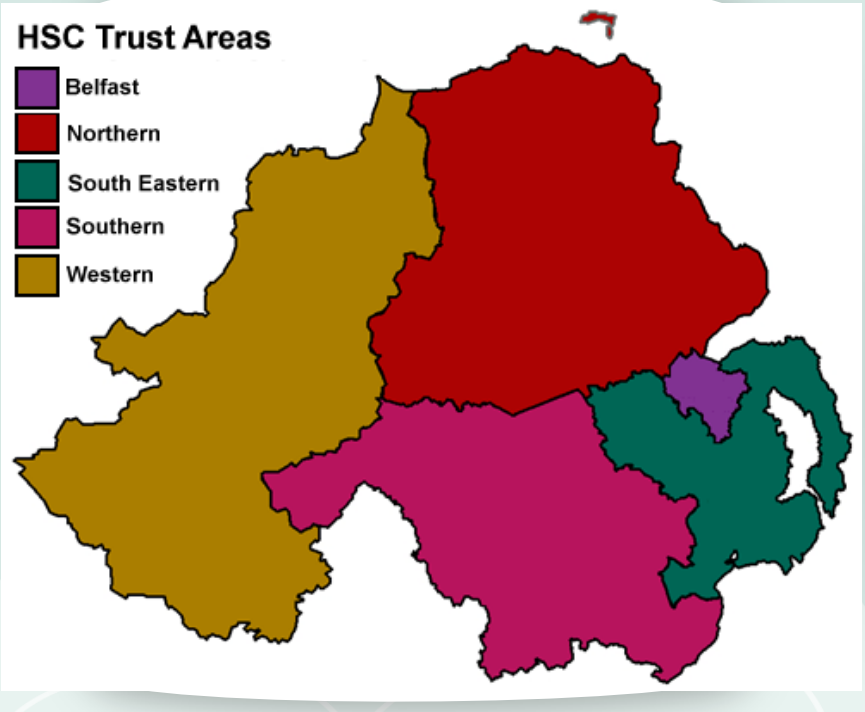
Eating Disorder Youth Service

EDYS

Our Mission

EDYS has been commissioned to deliver a specialist Step 3 outpatient service for children and young people, between the ages of 10 and 18 years, with a primary eating disorder.

EDYS provides specialist multi-disciplinary assessment and intervention for young people between the ages of 10 and 18 years, and consultation for young people aged less than 10 years, with a primary eating disorder, namely Anorexia Nervosa, Bulimia Nervosa and Other Specified Feeding or Eating Disorder (OSFED). Throughout assessment and intervention EDYS will build alliance and work collaboratively with the young person and family.



Patients seen from both South Eastern and Belfast Health and Social Care Trusts

HSC Belfast Health and Social Care Trust
caring supporting improving together

HSC South Eastern Health and Social Care Trust

Belfast Trust patients please send directly to Beechcroft.

South Eastern Trust patients refer via SPOE.

Where do we get referrals from?

- GP
- School nurses
- Dietitians
- Medical staff or Paediatricians on wards
- Mental health staff
- CAMHS step 3 non specialist
- Primary mental health or Special registrar

Service Objectives

- To provide a comprehensive eating disorder assessment with diagnosis for healthy outcomes to young people and families within a broad holistic/ systemic context.
- To offer family based interventions and support to young people and their families, building on strengths and assisting the young person and family to understand and manage the acute needs at home.
- To create a friendly, non– judgemental, culturally sensitive and welcoming atmosphere, that is responsive to diversity and difference.
- Actively involve child/ young person parents/ carers in assessment and interventions.
- Complete a comprehensive risk assessment as clinically indicated.

What is the criteria for the Eating Disorder Youth Service?

