

# NSW Eating Disorders Toolkit

A practice-Based Guide to  
the Inpatient management  
of Children and Adolescents with  
Eating Disorders



NSW Ministry of Health  
1 Reserve Road  
ST LEONARDS NSW 2065  
Tel. (02) 9391 9000  
Fax. (02) 9391 9101  
TTY. (02) 9391 9900  
[www.health.nsw.gov.au](http://www.health.nsw.gov.au)

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# Acknowledgements

The Toolkit is a revision of the original Toolkit whose development was facilitated by the former MH-Kids (now MH-Children and Young People) in conjunction with a variety of clinicians and academics throughout NSW, nationally and internationally.

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MH-CYP and InsideOut would like to thank the expert panel who assisted with the revision of this document:

- Ms Danielle Maloney
- Dr Sloane Madden
- Ms Joanne Titterton
- Ms Mel Hart
- Dr Julie Adamson
- Dr Michael Kohn
- Dr Rod McClymont
- Ms Carolyn Rae (Secretariat)
- Ms Marie Hamann

A small task group was involved in rewriting Medical and Physical Treatment section:

- Danielle Maloney (InsideOut Institute)
- Dr Joanne Morrison (ISLHD)
- Dr Julie Adamson (HNELHD)
- Prof Sloane Madden (SCHN)
- Prof Michael Kohn (WSLHD)
- Dr Claire Gaskin (SESLHD)

# Executive Summary

It is well recognised that early, timely and appropriate care will improve the likelihood of positive treatment outcomes for young people with an eating disorder. The high morbidity and mortality associated with eating disorders and the need for a multidisciplinary approach are well reported in the literature.

The NSW Eating Disorders Toolkit is a practice-based manual that aims to assist health professionals in applying best-practice principles in non-specialist inpatient settings in NSW. The Toolkit aims to assist with improving access to practical information, to facilitate consultation with specialist staff and to improve consistency of care for children and adolescents with eating disorders across NSW.

The Toolkit has been developed to provide practical information on key components of care for children and adolescents admitted with an eating disorder including:

- Triage in the Emergency Department;
- Assessment;
- Identifying those in need of admission;
- Admitting the patient;
- Accessing specialist assistance;
- Treatment planning;
- Implementing treatment (primarily medical, nutritional and psychological aspects);
- Involving the family and other health professionals;
- Transition from inpatient care; and
- Accessing further information and support.

The document has been developed with the busy clinician in mind, aiming to ensure easy access to relevant information. The Toolkit has been designed to provide user friendly “pull out” sections that can be easily identified and accessed separately.

The information described in the Toolkit was developed from the evidence-based literature, international eating disorder clinical practice guidelines, consultation with national and international experts and the experiences of clinicians working with patients with eating disorders in non-specialist settings. It is not the intention that this Toolkit acts as a stand-alone treatment manual as any management program must take into account the unique health care needs, and the context, of each individual patient and their family.

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# Abbreviations

Term	Definition
1:1	Nursing special one to one
ARFID	Avoidant Restrictive Food Intake Disorder
AN	Anorexia Nervosa
BSL	Blood Sugar/Glucose Level
BMC	Bone Mineral Content
BMI	Body Mass Index
BN	Bulimia Nervosa
BP	Blood Pressure
BPM	Beats Per Minute
CALD	Culturally and Linguistically Diverse
CAMHS	Child & Adolescent Mental Health Service
CBT	Cognitive Behaviour Therapy
DADHC	Department of Ageing, Disability and Home Care
DoE	Department of Education
DEXA	Dual-Energy X-ray Absorptiometry
FaCS	Family and Community Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECG	Electrocardiogram
ED	Eating Disorder
EDE	Eating Disorder Examination
EUC	Electrolytes, Urea, Creatinine
FBC	Full Blood Count
g	Gram
GP	General Practitioner
HCI	Health Care Interpreter
HCIS	Health Care Interpreter Service
HR	Heart Rate
HWR	Healthy Weight Range
IV	Intravenous
kcal	Kilocalorie
kg	Kilogram
kJ	Kilojoules

Term	Definition
<b>LFT</b>	Liver Function Test
<b>MAOI</b>	Monoamine Oxidase Inhibitor
<b>MET</b>	Motivational Enhancement Therapy
<b>MG/mg</b>	Milligrams
<b>MHA</b>	Mental Health Act
<b>ml</b>	Millilitre
<b>MPH</b>	Mid-Parental Height
<b>MRN</b>	Medical Record Number
<b>NESB</b>	Non English Speaking Background
<b>NG/NGT</b>	Naso-gastric/ Naso-gastric Tube
<b>NRVs</b>	Nutrient Reference Values
<b>NSW</b>	New South Wales
<b>NUM</b>	Nurse Unit Manager
<b>OCD</b>	Obsessive Compulsive Disorder
<b>OH&amp;S</b>	Occupational Health and Safety
<b>OSFED</b>	Other Specified Feeding and Eating Disorder
<b>PTSD</b>	Post Traumatic Stress Disorder
<b>RS</b>	Re-feeding Syndrome
<b>SSRI</b>	Selective Serotonin Reuptake Inhibitors
<b>TG</b>	Triglyceride
<b>TIS</b>	Telephone Interpreter Service
<b>USFED</b>	Unspecified Feeding and Eating Disorders



## Section 1

# Introduction to the Toolkit

## INTRODUCTION

The NSW Service Plan for People with Eating Disorders 2013-2018 was launched in 2013. With the release of the plan, every Local Health District and Specialty Network across NSW has now developed a local Eating Disorders Implementation Plan which ensures that all patients with eating disorders are appropriately cared for as close to home as possible.

This Toolkit acknowledges that the demand for inpatient services for eating disorders is significant and that many of the children and adolescents requiring hospitalisation may receive treatment in non-eating disorders specialist wards. With this in mind the Toolkit offers a resource for health professionals who find themselves caring for children and adolescents hospitalised with an eating disorder.

The recommendations within this Toolkit should be adapted to meet your patient's individual needs as well as your local service needs. It is not the intention that this Toolkit acts as a stand-alone treatment manual as any management program must take into account the unique health care needs, and the context, of each individual patient.

Information in the Toolkit has been considered by a group of experts working in the field of eating disorders to be of significant clinical importance. The Toolkit has also been developed in line with relevant State and National health policies and documents. Reference materials are not cited in the main text but relevant references and resources are fully cited in the Appendix.

## AIMS AND SCOPE OF THE TOOLKIT

The aim of the Toolkit is to provide practical information on key components of care for children and adolescents with an eating disorder admitted to inpatient settings across NSW.

### The Toolkit:

- complements current clinical practice guidelines by providing practical and useful strategies based on the current evidence;
- provides clarity regarding effective treatment approaches for clinicians; and
- improves consistency in practice across NSW.

The Toolkit is relevant for use with children and adolescents (aged 8-18 years) with all clinically significant eating disorders including Anorexia Nervosa (**AN**), Bulimia Nervosa (**BN**), Avoidant Restrictive Food Intake Disorder (**ARFID**), Other Specified Feeding and Eating Disorders (**OSFED**) and Unspecified Feeding and Eating Disorders (**USFED**) and secondary diagnosis eating disorders.

The Toolkit is designed for use in public hospitals, including paediatric, and mental health wards, particularly those in regional and rural areas throughout NSW. The target audience does not include private and specialist eating disorder units, although the Toolkit may be helpful in these settings.

It is important to note that hospital admissions are only one part of a lengthy treatment process for young people with an eating disorder. As such, admissions are not viewed as "curative", but necessary at times to restore mental, physical and social functioning to enable continued treatment in the community.

## HOW TO USE THE TOOLKIT

The document was developed with the busy clinician in mind, aiming to ensure easy access to relevant information. The Toolkit was written as a generic document, rather than discipline-based, to allow a flow through the patient admission.

The Toolkit has user-friendly “pull out” sections that can be easily identified and accessed separately. Key concepts and recommendations are highlighted throughout the document by use of text boxes and bolded text.

Implementing treatment has formed the largest component of the document and includes practical information on medical, nutritional and psychological care of patients.

It is envisaged staff will access and implement sections of the Toolkit that are most relevant to their needs or particular patient needs. For example, all registrars may be familiarised with the specific sections relevant to key medical management; dietitians should be familiar with sections on nutrition and refeeding; and all key clinicians should be familiar with the assessment, treatment planning and discharge planning sections.

The Toolkit may be used quite differently by different hospitals and may be adapted according to your local services, resources and expertise. Some Local Health Districts will have limited access to some of the key clinicians (e.g., clinical psychologists); so each service will need to determine what is possible and practical in their local area.

## WHAT IS AN EATING DISORDER?

Eating disorders are moderate to severe illnesses that are characterised by disturbances in thinking and behaviour around food, eating and body weight or shape, and are diagnosed according to specific psychological, behavioural and physiological characteristics.

The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 2013) outlines six types of disordered eating patterns:

**Anorexia Nervosa (AN)** is a serious illness associated with significant morbidity and mortality. The illness is characterised by a refusal to maintain a minimally normal weight for age and height, intense fear of weight gain, body image disturbance and denial of illness severity.

**Bulimia Nervosa (BN)** is a moderate to severe illness that is predominantly characterised by recurrent episodes on bingeing and purging behaviour.

**Binge Eating Disorder (BED)** is characterized by repeated episodes of binge eating without the use of purging or other compensatory measures following the binge. You cannot tell by looking at someone whether they have BED; people struggling with this disorder may be normal weight, overweight or obese.

**Avoidant Restrictive Food Intake Disorder (ARFID)** is characterised by individuals who have developed some type of problem with eating (or for very young children, a problem with feeding). As a result of the eating problem, the person isn't able to eat enough to get adequate calories or nutrition through their diet.

**Other Specified Feeding and Eating Disorders (OSFED)** is also a moderate to severe illness and may include eating disorders of clinical significance that do not meet the criteria for AN or BN. OSFED and USFED may be as severe as AN or BN .

**Unspecified Feeding and Eating Disorders (USFED)**

## GENERAL PRINCIPLES FOR ALL STAFF

The following are key principles for all staff working with children and adolescents with an eating disorder (see Appendix 9 for suggested reading).

### **Ensuring Safety**

A primary priority of care is to ensure that the young person is safe. This will include assessment and management of both the medical and psychological safety aspects of the young person.

### **Creating a Therapeutic Alliance**

Successful treatment is dependent on the creation of therapeutic alliance. A therapeutic alliance involves developing an empathic, supportive and trusting relationship with the patient (or sometimes the parents in the first instance). It is critical in reducing resistance and facilitating change. A positive therapeutic experience for the young person may also mean that they will access appropriate care at a later stage if required.

### **Involving Families**

Families should be involved in all aspects of care and considered as members of the treating team (unless there are care and protection issues). Care should be taken to avoid making families feel blamed for any aspect of the patient's illness.

### **Maintaining Realistic Expectations**

Eating disorders are chronic illnesses. Having realistic expectations about the hospital admission helps to contain family and staff anxiety. Patients will not be "cured" of their eating disorder at discharge.

### **Managing Distress**

Distress is very common for young people and their families admitted to hospital for treatment of their eating disorder. Recognising and assisting the young person and family to manage distress is essential.

### **Working with Strengths**

Focusing on strengths enhances assessment, treatment and building therapeutic alliance. Strengths should be assessed in terms of individual, family and psychosocial perspectives.

## Section 2

# Getting the Patient to Hospital

## PREADMISSION CONSIDERATIONS

### IMPORTANT POINTS

- Early detection and intervention may improve treatment outcomes and reduce the likelihood of the eating disorder progressing to a more serious stage.
- It is important to obtain enough information to assess the level of risk for each individual and to determine the most appropriate site for treatment.
- The clinical condition of the patient, the available local resources and the local clinician's experience in managing malnutrition should be the primary factors in deciding the appropriate location for care.

### What to Consider:

#### Nature of the Problem

- Is the presentation predominantly an eating disorder or another mental health issue?
- Is this something that can be managed within your current team?
- What type of health service or professional would best meet the needs of this individual?

#### Severity of the Illness

- Is the young person medically unstable?
- Is the young person psychologically unsafe (risk of suicide or significant self-harm)?
- Is the illness progressing despite intensive community-based care?

#### Geographical Location

- What community-based treatment services are available locally (e.g., local mental health team, dietitian with experience, therapist, paediatrician, child and adolescent psychiatrist)? (Note: local treatment services can be supported in their role by specialist services)

#### Age of the Young Person

- Some services may only accept referral for adolescents of a specific age band (e.g., younger adolescents or older adolescents).

## Selecting the Most Appropriate Site for Referral

Community-based care is the preferred option for treatment.

- **Inpatient admissions** should be used to manage acute medical and psychological risk or when less intensive interventions have been unsuccessful. When considering a referral to hospital:
  - it is important to discuss the situation with the treating team and the proposed treatment service;
  - consultation with a tertiary hospital with eating disorder services should be considered for more complicated patients, especially for those with medical comorbidity such as diabetes, cystic fibrosis or those who are pregnant; and
  - if urgent medical assistance is required, presentation to the emergency department should be the first point of contact.
- If **community based care** is required, it should involve establishing a multidisciplinary approach to treatment. Members of the treating team should ideally have expertise in treating adolescents with an eating disorder.

- **Referral for inpatient care** is indicated when there is significant deterioration or lack of improvement despite intensive community-based intervention, when the clinician feels beyond his or her capabilities or when hospitalisation is indicated.
- If unsure about local service options, contact your Eating Disorders Coordinator (<https://insideoutinstitute.org.au/support-organisations/new-south-wales>)

## Indications for Hospitalisation

### A hospital admission may be indicated for any of the following criteria:

- Heart Rate <50 bpm,
- Cardiac arrhythmia including a prolonged QTc interval (>450 msec)
- Postural tachycardia >20bpm increase heart rate
- Blood pressure <80/40 mm/Hg or postural drop >30 mm/Hg
- Temperature < 35.5°C
- Low serum potassium ≤3.0 mmol/L
- BSL <3.0mmol/L
- Other significant electrolyte imbalances
- BMI ≤ 14
- Rapid or consistent weight loss (e.g., > 1kg each week for six or more weeks)
- Acute dehydration or patient has ceased fluid intake
- Intensive community-based treatment has proven ineffective
- Comorbid or pre-existing psychiatric conditions that require hospitalisation
- Suicidality with an active intent and plan
- Other special considerations such as diabetes or pregnancy

## Information required when referring to Hospital

### Nature and extent of the problem

- Health professionals' perception of the problem and immediate concerns
- Current symptoms and their duration
- Severity of symptoms

### Assessment of safety issues

- Medical safety assessment would include blood pressure, heart rate, temperature, rate of weight loss (if present), current weight and height and results of blood tests.
- Psychological safety issues would include risk of self-harm or suicide and severity of co-morbid psychological conditions

### Interventions that have been attempted so far

- Include inpatient, day patient and out-patient care
- Indicate what has been helpful or perhaps less helpful

### Familial or social aspects

- Factors that may impact upon the young person

## When referring a young person for inpatient treatment:

- be open about why a referral is needed;
- discuss and describe the service or program the patient is being referred to;
- clarify what may happen after treatment at the service;
- all efforts should be made to ensure that the referral is supported and runs as smoothly as possible; and
- provide contact details for consumer organisations and support groups to the family (e.g. the Butterfly Foundation <https://thebutterflyfoundation.org.au/>)

## INTERVENTIONS REQUIRED

When considering suitability for admission, the following are considered to be the minimum levels of intervention for a child or adolescent admitted with an eating disorder. If the minimum requirements cannot be met, the patient should be transferred to a hospital that has the capacity to meet the minimum levels of intervention.

1. Regular paediatrician consultation. It is preferable that young people are admitted under a paediatrician; if this is not possible, a minimum weekly paediatrician consultation is required for patients who are admitted for management of anorexia nervosa or who are medically compromised (see Indications for Hospitalisation).
2. Psychiatry consultation is required, with ongoing management as determined by the psychiatrist. This may be via telepsychiatry or consultation with a psychiatrist from a specialist service.
3. Weekly dietitian consultation is required for patients who are being re-fed.
4. Weekly care review with the treating team.
5. Staff support and confidence in their ability to treat the patient.
6. Ongoing contact between the treating community team and the inpatient team is essential and must be viable.

## Involvement of Specialist Staff

Specialist staff with expertise in eating disorders are available for advice, consultation and support and can assist the hospital admission in many ways including providing expert guidance regarding assessment, identifying risks, appropriate treatment, management and referral of young people with an eating disorder.

Specialist eating disorder services may provide an assessment of the young person and recommend treatment approaches or strategies as part of the outreach service to the treating team (see Appendix 1 for statewide services and contacts).

### **Specialist eating disorders programs offer:**

- specific treatment settings, which are designed to address the more difficult problems, associated with eating disorders;
- a well developed, targeted, intensive program;
- best practice eating disorder treatments;
- specialty trained staff; and
- a therapeutic environment

### **Specialist assistance should be sought in the following circumstances:**

- the primary reason for admission is the eating disorder;
- the eating disorder is secondary, but forms a significant part of the admission treatment plan;
- when you are treating someone with an eating disorder and believe the situation is beyond your threshold of care or capabilities; and
- when you would like assistance or support in your work.

## Section 3

# The First 24 Hours in Hospital

## THE FIRST 24 HOURS - WHAT TO DO

It is essential in the first 24 hours that an appropriate assessment is conducted and an initial management plan is developed and implemented.

Key tasks involve:

1. **Conduct a thorough physical and psychological assessment** (as per “Emergency Department Triage Form”, see next page). This should be carried out by appropriate medical and mental health professionals.
2. **Obtain a brief history of the eating disorder** (including length of illness, interventions to date and parent or carer involvement and support).
3. **Determine the level of risk and most appropriate site for treatment.**
4. **Develop and implement an initial management plan.**

## EMERGENCY DEPARTMENT TRIAGE

The following tests should be conducted for all patients presenting to the Emergency Department with an eating disorder. Seek consultation if there are any concerns or signs indicating admission.

Assessment / Test Required	Signs Indicating Need For Admission Or Consultation
Temperature	<ul style="list-style-type: none"><li>• Temperature &lt;35.5°C</li><li>• Extremities look cold/blue</li></ul>
Blood pressure	<ul style="list-style-type: none"><li>• &lt;80/40 mm/Hg or postural drop &gt;30 mm/Hg</li></ul>
Pulse	<ul style="list-style-type: none"><li>• HR &lt; 50 bpm,</li><li>• Postural tachycardia &gt;20bpm &gt; in HR</li><li>• Check for regularity as well as rate</li></ul>
Height, weight, weight history Calculate BMI Centile	<ul style="list-style-type: none"><li>• Expected body weight BMI ≤ 14 or BMI centile less than 3%</li><li>• Rapid weight loss (e.g., &gt; 1kg/week for six or more weeks)</li></ul>
Bloods (EUC, FBC, LFTs, magnesium, phosphate)	<ul style="list-style-type: none"><li>• Low serum potassium (≤3.0mmol/L);</li><li>• BSL &lt;3.0mmol/L</li><li>• Other significant electrolyte disturbance</li></ul>
ECG	<ul style="list-style-type: none"><li>• Heart rate &lt;50;</li><li>• Prolonged QTc interval &gt;450msecs</li><li>• Arrhythmia</li></ul>
Other medical criteria	<ul style="list-style-type: none"><li>• Moderate-severe dehydration; ceased fluid intake</li><li>• Ketosis</li><li>• Other physical conditions e.g., pregnancy, diabetes</li></ul>
Brief history of eating disorder including extent of purging behaviours and past treatment	<ul style="list-style-type: none"><li>• BN with out of control vomiting</li><li>• Vomiting more than 4 times a day</li><li>• Weight loss of &gt;1kg/week for six weeks</li></ul>
Assess psychiatric comorbidity, e.g., depression, OCD, psychosis Risk assessment of suicidality, self-harm and harm to others	<ul style="list-style-type: none"><li>• Moderate to high suicidal ideation</li><li>• Active self-harm</li><li>• Moderate to high agitation and distress</li><li>• Other psychiatric condition requiring hospitalisation</li></ul>

## WHO TO INVOLVE

If any of the above signs arise, it is essential that you involve a consultant with expertise in this area. If there are no systems set up in your local District, please contact the following hospitals and ask for the eating disorders consultant (available 24 hours per day, 7 days per week):

The Children's Hospital Westmead (patients 8-16 years),  
Westmead Hospital (patients 16-18 years)  
(see Appendix 1 for statewide services and contacts).

## IF HOSPITAL ADMISSION IS NOT RECOMMENDED

If the patient is medically and psychologically stable and does not require a hospital admission, it is recommended that the patient be referred to their GP and a practitioner with expertise in treating children and adolescents with an eating disorder.

Consider referral to the local Child and Adolescent Mental Health Service (CAMHS) or Community Health Child and Family service (along with GP and dietitian) whichever is most appropriate in your District. If unsure about local service options, contact your Eating Disorders Coordinator (<https://insideoutinstitute.org.au/support-organisations/new-south-wales>)

A paediatrician should monitor patients who are medically compromised or significantly underweight.

Note: the fear associated with treatment may prevent young people answering some questions openly; assessment should include relevant family and carers.



