Orientation video for Pathway

BC Approach to Possible or Confirmed Eating Disorder in Child or Youth

Link to Point of Care Pathway – Pathways BC

QUICK LINKS

↓ Health Equity | ↓ Prevention | ↓ Management | ↓ Clinician Info | ↓ Patient / Caregiver Info | ↓ Clinician Training & Education

Bring awareness of equity considerations to each encounter

How you communicate matters: conscious of biases, culturally aware, and trauma informed

Presentation

- Common Presenting Features
- Differential Dx for Wt Loss/ Growth Failure
- Psychiatric Comorbidities

Screening

Eating Disorder Screening

- SDE
- NIAS

DSM-5 Criteria

- DSM-5

Comorbidities Screening

- Autism Youth
- PHQ-9 Youth
- Suicide Risk
- GAD-7
- Autism Child
- OCD Peds
- Anxiety Child
- Anxiety Parent
- Autistic Traits
- Substance Use

Assessment

- Initial Visit Template
- Confidentiality Clinician Info
- Parent History Form
- Confidentiality Parent Info

Common Investigations

- Initial Labs & ECG
- Imaging

Acuity Assessment At Each Encounter

- Obtain orthostatic vitals & blinded weight
- One or more medical instability criteria?
- Psychiatric / Suicide Risk? TASR-A Suicide Risk Toolkit
- Calculate % premorbid weight & % median BMI (%mBMI)
- Parent History Form

Call for advice if uncertain/ concerned re acuity

Requires Admission → Assess need for involuntary admission (Mental Health Act)

Wt Loss > 25% Premorbid Wt and/or Percent Median BMI for age & Sex < 75%

Wt Loss > 30% Premorbid Wt and/or Percent Median BMI for age & Sex < 70%

High Acuity: Hospital Stabilization Required

(Consider Peds Consultation; patient navigator/support)

Emergency Room

Send family with copy of: Emerg. Rm. Communication Tool

Weight Criterion

Consider amount and time frame of wt loss

High Acuity

Encourage urgent pediatric consultation to guide ER care and admission plans

Extreme Acuity

Encourage urgent consultation with BCCH Adolescent Medicine, to guide guide care planning

Phone: 604 875-2345

Not currently requiring hospitalization

If medically stable, MUST HAVE in-person, outpatient follow-ups. Also, refer to Regional ED Program and local specialists

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BC Approach to Possible or Confirmed Eating Disorder in Child or Youth: Management

QUICK LINKS

↓ Health Equity | ↓ Prevention | ↓ Clinician Info | ↓ Patient / Caregiver Info | ↓ Clinician Training & Education | ↓ Referrals

Working towards adequate food intake and limited energy expenditure is generally first priority

Supporting Effective Caregiver Communication

Initial Visit Template | Follow-up Visit Template | Specialist Triage Template | Guide to Community Medical Follow-up | Team Care Communication Cover Letter

Approach to take: Office Management

Building trust and rapport through repeated visits can help patients feel more comfortable in discussing their challenges

Biopsychosocial assessment attending to the whole person is foundational

Eating Disorders can present as ego-syntonic illness, and some people find it **difficult to acknowledge that they are struggling**

Assessment reliability can be improved through the **integration of collateral history obtained from caregivers** / loved ones

Serial comorbidities reassessment can inform treatment by providing perspective on their potential impacts on the patient's life

Outpatient Management

- Basics
- Beyond Basics

Emergency Rm Management

- Practical Resources

Inpatient Management

- Communication Tools
- Practical Resources

Transitions

Research Participation

CONSISTENCY IN APPROACH & MESSAGING is critical

Ensure regular transparent communication and shared treatment philosophy between patient, family/caregivers and all providers

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EDI Considerations in Eating Disorder Management and General Provision of Care

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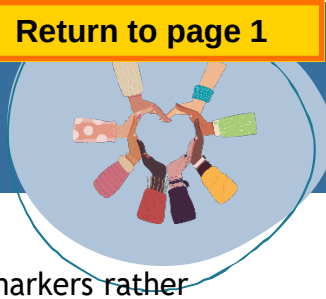

- Consider as indicators of health and well-being, a **Weight Inclusive Approach** which emphasizes anon-weight-based markers rather than a Weight-normative approach which focuses on weight, BMI and weight loss which can be stigmatizing for some patients.
- Consider an **Equity Access to Care** where everyone gets the care they need rather than Equality Access to Care where everyone benefits from the same supports.
- Important to elicit **goals of care/preferences** from the patient and then work with them when the eating disorder can potentially impede those goals through a motivational interviewing lens to shiftthe attachment to the eating disorder.
- The provider can provide a menu of options for the patient dealing with an eating disorder to receiveappropriate support and help from the provider.
- **Involve the family/caregiver** in support of the patient dealing with eating disorder particularlyaround opportunities i.e., family celebrations.
- Providers can bring **cultural humility** – the principle of constant learning through self-questioning, listening, immersion into patient's point of view and flexibility to address conscious and unconsciousbias and assumptions.
- Consider cultural and religious differences in foods and the socio-economic realities of wherethe patient and their family are situated in working with patient/caregiver to respect their environment.
- Be mindful of past and present trauma i.e., impact of colonization and perceived power dynamicswithin the healthcare setting and use a trauma sensitive and aware approach.
- Important to consider health literacy and explain in plain language.
- **Cultural Safety** – consider opportunities to continue learning through the Kelty website.
- **Consider Gender Diversity** and use gender inclusive language. Check in with patient as to how theywish to be addressed.
- **Address anti-Indigenous racism** by taking in webinars and by taking learning modules and start shifting one's approach. Examples of learning modules are: EQUIP healthcare; Sanyas Training; and Jordan's Principle.

Guides to Racialized Communties

ED in LGBT2SQ Communities

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Language Awareness and Sensitivity

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It is important for the Health Care Provider to know that Adolescents and Young Adults(AYA) with eating disorders can experience or perceive language differently than we intend, and an unintentional comment could trigger or perpetuate the disorder. It is important to notice, understand and be mindful of how the meaning of certain words may signify something very different to an AYA with an eating disorder, and appreciate that the eating disorder itself can alter the perception of the communication.

Motivational Interviewing

Emotion Coaching for Caregivers

Recommendations

One needs to exercise special care in the language they choose to use when communicating with AYA with eating disorders, to ensure this language is communicated and understood in the way that it was intended. The care of AYA with eating disorders is built upon relationships; shared language has the potential to cultivate trusting therapeutic relationships and improve patients' experiences and quality of care.Recommendations, based on limited research and expert opinion follow.

1. AYA with ED have different body weight, shapes, and sizes. They may be considered to be at a body weight that is appropriate for them, underweight or overweight.
2. The process of recovery from an ED is challenging. Changes in the body weight, shape, and size of AYA who needs to gain weight as part of their treatment, will be noted. It is important to avoid commenting about a person's changing body and appearance.
3. Avoid talking about dieting, exercise, and calories. Avoid putting the focus of theconversation on food alone.
4. Use non-triggering language, avoiding content and words that will upset or lead to further ED behaviours. For example, utilize phrases such as 'weight recovery' instead of'weight gain'; 'nutrition' or 'energy' instead of 'calories'; 'food is medicine' instead of 'you have to eat more food'.
5. Externalization of the ED is a therapeutic technique used in some treatments of ED to separate the AYA from the ED, i.e., someone has an ED, no one is an ED. Avoid terms like 'anorexic' and 'bulimic'.
6. Avoid using language that implies blame or suggests that the AYA is doing something wrong. Use compassionate and caring language. AYA are more likely to respond when you show concern about their health and well-being.
7. Incorporate a shared language approach: notice, understand, and be mindful of the meaning of certain words, phrases or sentences when communicating with an AYA withan ED.

The graphic below provides strategies for navigating discussions with individuals with Eating Disorders and validating the emotional experience. Examples were generated by one of the co-authors based on clinical experience (Tara Tandan, 2024). For additional communication strategies for adolescents and young adults with Eating Disorders, please see [York, Evans-Atkinson and Katzman (2021)](#).

Illustrations by Tessa Edmondson
@crackedeggart

Instead of saying:

Try saying:

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UBC THE UNIVERSITY OF BRITISH COLUMBIA BC Eating Disorders Research Excellence Cluster
SharedCare Partners for Patients

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Adapted from source: https://academic.oup.com/pch/article-abstract/26/1/8/5821146

Next

Empowering Caregivers to Support their Children & Youth with Eating Disorders: Emotion, Distress Tolerance & Fostering Resilience

Introduction

This handout provides essential tips and techniques for providers to support caregivers in their role of caring for their children and youth affected by eating disorders. It emphasizes building emotional awareness, resilience, and distress tolerance skills. The goal is to empower families to support their children, and to build confidence to navigate meal support challenges more effectively.

One Skill at a Time: Even within a short visit, non-therapist health care practitioners, can teach a single skill, to be practiced by the caregivers, between visits. The choice of which skill to focus on at a given visit may be guided by the specific challenges that the caregivers are describing in their day to day experiences. Skills are cumulative, build up and reinforce each other.

Skill #1: Identifying Emotions - Increasing Emotional Literacy

Emotion is a natural part of being human. The body often lets us know, through physical reactions, that we are experiencing particular emotions. We are also continually sensing and reacting to the behavior and emotions of others, and to the thoughts we generate about what we are perceiving. Our minds may or may not be conscious of our emotions and reactions, but our body gives us clues. Some examples of COMMON emotions, and how they may show up are:

- Anxiety: Racing heart, sweating, engaged muscles.
- Sadness: Slowed movements, heavy feeling, tears, tight throat.
- Anger: Tension, heat, narrowed eyes, clenched fists.

Recognizing Emotions:

Identifying and naming emotions in our loved ones (and ourselves) is an important skill in supporting connected caregiving. Connected caregiving can help build confidence and hope for parents.

Emotions are indicators of particular perceived needs.

Emotion	Perceived Needs
Anxiety	Safety and protection
Sadness	Comfort and solace
Anger	Boundaries and validation

Our tendency is to react (Action Tendency) to our perceived needs:

Emotion	Action Tendency	Example in Eating Disorders
Anxiety	Fight, flight, freeze, avoid	Not completing meals
Sadness	Crying, seeking connection	Tears and shut down during meal time
Anger	Enforcing boundaries (Seeking to have something stop or start)	Throwing food and other objects around meal times

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Skill #2: Accepting (Intense) Emotions As They Are

Riding the Wave: Emotional states are not fixed; they come and go, though in the moment, they can feel like they might last forever. Intense emotion don't tend to last, and can be experienced of as like a wave in the ocean, perhaps triggered by something that we are not aware of. The wave builds and becomes more intense over time, eventually hitting a peak, cresting and then gradually subsiding.

Work towards riding the wave (DBT Skill)

- Identify the emotion (name it to tame it)
- Acknowledge and accept the emotion
- Focus on your breath; create space
- Ride the wave - allow the emotion, don't fight it - it **will** pass
- Practice self-care

Skill #3: Fostering the Caregiver Resilience

Validate the Caregiver: Caring for young people with eating disorders is a marathon, not a sprint. Provider and Caregivers attending to and acknowledging a youth's strengths, as well as sharing hope, is critical both for the youth and for fostering caregiver resilience. The process of attending to and validating intense emotions in a loved one can be exhausting. Helping caregivers strategize about ways to take some time, potentially sharing the load with other supportive adults (as possible), and identifying any pragmatic ideas for their own self-care is an important opportunity for health care providers in supporting their patients and families.

Skill #4: Practicing "Non-Judgment" - Learned through caregiver coaching and careprovider modelling

1. **Practice being able to Observe and Describe:**
   - Stick to observable facts without adding judgments.
   - Recognize the difference between facts and judgments.
2. **Let Go of Labels and "Shoulds":**
   - Replace demands with feelings or desires.
   - Ask for permission.
   - Dont judge judging; focus on observing thoughts.

Skill #5: Validation (reduces anxiety and improves motivation and relationships):

- In paying attention to and deconstructing the emotional roots of a particular behavior, there is an opportunity to meet the underlying emotional need in a different way
- People do not need or want to be talked out of their feelings. They need to be listened to and heard
- Core strategies involve validation, support, presence, comfort, reassurance, attunement, collaborative problem-solving, and for intense emotions, riding the wave
- It is wise to respect boundaries and give reasonable space until the wave settles and it is safe to re-engage
- Caregivers can learn to
  - Understand emotions without necessarily agreeing with particular behaviors
  - Use body language (strategic approach to eye contact, gestures, posture, spacing), voice modulation (pitch, tone, volume) and facial expressions to convey their understanding
  - Apology has been shown to improve relationships, which can help challenge eating disorder identity

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Steps in Validation

1. **Attend** to the emotion and slow things down (breathe) to allow a mindful response. Pay attention by looking and acting interested.
2. **Label** the emotion: "Name it to tame it".
3. **Reflect** back to ensure that you are correctly hearing what is being said, and even attempt to take a stab at reflecting ("mind-reading") things that you sense, which may not have been overtly verbally stated.
4. **Reframe** to convey understanding of feelings: Replace "but" with "BECAUSE" or "AND".
5. **Communicate that you can see the other persons' perspective** and that it **makes sense** based on their current situation.

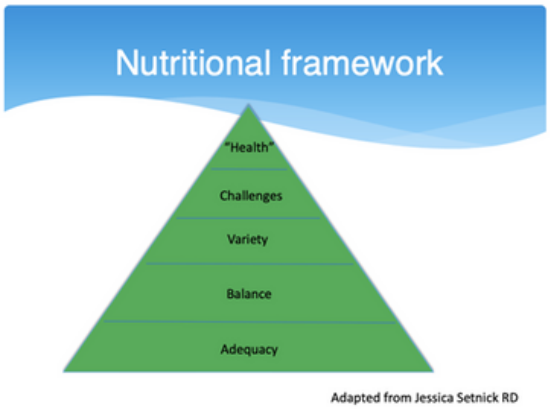
   Ex. I wish you could tell me that without swearing, and I'm seeing that the way I am communicating right now is not helpful. I can see that you are feeling angry because you can't go on that trip that you were really looking forward to, and we have placed so many limitations on what you can do lately.
6. Provide **emotional support:** meet the need for comfort, connection, space and reassurance.

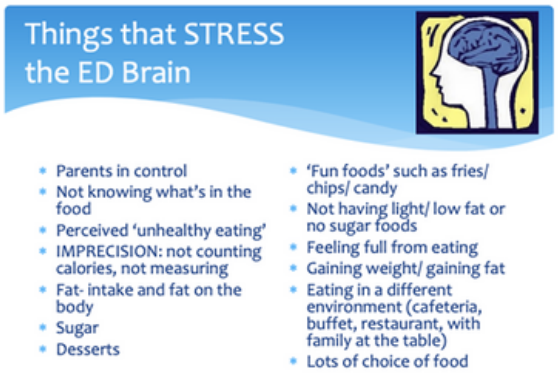
Skills for Managing Distress

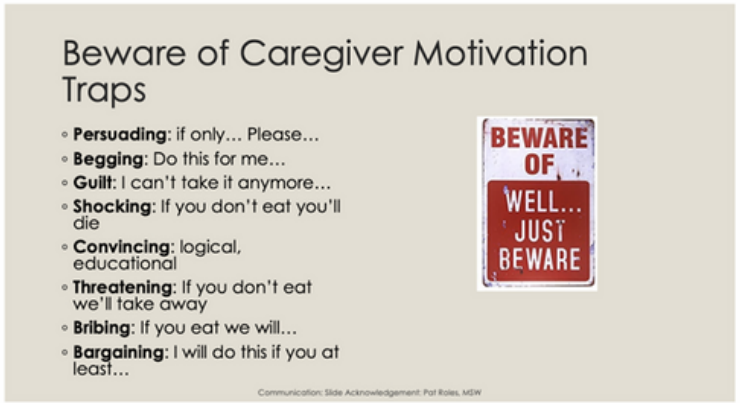
1. **Distress Tolerance - TIPP Modified:**
   - **Tip Temperature:** Use cold water or ice.
   - **Intense Exercise:** Engage in movements like stretching.
   - **Paced Breathing:** Practice breathing exercises.
   - **Progressive Muscle Relaxation:** Tense and relax muscle groups.
2. **Grounding Techniques - Using 5 Senses:**
   - Engage the senses to ground a spiraling thought.

