Eating Disorders Toolkit

A Practice-Based Guide to the Inpatient Management of Adolescents with Eating Disorders, with Special Reference to Regional and Rural Areas.
Acknowledgements

The Toolkit development was facilitated by MH-Kids in conjunction with a variety of clinicians and academics throughout NSW, nationally and internationally.

A full list of acknowledgements can be found in Appendix 1.

Eating Disorder Toolkit - A Practice-Based Guide to the Inpatient Management of Adolescents with Eating Disorders, with Special Reference to Regional and Rural Areas

This work is copyright. This document may be reproduced in whole for clinical use, study and training purposes subject to the inclusion of an acknowledgement of the source. It may not be reproduced for commercial usage or sale. Reproduction for purposes other than those indicated above requires written permission from MH-Kids.

Copyright © 2008 MH-Kids, NSW Health.
Locked Bag1, HRMC, NSW 2310. Ph: +61 2 49855830. Fax: +61 2 49855320

First Edition printed by WHO Printing & Presentations. 9 Bryant St, Tighes Hill, NSW 2297. Ph:+61 2 4969 4044. Fax: +61 2 4962 3162

To obtain a further copy please contact the Better Health Centre Publications Warehouse on Ph: 9816 0452.

MH-Kids

HUNTER NEW ENGLAND
NSW HEALTH
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 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 in care for adolescents with eating disorders across NSW.

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

- Involving the family and other health professionals,
- Accessing specialist assistance,
- Identifying those in need of admission,
- Admitting the patient,
- Assessment,
- Treatment planning,
- Implementing treatment (primarily medical, nutritional and psychological aspects),
- Discharge, 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. A clinician who is new to the management of eating disorders may find the Toolkit an invaluable resource of background information essential to the management of adolescents with an eating disorder. 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 has been 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. Due to the limited evidence base and often, conflicting views regarding inpatient management, recommendations should be applied carefully to individual clinical and organisational circumstances and should be followed with care. 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.
# Table of Contents

## Section 1: Introduction to the Toolkit
- Introduction .................................................................................................................. 1
- Aims and Scope of the Toolkit ....................................................................................... 1
- What is an Eating Disorder? ......................................................................................... 2
- How to Use the Toolkit ................................................................................................. 2
- General Principles For All Staff .................................................................................. 3

## Section 2: Getting the Patient to Hospital
- Preadmission Considerations ...................................................................................... 5
- Minimum Levels of Intervention ................................................................................ 8
- Involvement of Specialist Staff .................................................................................... 9

## Section 3: The First 24 Hours in Hospital
- The First 24 Hours – What To Do ............................................................................. 11
- Emergency Department Triage ................................................................................ 12
- Eating Disorders History .......................................................................................... 13
- Determining the Most Appropriate Site for Treatment ............................................ 14
- Management Plan ..................................................................................................... 15
- Admission Flowchart ............................................................................................... 16

## Section 4: Assessment and Treatment Planning
- Assessment of Suspected Eating Disorders ............................................................. 17
- Eating Disorder Assessment ....................................................................................... 18
- Risk Assessment and Management .......................................................................... 21
- Assessing Growth and Determining Healthy Weight Range .................................... 23
- Eating Disorder Clinical Summary ........................................................................... 27
- Formulation of a Treatment Plan .............................................................................. 30
- The Roles of the Multidisciplinary Team Members on the Ward .............................. 32
- Care (Case) Management ......................................................................................... 33
- Discharge From Hospital .......................................................................................... 34
- Involvement of the General Practitioner Before and After a Hospital Admission .... 36

## Section 5: Treatment and Management on the Ward
### Key Considerations For All Clinicians
- Therapeutic Alliance and Engagement .................................................................. 39
- Externalisation ........................................................................................................... 40
- Working with the Family and Carers ....................................................................... 41
- Team Cohesion and Consistency .............................................................................. 43

### Medical and Physical Treatment
- Refeeding Syndrome: Risk Assessment and Management .................................... 47
- Observation and Physical Monitoring .................................................................... 49
- Hypothermia ............................................................................................................. 50
- Amenorrhoea ........................................................................................................... 52
- Osteoporosis and Osteopaenia ................................................................................ 54
- Constipation ............................................................................................................ 57

### Eating, Nutrition and Physical Activity
- Refeeding Guideline ................................................................................................. 61
- Managing Meals and Snacks .................................................................................... 65
- Example Meal Plan .................................................................................................. 68
- Meal Plan Template .................................................................................................. 69
- Providing Nutrition Education .................................................................................. 70
- Bingeing .................................................................................................................... 72
- Purging ....................................................................................................................... 73
- Physical Activity ....................................................................................................... 74
Section 1: Introduction to the Toolkit
INTRODUCTION

This Toolkit offers a resource for health professionals who find themselves caring for adolescents hospitalised with an eating disorder.

If you are a clinician who is new to the management of patients with eating disorders, you will find this Toolkit an invaluable resource of background information and you will benefit from reading it from cover to cover. The Toolkit has been designed to provide user-friendly “pull out” sections that can be easily identified and accessed separately. 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 large 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 Toolkit has been developed for use in public hospitals, including paediatric general and mental health wards, particularly those in regional and rural areas throughout NSW. The target audience has not included private and specialist eating disorder units, although the Toolkit may be helpful in these settings. The Toolkit is relevant for use with adolescents (aged 12 - 18 years) with all clinically significant eating disorders including Anorexia Nervosa (AN), Bulimia Nervosa (BN), Eating Disorders-Not Otherwise Specified (EDNOS), and secondary diagnosis eating disorders. The Toolkit is aimed at medium to longer-term admissions (i.e., longer than 24-48 hours), and is not aimed at brief admissions for medical stabilisation only.

The aim of the Toolkit is to provide a practice-based manual for use by clinicians working with adolescents with eating disorders in inpatient settings, particularly in regional and rural areas. The Toolkit aims to:

- Complement current clinical practice guidelines by providing practical and useful strategies based on the current evidence
- To facilitate consultation with specialist staff
- To provide clarity regarding effective treatment approaches for clinicians
- To improve consistency in practice across NSW

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 healthy mental, physical and social functioning to enable continued treatment in the community.
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-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 2000) outlines three types of disordered eating patterns; AN, BN and EDNOS. 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 amenorrhoea in post-menarchal females. BN is a moderate to severe illness that is predominantly characterised by recurrent episodes on bingeing and purging behaviour. EDNOS 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. EDNOS may be as severe as AN or BN and is believed to be more prevalent. For a more detailed description or further discussion of the less typical eating disorders, please refer to the “Further Information section”.

HOW TO USE THE TOOLKIT

The Toolkit has been produced as a manual with sections that can be easily removed for use on a busy ward. It is envisaged staff will access and implement sections of the Toolkit that are most relevant to their needs or particular patient needs, rather than reading the document from front to back. For example, upon entering the service all Registrars may be familiarised with the specific sections relevant to key medical management. The dietitian should be familiar with sections on nutrition and refeeding. All key clinicians should be familiar with the assessment, treatment planning and discharge planning sections, and so forth.

Sections that would be required more quickly, such as the “Emergency Department Triage Checklist” and “Admission Flowchart” have been located towards the front of the manual to allow easy access. The toolkit has been produced as a generic document, rather than discipline-based, to allow a flow through the patient admission.

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

The following have been identified as key principles for all staff working with adolescents with an eating disorder.

**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. They may need several admissions and will usually require long-term ongoing community care.

**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.

**Minimising Harm**
Minimising harm should be considered for all treatment decisions and interactions with the young person. This includes consideration of physical and psychological harm by either initiating treatment or failing to take action when action is required.

**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.

**Understanding Emotions**
Difficulty in identifying and expressing feelings (alexithymia) can be common in those with eating disorders such as AN and BN. Recognising and working to improve these difficulties are important aspects of care.
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.
- Community-based care is the preferred option for treatment although, at times, more intensive treatment options will be required.
- Inpatient admissions are used when necessary, following other care options.
- 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.
- See “Eating Disorders Assessment” when a more thorough eating disorders assessment is indicated (if commencing treatment).
- Seek assistance when dealing with young people with a suspected or diagnosed eating disorder. See the “Survival Strategies for Clinicians” section for further information.

CONSIDERING THE MOST APPROPRIATE SITE FOR TREATMENT

Factors to Consider When Making a Referral

Nature of the Problem
- Is the presentation predominantly an eating disorder or another mental health issue?
- What are the main aims of treatment?
- 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 at risk of medical instability?
- Is the young person psychologically unsafe (risk of suicide or significant self-harm)?
- Is the severity of the eating disorder increasing over time rather than improving?
- 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, 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).

Health Insurance Status
- If the young person has private health insurance, this may increase the number of services they are able to access.
INDICATIONS FOR HOSPITALISATION

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

- Pulse <50 bpm, >100bpm or >20bpm increase
- Blood pressure <70/40 mm or postural drop >15mmHg
- Temperature < 35.5°C
- Low serum potassium ≤3.0 mmol/L, low serum phosphate or BSL <3.0mmol/L
- Other significant electrolyte imbalances
- Electrocardiogram (ECG) rate <50, prolonged QTc interval
- BMI Centile <5th
- Rapid or consistent weight loss (e.g., > 1kg each week over several 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

Linking in to a hospital admission

When considering a referral to hospital, it is important to discuss the situation with the treating team and the proposed treatment service. Specialist services should be consulted. If urgent medical assistance is required, presentation to the emergency department should be the first contact point.

TREATMENT OPTIONS AND TREATMENT SETTINGS

- Community-based care is the preferred treatment option and should involve establishing a multidisciplinary approach to treatment (including a General practitioner (GP), therapist and dietitian, with involvement of a paediatrician and child and adolescent psychiatrist).
- Specialist consultation should be sought for most cases of AN.
- The role and extent of involvement of each health professional may vary depending on the individual needs of the patient. Ideally, members of the treating team would have experience in treating young people with eating disorders, although such expertise may not be available in your area. In such instances it is recommended that the patient be referred to their GP and local Child and Adolescent Mental Health Service (CAMHS) and local dietitian. If there are no CAMHS clinicians, a referral to the Community Health Child and Family team (along with local GP and dietitian) may be an option.
- For patients with EDNOS and BN, request for consultation will depend on the severity of the illness, availability of specialist services and the experience, interest, skill and time of the clinicians involved.
- Local hospital admissions may be required via the emergency department if the young person is medically or psychologically unwell. Referral to a specialist unit or back to the community may occur following discharge.
- Referral for specialist 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.
INFORMATION REQUIRED WHEN REFERRING

Information required for referral to another service

Nature and extent of the problem
- Health professionals’ perception of the problem and immediate concerns
- Current symptoms present and duration of symptoms
- Current severity of symptoms
- Young person’s perception of the problem

Assessment of safety issues
- Medical safety assessment would include assessing results of blood tests, blood pressure, heart rate, temperature, rate of weight loss (if present), and current BMI/BMI Centile (see “Indications for Hospitalisation”).
- 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

INvolving the young person and family in referral

Important points to consider when referring someone for treatment:
- Be open about why a referral is needed.
- Discuss and describe the service or program the patient is being referred to. Provide written information if available.
- Clarify what may happen after treatment at the service (e.g., care by the community-based treatment team will need to continue after the hospital admission).
- All efforts should be made to ensure that the referral is supported and runs as smoothly as possible.

Consumer information

Consider providing contact details for consumer organisations and support groups to the family and/ or carers:
- Eating Disorders Foundation Inc. (EDF) – Ph: (02) 9412 4499, www.edf.org.au

Consumer transport assistance

Transport for Health (previously ‘Isolated Patients Travel and Accommodation Assistance Scheme’, IPTAAS) provides a range of transport and travel assistance to people who are disadvantaged by distance or who cannot access public and/or private transport. For office contact details or copies of the Transport for Health application visit: http://www.health.nsw.gov.au/living/transport/
MINIMUM LEVELS OF INTERVENTION

Minimum Levels of Intervention

When considering suitability for admission, the following are considered to be the minimum levels of intervention for an 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. Adolescent patients with eating disorders should be admitted to a paediatric adolescent medical ward or a specialist CAMHS unit wherever possible.

5. Weekly care review with the treating team.

6. Staff support and confidence in their ability to treat the patient.

7. Ongoing contact between the treating community team and the inpatient team is essential and must be viable.

Special Considerations: Consultation with a tertiary hospital with eating disorder services should be made for patients with diabetes, cystic fibrosis or those who are pregnant.
IN VOLVEMENT OF SPECIALIST STAFF

Specialist staff (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, management and referral of young people with an eating disorder.

Specialist staff may be of assistance in helping you to:

- Complete an assessment
- Identify risks associated with each individual
- Identify the most appropriate site for treatment (triaging)
- Develop treatment plans tailored to the needs of the individual
- Manage care of patients

Alternatively, specialist services may:

- Provide an assessment of the young person and recommend treatment approaches or strategies
- Provide specialist treatment for the young person

Specialist 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
- A therapeutic environment

WHEN TO ACCESS SPECIALIST ASSISTANCE

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
- When you would like assistance or support in your work

Please refer to the “Resource List” in the back of the manual for Statewide contacts and services
Section 3:
The First 24 Hours in Hospital
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.

<table>
<thead>
<tr>
<th>Assessment / Test Required</th>
<th>Signs Indicating Need For Admission Or Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature</td>
<td>▪ Temperature &lt;35.5°C</td>
</tr>
<tr>
<td></td>
<td>▪ Extremities look cold/blue</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>▪ BP &lt; 70/40mm or postural drop &gt; 15mmHg</td>
</tr>
<tr>
<td>Pulse</td>
<td>▪ HR &lt; 50 bpm, &gt;100bpm or &gt;20bpm ↑ in HR</td>
</tr>
<tr>
<td></td>
<td>▪ Check for regularity as well as rate</td>
</tr>
<tr>
<td>Height, weight, weight history Calculate BMI Centile</td>
<td>▪ BMI Centile &lt;5th</td>
</tr>
<tr>
<td></td>
<td>▪ Rapid weight loss (e.g., &gt; 1kg/week over several weeks)</td>
</tr>
<tr>
<td>Bloods (UEC, FBC, LFTs, magnesium and phosphate)</td>
<td>▪ Low serum potassium (≤3.0mmol/L); low serum phosphate or BSL &lt;3.0mmol/L</td>
</tr>
<tr>
<td></td>
<td>▪ Other significant electrolyte disturbance</td>
</tr>
<tr>
<td>ECG</td>
<td>▪ ECG rate &lt;50; Prolonged QTc interval &gt;450msecs</td>
</tr>
<tr>
<td></td>
<td>▪ Arrhythmia</td>
</tr>
<tr>
<td>Other medical criteria</td>
<td>▪ Moderate-severe dehydration; ceased fluid intake</td>
</tr>
<tr>
<td></td>
<td>▪ Ketosis</td>
</tr>
<tr>
<td></td>
<td>▪ Other physical conditions e.g., pregnancy, diabetes</td>
</tr>
<tr>
<td>Brief history of eating disorder including extent of purging behaviours and past treatment</td>
<td>▪ BN with out of control vomiting</td>
</tr>
<tr>
<td></td>
<td>▪ Vomiting more than 4 times a day</td>
</tr>
<tr>
<td></td>
<td>▪ Weight loss of &gt;1kg/week for four weeks</td>
</tr>
<tr>
<td>Assess psychiatric comorbidity, e.g., depression, OCD, psychosis Risk assessment of suicidality, self-harm and harm to others</td>
<td>▪ Moderate to high suicidal ideation</td>
</tr>
<tr>
<td></td>
<td>▪ Active self-harm</td>
</tr>
<tr>
<td></td>
<td>▪ Moderate to high agitation and distress</td>
</tr>
<tr>
<td></td>
<td>▪ Other psychiatric condition requiring hospitalisation</td>
</tr>
<tr>
<td>Other</td>
<td>▪ Aversive family relationships or severe family stress or strain</td>
</tr>
</tbody>
</table>

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 Area, 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 12-16 years), Ph: 98450000
Westmead Hospital (patients 15-18 years), Ph: 98455555

INDICATIONS FOR COMMUNITY REFERRAL

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 considered for referral to the local CAMHS and local Dietitian. If there are no CAMHS clinicians locally, a referral to the Community Health Child and Family team (along with GP and Dietitian) may be an option. The recommended approach for community care for people with an eating disorder is multidisciplinary coordinated care, including medical, psychological and dietetic health professionals, and others as indicated. A paediatrician should monitor patients who are medically compromised or significantly underweight.
EATING DISORDERS HISTORY

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

Date: ...........................................  Name: ...........................................

Medical History
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

Description of the Eating Disorder
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

Anthropometry

<table>
<thead>
<tr>
<th></th>
<th>Centile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height (cm)</td>
<td></td>
</tr>
<tr>
<td>Weight (kg)</td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td></td>
</tr>
</tbody>
</table>

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

Medications
........................................................................................................................................

Considerations (re Meds): □ Weight Gain □ Weight Loss □ Fluid □ TGs/BGLs □ Other

Weight Controlling Behaviour (frequency, intensity, duration)

<table>
<thead>
<tr>
<th>Dieting/ fasting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vomiting</td>
</tr>
</tbody>
</table>

Exercise

(Type, intensity, duration, frequency)

Substance misuse

(Laxatives, emetics, diuretics, alcohol, cocaine, amphetamines)

Binge Eating Behaviour

<table>
<thead>
<tr>
<th>Frequency of binge eating over past 3 months (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; Once fortnight</td>
</tr>
</tbody>
</table>

Eating Disorders Toolkit – The First 24 Hours in Hospital 13
DETERMINING THE MOST APPROPRIATE SITE FOR TREATMENT

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Recommended Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical instability</strong></td>
<td>Admission to hospital, under the care of a paediatrician or physician for medical stabilisation</td>
</tr>
<tr>
<td>As indicated by any of the parameters outlined in the Emergency Department Triage Form</td>
<td></td>
</tr>
<tr>
<td><strong>Complicated medical comorbidities</strong></td>
<td>If admission is required – transfer to a tertiary paediatric hospital (note pregnant adolescents require admission to a tertiary hospital with obstetric services)</td>
</tr>
<tr>
<td>e.g., Diabetes Mellitus, pregnancy, Cystic Fibrosis</td>
<td></td>
</tr>
<tr>
<td><strong>High psychiatric risk</strong></td>
<td>Transfer to a unit that can provide suitable containment (such as a mental health unit)</td>
</tr>
<tr>
<td>e.g., Suicidal, severe deliberate self-harm</td>
<td></td>
</tr>
<tr>
<td><strong>Long-term or serious eating disorder</strong></td>
<td>Refer to a specialist eating disorder unit/ program</td>
</tr>
<tr>
<td>▪ Not contained by local inpatient or community-based services, OR</td>
<td></td>
</tr>
<tr>
<td>▪ Local services not able to provide adequate or appropriate level of care</td>
<td></td>
</tr>
</tbody>
</table>

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

The following are key points to consider in developing the management plan for the first 24 hours.

1. Conduct base line blood tests (e.g., electrolytes, phosphate, and magnesium).

2. Conduct ECG and monitor 4th hourly observations (temperature, blood pressure, heart rate). Note the critical time for drop in body temperature is between 12-4am.

3. Treat abnormalities (e.g., dehydration).


5. Document risk assessment clearly (i.e., risk of absconding, self harm, suicide, aggression, refeeding syndrome, and cardiac compromise) – review daily thereafter.

6. Full ward restrictions (no leave from the ward) – review daily thereafter.

7. Consultation by paediatrician (and mental health clinician if available) within first 24hours to develop management plan.

8. Provide support to family and carers and involve them in assessment and decision-making regarding treatment.
Need for hospitalisation indicated

Seek specialist consultation

Admit to a paediatric ward (medical or psychiatric) under a paediatrician, physician or psychiatrist, as appropriate.

