phn NORTH WESTERN MELBOURNE

An Australian Government Initiative

Child mental health CoP Session 4: Eating Disorders

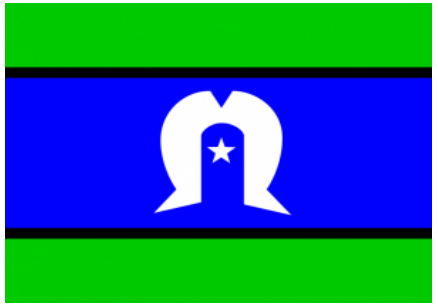
Tuesday 3 October 2023

The content in this session is valid at date of presentation

Acknowledgement of Country

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.

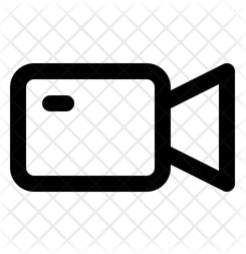


CoP guidelines
We agree to…

Stay on **mute** unless speaking

Raise your **hand** to speak

Keep conversations **confidential**



If possible, keep **camera on**

Introduce yourself and your role when speaking

Share **ideas** & promote everyone's **participation**

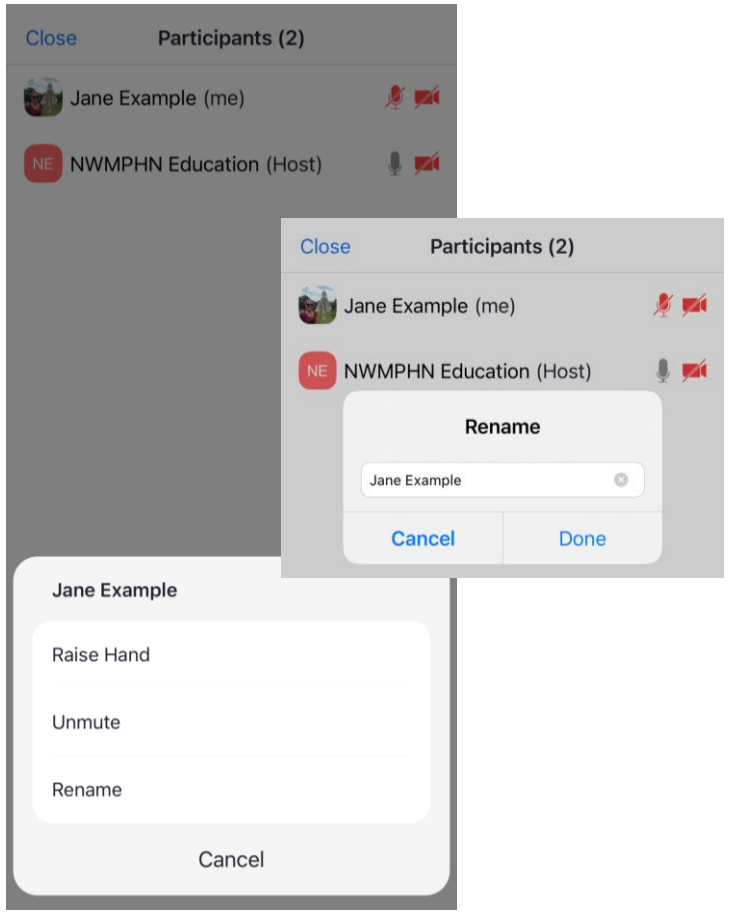
Acknowledge that we have **varied learning needs & interests**

