8: Summary sheet for liaison psychiatrists

Who is this for?
Liaison psychiatrists assessing and managing patients with severe eating disorders in general hospitals.
See also RCPsych's Liaison psychiatry for every acute hospital (CR183)

a. Risk assessment

Patients with eating disorders can appear well even though severely malnourished. The patient may falsify their weight and over-exercise. Consult the risk assessment tool (Chapter 2) and checklist (Appendix 3), and use measures that seem relevant to the patient you are assessing. Common risks relate to low weight, electrolyte imbalance and self-harm ideation. If needed, consult with an eating disorder psychiatrist.

See Chapter 2 and Appendix 3

b. Location of care

For a severely ill patient with an eating disorder, the safest inpatient bed is usually in a specialist unit or a dedicated specialist eating disorder bed. If that is not available or appropriate, the patient may require admission to a medical bed, and the medical team must be supported fully by the liaison psychiatric team. If eating disorder expertise needs reinforcing, the support of an eating disorders specialist in person or online should be obtained. The psychiatrist should support the medical team at all stages even if the patient is very ill and unable to communicate.

See Chapter 3

c. Safe refeeding

For most underweight patients with eating disorders, feeding can start between 1,400 and 2,000 kcal per day, rising by around 200 kcal per day until weight gain is achieved,. Some patients may require nasogastric feeding and advice on managing this is provided in Chapter 4. The possibility of refeeding syndrome (e.g. falling phosphate) should be borne in mind. For some patients with coexisting medical illness, lower rates of refeeding may be appropriate in which case underfeeding syndrome with nutritional deterioration must be avoided.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

The liaison psychiatrist should assess the patient for the presence of behaviours which may sabotage recovery. These include exercise including micro exercise, hiding or disposing of food or feed, and falsifying weight. These behaviours should be brought to the attention of

the medical team, who should be advised on how to manage them. Medication (e.g. olanzapine) may be advised to reduce anxiety in patients undergoing refeeding and the psychiatrist should advise the team on this.

See Chapter 6

e. Families and carers

The liaison psychiatrist is likely to meet with members of the family and will become aware of issues in the family which need to be addressed in treatment. These include extreme anxiety and disagreements between family members on treatment options. These issues need to be conveyed to the medical team. Meetings with the family should occur regularly with a member of the liaison psychiatric team together with members of the medical team.

See Chapter 7

f. Compulsory admission and treatment

The liaison psychiatrist will advise on the need for compulsory treatment under legal orders and may be involved in the arrangement of such treatment. The medical team must be fully informed on what treatments are allowed and there will need to be more frequent psychiatric consultation with the patient, family and medical team.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. To promote weight loss, the patient may avoid insulin or hypoglycaemic drugs, which can lead to failure of diabetic control. In the long term, increased severity of diabetic complications can occur. Psychiatrists and physicians must work closely together to optimise outcome in these complex clinical situations.

See Chapter 9 and Annexe 3