GUIDELINE

Eating disorders

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<th>Scope (Staff):</th>
<th>School health</th>
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<td>Scope (Area):</td>
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This document should be read in conjunction with this DISCLAIMER

**Background**

Eating disorders are serious and potentially life threatening mental illnesses, in which a person experiences severe disturbances in eating and exercise behaviours because of distortions in thoughts and emotions, especially those relating to body image or self-esteem, which can interfere in all aspects of their life and relationships. Eating disorders exist across all ages, cultural and socio-economic groups, and both genders. There are four different types of eating disorders classified as mental illnesses: anorexia nervosa, bulimia nervosa, binge eating disorder and eating disorders not otherwise specified (EDNOS).

The onset of eating disorders often occurs in adolescence, although problems may be evident in children as young as seven and throughout the lifespan. Among females in Australia, approximately 2-3% have anorexia or bulimia nervosa and one in five has symptoms of binge eating disorder. Furthermore, one in four young people diagnosed with anorexia nervosa are male.

The risk factors of eating disorders are complex and involve a combination of individual, biological, familial and socio-cultural factors. Low self-esteem and weight control behaviours are identified as the most significant risk factors.

The acute and chronic physical and psychological health consequences of eating disorders are well documented. Some of the physical consequences include complications of the gastrointestinal, cardiovascular, and endocrine systems, osteoporosis, severe malnutrition and brain dysfunction. These negative physical health consequences are more significant in children and adolescents as the eating and exercise behaviours can disrupt normal physical development.

When compared to the general population, people with eating disorders are at increased risk of premature death from suicide or natural causes, such as cardiac arrhythmia. Eating disorders can also have co-morbidities such as depression, anxiety obsessive-compulsive disorder and more recently overweight and obesity. In addition, those diagnosed with an eating disorder often carry the added burden of stigmatization.

Most young people who are identified early in the development of eating disorders, and who receive appropriate treatment, are reported to recover. Therefore, early identification and appropriate intervention are vital to prevent the progression of physical,
Eating disorders develop as a result of the coming together of a ‘critical cluster’ of risk factors (Appendix 1).

Often a trigger such as internal or external pressure to lose weight, particularly teasing or comments about appearance or size, dieting and stressful events precipitates its onset. Therefore, promoting positive self and body image, media literacy, coping skills, flexible eating habits and a positive approach to physical activity using the health promoting schools framework is critical to the prevention of this disease.

### Table: Types of Eating Disorders

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<tr>
<th>Type</th>
<th>Definition</th>
<th>Symptoms</th>
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| Anorexia Nervosa  | Anorexia nervosa is a syndrome in which the individual maintains a low weight as a result of a pre-occupation with body weight, construed either as a fear of fatness or pursuit of thinness. | • Use of extreme weight-loss strategies.  
• Intense fear of gaining weight or becoming ‘fat’.  
• Body image disturbance e.g. feeling ‘fat’ despite being underweight.  
• Loss of menstrual periods (females).  
• Extreme concern with body weight and

| Bulimia nervosa   | Bulimia nervosa is characterised by recurrent episodes of binge eating and secondly by compensatory behaviour (vomiting, purging, fasting or exercising or a combination of these) in order to prevent weight gain. | • Over-protection with food and weight resulting in ‘out of control’ eating patterns  
• Eating binges which involve the consumption of very large amounts of food.  
• Attempts to compensate for binges and weight gain by one or more of the following unhealthy measures: self- induced vomiting; misuse of laxatives, fluid or diet pills; excessive exercise; periods of strict dieting. |
| Binge Eating      | Periods of uncontrolled, impulsive or continuous eating to the point of being uncomfortably full. | • Repeated episodes of binge eating which often results in feelings of shame and self-hatred.  
• No compensatory behaviours (such as vomiting, laxative abuse, excessive exercise) after bingeing.  
• People with binge eating disorder may be within a healthy weight range or overweight. |
Eating Disorders Not Otherwise Specified (EDNOS)

If the person does not fit the description of anorexia, bulimia or binge eating disorder, but their attitude to food, weight, body size or shape is seriously interfering with their life.

- EDNOS is the most prevalent eating disorder
- EDNOS may include:
  - Those who have some, but not all of the characteristics of an eating disorder. For example, people who severely restrict food intake, but do not meet full criteria of anorexia nervosa;
  - Those who chew food and spit it out (without swallowing); Those who binge and purge irregularly, such as at times of increased stress.

