Eating Disorders: A professional resource for general practitioners

The National Eating Disorders Collaboration (NEDC) is funded by the Australian Government Department of Health.

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Evidence Experience Expertise

Contents

Introduction

Eating Disorders: A Professional Resource for General Practitioners will provide GPs with key information about identifying, responding to, and managing eating disorders.

For more in-depth information about the topics covered in this booklet, as well as an interactive learning experience that includes videos, resources and activities, access NEDC's free online training **Eating Disorder Core Skills: eLearning for GPs.**

Online Learning for General Practitioners

The National Eating Disorders Collaboration has developed **Eating Disorder Core Skills: eLearning for GPs** – comprehensive foundational eating disorder training developed specifically for GPs. The training provides GPs with the key information needed to provide best practice care for patients with eating disorders.

This freely accessible four-hour, self-paced and interactive online training includes practical real-life scenarios and activities, videos from leaders in the field and people with a lived experience of an eating disorder, up-to-date resources, and a formal assessment.

The training will equip GPs with the knowledge and skills needed to understand, identify and assess eating disorders, provide medical treatment, lead the multidisciplinary team, manage MBS items and provide ongoing recovery support.

Eating Disorder Core Skills: eLearning for GPs is accredited by:

- Royal Australian College of General Practitioners (RACGP) as a CPD Accredited Activity (40 points)
- General Practice Mental Health Standards Collaboration (GPMHSC) as Mental Health CPD
- Australian College of Rural and Remote Medicine (ACRRM) under the Professional Development Program

For more information and to access the training, click here.

The role of the GP in the treatment of eating disorders

GPs have a crucial role in the prevention, identification, diagnosis and medical management of eating disorders.

As a GP, you can:

- identify eating disorders by recognising and following up on warning signs, and proactively screening at-risk groups
- assess, diagnose and medically manage eating disorder presentations
- refer to eating disorder-specific mental health treatment
- refer to dietitian and other health professionals and medical specialists, as required
- manage the care team across the course of treatment
- prevent eating disorders through early intervention and patient education in cases of disordered eating/body image concerns, and through the promotion of body diversity and resilience.

Key Features for Early Identification

What are eating disorders?

Eating disorders are serious, complex mental illnesses accompanied by physical and psychiatric complications which may be severe and life threatening. They are characterised by disturbances in behaviours, thoughts and feelings towards body weight and shape, and/or food and eating.

Types of eating disorders

Eating disorders are classified into different types, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Fifth Edition (1). Classifications are made based on the symptoms and how often these occur.

Avoidant/restrictive food intake disorder (ARFID)

ARFID is characterised by a lack of interest, avoidance and aversion to food and eating. The restriction is not due to a body image disturbance, but a result of anxiety or phobia of food and/or eating, a heightened sensitivity to sensory aspects of food such as texture, taste or smell, or a lack of interest in food/eating secondary to low appetite. ARFID is associated with one or more of the following: significant weight loss, significant nutritional deficiency, dependence on enteral feeding or supplementation, and a marked interference with psychosocial functioning.

Anorexia nervosa

Anorexia nervosa is characterised by restriction of energy intake leading to significantly low body weight accompanied by an intense fear of weight gain and body image disturbance. Changes that happen in the brain because of starvation and malnutrition can make it hard for a person with anorexia nervosa to recognise that they are unwell, or to understand the potential impacts of the illness.

Atypical anorexia nervosa is a subtype of OSFED (see Page 7). A person with atypical anorexia nervosa will meet all of the criteria for anorexia nervosa, however, despite significant weight loss, the person's weight is within or above the normal BMI range. Atypical anorexia nervosa is serious and potentially life threatening, and will have similar impacts and complications to anorexia nervosa.

Bulimia nervosa

Bulimia nervosa is characterised by recurrent episodes of binge eating, followed by compensatory behaviours, such as vomiting or excessive exercise to prevent weight gain. A person with bulimia nervosa can become stuck in a cycle of eating in an out-of-control manner, followed by attempts to compensate for this, which can lead to feelings of shame, guilt and disgust. These behaviours can become more compulsive and uncontrollable over time, and lead to an obsession with food, thoughts about eating (or not eating), weight loss, dieting and body image.

Binge eating disorder (BED)

BED is characterised by recurrent episodes of binge eating, which involves eating a large amount of food in a short period of time. During a binge episode, the person feels unable to stop themselves eating, and it is often linked with high levels of distress. A person with BED will not use compensatory behaviours, such as self-induced vomiting or overexercising after binge eating.

Other specified feeding or eating disorders (OSFED)

A person with OSFED may present with many of the symptoms of other eating disorders such as anorexia nervosa, bulimia nervosa or BED but will not meet the full criteria for diagnosis of these disorders. This does not mean that the eating disorder is any less serious or dangerous. The medical complications and eating disorder thoughts and behaviours related to OSFED are as severe as other eating disorders.

Unspecified feeding or eating disorder (UFED)

UFED is a feeding and eating disorder that causes significant distress and impairment in social, occupational, or other important areas of functioning, however, does not meet the full criteria for any of the other feeding and eating disorders. This category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific feeding and eating disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., emergency room setting).

Pica

Pica is characterised by persistent eating of nonnutritive, nonfood substances, which is inappropriate to the development level of the individual.

Rumination disorder

Rumination disorder is characterised by the repeated regurgitation of food. The repeated regurgitation cannot be associated with another medical condition or occur exclusively in the course of another eating disorder diagnosis.