- The Eating Disorder Youth Service accepts referrals for
  - Anorexia Nervosa
  - Atypical Anorexia Nervosa
  - Bulimia Nervosa
  - Atypical Bulimia Nervosa

- EDYS is not currently funded for
  - Disordered eating
  - ARFID
  - ASD associated disordered eating

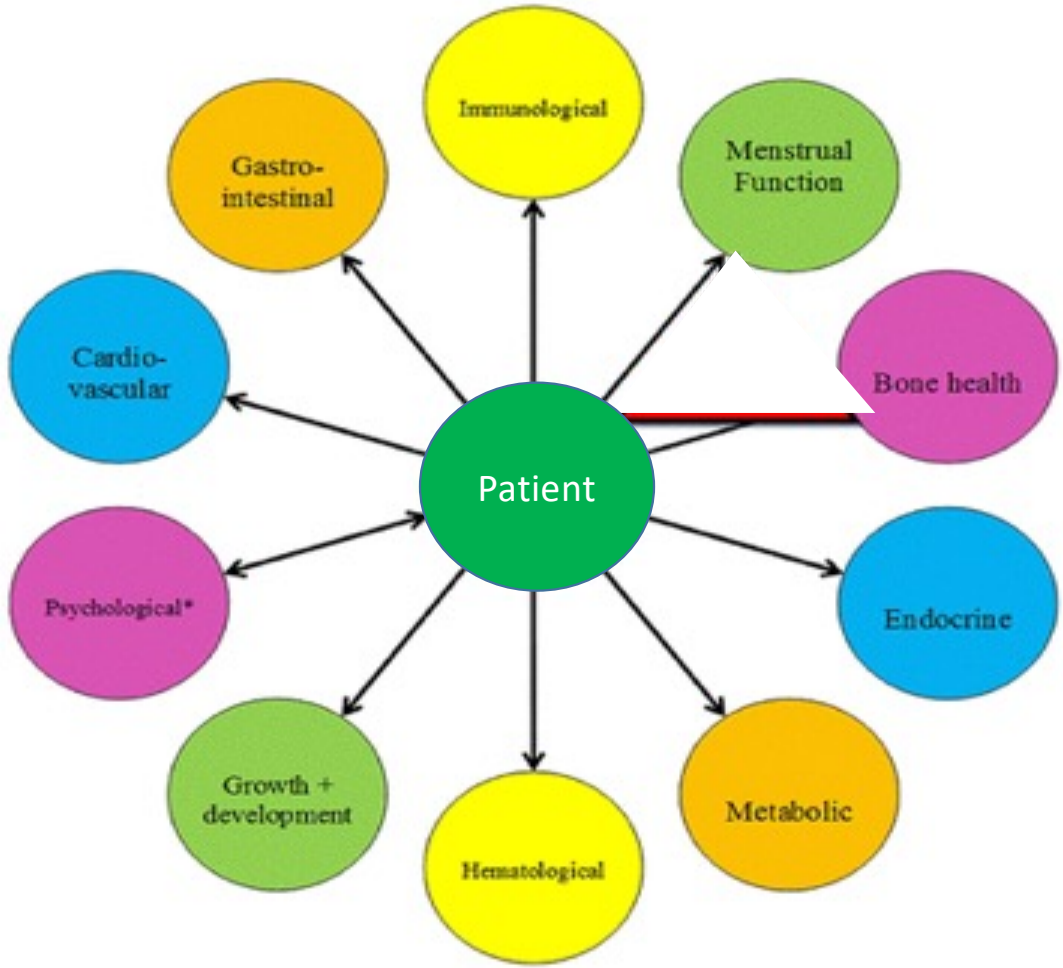
Anorexia Nervosa

- Lose weight rapidly/avoid weight gain in context of what is expected for age, sex, physical health.
- Methods include: restricting diet, restraining from eating specific foods, excessive exercising, self-induced vomiting, laxative abuse
- Usually a combination of the above
- Intense fear of weight gain or being fat
- Preoccupation with weight/shape/food/eating
- Abnormal cognitions regarding weight and shape – distorted body image

Bulimia Nervosa

- Recurrent episodes of binge eating, experience a sense of loss of control
- Attempts to avoid weight gain by self-induced vomiting, laxative abuse, diuretic abuse or excessive exercise
- Repeated episodes of bingeing and purging
- Weight may be within normal range
- Shape and weight concerns are core features