The Eating Disorders continuum

One way to view eating and weight related disorders is on a spectrum with natural eating at one end, anorexia and bulimia nervosa at the other end, and a range of other weight-related disorders in the middle, including EDNOS, disordered eating and binge eating disorder. Disordered eating refers to troublesome eating behaviours, such as restrictive dieting, bingeing or purging, which occur less frequently or are less severe than those required to meet the full criteria for the diagnosis of an eating disorder.

General Principles

- Eating disorders cannot be identified from a person’s appearance. A person with an eating disorder can be underweight, within a healthy weight range, or overweight. Unless questions specific to eating disorders are asked, this problem may remain undetected.
- Symptoms should not be accepted as ‘normal adolescent behaviour’. Early intervention is essential to avoid these behaviours developing into a serious disorder.
- Concerns expressed by parents, friends and teachers must be taken seriously and acted upon.
- Behaviour associated with eating disorders can be well hidden. Young people do not usually discuss their eating problems openly with friends and family, and often conceal their socially inappropriate behaviour.
- Eating disorders are often not seen as a problem to the young person, but instead are perceived as a solution, helping them feel calm and in control.
- Physical assessments of the young person such as height and weight, waist and hip circumference are not recommended.
• Prevent stigmatisation by increasing awareness about risk factors and warning signs among school staff to optimise early intervention.

• Convey care and respect, be non-judgemental. Assist the young person to feel comfortable in talking about personal information. Wherever possible, ensure that the adolescent feels like he/she is in control of the conversation and situation.

• Discuss ‘conditional confidentiality’ and explain the limitations of total confidentiality up front. Be mindful of the vulnerability of a young person who is suspected of having an eating disorder and whose mental health may be impaired.

• Encourage and support adolescents to inform their parents or guardian about significant health issues. The support provided should reflect the maturity of the individual, significance of the issue, and the particular circumstances of each case. Be mindful that a young person with an eating disorder and/or a mental health issue is likely to make impaired judgements about the risks of their eating or weight behaviours.

Making an Assessment and Planning Actions

The eating disorder assessment in a young person can occur over a number of sessions, unless the young person is deemed to be at immediate and/or severe risk. Refer to Appendix 2 for tips on ‘Talking to a young person about a suspected eating disorder’.

1. Identify the primary professional who will talk to the young person. Consider relationships between the young person and other school personnel such as a classroom teacher and who else may already be involved in a care plan such as a general practitioner, school principal or school psychologist. Consider level of competence and experience; always consult with line manager if there are any concerns.

2. Plan your Approach.

   Consider a good time and space for talking privately. Think about what can be achieved by the consultation including the immediate intervention, roles and responsibilities. Seek relevant information about eating disorders.

3. Build a Rapport

   Eating disorders and other weight related issues are potentially very sensitive topics. Start by building rapport with the young person so they feel safe and secure enough to begin the discussion.

4. Discuss conditional confidentiality.

   Explain to the young person that the consultation is private but there may be some information which may have to be shared to ensure the young person remains safe.

5. Conduct HEADSS Psychosocial Assessment

   This should start with less sensitive areas of a young person’s life and move towards more sensitive.

6. Asking the Sensitive Questions

   Refer to Appendix 2 for tips on ‘Talking to a young person about a suspected eating disorder’.

7. Review the Conversation
Consider the HEADSS Psychosocial Assessment in relation to risk factors and warning signs of eating disorders (see Appendix 1). Clearly document your assessment and decisions and actions.

8. Make a referral if necessary.

Explain the nature of the referral to the young person and the need to involve his/her parents (or guardian). Assist the young person to discuss this with his/her parents and explain that you will be making contact with them.

9. Contact parents (or guardian) to enact the referral.

Actively follow-up with the young person and their parent or guardian. If the referral is not followed through by the family, consult with line manager.

10. Ongoing role of the Community Health Nurse working in the school

The role of the community health nurse is dependent on parental consent and the care plan advised by the treating health professionals.

Aim to have a meeting at the school, preferably involving the treating team, and decide the role of each member of student services (and others as required). For the Community Health Nurse this may be an active role, or simply being the safe link at school for the young person for debriefing, support and advocacy. It is not appropriate for the Community Health Nurse working in the school to be providing any form of therapy.

The Role of Hospital School Services

Hospital School Services (HSS) provides educational support for students whose physical or mental health prevents them from successfully participating in their own school programs. Support is available to both public and private school students through direct teaching, liaison and teaching in the home setting.

HSS works closely with the Eating Disorders Program to provide support around educational matters for inpatients, day patients and outpatients. A teacher from HSS is available to liaise with the young person’s school regarding academic and peer related issues. This teacher can form a link between the student, parents, the enrolled school and the Eating Disorders Program in order to maximise communication and positive outcomes. For more information please see ‘Western Australian Resources’.

