RESTRICTIVE INTAKE SELF-HARM (RISH)

- *Practice considerations for the management of RISH across care settings and age*

This is a broad all-age document and, as such, clinical judgement must be exercised regarding applicability to your patient and/or clinical setting.

The evidence base for Restrictive Intake Self Harm (RISH) is limited and mostly applies to adult patients, with limited research relating to restricted intake exclusively as a form of self-harm. As such, please note that this is a collective consensus piece developed by an expert multi-disciplinary cohort of specialist clinicians.

This is not a clinical guideline. The document is intended to inform clinical management for patients presenting with RISH.

Contents

What is Restrictive Intake Self Harm (RISH)?

RISH is a formulation driven term which aims to describe the specific subset of patients who present with restricted intake (both foods and fluids) as a method of self-harm. The term self-harm encompasses harm that occurs when attempting to self regulate. Therefore, the formulation of self-harm should include an understanding of attachment seeking behaviour, self regulation and the communication of distress. A *formulation* is an explanation or hypothesis of how an individual comes to present with certain behavioural characteristics. RISH is different from Anorexia Nervosa (AN), where energy restriction is driven by an intense fear of gaining weight, distorted body image perception and an over-evaluation of one's own weight and shape.

Traditionally, those with a RISH presentation were categorised under Atypical AN, Other Specified Feeding and Eating Disorder (OSFED) or 'disordered eating'. Terminologies such as 'acute food refusal' have also been widely used. However, RISH doesn't fulfil the criteria traditionally associated with these descriptors. Forthcoming research from Fenton and Morris explored public and patient lived experience with a cohort of young people and their carers and found that such terminologies were experienced as unhelpful. Those with lived experience described the existing terminologies as belittling and overly broad. Disordered eating was considered confusingly similar to an eating disorder whilst also feeling dismissive and 'less serious'. Atypical AN was found to be a poor fit owing to differentiations in primary shape and weight concerns. Terminology concern was equally echoed in the disordered eating guidance by Transformation Partners (2022). Consequently, the term Restricted Intake Self-Harm (RISH) was created to address these concerns. Fenton and Morris also conducted a survey of 172 mental health professionals in the UK, finding that 73% of professionals stated they had treated 1 or more young people they identified as having RISH with 72% feeling that RISH had a different presentation with different treatment needs to those with AN.

We conceptualise RISH as one specific, individually named subset of disordered eating. The broad spectrum of disordered eating presentations can include disordered eating secondary to life events (such as bereavement), neurodivergent eating difference, extreme dieting, eating addiction, and more. Each of these wider disordered eating presentations requires tailored, formulation-driven treatment (Transformation Partners, 2022). However, it is out of the scope of this document to encompass all disordered eating presentations, subtypes and wider formulations.

Purpose of the document

RISH represents a specific eating distress requiring a tailored treatment strategy. Treating RISH as AN could lead to both psychological and medical deterioration. Although both present with food restriction, the underlying function and understanding of the food restriction is different. To avoid inadvertent harm caused by treatment (iatrogenic harm) it is important that treating clinicians understand the significance of psychological formulation and how this should guide their treatment planning.

Differentials and Overlaps

RISH exclusions

RISH is best understood as a *presentation of exclusion.* Other organic causes for the restricted intake should be explored and excluded (such as physical illness). Likewise, no other mental illness (such as AN, severe depression/ anxiety, psychosis etc), nor socio-cultural

limitations (such as lack of food availability or cultural/religious sanction) should better explain the presentation.

Similarities and differences in eating disorder presentations

There is significant overlap between those with RISH and AN (table 1 below). The main presentation of RISH includes self-harm, thoughts of dying by diet restriction and/or using diet restriction to manage difficult emotions and/or seeking care and connection and communicating psychological distress. Some of these symptoms may also be present in AN, particularly regarding using restriction to manage difficult emotions. Underlying this in both AN and RISH is commonly low self-esteem and a poor sense of self-identity. *This overlap can make it very difficult for clinicians to know what disorder(s) they are managing.* This is particularly difficult initially when there is not an established therapeutic relationship.

Table.1 – An overview of comparative presentation characteristics

	RISH	AN
Food	Often complete refusal inc. fluids. No planning or focus on detail. May eat normally / eat high calorie foods sporadically when not restricting. In this way, the restriction can appear 'yo-yo' in nature. For example: "I will not eat"	Rule bound. Calorie focused, highly controlled and planned. For example: "I can't eat"
Development	Rapid onset of severe restriction	Increasing pattern of restriction and rigidity
Compensatory Behaviours	May report a wide range of behaviours including self induced vomiting. These may, or may not, be actively carried out	Frequently associated with over exercise, vomiting or the misuse of laxatives etc. with attempts to hide/deny these behaviours.
Reporting mismatch (see detail below)	Typically, overt. Restriction concerns and compensatory behaviours are freely described / displayed. The severity is much more likely to be over-reported in comparison to objective clinical observation / metrics. Often describes nil energy consumption. Usually displays the restriction.	More likely to over report current intake and current weight and downplay severity. Compensatory behaviours are typically secretive.
Self harm	Yes, highly likely	50% of cases (Koutek, Kocourkova, & Dudova 2016)
Thinking style	Often cannot tell you why they are not eating. Often describes intense, chaotic and changeable views. Often describes severe anorexic cognitions that are evidenced inconsistently in behaviours or observations. May describe feeling overlooked or dismissed by others. May feel hypervigilant to feelings of rejection and invalidation.	Inflexible, detail focused and controlled. Will often express why they are not eating due to a fear of weight gain which is evidenced by behaviours.
Emotions	Anger, sadness mixed. Presents with a mood 'roller coaster'. This looks like spikes of highs though is dominantly low in mood.	Significant fear and very high anxiety about dietary intake and weight.

Weight (see detail below)	Often describes severe anorexic cognitions (including describing a strong fear of weight gain), though this is not evidenced consistently in their behaviours/observations.	Evidenced strong fear of weight gain

Understanding 'anorexic overlap' in RISH further

Individuals with RISH may become fixated on an *'illness identity'*. This often lends itself to a particular focus on physical health, especially where physical health risk is driven by anorexic beliefs. This is likely because physical risk, especially when associated with the high mortality risk of AN, typically elicits a rapid care response which may meet an underlying psychological need. This may explain the frequent report of severe eating disorder cognitions and a self-report of physical symptoms which are inconsistent with objective physical health measures. Examples of this include reporting no oral intake of food or fluid for several days that is driven by anorexic beliefs whilst objective clinical measures show no weight loss, low glucose or dehydration. This may be underpinned by the perceived lack of parity between physical and mental health and the individuals desire to have their distress validated and to receive the care and support they feel they need.

Given the requirement for eating disorder teams to meet standards for access to treatment times, individuals are often seen quickly when they present with rapid weight-loss and/or reports of eating disorder cognitions and behaviours. This is validating and is likely to inadvertently reinforce restrictive eating (reported or enacted) as a way of seeking care and/or communicating distress.

Complex Post Traumatic Stress Disorder (PTSD) and Emotionally Unstable Personality Disorder (EUPD)

As with other forms of self-harm, RISH may be more prevalent in those with EUPD or complex PTSD. RISH presenting in the context of a mental illness, such as EUPD, should follow the current treatment guidance but may need some wider consideration to account for RISH specific risks.

Information gathering

Clinicians should first complete a comprehensive holistic formulation which includes early developmental history. Expert clinical experience highlights various different psychological formulation models that should be considered. These include (but are not limited to):

- Acceptance and Commitment Therapy (ACT)
- Dialectical Behavioural Therapy (DBT)
- Cognitive Behavioural Therapy (CBT)
- Cognitive Analytical Therapy (CAT)
- Compassion Focused Therapy (CFT)

Which formulation model to use will be dependent on the individual. Formulation in RISH requires sufficient depth and understanding of nuance.