People with higher weight and eating disorders

Higher weight (termed 'obesity' in a biomedical context) is not an eating disorder or mental disorder. While there is not one universally agreed-upon term for people with higher weight, the term 'people at higher weight' is recommended in place of 'overweight' or 'obesity' as people with a lived experience have indicated this as their preference (2).

People with higher weight are at increased risk of disordered eating compared with the general population, while people who use unhealthy weight-control practices (e.g. fasting, purging, and diet pills) are more likely to be at a higher weight. People with eating disorders are more than twice as likely to contact health professionals for weight-reduction assistance than they are to seek treatment specifically for their eating disorder.

GPs caring for people with higher weight should screen patients for eating disorders as well as being aware of the possible unintended negative consequences of dieting and weight-reduction strategies.

Prevalence

Approximately one million Australians are living with an eating disorder in any given year; that is, 4% of the population (3).

Prevalence of eating disorders by diagnosis

Of people with an eating disorder, 3% have anorexia nervosa, 12% bulimia nervosa, 47% binge eating disorder (BED) and 38% other eating disorders* (3).

Prevalence of eating disorders by gender

While females comprise approximately 80% of people with anorexia nervosa and 70% of people with bulimia nervosa, recent data suggests that the prevalence of BED may be nearly as high in males as in females (4).

Emerging research suggests transgender and non-binary people are at two to four times greater risk of eating disorder symptoms or disordered eating behaviours than their cisgender counterparts (5).

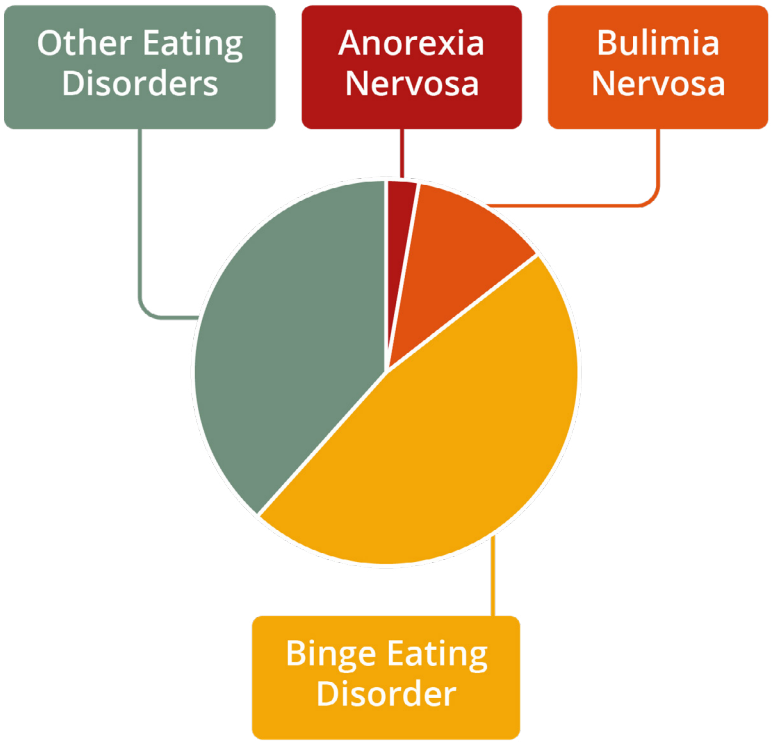

Figure 1: Prevalence of eating disorders by diagnosis

*Other Eating Disorders includes all other eating disorder diagnosis excluding anorexia nervosa, bulimia nervosa and BED.

Risk factors

Based on the known risk factors for eating disorders, high-risk groups and presentations have been identified. A patient presenting in these groups, or with these presentations, should lead the GP to screen for an eating disorder and, if required, conduct a comprehensive assessment.

High risk groups

People at a high risk of developing an eating disorder include:

- Females, especially during biological and social transition periods (e.g., onset of puberty, change in relationship status, pregnancy and postpartum, menopause, change in social role)
- Children and adolescents; although eating disorders can develop at any age, risk is highest for young men and women between 13 and 17 years of age (6)
- People engaging in competitive occupations, sports, performing arts and activities that emphasise thin body shape/weight requirements (e.g., modelling, gymnastics, horse riding, dancing, athletics, wrestling, boxing)
- Minority groups (e.g., LGBTQI+)

High risk presentations

People at a high risk of developing an eating disorder include presentations of individuals who:

- are seeking to **lose weight**
- are experiencing **weight loss**, intentional or unintentional
- are following a **diet** that limits energy intake, requires calorie counting or eliminates a food or food group
- are on restrictive diets due to food **intolerances or allergies** (e.g., coeliac disease, irritable bowel syndrome)
- are experiencing **comorbid conditions** that cause weight loss or gain/focus on body, weight, shape and eating (e.g., type 1 and type 2 diabetes, polycystic ovary syndrome, coeliac disease)
- are experiencing **mental health conditions** including anxiety and depression
- are experiencing **low self-esteem**
- are experiencing **substance misuse**
- have a history of **trauma**
- have current or historical experience of **food insecurity**
- have **perfectionist or compulsive personality traits**

Warning signs

There are several psychological, behavioural and physical signs or changes that may identify a patient is experiencing an eating disorder. A patient may present with no obvious signs and may appear well, although may have underlying eating disorder behaviours and be at medical or psychiatric risk.

