Thank you for being part of the treating team helping people recover from eating disorders. Managing such conditions requires the expertise of many health professionals. Working together enables treatment approaches to be more effective than when working in isolation.

Due to the high risk of morbidity and mortality associated with eating disorders and the wide range of physical abnormalities that commonly occur, it is important that appropriate medical investigation and follow-up occurs. There is a strong reliance on local GPs to provide this medical care and monitoring.

This package has been designed to support GPs when treating clients with eating disorders, so that the shared care approach has the best opportunity of being effective. The package focuses on services within the Hunter New England Area Health Service (HNEAHS) including speciality units such as the Child and Adolescent Mental Health Service (CAMHS) and the Centre for Psychotherapy, as well as services in regional areas that treat clients with eating disorders. These outpatient services do not offer direct medical assistance for people with eating disorders and highly value GPs’ input in treating these clients.

The package addresses:

• Services offered by CAMHS and the Centre for Psychotherapy
• The roles of each health professional
• The physical complications of eating disorders
• Which tests and examinations to conduct
• Indications for hospital admission – when and how to link in
• Information for parents and/or carers
• Further reading

Case consultation with staff from the Centre for Psychotherapy or CAHMS can be provided to your practice on request. For further support, GPs are welcome to attend an eating disorder network group for health professionals, which meets every three months. If you are interested, please contact the Centre for Psychotherapy for more information.

Liaising regularly with GPs regarding patient care is an essential part of treatment. We look forward to communicating with you and hope that you find this guide useful.

Yours sincerely

Anjanette Casey
Hunter New England Area Health Service
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The Centre for Psychotherapy is an outpatient service for adults over 18 years of age. It is located within the grounds of James Fletcher Hospital. Referred clients attend an initial assessment to explore how they can best be supported. Clients can be seen for individual therapy or in a group program. Clients also have access to a specialist dietitian. This service is free of charge.

The Child & Adolescent Mental Health Service (CAMHS) caters for individuals up to 18 years of age. There are currently teams based at Newcastle and Wallsend and another team planned to service the Maitland and Hunter Valley areas. The teams offer a range of specialist clinical services for children and adolescents and their families, including priority appointments for young people with eating disorders. The multidisciplinary teams consist of allied health staff (including psychologists, social workers, occupational therapists and dietitians), psychiatry registrars and a child & adolescent psychiatrist. This service is free of charge. The CAMHS team works closely with the Nexus Unit and the John Hunter Childrens Hospital, if admission is required for medical stabilisation or weight restoration.

An intake worker is on duty week days, within business hours, to discuss referrals to the service. The initial appointment will be with a member of the allied health team, providing an opportunity for the young person and their parent/carer to speak with the therapist.

In the past, it has been thought that children under the age of twelve do not develop eating disorders. CAMHS have treated children as young as nine with eating disorders and the literature reports cases of earlier onset. If you suspect an eating disorder in a child younger than twelve, it is important that a clinician with experience working with children with eating disorders conducts an assessment so that appropriate treatment can be offered when necessary.
An Overview of Regional Services Throughout HNEAHS

<table>
<thead>
<tr>
<th>Location</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tamworth</td>
<td>Mental Health Intake – ph: 1300 669757</td>
</tr>
<tr>
<td></td>
<td>Quentin Dignam – Clinical Psychologist ph: (02) 67677910</td>
</tr>
<tr>
<td></td>
<td>Tamworth Rural Referral Hospital</td>
</tr>
<tr>
<td></td>
<td>Deanne Harris – Dietitian ph: (02) 67678440</td>
</tr>
<tr>
<td>Armidale</td>
<td>Mental Health Intake – ph: 1300 669757</td>
</tr>
<tr>
<td></td>
<td>Armidale Community Health</td>
</tr>
<tr>
<td></td>
<td>Dietitian ph: (02) 6776 9600</td>
</tr>
<tr>
<td>Inverell</td>
<td>Mental Health Intake – ph: 1300 669757</td>
</tr>
<tr>
<td></td>
<td>Inverell Community Health</td>
</tr>
<tr>
<td></td>
<td>Dietitian – ph: (02) 6721 9600</td>
</tr>
<tr>
<td>Moree (including Bingara and Warialda)</td>
<td>Mental Health Intake – ph: 1300 669757</td>
</tr>
<tr>
<td></td>
<td>Moree Community Health</td>
</tr>
<tr>
<td></td>
<td>Pollyemma Antes – Dietitian ph: (02) 67570220</td>
</tr>
<tr>
<td>Taree/ Manning</td>
<td>Mental Health Intake – ph: 1300 669757</td>
</tr>
<tr>
<td></td>
<td>Greg Wilcox (Foster) – Registered Psychologist (No. as above)</td>
</tr>
<tr>
<td></td>
<td>Lois Ross (Taree) – Clinical Nurse Specialist ph: 65929403</td>
</tr>
<tr>
<td>Muswellbrook/ Upper Hunter</td>
<td>Mental Health Intake – ph: 1300 669757</td>
</tr>
<tr>
<td></td>
<td>Muswellbrook Community Health</td>
</tr>
<tr>
<td></td>
<td>Christine Johnson – Clinical Psychologist ph: (02) 65422050</td>
</tr>
<tr>
<td></td>
<td>Shaun Seldon – Dietitian ph: (02) 65422050</td>
</tr>
</tbody>
</table>

To discuss an eating disorder referral with a local contact regarding optimal service, advice and treatment, please consult the following list.
The primary goal of treatment is the restoration of physical and mental health through improved nutrition and the development of healthier behaviours.

- A thorough multidisciplinary assessment which will cover psychological, nutritional and medical domains including risk assessment (biopsychosocial model).

- The development of an individualised treatment plan in consultation with the treating team, the client and the client’s family (for children and adolescents). The treatment plan will aim to cover the psychological, nutritional and medical domains (coordinated/shared care model), though a greater emphasis may be given to one area depending on perceived need. Consistent messages are provided to the client by all team members (including GPs) in regards to menu plans, activity levels and goal weights. Engaging in the shared care model is a condition of treatment at the Child and Adolescent Mental Health Service (CAMHS) and the Centre for Psychotherapy (CFP).

