# Harm Reduction Principles for Individuals with Eating Disorders

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CEED acknowledges the Wurundjeri people of the Kulin Nations as the Traditional Custodians of the land we are meeting on today and pay our respects to Elders past and present.

*Walk Together*
By Dixon Patten
Gunnai and Yorta Yorta
Bayila Creative

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## Acknowledgement of Lived Experience

This artwork represents how I feel when I'm following my authentic self with a full heart. During recovery, I found that I was able to have these moments of feeling "ME" - the real self, doing things that align to "MY" values. When I feel these moments of authenticity, even if its not often, I feel so proud - like my heart is full and "mine".

The character in the image is holding her heart close, as a transformation of colour from b&w occurs. This is how I feel in those small moments. I can see clearly, & in colour. I can see ME (and its so exciting!)

Artwork by:
Sarah Nechama Israel.

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## About CEED

Strengthening the system of care to provide excellence in eating disorders treatment for Victorians


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## Poll: Who is here today?

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## Webinar Outline

- What is Harm Reduction?
- Why Consider Harm Reduction for Eating Disorders?
- When to use Harm Reduction Strategies
- Harm Reduction Approaches In Action

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## What is Harm Reduction?

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Definitions:

*"Harm reduction approaches invite people to **reduce the negative effects of behaviours** and **take steps toward improved safety and greater self-care** whilst keeping opportunities for further healing and recovery open."*

***"Harm reduction does not remove a person's primary coping mechanisms until others are in place"***

(Marlatt, 1996)

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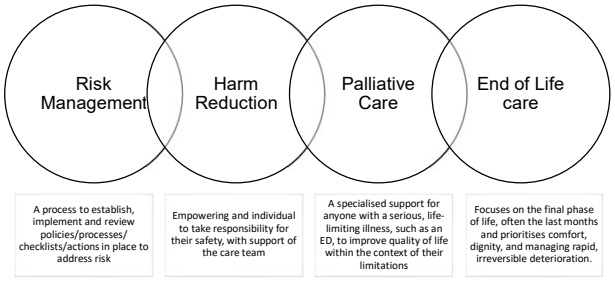
Consider the Distinction between:




| Risk Management | Harm Reduction | Palliative Care | End of Life care |
|---|---|---|---|
| A process to establish, implement and review policies/processes/ checklists/actions in place to address risk | Empowering and individual to take responsibility for their safety, with support of the care team | A specialised support for anyone with a serious, life-limiting illness, such as an ED, to improve quality of life within the context of their limitations | Focuses on the final phase of life, often the last months and prioritises comfort, dignity, and managing rapid, irreversible deterioration. |

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Key Principles

| Humanism | Pragmatism | Individualism |
|---|---|---|
| • Providers value, care for, respect, and dignify patients as individuals | • None of us will ever achieve perfect health behaviours | • Every person presents with their own needs and strengths |

| Autonomy | Incrementalism | Accountability w/o Termination |
|---|---|---|
| • Individuals ultimately make their own choices about health behaviour | • Any positive change is a step toward improved health, plan for lapses | • Providers help individuals understand that the consequences of harmful health behaviours are their own |

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**In practice, harm reduction approaches are routinely used within care for individuals presenting with mental health concerns**

- Supports meaningful engagement in self-care and professional support
- Invites the examination of values, aspirations and wishes, enhanced health, and improved quality of life
- Provides opportunities to safely experiment with small changes
- Compassion-focused and person-centred
- Harm reduction actions could save someone's life

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Theoretically, Harm Reduction Frameworks are Consistent with Other Frameworks and Movements in the Mental Health Field

- NEDC Holding Hope: Holding Hope Exploring Compassionate & Holistic Care Pathways for Longstanding Eating Disorders
- Victoria's Mental Health and Wellbeing Act 2022: Centres on person-centred, recovery-oriented care that prioritises human rights and increased autonomy

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## Why Consider Harm Reduction for Eating disorders

