Hurry Up and "Weight": Innovative Inter-Professional Outpatient Care for a Service User With Severe Anorexia Nervosa Awaiting Admission to (Specialized Elective) Inpatient Care in Canada

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ABSTRACT

Inpatient care for adults with eating disorders in Canada is limited. An innovative outpatient inter-disciplinary approach and a service use example are presented. With no current benchmark, this approach may offer a practical solution for outpatient teams seeking to be helpful when service users are left to wait for inpatient care.

Keywords: anorexia nervosa, eating disorders, group therapy, mental illness

RÉSUMÉ

Soins aux malades hospitalisés pour troubles de l'alimentation adultes au Canada sont limitée. Une approche interdisciplinaire novateur en consultation externe et un exemple de cas sont présentés. Avec aucun

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point de référence actuel, cette approche peut offrir une solution pratique pour les équipes ambulatoires qui cherchent à être utile lorsque les patients sont laissés à se dépêcher et d'attendre pour le traitement en milieu hospitalier.

Mots clés : anorexie mentale, manger des désordres, une thérapie de groupe, maladie mentale

Access to (specialized) inpatient care for adults with eating disorders in Canada is limited. This is a concern, given that anorexia nervosa (AN) is a serious psychiatric condition that may require referral and admission to a higher level of care (Klump, Bulik, Kaye, Treasure, & Tyson, 2009). Barriers to accessing inpatient services in Canada include the small number of provincially funded inpatient beds (e.g., approximately 20 beds in Ontario), many patients' geographical distance from a city where such services exist, and long wait times. Considerable financial and emotional strain is placed on service users when they are required to take a leave from school or work and be away from family supports while receiving care. There is currently no well-established method for managing individuals with this type of disorder while they await admission to inpatient care. This is problematic given that extended periods without direct intervention have generally been associated with a decreased commitment to treatment, a lower likelihood of symptom reduction, increased risk for treatment dropout, and later relapse (Carter et al., 2012).

AN is difficult to treat and has a number of accompanying complications, e.g., cardiac abnormalities, suicide attempts, etc., that may require multiple admissions to inpatient services (Strober, Grilo, & Mitchell, 2010). Adult outpatient programs across Canada typically set a minimum body mass index (BMI) criterion of 16.0 kg/m^2 for program admission. While the medical reasoning for this is sound, the reality of long wait times with no direct intervention for service users seeking a referral to inpatient care is a challenge. When service users are not cared for by outpatient teams, the responsibility may fall to the community physician who may have less expertise in managing the physical and psychological consequences of the illness, and may struggle to maintain service users' motivation for care. Thus, there is a need for novel outpatient approaches aimed at managing individuals while they await inpatient care or who have the potential to avert the need for an inpatient admission altogether.

We describe a pilot of an innovative inter-professional practice approach by a Canadian adult eating disorders team using an example of a service user with severe AN who received such outpatient care while awaiting inpatient admission. To our knowledge, which included a literature search conducted using the keywords anorexia nervosa, eating disorders, inpatient, Canadian, and group therapy (e.g., PsycINFO, PubMed), this is the first report to describe a Canadian service user with severe AN who was able to participate in such outpatient care while awaiting admission to inpatient care. The service user provided written, informed consent for the study which was reviewed and approved by the Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board.

AN INNOVATIVE OUTPATIENT APPROACH

This approach had elements that made it innovative: There was a provision of service despite a BMI that would traditionally reject someone for outpatient care by an inter-professional team consisting of a registered

dietitian (RD), nurse practitioner (NP), registered social worker (MSW, RSW), licensed clinical psychologist, and psychiatrist. The inter-professional approach also included evidence-based therapy groups, e.g., acceptance and commitment therapy (ACT) and cognitive remediation therapy (CRT) for adults with eating disorders, nutrition counselling, and regular medical monitoring and psychiatric follow-up. Manualized CRT was used (*Cognitive remediation programme for anorexia nervosa: A manual for practitioners*; Tchanturia, Davies, Reeder, & Wykes, 2010). In CRT, individuals learn how to reflect on the process of thinking rather than emphasis being placed on examining and evaluating the specific content of their thoughts (Tchanturia, Davies, Reeder, & Wykes, 2010). ACT is a treatment approach that helps individuals clarify personal values that are separate from the disorder. The novel inter-professional approach also consisted of self-monitoring using a cognitive behavioural therapy (CBT) approach, as well as nutritional counselling and a therapeutic meal support group to aid in nourishing the service user back to health. Physical health and weight were monitored regularly by the team. Psychometric measures were completed at the time of intake assessment and after six months, including Diener et al.'s (1985) Satisfaction with Life Scale (SWLS); the Beck Depression Inventory, 2nd Edition (BDI-II); the Beck Anxiety Inventory (BAI); and the Eating Disorders Inventory, 3rd Edition (EDI-3).

