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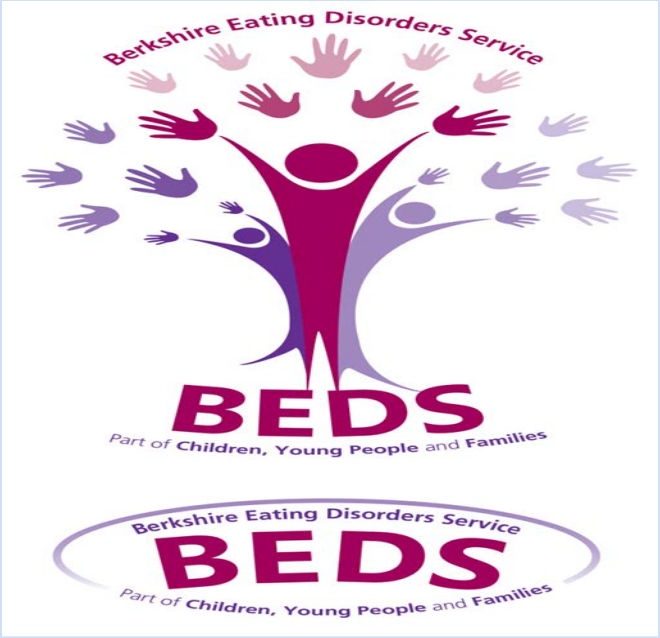
Berkshire Eating Disorder Service

Children Young People and Families (BEDS CYPF)



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Clinical Team Lead

With thanks **Dr Joanna Holliday, Eating Disorder Lead**
Buckinghamshire Child and Adolescent Mental Health Service

Healthcare from the heart of your community

Psychological Perspectives in Education & Primary Care

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Context

- Recognition that specialist services for young people with an eating disorder needed to be developed.
- 2014 £150m pledged to develop Specialist Eating Disorder Services (30m per year for 5years)
- Key Documents: Future in Mind (2015) & Access and Waiting Time Standard for CYP with an Eating Disorder: A Commissioning Guide (2015)
- BEDS CYPF launched in October 2016: commissioned for 100 referrals per annum

CYPF BEDS

- Specialist community assessment and treatment service for young people aged 8-18 presenting with Anorexia Nervosa, Bulimia, Binge Eating Disorder and Atypical Eating Disorders

- Open Monday to Friday 9-5 – operate from bases covering East and West: Maidenhead (Nicholson's House) and Reading (Erlegh House, UOR)

- Multi Disciplinary Team: Dieticians, Nurses, Psychiatrists, Psychologists and Psychotherapists (CBT, Family , Art and Dance & Movement) and admin.

Service Objectives

Improved access

AWT - Emergency: 24 hours, Urgent: 1 week, Routine: 4 weeks

Treatment

Delivery of NICE (2017) concordant treatment from first appointment

Multi Agency working

Develop collaborative working relationships with services working with young people: developing protocols with CAMHS, CYPF, GP's, A&E, Paediatrics, Social Services, and Education.

Participation

Promote active and full engagement of service users and their families in care: Parent/ carers support group, participation group

Use of Routine Outcome Measure (ROMS) to gather feedback

Training to GPs, schools, CAMHS and partner agencies

Referrals

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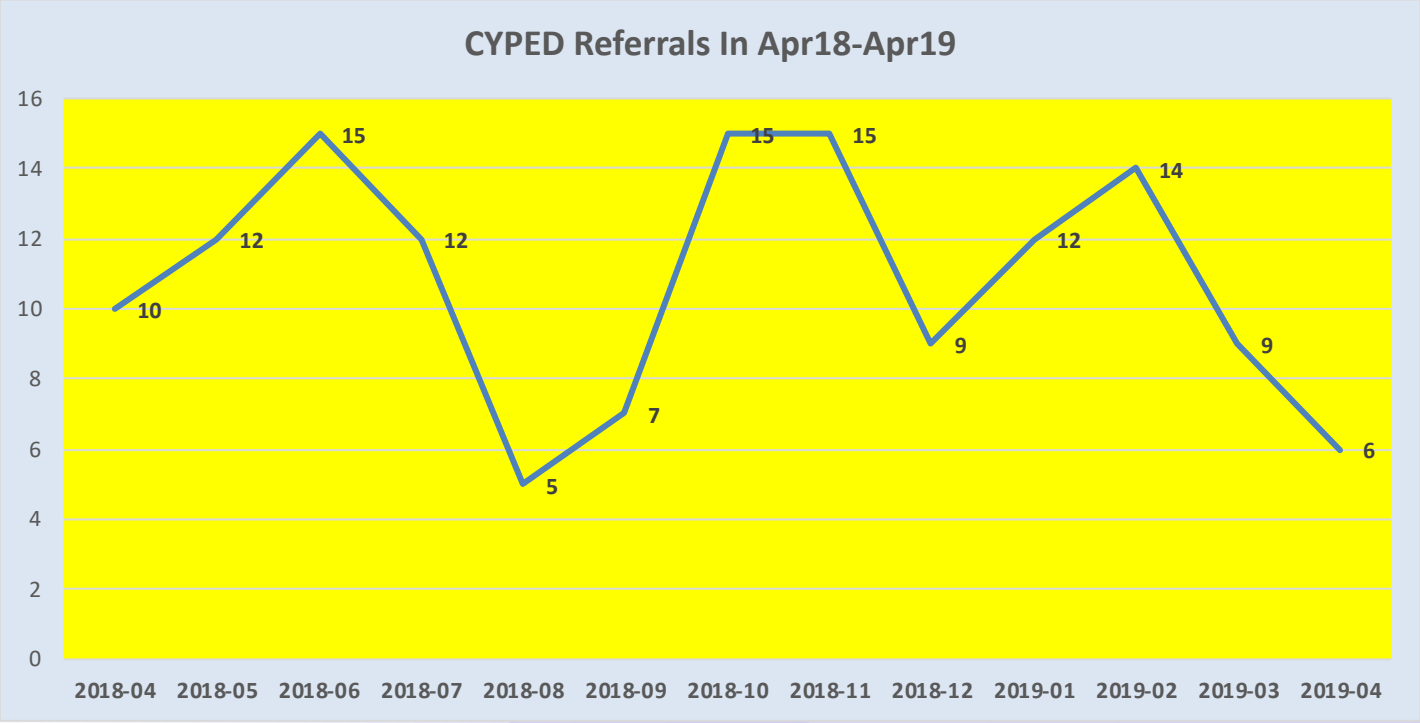
Number of referrals April 2018- April 2019	141