Psychological

Psychological warning signs may include:

- Preoccupation with eating, food (including activities related to food), body shape and weight
- Intense fear of weight gain
- Heightened anxiety or irritability around mealtimes
- Feeling of being 'out of control' around food
- Disturbed body image
- Extreme body dissatisfaction/negative body image
- Rigid 'black and white' thinking (e.g., thoughts about food being 'good' or 'bad')
- Heightened sensitivity to comments or criticism (real or perceived) about body shape or weight, eating or exercise habits
- Depression, anxiety, non-suicidal self-injury, or suicidality
- Low self-esteem or shame (e.g., feelings of shame, guilt and self-loathing)
- Using food as self-punishment (e.g., refusing to eat due to depression, stress or other emotional reasons)

Physical

Physical warning signs may include:

- Sudden weight loss, gain or fluctuation
- In children and adolescents, an unexplained decrease in growth curve or body mass index (BMI) percentiles
- Sensitivity to the cold (e.g., feeling cold most of the time, even in warm environments)
- Delayed onset, loss or disturbance of menstrual periods
- Reduced morning tumescence
- Signs of frequent vomiting (e.g., swollen cheeks or jawline, calluses on knuckles, bad breath, damage to teeth)
- Lanugo – fine hairs covering the body or face
- Fatigue or lethargy
- Fainting or dizziness
- Hot flashes or sweating episodes
- Gastrointestinal disturbances with no clear cause (e.g., gastroesophageal reflux, bloating, constipation, nausea, early satiety)
- Cardiorespiratory complications (e.g., chest pain, heart palpitations, orthostatic tachycardia/hypotension, dyspnea, oedema)
- Osteoporosis or osteopenia

Behavioural

Behavioural warning signs may include:

- Constant or repetitive dieting behaviour (e.g., fasting, counting calories/kilojoules, skipping meals, avoidance of certain food groups, underdosing insulin if type 1 diabetes present)
- Evidence of binge eating (e.g., disappearance of large amounts of food, hoarding of food in preparation for binge)
- Evidence of vomiting or laxative use for weight-control purposes (e.g., frequent trips to the bathroom during or after meals, regular purchasing of laxatives)
- Compulsive or excessive exercise patterns (e.g., exercising in bad weather, continuing to exercise when sick or injured, failure to take regular rest/recovery days, and experiencing distress if exercise is not possible)
- Patterns or obsessive rituals around food, food preparation and eating (e.g., eating very slowly, cutting food into very small pieces, insisting that meals are served at a certain time, rigid repetitive meal content, inflexible use of crockery and cutlery)
- Changes in food preferences (e.g., claiming to dislike foods previously enjoyed, sudden preoccupation with 'healthy eating', or replacing meals with fluids)
- Avoidance of, or change in behaviour in social situations involving food (e.g., no longer eating family meals at home, bringing own food to social events, refusal of food in social settings)
- Avoidance of eating by giving excuses (e.g., claiming to have already eaten, claiming to have an allergy/intolerance to particular foods)
- Social withdrawal or isolation from friends and family (e.g., avoidance of previously enjoyed activities)
- Changes in behaviour around food preparation and planning (e.g., shopping for food, preparing meals for others but not consuming meals themselves, taking control of family meals)
- Strong focus on weight and body shape (e.g., interest in weight loss or muscle building, dieting or bulking books and magazines)
- Repetitive or obsessive body checking behaviours (e.g., pinching waist or wrists, repeated self-weighing, excessive time spent looking in the mirror)
- Changes in clothing style (e.g., wearing baggy clothes, wearing more layers than necessary for the weather)
- Covert or secretive behaviour around food (e.g., secretly throwing out food, hiding uneaten food, eating in secret)
- Inappropriate hydration behaviours (e.g., consuming little to no fluids, or consuming excessive fluids above requirements)
- Continual denial of hunger
- Making rigid food rules (e.g., lists of 'good' and 'bad' foods)

'Watchful waiting' should never be used in the management of eating disorders. Early identification and access to effective treatment prevents the eating disorder from becoming established and improves the course and prognosis.

Initial Response

Screening

Screening for eating disorders can and should be a part of any GP assessment as any patient, at any stage of their life, can be experiencing an eating disorder. Screening may involve a formal screening tool and/or a series of non-judgmental, unstructured questions.

Screening tools

There are several screening tools that can be used in the primary care setting to assist in the detection of eating disorders.

Screening tools are not diagnostic eating disorder tools, but rather, are used to detect the possibility of an eating disorder and identify when a comprehensive assessment is warranted. The Eating Disorder Screen for Primary Care (ESP) below can be used as a screening tool in primary care settings.

Eating Disorder Screen for Primary Care (ESP) (7)

1. Are you satisfied with your eating patterns?
2. Do you ever eat in secret?
3. Does your weight affect the way you feel about yourself?
4. Have any members of your family suffered with an eating disorder?
5. Do you currently suffer with, or have you ever suffered in the past, with an eating disorder?

- A 'no' to question 1. is classified as an abnormal response.
- A 'yes' to questions 2-5 is classified as an abnormal response.
- Any abnormal response indicates that the patient needs further assessment.

Assessment

An assessment for an eating disorder involves two stages:

1. **Assessment of medical and psychiatric risk**
2. **Comprehensive assessment**
    a. **Medical assessment**
    b. **Assessment of eating disorder symptoms and severity**
    c. **Mental health assessment**

1. Assessment of medical and psychiatric risk

The **first priority** in assessing a patient for a possible eating disorder is securing medical and psychiatric safety. This step must be completed immediately following screening, at the initial session with the GP.

