Canadian Mental Health Association
Waterloo Wellington

Association canadienne pour la santé mentale
Waterloo Wellington

# A Community Approach to Managing Eating Disorders in the Waterloo-Wellington LHIN

November 9, 2016

Eating Disorders

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# Day in Psychiatry

# November 9, 2016

# Bingemans Conference Centre

# Kitchener, ON

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# Declaration of Conflict of Interest:

- I DO NOT have any affiliation with a pharmaceutical, medical device, or communications organization.

- I DO NOT INTEND to make therapeutic recommendations for medications that have not received regulatory approval ( e.g. “off-label” use).

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HLS Therapeutics

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# Mitigating Potential Conflicts of Interest:

Not applicable

# Additional Presenters

- Dr. Margaret MacSween, Child Psychiatrist
- Sue Graham, MSW

# Learning Objectives

- Review the epidemiology of eating disorders
- DSM V changes
- Assessment tool for primary care clinicians
- Indications for Hospitalization
- Discuss the CMHA Eating Disorders program and how the program differs for children and for adults
- Discuss expectations of a shared care model of managing eating disorders
- Questions

# Epidemiology of Eating Disorders

- 1.5% of Canadian women aged 15-24 have an eating disorder (Gov. of Canada 2002)
- The lifetime prevalence of anorexia and bulimia is estimated to be 0.9% (0.3%) and 1.5% (0.5%) respectively(Hoek, 2007)
- 10% of individuals with AN will die within 10 years of the onset of the disorder (Sullivan, 2002)
- Lifetime prevalence of BED is 3.5% (2.0%) (Hudson, 2007)
- Estimates for newer categories of eating disorders are in primary stages

# DSM V Changes

- Better represent  symptoms and behaviours across the lifespan
- Minimize use of catch-all diagnoses
- Make feeding and eating disorders recognizable to non-psychiatrists to facilitate better diagnosis

# Eating Disorders

- ✓ Presence of disturbed eating behavior
- ✓ Presence of characteristic psychological disturbance

Diagnostic Categories

1. Anorexia Nervosa
2. Bulimia Nervosa
3. Other Specified Feeding and Eating Disorders
4. Binge Eating Disorder
5. Avoidant/Restrictive Food Intake Disorder
6. Unspecified Feeding and Eating Disorder

# Anorexia Nervosa

- No more “refusal”
- No more amenorrhea

# Anorexia Nervosa

- Age of onset 12-40 years with peaks 12-14 years and 19-20 years
- Relapsing and remitting
- 15-20% of individuals with AN will develop a chronic form of the illness
- Severe psychosocial morbidity
- 60% eventual recovery rate

# Bulimia Nervosa

- Change in frequency of binge-eating and compensatory behaviour

# Bulimia Nervosa

- Age of onset 18-45 years and peaks between ages 16-20
- Relapsing and remitting
- 5-10% mortality rate
- Severe psychosocial morbidity
- Recovery rate unknown

# Binge Eating Disorder

- Recurrent episodes of binge eating
- Marked distress regarding binge eating
- No recurrent use of inappropriate compensatory behaviours

- Associated with 3 or more of:
  - Eating rapidly
  - Feeling uncomfortably full
  - Large amounts when not hungry
  - Feeling embarrassed
  - Feeling depressed or guilty

# Other Specified Feeding and Eating Disorder (OSFED)

- Atypical AN – weight is not below normal
- BN with less frequent behaviours
- BED with less frequent occurrences
- Purging disorders without binging
- Night eating syndrome – excessive night time food consumption

# Avoidant Restrictive Food Intake Disorder (ARFID)

Eating or feeding disturbances as manifested by persistent failure to meet appropriate nutritional and/or energy needs leading to 1 or more:

- Significant weight loss or failure to achieve expected weight gain or faltering growth in children
- Significant nutritional deficiency
- Dependence of enteral feeding or oral nutritional supplements
- Marked interferences with psychosocial functioning

# Unspecified Feeding or Eating Disorder (UFED)

Clinically significant distress/impairment of functioning

- Do not meet full criteria of any of the Feeding or Eating Disorders
- Can be used by physicians if they choose not to specify why criteria are not met eg. ER

# Assessment Tools for Primary Care

## SCOFF

Do you make yourself **S**ick because you feel uncomfortably full?

Do you worry you have lost **C**ontrol over how much you eat?

Have you recently lost more than **O**ne stone (14 lb = 1 stone) in a 3 month period?

Do you believe yourself to be **F**at when others say you are too thin?

Would you say that **F**ood dominates your life?

