Adult Eating Disorder Whole Team Training Curriculum – December 2019

NHS England and NHS Improvement

Contents

1.0 Background

The term eating disorders typically includes anorexia nervosa, bulimia nervosa, binge eating disorder and atypical presentations. The broader term 'Feeding and Eating Disorders' (FEDs) also includes Avoidant/Restrictive Food Intake Disorder (ARFID), as well as Rumination Disorder, Pica and other related disorders not typically classified as eating disorders. For the purposes of this document, a broad definition of eating disorders is used, to include some presentations that might be considered 'atypical' (such as non-fat phobic anorexia nervosa) or some forms of ARFID. Feeding and eating disorders are major health problems with high prevalence, morbidity and mortality, recognized as having some of the highest mortality rates of any psychiatric disorder. Meta-analyses of anorexia nervosa have reported a high mortality rate, with one study estimating it as 5.1 per 100,000 (with 1.3 per 100,000 deaths due to suicide) (Espie & Eisler, 2015). In contrast with these serious and known cases the majority of those with eating disorders do not become known to services – the exact figure is not known but it is estimated that eating disorders have a prevalence of approximately 6% (Galmiche, Dechelotte, Lambert, & Tavolacci, 2019; Ward, Rodriguez, Wright, Austin, & Long, 2019). Although the peak age of onset in the teens and early twenties, eating disorders occur across the lifespan. Indeed, the commonest eating disorder, Binge Eating Disorder, is most commonly found in middle age and is at least as common in men as women. People with eating disorders often have other mental health problems (for example anxiety and depression), which also need to be treated in order to get the best outcomes.

Offering evidence-based, high quality care and support as soon as possible can improve recovery rates, leads to fewer relapses and reduces the need for inpatient admissions. While there is no clear difference in weight gain or acceptability of treatment between community, day patient or inpatient settings for anorexia nervosa, bulimia nervosa, and binge eating disorder outpatient treatment is likely to be more cost effective, and treatment completion rates higher.

Eating Disorder Services for adults aged 18 or above which offer specialist, intensive expert help to people at a relatively early stage of their disorder are likely to be both effective and cost-effective in (a) providing early treatment, (b) reducing the need for long-term hospitalisation and (c) providing the combination of treatment components (e.g. physical health management, psychiatric management, therapeutic input, nursing input, dietician input, etc), and d) support improved awareness and early identification in the community e.g. GPs. There is a critical window for intervention because recovery is less likely if the disorder has remained untreated or inadequately treated for more than 3-5 years (Van Holle et al, 2008). This document provides a standardised national curriculum for all teams delivering care for adults with eating disorders within dedicated Adult Eating Disorder services. Although the whole team training is aimed at the needs of specialist community

practitioners, those working across the patient pathway, including referring and inpatient services, should be able to access the training. It supports the service transformation initiative for improving the delivery of dedicated community eating disorder services for adults and their families/carers/partners (hereafter termed supporters) as set out in 'Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care Guidance for commissioners and providers'.

1.1. Core Principles for Adult Eating Disorders services

The curriculum is based on the principles underpinning 'Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care Guidance for Commissioners and providers'. The principles aim to create a culture of full collaborative involvement of service users and supporters across staff and services.

Key principles are:

a. **Full partnership and collaboration with people with eating disorders in all aspects of care and service delivery.**
   Service user/patient participation is expected not only in the design of individual treatment packages but also in service design and delivery of care as well as the recruitment, training and appraisal of staff.

b. **Support and empower supporters and the person's support network.**
   Ensures that they are able to access and receive support to help their loved ones with an eating disorder whether or not the person is in treatment; and understand that the needs of partners and friends may be different from the needs of parents. Participation is expected in service design and delivery of care as well as the recruitment, training and appraisal of staff.

c. **Improve access to evidence based treatment and services**
   Supports the training of staff in standardised curricula of NICE approved and best evidenced therapies for the treatment of eating disorders and coexisting presentations. Whole team training, together with trainings in specific psychological interventions, supports the incorporation and dissemination of evidence-based practice into everyday care. The national training program will also deliver appropriate clinical supervision training to support effective supervision within teams and ensure professionals remain competent to deliver evidence-based treatment. The benefits of whole team training in this regard would be to encourage inter-professional learning and promote team cohesion.