- In addition to seeing their GP, treatments may include: Cognitive Behaviour Therapy, Narrative Therapy, Acceptance and Commitment Therapy (ACT), the Conversational Model, Maudsley Family Therapy and more generic Family Therapy, Nutritional Therapy, Psycho-education and Motivational Enhancement Therapy.

The GP’s role is to provide medical care and monitoring. They also provide supportive counselling if appropriate. GPs can play an essential role in advising when hospital is likely to be indicated.
The therapist aims to assist the client and/or their family (if under 18 years of age) in identifying factors that have contributed to and/or maintain the eating disorder, healthier ways of managing and experiencing emotions and to build a life and an identity away from the eating disorder. The therapist can be a psychologist, social worker, occupational therapist or visiting registrar.

Nutritional therapy aims to assist the client to improve their nutritional status, weight and health. The central focus of this is placed on facilitating healthy eating, attaining an appropriate weight status and promoting healthy body image in a safe and comfortable way. Nutrition therapy primarily focuses on normalising eating behaviours and facilitating healthy eating by establishing healthy dietary patterns (that are relaxed and flexible). Experienced dietitians use nutrition counselling skills to help facilitate these changes. Dietitians working with young people may also adopt a role as therapist within the Maudsley treatment model.

A rotating registrar is available periodically at CAMHS. Rotating registrars will have different levels of experience and familiarity with eating disorders. All registrars will be able to review clients for co-morbid diagnoses, such as depression and anxiety and be able to conduct a thorough risk assessment. Their role will always include liaison with the GP and the hospital system. More senior registrars may also play a more active role in both family and individual therapy. Sometimes delays in availability are common, due to the responsibilities and multiple roles the registrar fulfils at CAMHS.

A limited service with a psychiatrist, for review of medications, is available on request at CAMHS. The psychiatrist’s role is broad and not exclusive to working with clients with eating disorders.

Other members of the treatment team may include nurses, speech pathologists, occupational therapists, physiotherapists and school teachers/counsellors.
Whilst we can arrange consultancy for you, we don’t have medical expertise at our Centres. We therefore need you to help us with the following:

- Monitoring medical safety, with regular examinations and tests
- Contacting us when you notice medical issues arising
- Monitoring for existing or developing co-morbidities (e.g. anxiety, depression)
- Monitoring for relapses
- Deciding when hospital is indicated (you can contact the team for discussion around this)
- Identifying client at risk of refeeding syndrome (refer to Appendix Three)

We aim to speak to GPs regularly as it is a condition of treatment that a shared care approach is adopted.

These questions may be used as a means of screening clients for an eating disorder. Whist there is evidence that this tool produces some false positive results, it has been shown to be an effective screening tool for the primary health care setting.

1. Do you ever make yourself **vomit** because you feel uncomfortably full?
2. Do you worry you have lost **control** over how much you eat?
3. Have you recently lost more than one **stone** (approximately 6 kg) in a three-month period?
4. Do you believe yourself to be **fat** when others say you are too thin?
5. Would you say that **food** dominates your life?

Each positive response (yes) is given 1 point. A score of 2 or more indicates possible Anorexia Nervosa or Bulimia Nervosa.
One of the challenges at the primary level is engaging clients with eating disorders into treatment. Even on the first presentation, the most important task is to ensure the clients return. As they are often afraid of seeking help, a supportive approach is essential.

- It is important that adults are involved in the decision making process on all levels.
- Clients may find it less confrontational if they know they are able to discuss treatment options before deciding whether or not to engage in a treatment program.
- If clients choose not to engage in any treatment program, your role may be to continue to support them until they feel ready to seek further help. In this instance, the Centre for Psychotherapy will be happy to support you.

- It is essential to ensure that adults are in charge of caring for younger clients.
- Children or adolescents may often refuse to co-operate with the treatment program.
- It is important to allow the client to make decisions on non vital issues for themselves.
- Those issues regarding physical health and safety must be decided by the responsible adult(s) - ideally through a co-ordinated team approach.

- The family is one of the most important resources of treatment.
- Supporting the families of clients with eating disorders may result in a reduction in family distress, enhanced family function and improvements in eating behaviours.

See Appendix Six for handouts you can provide to parents and carers.
These rebates are provided under the Better Access to Mental Health Care Initiative, which allows those with eating problems to have access to high quality psychological care. This scheme allows all Australians to have access to effective psychological treatments from experienced health professionals. Below are some key points of the scheme:

- GPs can refer to Clinical Psychologists, Psychologists, Social Workers and Occupational Therapists who are registered with Medicare Australia.
- Clients must be referred by a GP, psychiatrist or paediatrician.
- Any person with an eating disorder (the scheme specifically excludes dementia, delirium, tobacco use disorder and mental retardation) can be treated under the scheme.
- The client must be managed by a GP under a GP Mental Health Care Plan or a psychiatrist assessment and management plan.
- If you are referred to a clinical psychologist under the scheme, they can provide a range of psychological therapies suited to the client’s problem. Other health professionals nominated under the scheme can treat using cognitive behavioural techniques, including psycho-education, relaxation strategies, skills training and interpersonal therapy.
- Clients are allowed up to twelve individual sessions in one calendar year. These sessions are provided in two sets of six, with the need for the second set to be reviewed by the referring medical practitioner. There are also twelve group sessions allowed per calendar year.
- Private health professionals must provide a written report to the referring medical practitioner following the first six services, and on completion of the treatment.
- The health care professional must have a Health Insurance Commission (HIC) provider number.

Practically, this means that a client must obtain a referral from a GP under a mental health care plan (Medicare item number 2710) to an eligible health professional, which entitles the client to twelve rebated treatment sessions.
For clients with both complex physical and psychological needs, requiring team-based care such as a patient with an eating disorder, the GP is able to use both the new **GP Mental Health Care Plan** under the Better Access initiative and the **Enhanced Primary Care (EPC) Plan** for team-based care.

For example, a client with an eating disorder may be referred to see a therapist on a GP Mental Health Care Plan and a dietitian on an Enhanced Primary Care Plan.

The Enhanced Primary Health Care Plan items (for team-based care) 721, 723, 725 and 727 continue to be available for patients with chronic medical conditions, including eating disorder patients with complex needs.

For more information:
Medicare Australia Ph: 132 150.
www.health.gov.au
www.gpaccess.com.au

The Centre for Eating & Dieting Disorders (CEDD) has developed an online training program that has been approved by RACGP for 40 Category 1 Points, and by ACRRM for 8 PDP points.