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

Admit to a service with special expertise in eating disorders.

Discharge home and link in with GP, local CAMHS and a local Dietitian. Monitoring by a paediatrician for those who are medically compromised or significantly underweight is required.
Section 4: Assessment and Treatment Planning
EATING DISORDER ASSESSMENT

KEY POINTS

- Complete a thorough, individualised assessment of the young person and their situation (allowing clear and appropriate decisions about treatment).
- Aim to assess risk (medical and psychological).
- Be patient- and family-centred.
- A comprehensive assessment is generally achieved by involvement of the multidisciplinary team.
- Appropriately trained mental health staff should carry out the majority of the family and individual assessment.
- Questioning should be searching, detailed and sensitive. Aim to validate the young person’s experience and demonstrate that you have heard what has been said by all family members.
- Attempt to gain some understanding of how the young person views their illness and what they feel will help or hinder their recovery.
- 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.
- Involve the patient and family in assessment, treatment and discharge planning.
- Adolescents are still growing and developing. Physical consequences of the eating disorder may be irreversible, though may be treatable if intervention is timely.
- See Appendix 5 for examples of psychometric assessment tools.

THE INDIVIDUAL INTERVIEW

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 THE PRESENTING ILLNESS

1. Patient’s perception of the problem and perceived impact on the patient and the family
2. Duration of illness
3. Description of the eating disorder symptoms (include onset, potential triggers and maintaining factors)
4. Weight controlling behaviours (restricting eating, vomiting, exercise, laxative use, and other substance misuse)
5. Current patterns of eating (including mealtime description, feelings associated with eating and binge eating episodes)
6. Presence of excessive exercise behaviours
7. Premorbid weight and growth
8. Degree of body image distortion; impact of potential weight gain
9. Insight into illness and motivation for change
10. Effects on school (e.g., academic progress, peer and teacher relationships, achievements, difficulties)
PAST AND CO-MORBID PSYCHIATRIC HISTORY

1. Past psychiatric history and treatment
2. Co-morbid conditions (mood and anxiety disorders are common)
3. Other psychological history including neglect, trauma, depression, self-harm, suicidal thoughts and bullying
4. Personality traits (e.g., perfectionism, obsessiveness)

SOCIAL AND FAMILY HISTORY

1. Personal interests (e.g., hobbies, sport, recreations) and strengths
2. History and details of family eating and dieting behaviours
3. Family history (e.g., mental illness)
4. Degree parents are working together consistently to care for the child
5. Relationships between family members
6. General atmosphere of the family (e.g., warmth, tension, closed)
7. Affective responses and communication processes between family members
8. Family strengths and weaknesses
9. Areas for consideration such as cohesion, adaptability, flexibility, hardiness, and problem solving
10. Cooperation, or willingness, of the family to work with the treating team

Note: HEEADSSS assessment is a useful tool in biopsychosocial assessment, although training is required (see Appendix 5).

MEDICAL INFORMATION

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

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 height.** Weigh without heavy clothing or shoes using calibrated scales (ideally those that will be used for future weighs). Measure height using a stadiometer.
- **Calculate BMI (weight kg/height m²).**
- **Chart weight, height and BMI** using age appropriate percentile charts. Include any other available measures to help assess progress. Rapid weight changes even within the normal percentile range can cause severe symptoms.
- **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.
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 (UEC), 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.
RISK ASSESSMENT AND MANAGEMENT

Assessment and management of risk is an ongoing process, not a single event.

DEFINITION OF RISK

Risk is defined as the probability of a negative consequence or the likelihood that a particular adverse event will recur.

Risk assessment enables...
the earliest identification and management of factors that may threaten or adversely affect the safety and well being of the young person with an eating disorder, staff or others.

Risk Management incorporates the following functions:

1. Identification of all potential risk exposures.
2. Rating the nature and severity of the risk.
3. Examination of possible solutions or remedies.
4. Selection of the most appropriate solution or remedy.
5. Implementation of the selected solution.
6. Monitoring of the solution to ensure effectiveness.
7. Reviewing and choosing an alternative solution or changing protocol if first approach not effective or if risk status has changed.

KEY PRINCIPLES

- Early identification facilitates appropriate management.
- Risk assessment is an ongoing process that should be carried out by all staff.
- Risk assessment is one part in the provision of care and should be used to inform the treatment plan as it develops.
- Risk assessment must occur within the context of risk management.
- The overall goal during admission is to provide care, not just to avoid risk.
- Risk assessment and risk management do not remove all risk.
- Risk assessment assumes that the assessment will be acted upon.
OTHER CONSIDERATIONS

- **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.

- Risk management aims to reduce and contain threats whenever possible. Risk assessment and management are based on protection and provision of basic emotional and physical needs in the treatment setting.

- In some cases risk assessment may result in the transfer of a patient to a more secure or appropriate setting.

- Sometimes there is a need for patients at higher risk (e.g., of self harm) to be held in a more secure environment – this is consistent with the 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.

- In anorexia nervosa, although weight and BMI are important indicators, they should not be considered the sole indicators of physical risk.

- 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.

- Whenever possible patients should be engaged and treated before reaching severe emaciation. This requires both early identification and intervention.

- 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.

---

For children & adolescents use BMI Centile charts. See section “Assessing Growth and Determining Healthy Weight Range”.

Eating Disorders Toolkit - Assessment and Treatment Planning 22
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. In some cases referral to a specialist paediatric endocrinologist may be indicated.

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; plotting on growth charts.
- Using growth charts to determine the growth trajectory.
- Calculating BMI and interpreting using BMI-for-age percentile charts.
- Other methods may be used to assess growth but require specialist training and facilities.

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 as accurately as possible, ideally with a stadiometer, on admission and subsequently at three monthly intervals.

OBTAINING PREVIOUS HEIGHT AND WEIGHT MEASUREMENTS

- Plotting and interpreting one-off measurements is not as useful as a series so obtain as many previous height and weight measurements as possible.
- The Personal Health Record or “blue book” can provide useful information on weight and length measurements in infancy and early childhood.
- Check previous medical records and seek previous measures from the parents or GP.
USING GROWTH CHARTS TO DETERMINE GROWTH TRAJECTORY

- The National Health and Medical Research Council (NH&MRC) has recommended that the American Centre for Disease Control (CDC) growth charts be used in Australia. Copies of these charts are included in Appendix 2. For additional charts and information visit www.cdc.gov/growthcharts
- Plot the accurate height and weight measurements on growth charts to obtain a pattern of growth or growth trajectory.

MID PARENTAL HEIGHT

Mid parental height (MPH) is a calculation that estimates the expected adult height of an individual based on their parents’ heights. This measurement may be helpful if there are inadequate data to determine growth trajectory.

HOW TO CALCULATE MID PARENTAL HEIGHT

Girls    MPH = [(Dad’s height – 13) + Mum’s height] / 2
Boys    MPH = [(Mum’s height + 13) + Dad’s height] / 2

For example, if mum is 165cm and dad is 176cm, their daughter’s MPH would be:
MPH = [(176-13)+165]/2 = [163+165]/2 = 328/2 = 164cm

And their son’s MPH would be:
MPH = [(165+13)+176]/2 = [178+176]/2 = 354/2 = 177cm

In our example the expected adult height (or MPH) of 164cm for the daughter is at the 50th percentile (pictured).

It would be expected that this girl’s height would track along the 50th percentile throughout her childhood and adolescence. If it is significantly above or below the 50th percentile, a referral to a paediatrician or paediatric endocrinologist for a more thorough growth assessment is indicated.
BODY MASS INDEX (BMI)

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

‘BMI FOR AGE’ IS USED FOR CHILDREN AND ADOLESCENTS

- Because body composition changes throughout childhood, BMI cannot be interpreted for children and adolescents in the same way as it is for adults. Instead, ‘BMI-for-age’ is used.
- BMI is plotted on gender-specific BMI percentile charts. Copies of the American Centre for Disease Control (CDC) BMI charts are included in Appendix 2. For additional charts and information visit [www.cdc.gov/growthcharts](http://www.cdc.gov/growthcharts)
- The BMI-for-age charts contain a series of curved lines indicating specific percentiles. The following cut-off points have been used to identify underweight and overweight in children and adolescents.

<table>
<thead>
<tr>
<th>BMI-for-age</th>
<th>Percentile Range</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5th percentile</td>
<td>Underweight</td>
<td></td>
</tr>
<tr>
<td>5th percentile to &lt;85th percentile</td>
<td>Normal</td>
<td></td>
</tr>
<tr>
<td>85th percentile to &lt;95th percentile</td>
<td>At Risk of Overweight</td>
<td></td>
</tr>
<tr>
<td>&gt; 95th percentile</td>
<td>Overweight</td>
<td></td>
</tr>
</tbody>
</table>

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.
- It is important to avoid long discussions or negotiations about HWR as this may ‘collude’ with the eating disorder and encourage a focus on weight rather than 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.

Physical recovery is the best indicator of healthy weight; hence HWR will be unique to each individual
APPROXIMATING THE HEALTHY WEIGHT RANGE

- Assess previous growth trajectory and set a HWR. HWR must allow for continued growth along the individual patient’s growth trajectory.
- Using BMI-for age, an estimation of a HWR can be made.
- A normal BMI is 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.
- BMI for 25th and 85th percentiles (ages 12–18) are listed below.

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

Example: a 12yr old girl who is 150cm tall would need to be 37-47kg 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 37-41kg.
# Eating Disorder Clinical Summary

<table>
<thead>
<tr>
<th>Name/MRN</th>
<th>Case Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date</td>
<td>Primary Nurse</td>
</tr>
<tr>
<td>Expected Discharge Date</td>
<td>Consultant</td>
</tr>
<tr>
<td>Carers</td>
<td>General Practitioner</td>
</tr>
</tbody>
</table>

## Diagnoses:

- ...
- ...

## Medical History (Including menstrual history):

- ...
- ...
- ...

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

- ...
- ...
- ...
- ...

## Medications:

- ...
- ...
- ...

## Considerations (re: Meds):

- Weight Gain
- Weight Loss
- Fluid
- TGs/BGLs
- Other

### Height:

<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Width</th>
<th>Height</th>
<th>%ile</th>
</tr>
</thead>
</table>

### Weight:

<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Width</th>
<th>Weight</th>
<th>%ile</th>
</tr>
</thead>
</table>

### BMI:

<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Width</th>
<th>BMI</th>
<th>%ile</th>
</tr>
</thead>
</table>

## Most Recent:

### Temperature

<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
</table>

### Blood Pressure

<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
</table>

### Pulse

<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
</table>

### Bone Densitometry

<table>
<thead>
<tr>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
</table>

### Pelvic Ultrasound

<table>
<thead>
<tr>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
</table>

### ECG - QTc

<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
</table>

## Estimated Nutrition Requirements:

- Energy
- Protein
- Fluid
**Eating Behaviour:**

Description of eating (restrictive patterns, dietary "rules"…)

**Weight Controlling Behaviour (frequency, intensity, duration):**

<table>
<thead>
<tr>
<th>Dieting/ fasting</th>
<th>Vomiting</th>
<th>Exercise (Type, intensity, duration, frequency, solitary, secretive, compulsive)</th>
<th>Substance misuse (Laxatives, emetics, diuretics, alcohol, cocaine, amphetamines)</th>
<th>Other (e.g., spitting food)</th>
</tr>
</thead>
</table>

**Binge Eating Behaviour:**

<table>
<thead>
<tr>
<th>Frequency of binge eating over past 3 months (circle)</th>
<th>&lt; Once fortnight</th>
<th>&lt; Once week</th>
<th>1-5 x week</th>
<th>Once a day</th>
<th>&gt; 2 x day</th>
<th>5-10 x day</th>
<th>&gt; 10 x day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typical times and settings for binge eating</td>
<td>☐ Morning</td>
<td>☐ Middle of Day</td>
<td>☐ Evening</td>
<td>☐ Alone</td>
<td>☐ Planned</td>
<td>☐ At home</td>
<td>☐ Other place</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood before, during and after episodes</td>
<td>Before</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>During</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>After</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Experience loss of control?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Not sure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Attitudes Towards Weight and Shape:**

<table>
<thead>
<tr>
<th>Level of self criticism</th>
<th>Whole body &amp; specific regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceptions of shape</td>
<td></td>
</tr>
<tr>
<td>Frequency of weighing, weight preoccupations and intrusive thoughts, response to weighing</td>
<td></td>
</tr>
<tr>
<td>Perception of others’ attitudes about patient’s weight</td>
<td></td>
</tr>
</tbody>
</table>
Physical Signs and Symptoms Checklist:

<table>
<thead>
<tr>
<th>Signs and Symptoms</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Agitation</td>
<td>Fatigue</td>
</tr>
<tr>
<td>Irritability</td>
<td>Weakness</td>
</tr>
<tr>
<td>Amenorrhoea</td>
<td>Low body weight</td>
</tr>
<tr>
<td>Oligomenorrhoea</td>
<td>Bradycardia</td>
</tr>
<tr>
<td>Constipation</td>
<td>Dental erosion</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>Dry skin</td>
</tr>
<tr>
<td>Abdominal bloating</td>
<td>Yellow/ orange skin</td>
</tr>
<tr>
<td>Cold intolerance</td>
<td>Oedema</td>
</tr>
<tr>
<td></td>
<td>Hair loss</td>
</tr>
<tr>
<td></td>
<td>Hypotension</td>
</tr>
<tr>
<td></td>
<td>Lanugo</td>
</tr>
<tr>
<td></td>
<td>Hypothermia</td>
</tr>
<tr>
<td></td>
<td>“Russell’s sign” (Lesions on dorsum of hand)</td>
</tr>
<tr>
<td></td>
<td>Salivary gland hypertrophy</td>
</tr>
</tbody>
</table>

Date | Na | K⁺ | Cl⁻ | PO₄⁻ | Mg²⁺ | Urea | Cr | Ferr. | B₁₂ | Folate | Bicarb |
|-----|----|----|-----|------|------|------|----|-------|-----|--------|--------|

Biochemistry:

Please note: This form is not approved for official use within the Area Health Service – this is a guide only.
FORMULATION OF A TREATMENT PLAN

KEY PRINCIPLES

- Bring together and make sense of all assessment information to develop a meaningful treatment plan.
- Obtain a detailed understanding of the young person’s presenting problems (i.e., eating disorder).
- Identify variables that are functionally related to these difficulties.
- Define admission goals.

KEY CONSIDERATIONS

Treatment plans should be implemented based upon short, medium or long-term admissions. Treatment plans must be tailored to the needs of each individual and to the diagnosis.

- Therapeutic alliance - developing an empathic, supportive and trusting relationship is crucial in reducing resistance and in facilitating change. This should be considered from the first point of contact with the patient.
- Patients will not leave hospital “cured” of their eating disorder, although they should be “health restored” sufficiently to promote ongoing treatment in the community. It is essential to consider realistic expectations for the admission.
- The focus of admission should not be solely based on weight alone and should consider a holistic approach to the individual.
- A detailed management plan is required including treatment targets and suggested time frames.
- Involve the young person, family and members of the team in the development and implementation of the treatment plan.

Parental input 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 must be recognised.
- 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., in the case of dehydration there can be no negotiation around the amount of fluid given to the young person to rehydrate them.

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. Physical and psychiatric stabilisation
2. Family psychoeducation, support and involvement
3. Weight and health restoration
4. Development of healthy eating behaviours
5. Enhancement of motivation to change
6. Improvement in core maladaptive thoughts, attitudes and feelings about food, weight and body image
7. Treatment of associated psychiatric conditions including depression and anxiety
8. Reduction of compensatory behaviours (e.g., vomiting, laxatives, over-exercise)
9. Facilitation of normal socialisation

Note: The use of harsh and punitive behavioural programs can make the development of a therapeutic alliance with the young person (and their family or carers) extremely difficult. See section titled “Working with the young person” for further information.
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 summarized below (in alphabetical order).

**Care Manager**
- Coordination of care and overall management of admission
- Responsible for ensuring tasks are followed through and completed
- Assist with the smooth transition from admission, to discharge and follow-up

**CAMHS Community Team**
- CAMHS have the potential to provide treatment and may form an integral part of the community shared care team
- The CAMHS team 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
- Motivational enhancement
- Group work

**Dietitian**
- Comprehensive nutrition assessment and ongoing management
- Provision of adequate nutrition to optimise nutritional status and growth
- Establish meal plans and refeeding regimes
- Facilitate the development of healthy eating behaviours
- Provision of nutrition education

**General Practitioner**
- Early detection and establishment of the seriousness of the condition
- Triage and referral to appropriate services
- Ongoing community medical care

**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
- Frequently nursing staff coordinate care for the young person

**Occupational Therapist**
- Assess functioning in self care, productivity (e.g., domestic, educational, vocational needs or skills), rest and leisure with particular emphasis on: initial stabilisation/early recovery and expected post discharge functioning
- Provide individual, group and/or family interventions as required in relation to the above. This may include coordination of a therapeutic (ward) program that also involves multidisciplinary input

**Paediatrician or Physician**
- Must be involved in all admissions due to the potentially serious medical complications
- Medical assessment & ongoing management
- Will usually be the lead clinician

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

**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 indigenous or CALD services, and community groups
- Child protection consultation
- Management of psychosocial complexities

---

Please also refer ‘Team Cohesion’ in section “Treatment on the Ward".
The role of the care manager may vary depending upon the time, experience and background of the health professional, and the agreed role within each treating team. The regular tasks of a care manager also will vary depending on the needs of the patient and family, stage of recovery and focus of treatment. Key roles involve coordinating care, providing overall management and responsibility for ensuring tasks are followed through and completed, and assisting with the smooth transition from admission, to discharge and follow-up.

**COMMON TASKS**

- Before admission (if the care manager is nominated and aware of the admission in advance), informing other staff members of the pending admission.
- Work with the clinical team to establish goals of admission.
- Refer to clinicians, other professionals or groups (e.g., school) as necessary.
- Introduce new care providers to the family.
- Attend weekly ward rounds to discuss the patient’s progress and clarify or modify treatment and discharge plans.
- Communicate with parents/carers (ideally, at least once per week face-to-face and phone calls as necessary) and directly involving other relevant professionals in such meetings.
- Liaise with agencies such as Department of Community Services (DoCS), Department of Ageing, Disability and Home Care (DADHC), Centrelink and Department of Education and Training (DET) where necessary.
- Coordinate appointments for the patient and/or parents with the treating team.
- Coordinate discharge, such as arranging discharge prescriptions and medication supply, writing a discharge summary, informing parents, and ensuring community follow-up appointments are in place.
- Inform the patient and family if you will be away on leave and arranging for another person to care manage in your absence.
- Participate in regular supervision. This will allow the opportunity to debrief and reflect on practice.
- Seek assistance from other clinicians when required. It is important not to exceed your professional knowledge base or boundaries.
DISCHARGE FROM HOSPITAL

Discharge planning should commence at the beginning of the admission and should be a gradual transition process. Planning will include determining indications of discharge readiness, where the young person will be discharged to and involving the community team in discharge planning from early in the admission. Factors to consider in readiness for discharge include the level of functioning of the young person, anticipated progress in the community, the discharge environment and follow-up arrangements.

CURRENT LEVEL OF FUNCTIONING

Factors to consider:
- Medical status (including residual medical problems)
- Nutritional status (including ability to consume adequate nutrition orally)
- Psychological and behavioural assessment (including degree of disordered eating thinking and behaviours)
- Family functioning and management of conflicts

Note: research indicates better outcomes for children discharged at or above a minimum healthy weight, in terms of lower relapse rates and more rapid recovery.

