

# **Guidance for dealing with young people with eating disorders within further education colleges in Gloucestershire**

**Eating Disorders Project**  
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## **Introduction**

This document has been produced by a multi-agency working group (see list of contributors), following consultation with relevant organisations within Gloucestershire.

The guidance will be accompanied by training for key staff within each organisation plus information leaflets and posters.

It is hoped that the guidance will be implemented by all relevant organisations within Gloucestershire, thereby encouraging consistency of practice and equality of access to services. Where evidence for the guidance exists, it has been referenced.

The guidance will be introduced in stages throughout Gloucestershire, so that any effects can be evaluated. This will allow the results to add to the available evidence. The guidance has been piloted in some sixth forms in Cheltenham and will be introduced across Gloucestershire from the summer of 2003 onwards.

## **Purpose**

This document aims to improve early identification and effective intervention for young people with eating disorders (secondary prevention). It provides guidance for people who are most likely to come into contact with young people who have an eating disorder.

## **The importance of early intervention**

Eating disorders usually begin during adolescence and affect up to 6% of adolescent girls<sup>1,2,3</sup>. Boys can develop eating disorders, but 90-95% of sufferers are female<sup>4</sup>.

Whilst some eating disorders are mild and can be a passing phase, it is usual for young people with moderate to severe eating disorders to suffer over several years with some people experiencing lifelong problems<sup>5</sup>. Up to 13% of those with Anorexia Nervosa die as a result of the effects of the disorder or by suicide<sup>6</sup>.

Early intervention can be highly effective and appears to prevent years of suffering for the young person and their family<sup>5</sup>. Family therapy approaches to treatment have been shown to be the most effective for young people with Anorexia Nervosa<sup>7</sup>. There is no

strong evidence for the superiority of any treatment for young people with Bulimia Nervosa or Atypical Eating Disorders, but involving the whole family in treatment is considered best practice<sup>8</sup>.

Attempts to prevent the development of eating disorders within schools have been shown to be ineffective<sup>9</sup>. There does not appear to have been any research to see if early intervention in schools improves detection and recovery rates.

## **The process of referral**

This guidance encourages college staff to be more aware of students who might suffer from an eating disorder. Once concerns have been raised, an appropriate member of staff should take responsibility for discussing the concerns with the young person and the College Counsellor.

The College Counsellor will then contact the young person and offer an appointment to initiate the process of assessment and if required, referral to the young person's GP. Their GP can then assess the situation, undertake any necessary physical investigations and refer on to the local Child and Adolescent Mental Health Service (CAMHS).

Referrals for young people with eating disorders are prioritised and an appointment will be offered as soon as possible. Urgent referrals will be seen very quickly. Young people are usually seen with their family and where necessary there will be liaison with college staff. Appointments are generally offered weekly or fortnightly initially. Most young people and their families are seen with decreasing frequency over the following year.

The most important aspect of intervention is advising parents to support and supervise their child to eat an adequate diet. Counselling for the young person alone does not necessarily result in improvement in the eating disorder behaviours.

If a young person is referred direct to CAMHS by their GP without involvement of the college or College Counsellor, there will not necessarily be liaison with the college.

Sometimes parents ask for referral to a private therapist, believing they will be seen quicker or will receive higher quality care. This often results in young people seeing a therapist who usually provides a service for adults and who does not involve the family in the management of the problem and does not liaise with college staff.

Sometimes admission is offered inappropriately and young people can be admitted to adult wards with no school facilities. Whilst it is reasonable for parents to choose to receive private care (and some private therapists do offer an appropriate service), it is important that they understand that a specialist service is available locally through the NHS and that specialist in-patient care is also available if required.

## **Difficulties with early identification and intervention**

- Eating disorders tend to be secretive and are associated with guilt and embarrassment.
- Young people with eating disorders do not usually view themselves as ill, so consequently do not seek help.
- Adults and adolescent peers often find it difficult to discuss their concerns with the young person with the eating disorder.
- If concerns are expressed, the young person often denies that they have a problem.
- Although Anorexia Nervosa is more visible due to extreme weight loss, most young people with eating disorders are not significantly underweight and go unnoticed.
- Adolescent peers might be aware of a problem, but feel they cannot approach an adult to expose their friend.
- It is not always clear how to access appropriate help or indeed who should provide it.
- Young people can engage adults or peers in inappropriate supportive relationships using their desire for confidentiality as a way to prevent referral or involvement of their parents.

## **Definitions**

The following definitions are for information. College staff will not be expected to diagnose whether a young person has an eating disorder. Eating Disorders are classified as mental illnesses and in severe cases young people can be admitted to hospital against their will by parental consent or after being detained under a section of the Mental Health Act.