There are four learning packages addressing both people at risk of developing eating disorders, and those displaying signs of illness. These packages are:

1. “Case Identification” covers risk factors, clinical signs and symptoms that may alert to the development of illness.
2. “Early Treatment” includes medical, psychological/psychiatric and nutritional/activity assessments.
3. “Management” includes developing a management plan that works, and acquiring the core skills and tools useful across the spectrum of eating disorders.
4. “Support & Consultation” (optional) covers specific issues such as working in a crisis situation and under special circumstances (such as pregnancy/diabetes etc).
There are many physical complications associated with eating disorders. Common complications related to weight loss and purging are listed in the table below. It is essential during both the restrictive and refeeding phase to monitor for these complications (as refeeding can lead to dangerous fluid and electrolyte shifts, see Appendix Three).

<table>
<thead>
<tr>
<th>Related to Weight Loss</th>
<th>Related to Purging</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metabolic:</strong> electrolyte abnormalities, sudden death.</td>
<td><strong>Metabolic:</strong> electrolyte abnormalities, particularly low potassium, chloride or magnesium, sudden death.</td>
</tr>
<tr>
<td><strong>Cachexia:</strong> loss of fat, muscle mass, reduced thyroid metabolism, cold intolerance, difficulty in maintaining core body temperature.</td>
<td><strong>Gastro:</strong> salivary gland and pancreatic inflammation, increased serum amylase, oesophageal and gastric erosion, dysfunctional bowel.</td>
</tr>
<tr>
<td><strong>Cardiac:</strong> loss of cardiac muscle, small heart, cardiac arrhythmias, prolonged QT interval, bradycardia, ventricular tachycardia, sudden death.</td>
<td><strong>Dental:</strong> erosion of dental enamel.</td>
</tr>
<tr>
<td><strong>Gastro:</strong> delayed gastric emptying, bloating, constipation, abdominal pain.</td>
<td><strong>Neuropsychiatric:</strong> seizures (due to large fluid shifts and electrolyte disturbance), mild neuropathies, fatigue and weakness, mild cognitive disorder.</td>
</tr>
<tr>
<td><strong>Reproductive:</strong> amenorrhoea, low luteinizing hormone and follicular stimulating hormone.</td>
<td></td>
</tr>
<tr>
<td><strong>Dermatological:</strong> lanugo (down-like hair), oedema.</td>
<td></td>
</tr>
<tr>
<td><strong>Haematological:</strong> leukopenia.</td>
<td></td>
</tr>
<tr>
<td><strong>Neuropsychiatric:</strong> abnormal.</td>
<td></td>
</tr>
<tr>
<td><strong>Renal:</strong> kidney impairment/failure.</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from Physical & Medical Complications Associated with Eating Disorders, Kaplan et al, 1994.
The following tests are recommended during the diagnostic phase and for ongoing consultations. If you have diagnosed the client with an eating disorder (See Appendix One), regular assessments are required to monitor for medical complications. Frequency of visits can depend on the severity of the illness. **We recommend that clients see their GP weekly initially, to ongoing visits fortnightly (dependent on need), and with at least monthly visits until well.**

<table>
<thead>
<tr>
<th>When</th>
<th>Examination</th>
<th>Test</th>
<th>Comments</th>
</tr>
</thead>
</table>
| On first examination | - Weight / Height  
- Weight History  
- Growth history  
- Signs of Dehydration  
- Blood Pressure  
(sitting and standing)  
- Pulse  
- Temperature | - UECs (esp. K, PO4, Mg, Na, creatinine)  
- Other blood tests (esp. B12, folate, Fe, renal and liver function)  
- Blood sugar levels  
- Bone Densitometry (if amenorrhoea > 6 mths)  
- ECG - depending on clinical indication or if BMI <15 (adults) | Note that weight / growth restoration is the optimal treatment to improve bone density. |
| On each visit  
- Essential | - Blood pressure  
- Pulse  
- Signs of Dehydration | - UECs (as above), weekly if BMI < 15 (adults)  
- Blood tests (as above)  
- ECG - if losing more than 1kg/wk for 3 months or BMI <15 (adults) | It is recommended that weight be monitored consistently by the same team member (this may be the GP or the dietitian) and on the same set of scales. Whoever takes responsibility for monitoring weight should communicate this information to other team members, the client and when appropriate, the client’s family. It is usually not recommended that weight be monitored by the client or the client’s family. |
| - As required | - Weight  
- Temperature |                                      |                                                                          |
| Yearly        | Bone Densitometry (if amenorrhoea > 6 mths)      |                                      |                                                                          |
All aspects of the physical examination and investigations of a client with an eating disorder need to be considered in a holistic manner. Normal blood results alone are not an indication that the client is safe from adverse physical complications.

Regular assessments are necessary. The physical or psychological status of a person with an eating disorder can change quickly and unpredictably. One off assessments are not recommended.

Co-morbidity is common and may require further assessment. A significant proportion of deaths associated with Anorexia Nervosa are due to suicide. All clients who disclose thoughts or plans for deliberate self harm or suicide require referral for a mental health assessment.

A risk assessment of harm to self and suicidality should be performed (in some form), at every assessment and follow up session. Clear documentation of your risk assessment is advised.

Any pattern of weight loss greater than 1 kg a week is of concern and in a client with an eating disorder, a very serious sign. This is irrespective of the actual weight and BMI of the client. For younger children, weight loss less than 1kg can also be concerning.

Blood pressure and pulse rate are more likely to reflect the actual physiological status of the person when performed with the client in a relaxed state. If a particular session has been difficult or distressing, haemodynamic parameters are likely to be falsely raised. It is important to keep this in mind when interpreting the measurement of these vital signs.

Decreased or absent fluid intake is an urgent medical matter. Irrespective of the client’s weight or psychological state, immediate referral to hospital is advised.
The primary treatment for people with eating disorders is psychotherapeutically based. If medication is indicated, it is important this is done in conjunction with a psychotherapeutic approach. Pharmacotherapy is not recommended as a sole source of treatment.

There are few well designed studies examining the role of pharmacotherapy in Anorexia Nervosa. Both nortriptyline and zinc have weak evidence for efficacy in Anorexia Nervosa. The use of a tricyclic anti-depressant (TCA) in this population is not recommended unless commenced by a specialist with ongoing specialist review. TCAs carry considerable risk in overdose.