ANTICIPATED PROGRESS IN THE COMMUNITY

A main goal following discharge should be to maintain physical and psychological well being through a sustained, healthy approach to eating and physical activity with ongoing psychological, nutritional, and medical monitoring and support. Potential difficulties post discharge should be outlined in a discharge summary, e.g., distress around returning to school, ongoing family conflict or re-emergence of eating disordered thinking and behaviours.

FOLLOW-UP ARRANGEMENTS

The discharge summary should outline the following:
- Clinical status on discharge and criteria for readmission
- Identification of the community care manager or coordinator (including roles and anticipated frequency of review)
- Identify multidisciplinary team members, their role and frequency of review (e.g., weekly for the first month, then reduce frequency as required). This may include the GP, psychologist, dietitian and others as required
- Liaison with paediatrician, psychiatrist and others (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 through a GP initiated care plan. 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, psychological or social-emotional factors. A readmission weight may be specified.

**Readmission may be required under the following circumstances:**
- 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)
- Significant medical complications (e.g., bradycardia)
- Acute/severe general psychopathology (e.g., major depressive disorder, obsessive compulsive disorder or substance dependence)
- 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, for example, 20% of patients fully recover 5 years after discharge and 70% at 10 years post-discharge. The longer healthy eating behaviours and appropriate weight can be sustained post-discharge, the more likely the patient is to eventually attain full recovery. An estimated 30% of adolescents with AN relapse 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:**
- Summarising the progress made during admission. Since the patient will continue to be symptomatic, it can be easy to lose sight of the gains that have been made (e.g., a greater awareness of the negative aspects of the disorder and a consequent willingness to at least consider recovery). Reviewing progress fosters a sense of accomplishment and increases confidence that change is possible.
- Acknowledging, validating and assisting with strategies to address any negative affect associated with discharge (e.g., anxiety about coping without the structure of the inpatient setting; terminating relationships with certain health professionals).
- Identifying impediments to continued recovery. A significant barrier to ongoing recovery in AN is the high value that patients may place on the anorexia symptoms and hence an ongoing sense of grief and/or failure at their loss (e.g., regretting the loss of their emaciated physique and the sense of control/achievement this provided). (See section on Motivation to Change).
- 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 (e.g., disordered eating, compensatory behaviours, dysfunctional attitudes regarding shape and weight, general psychopathology and relationship dysfunction). (See section on Psychological Interventions).
- 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).
- 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.
INVOLVEMENT OF THE GENERAL PRACTITIONER BEFORE AND 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 kept informed of treatment progress throughout the admission and be involved in discharge planning.

PRE-ADMISSION

- The GP will ideally have engaged with the young person and their family and completed a medical assessment
- The GP should be notified of admission of the young person to hospital

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 2 weeks 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 month (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

OTHER USEFUL INFORMATION

**GP shared care:** A shared care approach may be possible between the GP and local mental health team through a GP initiated care plan. This may be especially useful when access to community paediatric care is limited.

**GP Package:** “Treating Adults and Adolescents with Eating Disorders – A General Practitioners Guide” (Hunter New England AHS, NSW Health, 2007) is available from the Centre For Psychotherapy, Newcastle (Ph: 02 49246820).
ASSESSMENT OF SUSPECTED EATING DISORDERS

AT RISK GROUPS

In psychiatric populations, a screen for eating disorder pathology should form part of the standard assessment. An individual's risk may increase if they are:

- Female
- Aged 12 to 20
- An elite athlete, sportsperson or dancer
- On a restrictive diet for medical reasons
- A member of a family with a history of eating disorders
- Sufferers of sexual abuse and trauma

WARNING SIGNS

- Dieting behaviours (especially when kept private)
- Extreme dieting (fasting) or disordered eating habits
- Skipping meals
- Purging (such as vomiting or use of laxatives) or signs of purging (enlarged parotid glands, calluses on knuckles, cracked/split lips)
- Frequent bathroom visits especially after meals
- Excessive exercise behaviours (especially when solitary or secretive)
- Body dissatisfaction
- Weight loss or failure to reach expected gains

ASSESSMENT PARAMETERS

Weight and calculation of BMI centile
If eating disorder pathology is suspected it is essential to weigh the patient, measure their height and calculate a BMI centile. 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.

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.

Blood chemistry and ECG as required

---

1 See section titled “Assessing Growth and Determining Healthy Weight Range” for more information.
Section 5:
Treatment and Management on the Ward
Key Considerations For All Clinicians
Engagement refers to the process of forming an 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 an interest in their real issues, 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).

- 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 ALLIANCE 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
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.

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?”
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 should prevent the patient receiving conflicting messages regarding treatment and minimise 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 walk, spending time with siblings, playing with a family pet 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 Area Health Service 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.
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 leave”

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 will also be of assistance.
Medical and Physical Treatment
REFEEDING SYNDROME: RISK ASSESSMENT AND MANAGEMENT

Although rare, refeeding syndrome is a potential complication of refeeding and may be fatal. Any patient requiring intensive refeeding will be at risk of refeeding syndrome and should be managed accordingly.

WHAT IS REFEEDING SYNDROME?

Refeeding syndrome arises when severe electrolyte and fluid shifts associated with metabolic abnormalities occur with refeeding. Cardiac arrest and sudden death may result. This generally occurs within the first two weeks of refeeding and may occur regardless of the route of feeding (oral or enteral). The specific mechanisms behind refeeding syndrome remain unclear.

Clinical signs of refeeding syndrome may include:
- Acute cardiac failure
- Seizures
- Delirium
- Sudden death
- Arrhythmia

ASSESSMENT: IDENTIFYING PATIENTS AT RISK

Risk factors for refeeding syndrome may include the following:
- Patients requiring intensive refeeding
- Those with no oral nutrition for 7-10 days
- Patients who are severely underweight (BMI ≤14)
- Abnormal electrolytes before refeeding (phosphate, potassium and magnesium)
- Prolonged QTc interval on ECG
- Prolonged malnutrition or rapid weight loss whether underweight, overweight or a healthy weight (e.g., >1kg per week over several weeks)

PREVENTION OF REFEEDING SYNDROME

The following may assist in preventing the occurrence of refeeding syndrome:
- Check electrolytes and correct abnormalities before commencing refeeding
- Monitor electrolytes during refeeding
- Commence vitamin and mineral supplementation in those at risk as follows:

<table>
<thead>
<tr>
<th>Vitamin/Mineral</th>
<th>Recommended Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thiamine (if not covered by multivitamin)</td>
<td>100mg daily</td>
</tr>
<tr>
<td>Multivitamin and Mineral</td>
<td>RDI levels</td>
</tr>
<tr>
<td>Phosphate</td>
<td>1000mg daily</td>
</tr>
</tbody>
</table>

- Limit high carbohydrate fluid (soft drink, fruit juices, cordials) and nutrient-dense foods
- Commence refeeding incrementally
- For those indicated at risk of refeeding syndrome, caloric intake should be restricted and spread throughout the day to minimise excessive nutritional load. As tolerated, feeds may then be increased by gradual amounts. It may take up to 7-10 days to reach a final feeding regime.
MONITORING DURING REFEEDING

The principal biochemical hallmark of refeeding syndrome is severe, acute hypophosphataemia which usually occurs within 3–4 days of refeeding, although it may occur during the first two weeks. This may be associated with hypokalaemia, hypomagnesaemia, hypoglycaemia, sodium and fluid retention, and thiamine deficiency.

The following tests are recommended for monitoring the risk of refeeding syndrome:

<table>
<thead>
<tr>
<th>Test</th>
<th>Days 1-14</th>
<th>Days 14+</th>
<th>After Supplements Ceased</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrolytes (including phosphate and magnesium)</td>
<td>Daily</td>
<td>Weekly</td>
<td>Once Weekly</td>
</tr>
<tr>
<td>Blood Glucose</td>
<td>Daily</td>
<td>Weekly</td>
<td>Once Weekly</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>4th Hourly</td>
<td>Daily</td>
<td>Daily</td>
</tr>
<tr>
<td>Pulse</td>
<td>4th Hourly</td>
<td>Daily</td>
<td>Daily</td>
</tr>
<tr>
<td>Temperature</td>
<td>4th Hourly</td>
<td>Daily</td>
<td>Daily</td>
</tr>
<tr>
<td>Respiratory Rate</td>
<td>4th Hourly</td>
<td>Daily</td>
<td>Daily</td>
</tr>
<tr>
<td>Signs of Fluid Overload and Oedema</td>
<td>Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signs of Deterioration of Strength or Mental State</td>
<td>Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ECG (if other cardiac indicators abnormal)</td>
<td>Weekly</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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), urgent medical consultation should be requested. 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 every 24 hours
- Gradually increase feeds when electrolytes are stable

If serum levels fall below the normal range:
- **REDUCE FEEDS**
- Commence daily ECG monitoring
- Correct electrolyte levels with supplementation
- Recheck electrolytes every 24 hours
- Increase feeds gradually when electrolytes are stable
OBSERVATION AND PHYSICAL MONITORING

Medical monitoring during refeeding is essential.

1. Assess vital signs, fluid input, output, electrolytes (including phosphate) and observation for oedema, rapid weight gain, congestive cardiac failure (CCF) and gastrointestinal symptoms.
2. A familiar nurse should weigh the patient at approximately the same time of day. 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.

* Counting an accurate pulse rate may be more difficult than is commonly recognised. A 15-sec count time is the least accurate way of measuring pulse rate. A 60-sec count is probably the most accurate and efficient measure.

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

ACUTE & 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.

- Hypothermia as a result of chronic malnutrition (e.g., in the case of AN) should be treated early.

- Anecdotal evidence suggests that it is most unlikely that a patient with an eating disorder will experience a core body temperature below 33°C, purely as a manifestation of the disorder. However, such a low temperature would be life threatening in chronic hypothermia (AN).

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

1. The malnourished body is less able to generate heat (thermogenesis) due to depleted energy stores.

2. A depleted energy supply, combined with chronic malnutrition, disables the body’s natural heat generating mechanism – shivering.

3. A diminished subcutaneous fat supply accelerates heat loss.

4. Sufferers of eating disorders may purposefully make themselves cold in order to increase caloric expenditure. Strategies used may include wearing very light clothing, which is inappropriate to the climate, and taking cold showers or baths.

5. 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.

6. 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°C.
- Low-reading rectal thermometers are available, however, tympanic thermometers are used frequently in research and will most likely measure temperatures accurately at 35°C.

**Where to measure**
- Oral
- Tympanic
- Rectal
- Axillary

**How to Measure**
- Use more than 1 site to measure temperature
- Be consistent with methods used (same thermometer, same sites)
- Measure bilaterally (e.g., left and right ears)

**Which Reading to Take**
- Always record the lowest reading measured

MANAGEMENT OF HYPOTHERMIA ON THE WARD

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

**Core body temperature >35.5°C – 36.5°C**
(Mild chronic hypothermia)
- Contact medical officer for assessment
- Use passive external warming
  - Movement to a warm environment
  - Wrap patient in pre-warmed blankets
  - Give the patient a warm hat
- If not effective use minimally invasive active core rewarming:
  - External rewarming (Bair Hugger)
  - Use heating lamps ('infant warmers') around the bed
- Monitor closely for changes

**Core body temperature <35.5°C**
(Moderate – severe hypothermia)
- Contact medical officer for URGENT assessment
- Use passive & active rewarming
  - Movement to a warm environment
  - Wrap patient in warm blankets
  - Give the patient a warm hat
  - External rewarming (Bair Hugger)
  - Use heating lamps ('infant warmers') around the bed
- Monitor closely for changes

**iv** Also refer to section “Observations and Physical Monitoring”
AMENORRHOEA

- Amenorrhoea is a symptom and one of the diagnostic features of AN.
- Amenorrhoea in AN is due to hypothalamic mediated hypogonadotrophic 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

The 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.

Secondary Amenorrhoea

The absence of menses upon a history of menstruating normally. Females who have not menstruated for 3 months should be evaluated to determine the cause.

- Persistence of amenorrhoea > 6 months 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. There is individual variation in the weight required for resolution of hypogonadism and resumption of menses.
- A weight gain to at least 90% of Ideal Body Weight (IBW- the 50th Centile for height and age) is associated with resumption of menses in about 90 percent of patients within 6 months. Some patients will achieve normal gonadal function at a lower weight. Patients who engage in intensive exercise and/or ongoing disordered eating behaviour may need to maintain a higher weight for recovery.
- Generally, >22% body fat is required for regular menstrual cycles. A drop of 10-15% weight from an ideal body weight will result in a drop below 22% body fat and likely abnormal menstrual function.
- Patients may be monitored by measuring FSH, LH and oestradiol and/or pelvic ultrasound for objective evidence of recovery.
- In children who are pre-menarchal, progression of pubertal breast and genital development, as well as normal growth, indicate functional recovery. The presence of pubic or axillary hair alone may reflect adrenal function and is not a reliable indicator of gonadal function.
- Polycystic ovary syndrome is a common cause of irregular or absent menses in adolescents and young women and can co-occur with an eating disorder. In amenorrhoea secondary to polycystic ovary syndrome alone, oestradiol and FSH is usually normal and LH may be normal or elevated with an LH:FSH ratio > 2:1. Note that ultrasound features of polycystic ovaries is often absent, especially in young patients and is not required for the diagnosis.
Management Plan

A. Obtain a detailed medical history to help rule out other causes of amenorrhea, including pregnancy

B. Investigations - FSH, LH and oestradiol levels. Pelvic ultrasound may show prepubertal appearing ovaries and uterus

C. Other investigations may be indicated where there are other features suggesting possible dual pathology (e.g., chromosomes to exclude Turner's syndrome in short stature, other endocrine causes in patients with apparent healthy weight or normal sex hormone levels)

D. Facilitate weight gain towards a healthy target weight

E. Facilitate normal healthy eating behaviours

F. Monitor for normalisation of biochemistry, menstrual function, growth and pubertal development

G. Note that prescription of an Oral Contraception Pill (other than for contraception) to mimic ‘normal’ menstruation is NOT indicated. See section on Osteopaenia / Osteoporosis
Decreased bone density and strength is a common complication of eating disorders. In adolescents, eating disorders may interfere with peak bone mass acquisition leading to low peak bone mass and/or early loss of peak bone mass. Normal bone mass acquisition accelerates during puberty and is largely complete by the end of puberty. Failure to achieve normal peak bone mass or early loss of bone mass may lead to premature development of osteoporosis in later adulthood or, if severe may be associated with osteoporosis and fractures by early adulthood. Normally most of the variation in peak bone mass between individuals is determined by genetic factors. Individuals with lower base-line bone mass acquisition potential will be at particular risk of osteoporosis.

Factors related to reduced bone mineral density and the development of osteopaenia and osteoporosis may include:

- Decreased muscle mass
- Severity of malnutrition (dietary deficiency)
- Length of illness
- Earlier age of onset (delayed or arrested puberty)
- Duration of amenorrhoea
- Low oestrogen (or testosterone in males)
- Low IGF-1 (despite normal or elevated growth hormone)
- Hypercorticolism
- Laxative misuse
- Acid-base imbalance
- Inadequate calcium and vitamin D intake

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). In boys or in girls who are pre-menarchal, pubertal arrest, regression or slowed growth should prompt assessment of gonadotrophin/sex steroid status as well as measurement of IGF-1 and cortisol levels to assess for risk.

Where available, investigation of osteoporosis and osteopaenia should be considered for all patients who have been amenorrhoeic for 6 months or more and annually thereafter, or unless otherwise clinically indicated. Dual-Energy X-ray Absorptiometry (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.
**DIAGNOSIS OF OSTEOPOROSIS & OSTEOPAENIA**

**Methods**

- Tools that can be used to investigate bone size, density and mineral content include DEXA, Quantitative Computerised Tomography (QCT) and Quantitative Ultrasound. At present there is limited normative data for adolescent bones with QCT and ultrasound. Normal ranges are better established with DEXA. However, with small bone size or delayed bone maturity DEXA can give erroneously low bone mineral density results.
- DEXA is the usual tool for assessing and monitoring bone mineral density. Results are expressed as bone mineral content (BMC) in grams per cross-sectional area of bone (g/cm²).
- Interpretation of DEXA results should include consideration of size (patient height) and maturation (bone age).
- For use in adolescent patients, results must be stated relative to age specific norms (z-score, standard deviation from the mean). T-score results usually relate bone density relative to adult norms and are not appropriate in adolescents.

**DIAGNOSTIC CRITERIA**

**Osteopaenia**
1-2 standard deviations (z-score) below the mean bone mineral density for age and gender.

**Osteoporosis**
>2 standard deviations (z-score) below the mean bone mineral density for age and gender.

**OSTEOPOROSIS & 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.
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. Continue to increase weight until resumption of normal growth and sex hormone function (usually indicated by return of menses, growth and pubertal progression). Investigation results should show oestradiol (testosterone in males), IGF-1 and cortisol levels in the normal range for age or expected stage of puberty.
5. Foods containing calcium and vitamin D should be encouraged. Supplement intake of calcium if the patient is unable to meet the Nutrient Reference Values (NRVs) orally. If the patient is ward-bound for an extended period a vitamin D supplement should also be provided (see below for NRVs).
6. Whole body bone density scan (DEXA) for patients with AN with 6 month history of amenorrhoea; annually thereafter, unless otherwise indicated.

7. The use of HRT to minimise bone demineralisation, might be considered in patients with prolonged secondary amenorrhoea, otherwise this would be discouraged.

8. 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.

9. If osteopaenia 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. Refer to exercise guidelines.

### Nutrient Reference Values for Calcium and Vitamin D

<table>
<thead>
<tr>
<th>Nutrient</th>
<th>Males and females 12-18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium</td>
<td>1300mg</td>
</tr>
<tr>
<td>Recommended Dietary Intake</td>
<td></td>
</tr>
<tr>
<td>Vitamin D</td>
<td>5.0μg (determined by exposure to UV light)</td>
</tr>
<tr>
<td>Adequate Intake</td>
<td></td>
</tr>
</tbody>
</table>

### Use of Hormone Replacement Therapy (HRT)

There is general concern that use of HRT may cause premature epiphyseal fusion and growth retardation in adolescents. HRT may also have a secondary effect of reducing a patient’s motivation to become well.
CONSTIPATION

Constipation can be defined as the presence of symptoms such as discomfort, abdominal pain, rectal pain and hard stools. It is important to note that individuals vary in this regard and in what is a ‘normal’ occurrence of bowel movements per week.

CAUSES OF CONSTIPATION

Constipation often occurs in adolescents suffering from eating disorders due to:

- Decreased food and fluid intake
- Decreased fibre intake
- Lack of exercise
- Laxative abuse
- Some medications
- Weakness of the smooth muscle of the bowel
- Potassium and magnesium deficiencies
- Ignoring the urge to have a bowel movement
- Some medications

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.

Assess and treat the reasons for constipation

If bowel NOT impacted or blocked

If bowel impacted or blocked clear with enema

Work towards normalising diet

In consultation with the patient:

- Reintroduce regular meals. Small, frequent meals may be better tolerated.
- Gradually increase fibre intake. If the patient is receiving nasogastric feeds, use a fibre-containing feed.
- Encourage fluid intake (minimum 2L/day; boys may require up to 2.7L/day).

Encourage light physical activity

- Daily physical activity will help to stimulate peristalsis. The amount and intensity of exercise must be agreed by the team and balanced against the need to conserve energy if weight gain is a goal.
- With the introduction of exercise, the Dietitian should be consulted to determine additional nutrition requirements.

If constipation does not resolve, use a hydrophilic bulk-forming agent.
Eating, Nutrition and Physical Activity
Refeeding is indicated only when there is evidence of nutritional deficiency, e.g., if the patient is significantly underweight or there is evidence of metabolic changes associated with malnutrition. The primary aim of refeeding is to alleviate the short and long term physical and psychological sequelae of malnutrition. Refeeding should be directed by a medical practitioner and facilitated by a qualified dietitian.

