Multidisciplinary Masterclass: Best Practice in Eating Disorders

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Dr Sarah Trobe (00:00:01):

Good evening everyone and welcome to the MHPN Webinar on Multidisciplinary Masterclass. I'd like to start tonight by acknowledging the traditional owners on which we're all joining this evening. I'm joining from the lands of the Wurundjuri people of the Kulin Nation, and I'd like to pay my deepest respects to their elders past and present and note that these lands were never seated. I would also like to acknowledge the contribution of those with lived and living experience to the work that we do. I know that all of us on the panel have learned so much and are guided by those that share their stories, and I'd like to acknowledge any of those that are in the room with us this evening. So we've got a really packed full schedule tonight. We're really excited to have so many people joining us to talk about best Practise Multidisciplinary Care in Eating disorders.

(00:00:52):

I'm Sarah Trobe and I'm the National Director of the National Eating Disorders Collaboration, and I'm also a clinical psychologist. I'm joined by a wonderful panel from our sector and we've just had a wonderful few days together at our Australia and New Zealand Eating Disorders Conference, so it's really nice to be joining back together and also during Body Image and Eating Disorders Awareness Week here in Australia. So thank you everyone for taking the opportunity to engage in this learning experience with us tonight, and I really encourage you to engage in and connect with other resources and activities that are happening during the week. So tonight I will be facilitating a case discussion, a hypothetical case discussion through three different stories, and I'm joined by Amy Woods, a lived experience advisor and also counsellor Karen Spielman, our gp, Phillipa Hay, a psychiatrist, and Tom Scully, our dietitian. We'll be presenting and introducing a brief hypothetical case study and then we are going to be really on our toes and just thinking on the spot about how multidisciplinary care could work for this person.

(00:02:03):

I might throw in some curve balls, we'll just see where the conversation goes, but I'll be really leaning on our panel here if be thinking about how we can provide best case multidisciplinary care for these people, but also thinking about the complexities and challenges that MDT Care can bring and the challenges we might face in bringing a team together around different diagnostic presentations, really supporting a person with an eating disorder and other co co-occurring conditions. Also, I know that those in the audience will be joining us and from a perspective of different professions, and what I will say is when I talk about mental health professionals, I'm really talking about the broad number of professions that sit under that umbrella. So our psychologists, social workers, occupational therapists, counsellors, mental health nurses, so many different people can provide the mental health or psychological treatment, but rather than naming lots of different professions, I'll probably just use that term as we go through.

(00:03:03):

I guess what we'll also be thinking is thinking about risk and how we might be managing risk between our care team, how we're having conversations and communicating with each other as well, and really thinking about what does person-centered care mean and we'll be exploring some challenges to that if the care team are not aligned in our perspectives on the case. So I am going to

introduce the first case and we're not going to start easy. We're going to start with a fairly complex case but also something that's quite timely with some introduction of different medications that are coming onto the scene at the moment. So if the panel are with me, I would like to introduce our first case, which is Arthur. Arthur is a 44-year-old male. He has been referred by his GP to a dietitian, so I'm going to be throwing to Tom first.

(00:03:55):

He's been referred to Tom for weight management. So the GP has determined that Arthur is classified as overweight and so Arthur has come to you, Tom, to talk about weight management. Arthur hasn't started any medications, but he has expressed interest in talking about and exploring the option of GLP weight loss management, which are some of those drugs like ozempic which have come on the scene recently. Tom, when you first see Arthur, you complete your assessment and you identify that Arthur May have binge eating disorder. So I'm going to ask you the first question, Tom, is why would this case be complex? Where do you start with a presentation like the one that Arthur is bringing?

Tom Scully (00:04:44):

Yeah, thanks Sarah. I think it's definitely a common presentation that I am increasingly coming across. We know that rates of eating disorders are higher in people with weight and shape concern, particularly people engaging with weight management services, whether that's seeking bariatric surgery or weight loss medication. And yeah, it's tricky because on the one hand, often people's desire for weight loss makes a lot of sense. I want to feel more comfortable within myself or maybe I want to manage some health concerns. We know that weight loss attempts and behaviours that people engage in to lose weight can actually exacerbate eating disorder behaviours, particularly things like binge eating where we might see that restrict binge cycle come in. And so we want to I guess validate Arthur's desire to lose weight and just get a bit curious about what ways, if any, this might be feeding into some of the other things that are going on for him, like the binge eating. Yeah, so I guess I'd start with just being curious about what's the desire for weight loss for, is this something that you've been pushing for yourself or you're feeling pressure from other people perhaps to lose some weight and are there health concerns in here that maybe are increasing pressure to want to lose weight? Something like some insulin resistance or type two diabetes wouldn't be uncommon with this type of presentation or is this just about appearance and body image and how you feel within yourself?

(00:06:07):

I'd probably want to know a little bit about what he's done as well in terms of trying to lose weight in the past. Is this a first attempt or is there a bit of a history here that we could dig into?

Dr Sarah Trobe (00:06:16):

Yeah, nice. So obviously a more comprehensive assessment, getting a full picture of Arthur's history, his current presentation, and I was hearing in there too that there might've been some extra health information that you might want to obtain. How would you go about it if Arthur wasn't able to provide a full health history, what would be your approach with the GP in that instance?

Tom Scully (00:06:38):

Yeah, lovely. So I think Arthur's been referred, hopefully he's been referred with maybe a chronic disease management plan or something that has a bit of that information in there, but if that hasn't

been provided, then absolutely we make sure I've got consent to reach out and perhaps get some of that information from whoever's involved in his care team at the moment. We know that sometimes people particularly have got a bit of health stuff going on, might get a little bit overwhelmed or struggle to kind of remember all of the details. So yeah, chasing it up from where the records are kept.

Dr Sarah Trobe (00:07:08):

Yeah. Nice. Karen, I'm going to throw to you in this particular instance, if Arthur had first presented to you as an eating disorder informed gp, you're aware of the risks that can come with GLP and towards eating disorders, but Arthur came to you expressing interest in wanting to explore weight management. How would you approach that with him?

Dr Karen Spielman (00:07:31):

Thanks, Sarah. If others come to me first, then I would actually take a pretty similar approach to Tom taking my time to understand where he's coming from. We've learned a lot in the last few years about people's seeking weight management and there are a lot of people in general practise who are interested in the area. So there has been a lot of information coming to us loud and clear in general practise land probably overwhelms the eating disorder information a little bit. So I think one of my first approaches would be to take that into account and just make sure that I am coming from a weight neutral perspective to start with being curious about exactly as Tom said, what are his reasons and asking the question about relationship with food and with his body just to ascertain at a fairly early stage. And that's what I'm hoping to be able to educate my GP colleagues on that if we can start bringing this into the conversation earlier, it does help us to work out those risks that you're talking about, Sarah, because we know that if we miss an eating disorder in a person seeking weight management, that can be really dangerous

Dr Sarah Trobe (00:07:31):

Dr Karen Spielman (00:08:55):

Exacerbate the eating disorder. And on the other hand, we know that there are some risks of being overweight, understanding different people's language use, which I know that NEDC has been really great at and helping educate people, but that not necessarily the health risks may not necessarily be related to weight. So it becomes a very nuanced conversation and I would definitely be taking my time to try and work out where Arthur wants to start, as you said, a patient-centered approach.