Referral urgency	Numbers
Urgent	37
Routine	101

Source	% accepted
GP	80.6 %
Paediatrics	5.1 %
SCT CAMHS	6.1%
School	5.1%
Social care	1%
Dieticians	2%



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Referral pathway

GP

Any professional

Patient/parent

Common point of entry (CPE)
- More information collected
- Patient may be asked to see GP

BEDS CYPF Triage
Assess urgency

Review referral information

Telephone call to family

Send appointment

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What does the evidence say?

Early intervention is associated with improved outcomes

Early weight restoration predicts good outcome

Specialist outpatient treatment is best for most cases

Family involvement is important

Treatment approaches

- Family Based Treatment
- CBT-E
- MFT
- Guided self-help

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Treatments offered by BEDS CYPF

First Line Treatment (as recommended by NICE (2017))

Family Therapy (FT-AN, FT-BN)

Additional Treatments

Systemic Family Therapy Clinic/Family Therapy

Individual Therapy (CBT, Dance and Movement Psychotherapy, Art Psychotherapy)

Dietetic support

Parent/ carers support group and Participation group (monthly)

Body, Mind and Me Group

Introduction to Treatment Group

Multi-family Therapy Group

Monitoring Clinic

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What can be done and how in primary care settings?

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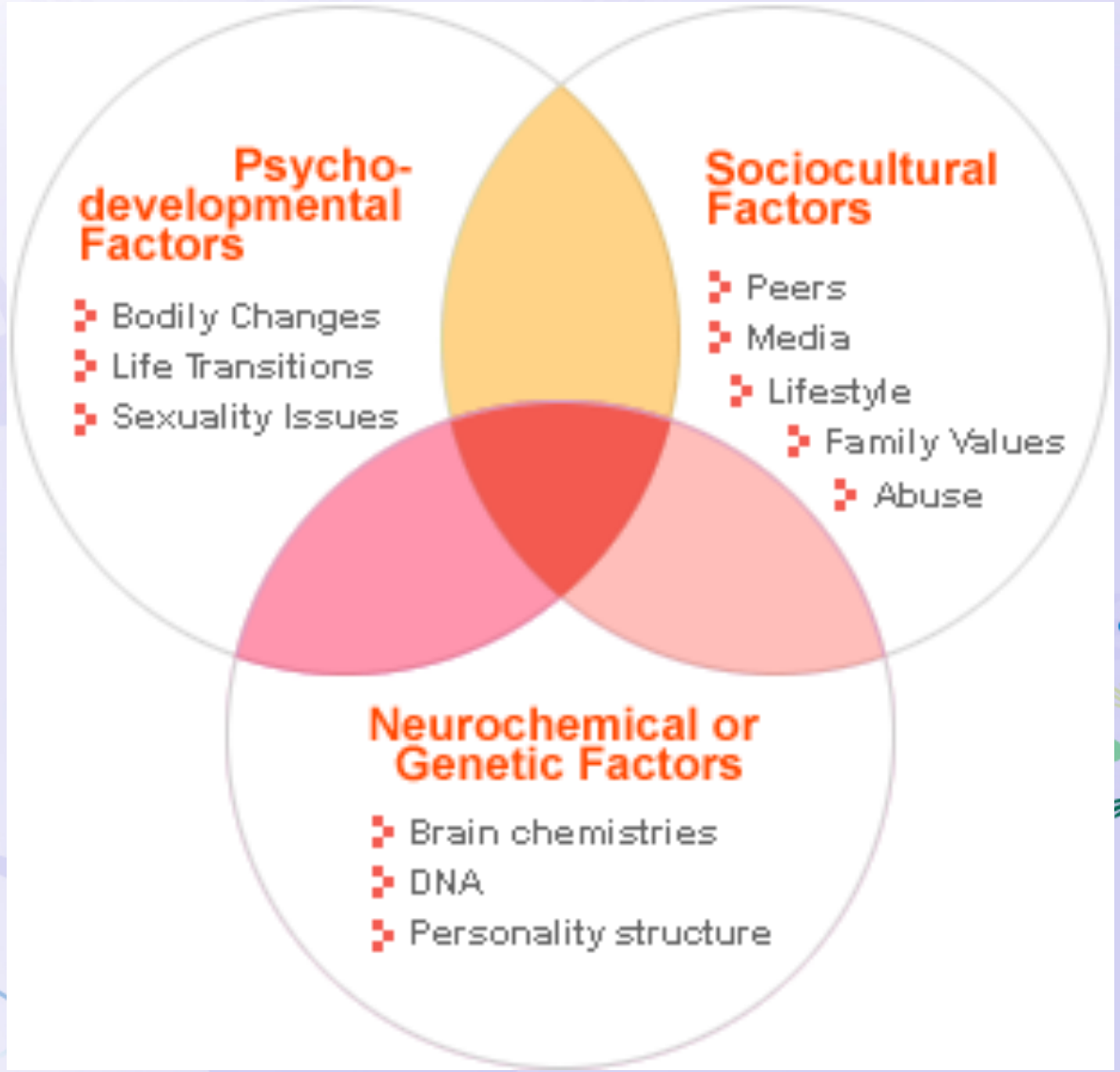
Defined eating disorders

- Anorexia nervosa
- Bulimia nervosa
- Binge eating disorder
- EDNOS
- ARFID

Causes of Eating Disorders



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News › Science

Britain's new diet: the 400-600-600 plan to counter obesity

share Save 108

400
600
600

Nearly two thirds of adults are now overweight, and one in five children is obese before primary school

Campaigns such as this can mislead. The suggestion that people can manage on 1600 calories / day applies to an Adult of average built. Tall, muscular or active people will have greater needs.