Practical Tips for Guiding Caregivers to Provide Effective Meal Support

1. Spending Time on Parent Psycho-Education: Nutritional Framework, ED Brain Stressors & Caregiver Traps







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2. Review Specific Implementation Tips for "Calm, Confident, Consistent and Compassionate" (4 C's) Meal Support

- **Meal Planning:**
  - Match menu choices with the recovery stage - ie. offer fewer choices earlier in process, as choice is overwhelming
  - Set clear limits with compassion, firmness, using plain and simple language
- **Meal Preparation:**
  - Adjust involvement based on recovery stage (No involvement early on is usually best).
  - Use distractions and set boundaries with empathy
- **Meal Completion:**
  - Anticipate triggers: Consider what is happening today that might make it difficult to eat, or what might make it easier (Reframe).
  - Aim for 100% meal completion in a timely manner.
  - Provide supervision, engagement, distraction, and positive role modelling re: food
  - Use compassionate firmness and prompting. Gentle encouragement; when stuck, encourage 1 more bite. Emotion coaching to meet needs of safety, comfort, clear boundaries, respect.
  - Avoid: Negotiation, judgment, arguments, and sensitive topics, especially around food and appearance.
- **Post-Meal Support:**
  - Recognize that post-meal anxiety, guilt, and pain are common.
  - Listen and observe re: thoughts, feelings, and reactions.
  - Help them manage feelings (which drive behaviors), using distraction, grounding techniques, validation, and TIPP (Temperature, Intense Exercise, Paced Breathing, Progressive Muscle Relaxation); aim to minimize compensatory behaviors like purging, exercise, and self-harm

Supporting youth with eating disorders requires patience, understanding, and the right set of tools. By using these tips and techniques, caregivers can provide effective support and foster a nurturing environment for recovery.

This handout is based on a presentation by Dr. Pei-Yoong Lam, Medical Director of the BC Provincial Specialized Eating Disorders Program for Children and Adolescents, at BC Children's Hospital.

Eating Disorders: Prevention Resources

Prevention Fact Sheet

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Prevention - Clinician

Brief Resources

Embody: Information for Providers
Evidence-based resources to help build your confidence so you can support kids of all ages

Embody for Professionals

National Eating Disorders Association (NEDA)
Eating Disorders Prevention

National Eating Disorders

In-Depth Resources

National Eating Disorders Collaboration (NEDC) - Risk & Protective Factors
The elements that contribute to the development of an eating disorder are complex, and involve a range of biological, psychological and sociocultural factors. An eating disorder is best understood as a complex interaction between these factors, and the presence of risk factors will vary from person to person.

NEDC - Risk & Protective Factors

A Meta-Analytic Review of Trials that Tested whether Eating Disorder Prevention Programs Prevent Eating Disorder Onset
Eric Stice, Z. Ayotola Onipede, & C. Nathan Marti

Meta-Analytic Review of Trials

Prevention of Eating Disorders: A Systematic Review and Meta-Analysis
Long Khanh-Dao Le, Jan J Barendregt, Phillipa Hay, & Cathrine Mihalopoulos

Prevention of Eating Disorders

Prevention - Patient & Family

Brief Resources

Embody: Raising Kids with a Healthy Body Image - Guide for Parents of Young Children
Info sheet on how to discuss body image and be a good role model for children.

Raising Kids with a Healthy Body Image

Next

Eating Disorders: Prevention Resources

Prevention Fact Sheet

Click for Emailable PDF of Links

Prevention - Patient & Family

	Brief Resources
Embody: Media Literacy - Guide for Parents and Youth Info sheet on media influences and how we can respond	Media Literacy Guide
Embody: Young Men and Disordered Eating - Guide for Parents and Youth Men and boys are also affected by eating disorders; this info sheet discusses potential risk factors and warning signs that may indicate an eating disorder and how these signs may be overlooked.	Young Men and Disordered Eating
Embody: Social Media Influencers and Diet Trends Info sheet on the dangers of social media influencers and diet trends.	Social Media Influencers and Diet Trends
Embody: The Overlap between Anxiety and Eating Disorders Info sheet on how anxiety, eating, and feeding disorders overlap and what they are.	Overlap between Anxiety and Eating Disorders
Embody: Health not Weight Info sheet focusing on how to prioritize health and healthy habits, rather than on weight and negative attitudes.	Health not Weight
Embody: Resources to Support Children and Youth Evidence-based resources on: common concerns, body image, navigating media, mental health & resilience, and eating & exercise	Embody BC Resources
Embody: How do I support my child who is struggling with body image? Info sheet on how parents and kids can create a more positive body image environment at home.	How do I support my Child?

Next

Eating Disorders: Prevention Resources

Prevention - Patient & Family

Brief Resources

Body Image for Tweens and Teens
Info on body image and body neutrality.

Body Image for Tweens and Teens

In-Depth Resources

BodyKind
Practical, evidence-informed tips, activities and webinars on being kind to ourselves and our bodies.

BodyKind

Body Peace
A FREE online resource for anyone 14+ in Canada. Whether you're dealing with an eating disorder, or are concerned about your relationship with food, exercise or your body, we're here to help. Our virtual resources include Peer Support Groups, Mentoring, workshops, and educational materials.

Body Peace Canada

BodyWhys: Body Image
This website is intended to broach all questions and concerns you may have in relation to body image. It includes research on body image, practical tips on promoting positive body image for people of all ages, genders, and identities (LGBTQIA+).

BodyWhys

Feed Your Instinct
An interactive tool designed to support parents of children and young people experiencing different types of eating and/or body image problems.

Feed Your Instinct

Foundry
Information, support, and resources to help you develop a better relationship with your body, no matter where you are on your journey.

Foundry BC

Eating Disorders: Prevention Resources

Prevention Fact Sheet

Prevention - Patient & Family

	In-Depth Resources
Embody: Information for Youth Trusted resources that can help youth during hard times.	Embody: Info for Youth
Embody: Information for Parents & Caregivers Trusted resources to help you support your child and encourage a healthy body image.	Embody: Info for Caregivers
Embody: Disordered Eating - A Guide for Parents & Youth Info sheet on forms of disordered eating, and what you can do to help.	Disordered Eating
EmbraceHub Body image resources.	Embrace Hub
Mental Health Foundations - Parent Coaching Videos "Emotion Focused" based communication skills.	Mental Health Foundations
Webinar: Don't Eat That, You'll Get Fat Susan Osher MSc, RD discusses the latest research and shares her clinical experience on creating a positive and nurturing food environment. She focuses on strategies that empower and educate children so that they are able to nourish themselves with self-love.	Don't Eat That, You'll Get Fat
Centre for Clinical Interventions - Looking After Others Information sheets about psychological disorders and problems such as low-self esteem and disordered eating, and provides information about evidence-based interventions.	Looking After Others
Centre for Clinical Interventions - Looking After Yourself Self-help information sheets and worksheets around disordered eating.	Looking After Yourself

Next

Eating Disorders: Prevention Resources

Prevention Fact Sheet

Prevention - Coach and Educator

Brief Resources

NEDC: Eating Disorders in Schools
Prevention, Early Identification, Response, and Recovery support. Please note, some resources are not applicable to the BC Context.

Eating Disorders in Schools

NEDIC: Workshop for Educators
We have developed two educational offerings geared to educators. The first focuses on spotting the signs of disordered eating and eating disorders and supporting students who are affected. The second is geared towards school climate and curriculum, and is fully customizable.

NEDIC: Workshop for Educators

Understanding Eating Disorders in BC Schools
Aiming to generate thoughtful discussion about eating disorders in schools such as prevention (what school personnel need to know and the role of school culture in promoting mental health), identification at school, intervention at school, and supporting recovery at school utilizing trauma informed strategies.

Understanding Eating Disorders in Schools

In-Depth Resources

Embrace Hub: Body Image Resources
Body image resources for young people, parents, teachers and sports coaches.

The Embrace Hub

BodySense
Based on Gail McVey's research from the early 000's about promoting positive body image in sport.

BodySense

Eating Disorders for Sport Coaches, Clubs and Teams
Info sheet on eating disorders in athletes, including prevention, identification, and early intervention.

Eating Disorders for Sport Coaches, Clubs, and Teams

Prevention - Coach and Educator

In-Depth Resources

Embody: Orthorexia - Taking Healthy Eating to an Unhealthy Extreme
Info sheet about orthorexia and the difference between healthy eating and dieting.

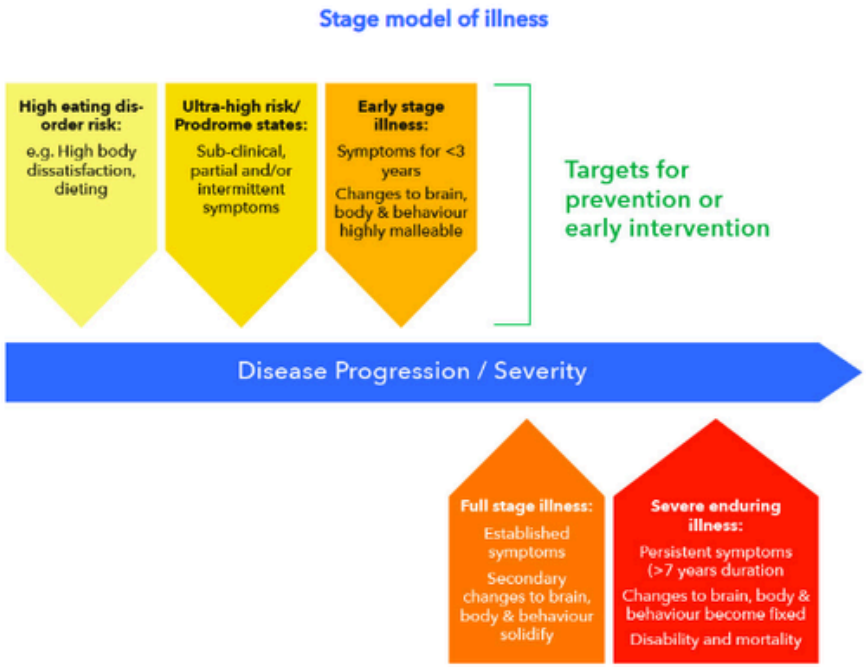
Taking Healthy Eating to an Unhealthy Extreme

Embody: Promoting Positive Body Image - Resource for Educators
Info sheet to support school staff and others to promote positive body image and healthier relationships with food, and help staff address weight-based bullying and concerns about a student's eating.

Promoting Positive Body Image

Embody: Guidelines for School Staff - Helping a Student with a Suspected Eating Disorder
Info sheet on warning signs and symptoms of an eating disorder and how to talk to a student who may be showing signs, how to inform parents, and next steps needed.

Guidelines for School Staff



Lang K, Glennon D, Mountfod V, McClelland J, Koskina, A, Brown A and Schmidt U (2017). Early intervention in eating disorders. Chapter in Wade T (Ed.): Encyclopedia of Feeding and Eating Disorders. Springer. Pp233-238. https://link.springer.com/referenceworkentry/10.1007/978-981-287-104-6_185

Eating Disorder Prevention for Clinicians:Tips and Tricks

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Clinicians are respected professionals with the capacity to foster child and youth well-being. In growing individuals, some foundational pillars of health include eating well, nourishing the body, mind and spirit, and developing a positive and accepting self-image. Negative attitudes about body weight, shape, and food are pervasive in society, and each of us brings our own related biases to our clinical encounters. Ultimately, we should all aim to encourage all children to build bodies capable of supporting them to function well in their daily lives.

Nutritional adequacy and regular eating are important building blocks for child and adolescent physical and mental health.
It is important to be aware of your own sociocultural attitudes about body shapes, dieting, and fat prejudices, especially given the position of authority held by physicians. For a free online resource designed to reduce weight bias and stigma among medical professionals, please visit: Healthy Minds - Balanced View.

Dieting in Young People: Is it a Problem?

Please be aware that dieting can trigger an eating disorder in vulnerable individuals. Given this, regular follow-up, with careful language, is particularly important in young people in whom you have identified body image dissatisfaction and dieting behaviours. Regardless of the reason for weighing or measuring a patient, it is important to attend to any discomfort signaled verbally or in a young person's body language; this is an early opportunity for screening and provides an opportunity to explore how your patient might be feeling in their body.

Conscious Communication

Always be mindful of your words and body language, particularly when engaging in conversations with young people about:
Pros/cons/sustainability of dieting Obesity: risks and management
Risk of unhealthy weight loss practices Role of activity

An example of a place to start a conversation is: "Many young people can feel stressed about how their bodies look, especially in a world where there are a lot of toxic messages about
body shape and size. How are you doing with this / Is this something we can talk about?"

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Prevention Tips: 5 Research Based Recommendations for Physicians (Neumark-Sztainer, 2009)

To focus less on weight and more on sustained behavioral change, physicians should:

- **Discourage Unhealthy Dieting:** Encourage patients to adopt eating and physical activity habits that are sustainable and health-promoting, rather than engaging in unhealthy dieting
    - Dieting often fails to achieve a patient's desired weight change because it may not be sustained long enough and does not always promote healthy eating patterns, potentially leading to episodes of overeating. Research has shown that dieting is linked to weight gain and the onset of obesity. Dieters are twice as likely to be overweight five years later compared to non-dieters. Adolescents who diet are at a higher risk of developing binge eating behaviors. Additionally, dieters are less likely to engage in protective behaviors such as regularly eating breakfast. It is important to be aware of sociocultural influences that may promote dieting.
    - Encourage Healthy Alternatives to Dieting
    - To promote a healthy lifestyle, it is important to avoid modeling dieting behaviors and instead guide individuals towards positive eating and physical activity behaviors that fit into a maintainable lifestyle. Education should be provided regarding alternative behaviors, such as eating fruits and vegetables regularly, paying attention (not obsession) to portion sizes and being mindful of internal signs of hunger and satiety. Additionally, practicing mindful eating can help foster a healthy relationship with food.
      It is crucial to avoid labeling foods as good or bad and to understand what people mean when they say they are trying to "eat more healthily". Emphasizing balanced physical activity is also an essential part of this approach.
- **Promote Positive Body Image:** Support the development of a positive body image to help patients maintain a healthy relationship with their bodies. Avoid using body image dissatisfaction as a motivator for change. Instead, promote body image satisfaction by discussing positive characteristics before addressing weight as a specific health outcome.
  Physicians should help patients develop a positive relationship with their bodies and encourage positive self-talk.
- **Encourage Family Meals:** Support the development of a positive body image to help patients maintain a healthy relationship with their bodies. Avoid using body image dissatisfaction as a motivator for change. Instead, promote body image satisfaction by discussing positive characteristics before addressing weight as a specific health outcome.
  Physicians should help patients develop a positive relationship with their bodies and encourage positive self-talk.
- **Reduce Weight-Centric Conversations:** Encourage families to talk less about weight and focus more on facilitating and modeling positive eating and physical activity habits

Next

- Physicians should practice a “weight-inclusive” approach rather than “weight-normative” approach. According to Fullerton (2016), a weight-normative approach posits that each person has an ideal weight and typically encourages patients to fall within a “normal range”, often suggesting weight loss or gain to achieve this ideal. In contrast, a weight-inclusive approach asserts that individuals can be healthy at any weight, provided they lead a healthy lifestyle. This method minimizes the emphasis on a patients’ weight and avoids assigning any inherent qualities to weight or body size, instead focusing on promoting overall healthy lifestyle changes

- **Address Weight Mistreatment:** Recognize that overweight teens may have experienced weight-related mistreatment and address this issue compassionately with both teens and their families.
  - Fletcher (2011) notes that overweight youth often struggle with popularity and are at risk of social isolation in school. Research indicates that obese children tend to have poor school attendance due to their negative perceptions. Obese children are more likely to have poor attendance, fewer friendships, and face ostracism. The significant stigma associated with obesity among children can lead to worsening self-perception for obese and overweight youth over time as they may experience rejection and neglect (Harris et al., 2016). Children who face rejection are more prone to feelings of loneliness, depression, and aggression. These children are also likely to become increasingly withdrawn, placing them at risk for future issues such as dropping out of school and delinquency. Thus, it is essential for physicians to discuss this issue with youth and their families with empathy and compassion. It is important for providers to highlight the difficulties that families have faced (Silver & Cronin, 2019) and provide psychosocial support.