The role of SSRIs has been recently examined. They appear to be of benefit if there is clear evidence of a co-morbid depressive or anxiety disorder. Their use in Bulimia Nervosa is well recognised and supported, with fluoxetine being the first line medication of choice. However, their use in Anorexia Nervosa without depressive features remains controversial. Vitamin and mineral supplementation is recommended where necessary.

The Royal Australian and New Zealand College of Psychiatrists also recommend the use of Olanzapine. This is thought to be useful in attenuating excessive activity, and may also play a role in assisting clients with abnormal perceptions and cognitions regarding weight and appearance to experience a reduction in these symptoms. As some clients experience rapid weight gain with Olanzapine, it is essential to monitor and appropriately manage potential distress. Olanzapine does not have PBS listing in Australia for use with clients with eating disorders. Its use in these conditions should be limited to specialist units who are able to supply the medication legally under separate budget schemes. Such a scheme is currently running in the Hunter Area from John Hunter Hospital for children and adolescents. However, its use is restricted to medical practitioners who work at either the Nexus inpatient unit or the CAMHS. The scheme is not available for adults.
Indications for Hospital Admission – when and how to link in

A Hospital Admission Might be Indicated if the Following Occur:

- Heart Rate <40 bpm (adults) or <50 bpm (children);
- BP <90/60 mm (adults) or <80/50 mm (children);
- Low potassium <3.0 mmol/L;
- Other significant electrolyte imbalances;
- Temperature < 36°C;
- Orthostatic change >20bpm increase HR, > 20 mm drop in blood pressure;
- If BMI < 14 (note BMI = weight Kg / height m2) (adults)
- Rapid weight loss (eg > 1Kg each week on ongoing basis);
- Suicidality with an active intent and plan;
- If the client has ceased fluid intake;
- If the client is at high risk of developing refeeding syndrome

How to Link in if You Think a Hospital Admission is Indicated:

For Adolescents

When considering a referral to a hospital, it is important to discuss the situation with the treating team. However if urgent medical assistance is required, presentation at the emergency department (ED) should be the first point of call. A pathway of care has been implemented at John Hunter Hospital Emergency Department (JHH ED) for people presenting with eating disorders.

Hunter New England Health provides paediatric hospital assistance for both medical stabilisation and/or weight restoration. The JHH has two units (J2 and NEXUS) that accept referrals for eating disorders. J2 is a general paediatric unit for medical stabilisation only, treating patients from 12-16 years old; NEXUS is a specialist unit that helps children with mental health difficulties from 5 -18 years old.

Other HNEAHS hospitals may provide medical stabilisation, however this needs to be negotiated with the admitting doctor prior to the referral. Please remember to contact the treating members of the CAMHS team to inform them of the situation.
If you require urgent medical advice regarding children or adolescents call:
- John Hunter Hospital, on-call paediatrician on 49 213 000
- Intake officer at NEXUS via John Hunter Hospital main switch on 49 213 000.
- For the Tamworth area contact the paediatric clinic on 67 678 740 to discuss admission

NB: If emergency services are required, ensure that you phone the ED doctor on duty before the client presents.

HNEAHS hospitals admit adults with eating disorders for short term medical stabilisation only. If weight restoration is required, referrals can be made to private hospitals (see below) or Royal Prince Alfred Hospital, Sydney.

If further information is required regarding weight restoration, please contact the dietitian at the Centre for Psychotherapy.

If medical stabilisation is required, contact the treating doctor at Emergency Department prior to the referral. In the Newcastle area, a pathway of care has been implemented at JHH ED for people presenting with eating disorders.

It may also be useful to write a letter detailing your specific concerns.

If you require urgent medical advice regarding an adult:
Please call the Gastroenterologist at JHH via the main switch on 49 213 000.

Northside Clinic, Greenwich, Sydney
A 98 bed psychiatric facility with 15 - 18 beds for people with an eating disorder.
Ph: (02)9433-3555

Wesley Private Hospital, Ashfield, Sydney
A 38-bed mental health facility with 10 beds for people with an eating disorder.
Ph: (02) 9716 1400
The Mental Health Act (2007) is a law that governs the care and treatment of people in NSW who experience a mental illness or mental disorder.

It stipulates that people with a mental illness must receive the best possible care and treatment in the least restrictive environment. Any interference with or restriction of their rights, dignity and self-respect is to be kept to a minimum.

The Mental Health Act only applies to persons who are defined as either mentally ill or mentally disordered as it is clearly outlined in the Act. These definitions are legal terms and are not interchangeable with the medical definition of a mentally ill person.

In terms of being classified as a mentally ill person, the client MUST have a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence of any one or more of the following symptoms or signs:

- Delusions
- Hallucinations
- Serious disorder of thought form
- Severe disturbance of mood
- Sustained or repeated irrational behaviour indicating that the person is having delusions or hallucinations.

In addition:

- The person must be at risk of serious harm to self or others (includes physical harm, harm to reputation, physical health, relationships, finances and self neglect)
- And that consideration is given to the continuing nature of the condition, including any likely deterioration
- And that no other care of a less restrictive kind is available.
Generally, the abnormal cognitions in Anorexia Nervosa are not classified as delusions and as such, the use of the Mental Health Act (2007), despite Anorexia Nervosa being clearly defined as a mental illness by medicine, is not advised. Even in the most extreme cases, attempts should be made for the client to be brought into hospital for an assessment without restrictions of the Act. If you are considering using the Mental Health Act to facilitate a psychiatric assessment, it is advised that you discuss it with the appropriate hospital based person prior to going ahead.

Inappropriate placement of adults and adolescents under the Mental Health Act is likely to have a detrimental effect on the client and their future therapeutic relationships with professionals.

The Guardianship Act provides for the appointment of a guardian to make decisions on behalf of a person, who is aged 16 years and over with a disability, who is unable to do so on their own or without support.

When a person with Anorexia Nervosa refuses treatment, carers may obtain a ‘legal order’ under guardianship legislation, or a public guardian can be appointed to take temporary control over the client’s care and make decisions on their behalf for a specified period.

This is a last resort option and only for the purpose of saving a life. More information is available on: www.gt.nsw.gov.au/ or for guardianship general enquires ph: 02 92653184.

