

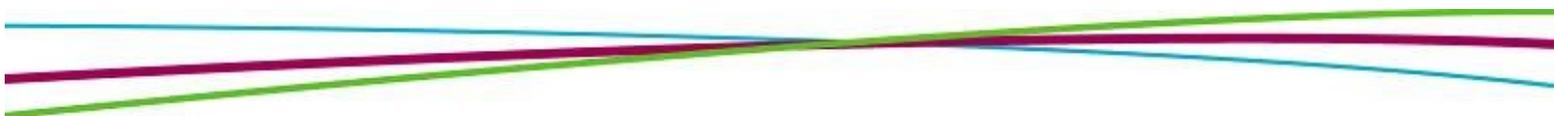


Sheffield Health and Social Care  
NHS Foundation Trust



# Eating Disorders Toolkit for Primary Care and Adult Mental Health Services

Sheffield Eating Disorders Service  
South Yorkshire Eating Disorders Association  
Sheffield Clinical Commissioning Group



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Sheffield Clinical Commissioning Group

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# EATING DISORDERS TOOLKIT FOR PRIMARY CARE AND ADULT MENTAL HEALTH SERVICES

Sheffield Eating Disorders Service  
South Yorkshire Eating Disorders Association  
Sheffield Clinical Commissioning Group (CCG)

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## 1. INTRODUCTION

This Eating Disorders Toolkit is designed to offer practical support to clinicians, both in understanding and in working with / supporting people with eating disorders.

In line with the stepped care model, only the most severe people will be seen by specialist services and, therefore, a need has been identified to offer guidance to health professionals at all levels, to enable them to provide advice, guidance and support to both sufferers and carers.

Although this Toolkit has mainly been written for Primary Care staff, it will provide a useful resource for anyone working with / interested in working with people with eating disorders.

Whilst the main scope of this document is directed towards adults with eating disorders, some references are made to children and young people. However, this Toolkit does not specifically address this particular client group and, as such, advice and support should be sought from CAMHS if required.

Where possible, the document is based on best evidence including national guidelines and is referenced to enable anyone with an interest to follow up enquiries more fully.

## 2. WHAT ARE EATING DISORDERS?

### 2.1. Anorexia Nervosa

Anorexia nervosa (AN) is an illness in which people keep their body weight low by dieting, vomiting or excessively exercising.

The illness is caused by an anxiety about body shape and weight that originates from a fear of being fat or from wanting to be thin. How people with anorexia nervosa see themselves is often at odds with how they are seen by others, and they will usually challenge the idea that they should gain weight. People with anorexia nervosa can see their weight loss as a positive achievement as it can help increase their confidence and self esteem. It can also contribute to a feeling of gaining control over body weight and shape.

Anorexia nervosa is, however, a serious condition that can cause severe physical problems because of the effects of starvation on the body. This can lead to loss of muscle strength and reduced bone strength in women and girls; in older girls and women, their periods often stop. Men can suffer from a lack of interest in sex or impotency.

The illness can affect people's relationship with family and friends, causing them to withdraw; it can also have an impact at school or in the workplace. The severity of the physical and emotional consequences of the condition is often not acknowledged or recognised, and people with anorexia nervosa often do not seek help.

**Anorexia nervosa in children and young people** is similar to that in adults in terms of its psychological characteristics. However, in addition to being of low weight, anorexia nervosa in children can lead to stunted growth and a delay in achieving developmental milestones, e.g. puberty.

## 2.2. Bulimia Nervosa

Bulimia nervosa (BN) is an illness in which people feel that they have lost control over their eating. As in anorexia nervosa, they evaluate themselves according to their body shape and weight. Indeed in some instances (although not all), bulimia nervosa develops out of anorexia nervosa. People with bulimia nervosa are caught in a cycle of eating large quantities of food (called 'binge eating'), and then vomiting, taking laxatives and diuretics (called 'purging'), or excessive exercising and fasting, in order to prevent weight gain. This behaviour can dominate daily life, and lead to difficulties in relationships and social situations. Usually people hide this behaviour from others, and their weight is often normal. People with bulimia nervosa tend not to seek help or support very readily.

People with bulimia nervosa can experience swings in their mood, and feel anxious and tense. They may also have very low self esteem and might try to hurt themselves by scratching or cutting. They may experience symptoms such as tiredness, feeling bloated, constipation, abdominal pain, irregular periods, or occasional swelling of the hands and feet. Excessive vomiting can cause problems with the teeth, while laxative misuse can seriously affect the heart.

**Bulimia nervosa in children and young people** is rare, although young people may have some of the symptoms of the condition.

## 2.3. Atypical Eating Disorders including Binge Eating Disorder

Atypical Eating Disorders (AED) or Eating Disorder Not Otherwise Specified (EDNOS), including Binge Eating Disorder (BED), may affect more than half of people with an eating disorder. These conditions are called 'atypical' eating disorders because they do not exactly fit the description of either anorexia nervosa or bulimia nervosa. People might have some of the symptoms of anorexia nervosa (such as dieting, binge eating, vomiting and a preoccupation with food), but not all; or they might have symptoms that fall between anorexia nervosa and bulimia nervosa; or they might move from one set of problems to another over time. Many people with an atypical eating disorder have suffered with anorexia nervosa or bulimia nervosa in the past.

Binge Eating Disorder (BED) is classified as an atypical eating disorder. With BED, people have episodes of binge eating, but do not try to control their weight by purging. A person with BED may feel anxious and tense, and their condition might have an effect on their social life and relationships.