Admission to hospital is indicated if a patient is at imminent risk of serious medical or psychiatric complications. Indicators for hospital admission for adults, adolescents and children are outlined in the Royal Australian and New Zealand College of Psychiatrists (RANZCP) clinical practice guidelines for the treatment of eating disorders.

The initial assessment of medical and psychiatric risk should include physical assessment and diagnostic tests, as well as a mental health risk assessment.

To assess medical and psychiatric risk, refer to the RANZCP clinical practice guidelines and/or the guidelines for admission and management available in your region.

2. Comprehensive assessment

a. Medical assessment

Physical assessment

- Measurement of height, weight, and determination of body mass index; record weight, height and BMI on growth charts for children and adolescents
- Sitting and orthostatic heart rate and blood pressure
- Body temperature
- Hydration status (e.g., poor skin turgor, slow capillary return)
- Assessment of skin, hair and nails (e.g., brittle nails, carotenaemia (orange discolouration), dry skin, lanugo hair, callused knuckles)
- Oral examination (e.g., dental erosions, gingivitis, pharyngeal redness and parotid enlargement)
- Assessment of breathing and breath (e.g., ketosis)
- Examination of periphery for circulation and oedema
- Gastrointestinal function (e.g., bloating, pain, constipation, diarrhoea)
- Menstrual history (e.g., menarche, last menstrual period, regularity, oral contraceptive use, oral contraceptive use that may be masking the impact of eating disorder on menstrual status)

Laboratory investigations

- **Blood tests**
  - Full blood count
  - Electrolytes, urea, creatinine
  - Liver enzymes or liver function test
  - Iron studies
  - B12, folate
  - Calcium, magnesium, phosphate
  - Hormonal testing – thyroid function tests, follicle stimulating hormone, luteinising hormone, oestradiol, prolactin
  - Blood glucose
- **Electrocardiography**
  - Electrocardiography – recommended for all patients to provide accurate cardiovascular results.
- **Bone densitometry**
  - Bone densitometry – relevant after 9-12 months of the disease or of amenorrhoea, and as a baseline in adolescents. The recommendation is for two-yearly scans thereafter while the DEXA scans are abnormal
- **Other tests**
  - Urinalysis
  - Plain X-rays – useful for identification of bone age in cases of delayed growth

b. Assessment of eating disorder symptoms and severity

The assessment of eating disorder symptoms and severity can be completed using the Eating Disorders Examination Questionnaire (EDE-Q).

The EDE-Q is a self-report questionnaire providing a measure of the range and severity of eating disorder behaviours. It is not a diagnostic tool, however, information from the EDE-Q can assist in forming an opinion on diagnosis, and the patient's answers can form useful prompts for further investigation.

The EDE-Q is a compulsory component of the Medicare Benefits Schedule (MBS) Eating Disorders Plan (EDP) for all eating disorders except anorexia nervosa. A patient must have an EDE-Q global score of greater than 3 to be eligible for an EDP.

The EDE-Q can be completed online with automated scoring and in print format.

c. Mental health assessment

The mental health assessment should include:

- psychiatric history including previous treatments, comorbidities and substance use
- family history of mental illness and/or eating disorders
- social and support context (e.g., living situation, support network including relationship with family, friends or spouse, school or work)
- a mental-state examination.

Diagnosis

Completing the three stages of the comprehensive assessment should enable the GP to provide an opinion on diagnosis. An eating disorder is diagnosed using the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) diagnostic criteria.

Treatment Pathways using Medicare Benefits Schedule (MBS)

Rapid access to effective treatment prevents the eating disorder from becoming established and improves the course and prognosis. 'Watchful waiting' should never be used in the management of eating disorders.

When referring under the MBS, GPs should complete the appropriate plan and refer to a mental health professional and, when indicated, a dietitian. A medical and a mental health professional working collaboratively constitute the minimum team for community eating disorder treatment. A referral to a dietitian should be completed when a patient experiencing an eating disorder requires nutrition education and support for effective treatment and recovery.

Referral using MBS can occur through an **Eating Disorders Plan (EDP)** or a **Mental Health Care Plan (MHCP)** and/or a **Chronic Disease Management Plan (CDMP)**. GPs should consider the best match for the patient's needs in the stepped system of care.

Eating Disorder Plan (EDP)

On 1 November 2019, the Australian Government introduced a suite of new MBS eating disorder items to support an evidence-based, best practice model of treatment for people with anorexia nervosa and other eligible patients with eating disorders. The changes are relevant for medical practitioners (including GPs, psychiatrists and paediatricians), and eligible psychologists, occupational therapists, social workers and dietitians. The information in this resource is sourced from the Quick Reference Guide for Eating Disorder MBS items.

To complete an EDP for an eligible patient, a GP can use the InsideOut Institute Eating Disorders Care Plan template.

What the EDP covers

Patients eligible for the EDP will be able to access comprehensive treatment and management services for a 12-month period, including:

- up to 40 eating disorder psychological treatment (EDPT) services
- up to 20 dietetic services
- review and ongoing management services to ensure that the patient accesses the appropriate level of intervention.

Eligibility for EDP

There are two cohorts of eligible patients who can access EDPs:

1. Patients with a clinical diagnosis of anorexia nervosa; or
2. Patients who meet the eligibility criteria (below) and have a clinical diagnosis of bulimia nervosa, binge eating disorder (BED) or other specified feeding and eating disorders (OSFED).