Notification to the Department of Community Services needs to be considered when the safety of a young person is significantly compromised due to an eating disorder, i.e. when risk level is high as part of your risk assessment and there is no intervention to address this. Similarly, notification must be considered when parents are refusing appropriate and reasonable treatment for their child. Please note that the risk to siblings, if parents are not able to acknowledge their needs, may also need to be discussed with parents and if necessary form part of a notification to DOCS.

Refer to Child Protection guidelines if needed or phone DOCS Helpline to clarify on ph:132 111
**Helpful Telephone Numbers**

| Psychological / Dietetic Advice | Centre for Psychotherapy  
(02) 4924 6820 |
|---------------------------------|---------------------------------------------------------------|
| (Or refer to regional contacts on page 5) | CAMHS  
Newcastle (02) 4925 7800  
Contacts: Stella Dyer (Adult Psychologist)  
Cath Wood (Adolescent Therapist)  
Anjanette Casey (Adult and Adolescent Dietitian)  
Claire Toohey (Adult Dietitian)  
Dyani Nevile (Adult Occupational Therapist) |
| Urgent Medical Advice | NEXUS (children and adolescents)  
(02) 4985 5800 |
| | J2 John Hunter Childrens Hospital (children and adolescents)  
(02) 4921 3000 |
| | Gastroenterology Department,  
John Hunter Hospital (adults)  
(02) 4921 3000  
Contacts: Julie Adamson (Adolescent Paediatrician)  
Anne Duggan (Adult Gastroenterologist)  
Intake Officer or Paediatric Medical Registrar |
| Useful Organisations | Centre for Eating and Dieting Disorders NSW  
(02) 9515 5843  
www.cedd.org.au |
| | Eating Disorder Foundation of NSW  
(02) 9412 4499  
www.edf.org.au |
| | Eating Disorder Foundation of Victoria  
(03) 9885 0318  
www.eatingdisorders.org.au |
Further Reading and References

Australian and New Zealand Clinical Practice Guidelines for the Treatment of Anorexia Nervosa,

Eating Disorders, A Parents’ Guide,

Evidence-based treatment of eating disorders,

Help your Teenager Beat an Eating Disorder,

Information on Eating Disorders for Health Practitioners,
The Eating Disorder Foundation of Victoria $10 per booklet (see website to order).

Information on Eating Disorders for Families, Partners and Friends,
The Eating Disorder Foundation of Victoria, $7.50 per booklet (see website section to order).

Nutritional Management of Anorexia Nervosa,
Clinical Practice Guidelines (Draft), Wakefield, A., and Williams, H et al. RPA Hospital and Wesley Private Hospital, 2006.

Management of Mental Disorders,

Medical Complications of Eating Disorders: An Update,

Physical & Medical Complications Associated with Eating Disorders,

Eating Disorders Toolkit, A Practice-Based Guide to the Inpatient Management of Adolescents with Eating Disorders, with Special Reference to Regional and Rural Areas,
We would like to acknowledge everyone who has contributed their time and expertise which has lead to the development of this guide and its second edition.

We are particularly thankful to the consultants, general practitioners, dietitians, psychologists, registrars and other health professionals across the Hunter New England Area Health Service who have provided input into the development of the package. Members involved in the working party of this document have included clinicians from the Community Adolescent Team, Centre for Psychotherapy, NEXUS, John Hunter Childrens Hospital and local GP Surgeries.

Principal contributors:
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Other people we would like to thank for their contribution include: Dr Anne Duggan, Dr Terri Parkin and Dr Miriam Grotowski.

For further information regarding the resource please contact:

Anjanette Casey
Dietitian
Centre for Psychotherapy
Hunter New England Mental Health
Newcastle NSW 2300
Ph: (02) 4924 6820
Diagnostic Criteria for Anorexia Nervosa (DSMIV) includes:

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g. weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

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 denial of the seriousness of the current low body weight.

D. In postmenarcheal females, amenorrhoea, i.e. the absence of at least three consecutive menstrual cycles (a women is considered to have amenorrhoea if her periods occur only following hormone, e.g. oestrogen administration)

During the current episode of Anorexia Nervosa, the person has not regularly engaged in binge eating or purging behaviour (i.e. self induced vomiting or the misuse of laxatives, diuretics or enemas).

During the current episode of Anorexia Nervosa, the person has regularly engaged in binge eating or purging behaviour (i.e. self induced vomiting or the misuse of laxatives, diuretics or enemas).
Diagnostic Criteria for Bulimia Nervosa (DSMIV) includes:

A. Recurrent episodes of binge eating, characterised by eating in a discrete period of time an amount of food that is larger than most people would eat during a similar period under similar circumstances and a sense of lack of control over eating during the episode.

B. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self induced vomiting, misuse of laxatives, diuretics, enemas or other medications, fasting or excessive exercise.

C. The binge eating and inappropriate compensatory behaviour both occur, on average, at least twice a week for 3 months.

D. Self evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

During the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviours, such as fasting or excessive exercise, but has not regularly engaged in self induced vomiting or the misuse of laxatives, diuretics or enemas.

During the current episode of Bulimia Nervosa, the person has regularly engaged in self induced vomiting or the misuse of laxatives, diuretics or enemas.
The Eating Disorder Not Otherwise Specified (EDNOS) category is for disorders of eating that do not meet the criteria for any specific eating disorder. Examples include:

1. For females, all the criteria for Anorexia Nervosa are met except that the individual has regular menses.

2. All the criteria for Anorexia Nervosa are met except that despite significant weight loss, the individual's current weight is in the normal range.

3. All the criteria for Bulimia Nervosa are met, except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week, or for a duration of less than 3 months.

4. The regular use of inappropriate compensatory behaviour by an individual of normal body weight after eating small amounts of food (e.g. self induced vomiting after the consumption of two cookies).

5. Repeatedly chewing and spitting out, but not swallowing large amounts of food.

When assessing a client, it is important to consider the differential diagnoses listed below. However, if an eating disorder is strongly implicated, please contact CAMHS or the Centre for Psychotherapy team rather than conducting intensive investigations.

