IMAGINE BETTER

CHN

Mental Health Presentations in General Practice

1 May 2021
Hyatt Hotel

phn ACT
An Australian Government Initiative

Capital Health Network
Partnering for better health

Acknowledgement of Country

Partnering for better health

I would like to acknowledge that this event is being held on the traditional lands of the Ngunnawal people, and pay my respect to elders, past, present, and emerging.

I wish to acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

I would also like to acknowledge and welcome Aboriginal and Torres Strait Islander people who may be attending today's event.

IMAGINE BETTER

phn ACT An Australian Government Initiative

Capital Health Network Partnering for better health

Housekeeping

CHN
Partnering for better health

- Bathrooms are on either side of the staircase
- Should there be an emergency evacuation the assembly point is out of the banquet entrance and to the left
- As part of the COVID-19 safety plan at the Hyatt Hotel everyone is required to use the Check in CBR app
- We would appreciate it if you could please switch off your mobile phone or put it on silent.

Learning outcomes

Partnering for better health

- Access HealthPathways to assist with assessment, management and referral of common mental health problems.
- Use course reference material and specialist information to identify, assess, manage and refer patients with common mental health problems.
- Use HealthPathways mental health clinical and service directories to support management of mental health concerns.
- Network with peers, mental health specialists and mental health service providers to optimise mental health management for patients."

Feedback

- A reminder that GPs can provide feedback to RACGP on the CPD activity provided today in confidence via the GP Feedback Form on the RACGP website

  https://www.racgp.org.au/education/professional-development/qi-cpd/2022-triennium/feedback

- No conflicts of interest have been declared by the presenters speaking today

Questions – Q&A sessions

Partnering for better health

- As you will see in the Event Program there are two scheduled Q&A sessions today
- If you have a question for one of the presenters, we ask that you please use the provided question sheets on your tables
- The question sheets will be collected after each presenter if you can please hand them to a CHN team member
- We will try to answer as many questions as time permits in the allocated Q&A sessions

Mood & Anxiety Disorders: Tips for Complex Presentations

Tabitha Frew

Clinical Psychologist

Ascentem Clinical Director

Scope

- Common general practice consultation
- Complex psychosocial maintaining factors
- Quick tips for your patient consult

Ascentem

Common general practice consultation - assumptions

- Adult female patient presents for a consult reporting low mood, fatigue, feeling on edge, and difficulties sleeping
- GP completes an MSE & suicide risk ax, medical history, family history of mental health, administers a screening tool (DASS-21/K-10), medication for symptoms & refer if indicated
- Advice is provided on lifestyle factors
- Insufficient consult time to consider interlinked biological, psychological & social factors that promote health or contribute to disease

Ascentem

Complex psychosocial maintaining factors

Shame-based presentations

- Undiagnosed PTSD, including dissociation +/- chronic self-harming
- Active family violence, homicidal ideation
- Gender identity issues
- Obsessional traits (body dysmorphia / OCD / hoarding)

Impulse-control presentations

- Underlying personality vulnerabilities
- Problematic gaming, gambling or pornography use

Neurodivergent presentations

- ASD and ADHD

Ascentem

Quick tips for complex patients in general practice

Obsessional traits

Adult DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure: 13 domains, thresholds for further inquiry

Meets cut-off for repetitive thoughts & behaviours:

- **Explore:** Hoarding: do you have trouble discarding things that most people would get rid of? Are you worried about having people over to your house due to clutter?
- **Assess:** OCD - Repetitive Thoughts & Behaviours Adult Scale
- **Explore:** Body dysmorphia - fixated beliefs about a specific body part – significant time spent looking in the mirror
- **Explore:** Gender dysphoria - fixation on secondary sex characteristics only – reiterate affirmative care

Ascentem

Impulse control problems

Adult DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure: 13 domains, thresholds for further inquiry

Meets cut-off for substance use:

- **Explore:** for trauma – sometimes when we have difficulties managing alcohol or other drug use, we might be trying to avoid memories of something distressing
- **Explore:** for other impulse control issues – gambling / pornography / gaming

Ascentem

Active domestic & family violence

Explore: do you feel unsafe because of anyone at home?

Establish permission: Do you feel comfortable talking about it with me today? Would you like me to contact support services with you? Can I place a note on your file?

Assess: dissociation, head injury, concussion, strangulation, sexual assault

Document: injuries – self-report of incidents – advise RE evidence

Caution: sedating medications, emails or providing information brochures, disempowering through helping

Ascentem

Chronic self-harming

- Personality disorder –not always a maintaining factor
- Empathy and a multidisciplinary team

Explore: adolescents - undiagnosed ADHD, ASD or PTSD

Explore: adolescents - first episode psychosis / illicit substance use

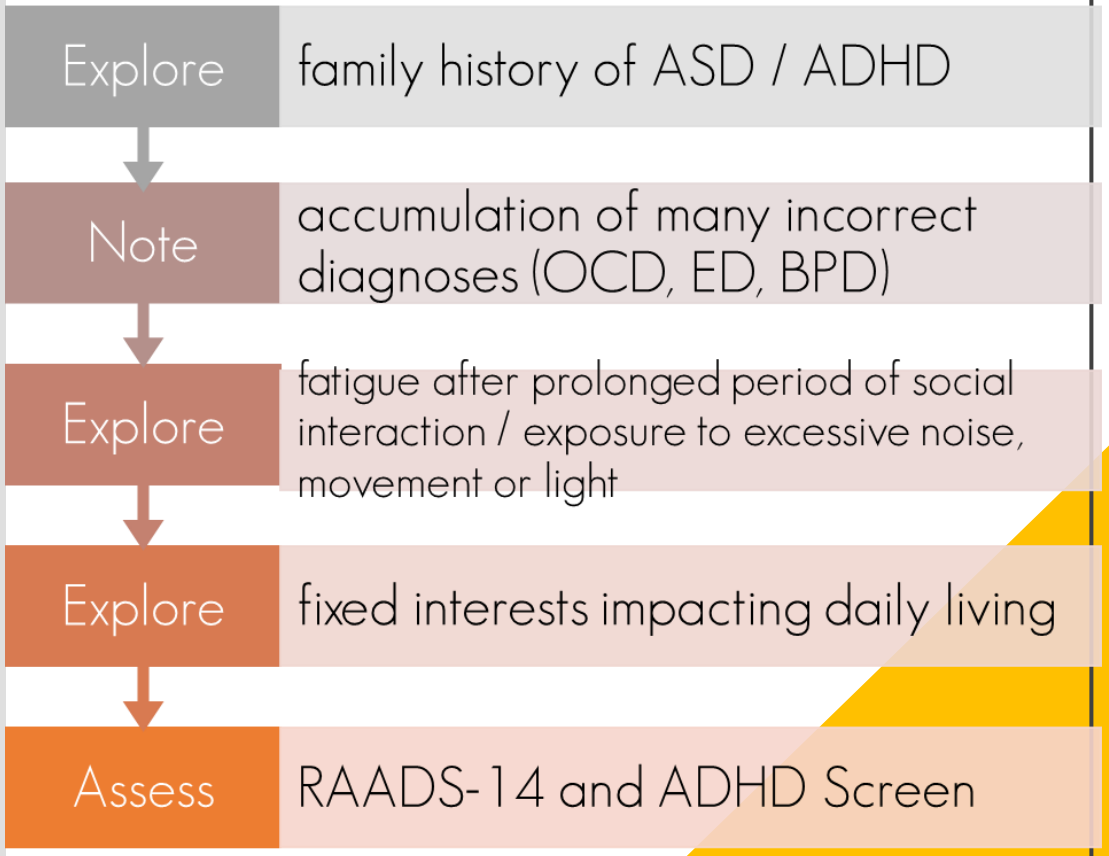
Explore: older adults – chronic pain and social isolation

Explore: current safety issues (CSA, DV, substance dependency)

Major self-mutilation – self-immolation or amputation – psychosis & personality & acute trauma

Ascentem

Neurodivergence



Ascentem

Thank you for listening

References can be provided on request

admin@ascentem.com

Ascentem

Assessing Harm for IPV: Tips for General Practice

Douglas P. Boer, Ph.D.

Professor of Clinical Psychology, University of Canberra

Registered Clinical Psychologist

Scope

- Common general practice consultation
- Presenting issue: Complex psychological and social factors
- Quick tips for your consult

Common general practice consultation

- Male adult patient presents for a consult reporting anger and agitation, low mood, problems concentrating, relationship stressors, substance use issues, and social withdrawal
- GP completes an MSE & suicide risk ax, medical history, family history of mental health, administers a screening tool (DASS-21/K-10), medication to treat symptoms & refers to psychologist / psychiatrist
- Advice is provided on stress management and benefits of social engagement
- Insufficient consult time to consider interlinked biopsychosocial factors that promote health or contribute to disease

Intimate Partner Violence (IPV)

- 1/3 women in Australia experience physical violence since the age of 15; 1/5 sexual violence; 1/3 has experienced physical and/or sexual violence perpetrated by a man since the age of 15.
- The most common forms of violence include physical, emotional, and economic abuse of an individual with whom the abuser has an intimate or romantic relationship.
- Due to the prevalence of IPV, all healthcare professionals, including psychologists, nurses, pharmacists, dentists, physician assistants, nurse practitioners, and physicians, will evaluate and possibly treat a victim or perpetrator of domestic or family violence in their practice.
- Intimate partner violence typically includes sexual or physical violence, psychological aggression, and stalking. This may include former or current intimate partners.