Patients with anorexia nervosa are eligible without any further criteria needing to be met. The eligibility criteria that need to be met for a patient with a clinical diagnosis of bulimia nervosa, BED and OSFED, are:

- EDE-Q scores ≥ 3 **and**
- The condition is characterised by rapid weight loss, or frequent binge eating, or inappropriate compensatory behaviour as manifested by 3 or more occurrences per week **and**
- Two of the following indicators are present:
  - clinically underweight with a body weight less than 85% of expected weight where weight loss is directly attributable to the eating disorder
  - current or high risk of medical complications due to eating disorder behaviours and symptoms
  - significant functional impairment resulting from serious comorbid medical or psychological conditions
  - admission to a hospital for an eating disorder in the previous 12 months
  - inadequate treatment response to evidence-based eating disorder treatment over the past 6 months despite active and consistent participation.

Mental Health Care Plan (MHCP)

A person who does not meet the criteria for an EDP can still receive up to 20 sessions of psychological treatment from a mental health professional under a MHCP (also known as the Better Access Initiative). Support is available through eligible psychologists, social workers, occupational therapists, GPs, and other medical practitioners.

The rebate is available to people with a diagnosed mental disorder, such as an eating disorder, or comorbid conditions such as depression and anxiety. Someone experiencing disordered eating alongside a diagnosed mental disorder can also access treatment under the Better Access Initiative.

A MHCP can be created by a GP and a referral made to an eligible treatment provider. After six sessions, the mental health professional must report back to the referring medical practitioner on the progress of treatment. The referring practitioner determines the need for further services and can re-refer for the remainder of the available psychological sessions.

An MHCP may also be considered as a support option for family and supports to manage their own mental health needs.

For more information on MHCPs see MBS factsheet for Practitioners and MBS Online.

Chronic Disease Management (CDM) Plan

CDM Plans are available for people living with chronic medical conditions and who require multidisciplinary, team-based care from a GP and at least two other health or care providers. This includes complex needs which may or may not be associated with an eating disorder. In some cases, it may be appropriate for management of a medical condition to be provided under a CDM and treatment for an eating disorder provided under an EDP. In this case, both plans and items can be used.

A CDM is developed and managed by a GP and this type of plan enables a GP to plan and coordinate the multidisciplinary care team and treatments.

For more information on CDM Plans see Services Australia.

Shared Care

Stepped system of care for eating disorders

The stepped system of care for eating disorders delivers evidence-based services that increase or decrease in intensity according to a person's changing psychological, physical, nutritional and functional needs.

GPs play a key role throughout all levels of the system of care for eating disorders. By understanding the stepped system of care for eating disorders and being informed about services available locally, regionally and online, GPs can support patients across the continuum of care, to access the right treatment at the right time.