References:

- Fletcher, A., Bonell, C., & Sorhaindo, A. (2011). You are what your friends EAT: Systematic review of social network analyses of young people’s eating behaviours and bodyweight. Journal of Epidemiology & Community Health, 65(6), 548–555. https://doi.org/10.1136/jech.2010.113936
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Knowledge translation support and document design was provided by Justine Y., in collaboration with the BC Eating DisordersResearch Excellence Cluster

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Common Presenting Features

	Signs & Symptoms	Physiologic Impact
General	Preoccupation with weight, food, or body Weight loss, gain, or fluctuations in weight Failure to gain appropriate weight in youth Fatigue, cold intolerance	Low energy, weakness
Neuropsychiatric	Poor concentration, insomnia, anxiety, low mood, obsessive behaviours, social withdrawal, self-harming behaviours	Seizures, brain atrophy, memory loss, decreased executive functioning, learning difficulties
Head and Neck	Oral trauma, parotid enlargement, temporal wasting, subconjunctival hemorrhage	Gingivitis, enamel erosion
Cardiorespiratory	Hypotension, bradycardia, arrythmias, dizziness, syncope, chest pain, palpitations, edema	Prolonged QTc, cardiac atrophy, pericardial effusion, congestive heart failure, mitral valve prolapse, sudden death
Gastrointestinal	Bloating, early satiety, epigastric discomfort, gastroesophageal reflux	Dysphagia, Esophagitis, Barrett's Esophagus, Mallory-Weiss Syndrome, Boerhaave Syndrome, gastroparesis, superior mesenteric artery syndrome, cathartic colon, acute pancreatitis, transaminitis
Endocrine & Metabolic	Hypoglycemia, delayed puberty, decreased libido, unexplained infertility, amenorrhea, or irregular menses, decreased erections	Hypoglycemia, sick euthyroid syndrome, cortisol dysregulation, pubertal suppression, infertility
Renal	Recurrent UTIs, acute kidney injury, fluid retention, decreased bladder control	Electrolyte abnormalities, (Hypokalemia, hypophosphatemia, metabolic alkalosis), chronic kidney injury
Growth & Musculoskeletal	Muscle wasting, short stature, failure to thrive	Decreased bone mineral density, fracture risk, growth stunting
Dermatologic	Lanugo, hair loss, carotenemia, Russell's sign, xerosis	Poor wound healing, easy bruising, acrocyanosis, cheilitis, nail dystrophy

Source: Mooney, J. (2023). Eating Disorders Toolkit: Standards of Practice in the Primary Care Setting (2nd Edition). Retrieved from: https://compassmentalstorage.azureedge.net/strap/assest/ED_Toolkit_11_Oct23_462ed2868.pdf

Differential Diagnosis for Weight Loss/Growth Failure

Eating disorders can mimic or co-occur with other illnesses. Pay attention to red flags that might suggest an alternate or co-occurring diagnosis. Throughout the diagnostic clarification process, work towards correcting energy balance; patient response can sometimes add diagnostic clarity.

Weight Loss/Failure to Thrive	Etiologies to Consider
Inadequate Intake	Food Insecurity/Psychosocial Stressors
	Esophageal Abnormalities (eg. GERD, Eosinophilic Esophagitis)
	Disorders resulting in decreased appetite (eg. mood/anxiety disorder, constipation)
	Picky Eater, Sensory Challenges
Impaired Absorption	Gastrointestinal: Celiac Disease, Inflammatory Bowel Disease, Severe Reflux
	Metabolic: Cystic Fibrosis
	Infection: Parasitic Infection

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Differential Diagnosis for Weight Loss/Growth Failure

Weight Loss/Failure to Thrive	Etiologies to Consider
Excessive Output/Losses	Relative Energy Deficiency Syndrome (athlete with mismatch between energy intake and output)
	CNS (vomiting with increased ICP)
	Chronic Infection: HIV, TB
	Endocrine: Diabetes
Increased Energy Requirements	Hyperthyroidism
	Malignancy
	Chronic Disease (eg. cardiac, renal)

Please note: Some of these conditions may be comorbid with eating disorders, rather than being solely differential diagnoses. For example: Crohns disease & ED, neoplasm & ED, etc.

Source: Hornberger, L. L., Lane, M. A., Lane, M., Breuner, C. C., Alderman, E. M., Grubb, L. K., ... & Baumberger, J. (2021). Identification and management of eating disorders in children and adolescents. Pediatrics, 147(1).

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Psychiatric Comorbidities

Psychiatric Comorbidity	Anxiety Disorders	Generalized Anxiety Disorder (GAD)	Social Anxiety	Obsessive Compulsive Disorder (OCD)
	Major Depressive Disorder (MDD)/ Depression	Bipolar Disorder	Personality Disorders	Substance Use Disorders
	Psychosis and Schizophrenia	Body Dysmorphic Disorder	Attention Deficit Hyperactive Disorder (ADHD)	Autism Spectrum Disorder (ASD)
	Post Traumatic Stress Disorder (PTSD)	Suicidality	Non-Suicidal Self-Injury	

Please see: Hambleton, A., Pepin, G., Le, A. et al. Psychiatric and medical comorbidities of eating disorders: findings from a rapid review of the literature. J Eat Disord 10, 132 (2022). https://doi.org/10.1186/s40337-022-00654-2 **for further details**

Diagnostic Criteria for Eating Disorders

Anorexia Nervosa

1. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, forchildren and adolescents, less than minimally expected.
2. Intense fear of gaining weight or of becoming fat, or persistent behavior that interfereswith weight gain, even though at a significantly low weight.
3. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognitionof the seriousness of the current low body weight.

Coding note: The ICD-10-CM code depends on the subtype.

Specify whether:

F50.01 Restricting type: During the last 3 months, the individual has not engaged in recurrent episodes of binge-eating or purging behavior (ie. self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

F50.02 Binge-eating/purging type: During the last 3 months, the individual has engaged in recurrent episodes of binge-eating or purging behavior (ie. self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Specify if:

In partial remission: After full criteria for anorexia nervosa were previously met, CriterionA (low body weight) has not been met for a sustained period of time, but either Criterion B (intense fear of gaining weight or becoming fat or behavior that interferes with weightgain) or Criterion C (disturbances in self-perception of weight and shape) is still met.
In full remission: After full criteria for anorexia nervosa were previously met, none of thecriteria have been met for a sustained period of time.

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Specify current severity:

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The minimum level of severity is based, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, on BMI percentile. The ranges below are derivedfrom World Health Organization categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

Mild: BMI ≥ 17 kg/m2
Moderate: BMI 16–16.99 kg/m2
Severe: BMI 15–15.99 kg/m2
Extreme: BMI < 15 kg/m2

Other Specified Feeding or Eating Disorder

Examples of presentations that can be specified using the "other specified" designation include the following:

1. **Atypical anorexia nervosa:** All the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual's weight is within or above the normal range. Individuals with atypical anorexia nervosa may experience many of the physiological complications associated with anorexia nervosa.
2. **Bulimia nervosa (of low frequency and/or limited duration):** All the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than 3 months.
3. **Binge-eating disorder (of low frequency and/or limited duration):** All the criteria for binge-eating disorder are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than 3 months.
4. **Purging disorder:** Recurrent purging behavior to influence weight or shape (e.g. self- induced vomiting, misuse of laxatives, diuretics, or other medications) in the absence of binge eating.
5. **Night eating syndrome:** Recurrent episodes of night eating, as manifested by eatingafter awakening from sleep or by excessive food consumption after the evening meal.
   There is awareness and recall of the eating. The night eating is not better explained byexternal influences such as changes in the individual's sleep-wake cycle or by local social norms. The night eating causes significant distress and/or impairment in functioning. The disordered pattern of eating is not better explained by binge-eating disorder or another mental disorder, including substance use, and is not attributable to another medical condition or to an effect of medication.

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Avoidant/Restrictive Food Intake Disorder

1. An eating or feeding disturbance (e.g. apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) associated with one (or more) of the following:
2. Significant weight loss (or failure to achieve expected weight gain or faltering growthin children).
3. Significant nutritional deficiency.
4. Dependence on enteral feeding or oral nutritional supplements.
5. Marked interference with psychosocial functioning.
6. The disturbance is not better explained by lack of available food or by an associatedculturally sanctioned practice.
7. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way inwhich one's body weight or shape is experienced.
8. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

Specify if:
In remission: After full criteria for avoidant/restrictive food intake disorder werepreviously met, the criteria have not been met for a sustained period of time.

Bulimia Disorder

1. Recurrent episodes of binge eating. An episode binge eating is characterized by both of the following:
2. Recurrent inappropriate compensatory behaviors to prevent weight gain, suchas self-induced vomiting, misuse of laxatives, diuretics or other medications, fasting, orexcessive exercise.
3. The binge eating and inappropriate compensatory behaviors both occur, on average,at least once a week for 3 months.
4. Self-evaluation is unduly influenced by body shape and weight.
5. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Specify if:

In partial remission: After full criteria for bulimia nervosa were previously met, some, but not all, of the criteria have been met for a sustained period of time.

In full remission: After full criteria for bulimia nervosa were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based on the frequency of inappropriate compensatorybehaviors (see below). The level of severity may be increased to reflect other symptomsand the degree of functional disability.

Mild: An average of 1-3 episodes of inappropriate compensatory behaviors per week.
Moderate: An average of 4-7 episodes of inappropriate compensatory behaviors per week.
Severe: An average of 8-13 episodes of inappropriate compensatory behaviors per week.
Extreme: An average of 14 or more episodes of inappropriate compensatory behaviors perweek.

Binge Eating Disorder

1. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
2. Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
3. A sense of lack of control overeating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
4. The binge-eating episodes are associated with three (or more) of the following:
    - Eating much more rapidly than normal.
    - Eating until feeling uncomfortably full.
    - Eating large amounts of food when not physically hungry.
    - Eating alone because of feeling embarrassed by how much one is eating.
    - Feeling disgusted with oneself, depressed, or very guilty afterward.
    - Marked distress regarding binge eating is present.
5. Binge eating occurs, on average, at least once a week for 3 months.
6. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

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Specify if:

In partial remission: After full criteria for binge-eating disorder were previously met,binge eating occurs at an average frequency of less than one episode per week for a sustained period of time.

In full remission: After full criteria for binge-eating disorder were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based on the frequency of episodes of binge eating (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

Mild: 1-3 binge-eating episodes per week.
Moderate: 4-7 binge-eating episodes per week.
Severe: 8-13 binge-eating episodes per week.
Extreme: 14 or more binge-eating episodes per week.

Unspecified Feeding or Eating Disorder

This category applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet thefull criteria for any of the disorders in the feeding and eating disorders diagnostic class.

The unspecified feeding or eating disorder 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., in emergency room settings).

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Rumination Disorder

1. Repeated regurgitation of food over a period of time of at least 1 month. Regurgitated food may be re-chewed, re-swallowed, or spit out.
2. The repeated regurgitation is not attributable to an associated gastrointestinal orother medical condition (e.g. gastroesophageal reflux, pyloric stenosis).
3. The eating disturbance does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, binge-eating disorder, or avoidant/restrictive food intakedisorder.
4. If the symptoms occur in the context of another mental disorder (e.g. intellectualdevelopmental disorder [intellectual disability] or another neurodevelopmental disorder), they are sufficiently severe to warrant additional clinical attention.

Specify if:
In remission: After full criteria for rumination disorder were previously met, the criteria have not been met for a sustained period of time.

Pica

1. Persistent eating of nonnutritive, nonfood substances over a period of at least 1month.
2. The eating of nonnutritive, nonfood substances is inappropriate to the developmentallevel of the individual.
3. The eating behavior is not part of a culturally supported or socially normative practice.
4. If the eating behavior occurs in the context of another mental disorder (e.g. intellectualdevelopmental disorder [intellectual disability], autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe towarrant additional clinical attention.
5. Coding Note: The ICD-10-CM codes for pica are F98.3 in children and F50.89 in adults.

Specify if:
In remission: After full criteria for pica were previously met, the criteria have not been met for a sustained period of time.

Knowledge translation support and document design was provided by A. Tung, in collaboration with the BC Eating DisordersResearch Excellence Cluster

Treatment for Children & Youth with Eating Disorders: The Basics

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Regional ED Programs | BC Specialized ED Programs | Foundry in Your Area

Expectations

Though people do not choose to develop eating disorders, and full recovery is possible,it is often a prolonged and non-linear process. Eating disorders usually involve some periods of restricted intake. See: Eating Disorders Information Sheet - What is Starvation Syndrome All patients benefit from reversal of restriction. With refeeding / weight gain and improved physical health as a frequent result of initial treatment, thereis often a corresponding expected, transient increase in psychological symptoms and distress. It is important to prepare patients and caregivers for this.

Goals

As stated in the AED REPORT 2021 | 4th EDITION, "in all patients with an ED, restoration or maintenance of an appropriate, healthy weight consistent with their preillness trajectory will significantly improve their physical, psychological, social, and emotional functioning". Therefore, treatment should focus on:

- Medical stability and managing any refeeding syndrome
- Nutritional rehabilitation (weight, micronutrients)
- Normalized behaviors - interruption of binge/purge cycle etc.
- Improved psychosocial/psychiatric well-being: where relevant, other therapeutic/psychological goals may be addressed in parallel.

Visits

Have the youth **come in regularly for medical checks** to monitor vital signs and weight.**Be mindful of how you talk** about weight or food, particularly around weight bias or a dieting mindset. In the eating disorder treatment programs, there is generally a philosophy of health at every size and that all foods can be part of a nutrition plan.
Don't be afraid to encourage the youth to **take steps to change their eating.** Set goalsthat are measurable and attainable and make the plan explicit. Challenge negative thinking patterns: See Calorie Counting and Regular Eating for Recovery
For youth struggling with binge eating, **focus** on helping them to decrease the loss of control feeling around food by having regular meals and snacks. Rather than suggesting they decrease a certain type of food, suggest ways they can add into their meals e.g. add in a balanced food item like a sandwich to help you not feel likeyou have to binge on

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cookies. **Avoid labeling foods as bad or good.**

Regular Nutrition

Whether someone is struggling with anorexia, bulimia, ARFID or binge eating, **a key firststep is having regular nutrition** throughout the day in adequate amounts. That said, each type of eating disorder benefits from slightly different approaches to achieve thisoverall goal.

- For individuals struggling with restrictive eating the initial goal is to **help them toget to the total amounts of nutrition compatible with health and to not be as focused on variety.** Meal supplements are a tool that can assist in this goal.
- For those struggling with binge eating ensuring that they are eating sufficient amounts during the day to decrease hunger which is a physiological driver of binging is important, followed by a focus on **helping them to develop coping strategies to manage the psychological triggers for binges.**
- Individuals struggling with specific fears around food that are non-weight/shape based can benefit from a **CBT informed hierarchy with graduated exposures to thefeared food situations.**

Involve Families/Caregivers/Support Network

Eating disorders thrive in secrecy and the research literature demonstrates that **familyinvolvement contributes to improved outcomes** for youth with eating disorders.

Family members (i.e., parents, caregivers, partners) should be included in ED treatmentwhenever possible.

Meal Support

Meal Support is **an integral part to helping** a young person struggling with an eatingdisorder.

This typically involves a parent or guardian sitting with the youth for all meals and snacks to provide support and encourage them to complete the nutrition. Families mayalso wish to involve school staff for certain meals.

The Kelty Eating Disorder Website has a video on meal support that can be helpful forfamilies to review

Refer

Refer to the local eating disorder program if the symptoms are impacting on functioning or the youth is underweight/malnourished (irrespective of BMI) and experiencing medical complications suchas bradycardia or there is a concern about impact to growth and development. Please be mindful of local referral criteria/exclusion, e.g. ARFID, Binge Eating Disorder.

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Specific Eating Disorder Therapy

Resources - Academy for Eating Disorders

The treatment with the most evidence for adolescents is family-based treatment (FBT), particularly for AN, BN, and ARFID. See: Eating Disorders Information Sheet - Family Based Therapy for consumers carers and professionals. For ARFID, exposure-based treatments and "food-chaining" are **largely effective.** There is some evidence to support cognitive behavioural therapy (specifically CBT-E) for older adolescents, and youth with Binge Eating Disorder (BED). This modality requires some level of motivationon the part of the youth and is not designed for youth that are ambivalent or not interested in treatment. Most publicly funded eating disorder programs will require caregiver involvement. Also stated in the AED REPORT 2021 | 4th EDITION, "Weight restoration alone is not sufficient in itself for full recovery. It is equally important that distorted body image and other ED thoughts/ behaviors, psychological and psychiatric comorbidities and any social or functional impairments be addressed by qualified professionals during the treatment of patients with EDs".
Understanding Motivational Interviewing can help to identify values-based treatmentgoals across types of Eating Disorders.

