ST VINCENT'S HOSPITAL MELBOURNE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

ASPIRE ACHIEVE INNOVATE

Austin HEALTH


# Pathways to care for people with eating disorders

Education session presented by BETRS clinicians
**Kaitlin McManus** (senior clinician/clinical psychologist), **Emanuala Araia** (senior clinician/health psychologist), **Emma Hagan** (peer support worker)

# What we will cover

- Eating Disorder basics (Emanuala)

- Increased prevalence of eating disorders in young people and adults since COVID (Kaitlin)

- Early warning signs for health professionals to be aware of and importance of early intervention (Emanuala)

- Lived experience perspective – navigating interactions with patients and supporting them to move forward with treatment (Emma)

- Referral options/pathways and importance of early intervention (Kaitlin)

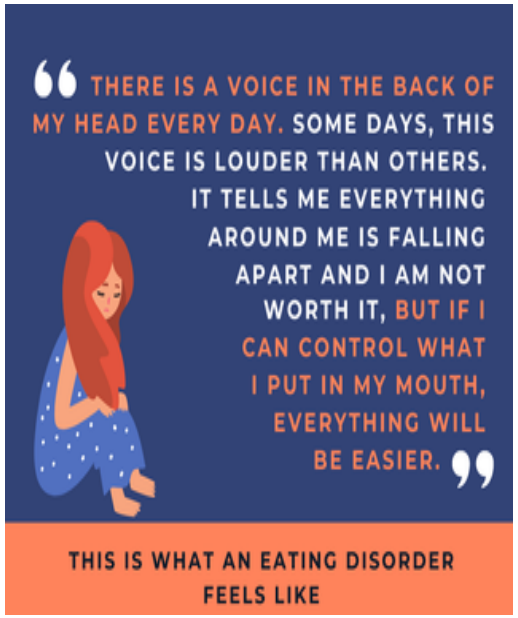

# Eating disorder myths

- Eating disorders are not just about food and weight.
- Often eating disorders develop with people using food (and other behaviours) as a coping mechanism to deal with uncomfortable or painful emotions or to help them feel more in control when feelings or situations seem overwhelming.

https://butterfly.org.au/eating-disorders/myths-about-eating-disorders/

# What is an eating disorder?

- An **unhealthy relationship** with food and weight that interferes with multiple areas.
- Can involve preoccupation with food, weight or exercise.
- Self-critical thoughts about body image, weight or shape.
- Can involve different weight-control behaviours including restriction, bingeing, purging, laxative use and over-exercise.




*National Association of Anorexia Nervosa and Associated Disorders*

National Eating Disorders Collaboration. Eating Disorders in Australia. 2021. Australian Government Department of Health. https://nedc.com.au/assets/Fact-Sheets/Eating-Disorders-in-Australia-ENG.pdf

**Table 1** Eating disorder classifications

| ICD-11essential features only | DSM-V official features |
|---|---|
| Anorexia nervosa<br>► Significantly low weight (BMI <18.5 kg/m$^2$)/rapid weight loss<br>► Persistent attempt to create calorie deficit<br>► Overvalued low body weight | Anorexia nervosa<br>► Significantly low weight and persistent attempt to create calorie deficit<br>► Intense fear of weight gain<br>► Disturbance of own body image perception |
| Bulimia nervosa<br>► Frequent binge eating episodes (once a week for at least a month)<br>► Repeat inappropriate compensatory behaviours to prevent weight gain (once a week for at least a month)<br>► Distress around bingeing/compensation<br>► Not meeting anorexia nervosa definition | Bulimia nervosa<br>► Frequent binge eating episodes (around once a week for 3 months)<br>► Repeat inappropriate compensatory behaviours to prevent weight gain<br>► Unduly influenced by body image<br>► Bingeing not exclusively during anorexia nervosa |
| Binge eating disorder<br>► Frequent binge eating episodes (once a week for at least 3 months)<br>► No regular compensatory behaviours to prevent weight gain<br>► No medical/other mental health explanation binges<br>► Distress around bingeing | Binge eating disorder<br>► Frequent binge eating episodes (at least once a week for 3 months)<br>► Binges involve three or more of: eating rapidly/eating until uncomfortably full/eating large amounts when not hungry/eating alone due to embarrassment over volume of consumption/feeling disgusted, depressed or guilty afterwards<br>► Distress around bingeing<br>► No regular compensatory behaviours to prevent weight gain |
| Avoidant-restrictive food intake disorder<br>► Avoidance/restriction of intake leading to one or both of: significant nutritional consequences/negative social consequences<br>► Eating pattern unrelated to body image preoccupation<br>► Unavailability of food/another illness is not a causal factor | Avoidant-restrictive food intake disorder<br>► Avoidance/restriction of intake leading to one or more of: nutritional deficiency/weight loss/need for alternative feeding routes/negative social consequences<br>► Unavailability of food/cultural or social norm is not a causal factor<br>► Not exclusively as part of another eating disorder or with body image issues<br>► If another medical/mental health condition considered related, symptoms sufficiently severe to warrant specific attention |
| | Unspecified feeding or eating disorder<br>► Characteristics of eating disorders however not fully fitting the diagnostic labels |

