

Northern Region Eating Disorders Continuum of Care



Te Poari Tautoko I Nga Rohe Ki Te Raki



A Community Partnership



Waitemata
District Health Board

Te Wai Awhina



a+ **AUCKLAND**
DISTRICT HEALTH BOARD
Te Toka Tumai

NORTHLAND DISTRICT HEALTH BOARD

Te Poari Hauora A Rohe O Te Tai Tokerau



Midland
District Health Boards
MENTAL HEALTH & ADDICTION
Service Development • Workforce Development • Partnerships & Relationships

Contents

Acronyms	3
Project Background and Context	4
Approach.....	5
Proposed Eating Disorders Service Continuum of Care.....	5
Guiding principles	5
Current state	5
The Enhanced Model	6
Key components of the continuum	7
Responsibility Matrix	9
Referral Pathway.....	10
Services across the Continuum	11
Local DHB Liaison Clinicians	11
REDS Specialist and Outreach Team	11
Hub & Spoke model	12
Medical Adult Inpatient Services – Local DHBs.....	13
Inpatient Services – Child and Adolescent.....	14
Adult Residential Treatment Services and Day Programme.....	15
Residential Treatment programme.....	15
Day Programme Services	16
Ashburn Clinic	17
Packages of Care (POC)	18

Appendices

- One: Eating Disorders Continuum of Care – Northern Regional Implementation Plan
Two: Summary of EDS National Service Specifications

Acronyms

AMHS	Adult Mental Health Service
AN	Anorexia Nervosa
AOD	Alcohol and Other Drugs
BN	Bulimia Nervosa
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behaviour Therapy
C&Y	Child and Youth
CFU	Child and Family Unit
DBT	Dialectic Behaviour Therapy
DHB	District Health Board
EDNOS	Eating Disorder Not Otherwise Specified
EDS	Eating Disorders Service
FTE	Full Time Equivalent
GP	General Practitioner
MDT	Multidisciplinary Team
MH	Mental Health
MHA	Mental Health and Addictions
MOH	Ministry of Health
NDSA	Northern DHB Support Agency
NGO	Non Government Organisation
PHO	Primary Health Organisation
REDS	Regional Eating Disorders Service
SSH	Starship Hospital
SMO	Senior Medical Officer

Project Background and Context

The *Northern Region Eating Disorders Services Plan 2008 – 2013* (in response to the 2008 Ministry of Health's *Future Directions for Eating Disorders Services* document) was submitted to the Ministry of Health in February 2009, by the Northern DHBs Support Agency (NDSA) on behalf of Regional Services Planning (Mental Health and Addictions).

The plan included a proposal to invest in expanding the range of services available in the Northern region for people with eating disorders and their families. Along with enhanced community and inpatient services, the expansion signalled included the development of a new dedicated residential treatment facility, day programme, and enhanced children's services at Starship Children's Hospital.

Additional funding was secured from the Ministry of Health to grow services, and subsequently *The Northern Region Eating Disorders Implementation Plan* (June 2009) was developed to guide the investment, planning and delivery of the enhanced services to ensure better outcomes for people who use these services.

A key element in the Implementation Plan was to describe, at a macro level, the Northern Regional Eating Disorders Continuum of Care (refer Appendix One)

One of the next key actions was to work with all stakeholders (current and new) to agree an overarching continuum of care reflective of the range of services to be delivered, and define pathways for different levels of need. It was also important to engage with Midland District Health Boards (DHBs) as key stakeholders in this process as they will be accessing Regional Eating Disorders Service on behalf of the population they serve.

Key deliverables for this project included:

- Services required to provide Eating Disorders Services
- Common types of interventions and activities provided across the continuum are clearly defined
- Reporting parameters and processes for agreed regional and local services are agreed
- A responsibility matrix describing key linkages and interfaces between and within services is developed
- An integrated care pathway illustrating common experiences of service users is described
- Local district service variations are described and agreed.

Significant discussions and workshops have occurred with service providers and special interest groups to assist in both agreeing and describing what the client pathway should look like with regards to an overarching model of care for Eating Disorders Services (EDS).

It is acknowledged that at the time of writing this document, DHBs and various services are at different stages of recruitment and service expansion, resulting in the development of this high level document that is intended to provide a framework and guidelines to describe the preferred client pathway. The intent is to allow for consistency in practice, whilst allowing for local flexibility where appropriate and required.

Approach

An Eating Disorders Services Governance Group was established to oversee all activity related to the Implementation Plan. A project manager was appointed who reported back to this group.

A number of workshops have been convened, as well as individual meetings with each DHB, which has subsequently informed the basis of this draft discussion document. It has quickly become apparent that each District Health Board (DHB) is developing their enhanced services slightly differently in order to meet the various existing models of service delivery, as well as the diversity of both geographical and local population needs.

Therefore, with the agreement of the EDS Governance group, we have proposed a high level, regionally acceptable pathway, that allows for flexibility for individual DHBs to adapt this approach accordingly to their specific needs. This also aligns appropriately with the 'hub and spoke' model for DHBs, where the Regional EDS service operates as the 'hub' and local DHBs operate as the 'spoke'.

Proposed Eating Disorders Service Continuum of Care

The following section details the guiding agreements that will inform service delivery, describes the key components of the continuum (specifically the referral pathways) and provides an overview of the role and functions of teams involved in various aspects of service delivery across the continuum.

Guiding principles

The following principles have been agreed by the sector:

- All referrals from primary care will first go to local DHB Mental Health services, i.e. Child & Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS)
- All access to specialist inpatient and residential treatment settings for clients with an eating disorder (under and over 15) will be managed by the Regional EDS service
- Once a referral has been made to a service, the GP and Mental Health Service will enter into a 'shared care' relationship agreement, which should involve ongoing physical interventions/treatment such as active medical monitoring and investigation.

Current state

Specialist Eating Disorder Services have been provided by the Regional Eating Disorders Team (REDS). This is a team of 18.8 FTEs, delivering services to the Northern region, as well as providing supervision (through a separate contract) to the Midland DHBs. Usual practice has been:

- Referrals from the primary sector (GPs) are accepted straight into Regional Eating Disorders Services (REDS) – all referrals must have ongoing GPs involvement
- Referrals were also accepted from Child and Adolescent Mental Health Services (CAMHS), Adult Mental Health Services (AMHS) and Psychiatric Liaison
- Referrals largely consist of people presenting with Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Eating Disorder not otherwise specified (EDNOS) – not obesity or binge eating
- It was not uncommon for people to waiting for more than 6 months to be seen by REDS, often receiving little or no input from other services during the waiting period
- This meant that people waiting for service often deteriorated, resulting in requiring longer and more intensive treatment interventions, which then resulted in further extending the waiting times for others.