Children need significantly higher calories than adults as their body is growing and the metabolic rates are higher than that of adults.

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Warning signs

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Lips

Are they obsessive about food?

Flips

Is their behaviour changing?

Hips

Do they have distorted beliefs about their body size?

Kips

Are they often tired or struggling to concentrate?

Nips

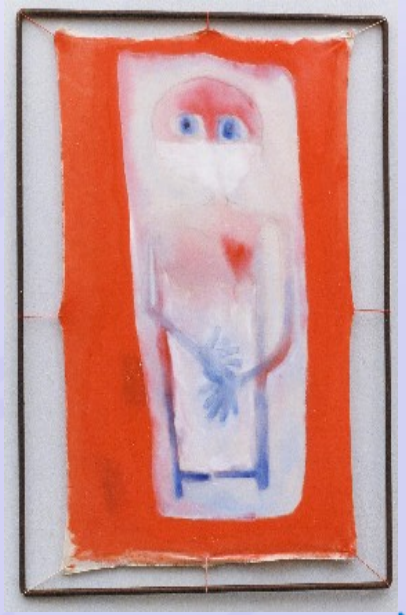
Do they disappear to the toilet after meals?

Skips

Have they started exercising excessively?

Anorexia nervosa

- Body weight below that expected for age, height and gender
- Fear of weight gain and behaviours to avoid this
- Abnormal perception of body weight and shape
- Self evaluation is overly dependent on weight or shape



Bulimia nervosa

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- Usually normal body weight
- Recurrent binge eating
- Purging behaviour (self-induced vomiting, laxatives)
- Self evaluation is overly dependent on weight or shape

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What might you notice?

- What are the things that you might notice if a young person has an eating disorder?
- What are the things the young person might notice themselves?
- Consider:
  - Physical
  - Psychological
  - Behavioural

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Physical signs

Other people notice

- Loss of weight
- Fainting/dizziness
- Lack of energy
- Poor sleep
- Swollen glands under jaw

Young person notices

- Feeling cold
- Loss of periods (females)
- Muscle weakness
- Constipation
- Feeling quickly full/bloating

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Behavioural signs

- Other people notice

- Change in personality
- More withdrawn
- Change in eating habits
- Secretiveness/hiding food
- Wearing baggy/warm clothes
- Frequent /long visits to the toilet
- Over-exercising/activity
- Focussing more or less on school work

- Young person notices

- Early morning waking (effect of starvation)
- Arguing more
- Going out less
- Becoming more obsessional
- Doing better/ worse at school

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Psychological signs

- Other people notice

- Increased preoccupation with body size, weight and shape
- Fear of weight gain and eating particular foods
- Low mood/irritability
- Preoccupation with food, recipes, cooking for others

- Young person notices
  - Feeling happier (initially)
  - Feeling unhappy
  - Feeling confused/unsure Feeling detached/numb
  - Thinking about food, weight and shape constantly
  - Poor concentration
  - Narrowing of interests

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The SCOFF questionnaire

- Do you make yourself **S**ick because you feel uncomfortably full?
- Do you worry that you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ne stone in a 3 month period?
- Do you believe yourself to be **F**at when others say you are too thin?
- Would you say that **F**ood dominates your life?

- Score 1 point for every 'yes'. A score of 2 or more indicates a likely case of an eating disorder.

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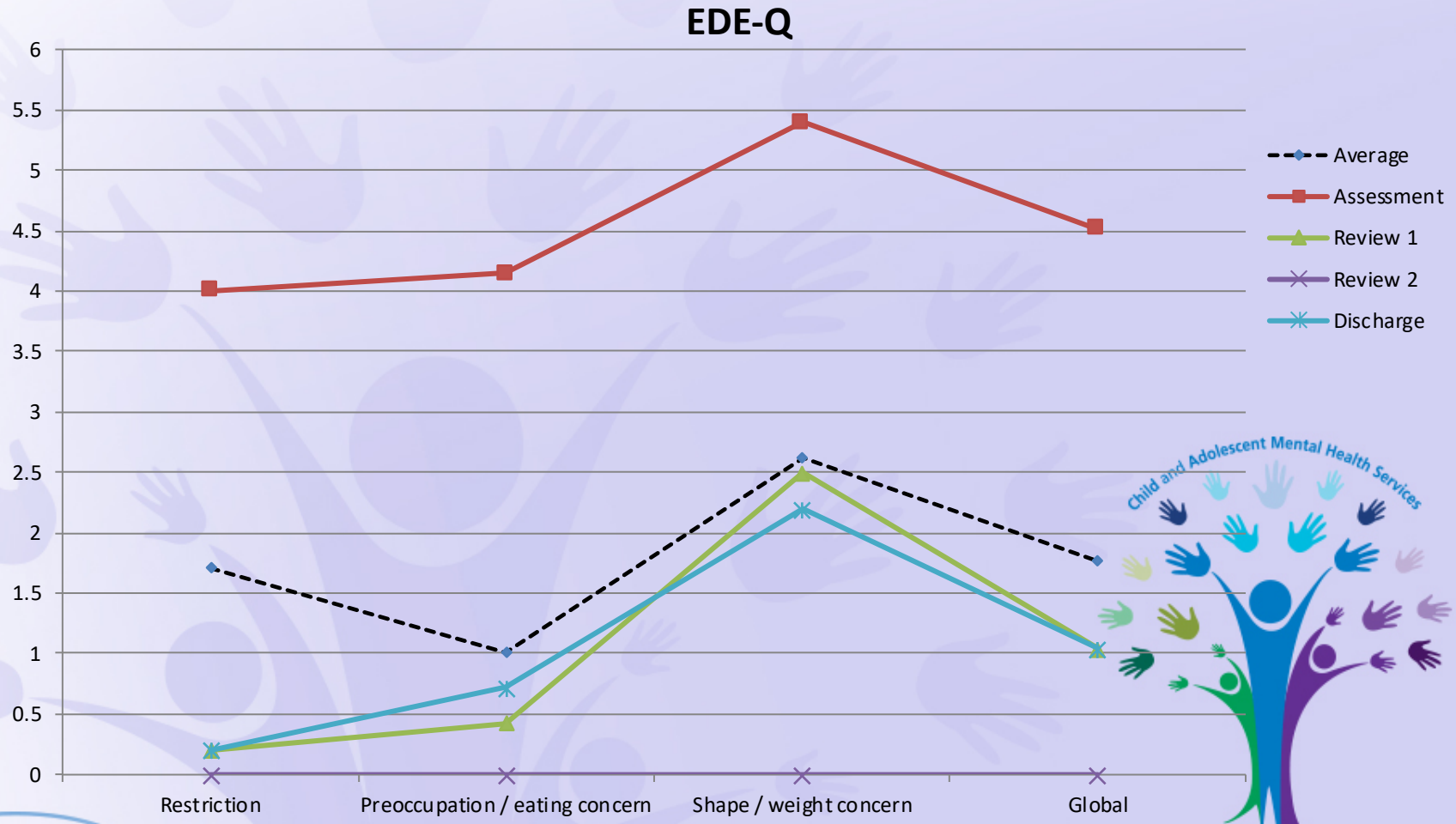
EDE – Q