Dr Sarah Trobe (00:09:34):

Yeah, beautiful. And so then it was just wonderful to have a gp, Karen that could hopefully have that time in the system that we have with possibly short session time with a gp and you've identified that Arthur does have binge eating disorder. What would that mean for where you refer Arthur and what that care team might look like?

Dr Karen Spielman (00:09:55):

Well, binge eating disorder as with all eating disorders requires such a beautiful communication between a multidisciplinary team and the older and wiser I get. The more I realise we cannot do

these things on our own people and their health issues are very complex and the more skilled and informed people that we communicate with, the better it is, the better outcomes it is for our patients. So I would definitely be including a dietitian and a psychologist and if there are any complications that we weren't able to manage at that primary health stage, then including specialist input from somebody like Philippa and her colleagues would be terrific as well because they can be complex comorbidities, can't they? With binge eating, we are more and more aware of a whole heap of common comorbidities.

Dr Sarah Trobe (00:10:50):

Beautiful. That was a perfect segue, Karen, I was actually going to go to you next Philip, just to think about the care team and recognising that understanding weight loss medications, it's a new thing that not the whole care team might even understand what they are, how they might interact, what the risks are, Philippa, how would you approach that with a care team if you felt that maybe the team weren't aligned in the treatment approach or understanding why we're trying to do what we're doing?

Prof Phillipa Hay (00:11:19):

Well, I'm really lucky. I work with a wonderful multidisciplinary team and they're really receptive to conversations about should we be using Aspic for this person or not, et cetera. And I think it's really important to think the fact that this is a comorbidity, this person has two problems, potentially certainly has a mental health problem, which is the binge eating disorder, and I'd definitely be referring back to Karen and saying, please fill out the eating disorder care plan because binge eating disorder is a significant mental health disorder with significant morbidity, comorbidities, depression, mood changes, and also putting my mental health professional hat on, not assuming this is bingeing eating disorder. Many people also have non purging forms of bulimia nervosa, so this person might be just going from binge to fast, binge to fast cycle and have very dysregulated eating and associated mental health impairments as a result of bulimia nervosa.

(00:12:25):

And the thing I'd be stressing to other is that it is a disorder and it's a very treatable disorder and no matter what happens with weight or pic, et cetera, we can help you with the eating disorder. There are actually very effective psychological therapies for binge eating disorder that work and so let's get on and help you with that. Not ignoring the fact there may be also significant medical comorbidities, but we have to think about what they are, what they may be, and working with a physician or with Karen, with the GP in terms of managing those. And really there's now I think a view that there is this now the lancer commission view of what's called clinical obesity, that there is high weight and then there is impacts of high weight on the person's metabolic status on the physical health and the cardiovascular status, et cetera. And that's a very different situation to where that isn't, there may be increased risks because of high weight, but there actually at the moment aren't a lot of medical comorbidities. So Wyn one says someone is overweight or high weight, that's a huge spectrum of presentation and it may be that Arthur doesn't have anything that really needs to be addressed, but he does have a significant mental health disorder and we can address it. So that's where I would start.

Dr Sarah Trobe (00:13:59):

Yeah, wonderful. There was so much in there. You'll all see me when I put my head down. I'm just jotting down notes and I'm going to come full circle back to you Philippa, but Amy, if it's okay, I wanted to throw to you in that a few of those ideas that were coming out there is around the idea of person-centered care that we might've identified binge eating disorder and Arthur is saying, I really want to lose weight. Do you have any reflections on person-centered care in this instance and how the care team can just provide that wraparound support for him?

Amy Woods (00:14:31):

Yeah, the thing that really strikes me here is making sure that we're understanding what Arthur's relationship is to kind of the world around him in the body that he's in. If he's presenting in a larger body, then we also need to understand what's his relationship to diet culture and weight stigma. What are the experiences negative or positive that he may have experienced around being in the body that he's in and how is that particularly impacting things like depression and anxiety and self-esteem and all of that. So what I think Karen and Tom and Phillip all really spoke to was kind of creating these spaces where he can have his body story sort of heard so we're not just jumping to a conclusion of, yep, okay, great, we're going to put you on the GLP one, or no, that's not happening. We're going to send you off for a therapy that you don't want.

(00:15:24):

But actually creating space to hear him in all of his complexity or all of his nuances so that we see him as a whole and that also he has space to unravel a little bit of that himself as well. Yeah, just this idea of having a pause, collective pause together and saying, all right, let's unravel this a little bit further before we make any decisions because ultimately this is his life and this is his body, and I think with eating disorder professionals, we're always like, no, go to treatment, go the treatment, but it's a really, really tricky world that we live in and it's even going to be even more complex for somebody that is living in a larger body.

Dr Sarah Trobe (00:16:09):

Thank you. Amy, you just got me reflecting. I was fortunate to attend a session on complexity at the conference on the weekend and the importance of us spending time in the place of formulation. We've got our basic CBTE formulation, but sometimes that doesn't capture all of the things that you were just talking about, Amy, and then we're adding in potential health conditions and how do they all interact and into play. I'm wondering about who should be doing that formulation with Arthur and then how do we make sure that that story reaches everyone else?

Amy Woods (00:16:47):

I think in a typical setting you'd be having a psychologist supporting that formulation, but I also really like the idea of having space for Arthur to actually work on his own formulation, so whether that's sort of collaborative with the psychologist or maybe that's that he starts with the psychologist and he goes home and with a partner or a loved one, he kind of continues to work on it because we need it to make sense for him and we need it to make sense for the care team as well. It's a connected thing. If he's got no idea what the psychologist is referring to, then what good is any sort of treatment or therapy or support going to be because it's totally misaligned with where he's, and I think it comes back to this really important point of communication. I know that when I've got clients where we've got a big care team, my typical practise would be to every time I see them is I just send a little quick update email and that just fits there. It might fit in their email and they don't

necessarily have a chance to read it, but I know that they can easily refer back to the latest information about how we're supporting someone through the current circumstances.

