COD-ED Community Nutrition Flowchart for Young Consumers with an Eating Disorder

A reference guide for Accredited Practising Dietitians to identify scope of practice in the provision of nutrition interventions in the community treatment of young people with eating disorders.

Receive referral for initial assessment - is there a clear diagnosis?

Yes

- Has diagnosis been made by an appropriate professional (e.g., GP, paediatrician, psychologist or psychiatrist)? Have you received adequate information in the referral?
- See DSM-5 for the classification of eating disorders if unclear (2).
- *If recently discharged from hospital gain handover from discharging APD including readmission criteria and protocol if possible.*

No

Screening

- The SCOFF questionnaire can assist with screening and early detection of an eating disorder (6).

Nutrition Assessment

- **If client meets criteria for admission as per CHQ guidelines (23), then liaise with GP for urgent medical assessment. If presenting with fainting/dizziness/chest pain/palpitations call QAS or present to nearest emergency department and notify GP. Do not progress.**
- A detailed nutrition assessment and diet history (8) would ideally be taken by a dietitian with paediatric experience or training (7).
- Essential to the assessment process is regular feedback to the GP and other treating health professionals regarding nutrition assessment and treatment progression. Treatment non-negotiables include but are not limited to regular medical monitoring and should be discussed in the first session.

Assessment of Nutrition Risks

- **Weight status** to determine restoration targets and compare to CHQ guidelines for admission criteria (23). Classify malnutrition status using weight loss, growth percentiles and predicted z-scores (https://peditools.org/growthpedi/) (30).
- **Macronutrient** and **micronutrient deficiencies** (e.g. Fe & Ca).
- Compliance with **supplementation** recommendations (e.g. multivitamin).
- **Refeeding risk:** see risk assessment over page to determine if consumer requires hospital admission for safe titration of nutrition with medical monitoring and communicate to GP immediately (1, 23).
- **Hydration:** total fluid intake and behaviours.
- **Compensatory behaviours:** Restriction/bingeing/purging/laxatives/ diuretics/diet pills/excessive exercise.
- **Gastrointestinal symptoms/conditions:** reflux, constipation, diarrhoea, symptoms of lactose intolerance.
- Review available **body composition** investigations (e.g. BMD, TBK, REE) (25).

Treatment Targets Identifiable on Nutrition Review

Body restoration to **at least** 85% of Expected Body Weight (EBW) is often an identified goal of **inpatient** treatment with further progress to >95%EBW expected as outpatient (23,31):

- Use of CDC Growth Charts to identify EBW using percentile tracking records or other methods such as 50th percentile BMI value or "matching" height and weight percentiles - with clinical judgment required for the tallest and shortest cases (32, 35).
- If weight gain is required, recommend 0.5-1.0kg per week restoration target (22,31).
- Other factors to be considered (e.g. growth, commencement/return of menses, pre-morbid weight) and use of clinical judgement.
- Individuals may be malnourished at a higher weight secondary to eating disorder behaviours (28).

Re-Nourishing a Malnourished Client

- Ensure Multivitamin supplementation (if additional supplementation is deemed necessary, consider risk level and need for hospital admission (23).
- Correct hydration practices.
- Collaboratively develop plan for nutrition for optimal health:
  - Aim for meals and snacks balanced in protein, carbohydrate and fats.
  - Recommend intake every 3 hours equaling at least 3 meals and 3 snacks per day to assist in blood glucose control.
  - To minimise potential gastrointestinal discomfort, consider initially recommending low fibre (+/- low lactose according to tolerance) containing meals and snacks, including the use of nutritional liquids (27).
  - Refer to GP for clinical management of constipation/reflux.
  - Minimise use of low calorie and nutrient poor filler foods (e.g. diet drinks, excessive caffeinated beverages, excessive vegetables) and foods consumed for a laxative effect (e.g. weight loss teas, chewing gum, caffeine).
  - Refeeding usually commences at 6300-8000kJ/d but intakes of up to and over 15000kJ/d may be required for weight restoration to EBW across the treatment continuum (23, 33). A thorough assessment of compensatory behaviours should precede all increases to the nutrition prescription. Consider appropriateness of self-restricted foods without a formal diagnosis (e.g. vegan diets, gluten intolerance, FODMAP).
  - In some cases, consider using the 2nd step approach of high-calorie drinks or commercial supplements.