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## Disordered Eating Increases Risk of Harm

- EDs associated with risk of harm to every system in the body.
- Risk of Death due to starvation, electrolyte imbalance and suicide, among others
- Risk of harm is further increased when more than one harmful behaviour occur simultaneously
  - Restrictive eating with physical activity increase risk of dehydration, abnormal electrolytes, heat related issues and injury.
  - Vomiting, use of laxatives or diuretics, dehydration and electrolyte loss during exercise can contribute to low potassium. Electrolyte fluctuations can cause an irregular heartbeat and possible heart attack.
  - Increased risk of cardiovascular complications when using substances that are associated with a fast or irregular heartbeat, i.e. Dissociatives & Psychedelics

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## A challenge that services face:

Physical and nutritional rehabilitation are generally accepted as central aspects of physical and mental recovery for people experiencing an eating disorder

***However…***

Physical and psychiatric risk is common among individuals with eating disorders presenting to mental health services, and risk does not remit from initial engagement

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## Key Question:

Could harm reduction approaches help to fill a critical gap in care for individuals with eating disorders?

No evidence in the general eating disorders literature, however, if we explore evidence from broader mental health contexts…

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## Evidence from Alcohol & Other Drugs and Longstanding EDs Research

HR approaches increase motivation & engagement with treatment
(Logan & Marlatt, 2010; Williams, Dobney, & Geller, 2010)

In HR approaches clients experienced treatment as less threatening
(Geller, 2012)

SSI are associated with reduced ED symptoms and impairment
(Fursland, Erceg-Hurn, Byrne, & McEvoy, 2018; Schleider, Dobias, Sung, & Mullarkey, 2020; Schleider, Smith, & Ahuvia, 2023).

Increased motivation correlates with improved treatment outcomes
(Hoetzel et al., 2013; Pauli et al., 2017; Sansfaçon et al., 2020)

**Most Importantly:** Harm Reduction Reduces Harm

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## CEED Harm reduction Resources

- Developed to provide guidance for clinicians to support clients to increase physical safety with support from the care team
- Framed for **adults** seeking mental health support who engage in eating behaviours that risk harm to that individual's physical safety
- Informed by:
  - Frameworks and empirical research from other mental health fields
  - Consultation with AOD, lived experience, health and mental health experts
- Initial publication: August 2021

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## Resource Development Process

- June 2020: Initial needs identified in the context of the emerging COVID-19 pandemic
  - Literature review
  - Scoping analysis survey
- September 2020: Discussion and planning meetings commence
  - Consultation with AOD services & lived-experience workforce
- December 2020: Initial documents developed
  - Internal review conducted among CEED team
- January – July 2021: Review process external to CEED team
  - Eating disorder organisations
  - Lived experience workforce
  - AOD peers
- August 2021: Online publication and dissemination of initial resources

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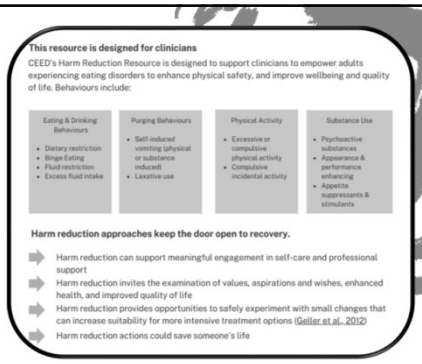
## 2025: Publication of Revised Resources

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## When to use Harm Reduction Strategies

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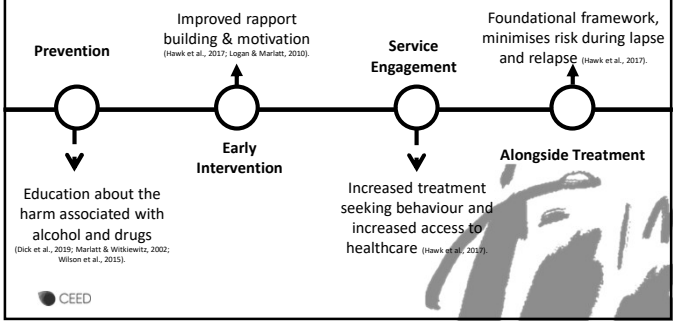
## Evidence from Alcohol and Other Drugs Research