Medical Management

Non-Pharmacologic Management Help Tips

Eating Disorders require medical monitoring including **regular weights and vital signs.** When doing a weight, we suggest asking the youth **if they feel comfortable with seeing the number,** as this can help build distress tolerance. Alternatively having themset onto the scale with their back to the number may be a less anxiety provoking situation. If discussing weight, **try to keep the conversation neutral and focus on the health consequences** of the situation, such as under-eating or having unstable vital signs.

If medically unstable (e.g., HR <45), patients should be referred to the local emergencydepartment for further assessment. See Eating Disorder Toolkit for Primary Practitioners and Eating Disorders: A Guide to Medical Care and Medical Pearls - Academy for Eating Disorders - Brief Video Clips for Provider Education for further details.

Activity & Exercise

Guide to Reintroducing Physical Activity

Shared Communication

Shared Communication Tool

Inpatient D/C Summary

Patient/Caregiver D/C Instructions

Transition of Care Comm. Tool

Inpt. D/C Instructions

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Medication Treatment

Pharmacologic Management

(Ref: Canadian practice guidelines for the treatment of children and adolescents with eating disorders)

Medications are **not the primary treatment** for eating disorders and are typically usedto manage comorbid symptoms of depression or anxiety.

Individuals, while at very low weight, are less likely to respond to an SSRI. It is important that **renourishment and weight restoration be considered** when decidingwhen to increase the SSRI.

There is some evidence that **high dose SSRIs may be beneficial** for individuals withbulimia nervosa.

Be careful about prescribing medications that may prolong the QTc interval.

- SSRI - **When treating comorbid mood and anxiety disorders consider an SSRI** suchas **fluoxetine or sertraline.** In individuals who are severely underweight SSRIs oftenhave limited effect and therefore you may wait until the youth has been able to increase nutrition and weight before starting an SSRI.
- Olanzapine - Olanzapine has been reported to **help some individuals with anorexianervosa.** The goal of the medication is **not to increase appetite or contribute to weight gain but rather target severe anxiety or mood symptoms.** Low doses of olanzapine should be employed in the range of 1.25-5mg per day. It is important to monitor for metabolic syndrome and QTc when on an atypical antipsychotic.
- Benzodiazepines - There is **no evidence to support the use of benzodiazepines** inyouth to reduce anxiety around eating.
- Higher Doses of SSRIs - **Higher doses of SSRIs (eg fluoxetine 60mg) has been shownto help the binge/purge urges** for individuals with bulimia nervosa.

References

- Some content adapted with permission from the Compass Eating Disorders Toolkit, BC Children's Hospital, 2023
- https://higherlogicdownload.s3.amazonaws.com/AEDWEB/27a3b69a-8aae-45b2- a04c-2a078d02145d/UploadedImages/Publications_Slider/2120_AED_Medical_Care_4th_E d_FINAL.pdf.

Knowledge translation support and document design was provided by A. Tung, in collaboration with the BC Eating Disorders Research Excellence Cluster

Would my patient with a possible or confirmed eating disorder benefit frompharmacotherapy?

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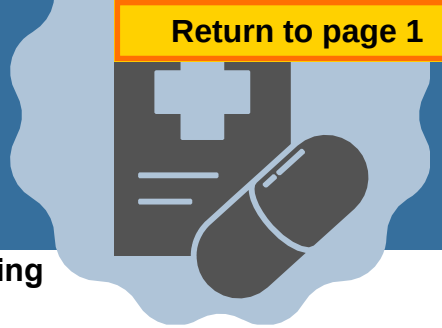

For help with considerations around prescribing (specific medication, indication, dosing,monitoring & safety etc.), consider calling BCCH Compass Line: 1-855-702-7272

Background:

- Medications are not the primary treatment for eating disorders
- In this population (with various states of malnutrition), symptoms of anxiety anddepression are common
- Pharmacotherapy for comorbid symptoms may be appropriate in some instances (e.g.anxiety or depression symptoms predating onset of eating disorder)
- Approach for severe and functionally impairing mood and anxiety symptoms is nuancedand may require expert consultation
- There is no evidence to support the use of benzodiazepines in youth to reduce anxietyaround eating
- Individuals who are very low weight are less likely to respond to an SSRI. It is important that renourishment and weight restoration be considered when deciding when to start orincrease an SSRI
- There is some evidence that high dose SSRIs may be beneficial for individuals with bulimianervosa (e.g. Adult Literature shows good evidence for fluoxetine in decreasing binge - purge urges). This can be considered with appropriate consultation
- Be careful about prescribing medications that may prolong the QTc interval, especially if there is more than 1 medication involved.

Second Generation Antipsychotics

(eg. Olanzapine/Aripiprazole/Quetiapine)

- Although the evidence-base supporting these specific medications is scant and of poor quality, expert opinion suggests potential benefit in carefully selected treatment contexts
  - With appropriate consultation (e.g. Child & Adolescent Psychiatry, Pediatrics, Adolescent Medicine, and others with expertise in the treatment of children and youth with eating disorders), these medications may be considered
  - Baseline bloodwork and ECG, and serial monitoring of clinical response and labs is required to gauge efficacy and safety
- **Olanzapine & Aripiprazole (and Quetiapine - BCCH expert opinion)** have been reported to help some

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individuals with anorexia nervosa. The goal of the medication is to target severe anxiety or mood symptoms, as opposed to the medication causing weight gain secondary to increased appetite.

- Olanzapine or aripiprazole may be reasonable treatment options for certain populations of children and adolescents with Anorexia Nervosa if monitored carefully.This is a weak recommendation
- Three small poor-quality studies found aripiprazole showed some modest benefit in adolescents with Anorexia Nervosa
- When utilized, these medications should be **initiated** at a very low dose and **titrated** very carefully
  - **Initiation**: Olanzapine: 0.625–1.25 mg, recognizing that smaller doses e.g. 0.625 mg olanzapine might be challenging to measure out. Typical starting dose often 1.25 -2.5 mg; Aripiprazole: 0.5–1.0 mg, recognizing that smaller doses e.g. 0.5 mg aripiprazole might be challenging to measure out. Typical starting dose often 1mg; Quetiapine: 12.5mg
  - **Titration**: e.g. Expert consultants may advise low doses of olanzapine, **titrated within** the range of 1.25-5mg per day for select cases

- It is important to monitor baseline and serial parameters for metabolic syndrome and QTc when on an atypical antipsychotic, and to consider medication treatment time frame and goals

Other Medications

- Although there are **additional promising medications** on the horizon, the use of other medications for the purposes of eating disorder treatment requires **more research** before definitive recommendations can be made. These medications should be a priority for research. These include:
  - **Selective Serotonin Reuptake Inhibitors** (fluoxetine for Bulimia Nervosa in Pediatric Population).
  - **Risperidone and Quetiapine** for use in **Anorexia Nervosa**.
  - **Atypical Antipsychotics** for use in **Avoidant/Restrictive Food Intake Disorder**.
  - **Mirtazapine** use for patients with Anorexia Nervosa.
- Medications that are not recommended & have no evidence to support their use in thetreatment of primary eating disorder symptoms, or are harmful:
  - Selective Norepinephrine Reuptake Inhibitors – no evidence
  - Mood Stabilizers - no evidence
  - Bupropion/Wellbutrin (Contraindicated) : not recommended for use in eating disorders, due to the elevated risks of seizures in this population

Sedation and Agitation:

- Need for sedation (e.g. for NG tube insertion) or for pharmacologic management of acuteagitation, arises from time to time in caring for children and youth with eating disorders
- **Common medications to use for NG tube insertion or acute, severe agitation** in youth with **eating disorders** may potentially include (**Table 1** is selected information from the full reference: Child Health BC Provincial Least Restraint Guideline):

Table 1
(Leung 2022, as cited in Child Health BC, 2022)

Medication Options	Action	Adverse Effects	Contraindications
Methotrimeprazine (Nozinan) Can be given PO or IM	Low potency First Gen Antipsychotic	Sedation, anticholinergic effects, postural hypotension, less risk of EPS vs haloperidol	Avoid: hypotension,anticholinergic delirium Caution: Seizure disorders, cardiac conditions, other QTc prolonging meds
Diphenhydramine (Benadryl) Can be given PO or IM	Antihistamine; anticholinergic	Sedation in agitation: anticholinergic effects; may prolong QTc, may cause paroxysmal agitation in neurodiverse individuals	Avoid: anticholinergic delirium Caution: ileus, narrow angle glaucoma
Lorazepam Can be given PO, SL, IM	Benzodiazepine	Mild CVS depression Potential respiratory depression, may cause paroxysmal agitation in neurodiverse individuals	Avoid: respiratorydepression Caution: patients taking opioids

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Loxapine Can be given PO or IM	Moderate potency First Gen Antipsychotic	Moderate incidence of EPS, dystonia and anticholinergic effects; may prolong QTc	Caution: cardiac conditions, seizure disorders, other QT prolonging medications, anticholinergic delirium

Management of Antipsychotic Medication Adverse Effects (uncommon but serious)		
Adverse Effect	**Medication**	**Dose**
Extrapyramidal Symptoms (EPS)	Benztropine	0.5-1.0 mg/dose PO/IM Max: 0.1 mg/kg/24hrs OR 6mg/24 hrs. For Acute Dystonia: 1-2mg/dose IM/IV
	Diphenhydramine	1mg/kg/dose PO/IM/IV (round to nearest 5mg) Max: 50mg/dose. Given with haloperidol to prevent dystonic reaction. For Acute Dystonia: Use IM/IV route

References:

1. Some content adapted with permission from the Compass Eating Disorders Toolkit, BC Children's Hospital, 2023
2. Canadian practice guidelines for the treatment of children and adolescents with eating disorders; Jennifer Couturier et. al, 2020, J. of Eating Disorders
3. Child Health BC. Provincial Least Restraint Guideline; Initial Management of Least Restraint in Emergent/Urgent Care and Inpatient Settings. Vancouver, BC: Child Health BC, January 2022: https://childhealthbc.ca/mhsu/least_restraint/guideline
4. https://psychiatryonline.org/doi/epdf/10.1176/appi.books.9780890424865
5. https://www.ementalhealth.ca/index.php?m=article&ID=61028

BC Children's Hospital | Compass Mental Health Supporting Providers

Pathways www.pathwaysbc.ca

THE UNIVERSITY OF BRITISH COLUMBIA BC Eating Disorders Research Excellence Cluster

SharedCare Partners for Patients

Knowledge translation support and document design was provided by A. Tung, in collaboration with the BC Eating Disorders Research Excellence Cluster

Specialist Triage Form

Dear Dr. : _____ **Date:** _____

Re: _____ **DOB:** _____

Referral Response

Thank you for your referral, it has been received.

Referral for Outpatient Consult:

- ☐ **Accepted**
  Your referral is complete. Your patient will be scheduled via our usual sheduling protocol.
- ☐ **On Hold**
  Due to evidence of acuity. Please refer to the Red Assessment Box on page one of the Clinical Care Pathway for guidance around instability criteria and recommended steps. Consider seeking immediate specialist advice with your local on-call Pediatric representative.
- ☐ **More Information Needed**
  In order to arrange an initial appointment, please provide us with additional information to facilitate triaging. In the interim, you may choose to contact this office directly to request a scheduled provider- to provider telephone advice call.

Triage Information for Pediatric Consult

Please provide all of the requested triage information, as able, including documentation of history, physical (including weight & orthostatic vitals), recent labs & ECG, and status of referral to Regional Eating Disorders Program. If referral is from a WIC or ER, please attempt to arrange for a patient follow-up visit somewhere to ensure that all requested info is obtained.

Please fill out the following:

1. **History**

Eating Disorder Behaviors:

- ☐ Selective (too picky)
- ☐ Restrictive (too little)
- ☐ Binge
- ☐ Purge
- ☐ Laxatives/Diet Pills
- ☐ Over-exercise
- ☐ Fluid excess or restriction
- ☐ Stimulants, synthroid, diuretics, energy, drinks, smoking, insulin

Psychiatric/Safety Concerns:

- ☐ Self-Harm
- ☐ Suicidal ideation
- ☐ Suicidal attempts
- ☐ Domestic violence/intimate partner violence
- ☐ Substance abuse
- ☐ Other (eg. comorbidities):

Please fill out the following:

2. Reproductive Data	
Menarche Data: _____	**LMP:** _____
Historical Amenorrhea: ☐ Yes ☐ No	**Hormonal Contraception:** ☐ Yes ☐ No
Details: _____	

3. Physical Exam			
Growth Data:	**Max Wt:** _____	**Max Ht:** _____	**Age/Year:** _____
	Min Wt: _____	**Please send any historical growth data as available.**	
Vital Signs:	**HR Lying:** _____	**HR Standing:** _____	
	BP Lying: _____	**BP Standing:** _____	

Investigations: CBC, diff, electrolytes, random glucose, BUN, Creatinine, Calcium, Phosphate, Magnesium, CRP, Zinc, Prealbumin, creatinine kinase, Ferritin, TSH, reproductive hormones (LH, FSH, Estradiol, Testosterone as appropriate), 25-OH Vitamin D, salivary amylase, UA, 12 lead ECG, last DEXA (if available)

4. Care Providers

Service:	**Name/Location/Contact:**	**Current:**	**Past:**
Mental Health Team			
Counselor/ Therapist			
Psychologist			

Next

Please fill out the following:

4. Care Providers			
Service:	**Name/Location/Contact:**	**Current:**	**Past:**
Dietitian			
Pediatrician/ Internist			
PCP			
Eating Disorder Program			
Other			
5. Intersectionality: Individual & Family Level Factors Impacting Care			
Patient Related:			
Family Related:			
Other:			

As per your regional conventions, please additionally consider immediate referral to your regional eating disorders program (see Referrals Section - bottom of page 2 on Clinical Care Pathway, for guidance). Note that direct referral from primary care to the regional program at the earliest opportunity helps minimize unnecessary barriers to and delays in care while on a community pediatrician's waitlist. Regional programs waitlists vary and may be lengthy.

Referral Status

Have you already referred to the local Secondary Care/Regional ED Program?

☐ **NO**

☐ **YES**

Date Referral Sent: _____

Travel / Activity Refund

Date

RE: _____

Dear Sir/Madam:

Please be aware that the above-named child/youth requires ongoing medical treatment and follow-up for a significant health condition. The youth and family have been advised, for medical reasons, not to travel/participate in_____at this time.

We would like to request that a full refund for travel / activity: _____ be made for this youth and family, as family support is an integral component in supporting health improvement for this child/youth.

Please contact (phone number):_____with any questions or concerns.

Yours Sincerely,

Print

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Teams / Coaches / Practice Accommodation

Date:

RE: _____

Dear Sir/Madam:

Please be aware that the above-named child/youth requires ongoing medical treatment and follow up. This may necessitate absences from practices and/or games and competitions due to scheduled appointments.

This child/youth may only be able to participate in a limited physical capacity. It is hoped that this capacity may gradually increase as their health improves. Some physical activity may need to be adapted or put on hold at this time. This child/youth requires such accommodations to support improved health outcomes.

We would strongly recommend including the child/youth and caregiver (as much as possible) in discussing options for how appropriate participation may be achieved. As care providers working with youth/family, we will provide information to the youth and their caregivers to guide those discussions. The youth may advocate for more activity than is medically recommended. Adapted inclusion in the social aspect of this youth's activity may be helpful and supported, depending on the specifics of the situation. Please ensure you are communicating with the caregivers for collateral information and nuances on how to proceed in adaptations, in line with medical recommendations.

Increased activity level can contribute to physical, social, and emotional fatigue. Flexibility and compassion on the part of the activity program is helpful in supporting this child/youth's health. If these accommodations are not able to be achieved, we would request that the youth/family be accommodated to withdraw, and their payment refunded.

Please contact (_____) with any questions or concerns.