Dr Sarah Trobe (00:18:00):

Yeah, thanks James. That's really, really helpful, Tom. Yeah, I'll sort about giving you, Tom read

Tom Scully (00:18:05):

My mind. I just wanted to add on to that. I think dietitians are probably not the first port of call that people would think when we think formulations, but we absolutely do our own kind of nutrition formulation type process, whether it's as formal as a mental health clinician might not, and I think it can be nice to kind of join the two together. Phillipa mentioned before this could be somebody who's got some metabolic health stuff going on and so digging into that, the initial instinct might be to say, oh, it's because he's overweight, but we know that binge eating behaviours often happen on maybe higher reward foods when those are happening regularly that there isn't a restriction. It could be that there's something to do with the type of food that this person's eating that's causing blood pressure to be a bit higher or cholesterol to be a little bit out of whack. And so getting the kind of bringing in the biology and the nutrition side of things as well. I think to go with what our psychs are doing on the mental health side of things can be quite helpful.

Dr Sarah Trobe (00:19:00):

Yeah, beautiful. It just keeps on coming back to, and I know we're talking about eating disorders and core principle of care is a multidisciplinary care team at absolute minimum mental health medical monitoring, but often the dietitian is involved and then depending on the person's experience, there might be other medical specialists, might be physiotherapy, peer support, et cetera. Coming back to that idea of health and mental health and how we're making a formulation about how will these things interact with each other, Karen, how do you approach that and then again, sequencing, how are we still supporting Arthur when we might have a myriad of things that we're trying to address at once?

Dr Karen Spielman (00:19:41):

Absolutely, and I was trying to think where I want to come in first on that question, Sarah, because there's my advocacy hat where, and I don't know how many people are listening to us, but I would love to advocate for people to support our system to allow longer consultations, higher patient rebates for longer consultations because this is really such a beautiful part of general practise where we've got mind and body, we have our physical risks, we have our mental health risks all sitting together with Arthur who let's assume he's got a good going binge eating disorder, but he may have depression anxiety, he may have Phillipa mentioned, the clinical obesity symptoms that may need more urgent attention. I feel personally that that does sit largely within general practise if the system allows it and if the GP is able to and interested. So I would be advocating for our clients and consumers to find a GP able to help them in a really interested way and be involved because that's when the magic happens where we actually, we have the thank you to Medicare, we have the ability to write plans, we have the ability to charge for case conferences, we have the ability to refer for further investigation.

(00:21:07):

So we are, as one of my beautiful GP mentors said many years ago, the head of the octopus in some ways, and if you find yourself a good GP and luck with everybody, psychiatrist, psychologists, dietitians, there are good ones and there are ones that might not be as capable in this scenario or as interested in this scenario,

Prof Phillipa Hay (00:21:29):

But

Dr Karen Spielman (00:21:29):

If you have somebody who's interested, that's where we go, okay, let's put it all together. And Sarah, I've also been loving the complexity talks in the conferences and we do this all day long. More and more people have complexity and so with the support of our really learn it and really beautifully communicating colleagues, we can do that together and we will get it quicker. We put the picture together to prioritise together. We just need the system to support us to do that a bit better.

Dr Sarah Trobe (00:22:05):

Absolutely. I'm going to come back to that idea of the session times and how does a GP manage the tentacles that is the octopus.

(00:22:11):

A beautiful reflection I had when we were talking about complexity and presentations is when people from different professional groups had the opportunity to say, oh, this is how I would approach the case. And it was wonderful to see we're all seeing the same person, but we have a social worker speaking and then an occupational therapist speaking a gp and everyone brings their own skillset and expertise to a case and how amazing that is to be really thinking about the whole person and then each of the person in the care team being able to address which parts suit. I guess we talked about the system Karen, and it's so wonderful that we've got Medicare items for eating disorders when people meet the eligibility criteria, but how do you as a GP then manage shorter session times when you are trying to juggle the tentacles of referrals to a multidisciplinary care? So imagine this is the care team, so there's five of us, but it might be more, it might be less,

Dr Karen Spielman (00:23:09):

I'm the wrong person to ask because I do long consultations, but we have the College of GPS president a couple of times ago used to talk about general practise as one long consultation, so we are picking up bits each time we see people, so we may not need the length of consultation for a new patient. We know a lot about our patients already. I've been looking after some patients for nearly 25 years. It's not going to take me long to do a formulation or to put these things together. Otherwise you just get people back. Everybody works in their own way and gps are as diverse as their patients. I always say you will find somebody who will take the time or you'll find somebody who will get you back and make a longer appointment or you'll find somebody who will say, here, go away and do these screeners and get this information and then come back. Or somebody might just make a quick referral. They know that one of their colleagues is down the road and they have the time to do it. So there's just so many ways of approaching it and the beauty of general practise,

Dr Sarah Trobe (00:24:21):

So just problem solving with the time you have and the people that you have available in the care team as well. Yeah, Tom,

Tom Scully (00:24:29):

I think a little bit of a divided conquer approach can sometimes be helpful in this scenario. Authors come to see me, I suspect binge eating disorder. It's not the role of a dietitian to diagnose that, but I can collect some really helpful information, provide a lovely detailed letter through to a GP to say, look, binge eating four times a week. Objectively large amounts of food. There's no compensating behaviours. I asked Arthur to do the online EDEQ through inside out and the score is above three for global EDEQ. What are your thoughts about eligibility for an eating disorder plan here? And then that takes a bit of the grunt work out from what Karen might need to do in a first session.

Dr Sarah Trobe (00:25:06):

Nice. I really love that Tom, and I know there's wonderful resources out there for gps, but we know that not all gps have a lot of knowledge about eating disorder, so we're trying to get the word out there about the GP hub. Just we can go in there. There's training, there's accredited resources out there for gps, but what you are helping to do is then upskill the MDT by providing letters saying, this is my assessment, and you can link them to maybe something that the GP could use in the case that they don't understand. Yeah, Phillipa,

Prof Phillipa Hay (00:25:35):

I was just going to add that I also prime Arthur. I say Arthur, there is this treatment and there are these things called these plans and this is the NEDP website and when you go and see your gp, this is the site to take them to. And actually if you print out and download a few things before and do the EDQ before that all will help set the scene for when you see your GP who has, and really gps do work very hard and don't have a lot of time. So that also I think empowering the patient. I think the person with the problem to understand what is it and what is it that is going to be needed if they're going to be referred on under the plans. But I have to say most people are often blown away by finding out that what they have has a name is a disorder, is a mental health disorder, and furthermore there is Medicare funded care for it. It's often just something people are blown away by.

Dr Sarah Trobe (00:26:31):

Beautiful. And that speaks to the stigma in society about different types of eating disorders that we just don't have general awareness of what these different diagnostic presentations are and that they're common. Yeah, thanks Philippa, Amy?