Referral Options

In the first instance, the young person should be referred to local services such as a general practitioner, clinical psychologist, dietician or Child and Adolescent Mental Health Service.

Princess Margaret Hospital – State-wide Service

The Eating Disorders Program is a free, specialised multidisciplinary service with outpatient, day patient and inpatient care. It accepts referrals for young people up to 16 years of age. Referrals are accepted state-wide from general practitioners, school psychologists, paediatricians, psychiatrists, social workers or community health nurses. The team accepts that a rapid response for some people is required and some children may require immediate hospitalisation.

The Team Triage Coordinator should be contacted to arrange emergency assessment or to discuss concerns. The referral should be made to:
Eating Disorder Program Triage Psychological Medicine Clinical Care Unit Princess Margaret Hospital for Children GPO Box D184 Perth WA 6001 Ph: (08) 9340 7012 Fax: (08) 9340 8398 Website:  http://www.pmh.health.wa.gov.au/services/eating_disorders/

Centre for Clinical Interventions – State-wide Service

The Centre for Clinical Interventions (CCI) is a specialised mental health program. It offers Cognitive Behaviour Therapy (CBT) for people diagnosed with an eating disorders. The Eating Disorders Program is one of the psychological treatment programs offered by CCI. It is a new service, using the latest and best-researched treatment available for eating disorders. Referrals are accepted for patients 16 years and above and as part of the public health system, the service offered is free. The referral should be made to:

Clinical Manager 233
James Street
Northbridge WA 6003
Ph: (08) 9227 4399
Fax: (08) 9328 5911
Email (general enquiries only): info.cci@health.wa.gov.au Website:  http://www.cci.health.wa.gov.au/

The Hollywood Clinic

This is a private, specialist multi-disciplinary assessment and treatment service. Services include monitoring of medical and nutritional states, group work including cognitive behavioural therapy, problem solving groups, discussion groups, relatives and friends’ psycho-educational groups for relatives and friends, family therapy and individual therapy. For further information about the program, referrals and assessment, please contact:

The Eating Disorders Program Coordinator The Hollywood Clinic
Hollywood private hospital Locked Bag 2002
Nedlands 6909
Telephone (08)9333 8000
Fax (08) 9423 5717
Website:  www.hollywood.ramsayhealth.com.au

Professional development

There are two levels of professional development offered by The Princess Margaret Hospital Eating Disorders Program:

1. Introductory workshops conducted within the school can be organised free of charge for teachers, nurses, psychologists and relevant others. For further details please call 9340 7012.

2. Advanced training for health professionals: See training calendar  
### Related internal policies, procedures and guidelines

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<th>Resource</th>
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<tr>
<td>Promoting Physical Activity in Schools Resource</td>
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<td>Promoting Healthy Eating in Schools Resource</td>
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<td>Promoting Mental Health and Resilience in Schools Resource</td>
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<td>Promoting Healthy Body Image in Schools Resource</td>
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### References


Eating disorders


Useful resources

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<tr>
<th>The Eating Disorder Foundation of Victoria – have a national eating disorders helpline</th>
<th>Phone: 1300 550 236 or Email: <a href="mailto:help@eatingdisorders.org.au">help@eatingdisorders.org.au</a>  <a href="http://www.eatingdisorders.org.au">www.eatingdisorders.org.au</a></th>
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<tr>
<td>Eating Disorders Australian National Network (EDANN) - is a national collaborative venture. EDANN members are recognised nationally and internationally as leaders in research, clinical practice and consumer representation.</td>
<td><a href="http://www.edann.org/">http://www.edann.org/</a></td>
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<td>The Victorian Centre of Excellence in Eating Disorders -</td>
<td><a href="http://www.ceed.org.au">www.ceed.org.au</a></td>
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<td>Facing food: a booklet about healthy eating for young people with a dieting disorder.</td>
<td><a href="http://www.caah.chw.edu.au/resources/books/">http://www.caah.chw.edu.au/resources/books/</a></td>
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<tr>
<td>Eating Disorders Association Resource Centre.</td>
<td><a href="http://www.uq.net.au/eda">www.uq.net.au/eda</a></td>
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<tr>
<td>New South Wales Centre for Eating and Dieting Disorders (CEDD).</td>
<td><a href="http://www.cedd.org.au">www.cedd.org.au</a></td>
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<td>The Butterfly Foundation - A community based organisation that supports eating disorder sufferers and their carers through direct financial relief, advocacy, campaigns, health promotion and early intervention</td>
<td><a href="http://www.thebutterflyfoundation.org.au">www.thebutterflyfoundation.org.au</a></td>
</tr>
<tr>
<td>Women’s Health Works – A community service providing information, education and counselling for women. Provides a community based parent education and support group and self help groups (for people over eighteen). Provides a directory of WA services for eating disorders. Phone: (08) 9300 1566 Fax: (08) 9300 1699</td>
<td><a href="mailto:info@womenshealthworks.org.au">info@womenshealthworks.org.au</a></td>
</tr>
<tr>
<td>Hospital School Services – Principal and General Enquiries: Phone: (08) 9340 8529 Fax: (08) 9382 2140 Email: <a href="mailto:hss@det.wa.edu.au">hss@det.wa.edu.au</a> Web: <a href="http://www.hospitalschoolservices.wa.edu.au">www.hospitalschoolservices.wa.edu.au</a></td>
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<tr>
<td>Centre for Clinical Interventions – provides useful information for professionals and carers</td>
<td><a href="http://www.cci.health.wa.gov.au/resources/consumers.cfm">http://www.cci.health.wa.gov.au/resources/consumers.cfm</a></td>
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<tr>
<td>Bridges Association Incorporated - is operated by people who have recovered from eating disorders, parents, carers, and health care professionals.</td>
<td><a href="http://www.bridges.net.au">www.bridges.net.au</a></td>
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<td>Carers WA - A non-profit, community based organisation whose role is to work in active partnership with carers, persons with care and support needs, health professionals, service providers, government and the wider community. They provide information,</td>
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Eating disorders

