1: Summary sheet for psychiatrists

Who is this for?
Child and adolescent, adult, specialist eating disorder psychiatrists assessing and managing patients with severe eating disorders. Note that there is dedicated guidance for liaison psychiatrists in summary 8 on page 18.

a. Risk assessment

Patients with eating disorders can appear well even though they are near to death. The fear of weight gain may lead the patient to falsify their weight and exercise. Please use any measures from the risk assessment tool provided (Chapter 2) that seem relevant to the patient you are assessing, including suicidal ideation. Take views of parents/close others into consideration when assessing risk.

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 a dedicated specialist eating disorder bed. In some situations, admission to a medical or paediatric bed may be necessary, and the medical team must be supported fully by the psychiatric team. If eating disorder expertise is not available in the inpatient setting, the support of an eating disorders specialist in person or online should be obtained.

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 consistent weight restoration is achieved. Some patients may require nasogastric feeding and advice on managing this is provided. The possibility of refeeding syndrome (e.g. falling phosphate) should be borne in mind and for some patients with coexisting medical illness, lower rates of refeeding may be appropriate. A decision tree is provided (Figure 4 of the guidance). If lower rates of calorie provision are used, underfeeding syndrome with nutritional deterioration must be avoided.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

The psychiatrist should assess the patient for their motivation, strength of psychopathology, and behaviours that may influence recovery. These include covert (micro) exercising, hiding or disposing of food or nasogastric feed, and falsifying weight by drinking water or wearing weights. These behaviours should be brought to the attention of

the clinical team who you should advise on how to manage them. Sometimes medication can help to reduce anxiety in patients undergoing refeeding, and the psychiatrist will be central in advising on, e.g. olanzapine as an adjunct to care.

See Chapter 6

e. Families and carers

The psychiatrist should talk to families and carers during treatment and ensure an appropriate level of involvement in decision-making while taking the patient's wishes into consideration. Psychiatrists are particularly well placed to address anxiety and disagreements between family members or carers on treatment options. These issues need to be conveyed to the medical team. Meetings with the family or carers and (in the case of younger patients) parents should occur regularly with a member of the psychiatric team together with a member of the medical team.

See Chapter 7

f. Compulsory admission and treatment

The psychiatrist will advise on the need for compulsory treatment under legal orders or, in children (rarely), parental consent, and may be involved in the arrangement of such treatment. The medical team must be fully informed on what treatments are legally allowed and psychiatric consultation with patient, family/carers, mental health advocate and medical team will need to be more frequent. Rarely, psychiatrists may need to raise safeguarding concerns.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. Insulin or hypoglycaemic drugs may be avoided by the patient to promote weight loss and this 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 outcomes in these complex clinical situations.

(see Chapter 9 and Annexe 3)