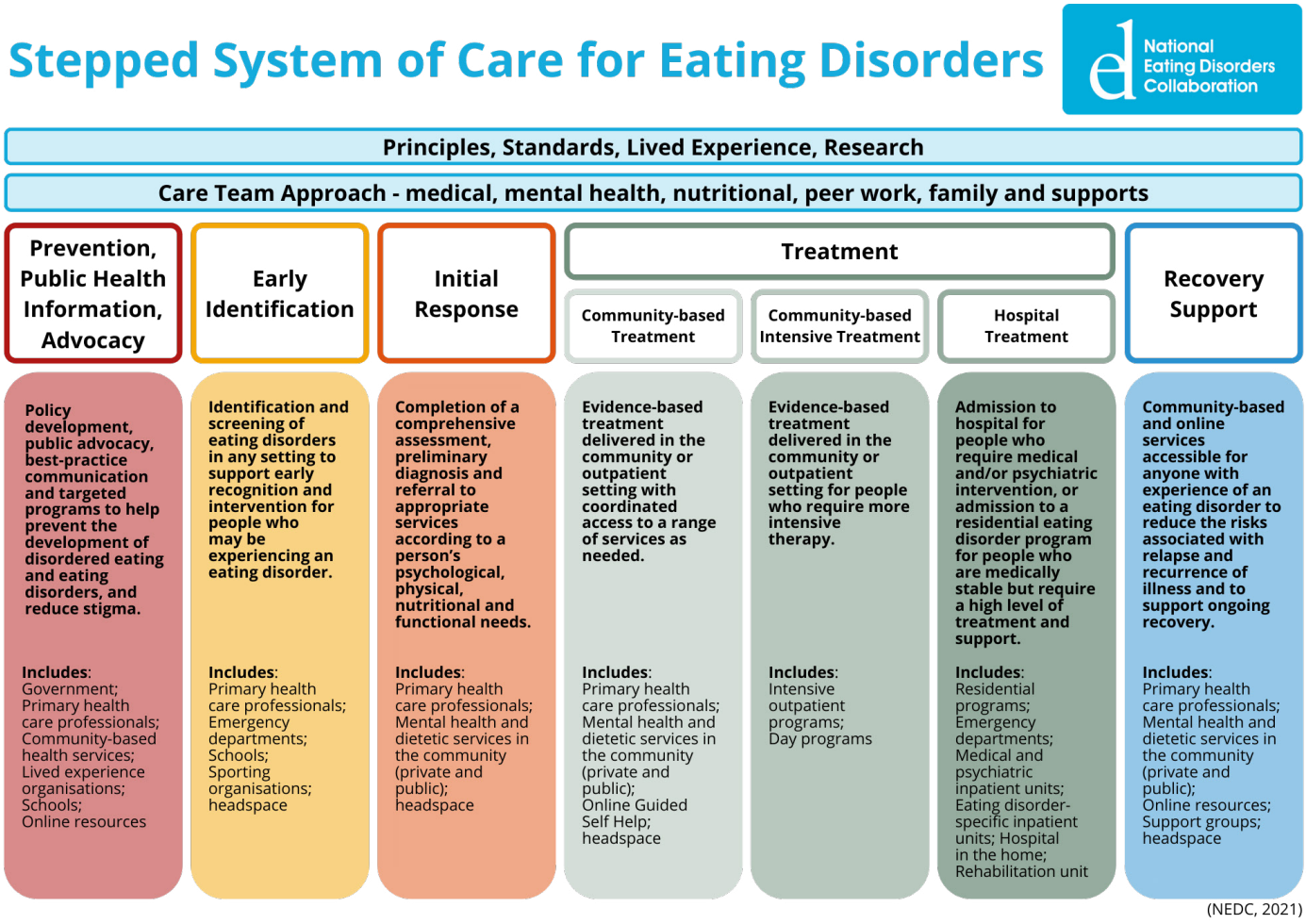

Figure 2: Stepped system of care for eating disorders

Support and treatment services

Support and treatment services are vital to the care and recovery of the patient experiencing an eating disorder. The eating disorder services available within Australia will differ from region to region.

There are several databases that can be used by GPs to identify potential referral options for patients experiencing an eating disorder. These databases can also be used by clinicians, patients/clients, and families and supports.

Depending on your region, you may also be able to locate support and treatment services through local mental health services, national and state-based eating disorder services, and lived experience organisations.

Butterfly National Helpline

Butterfly National Helpline has a practitioner database which is available for clinicians, patients, and families and supports. This screened database includes services and practitioners across all levels of the system of care throughout Australia. Click here for more information and to access the Butterfly National Helpline.

Australia & New Zealand Academy for Eating Disorders (ANZAED) Directory

ANZAED has a database of members which includes clinicians. The database can assist clinicians, patients, and families and supports to find appropriate referrals. Click here for more information and to access the ANZAED Directory.

National Eating Disorders Collaboration (NEDC) Service Locator

NEDC has a service locator which includes eating disorder support organisations and treatment services across Australia. Click here for more information and to access the NEDC Service Locator.

InsideOut Institute's Treatment Services Database

InsideOut Institute's Treatment Services Database can assist clinicians, patients, and families and supports to find private practitioners, community clinics or programs, day programs, in-hospital treatment and support groups. Click here for more information and to access InsideOut Institute's Treatment Services Database.

Eating Disorders Victoria (EDV) Hub

EDV Hub is a free and confidential service providing referral options to clinicians, patients, and families and supports. Click here for more information and to access the EDV Hub.

Primary Health Networks (PHNs)

PHNs improve access to primary care services and the coordination of care. PHNs may be able to direct clinicians to local support and treatment options. Click here to find the contact information of your local PHN.

HealthPathways

HealthPathways is a free, online health information portal for health professionals to help assess, manage and initiate referrals. Some PHN regions have eating disorder-specific HealthPathways. Click here for more information and to access HealthPathways.

The care team

The care team consists of the person living with an eating disorder and all people who will be involved in providing care, support, and/or treatment. Click here for more information on the care team.

The treatment team

The treatment team is a part of the care team and includes the health professionals and lived experience workforce involved in eating disorder treatment.

Eating disorders require a multidisciplinary team approach, and the treatment team works together to ensure the patient's needs are addressed across medical, psychological, nutritional and functional domains.

The community treatment team is centred around the patient and should be respectful of and responsive to the patient's specific health needs, preferences and values.

