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Provincial Health Services Authority

Compass Mental Health
Supporting Providers

Compass

Eating Disorder Lunch & Learn

Presenters:
Dr Seena Grewal, Dr Tara Tandan, Dr Katie Mitchell

Moderator: Dr. Priya Watson

October 4, 2023

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Land Acknowledgment

COMPASS

CHILD & YOUTH MENTAL HEALTH CASE CONSULTATION & EDUCATION FOR HEALTHCARE PROVIDERS

SERVICES

Case Consultation

Education

Service Navigation

Indigenous Care Coordination

For guidance on **clinical care** for child & youth mental health and substance use disorders:

Call **1-855-702-7272** or visit **compassbc.ca** for support with medications, counselling, diagnosis or treatment planning for children and youth in your practice.

For further **education** on common child & youth mental health and substance use disorders:

Visit **compassbc.ca/education** to find clinical toolkits, webinars, and curated resources.

Give us a call:

1-855-702-7272

Monday to Friday, 9 a.m. - 5 p.m. PST

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compassbc.ca

Housekeeping

- Questions will be answered at the end of the presentation. Please submit questions through the Q&A function.
- Please put any technical questions in the chat.
- The lunch & learn will be recorded and made available at compassbc.ca
- While this lunch & learn is not accredited, you may submit the activity as a Personal Learning Project under MOC Section 2.
- Please fill out the evaluation survey that will be emailed to you

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Disclosures

We have paid positions at BC Children's Hospital (PHSA).

Dr Watson - no other disclosures
Dr Grewal – no other disclosures
Dr Tandan - no other disclosures
Dr Mitchell - no other disclosures

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Speaker Introduction

Dr. Seena Grewal

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Speaker Introduction

Dr. Tara Tandan, MD, FRCPC

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Speaker Introduction

Dr. Katie Mitchell, MD, FRCPC, MPA

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Approaches to Eating Disorders in Primary Care

Seena Grewal, MD, MSc, FRCPC

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Land Acknowledgement

I respectfully acknowledge that the land on which I live is the unceded territory of the Coast Salish peoples, including the xʷməθkʷəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and səlilwətaɬ (Tsleil-Waututh) Nations.

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Disclosures

No conflicts of interest

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Objectives

1. Discuss approach to assessing eating disorders
2. Managing youth with eating disorders in your practice
3. Connecting families to eating disorder treatment