**KEY POINTS FOR ASSESSMENT**

- Conduct a thorough patient assessment (including recent diet, menstrual and weight history).
- Assess the risk of refeeding syndrome. If risk is indicated, follow the “Refeeding Syndrome: Risk Assessment and Management” section.
- It is essential, particularly in children and adolescents, that a dietitian determines the appropriate nutrition requirements for refeeding.
- Thorough medical assessment and monitoring is essential prior to and during refeeding. Electrolytes and cardiac status must also be monitored.

**REFEEDING OPTIONS**

**Preferred options for refeeding include:**
1. Oral intake (normal food and fluids)
2. Use of oral supplements
3. Nasogastric feeding

Oral intake should be encouraged as the preferred refeeding option. If the patient is medically unstable, however, naso-gastric feeding would be preferred.

Providing choice around refeeding may reinforce the message of variety and flexibility in eating and may enhance adherence to the nutrition plan. Choice around the process of refeeding should be provided for patients not at risk of refeeding syndrome. Time will need to be allocated to talk through the choices available and for providing the opportunity to consume foods and fluids orally.

**Examples of providing choice may include:**
- Drinking more supplements, consuming more energy-dense foods or having larger portions of food at mealtimes.
- Consuming food and fluid orally with the assistance of a menu plan, use of oral nutritional supplements or naso-gastric feeding.

Key points when considering choice include the following:
- It may not be practical to provide choice for extremely medically compromised or severely 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.
- 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.
- If the patient becomes increasingly anxious in the face of choice, the number of choices and the negotiations offered may need to be reduced.
ORAL REFEEDING

Key points to consider for oral refeeding include the following:

- The main aim of intervention should be to establish regular and appropriate meals and snacks to allow for nutritional rehabilitation (without compensatory behaviours).
- The amount, type and timing of meals and snacks to be consumed should be facilitated by a dietitian.
- Meal and snack choices should be appropriate in type and quantity for normal eating, and higher energy choices can be added to allow for weight gain. Once acceptable growth has been achieved, higher energy choices can be reduced.
- The nutrition plan should work towards achieving a healthy, balanced, nutritionally adequate daily intake. Oral intake should progress to meeting minimum daily requirements within food groups, with flexibility and variety.
- Meals and snacks should be spread throughout the day.
- Small goals should be set and gradually built upon (e.g., commence with ¼ meal at each meal). It may take up to two weeks for patients to be able to eat full meals and snacks.
- Adequate post-meal support is essential (see section titled “Meals and Snacks”).

ORAL SUPPLEMENTS

Medical nutrition supplements (e.g., tetra packs or puddings) may be a useful and acceptable solution for patients with high nutritional needs. This may be an easier alternative to increased oral intake, and may be less invasive than naso-gastric feeding. Supplements may also be offered in place of naso-gastric feeds as a way of encouraging improved oral intake and reduced reliance on enteral feeds. The use of oral nutritional supplements is not considered normal, healthy eating and should be considered as a short-term option only.

NASO-GASTRIC FEEDING

Naso-gastric feeding should be considered as a short-term intervention only. This may be used initially as the predominant source of nutrition and should be tapered off as oral nutrition improves.

The following should be considered when commencing naso-gastric 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.
- The use of nutrient dense feeds are not recommended in the early stages of re-feeding a patient who is at risk of re-feeding syndrome. 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. High fibre feeds may be preferable in those with constipation or abdominal discomfort.
- There are various ways to administer feeds including continuous, overnight or bolus feeds. The mode is flexible according to the individual needs of each patient.
- Feeds are usually started at a low rate and continued through the day (continuous feeds). This will reduce the nutritional load and allow for physical and psychological adjustment to increased nutritional intake.
Once patients are tolerating an adequate amount of feed, feeding may become intermittent (e.g., overnight) or may progress to bolus feeding (administering a particular volume of feed at regular intervals, as opposed to a continuous rate of feed). Overnight feeding may be used as a step towards bolus or oral feeding and may allow for increased appetite during the day. Bolus feeding can be given at meal and snack times to assist with establishing regular nutritional patterns throughout the day. Feeds may be given 3 times per day at mealtimes or as 6 smaller bolus feeds, depending on tolerance and preference. Tampering with continuous or overnight feeds should be monitored.

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

Commence refeeding slowly. It may take 7-10 days to reach a goal rate.

Monitor electrolytes, cardiac status and signs of refeeding syndrome.

Energy requirements may increase after the first few weeks of re-feeding due to increases in the metabolic rate and increased physical activity. Once an adequate weight gain has been achieved, nutritional intake can be reduced to allow for maintenance of growth.

NUTRITIONAL REQUIREMENTS

Determining appropriate energy requirements for refeeding can be difficult due to physical changes occurring during re-feeding (including metabolic rate), actual energy consumed and energy lost through activity or purging behaviours. The starting regime will also depend on many factors including the age, body size, level of nutrition and medical stability of the patient.

There is limited evidence in the literature to support recommending a specific refeeding regime in adolescents with eating disorders. Recommendations for commencing refeeding have ranged from 10-60kcal/kg/day (actual body weight) and may reach as high as 70 –100 kcal/kg/d or 3,500-4,500 calories (15,000-18,000kJ) depending on individual requirements.

In consideration of the current evidence and expert opinion, the following recommendations have been made (it is essential that patients are supplemented and monitored appropriately, please refer to the “Refeeding Syndrome” section):

- Patients may be commenced on 700-1,500kcal/day depending on individual needs.
- For younger or smaller adolescents, or those at higher medical risk, a lower rate of refeeding should be initiated. For those at risk of re-feeding syndrome, nutrition may be initially restricted to 700-900kcal/day with caloric intake spread throughout the day to minimise excessive nutritional load (eg continuous 24 hour feeding if using naso-gastric feeds). Nutritional intake can then be increased by gradual amounts over the proceeding two weeks or until the final requirements have been met.
- For older adolescents who are medically well, and at low risk of refeeding syndrome, initial nutrition plans may begin with 1,200-1,500 calories (5,000-6,300 kJ) per day. This may be continued for the first few days to allow for physical and psychological adjustment. Intake may then be increased by 500 calories (2,100 kJ) every 4-5 days until a desired rate of weight gain is achieved.
- Once an adequate weight has been achieved, nutritional intake can be reduced to allow for maintenance of growth.

Other nutrient requirements that will need to be considered include protein, carbohydrates, fluids, fibre, vitamins and minerals.
Refeeding Case Study 1

Example of how one could progress with implementing a refeeding regime in an older adolescent who was medically stable and at low risk of refeeding syndrome:

17 year old girl, height 163cm, weight 43kg, estimated energy requirements for 1kg/week weight gain 12,500kJ/3000calories, some oral intake over past 2 weeks, electrolytes normal.

First 24 Hours
Commence iso-osmolar feed at 40mls per hour for 12 hours.
If tolerated, increase rate to 60mls/hr for 12 hours.
This will provide, for example, 1200mls fluid (plus fluid flushes), 1260kcal (5280kJ) energy and 53g protein.

Following 24 Hours
60mls/hr X 24/24
This will provide, for example, 1440mls fluid (plus fluid flushes), 1500kcal (6340kJ) energy and 63g protein.

Gradually increase feeds to a final rate of 3000kcal (12,500kJ), which may take 7-10 days to reach. This may be achieved by increasing feeds by 500kcal (2,100kJ) every 4-5 days to allow for physical and psychological adjustment. Concentrated feeds may need to be used to avoid excess fluid input.

Refeeding Case Study 2

Example of how one could progress with implementing a refeeding regime in a younger adolescent who was at risk of refeeding syndrome:

12 year old girl, height 152cm, weight 28kg, estimated energy requirements for 1kg/week weight gain 11,000kJ/2600calories, minimal oral intake over past 2 weeks, serum phosphate lower end of normal.

First 24 Hours
Commence hypo-osmolar feed at 30mls per hour for 24 hours
This will provide, for example, 750mls fluid (plus fluid flushes), 750 kcal (3150kJ) energy and 28g protein.

Following 24 Hours
If tolerated, increase rate to 40mls per hour for 24 hours.
This will provide, for example, 960mls fluid (plus fluid flushes), 1000kcal (4200kJ) energy and 35g protein.

Gradually increase feeds by 10ml/hour per day to a final rate of 2600kcal (11,000kJ) (e.g., 110ml/hour continuous feed), which may take 7-10 days to reach. Concentrated feeds may need to be used to avoid excess fluid input.
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.

**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.
- 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 intake 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
- Siting at the table for a specified time period

- It is useful to set time limits on meals, e.g., 30mins for main meals, 15mins 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.

OBSERVATIONS

- 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.
 EXAMPLE MEAL PLAN

Meal Plan for Weight Maintenance

**Breakfast**
- 1 bowl (1 ½ cups) cereal (1 box)
- Milk (~200ml)
- 1 – 2 pieces of toast with margarine & topping
- 150ml juice

**Morning Tea**
- 1 Piece of fruit
- 3 biscuits & cheese
- 250ml drink (e.g., water)

**Lunch**
- 1 sandwich with salad & cheese/meat
- 250ml drink (e.g., water)
- 200ml yoghurt
- 1 piece of fruit

**Afternoon Tea**
- 1 piece of fruit
- Small handful of nuts
- 250ml drink (e.g., water)

**Dinner**
- ¼ plate meat, ½ plate vegies, ¼ plate pasta/ rice/ potato
- Dessert (e.g., pudding or custard)
- 250ml drink (e.g., water)
- 150ml juice

**Supper**
- 250ml milky hot drink (e.g., hot chocolate)
- 2 sweet biscuits

Note: depending on nutritional status, patients may be required to commence on ¼ of suggested meals and snacks and gradually build up to an adequate intake.

For patients in a hypermetabolic state, or needing to gain weight, the amount of food required would most likely be much greater than that presented in the above example (allowing for individual variation). For such patients the use of high energy, high protein nutrition principles is indicated and may involve the inclusion of high energy foods such as cake, chocolate, potato crisps, sweet biscuits and nutrition supplements.

The ability of the patient to include full fat dairy foods in the meal plan may be an indicator of recovery.
MEAL PLAN TEMPLATE

Date …… / …… / ……

Name…………………………………………………………………………………..

Dietitian…………………………………………………………………………………..

Breakfast

……………………………………………………
……………………………………………………
……………………………………………………
……………………………………………………
……………………………………………………

Lunch

……………………………………………………
……………………………………………………
……………………………………………………
……………………………………………………
……………………………………………………

Dinner

……………………………………………………
……………………………………………………
……………………………………………………
……………………………………………………
……………………………………………………

Morning Tea

……………………………………………………
……………………………………………………
……………………………………………………
……………………………………………………
……………………………………………………

Afternoon Tea

……………………………………………………
……………………………………………………
……………………………………………………
……………………………………………………
……………………………………………………

Supper

……………………………………………………
……………………………………………………
……………………………………………………
……………………………………………………
……………………………………………………

Extra Fluids

……………………………………………………
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 coordinates 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.
### The Right Information at the Right Times

<table>
<thead>
<tr>
<th>In the beginning</th>
<th>What Should be Included</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Being admitted</strong></td>
<td>- Information to assist the person cope with fear of eating and weight gain.</td>
</tr>
<tr>
<td><strong>Immedidate stabilisation</strong></td>
<td>- Explanation of initial variations in weight due to fluid shifts and glycogen storage.</td>
</tr>
<tr>
<td><strong>Restoration of hydration</strong></td>
<td>- Interpretation of metabolic changes and what this means for meeting energy and weight gain requirements.</td>
</tr>
<tr>
<td><strong>Prevention of refeeding syndrome</strong></td>
<td>- Understanding gastric and physical discomfort.</td>
</tr>
<tr>
<td><strong>Initial variations in weight</strong></td>
<td>- Explain that nasogastric feeding is an abnormal method of nutrition, especially for extended periods of time.</td>
</tr>
<tr>
<td><strong>Interpretation of metabolic changes</strong></td>
<td><strong>During admission</strong></td>
</tr>
<tr>
<td><strong>Education initially should be minimal</strong></td>
<td><strong>The effects of underweight and starvation on disruption of normal hunger and satiety, metabolism, cognitive function and mood.</strong></td>
</tr>
<tr>
<td><strong>Understanding gastric and physical discomfort.</strong></td>
<td><strong>Metabolism and energy balance.</strong></td>
</tr>
<tr>
<td><strong>Explain that nasogastric feeding</strong></td>
<td><strong>Protein for tissue repair, muscle restoration and then normal growth and development.</strong></td>
</tr>
<tr>
<td><strong>Education initially should be minimal due to stress and impaired cognitive ability.</strong></td>
<td><strong>Carbohydrate and fat for energy and nutrition needs.</strong></td>
</tr>
<tr>
<td><strong>Understanding gastric and physical discomfort.</strong></td>
<td><strong>Fluid intake and normal response to thirst.</strong></td>
</tr>
</tbody>
</table>

### Planning for discharge

| 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.** |
| **Nutrition for normal growth and development.** | **Amenorrhoea and osteoporosis.** |
| **Appropriate use of supplements.** | **The effect of restriction on bingeing behaviours.** |
| **The effect of restriction on bingeing behaviours.** | **Distinguishing between valid food preferences and eating disorder choices such as vegetarianism, allergies or low joule foods.** |
| **Distinguishing between valid food preferences and eating disorder choices such as vegetarianism, allergies or low joule foods.** | **Eating Disorders Toolkit – Eating, Nutrition & Physical Activity** |

| **Eating Disorders Toolkit – Eating, Nutrition & Physical Activity** | 71 |
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.
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

**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.
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.

**SAFETY**

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**

- Features of Excessive Exercise
  - Restless hyperactivity
  - Repetition of tasks unnecessarily
  - 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

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.

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

---

* See section “Treatment on the Ward – Medical & Physical (Observations and Physical Monitoring)” for critical signs and thresholds associated with medical stability.
- 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.

### Caught in the Act – A Case Study

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”

“Lets 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

Once medical stability is achieved, and weight gain has begun, more elements (other than gentle stretching) can be added to the program (see Appendix 6). 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.

---

vi For a more detailed staged exercise plan see Appendix "Exercise: Staged exercise program"
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.
Working with the Young Person
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 reflective statements and 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 counselling.

**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 underlying issues.** 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 your eating disorder is probably there for a good reason; we would like to find out what makes you sad and scared and why weight loss makes you feel better. We can help you with these things as soon as your health is stabilised”.

**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.

Focus on **PERSONAL GOALS.** Identify what values and goals the young person is really interested in and (in addition to showing an interest) return to this as an achievable goal for the admission. For example:

*A girl may value being very healthy and start to eat less and exercise more to achieve this goal. Gently discuss (from her perspective) how the eating disorder has adversely affected this value and how engaging in treatment might be scary but positive at the same time.*
BASIC 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.
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.

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 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.

A patient’s readiness for change 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

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.

ASSESSING READINESS TO CHANGE

Understanding a patient’s readiness for change is helpful in planning intervention and management, and can guide therapeutic processes in engaging the patient and creating opportunities for movement.

- To obtain an accurate understanding of the patient’s level of motivation to change, health professionals need to create a non-judgmental environment in which patients can feel safe to disclose and explore their lack of readiness to change.
- It can be helpful for health professionals to normalise feelings of ambivalence regarding change (e.g., “We know that many patients with anorexia nervosa have very mixed feelings about gaining weight.”)
- There are questionnaires available to assess how motivated the patient is to change anorexic symptoms and the barriers to the change process (see Appendix 5 for an example).

HELPING CREATE MOTIVATION

It can be useful to communicate an understanding of the importance and benefit the patient sees in the disorder, and hence the great difficulty they face in attempting to change (e.g., “I can see that losing weight is the one thing that has helped you to feel better about yourself”). Taking time to understand and validate a patient’s experience of good things the eating disorder might bring to their life can increase insight into the disorder and create movement towards being ready to share the problems the disorder brings.
POOR MOTIVATION TO CHANGE

There are two primary sources of poor motivation to change:

1. **Value of the disorder**: AN symptoms are highly valued by the patient because the symptoms are believed to have important psychological “survival” functions. Some of these functions include: helping the patient to have a sense of control over his/her self and life; helping the patient to feel a sense of accomplishment and strength; helping the patient to cope with emotional distress; and/or, helping the patient to communicate his/her need for support to others. As a result, patients struggle to give up the practice of self-starvation, which they see as essential, in some way, to their psychological survival.

2. **Lack of confidence**: The patient may fail to engage in the change process because they are not confident that they can successfully change. Especially if there have been previous admissions and relapses, the patient may no longer believe in their ability to overcome the eating disorder. Comorbid depression can also induce a sense of hopelessness in terms of recovery.

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.

Some helpful strategies

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.
Psychological management in an inpatient setting should focus on empathic engagement and therapeutic alliance with the patient and the family, as well as containment of distress and management of comorbid psychiatric symptoms. 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.

CBT is currently the treatment of choice for BN in adults. There is an increasing body of evidence to demonstrate the efficacy of CBT in the management of BN and a number of treatment manuals are available. 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.

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 over-ride 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.
Psychological Issues
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 DEPRESSION

Major Depressive Disorder (MDD) is the most commonly reported co-morbidity of AN. However, symptoms of depression can be seen in seriously underweight people due to the effects of starvation, and the observation of such does not necessitate the diagnosis of MDD. Symptoms 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, 50% of patients recover from depression. Individual therapy for depression has not been found to be helpful in patients who are malnourished.

Many young people with BN also display depressive symptoms or mood disorders (usually MDD or Dysthymic Disorder). Often symptoms begin at, or following, the onset of BN, but in other cases there is a clear pre-existing depressive disorder. Those with BN-Purging type have shown more symptoms of depression than the Non-Purging type. As with AN, symptoms of mood disturbance require thorough psychiatric assessment.

EATING DISORDERS AND ANXIETY

Up to 50% of individuals admitted for treatment of an eating disorder display symptoms of anxiety. It is important to consider that the presentation of an eating disorder may be masking an underlying anxiety disorder. Anxiety disorders tend to precede eating disorders, with social phobias, specific phobias and obsessive-compulsive disorder known to co-occur with AN and BN. General levels of anxiety may develop or worsen as weight is restored and treatment progresses.

*Obsessive-compulsive features in AN.* 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 SUBSTANCE MISUSE

High rates of substance misuse have been found among adults with eating disorders. Young people with eating disorders are less likely to misuse substances, though this remains a potential co-morbidity. 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.

