Everyone Has a Role
An introduction to the identification and treatment of eating disorders

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Part of the NSW Workforce Development and Training for Eating Disorders
Overview

- Eating disorders as core business
- Background and diagnosis
- Living with an eating disorder
- Screening & identification
- Assessment & risk management
- Treatment options
- Providing person-centred care
- Support for clinicians: local & statewide
- Resources and references
No question is too big or silly!

We are all here to learn from each other
What are eating disorders?

“All of these people suffer from a serious, life-threatening Eating Disorder.”

Image credit:
https://www.google.com.au/search?q=image+eating+disorders&espv=2&biw=1920&bih=950&source=lnms&tbm=isch&sa=X&ved=0ahUKEwi6md6ArOPQAhVBTy8KHcPGRiIQ_AUIBigB#imgrc=LbjQuV5mqaELxM%3A
NSW Health response to eating disorders

- Eating disorders are core business for the health system
- Whole of health concern and responsibility
- Treatment needs to be integrated into existing services
- Building workforce capacity is a key part of the Service Plan
- A Local Service Plan has been developed by each LHD/SN
# Eating Disorders: DSM-V

<table>
<thead>
<tr>
<th>ANOREXIA NERVOSA (AN)</th>
<th>BULIMIA NERVOSA (BN)</th>
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</thead>
<tbody>
<tr>
<td>• Restriction of energy intake, leading to significantly low body weight</td>
<td>• Recurrent episodes of binge eating characterised by:</td>
</tr>
<tr>
<td>• Intense fear of gaining weight or becoming fat, or persistent behaviour that interferes with weight gain (even though severely underweight)</td>
<td>○ Eating, in a discrete period of time (2 hours), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances</td>
</tr>
<tr>
<td>• Disturbance in the way one’s weight or shape is experienced, undue influence of body weight and shape on self-evaluation.</td>
<td>○ A sense of lack of control during these episodes</td>
</tr>
<tr>
<td>• Subtypes: Binge-purge &amp; restrictive</td>
<td>• Recurrent episodes of compensatory behaviours to prevent weight gain (e.g. self-induced vomiting, laxatives, diuretics, fasting or excessive exercise etc)</td>
</tr>
<tr>
<td></td>
<td>• Binge/purge at least once per week, for 3 months</td>
</tr>
<tr>
<td></td>
<td>• Self evaluation unduly influenced by body weight and shape</td>
</tr>
</tbody>
</table>
## Eating Disorders: DSM-V

<table>
<thead>
<tr>
<th>ARFID (Avoidant Restrictive Food Intake Disorder)</th>
<th>OSFED (Other Specified Feeding or Eating Disorder)</th>
</tr>
</thead>
</table>
| • A feeding or eating disturbance that is associated with one (or more) of the following:  
  o Significant weight loss or failure to achieve expected weight gain or growth  
  o Significant nutritional deficiency  
  o Dependence on enteral feeding or oral nutritional supplements  
  o Marked interference with psychosocial functioning  
  
• The feeding or eating may take one of the following forms:  
  o Lack of interest in eating food  
  o Avoidance based on sensory characteristics of food  
  o Concern about aversive consequences of eating food e.g. choking or vomiting  
  
• No disturbance re: body weight or shape  | • Symptoms do not meet the full criteria for any other eating disorder but do cause clinically significant distress or impairment in areas of functioning (e.g. social, occupational etc)  
  
• EXAMPLES  
  o **Atypical Anorexia Nervosa** - All criteria for An are met, except individuals weight is within or above normal range (despite significant weight loss)  
  o **Bulimia Nervosa** (low frequency or limited duration) - all of the criteria for BN are met, except that the binge eating and compensatory behaviours occur less than once per week, or for less than three months. |
# Eating Disorders: DSM-V

## Binge Eating Disorder (BED)
- Recurrent episodes of binge eating characterised by:
  - Eating, in a discrete period of time (2 hours), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances
  - A sense of lack of control during these episodes
- Significant distress following binge episodes (guilt, shame)

## Other Eating Disorders
- **Unspecified feeding or eating disorder (UFED)**
  - Behaviours cause clinically significant impairment or distress, but do not meet full criteria for any other feeding or eating disorder.
- **Pica**- persistent eating of non-nutritional substances (e.g. soil) which is inappropriate to the developmental level of individual. Must be clinically significant.
- **Rumination Disorder**- Repeated regurgitation of food (may be re-chewed, re-swallowed, or spat out)- not due to a medical condition.
Diagnosis: other possible presentations