Complex psychosocial factors in Intimate Partner Violence (IPV)

- Anger management issues
- Jealousy, possessive, suspicious, defensive
- Low self-esteem and emotionally dependent
- Feeling inferior and insecure
- Beliefs they have the right to control their partner, including finances and social activities
- Personality disorder (e.g., ASPD) or psychological disorder (e.g., psychosis)
- Learned behavior from growing up in a family where domestic violence was accepted
- Possible history of abuse within family of origin
- Alcohol and drug use – an impaired individual may be less likely to control violent impulses

Quick tips for complex patients in general practice

Know the risk issues (from the SARA-V3):

- **Perpetrator Risk Factors**
- P1. Intimate relationships
- P2. Non-intimate relationships
- P3. Employment/finances
- P4. Trauma/victimization
- P5. General antisocial conduct
- P6. Major mental disorder
- P7. Personality disorder
- P8. Substance use
- P9. Violent/suicidal ideation
- P10. Distorted thinking about IPV

- **Victim Vulnerability Factors**
- V1. Barriers to security
- V2. Barriers to independence
- V3. Interpersonal resources
- V4. Community resources
- V5. Attitudes or behavior
- V6. Mental health

If patient is a prior offender, what is the:

- **Nature of past and present IPV**
- N1. Intimidation
- N2. Threats
- N3. Physical harm
- N4. Sexual harm
- N5. Severe IPV
- N6. Chronic IPV
- N7. Escalating IPV
- N8. IPV-related supervision violations

- *Thank you for listening*
- *References can be provided on request*
- *douglas.boer@canberra.edu.au*

Mental Health Presentation

Jade Nolan

– A/g Senior Manager Access & Specialty Teams, Clinical Psychologist

Dr Nishad Samad - MBBS, FRANZCP

Consultant Psychiatrist

ACT Access Community MH

Murrumbateman Specialist centre

VMO Hyson Green

1st May 2021

Access Mental Health

- Single point of contact for new referrals across the ACT
  - 24/7 mental health telephone service
  - Urgent and non-urgent referrals
  - Priority line- Emergency Services, MHJHADS and Partner Community Organisations
  - GP Advisory Service

Access Mental health:

- A distinct access, assessment and triage team to promote greater access and consistency in service responses to access requests.

Home Assessment and Acute Response team:

-An acute response and intensive in-home treatment team which provides an alternative to in-patient admission

Community Recovery Service

- Clinical case management and care coordination with a focus on a strength –based approaches

Assessment service

- Comprehensive ‘non-urgent’ assessment service
- Capacity for short term review and intervention
- Support both referral to continuing care teams and referral back to primary care

More efficient review of referrals. These include post discharge OPAs, interstate patient transfers, discharges from AMC or Forensics and referrals from General Practice.

Each patient is discussed/triaged and a multidisciplinary management plan is implemented.

Please ensure all patients referred to AMHC are aware of their referral and are aware that we will contact them as part of the triage process.

AMHC offers an initial Mental health Clinician face to face appts, Phone assessments, MDT discussions, Calls/fax to GPs for further information if required, OPA for medical assessment.

At the conclusion of the Access episode of care of care process, a decision is made as to whether the patient can return back to Primary Care or if they require more specialized or intensive support, their care pathway is further discussed within MDT framework.

We have additional support persons that can provide psychosocial supports as clinically indicated for short term to ensure the safe transfer of care back to their GP.

DNA: there is a DNA policy that we follow. We will notify the patient's GP if there is a DNA.

Access Mental Health

Triage: 1800 629 354

02 6205 1065

Fax: 02 6174 7175

Available 24 hours a day, 7 days a week

Urgent and routine triage and assessment

ACT GP Advisory Line

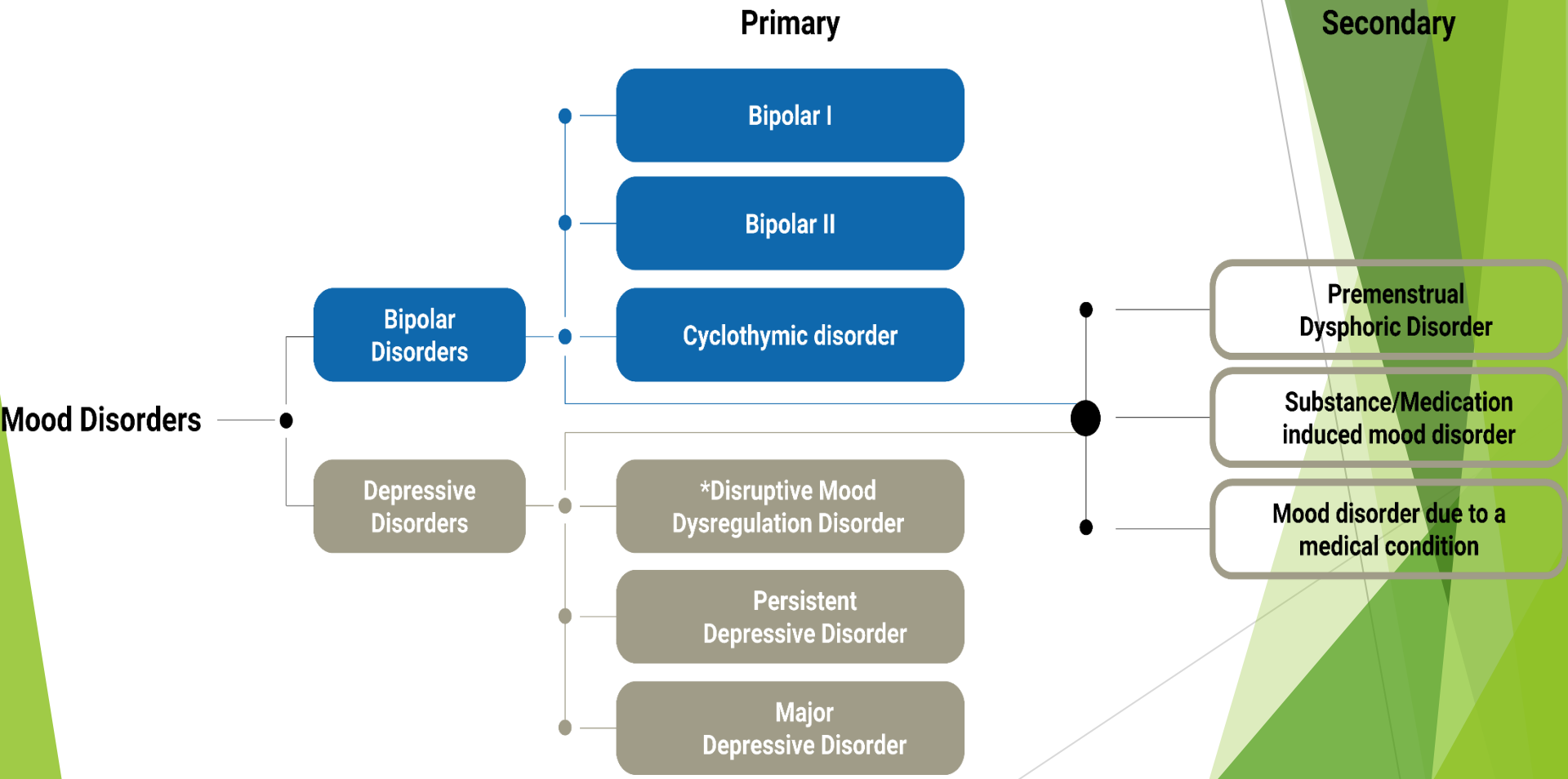
- GP Advisory line is available to assist GPs within ACT.
- Monday /Tuesday/Thursday/Friday

- Phone Contact: 02 62051000

- Access Community MH :
- Ph: 02 62072570
- Fax- 0261747175

Thank You

Classification of Mood Disorders



Depression Screening Tools

Anxiety and Depression Checklist (K10)

- Simple checklist to measure whether the patient has been affected by depression and anxiety during last 4 weeks[1]

Beck Depression Inventory (BDI)

- 21-item self-report rating inventory which measures symptoms and severity of depression[3]

Depression, Anxiety and Stress Scale (DASS)

- 42-item self-report instrument with capacity to discriminate between 3 related states of depression, anxiety and stress[2]

Patient Health Questionnaire-9 (PHQ-9)

- 9-question instrument for patients in primary care to monitor the severity of depression[4]

Self-screening tools may not necessarily identify patients with depression that need help[4]

1. Beyond Blue. Anxiety and depression checklist (K10). 2018. **2.** Psychology Foundation of Australia. DASS. 2018. **3.** American Psychological Association. Beck Depression Inventory (BDI). 2018.
4. Hopwood MJ and Malhi G. Med J Aust. 2016;204(9):329.