## EATING DISORDERS HISTORY

### Medical History


### Description of the Eating Disorder

### Anthropometry

	Height (cm)		Centile	
	Weight (kg)		Centile	
	BMI		Centile	

### Social History (Living situation, family or carer support, education, etc...)


### Medications


Considerations (re Meds):  Weight Gain    Weight Loss    Fluid    TGs/BSLs

Other

### Weight Controlling Behaviour (frequency, intensity, duration)

DiETING/fastING					
Vomiting					
Exercise (type, intensity, duration, frequency)					
Substance misuse (laxatives, emetics, diuretics, alcohol, cocaine, amphetamines)					

### Binge Eating Behaviour

#### Frequency of binge eating over past 3 months (circle)

< Once fortnight	< Once week	1-5 × week	Once a day	> 2 × day	5-10 × day	> 10 × day
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## DETERMINING MOST APPROPRIATE SITE FOR TRANSITION

The following may be used as a guide to assist in planning the most appropriate site for transitioning the young person

Indicator	Recommended Treatment
<b>Medical instability</b>	
As indicated by any of the parameters outlined in the "Emergency Department Triage Form"	Admission to hospital, under the care of a paediatrician or physician for medical stabilisation
<b>Complicated medical comorbidities</b>	
e.g., Diabetes Mellitus, pregnancy, Cystic Fibrosis	If admission is required – transfer to a tertiary paediatric hospital (note pregnant adolescents require admission to a tertiary hospital with obstetric services)
<b>High psychiatric risk</b>	
e.g., Suicidal, severe deliberate self-harm	Transfer to a unit that can provide suitable containment (such as a specialist child and adolescent mental health unit)
<b>Long-term or serious eating disorder</b>	
Not contained by local inpatient or community-based services,  OR  Local services not able to provide adequate or appropriate level of care  OR  Significant deterioration or lack of improvement despite intensive community-based intervention	Refer to a specialist eating disorder unit/ program (Referral for specialist care is also indicated when the clinician feels beyond his or her capabilities)

**If the patient does not meet criteria for admission to hospital, as a minimum:**

- Ensure follow-up with the patient's GP as soon as possible
- Ensure follow-up with the patient's community mental health team

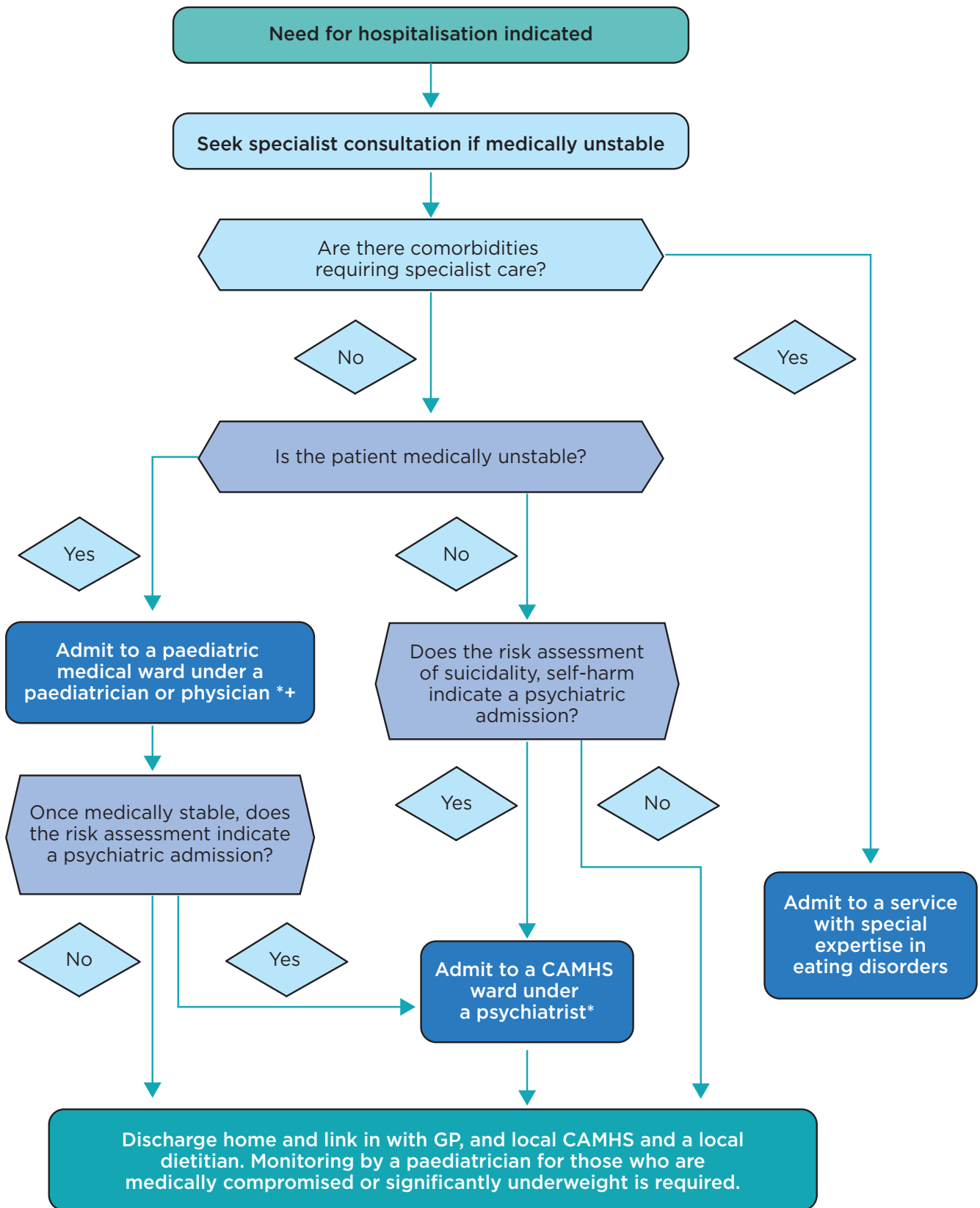
## MANAGEMENT PLAN FOR FIRST 24 HOURS

Consultation by paediatrician and mental health clinician if available should occur within first 24 hours to assist with developing a management plan.

The following should be considered in developing the management plan for the first 24 hours:

1. Conduct baseline blood tests (e.g., electrolytes, phosphate, and magnesium).
2. Conduct ECG and monitor. Continuous cardiac monitoring in those who are medically unstable and otherwise 4th hourly observations (temperature, blood pressure, heart rate).
3. Commence refeeding. Naso-gastric refeeding in the medically unstable including correction of dehydration where possible and supported meals in those who are not.
4. Commence prophylactic phosphate and correct other underlying electrolyte abnormalities. Avoid high glucose loads including the use of IV dextrose solutions to minimize the risk of refeeding syndrome
5. Conduct a risk assessment and implement 1:1 nursing if necessary – review risk assessment at the end of nursing handover. Document risk assessment clearly (i.e., risk of absconding, self harm, suicide, aggression, refeeding syndrome, and cardiac compromise) – review daily thereafter.
6. Provide support to family and carers and involve them in assessment and decision-making regarding treatment.

## ADMISSION FLOWCHART



\*If the hospital does not have a paediatric ward or paediatrician consultation at least once per week, the patient should be transferred to the nearest base hospital or specialist service.

\*Consult with mental health – visiting psychiatrist, consultation liaison nurse, local CAMHS, tele-health or consultation liaison service

## Section 4

# Assessment and Treatment Planning

## ASSESSMENT OF SUSPECTED EATING DISORDERS

The interview will be difficult for many young people and will depend, in part, on their level of insight to the illness as well as their medical and psychological status at the time. Parent or carer input is required to validate or supplement some of the interview findings.

### Medical Assessment

Collect information on pre-existing medical conditions, allergies, medications (including vitamins, minerals and complementary medicines), bowel function and a detailed menstrual history.

### Medical Investigations

**ECG** is useful in all patients (provides a more accurate resting pulse and assesses for arrhythmias especially prolonged QTc which is common with severe weight loss).

**Blood tests:** full blood count (FBC), electrolytes (EUC), liver function tests (LFTs), glucose, calcium, magnesium, and phosphate are mandatory in acute assessment especially if rehydration or refeeding is planned. These may all be normal even in very unwell patients. Thyroid stimulating hormone (TSH), Tri-iodothyronine (T3), Serum Thyroxine (T4), Follicle stimulating hormone (FSH), Luteinising Hormone (LH) and oestradiol should also be measured.

**Bone densitometry** if available and amenorrhoea persists > 6-12 months.

**Further investigations** to exclude other diagnoses & assess nutritional status may include: erythrocyte sedimentation rate (ESR), thyroid function, Ferritin, B12, folate, Anti-transglutaminase Antibodies, stool microscopy.

**Pelvic ultrasound and bone age** may be considered.

### Physical Assessment

Try to ensure that the physical examination is carried out sensitively. The patient will be exposing their body (a disliked aspect of themselves) to an unfamiliar person.

#### Weight and calculation of BMI centile

If eating disorder pathology is suspected it is essential to weigh the patient (without heavy clothing or shoes using calibrated scales), measure their height and calculate a BMI centile (using age appropriate percentile charts). Any individual whose body weight is reduced, less than expected, or has experienced a sudden or chronic loss of weight, should be assessed for the presence of an eating disorder. Note: Weight is an unreliable measure and has to be used in the context of previous weight, weight controlling behaviours and medical stability, amongst other things. In anorexia nervosa, although weight and BMI are important indicators, they should not be considered the sole indicators of physical risk.

#### Pulse, blood pressure (lying and standing) and temperature

**Assess for dehydration** (sunken eyes, dry lips and tongue, poor skin turgor, slow capillary return).

**Skin inspection:** acrocyanosis (blue discolouration), jaundice, carotenaemia (orange skin), dry skin, lanugo hair (soft downy hair on back and arms), callused knuckles (repeated induced vomiting), skin infections and lesions from self-harm.

**Oral examination:** dental erosions, pharyngeal redness and parotid enlargement may all occur with recurrent vomiting.

**General systems examination** is required for all patients to assess any pre-existing illness. Other findings in patients with an eating disorder may include cardiac flow murmurs, oedema, evidence of significant constipation and hepatomegaly with rapid weight change.

**Pubertal status** should be assessed using Tanner Stages.

**Urinalysis** may show high specific gravity and ketones in fasting patients.

## Other areas to explore:

### Menstrual History

The menstrual history should include age of menarche (if reached), regularity of menstrual periods, length of menstrual cycle, absence of any menstrual periods and date of last menstrual period.

### 24-hour recall

Take a 24-hour recall of the patient's food and fluid intake, ask if the last 24 hours is typical, and assess whether it meets minimum daily requirements for age. Purging or excessive exercise may be present if the individual is bingeing or significantly over-eating but remains at a healthy or low weight.

## Mental Health Assessment

Mental health assessment should occur in all medically stable patients prior to discharge or transfer from the emergency department. Psychiatric assessment should occur in medically unstable patients once acute medical treatment, including naso-gastric refeeding, has commenced. Mental health assessment should involve either a Mental Health CNC or Psychiatry Registrar in consultation with the Psychiatrist on call.

The key aspects of the individual interview include consideration of the history of the presenting illness, the past and co-morbid psychiatric history, as well as social and family history.

### History of presenting eating disorder illness:

- Onset and duration of illness
- Maximum and minimum weights
- Duration and speed of weight loss
- Methods of weight-loss (dietary restriction, exercise, purging)
- Fear of weight gain
- Abnormal body image
- Denial of illness severity
- Previous eating disorder admissions
- Patient's perception of the problem and perceived impact on the patient and the family
- Weight controlling behaviours such as:
  - restricting eating (e.g. skipping meals, fasting),
  - purging (such as vomiting or use of laxatives) or signs of purging (enlarged parotid glands, calluses on knuckles, cracked/split lips) vomiting, exercise, laxative use, and other substance misuse)
  - frequent bathroom visits especially after meals;
  - presence of excessive exercise behaviours
- Current patterns of eating (including mealtime description, feelings associated with eating and binge eating episodes)
- Premorbid weight and growth
- Degree of body image distortion; impact of potential weight gain
- Insight into illness and motivation for change
- Weight loss or failure to reach expected gains

## Presence of comorbid psychiatric illnesses

- Mood Disorders (Major Depressive Disorder, Bipolar Disorder)
- Anxiety Disorders (Generalised Anxiety Disorder, Social Anxiety Disorder, PTSD, Panic Disorder, Separation Anxiety Disorder)
- Obsessive Compulsive Disorder
- Psychotic Disorders
- Drug and Alcohol use

## Risk assessment (assessment and management of risk is an ongoing process, not a single event)

- Suicidal ideation
- Deliberate self-harm
- Past suicidal behaviour and deliberate self-harm
- Risk to others
- Sexual history

## Family and Social History

- Family composition
- Family stressors
- Family history of eating disorders or psychiatric disorders
- Effects on school (e.g., academic progress, peer and teacher relationships, achievements, difficulties)
- HEEADSSS is a useful tool in assessment (see Appendix 5).

## Past Medical and Psychiatric History

- Other psychological history including neglect, trauma, depression, self-harm, suicidal thoughts and bullying
- Personality traits (e.g., perfectionism, obsessiveness)

## Current Medications

## At Risk Groups

An individual's may be at an increased if risk if they are:

- Female
- Aged 12 to 20
- An elite athlete, sportsperson or dancer
- On a restrictive diet for medical reasons (eg IDDM)
- A member of a family with a history of eating disorders

## Mental Health Risk Management

- *Mental health risk management* has the specific concern of reducing harm to self, harm to others and disruption and destruction of the treatment setting. Avoiding the treatment setting by absconding and resisting treatment essential to survival are included in this definition.
- In some cases there is a need for patients at higher risk (e.g., of self harm) to be transferred to a more secure or appropriate setting – this is consistent with the NSW Mental Health Act 2007 and the requirement for provision of the least restrictive environment in which the “best possible care and treatment can be effectively given”.
- The level of risk to the patient's mental and physical health should be monitored as treatment progresses because it may increase, e.g., for those with anorexia nervosa, this may occur as weight increases or at times of transition such as moving between services.

- Attention should be paid to careful and adequate documentation, including assessment of risk, communication with other clinicians, decision-making process, and rationale for the treatment.
- Responses must be proactive, effective in meeting patient needs at the time, and satisfy ethical/regulatory requirements.
- The plan should document strategic directions for immediate response in patient management in times of increased risk, and serve as a communication tool.
- The plan should document longer-term responses or a hierarchy of responses depending on level of risk.
- Psychoeducation with the patient, their family and clinicians should include discussion of the risks and any uncertainties regarding treatment and outcomes. Due attention should be given to confidentiality issues with respect to psycho-education.

## ASSESSING GROWTH AND DETERMINING HEALTHY WEIGHT RANGE

Growth is influenced by many factors including ethnicity, family genetics, timing of puberty, chronic disease, psychosocial environment and nutrition. These factors should be considered as part of a comprehensive history and examination. If an organic growth disorder is suspected, a paediatrician should assess the patient (see Appendix 2 for growth and BMI centile charts).

### Methods to Assess Growth

For adolescents with an eating disorder the most important growth assessment methods are:

- Accurately measuring height and weight and plotting on growth charts.
- Obtaining previous height and weight measurements and plot on growth charts to obtain a pattern of growth or growth trajectory (Serial measures provide much more useful information than one-off assessments).
- Calculating BMI and interpreting using BMI-for-age percentile charts.

American Centre for Disease Control (CDC) growth charts are recommended for 2-18yr olds. These are available at [www.cdc.gov/growthcharts](http://www.cdc.gov/growthcharts)

## Measuring Weight and Height

### Weight

- Scales should be calibrated regularly and weight should be measured consecutively on the same scales.
- Patients should wear minimal clothing, empty their pockets and remove shoes.
- Where possible, weigh patients early in the morning, before breakfast and after urination.
- Limit weighing to once or twice weekly; frequent weighs can overemphasize its importance.
- Patients may manipulate their weight by water loading or concealing heavy objects. If this is suspected consider random or “surprise” weight measurement.

### Height

- Height should be measured ideally with a stadiometer, on admission and at least three monthly intervals during recovery to monitor resumption of normal growth.

## ‘BMI for Age’ Is Used for Children and Adolescents

- BMI is an anthropometric index of weight and height. It is not a diagnostic tool.
- BMI is calculated as follows:  $BMI = \text{weight (kg)} \div \text{height (m)}^2$
- BMI is plotted on gender-specific BMI percentile charts.



The following cut-off points have been used to identify underweight and overweight in children and adolescents.

BMI-for-age	< 5th percentile	Underweight
BMI-for-age	5th percentile to <85th percentile	Normal
BMI-for-age	85th percentile to <95th percentile	Overweight
BMI-for-age >	95th percentile	Obese

## Determining a Healthy Weight Range

Determining a healthy weight range helps patients, their family and the treating team plan management and assess progress.

- A healthy weight range (HWR) rather than a specific target weight should be set.
- Avoid long discussions or negotiations about recommended healthy weight range and encourage a focus on physical health as an outcome.
- The HWR is not necessarily the discharge weight. Patients may be discharged from hospital below the HWR and before full physical recovery depending on medical and/or psychological stability.
- Normal vital signs are indicators of physical recovery. However these can return to normal below a HWR or, if weight loss has been rapid, they can be abnormal within a HWR.
- For girls, return or commencement of menses is an indicator of physical recovery. Menses may take some time to return after weight restoration, or may sometimes return at a low weight.

## Approximating the Healthy Weight Range Using BMI for Age

- A normal BMI is from 5th percentile to <85th percentile. The 5th percentile is often too low for physical recovery to occur for patients with eating disorders.
- A BMI between the 25th and 85th percentiles is recommended, as this is more likely to correlate with physical recovery.
- Calculate the weights needed to correlate with the BMI range.
- Consider the previous growth trajectory and expected ongoing growth.

BMI for 25th and 85th percentiles (ages 12 -18) are listed below.

Age	Male		Female	
	HWR BMI = 25 <sup>th</sup> %ile	HWR BMI = 85 <sup>th</sup> %ile	HWR BMI = 25 <sup>th</sup> %ile	HWR BMI = 85 <sup>th</sup> %ile
12.0	16.4	21.0	16.5	21.7
12.5	16.7	21.4	16.8	22.2
13.0	17.0	21.8	17.0	22.5
13.5	17.3	22.2	17.4	23.0
14.0	17.6	22.6	17.6	23.3
14.5	17.9	23	17.9	23.7
15.0	18.2	23.4	18.2	24.0
15.5	18.6	23.8	18.4	24.3
16.0	18.9	24.2	18.6	24.6
16.5	19.2	24.6	18.9	24.9
17.0	19.5	24.9	19.1	25.2
17.5	19.8	25.2	19.3	25.4
18.0	20.0	25.6	19.4	25.6

**Example:** a 12yr old girl who is 150cm tall would need to be 37-47 kg to achieve a BMI of 16 to 21. If her growth has always previously been around the 25-50th percentiles her HWR may be set as 37-41 kg.

## EATING DISORDER CLINICAL SUMMARY

Name/MRN		Case Manager	
Admission Date		Primary Nurse	
Expected Discharge Date		Consultant	
Carers		General Practitioner	
Diagnoses:			
Medical History (including menstrual history):			
Social History (living situation, family or carer support, education, etc.):			
Medications:			
Considerations (re: Meds): <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Fluid <input type="checkbox"/> TGs/BSLs			
Other			
Height: ..... (m) (     ) %ile .....		Lowest Past Weight	Healthy Weight Range
Weight: ..... (kg) (     ) %ile .....			
BMI: .....(kg\m <sup>2</sup> ) (     ) %ile.....		Highest Past Weight	Goal Wt Gain/Week

### Most Recent:

Temperature					Blood Pressure					Pulse				
Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Bone Densitometry			Pelvic Ultrasound				ECG-QTc							
Date	Result		Date	Result			Date	Date	Date	Date	Date			
Estimated Nutrition Requirements:														
Energy				Protein				Fluid						

<b>Eating Behaviour:</b> Description of eating (restrictive patterns, dietary “rules”...)	
<b>Weight Controlling Behaviour (frequency, intensity, duration):</b>	
Dieting/ fasting	
Vomiting	
Exercise <i>(Type, intensity, duration, frequency, solitary, secretive, compulsive)</i>	
Substance misuse <i>(Laxatives, emetics, diuretics, alcohol, cocaine, amphetamines)</i>	
Other (e.g., spitting food)	

<b>Binge Eating Behaviour:</b>											
Frequency of binge eating over past 3 months (circle)	< once fortnight	< once week	1-5 x week	once a day	> 2 x day	5-10 x day	> 10 x day				
Typical times and settings for binge eating	<input type="radio"/> Morning		<input type="radio"/> Middle of Day		<input type="radio"/> Evening						
	<input type="radio"/> Alone		<input type="radio"/> Planned		<input type="radio"/> At home						
	<input type="radio"/> Other place										
Mood before, during and after episodes (1 = lowest; 10 = highest) (Circle)	Before	1	2	3	4	5	6	7	8	9	10
	During	1	2	3	4	5	6	7	8	9	10
	After	1	2	3	4	5	6	7	8	9	10
Experience loss of control?	<input type="radio"/> Yes		<input type="radio"/> No		<input type="radio"/> Not sure						

<b>Attitudes Towards Weight and Shape:</b>	
Level of self criticism <i>Whole body &amp; specific regions</i>	
Perceptions of shape	
Frequency of weighing, weight preoccupations and intrusive thoughts, response to weighing	
Perception of others’ attitudes about patient’s weight	

**Physical Signs and Symptoms Checklist:**

**Signs and Symptoms**

<input type="checkbox"/> Agitation	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Hair loss
<input type="checkbox"/> Irritability	<input type="checkbox"/> Weakness	<input type="checkbox"/> Hypotension
<input type="checkbox"/> Amenorrhoea	<input type="checkbox"/> Low body weight	<input type="checkbox"/> Lanugo
<input type="checkbox"/> Oligomenorrhea	<input type="checkbox"/> Bradycardia	<input type="checkbox"/> Hypothermia
<input type="checkbox"/> Constipation	<input type="checkbox"/> Dental erosion	<input type="checkbox"/> “Russell’s sign” (Lesions on dorsum of hand)
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Salivary gland hypertrophy
<input type="checkbox"/> Abdominal bloating	<input type="checkbox"/> Yellow/ orange skin	
<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Oedema	

**Biochemistry:**

Date	Na	K <sup>+</sup>	Chloride	PO <sup>4-</sup>	Mg <sup>2+</sup>	Urea	Cr	Ferr.	B <sub>12</sub>	Folate	Bicarb

Please note: This form is not approved for official use within the Local Health District – this is a guide only.

# FORMULATION OF A TREATMENT PLAN

## Key Considerations

Treatment plans must be tailored to the needs of each individual and to the diagnosis.

- Developing a calm, supportive, open and honest relationship is crucial in reducing resistance and in facilitating change. This should be considered from the first point of contact with the patient.
- It is essential to consider realistic expectations for the admission. The patient will not be 'cured' of their eating disorder in hospital, but hopefully sufficiently health restored to allow ongoing community based treatment.
- Involve the young person, family and members of the team in the development and implementation of the treatment plan.
- Parental engagement and commitment to treatment is an integral component of care. This should be seen as an ongoing process throughout treatment.
- A multi-disciplinary approach to eating disorders is required.
- CAMHS should be part of the treating team throughout all treatment phases.
- Establish "non-negotiable" elements of the plan. Choice may be offered in certain areas of the plan; however, other aspects would be considered essential for safety and wellbeing, and not able to be negotiated, at least not until a later stage in treatment or recovery. The use of non-negotiables, and a focus on safety aspects of treatment (physical, psychological and nutritional), can be particularly helpful when managing patients who are having difficulty adhering to treatment, are refusing to eat, or are in a pre-contemplative stage of change.
- Clearly document treatment plans and ensure access to all staff.

### Examples of Non-Negotiables

**Physical/medical safety**, e.g. performing necessary observations and investigations to monitor progress, especially during refeeding

**Nutrition**, e.g., if the young person needs to gain weight, as indicated by medical or physical assessment, there can be no negotiation of the amount of energy (or food) that is required. Similarly, there can be no negotiation around healthy nutrition whether the young person needs to gain weight or not.

**Leave from the ward**, e.g., if the young person is deemed unsafe to leave the ward for medical or other safety reasons this decision is non-negotiable.

## Treatment Plan

**Define the goals of admission, including timeframes and strategies. These may be based upon:**

1. Medical and psychiatric stabilisation
2. Establishment of safe eating and containment of eating disorder behaviours
3. Successful eating with parents
4. Treatment of associated psychiatric conditions including depression and anxiety
5. Organisation of outpatient follow-up

## Section 5

# Treatment and Management on the Ward

## Working as a Team

### The Roles of the Multidisciplinary Team Members on the Ward

Teamwork and collaboration are central to good working relationships and service delivery. Effective teamwork and collaboration is supported by key elements including agreed goals, an agreed treatment approach, effective communication styles, established ground rules, clear team roles and competent leadership.

The availability of and access to multidisciplinary team members will vary in regional and rural areas. Involvement may also depend on the expertise and interest of the clinician. Potential key roles for members of the multidisciplinary team are summarised below (in alphabetical order).

#### **CAMHS**

- CAMHS may form an integral part of the community shared care team. They should be contacted at the commencement of the young person's admission and remain involved during treatment and discharge planning.