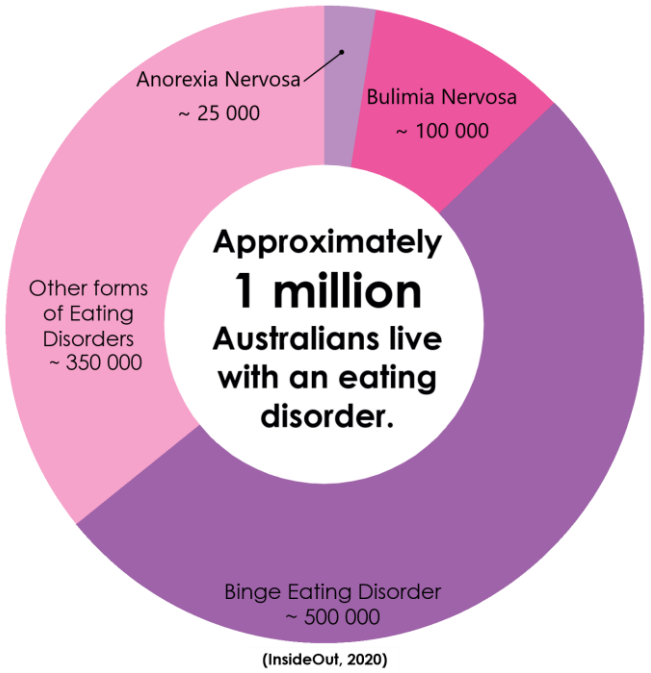
BMI, body mass index; DSM-V, Diagnostic and Statistical Manual of Mental Disorders-5; ICD, International Classification of Diseases.

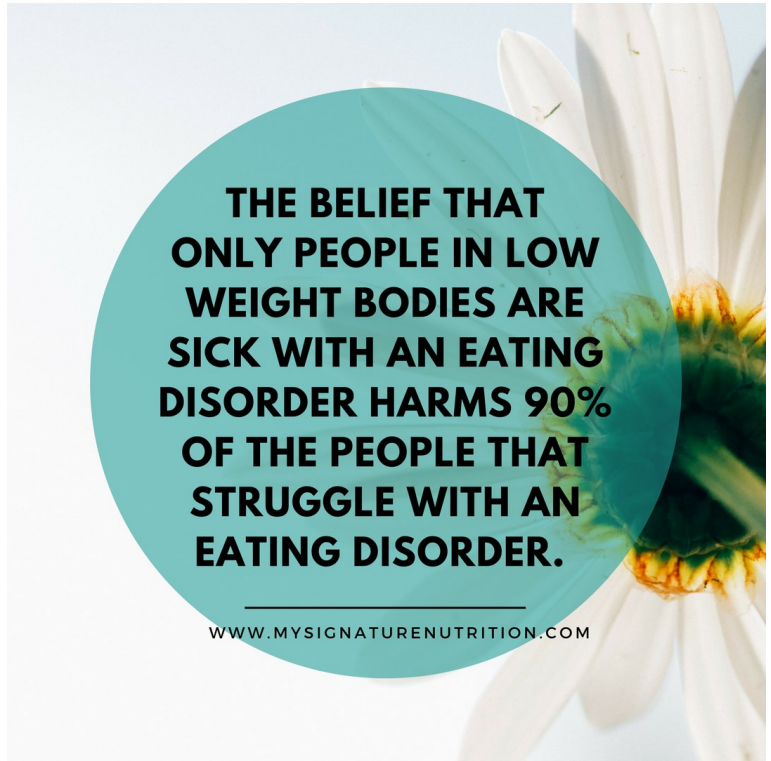
**Source**: Jafar AJN, Jafar WJJ, Everitt EK, *et al*. Recognising and managing eating disorders in the emergency department. *Postgraduate Medical Journal* Published Online First: 17 December 2021. doi: 10.1136/postgradmedj-2021-140253


**Source**: https://butterfly.org.au/get-involved/campaigns/anedlookslikeme/

"Atypical" AN: Does not meet weight criteria of AN - but fulfils all other criteria

*Not a helpful diagnostic label for some consumers as it perpetuates weight stigma and "not sick enough"/undeserving of treatment beliefs for people not living in a thin/underweight body.