Pharmacological treatment based on clinical profile:

Anxiety	SNRIs /SSRIs
Cognitive difficulties (learning, memory, decision making)	Duloxetine/Vortioxetine
Sleep Disturbances – eg Insomnia	Agomelatine /Mirtazapine
Fatigue	Bupropion
Pain	Duloxetine/TCAs
Melancholia(Psychomotor slowing)	TCAs
Psychotic Symptoms	Anti-psychotic medications in addition to anti-dep

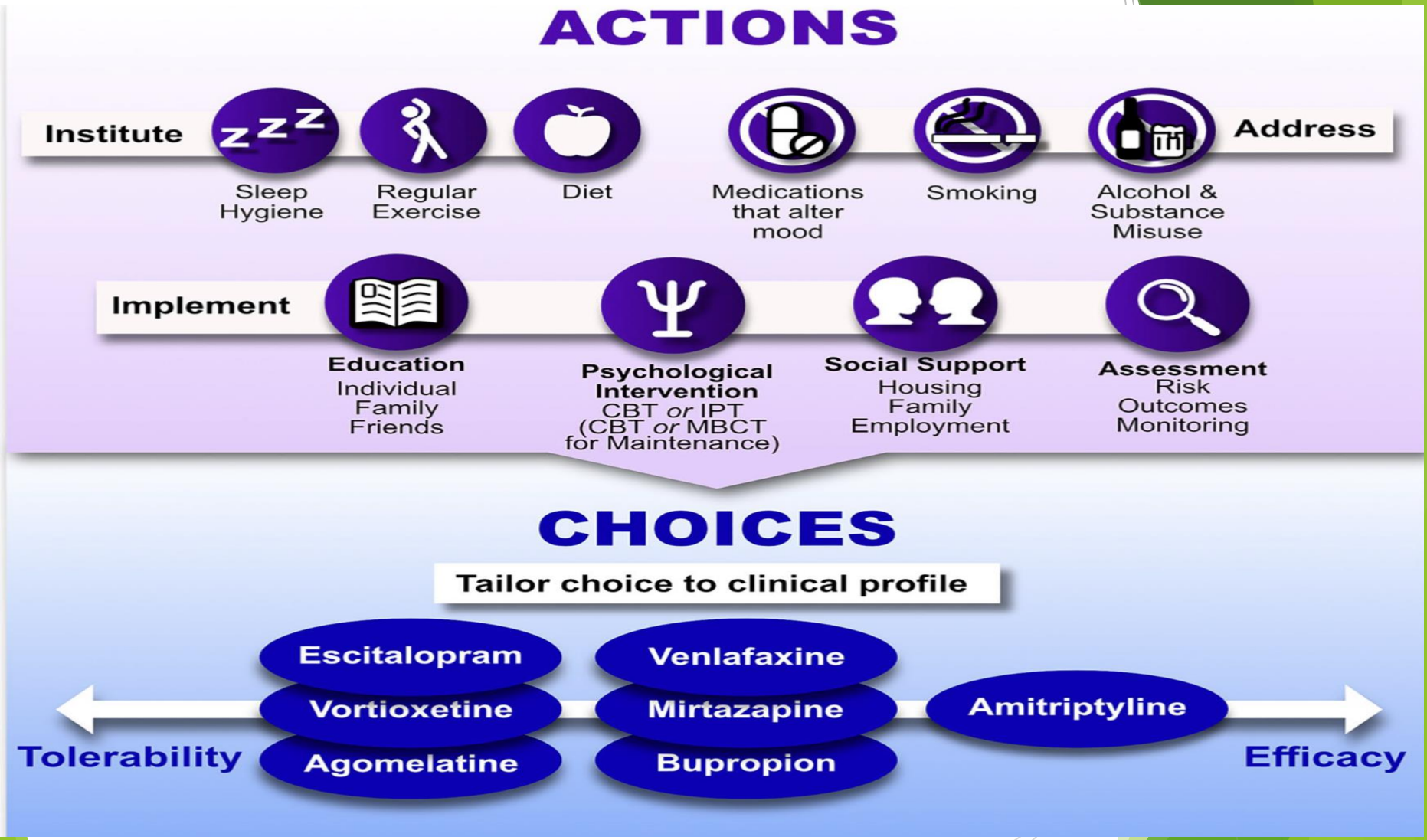
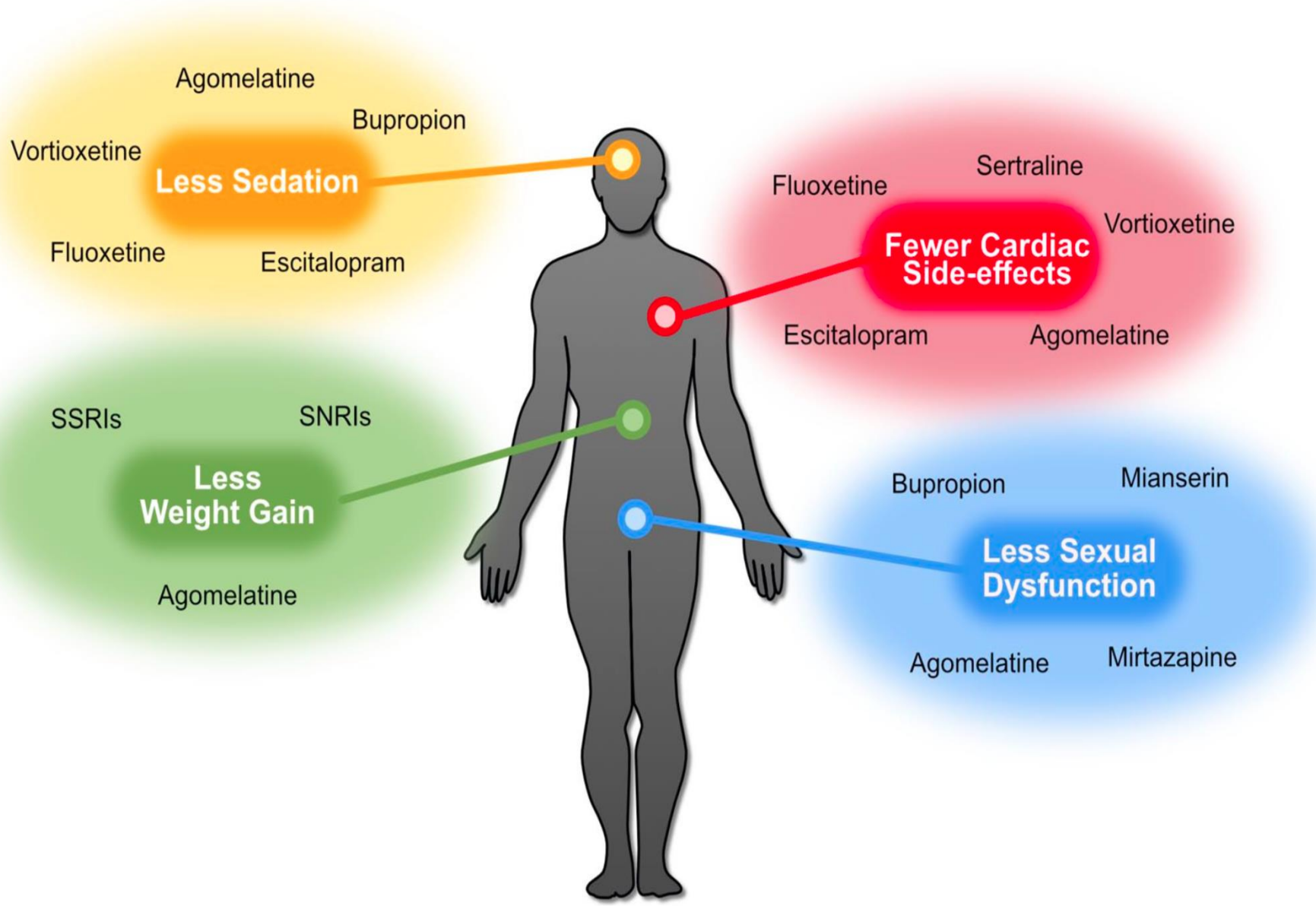

ACTIONS
Institute
Address
Sleep Hygiene
Regular Exercise
Diet
Medications that alter mood
Smoking
Alcohol & Substance Misuse
Implement
Education
Individual
Family
Friends
Psychological Intervention
CBT or IPT
(CBT or MBCT for Maintenance)
Social Support
Housing
Family
Employment
Assessment
Risk
Outcomes
Monitoring
CHOICES
Tailor choice to clinical profile
Escitalopram
Vortioxetine
Agomelatine
Venlafaxine
Mirtazapine
Bupropion
Amitriptyline
Tolerability
Efficacy

Table 10. Classes of antidepressants.

CLASS	ANTIDEPRESSANTS
Selective serotonin reuptake inhibitors (SSRIs)	Escitalopram, citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline
Serotonin-noradrenaline reuptake inhibitors (SNRIs)	Venlafaxine, duloxetine, desvenlafaxine, levomilnacipran, milnacipran
Selective noradrenergic reuptake inhibitors (NRIs)	Reboxetine, atomoxetine, teniloxazine
Noradrenaline-dopamine reuptake inhibitor (NDRI)	Bupropion[c]
Noradrenergic and specific serotonergic antagonist (NASSA)	Mirtazapine[c], mianserin[c]
Serotonin partial agonist and serotonin reuptake inhibitor (SPARI)	Vilazodone
Serotonin receptor antagonist and serotonin reuptake inhibitor (SARI)	Vortioxetine,[a] nefazodone, trazodone
Serotonin-noradrenaline reuptake inhibitor and serotonin receptor antagonist (SNRISA)	Amoxapine[c]
Noradrenaline reuptake inhibitor with serotonin receptor antagonism (NRISA)	Maprotiline[c]
Tricyclic antidepressants (TCAs)	Amitriptyline, clomipramine, dosulepin, doxepin, imipramine, nortriptyline
Monoamine oxidase inhibitor (MAOIs)	Moclobemide,[b] phenelzine, tranylcypromine
NMDA-glutaminergic receptor blockers	Esketamine, ketamine
Melatonergic agonist and selective serotonergic antagonism	Agomelatine
Atypical antipsychotics with potent $5HT_{2A/2C}$ receptor blockade	Aripiprazole, brexpiprazole, lurasidone, quetiapine, olanzapine, risperidone
Neurosteroid progesterone analogue and gamma aminobutyric acid (GABA) receptor modulator	Brexanolone

Antidepressant side effects.