**Atypical eating disorders in children and young people** are thought to be quite common, although little is known about binge eating disorder in this age group.

The following diagram is a helpful way of viewing the differences between the main eating disorders.

	ANOREXIA NERVOSA 1% or less	BULIMIA NERVOSA 2 – 4%	BINGE EATING DISORDER 4 – 5%
Dietary Restraint (All 3 groups dieting)	↓↓↓	↓↓	↓
Bingeing	+	+++	++
Purging	++	+++	-

## 2.4. Who is affected by Eating Disorders?

The average GP Surgery with a list of 5000 patients is likely to have 5 patients who meet full diagnostic criteria for anorexia nervosa and 50 who meet criteria for bulimia nervosa.

Several more patients will have some degree of disordered eating or eating distress and may fulfil criteria for an Atypical Eating Disorder (AED) or Eating Disorder Not Otherwise Specified (EDNOS).

Young females are most at risk and it is estimated that between 5 - 10% of adolescent girls have some degree of disordered eating. The typical age of onset is mid adolescence.

However males also develop eating disorders and the male to female ratio is 1:10. The ratio is higher up to 1:4 amongst young boys.

It is important to remember that eating disorders can occur across all socioeconomic and ethnic groups.

## 2.5. Development of an Eating Disorder

The development of an eating disorder requires predisposing and precipitating factors. Once established it may persist because of additional perpetuating or maintaining factors. The relative contributions of these factors and the timing and influence aren't fully understood.

Predisposing Factors	Precipitating Factors	Perpetuating Factors
<ul style="list-style-type: none"> <li>▪ Depression;</li> <li>▪ Low self-esteem;</li> <li>▪ Obesity;</li> <li>▪ Feeding difficulties when younger;</li> <li>▪ Sexual abuse as a child;</li> <li>▪ First degree relatives with an eating disorder;</li> <li>▪ Substance misuse in family;</li> <li>▪ Perfectionists;</li> <li>▪ Female: male ratio 10:1;</li> <li>▪ More likely to develop in western societies.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Dieting behaviour;</li> <li>▪ Puberty;</li> <li>▪ Separation;</li> <li>▪ Relationship changes and crises;</li> <li>▪ Illness;</li> <li>▪ Adverse comments from others / bullying.</li> </ul>	<p>Cognitive Events:</p> <ul style="list-style-type: none"> <li>▪ The cognitive distortions of semi-starvation;</li> <li>▪ Extreme over-evaluation of shape and weight.</li> </ul> <p>Interpersonal Events:</p> <ul style="list-style-type: none"> <li>▪ Change in relationships due to the illness;</li> <li>▪ Enhancement of self esteem;</li> <li>▪ Positive reward for self control.</li> </ul> <p>Physiological Events:</p> <ul style="list-style-type: none"> <li>▪ Semi-starvation;</li> <li>▪ Delayed gastric emptying;</li> <li>▪ Regression of adult hormone function.</li> </ul>

The three predisposing factors in yellow shading are those which may cause sufferers to try dieting as a solution to their problems. The use of dieting behaviour is the major precipitant to the development of an eating disorder and increases the likelihood of developing an eating disorder.

### 2.6. Presentation and Identification in Primary Care

Due to the shame and secrecy associated with eating disorders many patients are not known to their GP's. Research by Ogg et al (1<sup>1</sup>) shows that people with eating disorders visited the GP on multiple occasions prior to eating disorder diagnosis, presenting with gastrointestinal, gynaecological or psychological difficulties.

It is important to consider the possibility of an eating disorder, as if this is overlooked patients may be referred for costly and unnecessary physical investigations or prescribed medication such as laxatives which can further compound their difficulties. Younger patients may be brought to the GP by their parents, a friend or other family member. It is important to listen to these third party concerns.

**N.B. Early identification and treatment improves prognosis.**

### 2.7. Screening

In today's society, many people, particularly the young, feel under intense pressure to conform to cultural expectations to be thin. Physical and hormonal changes during puberty, such as growth spurts, 'puppy fat', menstruation in girls, changing body shape, etc. can clash with perceived cultural 'requirements'. These factors, combined with stresses at home, school or work, personal relationships, etc. can make young people vulnerable to the development of eating disorders at this time.

Primary care has a specific responsibility to identify individuals at risk at an early stage so that a prompt and timely intervention can be offered. Target groups for screening include:

- Young people (15-40) with low Body Mass Index (BMI) and females with loss of periods / menstrual disturbance, who are concerned with their weight when not overweight.
- Patients with gastrointestinal, gynaecological or psychological difficulties.
- Young patients with Type 1 diabetes and poor treatment adherence.

The NICE Eating Disorder Guideline (2004) (2<sup>2</sup>) suggests that one or two simple questions should be used with target groups:

- Do you think you have an eating problem? Do you worry excessively about your weight?

Alternatively, the five questions in the **SCOFF Questionnaire** below can be asked in any order. Two or more YES answers should prompt the GP to take a more detailed history.

▪ Do you make yourself <b>S</b> ick because you feel uncomfortably full?
▪ Do you worry you have lost <b>C</b> ontrol over how much you eat?
▪ Have you recently lost more than <b>O</b> ne stone in a three month period?
▪ Do you believe you are too <b>F</b> at when others say you are too thin?
▪ Would you say that <b>F</b> ood dominates your life?