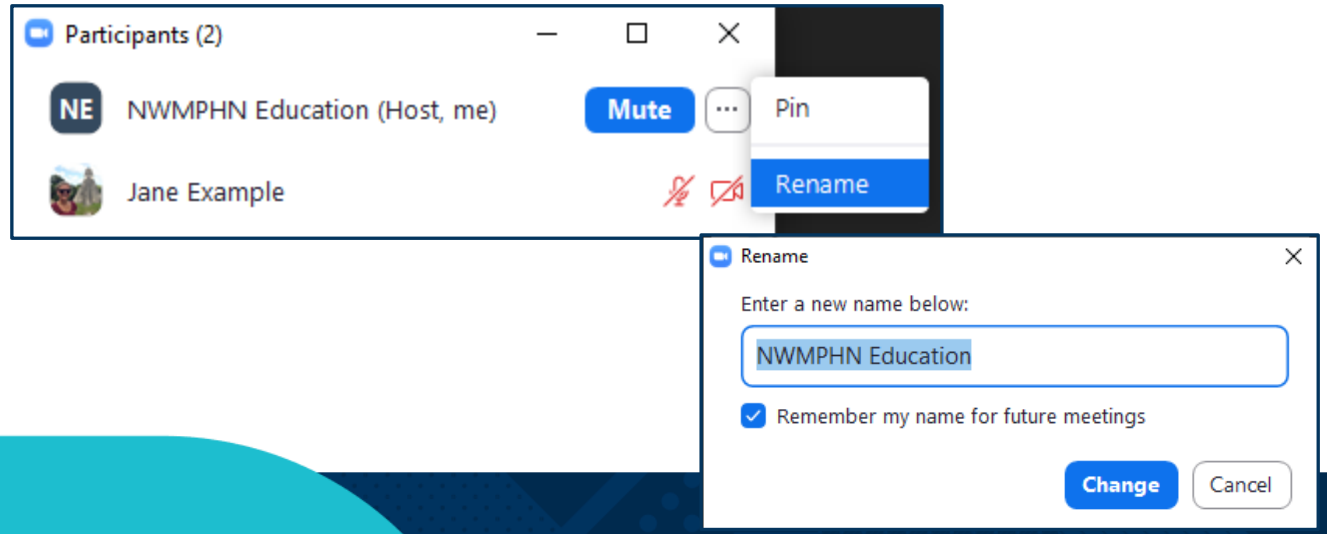
Ask **questions**

No question is silly

How to change your name in Zoom Meeting

1. Click on ***Participants***
2. **App:** click on your name
   Desktop: hover over your name and click the 3 dots
   Mac: hover over your name and click *More*
3. Click on ***Rename***
4. Enter the name you registered with and click
   Done / Change / Rename





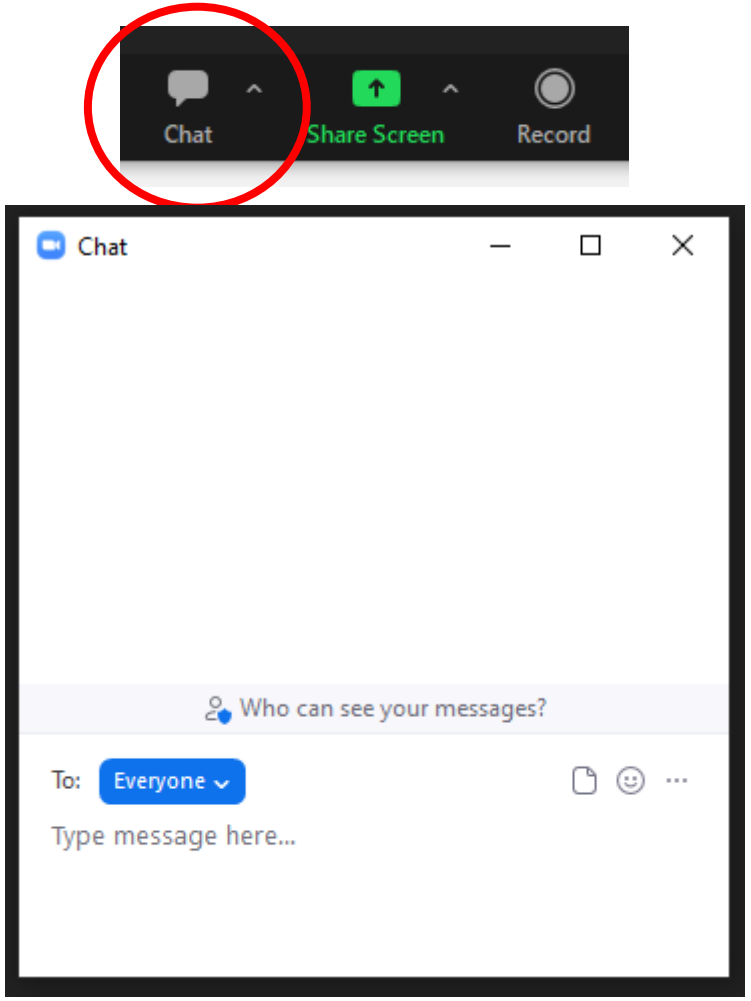
Housekeeping – Zoom Meeting

During the education component, please ask questions via the Chat box

This session is being recorded

Please ensure you join the session using the name you registered with so we can mark your attendance