Practical Strategies

- Look into the history; tease out the target symptoms, if patients are already on an SSRI or SNRI with previous good effect then use augmentation strategies.
- The rule usually is to start any anti-dep on low dose and gradually built dose – optimizing the dose at least in **first 3 weeks**

1. By adding a small dose of atypical anti-psychotic such as quetiapine/olanzapine/Risperidone - preferably nocte dose.
   - Or Augmentation with Valdoxan/Mirtazapine/Endep.

2. If a person has been on good trial of 2 -3 anti-dep in the past on good doses, augmented with another anti-dep/anti-psychotic and still is depressed /anxious with suicidal ideation then mood stabilizer such as Lithium/Lamotrigine can be added.
   - Give patients good trial at least of 2-4 weeks max of 12 weeks on one regime on effective doses.

Antidepressant switching Strategies

- **1. The Direct Switch**: Regime is suitable when first anti-dep is used for less than 6 weeks. Example could be from SSRI to SNRI such as to Duloxetine
- 2. **Taper and than immediate switch:** A good example is from Duloxetine to SSRI.
- **3. Taper and then switch after a wash out period:** Depends on half life of medications and chances of relapse
- **4. Cross Tapering:** Benefit- no break in treatment however, there can be pharmacodynamics and Pharmacokinetic interactions.

Caution:

- The co-administration of some anti-dep even when cross tapering is absolutely contraindicated:
- Eg Clomipramine should not be co-administered with SSRIs, Venlafaxine or Duloxetine.

- Due to the potential for serous drug interaction - Cross tapering between TCA and SSRI should be done very cautiously.

- Valdoxan is contraindicated with Fluvoxamine due to CYP 450 interactions.

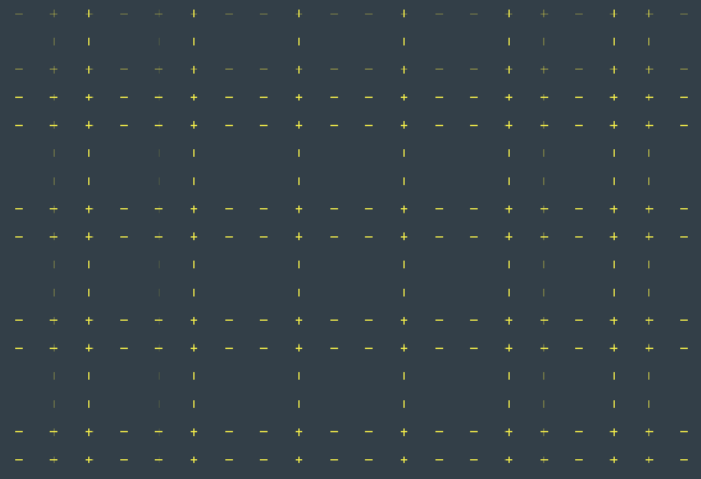
Table 3: Switching antidepressants - adapted from Maudsley Prescribing Guidelines 11th edition[4]

To / From	Non-selective, irreversible MAOI	Tricyclics	SSRIs (except fluoxetine)	Fluoxetine	Moclobemide	Reboxetine	SNRIs - duloxetine, venlafaxine, desvenlafaxine	Mirtazapine
Non-selective, irreversible MAOI		Taper & stop then wait for 2 weeks	Taper & stop then wait for 2 weeks	Taper & stop then wait for 2 weeks	Taper & stop then wait for 2 weeks	Taper & stop then wait for 2 weeks	Taper & stop then wait for 2 weeks	Taper & stop then wait for 2 weeks
Tricyclics	Taper & stop then wait for 2 weeks	Cross-taper cautiously	Halve dose & add SSRI then slow withdrawal	Halve dose & add fluoxetine then slow withdrawal	Taper & stop then wait for 1 week	Cross-taper cautiously	Cross-taper cautiously, start with low dose SNRI	Cross-taper cautiously
SSRIs (except fluoxetine)	Taper & stop then wait for 1 week	Cross-taper cautiously	Taper & stop then start new SSRI at a low dose	Taper & stop then start fluoxetine 10mg/day	Taper & stop then wait for 1 week	Cross-taper cautiously	Cross-taper cautiously, start with low dose SNRI & increase v slowly	Cross-taper cautiously
Fluoxetine	Taper & stop then wait 5-6 weeks	Taper & stop then wait 4-7 days. Start TCA at very low dose & increase slowly	Taper & stop then wait 4-7 days. Start fluoxetine at low dose & increase slowly		Taper & stop then wait at least 5 weeks	Cross-taper cautiously	Taper & stop. Start with low dose SNRI & increase very slowly	Cross-taper cautiously start mirtazapine 15mg/day
Moclobemide	Taper & stop then wait 24h	Taper & stop then wait 24h	Taper & stop then wait 24h	Taper & stop then wait 24h		Taper & stop then wait 24h	Taper & stop then wait 24h	Taper & stop then wait 24h
SNRIs - duloxetine, venlafaxine, desvenlafaxine	Taper & stop then wait at least 1 week	Cross-taper cautiously with low dose of TCA	Cross-taper cautiously with low dose of SSRI	Cross-taper cautiously with low dose of fluoxetine	Taper & stop then wait for 1 week	Cross-taper cautiously	Taper & stop then start new SNRI	Cross-taper cautiously
Mirtazapine	Taper & stop then wait for 2 weeks	Cross-taper cautiously with low dose of TCA	Cross-taper cautiously	Cross-taper cautiously	Taper & stop then wait for 1 week	Cross-taper cautiously	Cross-taper cautiously	

Thank You

Questions and Panel discussions.

Questions?



phn ACT
An Australian Government Initiative

Capital Health Network
Partnering for better health

Morning break

- 30 min break
- Presentations will recommence at 11.00am

Eating Disorders

Mental Health Presentations in General Practice
May 1st 2021

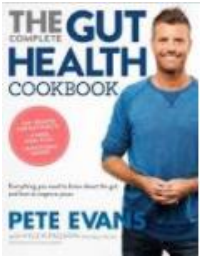
Kathryn Bell
Clinical Psychologist
Eating Disorders Service Co-Ordinator
Eating Disorders Program
Mental Health, Justice Health, and Alcohol & Other Drugs
Canberra Health Services

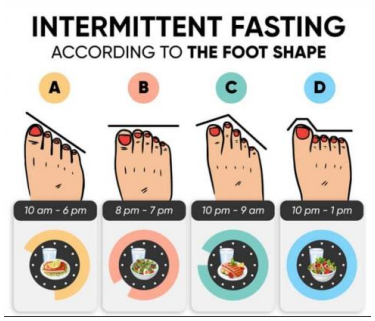
Learning Outcomes

- Function of eating disorder behaviour
- Goals of eating disorder treatment
- Where to refer
- Eating Disorders Program
- Therapy done at Eating Disorders Program

Examples: of disordered eating

- Fasting or chronic restrained eating
- Skipping meals
- Binge eating
- Self-induced vomiting
- Restrictive dieting
- Unbalanced eating (e.g. restricting a major food group such as ‘fatty’ foods or carbohydrates)
- Laxative, diuretic, enema misuse
- Steroid and creatine use – supplements designed to enhance athletic performance and alter physical appearance
- Using diet pills



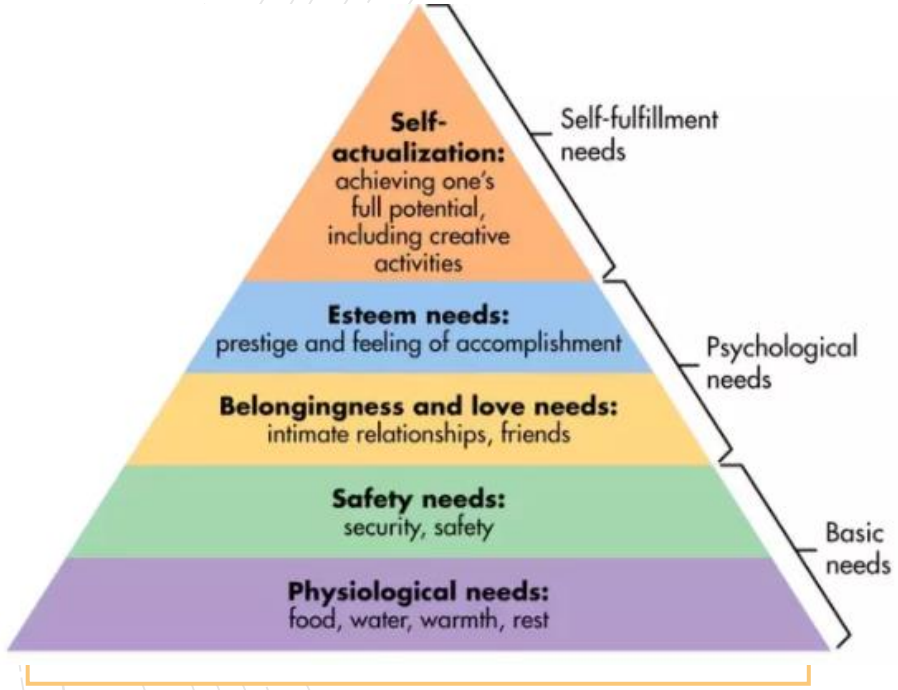


https://nedc.com.au/eating-disorders/eating-disorders-explained/disordered-eating-and-dieting/

It's not about the food….