Amy Woods (00:26:46):

Yeah, I think almost following on from what Philippa was saying is that often obviously in this scenario we've got this amazing GP in Karen, but that's not necessarily everybody's truth. And as Karen mentioned, we've got some gps who are really keen to upskill in this area. They've got a keen interest and then other gps who it's not their strong suit. And so being mindful that whenever we're seeing someone for the first time is that there may have been multiple attempts to seek support in the past there may have been multiple experiences of anti-fat bias discrimination, some really harmful interactions that may have unfortunately happened. And so every time someone steps into

an episode of care, for lack of a better term, they're bringing so much vulnerability with them and it almost can fall on the care team's shoulders to support a little bit of that healing from maybe past harms that have occurred as well. Just something to be really, really mindful of, again, coming back to this idea of the body story and the food story, it's also the help seeking story as well.

Dr Sarah Trobe (00:27:57):

Yeah, thanks Amy. It was a beautiful summary and even we're thinking where we've taken this case from and I knew I would do this tonight. I'm a terrible timekeeper. I'm watching the time and ignoring it as I'm more interested in talking to you all. But if we think about, so if Arthur had come in to a gp, what we would hope there is that the GP is able to take time to really explore Arthur's whole experience, really understanding where is this interest in weight loss, what is happening for his physical health and an awareness of using the gp. How as an example is stepping through, is there a possibility that there is an eating disorder there? And then being able to refer out to disorder informed practitioners using the databases, finding credentialed clinician to say, I know that they can get mental health treatment there, but having that full formulation is really important to think about the sequencing of treatment.

(00:28:52):

They might be really pressing physical health needs and we know that we've got a pressing mental health need there too. So how the team can then collaboratively work together to continue with treatment and maybe there are things happening at the same time, but making sure one doesn't actually impact on the other and worsen the eating disorder symptoms and all worsen health symptoms. There were some nice tips in there too about just sending an email saying, I've seen Arthur today, this is what's going on. Sending letters with links to resources supporting Arthur to advocate for himself. Is there anything I've missed? Philip?

Prof Phillipa Hay (00:29:30):

We haven't mentioned something I think which is trauma and I think trauma is such a common experience for people, both people in the high weight space, also people in the eating disorder space and that may not unfold for a while, but we've just got to remember that this is someone who may have had very significant trauma in their lifetime as well. So that kind of supporting the person, and I think as Amy as you said, but not rushing too fast, not saying we can sort this all out in six sessions of CBT, et cetera, but saying that the mental health professional you're going to meet is someone who will get to know you and it's really important that you have an empathy with them and that they have an empathy for you so that there is engagement as well because it doesn't always work out with the first psychologist, but it will work out with somebody and some issues that may unfold with time with someone in a therapeutic relationship that they can trust and remembering that behind the binge eating disorder is a lot more than just the eating it's mental health state and often trauma as well.

Tom Scully (00:30:41):

Yeah. Thanks for NEURODIVERGENCE as well. Neurodivergence, A DHD, binge eating disorder link, quite strong.

Dr Sarah Trobe (00:30:47):

Absolutely, absolutely. One theme I'm picking up here too is in terms of the possibly thousands online tonight, I hope thousands, that's how many we had sign up, but there'll be people online that have more expertise in eating disorders and there'll be people that, this is fairly new, but we're talking about mental health. Often eating disorders have felt like this specialist area, this siloed thing that you're either do eating disorders or you don't do eating disorders, but we are talking about mental health care, we're talking about trauma-informed care, person-centered care and thinking about how we're supporting whole person. We're not just focusing on an eating disorder, we are doing formulation like we do with any type of CBT or how we're providing any type of care. So just encourage those that are online that are less familiar with eating disorders is to just say, you can do this work using your general clinical skills and then learning about treatment for eating disorders, that there's some really clear trainings and models that we can learn from so that you can provide care for people. Yeah.

(00:31:51):

I'm going to close this case, Arthur's case now and I'm going to introduce the next case. So we're going to try and get through three and we'll see how we go. The next case is going to present different challenges for the care team. So I'm going to introduce Chris and Chris is a 9-year-old, so we're shifting age groups and Chris has been brought in to see the GP by his parents and the GP identifies that Chris has offered, so avoidant restrictive food intake disorder. Karen, I'm going to start with you. Where do you start in considering care pathways and referral pathways for someone with Alfred?

Dr Karen Spielman (00:32:35):

Thanks, Sarah. I think first thing to acknowledge is that Alfred is a reasonably new diagnosis and many gps won't know a lot about it.

Prof Phillipa Hay (00:32:44):

So

Dr Karen Spielman (00:32:45):

In terms of care pathways, I think it is pretty similar to other eating disorders in that we must have a multidisciplinary team and we must look for specialised support and particularly for Alfred, it's really important to have people on the team who know exactly how to treat it. But just to put in a little bit of a plug for GPS who may not have heard Offord that there are some good places to go for information. Recently we've done a masterclass on Alfred at the Australian Society of Psychological Medicine that'll be available on the website there, which included our session on Alfred and also there's some information in the GP hub as well. So I don't want to go into that first, but just to really acknowledge

Dr Sarah Trobe (00:33:40):

Great Karen,

Dr Karen Spielman (00:33:43):

That if they haven't heard of Alfred and they don't know what to do, don't panic, slow down. There are resources and of course any DC and Butterfly and all of the other terrific resources in the area will have pathways into finding out about it because there are very specific jobs for the gp. First,

even before Care Pathways, we are needing to look at comorbidities. We are needing to look at assessing nutritional deficiencies and to institute your management within that early stage. Whilst we are looking for expert support, whether it's a paediatrician or a dietitian or a psychologist, they need to understand how to manage it. So I think that's probably my first step is educate yourself, find out who's out there and create that team as well. Sadly, it doesn't qualify for the eating disorder management plan, but there are ways to access some support as you're aware, through mental health care plans and through chronic care management plans, which can include some sessions for the dietitian. So being able to use online resources I think is important too because it can be intensive treatment.

Dr Sarah Trobe (00:35:05):

So we're thinking at the moment then whilst the ideal is that we have an equipped public mental health system and a private mental health system that can respond to eating disorders, but after it is fairly new, and when we're saying new that everything takes time, research takes time to catch up so we know how we're treating it with evidence-based care. So people with Alfred are not eligible to access the Eden sort of management plan under Medicare, but they can access a mental healthcare plan and chronic disease management plan. What happens if you don't have anyone that you can refer to, particularly in your region, we are still upskilling a workforce to be able to respond to Alfred mental health, dietitians, speech pathologists, occupational therapists, depending on what that young person's experience is.

Dr Karen Spielman (00:35:56):

Is that still to me? Yeah.

Dr Sarah Trobe (00:35:58):

What would you do?

Dr Karen Spielman (00:36:00):

Well, I mean gps really are masters of finding information. We are not backwards in saying, I don't know, I dunno if I could speak for everybody, but I'm certainly not shy to say, I don't know, here, let's Google it together. And looking at the connected Anza treatment database inside out looking for information, there are other places to get information and just sharing that humility that we don't know everything. I think we are used to that. We are used to people coming in with, I've found this on Google, you get me this. So I don't think anybody expects us to know everything anymore.

