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Managing Severe Eating Disorders in the Community under a CTO or 'virtual CTO'

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Learning Outcomes

- Through the discussion on case management of people with eating disorders in the community under a virtual or actual CTO, the participants will have the opportunity to:
- Improve knowledge of compulsory treatment of people with anorexia nervosa in the community
- Identify the role of case management can play in assisting people with ED
- Recognise the challenges and identify possible strategies to assist trouble shooting

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Case Scenario

- Client 15+ years h/o severe and enduring anorexia nervosa
- 3 previous near death experiences
- Had recently lost 6 kg in 4 weeks post a 1 month admission
- BMI 7.7
- BMI range is 18.5 to 24.9

- Was admitted voluntarily to Missenden Hospital- Professor Marie Bashir Unit, then made involuntary under MHA.
- Discharge BMI: 13.6

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Compulsory Inpatient Treatment

1. A person has a mental illness if they have a seriously impairs the functioning of the person (temp/ perm) and has one of the following:

- Delusions: fixed idea that s/he is grossly overweight
- Serious disorders of thought form: includes concrete or illogical thinking
- Severe disturbance of mood: subsequent to severe malnourishment/ depression/ anxiety

Or

- if the person is behaving in a sustained or repeatedly irrational way which indicates the presence of these symptoms including refusing to eat, sabotaging treatment or exercising obsessively
- (Anina Johnson – Dep Pres MHRT, Malcom Schyvens – Dep Pres NCAT, Danielle Maloney- Dep Dir CEDD)

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Compulsory Inpatient Treatment

2 The person is at risk of serious harm

3 There is no other form of safe and effective care and voluntary care or a guardianship order is not adequate

On Discharge

- Decision made to treat under a Virtual CTO

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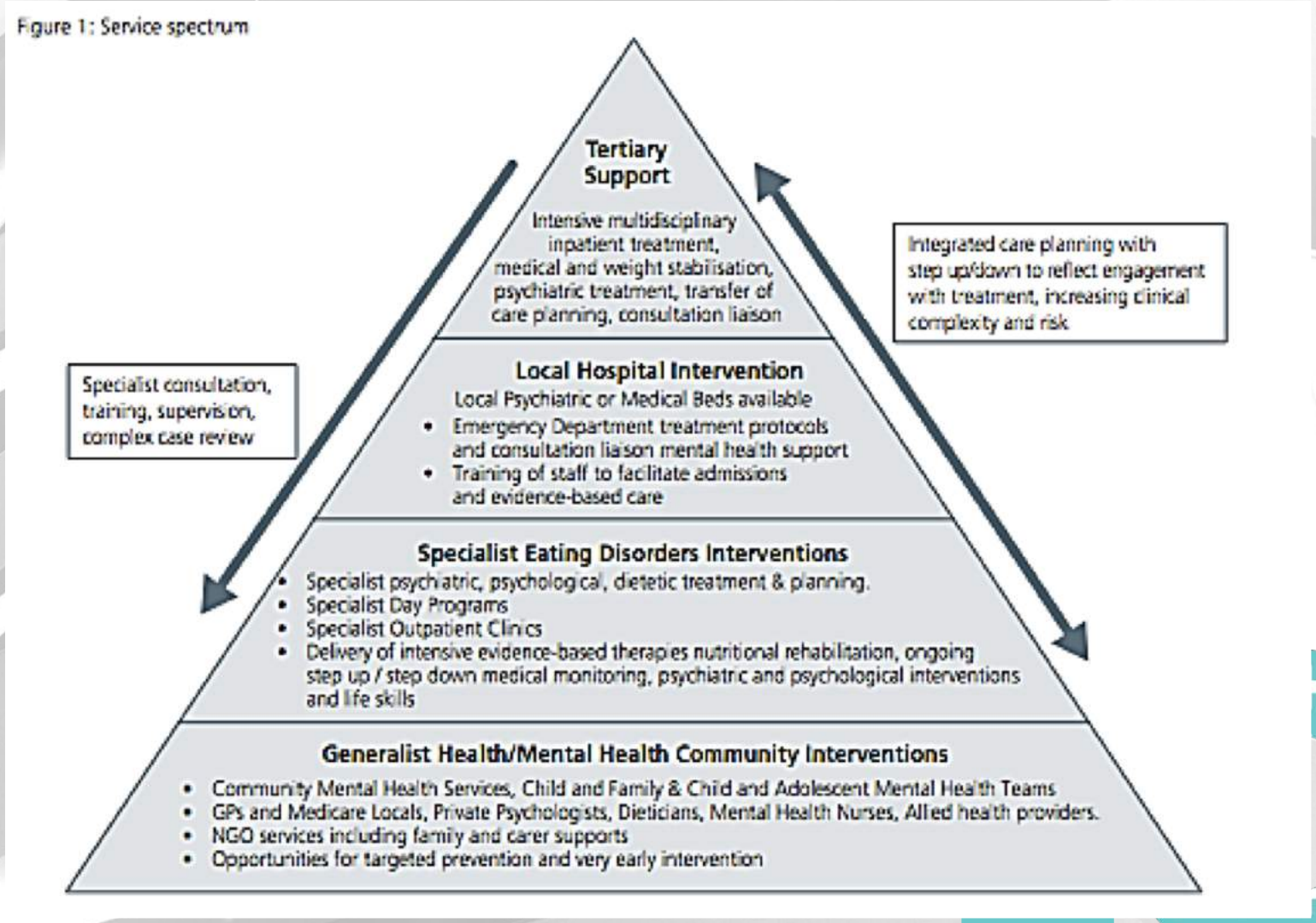
Service Spectrum Triangle