d. **Regular use of outcome and feedback measurement**
   Guides treatment and service delivery. Collaboratively uses routine progress and outcome measurement to support a person to identify and meet their goals for recovery

e. **Improve access through to services**
    i. increases awareness, reducing stigma, early identification and early intervention
    ii. broadens access to all FED diagnoses including BN, BED, OSFED and ARFID
    iii. accepts all presentations from those who present for the first time to those who have recurrent treatment needs, regardless of weight/BMI (body mass index) or physical and psychiatric comorbidities
    iv. have the skills to provide care across the lifespan, from younger people to older adults

f. **Care must be coordinated** with other services to reduce and prevent gaps in care during service transitions (age-related, geographical or community to inpatient transitions); using clear protocols and joint working agreements

g. **Offer intensive community treatment,** or be able to support day patient treatment, to reduce unnecessary or inappropriate inpatient admissions

The structure of the training, supervision, follow-through support, assessment, and the evaluation of fidelity will be determined by training providers. It is anticipated that training will commence across the country during 2020-21.

Enhancing eating disorder awareness and decreasing stigmatisation are considered key strategies for achieving improved access. All these factors are fully integrated into this document. More needs to be done to promote good experiences of care, which requires a full team approach and full involvement of people with eating disorders and their supporters. Inclusiveness and enhancing the engagement of people with eating disorders and their supporters is expected to create a spirit of collaborative care between those receiving care and the practitioner thus providing formal care and support. At the core of this initiative is empowering people with eating disorders and their supporters to take an active role in decisions about their care, to engage in shared clinical decision-making, to establish treatment goals appropriate to them, to choose the route to health that is best for them, and through this active engagement to strengthen their agency and trust). Participating in service design, understanding and modifying treatment progress via patient rated outcome measures (PROMs), and participating in the training of practitioners and managers, all serve to enhance a sense of agency. It is recommended that commissioners are also invited to attend and contribute to team development and training.

1.2 Introduction

This document outlines the curriculum for Adult Eating Disorder Team training and should be read in combination with the document 'Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care Guidance for commissioners and providers'. Training is

expected to be **delivered to all members of the team to support the team dynamic and cohesion**. The composition of an eating disorders team set out in the guidance is outlined below but it is acknowledged that this will vary as services vary in their capacity and scope.

In delivering care each Adult Eating Disorders team should be able to demonstrate how it meets each of the values and principles that are embedded in the commissioning guidance, NICE guidance and NICE quality standards. Compliance against these standards can be assessed through membership of the Quality Network for Eating Disorders Services (known as QED).

It is appreciated that not all members of multidisciplinary teams will each acquire all the individual skills described in this document; however, they must as a team share the knowledge and skills required to collaboratively provide a service which:

- Involves people and their supporters in developing referral pathways, and every aspect of service provision, service development, training, and the working of the team itself.
- Has sufficient understanding of the concepts and skills of assessment and treatment of eating disorders to contribute to an integrated multidisciplinary eating disorders team capable of delivering effective evidence-based interventions.
- Engages people with eating disorders and their supporters using principles and practice of shared decision making increasing their autonomy and trust.
- Understands the role of quality monitoring and development in service design and delivery and be familiar with local protocols and procedures to participate in these activities.
- Recognises the need to offer evidence-based treatments.
- Regularly uses outcome and feedback measurement to guide treatment and support shared decision making.

1.3 Composition of the team

Composition of adult eating disorders teams will vary and is likely to evolve over time in response to specific (local) needs and identified gaps in skills and competencies of the team. In general teams it will be multidisciplinary, combining both medical and non-medical staff that will include expert clinicians able to ensure safe management of the medical risks associated with eating disorders as well as the delivery of evidence-based eating disorder focused psychological treatments and their supervision. In order to achieve the appropriate level of specialist knowledge and skills within the team from medical and non-medical staff,

teams will generally include professionals with the following competencies or backgrounds (this list is not exhaustive):

- Psychiatry
- Clinical Psychology
- Family Therapy
- Psychological Therapists (e.g. CBT therapists)
- Dietetics
- Nursing
- Social work
- Counselling psychology
- Occupational Therapy
- Other professionals with medical/nursing expertise
- Peer support / Experts by experience contributing to the work of the team – representing a range of eating disorders and diversity (people with current/past ED and supporters)
- Other mental health practitioners contributing to the work of the team (e.g. clinical support workers, primary mental health worker, assistant psychologist)
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In addition to the clinical tasks, teams will have to cover a range of administrative and management roles including:

- Operational and service management
- Coordination of training needs
- Coordination at team level of regular data collection
- Coordination of clinical governance and quality

Teams will need to develop robust structures to ensure regular collaboration with people and their support networks.