Substance misuse more specifically related to eating disorders includes the use of laxatives, diuretics, diet pills and emetics. Misuse of medications such as stimulants and thyroxin may also occur. Many patients with eating disorders may not be forthcoming in describing their substance misuse and collaborative reports from parents can be helpful. A direct and non-judgmental approach is most helpful to elicit honest answers around substance misuse.
<table>
<thead>
<tr>
<th>Psychological Issue</th>
<th>Manifestation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Self-Esteem</td>
<td>Patients with eating disorders frequently report having low self-esteem and poor self-image, reporting feeling worthless and a ‘waste of space’, feeling bad or a failure and feeling unimportant, unnoticed or unloved. There is often active self-criticism, under-assertiveness and attempts to compensate for perceived inadequacies (e.g., through perfectionism or competitiveness). Low self esteem may lead to feelings of helplessness, apathy, powerlessness, a keen interest in pleasing others (including failing to express negative feelings to others), isolation, and even hostility towards others. If people feel negatively about themselves they tend to think everyone else does too.</td>
</tr>
<tr>
<td>Perfectionism</td>
<td>Parents frequently describe the patient as being the ‘perfect child’, who has always been well behaved, conscientious and successful. These children set very high standards for themselves in various domains, including academic achievement, physical activity, slimness and weight loss. Patients tend to be punitive or harsh with themselves and often describe feeling inadequate whenever standards are not met. These children are often noted to have difficulty expressing negative emotions, which is thought to be related to a difficulty in showing weakness or imperfection.</td>
</tr>
<tr>
<td>Competitiveness (With self and others)</td>
<td>This is often self-directed, wanting to surpass their previous efforts, or relentless striving. This can also be other-directed (e.g. competing with others on school marks, clothes or thinness) leading to feelings of anger, frustration and greater inadequacy.</td>
</tr>
<tr>
<td>Obsessionality</td>
<td>This includes perfectionism but also extends to valuing control (valuing symmetry, neatness and exactness, and difficulty tolerating uncertainty).</td>
</tr>
<tr>
<td>Affect tolerance and regulation</td>
<td>This may include difficulty calming or soothing self, anxiety, difficulty tolerating change, labile mood and drastic efforts to deal with intense negative feelings (this is often through physical means such as exercise or deliberate self-harm).</td>
</tr>
<tr>
<td>Identity Disturbance</td>
<td>This rarely applies to children or younger adolescents, whose identity and sense of self is still developing. In adults, identity disturbance may manifest as a sense of emptiness or ‘deadness’, falseness, inconsistency across different situations, ambiguity about values and preferences, uncertainty about sexuality, lack of direction for one’s future, or “foreclosure” (in younger people, prematurely deciding on one’s convictions and direction in life).</td>
</tr>
</tbody>
</table>
SECONDARY DIAGNOSIS EATING DISORDERS

The term ‘secondary diagnosis eating disorder’ may be used when the primary reason for admission of a person is for a non-eating disorder diagnosis (e.g., Post-Traumatic Stress Disorder), although a clinically significant eating disorder is present and creating difficulty for the patient. This will differ markedly from loss of appetite and/or weight loss in the absence of fear of fatness and body image disturbance associated with some psychiatric conditions, such as depression and anxiety.

If the eating disorder is acute or posing medical danger to the individual, this may need immediate intervention regardless of diagnostic status. 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 may result in increased risk of physical and mental health complications.

The treatment of secondary diagnosis eating disorders should be part of the overall treatment plan and should allow for the treatment of the primary diagnosis to take place. The same treatment strategies apply to the treatment of a secondary eating disorder diagnosis as they do with a primary eating disorder 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. There is some limited evidence to suggest that this is not the case in PTSD and as long as the individual is medically stable and cognitively able, treatment for PTSD should occur first.

In the case of BN, symptoms can commonly co-occur with drug and alcohol issues or as part of another psychiatric condition. The eating disorder behaviours need to be targeted and reduced in a similar manner to the other problem behaviours.

BODY IMAGE DISTURBANCE AND BODY DISSATISFACTION

A person’s body image is the picture of their body they have in their mind – it is the way in which they perceive their appearance. The concept of body image is closely related to a person’s psychological wellbeing and resilience. A high level of body image disturbance is a risk factor for eating disorders and a central characteristic of AN, BN and EDNOS.

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).

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.
Alexithymia is a term that means the inability to identify and express feelings with words. Those with alexithymia often have problems with emotional awareness, and understanding or describing their own emotions. They may also experience occasional physiological disturbances (related to distress) such as heart palpitations, stomach ache, or hot flushes without being able to make the association with distress. In addition, the young person with alexithymia may be puzzled by other people’s emotional reactions.

It should be considered, however, that the ability to recognise, label, express and tolerate emotion is a complex developmental task often not achieved in full until adulthood. Hence, many adolescents will struggle with one or more of these skills and will require varying degrees of education and support to improve their abilities.

The key features of alexithymia are:
- Difficulty identifying different types of feelings
- Difficulty distinguishing between emotional feelings and bodily feelings
- Limited understanding of what caused the feelings
- Difficulty verbalising feelings
- Limited emotional content in their imagination
- Lack of enjoyment and pleasure seeking

What to Do With The Young Person…
- Recognise alexithymia – don’t ignore it - the experience of alexithymia is what leads a person to discount or deny life experience.
- Build a ‘feelings vocabulary’ – encourage the young person to read about feelings, draw them, learn to name them.
- Encourage the person to think about feelings – reflect on them.
- Suggest they write about feelings in a personal diary.
- Help them to understand other people’s emotional needs judging by their verbal and physical cues – assist the young person to learn what cues are important.
- Maintain a predictable and stable routine, which helps to minimise anxiety.
- Help them establish a co-supportive relationship with an understanding person (e.g., therapist, friend, partner) who can help to compensate for weaknesses or help identify feelings.
Managing distress is an important part of treatment. Being in hospital is likely to be very 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.

The following may be useful in attempting to understand behaviours indicating distress:

- Acknowledge that the problem behaviour is purposeful and communicates thoughts and feelings of the young person to the treating team.
- Focus on understanding the behaviour, not just trying to change it.
- Identify the purpose of the behaviour:
  - Is it to get away from something or avoid doing things?
  - Is it to achieve a tangible reward (e.g., receiving desired things)?
  - Is it to provide automatic/sensory relief (e.g., self-regulation, coping with difficult feelings)?

Young people with an eating disorder may experience distress due to the fear of the treatment they feel will be imposed upon them, denial of illness, the family or patient being in conflict with each other (or with the treatment team) or low self-esteem.

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 strategies to assist in managing distress. Document these as part of the management plan; intervene early and prior to 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.
- Behaviours may be contained by changes in the environment. Participation in ward activities may increase if these include activities that the child likes.
- 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, repetitive, impulsive, non-lethal harming of one's body. It commonly includes cutting, scratching, 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 emotional pain. 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.
Social Issues
SOCIAL HEALTH OF THE YOUNG PERSON

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 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 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

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, grandparents, cousins, etc
- Assist the young person to re-link with their peer group, through visits, phone calls and letters to friends
- 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 caring for the young person outside of hospital.

HOW LEAVE IS MANAGED

- 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 to attend school, or social activities on weekends.
- Nearer to discharge, encourage leave for meals and overnight stays.
- Adult supervision is important during leave, to ensure the well-being of the patient.
- If leave is used as a reward, ensure that the person is not unduly penalised – rewards should be achievable and leave should be attainable if medically stable and as part of the whole program.
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.
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.
SCHOOL AND SCHOOL WORK

Education and socialisation are important aspects of everyday life for children and adolescents, even if seriously unwell. The young person is likely to return to school on recovery, therefore these crucial aspects of development should be fostered and facilitated while in the inpatient setting.

KEY POINTS

1. The treating team should allocate a representative to liaise with the patient’s school Learning Support Team. A school counsellor is attached to all schools and would have access to information regarding available supports, levels of cognitive functioning and behaviour difficulties of the young person.

2. School assessments can give the team valuable information on abilities, performance, peer relationships, general health, and eating behaviours. Provided that patient and/or parental consent has been given, this information can be discussed with the school counsellor and school executive.

3. Psychometric testing may be useful and may already have been conducted. The school counsellor can provide relevant information.

4. A team decision will be required regarding patient physical and mental status to cope with demands of schoolwork, how much and in what context. Wherever possible, the patient should be supported to attend their usual school to minimise disruption to normal life and to promote continuation of peer relationships.

5. The team will need to decide if patient is well enough to attend school for a period of time or if education support is required in the hospital setting until the patient is well enough to be reintegrated into the school environment. The McDonalds Learning program can be a useful resource to access tutorial assistance for patients who are chronically unwell.

6. Schooling options include teachers providing school work, organising a teacher to attend the hospital to provide educational support, part-time school attendance, reducing the number of subjects studied or focusing on subjects particularly enjoyed until the young person returns to health.

7. If attending school, determine the safe level of physical activity. A plan needs to be developed by the team for reintegration into the school environment. A risk management plan may need to be developed prior to the student attending school and should be done in consultation with the Department of Education & Training (DET) and Department of Health.

8. The volume and type of schoolwork must be matched to the young person’s physical and psychological health status. The need for perfection and control may be very important to the young person, often impacting on their ability to engage in new activities for fear of failure. Ensure the patient is not working too hard or trying to achieve too much. Also monitor if they are struggling with schoolwork. Students should be encouraged to ask for help if they need it.

9. Start with basic numeracy and literacy tasks that the young person enjoys and can achieve easily. Gradually incorporate more complex activities. Consider the patients physical condition and allow for variability in daily performance.

10. Work with the school to ensure that the young person doesn’t feel pressured to catch up with schoolwork and to set realistic goals. Remind the young person there is support within the school to assist them to achieve their education goals.

11. Similar supports are available for patients who attend TAFE or distance education.
OPTIONS FOR MANAGING SCHOOL WORK DURING HOSPITALISATION

Remain on ward for school or attend DET hospital school. Assess appropriate level of schoolwork by phoning the young person's usual school

Parent or NUM to arrange supply of material as per school curricula

Nursing staff to plan a daily patient schedule which incorporates time for schoolwork during usual school hours

Liaise with school re availability of teacher or tutor to attend ward to assist patient with school work

Nursing staff or play therapist to supervise that school is attended or work is carried out

Team appointments (where possible), play and leisure activities scheduled outside normal school hours Mon – Fri (if relevant)

Patient to attend usual school

Team to decide appropriate reintegration schedule, classes to be attended, and activity levels permitted

Team to arrange transport to and from hospital and school

Team to decide on level of activity that will be safe. The patient may be excluded from sports days and exercise classes

Team to liaise with school regarding availability of staff to monitor patient during meal times (initially patient may attend school outside of meal times)

Dietitian to liaise with hospital kitchen to provide appropriate take out meals for patient to consume at school
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

In the acute stages of AN, comorbid conditions such as depressive or obsessive-compulsive features may resolve with weight gain alone without the need for consideration of medication. Selective serotonin re-uptake inhibitors (SSRIs) may be beneficial in the treatment of comorbid depression and obsessive-compulsive disorder in the non-acute stage of AN. In patients who are weight restored, there is some limited (and conflicting) evidence for the role of SSRIs in reducing the risk of relapse. The role of Olanzapine needs further clinical evaluation, but has theoretical benefit in anxiolysis and reduction of distorted beliefs.

MEDICATIONS AND BULIMIA NERVOSA

Pharmacotherapy in combination with psychotherapy (such as CBT) has been shown to have the best outcome in the management of BN. From a recent Cochrane review overall greater remission rates for BN have been shown with the use of a single antidepressant agent over placebo. The Cochrane review also found no differential effect regarding efficacy and tolerability among the various classes of antidepressants. However, SSRIs are recommended over other antidepressants as first line medication due to accessibility and safety. 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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Used in which component of eating disorders</th>
<th>Monitoring (in addition to that outlined in drug monographs, e.g., MIMS)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRIs e.g., Fluoxetine Fluvoxamine Sertraline</td>
<td>Fluoxetine 40-80mg per day (higher doses recommend ed than used in depression)</td>
<td>In AN there is some (limited) evidence that Fluoxetine may prevent relapse in patients who have been weight restored. In BN there is strong evidence for reduction of frequency of binge eating and purging.</td>
<td>May cause hypomania/mania or increase rapidity of cycling of moods in patients with bipolar disorder (may be undiagnosed).</td>
<td>Fluoxetine - preferred antidepressant. May not work in patients who are severely malnourished due to neurotransmitter depletion. SSRIs recommended first line over other antidepressants (e.g., tricyclic antidepressants) due to accessibility, tolerability and reduction of symptoms. SSRIs may confer extra benefit in patients with concomitant depressive, anxious and obsessive-compulsive symptoms. SSRIs relatively contraindicated in patients with a first-degree relative with bipolar disorder.</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>2.5 to 10mg per day</td>
<td>Used sometimes in AN. May provide anxiolysis and reduce ruminations about weight and shape, compulsive hyperactivity, delusional cognitions and mood lability. In BN theoretically may be beneficial for similar presentations.</td>
<td>QTc monitoring with baseline and serial ECGs. Low risk- but may be significant in patients with extremely compromised cardiac function.</td>
<td>Consult cardiologist if patient has compromised cardiac function.</td>
</tr>
</tbody>
</table>

For specific medication enquiries contact your local pharmacist or The Psychotropic Drug Advisory Service – (03) 9389 2920
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.
- If a patient held as involuntary under the Mental Health Act (2007) absconds, alert the Mental Health unit and parents and inform the 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 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.
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 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

IN VOLUNTARY TREATMENT OF THOSE WITH EATING DISORDERS

Thecare 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 is undesirable and 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.

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 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 Mental Health Act allows involuntary treatment of an individual with a mental illness who is considered a risk to themselves or others. This requires admission to a declared mental health facility (or a private mental health facility). 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

More detailed information on admission legalities and procedures are provided in the Act.

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, although there should be a concerted effort to discharge the adolescent as soon as appropriate if they are under the age of 16. There is no restriction under the MHA as to what age a child or adolescent may be made an involuntary patient.

Can we have a patient who is detained as an involuntary 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. All legal procedures must to be adhered to, much the same as if the patient is admitted to a declared mental health facility.

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.
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.

GENERAL GUIDELINES

- Knowledge of, and experience with management of the disorder, promotes confidence and competence.
- Involvement in the decision making process at case reviews and awareness of the treating team’s plans should be universal for all staff involved.
- Regular debriefing sessions or clinical supervision should be available to all staff.
- Staff should have access to telephone support and advice, e.g., specialists in tertiary centres, specialist dietitians, and consultation-liaison nurses.
- Maintain professional development, e.g., local education, study leave, practical training, mentoring or working 1:1 with experienced staff.
- Develop support networks.
- Avoid destructive traps such as splitting, rescuing, distancing or overlooking your own needs.
- Seek feedback about your clinical role.
- Aim to become more skilled at handling the emotional aspects of work.

Resilience

Resilience is the ability to withstand the effects of adversity or the ability to bounce back from it. Resilience is learned and can be taught. There are five characteristics of resilient people:

- Positive, display a sense of security and self-assurance that life is complex but filled with opportunities.
- Focused, have a clear vision of what they would like to achieve.
- Flexible, have a high tolerance for ambiguity.
- Organised, can consolidate what appear to be several unrelated changes into a single effort with a central theme.
- Proactive, engage change rather than guard against it.
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.
Section 6:
Special Considerations
PREGNANCY AND EATING DISORDERS

The majority of females who suffer from eating disorders are at a childbearing age. Those with AN will by definition, be amenorrhoeic. However, it is possible for a female to ovulate without menstruating, and thus fall pregnant. Most women with eating disorders, although they have anovular cycles, are fertile.

Clinicians who care for pregnant adolescents should consider the possibility of an eating disorder in an adolescent who:

1. Is very anxious about her weight or shape, for example refuses to be weighed
2. Has an inappropriate view of a healthy weight for her height or weight gain in pregnancy
3. Has a low BMI\(^{vi}\)
4. Fails to gain weight at two consecutive prenatal visits
5. Has a history of periods of amenorrhoea, infertility, previous still birth, premature delivery or past infant feeding problems
6. Has poor circulation; cold or purple fingers
7. Has a history of dental caries (due to frequent vomiting)

POTENTIAL PROBLEMS AND COMPLICATIONS

**AN:** The patient may have excessive concerns about weight gain and body shape changes associated with pregnancy or lactation. These thoughts may persist even in one who has recovered to a healthy weight. Mothers with a history of AN have a higher rate of miscarriage and caesarean section. A low pre-pregnancy weight and low weight gain in pregnancy is associated with low infant birth weight and a higher incidence of malformations such as cleft lip and palate. These can be prevented by adequate weight gain in pregnancy.

**BN:** can occur in a woman with any BMI. It is characterised by periods of excessive eating followed by compensatory behaviours such as purging, fasting or exercising. Women with BN have a higher rate of miscarriage, hypertension during pregnancy and Caesarean section.

MANAGEMENT OF EATING DISORDERS & PREGNANCY

Referral to a tertiary treatment setting with specialist eating disorder clinicians is recommended, as this is likely to be a high-risk pregnancy both obstetrically and from an eating disorder perspective.

If a mother is managed locally the following is recommended:

1. **Team to include:**
   - Obstetrician and paediatrician
   - Mental health professionals (e.g., psychiatrist, psychologist, mental health nurse)
   - Dietitian

\(^{vi}\) For children & adolescents use BMI centile charts. See section “Assessing Growth & Determining Healthy Weight Range”.
2. Regular communication between all team members to set treatment goals, such as rate and amount of weight gain
3. Case management by the mental health professional (e.g., psychologist).
4. Regular monitoring of weight (as for all pregnant women). The patient with an eating disorder may not want to know their weight. This is acceptable as long as they are gaining adequate weight. If there is inadequate weight gain, the patient should be informed. Risk to the foetus should be communicated in a caring, understanding and empathic way but in a way that also emphasises the steps that need to occur to minimise harm to the unborn child. Address the patient’s fears of gaining weight empathically – refrain from using scare tactics to encourage her to eat. Instead focus on “eating for the baby” or “gaining weight for the baby so that the baby can grow normally”.
5. Nutrition support and enteral feeding may be required if the patient is unable to gain sufficient weight to allow normal growth of the developing foetus. The decision to intervene should be based on the pattern of weight gain throughout the pregnancy, requirements for weight gain, the development of the foetus and the ability of the patient to care for the unborn child in utero.
6. Provide education about the expected weight gain for pregnancy, the importance of weight gain and adequate nutrition for the baby’s normal growth and development.
7. Assist the patient to eliminate (or at least reduce) eating disordered behaviours such as restrictive eating, bingeing or purging.
8. Emphasis should also be placed on ongoing management of the eating disorder to allow for adequate breastfeeding and future modelling of healthy eating behaviours for the child.
9. Ensure there is a continuing care plan implemented post discharge for parenting support and eating disorder management.

Pregnancy

- It is important to consider the possibility of pregnancy in any female of reproductive age.
- Pregnancy can occur without menstrual periods if a female is still ovulating.
- It is necessary to inform all patients of the risk of pregnancy, especially those who are sexually active, and work out practical ways of avoiding pregnancy.
- The use of contraception in a still growing female may result in premature epiphyseal closure with effects on final adult height.
Research on lactation and breast-feeding by women with eating disorders is scant and anecdotal. It is reported that they are less likely to breastfeed, more likely to be concerned about their milk supply, to believe that their infant has an adverse reaction to their milk and to introduce bottle-feeding.

The effects of an eating disorder on infant feeding will vary with the type of eating disorder and whether the mother is currently symptomatic. Ways in which it may affect feeding include:

1. Breast-feeding with a low maternal bone mineral density leading to increased risk of fracture due to osteoporosis.
2. Effects of postural hypotension and fainting while holding the baby.
3. Increased tiredness and lethargy due to biochemical derangement.
4. Interference with the mother’s ability to detect satiety and hunger in her infant.
5. Limitation of feeds to prevent the infant becoming “fat”; inappropriate concerns about the infant weighing too much.
6. Prolonged exclusive breast-feeding to prevent infant from becoming “fat”.
7. Resultant failure to thrive in the infant.
8. Use of extended breast-feeding combined with mother’s food restriction to increase her post partum weight loss.
9. Increased incidence of post partum depression.
10. Poor maternal nutrition, especially energy, fat, calcium, iron and zinc, may affect breast milk constituents.
11. Maternal use of alcohol, drugs and laxatives in those with active symptomatology.
12. Spurious diagnoses of allergy or other reactions to milk components.
13. Less facilitating, more intrusive and conflicted feeding, and increased expression of negative emotion toward infant.

Postnatal Care

New mothers with a history of an eating disorder should be regularly monitored for possible infant feeding difficulties and failure to thrive.
CHILDREN WITH EATING DISORDERS

Eating disorders are rare before about the age of 8 years and appear to have a complex causality and more serious course than in adolescents. The most common presentation in this age group is AN. Other presentations may include BN, food avoidance emotional disorder (FAED), selective eating, restrictive eating, food refusal, functional dysphagia or pervasive refusal syndrome (see section under Further Information).