### **Anorexia Nervosa (AN)<sup>10,11</sup>**

The person with AN:

- purposely loses weight to a point at least 15% below that expected for their age, sex and height
- experiences changes in hormone levels which, in females result in amenorrhoea (if the weight loss occurs before puberty begins, sexual development will be delayed and growth might cease)
- feels driven to lose weight because they experience themselves as fat, even when at a subnormal weight
- is intensely afraid of becoming fat and preoccupied with worries about their body size and shape
- directs all their efforts towards controlling their weight by restricting their food intake, but may also binge eat, self induce vomiting, misuse laxatives or diuretics (purging behaviours), exercise excessively or misuse appetite suppressants

### **Bulimia Nervosa (BN)<sup>10,11</sup>**

The person with BN:

- experiences frequent episodes of binge eating, during which they consume a large amount of food within a short period of time

- feels overwhelmed by the urge to binge and can only stop eating once it becomes too uncomfortable to eat any more
- feels guilty, anxious and depressed, because they have been unable to control their appetite and they fear weight gain
- tries to regain control by getting rid of the calories consumed (the most common method used is vomiting, but they might misuse laxatives, diuretics or appetite suppressants, fast or excessively exercise)
- is usually within a normal weight range, but might be obese

### **Atypical Eating Disorders (AED)**<sup>10,11</sup>

The person with AED:

- is likely to be similar to people with AN or BN, but not quite meet those diagnostic criteria
- might vomit after eating small amounts of food
- might chew food and then spit it out
- might binge eat, but not attempt to get rid of the calories consumed (this behaviour is now called Binge Eating Disorder [BED]<sup>10</sup>, the phrase compulsive eating is sometimes used, but has never been adequately defined)
- might eat for emotional reasons (comfort eating), but not eat large amounts of food at one time.

**Obesity** is not an eating disorder per se and unlike an eating disorder is not a mental illness. However, many people who binge eat become obese and can have mental health problems.

**Warning signs**<sup>12,13</sup> (It is unlikely that a young person would present with all or even most of these signs. The list is intended to raise awareness of potential signs to look out for)

*Concern expressed by peers should always be taken seriously even if adults have observed no other signs.*

#### **Physical signs**

- |                                    |   |
|------------------------------------|---|
| • Weight loss                      | • Calluses on the knuckles of the dominant hand |
| • Dizziness, tiredness or fainting | • Tension headaches                             |
| • Feeling cold                     | • Menstrual disturbances                        |
| • Hair becomes dull and lifeless   | • Sore throats, mouth ulcers and tooth decay    |
| • Swollen cheeks                   | • Dehydration                                   |

## **Behavioural signs**

- Restriction of eating
- Difficulty sleeping
- Spending long periods of time reading cookery books
- Preference for eating alone
- Cooking meals for the family
- Always choosing low calorie foods
- Irritability, distress and arguing around mealtimes
- Strange behaviour around food
- Hiding, collecting or storing food
- Secretive eating
- Inability to tolerate unplanned events involving food
- Extreme irritability when meals are earlier or later than usual
- Using a lot of salt, vinegar or spicy substances
- Drinking a lot of water or fizzy drinks
- Frequent weighing
- Excessive exercising
- Gathering information on dieting
- Wearing baggy clothes
- Increase in activity including homework
- Increasing conscientiousness
- Insisting she is fat when she is not
- Increasing isolation and loss of friends
- Ritualistic behaviour and obsessions
- Disappearing to the toilet immediately after meals
- Secretive behaviour

## **Psychological signs**

- Preoccupation with food
- Sensitivity about eating
- Denial of hunger despite lack of food
- Feeling distressed or guilty after eating
- Fear of gaining weight
- Self dislike
- Moodiness
- Excessive perfectionism

## **Roles and responsibilities**

### **College staff**

- Observation of the young person's educational, social, behavioural, physical and emotional welfare within the college context.
- Identification of any worrying signs.
- Discussion with relevant colleagues to establish if there is cause for concern.
- Discussion with the young person to inform them of the need for referral to the College Counsellor.
- In most cases, consent should be sought to inform parents of the concerns and the need for referral to the College Counsellor.
- Referral to the College Counsellor.
- Liaison with the College Counsellor and health professionals.
- Advice and support to other students concerned about a friend with an eating disorder.

- Implementation and monitoring of any plan of action agreed with the Child and Adolescent Mental Health Service (CAMHS).