Case Example

The service user who participated in this pilot was Poppy (pseudonym), an adult with a 12 year history of AN. At intake assessment she reported a restricted nutritional intake, i.e., 600 k Cal daily (which included alcohol), significant weight loss, and amenorrhea. A vegetarian eating pattern at 12 years of age, which later shifted to veganism, was endorsed by her for ethical reasons. A history of fasting, laxative abuse, use of a herbal weight loss supplement and appetite suppressant (e.g., garcinia cambogia), and chewing and spitting food was described. Poppy was dissatisfied with her body image, had a fear of gaining weight, and over-monitored her weight and shape. She reported a number of medical complications of the disorder, including concentration difficulties, fatigue and low energy, lanugo hair and hair loss secondary to malnutrition, chest pain, and orthostatic dizziness. Blood pressure (BP) at intake was 90/72 standing and 106/64 supine, and her heart rate was 70 standing and 51 supine. Her weight at intake assessment was 39.4 kg and her height was 158.5 cm (BMI = 15.7 kg/m^2). A clinical interview by a psychiatrist and psychometric questionnaires administered by a clinical psychologist confirmed the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5) diagnosis of anorexia nervosa, restricting type, severe. A referral for inpatient care was initiated. However, Poppy had a number of concerns, including the estimated six months wait time for such inpatient care, a 2.5 hour driving distance to the closest inpatient program, having to be away from her supportive partner, and the costs associated with travel to the inpatient program (inpatient care itself was covered through the province's health plan).

Poppy expressed motivation for engaging in outpatient care while awaiting inpatient admission, but also expressed ambivalence towards weight gain. During the six months of outpatient care, she attended 14 sessions of CRT group and 12 sessions of ACT group delivered in a weekly 50 minute format. She completed weekly self-monitoring with a goal of normalizing eating and with individual check-ins to review self-monitoring forms from CBT and to further involve her partner with supporting her in making changes at home. Nutrition interventions included five individual sessions, a nutrition education group, 10

sessions of a meal planning group, and later attendance at a therapeutic meal support group. Monitoring was provided individually by the NP (e.g., a total of 17 appointments for medical monitoring) and with the team psychiatrist who provided five follow-up appointments over the six months. Overall, she attended an estimated four to six hours of outpatient care per week. Poppy made progress, increasing her nutritional intake by incorporating dairy and meat alternatives into her meal plan. She experienced a 4.5 kg weight increase (BMI = 16.8 kg/m^2) over the six months, which meant she no longer met criteria for admission to inpatient care. Her physical symptoms also improved with BP at 101/68 standing and 100/64 supine, while her heart rate was 90 standing and 80 supine after six months of this outpatient care. Poppy increased in overall satisfaction with life, and decreased in her scores on depressive and anxiety symptoms (although her scores were still elevated). Scores on drive for thinness, bulimia, body dissatisfaction, and eating disorder risk composite remained unchanged. Poppy's scores decreased for interpersonal insecurity, interoceptive deficits, interpersonal alienation, emotional dysregulation, perfectionism, ascetism, and maturity fears. Low self-esteem and personal alienation did not change.

IMPLICATIONS AND FUTURE DIRECTIONS

To our knowledge, this is the first report to describe a Canadian service user with severe AN who was able to participate in inter-professional outpatient care with a very low BMI while awaiting inpatient admission. Long wait times are not unusual for accessing inpatient care in Canada. This example demonstrates that a service user with severe AN was able to increase nutritional intake and weight status, improve overall satisfaction with life, and decrease some symptoms of the disorder by engaging in outpatient care. The progress of nourishing oneself back to a health status no longer meeting criteria for inpatient admission is noteworthy. Beyond the potential practical and cost-saving benefits of this approach (which was delivered as part of routine outpatient group-based care) compared with an expensive inpatient hospital admission, we found that this approach was helpful in aiding a service user to make some progress in symptom reduction. It was important that the outpatient care was started immediately after completing the intake assessment, that the service user was motivated for care, and that she had the support of her partner in making changes and attending meetings. Although the results of this innovative practice are promising, rigorous study of this approach is needed. This approach may offer a practical solution for outpatient teams seeking to be helpful when service users are left to wait for a higher level of care, such as an elective inpatient admission.

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