Yours Sincerely,

School Accommodation

Date

RE: _____

To Whom It May Concern:

Please be aware that the above student requires ongoing medical treatment and follow-up. This may necessitate absences from school up to twice weekly for scheduled appointments. Please encourage the student/caregivers to let teachers know in advance about absences due to medical appointments so that accommodations can be made for school assignments and/or deadlines.

Some students may only be able to attend school for half days, gradually increasing school time as their health improves. Physical education likely will need to be adapted or on hold for some students. Please allow for accommodation if this is requested by the student/caregiver.

We would strongly recommend including the student/family (as much as possible) in discussing options for how to make up for missed work and assignments. We also recommend reducing homework expectations, as this student requires a lot of rest. Homework should be cautiously reintroduced, in collaboration with the patient and family. It is recommended that teachers adapt the academic expectations from missed schoolwork during the student's absence, by making the student responsible for only the **core competencies.** Flexibility with deadlines for assignments and provision of opportunities for the student to develop alternative options for meeting course outcomes in collaboration with the educator is recommended.

Participation in school and activities may contribute to the student's physical, social, and emotional fatigue. Flexibility and compassion on the part of the subject teacher in extending deadlines and adapting assignments is helpful.

Please contact _____ with any questions or concerns.

Yours Sincerely,

[Name: _____]

Template: Eating Disorder Communication and Health Care Passport - Document for the Neuro-Diverse Patient with History of Dysregulation

[photo]

My name is : _____, I am an _____ year old _____ (gender identity).

My preferred pronouns are: _____

I have an eating disorder diagnosis of: _____

Other relevant diagnoses that I have include:

1. _____
2. _____
3. _____
4. _____
5. _____

Things I love: _____

General Principles of how you can best help me....

- ☐ Remain calm - be patient, tolerant, and understanding
- ☐ Please inform me of changes with as much time as possible to allow me to adjust
  - ☐ I may need more time than others to adjust to sudden and unexpected changes
  - ☐ _____
  - ☐ _____
- ☐ I self-regulate best in: _____spaces/situations
  - ☐ Please review my regulation strategies as they are very important to me
- ☐ Speak to me using _____ language

☐ I prefer (direct, concise and unambiguous) _____ language
- I often take things literally

☐ Always explain what will happen and why

☐ _____

☐ Please ask/tell me and wait for my response before you touch me

☐ Avoid physical touch unless essential for medical review and safety

☐ Be mindful of my personal space

☐ When distressed: I may _____. These are my coping strategies.

☐ I have a history of hurting others when I am distressed

☐ I do not have a history of hurting others

☐ I will not hurt you

☐ Please give me time to regulate on my own and/or communicate your actions before using physical or chemical restraint

RED SECTION: ESSENTIAL MEDICAL INFORMATION

[Names, pronouns]: _____

My Date of Birth: _____

Home Address: _____

Emergency Contact: _____

Telephone: _____

Email: _____

Family Doctor: _____

Community Therapist: _____

Community Dietician: _____

Diagnosis History: _____

_____

Allergies:

Known Drug Allergies: _____

Known Food Allergies:_____

Medications: _____

_____

Scheduled medications: _____

PRNS: _____

Next

ORANGE SECTION: ESSENTIAL MEDICAL INFORMATION

How to best COMMUNICATE with me:

- ☐ Ask me if it's a good time to meet
- ☐ I am a _____individual
- ☐ Please don't talk down to me
  - ☐ Be clear, concrete, concise
  - ☐ Avoid figurative language - I may take you literally
  - ☐ Keep questions short and specific
  - ☐ Eye contact is difficult for me
    - ☐ Please don't expect me to look at the person talking to me
- ☐ I always like choices
- ☐ I sometimes like choices, but too many choices overwhelm me
- ☐ Please support me TO AVODCATE FOR MYSELF WHEN:
  - ☐ I need a break
  - ☐ I need to leave/exit
  - ☐ I need to change the topic

Sensory Profile: *Please always ask to touch before doing so*

<u>Sensory inputs that bother me:</u>

Sounds: _____

Smells: _____

Movements: _____

Temperature: _____

Tactile: _____

Other: _____

Sensory inputs that I like:

Sounds: _____

Smells: _____

Movements: _____

Temperature: _____

Tactile: _____

Other: _____

Next

Regulation Plan:

Here is some information about what dysregulation might look like in me, how I summarize my behaviors, and how you can best support me when I am trying to regulate myself.

I have a history of: _____ when I am upset. Please exhaust all harm reduction options, prior to moving forward with instituting a higher level of support (ie. calling 911). Please communicate your plan to me so I have a chance to change my behavior.

Primary Dysregulation Behaviors:

_____
_____
_____
_____
_____
_____

Intermediate Dysregulation Behaviors:

_____
_____
_____
_____
_____
_____

Severe Dysregulation Behaviors:

_____
_____
_____
_____
_____
_____

Interventions:

- ☐ Verbal de-escalation, eg. redirect behavior, offer alternatives
- ☐ Constant observation
- ☐ Remove NG tube from room after self-removed
- ☐ Use sound machine for milieu
- ☐ Offer ice pack and/or ice, cold cloth, gloves (to rip), scratchy pad

Next

When you feel like you need to resort to chemical or physical restraints, please do the following:

1. Clearly explain the boundaries of which behaviors are acceptable and which behaviors need to stop
2. Please inform me when you have called security so I am aware of your plan
3. Please allow me the opportunity to be complaint to your direction prior to restraints
4. Please inform me if anyone is going to touch me (security, nursing, etc).

I have a history of: _____ when I am upset. Please exhaust all harm reduction options, prior to moving forward with instituting a higher level of support (ie. calling 911). Please communicate your plan to me so I have a chance to change my behavior.

GREEN SECTION: THINGS I LIKE/DISLIKE

Key things I want you to know about me:

Important people in my life:

Things I like to talk about:

Things that cheer me up:

Things that upset me:

Knowledge translation support and document design was provided by J. Yu, in collaboration with the BC Eating Disorders Research Excellence Cluster

Treatment for Children & Youth withEating Disorders:
Office Based Management

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Office Based Management

Using a non-judgmental motivational approach when discussing weight and food is important.

Be mindful of how you talk about weight or food, particularly around weight bias or a dieting mindset. Consider the general philosophy of **health at every size** (HAES) and that **all foods can be part of a nutrition plan**. Avoid labeling foods as good or bad.

Don't be afraid to encourage the youth to **take steps to change their eating.** Set goals that are measurable and attainable and make the plan explicit.

For those struggling with binge eating, ensuring that they are eating regularly, and in sufficient amounts to decrease hunger (which is a physiological driver of binging) is important, followed by a focus on **helping them to develop coping strategies to manage the psychological triggers for binges**. Rather than suggesting a decrease of certain types of food, suggest ways they can add to their nutrition (e.g. Adding in a balanced food item such as a sandwich to help them decrease the urge to binge).

↓ Advice for Emerg Dept Care

↓ Eating for Recovery

↓ ER Communication Tool

Knowledge translation support and document design was provided by A. Tung, in collaboration with the BC Eating Disorders Research Excellence Cluster

Regional ED Programs

BC Specialized ED

Foundry in Your Area

↓ BC Advice Options

Quick Guide: Community Medical Follow-up Visits for Children & Youth with Presumed Eating Disorder

Name:_____ **Premorbid Weight prior to ED onset:**_____**kg**

Age: _____**years** _____**months** **Treatment Goal Weight & Range (if known):** _____**kg**

Interval History:	**Interval Physical Examination:**
• **Whole Person Check in: How are you?** • Recent Intake • Binging/Purging • Laxatives/Diuretics/Diet Pills • Activity & Exercise • Mood • Self-Harm • Suicidal Thoughts/Actions	• Weight (in gown if possible) [kg] • Height (shoes off), periodic [cm] • Orthostatic HR/BP (lying and standing) • Oral Temperature (°C) • Hydration Status (mucous membranes, capillary refill, turgor, pulse volume, relative tachycardia) • Pulses, Cardiac Auscultation, Peripheral Perfusion, Edema • Abdominal Palpitation • Skin survey for rashes, colour changes or self-injury
Current Review of Systems:	**Periodic Investigations: at baseline &/or follow-up**
• Energy Level/Fatigue • Dizziness/Syncope • Headache • Palpitations/Chest Pain • Constipation/Diarrhea • Abdominal Pain • Cold Intolerance • Last Menstrual Bleed (with details)	• 12 lead ECG (may repeat periodically) • Lytes, BUN, Cr, Ca, Phos, Mg, glucose (weekly to monthly) • CBC, TSH, Urinalysis (may repeat periodically) • Estradiol or Testosterone (congruent with assigned sex), LH, FSH (consider Q2-3 month interval) • Consider bone density scan 1x/year if secondary amenorrhea > 6 months
FORMULATION:	
Medical: • Stable • Unstable (potentially needing medical hospitalization) • Bradycardia <45-50 bpm by palp, or on ECG), hypotension, hypothermia, prolonged QTc, electrolyte disturbance, dehydration, acute significant weight loss/ongoing weight loss despite outpatient care/inability to regain weight/FTT/extremely low weight for age and height (please see: Medical Instability Criteria for more info)	**Mental Health:** • Stable • Unstable (acutely suicidal, severe depression or anxiety, severe self-injury)

Reference Sheet: Community Medical Follow-up Visits for Children & Youth with Eating Disorders

ACTION PLAN:

Ongoing Monitoring:

- Frequency of medical visits (weekly to biweekly to monthly depending on acuity)
  *aiming for 0.2-**0.5** kg/wk weight gain as outpatient (double as inpatient)
- Frequency of investigations (monthly or more often if risk factors for abnormalities eg. refeeding, restricting, purging, laxatives)

Referrals:

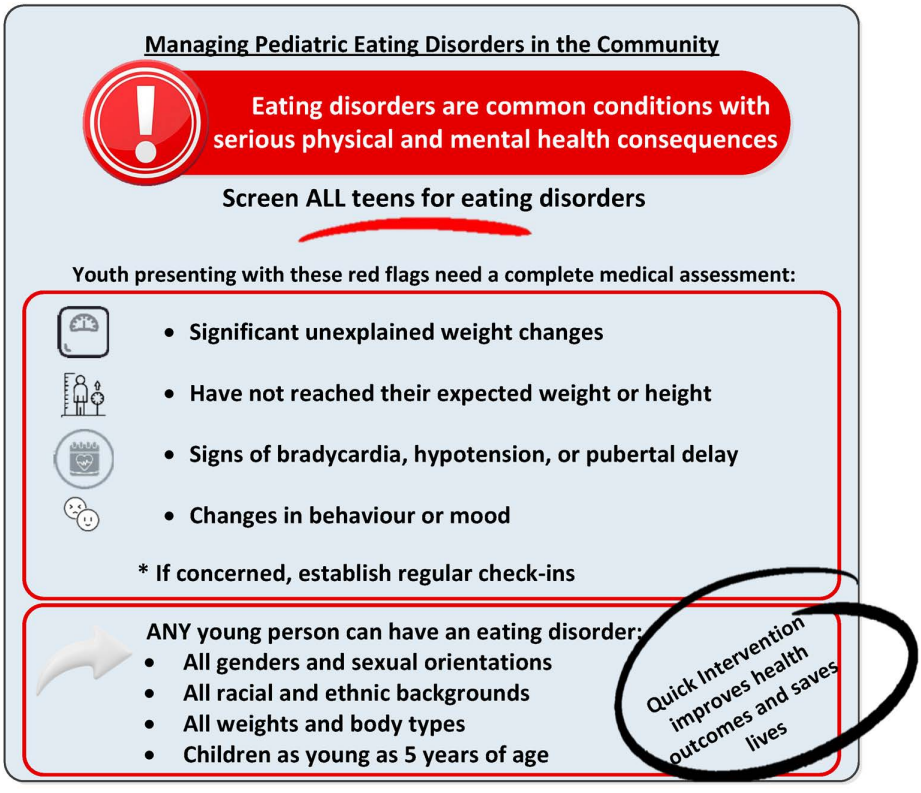
- Pediatric/Adolescent Medicine Providers
- Eating Disorders Programs and Teams (regional vs. provincial)
- Allied Health Public or Privately Funded (Registered Dietician, Psychologist, Registered Clinical Counsellor)
- Mental Health Resources/Teams

Patient and Family Advice/Education

***Resources Available on PathwaysBC and Compass BC**

- Psychoeducation and Motivational Enhancement
- Guidance towards Weight Restoration/Normalization of Eating and Activity
  *common sense advice regarding increasing intake & decreasing activity/exercise

PLEASE CALL FOR CONSULTATION/SUPPORT



Link to: CPS Position Statement: A Guide to the Community Management of Pediatric Eating Disorders

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Treatment for Children & Youth with Eating Disorders:
Office & Emergency Room Based Management

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Office & Emergency Room Based Management

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General Advice for ER Care

Pt. Advice: Eating for Recovery

ER Communication Tool

Other Emergency Room Resources

TREKK Emergency Room Guideline

BC Provincial Community Hospital EDR Care Protocol

BC Children's Hospital | Compass Mental Health Supporting Providers

Pathways www.pathwaysbc.ca

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Regional ED Programs

BC Specialized ED

Foundry in Your Area

BC Advice Options

Inpatient Communication Tools

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Form to Communicate Between Eating Disorder Team Members

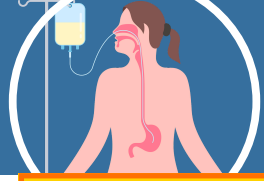
Inpatient Discharge Summary - PDF Version

Patient / Caregiver Discharge Instructions

Form to Communicate to Primary Care Provider

Inpatient Practical Resources Links

Use of NG Tubes in Children and Youth with Eating Disorders



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Disclaimer:

This document is for guidance only and not intended as a substitute for advice or professional judgment. Healthcare professionals should continue to use their own judgment, taking into consideration context, resources, and other relevant factors.

Link for Parents: NG tube feeding with anorexia: parents' questions

What is an NG Tube?

An NG (nasogastric) tube is a temporary means of providing nutritional rehabilitation, delivering food/fluid (and sometimes medicine) to the stomach through the nose, via the esophagus. The goal is to support supplemental caloric intake, assisting in medical stabilization, weight gain, and improved cognitive function.

NG tubes are typically used for a short period, ranging from a single feed (in and out), to days, or sometimes weeks to months. They may be employed when an individual is consistently struggling with oral nutrition (solid food or liquid meal replacements). NG feeding can be used as a helpful adjunct to oral feeding. A decision to use NG feeds requires clinical judgment, planning and a collaborative approach wherever possible, with close attention to physical and psychological comfort measures for the patient. It is crucial for the patient's care team to discuss the use of an NG tube with the patient and their family before administration. If ethical concerns and moral distress arise, consultation with eating disorders specialty care may be helpful.

How is an NG Tube Inserted?

The NG tube is a flexible tube which is lubricated and placed through the nose, down the throat and esophagus, and into the stomach. The patient may experience some discomfort during insertion; however, the procedure should not be painful. There are various medications (using topical and oral) which can be used to make the process easier.

Possible Scenarios for NG Insertion

- Young person meeting or deteriorating rapidly towards the criteria for medical instability (eg. if HR and/or BP low), AND unable to consistently complete oral nutrition (solid food per mouth and/or liquid meal replacement) required for medical stabilization. This situation may occur with multiple types of eating disorder diagnoses (ie. Anorexia Nervosa, ARFID, Unspecified ED, Other Specified ED)
- Young person meeting criteria for micro or macro-nutrient deficiency, requiring nutritional support above and beyond what is possible, despite robust therapeutic intervention aimed at optimizing oral intake (i.e. longer standing ARFID, sometimes associated with growth stunting and pubertal delay, with failure to respond to

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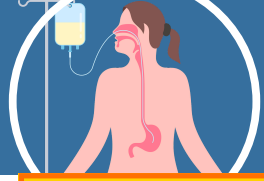
Use of NG Tubes in Children and Youth with Eating Disorders



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Note: There is significant nuance around medically necessary involuntary feeding, with use of the Mental Health Act. This process requires sound medical rationale, a well-prepared and communicated treatment plan (amongst patient, family and health care team), with clearly formulated and communicated endpoints. This can help contain anxiety and alleviate moral distress. If your team does not have much experience with this, consultation with medical ethics or with local or provincial eating disorders experts can be considered.