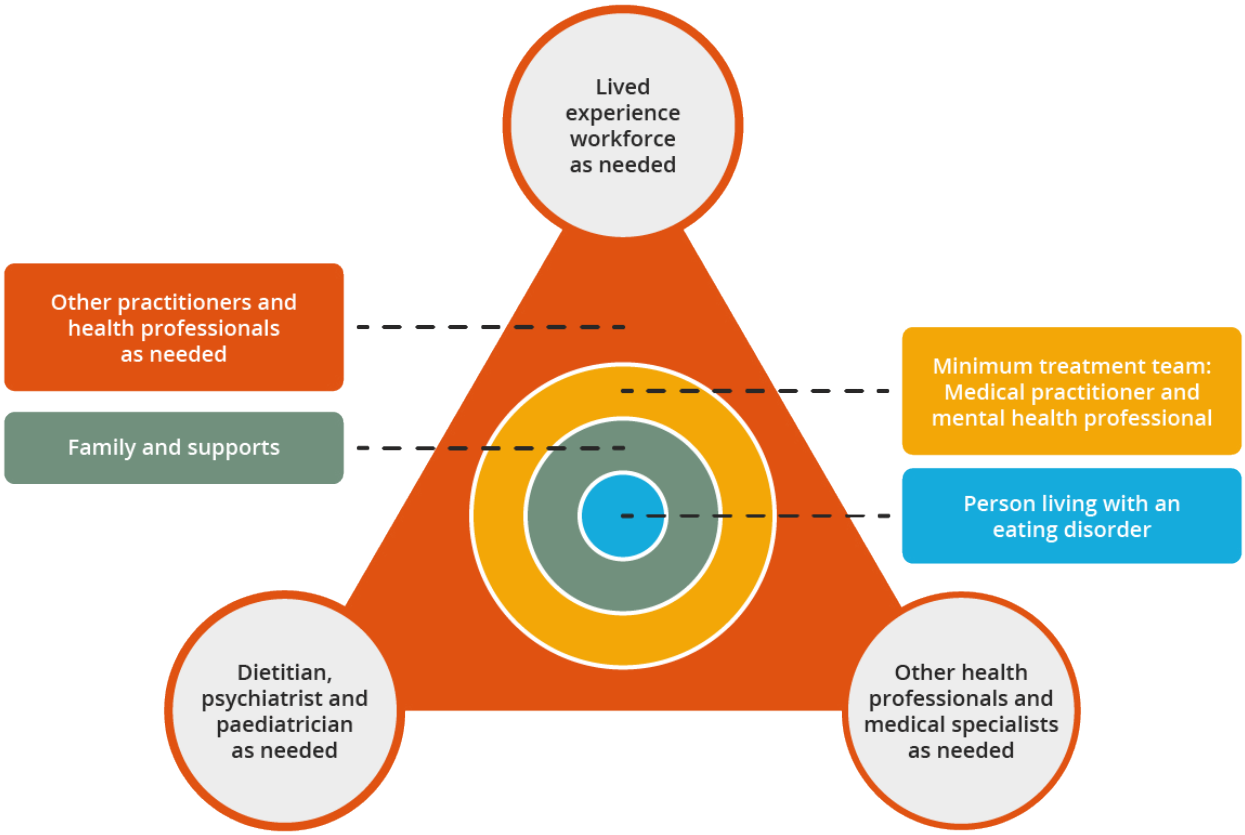

Figure 3: The care team

The minimum treatment team

The minimum treatment team in the community must include a medical practitioner and a mental health professional.

Medical practitioner

A medical practitioner could be a GP, paediatrician, physician, psychiatrist, or other qualified medical practitioner who is able to provide treatment and management of the physical symptoms of the eating disorder. This includes medical monitoring and treatment of medical complications associated with eating disorders. monitoring medical status, and sometimes prescribing medications.

GPs are often the first point of contact for a person experiencing disordered eating or an eating disorder and their families and supports. They are well positioned to provide medical care and treatment to a patient with an eating disorder.

Mental health professional

A mental health professional is an umbrella term for those professions that can provide psychological support and evidence-based psychological treatment for people experiencing an eating disorder. These professions include psychologists, social workers, occupational therapists, psychiatrists, counsellors, mental health nurses, nurse practitioners, and psychotherapists.

Other health and medical professionals

Other health and medical professionals may be involved in the treatment team as the key medical practitioner, the mental health treatment provider, or as a member of the broader treatment team including allied health. These include:

- Dietitians
- Psychiatrists
- Paediatricians
- Psychologists
- Social workers
- Occupational therapists
- Counsellors and psychotherapists
- Nurses
- Exercise physiologists
- Physiotherapists
- Speech pathologists
- Endocrinologists
- Gastroenterologists
- Cardiologists
- Nephrologists
- Physicians

Lived experience workforce

The lived experience workforce includes peer workers or lived experience workers who draw on their lived experience and knowledge of recovery from an eating disorder to help others achieve improved recovery outcomes.

Family and supports

Families, carers and supports play a crucial role in the care, support and recovery of people experiencing an eating disorder.

While the patient remains the centre of the care team, family and supports may be involved in decision making and should have their preferences and values respected.

Unless there are contraindications, or the adult person is opposed, GPs should partner with patients to ensure that family and/or supports are enlisted as allies during the assessment and treatment process. For children and adolescents, the involvement of family is crucial.

Family and/or supports can play an essential role by:

- helping the patient access treatment
- providing additional information throughout the assessment and progress reviews
- supporting the patient through the challenges of recovery.

Resources for family and supports

Supporting and caring for a loved one experiencing an eating disorder can be a challenging time for family and supports.

There are many helpful, practical and empowering resources available for the family and supports of a patient experiencing an eating disorder, and some of these resources have been outlined below.

Services and support

Butterfly Helpline

Eating Disorders Victoria (EDV)

The Victorian Centre for Excellence in Eating Disorders (CEED)

Eating Disorders Families Australia (EDFA)

Resources

Families Empowered and Supporting Treatment for Eating Disorders (F.E.A.S.T.)

Feed Your Instinct (FYI)

Centre for Clinical Interventions (CCI)

Mental Health First Aid Australia – Eating Disorder First Aid Guidelines

Treatment

Medical care

Medical monitoring and treatment of medical complications associated with the eating disorder are essential for all patients.

Medical monitoring

The GP plays a key role in the medical monitoring for a patient experiencing an eating disorder.

Refer to the CEED Medical Monitoring in Eating Disorders resource for more information on medical monitoring.

Medical monitoring includes:

Laboratory investigations

- Pathology
  - Full blood count
  - Electrolytes
  - Urea, creatinine
  - eGFR
  - Albumin
  - Liver enzymes
  - Iron studies, B12, folate, thiamine, vitamin D
  - Calcium, magnesium, phosphate
  - Blood glucose
  - FSH, LH, Oestradiol and progesterone in females
  - Testosterone in males
- Electrocardiography
  - Recommended for all patients to provide accurate cardiovascular results
- Bone densitometry
  - Recommended after 9-12 months of the disease or of amenorrhoea, and as a baseline in adolescents

Physical assessment

- Vital signs
  - Sitting and orthostatic heart rate
  - Sitting and orthostatic blood pressure
  - Body temperature
- Anthropometry
  - Height, weight, BMI, % of change in body weight
  - Record weight, height and BMI on growth charts for children and adolescents
- Menstrual function
  - Age of menarche
  - Frequency and quality of menses

Assessment of eating disorder symptoms

- Food intake
- Fluid intake
- Compensatory behaviours

Managing a patient awaiting treatment

A GP may be required to manage a patient who is awaiting eating disorder treatment.