*Dieting is the single most important risk factor for developing an eating disorder. Girls who diet moderately are five times more likely to develop an eating disorder than those who don't diet, and those who diet severely are 18 times more likely.*

https://www.eatingdisorders.org.au/eating-disorders-a-z/disordered-eating-and-dieting/

# Eating disorders, trauma and comorbidities

- **Over 80%** of adults diagnosed with an eating disorder have at **least one other psychiatric disorder** – most common are depression, anxiety, PTSD.
- ~ **58% of individuals diagnosed with an eating disorder have co-existing personality disorder**
  - 53.8% of patients with BPD also meet criteria for an eating disorder.
- ~ **Substance use disorder** presents in: 27% of individuals with AN; 36.8% of those with BN; and 23.3% of those with BED.
- Women with histories of **childhood physical and sexual abuse** were 3 x more likely to develop eating disorder psychopathology than women who reported no abuse & comorbidity with **PTSD and cPTSD** is well documented.
- **Higher rates of disordered eating have been described in chronic health conditions** that require dietary modification, including Celiac disease, Cystic Fibrosis and Diabetes.

***It is therefore important to screen for these co-occurring issues that may also increase psychiatric risk.***

**Sources:**

1. National Eating Disorders Collaboration. Eating Disorders in Australia. 2021. Australian Government Department of Health. https://nedc.com.au/assets/Fact-Sheets/Eating-Disorders-in-Australia-ENG.pdf
2. Eatingdisorderhope.com
3. Kong, S. and K. Bernstein, Childhood trauma as a predictor of eating psychopathology and its mediating variables in patients with eating disorders. Journal of Clinical Nursing, 2009. 18(13): p. 1897-1907

# Increased prevalence of eating disorders in young people and adults throughout COVID-19 pandemic

- Experience at BETRS: Referrals/enquiries/emails/consultations in 2018 compared to 2021 **more than doubled** (349 > 825).
- There was **a 63% increase in presentations to the Royal Children's Hospital Eating Disorder Service in Melbourne during 2020** with timings corresponding to COVID-19 related events such as increased stress and stringent COVID-19 restrictions.
- From 2021 to 2022 Eating Disorders Victoria (EDV) experienced a **300 per cent increase in demand for its services**.
- A recent study in The Lancet found COVID-19 has **increased the prevalence of eating disorders globally by as much as 15.3 per cent in 2020, compared to previous years.**

**Sources:**
https://www.abc.net.au/news/2022-05-20/eating-disorders-australian-families-struggle-care-covid/101078158
https://www.sydney.edu.au/news-opinion/news/2022/01/21/escalation-of-eating-disorders-during-covid-19-research-finds.html
https://www.eatingdisorders.org.au/eating-disorders-a-z/covid-19-and-eating-disorders/

**Australian research findings:**

- One of the largest national observational studies to capture the impact of the pandemic; **capturing the course of Australia's second wave, including Victoria's major lockdown (2020). Studied 1,723 people between 16-80 years.**

- COVID-19 pandemic has negatively impacted eating disorders with an **increase in body image concerns (88%) restriction (74%), binge eating (66%), purging and exercise behaviours in those with eating disorders** and **increased restriction and binge eating in the general population** .

- Of participants with clinically significant eating disorders, **40 percent had never received formal diagnosis or treatment.**

- The COVID-19 pandemic has also seen **increased rates of suicidal ideation and behaviour among people experiencing eating disorders when compared with pre-pandemic rates.**

- **Increased demand for community and inpatient services**, **along with an <u>increase in complexity</u> of presentations <u>involving high psychiatric and medical risk</u>**, has impacted on supports available at each level of the system of care.

- These increases in both disordered eating and eating disorders have **placed significant demands on families and supports**.

**Such negative impacts are likely due to:**

- The disruptions in access to treatment resulting from lockdowns and restrictions
- Self-isolation
- Food access limitations
- Changes in physical activity routines
- Increased anxiety and stress and environmental changes at home or work.