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Physical Assessment

- Basic physicals
  - Weight / height / work out % median BMI or BMI centiles (how to).
  - Pulse & BP: sitting & standing, look for postural drop of 10mm or more.
  - Feel the pulse / check the temperature
  - Pallor, cold extremities, lanugo hair, poor capillary refill
  - Squat or sit-up test / Knuckles / Parotid glands /
  - Signs of dehydration
  - Signs of Puberty

- Full Eating Disorders bloods battery – Glucose, FBC, RFT, LFT, TFT, ESR, CRP, Ca, Mg, Inorganic Phosphates (not same as Alkaline Phosphatase), Urine Routine
- ECG – QTc and any other anomalies
- USG Pelvis / Hormonal Assays / DEXA Bone Scans – not routine but when needed

The number on the scales and BMI can be misleading.

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- Weight as shown on scales needs to be understood bearing in mind a person's height, gender, age, activity levels among other things.
- A tall person or anyone muscular will automatically have a higher BMI

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Calculating % Median BMI

- BMI alone is unreliable under age 18
- Demonstrate
  - Use of excel spread sheet
  - Using Marsipan App
  - BMI centiles online via CDC website

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Date	W(KG)	H(M)	BMI	W(c)	H(c)	BMI(c)	W4H	100%
05/07/2019	18.4	1.1200	14.67	11.38	13.50	24.79	94.63	19.45
05/07/2019	28.21	1.1200	22.49	97.52	13.50	99.95	145.07	19.45

Date	W(KG)	H(M)	BMI	W(c)	H(c)	BMI(c)	W4H	100%
05/07/2019	55	1.5500	22.89	86.74	50.86	91.51	122.29	44.97
05/07/2019	43	1.5500	17.90	40.13	50.86	36.09	95.63	44.97

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Management

Interventions in primary care:

- **Psycho-education**
- **Re-feeding Syndrome**
- Specialist CAMHS Eating Disorder care package / programme
- Joint working between Secondary and Primary care
- **Prevention**

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Immediate Intervention

- Basic physicals
  - Weight / height / work out % median BMI or BMI centiles (how to).
  - Pulse & BP: sitting & standing, look for postural drop of 10mm or more.
  - Feel the pulse.
  - Pallor, cold extremities, lanugo hair, poor capillary refill
- Full Eating Disorders bloods battery
- ECG
- Dietetic advise: Milk, Milk and more Milk
- Spotting an emergency: Marsipan Risk tool App
- Re-feeding Syndrome

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Highlight Urgency and concern

- Too many young people are presenting with weight 25 to 35% below expected levels.
- Early opportunities need to be utilised fully.
- Psycho-education is likely to help a proportion of cases in early stages of the disorder.
- Emphasise that normal blood tests does not equal being healthy.
- Highlight high mortality rates associated with the illness.
- Eating Disorders need to be taken as seriously as treating cancer.

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What does not help?

- To say ‘it all seems fine’
- To suggest ‘it may be a passing phase’
- To be too economical ‘just eat more’.
- Certify fitness to go on overseas trips, excursions, intensive sports training and the like when body weight is below 85% Median BMI
- To say ‘she looks good’

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Psycho-education: key points

- Homeostasis: the body can live on borrowed time, create a sham of 'all is well' for a very long time.
- To maintain equilibrium, the body is quietly shutting down systems
  - Slower gut peristalsis (hence the bloating and constipation)
  - Diverting calcium and minerals from bones and other organs to the heart
  - Stopping periods (and with it shrinking ovaries and uterus).
  - Lack of oestrogen equals Osteopenia
  - Shrinking of the brain matter

Food types

- Carbohydrates broken down to Glucose is main source of energy.
- Between meals, Fat and Glycogen stores are main source of energy.
- 15-25% body fat is vital to sustain the factory that never stops. Fat is also required for producing certain hormones and vitamins among other things (insulation, cushioning organs, cell membrane, etc.)
- Protein alone does not help build muscle without above sources of energy.