### **College Counsellors**

- Provision of information regarding the boundaries of confidentiality.
- Identification of any worrying signs.
- Discussion with college staff to establish if there is cause for concern.
- Assessment of the young person's eating and purging behaviour, attitudes to weight and shape, physical, social and mental health.
- Evaluation of the young person's readiness to accept they have a problem and willingness to co-operate with interventions.
- Assessment of the young person's family situation and discussion regarding the need to inform parents.
- If young person consents, discussion with parent to establish their concerns, advise them of the situation and inform them of referral.
- Initial use of motivational interviewing and a self help book with the young person<sup>14</sup>.
- Referral to the young person's GP.
- Regular contact with young person whilst they await an appointment.
- Liaison with college staff and health professionals.
- Advice and support to other students concerned about a friend with an eating disorder.
- Advice and support to parents and lecturers.
- Implementation and monitoring of any plan of action agreed with the Child and Adolescent Mental Health Service.
- Provision of eating disorders leaflets and posters within the college.
- Liaison with CAMHS.
- Training and information for college staff.

### **Child and Adolescent Mental Health Services**

- Prompt response to receipt of referral from GP.
- Provision of an assessment appointment for the young person and their family.
- Provision of an assessment report, copied to the GP.
- Liaison with College Counsellor, GP and other relevant college staff.
- Provision of an agreed care plan.
- Treatment for the individual and their family.
- Co-ordination and evaluation of the care plan.

### **Clinical Co-ordinator - Eating Disorders**

- Provision of telephone advice and information to anyone concerned about a young person's eating.
- Provision of training for all relevant staff in contact with young people with eating disorders. Training will be provided on a rolling programme with updates available once people have undertaken the initial training.
- Provision of leaflets and posters.
- Evaluation of the effectiveness of the implementation of the guidance.
- Revision and distribution of updated guidance documents.

## **The role of parents and other students**

Parents and friends can play an essential role in identifying a problem and offering support to the young person. Whilst parents are obviously responsible for the welfare of their child, friends can only be responsible for themselves and their own actions. Despite this, many friends *feel* responsible. Friends should be encouraged to pass on concerns to an appropriate adult and to continue to provide friendship in as normal a way as possible.

Support is available for relatives and friends from the Eating Disorders Project 01452 891206.