Nutrition Interventions

The therapy that the child/adolescent (and family) is engaging in will assist you in determining the appropriate strategies (e.g. a meal plan may not be the answer). Review the evidence-based therapies over page and engage with other treating clinicians to discuss.

Patient reported allergies/intolerances/self-imposed restrictions are common. Unnecessary limitations on nutrient choice can impact negatively on nutritional rehabilitation. Medically diagnosed conditions (e.g. Coeliac, anaphylactic reactions to dairy protein, etc) must be acted upon.

RAVES principles can be used with young people: ***R**egularity* | ***A**dequacy* | ***V**ariety* | ***E**ating Socially* | ***S**pontaneity* (34)

CCI information and worksheets can be used for nutrition counselling purposes. These can be found under "resources for mental health practitioners" but use caution given that these resources are developed for adults.

Consider innovative strategies to encourage nutrition consumption and prevent compensatory behaviours (e.g. digital food record) for older adolescents undertaking CBT-E.

Review and Monitoring

- Communicate with the GP and treating team regularly regarding nutrition risk and progression with oral intake.
- Nominate a review timeline with objective outcome measures to assess the effectiveness of outpatient care (3).
- Reviews may start at frequent intervals (e.g. weekly/fortnightly) and transition to less frequent (e.g. monthly).
- Seek information about other treatment services/options in your local/surrounding areas (3) e.g. CYMHS clinics, CHQ CYMHS Eating Disorder Program (Greenslopes), EDQ, QuEDS (for older adolescents) and private options.

Further Information and Reading

Refeeding Risk Assessment (23)

	Child/Adolescent has one or more of the following:	Child/Adolescent has two or more of the following:
Risk of Refeeding Syndrome	• **BMI <5th centile** • **Weight loss of >15% within the previous 3-6 months** • **Very little nutritional intake for 10 days** • **Low serum levels of potassium, magnesium, calcium or phosphate prior to re-feeding**	• **BMI between 5th and 10th centile** • **Weight loss of >10% within previous 3-6 months** • **Very little intake for 5-7 days**

Resources

- **EDIG:** DAA Eating Disorders Interest Group Resources (14).
- **EDIG:** DAA Practice Tips & Resource List (15).
- **CCI:** Centre for Clinical Interventions (16).
- **NEDC:** National Eating Disorder Collaboration (17).
- **QHealth** supported **NEMO** site & **FEEDS** (19).
- **EDQ:** Eating Disorders Queensland (18).

Other Important Considerations

- It is necessary to have the support of a multidisciplinary team; including a GP/paediatrician and psychiatrist/psychologist/social worker/qualified therapist and communicate regularly (3, 4).
- Where able, ensure that the professionals involved have specialist experience in working with children and adolescents with eating disorders (3).
- Ensure that your client is receiving regular and adequate medical reviews with their GP (2). If the GP does not have experience in this area, refer them to their local CYMHS team or the NEDC's online resource Eating Disorders: A Professional Resource for General Practitioners (5).
- Involve parents/caregivers or other supports as appropriate and with consideration of patient and family wishes and treating team recommendations.
- Refer carers to the Eating Disorders QLD (EDQ) for additional support (18).

Therapeutic Stance, Boundaries and Scope

- An APD will work on the symptoms of the eating disorder (restricting, bingeing, purging, exercise etc.), which can be seen as the 'tip of the iceberg'. The underlying dynamics causing the eating disorder (e.g. self-esteem, body image, emotional regulation, mood and trauma) cannot be addressed without mental health support at a level guided by the GP and/or specialist psychiatrist, psychologist, qualified therapist or CYMHS clinician according to the severity of the diagnosis (3).
- See DAA's Role Statement for APDs practicing in the area of Eating Disorders (21).
- Set up professional supervision (3).
- Setting clear boundaries is vital when working with clients recovering from an Eating Disorder. See DA EDIG Guide for APD's New to Working in the Eating Disorder Specialty for more information (3).