Dr Sarah Trobe (00:36:41):

Yeah, you have to know a lot about a lot of things, Karen,

Dr Karen Spielman (00:36:44):

A lot about, a

Dr Sarah Trobe (00:36:44):

Little about

Dr Karen Spielman (00:36:46):

A lot, whatever way around. It is

Dr Sarah Trobe (00:36:48):

A little about a lot.

Prof Phillipa Hay (00:36:49):

Yeah.

Dr Sarah Trobe (00:36:51):

So Phillip, around the Eden management plan or a mental health care plan, there is a financial gap that the family are needing to pay. How would you approach it then if the family said, look, we just can't afford that gap payment. How else are we going to be able to support Kris?

Prof Phillipa Hay (00:37:09):

Well, we have to think about public healthcare services and indeed in sort of child mental health and child psychiatry, there are public mental health services and they will recognise and know what Arthur is. So think about your local public hospital, your local child and youth mental health services as well. Don't forget to seek out them because they may will be able to help and indeed offer a family based approach and an all round care approach for someone with offered. It's absolutely, you're going to have to have that multidisciplinary team you need because by definition there will be nutritional deficiencies if not significant loss of weight and the impact of that. So you do need the paediatrician and the dietitian as well. And the approach to care is very similar to that. For other young people that age with an eating disorder such as anorexia, it is a psycho behavioural approach involving the family. So that's what I would do. I would say look around, don't forget the public services. They may will be the first and good port of call for help. I dunno if Karen, you found that as well, but it's just my impression that in this age group the public services are probably as important as private.

Dr Karen Spielman (00:38:33):

Absolutely. And would know how to access those in our general practise. But also diagnosing the comorbidity opens more doors, doesn't it? So if we can recognise that there are often comorbidities in the different phenotypes of barford, if we can tease that out, then they may be more eligible for some of the public services

Prof Phillipa Hay (00:38:55):

And the things that Tom was talking about, very 9-year-old boys with Alfred, A DHD, autism, et cetera. And there may be services that can be accessed and need to be accessed to help with those very common comorbidities.

Dr Sarah Trobe (00:39:12):

Thank you. I was actually going to throw to you there Tom too is thinking about some of those co-occurring conditions. So we're hearing nutritional deficiencies are present if someone hasn't offered, so they're probably going to be seeing a dietitian and thinking about whether supplements or different dietary requirements, how do you then go about the care team for someone with Alfred might be quite large, you might have a speech pathologist if there is some kind of chewing or

swallowing, you might have an OT for sensory aversions. How do you go about then talking about what you are doing? Is it the same that we were talking about with Arthur? We send emails. Is there something different?

Tom Scully (00:39:53):

I think care teams tend to find their rhythm and probably it's a little bit different each time when there is complex needs going on and when there's a lot of people involved. I love to be able to bring people together if we can at least once just for a bit of a case consultation or as many people as possible so that we can just make sure we're really on the same page to start with. And then I find that the follow-up that happens after that is a lot easier because we really have a shared kind of understanding of what are the priorities here and who's doing what. And then the communication that comes afterwards via things like letters or maybe an email thread is a little bit easier to handle rather than 20 emails just trying to work out well. Where are we starting?

Dr Sarah Trobe (00:40:37):

Amy, do you have any reflections there in thinking about what might support an MDT in this instance, and we're thinking about, we've got nine year olds parents going, what is this thing? What's offered, what should the care be thinking about?

Amy Woods (00:40:54):

I mean the really obvious one is that we do need this really family oriented approach and actually all eating disorders benefit from having family support or friend support, chosen family, whoever that is, bringing people together as much as possible. But Chris is little, he's nine. So his parents, his immediate family, whatever that looks like are going to be absolutely crucial to his engagement with support and treatment. But also the next steps, what happens at home. It's really important and absolutely, like you said, it can be so overwhelming. So thinking about places like eating disorders, family Australia, feast website, eating disorders, Victoria, eating disorders, Queensland Butterfly, all of these really lived experience oriented organisations that can offer care support, offer a little bit of guidance around yes, everything that you're feeling is overwhelming, but it's absolutely normal and it's okay to even doing things like carer coaching, Phillipa mentioned family-based treatment sort of approaches before being able to actually talk to somebody who has cared for a loved one through the exact same treatment process as well.

(00:42:16):

Otherwise it's a lot. You've got a beautiful MDT, everyone's trying to hold it all together, but parents, extended family, whoever it is, really benefit from having their own support as well. And also of course, making sure that we are focusing on Kris and the challenges that he's identifying as well because mom or dad might come in and say, oh, we are really worried about X, Y, and Z, but Kris might go, actually, I just want to be able to eat the birthday cake at my friend's party. So making sure that we are adjusting treatment goals, so to speak, so that it's really reflecting what Chris is hoping for as well as what his family is needing to.

Dr Sarah Trobe (00:43:01):

Thanks Amy. I was actually, my son has, well not offered anymore because he's actually recovering. We're not tube feeding anymore. But thinking about those milestones of you just want your child to be able to go to school, what are our goals and what does recovery look like for a young person with

Ahed? What impact is this might be a phobia, it might be a sensory version. Actually having on, I keep on looking down, what's his name? Kris, on Kris's life. And so working with the family and I heard there to and the psychoeducation for the family, what is, ah, Alfred and Karen coming back to you, the three different subtypes of arford and the overlap of that. What's actually going on for Kris in terms of how his brain might be processing information, how his body might be having an aver reaction to certain types of food depending on his experiences. All of those things be really empowering for a families. They go, oh, I know why we're doing this because of this. Tom, I was going to throw to you.

Tom Scully (00:43:59):

Yeah, I just wanted to add on, I think you've done a lovely job of actually explaining some of this from the nutrition perspective. I think sometimes people can be really well-meaning or in intentioned, I'm really worried about this kid because they don't eat any vegetables or they don't eat this and they can be very competing priorities for young people with Alfred around, I really want 'em to have some broccoli and it's like, well actually this person's not eating enough that they're starting to fall off their growth curve and broccoli is probably not going to be the food that gets them there. So yeah, making sure that everyone's on the same page about potentially that's a goal for down the track. If it's important to Chris and it's important to quality of life, but that might not be where we start.