Certificates and CPD will not be issued if we cannot confirm your attendance



Psychiatrist – Dr Chidambaram Prakash

- Dr Chidambaram Prakash is a senior consultant child and adolescent psychiatrist at the RCH with over 20 years' experience.
- Prakash has worked in, and managed, general and specialist clinics within child psychiatry in metropolitan and regional public mental health services.
- Prakash has worked with children and adolescents from 4 to 18 years of age assessing and managing a variety of mental health issues.

GP Facilitator - Dr Sahar Iqbal

- Practicing as a GP at Goonawarra Medical Centre for the past 9 years

- Sahar's areas of interest are child and adolescent mental health and chronic disease management

Guest Speaker – Dr Michele Yeo

- Dr Michele Yeo is a paediatrician and adolescent physician in the Department of Adolescent Medicine.

- As well as looking after adolescent patients with chronic illness and complex medical and psychosocial needs, she is also the medical lead for the RCH Eating Disorders Service and enjoys the multidisciplinary aspect of patient care.

Agenda

Introduction and housekeeping	5 minutes
Education component: Eating Disorders *Paediatrician Dr. Michele Yeo*	30 minutes
Health Pathways	5 minutes
Case discussion Part 1 – Breakout room **Debrief**	12 minutes 10 minutes
Case discussion Part 2 – Breakout room **Debrief**	12 minutes 14 minutes
Conclusion	2 minutes

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Education component:

Eating Disorders

Dr Michele Yeo


UGLY
think
Ugly

Screening for Eating Disorders

Screening tools not particularly sensitive/ specific for adolescents

Hornberger, Pediatrics 2020

Nagata, Jama Int Med 2022

"The most effective screening device probably remains the health professional thinking about the possibility of an eating disorder."

(NICE, 2004)

What disorders will you see? DSM 5

- **Anorexia Nervosa**
- **Bulimia Nervosa**
- Binge Eating Disorder
- **Avoidant Restrictive Food Intake Disorder (ARFID)**
- **Other Specified Feeding and Eating Disorder (OSFED)**
  - **Atypical Anorexia Nervosa**
- Pica
- Rumination Disorder