The ideal staffing mix for a comprehensive adult eating disorder team is covered in more detail within the published document: Adult eating Disorders: Community, Inpatient and Intensive Day Patient Care: Guidance for commissioner and providers.

1.4 Resources and other guidelines

- Access and Waiting Time Standard for Children and Young People with an Eating Disorder: Commissioning Guide
- Care Act 2014
- Carers and Personalisation: Improving Outcomes
- Eating Disorders in the UK: Service Distribution, Service Development and Training (CR170)
- Equality Act 2010

• Guidance for Reporting Against Access and Waiting Time Standards: Children and Young People with an Eating Disorders, Early Intervention in Psychosis
• Guidance to Support the Introduction of Access and Waiting Time Standards for Mental Health Services in 2015/16
• Health and Social Care Act 2012
• Ignoring the Alarms: How NHS eating Disorder Services are Failing Patients – report from the Parliamentary and Health Service Ombudsman
• Managing Transitions When the Patient has an Eating Disorder (CR208)
• MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa (2nd edition)
• Mental Capacity Act 2005
• Mental Capacity Act 2005: Code of Practice
• Mental Health Act 1983
• NICE guideline [NG69] Eating disorders: recognition and treatment May 2017
• Mental Health Act 2007
• NICE guideline [NG69] Eating disorders: recognition and treatment May 2017
• NICE Quality standard [QS175] Eating disorders
• Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

2.0 Key learning outcomes for Adult Eating Disorders teams

2.1 Team learning outcomes

By the end of this training, members of the team should jointly have knowledge and skills in the following areas in order to enable the smooth, safe and effective functioning of a dedicated adult eating disorders team. As noted, it is expected that the team as a whole should be able to fulfil the following functions. However, individuals should have the skills to fulfil their role in the team, which may include autonomous delivery of care with little involvement of other team members. If this is the case, individuals should know the limits of their own expertise and their threshold for consulting a fellow team member.

- To integrate pathways of care, to co-ordinate, create and use effective shared care plans with other service providers, including voluntary sector services and GP practices.
- To plan and manage transitions between services, to include transition to and from in-patient care where this is needed with appropriate attention to continuity and consistency of care, and to receive patients transitioning from Children and Young People's eating disorders services in a planned and appropriate way
- To provide:

- Responsive and timely assessment
- Intervention early in the course of the disorder
- Assessment of the capability and capacity of the family/caring unit around the person with an eating disorder and the potential support they could provide to the recovery process
- Support (including psycho-education) for the person and their supporters, helping them to prepare for and understand their role in treatment
- Motivational support for those in need of treatment who are not yet willing to engage in treatment, and guidance for their supporters in how to guide their loved one into care
- Risk monitoring throughout the care pathway
- Assessment of the need for compulsory admission and treatment
- Evidence based treatments for eating disorders
- Recognition and management of physical and psychiatric comorbidities
- Accessible educational and support services for people and their families throughout their contact with the service.

To implement a quality assurance framework and understand quality standards to support access to high quality care.

- To recognise possible barriers to accessing treatment or the health care system for the person with an eating disorder and their supporter(s).
- To support people with eating disorders and their supporters in overcoming barriers to implementing treatment (including reluctance to engage in treatment).
- To develop practices that integrate diverse perspectives of team members with those of people with eating disorders and their supporters to inform treatment programmes, psycho-education and service development initiatives, training, and other activities.
- For the team to generate new ideas and problem solve difficulties encountered in delivering clinical services.
- To implement use of robust supervision structures to inform the treatment practices of individual team members on a regular basis and as a part of developing a coherent treatment philosophy across the team.
- To understand and manage dynamics within a team which may influence the functioning of the team in delivering effective treatment.
- To recognise how a team and individuals in a team may be affected by clinical

presentations, for example high risk patients.

- To use routine clinical measurement as a team (as well as individual clinicians) to guide and reflect on case management and monitor team treatment outcomes.
- To monitor and access team training requirements to develop team and individual training plans
    - Programme training and skills updates
    - Post-training support
- To develop a team culture that enables challenge and confidence of team members to raise concerns/whistle-blow.
- To develop a team culture of ongoing audit, outcome monitoring and self-evaluation to inform service development
- To develop a culture of ongoing learning to ensure service developments are informed by the latest scientific evidence

3.0 Knowledge required within the team

The entire team is required to have a critical understanding of the nature, phenomenology, epidemiology and diagnostic classification of eating disorders in people informed by research and applied within the context of their scope of practice. This must include the relevance of co-occurring conditions (mental and physical), and groups that are especially at risk or face particular issues, (e.g. males, individuals with learning disabilities) and those who may have experienced physical, sexual or emotional abuse. It is important that the team understands how to deliver person-centred or led care and consider personality, culture, physiology of starvation, management of malnutrition and the impact of eating disorders on the family members and friends, the process of adaptation / accommodation in the context of living with an eating disorders and the potential role of they have in the process of recovery. It is important that team members are aware of one another's areas of particular expertise and learn from each other.