Depression *
Anxiety Disorders, OCD, Psychogenic Vomiting **
Drug Abuse
Athletic Amenorrhoea
Chronic Infection
Thyrotoxicosis
Bowel Disease (e.g. IBS, Crohn’s disease)
Peptic Ulcer Disease
Malabsorption Syndrome
Lymphoma or Other
Diabetes Mellitus

* People experiencing primary depression may lose weight following the loss of appetite or motivation to eat. At the same time, depression can be secondary to the eating disorder, which usually resolves once refeeding occurs. You may find it helpful to investigate a family history of depression. Another key indicator is that people with primary depression often do not show concern about weight gain/caloric intake in food as do those experiencing an eating disorder.

** People with obsessional symptoms (e.g. fear of eating contaminated food, rituals surrounding food intake), may also experience weight loss, without necessarily having an eating disorder and will require a different type of treatment.
Regular review and physical examination is an important part of management for patients with eating disorder. Abnormal findings should alert the clinician to the need for further investigation or consultation.

<table>
<thead>
<tr>
<th>EXAMINATION AND INVESTIGATIONS</th>
<th>COMMENTS AND MANAGEMENT ISSUES</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>Measure with no shoes, ideally early in morning.</td>
<td>Initial assessment. For children and adolescents recheck height every three months.</td>
</tr>
<tr>
<td>Weight</td>
<td>Essential. Weigh with no shoes and minimal clothes. Ideally weigh at the same time of the day.</td>
<td>Regularly but no more than weekly initially and thereafter intermittently.</td>
</tr>
<tr>
<td>Body Mass Index/Height for Weight</td>
<td>Used to help assess risk and also to calculate minimum healthy weight range in adults.</td>
<td>On assessment and periodically for assessing progress.</td>
</tr>
<tr>
<td></td>
<td>The normal range for children and adolescents differs from the adult range and should be discussed with a specialist dietitian.</td>
<td></td>
</tr>
<tr>
<td>Pulse</td>
<td>Bradycardia can also indicate severity of malnutrition. 50-60 bpm = mild 40-50 bpm = moderate &lt;40 bpm = severe</td>
<td>At each assessment.</td>
</tr>
</tbody>
</table>
### Blood Pressure

Low blood pressure can indicate dehydration and will need urgent medical attention. Blood pressure measurements are age dependent. The adult ranges are:
- Mild BP <90/60, postural change 10-20mmHg
- Severe BP<80/50, postural change >20mmHg

At each assessment.

NB: Both pulse and BP can be affected by anxiety and can give falsely high values in the clinic setting when anxiety is experienced.

### Temperature

Hypothermia is a marker of severe malnutrition. Temperature < 36°C is significant.

At each assessment. Note clothing required and ask about difficulty with cold intolerance.

### FBC, Iron, Ferritin, B12, & RBC Folate

Mild leukopaenia is common & pancytopenia can occur. Ferritin may be high at presentation due to blood volume contraction but may fall following treatment.

Initial assessment. Repeat if previous tests abnormal or signs of deterioration are noted.

### Blood sugar levels

A regular carbohydrate intake and balanced diet during the day is essential to prevent hypoglycaemia.

Initial assessment. Repeat if signs of hypoglycaemia occur e.g. dizziness and confusion.

### Sodium

Low sodium may mean fluid overload
- Mild =125mmol/L to bottom of normal range
- Severe = <125mmol/L

Needs medical review. May require fluid restriction or sodium supplementation.

Initial assessment. Repeat if signs of deterioration are noted and if purging is known or suspected.
<table>
<thead>
<tr>
<th>EXAMINATION AND INVESTIGATIONS</th>
<th>COMMENTS AND MANAGEMENT ISSUES</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potassium</td>
<td>Low potassium can indicate purging or a refeeding problem. Elevated levels can indicate kidney dysfunction or dehydration. A potassium less than 3 mmol/L should prompt specialist consultation or assessment. Chronic deficiency at whole normal body level may not be reflected by serum values.</td>
<td>Initial assessment. Repeat if signs of deterioration are noted and if purging is known or suspected.</td>
</tr>
<tr>
<td>Urea</td>
<td>Elevated urea levels can be a sign of dehydration or catabolism of muscle. Promote adequate fluid intake or use intravenous saline drip. <strong>DO NOT</strong> use intravenous dextrose.</td>
<td>Initial assessment. Repeat if previous tests abnormal or signs of deterioration are noted.</td>
</tr>
<tr>
<td>Phosphate</td>
<td>Low phosphate can be an indicator of potential refeeding problems. Supplementation will be necessary. If low, discuss with specialist dietitian or physician.</td>
<td>Initial assessment. Repeat if previous tests abnormal or signs of deterioration are noted.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NB. Refeeding syndrome can occur with oral intake in an out patient setting.</td>
</tr>
<tr>
<td>Calcium</td>
<td>Low calcium can solely reflect a low blood albumin. Low corrected calcium may also be associated with magnesium deficiency.</td>
<td>Initial assessment. Repeat if previous tests abnormal or signs of deterioration are noted.</td>
</tr>
</tbody>
</table>
### EXAMINATION AND INVESTIGATIONS

<table>
<thead>
<tr>
<th>EXAMINATION AND INVESTIGATIONS</th>
<th>COMMENTS AND MANAGEMENT ISSUES</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magnesium</td>
<td>A low serum magnesium always indicates magnesium deficiency, a normal serum magnesium does not exclude deficiency. If low, discuss with specialist dietician or physician.</td>
<td>Initial assessment. Repeat if previous tests abnormal or signs of deterioration are noted.</td>
</tr>
<tr>
<td>Liver Function Tests</td>
<td>Abnormalities may occur due to fatty infiltration of the liver in starvation.</td>
<td>Initial assessment. Repeat if previous tests abnormal.</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>High levels may reflect response to malnutrition and resolve with weight gain in anorexia nervosa.</td>
<td>Not usually performed.</td>
</tr>
<tr>
<td>ECG QTc interval</td>
<td>A prolonged QTc is an indication of cardiac compromise and increases risks associated with electrolyte abnormalities, refeeding and medication use.</td>
<td>If weight loss is rapid, BMI&lt;15 (adults), or there are symptoms or signs of cardiovascular instability.</td>
</tr>
<tr>
<td>Bone density</td>
<td>Prolonged anorexia nervosa can lead to osteoporosis, as a result of low weight, reduced hormone levels and inadequate calcium intake. Weight gain to a normal range is the optimal strategy for improvement.</td>
<td>Bone density scans recommended for patients with amenorrhoea longer than six months and annually thereafter as indicated.</td>
</tr>
</tbody>
</table>
Refeeding syndrome is a relatively rare and serious complication of refeeding a patient, which can be fatal. 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).