Potential areas to identify an eating disorder



When assessing for an eating disorder or deciding whether to refer people for assessment, take into account any of the following that apply: (from NICE)

- an unusually low or high body mass index (BMI) or body weight for their age
- rapid weight loss
- dieting or restrictive eating practices (such as dieting when they are underweight) that are worrying them, their family members or carers, or professionals
- family members or carers report a change in eating behaviour
- social withdrawal, particularly from situations that involve food
- other mental health problems
- a disproportionate concern about their weight or shape (for example, concerns about weight a side effect of contraceptive medication)

- problems managing a chronic illness that affects diet, such as diabetes or coeliac disease
- menstrual or other endocrine disturbances, or unexplained gastrointestinal symptoms
- physical signs of:
- malnutrition, including poor circulation, dizziness, palpitations, fainting or pallor
- compensatory behaviours, including laxative or diet pill misuse, vomiting or excessive exercise
- abdominal pain that is associated with vomiting or restrictions in diet, and that cannot be fully explained by a medical condition
- unexplained electrolyte imbalance or hypoglycaemia
- atypical dental wear (such as erosion)
- whether they take part in activities associated with a high risk of eating disorders (for example, professional sport, fashion, dance, or modelling).

Assessment process

- Multidisciplinary assessment which includes 2 specialist therapists and specialist dietetics.
- Assessment may take 2-3 appointments.
- All assessments include:
  - Eating Disorder Examination (EDE edition 16.0d), Becks, CAMHS assessment, FACE risk assessment
  - Individualised dietetic assessment and initial treatment plans
  - Baseline clinical observations e.g. Weight for Height ratio
  - Diagnosis (following EDE and team discussion)
    - Anorexia Nervosa, Bulimia Nervosa, Other Specified Feeding or Eating disorder (OSFED), No diagnosis.

Treatment offered

- 5 step model of change (Bryant-Waugh 2006)
- CBT and CBT-E techniques (Fairburn/ Waller)
- Family support – Maudsley approach(Lock 2013)
- Body image – Waller et al 2008
- Specialist dietetics
- Psychiatric reviews

Nice Guidelines - Treatment

- NICE recommends that children and teens are treated with a family-based therapy approach for anorexia and bulimia.

- CBT (Cognitive Behavioural Therapy) is the next choice for anorexia and bulimia.

- FBT is family therapy that is focused on anorexia, as opposed to a more general form of family therapy where the focus might be on improving how family members interact with each other. What is key, in FBT for Anorexia Nervosa, is that parents are central to delivering the treatment

- NICE makes it clear that weight gain comes first:

"When treating anorexia nervosa, be aware that:

- helping people to reach a healthy body weight or BMI for their age is a key goal
- weight gain is key in supporting other psychological, physical and quality of life changes that are needed for improvement or recovery."

The Nice guideline for the treatment of bulimia in under-18s is the same as the first two preferred options for anorexia:

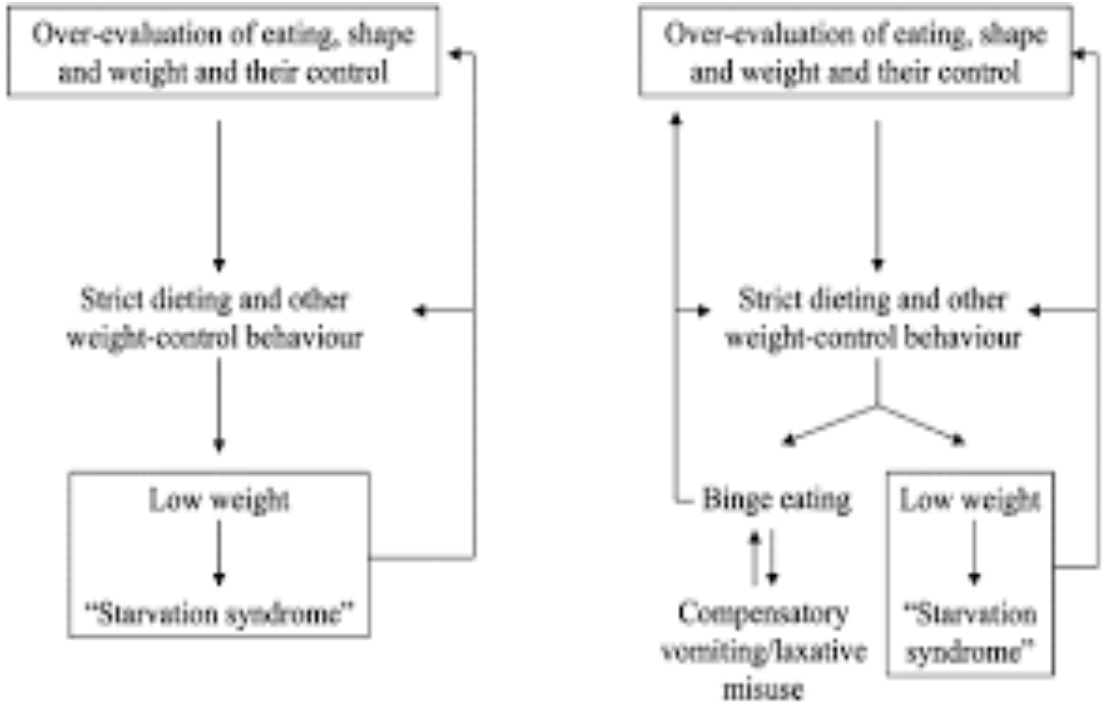
- bulimia-nervosa-focused family therapy (FT-BN)
- and if that is "unacceptable, contraindicated or ineffective", consider individual eating-disorder-focused cognitive behavioural therapy (CBT-ED)

Family therapy for bulimia is similar to family therapy for anorexia, except that right from the start of treatment there's more scope for dialogue and cooperation with the sufferer.

The Maudsley Approach

- Method of family based treatment for adolescents with anorexia, pioneered by Maudsley Hospital, London
- Applied to adolescents 18 and under who are living at home with their families, and attend outpatient eating disorder service
- Maudsley opposes opinion that families are not or to blame for development of eating difficulties but are a resource and essential in the successful treatment of it.
- **PHASE ONE** – Weight Restoration
- **PHASE TWO** – Returning control over eating to the adolescent
- **PHASE THREE** – Establishing healthy adolescent identity
- Family based treatment can prevent hospitalisation and assist in the adolescents recovery, with resourceful parents playing an active role together with the MDT

Overview of CBT-E Model for AN



Tips for engaging a young person with an Eating Disorder

- Firstly you want to communicate with young person – not their eating disorder. The eating disorder is in control, this is why they have come to services. Try to hold the image of 2 separate positions
- At the beginning of the therapeutic relationship we will hear the ED long before we will hear the young person engaging in conversation.
- Position – to have any conversation with young person – sit beside him/her. This young person is horrified by how they look, so the practitioner engaging in long eye contact is because practitioner finds them disgusting. This is the belief that the ED has created.
- Verbal – think about how you use language- find statements that you can here yourself saying " I know your ED doesn't like me but I want to help you" " I know your ED is telling you not to trust me, but I don't trust any ED "
- Young person with ED strive for " perfection" but this is unattainable – so they keep striving never to achieve. Good enough is much more achievable.

- Always be firm but fair – stick to the meal plan: food is the medicine
- Empower parents- they have fed their child from birth, they can do it again. Try to get them to position themselves with their child, not ED. They are the experts of their child.

Useful material

- Eva Musby – www.anorexiafamily.com
- Help Your Teenager Beat an Eating Disorder – James Lock and Daniel Le Grange
- Skills-based Learning for Caring for a Loved One with an Eating Disorder – The New Maudsley Method
- Centre for Clinical Interventions – www.cci.health.wa.gov.uk