Further to the initial holistic formulation, sensitive consideration should be given to the potential for this patient cohort to present with *complex socio-cultural impacts*. These include complex or difficult attachments, emotional dysregulation, family dynamics, social bullying or

the possibility of current/historic abuse/trauma. There may also be challenging housing or environment issues, including difficult financial circumstances.

Explorative curiosity should also be applied to considering co-presenting autism. Within autistic individuals the requirement for autonomy and control is even greater and should be balanced carefully against presenting clinical risk ensuring that all reasonable adjustments are accommodated. For example, these may include specific sensory requests relative to food or the environment, or routine rigidity (such as times of eating) which help to manage distress and anxiety.

The presentation of Restive Intake Self Harm

First and foremost, clinicians should understand their patient's behaviour compassionately and through a trauma-informed lens. Doing so seeks to understand the presenting behaviours as a consequence of their illness, life experiences or circumstances. It is not uncommon for those with RISH to elicit judgement and criticism from professionals. *Clinicians should have a reflective space to help reduce statements of blame, judgement or criticism from both their internal and external narrative.*

It is also integral that clinicians seek to understand the *function* of the restricted intake. This means to understand and consider the role of the restricted intake self-harm behaviour(s) for the individual. For some, as with other types of self-harm, the function may be around self-punishment, attempts at emotional regulation and/or connection-seeking. This appears to be linked to the hypervigilance of rejection and/or perceived invalidation. Understanding the function of the presenting behaviours is central to helpful treatment. Doing so also helps those with RISH from being misunderstood.

Presentation indicators of RISH

Low self-esteem and a poor sense of self-identity are core constructs within RISH. It is therefore important to acknowledge these factors when planning care and clinicians should have an understanding around how these factors may contribute to the maintenance of the presentation.

Consensus within the clinical working group and data case reports identify several further clinical presentation features. These cover behavioural, psychological, psycho-social, and historical domains. They demonstrate which clinical features might routinely be observed in those with a formulation of RISH. *It is important to note that these are not diagnostic and individuals may not present with all.*

Additional to those features outlined in **Table 1** (above), observed clinical features include noting that the patient:

- Presents with poor impulse control and may report a wide range of self-sabotaging/self-harming behaviours, including self induced vomiting.
- Often cannot tell you why they are not eating, and often displays intense, chaotic and changeable views.
- Often presents with an extreme fear of rejection. This leads to multiple intense attachments and a feeling of emotional emptiness which precedes restriction.
- Often presents with unstable friendships. This includes friendships which have a rapid, intense development and which have dramatic endings.

- May present with hatred of all aspects of themselves.
- May present as wishing to starve to death. This can be an expression of self-harm/self-hatred; of connection seeking; or from the belief that physical compromise is associated with accessing support.
- May typically have adverse childhood experiences (known as ACE's)

For example: including past/present domestic abuse

- Would often state a wish to be in hospital / not go home.
- Is likely to have, or has had, a variable engagement with education.

Presentation features in response to clinical treatment

When teams start to treat the food restriction, clinicians might typically experience and observe the following response(s):

Table 2 - *Presentation responses to clinical treatment*

Clinical treatment method	Observed Response
Imposed Increased Restrictive Practice (e.g.; *rigid meal plans, nasogastric feeding (NGF), restrictions on movement and freedom (such as stopping school, sports, social engagement or trips).*	Precipitative increases in the patient's restrictive eating and other behaviours. These other behaviours typically include resistance to feeding, the need for physical restraint, and an increased instance of all forms of self-harm.
Positive diversions are used (e.g.: engagement time that is spent with the individual on areas of their interest without having an eating/treatment focus*).*	When carried out with a caring clinician, these typically have a positive effect on the patient's restrictive behaviours.
Directly challenging observed eating*	Is experienced as invalidating and confrontational. Doing so typically leads to an inflammatory response in the patient's restrictive behaviours.
validating the emotion/distress but not observing or commenting upon the desired behaviour (eating)*	Typically leads to the desired behaviour (e.g. eating) continuing

* ***For example,*** *if a food is eaten in secret and is then confronted:* *"We know that you ate that chocolate bar yesterday as we found the wrappers. I'm wondering why you are saying you can't eat it today and you need to have a nasogastric feed?". This type of interaction typically leads to a doubling-down of the restriction and avoidance in order to 'prove' it.* ***Instead,*** *clinicians should note the observed behaviours as part of their own understanding and risk assessment and in the context of the formulation. This should be done whilst avoiding direct discussion or confrontation about it and continuing to*

provide ample opportunities for further 'unobserved' intake. This can help to break patterns of behaviour and become something to be helpfully explored within the safe space of therapy and formulation.

Managing risk

Positive risk taking

AN is amongst the highest mortality rates of mental illness (Beat, 2024). For this reason, the clinical management of AN is often perceived as inherently risk averse due to understandable clinician anxiety, particularly in the management of young people. In AN there is a need to balance risk with the need for care autonomy to maintain a least restrictive stance. This can often create anxiety within the system, leading to reactive practice.

In RISH the need to ensure that life-saving treatments are appropriately deployed needs to be balanced with the risk of them being used to meet a care need in the person. There is a risk of inadvertently reinforcing the behaviours, if there is an over focus on physical health and the medicalisation of difficulties. This may create a narrative around needing to present as physically unwell to receive care and/or meet emotional needs. *A highly restrictive and directive treatment plan for those with RISH can result in escalations of restrictive practice, trauma and clinical deterioration.* However, there is a balance to be found in ensuring physical health risks are managed safely. This highlights the importance of joint working with community mental health teams, acute services, wider community teams (including dietetics) and GPs.

Positive risk taking is a clinical strategy used for patients who struggle to feel empowered to manage their urges to self-harm, and helps patients to develop strategies which work for them. It facilitates a sense of autonomy over their condition and care. Positive risk taking acknowledges the risk and the need for a safety plan, but also acknowledges the risk of restrictive practices and their longer-term harm in this patient population.

Positive risk taking should be used when the formulation supports a RISH rather than AN formulation. This involves the individual retaining some control. Positive risk taking does not seek to remove that control unless a significant life-threatening situation is occurring.

Positive risk taking and how to use this is discussed in each of the treatment sections below.

Shared understanding of physical risk

Although RISH is not understood as a diagnostic eating disorder, the presenting and associated risks are still those of nutritional compromise. As such, the MEED Risk Framework for eating disorders across the age-range (RCP, 2022) is still the best-fit mental-health-based nutritional-risk framework to assess risk and safely manage re-feeding: college-report-cr233-medical-emergencies-in-eating-disorders-(meed)-guidance.pdf (rcpsych.ac.uk) (RCP, 2023)

A summarised crib sheet for MEED risk assessment (condensing MEED pages 30-36) can be found in Appendix 1.

***Reminder:** with infrequent eating restrictions or presentations of intermittent eating as seen in RISH you will routinely see fluctuations in glucose and ketones. These would be expected, and it may be unhelpful to focus heavily on them. Therefore, providing the patient*

does not have significantly compromised physical health, they would not need routine blood glucose monitoring.

Extreme restriction, followed by a rapid return to eating normal or large amounts of food may be a risk indicator for those above 18 years old. An expert dietitian is best placed to assess and support the management of any such re-feeding risks.

Managing other presentations of self-harm in RISH

Self-harm is often met with a significant level of stigma (Burke *et al*., 2019). It is therefore essential that careful consideration is given to developing a meaningful narrative around the person, and how self-harm factors into the context of their wider mental health. This is known as understanding the *underlying function of the behaviours.*

NICE (2022) recommends a need to prioritise the treatment of any comorbid or underlying mental health difficulties, rather than solely focusing on the self- harm itself.