Treatment of eating disorders in pre-pubertal children requires particular knowledge and skill. These children are more prone to severe physical complications and there is a high incidence of persisting morbidity. A rapidly initiated, intensive and comprehensive treatment program is required and should be conducted by child-oriented professionals who have expertise in eating disorders.

Children with an eating disorder require immediate consultation with child-oriented professionals who have expertise in eating disorders.
(See ‘Useful Resources’ section).
OBESITY

Obesity, while not considered a mental illness, and not included in the DSM IV classification of ‘eating disorders’, is a major public health concern. Both obesity and eating disorders are prevalent weight-related conditions with potentially serious consequences.

It is known that dieting is a risk factor for disordered eating. Studies have shown that girls who diet frequently are 12 times more likely to binge eat when compared to girls who do not diet. Boys have been found to have 7 times the risk of binge eating if dieting. Adolescents who diet and use unhealthy weight control strategies are at an increased risk of developing an eating disorder or becoming overweight or obese.

A large population-based study of adolescents found that more than half of adolescent girls and nearly one third of adolescent boys use unhealthy weight control practices, such as skipping meals, fasting, smoking cigarettes, vomiting and taking laxatives. The study also showed that one half of girls and one quarter of boys expressed dissatisfaction with their bodies. Excessive social pressure to be thin has also been found to increase unhealthy weight control practices and clinical eating disorders.

There is some concern that attempts to address only one problem, such as obesity, may inadvertently lead to other problems (such as eating disorders).

There is a role in assisting in prevention of both obesity and eating disorders through advocating for a healthy, balanced approach to eating and physical activity.

RECOMMENDATIONS

Whether developing interventions for eating disorders or obesity, the broad spectrum of eating and weight concerns should be taken into account. A coordinated, partnership approach is required.

Healthy Behaviour Messages to Convey For All

- Promotion of healthy lifestyle behaviours.
- Eating regular meals and snacks.
- Increasing awareness of the body cues for hunger and satiety.
- Enjoying physical activity.

Aim to Address Risk Factors in Partnership with Others

Risk factors may include dieting, self esteem, media, parental role modelling, teasing, weight-related attitudes of significant others, food availability in the school and home, and sociocultural and media messages regarding eating, activity and body image.
INDIGENOUS EATING DISORDER PHILOSOPHY

The incidence of eating disorders in the Aboriginal population is unknown. There are key principles for consideration when treating young people from this population.

GENERAL PRINCIPLES

Aboriginal health principles as outlined by NSW Health (Ensuring Progress in Aboriginal Health, 1999, NSW Health) have been developed to guide NSW public health workers and the Aboriginal Community in addressing Aboriginal health. These principles include:

- **A whole-of-life view of health** meaning a holistic and social view of health encompassing the physical, emotional, cultural and spiritual well being of individuals and communities.
- **A practical exercise of the principles of self-determination.**
- **Working partnerships** between health care providers and the wider Aboriginal community.
- **Cultural understanding** of Aboriginal kinship and family groups, languages, spiritual beliefs and ways of living in urban, rural and remote settings.
- **Recognition of trauma and loss** as a direct result of colonisation and dispossession which is further compounded by racism, social and economic disadvantage and the loss of access to land.

INTERVIEW / ASSESSMENT TECHNIQUES

- Choose an appropriate setting that will not engender fear/anxiety. Although sometimes difficult in acute settings, an open non-threatening space is ideal.
- Greet with a loose handshake without invading personal space (the amount of personal space is greater for Aboriginal people than non-indigenous).
- Provide an unhurried and clear explanation of who you/others are and your/their role.
- Give fleeting eye contact to avoid making the patient feel judged (the amount of eye-contact should be intuitively gauged by how much you are receiving). Avoiding eye contact may be culturally appropriate for some people.
- Sit side-by-side with the patient to allow closeness without intimidation.
- Talk slowly and wait for the patient to consider the response.
- In the reverse of normal practice, start with yes/no questions to alleviate any pressure on the individual to immediately ‘open up’.
- Explore the patient’s family network and spiritual beliefs about their problem before investigating their symptoms. Aboriginal people have a strong relationship with their community and spirituality and this should be understood before investigating symptoms.
GENERAL CONSIDERATIONS

- Commence with non-threatening statements, not questions.
- Involve the family and gather a simultaneous corroborative history. In a sense, the whole family may share the “illness”. The definition of “family” may be broader and far wider than non-indigenous communities. The family may also shed light on the cultural significance of the illness.
- Often there are individuals in the family who are given the responsibility to care for the individual. It is important to involve these carers as they have the clearest picture of the patient and their history.
- If the patient is uncommunicative regarding their illness, use a story about a fictitious third person that reminds you of the illness the person is experiencing. This can often overcome shyness or shame within the community.
- Be aware of sensitive areas including bereavement, ceremonial business (e.g., initiations), breaking of taboos and sexuality/fertility.
- Be patient and don’t expect full verbal histories when first meeting the individual and their family.

MANAGEMENT

- Always involve the family and carers in treatment plans.
- Always involve Aboriginal mental health workers, Aboriginal Liaison Officers or generalist Aboriginal health workers.

This section is intended to be read in conjunction with other sections in this document and should not be used as a sole management plan.
CULTURALLY AND LINGUISTICALLY DIVERSE SERVICES

BARRIERS TO ACCESSING MENTAL HEALTH SERVICES

Ethnic minority groups are usually under-represented in psychiatric services in Western nations. Differential access to services may be due to lack of knowledge about service availability, different explanatory models of illness and solutions, stigmatisation of mental illness, culturally unresponsive clinical practices and different pathways to care or referral.

Clinical services that are not culturally responsive may increase disengagement from treatment once services have been accessed. Engagement of culturally and linguistically diverse (CALD) services provides information to families to facilitate access to services, promotes positive attitudes to mental health and improves continuity of care.

STANDARD PROCEDURES FOR THE USE OF HEALTH CARE INTERPRETERS

It is N.S.W Government Policy for health care providers to seek the assistance of professional interpreters in order to ensure that Australians from non-English speaking backgrounds (NESB) have equal and appropriate access to services. The Health Care Interpreters’ Service (HCIS) was established to assist health care providers to carry out their professional responsibilities in a cross-cultural situation.

The benefits of using the HCIS is that it gives families the opportunity to ask questions about the health system, the treatment and/or procedure recommended and the risks involved, and to receive the information to make an informed choice to provide consent before treatment commences.

The benefits to health care providers include:

- Facilitation of accurate diagnosis and patient’s understanding of treatment
- Adherence to treatment (including medication)
- Ability to offer health promotion and prevention programs
- Effective management of chronic illness
- Reduction of hospitalisation rates
- Savings in unnecessary diagnostic tests, procedures, and health personnel time
- Prevention of misunderstandings that could result in legal action
- Translation of instructions to the family and special diets necessary for the treatment of the patient can be carried out by the HCIS

It is essential that Health Care Interpreters are present during interviews or discussions with the family with regard to the following situations or issues:

- Admission
- Medical histories, assessments and treatment plans
- Medical instructions
- Consent for procedures, treatment and research
- Psychiatric assessment and treatment
- Counselling
- Psychological assessment
- Discharge procedures and referrals
- Sexual assault, physical and emotional abuse
- Health education and promotion programs
- Explanation of medication
- Mental Health Review Tribunals and Magistrate’s enquiries

In situations of admission or discharge, where a HCI is not available on site, the Telephone Interpreting Service (TIS) may be a viable option. In cases of emergency, when a HCIS or TIS interpreter may not be available and a non professional interpreter or family member is relied upon, service providers must ensure that the HCIS is called as soon as possible to ensure that accurate information has been communicated and the medical history is accurate.

### HEALTH CARE INTERPRETER SERVICE

<table>
<thead>
<tr>
<th>Sydney West Area Health Service</th>
<th>Northern Sydney/Central Coast Area Health Service</th>
<th>Sydney South West Area Health Service/Western Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ph: (02) 9840 3456</td>
<td>Ph: (02) 9926 7560</td>
<td>Ph: (02) 9828 6088</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sydney South West Area Health Service/Eastern Zone</td>
<td>South East Sydney/Illawarra Area Health Service</td>
<td>Hunter New England Area Health Service</td>
</tr>
<tr>
<td>Ph: (02) 9515 9500</td>
<td>Ph: (02) 4274 4211</td>
<td>Ph: (02) 4924 6285</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All country areas of NSW (except Greater Murray &amp; Southern)</td>
<td>Illawarra region</td>
<td>Greater Murray &amp; Southern</td>
</tr>
<tr>
<td>Ph: 1800 674 994</td>
<td>Ph: (02) 4274 4211</td>
<td>Ph: 1800 247 272</td>
</tr>
</tbody>
</table>

### INTERPRETING SERVICES

<table>
<thead>
<tr>
<th>Translating &amp; Interpreting Service</th>
<th>Doctor’s Priority Line</th>
<th>Hospital Priority Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ph: 13 14 50 (Free Service)</td>
<td>Ph: 1300 131 450 (Free for Private Practitioners including GPs)</td>
<td>Ph: 1300 655 030</td>
</tr>
</tbody>
</table>
PATIENT RIGHTS & RESPONSIBILITIES

All families of NESB should be informed about the HCIS and their ability to access a professional health care interpreter. All health facilities need to display the contact phone number for the HCIS and the TIS. A copy of the HCIS pamphlet and patient rights and responsibilities pamphlet should made available to the family in the appropriate language. Families from a NESB should be informed of their rights to make a complaint if they are dissatisfied with a Health Service or the HCIS.

ACCESS TO INFORMATION ABOUT EATING DISORDERS

Written information should be provided to the family in the appropriate language. This should be seen as complementary to the HCIS and not replace the use of an Interpreter. Written and audio information about eating disorders can be accessed from:

www.chw.edu.au/prof/services/psychmed/healthykids/

NSW TRANSCULTURAL MENTAL HEALTH SERVICE

The service offers a free consultation and assessment service to health professionals providing mental health care to patients from CALD backgrounds living in NSW. The Transcultural Mental Health Service can be contacted on: Tel (02) 9840 3897.

NSW SERVICE FOR THE TREATMENT & REHABILITATION OF TORTURE & TRAUMA

The service assists survivors of torture and refugee trauma and provides resources to individuals who work with them to provide appropriate, effective and culturally sensitive services. The service can be contacted on: Tel (02) 8778 2000 Liverpool branch and (02) 9646 6666 Auburn Branch.

NSW REFUGEE HEALTH SERVICE

The service offers free health assessment clinics, advice and referral for people who have recently arrived from overseas on humanitarian grounds and provides consultation and support to mainstream health care workers working with refugees. The service can be contacted on: Tel: (02) 8778 0770.
STATEWIDE SERVICES AND CONTACTS

Eating Disorders Foundation Inc. – an organisation for the support of parents, families, carers and sufferers runs a 5-day-a-week phone line, support groups and referral service

02 94124499
www.edf.org.au

The Centre for Eating and Dieting Disorders – a website which offers information on services and support for people with an eating disorder

www.cedd.org.au

NSW Eating Disorder Coordinator – an individual appointed by the NSW Mental Health and Drug & Alcohol Office to offer coordination and support to eating disorder services throughout NSW, particularly for adults.

02 9515 5843
www.cedd.org.au

Child & Adolescent Specialist Eating Disorder Tertiary Service at The Children's Hospital Westmead (<16 years) – a specialist inpatient and outpatient unit capable of providing limited clinical liaison and support to non-specialist services via telepsychiatry

02 9845 0000

Westmead Hospital Adolescent Eating Disorder Program (>14 years) – an 8-bed 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 9845 5555

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 9382 1922 (for referrals)

Transport for Health (previously ‘Isolated Patients Travel and Accommodation Assistance Scheme', IPTAAS) - Provides a range of transport and travel assistance to people who are disadvantaged by distance or who cannot access public and/or private transport.

For office contact details or copies of the Transport for Health (IPTAAS) application for assistance go to the NSW Health Intranet at:

Section 7: Further Information and Resources
WHAT IS AN EATING DISORDER?

Eating disorders are characterised by an abnormal eating pattern and cognitive distortions related to food, weight and body image, which subsequently result in adverse effects on nutritional status, impaired health status and function and medical complications.

The DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 2000) outlines three types of disordered eating patterns; Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Eating Disorder Not Otherwise Specified (EDNOS), which are diagnosed according to specific psychological, behavioural and physiological characteristics.

COMMON THEMES FOR ALL PATIENTS WITH DISORDERED EATING

- Altered body perception (body image and body shape) e.g., “My thighs are too fat”
- Altered weight perception
- Fear of weight gain (even when severely underweight)
- Feelings of guilt and failure when weight is gained or an undesirable food (or binge) is eaten
- Concerns about eating in public
- Anxiety, depression, obsessive-compulsive features, social withdrawal, irritability, insomnia, self-harm (e.g., cutting), and decreased libido may also be present

ANOREXIA NERVOSA (AN)

The DSM-IV-TR states that AN presents as a refusal to maintain a minimally normal body weight (BMI <17.5).

Other features of AN include:
- Food restriction - calorie and/or fat restriction (e.g., <1000 calories and <10gms fat per day). Patients can present as vegetarians (e.g., diet based on fruit), avoid high glycaemic index foods, have an avoidance of occasional foods (e.g., chocolate, chips), and generally limit all high fat/calorie foods.
- Amenorrhoea or irregularity in menses.
- Excessive exercise, which can interfere with daily activities, occurs at inappropriate times, or in appropriate settings (e.g., “secret” exercising in bedroom at night).
- Excessive weighing.
- Intense fear of weight gain (at times increases even though weight decreases further).
- Using a mirror constantly to assess body shape and “fatness”.

---

*Body Mass Index calculated as weight (kg)/height (m^2)
- Constipation.
- Complaints of abdominal pain and bloating after eating small amounts of food/fluids.
- Cold intolerance (blue hands/fingers).
- Lethargy and poor concentration.
- Personality traits such as feelings of ineffectiveness, a desire to control one’s environment, inflexible thinking, limited social spontaneity, perfectionism, and restrained initiative and emotional expression may be evident.
- When in hospital routine nursing observations on the ward may show hypotension and hypothermia.
- Laboratory findings may present the following: leukopenia, mild anaemia, hypercholesterolaemia, elevated liver function tests (LFTs), dehydration/impaired renal function (elevated Blood Urea Nitrogen, BUN), unstable electrolytes, metabolic alkalosis (for self-induced vomiting), metabolic acidosis (laxative abuse), low serum oestrogen (females) and testosterone (males), decreased tri-iodothyronine (T3) and low-normal serum thyroxine (T4) levels. Sinus bradycardia may be seen on ECG.
- At times, a fine downy body hair (lanugo) may develop on the trunk, arms and facial area.
- At times, self-induced vomiting, even after small amounts of food (associated with dental enamel erosion) and misuse of laxatives/diuretics is present.

Two sub classifications of AN:
I. Restricting type (weight loss occurs by means of restricting overall food intake combined with excessive exercise); and,
II. Binge-eating/purging type (binge-eating with self induced vomiting, or self induced vomiting after small amounts of food and/or the misuse of laxatives/diuretics/enemas).

**BULIMIA NERVOSA (BN)**

BN is described as repeated episodes of binge eating (at least twice a week for 3 months) followed by inappropriate compensatory behaviours (self induced vomiting, but can also include misuse of laxatives/diuretics, fasting which can be for extended periods of time, or excessive exercise). A binge is defined as eating a quantity of food that most individuals would consider an excessive amount of food, in a time period of less than two hours.

**Other features of BN include:**
- Individuals are usually within their healthy weight ranges, or are overweight.
- BN sufferers describe a feeling of lack of control over eating and an inability to stop during binge eating sessions.
- Typical binge foods are high calorie, sweet foods that are usually restricted in the diet (e.g., ice-cream), however at times it will include whatever food is available.
- Between binges individuals usually select low calorie/low fat restrictive diets and avoid foods that are seen as “bad”.
- Vomiting is the most common compensatory behaviour – it relieves physical discomfort for the individual, and reduces the feelings of fear of weight gain following the binge intake. Loss of dental enamel can be evident.
Instruments, most commonly fingers, are used to stimulate the gag reflex, and marks may be evident on the hands/knuckles from this practice. Eventually BN sufferers may be able to vomit at will.

Fasting for a day or more post binge can occur to compensate for the binge intake.

Excessive exercise may be employed post binge in an attempt to counteract the intake of calories and reduce guilt.

BN sufferers attempt to conceal their binges and they occur in secrecy.

Personality traits such as low self-esteem, mood disorders and anxiety may be evident.

Substance abuse or dependence (e.g., alcohol or stimulants) can be evident in an attempt to control appetite and weight.

Laboratory findings may present the following: fluid and electrolyte abnormalities, metabolic alkalosis/elevated serum bicarbonate (loss of stomach acid). Diarrhoea (laxative abuse) can cause metabolic acidosis.

In some cases, the salivary glands (especially the parotid glands), may become enlarged.

Menstrual irregularity may occur.

Two sub-classifications of BN:
I. Purging type (patient employs self-induced vomiting or misuse of laxatives/diuretics post binge), and;
II. Non-purging type (uses excessive exercise or fasting post binge).

EATING DISORDER NOT OTHERWISE SPECIFIED (EDNOS)

EDNOS is the classification used when disordered eating patterns do not meet the criteria for either AN or BN. This does not make EDNOS less severe, but simply another type of eating disorder.

Examples of EDNOS include:
- Criteria for AN are met except the female has regular menses.
- Criteria for AN are met however despite significant weight loss, the individual’s weight remains within the healthy weight range.
- Criteria for BN are met, however binge eating/compensatory behaviours frequency occurs less than two times/week, or less than 3 months in duration.
- Individuals of a normal body weight who utilize compensatory behaviours after eating small amounts of food (e.g., vomiting after two biscuits).
- Individuals who repeatedly chew and spit food out (avoid swallowing large amounts of food).
- Individuals who have recurrent binge eating episodes without regular use of compensatory behaviours.
DIFFERENTIAL DIAGNOSIS

It is important to identify adolescents who may present with weight loss but who do not have an eating disorder. In this situation, weight loss may not be not intentional, there may be an absence of major distortion of body image, and weight gain to usual parameters may be desired. Other causes of weight loss include medical conditions (such as gastrointestinal disease, brain tumours, and malignancies) and mental health problems (such as depression, psychosis and schizophrenia), which should be investigated.

CHILDHOOD ONSET EATING DISORDERS AND EATING DISTURBANCES

The issue of diagnostic criteria in childhood has been widely debated. Syndrome recognition guidelines for children have been suggested and have become known as the “Great Ormond Street Criteria”. These guidelines include the following:

**Food Avoidance Emotional Disorder**
- Food avoidance not accounted for by a primary affective disorder.
- Weight loss.
- Mood disturbance not meeting the criteria for a primary affective disorder.
- No abnormal cognitions regarding weight or shape.
- No morbid preoccupation regarding weight or shape.
- No organic brain disease or psychosis.

**Selective Eating**
- Narrow range of foods for at least two years.
- Unwillingness to try new foods.
- No abnormal cognitions regarding weight or shape.
- No fear of choking or vomiting.
- Weight may be low, normal or high.

**Functional Dysphagia**
- Food avoidance.
- Fear of swallowing, choking or vomiting.
- No abnormal cognitions regarding weight or shape.
- No morbid preoccupation regarding weight or shape.
- No organic brain disease or psychosis.

**Pervasive Refusal Syndrome**
- Profound refusal to eat, drink, walk, talk or self-care.
- Determined resistance to efforts of help.
INFORMATION FOR PARENTS AND CARERS

What is an Eating Disorder?
Eating disorders, such as anorexia nervosa and bulimia nervosa, are serious illnesses. They occur mostly among females but can also affect males. Eating Disorders affect a person’s physical and mental health and can lead to the disruption of a person’s social and emotional life. Eating disorders also affect physical safety, sometimes to the point of being life threatening. Recovery from an eating disorder can be a very difficult time for the sufferer, their family and friends. It usually takes many months, often years, to recover.