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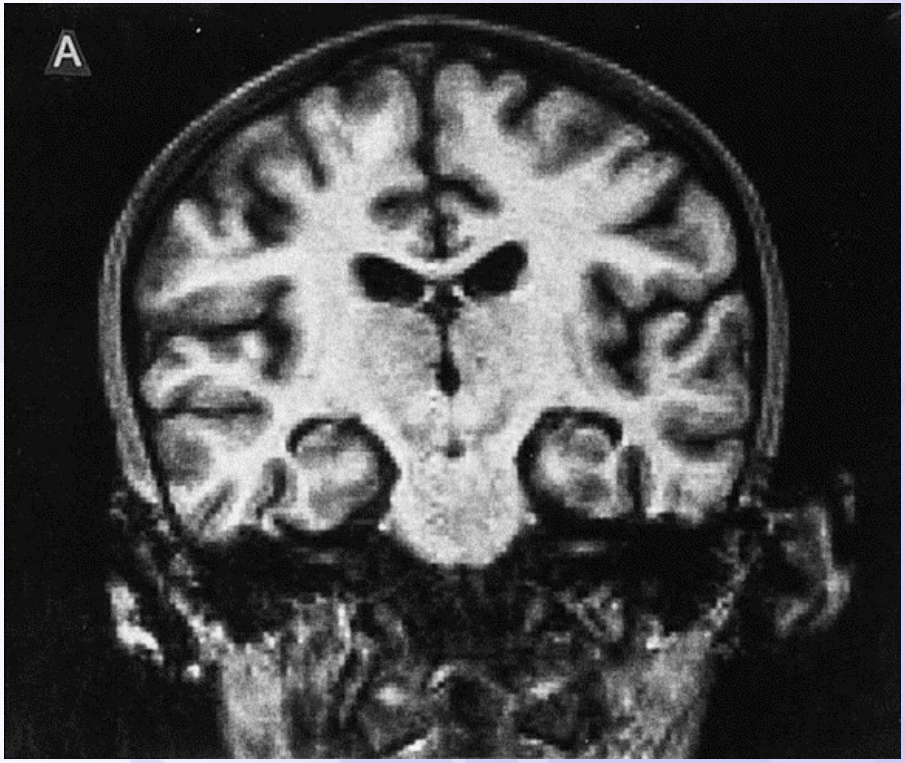
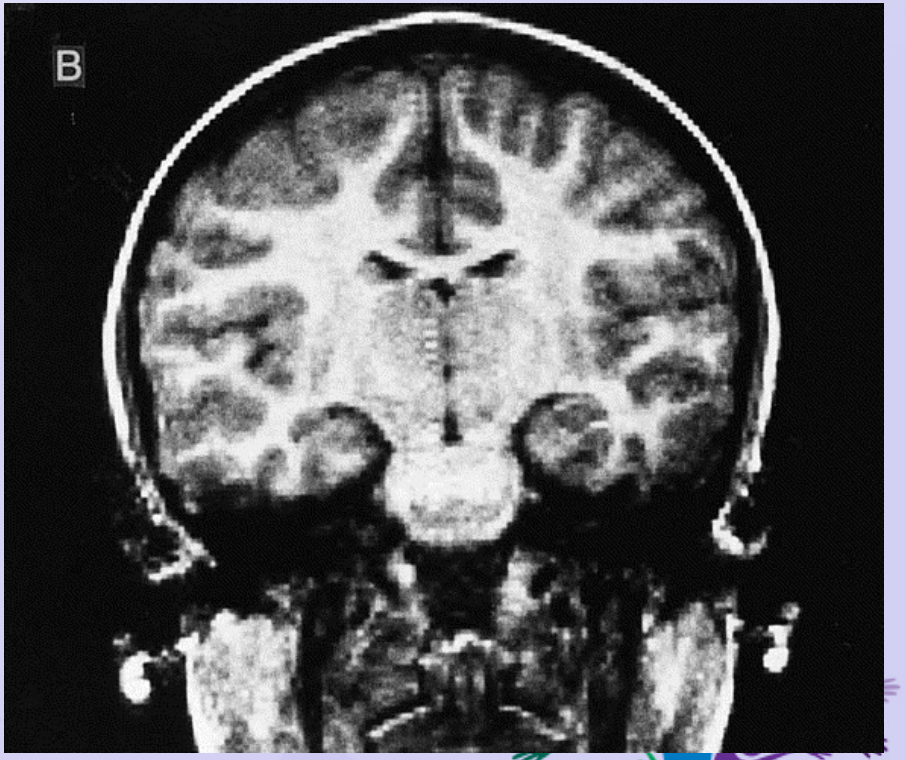
Use of images





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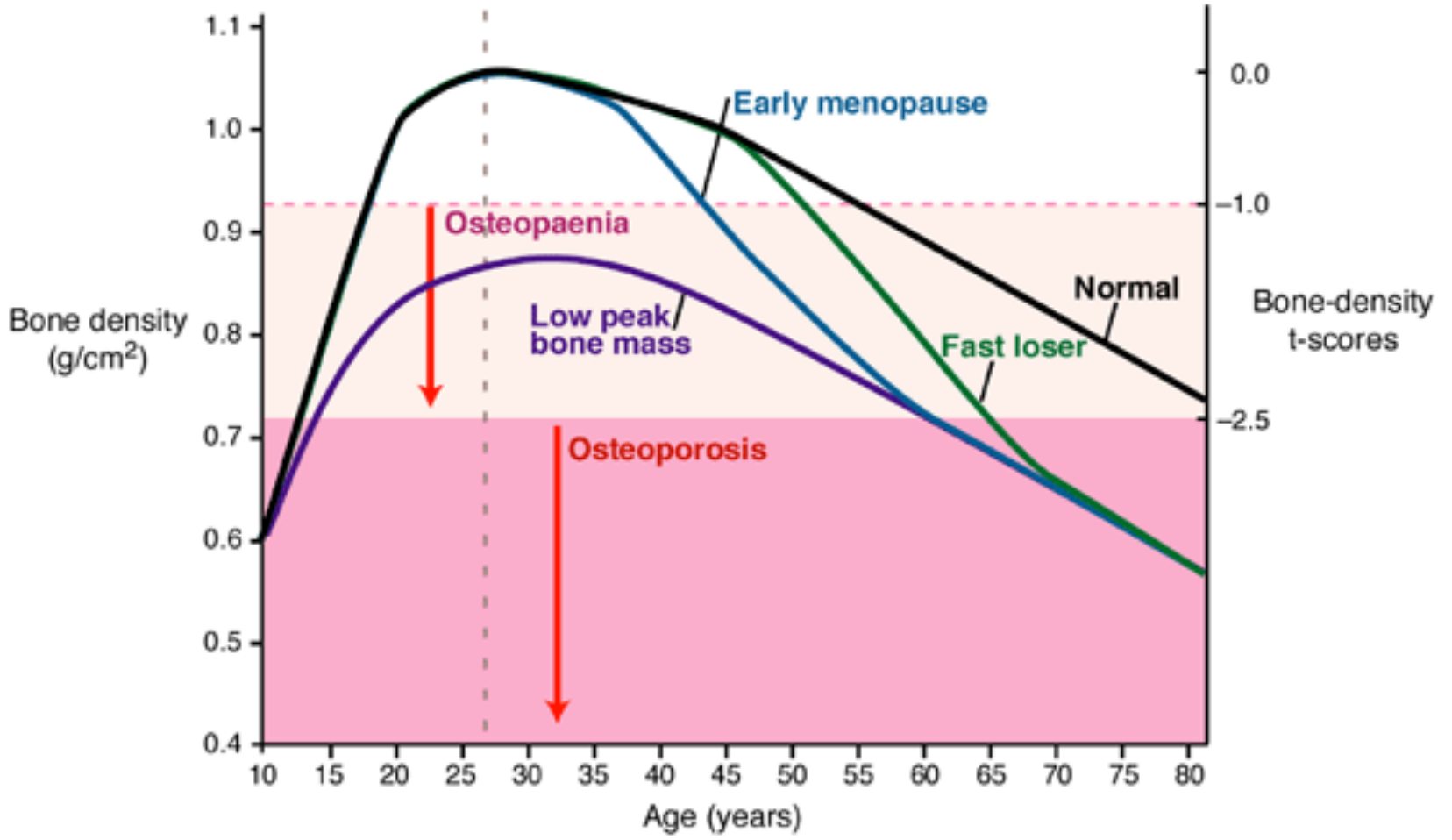