- Across Australia, initiatives to respond to the increased need for support and treatment have been introduced, including the:
  - **Swift adaptation to telehealth**
  **- Greater flexibility in appointment times and accessibility to people living all over Australia.**

- Public and private health and mental health services are **shifting their response and treatment options to better manage the increasing waitlists.**

- Strategies such as:
  - I**ncreased peer workforce involvement, online resources and support services, and tertiary consultation to other mental health services and programs** are being implemented to provide support for those individuals living with an eating disorder, their families and supports as they wait to access treatment.

Source: https://nedc.com.au/news/show/35/covid-19-information/

# Importance of early intervention

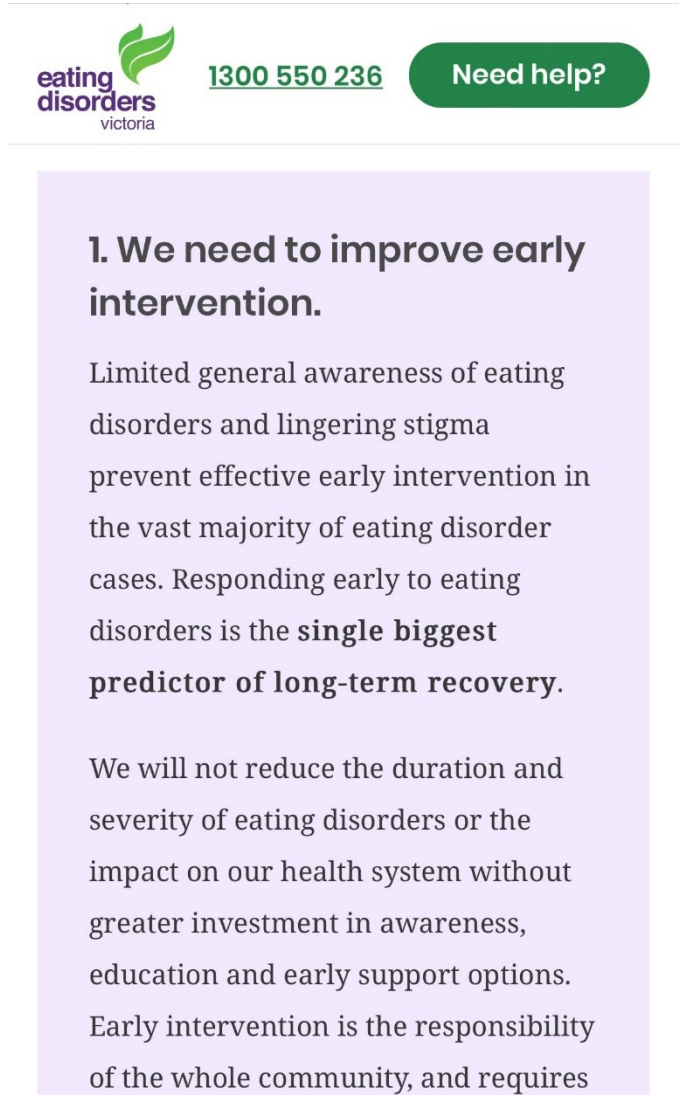
Research recently published in the medical journal JAMA Pediatrics found that **about 22 per cent of children and adolescents (of 63, 181 participants aged 7 – 18 years, 51.8 % girls) from 16 different countries showed signs of disordered eating.**

Parents and carers urged to watch for signs as study finds **one in five** children and adolescents experience disordered eating.

**Source:**
Global Proportion of Disordered Eating in Children and Adolescents: A Systematic Review and Meta-analysis | Adolescent Medicine | JAMA Pediatrics | JAMA Network

- Research on treatments for eating disorders, indicates that **early identification and treatment improves the speed of recovery, reduces symptoms to a greater extent and improves the likelihood of staying free of the illness**.
- For example, **when adolescents with anorexia nervosa are given family-based treatment** within **the first three years** of the illness onset they have **a much greater likelihood of recovery.**
- Early intervention can **reduce the impact of the eating disorder** through interventions for **at-risk populations, people experiencing an eating disorder for the first time and people experiencing indications of a relapse** or recurrence of illness.
- Successful early identification and intervention requires **clear access pathways and a coordinated approach suited to the individual's life stages and situation.** It also takes into account the **impact of environmental and social factors on mental health and wellbeing.**
- Early intervention **involves a range of health and other sectors, carers, advocates and families, and requires appropriate services accessible by well-supported referral pathways**.