Dr Sarah Trobe (00:44:40):

It comes back to what you were saying, getting everyone on the same page about what's happening. So if Chris is experiencing after that has three subtypes, he has sensory aversion, he has a phobia of eating and there's a disinterest in eating, but what's our starting point? Can we nourish Chris's body by getting in enough safe foods? Do we need supplements to make sure he's just getting enough of what he needs to keep growing and then can we address sensory aversions or an anxiety so that formulation with the family sequencing of the treatment goals as a shared team be really

Prof Phillipa Hay (00:45:20):

Important and personalising that I think for crush, because nobody really has to eat broccoli to survive. So working out how to get there and how to get there in a way that really supports him and he may never like broccoli,

Amy Woods (00:45:42):

I bet that's completely fine as well. Sometimes we can get really in the eating disorder world, we can get really focused on what someone's not eating or not having or not doing. But it's also about kind of flipping the script a little bit and looking from that strength-based approach and going, okay, well he's not having broccoli but he's eating three more foods and he did two months ago or something like that as well for seeing all those little, the goals or the milestones, like you said, Philippa being able to see that for what it is rather than from this kind of deficits approach as well. Especially he's nine

Dr Sarah Trobe (00:46:19):

Little, that got me thinking too, Amy, and leaning on from what you were saying Phillip or around if there was a co-occurring experience, if Kris was autistic, what does an adequate meal plan look like?

We're trying to nourish Kris, but we're not going to be striving for all foods. That's not going to be safe for Kris, but how would you approach that Philippa when thinking about what we want Kris to be able to eat?

Prof Phillipa Hay (00:46:51):

Well, I think it's really working with the dietitian and working out what Kris would like to eat, what he may be able to eat with some exposure or some encouragement or some support and what maybe he's never going to be able to eat, so let's not go there. But how we can get to a nourishing diet, really respecting his preferences, respecting his difficulties he may have with certain colours, textures, et cetera. We had a really lovely, he's at the conference just this last weekend, Australians Academy of Intersource conference in Melbourne, which was also about how may adapt things for people with autism. And there was a lovely example of actually weighing and when some people are weighed and you put the hospital gown on and someone who was autistic may be quite sensitive to the scratchiness of the gown. And this unit had addressed that by allowing the person to be weighed in a soft dressing gown that was their favourite dressing gown, but they'd weighed the dressing gown first and then weighed the person with the dressing gown and that just solved the entire problem went away.

(00:48:09):

So really trying to think around I think the square and yes, how can we adapt this? How can we be a bit more flexible? Hard sometimes in inpatient programmes where you're stuck with the hospital food and the dietitians I think struggle in hospitals as well because they struggle to talk to kitchens and get food set up that they're recommending. But in an outpatient setting, and when you're working with families, you can let your mind just flow and think of what could we do and what other types of foods or how we can get to a nourishing diet. At the end of the day, we all need to have food that's nourishing and that we can sit with other people and eat food in a comfortable way and that's all part of life and living. And that's what people with eating disorders don't have. And that's to be,

Dr Sarah Trobe (00:49:08):

I'm hearing that too, Phillip, in thinking about what's the eating disorder and what's this person and how we're actually able to tease out is the eating disorder saying don't, don't eat that. There's taking a full history of who is Chris, what's his life been like, what have his eating behaviours been like over a long time and now what's happening for him and what might be driving the restriction that's happening with Alfred. Tom, I want to throw to you just lastly in thinking about affirming care from a dietetics perspective. So in the case for Chris, if he was autistic, how would you approach nutritional management for him if he had sensory aversions?

Tom Scully (00:49:51):

Absolutely. So if there was concerns about malnutrition, we start with, well, what's safe, what works? And also what's the feeding environment? Because I think sometimes we focus a lot on what to eat but not the kind of how to often for people who have sensory sensitivities there can be increases and decreases in terms of foods that they'll accept or tolerate. And if we can create an environment for food that is a little bit more relaxed, a little bit calmer, we might find that somebody's tolerance just increases a little bit and we could get a little bit more in. So yeah, start with what works in terms of food we can supplement if there's big micronutrient gaps, things like a

zinc deficiency that might be impacting on taste and an appetite that could be compounding the problem and then taking what's important or where to from here approach, like's been mentioned by a few people, what foods would you like to work on? But always kind of grounding it in a, if we can get somebody to be a little bit better regulated at the mealtime, then perhaps acceptance of food might be a little bit higher. And I think responsive feeding therapy does a wonderful job of that as a bit of a framework.

Dr Sarah Trobe (00:51:01):

Nice, nice. Tom, as you are talking in Karen, you're similar. Is that me? If you're thinking from a psychologist perspective, you're just saying things that I don't understand and I'm really thinking about the MDT team is just recognising and respecting the expertise that the other people in the care team have. You're just saying things like, oh Tom, I didn't think about zinc because I don't know anything about zinc. That's not my job. So my scope of practise would be supporting Kris if there is an anxiety or we could do food training or something like that, but it's not to know how much zinc does Krish need. So making sure again that I'm respecting what you are telling me and I know enough about what I'm doing and able to share what I might be doing with Chris and then being able to provide consistent messaging to the family.

(00:51:49):

So I'm hearing what you are doing Tom, hearing what you are doing, Karen and Philippa, I mean you might be providing the family some support and then this is what I'm doing to help them. Beautiful. Have I missed anything? In thinking about Chris, we started with we're growing a workforce, so it might be a little bit more difficult to find referral pathways. There are Medicare items we need to be thinking about our public mental health system. CAMS teams are starting to upskill in Arthur. It's not a hundred percent, but there are definitely referral pathways and we need to be thinking based on our understanding of Chris's experience, whether it's we do need dietetics, need mental health, speech pathology might be there, occupational therapy, paediatrics, so broad care team. Anything else that I've missed to make sure Chris can get what he needs?

Tom Scully (00:52:44):

I think if we look at DSM criteria, it's diagnosed offered or it's diagnosed anorexia or an eating disorder. And I think in practise we probably see a little bit more murkiness than that. I work more with adult populations and young people, but we certainly see restrictive eating disorders with a significant body image focused with a lot of sensory sensitivity or fear component and also see cases of what was probably offered and then was significant malnutrition over time. This increasing preoccupation with food and body and fear of weight gain and yeah, I guess maybe Phillip or Karen who does diagnose could speak to this a little bit more. But yeah, just being aware that just because it's a diagnosis of afi, it doesn't mean that we might not be working with somebody who has some weight and shape concern as well.

Dr Karen Spielman (00:53:34):

Absolutely. And that's something that we addressed in the masterclass and the teaching that I've been doing with gps is that is another area where I'm learning a lot more about Alfred from my dietitian colleagues, is in people who are recovering from their eating disorder and who are then able to speak a little bit more comfortably about their sensory preferences in an affirming space. And I was thinking that our communication that we are modelling here is really the antidote to

treatment trauma, isn't it? Because there's so much misunderstanding that can happen in the system if we don't talk, but once can we learn from each other, we really are we saving the system money, aren't we because we're getting people on the right track, I hope earlier rather than going down may be well-meaning, but incorrect pathways of treatment because people aren't open to being curious and speaking together

Dr Sarah Trobe (00:54:34):

And recognising that the experience can change over time.