Evidenced-Based Psychological Therapies (13, 22)

Children and Adolescents with a diagnosed eating disorder are likely to be engaged with their local Child and Youth Mental Health Service who can deliver evidence-based treatments.

- Family Based Therapy (FBT) is considered first-line treatment for children and adolescents with Anorexia Nervosa – between 20-30 sessions ranging from 12-18 months. This approach aligns with parents being the expert on feeding their child. Dietitian intervention is not a standard part of this treatment but if it is used as an adjunct to therapy, ensure that it does not undermine the parental authority as the "expert" on feeding their child. It may be beneficial to consult with the parents separately in some circumstances to provide nutrition guidance and improve confidence.
- Cognitive Behavioural Therapy Enhanced (CBT-E) – another evidence-based treatment that may better suit a young person and their family (typically 30-40 sessions as required). Nutritional intervention can be offered as an adjunct to therapy.
- Other treatment options include but are not limited to: Adolescent Focussed Therapy; Multi-Family Behavioural Therapy; multidisciplinary treatment utilising the services of a psychologist, counsellor, dietitian and medical professional; case management and treatment for co-morbid conditions.

Discharging and When to Withdraw Treatment

- Review and reformulate if treatment is effective 1-3-monthly, according to treatment stage.
- Discharge of client is suitable when identified to be tracking on appropriate growth percentile and a regular, adequate and varied diet is achieved.
- Withdrawal of dietetic services is recommended if client is non-compliant with treatment non-negotiables, such as medical monitoring.
- Refer on to specialist treatment or back to GP if client requires a higher level of support, there is a lack of progression in treatment, there is a potential negative therapeutic outcome or breakdown of therapeutic alliance.

