dietitian in these settings. Furthermore, supporting complex needs patients through behaviour change is time consuming, requires the development of a good therapeutic relationship, and the need for frequent on-going support to ensure treatment outcomes are met. As a result, typical caseloads should not exceed five complex needs patients per day, or twenty per week. This needs to be considered when agreeing dietetic time in outpatient services.

Recommendations

Currently there are few specialist eating disorders Dietitians, and training and resources for those who are non-specialist are scarce. Therefore the following recommendations have been made:

- A dietetic consensus statement on the treatment of patients with eating disorders is developed.
- A national network of Dietitians working within the field of eating disorders for sharing resources, and promoting consistent evidenced based practice is developed.
- Increased mental health provision in undergraduate training
- Improved knowledge and skills training for student and postgraduate Dietitians in behaviour change e.g. Cognitive Behavioural Therapy, Motivational Enhancement Therapy and other similar psychological and counselling techniques.
- Further research is into the effectiveness of dietetic intervention in eating disorders in order to establish an evidence base for our practice.
- The development of outcome measures to support the research into the effectiveness of dietetic interventions.

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Hadigan, C. M., Anderson, E. J., and Miller, K. K. (2000) 'Assessment of Macronutrient and Micronutrient Intake in Women with Anorexia Nervosa' *International Journal of Eating Disorders* 28, 284-292

Mehler, P. S., and Anderson, A. E. (1999) *Eating Disorders: A guide to medical care and complications* London: The John Hopkins University Press

National Institute for Health and Clinical Excellence (2004) *Eating Disorders: Core interventions in the treatment and management of anoxia nervosa, bulimia nervosa and related eating disorders* London

Quality Improvement Scotland: Eating disorders Scotland Recommendations for Management and Treatment. (2006) which has an appendix on the role of the dietitian www.nhshealthquality.org/nhsqis/files/EATDISORDER_REP_NOV06

Royal College of Psychiatrists (2004) *Guidelines for the Nutritional Management of Anorexia Nervosa* London: Royal College of Psychiatrists

Appendix 1 - High physical and/or psychological risk patients

Patients can be considered high risk if they meet any of the following criteria:

- Rapid weight loss > 0.5 kg per week
- Regular purging behaviours
- Dual diagnosis e.g. Diabetes, Obsessive Compulsive Disorder, Depression, Borderline Personality Disorders, Post Viral Fatigue
- < BMI 16 Kg/m^2
-

Those at risk of developing refeeding syndrome as outlined below:

Criteria for determining people at high risk of developing refeeding problems
Patient has one or more of the following: • BMI less than 16 Kg/m^2 • weight loss greater than 15% within the last 3-6 months • Little or no nutritional intake for more than 10 days • Low levels of potassium, phosphate or magnesium prior to feeding • History of alcohol abuse or drugs including insulin, chemotherapy, antacids or diuretics • The presence of purging behaviours, such as vomiting and/or laxative misuse Or patient has two or more of the following: • BMI less than 18.5 Kg/m^2 • weight loss greater than 10% within the last 3-6 months • Little or no nutritional intake for more than 5 days