How long will my child be in hospital?
The amount of time people need to be in hospital is different for everyone. The length of admission depends on many things, including how long it takes for your child to become medically stable.

What will happen during the admission?
You will be asked lots of questions early on in the admission, as health professionals will want to find out as much as they can about your child’s medical and psychological history - you may even be asked the same questions a number of times by different people. Other tests will be conducted, such as blood tests and urine tests.

Why does my child need to be in hospital?
A young person will need to go to hospital when their safety (medical or psychological) is seriously at risk due to starvation or other behaviours or symptoms. Some medical complications that can arise include: anaemia, fainting or “blacking out”, slower pulse, low blood pressure, kidney problems, imbalance of electrolytes in the blood, and heart problems.

What if my child refuses to go to hospital?
Accessing care for your child as soon as possible is very important – the sooner your child accesses treatment the more likely it is that treatment will be successful. If your child is medically unsafe and scared about going to hospital, talk to your health professional about how to discuss treatment with them.

What can I be doing to help my child?
There are many things you can do to help your child as they recover from an eating disorder; after all, you are an important part of the treatment team. The treatment team will advise you of ways that you can get involved in the care of your child by becoming a “treatment ally”. This will vary across families depending on your child’s age, family circumstances and treatment approach. Talk to the team to understand what is happening, and to support your child in their efforts towards getting better.

Some strategies other parents have found helpful:
- Seeing the eating disorder as separate from the young person - talk about the disorder as a separate thing from the child.

Eating Disorders Toolkit – Further Information and Resources 135
My Child is in Hospital

- Understanding how eating disorders can affect behaviour can help you cope with the difficult emotions your child may be experiencing (such as anger). Remember, it is very difficult and distressing for young people with an eating disorder to eat normally - they are not just being naughty.
- The young person will need a lot of emotional support and families are in a good position to assist.
- Look after yourself – the illness can take its toll on the whole family, and it is important that families have support to be able to discuss their own needs.
- Enjoy usual, everyday activities as much as possible. You can play a significant role in recovery by helping your child to remember things they like to do in everyday life, outside of the eating disorder.
- Remember, recovery from an eating disorder is long term, and can take years. Just because a young person begins to eat again and gains weight, does not mean that the illness has gone away.

What will happen when my child is discharged?
During your child’s admission the team will have been working towards plans for discharge. It is most likely that a team of people, such as a GP, a psychologist and a dietitian, may have been identified as health professionals your child will see for treatment outside of hospital.

This “community-based” treatment is where most of the work will be done to help your child recover. In some areas a team approach may not be available. It is very important that your child is linked in with at least one health professional, such as a GP, to help them recover, and to ensure they receive treatment if they become medically unwell again and need a hospital admission.

I'm worried about my child coming home
It’s understandable that you might feel worried about your child going home – caring for a sick child can be very stressful. Talk to the treatment team about particular concerns you have – they may have some practical suggestions for how to manage any tricky behaviours or situations at home. They may also have suggestions of other people or organisations that can offer help or support.

Who can I contact for more information or if I need support?
You should approach your health professional and discuss any questions or concerns with them. Other places you can access information or help are:

- **Eating Disorders Foundation Inc.**
  An organisation for the support of parents, families, carers and sufferers.
  t 02 9412 4499  www.edf.org.au

- **The Centre for Eating and Dieting Disorders**
  A website which offers information on services and support for people with an eating disorder.
  www.cedd.org.au

- **Kids Helpline**
  t 1800 55 1800

- **Parent Line**
  t 132 005
HEALTH PROFESSIONALS – CLINICAL PRACTICE GUIDELINES


HEALTH PROFESSIONALS – BOOKS AND JOURNAL ARTICLES

**Assessment Tools**


**Eating Disorders**


**Medical Management**


**Psychological Management**


**Refeeding and Refeeding Syndrome**


**HEALTH PROFESSIONALS – POLICIES AND OTHER DOCUMENTS**

**NSW Health Policy Documents**


NSW Health Frontline Procedure for the Protection of Children and Young People

NSW Health Policy Directives:


PD2005_299: Protecting Children and Young People.

PD2006_003 Child Protection Issues for Mental Health Services – Risk of Harm Assessment Checklist

PD2006_104: Child Protection Roles and Responsibilities – Interagency

PD2006_105 Child Protection Roles and Responsibilities – Interagency

PD2007_023 Prenatal Reports

NSW Interagency Guidelines for Child Protection Intervention.

**Other Documents**


Mental Health Act (2007)

PARENT / CARER


YOUNG PERSON


Section 8: Toolkit Development Process
DEVELOPMENT OF THE TOOLKIT

DETERMINING THE NEED FOR THE TOOLKIT

MH-Kids, a service formerly known as the Child and Adolescent Mental Health Statewide Network (CAMHSNET), aims to improve the mental health care of children, adolescents and their families within NSW. One of the key roles of the organisation has been to improve access to resources, particularly for clinicians working in regional and rural areas. There was an identified need to develop the Toolkit: 1) to assist with improving access to practical information; 2) to facilitate consultation with specialist staff; and, 3) to improve consistency in care for adolescents with eating disorders in NSW.

SCOPE AND PURPOSE OF THE TOOLKIT

Needs analysis
In late 2004, a needs analysis survey was conducted among clinicians working in regional and rural inpatient settings. Results from the survey indicated an expressed need by clinicians for a resource that would provide practical information on eating disorders treatment in a user-friendly format. Survey findings assisted in establishing the structure and content of the Toolkit. Over 70% of respondents indicated that they would like documentation on care planning (89%), discharge planning (89%), assessment (87%), risk assessment (84%), legal issues (78%) and nasogastric feeding (73%). Other common requests included protocols and care plans, exercise, refeeding guidelines and liaison with mental health services.

Target audience
The Toolkit has been developed for use by all clinicians working with adolescents (aged 12-18 years) with an eating disorder in non-specialist inpatient settings in NSW. The Toolkit covers the more typical eating disorders (AN, BN and EDNOS). Children are not included as a target for the Toolkit due to need for treatment with child-oriented professionals who have expertise with eating disorders in this population group.

Links to specialist services/institutions
One of the key issues in considering the scope and purpose of the Toolkit was the need for facilitation and further development of links between specialist eating disorder facilities and non-specialist inpatient admissions in NSW. The Toolkit aimed to highlight the need for initiating contact at key time points (when patients are indicated for admission or are admitted to a non-specialist unit) and to improve access to specialist input by providing clear contact information.

Special consideration for regional and rural locations
Implementing treatment recommendations may vary depending on the treatment setting. Regional and rural areas may differ to metropolitan areas in terms of staffing, skill mix and access to resources. Special reference has been made wherever possible to the practical implementation of treatment recommendations in regional and rural settings.

Development in line with public health policy and relevant documents
Relevant State and National Health policies and documents and International Clinical Guidelines were reviewed to ensure that the Toolkit was developed in line with current policy and planning and evidence-based recommendations. Key themes for the Toolkit included ensuring equal access to appropriate treatment, timely and appropriate referral, improving transition and continuity of care, building capacity within the current workforce and building partnerships.

Eating Disorders Toolkit - Toolkit Development Process
Costing
Funding for the project was limited. A three-year part-time project officer position had been created and funded by MH-Kids to assist with the development, implementation and evaluation of the Toolkit. A significant number of clinicians from around NSW, other States and overseas were involved in the development of the original document, review of document drafts and developing implementation and evaluation plans.

DEVELOPMENT OF THE TOOLKIT

Formation of working parties
Recruitment to working parties was conducted by written invitation. Key national and international eating disorders treatment and research experts, along with known clinicians from all relevant disciplines throughout NSW, were identified and invited to participate. Participants were involved as a member of an interdisciplinary working party, as an expert reviewer and/or as a consultant.

Interdisciplinary working parties included:
- Consumer/carer
- Dietetic
- Ethical and legal
- Medical (paediatrician and psychiatrist)
- Nursing
- Occupational therapy
- Pharmacotherapy
- Physiotherapy
- Psychology
- Social work
- Transcultural

Specialist consultant input included eating disorders experts, Aboriginal health, epidemiology, policy and law.

Toolkit development group
The Toolkit development group was comprised of a Clinical Governance Committee and Core Working Party (including Project Officer) from MH-Kids. It was the responsibility of the Core Working Party to oversee and to participate in the development and review of draft documents and coordinate communications between working parties, reviewers and the Toolkit development group.

Participants in the Toolkit development were invited to an ‘inaugural meeting’ for the project. Working party members received detailed written instruction on the development of draft documents, including topics to be researched/considered and processes for literature review and appraisal. Due to working party members being located at a distance from each other an outline for communication between draft developers was also provided.

No remuneration was offered to expert reviewers, consultants or working party members for participation in the project. There were no conflicting interests evident.
Timelines
MH-Kids commenced the development of the Eating Disorders Toolkit, with the appointment of a project officer, in October 2004. Phase 1 included scoping of the project, including the identification of key recommendations and topics to be included in the document. The formation of working parties followed. Drafting of toolkit documents was conducted alternately with peer reviews, including 8 full draft Toolkit documents in total. The final stage included publishing and preparing the document for release.

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Phase 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scoping document and identifying recommendations</td>
<td>Formation of working parties</td>
<td>Drafting documents including intermittent consultation and peer review</td>
<td>Publication and launch</td>
</tr>
</tbody>
</table>

31 months

SELECTION OF TOOLKIT TOPICS (CRITERIA AND TOPIC SELECTION PROCESS)

Selection of toolkit topics (clinical issues addressed in the toolkit) was based on the content of three main clinical practice guidelines (CPGs) published for the management of eating disorders. These CPGs included:


Key recommendations for clinical practice, which were based on systematic review and meta-analyses of the literature in the field of eating disorders, were extracted from the three documents. The key recommendations were chosen based upon: (a) the relevance to an inpatient setting; (b) the relevance and applicability to regional and rural areas; (c) the relevance to non-specialist units or wards managing eating disorder admissions; (d) commonly asked questions from clinicians regarding the management of eating disorder admissions; and, (e) perceived importance based on the needs assessment and clinician request. Recommendations (along with levels of evidence) were then circulated to all working party members for comment. Working party members suggested additional topics or recommendations for inclusion in the framework.

These recommendations, along with research questions based on consultation and supervision with regional and rural clinicians throughout NSW, informed the content of the Toolkit and provided a structure from which to develop "practice-based" recommendations.
LITERATURE REVIEW

Key recommendations and research questions, to be expanded into “practice-based” recommendations, were divided into sections, based on discipline. Each disciplinary working party, led by a working party leader, was given verbal and written instruction on how to address each key recommendation and research question through literature review. This included information on framing clinical questions, searching the evidence (including example search strategies), appraising the evidence and applying the evidence.

Appraising the evidence according to National Health and Medical Research Council (NH&MRC) standards (i.e., as in systematically reviewing and applying meta-analyses to the literature) was not undertaken for this project, as the Toolkit is a practice-based manual rather than a purely evidence-based guideline. However, it was important that all working party members, involved in drafting sections of the toolkit, were aware of principles and limitations in relating evidence to practice. In addition, key recommendations derived from the evidence-based clinical guidelines were directly incorporated into the Toolkit.

FORMING TOOLKIT RECOMMENDATIONS

Due to often conflicting expert views regarding the inpatient management of eating disorders, and the limited nature of high-level evidence in the field of eating disorders, a conservative approach has been taken in making recommendations. It has been the endeavour of the core working party, and all those involved in the development of the Toolkit, to make the document as practical as possible, while still being informed by the evidence. As such, recommendations presented here may vary slightly from what is presented in the evidence-based literature.

Where conflicting views regarding content arose, the literature was reviewed (along with existing international guidelines) and levels of evidence were considered. Where there was a low level of evidence (such as refeeding), a conservative approach was taken.

The practice-based recommendations have been written with three main considerations: 1) consultation with evidence-based literature; 2) consultation with national and international research and clinical experts; and, 3) the experiences of clinicians working with patients with eating disorders.

Most of the level of evidence described in the document can be classified according to NH&MRC descriptions as Grade C or D. As such, recommendations should be applied carefully to individual clinical and organisational circumstances and should be followed with care.

CONSULTATION AND PEER REVIEW

Consultation and peer review of the Eating Disorder Toolkit draft documents has been wide and extensive. Initial consultation was held at an inaugural meeting of all members of the Clinical Governance Committee, core working party, and interdisciplinary working parties. Members who were unable to attend in person were invited to link in via videoconferencing. A total number of 130 people have been involved in the Toolkit development process.

Every draft document underwent external review (peer review by national and international experts in the field of eating disorders and interdisciplinary working party members) or internal review (by core working party members). External review was undertaken for at least 3 of the 8 full Toolkit draft documents. There was also extensive consultation between the core working party and interdisciplinary working party members during the development of each draft document.
PRESENTATION AND DISSEMINATION

Content and presentation of the toolkit

The Toolkit has been developed to provide practical information on key components of care for adolescents admitted with an eating disorder. This information has included involving the family and other health professionals, identifying those in need of admission, admitting the patient, assessment, treatment planning, implementing treatment, discharge and accessing further information and support. Implementing treatment has formed the largest component of the document and includes practical information on medical, nutritional and psychological care of patients.

The document has been developed with the busy clinician in mind, aiming to ensure easy access to relevant information. The document has been presented in a hard-covered format to allow easy transport and use on the ward (e.g., to team meetings). The document is ring-bound to allow sections to be removed as needed. Sections have been divided by components of care, colour-coded and indexed to allow easy access to relevant sections. Key concepts and recommendations have been highlighted throughout the document by use of text boxes and bolded text.

Information for families

Involvement of families in care has been highlighted throughout the document. In order to assist in facilitating family involvement, an information resource for families has been included in the document.

Distribution

The Toolkit will be distributed to all paediatric mental health and medical wards in NSW and freely available to be downloaded. Additional copies may be available from the Better Health Centre Publications Warehouse.

EVALUATION OF THE TOOLKIT

A feedback form has been developed and included in the Toolkit to assist with process evaluation. The aim is to review the Toolkit as required, depending on feedback and emerging evidence.

SUGGESTIONS FOR IMPROVING THE TOOLKIT

Suggestions for improving the Toolkit are encouraged. It is recognised that while there is a wealth of descriptive literature about treatment, the evidence base to guide treatment decisions has lagged. The Toolkit will need to further develop with the evolving evidence and in line with clinician need in the practical setting.
Eating Disorders Toolkit - Toolkit Development Process
Appendices
APPENDIX 1: ACKNOWLEDGEMENTS

Clinical Governance Committee
MH-Kids Management

Core Working Party
Melissa Hart (Working Party Leader)
Dr Sandra Heriot (Working Party Leader)
Kelly Monger (Project Officer)
Teri Stone (Working Party Leader)

External (Expert) Consultants
Dr Rachel Bryant-Waugh (Clinical Psychologist)
Dr Simon Clarke (Adolescent Physician)
Dr Janine Duke (Epidemiologist)
Raylene Gordon (Aboriginal Convenor)
Professor Phillipa Hay (Psychiatrist)
Dr Michael Kohn (Adolescent Physician)
Professor Bryan Lask (Child and Adolescent Psychiatrist)
Dr Sloane Madden (Child and Adolescent Psychiatrist)
Professor Kenneth Nunn (Child and Adolescent Psychiatrist)
Professor Susan Paxton (Clinical Psychologist)
Dr Titia Sprague (Policy Advisor)
Professor Stephen Touyz (Clinical Psychologist)

Working Party Members (Continued)
Kim Lane (Working Party Leader)
Judith Leahy
Peggy Lee
Katy Lennox
Talya Linker
Anne Lipzker
Martin Losurdo
Claire Lynch (Working Party Leader)
Sarah Maguire
Dr Kim Manhood
Peta Marks
Penny Maxwell (Working Party Leader)
Dr Rod McClymont
Brenda McLeod
Dr Patricia McVeagh
Maria Milic
Kim Millard
Tayebeh Mojarred
Gabrielle Mulcahy
Michelle Murray
Nicole Myers
Dyanhi Neville
Monique Newson
Fiona Nielson
Theresa Novak
Maureen O’Connor
Tracey Patricks
Veronica Pitcher
Alison Porter
Diana Renshaw
Dr Liz Rieger
Susan Ringwood
Dr Janice Russell
Kristy Saultry
Felicity Spencer (Working Party Leader)
Matthew Stanton (Co-working Party Leader)
Don Stewart
Helen Storey
Maureen Thorley
Chris Thornton
Kathryn Vaughan
Renee Verdon
Meg Vickery
Rhonda Winkill
Denise Wong See
Cath Wood

Other Contributors
Associate Professor John Attia
Lucas Bull
Sophie Diworth
Michael Donovan
Darren Faulkner
Lisa Gear
Sharon Searle
Claire Toohey
Cathie Turk
Joy Pennock
Michael Cowen
APPENDIX 2:
GROWTH AND BMI CENTILE CHARTS

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

*To Calculate BMI: Weight (kg) = Stature (cm) + Stature (cm) x 10,000
or Weight (lb) + Stature (in) = Stature (in) x 703

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

Eating Disorders Toolkit – Appendices 148
### Eating Disorders Toolkit – Appendices

#### 2 to 20 years: Boys

**Body mass index-for-age percentiles**

<table>
<thead>
<tr>
<th>Date</th>
<th>Age</th>
<th>Weight</th>
<th>Stature</th>
<th>BMI*</th>
<th>Comments</th>
</tr>
</thead>
</table>

**To Calculate BMI:**

- Weight (kg) = Stature (cm) + Stature (cm) x 10,000
- Weight (lb) = Stature (in) + Stature (in) x 703

---

*Published May 30, 2000 (modified 10/16/00).*

**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](http://www.cdc.gov/growthcharts)
APPENDIX 3:
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.
APPENDIX 4: PHYSICAL ACTIVITY: STRETCHES

KNEE TO CHEST STRETCH

With hands behind the knee, pull knee in to 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 leg below knee, bend hands at holding a towel slowly straighten knee until stretch is felt in back of thigh. Hold for 20 seconds. Stretch both sides.

Piriiformis / hip stretch

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

INNTER 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 downward to increase the stretch. Hold for 20 seconds.

QUADRICEPS / FRONT OF THIGH STRETCH

Pull right / left heel in toward 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 30 seconds. Stretch both sides.

CHEST STRETCH

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

ANGRY CAT STRETCH

Touch chin and flat one and arch back upwards. Try to squeeze each segment of your spine. Then lift chin and arch back and dip back downward. Repeat slowly 5 times.

MID BACK STRETCH

Sit on heels with feet body forwards, resting the chest on your knees and the floor. Reach the arms forward. 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 the 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.

Copyright 1999—2007 VHI
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)
- Childrens’ 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.