#### **Clinical Psychologist / Psychologist**

- Psychological assessment and treatment planning
- Family assessment and therapy
- Individual therapy
- Behaviour programmes

#### **Dietitian**

- Comprehensive nutrition assessment
- Establish meal plans and refeeding regimes
- Provision of nutrition education to parents and families

#### **Nurse**

- Implementing treatment plans on a daily basis
- Assessment and maintenance of patient safety
- Management and close monitoring of the patient's physical and emotional status

#### **Occupational Therapist**

- Assess functioning in self care, productivity
- Conduct sensory profile
- Provide individual, group and/or family interventions as required in relation to the above

#### **Paediatrician or Physician**

- Must be involved in all admissions due to the potentially serious medical complications
- Medical assessment & ongoing management

#### **Physiotherapist**

- Preparation and progression of a physical activity plan
- Educating patients and families on healthy levels of physical activity and return to sports
- Management of musculoskeletal issues associated with under-nutrition and/or over-exercise

#### **Psychiatrist**

- Should be involved in all admissions
- Comprehensive assessment, diagnosis and ongoing management of psychiatric needs
- May be the lead clinician in the treatment of the young person and their family

#### **School Teacher**

- Assessment of academic abilities
- Management of behaviour and development of social skills in the classroom
- Development and implementation of individual learning plans
- Liaison with other agencies and schools

#### **Social Worker**

- Provide individual, group and family intervention
- Links to external supports e.g., financial counselling, accommodation assistance
- Liaison with primary supports in the young person's social context, including Aboriginal or CALD services, and community groups
- Child protection consultation
- Management of psychosocial complexities

## CARE (CASE) MANAGEMENT

- Arrange multidisciplinary team meetings at least weekly to review care progress and planning
- Seek support and advice from specialized treatment centres when needed
- Participate in supervision to debrief and reflect

## Team Cohesion and Consistency

Conflict often arises when a patient is suffering from a complex clinical problem (such as an eating disorder) due to intense feelings, difficult situations and high anxiety among those involved in care. It is the responsibility of staff, however, to resolve such conflicts. It is inevitable that there will be differences in how staff perceive and approach patients with eating disorders and these differences need to be discussed within the team and a clearly agreed plan devised which is carried out in a unified way.

Frequently the words 'splitting' and 'manipulative' are used of patients with eating disorders and may contribute to inconsistent approaches by staff. It is important to attempt to understand the experience of the patient in such situations. The young person with an eating disorder generally has an overriding fear of putting on weight and will do anything to avoid doing so. Frequently this leads to desperate strategies to avoid eating and weight gain. An understanding of the fear that drives this behaviour is very helpful in developing empathy and working therapeutically with the patient.

**Splitting, in the simplest sense, is playing one person off against another. Examples of splitting behaviour may include:**

"The night nurses usually let me shower by myself"

"You are the only nurse here who understands me"

"The doctor said I could have a gate pass"

## Maintaining Consistency

A consistent team approach is essential in treating patients with eating disorders. Maintaining consistency will assist in reducing the likelihood of mixed messages, misunderstandings, opportunities for unhelpful negotiation and staff splitting. The following may be useful:

- Set clear team goals for the admission and communicate these to the patient, family and staff. Be specific about what aspects of care are non-negotiable and what needs to occur prior to discharge.
- Offer weekly multidisciplinary team meetings that provide clinicians with the opportunity to review admission goals and patient progress, voice concerns, consider ways to respond to particular behaviours, and agree on team-based decisions (such as leave from the ward).
- Ensure patients are aware that all decisions regarding their treatment/management plan are made in the team meeting. This will discourage splitting-type behaviour and provides the patient a sense of consistency in knowing when their questions/requests will be responded to.
- Maintain openness and transparency regarding differences that arise in the team about the need to set firm limits versus the need to nurture. Both positions may be correct and the need to move between these positions will vary depending on the stage of treatment.
- Plan regular family meetings with the treating team and family to ensure ongoing communication and to maintain family engagement in treatment.
- Close liaison with community follow-up services is important too.

## Ward Milieu

Creating and maintaining a safe, predictable and normalised environment is essential. It can be difficult balancing the needs of physically ill patients with those who have mental health disorders. Paediatric units vary in their access to the staff-such as occupational therapists or play therapists-that are often enlisted to work on maintaining a positive ward milieu. Other staff may need to be involved.

## Activities

In order to achieve a positive environment, an activity program may be coordinated and implemented by a staff member (preferably an occupational therapist) for patients with an eating disorder. The program should reflect age-appropriate routines for children and adolescents and incorporate:

1. Self-care (washing, laundry, dressing, eating),
2. Productivity (school, play), educational needs and vocational needs
3. Leisure (art/craft, music, socialising)

Patients should assist in identifying and developing appropriate activities within the program.

## General Guidelines

1. Provide opportunities to engage in activities that enable patients to develop and practice normal roles/routines (e.g., self-care, productivity, leisure).
2. Assess and address issues of lack of activity and social isolation (what activities does the patient enjoy? Who do they feel comfortable doing activity with?).
3. Provide the opportunity to develop and practice a range of skills including interpersonal, physical and psychosocial skills, including stress tolerance, emotion regulation and healthy mealtime routines.
4. Develop and practice distress tolerance strategies (self soothing, hand massage, foot spa, yoga, relaxation tapes, soothing music).
5. Provide the opportunity to have fun and engage in rewarding experiences.
6. Assist with improving patient self esteem and self-confidence (provide activity that targets the patient's challenges and gently increase difficulty).

## Example: Activity Promoting A Positive Ward Milieu

During the day, patients will often experience an increase in symptoms associated with their illness such as anxiety and/or agitation and this can lead to distress (and self harm for some patients). Often a pattern emerges, where one patient's distress begins to influence the rest of the ward, increasing anxiety and distress for all patients. The change in milieu may also affect staff and they may start to anticipate negative outcomes for the patients. In order to regain balance, group activity is used to engage the majority of patients, generating a positive focus. The distressed patient may then be assisted individually to engage in self-soothing techniques. This process has the ability to assist in restoring a positive ward milieu.



# Working with the Young Person and their Families and Carers

## Therapeutic Rapport and Engagement

Engagement refers to the process of forming a therapeutic relationship and alliance with a patient. It enables a more accurate assessment and a more collaborative mode of treatment. A therapeutic alliance involves developing an empathic, supportive and trusting relationship with the patient.

- The engagement process starts within the first moments of meeting the patient. Setting the tone early with the young person can establish a way to work together. Showing a genuine interest in them and a commitment to understanding how the eating disorder fits into their life can help them to engage in the stressful process of changing their eating behaviours and weight.
- Engagement is an ongoing process. It usually continues over several consultations or interviews and can be aided by informal contact with the patient (e.g., the degree of warmth and interest we use when greeting an inpatient around the nurses' station).
- It is the responsibility of the clinician to work on engagement even if the patient does not initially welcome it.
- Try to have regular and predictable times throughout the treatment process when the person knows they can talk to someone. Any staff member can work towards establishing a therapeutic alliance.

### A THERAPEUTIC RAPPORT CAN BE FORMED BY FOCUSING ON:

- Ensuring safety in a caring way
- Providing empathy and maintaining a warm stance towards the patient
- Trying to create a positive experience for the patient as much as possible
- Being transparent about your role and confidentiality issues

## Externalisation

Patients often view the eating disorder as one of the few aspects of their lives that is actually working – it seems to help them fulfil important needs, such as the need to feel successful and in control. Thus the patient may see the eating disorder as the most valuable aspect of the self. In more extreme cases, the eating disorder is not only seen as a highly valued aspect of the self, but is seen by the patient to be their entire self (e.g., *“I am an anorexic. I don't know who I would be or what I would feel if I wasn't an anorexic”*).

Although behaviours associated with the eating disorder are carried out by the patient, the confusion that the disorder is an aspect of their self (rather than a disorder or illness) can make it difficult for them to detach sufficiently from the disorder. Being able to detach from the disorder means that they can evaluate the role of the eating disorder in their life: both the positive *and* negative aspects. For this reason, a helpful strategy can be to externalise the eating disorder whereby both clinicians and patients are encouraged to talk about the disorder as a separate entity from the patient. Externalisation also enables clinicians to have empathy for patients even when the eating disorder behaviours are very difficult.

**When discussing treatment plans and goals, talk about the eating disorder as a ‘thing’ – an entity in itself – that can be controlling of the individual and in some ways harmful.**

“Our job on the ward is to give you back some control over the Eating Disorder and keep you healthy no matter what.”

“You are here because the Eating Disorder has gone too far and made staying healthy impossible for you.”

“While you are here, the rules and meals that are set by the nurses are there to stop the Eating Disorder from bossing you around anymore.”

“It looks like the Anorexia is really giving you a hard time at the moment for having eaten all of your dinner.”

“We’ve spoken about the ways Anorexia can seem like a best friend to you. I wonder if you can see any ways in which the Anorexia is making life harder for you?”

## Basic Counselling Skills

Counselling assists the young person to move away from disordered eating thoughts and behaviours, and to develop a healthy relationship with food, eating and the body. The process depends on the patient forming a trusting, professional relationship with the clinician and the clinician *showing a genuine interest in the whole person*. Good counselling skills will help the engagement process.

**LISTEN WELL.** Employ active listening skills such as asking questions to get more information and use *reflective or summarising statements* that are designed to demonstrate that you are interested in the person.

Be **RESPECTFUL** of the person’s emotions, culture and developing personality. When there is evidence that certain beliefs are maladaptive, these can be discussed respectfully with time, using questioning to help the patient to gain insight.

**GENUINE POSITIVE REGARD.** Being able to experience and convey a positive regard for the patient will aid rapport and trust. This will also enable you to *discover and focus on their strengths*, which can be used later in counseling, as well as for them to feel comfortable with being honest with you.

**EXPRESSING EMPATHY.** Empathy is the cornerstone of effective counselling. Empathy means forming an emotionally based understanding of some aspect of the other person’s emotional experience or their opinion about things. It is similar to putting yourself in their shoes (e.g., imagine living at home, interacting with parents, dealing with friends at school).

Show an **INTEREST in** how they are feeling and other issues in their life. While the main focus of any admission (in AN) is to restore weight and other health factors, it is helpful to convey that the team is concerned with more than weight. For example,

*“We know that you’re very distressed about what we’re getting you to eat in hospital, and because weight gain is essential for your physical recovery we can’t actually change that but we still absolutely want to know how you are feeling about that and will do what we can to help you to manage that.”*

Help them to utilize distress tolerance strategies. Given that the refeeding process is highly stressful for patients, work on personalized distress tolerance strategies with them to help manage their feelings (e.g. distraction, mindfulness, relaxation etc.)

**TRUST.** There are several ways that trust can be formed, including the discussion of confidentiality. Demonstrate to your patient in real ways, over time, that you mean what you say and say what you mean e.g. being clear about when you will visit and for how long.

## Basic Counselling Techniques

**ACTIVE LISTENING.** This involves using the ‘micro skills’ of verbal and non-verbal communication to demonstrate that you are interested and listening. These include things like nodding one’s head, body posture (open and oriented to the person), appropriate eye contact, and verbal gestures. It can also be useful to use open questioning techniques such as *“Can you help me to understand ...better?”* and *“How is ... difficult for you?”* when engaging in this process. For example, *“It sounds like you are finding it tough to follow the meal plan”*.

**REFLECTIVE LISTENING.** This refers to the way the clinician reflects back some of the things the patient is saying.

1. It demonstrates *interest* in the patient (e.g., “Aha. I see. So what you are saying is...”).
2. It demonstrates *empathy* (e.g., “I can tell from what you are saying – given how you feel – that gaining two kilos REALLY is a scary thing that you want to avoid at all costs”).
3. It provides an opportunity to *clarify* what the person’s thoughts and feelings are (e.g., “It sounds like when I told you that you need to gain one more kilo, you felt scared and angry at the same time, is that right?” and “So you are saying that having the nasogastric tube makes you feel out of control and that we don’t care about what you want, is that right?”).

**REFRAMING.** This is a similar listening technique that goes another step. It involves selectively feeding back to the patient something that you have heard them say and putting it to them in a slightly different context, but still true to their message:

*“When you say you felt out of control, would it be true to say that you felt overwhelmed and anxious at that time with everything that you felt you had to achieve?”*

**OR** Putting together two things that they have said at different times:

*“You said earlier that your mum can be strict and controlling and you said that she can be very worried about you when you are unwell. Do you think these could be the same things – she loves you, so she is worried, so she is strict?”*

**PROBLEM SOLVING.** Patients often ask (directly or indirectly) what to do or what we think. One method of managing such situations is to use the dilemma itself as an opportunity to help the patient develop problem-solving skills. Teaching the young person the following problem-solving steps can help them to be able to make their own decisions.

### Problem Solving in 5 steps

1. Pick one problem at a time and define it clearly.
2. Write down ALL the possible options that they and others can come up with.
3. For each option write down the advantages and disadvantages - both in the immediate-term and longer-term.
4. Pick the best option and do it.
5. Monitor the outcome. If things haven’t turned out for the best go back and start again.

Be careful not to get caught up in trying to solve problems which cannot change (e.g. the need to eat and gain weight) and focus on the ones you can help them to change (e.g. finding it hard to do school work, missing friends etc.)

## Issues in Counselling

### Confidentiality

It is important to discuss the limits of confidentiality with the patient and parents at the beginning of treatment. Limits arise when there are concerns for the safety of the patient or another person, or if it is necessary in order to provide effective treatment. Consent from the patient and parents (depending on the patient's age) must be obtained prior to speaking with other treatment providers. It is also useful for the entire team to be on the same page about eating disorder symptomology and risk issues so that they can be managed in a coordinated way.

### Professional distance

In any interaction there must be clear limits and boundaries that define the relationship in its professional context. Use a professional and private space where possible and keep self-disclosure to an absolute minimum. **It is important to remember that your role is not that of a friend, confidant or advocate.**

### When patients try to argue the non-negotiables

It is important for the treating team to be aware of the 'non-negotiables' of treatment. These may include decisions about re-feeding, meal plans, weight, how much physical activity is allowed, and so on. It is not uncommon for patients to argue about these things.

Ways to respond may include:

- "This isn't my decision (or anyone in particular), it's just what needs to happen. You can have some choice in how it's done though."
- "It sounds like you are doing it tough and this is really difficult. What do you think could help when it's hard like this?"

### When you feel cornered into focusing on weight/calories

- Try to recognise that it is quite easy to fall into this trap, particularly at times of heightened anxiety.
- Try not to buy into this and recognise it is the "eating disorder" trying to "trick" you into doing this.
- Try to remain focused on assisting the young person to build a healthy relationship with food, which does not include counting calories, measuring foods or focusing on weight.

#### What Hinders Counselling

- Engaging in battles regarding weight or nutrition goals - these are non-negotiable.
- Changing care plans without discussing them with the patient first.
- Being inconsistent.
- Blaming the patient for their behaviours.
- Poor communication with the family.
- Placing an unhelpful emphasis on weight gain, counting calories or focusing on exact measurements of foods.
- Being punitive or harsh in the treatment.

## Motivation

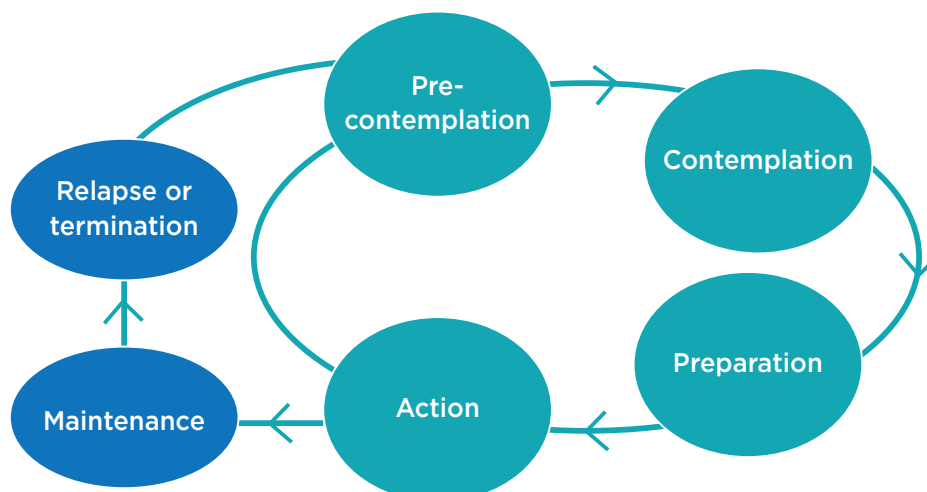
- Motivation to change may vary with different aspects of the disorder – a person may be eager to think less about food or work on psychological problems but not motivated to work on other issues related to the illness. Early in the admission, most patients with eating disorders are not motivated to change core symptoms, such as low weight (this is due to the nature of the illness). Most patients will continue to experience low levels of motivation to change throughout admission and/or experience fluctuations in their level of motivation.
- Patients who are profoundly malnourished will be unable to engage in psychological therapies until they are medically and nutritionally stable.
- When a patient’s motivation to change is low due to the strength of their illness, it can be noticed in various ways, such as:
  - Minimising the seriousness of his/her condition;
  - Being hostile and antagonistic towards staff and family;
  - Having mixed feelings about recovery;
  - Being secretive;
  - Losing weight or failure to make weight gains;
  - Not adhering with treatment;
  - Reporting a sense of pride in his/her symptoms; and/or,
  - Failing to make behavioural changes.

## Stages of Change

It is useful to be mindful of the fact that most patients will be in the pre-contemplation stage of treatment throughout their admission.

The “stages of change” model can be helpful in terms of describing a patient’s current level of motivation to change. Using motivation to gain weight as an example, the stages of change could appear as follows:

- A patient in the **pre-contemplation** stage either denies the severity of current weight and/or has no intention to gain weight.
- A patient in the **contemplation** stage is willing to think about change but is typically very ambivalent since he/she can see reasons to both change and to stay the same.
- A patient in the **preparation** stage has made a decision to gain weight and is planning the best methods for doing so but has not yet attempted to change.
- A patient in the **action** stage is actively attempting to gain weight.
- Finally, a patient in the **maintenance** stage has reached a healthy weight and is working to prevent any weight loss.



Adapted from Prochaska & DiClemente

## Expect and Plan for Resistance

Patients are often unable to meet certain expectations or directions during the inpatient treatment of eating disorders, for example those with AN may not eat certain food types, not eat an expected amount of food, not be weighed, not stay in a ward area, or not attend psychological treatment. Some patients refuse to engage in these behaviours, some patients lie about what they have or have not done. These behaviours should be expected, as the fear of weight gain and the desire for autonomy is quite intense.

It can be helpful to remember that resistance, refusal or deceit are not about the patient trying to be difficult or making your life more difficult. Rather these behaviours reflect the eating disorder's presence in the young person's life and their desperate attempts not to gain weight or to maintain autonomy.

Due to the distress associated with increased conflict and fears of re-feeding and weight gain that patients may reach a level of distress in which a **safety plan** (both for the ward and for any leave with parents) needs to be put in place. A thorough safety plan includes:

- Signs of symptoms of increasing levels of distress
- Options for distraction and other distress management techniques as distress increases
- A plan for increased supervision and support if the patient is highly distressed, self harming, having suicidal ideation or lashing out at others
- Ensure no access to means of self harm or suicide
- A plan of how to escalate further help if the patient becomes unsafe.

## Some helpful strategies to deal with resistance

1. Setting boundaries and consequences early:
  - Develop a written list of what is expected from each patient and what is non-negotiable.
  - Communicate the predicted outcomes or consequences if these expectations are, or are not, met.
2. Having one staff member work with the patient regarding their adherence to the program.
3. Responding consistently with ward rules, boundaries and behaviour management principles.
4. In a neutral tone (i.e., without pleading or irritation or other emotion) point out that the person is not adhering to the rules/expectations and what the consequences will be. Offer the patient some time to talk about it later if they need to.

For example: "It is understandable that you don't want to eat or get weighed. Perhaps you feel scared, overwhelmed or not in control. However, while you are here and while we are helping you to fight the eating disorder, this is not negotiable".

5. Reinforce positive behaviour with a reward or praise. Focus on the positives and avoid harsh consequences.

## Distress

Managing distress is an important part of treatment. Being in hospital is often distressing both for the patient and their family. Recognising distress requires close attention, as distress felt by the young person may not always be evident or demonstrated directly, e.g., anger may be expressed when feeling sad, rather than crying or looking upset. Sometimes, distress is expressed in problematic behaviour.

Young people with an eating disorder may experience distress due to the fear of the treatment particularly weight gain and reduction of exercise, denial of illness, the family or patient being in conflict with each other, the treatment team or other patients on the ward, low self-esteem or comorbid psychiatric illness.

## Managing Distress as Part of a Ward Program

- Reassure the family and patient that treatment is for the safety and wellbeing of the patient. Involve the family and patient in discussions and decision-making.
- Identify difficult times or situations (e.g., the evening meal) and assist with strategies to manage distress. Document these as part of the management plan and intervene early to avoid escalation of distress.
- Interpret behaviours as an understandable response to a perceived threat (rather than personally motivated). Externalise the eating disorder and other problem behaviours (the person is not the problem, the problem is the problem).
- Teach strategies to cope with distress, e.g., emotional tolerance, and relaxation skills.
- Encourage the patient to express emotions in a healthy, appropriate manner.
- Provide a structured plan for the day.
- Encourage regular visiting and phone support from appropriate family and friends within the treatment guidelines.
- If medically stable, incorporate regular short periods of supervised leave.
- Conduct regular risk assessments.
- If the patient becomes a risk to their own or others' safety, consider 1:1 nursing care or in extreme cases use of the Mental Health Act and transfer to a secure unit.

## Deliberate Self-Harm

Self-harm or self-injury is the act of deliberate, non-lethal harming of one's body. It commonly includes cutting, scratching, hitting oneself, picking scabs or interfering with wound healing, burning oneself and overdoses.

Self-harm does not imply that the patient has a personality disorder – up to 40% of adolescent mental health patients engage in self-harm behaviours. Self-harm may be an indication of poor problem solving and coping skills, and is used as a way to cope with distress. Self-harm may be a way to communicate to others that something is wrong and that the person needs assistance.

Strategies to assist the young person with managing self-harm should be discussed and documented as part of the management plan

## Clinical "What ifs?"

A 14-year-old girl with a long-standing eating disorder has been on the paediatric unit for some time. She has become something of a leader in relation to the other patients. Two young adolescent girls, admitted for management of their diabetes, start to refuse food and ask to be weighed regularly. What do we do?

- Has the treating clinician spoken with each girl about the issues?
- Does the patient with an eating disorder have a daily program?
- Is there scope to move beds around to separate the girls?
- Have rules been established about not talking about eating and weight within the ward?
- Is the situation serious enough to transfer any of the patients?
- Do all patients receive information on healthy eating?
- Has the use of weekend leave been considered to separate the girls temporarily?
- Do the patients' family/carers understand the ward rules?

A patient with an eating disorder is finding it difficult to cope with her program. She has been refusing food and asking other children on the ward to hide food for her. This is beginning to result in other patients ignoring the rules. What do we do?

- Is there a clear set of ward “rights and responsibilities”?
- Is the treating team consistent about routines and expectations?
- Has the treating clinician spoken with the patient about the issues?
- Is there scope to move beds around to separate the patients?
- Is there a need to increase the level of nursing observation?

The same patient has now started texting her friends both within the unit and outside. The situation reached a crisis point when nurses found a large amount of laxatives in her locker, brought in by friends at her insistence. What do we do?

- Consider the safety issues of mobile telephones on paediatric units – nurses cannot monitor calls, patients can both receive distressing and harassing communications and also send them. Many phones now have cameras, which raises privacy issues for all patients.
- Consider removing mobile phones on admission – removing them later in treatment may appear to be punitive

## Maintaining Social Connections

It is important to use a holistic approach to working with young people. This involves exploring the young person’s family and peer relationships, other social networks, and interests.

