# Is your service FREED ready?

FREED is intended to fit in with local processes and treatment pathways. However, certain components are key and service-level factors will impact implementation. The following questions are designed to help you think about how "FREED ready" your service is. If you are already using FREED, it can also be used to review how this is going.

All questions are in relation to 16 to 25-year-olds with an eating disorder of up to 3 years duration.


## Key FREED components

**1. Evidence-based practice**

**1.1 Does your service offer evidence-based eating disorder treatment** (see below)?

a) We are only able to provide eating disorder patients with monitoring and general support and can not offer full evidence-based treatment packages.
b) We provide eating disorder patients with a variety of treatment options, some of which are evidence-based.
c) We aim to provide all eating disorder patients with evidence-based care.

*NICE guidelines advise eating disorder-focused Cognitive Behaviour Therapy (CBT-ED), Maudsley Anorexia Nervosa Treatment for Adults (MANTRA), Specialist Supportive Clinical Management (SSCM) or eating disorder-focused Focal Psychodynamic Therapy (FPT) for adults with anorexia nervosa and similar presentations; anorexia nervosa-focused family therapy (FT) for children and young people with anorexia nervosa; Cognitive Behaviour Therapy guided self-help or group CBT-ED or individual CBT-ED for adults with bulimia nervosa, binge eating disorder and similar presentations; and bulimia nervosa-focused family therapy (FT) for children and young people with bulimia nervosa.*

**1.2 Does your service have a sufficient mix and number of staff for your referral population** (see below)?

a) We do not have a multidisciplinary team.
b) We have a multidisciplinary team but some disciplines are under-represented for our referral population.
c) We have a multidisciplinary team that is broadly in line with that recommended for our referral population

*The Royal College of Psychiatrists recommends that the broad composition of a specialist eating disorders service for a population of 1 million people should be 1.2 WTE consultant psychiatrists, 2.4 WTE senior and junior psychiatric trainees, 5.4 WTE psychological therapists, 28.8 WTE nurses, 1.2 WTE dieticians, 3.6 WTE occupational and creative*

*therapists, 4.2 WTE administrators and 0.6 WTE house-keepers. These figures are across outpatient and inpatient services for the population.*

**2. Waiting times**

**2.1 After being referred to the service, how long do young people usually wait for an assessment?**

a. Over 2 months.
b. Between 2 weeks and 2 months.
c. Within 2 weeks.

**2.2 After being referred to the service, how long do young people usually wait to start treatment?**

a) Over 6 months.
b) Between 1 month and 6 months.
c) Within 1 month.

**3. Pro-active engagement and intervention**

**3.1 Does your service actively try to contact and engage young people in treatment?**

a) We contact young people in the same way as all patients, and have to discharge them if they don't respond to initial opt-in letters or contact attempts.
b) We try to contact young people in different ways – phone, letter, email or text, depending on what they respond to. We make an effort to speak to them soon after referral to talk them through the next steps.
c) We try to contact young people in different ways – phone, letter, email or text, depending on what they respond to. We make an effort to speak to them soon after referral to talk them through the next steps. We are as flexible as possible with providing appointment times that fit their schedules and are accommodating of changes in availability around exam time or study commitments.

**3.2 Does your service you offer treatment to all individuals with eating disorders?**

a) We have severity criteria for treatment, which means that some patients with eating disorders are not accepted by our service.
b) We treat all patients with a diagnosable eating disorder.
c) We treat all patients with a diagnosable eating disorder. In addition, we may offer short-term treatment to young people with emerging eating disorder symptoms or recent reductions in symptoms, in order to promote full sustained recovery.

**3.3 Can your service identify a 'FREED champion'** (a clinician to manage referral and treatment pathways for young people)?

a) We do not have a FREED champion and would not be able to accommodate this.
b) We do not currently have a FREED champion but have scope to recruit one; OR, we have a FREED champion (or champions) but they do not have protected time for this role.
c) We have a FREED champion (or champions) with protected time for this role.

**4. Involving families and significant others**

**4.1 Do you involve, and offer support to, families and significant others?**

a) We do not routinely suggest that family members or significant others attend appointment or treatment sessions.

b) We routinely offer sessions with family members or significant others, but do not actively encourage this.
c) We actively encourage family members and/or significant others to have some involvement in young people's care.