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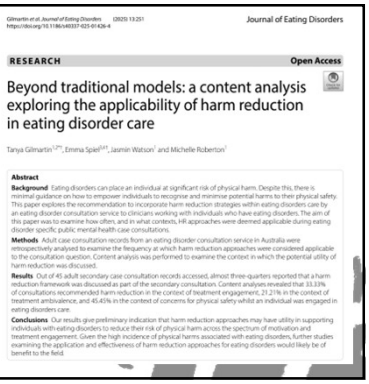
## Application of HR Resources

- Research Goals:
- Understand the recommendation of CEED Harm Reduction Resources in Clinical consultation
  - Between August 2021 and August 2022

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HR resources were discussed as an option to clinicians seeking consultation in the majority of adult cases. There were three main contexts where HR resources were explored as a potential recommendation.

| Seeking referral pathways | Perceived Low Readiness to Change | Risky ED behaviour in treatment |
|---|---|---|
| Clinicians expressed concerns about new service users/emerging ED patterns, seeking referral pathways. | Clinicians expressed concerns about client's reporting that they were not ready to address ED, not accepting a referral to ED specific treatment | Clinicians expressed concern about clients who were engaged in targeted ED care, but continuing to engage in risk behaviour |

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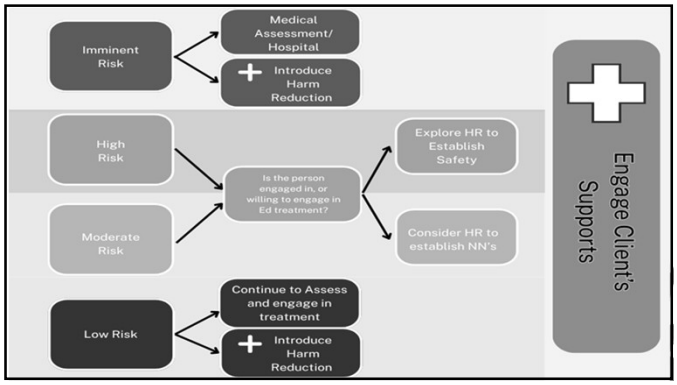


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## How does Harm Reduction fit in with evidence-based interventions?

- Use harm reduction approaches as an adjunct to evidence-based QoL and readiness interventions for eating disorders where **motivation to change is low and harmful behaviours are present**.
- Use harm reduction approaches as an adjunct to evidence-based behaviour change treatments for eating disorders where **motivation to change is moderate to high however harmful behaviours are yet to completely cease**.

*A Back Door approach to treatment and recovery*

*"Paradoxically, in helping clients build a more meaningful life for themselves with their ED, they often choose, over time, to decrease its impact in their lives on their terms. We describe this as a 'back door approach to recovery'" (Geller et al., 2012).*

**Harm reduction approaches do not stand alone**

- Follow general principles and clinical practice standards (Heruc et al., 2020).
- Utilise an evidence-based practice framework (Peterson et al., 2016).
- Practice trauma-informed care.
- Offer the most appropriate intervention in the most appropriate setting tailored to the needs of the individual (see NICE Guidelines and Treatment Setting Decision Matrix).

