ED Transitions Module 2:

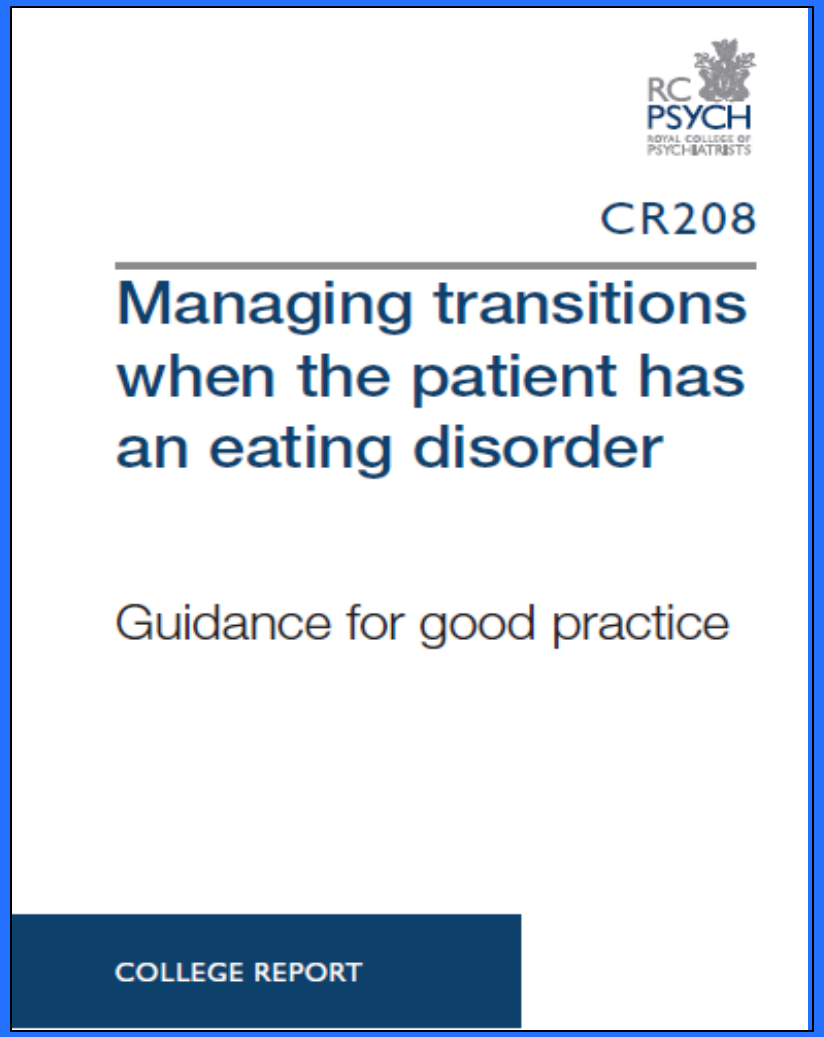
Supporting Transitions Between Services

Learning Objectives for Module 2

To understand:

- What a good transition between Child and Adolescent Eating Disorder Services (CAEDS) and Adult Eating Disorder Services (AEDS) should look like
- What preparation needs to occur for good transitions
- How services can develop better ways of co-working
- The practicalities of transition planning

A Key Guidance Document



RCPsych guidance is comprehensive and aspirational

It assumes a conventional CAEDS and AEDS divide

We decided to use this guidance to structure the information that follows

If you wish to see the full report, click on this link.

The importance of planning for transitions and tailoring your approach

RCPsych guidance suggests the need for clinician awareness of **ED-specific characteristics** that may make transitions hard.

Think for a moment about the young people you see:

Which of their characteristics may make it hard for them to accept a service transition?

The importance of planning for transitions and tailoring your approach

- Shame and avoidance
- Anxiety and intolerance of uncertainty
- Comorbidities: e.g. depression
- Low levels of cognitive flexibility, e.g. comorbid ASD diagnosis
- Ambivalence about treatment
- Impulsivity

The importance of planning for transitions and tailoring your approach

In planning for a service transition with young people, try to hold these characteristics and their different needs in mind.

You may also need to consider the individual circumstances of the young person - such as whether they are starting university, their cultural background or changes to their social life.

How to Tailor your Approach to Transitions to Your Patient

Psychological Characteristics of Patient	How to Tailor Your Approach to Transitions
Anxiety and intolerance of uncertainty	(a) Normalise – a degree of anxiety is normal in novel situations; (b) Find out what is most anxiety provoking about the transition & take action accordingly; (c) Highlight the positives of transition & provide a clear rationale for it. (d) Address uncertainties by providing good quality, relevant and accessible information.
Low levels of cognitive flexibility, e.g. comorbid ASD	Consider continuation of family work whilst progressing to individual treatment, taking into account the young person's need for a gradual adoption of transition-related changes.
Ambivalence about Treatment	(a) Take a proactive motivational stance that is appropriate to age and developmental stage. (b) Give options wherever you can. (c) Discuss negotiables and non-negotiables.