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.
<table>
<thead>
<tr>
<th><strong>APPENDIX 7:</strong> GLOSSARY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Absconing</strong></td>
</tr>
<tr>
<td><strong>Affective Disorders</strong></td>
</tr>
<tr>
<td><strong>Alexithymia</strong></td>
</tr>
<tr>
<td><strong>Amenorrhoea (Primary)</strong></td>
</tr>
<tr>
<td><strong>Amenorrhoea (Secondary)</strong></td>
</tr>
<tr>
<td><strong>Anorexia Nervosa</strong></td>
</tr>
<tr>
<td><strong>Anaemia</strong></td>
</tr>
</tbody>
</table>
| **Antidepressants** | Drugs that treat the symptoms of depression. There are three main types of antidepressant:  
- Selective serotonin re-uptake inhibitors (SSRIs),  
- Tricyclic antidepressants (TCAs) and related drugs, and  
- Monoamine oxidase inhibitors (MAOIs). |
| **Anxiety Disorders** | 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. |
| **Avoidant Personality Traits** |  
- Avoidance of occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection. For children, the DSM-IV 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.  
- Person may be unwilling to get involved with others unless certain of being liked. |
<table>
<thead>
<tr>
<th><strong>Binge eating disorder</strong></th>
<th>A syndrome in which there are repeated uncontrolled episodes of overeating but no use of compensatory weight-control behaviours.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BMI Centile chart</strong></td>
<td>A chart to link child Centiles of body mass index, weight and height.</td>
</tr>
</tbody>
</table>
| **Body Mass Index (BMI)** | 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 & adolescents.  
  
  \[ BMI = \frac{\text{weight (kg)}}{\text{height (m)}^2} \] |
| **Bradycardia**          | Slowness of the heart rate; pulse < 60 beats per minute.                                                                            |
| **Bulimia Nervosa**      | 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. |
| **Cognitive Behaviour Therapy (CBT)** | 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. |
| **Compulsions**          | Repetitive purposeful intentional behaviour performed according to rules to neutralise obsessions. These may include washing, checking, ordering, hoarding and avoiding rituals. |
| **Dependent Personality Traits** | 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. |
| **Dialectical Behaviour Therapy (DBT)** | Treatment that includes:  
  - Mindfulness skills  
  - Distress tolerance  
  - Emotional regulation  
  - Interpersonal effectiveness  
  This intervention can be effective in the treatment of Borderline Personality Disorder (BPD). |
<p>| <strong>Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)</strong> | A system for classification of psychological and psychiatric disorders prepared by the American Psychiatric Association. |
| <strong>Dual-Energy Xray Absorptiometry (DEXA)</strong> | 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. |
| <strong>Eating disorder not other specified (EDNOS)</strong> | Eating disorders that closely resemble AN and BN but are considered atypical, as they do not meet the precise diagnostic criteria for these conditions. |
| <strong>ECG (Electrocardiogram)</strong> | 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. |
| <strong>Ego-dystonic</strong> | The individual’s sense that a symptom is alien and not within their control. The opposite of ego-syntonic, this term refers to behaviour or mental acts, such as thoughts, feelings, and desires, which are incompatible or unacceptable to the individual’s sense of self. |
| <strong>Electrolytes</strong> | 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. |
| <strong>Emetics</strong> | 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. |
| <strong>Externalise</strong> | 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?” |
| <strong>Glucocorticoids</strong> | Type of corticosteroid involved in carbohydrate metabolism that also has anti-inflammatory and immospressive 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. |
| <strong>Glycaemic index</strong> | A method of ranking foods according to their effect on the blood glucose level. |</p>
<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypercholesterolemia</td>
<td>An increased blood cholesterol level</td>
</tr>
<tr>
<td>Hypercortisolism</td>
<td>Also known as Cushing's Syndrome, a disease caused by an excess of cortisol production.</td>
</tr>
<tr>
<td>Hyperglycaemia</td>
<td>High blood sugar (glucose)</td>
</tr>
<tr>
<td>Hyperkalaemia</td>
<td>High serum potassium</td>
</tr>
<tr>
<td>Hypernatraemia</td>
<td>High serum sodium</td>
</tr>
<tr>
<td>Hypertension</td>
<td>High blood pressure</td>
</tr>
<tr>
<td>Hypoglycaemia</td>
<td>Low blood sugar (glucose)</td>
</tr>
<tr>
<td>Hypokalaemia</td>
<td>Low serum potassium</td>
</tr>
<tr>
<td>Hyponatremia</td>
<td>Low serum sodium</td>
</tr>
<tr>
<td>Hypophosphataemian</td>
<td>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).</td>
</tr>
<tr>
<td>Hypotension</td>
<td>Low blood pressure</td>
</tr>
<tr>
<td>Hypothermia (acute)</td>
<td>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.</td>
</tr>
</tbody>
</table>
| Interpersonal therapy (IPT) | IPT was originally proposed as a short-term treatment for depression. It involves three stages:  
  - Identification of interpersonal problems that led to the development and maintenance of the problem  
  - Therapeutic contract for working on these interpersonal problems  
  - Addressing issues related to termination |
<p>| Lanugo hair             | 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. |
| Leukopenia              | Reduced white blood cell count                                               |
| Metabolic acidosis      | A disturbance in the body's acid-base balance: blood pH is low (under 7.35) signifying excessive acidity of the blood. |</p>
<table>
<thead>
<tr>
<th><strong>Metabolic alkalosis</strong></th>
<th>A primary increase in serum bicarbonate (HCO$_3^-$) concentration. It is a condition of excess base (alkali) in the body fluids. The opposite of excess acid (acidosis).</th>
</tr>
</thead>
</table>
| **Mid parental height** | A calculation that estimates the expected adult height of an individual based on their parents' heights.  
**HOW TO CALCULATE MID PARENTAL HEIGHT**  
Girls  MPH = [(Dad’s height – 13) + Mum’s height] / 2  
Boys   MPH = [(Mum’s height + 13) + Dad’s height] / 2 |
| **Motivation: Readiness to change** | There are 5 stages of ‘readiness to change’.  
1. Pre-contemplation: denial of any problem  
2. Contemplation: acknowledgement of a problem, but not of a need to change  
3. Preparation: acknowledgement of need to change, but not ready yet  
4. Action: wants help to change Maintenance: wants help to maintain the changes |
<p>| <strong>Motivational Enhancement therapy (MET)</strong> | 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. |
| <strong>Neutropenia</strong> | The number of white blood cells (neutrophils) in the blood is below normal. |
| <strong>NSW Mental Health Act 2007</strong> | A law that governs the care and treatment and control of people in NSW who experience a mental illness or mental disorder. |
| <strong>Obsessive Personality Traits</strong> | Obsessions are persistent ideas, thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress (DSM IV). |
| <strong>Oedema</strong> | 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. |
| <strong>Oligomeorrhoea</strong> | Infrequent menstruation with markedly diminished menstrual flow. |
| <strong>Orthostatic change</strong> | 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 &quot;20-10-20&quot; 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. |</p>
<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osteopaenia</td>
<td>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.</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>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.</td>
</tr>
<tr>
<td>Parasthesia</td>
<td>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.</td>
</tr>
<tr>
<td>Peripheral neuropathy</td>
<td>Injury to the nerves that supply sensation to the arms and legs.</td>
</tr>
<tr>
<td>Refeeding syndrome</td>
<td>Constellation of metabolic disturbances that occur as a result of reinstitution 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.</td>
</tr>
<tr>
<td>Reinforcement</td>
<td>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.</td>
</tr>
<tr>
<td>Russell's Sign</td>
<td>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.</td>
</tr>
<tr>
<td>Secondary diagnosis</td>
<td>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.</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td></td>
</tr>
<tr>
<td>Serum thyroxine (T4)</td>
<td>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.</td>
</tr>
<tr>
<td>Sinus Bradycardia</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Socratic Questioning</strong></td>
<td>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.</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Splitting</strong></td>
<td>Clinically, &quot;splitting&quot; 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.</td>
</tr>
<tr>
<td><strong>Tanner Stages</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Therapeutic Alliance</strong></td>
<td>Working with the patient to help overcome the illness. This involves developing an empathic, supportive and trusting relationship with the patient.</td>
</tr>
<tr>
<td><strong>Tri-iodothyronine (T3)</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
**APPENDIX 8: ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:1</td>
<td>Nursing special one to one</td>
</tr>
<tr>
<td>AN</td>
<td>Anorexia Nervosa</td>
</tr>
<tr>
<td>BGL</td>
<td>Blood Glucose Level</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>BN</td>
<td>Bulimia Nervosa</td>
</tr>
<tr>
<td>BP</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>BPM</td>
<td>Beats Per Minute</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child &amp; Adolescent Mental Health Service</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behaviour Therapy</td>
</tr>
<tr>
<td>DADHC</td>
<td>Department of Ageing, Disability and Home Care</td>
</tr>
<tr>
<td>DET</td>
<td>Department of Education and Training</td>
</tr>
<tr>
<td>DEXA</td>
<td>Dual-Energy X-ray Absorptiometry</td>
</tr>
<tr>
<td>DoCS</td>
<td>Department of Community Services</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
</tr>
<tr>
<td>ECG</td>
<td>Electrocardiogram</td>
</tr>
<tr>
<td>ED</td>
<td>Eating Disorder</td>
</tr>
<tr>
<td>EDE</td>
<td>Eating Disorder Examination</td>
</tr>
<tr>
<td>EDNOS</td>
<td>Eating Disorder Not-Otherwise Specified</td>
</tr>
<tr>
<td>FBC</td>
<td>Full Blood Count</td>
</tr>
<tr>
<td>gm</td>
<td>Gram</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HCI</td>
<td>Health Care Interpreter</td>
</tr>
<tr>
<td>HCIS</td>
<td>Health Care Interpreter Service</td>
</tr>
<tr>
<td>HR</td>
<td>Heart Rate</td>
</tr>
<tr>
<td>HWR</td>
<td>Healthy Weight Range</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>kcal</td>
<td>Kilocalorie</td>
</tr>
<tr>
<td>Kg</td>
<td>Kilogram</td>
</tr>
<tr>
<td>kJ</td>
<td>Kilojoules</td>
</tr>
<tr>
<td>LFT</td>
<td>Liver Function Test</td>
</tr>
<tr>
<td>MAOI</td>
<td>Monoamine Oxidase Inhibitor</td>
</tr>
<tr>
<td>MET</td>
<td>Motivational Enhancement Therapy</td>
</tr>
<tr>
<td>MG/mg</td>
<td>Milligrams</td>
</tr>
<tr>
<td>MHA</td>
<td>Mental Health Act</td>
</tr>
<tr>
<td>ml</td>
<td>Millilitre</td>
</tr>
<tr>
<td>MPH</td>
<td>Mid-Parental Height</td>
</tr>
<tr>
<td>MRN</td>
<td>Medical Record Number</td>
</tr>
<tr>
<td>NESB</td>
<td>Non English Speaking Background</td>
</tr>
<tr>
<td>NG/NGT</td>
<td>Naso-gastric/ Naso-gastric Tube</td>
</tr>
<tr>
<td>NRVs</td>
<td>Nutrient Reference Values</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>NUM</td>
<td>Nurse Unit Manager</td>
</tr>
<tr>
<td>OCD</td>
<td>Obsessive Compulsive Disorder</td>
</tr>
<tr>
<td>OH&amp;S</td>
<td>Occupational Health and Safety</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
</tr>
<tr>
<td>RS</td>
<td>Re-feeding Syndrome</td>
</tr>
<tr>
<td>SSRI</td>
<td>Selective Serotonin Reuptake Inhibitors</td>
</tr>
<tr>
<td>TG</td>
<td>Triglyceride</td>
</tr>
<tr>
<td>TIS</td>
<td>Telephone Interpreter Service</td>
</tr>
<tr>
<td>UEC</td>
<td>Urea, Electrolytes, Creatinine</td>
</tr>
</tbody>
</table>
APPENDIX 9: REFERENCES

The following references have been used in the development of specific sections. Please refer to “Resource List” for suggested reading and references.

Admission

Alexithymia

Amenorrhoea

Assessing Growth & Determining Target Weights
Children’s Specialists Division of Endocrinology (date of publication unknown), *Growth Charts*, last viewed 23/10/06, [http://childrensspecialists.com/body.cfm?id=720](http://childrensspecialists.com/body.cfm?id=720)

Medical College of Georgia. (February, 2004). Tanner Staging, last viewed 23/10/06, www.mcg.edu/pediatrics/CCNotebook/chapter3/tanner.htm


**Assessment of Eating Disorders**


**Children & Eating Disorders**


**Comorbidities**


**Constipation**


Culturally & Linguistically Diverse Services


Deliberate Self Harm

Emergency Department Triage


Glossary

Hypothermia


Indigenous Eating Disorders Philosophy

NSW Health Department. (1999). *Ensuring Progress in Aboriginal Health – A Policy for the NSW Health System*.


Laxatives & Diuretics


Legal Issues

NSW Interagency Guideline for Child Protection Intervention

NSW Health Frontline Procedure for the Protection of Children and Young People

NSW Health Policy Directives:
PD2005_299: Protecting Children and Young People.
PD2006_003 Child Protection Issues for Mental Health Services – Risk of Harm Assessment Checklist
PD2006_104: Child Protection Roles and Responsibilities – Interagency
PD2007_023 Prenatal Reports


Meals & Snacks

Observations and Physical Monitoring

Osteoporosis

Pharmacotherapy

Eating Disorders Toolkit – Appendices 167
Physical Activity

Preadmission Considerations


Pregnancy

Refeeding


**Survival Strategies For Clinicians**

Child and Adolescent Mental Health Statewide Network (CAMHSNET). (February, 2004). *Clinical Supervision Guidelines*.


**What is an Eating Disorder?**


APPENDIX 10: INDEX

**A**

- Absconding .................................. 22, 45
- Alexithymia .................................. 3, 84, 142, 150
- Amenorrhoea .................................. 29, 48, 50, 65, 142, 150
- Anaemia ........................................ 115, 119, 120
- Anorexia Nervosa .......................... 1, 3, 6, 22, 35, 48, 73, 77, 78, 81, 83, 93, 94, 96, 102, 105, 114, 115, 116, 119, 121, 122, 123, 128, 140, 141, 142, 144, 147, 149, 150, 151, 152, 153, 154, 155
- Antidepressants ............................. 93, 94, 142, 149
- Anxiety Disorders ............................ 142
- Arrhythmia .................................... 67
- Avoidant Personality Traits .............. 142

**B**

- Basal Metabolic Rate ....................... 148
- Bingeing ...................................... 93
- BMI centile chart .......................... 22, 102
- Body Mass Index ............................ 12, 17, 22, 23, 25, 26, 43, 50, 102, 114, 134, 143, 149, 150
- Bradycardia .................................. 35, 148
- Bulimia Nervosa .................. 3, 6, 12, 48, 66, 79, 81, 83, 93, 94, 102, 105, 115, 116, 119, 121, 122, 144, 147, 149, 153, 155

**C**

- Care (case) manager ....................... 33, 34, 39
- Child & Adolescent Mental Health Service (CAMHS) ............ 6, 30, 113, 149
- Clinical psychologist ..................... 34, 102, 103, 120, 133
- Clinical supervision ....................... 99
- Cognitive Behavioural Therapy ....... 66, 79, 93, 122, 143, 149
- Constipation .................................. 70
- Counselling .................................. 73, 79, 109
  - active listening ......................... 73
  - confidentiality .......................... 22, 36, 73, 75
  - problem solving ....................... 86
  - reframing ................................... 64
- Culturally and linguistically diverse 109, 149

**D**

- Dehydration .................................. 12, 115
- Depression .................................. 12, 31, 78, 81, 83, 93, 94, 104, 114, 140, 142, 145
- Diabetes ....................................... 8, 12, 14
- Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) .... 2, 114, 142, 149, 155
- Dialectical Behaviour Therapy ........ 143
- Dietitian ....................................... 6, 34, 36, 55, 56, 59, 64, 70, 120
- Diuretics ..................................... 67, 81, 115, 116
- Dual-Energy Xray Absorbtionmetry (DEXA) .................. 50, 144, 149

**E**

- Eating Disorder Not Otherwise Specified (EDNOS) ............ 1, 2, 6, 83, 116, 144, 149
- Electrocardiogram (ECG) .................. 12, 17, 43, 44, 45, 115, 149, 144
- Electrolytes ................................. 43, 44, 45, 57, 115, 119, 144
- Emetics ......................................... 81
- Enteral nutrition .................. 55, 65, 103
- Externalise .................................... 38, 40

**F**

- Fibre .................................. 67

**G**

- General Practitioner (GP) .................. 6, 14, 23, 34, 36, 113, 120, 123, 149
- Glycaemic index ............................. 114

**H**

- Hypertension .................................. 102
- Hypophosphataemia ......................... 145
- Hypotension .................................. 29, 104, 115
- Hypothermia (acute) ....................... 47, 115, 145, 152

**I**

- Indigenous .................................. 107, 108, 152
- Interpersonal therapy (IPT) .............. 145

**L**

- Leukopenia .................................. 115

**M**

- Malnutrition .................. 43, 46, 48, 55, 68, 70, 145
- Menstruation ................................. 146
- Mental health assessment .............. 96, 123
- Metabolic acidosis ....................... 115, 116
- Metabolic alkalosis ....................... 115, 116
- Motivation .................. 31, 35, 70, 71, 76, 77, 78, 88, 146
- Motivational Enhancement Therapy (MET) .................. 146, 149

**N**

- Neutropaenia .................................. 146
- Nurse ........................................ 27, 45, 102, 155
O

Obesity...................... 25, 43, 83, 106, 115, 143
Occupational Therapist......................89
Oedema..............................................45, 67
Oligomenorrhoea.................................48
Orthostatic change.............................146
Osteopaenia..........................50, 68, 147
Osteoporosis..................48, 50, 65, 68, 104, 147

P

Paediatrician............. 6, 23, 24, 34, 36, 102
Peripheral neuropathy......................68
Physiotherapist.........................70, 138
Pregnancy..................... 12, 14, 102, 103, 154
Psychiatrist......................6, 34, 98, 102, 133, 147
Psychologist....................34, 102, 103, 120, 133
Purging..................2, 12, 17, 35, 36, 40, 61, 67, 68, 93, 94, 102, 103, 115, 116, 143

R

Refeeding syndrome...........43, 44, 45, 65, 145

S

Schedule..................69
School................33, 34, 73, 82, 88, 89, 91, 113, 121, 142
Secondary diagnosis eating disorder........1, 83
Serum thyroxine (T4)........115, 148
Sinus bradycardia...............115, 148
Splitting..........................41, 59, 64, 99
Stages of change.....................77

T

Tanner stages..................148
Therapeutic alliance.............3, 30, 37, 79
Tri-iodothyronine (T3)..............115, 148
Eating Disorders Toolkit Feedback

Have you found the Toolkit a useful resource for your practice or learned anything new from reading the Toolkit? Is there any additional information you think would be useful to include in future editions? Is there anything you would change from the current content or formatting that you think would make the Toolkit more useable?

Please, let us know!

All feedback we receive will be considered in the development of future editions of the Eating Disorders Toolkit. You may wish to forward a completed evaluation form (below) or written feedback. Please forward all correspondence to:

Eating Disorders Toolkit
MH-Kids
Locked Bag 1
Hunter Region Mail Centre
NSW 2310
Ph: (02) 4985 5830

Date: ______/______/______     Profession: ____________________________

Contact Details (Optional — all information held in confidence)
Name: ________________________________________________________________________
Email: ________________________________________________________________________
Phone: ________________________________________________________________________
Postal Address: _______________________________________________________________________

(Please place an X in the box that best represents your views and add comments accordingly)

1. The different treatment/management options are clearly presented.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

2. Key recommendations are easily identifiable.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments
3. The Toolkit is supported with practical strategies and tools.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

Comments

4. The information is practical for clinicians on non-specialist wards.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

Comments

5. The information is presented in a format that is easy to read.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

Comments

6. The Toolkit contains adequate detail.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

Comments

7. Are there any changes that you feel should be made to any part of the Toolkit?

<table>
<thead>
<tr>
<th>Yes</th>
<th>Neutral</th>
<th>No</th>
</tr>
</thead>
</table>

If you answered yes, please comment
8. Is there any other information that you think should be included in the Toolkit?
   Yes  Neutral  No

   [ ]  [ ]  [ ]

   If you answered yes, please comment

9. What did you find most useful about the Toolkit?

10. What did you find least useful about the Toolkit?

11. Would you recommend this Toolkit for use in practice?

12. Any other comments?

   Thankyou for taking the time to fill in this form