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:
  - Thiamine (if not covered by multivitamin) 100mg daily
  - Multivitamin and Mineral RDI levels
  - Phosphate 1000mg daily
- 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. The Nice Guidelines (2004) recommend these patients be commenced at 50% of energy requirements for first 2 days, increasing to full requirements if clinical and biochemical monitoring reveals no problems.

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. It’s important to note that blood results alone do not indicate medical safety. Normal vital sign parameters do not guarantee normal physiological status.

# BMI Ranges

<table>
<thead>
<tr>
<th>Height (cm)</th>
<th>BMI Ranges (weight in Kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;14</td>
</tr>
<tr>
<td>140</td>
<td>4,7</td>
</tr>
<tr>
<td>142</td>
<td>4,8</td>
</tr>
<tr>
<td>144</td>
<td>4,9</td>
</tr>
<tr>
<td>146</td>
<td>4,9.5</td>
</tr>
<tr>
<td>148</td>
<td>4,10</td>
</tr>
<tr>
<td>150</td>
<td>4,11</td>
</tr>
<tr>
<td>152</td>
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<tr>
<td>198</td>
<td>6,6</td>
</tr>
<tr>
<td>200</td>
<td>6,7</td>
</tr>
</tbody>
</table>

*for people of Asian descent, a Healthy Weight Range may be within BMI 18.5-25
Whilst the Centers for Disease Control (CDC) attributes a normal BMI to be between the 5th and 85th percentile (on a population basis), the 5th percentile is often too low to enable physical recovery to occur for adolescents with eating disorders. The Child and Adolescent Mental Health Statewide Network recommend a healthy weight is more likely to be within the 25th–85th percentile for this population. Premorbid growth trajectories can also be a helpful indicator.

**Healthy weight is most accurately defined as the weight at which physical recovery occurs.**

BMIs for 25th and 85th percentiles (ages 12-18) are listed below

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

This information is supplied so that they can be reproduced and disseminated for psycho-education purposes.
Parenting is one of life’s most difficult jobs and one for which we receive very little preparation. Even when things are going well, it is common for parents/carers to wonder if they are “doing things right”. Combine this with an eating disorder and it is not surprising that people can often feel overwhelmed.

Living with someone who has an eating disorder can be very difficult. It can also be hard to know what to do, especially when the person struggling with the eating disorder can appear to be resistant to change (even though they might also want things to be different). During these times, feelings of confusion, anger and frustration are often experienced. To help families and carers through this difficult time, it can be useful to have information on eating disorders and tips on how to best support your friend or family member.

**Information for Parents and/or Carers**

- No one chooses to have an eating disorder. An eating disorder is a mental illness just like any other illness.

- It is common for people suffering from eating disorders to have poor self-esteem. Although they may be obsessed with their appearance, it is not a sign of vanity. While the focus may appear to be on body size, food and weight, underlying this may be a pervasive sense of low self worth. What we see is often not experienced by the person. For instance, they can genuinely see themselves as unworthy, a failure and overweight.

- If you are a parent reading this, it is not your fault that your child has an eating disorder. Eating disorders can be caused from a combination of reasons and we do not know why any one person develops this. As a parent, you have a very important role to play in the recovery process by supporting your child.

- Eating disorders are associated with changes to how the brain functions. These changes often result in poor memory and concentration, mood swings, especially irritability and even poor decision making. The behaviours may be the direct result of altered brain function and do not always represent simple defiance or disobedience.
Resistance to change and receiving help are common symptoms of having an eating disorder (in the same way that chest pain is a symptom of a heart attack). It is important during these times to not blame the person and to separate them from the illness.

Recovering from an eating disorder is a lengthy process, which takes many months and sometimes years. Even when physical health is restored, it can often take much longer to help them overcome the underlying worries. Although clinicians and other ‘experts’ can assist, unfortunately they have no magic cures.

Try not to blame the person for their eating problem. It is natural that you will sometimes feel frustrated, angry and exasperated. Remember that they are also feeling this way. It is the eating disorder that is causing the resistant behaviour and unpredictable emotions.

Eating disorders are associated with high levels of anxiety, so remember that the person suffering with an eating disorder is in distress. Express your love and affection as much as you can. Try to model calmness and gently explain that you are worried about their health, how unhappy they have become and that you will act in what you believe to be their best interests – the struggle is against the eating disorder, not them.

Ask about their treatment. If the person is an adult, ask how they are feeling and let them know that you are interested in their treatment if they would like to talk about it. If you have a child that is struggling with an eating disorder, speak to the professionals involved and agree on a consistent approach. After all, you are part of the treating team!

Try and set a time aside each day where discussion is not focussed on the eating disorder (this could include sports, current affairs or any other interesting topic). This allows you time to be a parent, partner or friend as you would be normally. Try not to lose sight of the healthy and positive attributes of your friend or family member.
If you are a parent whose child is struggling with anorexia nervosa, it can be very useful to form a plan with the treating team. As each family is different, this will vary depending on what is realistic for you, your child, and your family. It is important that family members support the plan and that it is consistent. To best assist your child, make joint decisions about your approach (if the child sees both parents), and communicate these consistently to the young person. Working together with people who care for your child and with the treating team is essential.

Do not engage in debating about weight or worry about weight, as this is a discussion where you will be speaking to the eating disorder not the person. Instead listen or discuss feelings, opinions, and original thinking, as this can be very helpful.

Discourage weighing at home. If they are going to be weighed, encourage them to do so with one health professional only.

If the person with an eating disorder is very underweight, discourage clothes shopping until the person is well into recovery. It can be very distressing for people who are reaching their healthy weight range to change clothing sizes and this can sometimes strengthen the hold of the eating disorder.

For many people with an eating disorder, meal times will be very distressing. Family and friends can help a person with an eating disorder in many ways at meal times. It will probably be useful to discuss how you can be helpful with the treating team and with the person suffering from an eating disorder.

Take care of yourself! Watching friends, partners, or family members struggle with an eating disorder can often place strain on relationships and is difficult for everyone involved. It is important that you take time to nurture yourself or your other relationships. Get support for yourself from your friends or a counsellor who will help you sort out how you are feeling. Ask your GP where you can gain support in your local area.
When someone you know has an eating disorder, it is normal to wonder how this could have occurred. There are many reasons why eating disorders develop and unfortunately we do not have clear answers at this point in time.