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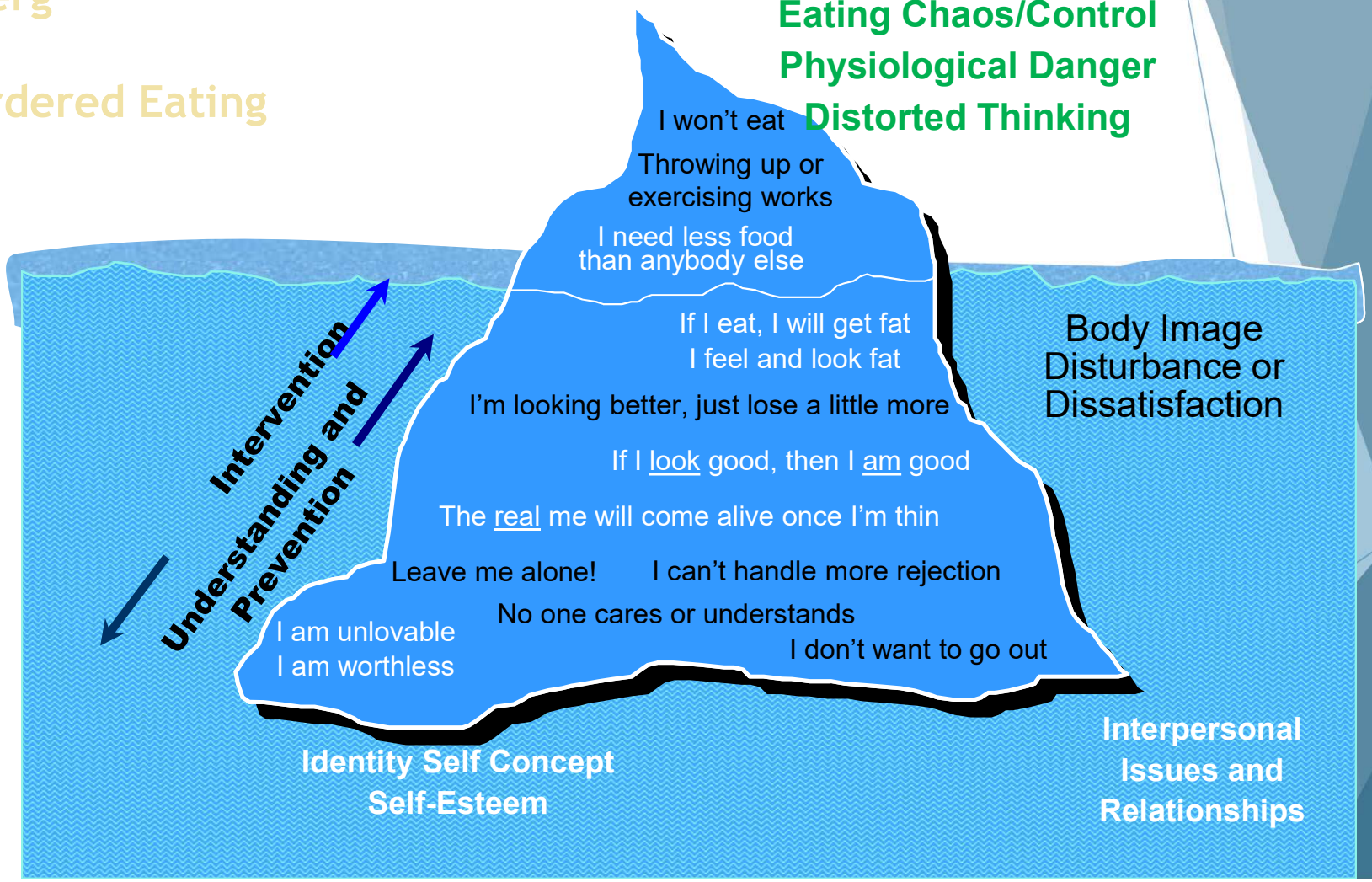
What are you assessing for?

- Disordered eating vs eating disorders
- DSM 5 EDs:
  - Anorexia Nervosa
  - Bulimia Nervosa
  - Avoidant Restrictive Food Intake Disorder (ARFID)
  - Binge Eating Disorder
  - Other Specified Feeding/Eating Disorder

Iceberg of Disordered Eating

The "Tip" of the Iceberg
(what we see and hear)
Eating Chaos/Control
Physiological Danger
Distorted Thinking



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Presentation in Primary Care

- Most individuals with ED identified first in primary practice
- Health service use higher in year preceding and after diagnosis compared to matched controls (Streigel-Moore et al 2008)
    - For all ED diagnoses
- Concerns often expressed by parent/guardian or visits for medical issues that are secondary to ED
- Having growth history helps identify concerns

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First Meeting

- Talk to youth and caregiver, if possible separately
- Do weight and height, vital signs, baseline bloodwork
  - Consider weighing with back to scale
  - Be very mindful if making comments about weight
- Encourage steps in changing eating or activity if there are concerns
  - FYI binge eating often driven by restriction
- Book a follow up appointment before youth leaves

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Questions for youth

Have you been changing your eating or exercise to lose weight?

How do you feel about the way you look?

Do you ever feel out of control with your eating?

How often are you eating each day?

Are there any particular foods you do not eat or do you follow a particular diet?

What worries do you have around eating?

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Questions for Caregivers

Have you noticed any change in the way your child eats?

Have you noticed any change in your child's weight?