Dr Karen Spielman (00:54:37):

Yeah,

Amy Woods (00:54:38):

Eating disorders, they're ever changing beast endlessly. Interesting.

Dr Sarah Trobe (00:54:43):

Yeah, thanks Karen. I think that you shared the link for the psychological medicine, so I think that would be a really important resource for people who want to learn a bit more about Alfred and I think inside out I've got e-learning, intro, e-learning and there's a few different webinars and trainings out there. So I encourage people to learn about more so that we do have clearer care pathways, that there are more practitioners across that really diverse and broad multidisciplinary care team that are able to respond to people of all ages that might be experiencing Alfred. Yeah. Alright, I think we're going to have time. I'm going to introduce our last case. So I'm going to introduce Lanie. And Lanie is an 18-year-old female. Lanie has been diagnosed with anorexia nervosa by her GP after her mother brought her in to see the gp worried this is the first presentation of an eating disorder.

(00:55:43):

Lonnie's parents are separated and Lanie has just started at university but is still living at home when Lanie and her mum came into the GP when they weren't really aligned with what their concerns were. So Lanie is not really willing to engage, doesn't really want to talk about it, but mum is really, really concerned. The key thing I'm pulling out there too is that Lonnie's 18, it's a tricky age, legally independent, still living at home. And so Amy, I'm going to start with you if that's all right. I just want you to maybe flesh that out a little bit more. What else do we need be thinking about in terms of complexity in this presentation?

Amy Woods (00:56:30):

I think I've worked with a lot of Lanie, so there's something really familiar about it, but also reflecting on my own lived experience, that real challenge at a stage where there's so much transformation happening in life. She's just finished year 12. She can now drink and drive and go to clubs and gamble and she's at university. So all of these huge big life changes. She's finished VCE, huge amount of stuff happening and what can sometimes happen is that the eating disorder becomes your thing. It's yours. You don't have to share it with anyone else. So you can be incredibly protective over the experience or really push back at any idea that it's problematic, even if there's lots and lots of evidence and your loved ones are kind of telling you that something needs to shift, something needs to change. What I kind of often think is that this can be a really helpful point for some peer

interaction talking to people that have had lived experience of an eating disorder, because I find that sometimes we can kind of do a little bit of translation.

(00:57:46):

We can kind of say, okay, well I think probably what mom is wanting is this, and then vice versa. You can even have some peer support with mom and say, Hey, look, often when somebody is at this stage of their illness, they're kind of experiencing this and that's why they're shutting down. So you can do a little bit of translation, a little bit of go-between, but also just it provides that non-judgmental space of that's free for Lani, for example, to be able to say all the weird and wonderful things that are in her head as well because it's such a shameful experience having any type of eating disorder, some definitely more than others. Shame has a big part, but if she hasn't been able to get any of that out before, it's really hard to then sit in front of a GP who you've known since you were six and actually say, I think I'm the most revolting human I've ever looked at. That's so intense and mom's sitting right there. So that can sometimes be a starting point to just get the words going.

Dr Sarah Trobe (00:58:53):

Beautiful. Thanks Amy. I mean there was many things in there that you said were very, very powerful. We talked about in Kris's case, about peer support, but for families to make sure our families are connected in with counselling and information and those sort of things. But this is the first time we've really talked about how peer support can be helpful to the person experiencing an eating disorder. I guess this is something that's growing and how we're promoting this is something that's out there. Can you tell me a little bit more about what the role of the peer support worker would be in the MDT? And then I'm going to think about how are we bringing in peer support into our MDTs?

Amy Woods (00:59:34):

Yeah, absolutely. So lived experience support really fits in that kind of psychosocial support, I guess, section of an MDT. And we're not looking at providing that active treatment or anything like that, but it's about having somebody that is sitting alongside lanie or whoever the person is, but is able to advocate for what Lanie needs or is wanting because that can be really hard to make sure that your voice is being heard but also just provides this companionship in it all. I think there's a really beautiful role for peer workers in eating disorder treatment in doing things like meal challenges or doing some guided self-help homework or whatever it is. So taking some activities that are therapeutic out of the therapy space and out into the real world, like going to some shops that maybe or going to social situations that have previously been too overwhelming. I know I've taken someone to the pancake parlour. She was really keen to have pancakes again and so that was an outing that we did, so there's a little bit more flexibility in kind of this in real time support that can be provided.

Dr Sarah Trobe (01:00:53):

Beautiful. Thanks Amy. I'm wondering if maybe Karen is because we are evolving and we are starting to bring peer support more into a care team, how you go about thinking about roles and responsibilities and communication when we have peer support?

Dr Karen Spielman (01:01:09):

Oh, terrific. Look, I'm so fortunate. I work in a private multidisciplinary eating disorder practise and we are so lucky that one of my colleagues has trained some support workers and we actually do have some lived experience workers who work with us, and I can only say how valuable it is exactly in the situation that you've described, Amy, to have somebody standing alongside our patients who can kind of coach and encourage them in a slightly different way. I think from an MDT point of view, it is something that we are still learning how to navigate because like you said Amy, it's not necessarily a direct clinical role, and so how we share information is something that needs to be really carefully thought about and curated within the MDT. So we are still learning, I have to say, I can only say it's very, very valuable and I feel very privileged to be able to offer it to some of my patients and I feel like it's something that should be grown, but also to recognise that many people won't have access to that. So I'm wondering how other people have access to that, whether it's through an online community or through Butterfly or other family support organisations. I think that's something that should definitely be considered.

Dr Sarah Trobe (01:02:36):

It's actually thinking that too as practitioners, regardless of who it is that's talking to Lanie is letting her know about the options. Many of the states have peer support face-to-face or there are online programmes that butterfly providers well. So us thinking about who is in the care team and us starting to expand and evolve in what our understanding of who can really support Lonnie. Karen, I'm going to stay with you here for a second in this instance for Lanie Lonnie's coming with her mum and there seems to be maybe some hostility or misalignment between and we are back. That was just a quick break all planned. Of course. I'm going to throw it back to you though, but we were just talking about this is what you're doing, you're supporting the family, you're holding Lanie in confidence and giving her the space through that.

Amy Woods (01:03:35):

Yeah.

Dr Sarah Trobe (01:03:37):

Tom, anything different? How would you approach this if Lonnie's been referred to you and mum wants to come to the sessions?

Tom Scully (01:03:45):

Yes. I think how wonderful for Lonnie to have such an active, involved caring person. Not all of my clients are I guess as fortunate as that, and so what I typically be wanting to do is how can we channel mom's concern and her passion about this into a way that's productive for everybody. If we have sessions together and nobody else knows what's happening, what do you think is going to happen when you get home and mom's going to want to know and she's going to PEs you and ask questions because she's worried. And so you know what if we just brought her in for a little bit and had a little bit of a chat with her at the end and you can tell me what's okay to talk about with her and what's not. I also take the angle of a lot of 18 year olds because also be adults and I very rarely meet an 18-year-old who is fully independent. And so you live at home, who does the shopping? Who does the cooking? If we're going to have a little bit of a chat about food, well we might need somebody else in here to get an idea of what's going on and so let's bring them in. And just looking for ways to get support person involvement. I find that if we can get it happening from the start,

often it's easy to continue. It's really hard to try and backend it from session 10 when somebody's used to just doing things quite independently.