Tips for NG Tube Planning, Insertions and Removal

- NG tubes can be discussed early in admission if there is any indication that this might be an upcoming treatment direction
  - Pay attention to your language, explaining the need for NG Tube use in a neutral way. Not to be framed as a threat; rather as a way of supporting needed nutrition in instances where there are blocks to achieving this (eg. strong ED cognitions with food refusal)
  - Often we can provide an opportunity for the patient to take a meal or snack orally first (solid food, or liquid meal replacement)
- Communication & Planning are critical ("Compassionately Firm Limits")
  - Provide youth & caregivers transparency about the treatment plan and validation around the difficulty of the experience
  - Assess and address patient and caregiver anxiety
  - Work with caregivers to help get them to align with the need for NG feeds as part of the treatment plan before presenting a plan to youth (potentially facilitating smoother conversation with youth)
  - Explain the procedure to the patient in advance - seek patient input and provide choice wherever possible
  - Use simple, clear, and direct language with a calm and soft voice
  - Decrease environmental stimulation (noise, lights, crowds)
  - In advance of procedure have a plan for if initial attempts are unsuccessful - be aware of local options
  - Considerations for success:
    - What has and has not worked well in the past (if past NG feeding)
    - Best timing
    - Consider specific patient factors: age, weight, allergies, drug contraindications, neurodiversity
    - Identify necessary supports
      - Providers (skilled at insertion, skilled at keeping patient regulated, rapport with patient)
      - All equipment gathered in advance (consider most suitable tube size), including feeds measured and ready to start
      - Parental presence as determined by patient and caregiver
      - Distracting activities (TV, comfort objects, music) - give choice
      - Consider oral pre-medication for anxiolysis, relaxation - beware of "drug factors", eg. potential paradoxical agitation with benzodiazepines. In using pharmacotherapy for this purpose please consider team familiarity, comfort, and monitoring capacity. May consider:
        - Lorazepam 0.5 - 2 mg (weight dependent dosing) sublingual, 20 min prior to NG insertion
        - Diphenhydramine - max 50 mg (weight-dependent dosing)
        - Topical anesthesia (lidocaine endotrachael spray) just before insertion (presuming provider familiarity and no contraindications)
    - Assess/document/monitor/debrief as needed
    - The goal for the majority of patients, is to transition them back to oral feeds prior to discharge, with removal of the NG Tube
    - In some instances, you may need to be prepared to just pull out the NGT and send the patient home, if need be, WHILE making sure that there is robust post-discharge follow up
    - Any child who has received NG Tube feeds while in hospital will require follow up within a week post discharge

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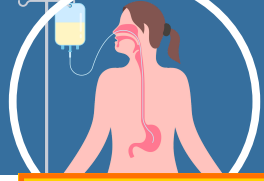
Use of NG Tubes in Children and Youth with Eating Disorders



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NG Tube Feeding

- Timing + Style of Feeds: The most patient centered approach is to explore patient preference and to consider this within the context of human resources supports, comfort, and experience

	Bolus Feeds	Continuous Feeds	24 Hour Feeds
Daytime	Advantages: Better mimics physiological eating (helps with reestablishing hunger, and satiety cues) Challenges: tolerance of rate of feed, interference with activities of daily living for home tube feeding	Advantages: Allows for slower rate in young people sensitive to feed rate (i.e. significant discomfort, vomiting) Challenges: Non-physiologic, requires pump, limited mobility for the length of feed unless a small portable pump is available, may cause distress to watch the feed given slowly during waking hours	Advantages: Conservative strategy in cases high risk for severe refeeding syndrome (eg. rapid weight loss / severe malnutrition at any BMI, BMI < 12 etc.) Allows slower rate to assist tolerance. Challenges: Distress of visualizing feeds, limited mobility
Overnight	Advantages: May be helpful in scenarios of anticipated NGT distress (i.e. past hx pulling tubes) as feed can be administered at a higher rate over shorter duration; may be used for top-ups of daytime feeds incompleted, and allows for more time for hunger cues for daytime eating Challenges: May not tolerate rate	Advantages: Allows for patient to be asleep during a feed, which may limit distress of visualizing feeds, allows for slower feed rate, a possible strategy to top up daytime PO feeds (may want to complete feed several hrs prior to first planned oral intake) Challenges: Non-physiologic, potentially less staff support for feeding challenges	

- Contingency plans
  - Bolus feeds in response to non-completion of oral intake
    - Immediately bolus replacement feed after missed/incomplete oral meal or snack
  - Overnight top-up feeds of total intake patient was not able to complete during the day
  - If NGT removed by patient, re-insert prn
  - In severe/extreme situations - Involuntary NGT insertion and feeds under the Mental Health Act, with nonpharmacologic support, and chemical and physical restraints may be needed. In these situations, please consider consultation with expert providers to discuss management planning, including the possibility of transfer to higher level of care.

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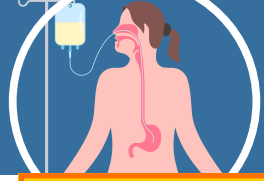
Use of NG Tubes in Children and Youth with Eating Disorders



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NG Tube Feeding cont'd

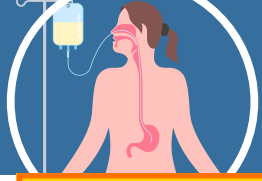
- Common medication combo **at BCCH** is:
  - Lorazepam / Ativan (1-2 mg) - benzodiazepine
  - Diphenhydramine/Benadryl (50 mg IM or PO) - Antihistamine, with drowsiness ("sedation") being targeted
  - Methotrimeprazine / Nozinan (5 mg IM or 10 mg PO) - Phenothiazine with analgesic, anti-emetic, and anxiolytic properties ; 1st generation typical antipsychotic (risk of anticholinergic & extrapyramidal symptoms and neuroleptic malignant syndrome. Sedating, with high incidence orthostatic hypotension. If using, ensure that drugs for EPS management are readily available)
- Consider any history of adverse medication responses - eg. paradoxical reactions to benzodiazepines; reactions to antipsychotics - eg. moderate extrapyramidal symptoms with loxapine, - 1st generation typical antipsychotic, including dystonic reactions in children and adolescents (treat with benztropine or diphenhydramine)
- Consider that some people feel MORE anxious with sedating medications
- Consider your experience and comfort with medication choice, risk/benefit profile, monitoring capacity, and local resources to manage challenges
- Alternate medications are hydroxyzine PO (Atarax) and Risperdal PO (0.25 mg)
- Call for advice if needing support
- References:
  - https://www.cacap-acpea.org/wp-content/uploads/EP5-jcacap-2024-wood-RA-ver-4.pdf
  - The Child Health BC Pediatric Least Restraint Guideline for use in emergent/urgent care and inpatient settings has been updated!

Equipment List

1. NG Tube of appropriate size
   - Suggestions:
     - #6-8 Fr for newborns - 9 year old
     - #10 Fr for 9 years and up
2. 2x10 mL syringe sterile water for flushing tube after removal of guidewire
3. Gloves
4. Kleenex
5. Cotton tip applicator (ex. Q tip)
6. Incontinence pad or towel and emesis basin
7. Water based lubricating jelly
8. Glass of water with straw if patient able to drink
9. 3-5 mL syringe for aspirating (small syringe produces less negative pressure when aspirating)
10. 20-50 mL syringe for flushing (large syringe produces less positive pressure when flushing) pH testing strip to test aspirate
11. Duodem or tegaderm tape
12. Permanent marker

Next

Use of NG Tubes in Children and Youth with Eating Disorders



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Benefits of Tube Feeding

- **Improved Physical and Psychological Health:** When patients are malnourished, both physical and psychological health decline. Tube feeding can provide some relief by increasing caloric intake, which can help stabilize and improve overall health. However, gaining weight can be also distressing for patients who are fed via NG tube, and ongoing psychologic support is important
- **Easier Digestion and Nutrient Absorption:** Liquid food is easier to digest and allows the body to absorb and process nutrients more efficiently, aiding in nutritional rehabilitation and decreasing discomfort
- **Reduced Gastrointestinal Distress:** Tube feeding may reduce gastrointestinal distress associated with eating disorder behaviors such as purging and laxative abuse.
- Eased Anxiety Around Oral Feeding: Tube feeding may help ease anxiety, for some individuals, around oral feeding, thereby aiding in weight restoration and medical stabilization.Feeling anxiety around oral eating is expected and normal. Anxiety needs to be tolerated in hospital for us to help parents and caregivers know that is safe to tolerate this anxiety at home too. Feeling anxiety around eating and still accomplishing the eating is important to eating disorder treatment. We cannot take this anxiety away entirely and we shouldn't set us up to expect this. Nutritional completion is essential during medical stabilization, our preference is for oral eating first with food and then with oral nutritional replacement. If that is not possible/completed fully, then we have indication to use an NG tube and expand here.

Risks of Tube Feeding

- Misplacement of tube (usually concern re: into airway)
  - Need to confirm with appropriate pH or AXR (see work standard in your institution)
- Disease entrenchment
  - For most of our patients we are not planning to discharge home with an NG; hence there needs to be a plan for an endpoint and exit strategy
  - In some instances, you may need to be prepared to just pull out the NGT and send the patient home, if need be, WHILE making sure that there is robust post-discharge follow up
- Severe Dysregulation Behaviors (uncommon but not unheard of) like wrapping NG tube around the neck. Eg. history of tying the tube around neck when distressed. If related concerns, please have trauma sheers readily available. And in such cases, if patient self removes NG, please remove it from the room for their safety

Knowledge translation support and document design was provided by Justine Y., in collaboration with the BC Eating Disorders Research Excellence Cluster

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INPATIENT: INDIVIDUALIZED CARE PROVIDER COMMUNICATION TOOL

PATIENT INFORMATION:

Name: _____

Identified Gender:_____ Pronouns: _____

School:_____ Grade:_____

Community/Location:_____

Diagnosis:_____

Comorbidities: _____

Special Identifiers (chronic health conditions/sports/hobbies):

_____

_____

_____

_____

KEY INFORMATION

Admission Date/Reason:_____

Admission Goals: _____

_____

Was Certification Required for Admission?:_____

Admission Weight: _____ Treatment Goal Weight (TGW):_____

% TGW: _____ Pace of Wt. Trend (eg. aiming 1 kg/wk gain): _____

Projected Timing of Discharge: _____

MEDICATION

Please Note: See current med rec.

Medications:	Allergies:

WHAT ARE THE RELEVANT ISSUES?

CNS/Psychiatric

Agitation: _____

Safety:_____

ED Behaviors (exercise, hide food, purge):_____

CVS

HR/BP/ECG: _____

Re-feeding Changes (eg. congestive heart failure, edema): _____

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FLUID/ELECTROLYTES/NUTRITION

Meal Plan/TFI/Adherence/Coping: _____

Family Engagement: _____

Re-feeding Syndrome Changes (glucose/phosphate/calcium): _____

_____

Supplements: _____

Renal Function (Ins/Outs/AKI): _____

Enuresis/Sweats/Renal Concentrating Defects: _____

Gastrointestinal:

Constipation_____ GER: _____ Purging:_____

ID/Heme:

Cytopenias: _____ Deficiencies: _____

Derm, MSK, Heme, Other: _____

Weight Monitoring

Strategy (Blind vs. Unblinded):

Blind
Unblind

Reminder: Arm Circumference (doctors to do this measurement)

Investigations:

Strategy (meds, Amatop, bloodwork/EMLA, childlife): _____

Lab Frequency: _____

Pending Results: _____

Radiology: _____

SAFETY

Please provide a short description in the boxes below.

Self-Harm and Violence	
Suicide Thoughts/ Attempts	
Elopement Risk	

Safety Precautions (eg. security on standby?):

STRENGTHS AND INTERESTS

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TRIGGERS/HELPFUL COMMUNICATION TIPS FOR THIS PATIENT

HELPFUL STRATEGIES:

Please see the following examples:

eg. **Ice packs:** during meal times, and if having a panic attack/anxious moment

eg. **Deep breaths:** prompt to take deep breaths if having a panic attack/anxious moment

eg. Personal Space: provide space and come back and check on pt in a few minutes (eg. patient agitated or exercising in bathroom)

eg. **Redirection:** not useful when doing OCD behaviors/exercise - okay to be out of room as long as in eyesight

MOBILITY/ACTIVITY/ADLs

Please provide a short description in the boxes below.

Activity Restrictions	
ADLs	
Passes	
Sleep/Wake	
Bathroom	
Other	

FEEDING STRATEGIES:

- ***Oral Nutrition***
- ***NG Feeds: Strategy***
- ***Pedialyte***
- ***Meal Support***
- ***Post-meal support***

Please see the following examples:

eg. **Pedialyte:** offer refrigerated when possible

eg**. Meal support**: put do not disturb sign on the door during meal times

eg. **Post meal support:** offer warm blanket, tums or simethicone, offer distraction like playing a game

Transition Within Eating Disorders Care:
Child and Adolescent to Adult

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The Primary Care Provider (GP, NP) and/or Pediatrician play an important role in the transition of eating disorders care from the child and youth to the adult care setting. Preparing the patient and their circle of care for this transition ideally begins at the time of diagnosis and continues to evolve with the patient's treatment plan. Given that the models of eating disorders care differ significantly between the pediatric and adult systems, it is critical for providers to ensure effective communication amongst all members of the health care team and the patient's circle of care.

Due to waitlists for Eating Disorders services, as patients approach late adolescence, it is important to consider early referral to optimize the likelihood of continuity of care without disruptions. It is helpful for providers, particularly the PCP, to be aware of the differences in treatment focus, information sharing, and carer support between pediatric and adult services. This way, they can educate and prepare the patient/family, while providing ongoing support. During times of transition between services, it is also imperative that PCP's are aware of the current treatment plans, so they can bridge communication gaps between adolescent and adult services.

Although pediatric and adult eating disorders services share similar multidisciplinary approaches with regards to medical, nutritional, and psychological treatment, there are often differences in care. One of the most notable differences is the level of motivation and responsibility expected of the patient engaging in care.

1. **Differences in Responsibility to Seek Care:**

   Although adolescents can consent to treatment, caregivers have a responsibility to seek appropriate treatment when the patient is under the age of 19. However, patients over the age of 19 are expected to seek out and engage in treatment as they desire. If a patient over the age of 19 refuses treatment for an Eating Disorder, it is unlikely the care team will actively pursue them to engage in services or treatment. Rather, they will encourage follow-up and be available when the patient is ready to engage in treatment. Parent and/or caregiver involvement is not mandatory, but highly encouraged by the health care team to improve health outcomes for the patient.

2. **Differences in Involvement of Support Network:**

   In the child and adolescent system, family and/or caregivers play an important role in the patient's circle of care. They can support with monitoring intake, symptom identification and management, and gathering other information essential for the health care team to follow an effective treatment plan. However, once a patient turns 19, they are afforded more autonomy around their care involvement, and more accountability for their decisions around engagement in treatment. Family and/or chosen family involvement is always recommended and encouraged by the care team, however, confidentiality and its limitations must be explained to both the patient and their circle of care.

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3. Differences in Treatment Approaches:

Child and adolescent programs may involve individual appointments with care team members to monitor and support physical and psychological well-being. Family/caregivers are often involved in family-based counseling, sometimes in combination with their own counseling sessions. Adolescents transitioning to the adult system may find themselves in more group-orientated treatment programs with a variety of patient demographics spanning different ages and experiences.

Any transition during Eating Disorder treatment can be considered a high-risk period for relapse, deterioration, and significant stress for the patient and their circle of care. Therefore, program teams and Primary Care and other health care providers should ensure that care is taken to support smooth transition for the patient and their circle of care. This can include timely referrals with warm handovers between the patient and clinicians, discharge documentation and written handover, and communication with the patient and their circle of care about expectations to ensure continuity of care.

During any transition period, patients and their circle of care may experience increased anxiety about transitioning to a new clinician or service. With this may come a sense of loss or fear of the unknown, which can lead to frustration or resistance from patients and their support network. It is important for all involved providers to acknowledge these potential emotions.

Open and clear communication infused with empathy and validation of the difficult period they are going through can help ease anxiety and fear. Alternatively, during transition, the patient may feel an increased sense of freedom and control in their treatment, which can sometimes be a risk for treatment disengagement. Primary Care Providers are uniquely positioned to work towards empowering transition patients to engage as active participants in their care.