Are they showing a new interest in having certain types of foods in the house or wanting to go grocery shopping with you?

Has your child expressed any discomfort about their appearance?

Have you noticed your child going to the bathroom more frequently after eating?

Was there a particular event that seemed to result in a change in your child's relationship to food?

Gather a developmental history around eating and food aversions.

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Standardized Tools

SCOFF – for 14 yo and older

Nine Item Avoidant/Restrictive Food Intake Screen (NAIS)

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Medical Assessment

- General physical
- Weight, height
  - BMI not used typically for youth
- CBC, electrolytes, TSH
- ECG

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Assessment for Co-occurring Conditions

- Anxiety
- Depression
- Obsessive Compulsive Disorder
- Autism Spectrum Disorder

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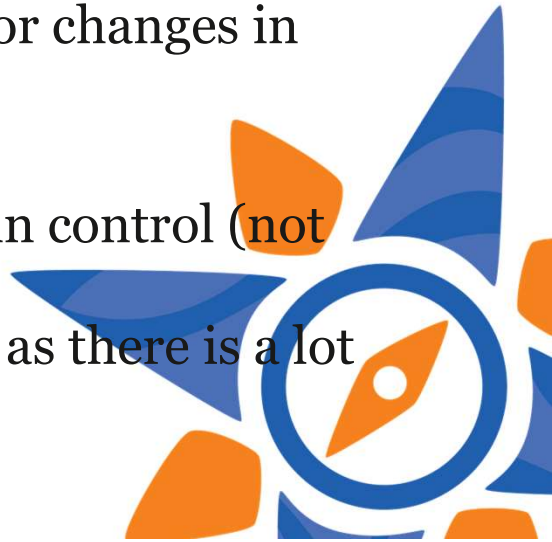
How to Discuss Diagnosis

- Key messages:
  - Worries about the impact on health, including brain health
  - Validate the emotions that may be expressed both for changes in eating and around getting treatment
  - Promote acceptance and change
  - May help to emphasize desire to help them remain in control (not food controlling you)
  - Families and youth may have differing perspectives as there is a lot of (mis)information about food/nutrition in society



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How to Talk About Food

- "food is medicine"
- Avoid labelling foods as good/bad
- Focus on stepwise changes family can make
- Promote families eating together
- Be aware of your own biases
- Regular nutrition is important for everyone
  - Including those struggling with binge eating
- There are many areas for practicing autonomy/control that aren't food related

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Management of ED

- Motivational approach
- Multiple conversations likely required
  - Repetition of key information
  - ED symptoms may be minimized by youth initially
- Consistency & persistency

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Follow Up Appointments

- Regular appointments for vital signs and weight if this is a concern
- Motivational interviewing strategies
- Distress tolerance strategies for youth and caregivers
- Caregivers are encouraged to take steps to support youth around eating
    - Preparation of meals/snacks, emotional support

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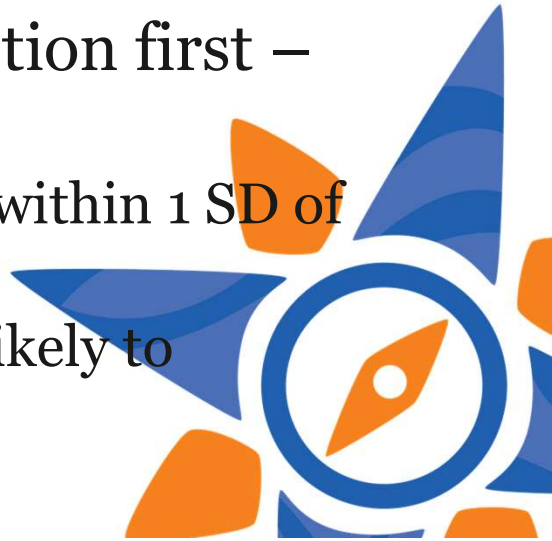
Therapeutic Interventions