The Enhanced Model

As per the EDS Implementation Plan, additional funding has been applied to the following service areas:

Service	Additional resource
Increased Northern Local DHB resources to undertake a 'Liaison' role	<ul style="list-style-type: none"> • 2 clinical FTEs for Auckland DHB • 2 clinical FTEs for Waitemata DHB • 2 clinical FTEs for Counties Manukau DHB • 1 clinical FTE for Northland DHB • 1 SMO FTE for local Northern DHB support (that sits with REDS team)
Increased Midland Local DHB resources to undertake a 'Liaison' role	<ul style="list-style-type: none"> • 3.2 clinical FTEs for Waikato DHB • 0.8 clinical FTE for Lakes DHB • 1.0 clinical FTE for Bay of Plenty DHB¹ • 0.4 clinical FTE for Tairāwhiti DHB • 0.5 clinical FTE for Taranaki DHB
Increased Regional resources (REDS) (Northern & Midland regions)	<ul style="list-style-type: none"> • 2 clinical FTEs that sit with REDS to provide support to the local DHB teams • 2 clinical FTEs that sit with REDS to provide support to the Day programme service (over 15 years) • 1 additional SMO • Reconfiguring EDS team to provide and 'outreach' function
Increased Inpatient, Residential Treatment and Day Programme services	<ul style="list-style-type: none"> • 9 new residential beds available for the over 15 year population, of which 8 beds are allocated to the Northern region, and 1 bed is allocated to Midland DHBs, as well as a newly funded day programme • 5 new inpatient beds situated at Starship Hospital for the under 15 year population, of which 4 beds are allocated to the Northern region, and 1 bed is allocated to the Midland DHBs.

¹ 0.5 FTE funded from Blueprint funding, with the balance made available from BOPDHB for their local EDS response

Key components of the continuum

The key components across the EDS service continuum/client pathway are:

Figure One: Components of the EDS Continuum



Each DHB has decided to adopt a slightly different approach to the role of the local DHB Liaison positions, and as a result, will be undertaking varying levels of focussed activity for each component described in the service continuum. For example, some DHBs have decided to employ dedicated full time FTEs to fill these positions, whilst others have part FTE positions reflective of a mixed multidisciplinary approach (e.g. some nursing, dietician, occupational therapy). This will influence types and depth of assessment, treatment and support that will be undertaken as part of the expanded level of service.

Additionally, there are mixed views as to whether the Local EDS Liaison coordinators maintain an active caseload, or undertake more of a 'consult and liaison' function, providing support to CAMHS and AMHS clinicians/key-workers and general medical staff. There is also variation on where the positions will be located within each DHB, for example some Liaison coordinators are aligned to Child and Adolescent Mental Health Services (CAMHS), Adult Mental Health Services (AMHS), or possibly a combination of both.

Each DHB is at various stages of planning and recruitment, and will be describing how they will progressed EDS service enhancement based on the skill and experience of the EDS Liaison coordinators, as well as responding to their local population needs and geographical issues.

The REDS team is currently undergoing a review of their structure, and are in the process of developing an 'outreach team' that will support the local DHBs as well as continuing to provide specialist EDS services for clients assessed as needing them.

The EDS Continuum of Care therefore proposes a high level framework that is descriptive rather than prescriptive in order to be reflective of the various DHB positions. As the enhanced local services evolve, we expect it will be possible to gain consensus on more detailed elements of the sub-components of the continuum that allows for regional consistency where sensible, but is also flexible enough to meet local DHB needs.

For the purposes of this Framework, the minimum elements that need to be considered in each service component include:

Figure Two: Eating Disorders Service Components

Service Component	Key elements
Referral	<ul style="list-style-type: none"> • Screening – Early recognition • Screening – Early identification • Interpretation of early warning signs (severity & need)
Assessment & Care Planning	<ul style="list-style-type: none"> • Medical assessment tailored to Eating Disorders (e.g. BMI, vital signs etc) • Risk assessment • Bio-psychosocial assessment tailored to Eating Disorders (e.g. cognition, behaviour etc) including <ul style="list-style-type: none"> ○ Family/whanau assessment in terms of family dynamics and impact ○ Mental health • Diagnosis (criteria, aetiology, applying diagnoses & formulation) • Assessment of risk within a family context • Ongoing support needs of families • Assessing risk of suicide • Physical assessment • Motivation • Initial treatment plan • MDT coordination
Treatment & Interventions	<ul style="list-style-type: none"> • Motivational interviewing (working with ambivalence, engagement with client group, managing ego-syntonic dynamics) • Application of tools (CBT, DBT) • Maudsley family therapy model • Monitoring of weight restoration, exercise management, compensatory symptom management (e.g. self harm) • Meal support • Pharmacology • Basic life support • Naso-gastric feeding • Anxiety management • Individual psychotherapy and family therapy • Facilitating groups for people with eating disorders • Education sessions for people with eating disorders and their families/whanau • Meaningful activity • Relapse prevention planning • Preparation for discharge including transition to follow-up services • Planned home visits • Day programme engagement • Support and treatment from outpatient services (EDS liaison, GP, CAMHS, AMHS)
Discharge	<ul style="list-style-type: none"> • Self management

Responsibility Matrix

The Governance and working groups have agreed that in the first instance, it would be useful to delineate what activity was likely to occur at primary, secondary and tertiary service levels when working with people with Eating Disorders, rather than focussing specifically on who would be providing the services. It was noted this will be an iterative process which will continue to be refined within the broader group and via DHB discussions as services evolve, and we have therefore described the high level activity rather than describe specifics. This will allow for a regionally consistent approach to be adopted whilst allowing for local DHB variation and flexibility as described in the responsibility matrix below.