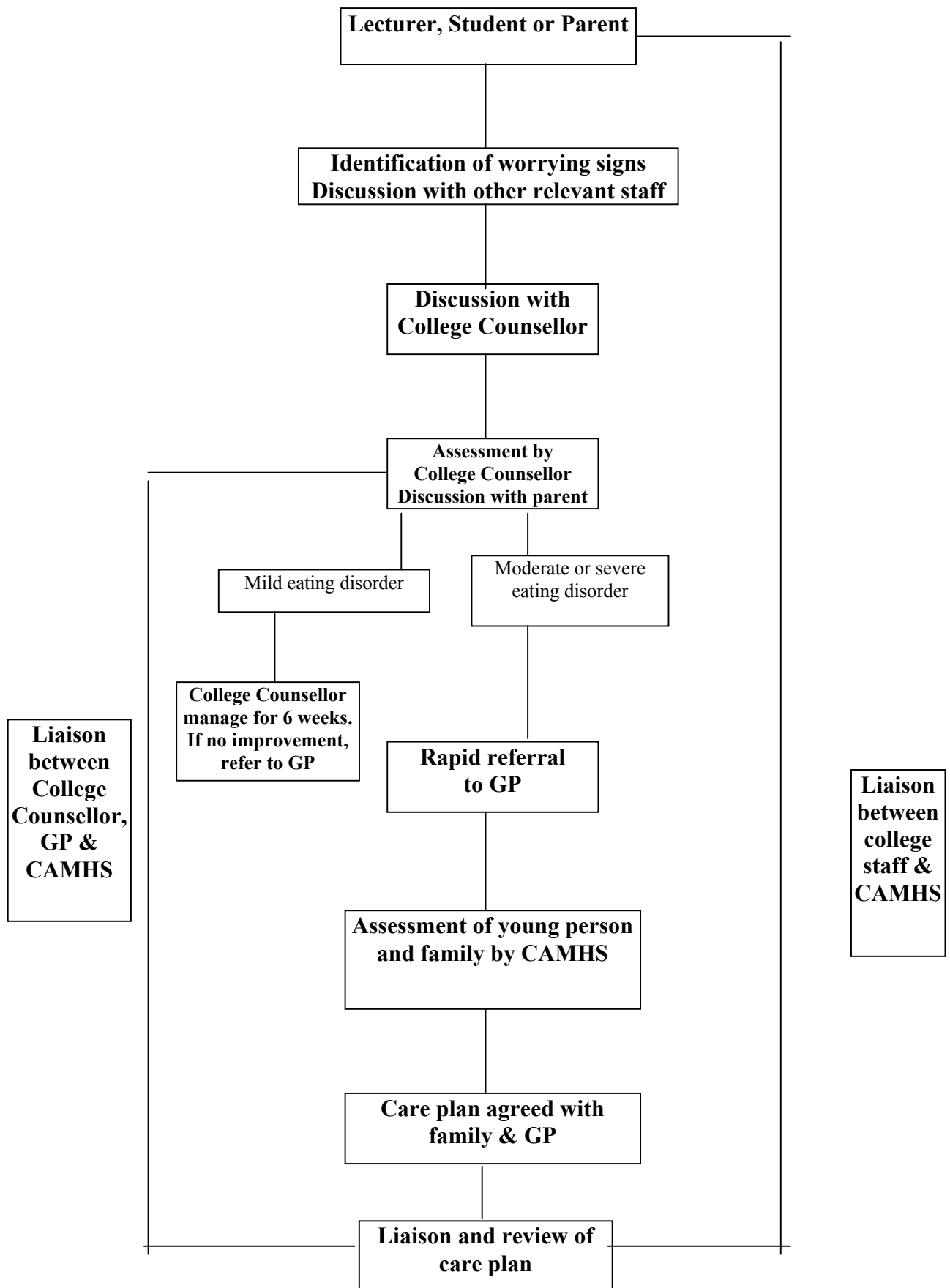
### **Parents**

- Identification of any worrying signs.
- Discussion with college staff, if appropriate, to establish if there is cause for concern.
- Discussion with the young person regarding concerns.
- Arrangement of an appointment with GP.

### **Students**

- Identification of any worrying signs.
- Discussion with the College Counsellor to establish if there is cause for concern.
- Possible discussion with the young person regarding concerns.

## College referral process



## Severity indicators

**Mild Eating Disorder** – at least one of the following behaviours:

Bingeing, purging, excessively exercising or fasting less than twice per week *or* severe dieting up to three days per week.

**Moderate Eating Disorder** – at least one of the following behaviours:

Bingeing, purging, excessively exercising or fasting at least twice per week *or* severe dieting most days.

**Severe Eating Disorder** – at least one of the following:

BMI <18, bingeing, purging, excessively exercising or fasting most days.

## Dissemination of guidance

The guidance will be disseminated via the usual process of distribution within each organisation. It is also planned that the guidance will be presented to key college staff at a training session. Each attendee will be given a copy. Staff who attend the training are responsible for sharing the guidance with their colleagues using the usual process of distribution of information within the college.

## Training

Training will be available on a rolling programme from the Eating Disorders Project. Requests for specific training events are also welcome. Contact 01452 891206.

## Contributors

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## References

1. **Hoek H.W.** (1993) Review of the Epidemiological Studies of Eating Disorders. *International Review of Psychiatry* 5, 61-74.
2. **Button E.J. and Whitehouse A.** (1981) Subclinical Anorexia Nervosa. *Psychological Medicine*, 11, 509-516.
3. **Patton G.C.** (1988) The Spectrum of Eating Disorder in Adolescence. *Journal of Psychosomatic Research* 32, 579-584.
4. **Hoek H.W.** (1995) The Distribution of Eating Disorders. In *Eating Disorders and Obesity: A Comprehensive Handbook*. Edited by Kelly D. Brownell and Christopher G. Fairburn. Guilford Press. New York.
5. **Hsu L.K.G.** (1990) Outcome. In *Eating Disorders*. By L.K. George Hsu. Guilford Press. New York.
6. **Neumarker K-J.** (2000) Mortality Rates and Causes of Death. *European Eating Disorders Review*, 8, 181-187.
7. **Eisler I., Dare C., Russell G.F. et al** (1997) Family and Individual Therapy in Anorexia Nervosa, A 5-year Follow-up. *Archives of General Psychiatry*, 54, 1025-1030.
8. **Lask B. and Bryant-Waugh R.** (2000) *Anorexia Nervosa and Related Eating Disorders in Childhood and Adolescence: Second Edition*. Edited by Bryan Lask and Rachel Bryant-Waugh. Psychology Press. Hove.
9. **Fairburn C.G.** (1995) The Prevention of Eating Disorders. In *Eating Disorders and Obesity: A Comprehensive Handbook*. Edited by Kelly D. Brownell and Christopher G. Fairburn. Guilford Press. New York.
10. **American Psychiatric Association** (1994) *Diagnostic and Statistical Manual of Mental Disorders (4th edition)* Washington, D.C.
11. **World Health Organisation** (1992) *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. Geneva.
12. **Bryant-Waugh R. and Lask B.** (1999) *Eating Disorders: A Parents' Guide*. Penguin.
13. **Hogg C.** (1995) *A Guide to Purchasing and Providing Services*. Eating Disorders Association.
14. **Schmidt U. and Treasure J.** (1993) *Getting Better Bit(e) by Bit(e)*. Psychology Press. Hove.