- Anorexia athletica - excessive, obsessive exercise
- Orthorexia - obsession with eating healthy food
- Manorexia - AN in males
- Pregorexia - fear of weight gain during pregnancy, restriction of food.
- Drunkorexia - food restriction, alcohol binge
- Muscle dysmorphia - obsession re: muscularity, excessive exercise/steroids etc
- Eating disorders in “mature women”
- Caloric restriction for longevity
- Diabulimia - Insulin restriction for weight loss Type I Diabetes
Background Facts & Stats

• ~ 1.2 million Australians living with an eating disorder (IOI, 2018)
• ~ 9% of the population (NEDC, 2016; IOI, 2018)
• Presentations of eating disorders in males and females are significantly increasing and may go undiagnosed (Hay et al., 20018; Hay et al., 2015)
Highest mortality and morbidity rate of any psychiatric illness

Mortality rates are almost twice as high for ED’s compared to normal population; rises to 5.86 times higher for people with AN (Arcelus et al., 2011)

Suicide major cause of death for people with ED’s (Pompili et al, 2006)
  – Approximately 1 in 5 deaths due to suicide (Arcelus et al., 2011)

Females account for approx. 64% of ED cases

Eating disorders are not a new phenomenon
Eating disorders can occur at any age

- AN peak onset usually early to mid-adolescents (Madden et al., 2009; Smink et al., 2012)
- BED and BN onset more common in later adolescent and young adulthood (Stice et al., 2013)
- Compared with other eating disorders, BED is more common among males and older individuals

Approx. 50% of people clinically recover from their eating disorder, demonstrated by an absence of symptoms (NEDC, 2012)

- Average 7 years to achieve full recovery (Wade et al., 2006)

The presentation of an ED may vary over time: AN ↔ BN (Agras et al., 2000)
Eating disorders are very serious mental illnesses with life threatening physical symptoms. However if they are caught early, people can fully recover.
Background: Developmental Factors

<table>
<thead>
<tr>
<th>Genetics/Biological Factors</th>
<th>Personality Characteristics</th>
<th>Environmental Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>No identified gene</td>
<td>Core low self esteem</td>
<td>Interpersonal factors (e.g. trauma, bullying etc.)</td>
</tr>
<tr>
<td>Obesity</td>
<td>Perfectionism</td>
<td>Social factors (cultural emphasis on thinness and muscular ideal = happiness, success etc.)</td>
</tr>
<tr>
<td>Type I (insulin dependent Diabetes)</td>
<td>Obsessive-compulsive traits</td>
<td>Certain sports where thinness is promoted (e.g. ballet, dance, gymnastics, running etc.)</td>
</tr>
<tr>
<td>Family History of ED or obesity</td>
<td>Over-value external reinforcement</td>
<td>Media influence- reinforcing thin/muscular cultural ideals</td>
</tr>
<tr>
<td></td>
<td>Impulsivity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avoidant coping style</td>
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</tbody>
</table>

Extreme **dieting and body dissatisfaction** are two of the highest risk factors for developing eating disorders.

Families **DO NOT cause eating disorders**
Background: high-risk groups

1. Women (particularly during transition periods)
2. Women with Polycystic Ovary Syndrome or Diabetes
3. Perinatal group
4. Athletes (male and female)
5. People with a family history of have a first degree relative with an eating disorder
6. People seeking help for weight loss
7. Adolescents $\rightarrow$ 12-29 years peak period for onset (Smink et al. 2012)
8. Dieters
9. Young people with obesity- 2.4 fold higher risk
Males and eating disorders

• Disordered eating amongst men is on the rise → bigger is better

• Muscle dysmorphia (‘bigorexia’)
  - Pre-occupation that one’s body too small or insufficiently muscular, despite having an average to very muscular physique (American Psychiatric Association, 2013)
  - Engage in strict dieting, excessive exercise (weight lifting), substance abuse (anabolic-androgenic steroids)

Table 1: Percentage of people with an eating disorder by diagnosis who are male (Hudson et al., 2007; Weltzin et al., 2005)
Effects: Starvation Syndrome

- Prolonged dietary restriction can lead to serious psychological & physical complications.
  - Many symptoms of eating disorders involving significant restriction, may actually be symptoms of starvation