- A way to manage emotions – e.g. numbing, vomiting releases endorphins
- Sense of achievement – positive reinforcement
- Sense of identity – feel "special"
- Avoidance of other stuff in life – focusing on eating disorder is a distraction
- Sense of control (related to point on avoidance)
- Communication
- Self-punishment

It is about the food…



- Cannot have psychological recovery without physical recovery
- Effects of starvation: lower mood, increased obsessional thinking, harder to make decisions, moodier and harder to regulate emotions, harder to concentrate.
- Exposure therapy is important for recovery: need to face fear of particular foods/quantity/feeling full/being a particular weight

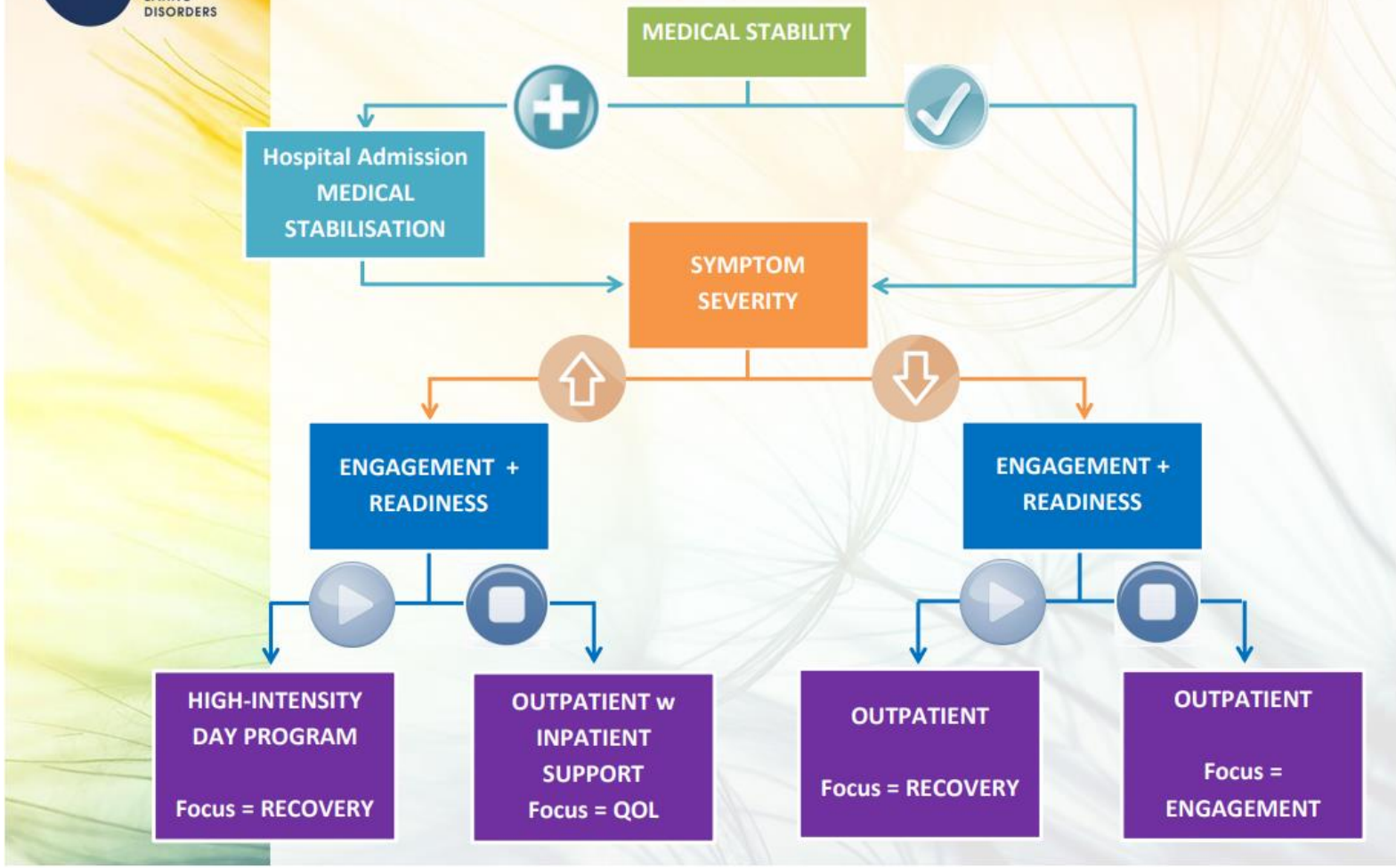
Goals of eating disorder treatment

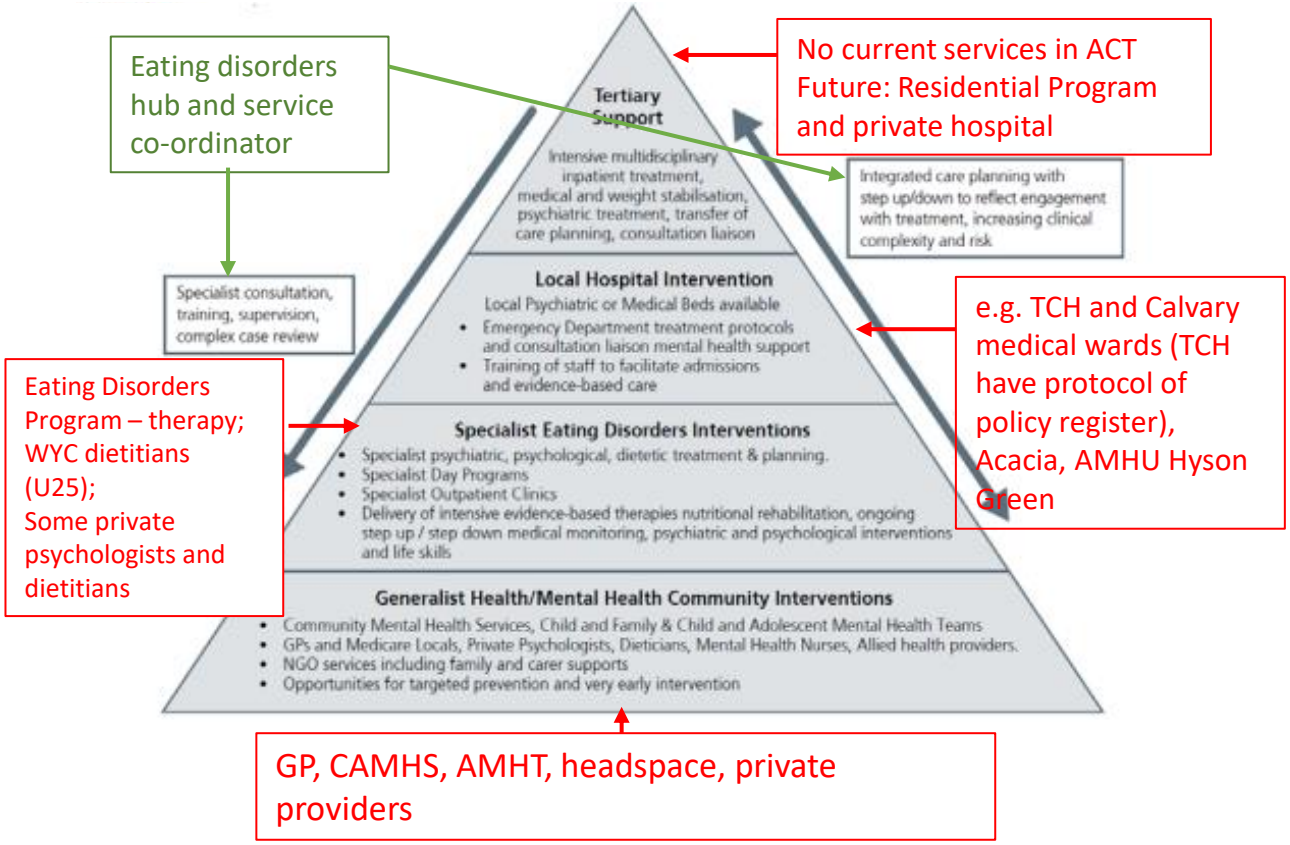
Establish regular and adequate eating – reverse psychological and physical effects of starvation

Teach strategies to address maintaining factors - e.g. emotion regulation, exposure to feared foods, interpersonal skills, enhancing other areas of life

CEED THE VICTORIAN CENTRE OF EXCELLENCE IN EATING DISORDERS

ED Treatment Setting Decision-Matrix for Adults (Geller, 2017)




Eating disorders hub and service co-ordinator
No current services in ACT
Future: Residential Program and private hospital
Integrated care planning with step up/down to reflect engagement with treatment, increasing clinical complexity and risk
Specialist consultation, training, supervision, complex case review
Eating Disorders Program – therapy; WYC dietitians (U25);
Some private psychologists and dietitians
e.g. TCH and Calvary medical wards (TCH have protocol of policy register), Acacia, AMHU Hyson Green
GP, CAMHS, AMHT, headspace, private providers
Tertiary Support
Intensive multidisciplinary inpatient treatment, medical and weight stabilisation, psychiatric treatment, transfer of care planning, consultation liaison
Local Hospital Intervention
Local Psychiatric or Medical Beds available
Emergency Department treatment protocols and consultation liaison mental health support
Training of staff to facilitate admissions and evidence-based care
Specialist Eating Disorders Interventions
Specialist psychiatric, psychological, dietetic treatment & planning.
Specialist Day Programs
Specialist Outpatient Clinics
Delivery of intensive evidence-based therapies nutritional rehabilitation, ongoing step up / step down medical monitoring, psychiatric and psychological interventions and life skills
Generalist Health/Mental Health Community Interventions
Community Mental Health Services, Child and Family & Child and Adolescent Mental Health Teams
GPs and Medicare Locals, Private Psychologists, Dieticians, Mental Health Nurses, Allied health providers.
NGO services including family and carer supports
Opportunities for targeted prevention and very early intervention

Eating Disorders Program

Outpatient Therapy Service sees across the lifespan – Time limited 10 to 40 sessions (weekly) CBT for adults and FBT for young people.