BC Children's Hospital has an OnTrac Toolkit with good comprehensive general informationfor Healthcare providers and both Youth and Families to prep for this transition in Care:

- Transition to Adult Care (BC Children's Hospital)
  - Parent & Family Checklist

BC Peds Society also has transition toolkit:

- BCPS Resources to support transition/transfer from Pediatric to Adult Care

Supplementary Article:

The Transition from the Child-Adolescent to Adult Systems of Care for Eating Disorders

Provincial Adult Tertiary & Specialized Eating Disorder Program (PATSED)

- PATSED Website
- PATSED Referral Form
- PATSED Treatment Pathway

Knowledge translation support and document design was provided by A. Tung, in collaboration with the BC Eating DisordersResearch Excellence Cluster

BC Specialized ED Programs:
Support for Eating Disorders

Eating Disorder Program - Child and Youth - Vancouver (St Paul's) [Providence Health] The provincial tertiary & specialized eating disorders program is dedicated to caring for people 17+ with eating disorders.Our program consists of a multidisciplinary team specialized in supporting patients who are working toward nutritional, medical, and psychosocial recovery goals. • **604-806-8347** • **Eating Disorders Consult Line:** • **604-806-8654 (Monday to Friday 8:00am - 4:00pm)** • **604-682-2344, dial '0' and ask for the on-call ED Internal Medicine physician (For after-hours only)**	Province-wide	Service provided 1:1 in-person
Eating Disorders Program - Child and Youth - BC Children's Hospital [Provincial Health Services Authority] The Provincial Specialized Eating Disorder Program at BC Children's Hospital is a comprehensive, interdisciplinary,specialized program to assess and treat children and adolescents with eating disorders. • **604-875-2106**	Province-wide	Service provided 1:1 in-person
Looking Glass Residence - Tertiary Specialized Eating Disorder Program [Looking Glass Foundation] Tertiary referral specialized residential treatment facility for BC residents aged 16 to 24 years with eating disorders in a home-like, therapeutic environment. This facility is managed by the Provincial Health Services Authority and affiliated with the B.C. Children's Hospital Eating Disorders Program. • **604-829-2585** • Toll-free: **1-888-980-5874** • Website: https://www.lookingglassbc.com/	Province-wide	Service provided in a group in-personService provided at a single location Service provided 1:1 in-person

Knowledge translation support and document design was provided by A. Tung, in collaboration with the BC Eating Disorders Research Excellence Cluster

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BC Advice Options:
Consultation Support for Eating Disorders

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BC Children's Hospital (BCCH) Adolescent Medicine (tel: **604-875-2345** (BCCH Switchboard)) is available for advice for **urgent medical management only** related to pediatric eating disorders and will be unable to advise re: psychiatric/case management.

For advice on psychiatric/case management, please consult:

- **Compass BC**
  - Monday to Friday, 0900-1700Tel: 1-855-702-7272
  - For <17yrs of age.
    - Physicians calling Compass BC can claim CME credits for time spent collaboratingwith a Compass Clinician.
    - Physicians calling Compass BC can bill for the consult call.

- **RACE line**
  - Monday to Friday, 0800-1700Local Calls: 604-696-2131
  - Toll Free: 1-877-696-2131
  - For >17yrs of age.
    - Physicians calling RACE line can bill for the consult call.

Knowledge translation support and document design was provided by A. Tung, in collaboration with the BC Eating Disorders ResearchExcellence Cluster

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Eating Disorders: Patient/Caregiver Resources

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Click for Emailable PDF of Links

General: Resources

	URL Link
Eating Disorders - Kelty Mental Health General patient and family information on eating disorders and treatment options.	Kelty Eating Disorders
Foundry BC Causes, signs, consequences, prevention and treatment options for eating disorders.	Foundry BC
National Initiative for Eating Disorders Canadian organization with information, blogs, education, and resources for eating disorders.	NIED
Eating Disorders and Neurobiology Info sheet on the role of genetics in eating disorders and how eating disorders affect the brain	Eating Disorders and Neurobiology
Eating Disorders - Royal Children's Hospital Melbourne (Australia) Information on different types of eating disorders, symptoms, and treatment.	Eating Disorders - Melbourne Children's Hospital
Eating Disorders (Australia) Guidance and support for eating disorders.	Eating Disorders - Australia
How to Approach Someone You Are Concerned About (Australia) Info sheet on how to be prepared and what to say to someone who may have an eating disorder	How to Approach Someone You're Concerned About
Consent & Confidentiality Information for Parents & Caregivers Handout for parents and caregivers.	Consent & Confidentiality Info

Eating Disorders: Patient/Caregiver Resources

General: Resources

	URL Link
Meal Support at a Glance Info sheet on strategies to help meal times go more smoothly and help youth complete their meals	Meal Support at a Glance
Family Based Treatment (FBT) for Eating Disorders Info sheet on family based treatment	Family Based Treatment
Eating Disorders and Anxiety Info sheet on the links between anxiety and eating disorders	Eating Disorders and Anxiety
Eating Disorders and My Sibling Info sheet on common emotions and feelings and tips for siblings of someone with an eating disorder	Eating Disorders and My Sibling
BC Children's Hospital Book List Clinician recommended book suggestions for youth with eating disorders.	BC Children's Hospital Book Recommendations
Resource Library - Kelty Mental Health Filterable resource list for various topics related to eating disorders	Kelty Mental Health

General: Videos/Online Education

CANPED Understanding eating disorders in adolescence - 6 Modules with educational videos	CANPED

Eating Disorders: Patient/Caregiver Resources

General: Videos/Online Education

	URL Link
Eva Musby: Help Your Child Eat with Trust, not Logic - The Bungee Jump Youtube Video - Building trust to help tolerate distress in spite of anorexia or anxiety	Eva Musby: Bungee Jump
Eating Disorders Meal Support - Helpful Approaches for Families Youtube Video - Strategies to help parents, caregivers and families provide meal support to youth.	Eating Disorders Meal Support
Eva Musby: Helping You Free Your Child of an Eating Disorder Youtube Video - how to help your child eat in spite of their eating disorder and provide mealtime support	Eva Musby: Helping You Free Your Child
Eva Musby: Growth Charts in Eating Disorders Youtube Video - Growth Charts & Goal Weight - Eating Disorder Recovery	Eva Musby: Growth Charts
What is a BMI or '% Weight for Height' Target, and how wrong it could be Youtube Video - how BMI should not be used to set a recovery weight or to pronounce people as healthy or unhealthy without a clinical assessment.	What is a BMI
BC Children's Hospital Meal Support: Helpful Approaches for Families Youtube Video - Strategies to help parents, caregivers and families provide meal support to youth.	Eating Disorders Meal Support
DBT Skills - Now Matters Now: Online Training and Videos DBT skills to help manage suicidal ideation	Now Matters Now
Dialectical Behavior Therapy A free course to help manage thoughts, emotions, and relationships.	Dialectical Behavior Therapy

Eating Disorders: Patient/Caregiver Resources

General: Videos/Online Education

	URL Link
Mental Health Foundations Emotion-focused family therapy resources for caregivers supporting a loved one with an eating disorder.	Mental Health Foundations

ARFID

	URL Link
Avoidant/Restrictive Food Intake Disorder (Duke University) Videos and resources on ARFID	ARFID - Duke University
ARFID - Eating Disorders Victoria Info sheet on ARFID.	ARFID Fact Sheet
Kelty Eating Disorders - ARFID Workbook Patient and family CBT workbook for ARFID.	Kelty Eating Disorders - ARFID

Binging

	URL Link
BODYWHYS Binge Eating: Breaking the Cycle of Self-Help Guide Towards Recovery BODYWHYS booklet on binge eating and recovery.	BODYWHYS Booklet

Diabetes

	URL Link
Eating Disorders and Diabetes Info sheet on eating disorders and diabetes	Eating Disorders and Diabetes

Eating Disorders: Patient/Caregiver Resources

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Diabetes

	URL Link
Eating Disorders Victoria - Eating Disorders and Diabetes Info sheet on eating disorders and diabetes	Eating Disorders and Diabetes
NEDC - Eating Disorders and Diabetes Info sheets on the link between eating disorders and diabetes.	NEDC - Eating Disorders and Diabetes

Exercise

	URL Link
Unhealthy Exercise Info sheet on the signs and consequences of unhealthy exercise	Unhealthy Exercise
Eating Disorders for Sport Coaches, Clubs, and Teams How to identify eating disorders in athletes and how to help	Eating Disorders for Sport Coaches, Clubs and Teams

Neurodiversity

	URL Link
PEACE Community - Autism and Eating Disorders (Patients) Information and resources for patients with autism and an eating disorder	PEACE Pathway - Patients
PEACE Community - Autism and Eating Disorders (Carers) Information and resources for carers for those with autism and an eating disorder	PEACE Pathway - Caregivers

Eating Disorders: Patient/Caregiver Resources

Neurodiversity

	URL Link
NEDC - Eating Disorders and Neurodivergence Report to destigmatized neurodivergent body awareness and image, feeding, eating experiences and behaviors.	NEDC - Eating Disorders and Neurodivergence

Purging

Eating Disorders and Looking After Your Teeth Info sheet on signs and symptoms of dental problems associated with eating disorders.	Looking After Your Teeth

Substance Use

Eating Disorders and Substance Use Info sheet on eating disorders and substance use.	Eating Disorders and Substance Use
BC Partners for Mental Health and Addictions Info Videos, podcasts, blogs, and self-screening test on mental health and substance use.	Here to Help

Self and Caregiver Management Focused Supports

FEAST 30 Days - Caregivers Helpful program delivering one lesson per day, via email, to caregivers, over the first 30 days. Focus is various topics related to eating disorders and caregiving	FEAST 30 Days
FEAST - Caregiver Forum Free service provided for parents of those suffering with eating disorders	FEAST - Caregiver Forum

Eating Disorders: Patient/Caregiver Resources

Self and Caregiver Management Focused Supports

	URL Link
Looking Glass BC Support resources for self-support and for others	Looking Glass BC
OPS: Online Peer Support Binge eating online peer support (Ages 14+)	Online Peer Support
Personal Recovery Space: Digital Peer Support Offers peer support via a secure digital forum for individuals seeking recovery from EDs and disordered eating	Personal Recovery Space
Hand in Hand Program (Looking Glass - Ages 16+) Peer support program that matches individuals with a trained volunteer	Hand in Hand Program
Self-Care when Caring for Someone with an Eating Disorder Info sheet on self-care tips when caring for someone with an eating disorder	Self-Care Fact Sheet
Self Harm - Calm App App that provides immediate activities and techniques to help break the cycle of self-harm behavior	Self- Harm - Calm App
Foundry BC - Virtual Counselling Foundry Virtual BC offers same day and scheduled virtual counselling sessions by video, audio and chat options to young people ages 12-24 and their caregivers.	Foundry BC - Virtual Counselling

Clinician Resources: Contents

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Outpatient Basics

Outpatient Beyond Basics

Emergency Department Resources

Inpatient Resources

Outpatient Basics

Information: Basic Management

	URL Link
Management Basics Treatment for Children and Youth with Eating Disorders - Expectations, Goals, Visits, etc.	Management Basics
PCP Toolkit Primary Care Practitioner Toolkit that provides a comprehensive overview of eating disorder care for all ages	PCP Toolkit
Compass Toolkit Toolkit discussing management strategies, scales and tools, medication, and resources.	Compass Toolkit
DSM-5-TR Diagnostic criteria for eating disorders	Diagnostic Criteria
Dexa Imaging Dexa Imaging info sheet - how to do dexa, who gets dexa and when?	Imaging in Eating Disorders
Eating Disorders Australia Fact Sheet Info sheet on Family Based Treatment - treatment option for youth with an ED.	AUS Fact Sheet - Family Based Treatment
Non-Pharmacological Management of Eating Disorders Discussion of therapeutic options and treatment strategies	Non-Pharmacological Management
Would my Patient with a Possible or Confirmed Eating Disorder Benefit from Pharmacotherapy? Info sheet on medication management.	Pharmacotherapy Tips

Outpatient Basics

Information: Basic Management

	URL Link
Nine Truths about Eating Disorders Info sheet on the nine truths about eating disorders.	Nine Truths about Eating Disorders

Training

	URL Link
Eating Disorder Training for GPs - Australia Resources about general practitioner eating disorder training.	Training for GPs
Introduction to Eating Disorders for Service Providers - Learning Hub Course Learning hub course orientation to health care providers new to the field of eating disorders.	Intro to Eating Disorders - Learning Hub

Multi-Media Resources

	URL Link
Eva Musby: Growth Charts in Eating Disorder Resources Youtube Video - Growth Charts & Goal Weight - Eating Disorder Recovery	Eva Musby: Growth Charts
Eva Musby: BMI in Eating Disorders Youtube Video - What is a BMI or '% Weight for Height' target and potential challenges with this approach	Eva Musby: BMI in Eating Disorders

Templates

	URL Link
Initial Visit Template Initial visit template, interview tips, and general information.	Initial Visit Template
Nutrition and Activity Contingency Plan Clinician can use this tool collaboratively with patients and families.	Pathways - Nutrition & Activity Plan

Outpatient Basics

Templates

	URL Link
SOAP Note Template Suggested check-list pending on what area of focus the PCP can spend their visit time on.	Pathways - SOAP Note
Letter to ER Doctor Provided to patient/caregiver to share with ER doctor	Pathways - ER Letter
Inpatient Eating Disorders Discharge Summary Template Inpatient ED Discharge Template	Pathways - Inpatient Discharge Summary Template
Specialist Triage Form Specialist triage form template and information.	Specialist Triage Form
School Accommodations Email Template Email template for school accommodations - send to school.	School Accommodations Template
Team/Coaches Accommodations Email Template Email template for sports/P.E. accommodations - send to teams/coaches.	Team/Coach Accommodations Template
Refund for Travel/Activity - Accommodations Email Template Email template requesting for travel/activity refund accommodations.	Refund for Travel Template
Shared Care Communication Tool Shared care communication tool template	Pathways - Shared Care Communication Tool

Outpatient Beyond Basics

General

	URL Link
Beyond the Basics - Landing Page Landing Page: Exercise, Neurobiology, Binging, Purging, Autism, and Eating Disorders	Pathways - Beyond the Basics
Return to Play: Clinician's Guide to Reintroducing Activity and Exercise for Children and Teens Recovering from Malnutrition Clinician's guide to reintroducing activity and exercise.	Return to Play Guide

Webinars

	URL Link
Don't Eat That, You'll Get Fat! - Webinar Youtube video discussing how the attitudes towards food, weight and obesity may increase the risk of eating disorders and poor body image of children.	Don't Eat That, You'll Get Fat!
Dental Care Tips While Experiencing an Eating Disorder - Webinar Youtube video aimed to provide tips to help maintain your oral health, comfort, and quality of life while experiencing or recovering from an eating disorder.	Dental Care Tips while Experiencing an Eating Disorder
In the Gaze of Others - Webinar Youtube video about social physique anxiety, exercise, and eating disorders.	In the Gaze of Others
Child and Youth Eating Disorders - Webinar Presenters: Dr. Julia Wong, Pei-Yoong Lam, Michelle Horn, and Vicki Klassen	UBC CPD Webinars

ARFID

	URL Link
Webinar: Understanding ARFID Youtube Video discussing ARFID.	Understanding ARFID

Outpatient Beyond Basics

ARFID

	URL Link
Eating Disorders Australia - ARFID Info sheet on Avoidant/Restrictive Food Intake Disorder	Eating Disorders AUS- ARFID
Duke University - ARFID Videos and resources from Duke Psychiatry.	Duke University - ARFID

Binge Eating

	URL Link
Overview of Binging: Psychoeducation & Care Guidance Info sheet on binging.	Pathways - Overview of Binging

Boys & Young Men

	URL Link
Webinar: Eating Disorders and Disordered Eating among Men Youtube Video: What to know and how to help boys and men with EDs/disordered eating.	Eating Disorders and Disordered Eating in Boys and Men

Culture & Racialized Communities

	URL Link
Eating Disorder Booklets Resources and eating disorder booklets in different languages	NEDC Eating Disorder Booklets
NEDIC Guides to ED in Black, Indigenous, and POC communities Resources and info about disordered eating and EDs in racialized communities.	NEDIC Guides to POC Communities

Outpatient Beyond Basics

Culture & Racialized Communities

URL Link

Eating Disorders in Racialized Communities
Webinar on resources, insights, and support for racialized communities experiencing EDs.