- Ancel Key’s Minnesota Study (Keys, 1944) - 36 young, healthy men restricted caloric intake for 6 months. Effects from the ‘Starvation Study’:
  - Attitudes and behaviour related to food and eating
  - Binge eating
  - Emotional and personality changes
  - Social and sexual changes
  - Physical changes

Video link
http://www.epi.umn.edu/cvdepi/video/the-minnesota-semistarvation-experiment/
Effects of starvation on the brain

• People with restrictive-type eating disorders:
  – Find it hard to engage in ‘bigger picture thinking’
  – Become very preoccupied with detail
  – Find it hard to see ‘the wood for the trees’

• Research has shown that there are **structural** changes (e.g. changes in grey/white matter) and **functional** changes (e.g. the way brain circuitry responds) to the brain as a result of malnutrition

• The effects of changes to the brain
  - **Behavioural** – avoidance, ritualistic behaviour, decreased interest in normal activities, physical agitation (e.g. pacing, twitching)
  - **Cognitive** – rigid/inflexible thinking, poor concentration, circular thinking, being stuck/perseverative on a topic, intolerance of uncertainty, low mood, altered taste perception, preoccupation with thoughts of food, eating, exercise etc.

People with AN have a hyper-responsive fear network. This means they have a very real fear of food & perceive it as threatening.
Living with Anorexia: ‘Ash’

Stigma and eating disorders

Stigma: when a person experiences negative attitudes/stereotypes because others perceive them as ‘different’

- Common **misperceptions** around eating disorders
  - Lifestyle choice, ‘diet-gone-wrong’, ‘just get over it!’; people choosing to engage in behaviours, people are ‘vain and superficial’ for worrying about appearance
  - Affects women and young people only
  - Perceived as being self-inflicted by general public and that people only have themselves to blame for the illness (Crisp et al., 2000) – healthcare providers hold similar views

- **Stigma has a huge impact** on the sufferer
  - Fear of being negatively evaluated; self-disgust
  - Concern that disclosure of illness will result in trivialisation of symptoms

- **Stigma has a significant barrier to help-seeking**
  - Only 22% sufferers receive specialist treatment for eating disorder (Swanson et al., 2011)
Stigma and eating disorders

- Eating disorders patients are:
  - “Less liked” than patients with schizophrenia
  - Seen as responsible for their illness as overdose takers, and more than patients with schizophrenia
  - Seen as self-inducing their illness
  - Urged to take self control

Attitudes of Medical Professionals towards Patients with Eating Disorders (1992)
What signs and symptoms might prompt you to engage in further screening for an eating disorder?
Screening: presenting to treatment

- Early intervention depends on early symptom detection
- Eating disorder is often **not** the main presenting problem (e.g. dizziness, fainting, seizures, IBS, allergy complaints, gastro problems, GAD, depression, D&A)
- Often seek help after a long period of illness: delay of 4 years between symptom onset and seeking treatment
- Primary health care: Only 23% seek treatment for ED (50% will seek treatment for weight management instead) (Hart et al., 2011)

If you have **any** suspicion that an eating disorder may be present, it is important to **screen further**
**Screening: hallmark symptoms**

<table>
<thead>
<tr>
<th>Anorexia Nervosa</th>
<th>Bulimia Nervosa</th>
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<tr>
<td><strong>Weight loss and malnutrition</strong></td>
<td><strong>Normal weight or overweight</strong></td>
</tr>
<tr>
<td>Dizziness, confusion, fainting</td>
<td>Salivary gland enlargement (from purging)</td>
</tr>
<tr>
<td>Dry, brittle hair</td>
<td>Oral and dental - enamel erosion</td>
</tr>
<tr>
<td>Lanugo hair, dry skin</td>
<td>Arrhythmias</td>
</tr>
<tr>
<td>Low blood pressure, postural drop, ECG voltage, cardiac arrhythmias (bradycardia)</td>
<td>Blood abnormalities/ electrolyte disturbance from purging (i.e. potassium, sodium)</td>
</tr>
<tr>
<td>Cachexia, muscle wasting</td>
<td>Hand calluses</td>
</tr>
<tr>
<td>Blood abnormalities (i.e. ↓glucose ↓white blood cell count, ↑cholesterol)</td>
<td>Diarrhoea</td>
</tr>
<tr>
<td>Oedema</td>
<td>Oedema</td>
</tr>
<tr>
<td>Loss of menses – amenorrhea</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis, bone fractures</td>
<td></td>
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<tr>
<td>Cold hands and feet, hypothermia</td>
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</table>

**Weight**

Low body weight, fear of weight gain, rapid weight loss/fluctuation (0.5-1kg/week over several weeks or 5% body weight irrespective of BMI).
Screening and identification

If you suspect that a person may have an underlying eating disorder, it is appropriate to ask more about their eating, dieting and exercise behaviours.