It is common for family relationships to become strained with the emergence of an eating disorder. Often family life can be disrupted and it is difficult to understand how or why. For example, the eating disorder may:

- Decide where and when the family can or cannot eat
- Control food/cooking in the house
- Make family members feel like they are ‘walking on eggshells’ when talking about food
- Encourage family members to maintain secrecy of eating disorder behaviours
- Result in bursts of anger and sometimes aggression when the young person is confronted about eating behaviours
- Prevent the young person from feeling able to talk about what is happening in their lives which can often be misunderstood as being deceitful.

It is also common, as the eating disorder becomes more entrenched and thoughts become more concentrated around food, for the young person to seem less interested or motivated to participate in things they would normally enjoy. For example, the young person may not enjoy their usual interests such as shopping or spending time with friends. It is crucial, while in hospital, that the young person maintains connections with their life outside of the eating disorder.

### Ways to help the young person maintain social connections

- The family should maintain regular contact with the young person while in hospital – siblings, parents, and grandparents
- Assist the young person to re-link with their peer group – phone calls and letters to friends and plan to see 1 or 2 friends whilst on leave from hospital or soon after discharge.
- Facilitate leave from the hospital when medically stable.
- Acquire school work from the young person’s school
- Encourage participation in ward activities in line with the young person’s interests – e.g., reading, craft



## Leave from the Ward

Permission for leave from the ward is a team decision, although overarching responsibility lies with the admitting doctor.

Leave from hospital has multiple benefits during the admission including:

- Helping to maintain the young person's connection with family and social relationships
- Reminding the young person of their life outside the eating disorder and hospital (which may also assist in increasing motivation to work at treatment goals for discharge)
- Rewarding positive behaviours and improvements in health status
- Giving the family opportunities to build their confidence in being able to manage and care for the young person outside of hospital.

## Managing Leave From The Ward

- Leave should only be permitted once the young person is medically stable
- Initially, encourage short periods of supervised leave within the hospital grounds once or twice a day
- As the admission continues, encourage leave outside of hospital with parents to practice eating.

## Evidence-based Therapies

A family-based approach is essential in the management of adolescents with an eating disorder.

Limited studies have been conducted on the effectiveness of individual psychological therapy for adolescents with eating disorders. Some evidence exists for the efficacy of the Maudsley model of family-based treatment in younger adolescents with AN and shorter duration of illness. Training and supervision is required.

There is an increasing body of evidence to demonstrate the efficacy of CBT in the management of BN in adults. It is suggested that CBT might be modified for use in young people with BN. There is also evidence for the efficacy of interpersonal psychotherapy (IPT) in the treatment of BN, although it appears to have delayed effects compared to CBT.

## Working with the Family and Carers

Working together and maintaining good communication between those involved in care is essential to ensure that the patient receives consistent care. Family members should be encouraged to participate in all aspects of care, including assessment, care planning, treatment, discharge and monitoring. Parental input, acceptance and commitment to treatment is an integral component of care planning. No young person with an eating disorder should be treated without parental involvement at some level, assuming there are no child protection issues.

**Eating Disorders can often slow down psychosocial development, so it is often appropriate to involve the family to a high degree even when the patient is a young adult.**

Health professionals should aim to assist the family to:

- Reduce their anxiety and distress
- Reduce self-blame around the illness
- Facilitate good communication and participation in care

Health professionals need to consider the special needs of some families or appropriate ways in which to work with particular groups (e.g., working with Aboriginal families or families of different cultural or religious backgrounds).

## Involving the Family

It is important to keep the following in mind when involving the family:

- Participation, open sharing and collaboration help to foster partnerships between the treating team, the child and the family.
- Holding regular meetings with families is important to evaluate treatment goals and patient progress, and to raise issues or discuss changes.
- More frequent contact may be necessary as issues or difficulties arise. Increased contact with families during more difficult times prevents the patient receiving conflicting messages regarding treatment and minimises potential distress. This is a primary role of the care manager, although all team members should be aware of the treatment plan and can communicate with the family.
- Having meals together in the supportive context of a ward environment can be a helpful way of involving the family. Where practical, and appropriate in the treatment phase, meals brought in by the family to share with the child may be useful in assisting the child's transition back to home life. It may also help the family develop confidence in their ability to care for their child.
- The young person and their family should maintain regular contact and engage in everyday activities, especially those that are usually done within the family, e.g., going for a short walk, spending time with siblings, playing board games or watching television. Such activities should help the child integrate back into family life.
- Consult with parents if the child is refusing to participate in a ward activity and problem-solve solutions together.
- Refer to section "Legal Issues and Eating Disorders" if issues arise regarding consent to treatment. If uncertainty exists contact the mental health service in your Local Health District for further guidance.

## Important Messages to Convey to Families

In order to empower families to be involved with the patient's recovery and in line with admission goals and treatment, the following factors should be considered:

- Be clear about the purpose of the admission (e.g., to initiate re-feeding and begin weight restoration, to interrupt bingeing and purging and begin restoration of healthy eating patterns, or to restore to a healthy weight).
- Avoid using specific numbers for weight and length of stay. Providing concrete numbers may make it difficult to accept a longer admission if required, or it may encourage the focus on a goal weight, rather than ongoing good health. Weight ranges and time frames can be used as a guide as long as the primary purpose of the admission is clearly communicated (to reach medical stability or when health has been restored).
- Reassure the family that admission is a short-term measure (in the overall length of the disorder) needed to reduce dangerous behaviours or to establish medical stability, and that treatment will need to continue in another form after the admission. Attempt to facilitate a realistic understanding about the average length of illness and recovery times.
- Psycho-education can allow the family to better understand the situation. Information regarding the eating disorder, the symptoms, the effects of the illness, treatments available, stages of the illness and recovery, and points for negotiation may be helpful. Discuss that the expression of 'negative emotions', such as anger, are part of recovery and may be a positive sign.
- Access to books and other resources may be very useful.
- Helping parents and siblings to externalise the illness and symptoms from the child are useful strategies. Conveying that behaviours are due to illness (not under the child's full control) can assist in reducing tendencies to lay blame.
- Eating disorders have a large impact on the patient's family, including siblings. Encourage the family to look after their own wellbeing by seeking supports for themselves and relying on existing support networks.

**The family can play a key role in recovery and should be viewed as a resource. Often the family will take up the role of refeeding/ caring for the child after admission.**

## Family Intervention

Family therapy is often offered to families of patients with eating disorders. The notion of family therapy, however, can bring a sense of shame or guilt for families – they may feel they are to blame for their child's illness. It is essential when working with families and carers to help them move beyond any sense of blame. The task is to help the family see themselves as a resource for recovery rather than as a breeding ground for pathology.

When adults take charge of the illness, it will almost always appear to be against the child's wishes. Parents will find themselves in situations where they will need to override their child's wishes – such as not eating enough food to stay healthy. This is likely to bring about conflict. For many parents, this conflict may be actively avoided in the short-term because it is unpleasant/upsetting for their child, and as a result causes distress in them. It must be remembered, however, that avoiding the conflict may maintain the illness. Supportive counselling can help enable parents to stand up to the illness, despite the conflict.

When families are separated, it is important to establish clear communications and methods for interactions. Openness about the family situation will help clarify issues and establish limits on interactions, if needed.

Some family factors may precipitate the onset of an eating disorder and current family functioning may maintain the eating disorder, so it is important to become aware of such factors (if present) in the assessment process.

Parents often need support in taking back responsibility for their child's well-being, especially after long stays in hospital.

# Medical and Physical Treatment

## Medical Instability

Children and adolescents with an eating disorder are at great risk of medical complications, in particular those presenting with Anorexia Nervosa. It is therefore essential to have efficient and timely medical assessment and subsequent treatment commenced. The cause of medical complications can be due to weight loss, the rapidity of the weight loss and the compensatory behaviours that may be being used. Refeeding should be directed by a medical practitioner and facilitated by a qualified dietitian.

Medical instability for the purpose of this document is defined as:

- HR <50
- Systolic BP < 80 systolic or postural decrease of more than 20 systolic
- Increase in HR of  $\geq 30$ bpm from supine to standing
- Temperature <35.5oC

And other medical indicators for medical admission include:

- BSL < 3.0
- Electrolyte abnormalities (in particular K and PO4)
- Cardiac conduction abnormality

If a person presents dehydrated, then this needs to be taken into consideration with their observations i.e. a person's heart rate will be higher when dehydrated however when it is corrected their observations will be lower.

- All medically unstable patients should have continuous monitoring of their heart rate and regular monitoring of their blood pressure and temperature.
- If a patient is deemed medically unstable treatment is to commence as soon as possible.
- Patients who are not medically unstable should have 4 hourly monitoring of heart rate, blood pressure and temperature.

## Refeeding

Preferred options for refeeding in **medically stable** patients include:

1. Oral intake (normal food and fluids)
2. Use of oral supplements
3. Nasogastric feeding

Preferred option for refeeding in **medically unstable** patients:

- Continuous nasogastric feeds with transition to oral feeding when appropriate is recommended to help manage refeeding risk

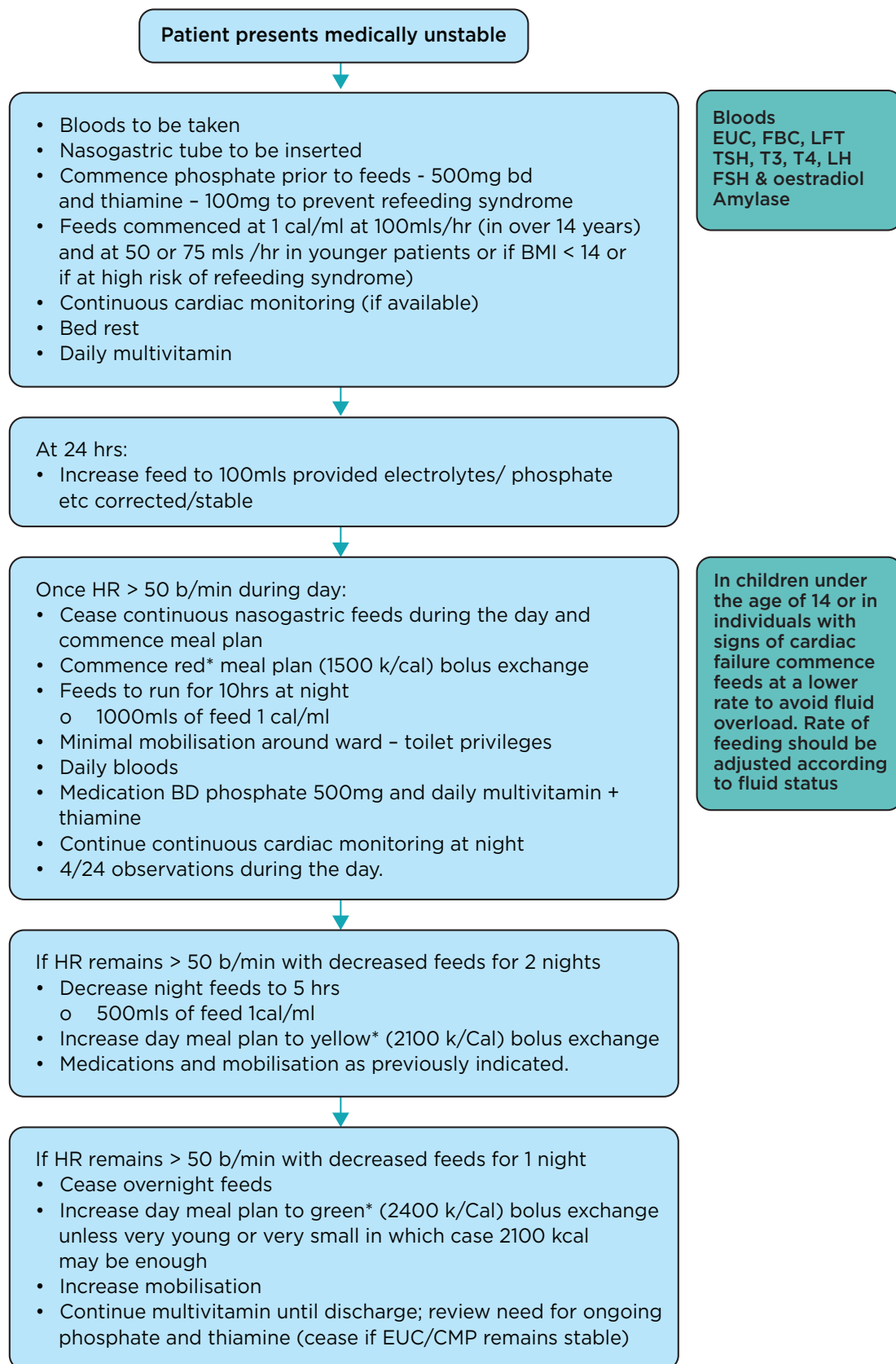
Many patients are admitted for medical stabilisation and will therefore require nasogastric feeding, however; some patients are admitted due to reasons such as self-harm, psychological distress, failed outpatient care, or carer difficulties who may not be medically unstable. In these cases, meal plans may be used with bolus exchange or nasogastric feeds if the meal plan is refused.

Key points when considering meal selection include the following:

- It is generally not best practice to provide food choice for medically compromised or malnourished patients.
- Some components of treatment will be considered as “non-negotiable” (e.g., weekly weight gains and consuming a specified amount of nutrition at meals and mid-meals). Lengthy discussions and negotiations around this should be avoided.

- Parents can contribute to the menu selection based on what the patient used to eat pre-morbidly (including long standing based cultural or religious reasons).
- Dietary limitations due to medical reasons need to have the medical issue verified (e.g. Coeliac disease).
- If the patient has difficulty adhering to the chosen method of refeeding within a specified period of time (e.g., 4-24 hours depending upon the urgency of the situation), the team will need to reconsider the most appropriate feeding method.

It is common for patients to become distressed at refeeding. Medication such as olanzapine may be used to alleviate distress. Please refer to section on pharmacotherapy (p 66)



Discharge is recommended when eating sufficiently to maintain stability and support ongoing recovery without supplements. Real recovery means real food.

\* Meal Plans in Appendix 8

## Nasogastric Feeding

Continuous nasogastric feeding should be used as the preferred method to achieve medical stability. Once medically stable for >24hrs, oral feeds can be commenced and gradually increased as NG feeds are tapered.

The following should be considered when commencing nasogastric feeding:

- Feeds may be commenced as the sole source of nutrition or may be accompanied by oral nutrition if the patient is managing a portion of requirements orally.
- Hypo-osmolar or iso-osmolar feeds may be used initially. Higher energy feeds may then be considered if energy requirements are substantial or to reduce the total volume of feed.
- There are various ways to administer feeds including continuous, overnight or bolus feeds. The mode is dependent on clinical status.
- Feeds commenced at depending on age, BMI and high risk of refeeding syndrome (see table below). This will reduce metabolic stress and allow for physical and psychological adjustment to increased nutritional intake. The age and size of the patient need to be considered.

### Guidelines for initiating continuous nasogastric refeeding:

Patient 14 years or older and not at higher risk of refeeding syndrome	1cal/mL at 100 mL/Hour	Reduce amount of nasogastric feeds and increase oral plan as observations improve ( <b>see flowchart on page 44</b> )
Patients under 14	1cal/mL at 50 mL/hour	Increase to 75mL/hour or 100 mL/hour after 24 hours depending on weight and age
Patients at higher risk of refeeding syndrome*	1cal/mL at 50 mL/hour	Increase to 100 mL/hour after 24 hours

\* **See list of risk factors on pages 45**

Continuous nasogastric feeding is less likely than bolus feeding to result in metabolic abnormalities or subjective discomfort and may be better tolerated by patients.

## Risk of Refeeding Syndrome

Refeeding syndrome is defined as potentially fatal electrolyte and fluid shifts associated with metabolic abnormalities in malnourished patients undergoing oral, enteral or parenteral refeeding. It is caused by a sudden shift from fat to carbohydrate metabolism and increased secretion of insulin when refeeding occurs. This insulin release stimulates cellular uptake of glucose, phosphate, potassium, magnesium and water. As a result, hypophosphataemia, hypokalaemia and hypomagnesaemia can occur and the clinical features of refeeding syndrome are a result of the functional deficits of these electrolytes. There is also increased cellular thiamine utilization which may result in deficiency, or worsen pre-existing deficiency, and reduced renal excretion of sodium and water.

The refeeding syndrome is rare and can be avoided through preventive strategies (correct electrolyte deficiencies, administration of phosphate and thiamine before refeeding).

The electrolyte disturbances of refeeding syndrome occur usually in the first 3-4 days, and cardiac complications (arrhythmias, cardiomyopathy, congestive cardiac failure) within the first 7 days followed by delirium or other neurological changes (seizures, encephalopathy, weakness, paraesthesia).

Those at highest risk of refeeding and who therefore should be commenced on continuous nasogastric feeds are those with:

- A BMI z-score < -2
- Weight loss of 10% or more in the last 3-6 months
- Little or no nutritional intake for more than 5 days
- Low levels of phosphate, potassium or magnesium before feeding

Consider reducing feeds to 50 cal/hour in these patients.

General advice	
Vitamin/Mineral	Recommended Dose
Thiamine (if not covered by multivitamin)	100mg daily (stopping after 5-7 days if the patient remains stable)
Multivitamin and Mineral	RDI
Phosphate	1000mg daily (usually as 500mg BD)

**Give first dose of phosphate and thiamine before any refeeding**

Limit high carbohydrate fluid (soft drink, fruit juices, cordials) and high carbohydrate foods  
 For patients who are at higher risk of refeeding syndrome it is safest to commence with continuous feeds as this reduces the risk of associated hypoglycaemia.

**Medical monitoring during refeeding is essential.**

1. Assess vital signs, fluid input, output, electrolytes (including phosphate) and monitor for oedema, rapid weight gain, congestive cardiac failure (CCF) and gastrointestinal symptoms.
2. Weighing should occur post voiding, before breakfast. The frequency of weighing will vary between units and may depend upon medical stability or patient progress
3. Continue to monitor nutrition, mental state, skin care, mobility and general physical wellbeing.

The following tests are recommended for monitoring the patient during refeeding

Nutrient Reference Values for Calcium and Vitamin D		
Test	Days 1-7	Days 7+
Electrolytes (including phosphate and magnesium)	Daily for 5 days Then second daily if normal	Bloods if clinically indicated after 7 days.
Blood glucose	If BSL low, 1 hourly until continuous feeds commenced and BSL stabilised.	
Urinalysis	Before being weighed	
Blood Pressure	4 hourly until medically stable then daily	
Pulse	continuous if medically unstable then 4 hourly	
Temperature**	4 hourly until medically stable then 6-8 hourly	
Respiratory Rate	4 hourly initially then 6-8 hourly	
Signs of Fluid Overload and Oedema	Daily	
Signs of Deterioration of Strength or Mental State	Daily	
ECG	On admission then as clinical picture dictates	
Weight	Twice weekly (can do more often if concern for refeeding syndrome or discrepancies in weights)	



\*Counting an accurate pulse rate may be more difficult than is commonly recognised. A 60 sec count is recommended as the most accurate and efficient measure.

\*\* Patients should not have their temperature taken within 15-20 minutes of drinking hot or cold fluids.

If a patient is dehydrated electrolyte levels may be misleading. It is important to repeat electrolyte studies daily in the first few days when a patient is hypovolemic.

## Management of Refeeding Syndrome

If signs of refeeding syndrome become evident (biochemical or clinical) the admitting/on call consultant or specialist responsible should be notified. The following can be used as a general guide to managing complications:

If serum levels fall substantially (but are still within the reference range):

- DO NOT INCREASE FEEDS
- Maintain feeds at the current rate
- Correct electrolyte levels with supplementation
- Recheck electrolytes within 12 hours
- Increase feeds when electrolytes are stable

If serum levels fall below the normal range

- MAINTAIN or REDUCE FEEDS
- Correct electrolyte levels with supplementation
- Recheck electrolytes every 6-8 hours until improving then every 12 hours until stable.
- Increase feeds when electrolytes are stable

# Hypothermia

## Acute and Chronic Hypothermia

- Acute Hypothermia is defined as an unintentional drop in core body temperature below 35.5° C. The body’s compensatory mechanisms to conserve heat begin to fail.
- Chronic hypothermia can occur as a result of malnutrition.

Clinical practice is based on the literature of hypothermia, environmental exposure, and anecdotal evidence. This is clearly an area of needed research.

## Special Considerations for Eating Disorders

- A depleted energy supply combined with weight loss disables the body’s natural temperature regulation.
- A diminished subcutaneous fat supply accelerates heat loss.
- Patients moving from warm to colder climates or environments may “decompensate” i.e. their body is not able to physiologically compensate for the change in climate.
- Thermoregulatory mechanisms should be considered as part of a medical history - how well is the patient able to keep themselves warm, especially at night or when asleep.

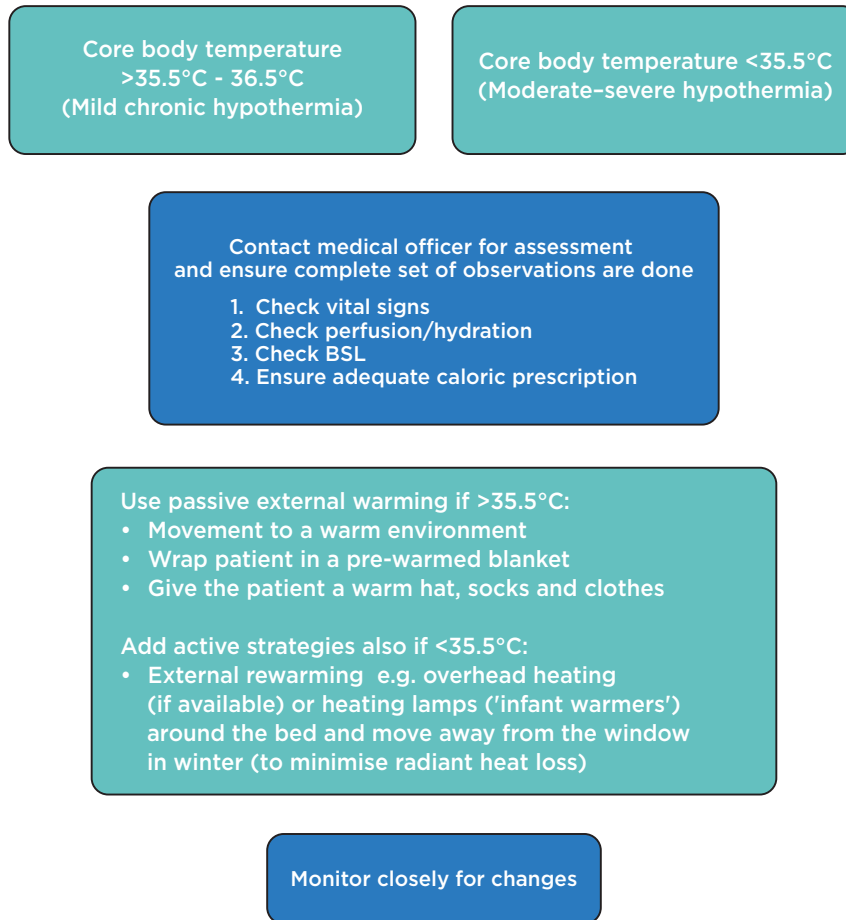
## Measuring Core Body Temperature

- Measurement of core body temperature can be difficult in cases of hypothermia.
- Standard ward thermometers usually only measure temperatures as low as 34.4 degrees Celsius.
- Tympanic thermometers are used frequently in research and will most likely measure temperatures accurately at 35 degrees Celsius

Where to Measure	How to Measure	Which Reading to Take
Oral	<ul style="list-style-type: none"><li>• Use more than one site to measure temperature</li><li>• Be consistent with methods used (same thermometer, same site)</li><li>• Measure bilaterally) e.g. left and right ears</li></ul>	Always record the lowest reading measured
Tympanic		
Axillary		

## Management of Hypothermia on the Ward

A key strategy for managing hypothermia is the provision of adequate calories.