This is particularly important when RISH presents alongside other methods of self-harm and a person is struggling to regulate their emotional state. In these cases there may be some sense of control and relief through restriction. Starvation is known to alter the intensity of a person's emotional state (Hatch *et al.*, 2010). Therefore, where a person presents with RISH, they may be worried that the frequency or intensity of other methods of self-harm and/or thoughts of suicidality, will increase if/as intake improves.

When the swing between mixed methods of self-harm occurs it is often met with quite high levels of shame and distress. Therefore it is essential to be mindful of this when implementing any intervention. Where appropriate, NICE (2022) recommended interventions for self-harm such as dialectical behavioural therapy may help in addressing this clinical dilemma.

For adult populations, offering a structured, person-centred, CBT informed psychological intervention is recommended.

For children and young people (CYP) where features of significant emotional dysregulation are present and there are frequent episodes of self-harm, the recommendation is to consider DBT adapted for adolescents (DBT-A) (Kothgassner *et al*., 2021). Age and any planned transitions should be considered when developing treatment pathways.

Supporting caregivers in their understanding of risk

Where appropriate, *support for caregivers should be offered concurrently with therapeutic treatment* as this can be a confusing and frustrating time for them. Parents or caregivers can view RISH as less harmful than other forms of self-harm and may therefore inadvertently reinforce it. Circumstances like this can occur due to a number of reasons. One such example is a family's belief that oral restriction is less harmful in comparison to other self-harm methods (such as cutting, headbanging or overdosing) that often leave people feeling powerless to help. This may lead to the restriction being inadvertently reinforced, where the risk to life inadvertently increases. At times it may conversely create significant caregiver anxiety. In either occurrence, it is likely to elicit extreme responses which may be unhelpful and which would benefit from caregiver support.

Additionally, the perception of weight loss and control is often viewed positively within society. This may misplace value around restriction resulting in unintended consequences to the sufferer. It may also be perceived as less stigmatising than non-suicidal self-injury (Burke *et al*., 2019).

Individuals and caregivers may also feel frustrated regarding treatment options being different, where the person's difficulties have been framed as an eating disorder incorrectly. Caregivers are also likely to be disheartened if a person recovering from a severe RISH episode starts to self-harm in other ways.

Psychoeducation and systemic work can support caregivers to understand the interplay between self-harm and RISH, help manage their expectations and dispel misperceptions around treatment. Psychoeducation can also help to empower families to support their loved ones in the future.

Medication

The primary approach to treatment for RISH is a psychological approach with a robust and informed multi-disciplinary team (MDT).

There is no evidence to exclusively support the use of medication specifically in those with RISH. However, some medications can be considered as a therapy adjunct depending on the individual presentation. These medications are sometimes prescribed for use in wider presentations and in co-presenting clinical features and prescribing clinicians should always follow any respective safety guidelines.

These pharmaceutical options include:

- *Olanzapine* – which, when used off-licence, has an evidence base for precipitating weight gain and in distress reduction within anorexic populations (Attia *et* al., 2019; Han *et al*., 2022).
- *Promethazine* – which has an evidence base for improvements in emotional dysregulation (Kiningham, 2007)

Treatment intervention considerations

The following are suggestions of changes to clinical practice / approach that more helpfully support the recovery of a person with RISH. These described differences in clinical practice are grounded in theory which supports patient empowerment, encouraging and enabling patient choice and autonomy wherever this is possible.

Considerations applicable across all clinical settings:

- ✓ *The lead clinician should have specialist expertise in emotional dysregulation* (such as having training and clinical skills in DBT therapy and/or expertise in relational therapies such as CAT, attachment models and systemic frameworks). However, as RISH is a formulation-based disordered eating presentation sharing the same risk framework (RCP, 2023), *advice/input from a specialist eating disorder team is an essential component* where this is medically indicated. As there are features of both self-harm and malnutrition risk, services should ideally work together using a shared understanding of the formulation. Those with lived experience tell us that joint

assessment appointments between eating disorder and general mental health teams can provide positive validation and understanding. However, receiving a primary, targeted eating disorder treatment from an eating disorder team is more likely to be unhelpful to the treatment outcome and maintain the difficulties. Equally, being discharged or declined from an eating disorder service following assessment can be highly invalidating which can perpetuate the difficulties. As such, there should be careful consideration of the appropriate skills and expertise needed for sensitive, holistic assessment according to the individual's needs and service expertise.

✓ Clinicians should collaborate with the individual to *establish their view of what is needed to support a safe therapeutic experience for them.*

***For example** – enabling choice about which clinician / professional they see, where they wish to be seen, the appointment time, how cancellations are managed, etc.*

✓ Individuals with RISH often inadvertently create professional anxiety and team 'splitting' (Haslam *et al*., 2022). Splitting is the psychological mechanism of seeing someone as either good or bad, idealised or devalued. This can also apply to whole teams being categorised in this way and inadvertently then pulled into "rescuer" or "reject" roles. In the short-term this can help a person manage difficult emotions, but in the long term this can contribute to perpetuating unstable relationships. Teams can also struggle when faced with being fragmented into good or bad clinicians. Where these anxieties are not contained and remain unresolved can lead teams to invalidating responses and care that is re-traumatising (Haslam *et al*., 2022). Therefore, *maintaining an active recognition of team anxieties, splitting and robustly practising good communication, collaboration and open team reflection is essential*. This includes the effective use of structured multi-agency meetings, as well as the importance of routine, healthy inter-team discussions. These team discussions, dialogues and meetings are likely to be necessary at a more regular frequency than is required in other eating disorder presentations.

***An example** of an innovative community multi-agency approach is outlined in Appendix 2.*

✓ *Routine team co-collaboration helps the wider team ensure they are giving clear and consistent messages in treatment.* This avoids inadvertently reinforcing the message for an individual that they need to be very unwell to be cared for, or for their distress to be taken seriously. To mitigate against this, *teams should offer an approach of regular, consistent, empathetic and concerned treatment regardless of improvements* in physical and psychological health. See also Table 2 (page 6)

✓ *In those with RISH, the treatment emphasis should be taken off weight and food.* Therefore, although the dietitian should be involved in overseeing nutritional-rehabilitation or managing the refeeding risk, *dietetic input should not be first-line and should be offered as a 'light touch' consulting-intervention to support the overall treatment.* Time focusing on food, intake, and dietary negotiations is likely to be less helpful and more likely to exacerbate the eating difficulties and associated risks. In this way, the dietitian should act to support the wider care team rather than interacting extensively with the patient. Meal plans designed for use in AN should be avoided in most cases.

***For example**, this may mean that the dietitian acts in a scaffolding approach only, works indirectly, or is only involved to help manage an acute feeding risk or nasogastric feeding plan.*

- ✓ *A fully collaborative formulation should be used to create a care plan which keeps the patient's needs front and centre*. Re-formulation should occur a minimum of every 6 weeks thereafter. It is essential to routinely review treatment plan effectiveness, and to consider the behaviour function and any differentials.
- ✓ There should be an active awareness of how much time is spent completing restrictive interventions compared with time spent completing positive diversions. *Teams should try to keep the positive diversions as a larger proportion of time than those associated with restrictive practice*

Examples of restrictive interventions include *nasogastric feeding, meal support, and measuring / attempting to control fluid intake. Positive diversion examples include playing games and/or listening and engaging in conversation that is not about restrictive behaviours, risk or medical presentation.*

- ✓ Psychoeducation for parents and carers is essential to help parents understand why a different treatment approach is being used, and which markers/outcomes are being used to evaluate effectiveness.

Considerations specific to community settings

- ✓ *Offer consistent appointments with the same person.* This helps to provide a safe therapeutic relationship. This may mean offering consistency regarding the day and time of appointments if appropriate/possible.
- ✓ *Develop a comprehensive collaborative crisis plan, with a biopsychosocial risk management approach*. This means translating the co-produced patient-facing crisis plan into an additional service-facing crisis plan to ensure a consistent response.