The aim is to promote openness and disclosure amongst patients who may be ambivalent about seeking help. Denial is common in Anorexia Nervosa and, therefore, even these symptoms may be denied. Again it is important to obtain the views of friends and family as part of the assessment. The availability of leaflets at the surgery may promote disclosure.

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<sup>1</sup> Ogg, et al. (1998). "General Practice Consultation Patterns Preceding Diagnosis of Eating Disorders." International Journal of Eating Disorders. Vol. 22. Issue 1. Pg. 89 – 93.

<sup>2</sup> National Institute of Clinical Excellence (NICE) (2004) – Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders. Clinical Guideline CG9. <http://www.nice.org.uk/CG009>

### 3. ASSESSMENT

Assessment of people with eating disorders should be comprehensive and include **physical**, **psychological** and **social** aspects and a comprehensive assessment of risk to self.

Physical	Psychological	Social
<ul style="list-style-type: none"> <li>▪ Body Mass Index (BMI);</li> <li>▪ Menstrual status;</li> <li>▪ Blood chemistry: (FBC, U&amp;Es, TFT &amp; LFT);</li> <li>▪ History of weight loss.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Psychological triggers, e.g. bereavement;</li> <li>▪ Attitude to body shape and weight;</li> <li>▪ Impact on self esteem;</li> <li>▪ Motivation to change.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Family and home situation;</li> <li>▪ Employment / occupation;</li> <li>▪ Impact on social functioning;</li> <li>▪ Use of leisure time etc;</li> </ul>

#### 3.1. Format of Initial Assessment

The initial assessment should be presented under the following headings:

- Personal history, family history and social situation;
- History of eating disorder - How did it begin, develop and what is the current situation;
- Current eating patterns - typical day / food restriction / frequency of bulimic episodes and compensatory behaviours;
- Physical risk factors, height weight and BMI;
- Attitude to body image and self esteem;
- Mood and motivation to change.

A brief Eating Disorders Assessment pro-forma (see Appendix D) has been developed which can be carried out by the GP or Practice Nurse.

#### 3.2. Core Principles

##### ▪ **Assessment and Co-ordination of Care**

The GP has been designated with responsibility for the initial assessment and co-ordination of care including determining the need for emergency medical or psychiatric assessment.

The GP's initial assessment should cover the physical, psychological and social aspects as above. Following assessment, the GP should agree the next steps with the patient and assess the need for further referral, either to sector community mental health team (CMHT), specialist eating disorder service or the need for emergency, medical or psychiatric assessment.

##### ▪ **Providing Good Information and Support**

The GP / practice nurse or primary mental health care worker should provide information about eating disorders and local self help groups / resources, etc. to the patient and carers (e.g. SYEDA – see Section 9.2 and 9.3).

### ▪ **Getting Help Early**

Early intervention improves prognosis and, therefore, people with eating disorders seeking help should be assessed and referred as soon as possible. Early treatment is especially important for those with a risk of severe emaciation.

### ▪ **Management of Physical Aspects**

Eating disorders have important physical consequences which need to be assessed and monitored. Of specific importance:

- Weight and BMI should be regularly monitored where patients are at low weight;
- Regular blood tests should be carried out, including FBC, U&Es, LFT and TFT;
- It is essential to liaise regularly with all services / healthcare professionals involved, eg. Sector CMHT, CPA Care Co-ordinator, staff within Sheffield Eating Disorders Service, dietician, etc.

### ▪ **Additional Considerations for Children and Adolescents**

It is vital to closely monitor growth and development of children and adolescents with eating disorders. Where growth or development is affected despite adequate nutrition, paediatric advice should be sought. Where possible family members, including siblings, should normally be included in interventions.

When assessing and treating children and adolescents, healthcare professionals should be alert to indicators of abuse (emotional, physical and sexual).

## **3.3. Making the Diagnosis**

Detailed diagnostic criteria can be found in DSM-IV and ICD-10. However, in general terms, eating disorders fall into the following diagnostic categories.

### **Anorexia Nervosa (AN)**

- Body weight is maintained 15% below expected for age and height / BMI <17.5kg/m<sup>2</sup>;
- Weight loss is induced by restriction of food intake, self induced vomiting or purging, excessive exercise or use of appetite suppressants or diuretics;
- Loss of three consecutive menstrual periods in females / loss of sexual interest or libido in males;
- Disturbed body image;
- There are two subtypes: Restrictive or Binge Purge subtype.

### **Bulimia Nervosa (BN)**

- 2 or more binge-eating episodes per month over a three month period;
- Use of inappropriate compensatory behaviours such as self induced vomiting, laxative or diuretic use or excessive exercise;
- Self evaluation unduly influenced by body shape and weight concerns;
- Usually occurs when weight is within the normal range.

### **Binge Eating Disorder (BED)**

- As above but in the absence of purging behaviours;
- Often associated with obesity

**Eating Disorder Not Otherwise Specified (EDNOS)**

- Fulfils some, but not all, of the criteria for AN or BN.

**3.4. Outcome of Assessment**

Outcome of assessment (see flowchart – Appendix A):

Mild	Moderate	Severe
Minimal risk factors, disturbed eating patterns, recent onset, well motivated, does not yet meet diagnostic criteria for Anorexia Nervosa or Bulimia Nervosa.	BMI between 16 and 17.5 or bulimic episodes occurring between approx 2 - 5 x per week for 6 months , some evidence of depression, well motivated.	BMI less than 16 or daily / more than daily bulimic episodes associated with depression / self harm or other co morbidity / poor motivation.