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## Harm Reduction Approaches In Action

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**General Risk Management**

- Assess Disordered Eating Behaviour, Understand the features of the behaviour
- Identify level of risk and appropriate immediate response (if necessary)
- Connect & Collaborate with Care Team
- Establish or revise parameters for step-up and step-down in treatment
- Seek to understand the function of the behaviour
- Agree with the client on appropriate strategies to reduce harm for the individual

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## Case study

- **New Client:** Sarah is 23yo female and presents to your service with Anorexia Nervosa- Binge/Purge subtype. She is currently underweight with amenorrhea.
- **Eating Disorder and Eating Behaviour:** Sarah has experienced an eating disorder for 4 years, and is currently fasting consuming 1 meal per day. She reports experiencing binge-purge episodes 3-4 times per week which can last up to three hours and feel frantic.
- **Exercise:** Rigid daily exercise, she reports that this is to help maintain weight and to manage anxiety/mood.
  - Includes a 60-90min walk/run daily.
  - At times when she has not been able to exercise she has consumed **alcohol at excessive levels** due to high anxiety. Currently only consuming 3-4 alcoholic drinks daily in afternoon/evening
- **Treatment Experience**: Sarah has had multiple medical, psychiatric and eating-disorder specific admissions, attended day-patent programs and has began eating-disorder specific treatment previously before dropping out.
  - Reports that she does not want to go to hospital, but she is afraid of weight gain that she thinks will be associated with weight restoration.
  - Does not see recovery as an option and feels pressured by family to seek support, as her past treatment experience have felt pressured, and out of her control.
- Sarah has completed university and has recently got her first "professional" job. She is concerned about taking leave for hospital admissions, or her boss finding out about her mental health issues.

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- Identify risk Behaviours
- Understand **frequency** of Behaviours
- Understand **severity** of behaviour
- Understand **patterns** of behaviour, how behaviours occur separately and together

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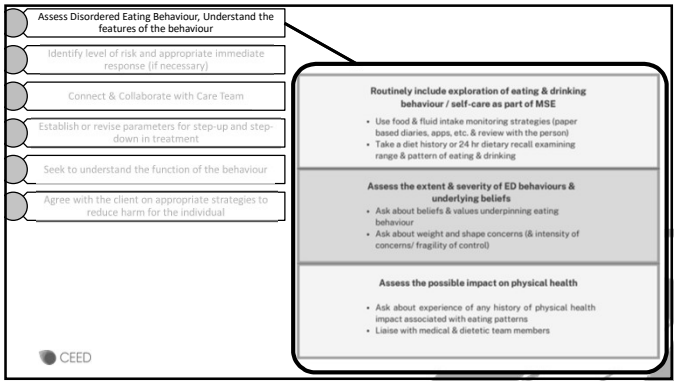


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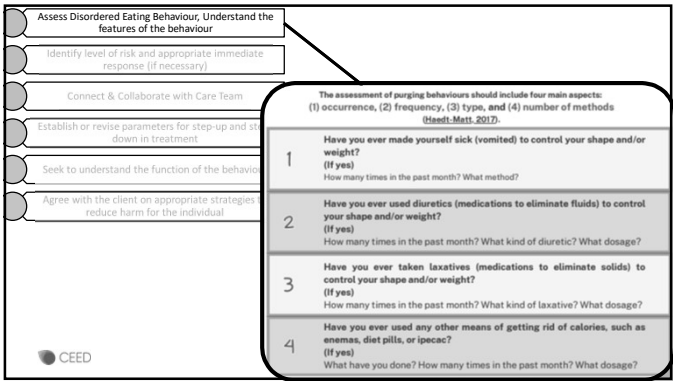


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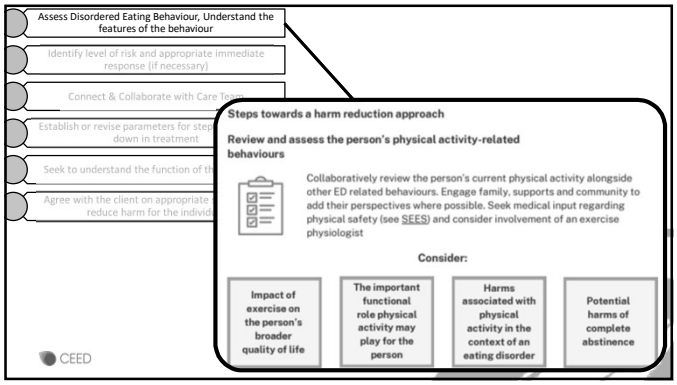