Figure 1: Service spectrum



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NSW Service Support Plan

Expectations of LHDs - Goal to provide:

- Structured case management
- Coordinated care planning
- Monitoring of transition between services
- Continuity of care
- Use of Mental Health Act if involuntary admission required

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Virtual CTO Overview

Contract stipulated:

- Expectations re weight gain
- Clear indicators for warnings due to maintenance or loss
- Required weight gain and timeframes
- To be weighed atleast weekly
- Appointments to be attended (psychiatrist, psychologist, dietician, weigh in, case manager, GP)
- BMI level that would trigger admission
- Where client would be admitted (voluntary or involuntary – medical / psychiatric)
- Supports, advice and supervision for CMHT

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Example Virtual CTO

BMI </=12.8 → 2 consecutive warnings → Gain/Admit

If BMI in region of 12.8 → 2 Consecutive warnings to gain → Admit regardless of BMI. 3rd week must maintain

4th week must gain or warning → If returns to 12.8 → Then Admit

BMI </= 12.5 → Admission

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Community Case Management Role

- Holistic care: separating the illness from the individual
- Support of client and their family
- Opportunities to link with services / supports for consumer recovery goals
- Advocacy (choice of therapist)
- Facilitate clear communication pathways

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Community Case Management Role 2

- Monitoring compliance with Virtual CTO
- Suicide risk assessment/ MSE
- If weight indicates need for admission and refuses, organise ambulance and schedule
- Coordinate care between inpatient treatment and community follow up
- Requesting case consultation meetings when system not working

- NOT ROLE TO:
- Determine details of contact
- Organise med/ private psychiatric admission

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Local Supports

- Team leader and Team
- LHD ED Coordinator, Outreach Team, CEDD
- Local policies for pathways between private and public
- Informal and formal supervision

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Navigating Public/ Private pathways

- Develop relationships
- Coordinate care planning
- Be clear about your role and limitations
- Document all communication and updates on client's weight

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Practical Considerations

- Meet client and carer prior to discharge
- For virtual CTO, conversation pre-discharge if consumer withdraws consent (Ethics Dept, CEDD)
- Is the cut off BMI for admission 13.50 or 13.59?
- Weigh in – what weight triggers twice weekly?
- Timeframes important (org adm after weigh in, not next psych review)
- Medical inpatient pathways organised
- Weigh ins when psychiatrist and dietician on holidays/ PH's
- Expectation that you are informed when consumer goes on leave and organise home visit for continuity of care
- Regular GP medical check ups for Health records
- Consumer more stable when there are clear boundaries and structure
- Reach out for support

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Journey to a Community Treatment Order

Instigated and Implemented by a Local Adult Community Mental Health Team

Wayne Borg

Psychologist, Sutherland CMH

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Background: 'Maree'