Variation in the bone density of women at different ages

Blood checks:

what to lookout for and how to manage?

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Parameter	Intervention
Low Hb / Iron / MCH	Supplement
Calcium below 2.2	Supplement
Na /K	If very low consider referral to Paediatric A/E
PO4 between 0.5 to 1	**2 x 500mg Phosphate Sandoz as loading and then 1 TDS for 2-3 weeks, taper and stop with intermittent blood tests.**
PO4 under 0.5	**Admit for IV infusion**
Very Low Mg	Admit for infusion
Raised MCV	Consider Folate, B12 and Cu levels
LFT / RFT / TFT / WBC / Platelets	Usually minor changes that correct with time and nutrition, appropriate water intake
Raised clotting time	Platelet levels, clotting studies, Vit K

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Risk Assessment

Risk Categories

- Body Mass
- Cardiovascular Health
- ECG Abnormalities
- Hydration Status
- Temperature
- Biochemical Abnormalities
- Calorie Intake
- Engagement With Management Plan
- Activity and Exercise
- Self Harm and Suicide
- Muscular Weakness
- Other Mental Health Diagnoses
- Other

Risks

Red Criteria

Percentage Median BMI <70%

[Approximates to below 0.4th BMI centile]

OR

Recent loss of weight of 1kg or more/week for two consecutive weeks

Amber Criteria

Percentage Median BMI 70-80%

[Approximates to between 2nd and 0.4th BMI centile]

OR

Recent loss of weight of 500g-999g/week for two consecutive weeks

Green Criteria

Percentage Median BMI 80-85%

[Approximates to between 9th and 2nd BMI centile]

OR

Recent weight loss of up to 500g/week for two consecutive weeks

Blue Criteria

Percentage Median BMI>85%

[Approximates to above 9th BMI centile]

OR

No weight loss over past two weeks

Red Criteria

Heart rate (awake) <40 bpm

History of Recurrent Syncope

Marked orthostatic changes

(fall in systolic blood pressure of 20mmHg or more, or below 04th-2nd centiles for age, or increase in heart rate up to 30bpm)

Irregular heart rhythm (does not include sinus arrhythmia)

Amber Criteria

Heart rate (awake) 40-50bpm

Sitting Blood Pressure

Systolic
<04th centile (84-88mmHg depending on age and sex)
Diastolic
<04th centile (35-40 mmHg depending on age and sex)

Moderate orthostatic cardiovascular changes (fall in systolic blood pressure of 15mmHg or more, or diastolic blood pressure fall of 10mmHg or more within 3 mins standing, or increase in heart rate up to 30bpm)

Occasional syncope

Green Criteria

Heart rate (awake) 50-60bpm

Sitting Blood Pressure

Systolic
<2nd centile (88 - 102mmHg depending on age and sex)
Diastolic
<2nd centile (40 - 45mmHg depending on age and sex
Pre-syncopal symptoms but no orthostatic cardiovascular changes

Cool peripheries. Prolonged peripheral capillary refill time (normal central capillary refill time)

Blue Criteria

Heart rate (awake) >60bpm

Normal sitting blood pressure

for age and sex with reference to centile charts

Normal orthostatic cardiovascular changes

Normal heart rhythm

Red Criteria

Severe dehydration (10%)

Reduced urine output
Dry mouth
Decreased skin turgor
sunken eyes
Tachypnoea
Tachycardia

Amber Criteria

Moderate dehydration (5-10%)

Reduced urine output
Dry mouth
Normal skin turgor
Some tachypnoea
Some tachycardia
Peripheral oedema

Green Criteria

Mild <5%

May have dry mouth or not clinically dehydrated but with concerns about risk of dehydration with negative fluid balance.

Blue Criteria

Not clinically dehydrated

Red Criteria

Acute food refusal

OR

estimated calorie intake 400-600kcal per day

Amber Criteria

Severe restriction

(less than 50% of required intake).
Vomiting.

Purging with laxatives

Green Criteria

Moderate restriction
Bingeing

Blue Criteria

Mild Restriction
No Bingeing

Red Criteria

35.5 degrees Celsius (tympanic)