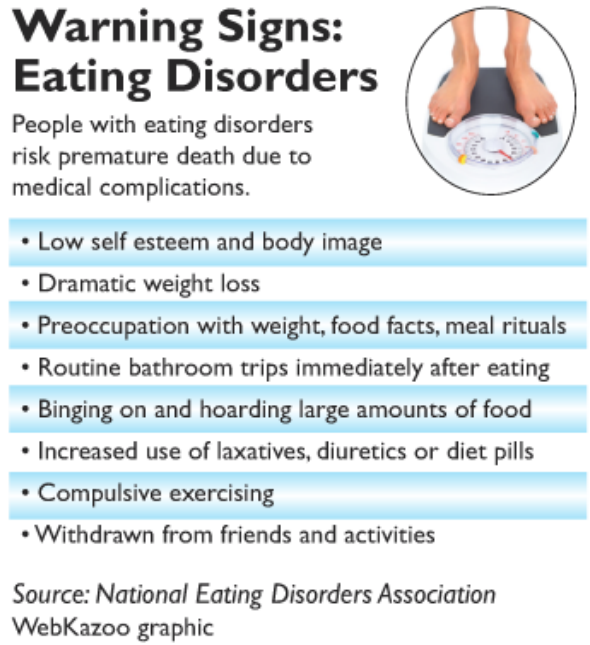
**Sources:**
https://nedc.com.au/eating-disorders/early-intervention/
https://www.nationaleatingdisorders.org/blog/why-early-intervention-eating-disorders-essential



# Early warning signs

Table 2. Eating disorder warning signs1,2,7,14,18,24

| | |
|---|---|
| **Behavioural** | |
| •Avoiding eating in public<br>•Fussy eater/banned foods<br>•Cooking for others yet not eating<br>•Frequent weighing<br>•Excessive exercise<br>•Stressed when unable to exercise<br>•Trains through injury<br>•Restricted/rigid diet<br>•Wears baggy clothing<br>•Avoiding meals<br>•Raiding the refrigerator<br>•Eating low-calorie foods | •Excessive use of the toilet<br>•Body checking<br>•Constant focus on food, diet and exercise<br>•Has different meals to rest of family<br>•Social isolation<br>•Calorie counting<br>•Use of diet pills, laxatives, supplements<br>•Throws away food<br>•Denies problem<br>•Slow eating/picking at food<br>•Developing 'allergies' to food<br>•Eating in secret |
| **Psychological** | |
| •Anxiety, especially in regards to food/eating<br>•Depression<br>•Social phobia/withdrawal<br>•Distorted body image<br>•Negative body image<br>•Feelings of lack of control<br>•Suicidality | •Poor concentration<br>•Perfectionism<br>•Low self-esteem<br>•Guilt, especially around food<br>•Obsessiveness<br>•Subtle cognitive changes<br>•Hopelessness |
| **Physical** | |
| •Sensitivity to the cold<br>•Brittle nails<br>•Dorsal finger callouses<br>•Stress fractures<br>•Muscle cramps<br>•Dental caries<br>•Parotid enlargement<br>•Irregular or cessation of menstruation<br>•Gastrointestinal symptoms – bloating, nausea<br>•Anaemia<br>•Insomnia | •Dry hair or skin<br>•Lanugo<br>•Feeling faint, cold or tired<br>•Bone pain<br>•Injuries due to over-exercising<br>•Gingivitis<br>•Self harm<br>•Abdominal pain/distension<br>•Early satiety<br>•Hypercarotenaemia<br>•Halitosis |




**Source:**
https://www.racgp.org.au/afp/2017/november/early-detection-of-eating-disorders/#ref-1

*Resources for GP's https://www.eatingdisorders.org.au/early-intervention-identification-for-professionals/racgp-training-for-gps/

*Resources/training for health professionals https://www.eatingdisorders.org.au/early-intervention-identification-for-professionals/eating-disorder-programs-for-other-health-professionals/

# Uncovering a hidden illness and barriers to early identification

Individuals may present with **'unrelated complaints'** such as:

- **Psychological issues** such as stress, depression or anxiety
- **Physical complaints** such as fatigue, dizziness, gastrointestinal problems (especially constipation and bloating) and, **for female patients,** menstrual irregularities
- **Chronic health problems** such as osteoporosis
- **Socioeconomic consequences** such as financial insecurity due to inability to sustain employment.