- Maree is currently 23 years of age.
- Long history of Anorexia Nervosa (AN), first diagnosed at 12yo.
- First admission at 12yo. Multiple involuntary and voluntary hospital admissions over time.
- Significant history of…
- Severe malnutrition and loss of 30 percent of body weight
- Lowest BMI < = 9
- Water loading and falsifying weight
- Medical complications of AN (including electrolyte disturbance, bradycardia, liver derangement and coagulopathy)
- Discharging self against medical advice
- Absconding
- Declining involvement with Community Mental Health Team

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Background: 'Maree'

- In 2015, Maree was admitted to The Sutherland Hospital with medical complications of AN:
- Extreme cachexia
- Weight 31kg, Height 170cm, BMI 10.7.
- Heart rate < 40bpm
- Transferred to tertiary inpatient setting:
- Weight increased to 44-45kg (BMI 15.4 at time of discharge)
- Upon discharge, Maree remained ambivalent about recovery but motivated to stay physically well enough to remain out of hospital

- In early 2016, Maree was referred to our local Community Mental Health Team upon discharge from tertiary inpatient setting

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Journey to the CTO

- Maree was allocated to me as her Primary Clinician in September 2016.
- Community follow up has included:
- Regular appointments (initially weekly) with her GP, for medical monitoring (including obs, bloods, and weight)
- Weekly/Fortnightly appointments with Adult Community Mental Health Team (CMHT) primary clinician, Wayne Borg
- Reviews with CMHT Consultant Psychiatrist, Dr Sophie Kavanagh, as clinically indicated
- Regular reviews with Dr Lyn Chiem (Consultant Psychiatrist) and Stephanie Bakhos (Dietician) through the Eating Disorders Outpatient Clinic at Royal Prince Alfred (RPA)

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The Journey Continues

- Maree started to disengage from all treating clinicians in February 2018, following an overseas family holiday.
- Care Conference was held with all members of her treating team (incl. GP). Concerns identified:
- Recent weight loss (Last known weight prior to brief voluntary medical admission).
- Recent bradycardia and neutropenia, leading to brief voluntary medical admission.
- Maree had not been reviewed by her GP since this admission.
- Maree wanting to be “left alone” and refusing to allow team to liaise with NOK.
- Agreed to apply for a CTO from the Community.

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The Journey Continues

- In the first instance, I wanted to get it right, so I asked around for ideas of how to put together a CTO for someone with an eating disorder.

- I received a number of sample CTOs, and wanted to use these in developing one that could be used by our Service.

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The Journey Continues

- When I first applied for the Hearing, I had a number of phone calls from the Tribunal members asking questions about the CTO, particularly in regard to the language used (I was trying to use recovery-based language) and why there was no medication.

- I was beginning to have my doubts about the process and wonder why it was so complicated?!

- I continued to refine the CTO treatment plan and the report, checking in along the way with specialists in the field of eating disorders.

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The Journey Continues

- Due to concerns about the risk of Maree's physical health deteriorating, I called and negotiated with the MHRT to bring the notice of the hearing forward, from the usual three week period, to one week. They were very supportive of this.

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The Hearing

- I was unable to be present at the Hearing, and so Dr Sophie Kavanagh (CMHT Consultant Psychiatrist) was there to present our reasons for the application of a CTO.

- Maree was present by phone at the Hearing

- "MHRT had a number of questions about the CTO and whether some aspects of the CTO fell within the legislation, describing it as unorthodox."

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The Hearing

- Dr Kavanagh was willing to make the changes to the CTO as suggested by the members of the Tribunal

- These changes included:
- Re-wording some aspects
- Specifying how often Maree had to attend appointments
- Removing the requirement that she eat a specified number of meals a day.

- After some deliberation, the Tribunal agreed to grant the CTO with the above changes made.

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The Present Time

- Interesting process, with some challenges along the way, but it has been well worth the effort.
- Maree has re-connected to treatment.
- CTO uploaded in EMR as is the report.

- Thanks to so many people. Dr Chiem, Dr Kavanagh, Sarah Reynolds, Stephanie Bakhos, Kate Boyd, Leonie Keogh, and many others.

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THANK YOU

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