***Example** service-facing management plan template can be found in Appendix 3.*

- ✓ *There should be early involvement of multiple agencies*. This is essential for ensuring consistency of approach which is calming and containing for an individual in distress. On an ongoing basis, these multiple agencies should convene regularly to ensure there are clear roles and responsibilities and consistent approaches.

***Examples** of agencies include social care, acute teams, mental health teams, dietitians, and any 3rd sector support organisations (and schools for children and young people).*

- ✓ *Early involvement of a psychologist as the lead clinician, or a psychologist providing support to the lead clinician, is important.* Consideration should also be given to including psychiatry regarding formulation and the management of risk including therapeutic positive risk taking. A psychiatrist is essential when considering medication or the use of the mental health act as part of the treatment plan.
- ✓ Positive risk in the community may include *supporting graded reintegration to school or hobbies*. This can be particularly important when an individual is heavily invested in an illness identity and as a means of improving positive diversions and protective factors.

Considerations specific to all inpatient settings:

- ✓ *There should be a flexible approach to food*. This includes allowing self catering (where possible), meals out and snacks in the patient's room.
- ✓ *If the patient shows signs of attachment to a specific member(s) of staff, that staff member should only provide support and positive diversions* and should no longer provide input for physical health concerns and feeding.

***Examples** of positive diversion include mental health support, therapeutic input, emotional regulation skills, self-esteem work, social integration etc.*

- ✓ Treating teams should aim to *make restrictive interventions boring and functional* compared to the positive diversions.

***Examples** of Restrictive interventions include monitoring physical health (inc. weight), providing meals, etc.*

Considerations specific to acute hospital settings:

- ✓ *Where possible, acute teams should discuss the management plan with the patient's community care team before admitting*. This enables a consideration of the holistic formulation, facilitating a collaborative approach which reduces splitting. Community teams should have good links established with their local acute teams.

***Examples** of good link working include regular meetings, the consideration of a RISH pathway, and reflective 'lessons learned' meetings following any admission.*

- ✓ Acute teams should routinely be questioning: *is the admission needed? Is the patient physically compromised?* You should try to consider all safe alternatives to admission.

***Examples** of alternative treatments could include outpatient treatment, intensive home-support in-reach or RISH educated crisis support. The inclusion of acute consultants into the multi-agency team that are experienced in RISH and reactive to urgent outpatient reviews which help to avoid admissions to restrictive practice.*

Considerations specific to psychiatric inpatient settings

- ✓ *DBT informed approaches are often helpful.*
- ✓ *Ensure that you maintain a consistent behavioural plan* including positive diversions on and off the ward. Some of these will be tied to managing meals, others will occur regardless.
- ✓ Consistent boundaries should be used. Consideration should also be given to the use of a *'contract of expectations'*. This contract can help patients by grounding expectations and providing consistent boundaries.

For example:
I work with my team to make and use my crisis plan to help manage my emotions.
I will seek help from (unit) staff if I am feeling worried, unsafe or struggling with difficult thoughts.
I understand that I am expected to have leave (unit) with my parent and that staff will encourage this.

I understand that I have urges to restrict my diet: my aim is to be supported to maintain a level of regulation that allows me to make my own choices.
I understand that if I do not follow my meal plan the team will review whether it is safe for me to remain in (name of unit).

- ✓ *It is important to contain professional anxiety around risk* when the patient is not eating or drinking (with/without showing physical compromise (MEED, RCP 2023)), with clear plans of when and how to proceed. For children and young people, supporting parent/carer anxiety through shared understanding is also important.

For example:
Consider RISH in a similar way to those at risk of overdose. In those cases, the patient wouldn't be immediately restricted from engaging in positive and meaningful activities. Therefore, in RISH, treating teams are encouraged to use risk management strategies and have an understanding of when professional restriction is required due to health compromise. However, this should be nuanced and should always seek to enhance control, autonomy and self-efficacy. As the psychological formulation is different to AN, enhancing rather than restricting is more powerful and effective.

- ✓ *There should be clear and agreed parameters set with input from acute colleagues.* This is essential for considering when naso-gastric feeding (NGF) could be required and how this could be facilitated.

Considerations specific to social care settings for children and young people (CYP)

- ✓ Although this does not apply to all, CYP with RISH may be more likely to have experienced ACE's.
- ✓ There should be clear and careful assessment involving the young person, their family and mental health practitioners. *It can take time for CYP with this condition to build a trusted relationship to allow disclosure.*
- ✓ *Alternatives to home may need to be considered* to ensure the individual is in a safe environment where they feel able to eat, if this cannot be achieved in hospital or at home.
- ✓ CYP will typically not transition from NGF to oral intake until they feel there is a safe place for this. *NGF use does not preclude consideration of other discharge options* involving alternatives to home. Collective clinical experience has shown us that patients with RISH will perceive clinical environments as safe environments. Consequently, they become heavily attached to these environments and escalate restrictive behaviours when faced with discharge. *Social care has a significant role to play in facilitating safe discharges from inpatient care.*

Case experience example:
A foster child is admitted to an acute ward with total acute food and fluid refusal and placed on a necessary NGF. Their foster placement has broken down and the patient is categoric in clearly communicating that they will not return there. Treating teams spend over 4 months engaging the patient in CBT and trying to establish motivation. There is no change to her oral intake. When social care permanently rules out the possibility of discharge back to her existing foster placement, the patient resumes a full oral intake.

Should routine weight monitoring be used for patients with RISH?

MEED guidelines offer risk-based weight monitoring guidance for all eating disorders (RCP, 2023). Routine weight monitoring is incredibly helpful for eating disorder presentations with acute chronic restriction. However, these are *unlikely to be appropriate to use routinely in RISH presentations*. This is because a weight focus perpetuates the emphasis on food and weight as a modality to meet a care need, consequently serving to perpetuate the difficulties.

> ***As a reframing example**, in other forms of self-harm clinicians would not routinely use physical health checks to assess risk. For example, it would not usually be helpful to recurrently ask to see a person's arms to assess for self injury.*

Practice considerations to improve weight monitoring in RISH:

- ✓ *Use for assessment* as needed but use more global or creative assessments for physical health (such as physical appearance and engagement). A highly skilled clinician is likely to be necessary for this.
- ✓ *Consider weight trajectory* rather than only focusing on small, acute changes.
- ✓ Where at all possible, *all decisions about physical health monitoring should be decided collaboratively with the patient*. They should clearly steer what monitoring is used and how it is carried out. You should aim to empower the individual to think with the care team about what physical health parameters can be included.

> ***For example,** the patient may be very happy to have their blood pressure taken, but not their weight due to the lower emotive attachment of this.*

> ***Remember:** some forms of physical monitoring (such as weight) are associated with very strong emotions. These emotions can be very difficult to manage, particularly if the individual has poorly adapted coping skills.*

Should strictly controlled meal plans be used for patients with RISH?

A strictly controlled meal plan allows for the monitoring of calorie content. This helps clinicians to predict and restore physical health, promotes an energy adequate intake and relieves professional anxiety. However, *doing so promotes dependency on external factors*, such as those clinicians supporting the meals. Typically, it reduces self-efficacy and agency which can then result in escalating restriction and resistance across all presentations. This can cause intense attachments to those providing meal support, making moving away from services and treatment additionally challenging.

As the formulation of RISH is one in which it is helpful to tolerate distress, 'ride the anxiety wave' and not perpetuate the difficulties, it is important for clinicians to understand how to tolerate a safe minimum intake. This will be different for everyone. It requires a considered understanding of the patient's physical risk alongside their need to be weighed and monitored, whilst simultaneously considering the potential negative consequences that can arise from hyper-focusing on oral intake. *Exclusively focusing on food can perpetuate food as the problem, consequently perpetuating food restriction.* It is imperative therefore that clinicians can hold a balanced, nuanced and formulation-driven understanding of the clinical problem. This will avoid applying poorly considered AN treatment due to raised levels of professional anxiety.