- Majority evidence for family interventions
  - Minimal evidence for individual therapy for youth
- Most treatment focuses on symptom interruption first – eating/exercise vs cognitions
  - Body image thoughts often require years to get within 1 SD of normative for adults with AN
  - For youth body image evolves over time – less likely to resonate with the BI treatments



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Medication

- Medication is not the primary treatment
- Prescribe for comorbidities
- Be honest about the limitations of literature
- Very little evidence to show any medication impacts on ED cognitions
- SSRIs less effective when low weight

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Medication

- Some evidence for:
  - High dose SSRIs for BN
  - Olanzapine for ARFID
  - Vyvanse for BED
- Bupropion contraindicated

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What to expect at assessment with ED program

- Medical status informs intervention
- Multidisciplinary teams
- Strict meal plans are not typically provided
- For youth programs caregivers are required to be involved in some way
- ED treatment is for the "tip" of the iceberg
    - May be referred for tx of comorbidity to other services

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Connecting Families to ED Services in the Province

Pathways project

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References

- Klein DA, Sylvester JE, Schvey NA. Eating Disorders in Primary Care: Diagnosis and Management. Am Fam Physician. 2021 Jan 1;103(1):22-32. Erratum in: Am Fam Physician. 2021 Mar 1;103(5):263. PMID: 33382560.
- Striegel-Moore, R., DeBar, L., Wilson, G., Dickerson, J., Rosselli, F., Perrin, N., . . . Kraemer, H. (2008). Health services use in eating disorders. Psychological Medicine, 38(10), 1465-1474. doi:10.1017/S0033291707001833

Child & Youth Eating Disorders Complex Clinical Care Pathway

A Doctors of BC - Shared Care Initiative

Dr. Tara Tandan & Dr. Katie Mitchell

October 4, 2023
12pm-1pm PST

BC Children's Hospital

SharedCare
Partners for Patients

Disclosures

Project Physician Leads:
Dr. Tara Tandan
Dr. Katie Mitchell
Dr. Shirley Sze
Dr. Joan Fujiwara

Presenters: Dr. Tara Tandan, Dr. Katie Mitchell

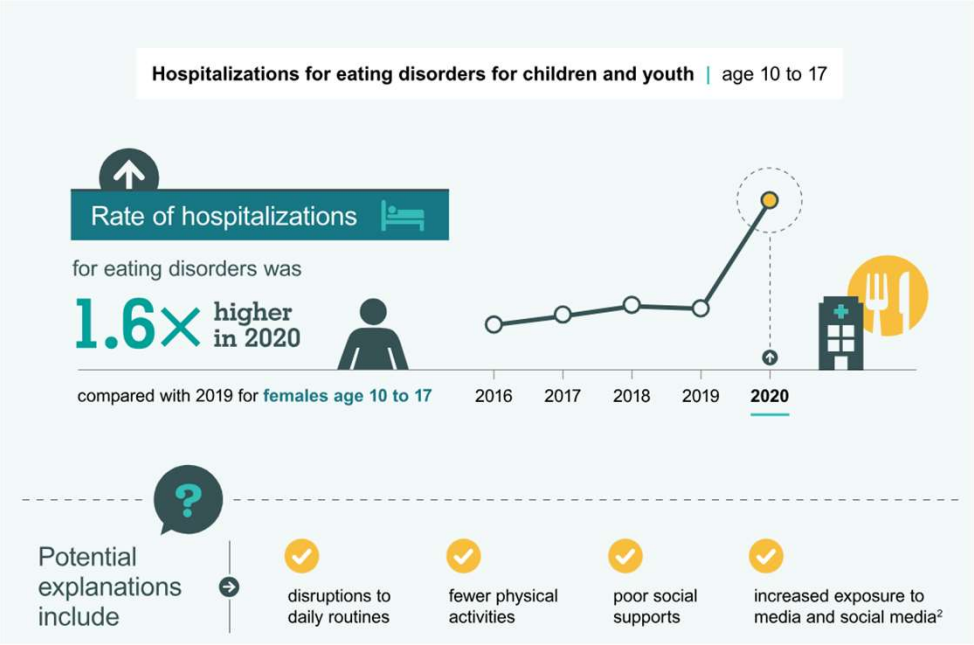
Relationships (all presenters) with commercial interests:
“I have nothing to disclose”

