COD-ED Community Flowchart for Dietitians working with Adults with an Eating Disorder

Nutrition intervention, including nutrition counselling by an Accredited Practising Dietitian (APD), is an essential component of the team treatment of patients with eating disorders across the continuum of care (1).

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

Yes

- Has diagnosis been made by an appropriate professional (e.g. GP, 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 concerned client meets criteria for admission as per QuEDS guidelines then liaise with GP for urgent medical assessment. If presenting with fainting/dizziness/chest pain call QAS or present to nearest emergency department and notify GP. Do not progress.**
- A detailed nutrition assessment and diet history should be taken by an APD (7).
- Essential to the assessment process is regular feedback to GP re: diagnostic clarification, nutrition assessment & treatment progression. Treatment non-negotiables may include but are not limited to regular medical monitoring by GP and should be discussed in the first session.

Assessment of nutrition risks as follows

- **Weight status** to determine restoration targets and compare to QuEDS guidelines for admission criteria (23).
- **Macronutrient** and **micronutrient deficiencies** (e.g. Fe & Ca).
- Compliance with **supplementation** recommendations (e.g. thiamine, potassium, multivitamin).
- **Refeeding risk**: determine if consumer requires hospital admission for safe titration of nutrition with medical monitoring and communicate to GP immediately (1, 23, 24).
- **Hydration:** total fluid intake and behaviours (7) & monitor for fluid loading
- **Compensatory behaviours:** Purging/laxatives/diuretics/diet pills/excessive exercise/restriction/bingeing.
- **Gastrointestinal symptoms:** E.g. reflux, constipation, diarrhoea, symptoms of lactose intolerance.
- Consider **body composition** investigations (e.g. BMD, REE) (25). E.g. referral to Body Composition Laboratory at CNRC, LCCH.

Nutrition restoration targets

Restoration to a healthy weight (usually BMI ≥ 20kg/m^2 (10):

- Recommend 0.5kg per week restoration target (22).
- Individual factors to be considered (e.g. return of menses & pre-morbid weight) and use of clinical judgement.
- Individuals may be malnourished at a higher weight (BMI ≥ 20) secondary to eating disorder behaviours or due to a naturally higher set point (28).
- **Emphasis should always be on adequate and regular nutrition as opposed to weight loss even in overweight individuals.**
- Consider Non-Diet paradigm and Health at Every Size® approach. For more information see these references (11, 12).

Re-nourishing a malnourished client

- Ensure Thiamine and Multivitamin supplementation (see QuEDS guidelines (23).
- Correct hydration practices
- Collaboratively develop a plan for nutrition for optimal health:
  - Aim for meals and snacks balanced in protein, carbohydrate and fats.
  - Aim to eat every 3 hours during the day equaling at least 3 meals & 3 snacks per day to assist in blood glucose control.
  - To minimise potential gastrointestinal discomfort, consider initially recommending small, low fibre (and consider low lactose and/or monitor tolerance (29)) containing meals and snacks, including the use of nutritious liquids (27).
  - Refer to GP for clinical management of constipation (avoiding stimulant laxatives) and reflux etc. (23).
  - Minimize 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).
  - Intakes of up to and over 12MJ/d may be required for weight restoration (23)

Nutrition intervention for all clients

The '*Moving towards Natural Eating*' resource on the DAA Eating Disorder Interest group webpage describes a 'phased' approach to working with clients in supporting them move towards natural eating (9).

Use the **RAVES** principles (Shane Jeffrey): ***R****egularity | **A**dequacy | **V**ariety | **E**ating Socially | **S**pontaneity*

Consider innovative strategies to encourage nutrition and minimise compensatory behaviours (e.g. digital food record applications).

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 (weekly/fortnightly) and transition to less frequently (e.g. monthly).
- Seek information about other treatment services/options in your local/surrounding areas (3) e.g. day programs (QuEDS/private day programs (20),EDQ, QuEDS Specialist Consultation Clinic (for further assessment & referral options) and, time-limited evidence based therapies via both QuEDS and private options (page 2).
- **Include family/carers where appropriate.**

Further Information and Reading

Refeeding Risk Assessment (24)

Recognise at risk patients (5)	Patient has one or more of the following:	Patient has two or more of the following:
	• BMI less than 16 kg/m^2 • Unintentional weight loss greater than 15% within the last 3-6 months • Little or no nutritional intake for more than 10 days • Low levels of potassium, phosphate or magnesium prior to feeding attributable to malnutrition	• BMI less than 18.5kg/m^2 • Unintentional weight loss greater than 10% within the last 3-6 months • Little or no nutritional intake for more than 5 days • A history of alcohol abuse

NB 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. Clinical judgement should be used as to the appropriateness of other restrictions without a formal diagnosis (e.g. gluten intolerance, FODMAP, vegan choices etc)

Other important considerations

- It is ideal to have the support of a multidisciplinary team; including a GP and (where appropriate) psychiatrist/psychologist/ counsellor/social worker and communicate regularly (3, 4).
- Where able, ensure that the professionals involved have specialist experience in working with clients 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 the QuEDs website (3) or the NEDC's online resource Eating Disorders: A Professional Resource for General Practitioners (5).
- Plan all treatment with the client collaboratively (3).
- Involve carers, family or close friends as per the client's preferences. Refer carers to Eating Disorders Queensland (EDQ) for additional support (18).