Another **barrier to early identification is delayed presentation**. Some individual client factors that may contribute to this include:

•**ambivalence** about recovery
•**stigma and shame**
•**denial of, and failure to, perceive the severity** of the illness
•**low motivation** to change
•**negative attitudes** towards seeking help
•**lack of knowledge** about available resources
•**practical issues** (e.g. distance, cost).

**Source:**
https://www.racgp.org.au/afp/2017/november/early-detection-of-eating-disorders/#ref-1

# Early identification and screening questions

**Box 1 Potential flags to pay attention to in uncovering a hidden diagnosis**

- Typical profile: academically high-achieving young female or athlete.
- Atypical profile: increasing in males and ethnic minorities.
- Frequent abdominal pain/bloating/constipation/diarrhoea/reflux/vomiting.
- Menstrual disturbance; subfertility; low libido.
- Unexplained cardiac arrhythmias, electrolyte disturbance, hypoglycaemia, hepatic dysfunction.
- Low pulse in the apparently athletic young person.
- Low energy fractures in young people with reduced bone mineral density.
- Agitation; microexercise around bed space.
- Warm clothes in hot weather; oversized, full coverage clothes.
- Comorbidities as a cover for weight loss:
  - Coeliac disease.
  - Type 1 diabetes mellitus*.
  - Food allergies.
  - Substance/alcohol abuse*.

*Along with personality disorders and attempted suicide these risk factors increase mortality.

**Box 3 Medical presentations of eating disorders**

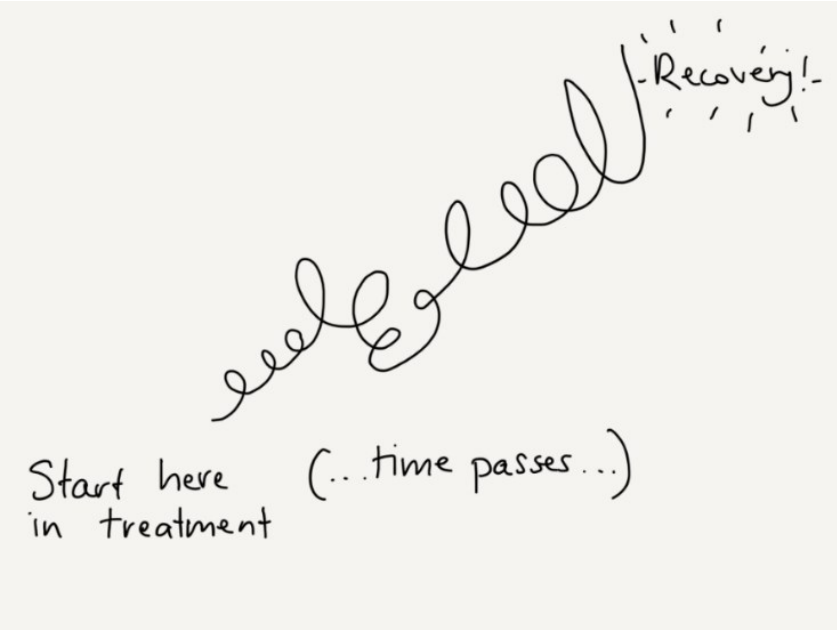
- Altered gastrointestinal tract function presenting with:
  - Reflux.
  - Bloating.
  - Constipation.
  - Non-specific abdominal pain.
- Misuse of laxatives presenting with
  - Diarrhoea.
  - Biochemical abnormalities.
- Mallory-Weiss tears (from frequent vomiting)
- Dizziness, syncope, fatigue, chest pain palpitations and seizures associated with:
  - Electrolyte disturbance.
  - Dehydration.
  - Structural cardiac change.
  - Significant malnutrition.[93]

