Rotherham Doncaster and South Humber NHS Foundation Trust

Pen Portrait

Community Eating Disorder Service
Rotherham Locality Case

Dave Donovan (CAMHS Eating Disorder Nurse)

02- Aug-19

RDaSH leading the way with care

Children and Young People's Mental Health Services

CAMHS PEN PORTRAIT

Practitioner Name	Dave Donovan (CAMHS Eating Disorder Nurse)
Area of Practice	Eating Disorders, CAMHS

Child/young Person/Family Presenting issue(s)

A* first started to experience thoughts about food and her body around 3 years ago when she started a vegetarian diet. In November 2017 she changed from vegetarian to a vegan diet. Family noticed concerns in July 2018 whilst on a family holiday. A* wanted to have a "beach body" and only wanted to eat foods she saw as "less fattening". She gradually reduced her intake at all meals, including cutting out sugars and pasta dishes, as well as not allowing herself to have snacks, even if she was hungry. She reduced the portion size of her meals drastically, but did continue to have three meals daily. When parents noticed the food and weight concerns in July 2018, A* found shopping for food and eating in unfamiliar places very distressing. When the family returned from this holiday they sought help from services. GP made an initial referral to voluntary agency for support around eating and weight loss. She was seen 5 times from start of September 2018 by this voluntary service, but mum continued to be concerned about A*.

However, when this was not achieving results in weight restoration, this agency, and GP referred to CEDS in October 2019. CEDS conducted telephone triage within Access and Waiting Time standards and invited family to assessment, due to identified concerns about A* exercising at home using fitness DVDs as well as Zumba, and continued dietary restriction and a desire for thinness.

At assessment A* presented as having lost further weight from that reported on referral. She had physical and psychological symptoms of Anorexia Nervosa. She had missed periods since March 2018, and was significantly underweight for her age and height. Blood results were also suggesting of physical compromise. These were monitored regularly for improvement as per Junior MARSIPAN guidance. Diagnosis was given, and exploration of treatment options for A*. Considered Family Based Treatment as first line, due to A* not being cognitively able to challenge anorexic thoughts independently.

Family Based Treatment was offered and engaged with by family, with support and supervision by parents and support from CEDS. Pen Portrait author was lead professional working and supporting A* and family, with support from specialist CEDS dietitian in relation to vegan diet and weight restoration, as well as non-face-to-face review in MDT meetings regularly.

Sessions have been weekly initially to support with returning control of food portions, choices and meals times to parents. This was difficult, but parents were able to challenge A* and support her with this, though did sometimes require additional support over telephone to guide through difficult meal or snack times.

A* initially lost weight due to parental challenges, and the time of year. She struggled over Christmas and festive period due to presentation of food, but in January 2019 began to gradually restore her weight with first significant gains beginning to occur.

Support continued to follow FBT approach, with sessions reducing from weekly to 10 daily; 2 weekly; 3 weekly and so forth. A* was able to reach 97% medianBMI in April 2019, and having return of periods at roughly the same time. As frequency of sessions was reduced, it was noticed that A* began to engage more in sessions, and was speaking more openly about what she found difficult and what was helping. She was able to discuss with parents about appropriately having control of food returned to her, which was done with parental agreement, and supervision. A* did struggle with this initially as well, as she was worried she would make the wrong choices for recovery, or that her anorexia would negatively influence her perception of weight and body shape, as well as food portions. However, with support she has been able to consistently make appropriate choices with her dietary intake and maintained her weight within 95-105% medianBMI range which is thought to be healthy for her age and height.

A* has managed to engage well in multiple celebrations including family birthdays, family holidays, her own birthday and school leaving prom all of which involved food aspect. She has been able to engage in these activities well, and maintained her weight, successfully challenging anorexic cognitions at each time.

A* is currently still under care of CEDS, but FBT work is nearing completion with no identified complicating factors or need for additional work. However, if this is identified, then CEDS will respond to A*'s individual care needs.

*pseudonym used for confidentiality.

What evidence can you relate to the issues identified?

Access and Waiting Time Standards –
A*'s care was triaged within 24 hours of receipt of referral, and thought to be routine in terms of level of urgency. Physical monitoring was requested through GP, and consideration given to if A*'s case remained routine after additional physical information provided. She was seen 10 days after triage within the same waiting time standards.

NICE Guidance for Management of Eating Disorders in patient over 8 years –
Guidelines were used to identify suitable range of treatment options. Family Based treatment was considered as firstline approach for treatment/therapeutic intervention. Range of additional support was also identified, including specialist dietetic support, and physical monitoring.

Junior MARSIPAN –
A*'s care was provided in line with junior MARSIPAN guidance for physical monitoring, to assess her physical recovery. Blood Pressure, pulse, height and weight were checked regularly, as were blood results, and a medianBMI was calculated at alternate appointments.

Following your assessment what was your evaluation of the child / young person's / family's needs?

A* was diagnoses with Anorexia Nervosa at her assessment. Although she had lost weight from referral to assessment, she remained relatively physically stable, in accordance to Junior MARSIPAN guidance. She was offered regular weekly

therapeutic sessions to provide Family Based Treatment, as well as dietetic input. Parents were included in this care plan, and formed key part of the Family Based Treatment and A*'s recovery.

Consideration was given as to whether A* could be supported in community, or if her physical stability required additional input and support. However, when evidence of early recovery and weight restoration this was not clinically indicated.

Following your package of care what has improved for the child / young person / family?

Following input from CEDS, A* has restored weight from 80% medianBMI to 96% at present. She has had return of menstrual periods, and commented that she feels her anorexic thinking has reduced in intensity. She has maintained full time education throughout her treatment, and completed her GCSEs without additional time, or medical support. A* has maintained good supportive relationships with family and peers throughout her treatment, as well as being able to maintain a vegan diet from referral to present.

Parents and A* feel that she has significantly recovered in her thinking, and no longer feel that she needs her meals monitoring, or to have parental support in checking portion sizes or food content. She has had full return of independence around food, but does continue to eat with the family now, rather than independently.

Conversations have been had with A* and family about discharge, and it has been agreed that A* is likely ready for discharge in near future after intensive input from CEDS.

Did you gain feedback from the child / young person / family?

A* and family have commented on the support from CEDS. Eating Disorder Evaluation Questionnaire version 6 has suggested improvement in clinical presentation. Continuous checking of engagement and of benefit has been sought from family, to ensure that A* and family have been finding sessions helpful and beneficial. Family have contacted CEDS between sessions at times and present as having good working relationships with CEDS. Mum and A* have separately commented that they feel the service has been positive and "instrumental" in A*'s recovery.

Session Rating Scales have also been used to help A* express if appointments are helpful, and highlight areas for service and practitioner development.

Evaluation of Service Questionnaires not yet completed.

Has your practice changed/developed as a result of working with this child / young person / family?

Working with A* and family has helped CEDS in solidifying the NICE guidance and the effectiveness of Family Based Treatment for Anorexia Nervosa when the young person does not have any complicating additional mental health needs of co-morbidities.
The case highlights the manualised approach working well for families and young people. Reflection on this case has helped the portrait author to improve confidence in delivery of the FBT approach, and the effectiveness of manualised

treatment.