OR

35.0 degrees Celsius axillary

Amber Criteria

<36 degrees Celsius

Green Criteria

Normal

Blue Criteria

Normal

Red Criteria

Hypophosphataemia
Hypokalaemia
Hyponatraemia
Hypocalcaemia

Amber Criteria

Hypophosphataemia
Hypokalaemia
Hyponatraemia
Hypocalcaemia

Green Criteria

Normal Results

Blue Criteria

Normal Results

JUNIOR MARSIPAN – Risk Assessment framework				
	Red (high risk)	**Amber (alert to high concern)**	**Green (moderate risk)**	**Blue (low risk)**
Body mass	% median BMI/W4H < 70% (~below 0.4th BMI centile). Recent loss of ≥ 1kg for 2 consecutive weeks	% median BMI/W4H 70-80% (~between 2nd and 0.4th BMI centile) Recent loss ≥ 500 – 999 g/week for 2 consecutive weeks	% median BMI/W4H 80-85% (~between 9th and 2nd BMI centile) Recent loss <500g/week for 2 consecutive weeks	% median BMI/W4H > 85% (~ above 9th BMI centile) No weight loss over past 2 weeks
Cardiovascular health	Heart rate (awake) < 40bpm Marked orthostatic changes (in systolic BP of ≥ 20mmHG, or in heart rate > 30 bpm) History of recurrent syncope Irregular heart rhythm (does not include sinus arrhythmia)	Heart rate (awake) 40-50 bpm Moderate orthostatic		
ECG abnormalities	See Junior Marsipan for more details			
Hydration status	Fluid refusal Severe dehydration (<10%): reduced urine input, dry mouth, decreased skin turgor, sunken eyes, tachypnoe, tachycardia.	Severe fluid restriction Moderate dehydration (5-10%): reduced urine output, dry mouth, normal skin turgor, some tachypnea, some tachycardia, peripheral oedema.	Fluid restriction Mild dehydration (<5%): dry mouth or not clinically dehydrated but with concerns about risk of dehydration with negative fluid balance.	Not clinically dehydrated
Temperature	< 35.5 °C (tympanic) or 35.0 °C (axillary)	< 36 °C	-	-
Biochemical abnormalities	Hypophosphataemia, Hypokalaemia, hypoalbuminaemia, hypoglycaemia, hyponatraemia, hypocalcaemia.	Hypophoshataemia, hypokalaemia, hyponatraemia, hypocalcaemia.	-	-

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What is Refeeding Syndrome

- Potentially fatal shift in fluids and electrolytes that occur in malnourished patients upon re-feeding, which is insulin mediated.
- In starvation the secretion of insulin is decreased in response to a reduced intake of carbohydrates. Instead fat and protein stores are catabolised to produce energy. This results in an intracellular loss of electrolytes, in particular phosphate. Malnourished patients' intracellular phosphate stores can be depleted despite normal serum phosphate concentrations. When they start to feed a sudden shift from fat to carbohydrate metabolism occurs and secretion of insulin increases. This stimulates cellular uptake of phosphate, which can lead to profound hypophosphataemia.
  This phenomenon usually occurs within 2-5 days of starting to feed again. There is risk of up to 14 days following refeeding being commenced.

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What is Refeeding Syndrome

- Serum phosphate concentrations of less than 0.50mmol/l (normal range 0.85-1.40mmol/l) can produce the clincial features of re-feeding syndrome, which include rhabdomyolysis, leucocyte dysfunction, respiratory failure, cardiac failure, hypotension, arrythmias, seizures, coma and sudden death. Importantly, the early clinical features of re-feeding syndrome are non specific and may go unrecognised.

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Factors Increasing Risk of Re-feeding Syndrome

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- Those children / young people with:
- Very low weight (in particular those <70-80% weight for height/median Body Mass Index (BMI) / less than -2 to -3 Standard Deviation (SD) BMI) or fast rates of weight loss prior to commencing re-feeding, including massive weight loss in obese patients.
- Minimal or no nutrition prior to commencement of feeds/severe malnutrition, including anorexia nervosa, or chronic malabsorption.
- Prolonged intravenous (IV) fluid therapy/ fasting/ nil by mouth.
- Previous history of re-feeding syndrome.
- Electrolyte abnormalities prior to starting feeds.
- Low white cell count

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Nutritional Advice (applicable with re-feeding risk)

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- The following options are suggested as part of safely re-introducing food.
-
- **Milk snacks:** Add in semi skimmed milk x3/day in between meals – e.g.:
- **Mid morn:** 1 cup(250mls) milk
- **Mid afternoon**: 1 cup milk
- **Before bed:** 1cup milk
-
- **Add in one starchy food option to your current food intake**. Choose from **ONE** of the following:
- ½ cup of cereal/ ½ cup cooked porridge
- 1 medium slice bread/x3 crackers/ ½ break roll/ 1 small wrap
- ½ cup cooked rice/pasta/quinoa/barley
- 1 small jacket potato (to fit ½ the palm of your hand)/1 rounded serving spoon of mashed potato or 2 egg sized potatoes
- 1 digestive biscuit

- At your next appointment, you and your family will be further supported and guided in regards to ensuring your intake is appropriate and increased as is necessary.

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Medication

- No known medication for Anorexia
- Treat symptomatically –
  - Emotional dysregulation: Olanzapine / Aripiprazole
  - Mood and Anxiety Disorders with SSRIs
  - ADHD but beware of appetite loss as a trigger for relapse or perpetuating AN – consider Guanfacine
  - Supplements, specialist energy drinks
  - Avoid laxatives (bulk better than osmotic)
  - Avoid OC Pills as best as possible

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Scans

- If amenorrhea for 12 months, appropriate to request a DEXA bone density scan
- NB: Oral Oestrogen is not effective to help with improvement of bone density
- Pelvic scan:
  - If weight is below 90% and the person claims to be menstruating. Always confirm.
  - 95% weight restored and no sign of periods returning.

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Deception

- Water loading
- Weights in pockets, underwear
- Weights in hair
- Heavier clothes
- Multiple layers when being weighed
  - May need to pat down
  - Ask to change into a gown
  - Repeat weight
  - Monitor mid-arm circumference
- Requests for laxatives to treat constipation
- Oral contraceptive pills
- Mismanagement of diabetes

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Treatments offered by BEDS CYPF

First Line Treatment (as recommended by NICE (2017))

Family Therapy (FT-AN, FT-BN)

Additional Treatments

Systemic Family Therapy Clinic/Family Therapy

Individual Therapy (CBT, Dance and Movement Psychotherapy, Art Psychotherapy)

Dietetic support

Parent/ carers support group and Participation group (monthly)

Body, Mind and Me Group

Introduction to Treatment Group

Multi-family Therapy Group

Monitoring Clinic

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Family Therapy for A.N/B.N

Aims are to:

- restore weight and normalise eating
- promotes healthy adolescent development

Sessions are delivered over 6-12 months (20-30 sessions). Includes a family meal in the clinic .