## Amenorrhoea

- Amenorrhoea in AN is due to functional hypogonadotropic hypogonadism (suppressed secretion of FSH and LH with secondary low ovarian oestrogen).
- Although primarily considered a manifestation of low weight or malnutrition, it can occur following prolonged weight loss or erratic eating behaviour even while still at a 'normal' weight and also as a response to prolonged intensive exercise as occurs in the 'Female Athlete Triad' (a syndrome of disordered eating, amenorrhoea and osteoporosis).
- Amenorrhoea and oligomenorrhoea (irregular menses) can also occur in patients with BN (including patients of a healthy weight).

### Menstrual History

- Menarchal status
- Date of last period
- Patterns of menstruation
- Episodes of absence of menses
- Use of oral contraceptive pill

Primary Amenorrhoea	Secondary Amenorrhoea
The absence of menses by age 14 plus the absence of secondary sex characteristics; <b>OR</b> , the absence of menses by age 16 in the presence of normal pubertal development.	The absence of menses following a history of menstruating normally. Females who have not menstruated for 3 months should be evaluated to determine the cause.

- Persistence of amenorrhoea is associated with lowered bone mineral density.
- Menses usually return upon achieving satisfactory weight gain, although regular menses may be delayed for up to 12 months.
- Patients may be monitored by measuring, FSH, LH and oestradiol for objective evidence of recovery.
- In children who are pre-menarchal, progression of pubertal breasts and genital development, as well as normal growth, indicate functional recovery and normalisation of T3.

### Management Plan

- Obtain a detailed medical history to help rule out other causes of amenorrhoea, including pregnancy
- Investigations: FSH, LH and oestradiol levels. Pelvic ultrasound may show prepubertal appearing ovaries and uterus.
- Other investigations may be indicated where there are other features suggesting possible dual pathology (e.g. chromosomes to exclude Turners syndrome in short stature, other endocrine causes in patients with apparent healthy weight or normal sex hormone levels)
- Facilitate weight gain towards a healthy target weight
- Facilitate normal healthy eating behaviours
- Monitor for normalisation of biochemistry, menstrual function, growth, and pubertal development
- Prescription of an oral contraception pill (other than for contraception) to mimic "normal" menstruation is **NOT** indicated and should be discouraged. See section on Osteopenia/Osteoporosis

# Osteoporosis and Osteopaenia

## Bone Health and Eating Disorders

Decreased bone density and strength is a common complication of eating disorders. Eating disorders may interfere with peak bone mass acquisition during adolescence.

Failure to achieve normal peak bone mass or early loss of bone mass may lead to premature development of osteoporosis in adulthood and increased risk of fractures by early adulthood.

Persisting amenorrhoea, even in individuals with apparent minimal weight loss or low normal range BMI remains a strong risk factor if due to hypogonadism (low gonadotrophin and sex hormone levels). Pubertal arrest, regression or slowed growth should prompt assessment of hormonal status, and if persistent, consideration of endocrinology opinion.

Indicators of Risk	Referral	Complications
<ul style="list-style-type: none"><li>Malnutrition &gt; 6 months</li></ul>	Medical team	<ul style="list-style-type: none"><li>Stress fractures (feet, legs, pelvis)</li></ul>
<ul style="list-style-type: none"><li>Low body weight &gt; 6 months</li></ul>	Endocrinologist	<ul style="list-style-type: none"><li>Compression fractures (spine)</li></ul>
<ul style="list-style-type: none"><li>Amenorrhoea</li></ul>	Dietitian	<ul style="list-style-type: none"><li>Fracture of the hip</li></ul>
<ul style="list-style-type: none"><li>Pubertal delay or arrest</li></ul>		<ul style="list-style-type: none"><li>Chronic pain</li></ul>
<ul style="list-style-type: none"><li>Family history of osteoporosis</li></ul>	Physiotherapist	<ul style="list-style-type: none"><li>Loss of height</li></ul>

Where available, investigation of osteoporosis and osteopenia should be considered for all patients who have been amenorrhoeic for more than six months and annually thereafter.

## Osteoporosis and Osteopaenia Management Plan

The key to prevention or minimizing osteoporosis is nutritional rehabilitation and the resumption of normal sex hormone metabolism (usually indicated by resumption of menses in girls).

1. Restoration of adequate nutritional status, including an increased energy intake to support adequate hormone production, return of menses and normal growth.
2. Restoration of normal weight and increased muscle mass.
3. Medical assessment of risk factors, or conditions, associated with osteoporosis (e.g., prolonged glucocorticoid therapy, chronic liver and renal disease, malabsorption disorders or thyroxine excess).
4. Ensure adequate intake of calcium and vitamin D. Supplement intake of calcium if the patient is unable to meet their nutritional requirements orally. If the patient is ward-bound for an extended period, consider adding a vitamin D supplement.
5. Whole body DEXA for patients with AN delayed menarche or secondary amenorrhoea for more than 6 months. Consider DEXA in boys with prolonged under-nutrition and other risk factors too.
6. Consider formal endocrine consultation for those with prolonged secondary amenorrhoea or documented low bone density.
7. The use of bisphosphonates in AN has not been sufficiently studied. Initial results indicate that attainment of normal weight is the most effective measure. Bisphosphonates are potential teratogens and thus are relatively contraindicated in the adolescent age group.
8. If osteopenia or osteoporosis is detected refer to a physiotherapist. A weight bearing and resistance program can be initiated if the patient is medically stable and nutritional intake allows for increased energy expenditure. See Appendix 4: Physical Activity: Stretches.

## Nutrient Reference Values for Calcium and Vitamin D

### Males and females 12-18 years

Calcium - Recommended Dietary Intake	1300mg
Vitamin D - Adequate Intake	1000 IU/day

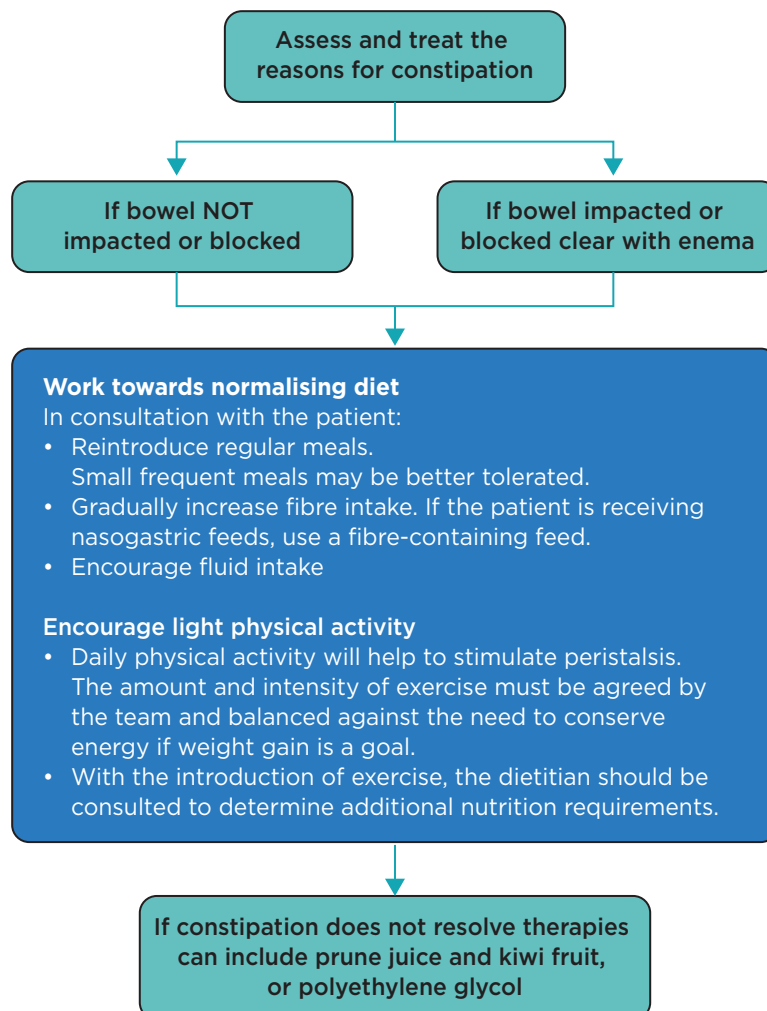
## Constipation

There is considerable individual variation in 'normal' bowel patterns. Constipation can be defined as the presence of symptoms such as discomfort, abdominal pain, rectal pain, and hard stools.

It is essential to keep in mind, however, that patients may attempt to procure laxatives from health professionals in order to purge.

## Treating Constipation

The use of stimulant laxatives in patients with eating disorders should be avoided whenever possible.



## Goals for Discharge

Basic goals for discharge are:

1. Medical stability (ie a 'safe weight' maintenance with accepted physical activity - emphasise this is not a final weight)
2. Eating sufficiently to maintain stability and support ongoing recovery without supplements. Real recovery means real food.
3. Must have a clear management plan (medical and psychological) with follow-up appointments within a week of discharge. This usually means agreed GP appointments in place, weekly CAMHS/psychologist appointments, and paediatrician appointment planned within 2-4 weeks

# Eating, Nutrition and Physical Activity

## Managing Meals and Snacks

Key points to consider when planning or managing mealtimes include:

- Tailor mealtime management to the specific needs of the patient.
- There is no 'right approach' however it is important that staff and the family work as a team.
- Disagreements regarding mealtime approach should be dealt with away from the table.
- If adults are unable to work together, it is more likely that mealtimes will be difficult for the patient.
- Accurately document all food and fluids consumed on a food record chart (including the type and quantity of foods). It can be helpful for the patient if this is done discretely (i.e., without talking loudly about food eaten in front of other patients, or at the dining table).
- Observe and document conversations about diet/food and any disordered eating behaviours during meal consumption.
- Ensure that mealtimes remain as relaxed as possible and not experienced as examining every mouthful consumed.

### Normal healthy eating includes:

- Eating a variety of foods from all food groups
- Eating a variety of foods within food groups
- Eating adequate amounts of food for normal growth and development
- Being able to eat when hungry and to stop eating when full
- Being able to be flexible about what foods are eaten and at what times of the day.

## The Use of Meal Plans

- Individual meal plans may facilitate common nutritional goals and awareness of appropriate types, quantities and timing of foods (see Appendix 8 for meal plans).
- A qualified dietitian, with the treating team, patient and their family, should facilitate devising the meal plan. A dietitian will ensure nutritional adequacy and assess the risk associated with re-feeding.
- It is not advisable to discuss calories with the patient. Instead talk in terms of a healthy diet or whole foods. If the patient asks to discuss calories (e.g., "How many calories are on my meal plan") gently explain that it is unhelpful to discuss and attempt to direct the conversation towards healthy eating and whole foods.
- Provide a copy of the meal plan to the patient, parents/carers and other members of the treating team to optimise consistency in approach and minimise the potential for splitting. It is sometimes helpful to explain to the family and staff the importance of supporting the patient to adhere to the meal plan, and of not giving in to requests to alter the amounts of food listed. Ideally, changes to the meal plan should only occur with the dietitian and patient to avoid confusion and miscommunication amongst the team.
- Questions about meal plans or substitution should be referred to the dietitian.

## Social Eating

- Ideally the patient should sit with other young people at a dining table to eat meals. If the patient has to sit in their room to eat they should be seated at a table and not on their bed. Ideally, someone else should also sit with the patient – family and friends can be encouraged to eat a meal with the patient to model social eating behaviours.
- As this is a highly anxiety-provoking situation for patients, staff members should be present to model healthy eating and support the patient when necessary.
- Staff members can also help to direct conversation away from food and calories and promote normal



social interaction. It is essential that staff do not discuss their own issues with dieting or body image concerns in front of patients.

- Acknowledge that the patient will find meal times difficult – the team may decide to allow the patient to initially eat separately from other children and gradually work towards eating in a more social setting.
- If the patient is being fed nasogastrically they should sit at the table during meal times and be given every opportunity to consume a meal and participate in this social event.

## Meal and Snack Choices

- Nutrition goals must work towards three regular meals and three snacks.
- Although it may seem a lot to the patient, six smaller meals may be better tolerated (physically and psychologically) than three larger meals.
- Food ‘dislikes’ are common among patients with eating disorders, and may be a way of limiting the intake of ‘scary’ foods. The management of food dislikes should be approached as a team and consideration given to premorbid food preferences and dislikes (discuss with parents/carers). It may be necessary to include foods on the meal plan that the patient does not want in order to meet nutrition and treatment related goals. It may be helpful to initiate basic ‘rules’ for the unit regarding food dislikes, e.g., the patient can nominate three foods he/she dislikes but must eat all other foods (within reason).
- Vegetarian menus are generally only allowed if the patient became vegetarian well before the onset of the eating disorder.
- Reported “allergies” to specific foods must be discussed with the medical officer and treated with caution. This may be part of the eating disorder as opposed to a “true” food allergy.
- Provide the regular hospital menu. Paediatric menus are generally not appropriate for adolescents.
- Aim to decrease or eliminate low fat foods and beverages during the admission.
- Limit chewing gum, lollies and excessively high carbohydrate fluids with little nutritional value.
- Food and beverages from outside sources are usually not an option unless there has been consultation and agreement with the team.

## Post Meal Support

It may be helpful to initiate routine post meal support for patients, especially if they are anxious or agitated after meals. Such support may include:

- Relaxation (using techniques previously learned) and breathing exercises
- Distraction (e.g., activity, talking, reading, watching television, talking on the telephone)
- Hand massage
- Social activity

## Setting Goals and Limits

Goals and limits around meal times should be individually tailored to the patient and developed in consultation with the patient. Examples of mealtime goals may include:

- Not playing with food
- Touching food to the lips
- Eating 3/4 of the meal
- Eating a particular ‘scary’ food
- Sitting at the table for a specified time period
- It is useful to set time limits on meals, e.g., 30 mins for main meals, 15 mins for snacks.
- To prevent purging, it is recommended that no access to toilets/bathrooms be allowed for 1 hour after meals. Patients should be encouraged to use the toilet before meal times as part of the ward routine.
- It can often be difficult to be firm about nutrition requirements, especially when the patient is distressed. It is very important, however, to be clear that nutrition requirements are not negotiable.

**Staff should ensure that foods chosen are appropriate in terms of:**

- Quantity of food
- Type of food
- Meal time

## Providing Nutrition Education

Nutrition education or *re-education* is an ongoing process to support behaviour and thinking changes towards better health and recovery. It aims to:

- Explain treatment
- Help put symptoms, blood test results and weight changes in perspective
- Correct or put in perspective less helpful ideas
- Assist the person to take more responsibility for their own health
- Prepare for discharge, challenges and maintenance of recovery

### Important Principles

Education reinforces the focus of treatment to improve overall health, including but not only focused on weight restoration. It can include nutrient status, metabolism and energy changes, body composition and hydration, eating and compensatory behaviour or social and family eating.

- Generally education should be immediately relevant, simple, time limited and unemotional – complex terminology should be avoided.
- It should be helpful in reframing knowledge for health, not part of arguing with the patient or about treatment. Providing written information can also be helpful.
- Using motivational interviewing to judge the timing, type and purpose of information can be useful.
- Nutrition information can easily create conflict. Members of the treating team may have different dietary ideas and patients may hear and distort information selectively. Coping with mixed messages about food and nutrition is a normal part of life, but in a ward, nutrition education for the team and families can help to minimize conflict and reinforce desired messages.

## Who Provides Education?

All staff that deal with immediate questions about eating, weight or the treatment program, and are involved with the treatment plan, can have a role. Someone on the team (e.g., a dietitian) should be the source of expert knowledge and be the person who primarily co-ordinates and provides education. This avoids team splitting or discrepancies. Consultation with the whole team however helps to identify issues, put them in perspective and plan the education as an integrated part of the inpatient stay.

### Case Study

Emily is admitted and commenced on a strict meal plan and nasogastric feeding. At this stage, information is simple and short and related to her medical condition, state of starvation and what her medical tests are showing. It is important to validate Emily's distress and fear about eating and any physical discomfort but not to argue about treatment via nutrition.

As Emily improves, education can address the need for regular eating patterns to meet nutrient and energy needs but with increasing food variety and flexibility. Any misuse of information is carefully corrected with accurate information. As normal hunger returns, education is provided to assist with appetite, weight fears and bingeing risk. Awareness of osteoporosis and shifting the focus to energy for living helps her decide to recover.

Prior to discharge Emily needs help with maintaining progress and coping with family and social situations. Later during recovery, she is ready to find out more about normal nutrition and weight management. She learns to choose food by actual taste and commonsense and uses normal hunger and satiety cues to guide food quantities. She recognises when stress is causing restriction or bingeing and intervenes

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## In the beginning

Being admitted means the person is not able to take responsibility for their own health and nutrition. Immediate stabilisation, restoration of hydration, energy intake and prevention of refeeding syndrome is the focus of treatment. Education initially should be minimal due to stress and impaired cognitive ability.

- Information to assist the person cope with fear of eating and weight gain.
- Explanation of initial variations in weight due to fluid shifts and glycogen storage.
- Interpretation of metabolic changes and what this means for meeting energy and weight gain requirements.
- Understanding gastric and physical discomfort.
- Explain that nasogastric feeding is an abnormal method of nutrition, especially for extended periods of time.

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## During admission

There are usually firm guidelines for eating when on the ward. Nutrition education supports these guidelines but meal times are emotionally difficult and may not be the best time to provide information.

As nutrition and cognitive function improve, more education can be included.

As hunger returns, education to assist with fear of hunger or bingeing and weight gain is helpful.

Gradually shift to an emphasis on more normal and flexible attitudes and behaviours.

- The effects of underweight and starvation on disruption of normal hunger and satiety, metabolism, cognitive function and mood.
- Metabolism and energy balance.
- Protein for tissue repair, muscle restoration and then normal growth and development.
- Carbohydrate and fat for energy and nutrition needs.
- Fluid intake and normal response to thirst.
- Food variety and balance, speed of eating and food related behaviours.
- Nutrition for normal growth and development.
- Amenorrhoea and osteoporosis.
- Appropriate use of supplements.
- The effect of restriction on bingeing behaviours.
- Distinguishing between valid food preferences and eating disorder choices such as vegetarianism, allergies or low joule foods.

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## Planning for transition

Information on anticipated challenges to maintaining recovery post discharge and relapse prevention.

- Regular eating and menu planning to assist managing hunger and satiety concerns until full weight restoration and return of normal body cues.
  - Eventual flexibility with family and social eating.
  - Nutrition supports good health and it is good health that allows energy, confidence, exercise, and stress management.
-

## Bingeing

Managing bingeing behaviours on the ward can be difficult, especially if there are limited staff available to monitor and assist with such behaviour. It is important to identify, on admission to the ward, which patients are at risk of engaging in bingeing behaviour, as not all patients will need such assistance.

### Risk indicators for bingeing behaviour:

- Past history of objective bingeing
- Hoarding of food
- Secretive behaviours around food
- Food going missing without explanation

## Useful Strategies in the Management of Binge Eating

The following may be useful in assisting patients to manage binge eating:

1. Identify triggers and potentially difficult times for bingeing (e.g., mid-afternoon to evening), which may be different for each patient.
2. Ask the patient what might be helpful in preventing binge episodes at these times, and how staff may assist. Examples may include breathing exercises, distraction or being with a staff member.
3. Cognitive Behaviour Therapy (CBT), alone or in combination with medication, is the treatment of choice for patients with BN. Other strategies, such as limiting access to food (see below) and distraction, may be useful particularly in acute stages.
4. Identify useful strategies to reduce binge eating, encourage patient to utilise these and ensure strategies are documented in the management plan.
5. Encourage the patient to approach a staff member for assistance if feelings associated with bingeing arise.

## Limiting Access to Excess Food

The following may be of assistance in reducing access to food outside planned meals and snacks:

- Food should not be brought in by patients, or their families or friends, unless previously approved by the team (including dietitian). Food purchased at a food machine or hospital cafeteria should be supervised by a staff member.
- Food should not be kept with the patient or in the patient's room. Food brought in to the hospital should be handed to staff.
- Mealtimes should be monitored.
- Meals should be eaten at the common dining table (not in front of the television).
- If possible, the dietitian should check the menu after being completed by the patient. More than one menu can be filled out at a time (e.g., a full week of menus). Checking the menu with the patient can be a good education tool. If this is not possible the nutrition assistant or nursing staff may agree to alert the dietitian if over-ordering is apparent.
- Catering staff should remove all food not eaten at meal times.

## Purging

The aims of addressing purging behaviour may include:

1. Assessment and management of medical complications, including fluid and electrolyte balance;
2. Exploration of triggers that lead to compensatory behaviours;
3. Improvement of skills in managing emotions around food, weight and body image; and
4. Where appropriate, implementing dental hygiene strategies.

### Steps To Cease Laxatives, Diuretics & Vomiting

Self-induced vomiting, laxative and diuretic abuse have been widely reported in older adolescents with eating disorders. Many different types of laxatives are available as over-the-counter medications but stimulant laxatives are the type most commonly used. The process of stopping laxatives and diuretics must be conducted carefully and under the direction of a qualified medical practitioner.

#### Step 1: Explain why purging should be ceased

If the patient is cognitively compromised, this explanation should be brief. Some reasons for purging cessation include:

- Electrolyte imbalance, which can lead to muscle weakness, renal impairment, arrhythmia or sudden death.
- Fluid imbalance, which can lead to fluctuations in weight and rebound oedema.
- Diarrhoea, constipation and at times faecal incontinence.
- Potential to cause permanent damage to the colon and teeth, damage to the oesophageal lining, gastrointestinal bleeding and reflux.

#### Step 2: Explain that purging is ineffective in dieting

Absorption of nutrients (except water) occurs mostly in the small intestine and laxatives primarily work in the large intestine. When patients learn that laxatives and diuretics do not cause an energy deficit and that vomiting only rids the body of a very small proportion of calories ingested, patients often agree to discontinue.

#### Step 3: Discontinue use of purgative agents and restrict opportunities to purge

- Stimulant laxatives can be stopped abruptly. Lactulose can be prescribed if there are concerns about faecal impaction.
- Supervise bathroom use. No bathroom access 1 hour after meals and limit time off the ward after meal times.
- Do not leave tissues, bins, buckets, syringes or jugs near the patient as they may be used to purge feeds orally or via their nasogastric tube.

#### Step 4: Encourage healthy use of fibre, fluids & exercise

- The patient may be reluctant to drink adequately, particularly if rebound oedema and subsequent weight gain occur. Reassure the patient that the oedema and weight gain will resolve and continue to encourage fluid intake.
- A high fibre diet should be encouraged and may need gradual introduction.
- Establish regular meals. The use of a food and feelings diary can be beneficial.
- Light exercise should be encouraged to promote peristalsis.

#### Step 5: Monitor

- Monitor bowel movements. Investigate if there are no movements for 5-7 days.
- Monitor fluid balance. Oedema is common and should resolve within 1-2 days.
- Electrolytes and cardiac function will need to be monitored regularly.

## Physical Activity

Excessive exercise is common among patients with eating disorders. It is important that this is assessed and managed for the patient to return to health.

Allowing patients to participate in graded, appropriate forms of physical activity and providing education on healthy exercise and sporting habits can assist recovery (see appendix 3 and 4).