Figure Three: Responsibility Matrix and Key Linkages

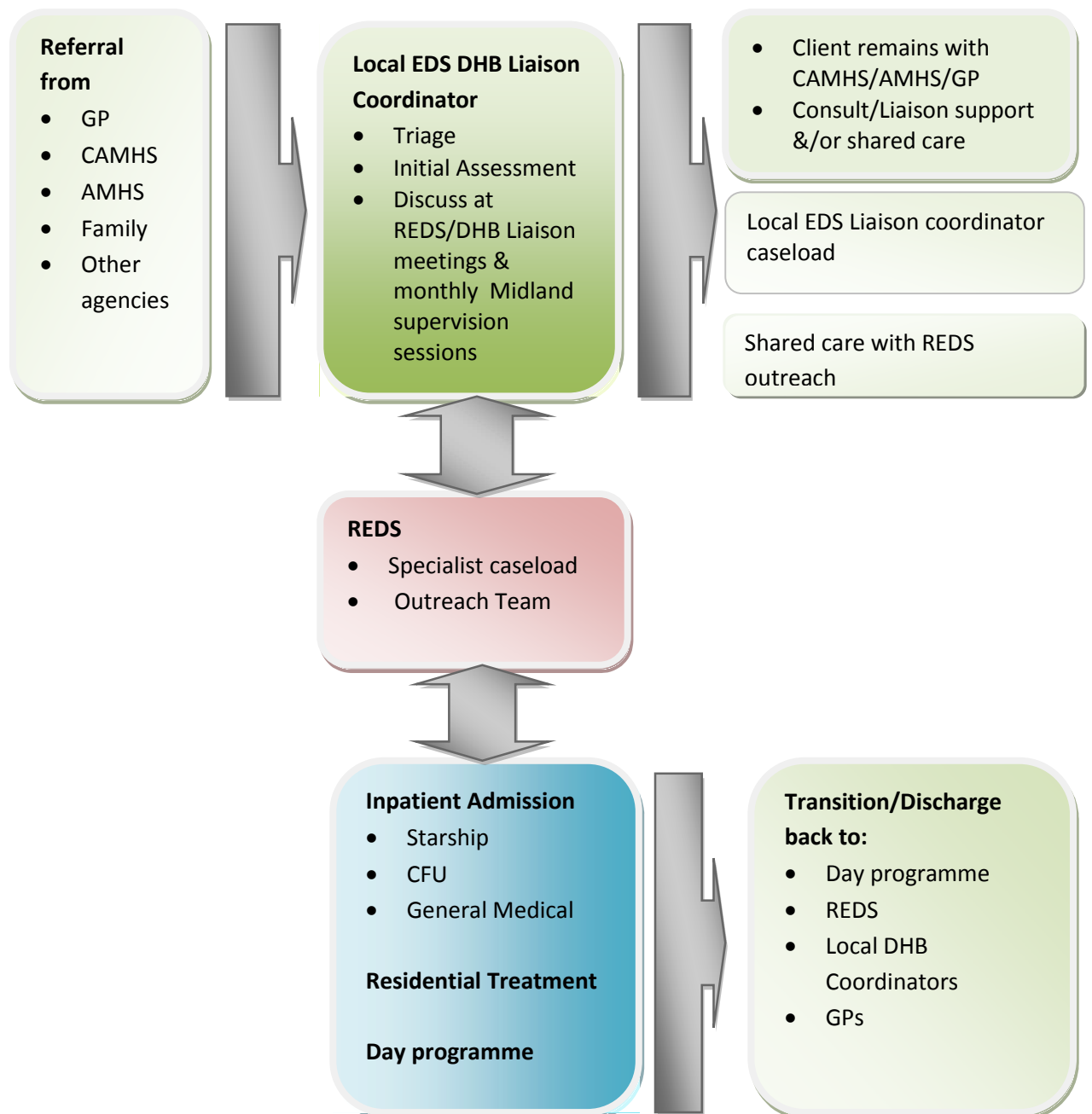
Level	Focus	Key linkages & interfaces
Primary Care <ul style="list-style-type: none"> • GPs 	Promotion & prevention Assessment and medical/physiological monitoring Consult/liaison Family support & engagement	<ul style="list-style-type: none"> • Local DHB EDS Liaison Coordinators • GPs • PHOs • School Counsellors • Community & Voluntary sector (e.g. EDCC, EDEN, EDANZ) • NGOs • Youth services • Maori health providers • Pacific health providers • Public health nurses
Secondary Care/Community <ul style="list-style-type: none"> • AMHS • CAMHS • Local EDS Liaison coordinators 	Mild to moderate ED <ul style="list-style-type: none"> • Triage, prioritisation & referral • Consult, liaison & advice • Meal support training • Education • Case Management • Shared Care 	<ul style="list-style-type: none"> • Child & Youth MH services • AMH services (Community & Inpatient) • Local DHB Steering groups • Regional Eating Disorder Services • NGOs • AOD services • Liaison Psychiatry • Dieticians • Paediatricians/units • Physicians • Adult medical units
Secondary Care/Specialist & Intensive <ul style="list-style-type: none"> • REDS • Specialist services 	Severe and enduring ED <ul style="list-style-type: none"> • REDS access manage referrals to <ul style="list-style-type: none"> - Day programmes - Packages of Care - Residential Treatment services • Paediatric medical units • C&Y MH units • Adult medical units • Adult MH units 	<ul style="list-style-type: none"> • Child & Youth MH services • AMH services (Community & Inpatient) • Regional Eating Disorder Services • NGOs • AOD services • Liaison Psychiatry • Dieticians • Paediatricians/units • Physicians

Referral Pathway

Usual practice has been that all referrals for people requiring specialist EDS services were received directly by the Regional Eating Disorders Team (REDS). With the enhanced spectrum of Eating Disorder services available now, referrals will now be directed to the Local EDS Liaison coordinators in the first instance, for triage and an initial assessment.

All referrals will be discussed at the regular liaison meetings between REDS and all local DHBs, as well as via the Midland monthly supervision sessions, where a decision regarding the most appropriate treatment approach/setting will be agreed as per the pathway below:

Figure Four: Proposed EDS Referral Pathway



Services across the Continuum

For the purpose of this draft discussion document, we have identified 4 key service areas across the continuum. These are described in more detail below.

Local DHB Liaison Clinicians

The Liaison roles are filled with designated eating disorder clinicians who are embedded in either Child and Adolescent Mental Health Services (CAMHS), or Adult Mental Health Services (AMHS) across the Northern and Midland DHBs. Although each DHB may be structuring this role and function in a slightly different fashion, they will provide a link to REDS services and will provide, facilitate or be involved in:

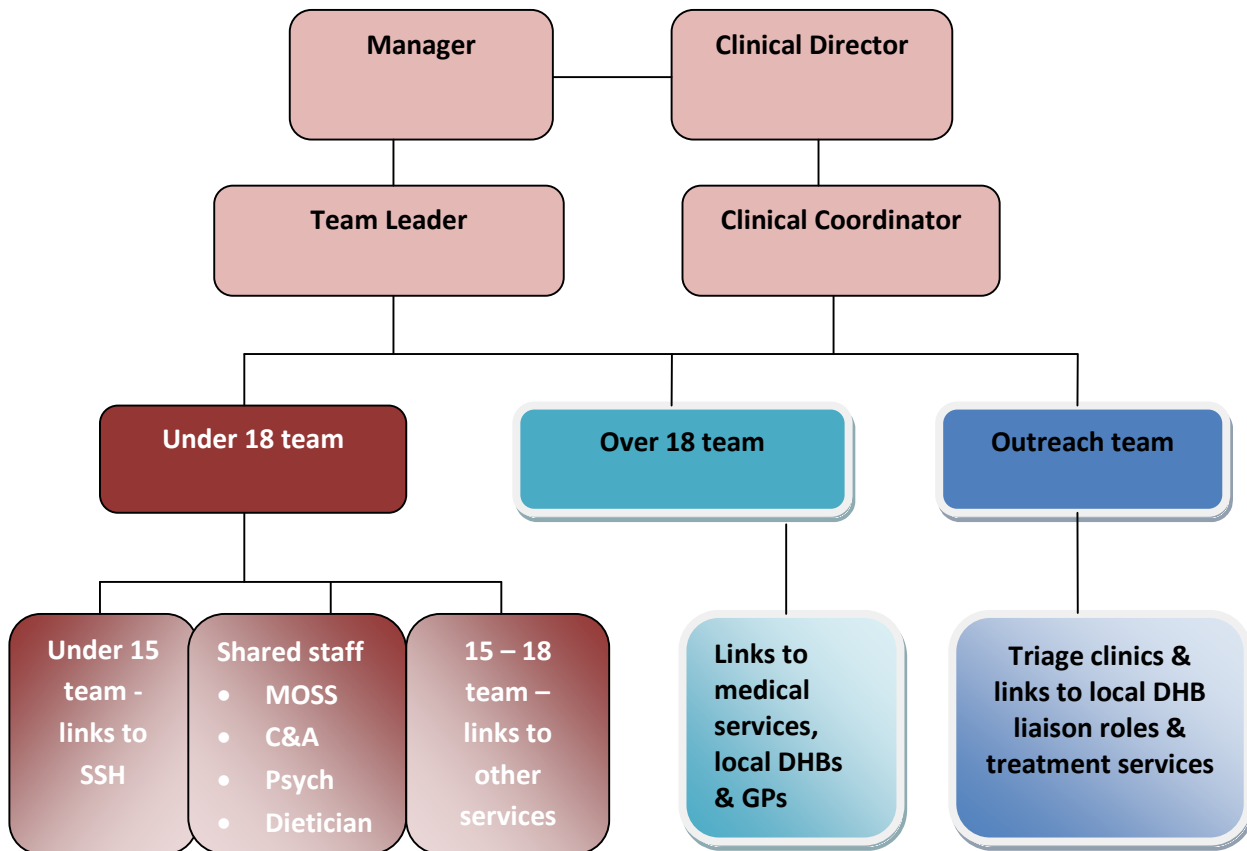
- Processing and triage of referrals with support from the REDS outreach team
- Regular Liaison meetings with REDS services
- Oversight for clients engaged with CAMHS or AMHS
- Liaison with primary care
- Identifying the resources required to support individuals under the care of CAMHS or AMHS
- Undertaking a case management/key worker role, or provide assessment & treatment advice to case managers/key workers within CAMHS or AMHS
- Regular monitoring of identified individuals within CAMHS or AMHS, including coordinating and facilitating referrals to REDS where further assessment/treatment options need to be considered.

REDS Specialist and Outreach Team

The REDS outreach team will provide support to the DHB liaison roles and assist in building capacity and capability through liaison, support, supervision and teaching via the following approach:

- Regular (at least monthly) meetings with local DHB liaison staff which includes triage, case reviews, discussion of new referrals and ongoing clients, care planning, teaching and training as identified, as well as regular/ad hoc support to individual liaison staff as identified and required
- Develop a shared understanding of the basic principles and fundamentals of the provision of treatment for EDS clients
- Assisting with the interface with primary sectors (e.g. support of medical management provided by GPs)
- Potential to provide outreach clinics (e.g. Dietician services) for CAMHS and AMHS for the greater Auckland metro region
- Flexible support for the more geographically distant DHBs such as Midland and Northland based on need (hub and spoke model) via teleconferences, videoconferences, face:face sessions providing the opportunity for supervision, case reviews, assessment, peer review, consultation and liaison, training, mentoring and support
- Provide access to specialist consultations where a second opinion is required, as well as offering joint assessments with REDS and Local DHB liaison staff and teams
- Ensure flexibility to develop different models based on DHBs specific and individual needs as service provision evolves.

The REDS team structure is described below:



Hub & Spoke model

Currently, the REDS team provides support and input from their clinicians to provide “hub and spoke” supervision and training for all identified primary, secondary and NGO services involved in Eating Disorders as part of the current Supervision and Training contract with Midland. The monthly meetings that currently occur (10 per year) are perceived as being a highly effective forum for supervision, training and peer review, and also have been used to enable key decisions to be made in the past (e.g. agreeing prioritisation and access for inpatient beds).

The level of clinical support, supervision and training/mentoring for all local DHBs from REDS will be enhanced as part of the increased ‘local support’ FTEs from the REDS outreach team. This support may take the form of being available for hands on or joint assessments and input/support for the small group of intensive clients unable to be managed by local DHB eating disorders services (the ‘spoke’) with support from REDS (the ‘hub’).

The two key factors required for an effective ‘hub and spoke’ approach to eating disorder service delivery are:

- Ensure that dedicated resources in all of the ‘spoke’ DHBs
- Scheduling planned meetings and video conferences at regular intervals regardless of whether or not the ‘spoke’ DHB has existing clients being seen at the time, maintaining relationships and ensuring that time is devoted to reflection, supervision and training.

From the 'hub' perspective, this may also be described as a consultative service that will be provided by senior medical staff, nurses and/or other allied health professionals that are part of the REDS team, who have specialist knowledge, expertise and experience in the management and treatment of eating disorders.

The mechanics of how this support will be provided needs to be formalised, but could take the form of regular consult/liaison meetings, case reviews, videoconferences, or face:face clinics where applicable and indicated. Midland DHBs would also be supportive of REDS identifying one contact person from the REDS team that could be the contact person facilitating access to Starship Inpatient beds (under 15 years) as well as the Residential Treatment service and where appropriate, the day programme.

Medical Adult Inpatient Services – Local DHBs

Where inpatient admission may be indicated, a range of requirements, issues and treatment options needs to be considered based on each individuals presentation and needs. They will frequently present with one or more of the following features – often in combination:

- Acute medical complications of malnutrition (e.g. syncope, seizures, cardiac failure etc)
- Severe dehydration
- Risk of re-feeding syndrome
- Electrolyte imbalance
- Physiological instability
- Cardiac abnormalities
- Hepatic or renal compromise
- Poorly controlled diabetes.

The primary goals of a medical inpatient admission are therefore:

- Sufficient correction of electrolyte imbalance
- Sufficient re-feeding to stabilise medical status and correct sequelae of acute starvation
- Refeeding at a point that the risk of refeeding syndrome is no longer present.