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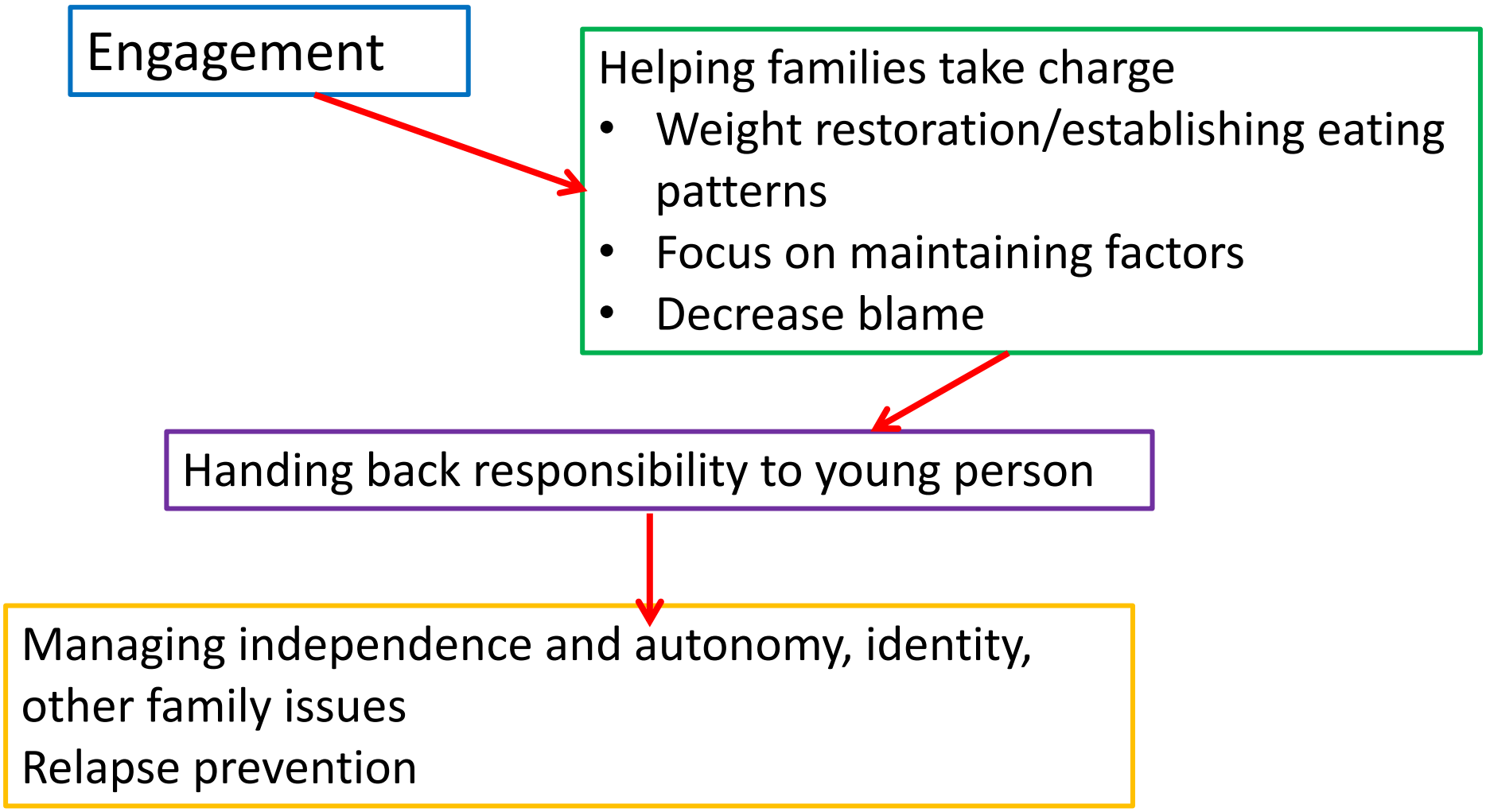
Family therapy treatment for AN/BN



Family Therapy-AN/BN

- Not family therapy in true sense
- Goal is to empower parents to care for the young person by ensuring adequate intake
- Shift authority to parents
- Instill fear/manage misplaced expectations – cancer analogy
- Make parents responsible for improvements
- Behavioural approach (e.g. door to kitchen, padlock on bathrooms, access to devices and apps or pro-Ana websites).
- Session 2 – meal (symbolic victory where possible).
- Use Externalisation – Annie / Ms Control / Shadow Dude
- 3 to 4 phases of FBT – weight restoration / consolidation / autonomy passed on to YP

Shared care between Primary and Secondary Specialist Services

Berkshire Healthcare NHS
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- At point of referral
  - Provide the vital information -
  - Height, weight, pulse, BP, blood results, ECG.
- During engagement with our service
  - Repeat bloods, at times weekly or even twice a week at peak of risk of re-feeding syndrome
  - Medication refills / treat mineral and vitamin deficiency
  - Scans
- Post-discharge
  - Step-down monitoring

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Prevention programmes:

Can we nip it in the bud?

- Immunisation programme works.
- Will a confidential MOT-like check help?
- Reconsider how health information on healthy eating in relation to risk of obesity is delivered.
- Emphasis on broader multi-faceted development, pastoral care, early intervention in regard to – social anxiety and sense of self issues.

Berkshire Healthcare NHS
NHS Foundation Trust

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https://cypf.berkshirehealthcare.nhs.uk/our-services/mental-health-services-camhs/berkshire-eating-disorders-service-beds/

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CAMHS Eating Disorder guidelines for schools
National Eating Disorder Charity website
http://www.b-eat.co.uk/Home

The MindEd website, launched in 2014, is a free e-learning resource to help adults to identify and understand children and young people with mental health issues.

Junior MARSIPAN (2012) from Royal College of Psychiatrists covers physical risk assessment in detail

Morgan JF, Reid F, Lacey JH (2000). "The SCOFF questionnaire: a new screening tool for eating disorders.". *West J Med* **172** (3): 164–5.

Access and Waiting Time Standard for Children and Young People with an Eating Disorder (2015) NHS England