### Safety

Cardiovascular and biochemical manifestations in eating disorders should be considered in the decision to include physical activity in the treatment plan. Prior to participating in physical activity the patient should be assessed as medically fit to do so by the medical team.

Physical activity may be helpful or harmful depending on the medical and physical condition of the patient. Patients who exercise unsupervised, and/or who are medically unstable, may further compromise their medical and nutritional status. Medical stability can be extremely sensitive to minor changes in nutritional intake, physical activity, or purging behaviours. Team members supervising a patient's physical activity plan should be kept well informed of events in the patient's day that might compromise this stability.

People with eating disorders may also present with peripheral neuropathy, secondary to under-nutrition. The risk of injury, such as stress fractures and other structural damage, is increased in such cases due to an elevated pain threshold associated with reduced sensation in the peripheries. When a patient has a history of ignoring the body's messages and exercising in the presence of pain or fatigue, their risk of injury may be further elevated.

### Excessive Physical Activity

Excessive exercise increases the risk of osteopaenia and osteoporosis, musculoskeletal injury, including stress fractures, and osteoarthritis later in life. It will contribute to medical instability and prevent weight recovery.

#### Features of Excessive Exercise

- Repetition of tasks unnecessarily
- Restless hyperactivity
- Solitary exercise
- Secretive exercise
- Exercising due to a preoccupation with low weight and physical appearance
- 'Debting': keeping a mental note of exercise performed to determine 'allowed' caloric intake, and vice versa
- Compulsive patterns: rigid and perfectionistic
- Pathological patterns: may exercise when injured, in pain, fatigued or dizzy
- Exercise is inhibiting interpersonal, social, educational and vocational activities
- Increased anxiety when prevented from exercising

## Managing Excessive Physical Activity

The following points should be considered to effectively manage excessive exercise behaviours:

- Identify the patient's excessive exercise behaviours (this may also require a separate interview with the family);
- Assist the young person to identify their exercise behaviours as excessive and unsafe;
- Identify stressors that lead to these behaviours (e.g., before or after meal times, when alone in bathroom);
- Create a plan with the young person to help manage these stressors (e.g., schedule distraction strategies pre/post meal times, supervised bathroom access);
- Collaborate in goal setting with the young person and team to decrease solitary exercising. A graded approach is often required;
- Address false beliefs around exercise and provide correct information;
- Daily performance of a prescribed physical activity plan, to decrease anxiety and experience healthy exercise for health stage.

### Case Study: Caught in the Act

Joanne is observed to be doing star jumps by her bedside behind closed curtains. The nurse approaches the bedside and asks to pull the curtains back. Joanne initially resists but the nurse reminds her that it is ward policy to have the curtains open. The nurse says

"It seems like you're finding it hard to manage your exercise today."

"What can we do to help you?"

"Let's look at the goals you set this week about exercise"

"Let's go through the things you find helpful to distract you"

"Is there something else I could help you get started with?"

Joanne didn't think anything could help; she just wanted to finish her 500 star jumps. Joanne had previously found that drawing or making bracelets was a good distraction for her. This was documented in her management plan, so the nurse was able to re-direct Joanne to these activities.

#### Key Points:

- Validate the patient's distress.
- Frame limitations as a safety measure, not a punishment.
- Avoid negotiations.
- Refer patient back to weekly goals and the management plan.
- Address the behaviour with the patient, and move the focus away from weight or exercise towards management of their distress.

## The Role of Physical Activity as Part of Recovery

Supervised activity in medically stable patients can assist in restoring and retaining bone mass, joint flexibility and muscle strength. Physical activity also assists in the deposition of lean muscle mass during weight gain. A physiotherapist, when available, should supervise a graded physical activity program incorporating stretching, strengthening and core stability. Incorporating physical activity as part of an overall treatment program can promote motivation to change and assist recovery.

Allowing the young person to participate in graded levels of activity can have a number of benefits:

- Helps to rebuild a healthy musculoskeletal and cardiovascular system
- Enhances trust in the team, reinforcing the idea that we are supporting them in reaching a state of health rather than 'fattening them up'
- Assists in managing constipation secondary to refeeding

- Assists with anxiety reduction and mood elevation
- Provides an opportunity for positive physical experiences to promote acceptance of the body during weight recovery
- Helps to facilitate responsibility for self, rather than cause more feelings of loss of control, helplessness and resentment.
- Promotes general well-being
- Assists the return to a normal balanced lifestyle

## Physical Activity Guidelines During Recovery<sup>vi</sup>

Once medical stability is achieved, and weight gain has begun, more elements (other than gentle stretching) can be added to the program (see Appendix 3). Progression is determined by a number of physical, behavioural and psychological parameters. Ongoing medical stability, weight gain, adherence with the treatment program, motivation to change, insight into exercise behaviours and an ability to contain them are all factors to be considered. The decision to progress the physical activity plan must be agreed upon by the multidisciplinary team. Close collaboration with the dietitian is required to ensure the patient has recovered enough nutritional reserves to be able to tolerate the activity.

Treatment of musculoskeletal issues should be performed within a framework of caring for a fatigued and ravaged body. Assisting patients to identify the harmful consequences of their eating disorder can help to break through the denial of their illness, and be a powerful motivator to change. Interventions should aim to provide positive physical experiences that can assist the patient to re-discover their bodies as vehicles through which life can be enjoyed.

## Exercise and Lifestyle Education

Initially the patient may be too unwell to accept education and advice due to poor cognitive function related to malnutrition, or being in a pre-contemplative stage of change. The educational aspects of treatment are most effective once the patient has begun to gain weight.

Addressing misconceptions the young person and parents have around physical activity and health is essential. The patient may not have accurate knowledge of matters such as healthy levels of physical activity and the negative effects of excessive exercise in the presence of malnutrition. False beliefs must be challenged and accurate information provided.

The patient should be encouraged to understand the concepts of 'healthy' physical activity and begin to see it as a way to maintain health, a form of relaxation, a way of being sociable, having fun and contributing to an overall better mood. Parents may have their own beliefs or expectations on how active they wish their child to be. Sessions with the family may be required to discuss these beliefs and determine what type and amount of physical activity will support the young person's recovery and contribute to a healthy balanced lifestyle.

Returning to sports is often a big question on the minds of patients and their families. A return to normal healthy levels of physical activity can be permitted once the patient has been stable at or above their minimum healthy weight for a minimum period of 3 months, or as otherwise directed by the medical team or practitioner.

When planning a patient's return to sport the following points must be considered:

- **Risk of fracture or injury:** For patients with low bone mineral density, contact sports or those with an increased risk of falling are discouraged (e.g., horse-riding, rollerblading)
- **Motivation to exercise:** Is the patient wanting to exercise for healthy reasons or for eating disorder reasons?
- **Type of sport:** Vigorous, competitive, or body image based types of physical activity can promote anorexic thoughts and compromise recovery (e.g., athletics, swimming, ballet).



## General Guidelines

- Prolonged bed rest is inadvisable unless medically indicated.
- A physiotherapist should design and supervise a graded exercise program.
- Excessive exercise can lead to serious cardiovascular and musculoskeletal complications.
- Appropriate activity levels for each patient should be decided by the treating team, documented as part of the management plan and communicated clearly to the patient, their family and staff members.
- Patients should be discouraged from solitary exercise on the ward, e.g., running, star jumps, pacing up and down the hall, etc.
- Patients may be allowed to walk slowly around the ward, although this will need to be monitored.
- As nutritional status improves, the activity program can progress. Avoid bargaining and negotiating around physical activity versus the eating plan.
- Exercise guidelines for discharge should be discussed with the patient, their family and community team.

# Managing Comorbidity

## Comorbidity in Eating Disorders

Many young people with an eating disorder have additional psychiatric diagnoses. Individuals with eating disorders and co-morbid psychiatric conditions usually require longer treatment and may have poorer outcomes. The most frequent co-morbidities are depression, anxiety (including obsessive-compulsive disorder) and substance misuse.

## Eating Disorders and Anxiety

Anxiety disorders are the most commonly identified comorbid psychiatric disorders in individuals with eating disorders affecting 50% or more people. The most common comorbid anxiety disorders are social phobia, PTSD and OCD with higher levels of eating disorder pathology associated with comorbid anxiety disorders. What remains unclear is the temporal relationship between AN and anxiety disorders with a number of studies indicating that anxiety disorders frequently predate the onset of AN. General levels of anxiety may develop or worsen as weight is restored and treatment progresses.

Most young people with an eating disorder will have preoccupying thoughts related to food, weight and shape. Compulsive or ritualistic food related behaviours are also common, e.g., chopping up food into very small pieces, eating very slowly, chewing foods a certain number of times and hoarding food.

## Eating Disorders and Depression

Co-morbid Major Depressive Disorder (MDD) is commonly seen in 40% or more of people with eating disorders, however, symptoms of depression can be seen in underweight people due to the effects of starvation. Symptoms of starvation may include low mood, irritability, insomnia and social withdrawal. Mood disturbance can also be observed during the re-feeding process due to internal levels of distress. Symptoms of mood disturbance in AN require thorough psychiatric assessment and should be assessed initially and following weight restoration. With weight restoration up to 50% of patients recover from depression.

## Eating Disorders and Substance Misuse

High rates of substance misuse have been found among adults with eating disorders. Substance misuse often involves the use of amphetamines, caffeine and tobacco to control appetite and weight. A broader range of substances, particularly alcohol, may be misused in young people with BN.

## Treating Comorbid Psychiatric Issues

Treatment of comorbid psychiatric illnesses should occur once eating disorder treatment has been instituted and be focused on supporting the successful treatment of the eating disorder. Treatment of malnutrition is central to the successful treatment of comorbid mood and anxiety disorders though on occasions additional treatment of psychiatric comorbidities including evidence-based psychological therapies or psychotropic medication may be indicated. It should be noted that underweight individuals are less likely to respond to anti-depressant medication for treatment of depression and anxiety.

The term 'secondary diagnosis eating disorder' may be used when the primary reason for admission of a person is for a non-eating disorder psychiatric diagnosis (e.g., Post-Traumatic Stress Disorder), although a clinically significant eating disorder. In general if a significant eating disorder is posing a medical danger to the individual it will need immediate intervention. Behaviours need to be considered as part of the whole presentation and prioritised in terms of urgency for intervention, along with all other presenting symptoms. If left untreated, secondary diagnosis eating disorders will result in increased risk of physical and mental health complications and prevent successful treatment of the primary diagnosis.

In the case of AN (and often BN), most specialists agree that treatment needs to precede or occur in tandem with treatment for other co-morbid conditions.

## Body Image Disturbance and Body Dissatisfaction

A person's body image is the way in which they perceive their body and appearance. A high level of body image disturbance is a risk factor for eating disorders and a central characteristic of AN, BN, OSFED and USFED.

A person with an eating disorder commonly has a body image that does not match others' perceptions of their body. Often, a person with an eating disorder will perceive that they are overweight, or that certain parts of their body are too fat (often abdomen, buttocks and thighs) despite being normal weight or underweight.

It is important to acknowledge that this is a true feeling, part of the eating disorder and something that can create a great deal of distress for the patient. Dissatisfaction with one's body shape results in a strong desire to change it. Failed attempts (e.g., not losing enough weight, not achieving desired shape) may result in further self-loathing. Many patients with AN tend to have a tremendous sense of dissatisfaction regarding their bodily appearance. This can initially become worse as treatment progresses and weight increases.

# Pharmacotherapy

## Pharmacotherapy

### Key Considerations

- Some patients may present in a malnourished state with medical compromise and have impaired renal, hepatic or cardiac function. Electrolytes may also be abnormal.
- In patients with compromised cardiac function, care should be taken with medications that prolong QTc. Baseline and follow-up ECGs should be undertaken if a medication is used that has been associated with QTc prolongation. Consult a pharmacist or drug monograph for further information on particular medications that prolong QTc interval.
- There is a risk that medications may be purged with food in this population and medication dosing should be tailored to minimize this risk. Generally if purging takes place up to two hours after ingesting medication, the efficacy of medications will be compromised, with particular risk in the first half hour.

### Medications and Anorexia Nervosa

Recent systematic reviews of RCTs and meta-analyses of the pharmacological treatment of AN suggest weak evidence for the use of any psychotropic agents with no evidence that the selective serotonin re-uptake inhibitors (SSRIs) treat the core feature of AN or prevent relapse. Low doses of antipsychotics such as olanzapine or quetiapine may be helpful when patients are severely anxious and demonstrate obsessive eating-related ruminations, but more trials are needed. Caution is required for any psychotropic medication, as physical problems secondary to anorexia nervosa may place individuals at greater risk of adverse side effects.

In the acute stages of AN, comorbid conditions such as anxiety, depression or obsessive-compulsive features may resolve with weight gain alone without the need for consideration of medication. SSRIs may be beneficial in the treatment of comorbid anxiety disorders, depression and obsessive-compulsive disorder in the non-acute stage of AN.

### Medications and Bulimia Nervosa

Selective serotonin re-uptake inhibitors (SSRIs) in combination with psychotherapy (such as CBT) has been shown to have the best outcome in the management of BN though SSRIs on their own have been shown to reduce binge eating episodes and purging in BN. The majority of trials have been conducted with Fluoxetine. While pharmacotherapy may be effective in treating target symptoms of bingeing and purging, few patients achieve remission with pharmacotherapy alone.

## Medications used in Eating Disorders

Medication	Dose	Used in which component of eating disorders	Monitoring (in addition to that outlined in drug monographs, e.g., MIMS)	Comments
<b>SSRIs</b> e.g., Fluoxetine Sertraline <b>Escitalopram</b>	Fluoxetine 20-60mg per day	In AN there is no evidence that the SSRIs treat core symptoms or prevent relapse  In BN there is strong evidence for reduction of frequency of binge eating and purging when given in high dose (40-60mg).	Common side-effects include headaches and nausea though these generally resolve over a number of days to weeks.  May increase anxiety particularly if started at too high a dose. In individuals with suicidal thoughts this may increase the frequency of such thoughts.  In 1-2% of cases may cause hypomania. This risk can be minimised by starting at a low dose and increasing dose judiciously.	Fluoxetine – preferred antidepressant.  May not work in patients who are severely malnourished due to neurotransmitter depletion.  SSRIs may confer extra benefit in patients with concomitant depressive, anxious and obsessive-compulsive symptoms.
<b>Olanzapine</b>	2.5 to 10mg per day	May reduce anxiety and ruminations about weight and shape, compulsive hyperactivity, delusional cognitions and mood lability.	QTc monitoring with baseline and serial ECGs. Low risk – but may be significant in patients with extremely compromised cardiac function.	Consult cardiologist if patient has compromised cardiac function.

# Other management issues

## Absconding from the Ward

Most patients with an eating disorder will be managed in a paediatric ward where there is considerable freedom of movement for both patients and visitors. Despite this, it is rare for patients to abscond. In cases where absconding does happen, the young person tends to remain in close proximity to the ward and generally within the hospital grounds. Absconding is most likely to occur when the patient is not feeling listened to or in an attempt to communicate distress and elicit support. Patients who abscond from the ward should be considered at acute risk and urgent action taken.

### In the event of a patient absconding

- Refer to the hospital policy and alert security, the nurse manager, responsible medical officer, parents and police.
- The decision to physically coerce the patient into returning to the ward is a difficult one – duty of care and the likelihood of imminent danger to the patient may necessitate this but it must be weighed up against the risk of injury to the patient or staff.
- Where a patient is brought back to the ward an assessment needs to be made about the need for the patient to remain in inpatient treatment and the risk of further absconding. If there is a need for ongoing treatment, issues of placement, supervision and involuntary treatment need to be made.

Note: It may not be possible to make paediatric units sufficiently secure for young people at high risk of absconding.

### Prevention

- The patient's room should be in sight of the nurses' station.
- Regularly sight the patient.
- Conduct a daily risk assessment and mental status assessment.
- Be alert to additional stressors and offer extra support at these times. The patient may be unable to effectively problem solve when acutely ill.
- Ensure the family and patient understand and agree with the treatment plan.
- Ensure full handover at the completion of each shift.
- Provide the patient with sufficient diversional activities.

## Indications and Management of Abuse

### How Do I Know if a Child is Being Neglected or Abused?

All children and adolescents are entitled to commitment from adults/carers, provision of need (physical and emotional), and protection from harm. As such any mental health assessment should include assessment of past or current abuse. Such an assessment should be seen as routine. While there is a risk that children and their families may feel accused or confronted by such enquiries, this is most likely when the clinician feels uncomfortable with such questions and least likely when it is presented as a routine part of the history.

There are common physical and behavioural signs of abuse and neglect but the presence of any one of these signs does not necessarily mean that there has been neglect or abuse. Many of these problems occur without any abuse or neglect and are due to other mental health problems. It is important to identify the cause and nature of such problems and to assess other life circumstances. For example, social or geographic isolation of the child or family (including lack of access to extended family), abuse or neglect of a sibling, family history of violence (including domestic violence, physical or mental health issues for the parent or caregiver affecting their ability to care for the child), and the parent or caregiver's abuse of alcohol or other drugs affecting their ability to care for the child.

There are different forms of child abuse. These include neglect, and physical, emotional and sexual abuse.

**Neglect:** Continued failure by a parent or caregiver to provide a child or young person with the basic things needed for proper growth and development (e.g., food, clothing, shelter, medical and dental care, adequate supervision, stimulation). One indication of neglect may be low weight for age (due to inadequate diet provision) but low weight is also an indication of AN – it is important to consider other signs and symptoms and the context in which they occur.

**Physical abuse:** The use of excessive force against a child resulting in either physical injury or psychological distress. It is important to remember that such force is inappropriate regardless of the reason for its use.

**Emotional abuse:** Behaviour by a parent or caregiver that results in significant emotional disturbance or trauma for the young person, e.g., excessive criticism, withholding affection, exposure to domestic violence, teasing or ignoring child, withholding praise and attention, persistent hostility and intimidation or threatening behaviour.

**Sexual abuse:** Involves an adult engaging in any sexual activity with a child or adolescent. Often children are bribed or threatened physically and psychologically to make them participate in the activity.

### What Can I Do

Children and young people have a right to be safe. Protecting children and young people from harm is everyone's business. It is important to discuss your concerns in the team, report concerns to your supervisors and to make a notification to the Department of Family and Community Services about a child or young person's safety or well being, in accordance with NSW Health and child protection policies.

## Legal Issues and Eating Disorders

### Involuntary Treatment of Children and Adolescents with Eating Disorders

The care and management of those with severe eating disorders and the physical complications associated with it is best carried out in specialist eating disorder units, however, there are times when this is not possible or, for individual reasons, the best option. While the use of compulsory treatment in adolescents with eating disorders should be avoided whenever possible, situations will arise in which compulsory treatment may become necessary because of the:

- refusal of medical treatment that is life saving
- refusal of psychological treatment that is life saving

The treating team may need to consider options to enforce treatment if this is the case, irrespective of the inpatient setting (i.e. paediatric ward or gazetted mental health unit)

**The involuntary treatment of a patient with an eating disorder is a serious matter and requires an effective care partnership between paediatric and mental health professionals. Healthcare professionals without specialist experience of eating disorders, or in situations of uncertainty, should seek advice from an appropriate specialist when contemplating a compulsory admission. All effort should be made to ensure high quality assessment and treatment planning, good communication and adherence to appropriate procedure.**

## Parental Consent

In NSW the legal age for medical consent is 14 years. Where children who are refusing treatment are less than 14 years, treatment can be given on the basis of parental consent.

An adolescent, over the age of 14 may also be a voluntary patient in a mental health unit, regardless of parental wishes. This requires agreement by the treating doctors that admission is necessary.

## Child Protection Legislation

In cases of children under 16 years of age where parents are refusing treatment and such refusal is deemed by the treating team to be placing the child at risk, mandatory reporting to the Department of Family and Community Services is required. An Emergency Care order may be sought through the Department to allow appropriate treatment to proceed.

## The Guardianship Tribunal

The Guardianship Tribunal is empowered to consent to treatment or appoint a legal guardian capable of consenting to treatment on behalf of an individual deemed incapable of giving appropriate consent for their own treatment. In reality such orders are generally only applied to individuals over the age of 16 years.

## Use of the Mental Health Act

The NSW Mental Health Act 2007 allows involuntary treatment of an individual with a mental illness who is considered a risk to themselves or others. This requires admission to a gazetted mental health unit. It is imperative that there is adherence to the criteria for involuntary admission, which states that, the patient:

- a) has a mental illness, or is a mentally disordered person, according to the definitions under the Mental Health Act (2007) which refers to the presence of delusions, hallucinations, disturbance of mood and/or thought or sustained or repeated irrational behaviour indicating same);
- b) is at risk of serious harm;
- c) that the condition is continuing or at risk of deterioration; and,
- d) there is no alternative for treatment of a less restrictive nature. The admission must be made by an “authorised medical officer” of a mental health facility, ie. the medical superintendent of the mental health facility, or a medical officer, nominated by the medical superintendent for the purposes of this Act, attached to the mental health facility concerned

Involuntary treatment is only available where voluntary treatment is not successful or the person lacks the capacity to consent to voluntary treatment. Eating Disorders are conditions which lead to an inability to make rational decisions about food intake despite the threat to life.

There is no restriction under the MHA as to what age a child or adolescent may be made an involuntary patient.



Mental Illness is characterised by:

- delusions (eg a fixed idea that s/he is grossly overweight)
- serious disturbance of mood (e.g. lability of mood, esp. if also has depression or anxiety)
- serious disturbance of thought form (thought processes may be illogical from cognitive impact of starvation)
- irrational behaviour indicating one or more of the above (refusing to eat, sabotaging treatment options, exercising obsessively)

Treatment under the Mental Health Act 2007 can include:

- Medication
- Restrictions on movement
- Meal plans and other dietary measures
- CBT and other psychological therapies
- Re-hydration or naso-gastric feeding

### **Can we have a scheduled patient on a paediatric unit?**

Yes, but there are a number of legal issues, which must be considered. Technically speaking, the young person is admitted to a mental health unit and then placed on leave to the paediatric unit, at the direction of the medical superintendent to allow appropriate medical care. All legal procedures must be adhered to, much the same as if the patient is admitted to a declared mental health unit, including their appearance before a Magistrate to issue the Temporary Treatment Order.

## **The Family**

It is imperative that every effort is made to align the family in treatment and to keep them informed of their child's progress and treatment options. This should remain the case even if the patient is under an Emergency Care Order or The Mental Health Act.

## **Survival Strategies for Clinicians**

### **Support and Supervision**

Rural and remote clinicians often work in isolation and it may be difficult to access clinical support and supervision. Add to this that eating disorders can be challenging to manage and the reasons to develop some survival strategies become self-evident. Sometimes the struggle to overcome the illness can leave less experienced clinicians feeling disheartened, sad, angry and exhausted, and may lead to the clinician distancing from the young person and/or the family. Clinicians can also describe the joy of success when a patient begins to regain health and the enormous rewards in terms of learning.

### **Clinical Supervision**

Clinical supervision provides time out, an opportunity in the context of an ongoing professional relationship with an experienced practitioner, to engage in guided reflection on current practice in ways designed to develop and enhance that practice in the future.

It facilitates and provides:

- a safe and supportive environment in which to explore and reflect on practice;
- the opportunity to develop clinical and professional skills to enhance delivery of care to patients;
- assistance in containing the stresses of working within a demanding and complex environment; and,
- a setting in which to explore professional conduct, ethics and personal issues.

## Section 6

# Transition Planning

## Transition from Hospital

Transition planning should commence at the beginning of the admission. Planning will include determining where the young person will be transitioned to and involvement of the community treatment team in transition planning. Factors to consider in readiness for transition include the level of functioning of the young person, the transition environment and follow-up arrangements.