These medical inpatient admissions require active collaboration of the Medical team, Psychiatric liaison, the REDS outreach team and Local DHB EDS clinicians.

Adult medical admissions in local hospitals for 'uncomplicated' admissions for people requiring medical stabilisation

- Short term interventions to provide medical stabilisation without a focus on nutritional rehabilitation
- Correction of dehydration and electrolyte imbalance, not only by weight, but also by medical status
- These admissions may not need significant specialist EDS treatment as typically they are only for a few days
- Referrals may also come from local AMHS.

Adult medical admissions in local hospitals for 'complex' admissions for people requiring re-feeding

- As per regional agreement, complex medical re-feeding will continue to occur at local DHB general hospitals
- The focus of the admission is for correction of starvation and initial nutritional rehabilitation with the management of the risk of re-feeding syndrome, and this is not considered to be an admission to actively treat the anorexia
- These admissions do however require management of the anorexic 'behaviour' that does require a lot of skill from the medical treatment team and clinicians who are familiar with this type of admission. Confidence, clear protocols and an established, supportive team culture can assure a more positive outcome
- This approach does require strong Psychiatric Liaison input, as well as the involvement of experienced general nursing staff familiar with these types of presentations
- There remains the expectation that these admissions will be supported by the REDS outreach team (including the SMO) as well as the local EDS liaison clinicians.

Inpatient Services – Child and Adolescent

Under 15 years Starship Inpatient Admissions

- Follows the medical model focus on weight recovery – this is supported by evidence that there is a need for an assertive rapid response intervention for younger people due to the higher risk of rapid deterioration
- The key focus is on correction of starvation and nutritional rehabilitation
- Access to the Starship beds is via the REDS team, in conjunction with the Clinical Leads at Starship Hospital
- Usually REDS will conduct an assessment and facilitate admission as required, however in cases where a direct admission based on a referral from a GP, paediatrician, local DHB EDS Liaison coordinator or CAMHS service is received, REDS should be notified and involved as early as possible
- Such referrals and admissions are also discussed at the liaison meetings, where follow-up and care agreements as part of discharge planning are confirmed
- A transition plan must be in place at the time of admission. The referring DHB must be willing to accept the client back after admission, and provide outpatient management and follow-up
- The local DHB EDS Liaison clinician will also attend some case reviews, either in person, tele/videoconference or via REDS representation
- For referrals outside of Auckland, the patient must be medically stabilised prior to transfer, and the parents/caregivers must be willing to come to, and stay in Auckland to attend at least one weekly case management meeting, as well as be present at some meals and over weekends
- Inpatient treatment may be for a period of weeks or months, depending on the severity of illness and needs of the individual.

Child and Family Unit (CFU)

- This is also a potential service delivery area that may be considered as an option for some young people
- Indications for admission to the CFU may not necessarily have a focus on weight recovery (although this may be appropriate for some individuals)
- It should be considered as a preferred treatment setting for under 18 year olds whose eating disorder symptoms present in the context of a broader co-morbid presentation
- If the young person is under the care of a CAMHS service, but may benefit from a higher level of supervision and/or there is a need to engage closely with the family, or in need of further assessment or assistance with other aspects of their life (e.g. school engagement)
- For people being treated by REDS and have plateaued in their recovery journey, admission to CFU can assist in supporting the family system, and provides a less pressured environment for the family to be resourced.

Adult Residential Treatment Services and Day Programme

This service is currently being established and will be closely aligned with REDS and Northern and Midland region hospital inpatient facilities involved in medical stabilisation for people with severe anorexia nervosa. The service will operate as an integrated system with staff from Challenge Trust and REDS working with service users and their families/whanau on a regular basis. It will also be linked with a range of other providers of services including general practice, mental health services and hospital inpatient services.

Access to both the residential service and day programme will be managed by REDS, and will include access for those clients coming directly from the Northern and Midland regions hospital inpatient facilities or communities. This will be achieved in close collaboration with Clinical Leads from Challenge Trust, who retain clinical and operational accountability for the residential treatment service.

Residential Treatment programme

The key components of this service are currently being developed, and include:

- 24 hour residential accommodation in an age appropriate homelike setting
- 24 hour staffing with clinical staff on site when clients are in residence
- Transfer to and from Northern and Midland region hospital inpatient services
- Supported and/or supervised meals
- Evidence based treatment and relapse prevention planning by appropriately qualified staff, including group and/or individual treatment and therapy involving family/whanau where appropriate
- Close monitoring of physical and mental wellbeing of clients
- Engagement with family/whanau
- Transition planning.

Referrals will be received via REDS for people who are medically stable, have a severe eating disorder, for whom outpatient treatment is either not indicated or individuals who have not responded to outpatient care, and therefore require the expertise and interventions of the residential treatment service.

Specific factors considered before referring and admitting a client to the service include

- The complexity of the client's needs due to co-morbid physical health conditions
- The complexity of the client's needs due to co-morbid mental illness
- Clients suicide risk
- The ability to maintain the involvement of the clients family/whanau in treatment (and involvement of the client in their family/whanau), particularly when the client is an adolescent or a parent/caregiver.

The residential treatment programme will provide 9 beds (8 for the Northern region and 1 for Midland). This will be a phased approach, with 4 beds to be established initially, operating at full capacity by January 2011.

Treatment in the service will take into account the clients' Body Mass Index (BMI) and severity of eating disorder symptomology (e.g. eating disorder behaviour and cognition), as well as assessment of motivational stage of change in order to tailor treatment accordingly. Treatment must also allow for individualised care in the context of a clear programme structure. In addition to group based treatment there will also be provision of individual therapeutic support where necessary.

Treatment will be provided to accommodate starvation induced effects on cognitive functioning. In some instances, where an individual presents with poor motivation, no insight and is resistant to treatment due to a severe state of starvation, compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 may occasionally have a role in order to commence treatment in a structured setting.

The expected length of stay is approximately 6 – 10 weeks depending on the severity and complexity of the eating disorder.

The treatment services will be provided with the following aims as part of recovery:

- Weight restoration through nutritional rehabilitation
- Identification and limitation of eating disorder behaviours and establishment of regular eating patterns and normal eating behaviours
- Management of excessive exercise behaviour
- Management of medical complications of Anorexia Nervosa
- Psychological therapy to begin to address anorexic cognitions and core beliefs
- Development of skills and coping strategies
- Identification of and addressing maintaining factors contributing to the eating disorder
- Identification of and addressing co-morbid psychiatric conditions as well as predisposing traits like cognitive rigidity and emotional recognition deficits
- Motivational enhancement to increase stage of change to allow for transition to Day programme treatment.