3.1 Nature of the eating disorder

- Definition and core symptoms of eating disorders
    - Classification - DSM-5/ICD-10 or 11 Feeding and Eating Disorders
    - Common presenting features
    - Common complications.

- General understanding of co-occurring disorders (and knowledge of NICE concordant approaches of their treatment) which would include, but not be limited to:
    - Psychiatric comorbidities:
        - Mood disorder
        - Anxiety disorder
        - Obsessive compulsive disorder
        - Personality factors/disorder
        - ADHD
        - ASD
        - Self-harm
        - Psychosis
        - PTSD
        - Substance misuse
    - Physical conditions e.g.:
        - pregnancy,
        - diabetes,
        - bone health,
        - dental health)
        - metabolic disorders
        - endocrine disorders
- Course of disorder
- Epidemiology of disorder.

3.2 Biological and psychological models of eating disorders (aetiological, risk and maintaining factors of eating disorder)

- Biological factors including
    - Genetic contributions to eating disorders and other neurobiological factors
    - Key findings of brain imaging studies
    - Food and appetite regulation

- Psychological factors including
    - Cognitive style/strengths and weaknesses
    - Temperament and personality traits
    - Developmental issues
    - Gender

- Family, social and cultural factors including
    - Awareness of relevant family and peer influences on food, weight and eating behaviours, and the potential impact of cultural/religious practices
    - Impact of media, the thin ideal, weight stigma and obesity trends on eating disorder risk
    - Awareness of the role of social adversity including maltreatment, bullying, trauma, any physical, sexual or emotional abuse, neglect.

- Knowledge of a range of theories for how these risks interact to result in or moderate the presentation of eating disorders

3.3 Physical effects of eating disorders

Individual team members all need to have a sound basic knowledge of nutrition in terms of nutritional needs and implications of nutritional inadequacies.

- Nutritional principles and effects of starvation
    - Knowledge of the physiological effects of malnutrition and other eating disorder symptoms such as bingeing and purging, and over exercising
    - Awareness of the physical and medical risks of the full range of eating disorder symptoms e.g. constipation, bloating, and how these are affected when intake is increased.
    - Knowledge of nutrition principles sufficient to be able to contribute to the nutritional management of a person with an eating disorder and support the implementation of a programme designed by a dietitian.

3.4 Patients and their supporters' experience and expertise

- Team members have knowledge of:
    - The varying points of view and experiences of patients and their supporters/carers in relation to eating disorders
    - How the eating disorder may impact on individual supporters and the family/social group as a whole
    - How the family and social context can affect the course of the eating disorder
    - Working with the supporters to support the course of treatment
    - A range of accessible, appropriate materials supporting treatment
    - Reading and self-help material - web-based, guided self-help, self-help books for patients, carers/supporters and families; leaflets that are gender and language appropriate.
    - Knowledge about the impact of social media

- Peer-to-peer support and its therapeutic use.

3.5 Treatment options

- Models of intervention and their evidence base - all staff need to be familiar with a range of evidence-based interventions for the treatment of eating disorders, co-morbid disorders and co-existing problems appropriate to varying levels of clinical need.
- Specific members of the team will have more detailed knowledge and higher level of competence in the delivery of the specific NICE concordant and other relevant treatment approaches and be able to provide supervision, support and consultation to less experienced members.
- The team as a whole would be expected to have the capacity to provide the following interventions in an evidence-based way, and all team members should be familiar with:
    - BN focused Guided self-help
    - BED focused Guided self-help
    - Group eating-disorder-focused cognitive behavioural therapy for binge eating disorder
    - Individual eating-disorder-focused cognitive behavioural therapy (CBT-ED)
    - Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)
    - Specialist Supportive Clinical Management (SSCM)
    - Parent/carer interventions
    - Physical interventions
    - Nutritional interventions including nutritional supplementation
    - Indications for psychopharmacology
    - Interventions for comorbid diabetes and ED
    - Interventions for ED in pregnant women

