Community Meal Support Within a Tertiary Eating Disorder Specialist Service (T.E.S.S.)

Tyree Weir (Assistant Practitioner) & J. Walsh (Consultant Clinical Psychologist)

Background
There is a dearth of treatment research, minimal evidence base and limited maintained recovery associated with many models of treatment for people with Eating Disorders (EDs). Thus the "acute need to study innovative treatment approaches" particularly for more severe presentations is therefore promoted.

Meal support (MS)  "Meal support is a form of emotional support provided to a person struggling with an eating disorder before, during and after meals and snaks in an effort to increase the person’s success with meal/snack completion" resulting in the introduction of MS in TESS settings. MS is a well-recognised component of treatment (with clearly established guidance) and patient opinion has been sought. However, no literature is available for community MS, both in terms of acceptability and effectiveness.

MS in TESS
- A cornerstone feature of intensive MDT interventions for those with severe EDs resulting in complex needs.
- Implementation follows dietician assessment and specifications of MS intervention plan is based on agreed objectives (boundaries and expectations of patient and staff) and review periods, clearly defined.
- Maximum intensity of three days on weekdays for at least limited periods. Focus on skill development coinciding with MS frequency reduction (care team members or staff) may be trained to offer additional sessions.
- An Assistant Practitioner (whose role is dedicated to providing and up-skilling others in MS) leads on delivery, but mostly the MDT contributes.

Aims and objectives
- To investigate patient’s experience of community MS, and to establish the barriers and facilitators why some do not engage.
- To identify the demographic characteristics of all patients offered MS, and to establish if there were any differences in key outcomes between those who engaged and those who declined or discontinued.
- To examine variations in how MS differed in duration and frequency, consider potential influencing factors.

Methods
- An anonymous postal self-report questionnaire designed and administered to patients offered MS and received (n=30). MS was provided in MS (3 sessions or more), had participated in MS in the past, or had declined or discontinued earlier having had two sessions or less (n=19). Engaged (n=12), declined (n=7). All remained open to TESS.
- A retrospective review of case notes of all patients who met the same criteria from January 2015-December 2017, including discharged patients (n=26). Data analysed descriptively and included only MS offered by TESS clinicians.
- Demographic information, diagnosis, BMI, risk status, frequency of MS contacts and length of engagement, further MS episodes, and subsequent out of area specialist ED hospital admission examined

Outcomes and Results
Patient Experience Questionnaire
All responders (n=37, 33% response rate) that engaged in MS, thus not possible to establish reasons behind non-engagement.
All responded strongly favourably (mean 9.9 on a scale of 1-10, 10 being most supportive) and all felt it tailored to their individual need.

Retrospective review of case notes

One patient was offered and engaged in MS over three distinct episodes, all other patients were 1-3 times engaged.

Primary reason for offering MS: weight restoration (n=16, 42%), regulating eating pattern and reduce/stop purging (n=6, 23%), halt further weight loss prior to being admitted to a specialist facility (n=3, 8%), and further assessment and formulation (n=3, 8%).

Demographic characteristics of those who engaged versus those who didn’t
More patients engaged (n=9, 77%) than declined (n=3, 23%) (p<0.05) Overall those who engaged were slightly older (mean 32, median 26, range 16-63) than those who didn’t (mean 27, median 21, 20-41) Diagnosis showed similar spread

Differences in key outcomes between those who engaged and those who didn’t

Weight Restoration
Ten patients (69%) engaged in MS and six declined/designed (31%).

Potential Influencing Factors
Table 3 show the frequency of weekly MS contacts (at the highest point of frequency) for those with BMI’s <15 and >15, and with physical risk status of ‘moderate’ – ‘high’, and ‘very-high’ highs.

Conclusions
*The patient experience questionnaire highlighted that overall MS was well received by patients in TESS.
It was not possible to ascertain any views of individuals who declined engagement. TESS is continuing to send the MS questionnaire. However a methodological change will see it administered bimonthly after the patient has completed MS or deciding on intervention in order to gain feedback from non-engagers by seeking ‘live feedback’ and to increase sample size in general. Questionnaire feedback has supported a change in practice around the setting of boundaries and expectations, whereby we include previous patient feedback (e.g. they have felt watched), and explain the rationale behind it.

*The project supports that MS has high utility in TESS and is offered to a wide age range of patients, across the spectrum of ED diagnoses that we see, and is used to support different treatment goals. The vast majority can be supported in their own homes but it can be used to ‘up-step’ treatment into local hospital environments.

*It certainly appears that MS as part of an intensive MDT intervention is important to support weight regain (a mean change of 1.9 BMI points was achieved in patients working towards weight restoration) and this is supported by clinical intuition/opinion.
- Based on tentative indications, it seems that more weight restoration is achieved when MS part of the treatment plan. It is acknowledged that comparative data is small (and should only be used as a rough guide for reflection) and other factors could be important e.g. motivation levels may be lower in those that did not receive MS. This group also had a higher starting BMI (thus the clinical team and patients may have stressed/place less importance on this).
- Some patients receive MS as a bridge whilst waiting for specialist inpatient treatment. All such patients initially presented to TESS at a dangerous BMI and were at high risk of re-feeding syndrome. MS served to enhance safety, socialised them to expectations of inpatient care, whilst developing our therapeutic relationship.
- With the exception of planned specialist admissions, only one client receiving MS went on to be referred to a specialist EDU and as of April 2018 no further admissions for this group have been sought. There was a wider range of MS duration but the mean duration for those aiming to restore some weight or stabilise their weight control behaviour was similar at around two months. The weight restoration group generally received more weekly contacts.

*Important influencing factors with regards to intensity seemed to be BMI and physical risk status (with people with lower BMI’s and otherwise specified physical risk status being watched more than those with higher BMI’s and high physical risk status).

This is perhaps not surprising that those with more severe presentations would be offered a higher intensity of input.

*It is important to note that the majority of clients are able to tolerate the duration and frequency of MS offered. In conclusion, TESS views MS as a highly valuable and effective intervention for people with ED’s. In the future it would be helpful to consider if and how inpatient protocols should differ for MS delivery in the community, and look towards the clinicians who deliver it to the patients. It would be helpful to further develop these in a way that provides structure but accounts for individual need.

References