Links and References

1. American dietetics association Position of the American Dietetic Association: Nutrition Intervention in the Treatment of Eating Disorders - Journal of the American Dietetic Association https://www.jandonline.org/article/S0002-8223(11)00712-7/fulltext
2. Classifying eating disorders https://www.eatingdisorders.org.au/eating-disorders/what-is-an-eating-disorder/classifying-eating-disorders/dsm-5
3. DA Eating Disorder Role Statement Eating disorder role statement (dietitiansaustralia.org.au)
4. RANZCP https://www.ranzcp.org/Files/Resources/Publications/CPG/Clinician/Eating-Disorders-CPG.aspx%5C
5. Eating Disorders: A Professional Resource for General Practitioners https://www.nedc.com.au/assets/NEDC-Resources/NEDC-Resource-GPs.pdf
6. SCOFF Questionnaire http://ceed.org.au/sites/default/files/resources/documents/SCOFF%20Questionnaire%20August%202016.pdf
7. Junior MARSIPAN – Management of Really Sick Patients under 18 with Anorexia Nervosa. Accessed from: https://pubmed.ncbi.nlm.nih.gov/26407730/
8. DA Assessment Template for Use in the Area of Eating Disorders (EDIG) https://member.dietitiansaustralia.org.au/Common/Uploaded%20files/DAA/Resource_Library/2021/Nutrition_assessment.pdf
9. DA Moving Towards Natural Eating (EDIG) https://member.dietitiansaustralia.org.au/Common/Uploaded%20files/DAA/Resource_Library/2021/Moving_towards_natural_and_normal_eating.pdf
10. Fairburn, C. 2008. Cognitive Behaviour Therapy and Eating Disorders. p159 – 180.
11. Health Not Diets http://www.healthnotdiets.com/
12. The Mindful Dietitian http://www.themindfuldietitian.com.au/
13. The Butterfly Foundation National Agenda https://butterfly.org.au/wp-content/uploads/2020/05/National-Agenda-for-Eating-Disorders-2018.pdf
14. DA Eating Disorders Interest Group Resources: https://member.dietitiansaustralia.org.au/Portal/Membership/Resource-Library/Resource-Content/741.aspx?seqn=741
15. DA Eating Disorder Role Statement https://dietitiansaustralia.org.au/sites/default/files/2023-03/Eating-Disorder-Role-Statement-2023.pdf
16. Centre For Clinical Interventions (CCI) https://www.cci.health.wa.gov.au/resources/looking-after-yourself/disordered-eating
17. NEDC National Eating Disorder Collaboration - http://www.nedc.com.au/
18. Eating Disorders Queensland (EDQ) https://eatingdisordersqueensland.org.au/
19. Nutrition Education Materials Online (NEMO) https://www.health.qld.gov.au/nutrition
20. Queensland Eating Disorder Service (QuEDS) Day Program - https://metronorth.health.qld.gov.au/rbwh/wp-content/uploads/sites/2/2017/06/outpatient-day-patient-services-eating-disorder.pdf
21. DA Eating Disorder Role Statement https://dietitiansaustralia.org.au/sites/default/files/2023-03/Eating-Disorder-Role-Statement-2023.pdf
22. NICE Guidelines Eating disorders: recognition and treatment https://www.nice.org.uk/guidance/ng69/resources/eating-disorders-recognition-and-treatment-pdf-1837582159813
23. *Access Pathways and Quick Reference Guides for the Assessment and Management of Children and Adolescents with Eating Disorders in QLD*: search CHQ Policies and Procedures (Governance eCatalogue) – not yet released as of April 2019. In the absence of, use *Nutritional Management of Children and Adolescents with Eating Disorders* available at https://qheps.health.qld.gov.au/__data/assets/pdf_file/0017/701630/gdl-00505.pdf .
24. Metro North Hospital and Health Service Refeeding Syndrome in Adults - Identification and Management https://qheps.health.qld.gov.au/__data/assets/pdf_file/0042/1479957/003454.pdf
25. Children's Health Research Centre Body Composition Laboratory - https://child-health-research.centre.uq.edu.au/event/session/2084
26. Rigaud D, Bedig G, Merrouche M, Vulpillat M, Bonfils S, Apfelbaum M. Delayed gastric emptying in anorexia nervosa is improved by completion of a renutrition program. Dig Dis Sci 1988;33:919–925. Abstract available from: https://www.ncbi.nlm.nih.gov/pubmed/3391083
27. Mehler, P. and Brown, C. 2015 Anorexia nervosa – medical complications. Abstract can be accessed from: https://jeatdisord.biomedcentral.com/articles/10.1186/s40337-015-0040-8
28. Whitelaw, M., Gilbertson, H., Lee, K. and Sawyer, S. 2014 Restrictive Eating Disorders Among Adolescent Inpatients. Pediatrics (Sept 2014) Accessed from: http://pediatrics.aappublications.org/content/134/3/e758
29. Dickstein, L., Franco, K., Rome, E. and Auron M. 2014. Recognizing, managing medical consequences of eating disorders in primary care. Abstract can be accessed from: https://pubmed.ncbi.nlm.nih.gov/24692444/
30. Society for Adolescent Health and Medicine. 2015. Position Paper of the Society for Adolescent Health and Medicine: Medical Management of Restrictive Eating Disorders in Adolescents and Young Adults. Accessed July, 2018 from https://www.clinicalkey.com.au/#!/content/playContent/1-s2.0-S1054139X14006867?returnurl=https:%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS1054139X14006867%3Fshowall%3Dtrue&referrer=https:%2F%2Fwww.ncbi.nlm.nih.gov
31. Le Grange, D et al. Early Weight Gain Predicts Outcome in Two Treatments for Adolescent Anorexia Nervosa. Int J Eat Disord. 2014: 47(2): 124-129.
32. Le Grange, D et al. (2012) Calculation of Expected Body Weight in Adolescents with Eating Disorders. Paediatrics, 2012: 129(2) 438-446.
33. QuEDS: A Guide to admission and inpatient treatment for people with eating disorders in Queensland https://metronorth.health.qld.gov.au/rbwh/wp-content/uploads/sites/2/2017/07/guide-to-admission-and-inpatient-treatment-eating-disorder.pdf
34. RAVES Handout by Shane Jeffrey https://static1.squarespace.com/static/632907d4424d9b18e38ae0eb/t/641114b56ceca90e5b72a9f3/1678841028090/RAVES+Handout
35. CHQ CYMHS EDP (2018) Calculation of expected body weights in the treatment of eating disorders. Accessible via QHEPS: https://qheps.health.qld.gov.au/__data/assets/pdf_file/0025/2305366/gdl-50025.pdf