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<th>support and counselling for people caring for those experiencing eating disorders. Phone: (08) 9444 5922 Fax: (08) 9444 8966 24hr Carer Counselling Line: 1800 007 332 Email: <a href="mailto:info@carerswa.asn.au">info@carerswa.asn.au</a></th>
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<tr>
<td>ARAFMI Mental Health Carers &amp; Friends Association Incorporated. ARAFMI is a non-profit community based organisation that provides information and support for families and friends of people with a mental health issues. This includes family support counselling, support group program advocacy, respite and community education. Groups programs specific to eating disorders are sometimes available. Offices throughout metropolitan Perth and in rural areas. Phone: (08) 9228 0579 <a href="http://www.arafmi.asn.au">www.arafmi.asn.au</a></td>
</tr>
<tr>
<td>Community Mental Health Services - There is a comprehensive range of public mental health services. Mental health care is provided for children, adolescents, adults and older people. Health Info: 1300 135 030</td>
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<tr>
<td>Mental Health Emergency Response Line (24hr) 1300 555 788</td>
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APPENDIX 1: Risk Factors and Warning signs

Genetic Factors
- Many studies have shown that eating disorders can have a genetic component.

Physical Risk Factors
- A feeling of reaching puberty too early (for females) or too late (males) has long been considered a risk factor for an eating disorder.
- Illnesses such as Type One diabetes.
- A history of body weight fluctuations, dieting and calorie restriction are risk factors, especially when these begin at an early age or are repetitive.

Severe Life Stresses
- Life stresses have been implicated as risk factors in eating disorders. For example, approximately 70% of anorexia nervosa and bulimia nervosa cases are triggered by severe life events. These stresses most commonly occur in the area of close relationships with family or friends.
- Some evidence suggests that traumatic events such as childhood sexual abuse are potential risk factors.

Familial Factors
- Family ‘fad’ dieting and undue concern about the importance of weight and shape may contribute to eating disorders in vulnerable adolescents.
- There is some evidence demonstrating ‘high concern’ parenting in a number of adolescent cases of anorexia nervosa which arose in infancy and long predated the onset of eating difficulties.
- Family tensions/dysfunction are also seen as a risk factor.

Socio-cultural factors
- Societal pressures to be thin can foster an internalisation of a thin ideal and body dissatisfaction which in turn leads to dieting behaviour and therefore places the person at risk of eating disorders.
- Specific groups at risk are athletes, dancers and models.

Personality Factors
- Personality traits, including high self-expectations and perfectionism may promote the relentless pursuit of the ‘thin ideal’.
- Difficulty with interpersonal relationships is seen as a risk factor.
- Personality traits can be seen as both a risk and maintaining factor.

Impulsivity
- General problems in the area of impulse control have been proposed as risk factors for eating disorders as they may render the individual vulnerable to episodes of uncontrollable binge eating.