1. ‘I’m wondering if you have any concerns about your eating or your weight at all’
2. ‘Do you worry about your weight, or is eating an issue for you?’
   (NICE, 2004)

If a person answers YES to either of those questions, progress to the SCOFF & calculate the person’s Body Mass Index

** If parents are concerned, you should always screen further
Screening: the SCOFF

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 more than One stone (6.35kg) in a 3-month period?
4. Do you believe yourself to be Fat when others say you are too thin?
5. Would you say that Food dominated your life?

An answer of ‘yes’ to two or more questions indicates the need for a more comprehensive assessment.
Screening: children & adolescents

- **Early warning signs**

| Behavioural | Disordered eating patterns; cutting out food groups; prolonged time to eat meals; more concerned with food preparation; changes in diet preferences (e.g. increased dislikes; vegetarian with no real ethical reason; dieting/fasting); fear of weight gain; vomiting; excessive exercise; eating alone/in secret; expressing body dissatisfaction |
| Mood changes | Irritable; depressed; anxious; isolated from peers |
| Physical | Low energy; lethargic or spurts of energy (increase exercise); weight loss; layering of clothes |

** Child may be excelling in other areas of life (e.g. school) even though suffering from eating disorder

- **Often at great risk of medical complications**
  - Threshold much lower for medical complications than adults (e.g. HR is 50 vs 40 for adults) and deterioration can happen quickly

- **Negative long-term health consequences can be stronger**
  - Osteoporosis and amenorrhea can have a sig. impact on development

It is Important to ask parents several questions so you get a detailed picture of how the child is behaving.
Screening: children & adolescents

These pictures show a pair of twins aged 3 and 13, one of whom developed AN aged 8 and remained unwell for 5 years. She suffered sig. growth delay.
Case study- Julie

Julie is a 17 year old female in year 12 of High school. She lives with her parents Jan and John, and younger brother Josh (15 years). John and Jan both work full time and so Julie and Josh catch the bus to and from school.

Julie is a very dedicated student and achieves very high scores in her exams. Recently her teachers have noticed that she has become withdrawn from her friends and spends most of her lunches in the library studying. She appears anxious and depressed, and appears fidgety during class at times. She frequently asks to leave the classroom for bathroom breaks. Her teachers have also noticed her school uniform has become baggy on her and she often wears a jumper, even on hot days.

She is referred to the school counsellor. When asked Julie attributes her weight loss to a loss of appetite resulting from anxiety about the pending HSC exams. Julie would like help managing her stress about the HSC.

Are there any signs and symptoms that indicate this might be an eating disorder?
What else do we need to know?
Screening for eating disorders should be part of any mental health assessment.
How is screening for eating disorders integrated into your work place?
Assessment

- Medical and psychiatric assessment required at all levels of care:
  - Medical (e.g. bloods, ECG, obs)
  - Psychiatric (e.g. suicidality, DSH, co-morbidity)
  - Weight: (BMI – [weight in kg] / [height in m]^2), amount of weight lost & rapidity of weight loss

- Depending on setting and presentation, assessment may also involve:
  - Dietetic input (especially if indictors for re-feeding are present)
  - Eating disorder specific assessment

- Standardised questionnaires and diagnostic assessments available
  - (e.g.) Eating Disorder Examination Questionnaire (EDE-Q); DASS; K10

** For further information about indicators for an inpatient admission:
→ ‘Inpatient Management of Adults and Children with an Eating Disorders’ (NSW Health)
Treatment: continuum of care

- Tertiary Hospital
  - Specialised, inpatient treatment

- Local Hospital Interventions
  - Local inpatient medical or mental health wards

- Specialist Eating Disorder Interventions
  - Day Programs, Specialist Outpatient Programs, Community Mental Health/ICAMHS CBT-E/FBT

- Generalist Health/Mental Health Interventions
  - GPs, private psychologists/dietitians
  - Also some guided self-help and etheryapy options available

- Depends on treatment dose & level of support required
- Step-up/step-down paradigm
- Functional recovery model
- Integrated care planning