Objectives

- **Project Inception:** Describe rationale
- **Pathway Overview:** Explain structure of care pathway and how it will improve care and navigation experience
- **Next Steps:** Summarize expected project outcomes & timeline for pathway launch

Rationale

- Primary Care Providers (PCPs) and General Pediatricians are increasingly being called upon to co-manage influx of child/youth eating disorder patients, especially since the onset of COVID-19



CIHI, 2022: https://www.cihi.ca/en/children-and-youth-mental-health-in-canada

Project Aims & Process

- Co-design process between generalist, specialist, allied health providers, and those with lived experience

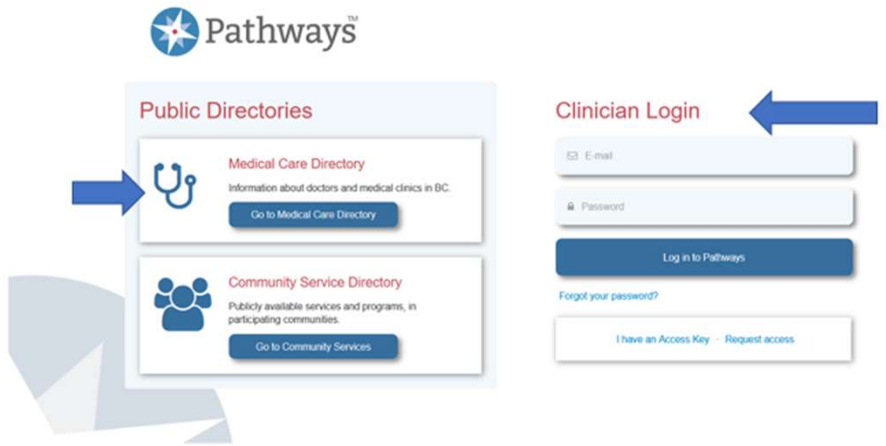
- To increase knowledge and competence of practitioners through availability of a ***Complex Clinical Care Pathway for Child and Youth Eating Disorders***
  - Clinical decision making tool with embedded, locally tailored resources, links, tools and referral information
  - Coming to "Pathways BC" & "Compass BC"