Dr Sarah Trobe (01:04:59):

Yeah, beautiful. So having that conversations early, still clarifying roles and helping Lanie to see the role that mom can play a part of the care team.

Tom Scully (01:05:09):

Absolutely.

Dr Sarah Trobe (01:05:10):

We talk about this treatment team, but families and supports and communities, they're the ones that are going to be helping Lani to get through.

Tom Scully (01:05:17):

Yeah, I mean if you think about Lonnie, you had received a cancer diagnosis or something, nobody would be like, oh, just drive yourself into chemo appointment and just do this and all of it. People would be kind of coming around for support and containment and so really just trying to foster the same mentality as much as possible. Yes, independence, but with support.

Amy Woods (01:05:39):

Yeah, thanks

Dr Sarah Trobe (01:05:39):

Tom.

Amy Woods (01:05:41):

Just to jump on that as well, something that can be really useful from, again, the live experience space or even kind of just an individual counselling or individual therapy space is also making sure that we're clarifying with Lonnie that mum is the safe person to have in the room. Often we see a young person coming with their family and we assume, okay, we've got to have them there. Absolutely. We all want everyone to be in there together and to support as unified team, but not every young person is turning up like Tom said, with a really supportive safe network around 'em. So I guess that's again, as Karen kind of said, when you have that space just with Lonnie is just making sure that number one, the consent is there, but for mom or whoever it is to be involved. But just checking in about the dynamics in that relationship because even if she's kind of semi on board, semi not on board, then the rest of the MDT can also tailor how they interact with mom to kind of work to get her a little bit on board, but also support Lanie in the challenging dynamic that might be there.

Dr Sarah Trobe (01:06:52):

Beautiful. Thanks Ames. Phillip, I'm going to throw to you just thinking about risk.

Prof Phillipa Hay (01:06:58):

So

Dr Sarah Trobe (01:06:59):

Lanie has low weight anorexia and so there is chance there might be medical risk, psychiatric risk, nutritional risk. So in this instance, how are we going to support Lanie and her family mom, dad, we haven't talked much about dad, but Lonnie's got a good relationship with dad but lives in a separate house. How would you approach managing risk in this instance?

Prof Phillipa Hay (01:07:23):

No, it's a really good question and I think it's one of the great challenges of working in this space is that that risk arouses anxiety in the healthcare professionals, we're all worried about that as well and managing our own anxiety and our own concerns about that level of risk and what point should I be thinking this person really needs to be in a higher intensity care setting, needs to be in a day programme or an inpatient programme, what are the parameters around that? And of course for every person it is different. It's not an easy textbook thing where they have this, that and the other and therefore straight off and hospital, et cetera. And they also may be, we don't know much about Lani, but they often have significant comorbidities as well. There may be a history of self-harm as well. Lani may have been to the emergency department already and engaged tentatively with the mental health services and the public hospital via the emergency department or not.

(01:08:28):

We don't know. We just don't have that sort of history. So it is there and it's really managing that risk being very, I think being transparent with Lanie and with her mother and the family about that and about what the risks are and how we're going to try and manage those. And as much as possible when we know that's people's preference is to be supported in the least restrictive care environment and be supported to have care and treatment in their home environment as much as possible. So we probably have that as the first option if we can manage and there isn't a high level of immediate medical or psychiatric risk at the time, we would support the person. And one thing I've learned through working in this field for a long time is to go slowly. Lanie is not all there at the moment. She has come along because mom has brought the GP is concerned, et cetera.

(01:09:34):

So to go slowly not to sort of launch and to say, Lanie, this is what we're going to do right now and this is what you're going to need to eat and you've got a dietitian, just take it slowly. Just try and get to know Lanie where she's coming from and you can take a little bit of time. Everything doesn't have to be done immediately as well because because remembering that she's really scared, probably really scared about what recovery might mean, what the anorexia has meant to her, how it's maybe been helping her navigate some other things in her life. And when we start talking about, well, it's a disorder and we're going to take this away immediately, she's probably thinking, what does that lead me with in some way, anorexia, as I was saying earlier, that binge eating disorder, they have mental health disorders and there's often it's a way of being in control of coping, of navigating through life in some way that will only become perhaps apparent if we really get to know Lanie over some time.

Dr Sarah Trobe (01:10:42):

Beautiful. What stood out to me there, and we're going to pull this to a close in a moment, but risk might pop up anywhere. They might be seeing the dietitian, a mental health professional, GP, psychiatrist, peer support, so it's actually understanding our own scope of practise, knowing what warning signs are, what's a warning sign of a physical risk, but I'm a mental health professional and knowing how I'm going to then connect Lani in with the medical practitioner if it's physical risk that

I'm identifying. So knowing what I need to know and then how I'm going to be connecting with the rest of the team, which is so crucial in all the cases with Chris and Arthur and Lanie, the key things are taking our time, understanding what's going on for the person, doing that formulation, bringing the care team in, so we've got that shared understanding with the person and their family.

Prof Phillipa Hay (01:11:31):

And I say this is a shared thing and I really rely on gps to really help manage and navigate those risks as well. And good communication, but picking up the phone, having a chat because often everybody is anxious and just having a chat, talking over the phone about the person is so helpful I think in terms of the multid team and supporting each other in the team.

Dr Sarah Trobe (01:11:57):

Beautiful. Thanks, Philippa. Look, we are at the end of the webinar. I firstly want to say thank you to the wonderful panel. We've been through three different cases and we've gone in different loop D loops depending on kind of what cropped up, there were really key themes in there about eating disorders. We need multidisciplinary care that's just core business in the way that we provide care. It can be across a number of different professional groups depending on what's going on for the person and the importance of knowing what the scope is and the role of each of the professionals in the care team is, and having clear roles and responsibilities and way of communicating with each other to make sure that the person can receive holistic care, that we're all on the same page together and we're really listening to the person and what their experience is.

(01:12:45):

If for those joining us tonight, MHPN would love to hear what you thought of tonight's webinar. So via the button below the video, please let us know via the survey. If you would like to claim CPD, you can access the learning outcomes in the supporting resources tab and statements of attendance. We'll be available in the portal and a link to the recording and webinar resources will also be emailed to you within the week. But thank you for joining us on a, I was about to say Wednesday, but it's Tuesday. And please connect with other MHPN resources and the resources that the panel have been able to share. But thanks everyone and have a lovely evening.