- Functional recovery model
- Integrated care planning
- Step-up/step-down paradigm
- Depends on treatment dose & level of support required
People with eating disorders are often ambivalent and fearful of engaging in treatment. A harm minimisation approach that brings about symptom change and treatment in the least restrictive environment should be considered at all times.
Treatment: involuntary

- Refusal of care and denial of illness not uncommon particularly if person very medically unwell
- Psychiatrist should always be involved
- Involuntary treatment is an intervention implemented for safety, in emergency circumstances
- Conduct in compassionate and collaborative way where possible
- Compulsory care may be initiated via:
  - Mental Health Act
  - Guardianship
1. **Family Based Therapy (Lock & Le Grange)**
   - Optimal treatment for C&A with short-moderation illness duration (<3 years)
   - 50-90% success rate at 5 years FU (Le Grange & Lock, 2010)
   - Supports parents/carers to take primary responsibility for their child’s recovery
   - 3 phases: (1) weight restoration (90% EBW, 1-10 weeks); (2) returning control over eating to adolescent (fortnightly 6 weeks); (3) establishing healthy adolescent identity (3 weeks)
   - Exclusion - Acute suicidality/child protection issues/ DV / acute parental MH problem

2. **Cognitive Behaviour Therapy-Enhanced (Fairburn)**
   - Has expanded from CBT-BN (1981) → ‘transdiagnostic’ in scope
   - 20-40 sessions, individual treatment focusing on factors maintaining the illness
   - Adults with eating disorders
   - Engagement/formulation/psychoeducation, regular eating patterns, cognitive and behavioural coping strategies, modifying cognitions about weight & shape, maintenance.

3. **Motivational Enhancement Therapy; Interpersonal Therapy, DBT**
Case Study - Julie Part 2

• Julie is referred to the school counsellor who after screening, feels Julie may be suffering from an eating disorder. She contacts Julies parents and encourages them to take her to the GP for an assessment.

• The GP determines that Julie has Anorexia Nervosa, and is also purging. After running a battery of tests he is confident she is not currently at medical risk, and does not need to go to hospital. He refers her to a psychologist who commences Family Based Therapy with Julie and her family.

• As part of her treatment, the therapist has recommended Julie take two weeks off school so her parents can closely monitor her eating and start the refeeding. Jan also takes two weeks off work to do this.

• After two weeks Julie returns to school but is still in treatment. Her mother attends the school daily during recess and lunch to supervise her meals.

• What can the school do to support Julie and her family during her time off school?

• What can the school do to assist with Julies recovery when she returns to school?
Treatment: challenges

- Can demonstrate challenging and risky behaviours → designed to protect the illness
- Ego-syntonic
- Ambivalence towards treatment → can lead to resistance
- Can be perceived as ‘difficult’
- Combination of medical, psychological and behavioural issues
- Recovery rate can be slow
- High drop-out rate from treatment
- Working with clients who resist our treatment is hard
- Treatment can sometimes feel punitive
- Effects of starvation & brain changes → cognitive difficulties
Resistance to engage in treatment and ambivalence about giving up the eating disorder are core features of this illness. Approaches that involve kind, firm and honest conversations about interventions work best.
I am a psychologist who specializes in the detection and prevention of unhealthy relationships between parents and children. After careful assessment of your family, I am convinced that it was a terrible mistake for you to have your daughter. You may feel quite attached to her at the moment, but in the long run it simply won’t work out.

Whatever pleasure you may think you are getting out of this relationship, a detached and objective observer can see that you are losing a great deal too. You are tired and rundown, you lack sufficient energy for many of the activities you used to find rewarding, you spend less time with your friends, and sometimes your work has suffered. You have become so preoccupied with this child that you are unable to make a realistic assessment of how she has actually affected your life.

Therefore, I have decided to take your daughter away. I can appreciate that you feel angry with me just now, and may not believe it is my right to interfere —but eventually you will come to understand that I have acted in your own best interest. With your child gone, you will be able to return to the life you had before you became a parent.

Enhancing motivation for change in treatment-resistant eating disorders, K Vitousek, S Watson, GT Wilson - Clinical psychology review, 1998
Providing person-centred care

- Collaboration and empathy
- Engagement is crucial
- Externalising - see the person as *separate* to the illness
- Ambivalence is core part of an eating disorder – roll with resistance
- Stages of change – meet patient at stage of change
- Clear communication – be aware of cognitive impairment
These clients are engaging in a constant battle with the eating disorder. We need to work with the person, against the illness.
Community Mental Health Centres- Bowral, Macarthur, Liverpool/Fairfield, and Bankstown.