*One point for "yes"; a score of ≥ 2 indicates likely case AN or BN*

Sim, McAlpine, Grothe, Himes, Cockerill & Clark, 2010

# Indications for Hospitalization

## *Children and Adolescents*

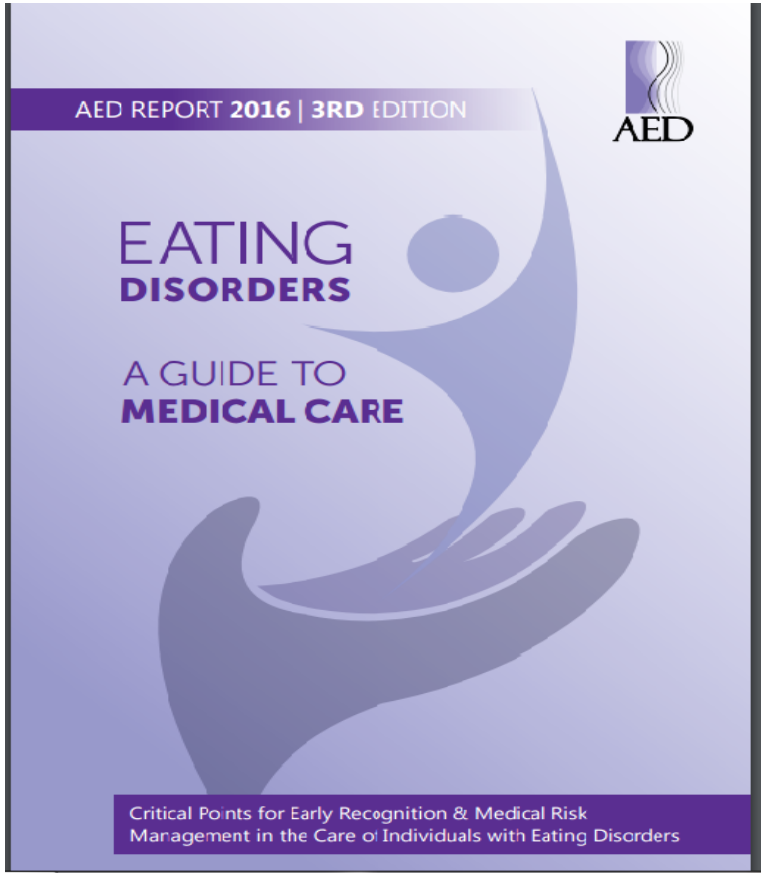
- Weight < 85 % of best estimate
- Orthostatic hypotension (with an increase in pulse of > 20 bpm or a drop in blood pressure of > 20 mm Hg/minute from supine to standing)
- Blood pressure < 80/50 mm Hg
- Heart rate < 45bpm
- Hypokalemia, hypophosphatemia, hypomagnesemia
- Syncope or dehydration
- Prolonged QTc (> 440ms)

# Indications for Hospitalization

*Adults*

- Weight < 75% of best estimate
- Heart rate < 40
- Blood pressure < 90/60 mm Hg
- Hypokalemia, hypophosphatemia, hypomagnesemia, hypoglycemia
- Dehydration or syncope
- Hepatic, renal, or cardiovascular organ compromise requiring acute treatment
- Poorly controlled diabetes
- Prolonged QTc (> 440ms)

# Medical Care




http://www.aedweb.org/index.php/education/eating-disorder-information/eating-disorder-information-13

# Children and Adolescents

- Comprehensive assessment which includes Nurse Practitioner, Registered Dietician and Psycho-social assessment of the child and family
- Historically, Family Based Treatment (FBT) is primary focus of intervention
- In recent years more modified versions and adjunct treatments to increase responsiveness

# Evidence Based Treatment: FBT

- FBT (aka: Maudsley Model) is the only evidence based approach for children and adolescents

- For AN:
  - ~50% of adolescent patients with AN fully recover at 1 year follow up with FBT
  - Additional 35 – 40 % significantly improve after 5 years

- For BN:
  - Statistically superior to individual psychotherapy
  - 30-40% abstain from bingeing & purging after treatment with FBT

- Consists of three phases: Weight Restoration, Returning control, Adolescent Identity

# Family-Based Treatment for AN Principles

- Parents portion all meals and snacks.  All that is expected to be consumed is on plate
- Parents determine all meals and snacks
- Parents determine the time/schedule for all meals and snacks
- 24/7 supervision by parents only
- Separation of ED from individual (child's behaviour is symptoms of illness)

# Family-Based Treatment for AN Principles

- Aligned parents
- No negotiation or debates of meals with child
- All responsibility falls on parents for weight gain
- Not looking at the cause of ED until weight is restored, if necessary
- Act now perspective: life stops until (s)he eats- longer the illness decrease in recovery chances

# Treatment: Case Example

Phase 1 (8-10 sessions)

Goals

- Keep family focused on ED and weight restoration efforts
- Help parents take charge/interrupt symptoms
- Mobilize sibling support
- Externalize the illness

Treatment

- Weekly sessions with prime clinician
- Dietitian as needed
- Nurse practitioner stayed involved first 4 months based on level of risk then referred back to GP
- Psychiatry consult if required (medication, safety concerns)