NEDIC Webinar

NEDIC: Let's Talk About Culturally Sensitive Care
Info sheet on culturally sensitive eating disorders care.

Culturally Sensitive Care

Diabetes

URL Link

Type 1 Diabetes & Disordered Eating
Webinar on Type 1 diabetes and disordered eating.

Type 1 Diabetes and Disordered Eating

Eating Disorders AUS Fact Sheet
Info sheet on eating disorders and diabetes.

Eating Disorders and Diabetes - Fact Sheet

Food Insecurity Intersectionality

URL Link

Feeding Hunger Within: ED Narratives Amongst Food Insecure and Street Involved Youth
Webinar on the intersection of poverty, homelessness, and street involvement and eating disorders.

Feeding Hunger Within

LGBT2SQ

URL Link

LGBT2SQ
Relationships with food and disrupted eating behaviors in LGBT2SQ communities.

Pathways - LGBT2SQ

Eating while Transgender
NEDIC: A lived experience account on eating while transgender.

Eating While Transgender

Outpatient Beyond Basics

LGBT2SQ

	URL Link
Improving Body Image Supports for Transgender People NEDIC: Supports and consideration regarding body image for transgender people.	NEDIC: Body Image Supports for Transgender People
Eating Disorders: Who is Affected? NEDIC Youtube Video.	Who is Affected?
Recovery During the Holidays - Support for Trans People NEDIC: Blog post on ED recovery during the holidays for trans people.	Recovery During the Holidays
Shining a Light on Gender Identity and Eating Disorders Blog post on the intersection of gender identity and eating disorders.	Shining a Light on Gender Identity and Eating Disorders
Full Spectrum Support: Offering Gender Inclusive ED Care for All Genders - Webinar NEDIC webinar offering gender inclusive ED care.	Offering Gender Inclusive ED Care for All Genders

Neurodiversity

Neurodiversity and Eating Disorders - NEDIC Webinar Webinar on the interactions of neurodiversity and eating disorders and examples of neurodiversity-affirming eating disorder care.	Neurodiversity and Eating Disorders
NEDC: Eating Disorders & Neurodivergence Report on research and live experience regarding the prevention, early identification, and treatment of eating disorders and disordered eating for neurodivergent people.	Eating Disorders & Neurodivergence

Outpatient Beyond Basics

Neurodiversity

	URL Link
Autism Spectrum Disorder (ASD) BC Provincial Enhanced Care Pathway Clinicians will have the information and tools necessary to assess patients for Autism Spectrum Disorder (ASD) and to streamline the diagnostic referral process.	ASD Pathway
Welcome to the Peace Community! Resources on how to best support someone with an eating disorder and autism.	Peace Community
Clinicians Support: Initial Meeting Support upon meeting a patient for the first time - information to be looking out for.	PEACE Pathway - Clinicians Support: initial meeting

Performance Enhancement & Supplements

	URL Link
Article: American Academy of Pediatrics - Performance Enhancing Substances Review on current epidemiology of performance enhancing substances in the pediatric population.	Use of Performance-Enhancing Substances
Dietary Supplements (Kyle Ganson U of T) Webinar on the current public policy landscape related to dietary supplements in Canada, including the gaps that put people at risk and recommendations to address these gaps.	Dietary Supplements Webinar

Physical Activity

	URL Link
Wellness in Exercise and Sport: Approach with the Highly Active Pediatric Patient Info sheet on wellness in exercise and sport.	Pathways - Wellness in Exercise and Sport
Unhealthy Exercise PDF Info sheet on healthy and unhealthy exercise.	Unhealthy Exercise

Outpatient Beyond Basics

Self Harm (NSSI) & Suicidality

	URL Link
DBT Skills and Eating Disorders Treatment Webinar introducing key DBT skills that may be helpful in promoting a greater sense of body acceptance.	DBT Skills Webinar
FEAST - Suicidality in Eating Disorders Article and resources on suicidality and eating disorders.	Suicidality in Eating Disorders
Compass BC Toolkit: Suicide Risk Assessment Suicide risk assessment, scales, tools, and management strategies.	Compass Toolkit
NEDIC - Eating Disorders and Suicide Bulletin on suicide and EDs - prevalence, best practices, and strategies.	NEDIC: Eating Disorders and Suicide
Eating Disorders and DBT How DBT skills may help families navigate suicide and self injury for those with eating disorders.	Eating Disorders and DBT
Eating Disorders and Emotional Dysregulation - Youtube Helping families navigate (Anita Federici)	Eating Disorders and Emotional Dysregulation

Outpatient Beyond Basics

Substance Use

	URL Link
BC Provincial Child and Youth Substance Use Care Pathway Clinicians will have the information and tools necessary to assess patients for Substance Use (SU) and to streamline the diagnostic referral process.	Substance Use Pathway
Eating Disorders and Substance Use - Learning Hub Course Learning hub course for all adult and child and youth mental health and substance use clinical staff, contracted agencies, and tertiary programs.	Substance Use - Learning Hub
NEDIC Webinar: C-CARE: A Comprehensive Treatment Model for Concurrent Eating Disorders and Substance Use Disorders Webinar introducing a model for treating concurrent EDs and substance use disorders.	NEDIC Webinar
NEDC: Eating Disorders and Substance Use NEDC article on eating disorders and co-occurrence with substance use - impacts, consequences, and warning signs.	NEDC: Eating Disorders
Canadian Centre on Substance Use: When Eating Disorders and Substance Abuse Problems Collide NEDIC article on understanding, preventing, identifying and addressing EDs and substance abuse issues in youth.	Canadian Centre on Substance Use
Eating Disorders Victoria (AUS) Info sheet on eating disorders and substance use.	Eating Disorders and Substance Use

Emergency Department Care

Emergency Department Resources

	URL Link
Admission Guidelines Admission/assessment/intervention guidelines for unstable patients with eating disorders.	Admission Guidelines
Letter to ER Doctor Provided to patient/caregiver to share with ER doctor	ER Letter
TREKK: Bottom Line Recommendations: Summary of Pediatric Emergency Care Information for Health Care Providers Document addressing acute medical and psychiatric complications of eating disorders presenting to the ER.	TREKK: Eating Disorders
BC Advice for Emergency Department Care of Children/Youth with Suspected/Known Eating Disorders Info sheet on emergency department care for youth with suspected/known eating disorders.	Pathways: Advice for ER
BC Provincial Pediatric Eating Disorders ER Protocol & Discharge Form Pediatric eating disorder ER care, protocol, and discharge form.	Pathways: Pediatric Discharge Form
Managing Dysregulation BC Least Restraint Guidelines for emergent/urgent care and inpatient settings	Child Health BC Provincial Least Restraint Guidelines

Inpatient Care

Inpatient Resources

	URL Link
Inpatient Inter-Provider Communication Tool Inpatient individualized care provider communication tool template.	Inpatient Inter-Provider Communication Tool
Helpful Tables for Medication Management of Acute Agitation Journal of Canadian Academy of Child & Adolescent Psychiatry, April 2024	Tables for Medication Management of Dysregulation
BC Least Restraint Guidelines from Child Health BC Initial management of least restraint in emergent/urgent care and inpatient settings guidelines.	Child Health BC Provincial Least Restraint Guidelines
Use of NG Tubes in Children and Youth with Eating Disorders Info sheet on NG feeding.	NG Feeding
Consent & Confidentiality Info for Parents/Caregivers Seeking Help for Children & Youth with an Eating Disorder Helping providers and caregivers understand nuances regarding consent and confidentiality	Consent & Confidentiality
Emotion Coaching for Caregivers: Steps, Tips & Tricks Helping providers and caregivers learn emotion coaching skills	Emotion Coaching for Caregivers
Inpatient Discharge Form - Fillable PDF Inpatient discharge form and instructions	Inpatient Discharge Form - PDF

Inpatient Care

Inpatient Resources

	URL Link
A Guide to Your Stay in the Hospital Booklet Inpatient stay booklet for patients. Adapted for provincial use from Fraser Health Authority.	A Guide to Your Stay in the Hospital Booklet
When your Child is in the Hospital Booklet Inpatient stay booklet for parents/caregivers. Adapted for provincial use from Fraser Health Authority.	When your Child is in the Hospital Booklet

Eating Disorders:
Training & Education

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Learning Hub Courses (Basic on Eating Disorders)	Introduction to Eating Disorders for Service Providers	
	Eating Disorders and Substance Use	
Inside Out Institute - Australian Resources	The Foundations of Eating Disorders	This e-learning course is $1 and covers the foundations of eating disorders
	e-Learning	
	Health Professionals	
	The Essentials: Training Clinicians in Eating Disorders	$280 E-Learning Course
Inside Out - Webinars	Inside Out: Webinars - Eating Disorders	
Motivational Interviewing	Understanding Motivational Interviewing	

BC Provincial and Regional Eating Disorder Programs and Services

Print

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Regional Programs/Services *Program details can change over time, so we recommend you look at **Pathways BC** for most up to date information	**Service Area**	**Ways to Access**
Eating Disorder Program - Child and Youth - Central Island [Island Health] A multidisciplinary Eating Disorder support with a focus on Family Based Therapy. • **250-618-9962** • Website: https://www.islandhealth.ca/our-services/eating...	Ladysmith, Nanaimo	Service provided 1:1 in-person Service provided online: email / video / on-line
Eating Disorder Program - Child and Youth - Central Okanagan [Interior Health] Provides eating disorder services to children and youth up to 18. • **250-868-7788** • **250-549-5404** • **250-837-7612** • **250-832-1719**	Kelowna, Lake Country, Penticton	Service provided in a group in-person Service provided 1:1 in-person Service provided online: email / video / on-line
Eating Disorder Program - Child and Youth - Cowichan Valley [Ministry of Children and Family Development] Provides eating disorder services to children, youth ages 0-18 and their families. • **250 715-2725** • Website: https://www2.gov.bc.ca/gov/content/health...	Duncan	Service provided 1:1 in-person
Eating Disorder Program - Child and Youth - East Kootenay [Interior Health] Provides eating disorder services to children and youth up to 18. • **250-426-1514 (Cranbrook)** • Toll-free: **1-888-426-7566 Interior Crisis Line Network (24 hours): 1-888-353-2273**	Cranbrook, Creston, Golden	Service provided in a group in-person Service provided 1:1 in-person

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Eating Disorder Program - Child and Youth - Fraser East [Ministry of Children and Family Development] Provides eating disorder services to children, youth ages 0-18 and their families. • Location Finder: https://www2.gov.bc.ca/gov/content/health... • **604-870-5880 (Abbotsford - Ages 6-18)** • **604-852-2686 (Abbotsford - Ages 0-5)** • **604-796-1044 (Agassiz)** • **604-702-2311 (Chilliwack)** • **604-869-4900 (Hope)** • **604-820-4300 (Mission)**	Abbotsford, Agassiz, Chilliwack	Service provided at multiple locations Service provided in a group in-person Service provided 1:1 in-person
Eating Disorder Program - Child and Youth - Fraser North [Ministry of Children and Family Development] Provides eating disorder services to children, youth ages 6-18 and their families. • **236-468-2373 (Port Moody)** • Website: https://www2.gov.bc.ca/gov/content/health... • **604-660-9495 (New Westminster)** • **604-466-7300 (Maple Ridge)** • **604-660-9544 (Burnaby - Metrotown)** • **778-572-2370 (Burnaby - Brentwood)**	Burnaby, Maple Ridge, New Westminster	Service provided in a group in-person Service provided 1:1 in-person
Eating Disorder Program - Child and Youth - Fraser South [Ministry of Children and Family Development] Provides eating disorder services to children, youth ages 6-18 and their families. • **604-592-3700**	Delta, Langley, South Surrey	Service provided in a group in-person Service provided 1:1 in-person
Eating Disorder Program - Child and Youth - Kamloops and Thompson-Nicola/Cariboo [Interior Health] Provides eating disorder services to children and youth up to 18. • **250-554-5800** • Toll-free: **Centralized Screening: 1-800-663-9122**	100 Mile House, Ashcroft, Barriere	Service provided in a group in-person Service provided 1:1 in-person

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Eating Disorder Program - Child and Youth - North Island [Island Health] Voluntary outpatient program for the treatment of eating disorders. • **250-331-5900 ext. 65321** • Website: https://www.islandhealth.ca/our-services/eating...	Courtenay	Service provided by phone Service provided 1:1 in-person Service provided online: email / video / on-line
Eating Disorder Program - Child and Youth - South Island [Ministry of Children and Family Development] Voluntary community program for the treatment of eating disorders. • **250-387-0000** • Website: https://keltyeatingdisorders.ca/south-vancouver...	Galiano Island, Langford, Mayne Island	Service provided in a group in-person Service provided at a single location Service provided 1:1 in-person Service provided online: email / video / on-line
Eating Disorder Program - Child and Youth - West Kootenays [Interior Health] Provides eating disorder services to children and youth up to 18. • **250-505-7252 (Castlegar)**	Castlegar, Christina Lake, Grand Forks	Service provided in a group in-person Service provided 1:1 in-person
Eating Disorders Program - Child and Youth - North Shore [Vancouver Coastal Health] Offers community-based assessment and on going treatment for youth with disordered eating and eating disorders. For children and youth aged 12-18 who live in the North Shore, Bowen Island, Sunshine Coast, and Sea to Sky regions. • **604-984-5060** • Website: https://foundrybc.ca/northshore/	Bowen Island, Gibsons, Lillooet	Service provided at a single location Service provided 1:1 in-person

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Eating Disorders Program - Child and Youth - Northern Health [Northern Health] Provides assessments, consultation, and treatment, as well as individual and family education and support for children and adolescents with Eating Disorders. Consultation, assessment and treatment to the Northern region available through Zoom and teams. • **250-645-7440** • Website: https://www.northernhealth.ca/services/mental...	Northern Health Area	Service provided at a single location Service provided 1:1 in-person Service provided online: email / video / on-line
Eating Disorders Program - Child and Youth - Richmond [Ministry of Children and Family Development] Offers community-based assessment and treatment for youth and families with eating disorders. For people 11 -17 years who live in Richmond and have a diagnosis of anorexia and/or bulimia nervosa. • **604-207-2511** • Website: https://www.vch.ca/en/service/eating-disorders...	Richmond	Service provided at a single location Service provided 1:1 in-person
Eating Disorders Program - Child and Youth - Vancouver [Vancouver Coastal Health] Offers community-based assessment and treatment for youth and families with eating disorders. • **604-675-2531** • Website: https://www.vch.ca/en/service/eating-disorders...	Vancouver	Service provided at a single location Service provided 1:1 in-person Service provided online: email / video / on-line

Provincial Programs/Services	**Service Area**	**Ways to Access**
Eating Disorders Program - Child and Youth - BC Children's Hospital [Provincial Health Services Authority]	Province-wide	Service provided 1:1 in-person

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Provincial Programs/Services	Service Area	Ways to Access
The Provincial Specialized Eating Disorder Program at BC Children's Hospital is a comprehensive, interdisciplinary, specialized program to assess and treat children and adolescents with eating disorders • **604-875-2106**		
Eating Disorder Program - Child and Youth - Vancouver (St Paul's) [Providence Health] The provincial tertiary & specialized eating disorders program is dedicated to caring for people 17+ with eating disorders. Our program consists of a multidisciplinary team specialized in supporting patients who are working toward nutritional, medical, and psychosocial recovery goals. • **604-806-8347** • **Eating Disorders Consult Line:** • **604-806-8654 (Monday to Friday 8:00am - 4:00pm)** • **604-682-2344, dial '0' and ask for the on-call ED Internal Medicine physician (For after-hours only)**	Province-wide	Service provided 1:1 in-person
Looking Glass Residence - Tertiary Specialized Eating Disorder Program [Looking Glass Foundation] Tertiary referral specialized residential treatment facility for BC residents aged 16 to 24 years with eating disorders in a home-like, therapeutic environment. This facility is managed by the Provincial Health Services Authority and affiliated with the B.C. Children's Hospital Eating Disorders Program. • **604-829-2585** • Toll-free: **1-888-980-5874** • Website: https://www.lookingglassbc.com/	Province-wide	Service provided in a group in-person Service provided at a single location Service provided 1:1 in-person