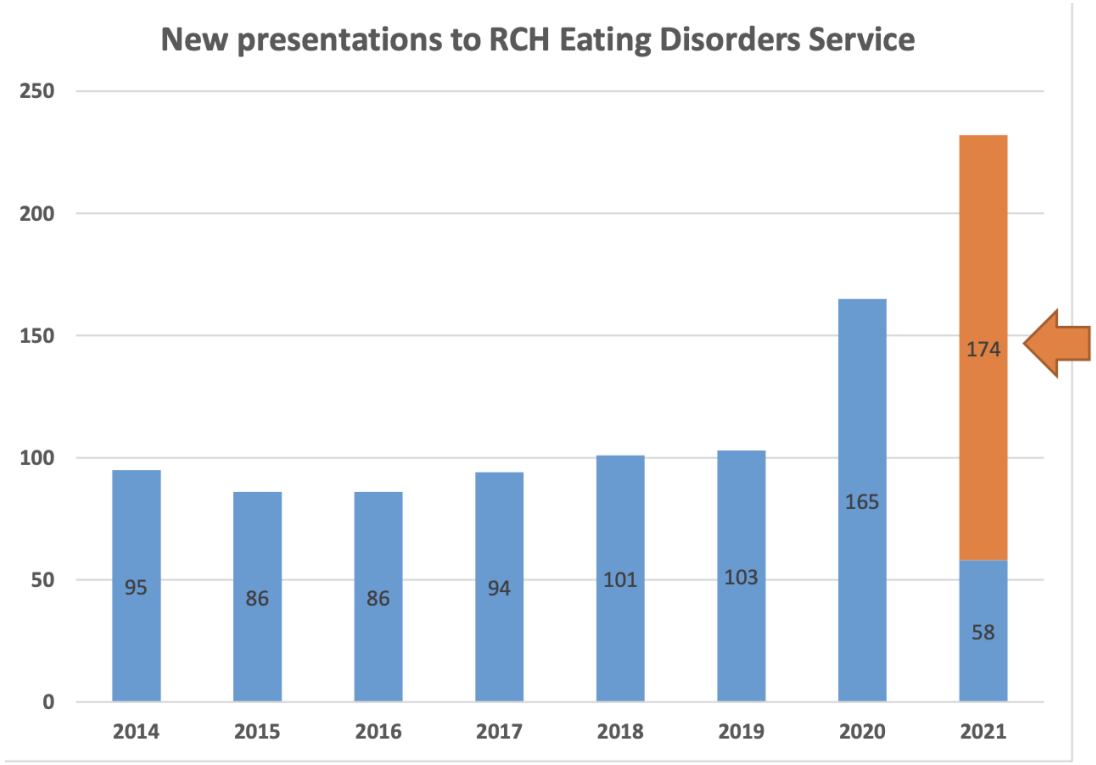
Epidemiology

- Adolescence peak age of onset
- 3rd most common chronic illness in female teenagers (asthma, obesity)
- Affects all ethnicities and social groups

- AN
  - Lifetime prev 0.9-2.2% females; 0.2-0.3% male
  - Overall incidence stable but increasing in adolescent females
  - Earlier onset than BN
- BN
  - Lifetime prev 1.5-2% (0.5% male)

Keski-Rahkonen Eat Disord Rev 2018
Hoek, Curr Op Psych 2016

Impact of Covid-19 pandemic



Numbers replicated in studies worldwide

Increased numbers presenting to emergency departments, outpatients and hospital admissions

Phillipou A, Int J Eat Disord 2020

Lin J, J Adol Health 2021

Devoe D, Int J Eat Disord 2023

Anorexia Nervosa

A. Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a **weight that is less than minimally normal, or, for children and adolescents, less than that minimally expected.**

B. Intense fear of gaining weight or becoming fat, or **persistent behavior that interferes with weight gain**, even though at a significantly low weight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or **persistent lack of recognition of the seriousness of the current low body weight.**

   - **Restricting subtype**
   - **Binge/Purge subtype**

Atypical Anorexia Nervosa

- Individuals meet all criteria for AN with exception of the weight criterion: individual remains within or above normal weight despite significant weight loss

Bulimia Nervosa

- Recurrent binge eating
- Inappropriate compensatory weight control behaviours
- Frequency ≥ 1 / week for 3 months
- Self-evaluation unduly influenced by body weight/shape
- Absence of Anorexia Nervosa

- Binge eating = eating in a discrete period an amount of food that is definitely larger than most would eat in a similar situation & time period + a sense of lack of control over eating during episodes

Avoidant Restrictive Food Intake Disorder

What ARFID IS

A persistent problem with feeding or eating leading to an inability to take in adequate nutrition/coupled with one of the following:

- substantial weight loss or failure to gain weight in growing children/adolescents
- major nutritional deficiency
- dependence on oral nutritional supplement or nasogastric tube feeds
- marked interference with psychosocial functioning

What ARFID is NOT

- Associated with body image disturbance
- Due to scarcity of food (eg neglect) or related to culturally sanctioned practice (eg fasting)
- Explained by another medical problem or psychiatric disorder, such that the eating problem resolves with the treatment of the medical or psychiatric disorder

Avoidant/Restrictive Food Intake Disorder (ARFID)

Heterogenous disorder: 3 major types of presentations

1) Sensory food aversions, very restricted range of foods

2) Lack of interest in eating
   - Low appetite, early satiety

3) Fear of aversive consequences
   - Phobia of vomiting/choking/ anaphylaxis
   - Gastrointestinal symptoms, abdominal pain, functional dysphagia
   - Tend to present more acutely with weight loss