# Treatment: Case Example

## Phase 2 (6 sessions)

Goals

- Maintain parental management until youth is gaining weight independently
- Transfer food/weight control to adolescent (age dependent)
- Encourage adolescent to engage in normal adolescent activities that involve peers, eating, exercise

Treatment

- Bi-weekly sessions with prime clinician
- Dietitian as needed
- Psychiatry consult if required (no improvement in mood/safety)

# Case Example

## Phase 3 (2-4 Sessions)

Goals

- Repair to parent-child relationship (if needed) now that AN is in remission
- Review and problem-solve adolescent development
- Terminate treatment

Treatment

- Monthly meetings with prime clinician

# FBT Non-Responders

**Emotion Focused Family Therapy (EFFT)**

- As an addition to FBT or a treatment to use as a “review” if FBT is at a stand still.
- Focuses on “blocks” that get in the way of parents being able to successfully and confidently weight restore child
- Emotion Coaching to help with communication during difficult moments

**Motivational Interviewing & CBT-Enhanced**

- If parents are unable to do FBT (due to severe mental illness, abuse, etc.)
- Motivate child first, in order to do the work for ED-Treatment
- Use CBT-E (time limited) to work on reduction/cessation of ED symptoms

# Younger Children

- Lack of weight gain or growth in a growing child
- Eating less with refusal to eat with vague or no explanation
- Hyperactivity or restlessness
- Increased interest in cooking and/or watching cooking shows
- Poor body image/drive for thinness not necessarily needed for diagnosis in younger populations

# Treatment for Adults

- Comprehensive Assessment up front includes, Nurse Practitioner, Registered Dietician and Psycho-Social Assessment
- Primarily a group based model of treatment which includes: Psycho-ED, Motivational Enhancement Therapy, Skills, Symptom Interruption, Menu Planning and Body Image
- Individual check ins occur between groups but we typically do not offer individual therapy for adult eating disorders
- Research indicates group therapy as effective and allows us to serve more people
- Exceptions are made when clinically appropriate

# Treatment for Adults

- Assessment
- Psycho-education group- 1 day
- Motivation Enhancement group- 6 weeks
- Dialectical Behaviour Therapy Skills group -12 weeks

# Treatment for Adults

- Symptom Interruption group-12 weeks
- Body image group- 6 weeks
- Art expression group – 6 weeks
- Relapse Prevention group- ongoing

# Referral Process

- We are a community based treatment program serving adults, children and families in Wellington County and Waterloo Region  who struggle with an eating disorder

- Eating Disorders Referrals are managed through our centralized system at HERE24SEVEN

  1-844-437-3247

# Referral Process

- Anyone can make a referral to our ED programs
- Some requirements:
  - For children and youth the family must be aware that it is family based treatment
  - Must not be actively suicidal or psychotic.
  - if they have significant drug addiction, consider this the priority
  - Must be willing to be monitored by GP or Nurse Practitioner

# Shared Care Model for Managing Eating Disorders

- Clear role definitions: medical management, psycho-therapy, nutrition therapy, case management, medication management, diagnosis
- Ongoing communication with other treatment centers and private practitioners re: progress of clients
- Consultation with other care providers re: treatment needs and provide education about Eating Disorders.
- Communication/ consistent messages to clients. Assessments mailed out to referral sources. Closure letters sent to referral sources ( GP, psychiatrist)

# Shared Care for Managing Eating Disorders

- Working together to provide the best care also means looking at our own biases as HCPs
- Weight stigma and bias are barriers to early identification and treatment interfering for EDs
- It may impede our progress in addressing the relationship between weight and health

# What's Your Bias?

- I feel that patients with obesity are often non-compliant with treatment recommendations.
- I feel that patients with obesity lack motivation to make lifestyle changes.
- Other health providers in my field often have negative stereotypes toward patients with obesity.
- I have heard/witnessed other professionals in my field make negative comments about patients with obesity.

# What's Your Bias?

- It is difficult to feel empathy for a patient with obesity.
- Treating a patient with obesity is more frustrating than treating a non-obese patient.
- I would rather treat a non-obese patient than a patient with obesity

# Turning the Traditional Paradigm Around

- Historically, Losing weight = the only way to be healthy
- What we know now from research through a Health At Every Size lens:
  - that large bodies can be fit and healthy and living a healthy lifestyle
  - Those slightly overweight are at less risk for certain medical conditions than those who are underweight
  - Research has shown that genetics play an important role in body size
- Talk with your patients about health, not just weight
- Use indicators of health other than BMI

# Helpful Links

- www.maudsleyparents.org
- www.feast-ed.org
- www.nedic.ca
- www.ocoped.ca
- www.balancedviewbc.ca
- www.haescommunity.org
- www.haltonhealthcare.on.ca/site_Files/Content/Documents/PDFs/Eating_Disorders_Tool.pdf

# Questions?