Point of Care Tool on Pathways BC

www.PathwaysBC.ca

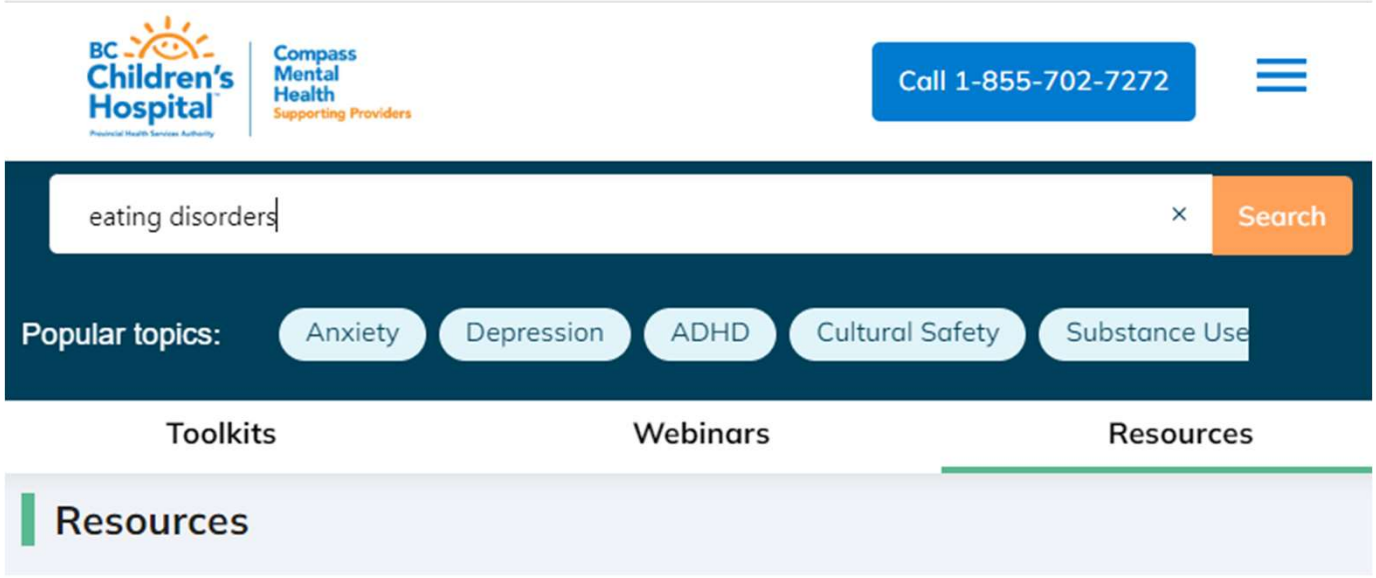
Pathways www.pathwaysbc.ca
Beyond specialist lookups
A curated gateway to internet clinical tools
for all BC physicians and their teams

To request access: contact-us@pathwaysbc.ca



Comprehensive Care Pathway on CompassBC

www.CompassBC.ca



Pathway Demo

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

QUICK LINKS

↓ Prevention | ↓ Health Equity & Mindful Communication | ↓ Patient / Family Info | ↓ Research Participation | ↓ Clinician Info | ↓ Referrals & Clinician Supports

Be aware about patients and families who might benefit from an equity lens.

Presentation
- Identification
- Differential Dx
- Presenting Features
- Comorbidities

Screening & Assessment
- Eating Disorder Screening
- Comorbidities Screening

History – Physical
- History
- Physcial

Common Investigations
- Initial Labs & ECG
- Imaging

Acuity Assessment At Each Encounter

Step 1: Obtain orthostatic vitals & blinded weight

Step 2: Assess for 1 or more medical instability criteria

Step 3: Assess for Mental Health Presentation requiring hospitalization

Step 4: Calculate percent premorbid weight & percent median BMI (%mBMI)

If uncertain/concerned re: acuity, call Pediatrician/Adolescent Medicine for advice

YES

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

YES

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

YES

High Acuity: Hospital Stabilization Required
(Consider Peds Consultation; patient navigator/support)

Emergency Room

Send family with copy of: Emerg. Rm. Communication

Weight Criterion
Consider amount and time frame of weight loss

High Acuity

Encourage urgent pediatric consultation to guide ER care and admission plans

Extreme Acuity

Encourage urgent BCCH Adolescent Medicine to guide care planning
Phone: 604 875-2161

Not currently requiring hospitalization

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

How you communicate matters, be:
- trauma informed
- culturally aware and safe
- unbiased
- eating disorders informed language (patient centered)

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SharedCare Partners for Patients

SDE | NIAS | OCD | KADS 6 | GAD 7 | SCARED (p) | SCARED (c) | PHQ 9 (teen)

Return to p1

Screening & Diagnostic Tools

Eating Disorder Screening Tools

- SDE Eating Disorder
- NIAS Eating Disorder
- DSM-V Criteria

Comorbid Condition Screening Tools

- SCARED-child Anxiety
- SCARED-parent Anxiety
- GAD-7 Anxiety
- OCD Screening
- PHQ-9 (teen) Depression
- KADS 6 (child) Depression
- SNAP-IV ADHD

Return to p1

Screen for Disordered Eating (SDE)