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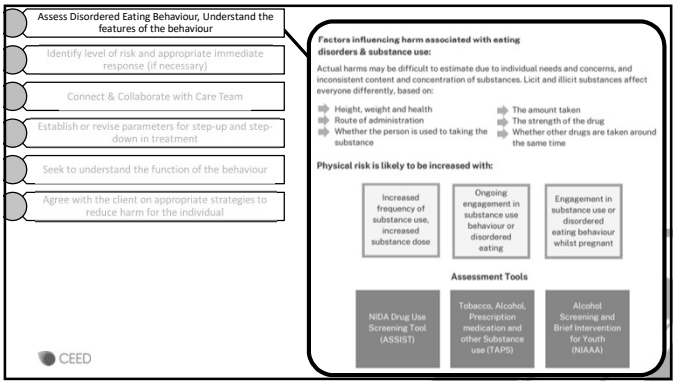


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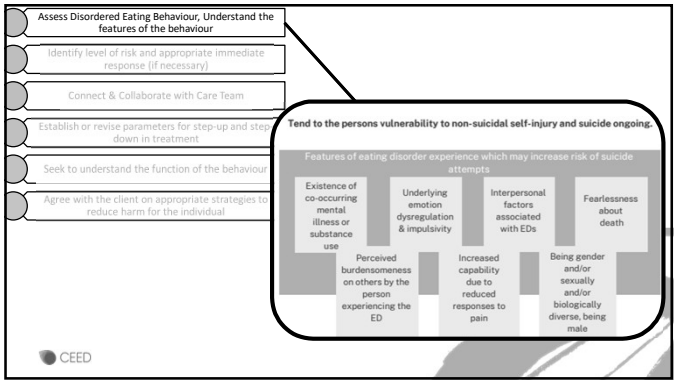


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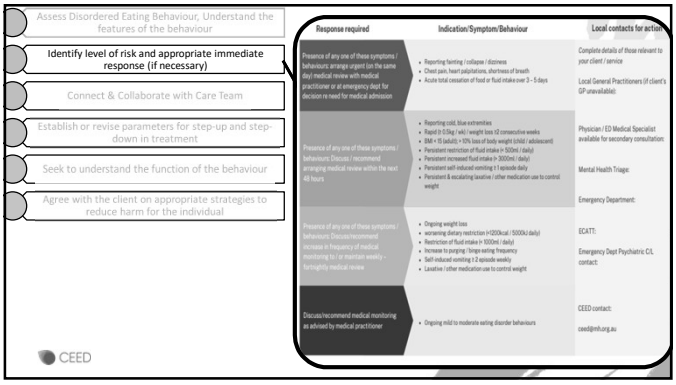


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Identify level of risk and appropriate immediate response (if necessary)
Connect & Collaborate with Care Team
Establish or revise parameters for step-up and step-down in treatment
Seek to understand the function of the behaviour
Agree with the client on appropriate strategies to reduce harm for the individual

- **If new client:**
  - –Establish and connect with care team
  - –Define roles
- **If Existing Client:**
  - –Connect with care team
  - –Collaborate on a shared understanding of current risks.

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**Mental Health** — Leads treatment and weighs client as appropriate, maintains engagement with service

**Medical** — Medical assessment and management

**Basic Care Team** — Important to have a clear understanding of when to step up treatment intensity

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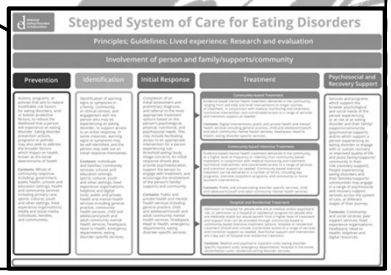


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Builds a foundation for exploring safer alternatives

Individualism: Everyone has needs & strengths

Why is someone doing what they are doing?