However, this does not mean we are powerless. We can all play a role in helping to promote healthy bodies. Here are a few ideas that you can do to promote healthier attitudes in your family and wider community:

• Educate yourself and discuss with those you care about on the dangers of excessive dieting.

• Discuss and challenge advertisements that link thinness to happiness/success. Such advertisements often lead a person to feel inferior with the promise of a ‘magic result’ if a certain ‘look’ is achieved.

• Let children grow and develop at their own pace (e.g. at school, sports etc). It can be useful to acknowledge that people usually have a wide range of talents and that it is normal to have different levels of skills in different areas. This also naturally varies from person to person.

• Adolescents need a balance between rules and limits on the one hand and freedom and responsibilities on the other. Allow adolescents to make appropriate choices, within safe limits and let them experience the consequences of their own decisions.

• Be aware of stress and pain in the lives of friends and family. It can be more useful to not ‘fix’ someone else’s problems but rather let the person work through the issues and grow from the experience.

• See your primary role as one of love, support and encouragement.

• Teach and model a healthy approach to nutrition at home. Distinguish between dieting and a healthy dietary intake, as many people think they are synonymous.
• Be an advocate and role model for others. This could vary from appreciating body diversity, avoiding criticising people who not conform to cultural standards of thinness (and challenge those who do), to having a healthy approach to food and minimising time talking about diets and physical appearance. Expressing an admiration for healthy bodies (irrespective of size), including your own, can be very powerful.

• Avoid encouraging people to lose weight (if concerned about whether your loved one is overweight, encourage them to seek help from a health professional). Express your love and caring regardless of how they look and encourage them to be healthy.

• If a friend, partner or family member wants to lose weight, find out what he or she wants to achieve by dieting. If the goals are unrealistic, or if the individual is feeling inadequate and unacceptable, deal with those issues directly. If these feelings persist, seek help from a counsellor or therapist who is trained to work with dieting disorders.

• If you are concerned about an individual’s behaviour, discuss your concerns with the person in a warm, understanding and non-judgemental manner. Encourage the individual to clarify the main problems he or she is facing. Reassure them that it is alright to ask for help and then actively assist the individual to find appropriate help if that is what he or she desires.

Acknowledgements:

Management of Mental Disorders,

Eating Disorders, A Parents’ Guide,

Help your Teenager Beat an Eating Disorder
<table>
<thead>
<tr>
<th>Referral to</th>
<th>Centre for Psychotherapy (18 years and above)</th>
<th>CAMHS (up to 18 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Service</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adolescent Service</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Eating Disorders Referral Form

Date: / / 

<table>
<thead>
<tr>
<th>Client Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Name</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Telephone</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
</tbody>
</table>

If adolescent or child also include:

<table>
<thead>
<tr>
<th>Parent/Carer Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Siblings</td>
</tr>
<tr>
<td>Name and Ages</td>
</tr>
<tr>
<td>School Attended</td>
</tr>
</tbody>
</table>

Aboriginal ☐ Torres Strait Islander ☐ NESB ☐ Interpreter Required ☐

<table>
<thead>
<tr>
<th>Referrer Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Designation</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Telephone</td>
</tr>
</tbody>
</table>

Purpose of referral Diagnostic review, opinion about management, shared care approach, other

Please note that if the referral is for therapy, a shared care approach with their GP is a condition of treatment.

The Clinical Problem (Eating and Other issues)
As well as the clinician’s evaluation its is helpful to include a comment about the client’s perspective and their motivation for treatment. Often other people are affected (Family, children, spouse, employers and so on) and if so a comment about this may be helpful.

Please also note any co-morbidity.
Eating Disorder Symptoms:  
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Frequency/Duration if Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restrictive eating</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Loss of menstrual periods</td>
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<tr>
<td>Repeated bouts of binge eating</td>
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<tr>
<td>Vomiting</td>
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<tr>
<td>Laxative Abuse</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Excessive Exercise</td>
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</tbody>
</table>

Course of Treatment so far, including medication  
(Current therapy - please mention other agencies and therapists who are directly involved)

Past Treatment (comment if possible on outcome)

Any Complicating Factors?  
(Eg legal matters, transport & access problems, substance abuse, violence towards self or others)

Body Mass Index:  
<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Total weight lost (if applicable):</td>
<td></td>
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<tr>
<td>Weight loss still occurring?</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Please Indicate if Within Acceptable Range</th>
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<tbody>
<tr>
<td>Dehydration</td>
<td></td>
<td></td>
<td></td>
<td>Iron Status</td>
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<tr>
<td>Blood Pressure</td>
<td>B12</td>
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<tr>
<td>Heart Rate</td>
<td>Folate</td>
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<tr>
<td>Temperature</td>
<td>ECG (Depending on Clinical Indication Or BMI &lt;14)</td>
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<tr>
<td>Electrolytes</td>
<td>Phosphate (Depending on Clinical Indication)</td>
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<tr>
<td>Renal Function</td>
<td>Magnesium (Depending on Clinical Indication)</td>
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<tr>
<td>Liver Function</td>
<td>Bone Densitometry (if Amenorrhoea &gt; 6 months)</td>
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</tbody>
</table>

Please note that the Eating Disorder staff are not in a position to interpret pathology results and do not do medical management.

PLEASE RETURN TO THE EATING DISORDERS SERVICE AT THE ABOVE ADDRESS WITH A COPY OF ANY RELEVANT TESTS.
We are keen to receive feedback from GPs about this resource. If you have few moments and would like to provide comment, please return the following form to Anjanette Casey at Centre for Psychotherapy, PO Box 833, Newcastle, NSW, 2300 or via fax on 02 4924 6801.

How useful did you find the guide? (please circle)

Not at all  Somewhat useful  Moderately useful  Very useful

What did you find most useful?

________________________________________________________________________
________________________________________________________________________

What did you find least useful?

________________________________________________________________________
________________________________________________________________________

How could we improve this resource?

________________________________________________________________________
________________________________________________________________________

Do you need further support when treating people with eating disorders? If so, what would you like?

________________________________________________________________________
________________________________________________________________________

Any other comments?

________________________________________________________________________
________________________________________________________________________