When a patient is awaiting treatment, the GP's role includes:

- scheduling regular reviews for ongoing medical monitoring
- provision of nutrition and mental health support in scope of role as GP
- referral to eating disorder education and online support
- referral to Butterfly National Helpline and state-based services where available
- engaging and educating family and supports, as appropriate, to provide support

Nutrition support

Nutritional care is essential for medical stabilisation and nutrition rehabilitation in the treatment of a patient with an eating disorder.

The GP can provide nutrition support to a patient by encouraging a regular and normalised nutritional intake and eating behaviours.

In some cases, a referral may be made to an accredited practising dietitian when a patient experiencing an eating disorder requires nutrition education and support for effective treatment and recovery.

There are several evidence-based nutritional interventions that GPs can use to help guide patients with their nutritional intake and build a positive relationship with food:

Regularity, Adequacy, Variety, Eating Socially and Spontaneity (RAVES) eating model

RAVES (8) is an evidence-informed eating disorder treatment framework. RAVES provides a step-by-step guide to support the development of positive food relationships through combining science and personal values. It can be applied across all eating disorder diagnoses. The RAVES framework involves five stages including:

- Regularity
- Adequacy
- Variety
- Eating socially
- Spontaneity

The Recovery from Eating Disorders for Life (REAL) Food Guide

The REAL Food Guide (9) is an evidence-based, user-friendly guide that can be used by clinicians to educate patients about components of a balanced and healthy lifestyle.

It is designed specifically for people in recovery from eating disorders. This meal planning guide can be used to ensure a patient's energy and nutritional requirements are met, and important nutrition education messages are reinforced.

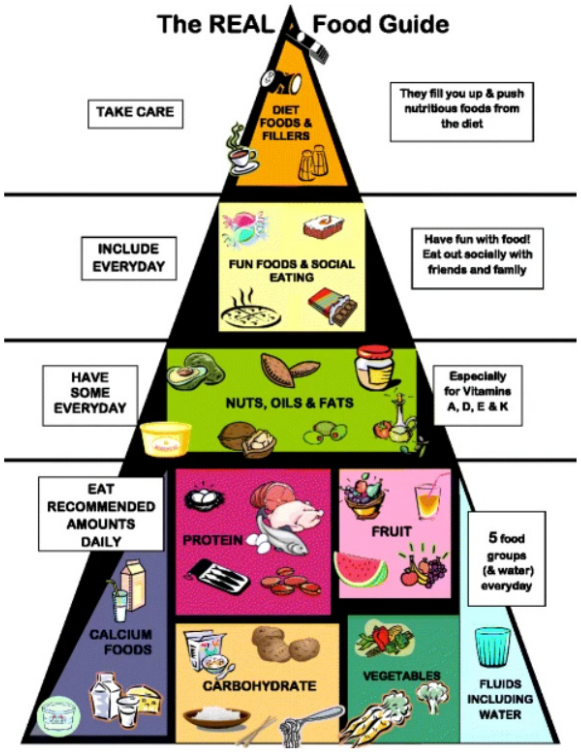

Figure 4: The REAL Food Guide (9)

Mental health support

Evidence-based psychological therapies are a fundamental component of eating disorder treatment. Delivering mental health intervention early in the course of illness provides the best chance of a full recovery from an eating disorder.

The mental health intervention will be delivered by a mental health clinician, such as a psychologist, with eating disorder training and skills. In one exception to this, GPs who have completed an appropriate Focused Psychological Strategies (FPS) program may train in and deliver Cognitive Behaviour Therapy Guided Self-Help (CBT-GSH) to their patients.

The role of the GP in providing mental health support

While the mental health clinician will deliver the evidence-based psychological treatment, GPs continue to play an important role in providing mental health support to the patient. Many patients find their GP an important source of support throughout the treatment journey.

GPs have the unique role of being a consistent member of the treatment team despite the patient stepping up or down to different services within the system of care. This continuity of care inspires trust and confidence, contributing to a strong therapeutic relationship and patient engagement.

Continuing to listen with understanding and presenting in a warm, considerate and non-judgmental manner are fundamental to building and maintaining rapport and providing ongoing care.

Recovery Support

Recovery support

The course of eating disorder recovery is different for everyone. Recovery tends to be a process that takes time and is often characterised by periods of progress and relapse. For some people, recovery is an ongoing process while for others recovery means an end to all eating disorder thoughts, symptoms and behaviours.

GPs have an integral role in providing ongoing recovery support to a patient who has experienced, or is experiencing, an eating disorder and this may continue even after the patient has ceased treatment with other professionals.

The GP's role in recovery support may include:

- monitoring for signs of relapse
- ongoing review and medical monitoring as clinically appropriate
- providing information and resources
- re-referral to the treatment team for ongoing support as required
- referral to support groups
- referral to intensive or inpatient treatment as required

This booklet has provided you with information about the role of the GP in identifying, responding, and managing eating disorders in general practice.

For more in-depth information about the topics covered in this booklet, as well as an interactive learning experience that includes videos, resources and activities, access NEDC's free online training **Eating Disorder Core Skills: eLearning for GPs** here.

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info@nedc.com.au
www.nedc.com.au

National Eating Disorders Collaboration

Evidence Experience Expertise