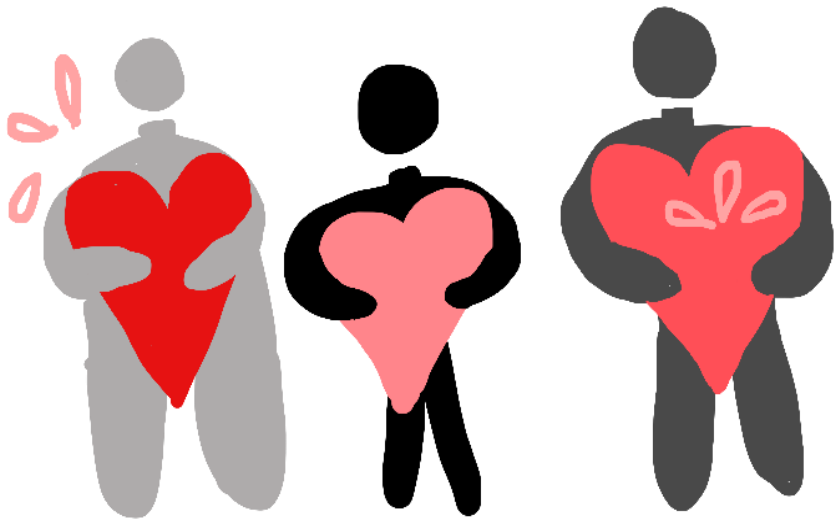
**Box 2 SCOFF Questionnaire[26]**

- Do you make yourself SICK because you feel uncomfortably full?
- Do you worry you have lost CONTROL over how much you eat?
- Have you recently lost ONE stone in a 3-month month period?
- Do you believe yourself FAT when others say you are too thin?
- Would you say that FOOD dominates your life?

**Source**: Jafar AJN, Jafar WJJ, Everitt EK, *et al*. Recognising and managing eating disorders in the emergency department. *Postgraduate Medical Journal* Published Online First: 17 December 2021. doi: 10.1136/postgradmedj-2021-140253

# Lived experience perspective – navigating interactions with patients and supporting them to move forward with treatment



# Eating disorder treatment and recovery

It is estimated that **75% of people with an eating disorder don't seek professional help.**


Some reasons/barriers for not accessing treatment include:

- **Stigma, shame**
- **Denial, low motivation for change**
- **Failure to perceive the severity of the illness – "not sick enough" beliefs**
- **Cost of treatment**
- **Lack of encouragement and lack of knowledge** about how to access help resources.

- The most effective treatment for eating disorder is **person-centred care,** tailored to suit the individual's illness, situation and needs.
- **Multi-disciplinary approach** – combined medical, dietetic and psychological interventions has best evidence base for recovery.
- The average time taken to recover from all types of eating disorders, after seeking treatment is **1-6 years.**
- When skilled and knowledgeable health professionals deliver treatment, **full recovery and good quality of life can be achieved for the majority of people with eating disorders.**

Sources:
- RANZCP: Clinical practice guideline on the treatment of eating disorders. 2014. https://www.ranzcp.org/practice-education/guidelines-and-resources-for-practice/eating-disorders-cpg-and-associated-resources
- https://www.eatingdisorders.org.au/eating-disorders-a-z/eating-disorder-statistics-and-key-research/?gclid=EAIaIQobChMIieTt7_X--gIVaZNmAh2VHA2oEAAYASAAEgKq9_D_BwE

# What is the role of a medical admission?

- Acute medical stabilisation when consumer is deemed at significant medical risk.
- To begin weight restoration.
- To interrupt eating disorder behaviours in a supported environment.
- With aims of the consumer restoring sufficient weight and becoming medically stable enough to engage in psychological treatment for eating disorder and/or to be able to continue on a recovery trajectory in a less supported environment.
- Additional roles may be in validating severity of illness, kick-starting some motivation to change.

# Adult Victorian services/supports

*There are new services in Victoria in development for people across the lifespan**

**First line community treatment for eating disorders:**

**-** GP, community dietitian, psychologist. ***Carer/support person involvement but often not included in treatment.**

**- Eating disorder treatment and management plans (EDTMP) -** Medicare subsidy for **20 sessions with a dietitian & up to 40 sessions** with a mental health clinician over a 12 month period.

**Public system:**
Three eating disorder specialist services for adults based on catchment areas:

- Royal Melbourne Hospital (North-West Vic)
- St Vincent's (BETRS)/Austin (EDU) (North-East Vic)
- Monash (South-East Vic)

*Also Primary Mental Health Program through the regional triage service Bendigo (Loddon/Campaspe/Southern Mallee catchments)

AMHS – some may offer some eating disorder treatment but often specialist services are managing eating disorder and AMHT are managing risk/comorbidities.

http://www3.health.vic.gov.au/mentalhealthservices/

**Private system:**
- The Geelong Clinic (inpatient)
- The Melbourne Clinic (day program and inpatient)
- Wandi Nerida (Australia's only residential treatment facility)

CEED THE VICTORIAN CENTRE OF EXCELLENCE IN EATING DISORDERS

eating disorders victoria

Butterfly LET'S TALK eating disorders

# Child and youth services/supports

**First line community treatment for eating disorders:**

- GP, community dietitian, psychologist – **family based treatment (FBT**), carer involvement.
- **Eating disorder treatment and management plans (EDTMP) -** Medicare subsidy for 20 sessions with a dietitian & up to 40 sessions with a mental health clinician over a 12 month period.