Day Programme Services

The Day Programme Services will be provided for clients to meet a range of individual needs. The expected length of stay is 6 – 8 weeks dependent on the severity of presentation of the eating disorder and the client's progress in treatment.

Two types of day programme will be provided:

- An intensive service that caters for clients' who have more acute needs. These clients will be referred directly from the community, or could be clients who are transitioning from the residential treatment programme and are living back at home
- A less intensive service that provides continuity of service for clients who are, or maybe moving towards outpatient services as they improve towards recovery, aiming to prevent the clients requiring a higher acuity service. This service has an emphasis on strengthening the client's ability to take responsibility for the management of their eating disorder behaviour, including meal preparation and social eating during outings.

Treatment will be provided with the following aims:

- Further weight gain
- Reduction of eating disorder cognitions
- Development of skills and competencies for the client to increasingly be able to take on more responsibility to self manage eating disorder behaviours
- Enhancement of individuals motivation to advanced stages of change
- Identification and addressing of maintaining factors and co-morbidities contributing to eating disorder.

The composition of the multidisciplinary team for both the residential treatment service and day programme is currently being agreed, but the total 19.7 FTEs is likely to consist of the following mix:

- 2.8 FTE Psychologist
- 1.0 FTE Psychiatrist
- 1.0 FTE Charge Nurse
- 9.0 FTE Registered Nurses
- 1.0 FTE Occupational Therapist
- 1.0 FTE Dietician
- 3.4 FTE Support Workers
- 0.5 FTE Physiotherapist.

Further staff mix requirements will be assessed as appropriate, and will include (but not limited to) General Practitioners, Art therapist, and staff members may work across both services to provide continuity and to facilitate transition across the services.

Ashburn Clinic

- A Therapeutic Community based treatment model appropriate for individuals with a long duration of Anorexia Nervosa who tend to present with multiple co-morbidities and longstanding entrenchment of anorexia as part of their identity which leads to significant impairment of interpersonal functioning
- REDS will be involved in assessing the suitability of a client for admission to Ashburn Clinic, specifically related to an individual's level of motivation, and their ability to engage in the treatment programme, as in most cases such clients would already be involved with, or known to REDS and local DHB EDS liaison staff
- Such clients would have been assessed as not suitable for the residential service, which focuses on active engagement in weight recovery.

Packages of Care (POC)

In the initial EDS Implementation Plan, reference was made to considering flexible Packages of Care (POC) as a useful treatment option based on individuals' needs, to provide flexible, wrap around support for clients and/or their families/whanau or caregivers. There is no dedicated funding for individual POCs that have been identified as part of the EDS Continuum of Care, but should this option be considered key to an individual's treatment plan and recovery, DHBs continue to have the facility to access some flexi funding via their internal DHB mental health processes.

Appendix One Northern Regional Eating Disorders Continuum of Care

Eating Disorders Services Continuum of Care

Community					Intensive	
<p>Prevention</p> <p>Promotion</p>	<ul style="list-style-type: none"> • Primary Care • GPs 	<p>Child & Adolescent Mental health</p> <p>Community Adult Mental Health Teams</p>	<p>Shared Care</p>	<p>Specialist Eating Disorders Community Services</p>	<p>Day Programmes</p>	<p>Inpatient Services</p> <p>Residential Treatment Services</p>
<p>Community Agencies e.g. <i>Eating Disorders Community Coalition (EDCC)</i></p> <p><i>Eating Difficulties Education Network (EDEN)</i></p> <p><i>Eating Disorders Association of NZ (EDANZ)</i></p>	<ul style="list-style-type: none"> • GPs • PHOs • School Counsellors • Community & Voluntary sector • NGOs • Youth Services • Maori health providers • Public Health Nurses • Pacific health providers 	<ul style="list-style-type: none"> • C & Y MH services • Community MH services • Eating Disorder Services • Adult Mental Health Units • NGOs • AOD services 	<ul style="list-style-type: none"> • Liaison Psychiatry • Dieticians • Paediatricians • Physicians 	<ul style="list-style-type: none"> • Packages of care • Consult Liaison • EDS services 	<ul style="list-style-type: none"> • Day programme • Packages of care 	<ul style="list-style-type: none"> • Residential treatment • Paediatric medical units • Child and Youth Mental Health Units • Adult Medical Units • Adult Mental Health Units
Level 1		Level 2			Level 3	

Appendix Two: Summary of National Service Specification Framework related to EDS

This is a hierarchy of service specifications that defines the services to be delivered, and describes the key objectives related to specific service types.

The specifications related to Eating Disorder Services can be sourced from the Ministry of Health website (<http://www.nsf.health.govt.nz/apps/nsfl.nsf/pagesmh/150>) and are summarised below:

Tier	Title	Description
One	Mental Health and Addiction Services	<p>The tier one service specification provides the overarching specification for all specialist mental health and addiction services (the Service). Tier two and tier three service specifications are supplementary to this service specification and provide additional service-specific detail. Please refer to the accompanying glossary for definitions of terms used within the tier one, two and three service specifications.</p> <p>Eligible people will have timely access to high- quality, trustworthy, responsive mental health and addiction services ranging across the spectrum of promotion and prevention, through to primary, secondary and tertiary services. The specialist mental health and addiction services included in this range of specifications are publicly funded for those who are most severely affected by mental illness or addiction. However, it is recognised that a focus on early intervention strategies will mean specialist services may be delivered to people who are more at risk of developing a severe mental illness or addiction.</p>

Tier	Title	Description
Two	Eating Disorders	<p>The tier two service specification for Eating Disorders Services (the Service) is linked to tier one Mental Health and Addiction and the range of tier three Eating Disorders Services. This tier two service specification is the overarching document for the Eating Disorders Services specifications. It defines the services and their objectives in the delivery of a range of eating disorders services.</p> <ul style="list-style-type: none"> <p>• Service Definition</p> <p>The term ‘eating disorders’ encompasses a range of conditions that have overlapping psychiatric and medical symptoms. These conditions are considered to have multi-factorial aetiology with strong genetic as well as environmental factors. They present with complex psychological, psychiatric and medical symptoms that may involve acute and chronic complications that can be life-threatening and/or life-long. Eating disorder diagnoses include AN, BN & EDNOS.</p> <p>• Service Users</p> <p>The service users are those who are eligible at any age. Eating Disorders in children and young adolescents differ from older age groups because of differences in physiology, development and cognition. Early intervention along with involving and supporting families/whanau in treatment is crucial.</p> <p>• Entry and Exit Criteria</p> <p>Referral criteria and processes to access Eating Disorders services are specific to the Service provided and noted in the tier three service specifications as per below.</p> <p>• Key processes</p> <p>The following processes apply, but are not limited to: assessment, treatment, intervention and support, review, support</p> <p>• Settings</p> <p>The treatment environment may be different for children and adolescents, and wherever possible, children and adolescents should be separated from adult service users. Typically, children (under 15 years old) need to be treated in a paediatric/child and adolescent mental health service (CAMHS) environment, with specialist eating disorders liaison/consultation/support. Older adolescents (15 to 19 years old) should be treated in a child, adolescence and youth and/or eating disorders environment, and adults should be treated by the eating disorders and community mental health team. There needs to be flexibility based on developmental need rather than age.</p>