- In addition, the team as a whole would be expected to have knowledge of the following treatments and may be familiar with and have the specific competence to deliver some of these in an evidence-based way:
    - Eating-Disorder-Focused Focal Psychodynamic Therapy (FPT).
    - NICE concordant treatments for comorbidities or co-occurring conditions e.g. depression, OCD, anxiety disorders, self-harm and other presentations
    - Other psychological interventions (e.g. psychoeducation, meal time interventions/meal time support living skills, sensory interventions)

    - Understand general principles of working and engaging with adults and their partners/families and carers
    - Understand how to assess motivation and readiness to change
    - Understand the principles of recovery-based approaches

- Indicators for specific treatment approaches
    - Knowledge to recognise when specific treatments are indicated or not indicated
    - Importance of individual and supporter preference

- Knowledge of contexts and interfaces of treatment
    - Transition protocols between services including reasons for sharing care plans
    - When to use other clinical services such as hospital admission – both medical and psychiatric
    - Requirements of effective discharge planning
    - Indicators for in-patient (acute medical, general adult mental health or specialist eating disorders unit), out-patient, day patient, other treatment context
    - When to seek independent advice.

- Knowledge of relevant mental health legislation
    - Requirements for establishing consent status and capacity
    - Decision making and communication
    - Use of legislation
    - Compulsory treatment

- Knowledge of relapse prevention
    - Pre-lapse, lapse and relapse indicators
    - Principles of recovery

4.0 Skills of the team

Members of the team will demonstrate generic competency and specialist competency in areas relevant to their team role. The team will maximise the skills and knowledge of individual team members and identify practices required for the delivery of a well-functioning and coherent eating disorders team and service, harnessing the multi-disciplinary expertise.

The whole team will work together using a needs led person-centred model when offering treatment to the young person and their family or carers.

We would encourage baseline diagnostic assessments, where each member of the team completes their assessment in a systematic way using an assessment protocol developed by the multidisciplinary team, including completion of baseline measures. The multidisciplinary team contribute to diagnostic formulation and risk assessment for more all patients or only more complex patients as needs/skill/capacity allow and as agreed by the team. Team members then use a shared decision-making approach to agree a care plan with the person with an eating disorders and their supporters as appropriate.

4.1 Engagement and role of person with an eating disorder and their supporters from first contact

- Ability to engage people with eating disorders in thinking about the pros and cons of involving supporters such as family, partners, friends or their wider support network in their care; who might be best placed to support them; and what level of involvement would be appropriate.
- Ability to explain the nature of the disorder to people with eating disorders and their supporters
    - Positively engage with people with an eating disorder and their supporters as appropriate from first contact and during assessment
    - Express confidence in talking with people and their supporters
    - Express in a sensitive manner awareness of impact and effect of eating disorder on all family members including siblings
    - Discuss the physical and psychological effects of starvation, laxative & substance abuse, excessive exercise
    - Discuss understanding of development and formulation of eating disorder
    - Identify clear actions/collaborative involvement of people and their supporters in care planning as agreed
- Ability to explain treatment plan to people and their supporting family members
    - Promote open and collaborative conversations with people and families
    - Explain different treatment options and their aims
    - Discuss common elements of different treatments
    - Promote people making their own choices about treatment, whenever possible and safe to do so
    - Negotiate roles of supporters in treatment
    - Signposting to an alternative service/further support for families/carers/partners, including to support needs of children of people

with eating disorders

- Ability to engage the person, and family or carer in treatment and maintain their motivation
    - Ability to elicit and explore sensitive information, including the mental well-being of the patient, their family, partner or carer, without inducing shame or undermining the treatment alliance
    - Ability to maintain a non-judgmental attitude to patients, families and carers
    - Creating a safe base for treatment engagement
    - Skills related to engaging people who may express ambivalence about the need for treatment and reluctance to change
    - Skills related to developing and enhancing motivation and hope
    - Ability to maintain a supportive and open stance towards people with eating disorders who choose not to or are currently unable to fully engage in a planned programme of care, including providing appropriate advice and signposting to other parts of the pathway

4.2 Team consultation and referral management skills

- Ability to manage team interactions and dynamics
    - Use of strategies to support team interactions
    - Recognise and address team conflict

- Ability to screen and prioritise referrals
    - Direct and sign-post referrals to appropriate assessment and treatment within the CED
    - Direct and sign-post referrals to appropriate assessment and treatment in other services relevant to need
- Engagement with local services supporting mental health and emotional well-being in people (e.g. schools, universities, voluntary sector services, GPO practices)
- Enabling referral pathways, supporting returning students after treatment
- Contributing to training and consultation needs of people working in these sectors

4.3 Assessment of eating disorders including medical assessment

The team have the ability to:

- Use multidisciplinary skills and knowledge to understand and diagnose the eating disorder and to develop an individualised formulation and treatment plan
- Assess capacity and consent status and to address these as potential barriers to treatment.
- Ability to recognize the need to assess the cognitive ability of the person.
- Assess relative contributions of specific eating disorder features to the treatment plan and risk profile e.g. self-induced vomiting, excessive exercise, severe body image disturbance
- Assess indicators for the suitability and safety of community-based treatment for a person and their supporter(s)
- Recognise when additional, more intensive care (medical admission, day care, psychiatric admission) may be required
- Recognise when additional physical assessment is required and consider appropriate screening
- Communicate about the long-term consequences of eating disorders
- Recognise/diagnose co-occurring disorders and identify appropriate interventions
- Communicate to the person and their family/carer/partner an individualised formulation that takes into account individual, family and broader contextual factors
- Explain the principles of the different available treatments to people and their supporters (where appropriate) including the evidence base and potential strengths and limitations of each approach
- Adapt communication and clinical interventions for people and family members with, for example, learning disability, autism spectrum disorders, and other disorders
- Adapt assessment for people undergoing or who have undergone bariatric surgery, and understand the impact of surgery on eating behaviour
- Work with psychological and family factors supporting and detracting from engagement in assessment and later treatment
- Collaboratively develop and organise goal setting with the person and supporters as appropriate
- Agree with the person and their supporters the best way their supporters can provide support to improve the person's eating behaviours
- Provide support to improve the person's eating behaviours
- Explore motivation to change and negotiate safe ways of managing eating disorder

behaviours and ensure that early changes provide stepping stones for further change and re-evaluation of treatment targets to balance the need for patient autonomy with managing risks safely

4.4 Tailoring assessment, treatment and management according to patients' developmental needs and illness stage

Team members have the ability to assess the needs of, and the skills to treat and care for, patients at different illness stages and life stages.
They are able to adapt their communication with and approach to the patient and their supporters during assessment and treatment according to the patient's illness and developmental/life stage and also to adapt treatment goals accordingly.
In relation to life stages:

- The team are familiar with the concept of emerging adulthood and able to tailor their approach to the patient's ED to the developmental needs of this phase (i.e. balance the wish for independence and need to involve supporters) and the practical issues that arise from multiple transitions and uncertainties during this life phase.
- The team are able to tailor their approach to the needs of patients with EDs who are pregnant and those who have children and to think about and address the needs of the whole family.
- The team are able to tailor their approach to older patients with eating disorders who may be peri- or postmenopausal and help them address the challenges, losses and opportunities of older adulthood and the interplay of this with the ED.

In relation to illness stages:

- The team are able to tailor their approach to patients at both ends of the spectrum, i.e. those presenting for the first time with a recent onset ED and those with long-standing EDs and multiple treatments.
- The team are familiar with evidence-based models for early intervention, such as FREED, and offer a dedicated early intervention pathway where possible
- The team are able to adapt their approach to effectively assess, engage and work with patients presenting with a first episode illness and to tailor psychoeducation and treatment goals accordingly, i.e. emphasis on the malleability/reversibility of changes to brain, body and behaviour early on and using this to support full recovery.
- The team are able to provide support, care and treatment for patients who are unresponsive to patients who are unresponsive to multiple courses of evidence-based treatment and to collaboratively (with patient and supporters) adapt

treatment goals where appropriate, e.g. towards achieving greater medical stability and improved quality of life.

4.4 Risk assessment

The team have the ability to:

- Use a holistic risk assessment within an agreed framework to develop a risk management plan. This should include physical, psychological and social risks, and also immediate, medium and long term risks.
- Identify physical health risks for people with an eating disorder
- Assess and manage risk associated with weight loss and / or bulimic behaviours and monitor the speed of weight loss as well as current BMI
- Assess and manage psychiatric risks such as neglect, self-harm and suicidal intent/acts
- Recognise the interaction between psychological states and physical risk
- Recognise and identify appropriate actions following risk assessment
- Involve the family or carer in risk management
- Involve GP/ acute hospital in risk management
- Provide advice and support to colleagues in other parts of the health system in situations where the person with an ED is choosing or unable to currently engage in formal care

4.5 Assessment of physical health needs

The team has the ability to:

- Consider, and with appropriate consultation exclude, an organic illness that may underlie weight loss or other symptoms
- Define and specify physical health needs and use the initial assessment to advise on further monitoring of physical health needs
- Assess physical health status including assessment of vitamin and mineral deficiencies and offer supplementation as appropriate
- Correctly interpret serial weight and growth measurements
- Assess nutritional needs
- Assess risk of refeeding syndrome
- Recognise acute physical signs (dizziness, fainting, dry lips, feeling cold etc.) including assessment of core eating disorder symptoms (physical and mental)

- Recognise when substances (particularly, but not only, laxatives) are being used for purposes of weight control
- Recognise symptoms of co-occurring substance and alcohol abuse
- Monitor weight/BP/(erect and supine)/pulse/core temperature; blood tests including full blood count, urea and electrolytes, liver function, calcium, phosphate, magnesium, bicarbonate, plasma glucose, CRP)
- Communicate about the longer-term physical consequences (cardiac health, menstrual disturbances, bone health) of eating disorders
- Elicit indicators of change in physical risk
- Recognise when measures need to be age, gender and ethnicity appropriate
- Management of emergencies, using MARSIPAN guidance including knowing when to admit to a medical inpatient or day patient service for medical stabilisation and to initiate refeeding for those whose physical health is severely compromised,

4.6 Skills required to deliver effective treatment

This requires a breadth of specialist expertise and team competence in a range of treatments that takes into account the individual and supporter's choice where appropriate to achieve good outcomes. Teams will use evidence-based interventions for treatment of eating disorders and co-existing mental health problems whenever possible.

The team have the ability to:

- Use focused eating disorder interventions from relevant treatment manuals and flexibly match them to the specific needs of the individual and the family
- Engage the individual and their supporters in the treatment process that is appropriate to their cognitive level and background
- Understand, recognise and negotiate the different levels of motivation to change in the individual and their families
- Develop a working formulation of the whole case, including its relational and contextual aspects
- Create decision making contexts in which individual 's views can be balanced alongside those of their supporters and health care professionals, as appropriate to their developmental stage, level of risk and capacity
- Maintain a focus on involving supporters throughout treatment where appropriate, identify resilience factors of all participants as well as potential constraints throughout treatment

- Offer supporters training in skills that support eating disorder intervention – including supporters whose loved one has not themselves presented for treatment
- Take into account the nature of family relationships and how these can enhance and/or constrain treatment
- Manage safely the level of physical risk and severity of malnutrition
- Consider and address co-morbidities and co-occurring conditions or other complex presentations in collaboration with other services if required
- Deliver nutritional management of malnutrition and disordered eating
    - consider meal planning
    - energy intake and requirements
    - risk of refeeding syndrome
- Manage the transition between different phases of treatment from an early focus on managing eating behaviours and other eating disorder symptoms to addressing broader underlying issues commonly related to functions of the eating disorder, emotional coping, social relationships, identity and self-esteem
- Manage issues around transitions and transition planning
- Discuss and manage collaboratively with the individual and their supporters as appropriate, the process of ending treatment in a timely manner and in a way that meets the need of the individual and their family members

4.7 Routine and accurate monitoring and clinical use of progress and outcomes in collaboration with individuals and families or carers

The team have the ability to:

- Collaboratively agree with the individual and the family or carers the measures to use to guide treatment, and end of treatment outcomes within an agreed outcomes framework
- Use treatment progress and outcome monitoring in a way that aligns with the requirements of the mental health services dataset
- Implement progress and outcome monitoring for a range of outcomes, for example
    - Core physical health monitoring
    - Eating disorder symptom monitoring such as weight gain and other core symptoms of eating disorders
    - Co-occurring symptom monitoring
    - Family, social and relational functioning outcomes

- Create a trusting relationship as part of effective outcome monitoring (e.g. regular weighing)
- Collaboratively develop person-centred outcomes with the individual and their supporters as appropriate
- Implement measures relevant to treatment progress to inform treatment process and to monitor progress.

4.8 Multidisciplinary management of care

- Care co-ordination as part of multidisciplinary the Adult Eating Disorders service.

  All members of the multidisciplinary team who provide care coordination will develop sufficient skills in eating disorders and focused interventions to allow them to work with people and their supporters and have the ability to:

  - Act as care co-ordinator including risk assessment for people and their supporters including organising medical reviews
  - Link and act as point of contact for people and supporters, the agencies and other members of multidisciplinary team
  - Co-ordinate overall clinical care and additional treatments when required for the treatment of comorbidities with eating disorders
  - Pro-actively co-ordinate transfer from the Children and Young People's eating disorder service if required
  - Present and discuss the case and the case formulation to the multidisciplinary team in the team meetings, team supervision and individual supervision.
  - Take the feedback from team and individual supervision to the person and supporters and discuss changes in the care plan as a result of the decisions/feedback from the multidisciplinary team meetings and supervision
  - Oversee transition from and into hospital
  - Act as a point of contact for patients on Community Treatment Orders