**3.5. Specific Risk Factors Associated with Severe Eating Disorders**

Low BMI	Low Potassium	Low Mood
<ul style="list-style-type: none"> <li>▪ BMI &lt;17.5: Meets diagnostic criteria for Anorexia Nervosa.</li> <li>▪ BMI 15: Requires urgent referral.</li> <li>▪ BMI &lt;14: Requires Medical or Specialist Admission.</li> </ul>	<ul style="list-style-type: none"> <li>▪ 3.5: Normal range.</li> <li>▪ &lt;3.5: Treat and monitor.</li> <li>▪ &lt;2.5: Seek urgent medical opinion or admit to hospital.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Assess suicidal thoughts and risk factors.</li> </ul>

**4. REFERRAL PATHWAYS**

Please refer to the referral pathway flow diagram (Appendix A) for full details. An Eating Disorders Service referral form can be found at Appendix B.

CRITERIA FOR REFERRAL	
Anorexia Nervosa (AN)	Bulimia Nervosa (BN)
<ul style="list-style-type: none"> <li>▪ Refer all adult patients who meet diagnostic criteria for AN routinely to the Sheffield Eating Disorders Service.</li> <li>▪ Those with a BMI of &lt;15 will be assessed on an urgent basis by Sheffield Eating Disorders Service (SEDS).</li> <li>▪ Admit patients medically if BMI &lt;13.5.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Mild / Moderate BN - manage initially in primary care.</li> <li>▪ Moderate / Severe BN with minimal psychiatric co-morbidity – refer directly to the Sheffield Eating Disorders Service.</li> <li>▪ Moderate / Severe BN with psychiatric co-morbidity – refer to Sheffield Eating Disorders Service.</li> <li>▪ Severe BN / Severe co-morbidity – consider priorities. Client may need to be assessed by Sheffield Eating Disorders Service as well as a CMHT via Care Programme Approach (CPA).</li> </ul>

### 5. THE STEPPED CARE MODEL IN SHEFFIELD

#### 5.1. Primary Care

The GP and Primary Mental Health Care Team have a very important role in supporting people with eating disorders across the range of severity. Sheffield has pioneered the Primary Care Management of eating disorders nationally, with two Award winning Nurse-led Eating Disorders Clinics at the University Health Service and at the Porter Brook Medical Centre and other expertise in the city. Based on this experience the following strategies can be offered.

A brief Eating Disorders Assessment pro-forma (see Appendix D) has been developed which can be carried out by the GP or Practice Nurse. NB. If seeing the GP, a double appointment may be required or half an hour with the Practice Nurse. The style of the assessment should be collaborative and it can help to give the patient self report questionnaires such as the EAT, BITE or Eating Disorders Self Help Questionnaire (see Appendix C).

Following assessment it should be possible to decide whether the patient has Anorexia Nervosa, Bulimia Nervosa, Eating Disorder Not Otherwise Specified or Binge Eating Disorder and to determine whether this is a mild, moderate or severe problem. If the problem is mild to moderate the patient may be suitable for Primary Care management.

#### **Supporting Someone with Anorexia Nervosa**

Supporting someone with Anorexia Nervosa can be complex as they may be in denial of their illness. The following aims may be relevant.

- Provide psychological support and aim to reduce the impact of psychological stress;
- Explain BMI and set target for weight maintenance initially and at a later stage for weight gain (0.5 kg per week);
- Suggest the use of a food diary to assess current intake and make suggestions for change;
- Involvement of parents is vital when managing young people with eating disorders;
- Ongoing monitoring of physical health is essential;
- There are self help books for people with **Anorexia Nervosa** and for their friends and family (see Section 9.6).

#### **Supporting Someone with Bulimia Nervosa**

Patients with **Bulimia Nervosa** and **Binge Eating** problems are most amenable to Primary Care management as NICE recommends that adults with BN should be encouraged to follow an evidence based self help programme initially. Guided Self-Help (GSH) refers to support for the patient to follow the self help manual with support from a health professional, friend or carer.

#### **Suitability for Guided Self Help (GSH):**

NICE Guidelines recommend an evidenced based self help programme as a possible first step for people with Bulimia Nervosa. A computerised CBT programme "Overcoming Bulimia Online" may be available in some surgeries and via SYEDA. <http://www.overcomingbulimiaonline.com/>

GSH is **suitable** for people with:

- Mild to moderate difficulties who are ready to change.
- Good social support.

GSH is **less suitable** for:

- Women who are pregnant;
- Clients with diabetes;
- Poor social support or motivation.

The recommended self help manuals are listed in Section 9.6. A useful worksheet to complete with the client (or given as homework) as part of assessment and / or a guided self help intervention can be found at Appendix E. This can be used prior to a client commencing "Overcoming Bulimia Online".

Encourage a collaborative approach and recommend SEDS Self Help booklet or other self help books (listed) which provide:

- Psycho-education on effects of starvation / purging / nutritional needs;
- Exploratory exercises developed to build motivation for change and identify triggers;
- Monitoring sheets for eating and mood;
- Self esteem and relaxation exercises.

### 5.2. Community Mental Health Teams (CMHTs)

CMHTs are multidisciplinary mental health teams providing a service to people aged 16 - 64 who require a secondary mental health service and have a severe and / or complex mental health problem, other than psychosis. This includes people with eating disorders depending on their levels of severity and / or complexity.