Tier	Title	Description
Three	Eating Disorders Inpatient, Intensive Treatment and Consultative Service	<ul style="list-style-type: none"> • Service Definition The Service provides specialist recovery-orientated inpatient treatment for people with eating disorders in need of close medical and psychiatric observation and/or intensive support and treatment. This will be provided in a dedicated eating disorder unit within a hospital setting with appropriately trained and experienced multi-disciplinary staff. Inpatient treatment may be for a period of weeks or months, depending on the severity of illness and needs of the service user. The aim of inpatient treatment is to reduce the physical risks associated with an eating disorder and focus on the psychological aspects of the eating disorder. The Service will be integrated with a clinical outpatient service and may include a day programme as part of a stepped down continuum of care. As a speciality service delivering to a wide geographical area, consultation will be provided to clinicians to support Service users where possible in their own communities, including provision of case discussions, team meetings, telephone contact, teleconferences, staff training and supervision. The details for this Service is outlined in the specification; <i>Consultative Service within a Specialist Eating Disorder Service.</i> • Service Objectives This inpatient service will include, but is not limited to: <ul style="list-style-type: none"> ○ designated eating disorders inpatient beds in an age- and gender-appropriate hospital setting ○ medical and psychiatric treatment, monitoring, management, support and rehabilitation ○ engagement with the service user’s family and whānau and, where appropriate, family and whānau should be involved in the service user’s treatment programme ○ integration with clinical outpatient and community mental health services, including the DHB where the patient resides ○ integrated clinical pathway and continuum of care ○ supported and/or supervised meals ○ education about coping strategies and managing physical good health, including nutrition and eating practices ○ crisis intervention and prevention of the escalation of the service user’s illness ○ risk management within which the least restrictive intervention strategies are used ○ appropriate support and consultation for referrers on the waiting list for inpatient services ○ relapse prevention and maintenance, which may include discharge to outpatient and community services ○ wherever possible, evidence-based treatment in line with international guidelines should be used ○ appropriate transition planning and links with other services.

- **General**

Individualised recovery plans encompassing treatment, risk and relapse prevention are developed with each person admitted to the service. The plan should be comprehensive, based on assessed needs and include identified goals for the period of inpatient care. Plans are developed in conjunction with the individual concerned, relevant community or outpatient services and, where appropriate, family and whānau. Accommodation and personal care services are provided at no cost to the service user, including the provision of personal care items when such items are lacking on admission.

- **Service Users**

This Service is for eligible people of any age.

- **Entry and Exit Criteria**

Referral to this Service is from a secondary mental health services generally, although it may be necessary for a primary care provider to refer a person in urgent need of tertiary care.

- **Service Components**

Processes include but are not limited to assessment; treatment, intervention and support, review, discharge, consultation and liaison.

More specifically Assessment in Eating Disorder Services require an appropriate eating disorder specialist assessment including, but not limited to:

- comprehensive physical state, including potential need for medical stabilisation and other physical health requirements
- full mental health assessment and focus on eating disorder symptomatology and co-existing disorders or issues, such as drug and alcohol use, personality disorders, risks.
- Provision will be made for specialised assessments and intervention for particular sub-groups, including service users experiencing:
 - anorexia, bulimia or EDNOS
 - co-existing problems of eating disorders and substance abuse or other disorders
 - severely compromised physical condition.

Tier	Title	Description
	Consultative Service within a Specialist Eating Disorder Service	<ul style="list-style-type: none"> <p>• Service Definition</p> <p>The Service will have specialist knowledge, expertise and experience in the management and treatment of eating disorders. The Service will operate as a hub in a hub and spoke model, and the Service provider will be up to date with eating disorder research and treatments, and link with other eating disorder services on a national and international level.</p> <p>• Service Objectives</p> <p>The Service, acting as a hub to other spoke DHBs, will provide:</p> <ul style="list-style-type: none"> ○ consultation, resources and expert advice to clinicians to allow them to support service users in their own communities ○ advice on referrals when a higher level of care/treatment is required ○ provision of case discussions, team meetings and regular telephone contact with spoke DHBs ○ training and supervision to spoke DHBs ○ specialist advice to general medical and psychiatric wards in regions where clients may have been admitted ○ advice on eating disorder treatments across the age groups. <p>• Service Users</p> <p>The Service users will be DHBs accessing advice from the Eating Disorder Service.</p> <p>• Entry and Exit Criteria</p> <p>The lead DHB Provider will negotiate with other DHB Providers the Service provided.</p> <p>• Service Components</p> <p>The processes include but are not limited to:</p> <ul style="list-style-type: none"> ○ assessment ○ treatment ○ intervention and support ○ Review ○ Discharge ○ consultation and liaison. <p>• Settings</p> <p>The Service will be community based and the provider will advise providers in Community or hospital based settings.</p>

Tier	Title	Description
	Clinical Outpatient Services for Eating Disorders	<ul style="list-style-type: none"> • Service Definition The Service provides specialised recovery-oriented clinical services for people requiring treatment for eating disorders in an outpatient or community setting. It is recommended that, to provide a continuum of care, wherever possible this Service is integrated with an inpatient or residential eating disorder service. • Service Objectives The Service will include, but will not be limited to: <ul style="list-style-type: none"> ○ specialist assessment and diagnosis ○ treatment, therapy and ongoing monitoring of symptoms and regular review of progress and treatment ○ each Service user will be assigned a care co-ordinator to ensure continuity and well co-ordinated care ○ involvement of family/whānau and significant others in the assessment and treatment process, and recognition of the pivotal role that family/whānau play ○ access to resources within the community to assist and support the Service user’s recovery ○ education to General Practitioners and other primary health care workers ○ access to cultural services in accordance with needs of Service users ○ development of individual recovery plans as outlined in tier one service specifications for mental health and addiction services ○ provision of specialist advice to other health professionals, including mental health services involved in the care of the individual/family. <p>Provision will be made for specialised assessments and intervention for particular sub-groups, including service users experiencing:</p> <ul style="list-style-type: none"> ○ anorexia, bulimia or an eating disorder not otherwise specified (EDNOS) ○ co-existing problems of eating disorders and substance abuse or other disorders ○ severely compromised physical condition. <ul style="list-style-type: none"> • General Where possible, care will be provided in conjunction with primary health services. At the least, there will be documented clear communication with any primary health providers regarding the role of the eating disorders service, the treatment plan and progress, and its completion, with consideration to health information legislation and regulations.