Show empathy & understanding.

Provides a safe, non-judgemental environment

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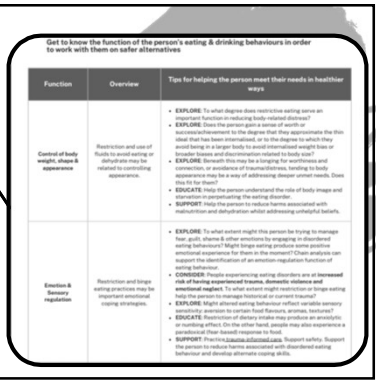


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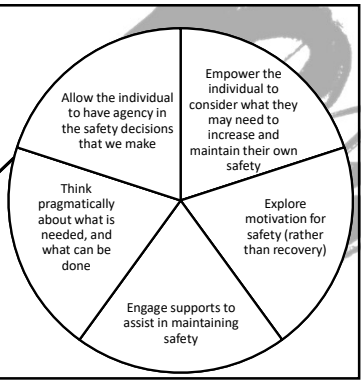


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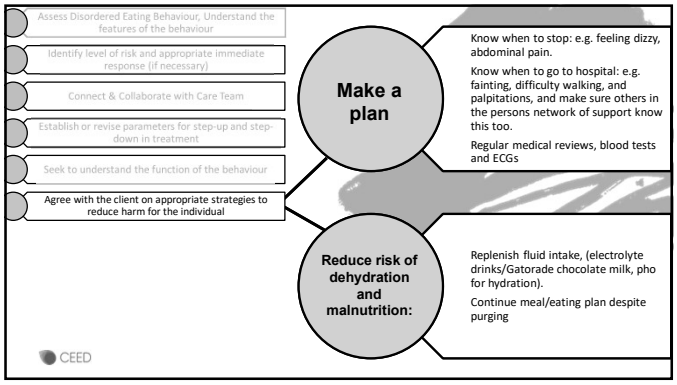
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Make a plan
Know when to stop: e.g. feeling dizzy, abdominal pain.
Know when to go to hospital: e.g. fainting, difficulty walking, and palpitations, and make sure others in the persons network of support know this too.
Regular medical reviews, blood tests and ECGs
Reduce risk of dehydration and malnutrition:
Replenish fluid intake, (electrolyte drinks/Gatorade chocolate milk, pho for hydration).
Continue meal/eating plan despite purging
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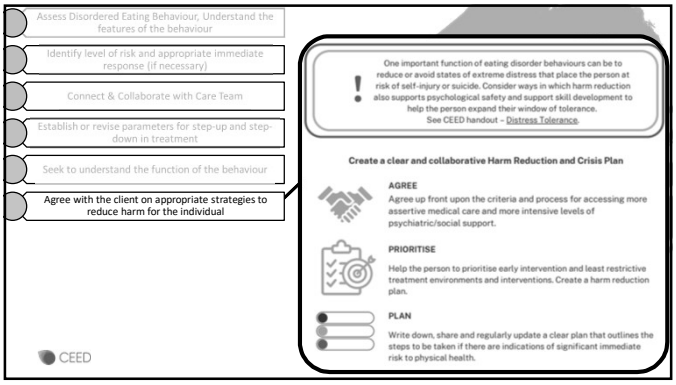
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One important function of eating disorder behaviours can be to reduce or avoid states of extreme distress that place the person at risk of self-injury or suicide. Consider ways in which harm reduction also supports psychological safety and support skill development to help the person expand their window of tolerance.
See CEED handout – Distress Tolerance.
Create a clear and collaborative Harm Reduction and Crisis Plan
AGREE
Agree up front upon the criteria and process for accessing more assertive medical care and more intensive levels of psychiatric/social support.
PRIORITISE
Help the person to prioritise early intervention and least restrictive treatment environments and interventions. Create a harm reduction plan.
PLAN
Write down, share and regularly update a clear plan that outlines the steps to be taken if there are indications of significant immediate risk to physical health.
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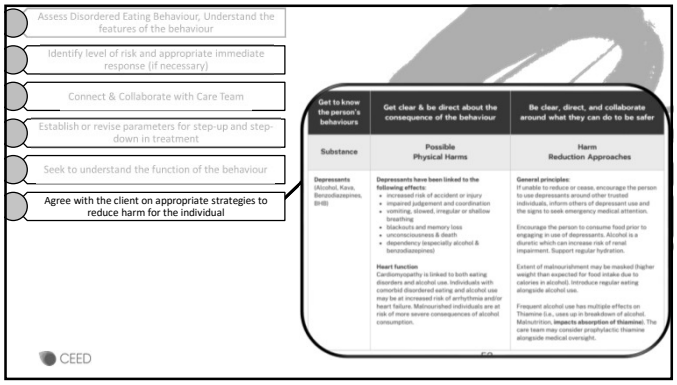
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Get to know the person's behaviours
Get clear & be direct about the consequence of the behaviour