Sector teams are generally the first point of contact for the referral of moderate eating disorders where there is also psychiatric co-morbidity. They will screen referrals as to suitability for the specialist eating disorder service, meeting the threshold for sector team input, or for management in a Primary Care setting. Initial assessments may be offered to assist with this process.

Care co-ordination may be offered from this service, this role generally being performed by nurses or social workers who are able to work in conjunction with SEDS, using them for advice and / or consultation, or for joint working arrangements dependant on individual needs. This may entail care planning, ongoing assessment including risk, monitoring of physical and mental health, and encouragement and support in undertaking evidence based self help programmes.

Sector teams can offer input from Occupational and Art Therapists, Psychology, and Cognitive Behavioural Therapy. With regards to psychotherapeutic approaches, including Cognitive Analytical Therapy (CAT) and Cognitive Behavioural Therapy (CBT), the focus of this would tend to be upon any co-morbid problems. Additionally, Psychiatrists within the team are able to provide medical cover, particularly in relation to any medication needs that may need addressing.

### 5.3. Sheffield Eating Disorders Service (SEDS)

The SHSC Sheffield Eating Disorders Service is a community-based outpatient service, providing assessment and psychologically based interventions to those suffering from severe eating disorders.

The team comprises a number of qualified full and part time staff. Currently the staff mix of the team includes psychiatry, clinical psychology, nursing and input from the Clinical Service Manager who is from an occupational therapy background. Following referral from the GP or Sector CMHT, clients will be offered an assessment appointment. The assessment may take place over a number of appointments until a plan of care can be developed.

We provide both individual and group therapy to support people in working towards recovery from their eating disorder. Therapies offered at Sheffield Eating Disorders Service include Motivational Interviewing, Cognitive Behavioural Psychotherapy, Cognitive Analytical Therapy and Structured Guided Self Help. The Service works in collaboration with Primary Care and the Sector CMHTs.

### **What treatment options are available?**

#### **Treatment for Anorexia Nervosa:**

The Department of Health (DH) recommends treatment focused on recovery from Anorexia Nervosa to last at least six months. (<http://guidance.nice.org.uk/CG9>). Appointments are usually weekly and could be for:

- Individual Cognitive Behavioural Therapy (CBT).
- Individual Cognitive Analytic Therapy (CAT).
- Motivational and supportive sessions.

#### **Treatment for Bulimia Nervosa:**

According to DH guidelines, treatment focused on recovery from Bulimia Nervosa usually lasts four to five months. Appointments are usually offered fortnightly for:

- Guided Self Help (GSH). SEDS offers a computerised GSH for Bulimia Nervosa programme for individuals with moderate BN, good motivation and minimal psychiatric co-morbidity. The programme takes place over 8 sessions following a period of assessment.

Or offered weekly for:

- Individual Cognitive Behavioural Therapy (CBT).
- Individual Cognitive Analytic Therapy (CAT).
- Group Therapy Programme.
- Motivational & supportive sessions.
- Long Term Risk Management Programme.

### **Patients Requiring Inpatient Care**

A minority of patients require inpatient care. Sheffield Eating Disorders Service has developed a close working relationship with Hadfield One Ward – Northern General Hospital (NGH) regarding patients with low BMI or experiencing medical complications of an eating disorder. For those patients who require admission to a specialist eating disorders unit, SEDS applies for funding to the CCG to support an inpatient admission to a specialist unit, e.g. Yorkshire Centre for Eating Disorders (YCED) in Leeds.

### **How can I contact the Sheffield Eating Disorders Service?**

Sheffield Eating Disorders Service is open from Monday to Friday (excluding bank holidays) between 9:00 am – 5:00 pm. You are welcome to leave a message on our 24 hour answer-machine (0114 271 6938). We will respond to your message at the earliest opportunity.

### 6. CHILDREN UNDER 16

Children and Young People under the age of 16 should be referred to the Child and Adolescent Mental Health Service (CAMHS) as for other behavioural, emotional, psychological and psychiatric presentations. There are 3 Community CAMHS Teams covering the City based at:

- **Centenary House**, 55 Albert Terrace Road, S6 3BR. Tel: 2261921/2/3. Fax: 2262160.
- **Flockton House**, Union Road, S11 9EF. Tel: 2262304/5 and 2262307. Fax: 2262306
- **Beighton Community Hospital**, Sevenairs Road, S20 6NZ. Tel: 2716540/1/2. Fax: 2716520

Referrals should **not** be made directly to Oakwood Young People's Centre<sup>3</sup> for secondary age children (or to Shirle Hill for any younger child – under 12 years).

CAMHS Teams would find it **helpful** to know the following, if possible, in addition to the usual details when receiving a referral concerning a young person with a possible eating disorder:

- Current weight, height and blood pressure;
- Previous 'normal' weight and pre-morbid height and age at that time (if known);
- Speed of weight loss; duration of the problem;
- Patient's perception of how they look, e.g. very fat; a bit over-weight...;
- Presence of history of vomiting;
- Presence of history of excessive exercise;
- Family history of eating disorders / problems;
- An idea of what the current dietary intake consists of.

When referring to CAMHS it would also be helpful to consider making a simultaneous referral to Sheffield Children's Hospital for both Paediatric evaluation and Dietetics advice. There will be occasions when Medical intervention is more of a priority in the first instance than psychological needs. If there is any doubt please telephone your CAMHS Team, and ask for a telephone consultation. We always find it useful to know what the referred young person thinks about being referred to our Service as they usually do not seek the referral themselves. This is especially important in cases of Anorexia Nervosa and other eating disorders.