- **Service Users**

The Service users will include eligible people of all ages.

- **Entry and Exit Criteria**

Referrals to this Service, from primary health services, community eating disorders services, community and inpatient mental health services.

- **Service Components**

The processes include but are not limited to:

- Assessment
- Treatment
- intervention and support
- review
- discharge
- consultation and liaison.

- **Settings**

The Service is provided in community based settings.

Tier	Title	Description
	Community Service for Eating Disorders	<ul style="list-style-type: none"> • Service Definition The Service provides early identification, treatment and recovery-oriented community services for people requiring support for eating disorder issues. It is recommended this Service has clear referral pathways with a clinical outpatient, inpatient and, where available, residential eating disorders service and links with primary care. This is a community-based service for those at risk of relapse or developing more severe eating disorders, or those who are transitioning into or out of clinical eating disorders services. The Service may also provide support and resources to family and whānau, health workers and members of the community. • Service Objectives The Service may include, but will not be limited to: <ul style="list-style-type: none"> ○ counselling and support and regularly monitoring of progress and wellbeing ○ advice around the criteria and process for referral into clinical services ○ support to service users, including their family and whānau, who are on waiting lists for speciality services ○ culturally responsive services and linkages with other health services ○ attention to matters in relation to early identification and treatment, maintenance of health, relapse prevention, problem prevention and promotion of good mental health ○ information about, and access to, services within the community ○ liaison with other health professionals involved in the care of the individual/family ○ education, support and advocacy services for family and whānau ○ education, training and information to health workers, schools and others in the community about early identification and intervention, referral processes, prevention initiatives ○ act as an eating disorder resource for the members of the public. • General Where appropriate, care will be provided in conjunction with primary health services. There will be clear communication with any primary health providers regarding the support/therapeutic plan and progress. For all people under the care of other services for their eating problems, there will be clear communication regarding the role of the community eating disorders service.

- **Service Users**

The Service users will be eligible people of all ages.

- **Entry and Exit Criteria**

Referrals will be received from any source, including primary health services, clinical outpatient eating disorder services, community and inpatient mental health services and self-referral.

The Service will have clear referral processes/guidelines to support seamless transitions into clinical eating disorders services where appropriate.

- **Service Components**

The processes include but are not limited to:

- Assessment
- Treatment
- intervention and support
- Review
- Discharge
- consultation and liaison.

- **Settings**

The Service is provided in community based settings.

Tier	Title	Description
	Eating Disorders Liaison Service	<ul style="list-style-type: none"> <li data-bbox="562 276 831 300">• Service Definition The Service supports staff working to treat eating disorders in their DHB area, including staff in primary services. The Service also acts as a liaison on behalf of the local DHB Community Mental Health Team with the lead DHB specialist eating disorder provider. This Service is only for DHBs when there is no secondary specialist clinical eating disorder service (i.e. this is for ‘spoke’ DHBs in the ‘hub and spoke’ model). <li data-bbox="562 491 837 515">• Service Objectives The Service is likely to be based in the Community Mental Health Team of a DHB, and will include responsibility for eating disorders services within that DHB. The DHB liaison service will: <ul style="list-style-type: none"> <li data-bbox="562 600 1783 624">○ facilitate clear communication between the DHB and eating disorders services, and between DHBs <li data-bbox="562 635 1980 699">○ be the key DHB linkage between primary and secondary services, particularly in providing general practitioners and other primary care practitioners with advice, support and assistance with referrals and with supporting family/whānau <li data-bbox="562 710 1267 734">○ advise, guide and support staff in primary care services <li data-bbox="562 745 1944 769">○ assist with the supervision and professional development of staff involved in providing EDS services in their DHB <li data-bbox="562 780 1794 804">○ be involved in referrals and transitions of service users to and from medical and psychiatric settings <li data-bbox="562 815 1798 839">○ provide liaison/advice/input to medical and psychiatric services treating those with eating disorders <li data-bbox="562 850 1442 874">○ receive support and education from tertiary eating disorders services. <li data-bbox="562 927 775 951">• Service Users The Service users will be others within the district, both DHB and Primary Care Providers requiring advice and support with the management of Eating disorders Service users. <li data-bbox="562 1074 880 1098">• Entry and Exit Criteria This Service will be accessible to primary care and DHB workers, supporting those service users who experience anorexia, bulimia and EDNOS, and their family/whānau and carers. <li data-bbox="562 1220 862 1244">• Service Components The processes include but are not limited to consultation and liaison. <li data-bbox="562 1329 712 1353">• Settings The Service is usually community based but maybe in a hospital setting.

Tier	Title	Description
	Specialist Eating Disorders Service (with Accommodation)	<ul style="list-style-type: none"> • Service Definition The Service provides recovery-orientated accommodation and treatment for people with an eating disorder. This is a 24-hour service and will include appropriate assessment, monitoring, treatment and support for people aged 15 years and older. The Service may be used as planned respite, an alternative to acute admission or as a step down from inpatient care. It is likely that people will stay in this service for a period of weeks/months. • Service Objectives The Service will be part of, or closely aligned with, a clinical eating disorder service and hospital inpatient facilities. The Service will include: <ul style="list-style-type: none"> ○ 24-hour residential accommodation in an age-appropriate home-like setting, with 24-hour staffing with on-call clinical staff ○ transfer to and from hospital inpatient services ○ supported and/or supervised meals ○ treatment and relapse prevention planning ○ close monitoring of physical and mental wellbeing ○ engagement with family/whānau ○ transition planning. <p>The Service will provide a day programme that will include:</p> <ul style="list-style-type: none"> ○ group and/or individual based treatment and therapy involving family/whānau where appropriate ○ supported and/or supervised meals. • Service Users The Service users include eligible people of any age • Entry and Exit Criteria Access to the Service will be by referral from a clinical outpatient eating disorder service, inpatient services or, where appropriate, community mental health team or primary health services.

- **Service Components**

The processes include but are not limited to:

- Assessment
- Treatment
- intervention and support
- review
- discharge
- consultation and liaison.

- **Settings**

The Service is provided in community based settings. The treatment needs are different for adolescents and adults. Separation between adolescents and adults in both treatment and accommodation is recommended. This could occur in the same facility or in separate facilities.