Can present with a mix of rationales for not eating

Thomas JJ, et al. *Curr Psychiatry Rep*. 2017

ARFID - prevalence

- Tertiary North American paediatric centres - ED programs- 5-14%
- Swiss community-based study – 3%
- Australian population based >15y – 0.3%

Ornstein 2013, Fisher 2014, Forman 2014, Kurz 2014, Hay 2017

- Males > females
- Younger
- Comorbid medical and psychiatric disorder
  - Anxiety disorder in 50% of ARFID in 1 study
  - OCD, ASD also common
- Can be as malnourished as AN

Norris, J Eat Disord 2014, Fisher, J Adol Health 2014, Nicely , J Eat Disord 2014

Comparison of Eating Disorders

	Anorexia Nervosa/Atypical AN	Bulimia Nervosa	ARFID
Significant weight loss/ failure to gain	Yes	No	Maybe
Underweight	Yes/Not yet	No	Maybe
Body image disturbance	Yes	Yes	No
Binge eating	Maybe	Yes	No
Fasting/laxatives/ exercise/vomiting[1]	Maybe	Yes	No

Best Practice Approach in Primary care

Early recognition, assessment and appropriate referral

- Establish rapport
- Assess current physical and psychological state
- Establish safety - Physical and psychological
- Exclude underlying physical illness
- Appropriate referral
- Co-ordinate treating/care team
- Ongoing monitoring of medical / psychological state

History – Helpful questions

- Hx of eating behaviour over time
  - Fussy/ selective eating/ dieting
- Current intake (24h dietary history)
- Pattern of avoidance
  - Restricting: skipping meals/ snacks / reducing portion sizes
- Binge eating
- Purging
- Max and min weight
- Body image
- Exercise
  - Private exercise , walking
- Periods
- HEADSS – Context
- Fhx of EDs/ psychopathology

Mental health assessment

- **Important to look for comorbidity**
  - Depression
  - Anxiety Disorder: unusual rules, rituals, fear of judgement
  - ASD

Examination

- Weight, Height (nb growth chart)
- BMI, BMI centile & % Median BMI (% of 50th centile BMI)
- Temperature
- Lying and standing PR (2 mins lying, 2 mins standing)
- Lying and standing BP
- Capillary refill
- Tanner staging
- Signs of severity – cognitive slowing, cachexia, peripheral oedema, inability to sit up/ squat –stand (SUSS)
- Signs of purging

Relevant investigations

- Exclude organic disease – Diabetes, Thyroid disease, Inflammatory bowel disease, Coeliac disease etc
  - ESR, TSH, Coeliac screen, FWTU, BSL

- Check for complications
  - Iron/ B12/ folate levels
  - Vit D levels
  - UEC, Ca/ Mg/PO4
  - FSH, LH and Oestradiol
  - Bone age
  - Bone mineral densitometry -DEXA

Review of psychological interventions

Evidence Based Psychosocial Interventions for Eating Disorders in Adolescents (James Lock Jan 2015)			
	Anorexia Nervosa/Atypical AN	**Bulimia Nervosa**	**ARFID**
Level 1 Well established Treatment	FBT		
Level 2 Probably efficacious treatment	Systemic Family Therapy CBT-E Adolescent Focused Treatment (AFT)		
Level 3 Possibly efficacious treatment	Multi Family therapy Temperament Based Treatment	FBT, CBT,	FBT – Unified Protocol CBT-AR
Level 4 Experimental treatment		CBT, Individual psychotherapy	
Level 5 Questionable efficacy			

What makes us worry?