#### Dietetics

Dietetic input for eating disorders is available as part of Child and Adolescent Mental Health Services (CAMHS) in Sheffield.

Provision of a Dietetic input for children under 16 yrs is available as part of Tier III and Tier IV services.

A referral to the Dietetic service can only be accepted if it is made by one of the Child and Family Therapy teams or Consultant Paediatrician and is specifically for children who have been diagnosed as having an eating disorder. Direct referral from a GP cannot be accepted.

Dietetic input is also available for children diagnosed as having an eating disorder who are admitted to Oakwood Young Person's Centre or to Sheffield Children's Hospital.

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<sup>3</sup> Please note, from winter 2010 (date to be confirmed) Oakwood Young People's Centre will be relocating to the Becton Centre for Young People in Beighton and will be reconfigured as two units: Emerald Lodge for children aged 10-14 years and Sapphire Lodge for young people aged 14-17 years.

### 7. NICE CLINICAL GUIDELINES

The National Institute of Clinical Excellence (NICE) published the NICE Clinical Guideline No. 9: “Eating Disorders: Core Interventions in the Treatment and Management of Anorexia, Bulimia Nervosa and Related Eating Disorders” in January 2004. <http://www.nice.org.uk/CG009>

As with all NICE clinical guidelines, they are based on the best available evidence and provide recommendations to healthcare professionals with respect to interventions and treatments based on the evidence base.

The high level guidance for both anorexia nervosa and bulimia nervosa are as follows:

#### Anorexia Nervosa

- Most people with anorexia nervosa should be managed on an outpatient basis with psychological treatment provided by a service that is competent in giving that treatment and assessing the physical risk of people with eating disorders.
- People with anorexia nervosa requiring inpatient treatment should be admitted to a setting that can provide the skilled implementation of refeeding with careful physical monitoring (particularly in the first few days of refeeding) in combination with psychosocial interventions.
- Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa.

#### Bulimia Nervosa

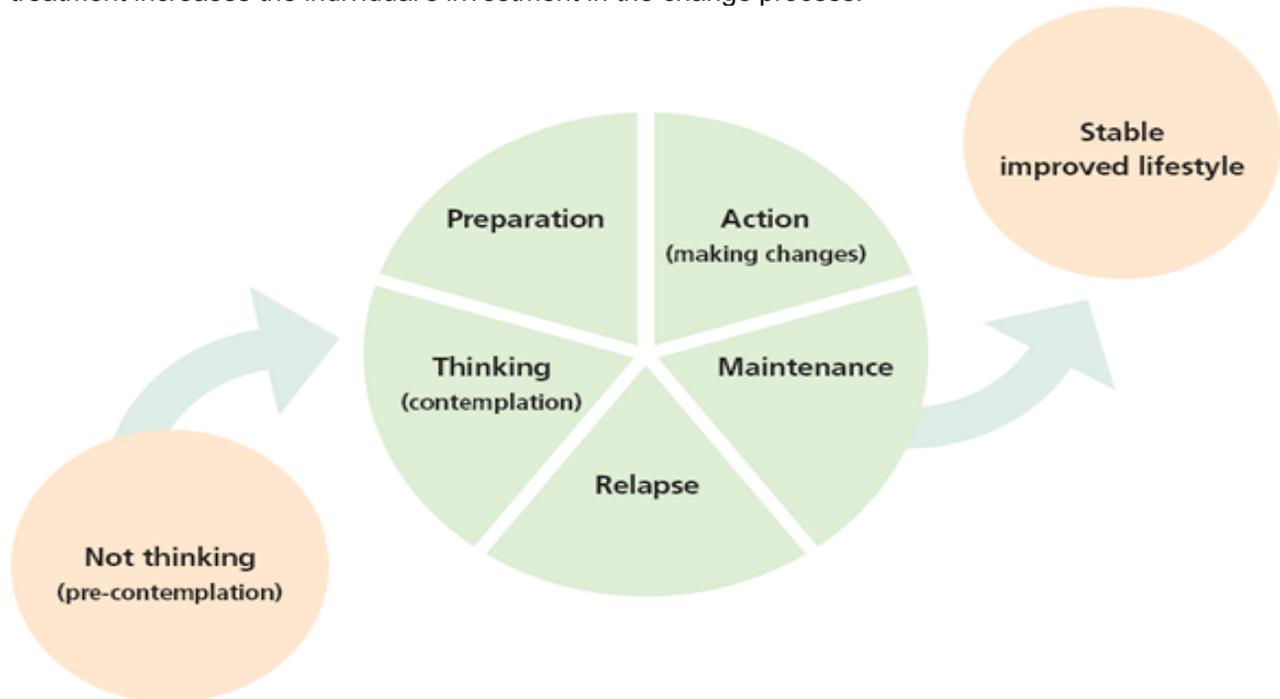
- As a possible first step, patients with bulimia nervosa should be encouraged to follow an evidence based self help programme.
- As an alternative or additional first step to using an evidence based self help programme, adults with bulimia nervosa may be offered a trial of an antidepressant drug.
- Cognitive Behavioural Therapy for bulimia nervosa (CBT-BN), a specifically adapted form of CBT, should be offered to adults with bulimia nervosa. The course of treatment should be for 16 to 20 sessions over 4 to 5 months.
- Adolescents with bulimia nervosa may be treated with CBT-BN, adapted as needed to suit their age, circumstances and level of development, and including the family as appropriate.