Resources

- **QuEDS (Qld Eating Disorder Service):** https://metronorth.health.qld.gov.au/rbwh/healthcare-services/eating-disorder
- **QHealth supported NEMO site & FEEDS** (19).
- **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).
- **EDQ:** Eating Disorders Queensland (18).

Therapeutic Stance, Boundaries and Scope

- Work within a **motivational interviewing** and collaborative stance (3).
- 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) are best addressed where possible with mental health support (3) at a level guided by the GP and by the severity of the diagnosis eg specialist psychiatrist, psychologist, counsellor or GP.
- See DAA's Role Statement for APDs practicing in the area of Eating Disorders (21).
- Set up professional supervision with a specialist dietitian (3).
- Setting clear boundaries is vital when working with clients recovering from an Eating Disorder, see EDIG Guide for APD's New to Working in the Eating Disorder Specialty for more information (3).

Evidenced Based Psychological Therapies (13, 22)

Anorexia Nervosa

- Cognitive Behavioural Therapy Enhanced (CBT-E) for adults – a minimum of 20 sessions with extension to 50 sessions as required.
- Specialist Supportive Clinical Management (SSCM) for adults – 20 or more weekly sessions.
- Maudsley Anorexia Nervosa Treatment for Adults (MANTRA) – typically consists of 20 sessions.
- Maudsley Family Based Therapy (FBT) for adolescents/young adults – between 20 & 30 sessions.
- Nutritional Interventions as an adjunct to therapy.

Bulimia Nervosa and Binge Eating Disorder

- Cognitive Behavioural Therapy Enhanced (CBT-E) – 20 sessions delivered over a minimum 5 months period.
- Interpersonal Psychotherapy – delivered over an 8 to 12 months period.
- Nutritional Interventions as an adjunct to therapy.

Discharge and when to withdraw treatment

- **If concerned client meets criteria for admission as per QuEDS guidelines then liaise with GP for urgent medical assessment. If presenting with fainting/dizziness/chest pain call QAS or present to nearest emergency department and notify GP. Do not progress.**
- Review effectiveness of treatment plan every 2 - 3months and reformulate as required.
- Withdrawal of dietetic services is recommended if a client is non-compliant with treatment non-negotiables, such as medical monitoring. Regular medical monitoring is considered a non-negotiable for moderate to high risk clients.
- Consider referring on to specialist treatment if the clinician is not experienced in eating disorders, treatment is not progressing, client is requiring a higher level of support, there is a lack of progression in treatment or there is a potential negative therapeutic outcome or breakdown of therapeutic alliance.

Links and References:

1. American dietetics association http://www.sisdca.it/public/pdf/on-of-the-American-Dietetic-Association,------nutrition-intervention-in-the-treatment-of-eating-disorders[1].pdf
2. Classifying eating disorders https://www.eatingdisorders.org.au/eating-disorders/what-is-an-eating-disorder/classifying-eating-disorders/dsm-5
3. DAA EDIG Guide for Accredited Practising Dietitians New to Working in the Eating Disorder Specialty https://daa.asn.au/resource/1-role-of-eating-disorder-dietitian-practice-tips-resource-list-edig/?referer=search
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://cedd.org.au/wordpress/wp-content/uploads/2015/04/SCOFF-Questionnaire.pdf
7. DAA Practice Recommendations for the Nutritional Management of Anorexia Nervosa in Adults http://cedd.org.au/wordpress/wp-content/uploads/2014/09/Practice-Recommendations-for-the-Nutritional-Assessment-of-Anorexia-Nervosa-in-Adults-Developed-by-Australian-Dietitians-2009.pdf
8. DAA Assessment Template for Use in the Area of Eating Disorders (EDIG) https://daa.asn.au/resource/3-assessment-template-for-use-in-the-area-of-eating-disorders-edig/?referer=search
9. DAA Appetite & Moving Towards Natural Eating (EDIG) https://daa.asn.au/resource/7-appetite-moving-towards-natural-eating-edig/?referer=search
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://thebutterflyfoundation.org.au/assets/Uploads/National-Agenda-for-Eating-Disorders-2018.pdf
14. DAA Eating Disorders Interest Group Resources https://daa.asn.au/member-community/practice-networks/eating-disorders/eating-disorders-interest-group-resources/
15. DAA Role of Eating Disorder Dietitian, Practice Tips & Resource List (EDIG) https://daa.asn.au/resource/1-role-of-eating-disorder-dietitian-practice-tips-resource-list-edig/?referer=search
16. Centre For Clinical Interventions (CCI) https://www.cci.health.wa.gov.au/resources/looking-after-yourself/disordered-eating
17. National Eating Disorder Collaboration (NEDC) - 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. DAA Role Statement for APDs practising in the area of Eating Disorders https://daa.asn.au/wp-content/uploads/2015/05/Eating-Disorders-Role-Statement-1.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. 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
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/about/services-and-facilities/body-composition-laboratory-0
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
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