Behavioural warning signs can include:
- Severe dieting behaviours including periods of fasting, avoiding food groups, counting calories.
- Evidence of binge eating e.g. disappearance of or hoarding food.
- Abnormal social isolation or withdrawal from family or friends.
• Obsessive rituals such as only drinking out of a certain cup.
• Preoccupation with own of others eating behaviours.
• Refusal, or making excuses, to avoid eating with others.
• Lying about amount or type of food consumed or evading questions about eating and weight.
• Comments about ‘permissible’ eating/foods – e.g. “I shouldn’t eat this”.
• Wearing baggy or layered clothing.
• Excessive, obsessive or ritualistic exercise patterns.
• Evidence of vomiting or laxative use e.g. disappearance or making trips to the toilet during or after eating.
• Drug/alcohol misuse.

Physical warning signs can include:

• Weight loss, weight gain or fluctuations in weight.
• Sensitivity to cold or feeling cold most of the time.
• Faintness, dizziness or fatigue.
• Irregular or absent menstrual cycles.
• Swelling around the cheeks or jaw or damage to teeth from vomiting.

Psychological warning signs can include:

• Preoccupation with food, weight and body shape.
• Extreme body dissatisfaction.
• Distorted body shape.
• Sensitivity to comments or criticism about exercise, food or weight.
• Depression, mood swings, anxiety or irritability.
• Low self-esteem.

Sourced from References 1, 2, 6, 7
APPENDIX 2: Talking to a young person about a suspected eating disorder

Start with positives
For example, talk about the young person’s sense of fun, friendliness and other positives. Ensure you do not include physical aspects such as appearance. Be aware that the person may respond negatively no matter how sensitively you approach them.

Lead into your concerns and focus on emotions rather than food and weight “I’m talking to you today because I’m a bit concerned about how things have been going for you. I’ve noticed you seem really tired and sad lately; you also appear to be looking unwell. I have been wondering if you worry about anything in particular and whether this worry has got a bit out of hand?”

Provide choices
“Who you would feel OK talking to about how you are feeling?”

Reassure
Let the young person know you are a safe person to talk to and want to help.

Ask the right questions
Conduct the HEADSS Psychosocial Assessment which should start with less sensitive areas of a young person’s life and move towards more sensitive. “I’d like to ask you a few personal questions. You don’t have to answer these if you don’t feel comfortable. The reason I want to ask these questions is to get a picture of your life and your overall health, and to give you a chance to talk about things that might be of concern to you. Remember that anything we discuss will be kept confidential unless you tell me something that makes me concerned about your safety or someone else’s safety, I can not keep that confidential. Is it OK if I ask you some more questions now?”

Ask the sensitive questions
Try to normalise eating, body image and weight in the discussion first. For example, talk about how many young people tend to worry about their weight and what they eat. Ask the young person how they feel about that.

The SCOFF questionnaire is identified as a useful preliminary tool to assess adolescents with a suspected eating disorder in a school/community health setting. A referral for a medical assessment is recommended if the young person answers yes to any one of the five questions. It is important to note that these questions should be embedded in the conversation, and not asked one after the other.

1. Do you make yourself Sick because you feel uncomfortably full?
2. Do you worry you have lost Control over how much you eat?
3. Have you recently lost Over 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?
**NOTE: If the health professional judges that there is cause for concern, a referral for a medical assessment and diagnosis should be made despite results of the assessment tool. This tool does not replace a medical assessment conducted by health specialists to diagnose an eating disorder.**

Keep an open mind

The young person may be evasive when answering questions, for example saying “Everything is going fine”. This may indicate that the young person is not ready to discuss issues or may not see their eating and exercise patterns as a problem.

Provide Information

For example, have phone numbers or websites written down ready to give the young person; be careful not to overwhelm the young person with too much information.

The SCOFF QUESTIONNAIRE

The SCOFF questionnaire is identified as a useful preliminary tool to assess adolescents with a suspected eating disorder in a school/community health setting. It consists of five questions asking about intentional vomiting, loss of control over eating, weight loss, body dissatisfaction and intrusive thoughts about food. A referral for a medical assessment is recommended if the young person answers yes to any one of the five questions.

The SCOFF questionnaire accounts for the subjects’ developmental needs, is equally applicable to both genders, reveals symptoms that would otherwise remain undetected, and is easy to interpret. Self-reported eating habits are suggested by research to be a reliable indicator of eating patterns. However, it is also important to note that a young person who has an eating disorder may actively avoid questions relating to eating and insist there is not a problem.

If the professional judgement of the community health nurse suggests cause for concern, a referral for a medical assessment and diagnosis should be made despite results of the assessment tool. This tool does not replace a medical assessment conducted by health specialists to diagnose an eating disorder.
This document can be made available in alternative formats on request for a person with a disability.

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