
CONFERENCE ABSTRACT**Development of an Integrated National Model of Care for Eating Disorder
Services across Multiple Settings**17th International Conference on Integrated Care, Dublin, 08-10 May 2017

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Introduction: (comprising background and problem statement) Eating disorders have the highest mortality and morbidity of all of the mental health conditions, with top causes of death including cardiac and suicide (Arcelus, 2011). Patients with eating disorders present across the age range and transition across multiple service boundaries including primary care, mental health, paediatrics, acute medicine, and emergency departments. Evidence based treatment improves eating disorder outcomes substantially (Lock, 2015). Ireland has had no public eating disorder service to date. With a growing incidence, the development of a national clinical programme for eating disorders was prioritised by HSE.

Description of policy context and objective: The development of a national eating disorder services is part of HSE's national strategy and clinical programme which aims to deliver integrated, accessible clinician developed care to patients. In the absence of existing policy and service for eating disorders, a national working group was established in order to develop an integrated Model of Care for HSE eating disorder services.

Targeted population: The Model of Care for eating disorders targets all patients with DSM V/ ICD 10 eating disorders (approximately 188, 895 patients in Ireland will develop eating disorders in their lifetime; estimated incidence in Ireland is approximately 1756 cases per annum). Child, adolescent and adult patients are included at all stages of illness and levels of severity. Settings include mental health, primary care and acute hospitals.

Highlights: (innovation, Impact and outcomes) The working group comprised of 16 clinicians from both child and adult services representing stakeholder groups (psychiatry, psychology, social work, OT dietetics and nursing), a national manager, and national patient support group representative. This geographically spread group took an incremental approach to developing the model of care, progressing from papers on uniprofessional roles and views, through a patient and evidence lens, towards an interprofessional collaborative consensus model of care which was strongly evidence based. External consultation with other HSE national clinical programmes in paediatrics, acute medicine and primary was integrated into the document. This 360 degree approach to developing the national model of care enabled individual positions to be addressed and has ensured acceptability and feasibility across multiple professions, settings and services.

Comments on transferability: This 360 degree incremental approach to Model of Care design is adaptable to other complex disorders presenting to multiple service settings and which require an integrated approach.

Conclusions: (comprising key findings, discussion and lessons learned) The initial stages of working group formation, when stakeholders described their roles and individual perspectives to the group, was key to addressing professional tribalism and moving towards a collaborative group stance and model of care. Patient representation at all meetings was essential to this, as it kept patient values and needs central to this varied group of stakeholders. External consultation in the later stages but before completion, enabled future interagency collaboration. Integrated pilot projects are now being developed across these programmes as the model of care moves towards implementation.

Keywords: eating disorders; interprofessional; integrated; model; strategy