An alternative *to using a tightly controlled meal plan could be meeting with the dietitian and following a specified structure and food routine. Working in this way facilitates permission to eat, validates the need for care seeking and can be adequately containing to an individual's distress without resorting to a prescribed meal plan.*

The restriction of fluid intake is associated with RISH presentations. This can be more acutely high risk and more likely to precipitate anxiety. However, we know that in some RISH presentations the ingestion of fluid can occur outside both observations and what is verbally reported. Urinary sodium and blood tests can be used to understand the clinical picture compared with the reported picture, though in most cases physical and clinical observations are adequate. In all cases, *dehydration should be proven and symptomatic before restrictive interventions are used* (such as citing an intravenous drip).

An example *of reporting mismatch:*
The patient reports no oral fluid intake and is observed to have no oral fluid intake, yet presents with only mild dehydration. This is because the patient has been drinking during long showers, or bathroom breaks.

Where dehydration is found and is causing physical health compromise, a strict fluid plan may need to be enforced. However, you should also ensure that you provide ample access to fluids which can be consumed unobserved. Ideally, this should include flexibility about which fluids are most appealing. This helps to facilitate drinking without hypervigilant focus.

Admissions for those with AN often include care planning arrangements which support obtaining an accurate (dry) morning weight. These can include restricting unobserved bathroom access overnight or first thing in the morning (for example). However, for those with RISH, the principal aim is to promote oral fluid intake, rather than to obtain an accurate weight.

Should Oral Nutritional Supplements (ONS) be used for patients with RISH?

Using ONS as a form of prescribed nutritional medication *can act as validation* in those seeking care through nutritional restriction. Conversely, it can also break a restrictive cycle to precipitate oral change and is less iatrogenic and institutionalising than escalating to a higher restrictive practice (such as NGF). However, using ONS can be difficult to move away from as it is highly effective at communicating a care need through a visual / medical mechanism. Therefore, *any use of ONS in those with RISH should be co-concurrent with an agreed exit plan away from this strategy*.

Clarification: An exit plan means supporting the patient to return to / start oral nutrition.

Should nasogastric tube feeding (NGF) be used for patients with RISH?

The decision to use NGF will not be appropriate for all. It should therefore be an MDT formulation-driven decision which robustly accounts for both physical health and psychological functioning.

NGF is most often considered a life-saving treatment intervention to be used as a last resort where there is clear evidence of significant physical health compromise. For example, arising from using a combination of MEED (RCP, 2023) and the appropriate corresponding early warning score (e.g. Paediatric Early Warning Score (PEWS) / National Early Warning Score

(NEWS)). As such, NGF *should never be classed as an unavailable treatment intervention for any person with an eating disorder regardless of their formulation/psychopathology.*

However, NGF can promote dependency and intense attachments on external factors (such as the treating team), reducing self-efficacy and agency. This can result in escalating self-harm or resistance to NGF. Additionally, NGF can mimic abuse or can become abusive, exacerbating trauma (Fuller *et al*., 2023). It is also difficult to manage on an outpatient basis leading to it commonly occurring in the inpatient setting which promotes institutionalisation. *NGF should always be the last resort after all other least-restrictive practices have been considered*. It should be *offered for the shortest period of time* necessary for medical stabilisation as it can be harmful, particularly when under restraint (Fuller *et al*., 2023).

Conversely, although NGF is most often understood as a life-saving treatment intervention teams should also recognise that in some cases NGF can serve as a therapeutic nutrition support tool. Used in this way, it can stabilise medical risk and offer validation whilst other aspects of therapy are worked on. However, in both cases, clinical experience notes that the mechanism of NGF communicates a strong, visual care need which often increases the patient's reliance on this. Therefore, *any use of NGF in those with RISH should be co-concurrent with an agreed exit plan away from this strategy. Where possible NGF should not be associated with the need for continuous hospitalisation.*

Before an NGF plan is put in place, the following should be checked (both initially and prior to every feed):

1. Has the patient been encouraged to follow an oral diet?

Creative *examples* *of this include* ✓ *Offering varied oral options* ✓ *Enabling local leave to cafés/restaurants* ✓ *Ensuring the availability of preferred snacks in the patient's room* ✓ *Facilitating time off wards to access food* ✓ *Bringing food onto ward including takeaways etc.* ✓ *Offering distractions and activities during or after the consumption of food/fluids*

2. *(For some patients this may be helpful)* - Has the patient met with the dietitian to formulate an individually tailored meal plan using foods that the patient feels they are able to eat at present?
3. *(For some patients this may be helpful)* - Has the patient been encouraged to follow an oral nutritional supplement plan (which can be described to them as a medical prescription) rather than an oral food intake for the time being?

If NGF is considered an essential life-saving requirement, this should be clearly explained to the patient, with an adequate rationale and any communication adjustments made. Contraindications should always be considered and local policy followed regarding safe tube insertion and use. The following should then be discussed and considered:

1. Is the patient able to consent to NGF and accept this with hand support only?
2. Are there any grounding techniques / distraction techniques that the patient may find helpful before, during and/or after?
3. Have you explored and implemented sensory minimisers?
4. Have you explored and offered all available choices?

***Examples** of sensory minimisers include having lights on/off, blinds open/closed, having background noise/music on/off, considering the number of people in the room etc.*

***Examples** of exploring all available choices include which nostril the tube is sited in, who is present in the room or completes the procedure (within reason), which type of securing tape is used, whether the curtains are drawn or open etc.*

If NGF necessitates the use of physical interventions (restraint), this should only be carried out under the correct legal framework. Where the patient is not consenting to the intervention, a Mental Health Act (MHA) assessment can be utilised under the direction of the approved clinician in charge of their treatment.

To support the implementation of NGF under the MHA and any post intervention planning, the following should be carefully considered:

- ✓ *Understand the formulation and mitigate wherever possible any iatrogenic harm and precipitation of trauma.*
- ✓ *Enable empathetic discussion* about facilitating and enabling resistance in a non-violent way.

***Examples** of supporting non-violent resistance include supporting the patient to show their emotions and non-compliance through stomping rather than kicking, banging on chair arms rather than hitting and shouting rather than spitting etc.*

- ✓ *Staff should be appropriately trained in the technique of safe restraint specifically for NGF* and the associated clinical risks. This is important as there are unique risks arising from restraint with NGF including aspiration and nasal trauma. Understanding and mitigating against these risks is paramount.
- ✓ *It is essential that the least restrictive method is always used*. This may change on a daily basis. Therefore, all of the above should continue to be explored before each feed with the patient.

***For example**: the patient may accept one feed orally or as an ONS even if this hasn't happened before, and doesn't happen again.*

- ✓ *Staff should explain the holds used during NGF* and the patient should be *able to choose* which they would prefer (if safe for patient and staff to do so).
- ✓ You should always be asking the question: *Is the use of physical interventions proportionate for the level of risk (both physical and/or psychological)?'*
- ✓ *NGF under physical intervention must be agreed and led by a consultant psychiatrist supported by an MDT.*
- ✓ There should be a collaborative and proactive approach, where the patient and treating team should *try to work towards an 'exit plan'*.

Further extensive information on paediatric restrictive practice and NGF can be found from the e-learning module available from: Paediatric restrictive practices and nasogastric feeding guidance (NHS Learning Hub website)
*Unfortunately, there is no adult equivalent website currently available.

Treatment considerations for NGF:

- ✓ A person-centred care plan should be followed for pre, during and post any NGF.