**Public system (12-25 years):**

Four eating disorder specialist services for children and adolescents based on catchment areas:

- Royal Children's Hospital
- Austin
- Monash
- Barwon Health

*Paediatric/adolescent medical assessment and monitoring as outpatient as well as referrals to inpatient specialist medical care can also be accessed via Box Hill Hospital.

- Assessment/treatment (e.g. FBT) can also be accessed via most CAMHS/CYMHS teams based on catchment http://www3.health.vic.gov.au/mentalhealthservices/

**Community :**

- Headspace (12-24 years)
- The Bouverie Centre (family approaches to mental health including eating disorders)

**Private system:**

- The Geelong Clinic (inpatient) 16 + years
- The Melbourne Clinic (day program and inpatient) 16 + years

# Support services for consumers, families, clinicians

**For consumers -**
- Eating Disorders Victoria https://www.eatingdisorders.org.au/
- Butterfly foundation https://butterfly.org.au/get-support/helpline/
- Eating Disorders Families Australia https://edfa.org.au/

**For clinicians -**
- CEED Victorian public mental health service development/training/case consultation service https://ceed.org.au/
- Clinicians can also contact Eating Disorders Victoria for information related to navigating service system and referrals.

*Families/support people and clinicians can also contact some specialist eating disorder service intake teams for secondary consult/discussions of referrals.

# BETRS referral process

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**Referrals**

- **Anyone 18+** who thinks they may have an eating or body image problem is encouraged to contact BETRS following a discussion with their doctor and/or health professional. Concerned family members can contact BETRS for information or advice and assistance with the referral process.
- Referrals from health professionals will be accepted with **accompanying information from the patient's GP.** To download a BETRS Referral form please click here and once completed please **fax the referral to 9231 5701** or send via mail to: **betrs@svha.org.au**
- Please note the referral also has a consumer self-report section.
- Referrals are accepted from: AMHS, GP's, psychologists, psychiatrists, paediatric services, other ED specialists
- **BETRS website:**

https://www.svhm.org.au/our-services/departments-and-services/b/body-image-eating-disorders-treatment-and-recovery-service-betrs

# BETRS services

**1. Intake**

**2. Assessment**

- EDU assessments (one two hour appointment)
- Outpatient assessments (two-four appointments) with mental health clinician and one dietetic assessment
- Psychiatric review as clinically indicated

**Treatment**

BETRS will be engaging in service development in 2023, including increasing inclusion of families/support people in treatment.

**Individual treatment**

**Only offering in very limited capacity*

- **CBT-E** (20 sessions) for AN, OSFED/AAN, BN, BED, leading evidence-based treatment for adults (especially those with BN/BED).
- **SSCM** (20 sessions) for AN/AAN, SED, those struggling with ambivalence/motivation to change, have tried previous evidence based treatments/had previous inpatient/outpatient treatment/living regionally.

# BETRS services

**Day patient program (DPP)**

- 6-week closed group for those with AN and BN
- Facilitates weight restoration and meal plan reviews
- Meal support and therapeutic groups
- Social eating exposure outings
- Telehealth and in person
- Weekly reviews (“knowing how you’re going meeting”) with multidisciplinary team
- Weekly key worker sessions (30 minutes)
- Two step down appointments across two weeks after program finishes

**Inpatient treatment (Austin eating disorder unit)**

- 5 bed unit co-located with adult acute psychiatric unit
- Three weeks average duration of admission
- Includes weekly ward rounds, meal support and therapeutic groups
- Facilitates weight restoration
- Referral via BETRS or subject to bed availability transfer between hospitals

# BETRS contact details

ST VINCENT'S HOSPITAL MELBOURNE
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- **The Body Image Eating Disorders Treatment & Recovery Service (BETRS)**
  10-12 Gertrude Street
  Fitzroy VIC 3065

- PO BOX 2900

Fitzroy VIC 3065

- Tel: (+61 3) 9231 5718 is our Clinical Intake Service which operates from Monday to Friday between 9:30 AM and 11: 30 AM and is the first point of contact for anyone wanting to refer themselves or others to the service.

- (+61 3) 9231 5700 for general inquiries

- Fax: (+61 3) 9231 5701

- Email: betrs@svha.org.au

# Questions?