Evidence based treatments for children/adolescents (FBT) and adults (CBT-E) with moderate-severe eating disorders.

Referral via Mental Health Triage Access Line (MHTAL) 1800 011 051

Must be medically stable- if not, refer to nearest emergency department or dial 000.
SWSLHD Community team composition & care

- Patients seen within a multidisciplinary framework
- Minimum access to an eating disorders trained clinician and psychiatrist/registrar
- Shared care model - mandatory GP involvement
- Other:
  - Paediatrician, Obstetrician etc.
  - Dietetics* (referral by GP)
  - Family/carers
  - School/ counsellors
SWSLHD Inpatient Services

Anyone who is medically unstable should present to their nearest emergency department

Campbelltown Hospital
- Initial pilot site
- Pathways for planned and unplanned admissions (ED or GP/physician referral)
- Multidisciplinary inpatient care

SWSLHD Hospitals- present to any ED Bowral, Camden/Campbelltown, Liverpool, Fairfield, Bankstown
Campbelltown Hospital team composition

**Adult**
- Medical ward
- Gastroenterology
- Consultation Liaison Psychiatry
- Nursing
- Dietetics
- Family/carer engagement where possible
- Other* (e.g. community mental health, private provider etc.)

**Paediatric**
- Paediatric medical ward
- Paediatrics
- Consultation Liaison Psychiatry
- Nursing
- Dietetics
- Family/carers
- Other* (e.g. ICAMHS)
Other services- pathways to care

• Tertiary services in NSW:
  – Adults: Peter Beumont Unit, Royal Prince Alfred Hospital (9 beds) - ph: 9515 1430
  – C&A: Westmead Children’s Hospital (8 beds) – ph: 9845 2446
  – Day programs/outpatient programs
  – Family/carer education seminars
  – Outreach support for clinicians
• GP + referral to a private psychologist +/- dietician
• Other services (including private) listed on InsideOut Institute treatment services database
  https://insideoutinstitute.org.au/treatment-services

[Image: Treatment Services Database]
The Essentials: Training Clinicians in Eating Disorders

This eLearning training comprehensively addresses the nature, identification, assessment and treatment of eating disorders. It will provide you with comprehensive training in the medical, psychological and dietetic management of individuals with eating disorders. This is the Centre for Eating and Dieting Disorders original online training program.
Training

INSIDEOUT Institute for Eating Disorders ELEARNING

https://insideoutinstitute.org.au/

Treatment

Family Based Treatment for Children & Adolescents with Anorexia Nervosa: The Basics
Cognitive Behavioural Therapy for Eating Disorders: A Practice Based Introduction
Support for clinicians

**Individual and team support**
- Be aware of splitting within treatment team – communication *essential*
- Supervision – preventing burnout
- Transference & counter-transference

**Local and statewide support**
- Local Eating Disorder Coordinator → (02) 9616 4056; Linda.Lazar@health.nsw.gov.au
- Tertiary eating disorder services Outreach support
  - Adult: Royal Prince Alfred Hospital Ph: 0472 843 063
  - Child & Adolescent: Westmead Childrens Hospital Ph: 9845 2446
- InsideOut Institute: (02) 8627 5690
  - E-learning programs
  - Resources
Take-home messages

- Eating disorders are **core business** for all health services
- They are **serious illnesses** with sig. psychiatric and medical risk
- Full **recovery** is possible - especially if the eating disorder is identified and treated early on
- **Identification** and screening is essential – patients may be unlikely to disclose symptoms unless prompted
- **Ambivalence** about letting go of the eating disorder is a central feature of this illness
- Engagement, **empathy** and compassion are key
Resources

- Centre for Eating and Dieting Disorders: www.cedd.org.au
- Inside Out Institute of Eating Disorders: www.insideoutinstitute.org.au
- Eating Disorders: A Professional Resource for General Practitioners (NEDC)
- Guidelines for the Inpatient Management of Adult Eating Disorders in General Medical and Psychiatric Settings in NSW (NSW Health)
- Mental Health Triage Access Line (MHTAL) 1800 011 051
Evaluation Survey

Please complete the survey provided

Thank you for your time! 😊
References