CBT and FBT are offered as they are recommended by NICE guidelines for all adult and adolescent eating disorder presentations respectively (though less evidence for CBT when person presents with a BMI below 17.5).

- Primary presenting issue of a moderate to severe eating disorder (underpinned by weight and shape concerns)
- Motivated to make behavioural change and would benefit (voluntary)
- ACT residents
- GP referral – ensures that GP is involved, completes medical assessment, and monitors medical status while receiving therapy at EDP. Consistent with interstate programs. No medical support at EDP. **Information on referral informs triage**.
- Waiting times
- BMI – 15 to 40 – consistent with recommendation in CBT treatment manual.
- Staff: Manager, 4.5 FTE clinicians (currently 2.5), dietitian and psychiatrist each 1 day/wk – see those in active therapy.

Phase	FBT – 20 sessions in 12 months	CBT-E – 20 - 40 sessions in approx. 6 - 12 months	RAVES
1	• Parents take responsibility of establishing regular and adequate eating and disrupting compensatory behaviours (e.g. over-exercise, self-induced vomiting, laxative and other pill use) • 10 sessions - weekly • Aim 0.5 to 1.0kg weight gain per week. • Family meal • EXPOSURE • Nutritional rehabilitation	• Work with individual establish regular and adequate eating • Twice a week for 4 weeks • EXPOSURE – food rules re delaying eating • Nutritional rehabilitation	R – Regular A – Adequate Medical stability
2	• YP starts to take responsibility for food choices under parents' supervision • Fortnightly	• Review treatment • 1 – 2 sessions	V - Variety E – Eating Socially Social Connection
3	• Life without the eating disorder • 4- to 6-weekly	• Address maintaining factors (e.g. emotion regulation, over-evaluation of weight and shape, interpersonal effectiveness)	S – Spontaneity Intuitive Eating "Getting back to nature"

Core Principles of FBT

The family are viewed as the best resource to bring about recovery.

Parents are the drivers and decision makers of treatment, not the young person. Parental authority and unity needed to facilitate recovery.

Eating Disorder is Externalised or separated from the sufferer & the ED is targeted to reduce blame and criticism.

Primarily a behavioural intervention, it is hoped that thoughts will shift with the exposure and habitation to the foods

Psychoeducation – dangers of severe malnutrition; regular eating; cognitive and emotional changes

Shared understanding of healthy weight range for individual/ historical weight/height trajectory & BMI as indicators of progress in therapeutic intervention.

What works and what doesn't when working as a GP with people with body image and eating issues

Vivienne Lewis

Clinical Psychologist

About your presenter

- Clinical Psychologist (18 years) specializing in treating children, adolescents and adults with body image and eating issues
- Academic at the University of Canberra and Director of Master of Clinical Psychology Program and runs own practice
- Author of ‘Positive Bodies. Loving the Skin You’re In. and No Body’s Perfect’.
- Currently writing a book for professionals including GPs on how to work with people with eating and body image issues
- Contact details: 0411801556 or vivienne.lewis@canberra.edu.au

Recent study conducted at UC on GP's perspectives of working with people with disordered eating (Emma Coy, 2019 honours; V. Lewis, M. Minehan, supervisors)

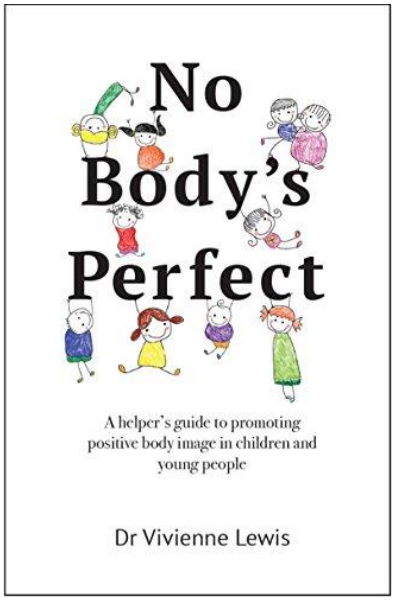
Qualitative research with ACT GPs

Important to acknowledge that working with people with eating disorders is challenging. Don't work in isolation

GPs can feel alone and under resourced

What are GPs concerned about?

- Reluctant to open the box
- Not enough time to build rapport (rapport is essential according to patients)
- Recovery can take 2-5 years
- Poor prognosis
- Managing risk
- Expectations vs reality
- Forming the multidisciplinary team



What's important to GPs?

- Good communication with the treating team
- Sharing the risk
- Support from other professionals
- Having more time for consultation and follow up

Patient experiences

- Hold back from telling GP
- Put off by being weighed or feeling judged
- Want to be involved in decision making
- Often feel relieved when taken seriously and ED identified and diagnosed
- Want consistency of care

What's important to patients?

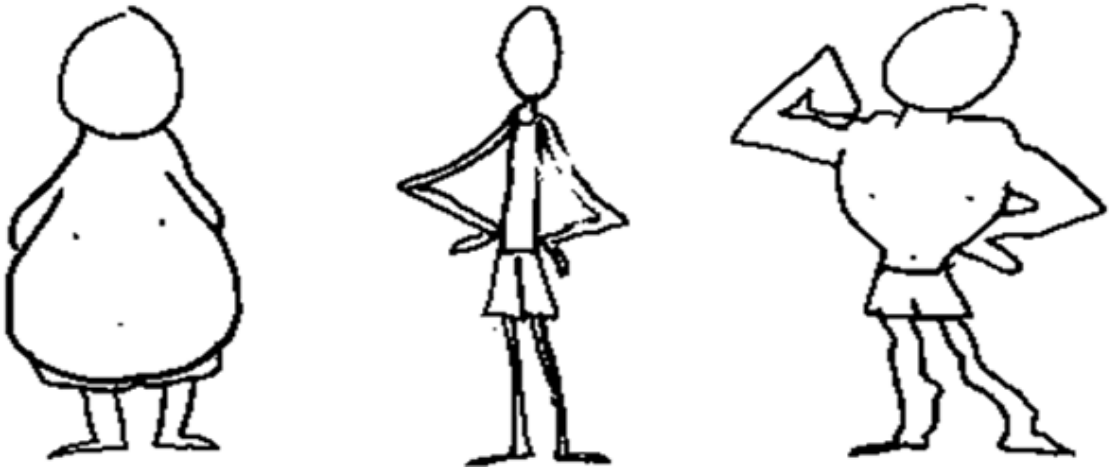
- The therapeutic relationship
- Not to comment on weight
- Realise being weighed can be very distressing
- That the treating team communicate well with each other
- GP training

Important considerations

- Spend time with patients to build rapport
- Ask about eating and body image
- Realise patients are at different stages of change and motivation
- Psychoeducation is important especially medical complications and risks
- Must work with a team
- Get to know the services in ACT including EDP

What's your stereotype of someone with an eating disorder?

What is the reality?