- Rapid weight loss over a short period
  - More likely to become bradycardic
- Period of starvation/ very low intake followed by increased eating
  - Development of the refeeding syndrome
- Frequent vomiting
  - Hypokalaemia

Safer Care Victoria / RCH Guidelines

Consider medical admission for those with:

- **Significant electrolyte disturbance (K < 3.0)**
- **HR ≤ 50bpm**
- Postural HR increase ≥30 bpm
- Resting systolic BP ≤80 mmHg
- **Postural systolic drop ≥ 20mmHg**
- Hypothermia <35.5C
- Dehydration
- Arrhythmia or prolonged QTc >0.45s
- Weight <75% of their expected body weight or rapid weight loss (>10-15% in 3-6 months is significant)
- Out of control ED compensatory behaviours eg prolonged fasting/ inability to eat at home/ uncontrolled purging and exercising
- Admission may be appropriate in rare circumstances where community management is not effective

Useful resources

- RANZCP Guidelines
  - https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/eating-disorders-cpg-and-associated-resources

- RCP Medical Emergencies in Eating Disorders (MEED)
  - https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2022-college-reports/cr233

Resources for parents/carers

- **EDV Carer Support**
  - Carer Coaching
  - Carer Courses
  - Telehealth counselling for carers
  - https://www.eatingdisorders.org.au/for-family-and-friends/edv-services-for-carers/
- **Butterfly Program**
  - https://butterfly.org.au/get-support/support-programs/
- **Eating Disorder Families Australia**
  - https://edfa.org.au/

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Case studies

Breakout 1 – Case study

James is a 12-year-old boy who is a keen soccer player, has a home ‘gym’ and a strong interest in maintaining a balanced nutritional intake. He reads up about exercise and nutrition on the internet and asks his mum to cook healthy meals for him. James is one of two children and lives at home with his younger sister and parents Amber and Phil who work full time in office jobs. His family tends to eat healthy and partake in some physical activity.

James has recently started eating more protein-based foods, takes great interest in grocery shopping with his dad and insists on buying items like salmon, lamb, and protein bars for ‘sustenance’. When Amber explained to him that milk, wholemeal foods such as wholegrain bread and a handful of nuts i.e. almonds are equally good for sustenance and recovery James snapped at her and asked her to stop preaching as he knew what he was doing. James has started to insist that Phil cook all meat on the bbq or the weber grill and has recently started using the air fryer for most food that he consumes.

Breakout 1 – Case study continued

James has started running long distance and is also lifting a lot of weights. He has also started consuming raw egg white smoothies so he can bulk up. Amber and Phil are concerned for him given his age and the weights he is lifting in case he may injure himself. They try to encourage him to pace himself. James finds them very annoying and ends up arguing with them most of the time. He measures his biceps and thighs and tracks his progress and is very proud of how far he has come. He is saving up money to buy a weighing scale that calculates body fat.

At the last parent teacher meeting, James's teacher advised Amber and Phil that James talks about little else than his fitness regime and his healthy eating. Amber and Phil also feel that this is becoming a sensitive topic to approach at home, and they cannot speak to James about it without touching a raw nerve.

Breakout 1 – Case study continued

Both Amber and Phil are concerned about approaching James regarding his fitness regime or his food intake as James snaps and puts up a fight and says that he knows what he is doing.

- Who do you think Amber and Phil can speak to in relation to the issues they are having with James?
- What are some online resources/organisations that Amber and Phil can access for support with James?
- What impact can a positive role model/mentor have on James and how can Amber and Phil utilise that to benefit James?

Breakout 2 – Case study

Amber speaks to James's teacher who suggests they book a meeting with the school's wellbeing coordinator. Amber and Phil have come to see the school's wellbeing coordinator i.e. **you** regarding the issues they are facing at home with James's eating and fitness regime. Both parents are concerned and not sure how to approach the topic with James. They also feel the more they 'poke' him, the more determined he gets and instead of helping him, it has the opposite effect.

- What are some questions you may ask to better understand the history /issue?
- What advice can you offer them?
- What services you may refer them to?
- Who can you link James up with at school as he is a keen soccer player?

Session Conclusion

Next session – Tuesday 14th November on Assessment and management of mental health disorders in neurodiverse children and young people (same time – 6:30-8pm)

You will receive a post session email within a week which will include slides and resources discussed during this session.

Attendance certificate will be received within 4-6 weeks.

RACGP CPD hours will be uploaded within 30 days.

To attend further education sessions, visit,

https://nwmphn.org.au/resources-events/events/

This session was recorded, and you will be able to view the recording at this link within the next week.

https://nwmphn.org.au/resources-events/resources/

We value your feedback, let us know your thoughts.

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