Additional resources: PEACE: advice on EDs and autism

How to Tailor your Approach to Transitions to Your Patient

Psychological Characteristics of Young Person	How to Tailor Your Approach to Transitions
Impulsivity	Involve the young person in creating a well-structured care plan, for them to refer to. Transition preparation should be goal directed with progress carefully monitored and recorded.
Depression	Provide a positive, hopeful stance. Transition offers an opportunity for a fresh start to support the young person's recovery.
Shame and avoidance	More common for those purging. Arrange peer-support during the transition if possible, to help alleviate feelings of shame and avoidance.

Starting conversations about transitions and involving parents and carers

RCPsych guidance recommends:

Where possible, discussions about transition should start **at least 6 months** before the planned transition

Transition meetings should be set up at the earliest opportunity involving the young person and their family/carers

Good quality **information** should be provided to patients and their carers

Addressing expectations around **autonomy and confidentiality** is particularly important

"We had maybe two meetings with both my current child therapist and my new adult therapist and myself, so I could voice my concerns (about my anxiety around my family no longer being involved)."

Young person

Timings for Transitions

RCPsych guidance states that when deciding the **time of transition** from CAEDS to AEDS, the following factors should be taken into account:

- Young person's degree of maturity and independence from family
- Links with other medical and social services
- The views of the young person and carers
- Geographical moves (e.g. moving to a new city or town for university)
- The need for ongoing work with the family/carers
- Education and employment issues

Timings for Transitions

Transitions should be delayed if there is a crisis.

Conversely, there may be an opportunity for an early transition to AEDS if the young person is better suited to AEDS, and they feel comfortable doing so.

RCPsych recommendation	What might this look like in practice
Young person's maturity and separation from family	If maturity is low and dependence on family is high, consider continuation of family work under CAEDS with a co-therapist from AEDS, and/or individual treatment from AEDS. Frame transition as an opportunity for personal growth.
Need for ongoing work with the family	As above, or consider offering multi-family group given its suitability in older adolescents/emerging adults. If available, give family members the option of attending a carers support group.
Education/employment issues	Consider delaying transition till after important exams or work deadlines/interviews. May-June tends to be the busiest period of the year for school exams.
Link with other medical & social services	GP and other relevant services to be involved at the planning stage (e.g. in a short meeting), as needed.
Wishes of patients and carers	At the start of the transition process, ask for the views of the young person and carers on what they ideally would want the transition to look like, and what support they will need.
Delay transition if there is a crisis	Delay the transition until the young person has stabilised.

Attachment Issues

Respect for the importance of **attachments** and **therapeutic alliances** is crucial in the work towards recovery from an eating disorder.

A sensitive and **developmentally informed approach** to a transition may transform it from a traumatic and disjointed experience into an opportunity for building resilience and healthy maturation.

“It takes a lot for you to just tell a random person your problems.

So, you have some appointments with [adult healthcare providers] and my therapist now, so just dipping my feet in the water with them.”

Nadarajah et al.

Ensuring good working relationships between CAEDS, AEDS and other services

The transition coordinator

- A transition coordinator should be appointed for transitions between CAMHS and AMHS
- This may involve the **identification of a key worker** from each service or a permanent joint post shared between services.
- The role of the transition coordinator is to **guide and support** patient and carers through the transition process and function as a **point of contact.**

Clear protocols and pathways

- Services should have clear protocols and pathways for patients transitioning between them.
- Patients and their carers, as well as clinicians and managers, should be **consulted** during the **development and evolution** of such protocols.

Additional resources

Download an example CAEDS transitions flow chart

Download an example Transitions Protocol

Providing good information

- From the earliest stage the provision of **good-quality information** to the patient and their family/carers will be important.
- This may include facts about the service they may be joining, as well as about the process of transition itself.
- Aspects of care planning and how that is communicated will be part of this.

Ensuring good working relationships between CAEDS, AEDS and other services

RCPsych guidance emphasises:
Good working relationships between CAEDS and AEDS and an **understanding** of each other's way of working need to be nurtured.
They also say:

Joint working and training fosters a spirit of **mutual respect** and **reciprocal learning** between services.

This can also prevent splits developing; these can occur, e.g. when clinicians from one team imply that the other provides an inferior service.

This point is important.

There is some research evidence suggesting that CAEDS and AEDS clinicians do sometimes hold biased beliefs about each other (Lockertsen et al., 2020).

So, let's look at this in some more detail...

CAEDS and AEDS practitioners are different ‘tribes’ and may hold unhelpful beliefs about each other

Reflection: Do any of the thoughts shown here ever go through your mind when you are dealing with colleagues from your partner team?