Myths busted

- Males have body image and eating issues to
- You can’t judge an eating disorder by what someone looks like. Examples of obese or overweight patients with severe restrictive eating disorders

Assessment

- Physical health including bloods, bone density, weight, hormones
- Eating Disorder Questionnaire for additional Medicare rebates
- Assess regularly – look for changes

Essentials

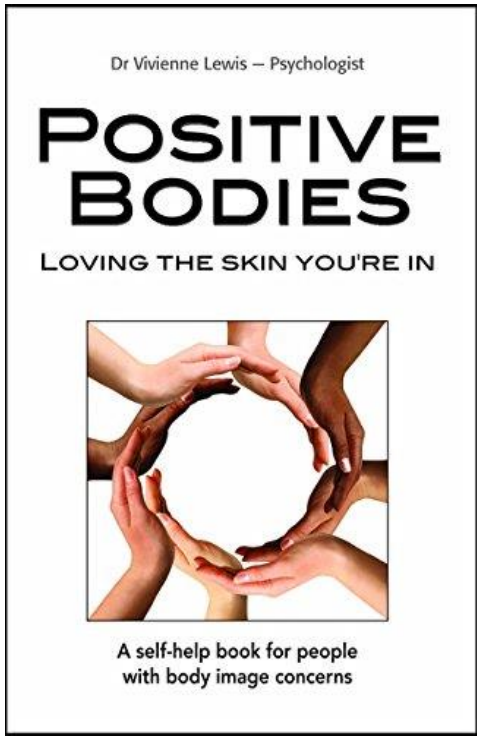
- No judgement
- Empathise
- Ask where client is at
- Seek permission
- Set goals – client's, yours, parents
- Must build trust
- Work collaboratively
- The need to involve others
- Externalise the ED – it is a condition, its not you

Treatment

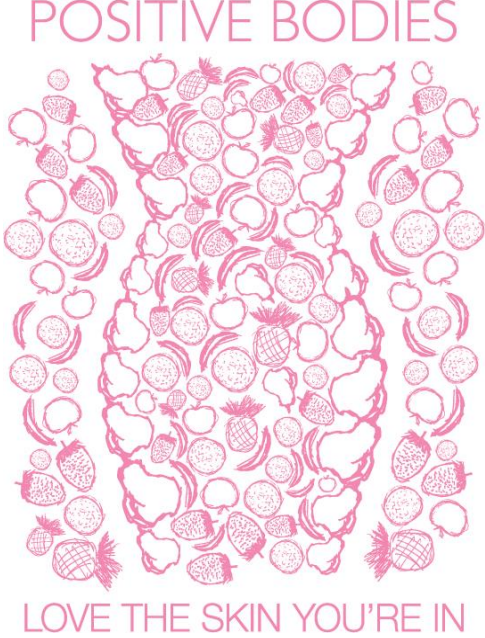
- Requires at team
- Need to communicate between team and gain client permission for this
- Psychologist –Australian Psychological Society referral services
- Look for psychologists in your area and who you know about
- Engage psychiatrist?
- Engage parents and loved ones
- Dietician

Core components of CBT

- Goal setting: changing attitude, not appearance
- Education around diagnosis and dangers
- What is body image and what is its significance?
- The development of a negative body image
- Changing behavior to change feelings
- Dealing with anxiety and body distress
- Changing attitudes and thinking
- Stopping ritualistic body behaviours and eliminating fears
- General health: sleep, stress management
- Self-esteem building



Resources



- Butterfly foundation
- No Body's Perfect – Lewis, V
- Positive Bodies: Loving The Skin You're In – Lewis, V
- Australian Psychological Society – tip sheets

Eating Disorders

Presented by Accredited Practising Dietitian

GEORGIA HOUSTON

gh NUTRITION

Hi there!
I'm Georgia Houston.

Accredited Practising Dietitian, specialising in eating disorders.

Private Practice, GH Nutrition, located in Griffith.

Master of Nutrition and Dietetics and Graduate Diploma in Nutritional Science at UC and Bachelor of Science (Psychology) at ANU.

Food product line, selling healthy cereals and energy balls to local grocers and cafes.

Program

How eating disorders chose me

Eating Disorder Plan and when to be used

Blood work - what to look out for

RAVES model

What to do if a patient is not compliant with the dietitian's advice

Referral details.

My own experience with an eating disorder

- 19-22 years old.
- Orthorexia Nervosa - not currently classified as an official ED diagnosis but growing recognition that it may be a distinct ED.
- An obsession with healthy, or "clean" eating. People will obsess about the benefits of food and **food quality, not necessarily food quantity.**
- Just like some of you sitting here today, unsure what to do, this was the same for myself and my parents but tenfold.
- Butterfly Foundation was my parents first point of contact, then GP and EDP for assessment. All of this was very overwhelming.
- I felt scared, ashamed and alone.
- Inappropriate referrals, labels and costs involved were setbacks.
- Motivated to get better so I could prevent this from happening to other young women.
- Today = my own private practice, specialising in ED. Plus, go into high schools to talk about ED awareness and prevention.

Eating Disorder Plan (EDP)

GP EATING DISORDERS PLAN (EDP)

Item Nos: 90250 - 90257

GP DETAILS

GP Name Provider No.	<UsrName> <DrProviderNo>	Practice Name & address	<Practice> <DrStreet> <DrCity> <DrState>

Practice postcode	<DrPostcode>	Practice phone	<DrPhone>	Practice fax	<DrFax>

GP or practice email	<DrEmail>
GP preferred method/s of multidisciplinary team communication	□ Letter □ Email. _____ □ SMS _____ □ Phone call _____ □ Other _____

PATIENT DETAILS

First Name	<PtFirstName>	Last Name	<PtSurname>
Date of Birth	<PtDoB>	Age	<PtAge>

Marital Status	□ Never Married □ Widowed □ Divorced □ Separated □ Married/De facto
Current Gender Identity	□ Female □ Male □ Non-binary □ Not Stated □Transgender Female/Male-Female □ Transgender Male/Female-Male
Address	<PtStreet>

Suburb	<PtCity>	Postcode	<PtPostcode>
Phone 1	<PtPhoneMob>	Phone 2	
Country of Birth		Cultural Identity	

Aboriginal or Torres Strait Islander	□ Aboriginal □ Torres Strait Islander □ Both □ Neither □ Unknown
Main language spoken at home	

- Began 1 November 2019 - 64 new MBS items introduced to support a model of best practice, evidence-based care for eating disorders.
- **Medicare rebates for up to 40 psychological sessions and 20 dietetic sessions within a 12-month period.** For example, if an EDP is commenced on the 3rd March 2021, it will be valid until the 2nd of March 2022.
- Differs to Mental Health Plan - only allows access to 10 psychological rebates.

Forms to complete

Eating Disorder Care Plan (EDP) Item

- Nos for GP's: 90250-90257 Long
- appointment needed.

EDE-Q - Eating Disorder Examination Questionnaire

- An EDE-Q score over 3, indicating a level of illness severity, is one of the eligibility criteria for the Medicare Items for people with a Bulimia Nervosa or OSFED diagnosis.

GP Care Plan Review Template

- The GP can use this template to complete the Eating Disorder Care Plan Review at session 10, 20 and 30 (needed for psychologists only). Dietitian only required to report back after 1st and 20th session or as clinically required.

An individual who has a clinical diagnosis of Anorexia Nervosa OR

Eligibility for EDP

- An individual has a clinical diagnosis of Bulimia Nervosa, Binge Eating Disorder or Other Specified Feeding or Eating Disorder (OSFED) and meets the following eligibility criteria:
  - Global EDE-Q score of 3 or higher; and
  - The patient's condition is characterised by rapid weight loss, or frequent binge eating or inappropriate compensatory behaviour as manifested by 3 or more occurrences per week; and
  - The patient has at least two of the following indicators:
    - Clinically underweight with a body weight less than 85% of expected weight where weight loss is directly attributable to the eating disorder.
    - Current or high risk of medical complications due to eating disorder behaviours or symptoms.
    - Serious comorbid medical or psychological conditions significantly impacting on medical or psychological health status and function.
    - Overnight inpatient admission for an eating disorder in the previous 12 months.
    - Inadequate treatment response to evidence-based eating disorder treatment over the past six months despite active and consistent participation.
- NOTE: Avoidant Restrictive Food Intake Disorder - not eligible for EDP.

Eligibility for EDP

Eating Disorder examination questionnaire (EDE-Q 6.0)

Instructions: The following questions are concerned with the past four weeks (28 days) only.

Please read each question carefully. Please answer all the questions. Thank you.

Questions 1 to 12: Please circle the appropriate number on the right. Remember that the questions only refer to the past four weeks (28 days) only.

	ON HOW MANY OF THE PAST 28 DAYS ...	NO DAYS	1-5 DAYS	6-12 DAYS	13-15 DAYS	16-22 DAYS	23-27 DAYS	EV
1	Have you been deliberately **trying** to limit the amount of food you eat to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	
2	Have you gone for long periods of time (8 waking hours or more) without eating anything at all in order to influence your shape or weight?	0	1	2	3	4	5	
3	Have you **tried** to exclude from your diet any foods that you like in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	
4	Have you **tried** to follow definite rules regarding your eating (for example, a calorie limit) in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	
5	Have you had a definite desire to have an **empty** stomach with the aim of influencing your shape or weight?	0	1	2	3	4	5	
6	Have you had a definite desire to have a **totally flat** stomach?	0	1	2	3	4	5	

What to look out for - Refeeding risk

Characterised by the occurrence of cardiac failure, delirium and death due to the **metabolic derangements that can occur during the refeeding of a malnourished individual (first two weeks of refeeding).**

Occurs when:

- Most likely to develop in those with BMI <14 (should be hospitalised at this point).
- A body in starvation receives an influx of enteral glucose.
- Causes an insulin surge - driving glucose, fluid and electrolytes into the intracellular space.
- Results in a **rapid reduction of (already depleted) serum electrolytes i.e. phosphate, potassium and magnesium.** Causes hypophosphatemia, cardiac and neurological events and sudden death.
- Rare and can be avoided i.e. correcting electrolytes, especially phosphate, plus initiating refeeding with a low caloric intake.