- ✓ A food first approach should be taken. Therefore it may be preferable to remove the tube between feeds. Doing so also reduces the risk of the nasogastric tube (NGT) being tampered with or used for other forms of self-harm such as ligaturing. Conversely, leaving the nasogastric tube in situ can be the least restrictive option and re-passing the tube should never be used as a pain-associated deterrent to NGF. *Which option to use for your patient should be made by the whole MDT,* with patient input and consideration to the broader context of least restrictive practice (such as the patient's sensory profile). The overall risk should be considered alongside the potential of associated trauma.
- ✓ *At every feed there should still be the opportunity to do something differently* and avoid more restrictive feeding practices. It may also be appropriate (risk dependent according to malnutrition and chronicity) to feed only once per day (Fuller and Philpot, 2020), or not to feed daily. This should be discussed by the full MDT and led by an appropriately skilled dietitian.
- ✓ *Supporting any attempted efforts at change, even if a full goal is not reached, is helpful.*

> ***As an example*** *(assuming the physical risk level is safe):*
> *A patient is prescribed a 400 kcal breakfast but manages to eat only half a Weetabix (<50 kcals). Rather than replacing the rest of the missed nutrition with an NGF the care team accept that breakfast has been eaten and tolerate this as an example of taking a positive risk. Doing so improves self-efficacy and avoids punitive punishments which could take away the progress made.*
>
> *This is also an example of how oral nutrition can be used flexibly as a therapeutic tool when compared to NGF: where nutrition will always be maximised to ensure that the restrictive intervention occurs for the shortest possible period of time.*

- ✓ *Positive diversions and engagement activities should also continue between NGFs*. Positive diversions are a protective factor for moving a patient away from their restrictive behaviours, facilitating discharge and preventing unhelpful cycles of restrictive interventions and admissions. *The decision to remove these should only be made on the basis of uncontainable physical risk.*

Further feeding considerations

- ✓ There should be consideration of how to support staff through distress tolerance and positive risk taking. Staff may feel they are not providing active treatment where they would otherwise routinely provide focused meal plans or NGF. Making a calculated, appropriate and risk-reasonable MDT decision to move away from such examples of usual treatment can precipitate staff distress. *Ensuring that staff are adequately supported through clinical and managerial supervision is essential*.
- ✓ *Neither ONS, nor NGF, should ever be used as a "threat" or weaponized* as part of a collaborative and holistic treatment plan.

> ***An example*** *of weaponized feeding would be:*
> *A patient receives a 400 kcal oral meal which they cannot fully complete, and manage to only consume 300 kcal of this. To act as a "threat" for non-completion a significantly higher number of calories are used. In this case, the 100 kcal that was not completed now requires the patient to consume an additional 300 kcal ONS or additional 600 kcal if they need a NGT.*

- ✓ *Weaponized feeding is different from restorative feeding.* Weaponized feeding pertains to punitive, threat-based feeding adjustments. Restorative feeding refers to using higher feeding calories through a NGF compared with an oral plan. With restorative NGF the aim is to improve nutritional status in the shortest possible duration whilst using the most restrictive method. Doing so, allows food to be used more flexibly which maintains the oral intake as therapeutic.

- ✓ In all cases of NGF care planning, blanket rules and assumptions should be avoided and replaced with collaborative, empathetic and clear therapeutic conversations with appropriate boundaries.

Recovery-limiting behaviours in inpatient settings

With an admission for AN, the following would be routinely recommended and required: full supervision of meals (including parental meal observation for young people); limited bathroom access (particularly unsupervised); and restricted physical movement/exercise. However, as RISH admissions are driven by a different psychopathology which may become exacerbated by this tight control, it would instead be advisable to consider:

- ✓ Is there a risk of vomiting which is being used as an additional self-harm modality? If so, how can this risk be managed / minimised in the context of self-harm support, and what would need to be put in place to support this?
- ✓ How might meal observation be carried out in a way that minimises restrictive control and overt observation?

> ***For example:*** *could the same staff member take and remove the plate of food? This would enable them to record the food intake and observe any attempts to hide food.* ***Remember*** *that food restrictions for those with RISH are not usually "hidden". Therefore, any behaviour to restrict and secrete food is intended to be found/seen.*

- ✓ Excessive exercise may be observed in those with RISH. Given the difference in formulation from those with AN, teams should avoid the assumption that exercise is driven exclusively by a desire to burn calories and lose weight. Instead, exercise behaviour may be driven by emotional regulation, sensory regulation, used as a further self-harm modality or as a maladaptive coping strategy to communicate a care need. Rather than seeking to abruptly stop exercise behaviours, teams need to skilfully address the underlying function of the behaviour and find collaborative ways to minimise their impact. Doing so is harm-reducing and concurrently acknowledges that excessive exercise is a recovery (progress) limiting behaviour that can exacerbate risks.

> ***For example:*** *what is the impact on health/weight recovery through this exercise expenditure? The restriction of movement can exacerbate the presentation so teams should ensure that any restriction to movement has robust physical risk grounds. Examples of physical impact which would necessitate movement limitations include dizziness, postural hypotension, low heart rate and physical weakness.*

Weekend cover planning

It is not unusual for individuals with RISH to present acutely out-of-hours. This can be perpetuated by several factors:

- Evenings and weekends can have less daily-life structure that helps to support grounding. This lack of structure can contribute to higher states of arousal and emotional dysregulation, leading to an increase in developed unhelpful coping strategies.
- Evenings and weekends typically have fewer points of professional contact with known and existing relationships. Contacts with a therapeutic relationship can help to de-escalate arousal states before unhelpful behaviours increase.
- The patient may have an awareness that they receive a different response out of hours and away from their usual care team.

> ***For example:*** *the patient may be more likely to be admitted if they are seen by professionals who are not from their usual care team. This can be appealing to an individual who is seeking to have their needs met.*

Out-of-hours presentations across an ill-prepared system can contribute to a maintenance of the unhelpful coping behaviours. This can lead to a cycle of restrictive inappropriate admissions. To reduce this risk:

- ✓ Ensure there is a consistent understanding across teams about the presenting behaviours being a symptom of the patient seeking to address an unmet need.
- ✓ Have a co-produced plan in place to help the system understand the patient's needs out of hours, and how better to meet these in a way that is compassionate and empathetic. The patient experience should never feel dismissive or judged.
- ✓ Plans should include a shared and consistent understanding about treatment aims, positive risk taking and minimising professional anxiety.

The role of crisis teams

Consensus of the working group was that that crisis teams across the country appear to be less familiar with restricted eating as a modality of self harm. Collective experience tells us that since the treatment pathway segwayed into specialist eating disorder teams, the crisis teams feel less skilled in supporting presentations involving eating restriction.

However, crisis clinicians are incredibly skilled and experienced at managing other presentations of self-harm. *With appropriate training and support, this places crisis teams in an excellent position to support patients with RISH.*

> **Examples** of additional training and support might include:
>
> - Training across various eating disorder/distress presentations, including an understanding of differentiations and risk management
> - Establishing regular meetings with community teams regarding the management of RISH patients to ensure consistent communication, approach and handovers of care
> - The development of RISH protocols if/as appropriate
> - Improved links with acute wards to support smooth transition and a consistent approach to risk
> - *Considering an out-of-hours pathway to quickly assess reported physical risk to support a positive risk-taking approach.*

Restrictive Intake Self Harm safety planning

Any safety plan for RISH should focus on the self-harm modality and consider the function of the restrictive intake. For example, this would include the triggers, perpetuating factors and presenting behaviours, rather than mimicking a typical AN safety plan. Focus should be on containing distress and ensuring consistent responses across the system, including from parents/carers (where applicable). The nutrition and hydration specific component should be less dominant.

Teams should also consider developing a 'passport style' safety plan that the patient carries with them. A passport increases ownership and self-efficacy, following the patient through all care settings to provide consistent support. It may also be helpful for patients who present to Accident and Emergency departments (A&E) to be assessed by Psychiatric Liaison in the first instance. This could reduce the medicalisation of the presentation if physical risks are managed.