If so what does that say about your team relationships?

How might this affect transitions of patients?

..they only deal with nice, easy straightforward cases

…they deal only with complex, chronic (hopeless) cases

…if we had the amount of resources they had we’d do brilliantly

…you’d better get well soon, because otherwise you will be sent over to THEM

…they leave us to pick up their dirty work

… they exclude families, are focused on impairment or deficits & are remedial/palliative in approach

Some ideas for how you can strengthen co-working with your CAEDS or AEDS colleagues

Regular joint learning events or training sessions between teams

Regular meetings between transition champions in both teams

Shared posts

Shared projects & initiatives

Joint public-facing initiatives, e.g. conferences, open days, websites, joint GP liaison, joint training of others, e.g. on MEED

Joint quality improvement/research: e.g. find out how big the referral gap is between CAEDS and AEDS in your locality

Joint treatment provision e.g. multi-family groups

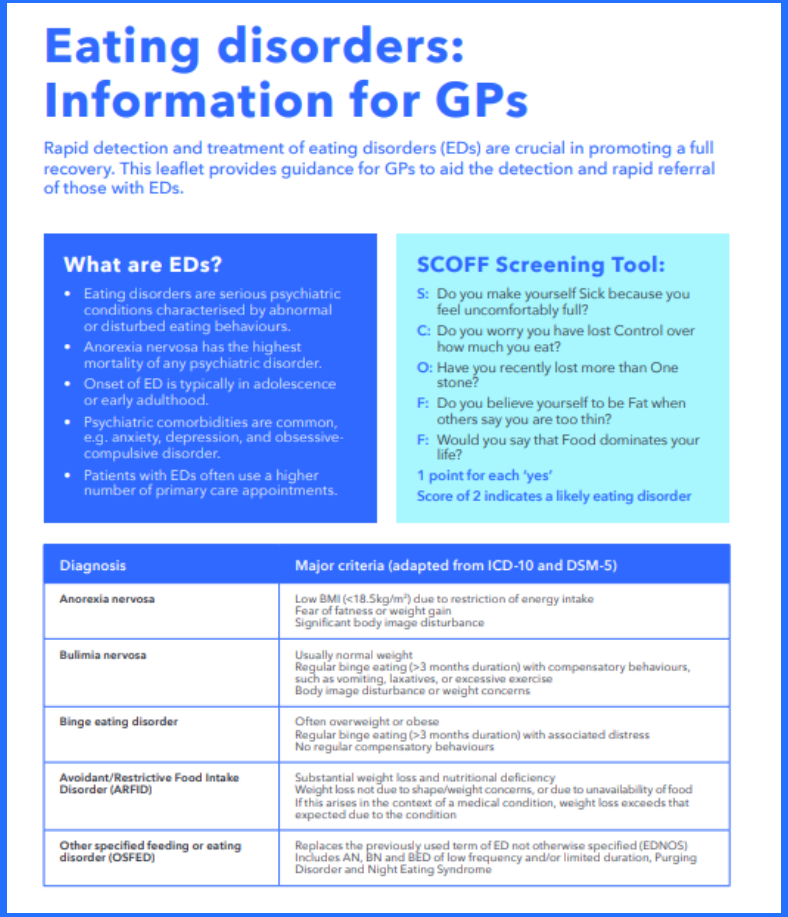
There are many other ways in which teams can co-work more creatively. Let your imagination run riot.

Building good relationships between other services

RCPsych Guidance states:

Where there has been significant involvement of **paediatric** or **medical services** or **social care**, these services should be involved in transition planning.

It is helpful when general practitioners (GPs) can be involved in **planning** and **facilitating** the transition; when they cannot be directly involved, minutes of meetings should be copied to them.



Eating disorders: Information for GPs

Rapid detection and treatment of eating disorders (EDs) are crucial in promoting a full recovery. This leaflet provides guidance for GPs to aid the detection and rapid referral of those with EDs.

What are EDs?

- Eating disorders are serious psychiatric conditions characterised by abnormal or disturbed eating behaviours.
- Anorexia nervosa has the highest mortality of any psychiatric disorder.
- Onset of ED is typically in adolescence or early adulthood.
- Psychiatric comorbidities are common, e.g. anxiety, depression, and obsessive-compulsive disorder.
- Patients with EDs often use a higher number of primary care appointments.

SCOFF Screening Tool:

S: Do you make yourself Sick because you feel uncomfortably full?
C: Do you worry you have lost Control over how much you eat?
O: Have you recently lost more than One stone?
F: Do you believe yourself to be Fat when others say you are too thin?
F: Would you say that Food dominates your life?