#### Additional Guidance

- Pharmacological Interventions: The Selective Serotonin Reuptake Inhibitors (SSRIs) may have a useful role in symptom reduction for bulimia nervosa. However, they should not be the primary treatment and should be used in conjunction with therapy or self help.
- Physical management: Careful monitoring of electrolytes and attention to dental hygiene and check ups is essential.
- Specialist psychological interventions: For adults, Cognitive Behavioural Therapy (CBT) is recommended at > 16 – 20 sessions over 4 – 5 months; other approaches including Interpersonal Therapy (IPT) or Cognitive Analytical Therapy (CAT) may be useful where CBT is not successful or is declined. This takes approximately 8 – 12 months.

## 8. ENGAGEMENT AND MOTIVATION

People with eating disorders are ambivalent about change. A very important part of any intervention involves acknowledging ambivalence and helping the individual plan what steps would need to be taken to promote change. It can help to explain the stage of change model to the individual to allow him or her to identify where they are in the cycle. Exploring options and giving the individual choices about his or her treatment increases the individual's investment in the change process.



The trans-theoretical model is a model (3<sup>4</sup>) which describes the process of change, focusing particularly on decision making processes associated with change. At each stage of the model, different emotions, thoughts and behaviours come into play.

**There are five stages in the model of change process:**

**Pre-contemplation** is where the individual is not intending to take any action to change. This may be because they don't understand why they need to change, or because past attempts to change were unsuccessful.

**Contemplation** is where there is emerging awareness of the need to change / weighing up pros and cons.

**Preparation** is when people are moving towards a decision to change and begin to develop a plan of action about how they are going to take steps to change.

**Action** is when people make significant adjustments to their lifestyle and behaviours in order for change to occur.

**Maintenance** is when people are working to prevent relapse, rather than concentrating on initial behaviour changes.

<sup>4</sup> Prochaska, J. O & Di Clemente, C. C (1986). "Towards a comprehensive model of change". In: W.R. Miller and N. Heather (Eds). "Treating Addictive Behaviours: Processes of Change". New York: Plenum Press.

It is important to remember even if a step or two backwards is taken, a person can always move forward again. Even if at a particular point in time there is no desire to change, it doesn't mean there will never be.

Motivation to change is the best predictor of change. Motivation can be easily influenced in a positive and negative way by personal circumstances, the environment or by the person they are working with, for example.

## 9. ESSENTIAL INFORMATION FOR CLIENTS AND FAMILIES

### 9.1 Key Facts

- Purging and severe starvation may cause serious physical harm. Both Anorexia Nervosa and Bulimia Nervosa can be life threatening if left untreated. With the right treatment a good proportion of people with eating difficulties recover.
- Laxative abuse does not significantly reduce the absorption of calories. Laxative abuse should be reduced on a gradual basis to prevent constipation.
- Both purging and laxative abuse can cause electrolyte imbalances that carry the risk of cardiac problems. Anyone who regularly vomits or uses laxatives should attend their GP for regular blood monitoring.
- Purging and severe dieting are ineffective ways of achieving lasting weight control.
- People who have both diabetes and an eating disorder are at greater risk of physical complications, therefore, treatment is essential. People with Type 1 diabetes and an eating disorder should have intensive regular physical monitoring because they are at high risk of retinopathy and other associated complications.
- Pregnant women with eating disorders require careful monitoring throughout pregnancy and the post partum period.
- People with an eating disorder should have regular dental reviews. Regular vomiting is associated with dental enamel erosion. People should be advised to not brush their teeth directly after vomiting as dental enamel is softened by stomach acid and vulnerable to damage. They should instead use an alcohol-free mouthwash to freshen their breath.
- People with eating disorders who are amenorrhoeic are vulnerable to osteoporosis and related bone disorders. Those affected should refrain from physical activity that significantly increases the likelihood of falls.
- Information leaflets, self help books and organisations such as the Eating Disorders Association (EDA) and SYEDA are helpful in explaining the diagnosis and treatment options and providing practical information and support.
- An online programme “Overcoming Anorexia Online”, for carers of people with anorexia nervosa may shortly be available via surgeries, SYEDA and, for clients of Sheffield Eating Disorders Service. <http://www.overcominganorexiaonline.com/>

### 9.2 Eating Disorder Outreach Clinics

- Nurse led clinics have been established at the University Health Service and at the Porter Brook Medical Centre for their patients;
- Early assessment and guided self help is provided for all but the most severe cases;
- This model could be extended to other CCG areas as it provides a triage system and increases capacity in the system.

### 9.3 South Yorkshire Eating Disorders Association (SYEDA):



SYEDA is the lead voluntary sector organisation in South Yorkshire on eating disorders. SYEDA provides a range of services to support people presenting with a mild to moderate eating disorder and to those involved in their care (family, partners and friends). Referrals can be made directly or on a self referral basis where the patient falls into the category of mild to moderate. Healthcare professionals are able to contact SYEDA to obtain further information on behalf of patients.

Although initial assessment and some services are free, most of the services now involve low cost charge with concessions available for non waged patients.