## Current Level of Functioning

Factors to consider:

- Medical status (medical stability)
- Nutritional status (including ability to consume adequate nutrition orally)
- Psychological and behavioural assessment (including psychological safety and disordered eating behaviours)
- Family support

## Follow-Up Arrangements

The discharge summary should outline the following:

- Clinical status on discharge and criteria for readmission
- Identification and liaison with the community treatment team, including their role and frequency of review (e.g., weekly for the first month, then reduce frequency as required). This may include the paediatrician, psychiatrist, GP, psychologist, dietitian and others as required
- Liaison with other support services (e.g., school)
- Relapse prevention strategies

**General practitioner shared care** – a shared care approach may be possible between the GP and local mental health team. This may be especially useful when access to community paediatric care is limited.

## Criteria For Re-Admission

The criteria for readmission should be specified and may include physical and psychological indicators. A readmission weight may be specified.

**Readmission may be required under the following circumstances:**

- Significant medical complications (e.g., bradycardia)
- Acute/severe general psychopathology (e.g., major depressive disorder, obsessive compulsive disorder or substance dependence)
- Failure to respond to community-based care in terms of ongoing weight gain or stabilisation, or other eating disorder symptoms (e.g., binge eating and purging)
- Insufficient social support (e.g., severe family dysfunction or a lack of community-based services)

## Relapse Prevention

Full recovery is a lengthy process and some patients will require several hospital admissions. For those with AN 30 to 50% of patients fully recover within 12 months of treatment and up to 70% at 5 years post-treatment. An estimated 30% of adolescents with AN will require readmission following discharge from hospital, with most relapsing within the first year. Assisting patients to continue their progress after discharge is crucial.

In preparing for discharge, effective strategies may include:

- Ensuring that the young person is linked in with key clinicians in the community for ongoing monitoring and support.
- Regular monitoring of eating disorder pathology, including weight status, post-discharge is essential.
- Identifying impediments to continued recovery.
- Identifying areas that require ongoing focus and developing a discharge plan regarding further treatment. Ongoing treatment post-discharge is necessary to maintain any weight restoration achieved during hospitalisation and to target ongoing problems
- Understanding the warning signs of relapse (e.g., rapid weight loss or gain; the emergence of binge eating or compensatory behaviours; an intensification of food/body preoccupations) and developing a plan for responding to any indications of relapse (including clarifying indications for readmission).

## Involvement of the General Practitioner After a Hospital Admission

The GP's role may be flexible and will depend on the level of expertise, the needs of the patient, the expectations of the team and the GP's availability. The GP may be involved as a sole medical practitioner in the community, as part of a shared care model with community teams and/ or as part of a GP initiated care plan for mental health. The GP should be notified of admission of the young person to hospital and kept informed of treatment progress throughout the admission and be involved in transition planning.

## During Admission

The GP should be kept informed of the progress of treatment and anticipated discharge plan

- For extended admissions the GP should be kept informed on a monthly basis
- The GP may wish to contact the patient or family during the admission where appropriate and within the confines of confidentiality
- If a GP has not been involved prior to admission, the young person and family may nominate a GP to work with post-discharge (preferably contact has already been initiated at admission)
- Prior to discharge ensure planning is in place for follow-up care with the GP for the young person and family. The initial appointment should be in place prior to discharge (for no longer than 1 week post-discharge)
- Timely notification of discharge is of vital importance to the GP

## Post Admission

It is essential that the GP is involved in the management of the young person following discharge

- A person discharged from hospital with an eating disorder should be seeing a GP at least once per fortnight (more often if rapid weight loss is a risk, if engaging in regular purging, or if any medical threat is present)
- Where possible, the GP should work as a part of a multidisciplinary team including at minimum a dietitian, paediatrician and mental health clinician

## Section 7

# Special Considerations

## Diabetes and Eating Disorders

### Be Aware!!

Young people with Type 1 Diabetes Mellitus have an increased risk of eating disorders. Intentional reduction or omission of insulin to achieve weight loss is a common strategy used by young people with diabetes and eating disorders.

Young people with Type 1 Diabetes Mellitus and eating disorders may have associated problems of poor glycaemic control including hyperglycaemia and hypoglycaemia, and an increased risk of diabetic complications.

## Recommendations

Experienced multidisciplinary Diabetes and Mental Health teams should jointly manage young people with Type 1 Diabetes Mellitus in whom eating disorders have been identified.

In practice, inpatient treatment of young people with diabetes and eating disorders should be conducted in consultation with a specialist unit or by a multidisciplinary team in an outreach diabetes centre in close liaison with the appropriate tertiary centre.

## Eating Disorders in the Aboriginal Community

The incidence of eating disorders in the Aboriginal population is unknown. There is a dearth of relevant eating disorders research in Aboriginal populations. In Australia studies of indigenous peoples are confined to adolescent samples and have been focussed on body image disturbance and have had small sample sizes.

The Aboriginal Health Impact Statement along with the NSW Aboriginal Health Plan 2013-2023 define the principles through which health staff should deliver health services to the Aboriginal population. These can be found at the following link:

<http://www.health.nsw.gov.au/aboriginal/Pages/policies-and-documents.aspx>

Eating Disorders treatment, especially for Anorexia often involves the family in monitoring and controlling the meals of the sufferer. The definition of “family” may be broader and far wider than non-Aboriginal communities. Special consideration may need to be given to deliver this component of treatment in Aboriginal families where there may be shared responsibility for children and adolescents.

## Culturally and Linguistically Diverse

Eating disorders appear worldwide and affect people of all nationalities. NSW policies relating to working with people from culturally and linguistically diverse backgrounds should be followed, such as using interpreters when required.

When working with people with eating disorders and their families it is important to understand the cultural attitudes to food that they and their family might hold. This can help to direct treatment. Some therapies may be more difficult through an interpreter, such as family therapy but this does not mean that it cannot be done.

## Appendix 1

# Statewide Services and Contacts

**InsideOut Institute** – which offers online training and resources to health professionals, information on services and support for people with an eating disorder.

admin@insideoutinstitute.org.au  
<https://insideoutinstitute.org.au/>

**NSW Eating Disorder Coordinator** – Eating Disorders specialists appointed in each local health district and specialty network across NSW to offer clinical consultation to health professionals in their area. Find the location of your local coordinator on the InsideOut website <https://insideoutinstitute.org.au/>

**SCHN Eating Disorder Service (The Children’s Hospital at Westmead and Sydney Children’s Hospital, Randwick)** provides specialist inpatient, outpatient and intensive day program services to children and adolescents >16 years of age at first presentation. Clinical consultation and support are available to non-specialist services.

Enquiries can be made through central intake on 02 98452446 or after hours to the Adolescent Medicine Consultant on call 02 9845 0000.

**Westmead Hospital Adolescent Eating Disorder Program (>15 years)** – a specialist inpatient and outpatient program for young people (attending high school), capable of providing comprehensive medical, nursing and limited psychiatric teleconference support to non-specialist teams.

02 88906788 (office hours)  
02 88905555 (after hours)

**Adolescent Medicine at Sydney Children’s Hospital (Child and Adolescent Mental Health Service)** – a specialist service providing inpatient, outpatient and day program services to children aged 16 years and under. Referral should be made via the GP.

02 93824347 (enquiries)  
02 93824347 (appointments)

**The Butterfly Foundation** – an organisation for the support of all people affected by eating disorders.

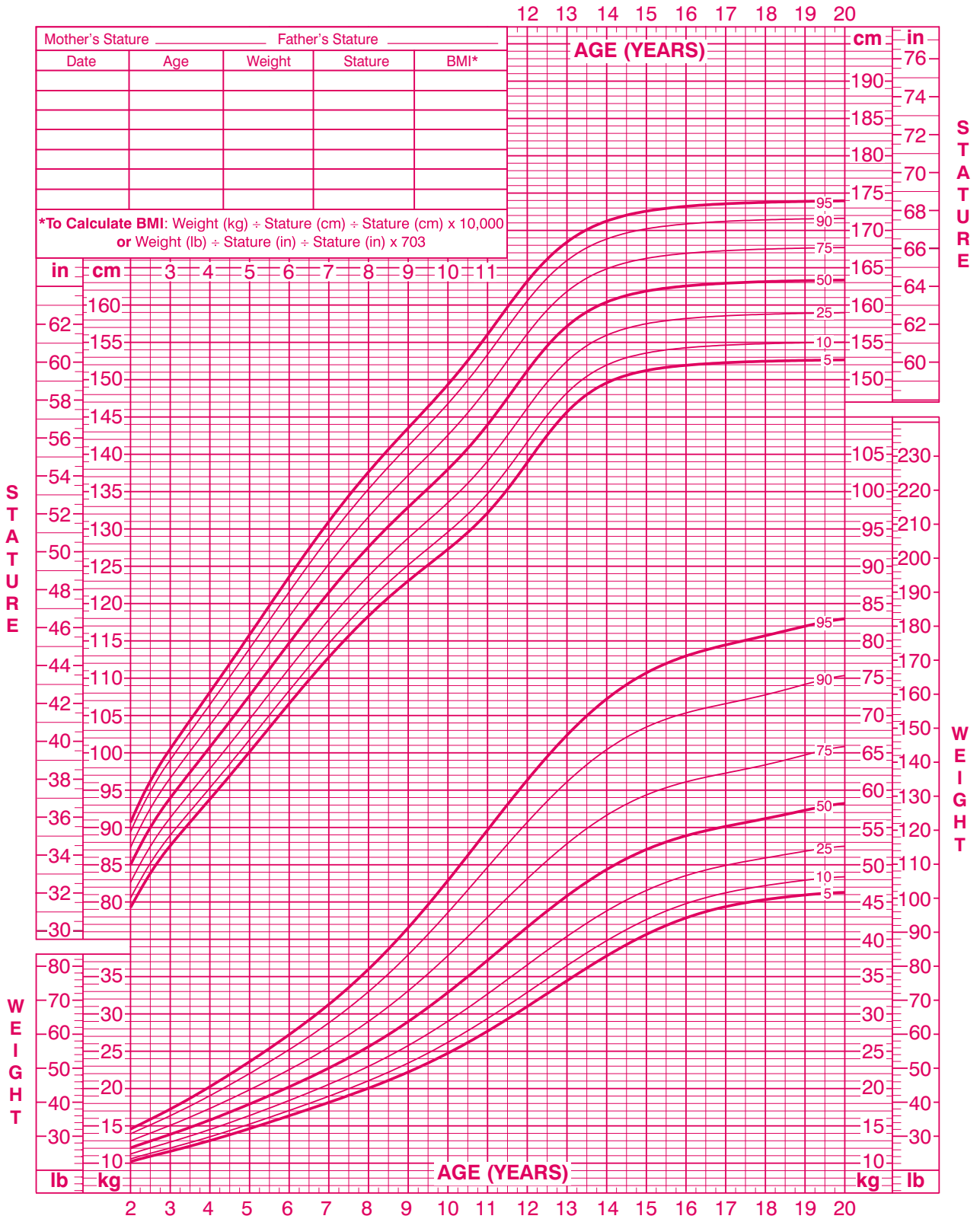
02 9412 4499  
<https://thebutterflyfoundation.org.au/>



# 2 to 20 years: Girls Stature-for-age and Weight-for-age percentiles

NAME \_\_\_\_\_

RECORD # \_\_\_\_\_



Published May 30, 2000 (modified 11/21/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).  
<http://www.cdc.gov/growthcharts>



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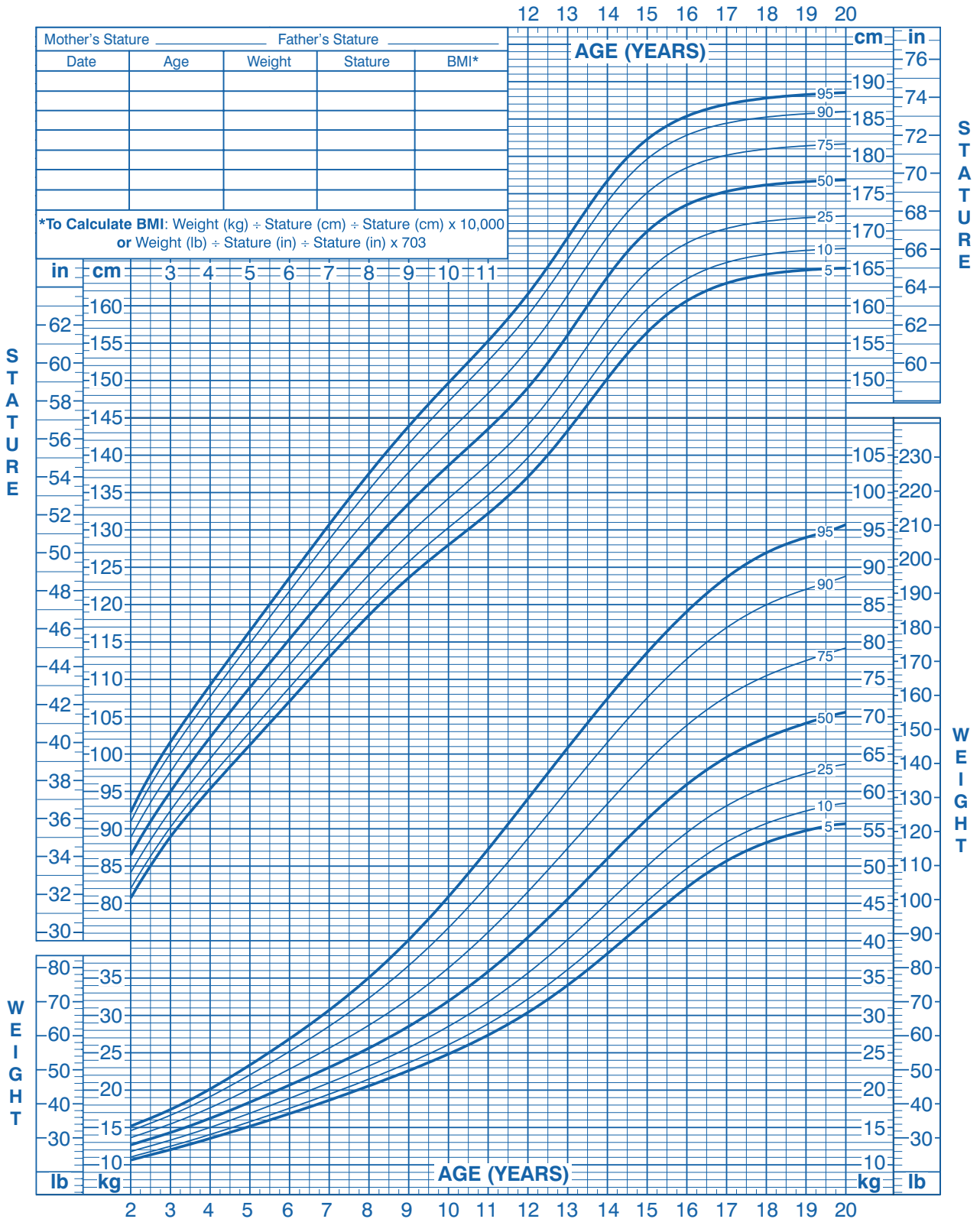




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# Physical Activity: Staged Program Example for Use by a Physiotherapist

**Admission** Assessment by Medical Team  
Medical Status Determined

## Medically Unstable

Leave off ward (if allowed) in wheelchair to conserve energy

## Medically Stable

Stretches in lying and sitting may be performed with supervision

Encourage awareness of breath

Identify patterns of muscle tension (see stretching suggestions page attached)

Leave off ward (if allowed) in wheelchair or at a relaxed walking pace (at medical team's discretion)

## Continued Medical Stability and Weight Gain

Continue supervised stretches

Begin basic core stability

Assist patient to identify muscle tightness | deconditioning as a negative consequence of the eating disorder

Assist patient to view the physical activity plan as an opportunity to help nurture and heal their body

Supervised leave off ward - staff / family to model relaxed walking pace

## Continued Medical Stability and Further Weight Gain

Demonstrated Control of Over-Exercising Behaviours on the Ward

Patient may perform stretches independently on ward

Continue core stability

Upper and lower body strengthening

Games - ball games etc, non-competitive, relaxed and fun!

Exercise education

## Discharge Planning

- Create a physical activity plan in collaboration with the patient and their family to minimise confusion and limit potential arguments and bargaining in the home.
- Type of activity, length of activity and number of opportunities for physical activity per week should be agreed upon.
- Extra energy expenditure due to returning to school should be taken into account.
- Investigating school sport | physical education (PE) is important as the level of intensity or competition may not be appropriate.
- Encourage the family to communicate with PE teachers or coaches.

# Physical Activity: Stretches

Created by: Toolkit Physiotherapy Working Party  
 Stretching suggestions – for use by a Physiotherapist

Jan 22, 2007  
 Routine for Eating Disorders Toolkit

## Knee to neck stretch



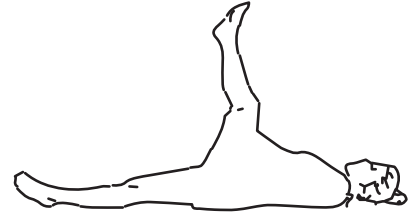
With hands behind the knee, pull knee into chest until a comfortable stretch is felt in lower back and buttocks. Keep back relaxed. Hold for 20 seconds.

## Lumbar rotation stretch



Lie on back with right/left knee drawn toward chest. Slowly bring bent leg across body until stretch is felt in lower back/hip area. Hold for 20 seconds. Stretch both sides.

## Hamstring back of thigh stretch



Supporting the heel behind knee (with hands or holding a towel) slowly straighten knee until stretch is felt in back of thigh. Hold for 20 seconds. Stretch both sides.

## Piriformis stretch



Cross right/left leg over other thigh and place elbow over outside of knee. Gently stretch buttock muscles by pushing bent knee across body. Hold for 20 seconds. Stretch both sides.

## Inner thigh/groin stretch



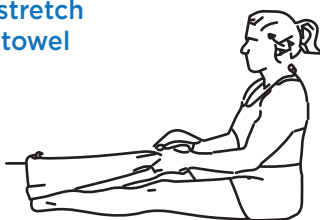
Sitting tall, place heels together and pull feet toward groin until stretch is felt in groin and inner thigh. Gently work the knees downwards to increase the stretch. Hold for 20 seconds.

## Quadriceps/front of thigh stretch



Pull right/left heel in towards buttocks until a comfortable stretch is felt in front of thigh. Hold for 20 seconds. Stretch both sides.

## Calf stretch with towel



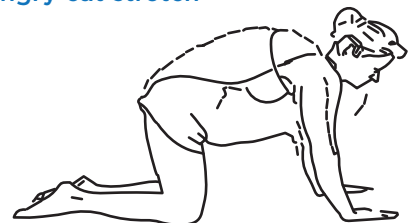
Sit with knee straight and towel looped around right/left foot. Gently pull on towel until stretch is felt in calf. Hold for 20 seconds. Stretch both sides.

## Chest stretch



Lift hands behind back and open out the chest, keeping shoulders low. Slowly raise and straighten arms. Hold for 20 seconds.

## Angry cat stretch



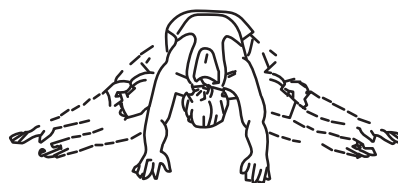
Tuck in chin and tailbone and arch back upwards. Try to move each segment of your spine. Then lift chin and tailbone and dip back downwards. Repeat slowly 5 times.

## Mid back stretch



Sit on heels then fold body forwards, resting chest on your knees and the floor. Reach forwards. Hold for 20 seconds. This should be a very relaxing stretch.

## Mid back and side body stretch



Reach to each side as far as possible, keeping chest low to floor and hips sitting back on heels. Hold for 20 seconds.

## Spinal mobility back stretch



Peel your spine up off the floor by pushing through forearms. Keep shoulders low and open the chest. Hold for 10 seconds. Peel your body back down to the floor, trying to bend each small block of your spine. Repeat 2 times.

## Appendix 5

# Assessment and Screening Tools

Limited data are available on psychometric properties of assessment and screening tools for eating disorders in adolescents. Some measures that can be implemented include:

### Interview:

- EDE 14 years (Fairburn & Cooper, 1993)
- EDE-child version (Bryant-Waugh, Cooper, Taylor & Lask, 1996)

### Self Report:

- Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ) 14 years (Rieger, Touyz & Beumont, 2002)
- Canadian Occupational Performance Measure (COPM), Adolescent leisure interest profile (Law, Baptiste, Carswell, McColl, Polatajko & Pollock, 1999) (designed for use by occupational therapist)
- Children's Eating Attitudes Test (ChEAT; Maloney, McGuire, & Daniels, 1988)
- Kids' Eating Disorder Survey (Childress, Brewerton, Hodges & Jarrell, 1993)

### HEEADSSS (the revised version)

HEEADSSS (Goldenring & Rosen, 2004) is a system for organizing the psychosocial history and has been used in many countries. A series of questions are proposed under each section to facilitate effective history taking.

The HEEADSSS assessment encompasses:

- Home
- Education/employment
- Eating
- peer group
- Activities
- Drugs
- Sexuality
- Suicide/depression
- Safety

## Appendix 6

# Stages of Recovery

In patients with AN particularly, there are certain patterns of behaviour that seem to predominate at certain times.

These patterns occur in three stages (see diagram below, which illustrates recovery over a 12 month period). The y-axis indicates intensity level.

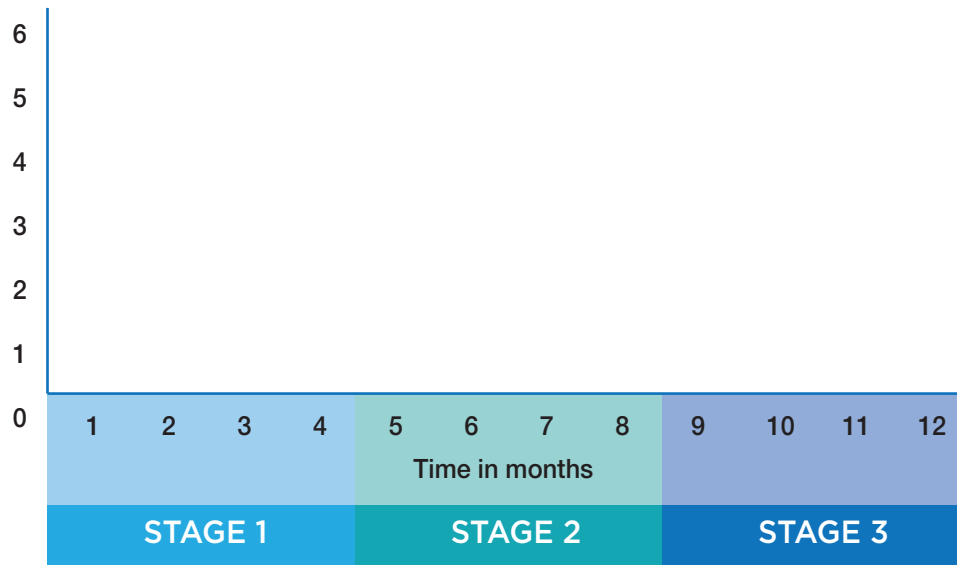


Figure reproduced with permission from Lask, B., & Bryant-Waugh, R. (2007). *Anorexia nervosa and related eating disorders in childhood and adolescence* 3rd ed. London: Brunner-Routledge.