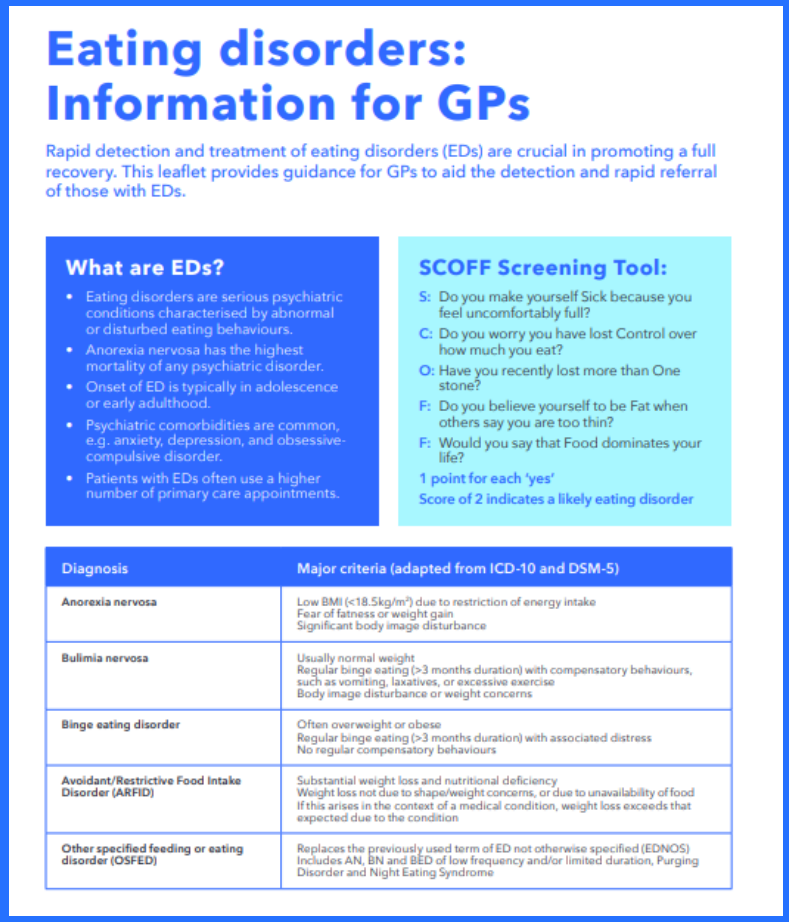
1 point for each 'yes'
Score of 2 indicates a likely eating disorder

Diagnosis	Major criteria (adapted from ICD-10 and DSM-5)
Anorexia nervosa	Low BMI (<18.5kg/m²) due to restriction of energy intake Fear of fatness or weight gain Significant body image disturbance
Bulimia nervosa	Usually normal weight Regular binge eating (>3 months duration) with compensatory behaviours, such as vomiting, laxatives, or excessive exercise Body image disturbance or weight concerns
Binge eating disorder	Often overweight or obese Regular binge eating (>3 months duration) with associated distress No regular compensatory behaviours
Avoidant/Restrictive Food Intake Disorder (ARFID)	Substantial weight loss and nutritional deficiency Weight loss not due to shape/weight concerns, or due to unavailability of food If this arises in the context of a medical condition, weight loss exceeds that expected due to the condition
Other specified feeding or eating disorder (OSFED)	Replaces the previously used term of ED not otherwise specified (EDNOS) Includes AN, BN and BED of low frequency and/or limited duration, Purging Disorder and Night Eating Syndrome

Building good relationships between other services

It is also important to note that ideal practice is likely to be very resource intensive, especially during periods where relationships between services are changing or developing.

As such it is important to look at efficient working practices and have open conversations about resource challenges or possible areas for efficiency improvements.



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The practicalities of good transitions - The Transition Care Plan

An agreed and **well-structured, patient-centred care plan**, focused on the **individua**l rather than on organisational considerations, can be the most important single element in the whole transition experience.

The young person must be consulted and involved in discussions about the care plan, taking into account their:

- stage of recovery
- level of maturity
- personality

Additional resources

Download an example transitions care plan

Download an alternative transitions care planning tool

Dunn et al: young people and parents agreed that transition preparation should be asset- rather than deficit-focused.

Building self-confidence was seen as key, along with resilience, help-seeking, coping strategies, self-esteem, organisation & social skills

Multidisciplinary discharge planning meeting & Joint working

Formal handover of care should be structured by at least one specific **multidisciplinary discharge planning meeting**.

More than one meeting may be required, if the transition process lasts over several months

> If I had known more about what adult services would have been like, that would have really helped. That would have encourage me to consider it as an option.
>
> **Young person**

There should be an overlap period of joint working by both services during the transition, in order to:

- explore and explain the differences in the ways of working between the two services
- help the patient to get to know key members of staff from the new service
- put in place arrangements for the necessary therapeutic interventions