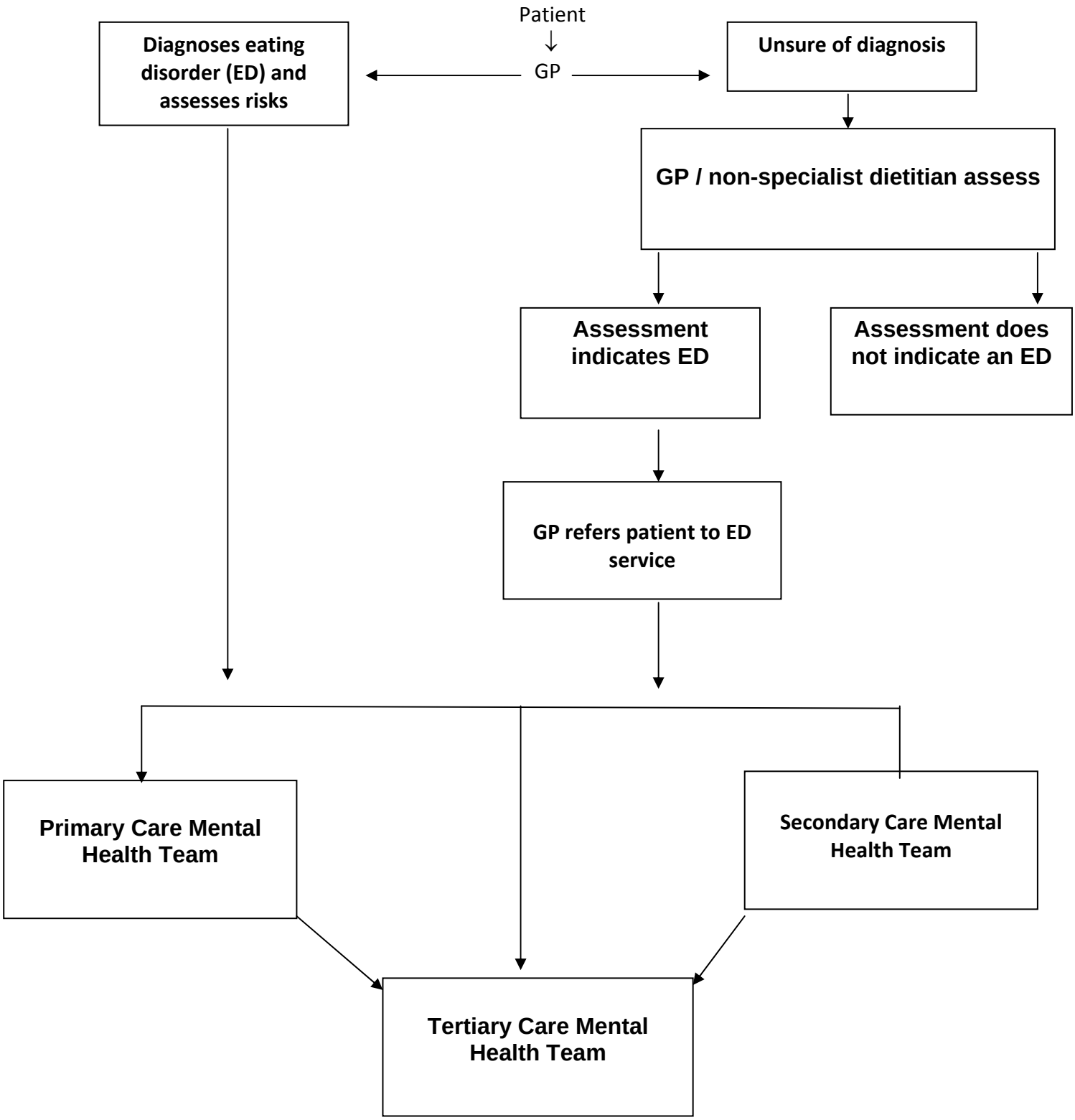
Appendix 2 – Other health professionals within the MDT

Examples of MDT members working with patients with eating disorders:

- GP
- Dietitian
- Clinical Psychologist
- Community Psychiatric Nurse
- Psychiatrist
- Nurse Therapist (e.g. Cognitive Behaviour Therapist)
- Psychotherapist
- Family/Systemic Therapist
- Art Therapist
- Physiotherapist
- Occupational Therapist
- Social Worker

A 'team' will include the patient's GP and other healthcare professionals from the list above. This is not an exhaustive list.

Appendix 3 - Referral pathway for patients with an eating disorder



Local referral pathway guidelines should also be referred to.

