

# 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)?
- 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 or EDE-Q can assist with screening and early detection of an eating disorder (6).

### Nutrition Assessment

- **If client meets criteria for admission per QuEDS guidelines, 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 (and do not progress further in this flow chart).**
- 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 and treatment progression. Treatment non-negotiables should be discussed in the first session and may include regular medical monitoring by GP.
- Utilise the DAA assessment template for use in the area of eating disorders resource (EDIG) (8).

### Assess 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 – if yes, communicate to GP immediately (1,23,24).
- **Hydration:** total fluid intake and monitor for fluid loading, inadequate fluid intake (7).
- **Compensatory behaviours:** Purging/laxatives/diuretics/diet pills/excessive exercise/restriction/bingeing.
- **Gastrointestinal symptoms:** e.g., reflux, constipation, diarrhoea, symptoms of lactose intolerance.

### Treatment targets

Restoration to a healthy weight (usually BMI  $\geq 20\text{kg/m}^2$ ) (10):

- Recommend 0.5-1kg per week restoration target (22).
- Individual factors to be considered (e.g., return of menses and pre-morbid weight) and use of clinical judgement.
- **Emphasis should always be on adequate and regular nutrition as opposed to weight loss (including in larger bodied individuals).** Individuals may be malnourished at a higher weight (BMI  $\geq 20$ ) secondary to eating disorder behaviours or due to a naturally higher set point (28).
- Consider Non-Diet paradigm and Health at Every Size® approach (11,12).

### Re-nourishing a malnourished client

- Ensure Thiamine and Multivitamin supplementation (see QuEDS guidelines (23)).
- Correct hydration practices.
- Collaboratively develop a nutrition plan for optimal health:
  - Aim for meals and snacks balanced in protein, carbohydrate and fats.
  - Rule of 3's (3 main meals, 3 snacks, 3 hours apart),
  - To minimise potential gastrointestinal discomfort, consider initially recommending small, low fibre (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).
  - Limit 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

Support clients to move towards natural eating by:

- 'Moving towards Natural Eating' resource on the DA Eating Disorder Interest group webpage (9).
- **RAVES** principles (Shane Jeffrey): **Regularity, Adequacy, Variety, Eating Socially, Spontaneity**
- Consider innovative strategies to encourage nutrition and minimise compensatory behaviours (e.g., digital food record applications – Recovery Record).

### 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 and referral options) and time-limited, evidence-based therapies via both QuEDS and private options (see page 2).
- Review effectiveness of treatment plan every 2 – 3 months and reformulate as required.
- **Include family/carers/support persons where appropriate.**

## Further Information and Reading

### Refeeding Risk Assessment (24)

Risk of Refeeding Syndrome	Patient has one or more of the following:	Patient has two or more of the following:
	<ul style="list-style-type: none"> <li>Weight loss greater than 15% within the last 3-6 months</li> <li>Little or no nutritional intake for more than 10 days</li> <li>Low levels of potassium, phosphate or magnesium prior to feeding attributable to malnutrition</li> <li>BMI less than 16kg/m<sup>2</sup></li> </ul>	<ul style="list-style-type: none"> <li>Weight loss greater than 10% within the last 3-6 months</li> <li>Little or no nutritional intake for more than 5 days</li> <li>A history of behaviours which deplete electrolyte/thiamine stores e.g. alcohol dependence, excessive vomiting, laxative abuse</li> <li>BMI less than 18.5kg/m<sup>2</sup></li> </ul>

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 foods 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).
- Encourage involvement of loved ones (carers, family, or close friends). Refer carers to Eating Disorders Queensland (EDQ) for additional support (3).

### Resources

- QuEDS (Qld Eating Disorder Service):** <https://metronorth.health.qld.gov.au/rbwh/healthcare-services/eating-disorder>
- QLD Health NEMO Eating Disorders (19)**
- NEDC: Eating Disorders and the Dietitian Decision Making Tool for adults experiencing an eating disorder (30)**
- EDIG: DA Eating Disorders Interest Group Resources (14)**
- 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 with mental health support (3) at a level which is guided by both the GP, and severity of the diagnosis e.g., specialist psychiatrist, psychologist, counsellor or GP.
- See DA'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 DA 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 and 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-month period.
- Interpersonal Psychotherapy – delivered over an 8-12-month period.
- Nutritional Interventions as an adjunct to therapy.

### Discharge and when to withdraw treatment

- 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, the 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.
- If the client is progressing well, a reduced frequency of sessions with increased autonomy for nutrition related decisions is appropriate in the lead up to discharge, with emphasis on relapse prevention plans.

## 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](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 \(dietitiansaustralia.org.au\)](http://dietitiansaustralia.org.au)
4. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders <https://www.ranzcp.org/getmedia/0ee7d923-af5f-44ad-b411-46edf10ba0b8/eating-disorders-cpg.pdf>
5. Eating Disorders: A Professional Resource for General Practitioners <https://www.nedc.com.au/assets/NEDC-Resources/NEDC-Resource-GPs.pdf>
6. SCOFF Questionnaire [https://ceed.org.au/resources\\_links/scoff-questionnaire/](https://ceed.org.au/resources_links/scoff-questionnaire/)
7. DA Practice Recommendations for the Nutritional Management of Anorexia Nervosa in Adults <https://insideoutinstitute.org.au/assets/practice%20recommendations%20for%20the%20nutritional%20management%20of%20anorexia%20nervosa%20in%20adults.pdf>
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](https://member.dietitiansaustralia.org.au/Common/Uploaded%20files/DAA/Resource_Library/2021/Nutrition_assessment.pdf)
9. DA Moving Towards Natural and Normal Eating (EDIG) [https://member.dietitiansaustralia.org.au/Common/Uploaded%20files/DAA/Resource\\_Library/2021/Moving\\_towards\\_natural\\_and\\_normal\\_eating.pdf](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. 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/2/2019/06/queds-day-program-rreferrers.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. 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](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. Centre For Clinical Interventions (CCI) - Set Point Theory Resource <https://www.cci.health.wa.gov.au/~media/CCI/Mental-Health-Professionals/Eating-Disorders/Eating-Disorders---Information-Sheets/Eating-Disorders-Information-Sheet---Set-Point-Theory.pdf>
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://www.ncbi.nlm.nih.gov/pubmed/24692444>
30. NEDC Eating Disorders and the Dietitian Decision Making Tool for adults experiencing an eating disorder <https://nedc.com.au/assets/NEDC-Resources/NEDC-and-DAA-Eating-Disorders-and-the-Dietitian-Decision-Making-Tool.pdf>