### Stage 1 (Eating problem)

The patient appears to be preoccupied with food intake and weight, almost to the exclusion of other considerations. Typically, the patient is unable to recognise that she has a problem. Some patients may also go through a stage of regression. Once treatment is initiated improvement in eating symptoms allow Stage 2 to occur.

### Stage 2 (Assertiveness)

The patient becomes increasingly assertive and more open in expression of strong, negative feelings. The behaviour might appear uncharacteristic for the individual and lead to significant distress for parents. There may appear to be an absence of concern for the person to whom the behaviours are directed. Some clinicians may feel that the patient is worsening, though this is quite normal and is necessary for progression to the final stage.

### Stage 3 (Age-appropriate expression of feelings)

As Stage 2 behaviour diminishes, this is gradually replaced by more age-appropriate expression of feelings. For example, anger may be directed at the person concerned and within a few minutes the patient may discuss this in a rational, calm manner. The child is well on the way to recovery.

## Appendix 7

# Glossary

Term	Definition
<b>Absconding</b>	Refers to the process of a patient leaving hospital without permission.
<b>Affective Disorders</b>	Otherwise known as the mood disorders, this refers to disorders in which disturbance of mood is the predominant feature (included depressive disorders and bipolar disorders).
<b>Alexithymia</b>	Inability to express feelings with words. Those with alexithymia often have problems with emotional awareness, and the ability to identify, understand or describe their own emotions.
<b>Amenorrhoea (Primary)</b>	Absence of menses by age 14 plus the absence of secondary sex characteristics or the absence of menses by age 16 in the presence of normal pubertal development.
<b>Amenorrhoea (Secondary)</b>	Absence of menses upon a history of menstruating normally.
<b>Anorexia Nervosa</b>	Anorexia Nervosa is characterised by a restriction of oral intake, refusal to maintain or gain weight at a level that is a minimally normal weight, a fear of gaining weight or becoming fat, abnormal body image and amenorrhoea.
<b>Anaemia</b>	General name for a range of disorders affecting red blood cells. Iron-deficiency anaemia is frequently encountered in AN because of an inadequate dietary intake of iron.
<b>Antidepressants</b>	Drugs that treat the symptoms of depression. There are three main types of antidepressant: <ul style="list-style-type: none"> <li>• Selective serotonin re-uptake inhibitors (SSRIs),</li> <li>• Tricyclic antidepressants (TCAs) and related drugs, and</li> <li>• Monoamine oxidase inhibitors (MAOIs).</li> </ul>
<b>Anxiety Disorders</b>	Anxiety disorders are the most common of all the mental health disorders. Specific anxiety disorders are: Generalized Anxiety Disorder, Panic Disorder, Agoraphobia, Social Phobia, Obsessive Compulsive Disorder, Specific Phobia and Post-Traumatic Stress Disorder.
<b>ARFID</b>	Avoidant Restrictive Food Intake
<b>Avoidant Personality Traits</b>	<ul style="list-style-type: none"> <li>• Avoidance of occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection. For children, the <i>DSM-IV</i> reference to occupational activities can apply to school. Children with avoidant personality traits often have marked difficulty with new classes, presentations in front of the class, and less-structured times such as recess or lunch.</li> <li>• Person may be unwilling to get involved with others unless certain of being liked.</li> </ul>
<b>Binge eating disorder</b>	A syndrome in which there are repeated uncontrolled episodes of overeating but no use of compensatory weight-control behaviours.
<b>BMI Centile chart</b>	A chart to link child Centiles of body mass index, weight and height.
<b>Body Mass Index (BMI)</b>	BMI is used as a screening tool for adults to identify those who are underweight or overweight. BMI is an anthropometric index of weight and height. BMI Centile charts must be used for children and adolescents. <b>BMI = weight (kg) ÷ height (m)<sup>2</sup></b>
<b>Bradycardia</b>	Slowness of the heart rate; pulse < 60 beats per minute.
<b>Bulimia Nervosa</b>	Syndrome characterised by recurrent binge eating and inappropriate compensatory behaviour (vomiting, purging, fasting or exercising) occurring at least twice a week for three months. Self-evaluation is based on body shape and weight and there is a subjective feeling of loss of control over eating.
<b>Cognitive Behaviour Therapy (CBT)</b>	An intervention based on the assumption that mood and behaviour is largely determined by the way in which a person thinks about the world. It assists an individual to monitor their thoughts, and recognise the connections between their thoughts, mood and behaviour.
<b>Compulsions</b>	Repetitive purposeful intentional behaviour performed according to rules to neutralise obsessions. These may include washing, checking, ordering, hoarding and avoiding rituals.

Term	Definition
<b>Dependent Personality Traits</b>	Traits that are associated with strong dependency-related needs, such as difficulty in making everyday decisions because of exaggerated fears of being unable to care for himself or herself, going to excessive lengths to obtain nurturance and support from others and a preoccupation with mild criticism or disapproval.
<b>Dialectical Behaviour Therapy (DBT)</b>	Treatment that includes: <ul style="list-style-type: none"> <li>• Mindfulness skills</li> <li>• Distress tolerance</li> <li>• Emotional regulation</li> <li>• Interpersonal effectiveness</li> </ul> This intervention can be effective in the treatment of Borderline Personality Disorder (BPD).
<b>Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)</b>	A system for classification of psychological and psychiatric disorders prepared by the American Psychiatric Association.
<b>Dual-Energy Xray Absorptiometry (DEXA)</b>	A tool used to investigate bone size, density and mineral content. DEXA scanning services for adults are widely available, however, many services do not have the required software with age specific normal ranges to allow for meaningful interpretation in children and adolescents.
<b>Eating disorder not otherwise specified (EDNOS)</b>	Eating disorders that closely resemble AN and BN but are considered atypical, as they do not meet the precise diagnostic criteria for these conditions.
<b>ECG (Electrocardiogram)</b>	A recording of the electrical activity of the heart on a moving strip of paper. The electrocardiogram detects and records the electrical potential of the heart during contraction.
<b>Electrolytes</b>	Electrolytes are substances that become ions in solution and acquire the capacity to conduct electricity. The balance of the electrolytes in our bodies is essential for normal function of cells and organs. Electrolytes are important because they are what cells (especially nerve, heart, muscle) use to maintain voltages across their cell membranes and to carry electrical impulses (nerve impulses, muscle contractions) across themselves and to other cells. Typically, tests for electrolytes measure levels of sodium, potassium, chloride, and bicarbonate in the body.
<b>Emetics</b>	Something that causes emesis or vomiting (e.g., ipecac is an emetic). This is sold over the counter at pharmacies and is intended for use after ingestion of poison.
<b>Externalise</b>	Externalising locates problems, not within individuals, but as a product of culture and history. It is a way of enabling people to realise that they and their problem are not the same thing. For example an externalising question may be “how long has the eating disorder been running your life?”
<b>Glucocorticoids</b>	Type of corticosteroid involved in carbohydrate metabolism that also has anti-inflammatory and immunosuppressive properties. Cortisol (hydrocortisone) is the most important human glucocorticoid. Glucocorticoids are produced naturally by the human body in the adrenal cortex or may be given therapeutically.
<b>Glycaemic index</b>	A method of ranking foods according to their effect on the blood glucose level.
<b>Hypercholesterolemia</b>	An increased blood cholesterol level
<b>Hypercortisolism</b>	Also known as Cushing’s Syndrome, a disease caused by an excess of cortisol production.
<b>Hyperglycaemia</b>	High blood sugar (glucose)
<b>Hyperkalaemia</b>	High serum potassium
<b>Hypernatraemia</b>	High serum sodium
<b>Hypertension</b>	High blood pressure
<b>Hypoglycaemia</b>	Low blood sugar (glucose)
<b>Hypokalaemia</b>	Low serum potassium
<b>Hyponatraemia</b>	Low serum sodium
<b>Hypophosphataemia</b>	Hypophosphatemia is an electrolyte disturbance in which there is an abnormally depleted level of phosphate in the blood. This can be caused when malnourished patients are fed a large amount of carbohydrates which have a high phosphorus demand (refeeding syndrome).

Term	Definition
<b>Hypotension</b>	Low blood pressure
<b>Hypothermia (acute)</b>	Hypothermia is defined as an unintentional drop in core body temperature below 35.5°C. Below this point the body's compensatory mechanisms to conserve heat begin to fail.
<b>Interpersonal therapy (IPT)</b>	<p>IPT was originally proposed as a short-term treatment for depression. It involves three stages:</p> <ul style="list-style-type: none"> <li>• Identification of interpersonal problems that led to the development and maintenance of the problem</li> <li>• Therapeutic contract for working on these interpersonal problems</li> <li>• Addressing issues related to termination</li> </ul>
<b>Lanugo hair</b>	Soft downy hair especially on the back and arms caused by a protective mechanism built-in to the body to help keep a person warm during periods of starvation and malnutrition, and the hormonal imbalances that result.
<b>Leukopenia</b>	Reduced white blood cell count
<b>Metabolic acidosis</b>	A disturbance in the body's acid-base balance: blood pH is low (under 7.35) signifying excessive acidity of the blood.
<b>Metabolic alkalosis</b>	A primary increase in serum bicarbonate (HCO <sub>3</sub> <sup>-</sup> ) concentration. It is a condition of excess base (alkali) in the body fluids. The opposite of excess acid (acidosis).
<b>Mid parental height</b>	<p>A calculation that estimates the expected adult height of an individual based on their parents' heights.</p> <p><b>HOW TO CALCULATE MID PARENTAL HEIGHT</b>            Girls MPH = [(Dad's height - 13) + Mum's height] / 2            Boys MPH = [(Mum's height + 13) + Dad's height] / 2</p>
<b>Motivation: Readiness to change</b>	<p>There are 5 stages of 'readiness to change':</p> <ol style="list-style-type: none"> <li>1. Pre-contemplation: denial of any problem</li> <li>2. Contemplation: acknowledgement of a problem, but not of a need to change</li> <li>3. Preparation: acknowledgement of need to change, but not ready yet</li> <li>4. Action: wants help to change Maintenance: wants help to maintain the changes</li> </ol>
<b>Motivational Enhancement therapy (MET)</b>	A method of therapy that targets denial and resistance to change. Interventions initially seek to ascertain the patient's current state of change and then to treat them at their current level of commitment.
<b>Neutropenia</b>	The number of white blood cells (neutrophils) in the blood is below normal.
<b>NSW Mental Health Act 1990</b>	A law that governs the care and treatment of people in NSW who experience a mental illness or mental disorder.
<b>Obsessive Personality Traits</b>	Obsessions are persistent ideas, thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress (DSM IV).
<b>Oedema</b>	The presence of abnormally large amounts of fluid in the intracellular tissue spaces of the body, usually applied to demonstrable accumulation of excessive fluid in the subcutaneous tissues.
<b>Oligomenorrhoea</b>	Infrequent menstruation with markedly diminished menstrual flow.
<b>Orthostatic change</b>	Orthostatic, tilt or postural vital signs (VS) are serial measurements of blood pressure and pulse that are taken with the patient in the supine, sitting, and standing positions. Results are used to assess possible volume depletion. There is little agreement as to what indicates a significant orthostatic change and what is considered a positive tilt test. The "20-10-20" rule may be used as a guide. The rule refers to the expected decrease in systolic B/P (up to 20 mm Hg), a rise in diastolic B/P of 10 mmHg (millimetres of mercury) and an increase in heart rate by 20 beats per minute.
<b>Osteopaenia</b>	Mild thinning of the bone mass. This is common in people with AN and occurs early in the course of the disease. Girls with AN are less likely to reach their peak bone density and therefore may be at increased risk for osteoporosis and fracture throughout life.
<b>Osteoporosis</b>	Condition in which the bones become less dense, fragile and brittle, leading to a higher risk of fractures (breaks or cracks) than normal bone. Osteoporosis occurs when bones lose minerals such as calcium, and the body cannot replace these minerals fast enough to keep the bones healthy.



Term	Definition
<b>Parasthesia</b>	Sensation of tingling, pricking, or numbness of the skin with no apparent long-term physical effect, more generally known as the feeling of pins and needles. Can be one of the symptoms resulting from starvation.
<b>Peripheral neuropathy</b>	Injury to the nerves that supply sensation to the arms and legs.
<b>Refeeding syndrome</b>	Constellation of metabolic disturbances that occur as a result of reinstatement of nutrition to patients who are starved or severely malnourished. It occurs when previously malnourished patients are fed with high carbohydrate loads. The result may be a rapid fall in phosphate, magnesium and potassium, along with an increasing ECF volume. Can be fatal if not treated.
<b>Reinforcement</b>	When something is reinforced it becomes stronger. In operant or instrumental conditioning one key concept is that reinforcers strengthen behaviour. For example, attempting to make mealtimes relaxed and pleasant may strengthen, or increase, positive eating behaviours.
<b>Russell's Sign</b>	An indication of BN in which abrasions and scars occur on the back of the hands as a result of manual attempts to induce vomiting.
<b>Schedule</b>	Under the NSW Mental Health Act, this refers to the form, Schedule 2 (S21), which is written by a medical practitioner or Accredited Person when it is necessary to admit a person to a psychiatric hospital involuntarily. If a patient is scheduled to hospital s/he will need: <ul style="list-style-type: none"> <li>• Examination within four hours of arrival</li> <li>• A form and explanation of their legal rights</li> <li>• A second examination by a different doctor within 12 hours</li> <li>• If neither mentally ill or disordered they must be discharged</li> <li>• In most cases a second/third examination by a psychiatrist as soon as practicable</li> <li>• A person brought by police and found not mentally ill must be returned to police custody or released within one hour</li> </ul>
<b>Secondary Diagnosis Eating Disorder</b>	The primary reason for admission is for a non-eating disorder diagnosis (e.g., Post-Traumatic Stress Disorder), although a clinically significant eating disorder co-exists.
<b>Serum thyroxine (T4)</b>	Test that measures the amount of T4 in the blood. T4 is the major hormone controlling the basal metabolic rate. This test may be performed as part of an evaluation of thyroid function.
<b>Sinus Bradycardia</b>	Sinus cardiac rhythm with a resting heart rate of 60 beats/minute. The sinus bradycardia rhythm is similar to normal sinus rhythm, except that the RR interval is longer. The symptoms of sinus bradycardia include dyspnea, dizziness, and extreme fatigue.
<b>Socratic Questioning</b>	Teaching by asking rather than telling. The Socratic method has been adapted for psychotherapy, and can be used to clarify meaning, feeling, and consequences, as well as to gradually unfold insight, or explore alternative actions.
<b>Splitting</b>	Clinically, "splitting" refers to the tendency to view people or events as either all good or all bad. It is a way of coping that allows a person to hold opposite, unintegrated views. Splitting may occur within the patient, or between patient and staff, staff and staff, other patients and other staff. Splitting in the simplest sense is playing one person off against another.
<b>Tanner Stages</b>	Measure of an individual's pubertal development is the Tanner staging of puberty, also known as the sexual maturity rating (SMR). The Tanner stages (also known as the Tanner scale) are stages of physical development in children, adolescents and adults, which define physical measurements of development based on external primary and secondary sex characteristics, such as the size of the breasts, genitalia and development of pubic hair.
<b>Therapeutic Alliance</b>	Working with the patient to help overcome the illness. This involves developing an empathic, supportive and trusting relationship with the patient.
<b>Tri-iodothyronine (T3)</b>	T3 is measured as part of a thyroid function evaluation. T3 may be measured in cases in which there is some doubt about whether the patient has hyperthyroidism or hypothyroidism. The thyroid hormones thyroxine (T4) and triiodothyronine (T3) are essential for normal growth and development, and for the regulation of metabolic rates in every cell of the body.
<b>USFED</b>	Unspecified Feeding and Eating Disorders

# Meal Plans

NAME

ORANGE  
MEAL PLAN

Date: \_\_\_\_\_

## Nutrition Management Plan

<b>Breakfast:</b>	2 sl bread or equivalent + marg and spreads <b>OR</b> 1 serve cereal and milk 1 serve dairy 1 serve fruit <b>OR</b> fruit juice (220ml)	(150ml Ensure P) (110ml Ensure P) (50ml Ensure P)
<b>Am Tea:</b>	1 serve fruit 1 bread/equivalent + topping	(50ml Ensure P) (80ml Ensure P)
<b>Lunch:</b>	1 sandwich with egg/ meat/ fish/ cheese/ peanut butter 1 serve dairy May have a glass of water/ cordial if requested (250ml)	(145ml Ensure P) (110ml Ensure P)
<b>Pm Tea:</b>	1 serve dairy	(110ml Ensure P)
<b>Dinner:</b>	1 serve meat/ fish/ chicken/ vegetarian meal 1 serves potato/ rice/ pasta/ chips 1 serve vegetables <b>OR</b> 1 serve salad 1 serve dessert May have a glass of water/ cordial if requested (250ml)	(110ml Ensure P) (70ml Ensure P) (20ml Ensure P) (120ml Ensure P)
<b>Supper:</b>	1 serve dairy	(110ml Ensure P)
<b>Overnight Feed:</b>		

Please see separate information sheets regarding meal time behaviour, menu ordering, appropriate toppings and alternative foods available to order.

NAME

YELLOW  
MEAL PLAN

Date: \_\_\_\_\_

## Nutrition Management Plan

<b>Breakfast:</b>	2 sl bread or equivalent + marg and spreads <b>OR</b> 1 serve cereal and milk 1 serve fruit <b>OR</b> fruit juice (220ml) 1 serve dairy	(150ml Ensure P) (50ml Ensure P) (110ml Ensure P)
<b>Am Tea:</b>	1 serve fruit 1 serve bread/equivalent + topping	(50ml Ensure P) (80ml Ensure P)
<b>Lunch:</b>	1 sandwich with egg/ meat/ fish/ cheese/ peanut butter 1 serve dairy May have a glass of water/ cordial if requested (250ml)	(145ml Ensure P) (110ml Ensure P)
<b>Pm Tea:</b>	1 serve dairy 1 serve bread/equivalent + topping	(110ml Ensure P) (80ml Ensure P)
<b>Dinner:</b>	1 serve meat/ fish/ chicken/ vegetarian meal 2 serves potato/ rice/ pasta/ chips 2 serves vegetables <b>OR</b> 2 serves salad 1 serve dessert May have a glass of water/ cordial if requested (250ml)	(110ml Ensure P) (140ml Ensure P) (20ml Ensure P) (120ml Ensure P)
<b>Supper:</b>	1 serve dairy 1 serve bread/equivalent + topping	(110ml Ensure P) (50ml Ensure P)
<b>Overnight Feed:</b>		

Please see separate information sheets regarding meal time behaviour, menu ordering, appropriate toppings and alternative foods available to order.

NAME

GREEN  
MEAL PLAN

Date: \_\_\_\_\_

## Nutrition Management Plan

<b>Breakfast:</b>	2 sl bread or equivalent + marg and spreads <b>OR</b> 1 serve cereal and milk 1 serve fruit <b>OR</b> fruit juice (220ml) 1 serve dairy	(150ml Ensure P) (50ml Ensure P) (110ml Ensure P)
<b>Am Tea:</b>	1 serve fruit 1 serve bread/equivalent + topping	(50ml Ensure P) (80ml Ensure P)
<b>Lunch:</b>	2 sandwiches with egg/ meat/ fish/ cheese/ peanut butter 1 serve dairy May have a glass of water/ cordial if requested (250ml)	(290ml Ensure P) (110ml Ensure P)
<b>Pm Tea:</b>	1 serve dairy 1 serve bread/equivalent + topping	(110ml Ensure P) (80ml Ensure P)
<b>Dinner:</b>	1 serve meat/ fish/ chicken/ vegetarian meal 2 serves potato/ rice/ pasta/ chips 2 serves vegetables <b>OR</b> 2 serves salad 1 serve dessert 1 fruit juice (220ml)	(110ml Ensure P) (140ml Ensure P) (20ml Ensure P) (120ml Ensure P) (50ml Ensure P)
<b>Supper:</b>	1 serve dairy 1 serve fruit	(110ml Ensure P) (50ml Ensure P)
<b>Overnight Feed:</b>		

Please see separate information sheets regarding meal time behaviour, menu ordering, appropriate toppings and alternative foods available to order.

NAME

BLUE  
MEAL PLAN

Date: \_\_\_\_\_

## Nutrition Management Plan

<b>Breakfast:</b>	2 sl bread or equivalent + marg and spreads <b>OR</b> 1 serve cereal and milk 1 serve fruit <b>OR</b> fruit juice (220ml) 1 serve dairy 1 serve bread/equivalent + topping	(150ml Ensure P) (50ml Ensure P) (110ml Ensure P) (80ml Ensure P)
<b>Am Tea:</b>	1 serve fruit 1 serve dairy 1 serve bread/equivalent + topping	(50ml Ensure P) (110ml Ensure P) (80ml Ensure P)
<b>Lunch:</b>	2 sandwiches with egg/ meat/ fish/ cheese/ peanut butter 1 serve dairy May have a glass of water/ cordial if requested (250ml)	(290ml Ensure P) (110ml Ensure P)
<b>Pm Tea:</b>	1 serve bread/equivalent + topping 1 serve dairy	(80ml Ensure P) (110ml Ensure P)
<b>Dinner:</b>	1 serve meat/ fish/ chicken/ vegetarian meal 2 serves potato/ rice/ pasta/ chips 2 serves vegetables <b>OR</b> 2 serves salad 1 serve dessert 1 fruit juice (220ml)	(110ml Ensure P) (140ml Ensure P) (20ml Ensure P) (120ml Ensure P) (50ml Ensure P)
<b>Supper:</b>	1 serve dairy 1 serve fruit	(110ml Ensure P) (50ml Ensure P)

**Overnight Feed:**

Please see separate information sheets regarding meal time behaviour, menu ordering, appropriate toppings and alternative foods available to order.

NAME

PURPLE  
MEAL PLAN

Date: \_\_\_\_\_

## Nutrition Management Plan

<b>Breakfast:</b>	4 sl bread or equivalent + marg and spreads <b>OR</b> 2 serves cereal and 2 x milk <b>OR</b> 1 serve cereal with milk + 2 sl bread + marg and spreads 1 serve fruit <b>OR</b> fruit juice (220ml) 1 serve dairy	(300ml Ensure P) (300ml Ensure P) (50ml Ensure P) (110ml Ensure P)
<b>Am Tea:</b>	1 serve fruit 1 serve dairy 2 serves bread/equivalent + topping	(50ml Ensure P) (110ml Ensure P) (160ml Ensure P)
<b>Lunch:</b>	2 sandwiches with egg/ meat/ fish/ cheese/ peanut butter 1 serve dairy May have a glass of water/ cordial if requested (250ml)	(290ml Ensure P) (110ml Ensure P)
<b>Pm Tea:</b>	1 serve bread/equivalent + topping 1 serve dairy	(80ml Ensure P) (110ml Ensure P)
<b>Dinner:</b>	1 serve meat/ fish/ chicken/ vegetarian meal 2 serves potato/ rice/ pasta/ chips 2 serves vegetables <b>OR</b> 2 serves salad 1 serve dessert 1 fruit juice (220ml)	(110ml Ensure P) (140ml Ensure P) (20ml Ensure P) (120ml Ensure P) (50ml Ensure P)
<b>Supper:</b>	1 serve dairy 1 serve bread/equivalent + topping 1 serve fruit	(110ml Ensure P) (80ml Ensure P) (50ml Ensure P)

### Overnight Feed:

Please see separate information sheets regarding meal time behaviour, menu ordering, appropriate toppings and alternative foods available to order.

## Appendix 9

# References and Suggested Readings

*The following references have been used in the development of specific sections.*

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