Appendix 4 - Training courses/conferences and organisations

In considering the continuing professional development requirements of dietitians working in eating disorders, training courses/conferences and organisations are detailed below. This is not an exhaustive list.

- Annual Aberdeen Eating Disorders Conference. The Aberdeen conference is excellent value for money and strongly supports input from allied health professionals, including dietetics.

- Beat. This is the official eating disorders registered charity, providing information and help on all aspects of eating disorders for sufferers, carers and professionals. Further details are available from www.b-eat.co.uk

- Behaviour Change Skills level 1-3. These courses include enhanced communication, and motivational and counselling skills to support behaviour change, which are essential for all specialist eating disorders dietitians, and are supported BDA. For further details contact Dympna Pearson at dympna.pearson@ntlworld.com

- BDA Mental Health Group. This is a specialist group of the BDA that has over 200 dietitians working in the field of mental health, eating disorders and learning disabilities. The web site has an excellent resource section and membership includes regular e-mail updates in this clinical area. Further details are available from www.dietitiansmentalhealthgroup.org.uk

- BDA Mental Health Group: Introduction to Mental Health course. This includes an introduction to working in mental health and eating disorders; suitable for those beginning to work in this area. Further details are available from www.bda.uk.com

- BDA Mental Health Group: Modules provided by Leeds Metropolitan University in collaboration with MHG: Eating disorders and Mental Health, Multidisciplinary Approaches to Eating Disorders, Design and Delivery of Psychological Therapies, Introduction to CBT. www.leedsmet.ac.uk E-mail: J.Copeman@leedsmet.ac.uk

- Counselling skills. Details of accredited courses are available from the British Association for Counselling and Psychotherapy at www.bacp.co.uk

- Cognitive Behaviour Therapy. Further information and details of nationwide courses are available from the British Association for Behavioural and Cognitive Psychotherapists at www.babcp.com

- EDNET. This is a network that has been set up for all health professionals working with patients with eating disorders at www.ednet.co.uk

- International Conference on Eating Disorders. This conference is run biannually and will appeal to those interested in the assessment and treatment of people with eating disorders and who would like to learn more about the very latest developments in this field.

- Motivational Enhancement Therapy. The Eating Disorders Unit of the South London and Maudsley NHS Trust offers regular courses in the management and treatment of eating disorders. Further details are available from: Christine Hallums, Training Administrator, Eating Disorders Unit, Bethlem Royal Hospital, Monks Orchard Road, Beckenham, Kent, BR3 3BX.

- Regional Eating Disorder Interest Groups. These are regional groups run by dietitians, offering peer support and supervision, as well as an opportunity to share resources and examples of best practice locally. Further details are available from www.dietitiansmentalhealthgroup.org.uk. On the website, click on the RIG tab to see the contact details of your local group.

Appendix 5 - Recommended reading list

Clinical

European Eating Disorders Review. The professional journal of the Eating Disorders Association published bi-monthly by John Wiley and Sons, Ltd.

Fairburn, C., and Brownell, K. (2002) *Eating Disorders- A Comprehensive Handbook* (2nd Edition). Guilford Press.

Garner, D. M., and Garfinkel, P. E. (1997) 2nd Edn. *Handbook of Treatment for Eating Disorders*. Guilford Press.

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International Journal of Eating Disorders. An official publication of The Academy for Eating Disorders. USA.

Institute of Psychiatry: For health and education professionals. Web downloads include risk assessment tables and BMI tables: www.iop.kcl.ac.uk/sites/edu/?id=73

Mental Health Group Guide to Clinical Dietetic Practice in Eating disorders - due for publication 2011.

Morgan, J. F., Reid, F., and Lacey, J. H. (1999) The SCOFF questionnaire: Assessment of a new screening tool for eating disorders. *British Medical Journal*. 319, 1467-1468

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Thomas, B. (2001) 3rd Edn. *Manual of Dietetic Practice*. Blackwell Science.

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Self Help Manuals

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