1. Do you often feel the desire to eat when you are emotionally upset or stressed?	**YES**	**NO**
2. Do you often feel that you can't control what or how much you eat?	**YES**	**NO**
3. Do you sometimes make yourself throw up (vomit) to control your weight?	**YES**	**NO**
4. Are you often preoccupied with a desire to be thinner?	**YES**	**NO**
5. Do you believe yourself to be fat when others say you are thin?	**YES**	**NO**

Maguen, Hebenstreit, Yongmei, Dinh, Donalson, Dalton, Rubin, and Masheb Screen for Disordered Eating: Improving the accuracy of eating disorder screening in primary care. Gen Hosp Psychiatry. 2018 Jan - Feb;50:20-25

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Return to p1

Indicators of medical instability:

☐ Glucose <3.0 mmol/L	☐ Resting supine heart rate < 45/min
☐ Potassium <3.0 mmol/L	☐ Hypotension (<85/45 mmHg)
☐ Phosphate <0.8 mmol/L	☐ Orthostatic drop in BP >20mmHg
☐ Magnesium <0.7 mmol/L	☐ Temperature (oral) <36 degrees Celsius
☐ Any ECG abnormalities, including QTc >0.46s	☐ Refeeding Risk (see Refeeding Risk table below)
	☐ Extreme malnutrition (<70% of TGW)

Refeeding Syndrome Risk	Mild	Moderate	Severe
Criteria	• >90% TGW • Reasonable energy (>1000 kcal/day) intake for >10 days • No history of RFS • Slow rate of weight loss • No diuretic, laxative, orinsulin misuse • Normal electrolytes • No alcohol intake	• 70-90% TGW • Some energy intake (>500kcal/day) for >10 days • No history of RFS • Slow rate of weight loss • No diuretic, laxative, orinsulin misuse • Normal electrolytes • No alcohol intake	• <70% TGW • Chronically under-nourishedor little to no energy intake (<500 kcal/day) for >10 days • Previous history of RFS • Rapid or profound weight loss (>10-15% of total bodymass in 3-6 months) • Diuretic, laxative, insulin, etcmisuse • Abnormal electrolytes • Significant alcohol intake
Meal plan selection and other associated actions	• Start higher meal plan(>2000 kcal/day). • Consider oral sodium phosphate supplements prophylactically. • Consider RFS labs on 4thand 5th day of refeeding	• Start higher meal plan(1700-2000 kcal/day). • Consider oral sodium phosphate supplements prophylactically. • Consider thiamine prophylactically. • RFS daily labs for a minimum of 5 consecutive days. Consider extending to 5 – 7 days. • Consider RFS labs the dayafter stopping oral phosphate.	• Start lower meal plan (<1700kcal/day) and advance slowly. • Add oral sodium phosphate supplements prophylactically. • Add thiamine prophylactically at 2mg/kg/day (max 200mg) x10 days* • Daily to twice daily RFS labsfor a minimum of 5 consecutive days. Consider extending to 7-10 days. • RFS labs the day after stopping oral phosphate. • Order egg crate or Hillrom mattress and monitor for bedsores. • Monitor for substance withdrawal as indicated. ***Consult BCCH Adolescent Medicine team.***

TGW: Treatment goal weight

IMPORTANT: This table cannot replace careful clinical observation and judgment in patient management.

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

QUICK LINKS

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

Eating Disorder Follow-Up Visit Template

Team Care Communication Cover Letter

Approach to take

Patients often find it difficult to acknowledge their Eating Disorder; repeated visits may be needed to build trust.

Collateral history from caregivers is important.

Assessment

- Medical
- Psycho-social
- Mental/Emotional Wellness
- Co-occurring Conditions

Management

Basic Management

Encourage family involvement

Compassionate communication of concerns for patient safety

Beyond Basics Management

Transitioning to Adult Care

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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Timelines & Next Steps

- Project funded for 2 years (Sept 2022 - 2024)
- Planning for Dec. 2023 soft launch accompanied by promotional efforts (KT) and iterative evaluation.

Thank you!