- Care planning and intervention framework

  The team have the ability to:

  - Develop and co-ordinate multiagency care plans
  - Review care and intervention plans
  - Use the legal framework for consent and confidentiality
  - Implement a Care Programme Approach (CPA) framework and manage lack of engagement/motivation in relation to it

- Communicate complex information to people and their families/carers/partners in an accessible and acceptable way for them
- Implement the specific roles of the multi-disciplinary team

- Non-(ED) specific management issues

  The team have the ability to:
  - Manage safeguarding considerations (including capacity and social care issues)
  - Deliver care with awareness of relevant cultural/religious practices relating to food and eating
  - Understand the issues around stigma for people with mental health needs including but not specific to eating disorders
  - Understand the issues around admission of an eating disorder on an acute medical ward
  - Be sensitive to issues relating to sexual orientation/ identity

4.9 Consultation and training

The team have the ability to:

- Deliver training and eating disorder awareness to other professionals and providers working in health care, education, voluntary and other sectors/organisations (e.g. sports, justice system)
- Communicate and advise on eating disorder treatment, management and support strategies in different health care and other settings
- Deliver training and eating disorder awareness to the wider public, people with eating disorders, carers and close others.
- Support prevention and early intervention programmes in schools, colleges, Universities and other settings
- Improve community awareness, reducing eating disorder and weight-related stigma and addressing any stigmatising attitudes and misconceptions of staff from other teams, services and sectors, and the general public
- Provide effective evidence-based materials to increase accurate understanding of eating disorders
- Provide staff training in knowledge and skills outlined above

4.10 Transitions and discharge from care

The team have the ability to:

- Understand and appropriately respond to anxieties and concerns associated with discharge from the eating disorders service
- Use effective and timely pathways to discharge
- Identify indicators for discharge
- Complete and communicate joint plans about discharge, including relapse prevention plans
- Collaboratively support transition of care between different service levels (e.g. specialist inpatient, day patient and outpatient) and different services (e.g. from eating disorder service to CMHT or primary care)
- View day or inpatient care as part of an integrated treatment programme with Children and Young People's eating disorders services, ensuring continuity of psychological interventions where appropriate
- Maintain an integrated care pathway with the day patient or inpatient team by advising on care and management, both during the admission and when planning discharge or transition
- Keep the person's supporters involved throughout levels of care as agreed
- Be aware of and able to cater to the specific transition care needs of young people who are referred to Adult Eating Disorders teams from Children and Young People's eating disorders services, given different team cultures and treatment approaches.
- Be aware of and cater to the specific transition care needs of university students with eating disorders, to facilitate timely treatment, care, both at home and at university.

4.11 To support effective participation of people and their supporters in eating disorder service provision treatment and training

The team have the ability to:

- Collaboratively involve people with lived experience of eating disorders and supporters at all levels of service and treatment development
- Directly involve people with lived experience of eating disorders and supporters in training eating disorders and other staff in relation to their expertise and perspectives
- Address the experiences of, and tackle and reduce effects of eating and weight-related stigma and other areas of stigmatisation and discrimination
- Support people with eating disorders and supporters in their role as experts by experience (e.g. to provide information about the service and about the experience of managing and recovering from eating disorders)

4.12 Individual development outcomes for team practitioner

Individuals in the team:

- Have the ability to work jointly with other professionals to utilise all available expertise in assessment and treatment
- Have the capacity for self-direction in engaging with and creatively responding to basic therapeutic problems
- Have the ability to recognise, assess and manage risk
- Have the capacity to effectively use supervision and know the limit of their own skills and competencies and when to seek advice.
- Are self-reflective in relation to their own personal and professional responses to the issues around eating disorders and related issues such as depression, self-harm, or violence
- Practice with an empirical orientation and continue to advance personal knowledge and acquire the skills to be able to make such knowledge available to the team to improve its understanding of eating disorders and their treatment in people

4.13 Supervisory processes and role of supervision

Individuals in the team have the ability to:

- Access expert supervision
    - Members of the team with advanced training will provide regular supervision for the team and where appropriate will co-work cases with more complex presentations.
        - Ability to provide model specific expert supervision
- Use regular progress, outcome and feedback measurement in supervision including peer group supervision
- Receive post-training support and supervision
- Develop and agree on personal and team skills development plans
- Manage caseloads and specific problems in treatment

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