The safety plan should understand the patient's journey, points of contact, and specific safety planning information within each care setting.

Helpful communication styles

It is essential that all clinicians are compassionate and non-judgemental in their communication with those experiencing RISH. Clinicians should be engaged in actively listening to the patient's and/or family's needs and challenges, alongside holding strong professional boundaries.

Appearing directive, confrontational, dismissive, judgemental, controlling and critical would be significantly detrimental to relationship forming and positive therapeutic engagement.

Teams should also be mindful that language is important and holds meaning. They should *especially avoid expressed and internalised dialogue about the presentation being 'attention seeking'.*

Broader ethical considerations

Clinicians are being inherently ethically minded in applying a RISH approach and working to avoid using an unhelpful or assumptive treatment plan.

There is a risk in RISH of institutionalisation, with the patient dependent on NGF, particularly one with restraint. This would typically manifest as cycles of NGF with restraint and restriction, and prolonged hospital admission. In such instances, teams should consider the use of an ethical panel and a second opinion (following their local guidelines). This is particularly important if the intervention is ongoing beyond 3 months.

Supervision advice for staff

RISH clinical practice inherently includes systemic thinking and holding uncomfortable risks. Adequately skilled, robust clinical supervision is essential for all staff treating RISH patients. Clinical supervision can also support the identification of unhelpful team dynamics to prevent 'splitting' occurring (Haslam *et al*., 2022). There is also a risk of organisational trauma with a resultant impact on the clinician's ability to make helpful therapeutic decisions. All such care and risk-taking decisions should be MDT based and staff should have appropriate restorative

and reflective clinical supervision to retain their ongoing mental fitness to practice (HCPC, 2024), thus ensuring ongoing high-quality safe patient care (CQC, 2023).

Psychologists are likely best placed to offer supervision in this capacity, though all supervisors should be adequately skilled in the variance of eating disorders and in trauma informed care. To meet this need, it may be necessary to explore supervision options outside the organisation.

Authors

This document was written and co-produced by specialist clinicians with experience across the ages, in eating disorders and across mental health disorders, and across clinical care settings. As such, it broadly represents the emerging national practice consensus. The document aims to improve awareness and understanding of RISH and provide practice considerations to help inform clinical practice.

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Glossary of terms

A&E	Accident and Emergency Department
ACE	Adverse Childhood Experiences
ACT	Acceptance and Commitment Therapy
AN	Anorexia Nervosa
CAT	Cognitive Analytic Therapy
CBT	Cognitive Behavioural Therapy
CFT	Compassion Focused Therapy
CYP	Children and young people
DBT	Dialectical Behavioural Therapy
EUPD	Emotionally Unstable Personality Disorder
MDT	Multidisciplinary Team
MEED	Medical Emergencies in Eating Disorders
MHA	Mental Health Act
NEWS	National Early Warning Score
NGF	Nasogastric Feeding
NGT	Nasogastric tube
ONS	Oral Nutritional Support
OSFED	Other Specified Feeding and Eating Disorder
PEWS	Paediatric Early Warning System
PTSD	Post Traumatic Stress Disorder
RISH	Restricted Intake Self Harm

Appendix 1 All age MEED Risk Assessment Framework Crib Sheet from page 31

	RED	AMBER	GREEN
% W4H / m%BMI / BMI	Under 18: %mBMI <70% Over 18: BMI <13 kg/m2	Under 18: %mBMI 70-80% Over 18: BMI 13-14.9 kg/m2	Under 18: %mBMI >80%W4H Over 18: BMI >15 kg/m2
Weight loss	Recent weight loss ≥1kg/week x2/52 in undernourished pt/rapid weight loss at any weight (e.g. in obesity/ARFID)	Recent weight loss of 500-999g/week for 2/52 in an undernourished patient	Recent weight loss of up to 500g/week or fluctuating weight
Pulse	<40 bpm	40-50 bpm	>50 bpm
Cardio-vascular Health	**Standing systolic BP <0.4th centile** with recurrent syncope + **postural systolic drop >20mmHg / increase in HR >30BPM (35BPM in >16 years)**	**Standing systolic BP <0.4th centile** with occasional syncope; **postural systolic drop >15mmHg / increase in HR ≤30BPM (35BPM in >16 years)**	Normal standing systolic BP for age and gender with reference to centile charts. Normal orthostatic cardiovascular changes. Normal heart rhythm
ECG abnormalities	**>18 years**: QTc >460 ms (female) or 450 ms (male) **18+ years:** QTc >450ms (female), 430ms (male) **(all)** And/or any other significant ECG anomaly	**>18 years**: QTc >460ms (female) or 450 ms (male) **18+ years**: QTc >450ms (female), >430ms (male). **(all)** and no other ECG anomaly. Taking QTc prolonging medication	**>18 years** QTc <460ms (female) or 450 (male) **18+ years:** QTc <450ms (female) or <430ms (male)
Dehydration status	Fluid refusal Severe dehydration	Severe fluid restriction, moderate dehydration	Minimal fluid restriction, mild dehydration
Temperature	<35.5°C Tympanic <35°C Axillary	<36°C	>36°C
Biochemical abnormalities	Hypophosphataemia* + falling phosphate. Hypokalaemia (<2.5 mmol/l). Hypoalbuminaemia. Hypoglycaemia (<3mmol/l). Hyponatraemia. Hypocalcaemia. Transaminases (>3x normal range). DM: HbA1C >10% (86mmol/mol). ***Note differences in normal phosphate level by age:** **3–10 years, 1.2–1.8mmol/L;** **10–15 years, 1.1–1.75mmol/L;** **>15 years, 0.8–1.45mmol/L.**		
Haematology	Low WCC (<3.8) Haemoglobin (<10g/L)		
Purging Behaviour	Multiple daily vomiting and/or laxative abuse	Regular (≥3x/week) vomiting and/or laxative abuse	
Disordered eating behaviours	Acute food refusal <500kcal/day x≥2 days		
Engagement with management plan	Violent when parents try to limit behaviour or encourage food/fluid intake. Self harm. Parents unable to implement prescribed meal plan	Poor insight into eating problems, lacks motivation. Parents / carers unable to implement prescribed meal plan	Some insight into problems, some motivation. Ambivalence but not active resistance
Activity and exercise	High levels dysfunctional exercise (>2hrs/day) in context of malnutrition	Moderate levels dysfunctional exercise in the context of malnutrition (>1hr/day)	Mild levels of dysfunctional exercise in the context of malnutrition (<1hr/day)
Musculo-Skeletal Squat/ Sit up test	Unable to complete sit-up or squat without using arms as leverage (alert)	Unable to complete sit-up or squat without using arms to balance (concern)	Able to complete sit-up and squat without difficulty
Other clinical state	Life-threatening medical condition	Non-life-threatening physical compromise	Evidence of physical compromise
Mental Health State	Self-poisoning, suicidal ideas with moderate to high risk of completed suicide	Cutting or similar behaviours, suicidal ideas with low risk of completed suicide	

Full MEED guidance (RCP, 2023) with additional detail can be found: [college-report-cr233-medical-emergencies-in-eating-disorders-(meed)-guidance.pdf (rcpsych.ac.uk)]

Appendix 2 - RISH Pod (innovative community practice example)

This practice innovation example has come from the Children and Young People's Eating Disorder Service (CYPS-CEDS) from North Tyne. It is shared with permission but it is acknowledged that it is not an evidence-based practice example.

The initiative arose following an observed increase in individuals presenting to services with RISH presentations alongside an acknowledgement that the eating disorder team treatment often exacerbated the presentation and the other community treatment teams felt poorly skilled and equipped to best support these patients. This led to clinicians and patients reaching crisis situations with their physical or mental health needing inpatient admission.