Be clear, direct, and collaborate around what they can do to be safer
Substance
Possible Physical Harms
Harm Reduction Approaches
Depressants (Alcohol, Kava, Benzodiazepines, BHB)
Depressants have been linked to the following effects:
increased risk of accident or injury
impaired judgement and coordination
vomiting, slowed, irregular or shallow breathing
blackouts and memory loss
unconsciousness & death
dependency (especially alcohol & benzodiazepines)
Heart function
Cardiomyopathy is linked to both eating disorders and alcohol use. Individuals with comorbid disordered eating and alcohol use may be at increased risk of arrhythmia and/or heart failure. Malnourished individuals are at risk of more severe consequences of alcohol consumption.
General principles:
If unable to reduce or cease, encourage the person to use depressants around other trusted individuals, inform others of depressant use and the signs to seek emergency medical attention.
Encourage the person to consume food prior to engaging in use of depressants. Alcohol is a diuretic which can increase risk of renal impairment. Support regular hydration.
Extent of malnourishment may be masked (higher weight than expected for food intake due to calories in alcohol). Introduce regular eating alongside alcohol use.
Frequent alcohol use has multiple effects on Thiamine (i.e., uses up in breakdown of alcohol, Malnutrition, impacts absorption of thiamine). The care team may consider prophylactic thiamine alongside medical oversight.
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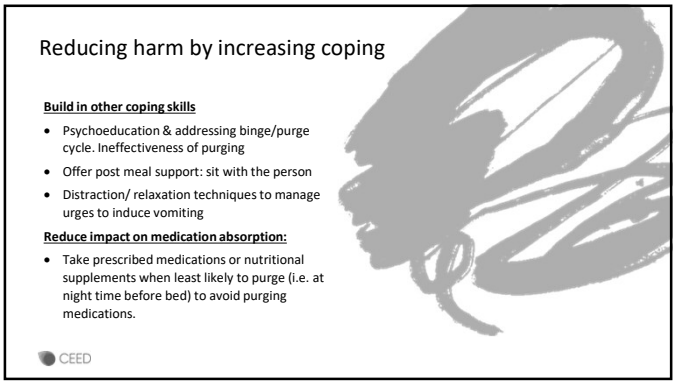
Reducing harm by increasing coping
Build in other coping skills
Psychoeducation & addressing binge/purge cycle. Ineffectiveness of purging
Offer post meal support: sit with the person
Distraction/ relaxation techniques to manage urges to induce vomiting
Reduce impact on medication absorption:
Take prescribed medications or nutritional supplements when least likely to purge (i.e. at night time before bed) to avoid purging medications.
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ANY QUESTIONS?
PLEASE COMPLETE OUR EVALUATION!
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