Indicators for admission to hospital based on refeeding risk (adults)

RE-FEEDING RISK	HIGH	EXTREME
Weight	Body Mass Index (BMI) < 16kg/m^2	BMI < 14kg/m^2
Weight loss	> 10% body weight loss within the last 3-6 months or ≥1 kg/week over several weeks	
Oral Intake	Little or no nutritional intake for > 5 days (<500 kcal, or 50 g carbohydrate/d)& underweight (BMI <18.5kg/m^2)	
Systolic BP	< 90mmHg	< 80mmHg
Postural BP	>10mmHg drop when standing	>20mmHg drop when standing
Heart Rate		< 40bpm or >110bpm or significant postural tachycardia (> 10bpm when standing)
Temperature	<35.5°C	<35°C or extremities are cold and blue
ECG findings		Any arrhythmia including QTc prolongation or non-specific ST or T wave changes including inversion or biphasic waves
Blood sugar	<3.5mmol/L	<2.5mol/L
Sodium	<130mmol/L	<125mmol/L
Potassium	<3.5mmol/L	<3.0mmol/L
Magnesium	0.7 – 1.0mmol/L	<0.7mmol/L
Phosphate	0.8mmol/L	<0.8mmol/L
Albumin	<35g/L	<30g/L

Canberra Hospital and Health Services
Clinical Guideline
Adults with Eating Disorders - Management of (Inpatients)

Indicators for admission based on refeeding risk (adults)

Albumin	[illegible]	[illegible]
Liver enzymes	Mildly elevated	Markedly elevated (aspartate transaminase (AST) or alanine transaminase (ALT)>500)
Neutrophils	<2.0 x10^9/L	<1.0x10^9/L
Severity of Eating disorder Symptoms	- Bulimia nervosa (BN) without control of vomiting - Vomiting more than 4 times per day - BN with hypokalaemia - Excessive daily laxative use	
Risk Assessment	- Suicidal ideation - Active self-harm - Moderate to high agitation and distress - Other psychiatric condition requiring hospitalisation	
Other	- Not responding to outpatient treatment - Averse family relationships or severe family stress	
Note: any biochemical abnormality that has not responded to adequate replacement within the first 24 hours of admission should be reviewed by a medical registrar urgently		

Canberra Hospital and Health Services
Clinical Guideline
Adults with Eating Disorders – Management of (Inpatients)

Indicators for admission based on refeeding risk (children and adolescents)

Indications for Hospitalisation

A hospital admission may be indicated for any of the following criteria:

- Heart Rate <50 bpm,
- Cardia arrhythmia including a prolonged QTc interval (>450 msec)
- Postural tachycardia >20bpm increase heart rate
- Blood pressure <80/40 mm/Hg or postural drop >30 mm/Hg
- Temperature < 35.5°C
- Low serum potassium ≤3.0 mmol/L
- BSL <3.0mmol/L
- Other significant electrolyte imbalances
- BMI ≤ 14
- Rapid or consistent weight loss (e.g., > 1kg each week for six or more weeks)
- Acute dehydration or patient has ceased fluid intake
- Intensive community-based treatment has proven ineffective
- Comorbid or pre-existing psychiatric conditions that require hospitalisation
- Suicidality with an active intent and plan
- Other special considerations such as diabetes or pregnancy

NSW Eating Disorders Toolkit
A PRACTICE-BASED GUIDE TO THE INPATIENT MANAGEMENT OF CHILDREN AND ADOLESCENTS WITH EATING DISORDERS

RAVES model

- Created by Australian APD Shane Jeffreys.
- RAVES is an acronym that provides a step-by-step process to help with developing a healthy relationship with food.
- RAVES stands for Regularity, Adequacy, Variety, Eating Socially and Spontaneity.
- Sequential and compliments the pace and progress of the patient. Best completed with a multidisciplinary team i.e. Psychologist and Dietitian.

Regularity

- Foundation of healthy eating. At this stage, I don't care what the patient is eating.
- Regular eating consists of three main meals and two to three snacks (breakfast, morning tea, lunch, afternoon tea, dinner and dessert).
- Regular eating helps to:
  - Reduce grazing
  - Prevent binge eating
  - Improve metabolism
  - Strengthen digestive muscles
  - Improve bowel regularity
  - Maintain stable blood sugar levels throughout the day
  - Develop regular hunger and satiety signals
  - Provide an opportunity to spread nutrition throughout the day and meet nutritional requirements.

Adequacy

- Achieving nutritional adequacy involves eating all food groups in a way that will provide your body with what it needs for optimal functioning. Here I look at what the patient is eating and is it enough.

- This helps to achieve medical stabilisation, nutritional rehabilitation, and an appropriate goal weight **range.**

- When the brain is properly nourished, it can carry out vital processes such as perception, problem-solving, planning, memory, decision making, and emotion regulation. Once semistarvation has been corrected, an individual will be in a better position cognitively to address the underlying thoughts and feelings that keep disordered eating behaviours going. This is called starvation syndrome.

Variety

- This step involves developing a positive relationship with food and lays the foundation for more social eating, ultimately allowing the patient to improve their quality of life.

- Variety involves moving beyond safe foods or the notion of ‘good and bad’ foods. It allows food to become more interesting and enjoyable.

Eating Socially

- Eating socially is about being able to go to a café with friends, or going to a family member's house for lunch.

- This can be challenging as it involves other people preparing and serving food, however, it is an important step towards gaining and maintaining a healthy relationship with food.
- It also helps to strengthen social connectedness. This is important because social networks can help to distract from disordered eating thoughts.
- Until patients are renourished and ready to be eating socially, I encourage them to eat their safe foods/home-cooked. Eating socially, if not ready, can cause setbacks into ED behaviours i.e. restriction/bingeing/purging.

Spontaneity

- This last step is about having a more natural relationship with food i.e. life before the eating disorder.

- At its core, spontaneity is about being flexible with food and eating. For example, the patient may have had plans to make a certain meal for dinner and then gets invited to dinner with a friend last minute. Spontaneity allows the patient to be able to accept the invite, even though it is not what was originally planned.

- Spontaneity helps to manage unpredictable situations and further facilitate social connectedness. In this way, spontaneity is advantageous for sustaining recovery in the long term.

When a patient isn't following the dietitian's advice?

- Case-based.
- Offer other health professionals/dietitians. People connect with different people.
- Visit Find an APD on the Dietitians Australia website - list and contact details.
- Encourage eating more safe foods. For example, if eating 2 meals a day, encourage the patient to incorporate another meal or snack, based on safe foods. The goal is 3 main meals and 3 snacks.
- Using clinical judgement, weekly bloods/check-up by nurses/GP to monitor health
- If a child/teen, ask the parent to take back full control of food preparation and choices. Might mean getting school involved/parent sitting with the child for every meal and snack.
- Keep it simple - plate model (peace sign) for main meals. Nil talk of calories.

Referral details

Email

info@ghnutrition.com.au

Website

www.ghnutrition.com.au

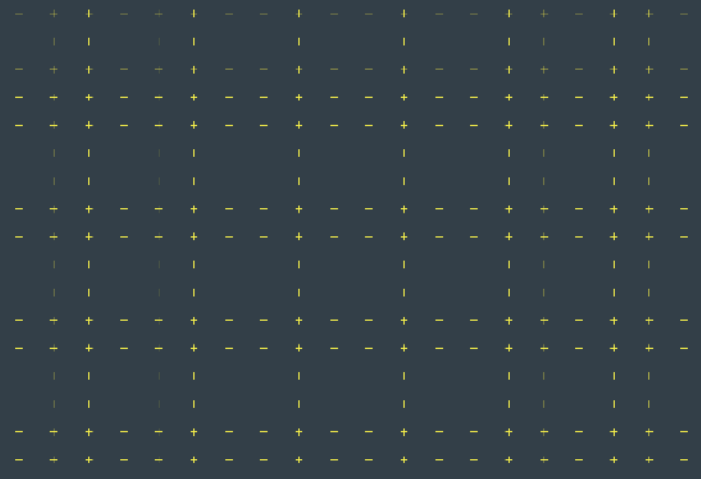
Phone number

0412 531 290

Address

7 Murray Crescent, Griffith, ACT 2603.

Questions?



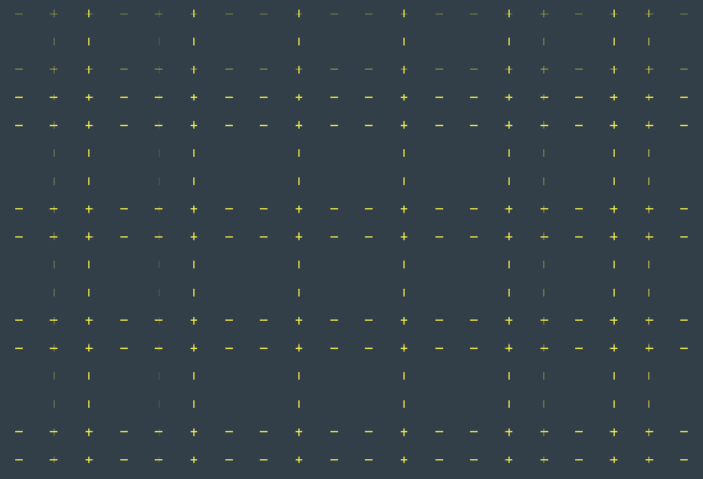
phn ACT
An Australian Government Initiative

Capital Health Network
Partnering for better health

Closing Remarks

- The evaluation surveys will be sent out shortly after the event. The evaluation survey will need to be completed in order to receive the CPD points for attending today.

- Please return your name badges to the registration desk on your way out so they can be reused.



phn ACT
An Australian Government Initiative

Capital Health Network
Partnering for better health

IMAGINE BETTER

Thank You!

www.chnact.org.au

phn ACT
An Australian Government Initiative

Capital Health Network
Partnering for better health