The aim of the approach is to make the expert MDT panel (the so-called 'Pod') available to members of the community mental health teams in a timely manner to prevent patient deterioration and reduce inpatient admissions.

What is the RISH Pod?

The RISH Pod is an established local agreement which links clinical expertise across teams and care-systems quickly, and without delay. The MDT Pod panel has representatives from children and young people's mental health services, CYPS-CEDS, paediatrics, universal crisis team and psychiatric liaison teams.

The guiding principle

The guiding principle of the RISH Pod is the *'stop the line'* approach to care and treatment. The stop the line concept is grounded in industry. It comes from a mechanism used on Toyota production lines that enables *any* worker to stop the production line if *any* problem is encountered. Stopping the line means that the *entire* production line is stopped until not only a problem is fixed, but that it is fixed at its *root*. This practice enabled Toyota's production lines to increase productivity. Within the NHS, this principle is typically found in policy relating to patient safety such as in cases of staffing, or the observation of any risk or incident. Used here, the guiding principle asserts that acting without appropriate skill and information may contribute to iatrogenic harm. As such, treating clinicians and teams should stop any potentially unhelpful intervention/action/assumption, and immediately call upon the local agreement which enacts a swift multi-agency discussion and MDT informed plan of care (within 5 working days).

Clinical application

In-line with all principles within these practice suggestions, presenting physical risks must be carefully weighed against the risk of inadvertent presentation escalation. Should risks necessitate intervention sooner than 5-working days the clinical care team must ensure that the patient receives adequate access to this care (such as attendance at A&E, supported by on-call psychiatry as appropriate). The soonest available RISH Pod discussion would then be called (within 5 days of the referral) and the treatment plan MDT supported and informed for care going forwards.

Benefits of the initiative:

For patients

- Maintaining a ‘core’ treating teams as far as possible aids therapeutic alliance and a smoother patient journey
- They are able to meaningfully develop an understanding of their difficulties due to clarity in the clinical team formulation which arises from multiagency consideration of the holistic challenges
- In most cases, rapid MDT discussion and subsequent MDT informed care planning avoids A&E/hospital admission.
- Where admission is required, information is able to flow seamlessly through partnerships contributing towards a consistent approach to boundaries and treatment which are therapeutically important.

For Mental Health Teams

- Increases their confidence in managing nutritional risks and the associated physical complications
- Develops helpful links and positive relationships with the CYPS-CEDS team, the paediatric team and with other teams within CYPS
- Improves confidence in providing psychoeducation and support to families as well as improving confidence in complex formulation. This enables access to appropriate interventions and adjacent teams.

For Paediatric teams

- Fosters positive reciprocal support between CYPS-CEDS and paediatric teams with regards to the management of patients with low weight and nutritional risk
- Builds good relationships with the community different mental health teams

Appendix 3

SERVICE FACING MANAGEMENT PLAN

Context

<Name> receiving treatment for Restricted Intake Self-Harm (RISH) formulation of needs. It was agreed at multidisciplinary meetings that a consistent positive risk-taking management plan whilst *<name>* is receiving treatment is necessary to support staff in the decision-making process.

Aim of the plan

The aim of the plan is to reduce the likelihood of service responses which inadvertently reinforce *<name>* risky behaviour over the longer term and reduce the likelihood of them achieving their goals. As this service facing management plan is to support clinicians, *<name>* **has not been involved in the development of this plan**. However, they have engaged with the development of their safety plan, are aware *(and in agreement)* with their formulation, and these complement the aims of this plan.

Situation this plan applies to:

For example: whilst the individual is receiving inpatient treatment

Brief formulation of difficulties
<include>

Description of known chronic presenting patterns
(To be read in conjunction with risk assessment documentation)

For example:

- *Episodes of refusing to eat, other forms of self harm, use of NG and how long this has been occurring. How the expressions of distress are conveyed eg by making statements about starving themselves or how long they have refused food/ fluids. How the individual responds to offers of support. Why they feel they need to self harm (eg guilt, numbing emotion etc)*
- *Triggers and what has increased risk behaviours.*
- *Soothers and what has reduced risk behaviours.*

Description of acute patterns

For example: has the restriction always been displayed or communicated to health care professionals? Has the individual made attempts to avoid discovery of suicide attempts?

It is important however that staff remain vigilant for any deviation from the known pattern or changes in circumstances, and that risk is continuously assessed.

Risk / benefits

A risk /benefit analysis of this current plan should be undertaken.
Example wording: the aim of the current plan is to reduce the potential for service responses to inadvertently increase risk over the longer term by maintaining and

escalating the current behaviour. Whilst there are short term risks inherent in the plan, including a low risk of death by starvation or misadventure, and increased risk of NGT use, it is considered that the benefits of the plan outweigh the risks over the longer term. Continuing the current patterns of behaviour is also inconsistent with recovery goals, by undermining the development of self-management skills and reducing the opportunity for <name> to develop a sense of responsibility and self-efficacy without the need to rely on others to keep them safe.

Guidance (as discussed in a multidisciplinary meeting).

Each situation must be individually assessed and approached in terms of imminent risk. The recommended approach when *<name>* is presenting in line with known chronic patterns of behavior is as follows:

General approach:

Example plan

- *Use SET approach (support, empathy, truth) when communicating with the individual. It is important to validate the underlying distress whilst being firm about the need for certain actions to be taken. Validating their distress and spending some time talking to the individual first is important before moving onto problem solving, as they may not able to make helpful decisions when in a highly agitated state.*
- *The aim is to provide a consistent response so as not to provide intermittent reinforcement. It is possible that this management plan may initially increase <name> expression of distress as they test out the boundaries and get used to different ways of being managed. It is also inevitable that <name> will "wobble" at times. However, if the plan is followed consistently and compassionately, with attention paid to validating distress, such episodes are likely to reduce.*
- *<name> is likely to respond well to having clear goals and plans. Therefore, it can be helpful if professionals help the individual to reflect and focus on future goals.*
- *Encourage / coach to use DBT skills, prompt cards and self soothe box, being sensitive to <name> fears e.g., around feeling guilty and unworthy of help.*
- *If they are an inpatient, ensure that they will have the same amount of support, activities and one to ones as others around them.*

Self-harm Approach

Example plan

- *If <name> states that they will not eat/drink, support should be offered and they should be encouraged to eat/drink. Continuous risk assessment is needed: if their presentation deviates from the chronic pattern, it may be appropriate to review whether an NGF plan is necessary. However, if their presentation is in line with the chronic pattern, they should be allowed to restrict in line with the positive risk-taking documentation.*
- *If <name> calls for support they should be supported over the telephone. Again, the principles of validating the distress to enable them to become more emotionally regulated before starting problem solving applies. <name> should be made aware of support that can be provided, e.g., the crisis team if they*

have self-harmed. They should be aware that if they have taken an overdose or need wound care, they need to seek appropriate medical attention and can attend A&E.

- *If <name>is refusing nutrition within the chronic pattern, they will usually become calm again after expressing distress and be better able to make good decisions.*

Interactions with others

Example plan

- *<name> should be asked to agree to seek help from their clinician(s) if they are struggling with interpersonal relationships (friendships, family or others). They should be encouraged to listen to their clinician's feedback about their relationships with others. If the clinicians observe any difficulties, they can therefore approach <name> for a supportive discussion to help them to reflect on their interpersonal patterns.*

Mental health support:

Example plan

- *A collaborative plan should be developed with <name> which they have a copy of.*
- *<name> should be encouraged to make appropriate use of the support provided by the team or the Crisis Team alongside regular appointments with members of their clinicians.*

THIS SERVICE MANAGEMENT PLAN SHOULD BE REVIEWED AND UPDATED FOLLOWING ANY INCIDENTS OR KNOWN CHANGES IN CIRCUMSTANCES.

Service management plan example created by Dr Clare Fenton, Consultant Psychiatrist.