**5. Attention to issues specific to young people**

**5.1 Do you attend to issues specific to young people** (e.g., transitions to university, work or away from home; transitions from child/adolescent treatment services; social media use; the adjustment to adulthood and associated identity formation)?

a) We offer treatment to young people in a similar fashion to other patients within the service, and do not routinely consider issues specific to this age group.
b) We will attend to age-specific issues that young people bring to treatment but would not ask about these areas directly.
c) We routinely ask about difficulties that may be relevant to young people with eating disorders, at assessment and in treatment.

## Service factors that impact FREED

**6. Service dynamics**

**6.1 Is your team open to innovation and change?**

a) We prefer to continue with established systems rather than trial new approaches.
b) We are interested in innovation but do not regularly find time to attend to this within the service.
c) We regularly think about options for innovation and quality improvement, and can identify examples of service improvements that we are proud of.

**6.2 Is your team open to role, task and knowledge sharing?**

a) Staff generally have set roles according to discipline or experience, and do not usually vary from these or engage in within or cross-team knowledge sharing.
b) Roles, tasks and knowledge are shared within the team to some extent (e.g., all individuals are invited to contribute to team training or reflective practice; therapy may be delivered by nurse therapists, psychologists or psychiatrists; we value multidisciplinary input to treatment planning).
c) Roles, tasks and knowledge are shared within the team and we also welcome cross-team knowledge sharing (e.g., with other eating disorder services or with other local mental health teams).

**6.3 Is the team usually settled with most staff members present and posts filled?**

a) We have a high degree of staff changeover and often have unfilled posts.
b) We have periods with unfilled posts, but this does not usually disrupt team functioning.
c) We have a stable team and can usually plan for foreseeable staff absences without disruptions to the service.

**6.4 Is your service passionate about providing best patient care?**

a) Staff are often 'burnt out' and lack enthusiasm for high quality care.
b) We are passionate about best care for patients but this sometimes gets forgotten when staff are under pressure.
c) We are passionate about best care for patients and this guides the work that we do.

**6.5 Does your service ensure regular access to clinical supervision?**

a. Supervision occurs rarely and/or staff members are not required to attend.
b. Supervision occurs at least monthly and staff members are expected to attend.
c. Supervision occurs more than once per month and staff members are expected to attend.

**6.6 Does your service have a strong relationship with senior management and chief executives?**

a) We have a variable relationship with the senior team and it is difficult to obtain support for service innovation and improvement.
b) We have a good relationship with the senior team but are not always able to obtain support for service innovation and improvement.
c) We have a good relationship with the senior team and they are usually supportive of ideas for service improvement.

**7. Commissioning and referral pathways**

**7.1 Does your service have a good relationship with local Clinical Commissioning Groups and referrers?**

a) We have variable relationships with commissioners / referrers and this can compromise our referral pathways.
b) We are usually able to talk with commissioners / referrers to overcome any difficulties with referrals.
c) We have a good relationship with commissioners / referrers and referral pathways operate smoothly.

**7.2 Does your commissioning model support early intervention?**

a) We are funded through block contracts, so would struggle if our referrals increased; OR, we receive care contracts for patients that require case-by-case CCG approval, often taking > 4 weeks; OR, we receive care contracts for patients that fund limited input only (e.g., assessment and no treatment).
b) We receive care contracts for patients that require case-by-case CCG approval, but this is usually given within 4 weeks. Patients are generally funded for an adequate number of sessions.
c) We automatically receive care contracts for referred patients and these generally fund an adequate number of sessions.

**8. Is your service willing to work with us?**

a) We are not interested in joining the FREED network.
b) We are provisionally interested in joining the FREED network.
c) Yes! We are interested in joining the FREED network and are keen to work with others involved.

**Results**

Mostly c's? You are already operating in a fashion consistent with FREED!

Mostly b's? You are well on the way to FREED and it shouldn't be too difficult to adjust your processes to adopt FREED protocols.

Mostly a's? It will be harder for your service to adopt FREED, but we can help you think about steps to get there.