Services open to all (without undergoing an assessment) include:

- **Helpline (free):** 0114 272 8855 for information or to talk. Staffed Tuesday and Thursday – 10.00 am – 5.00 pm.
- **Support Groups (free):** Held the first Tuesday of each month: 7.00 pm - 8.30 pm for people with an eating disorder and for carers (parents and partners).
- **Information (£2.00 per book borrowed):** A library is available and books (including self help books and personal stories) can be borrowed as well as a range of leaflets and handouts.
- **One to one assessment (free):** People wishing to access services are invited to attend a non-medical assessment with the services coordinator to assess individual needs.

Once an assessment has been carried out the following services may be accessed:

- **Complementary therapies (charges apply):** A range of therapies are available to both people with an eating disorder and carers.
- **My body my self workshops (charges apply):** A six week course for people with an eating disorder which looks at body image and self esteem.
- **Dietetic advice (free):** Monthly slots with a dietician experienced in eating disorders for people engaged in therapy / counselling.
- **One to one support sessions (free):** Mentoring / befriending sessions for people engaged in or wanting to work towards recovery.
- **Counselling (charges apply):** SYEDA has a small provision for counselling with a number of trainee and qualified counsellors for people presenting with mild to moderate eating disorders.

- **CBT (charges apply):** Weekly sessions with a CBT sessional worker who is experienced in working with eating disorders.

For carers (parents, partners):

- **One to one practical support (charges apply):** Hourly sessions for family members giving a chance to offload and acquire skills on caring for a loved with an eating disorder.
- **Treading on eggshells (charges apply):** A 6 week skills based workshop teaching carers skills to help support somebody with an eating disorder.
- **Counselling (charges apply):** We have a small number of counsellors available to support carers needing longer term therapeutic support.
- **Complementary therapies (charges apply).**

SYEDA (South Yorkshire Eating Disorders Association)  
26 – 28 Bedford Street, Neepsend, Sheffield S6 3BT.

Email: [info@syeda.org.uk](mailto:info@syeda.org.uk)  
Website: [www.syeda.com](http://www.syeda.com)  
Help-line: 0114 272 8855  
Admin-line: 0114 272 8822

The helpline is available on Tuesdays and Thursdays from 10.00 am – 5.00 pm. The admin-line is staffed in office hours.

### 9.4 BEAT (Beating Eating Disorders)



A UK wide charity providing information, help and support for people affected by eating disorders.

103 Prince of Wales Road, Norwich NR1 1DW.

- Telephone: 0870 770 3256
- Helpline: 0845 634 1414
- Web Page: [www.b-eat.co.uk](http://www.b-eat.co.uk)
- Youth Line: 0845 634 7650
- Email: [info@b-eat.co.uk](mailto:info@b-eat.co.uk)

### 9.5 Specialist NHS Services

#### Sheffield Eating Disorders Service:

St George's Community Health Centre  
Winter Street  
SHEFFIELD  
S3 7ND

Telephone: 0114 271 6938 / 6969      Fax: 0114 226 2223

Accessed by GP referral via the sector mental health team using standard referral form.

The service has published a self-help book called the Personal Notebook. Copies of the Personal Notebook cost £5.00 each / £4.00 each for orders of 10+ copies.

### The Yorkshire Centre for Eating Disorders (YCED):

This is the nearest NHS specialist inpatient unit to Sheffield. Accessed via a referral to Sheffield Eating Disorders Service who will be required to make a funding request to Sheffield CCG.

Seacroft Hospital  
York Road  
LEEDS  
West Yorkshire

Telephone: 0113 305 6400

### 9.6 Self Help Books

- Crisp, A.H., (1996) "Anorexia Nervosa & the Wish to Change", Psychology Press (2nd Edition): ISBN 0863774083
- Treasure, J., (1997) "Breaking Free from Anorexia Nervosa: A Survival Guide for Families, Friends and Sufferers", Psychology Press; ISBN 0863777600
- Freeman, C. & Cooper, P., (2001) "Overcoming Anorexia nervosa: A Self-Help Guide" Robinson Press; ISBN 1854879693
- Cooper, P., (1993) "Bulimia Nervosa & Binge Eating- A guide to Recovery" Constable and Robinson Ltd: ISBN 1854871714
- Schmidt, U & Treasure, J. (1993) "Getting Better Bit(e) by Bit(e)", Psychology Press; ISBN 0863773222
- Fairburn, C.G. (1995) "Overcoming Binge Eating", Guildford Press; ISBN 0898621798
- Treasure, J. (1997) 'Anorexia Nervosa: A Survival Guide for Families, Friends and Sufferers'. Psychology Press
- Treasure, J. (2007) 'Caring for a loved one with an eating disorder: The new Maudsley Method. Routledge.

### 9.7 Additional Resources

- [www.bmjlearning.com](http://www.bmjlearning.com) (has two excellent modules on AN and BN).
- [www.edauk.com](http://www.edauk.com)
- [www.eatingresearch.com](http://www.eatingresearch.com)
- [www.mentalhealth.org.uk](http://www.mentalhealth.org.uk)
- [www.patient.co.uk](http://www.patient.co.uk)
- [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)
- [www.patient.co.uk](http://www.patient.co.uk)
- [www.overcomingbulimiaonline.com/](http://www.overcomingbulimiaonline.com/)
- [www.overcominganorexiaonline.com/](http://www.overcominganorexiaonline.com/)

### 9.8 Glossary of Terms

List of terms, abbreviations and acronyms used in this document:

Acronym	Term
AED	Atypical Eating Disorder
AN	Anorexia Nervosa
BED	Binge Eating Disorder
BMI	Body Mass Index
BN	Bulimia Nervosa
CCG	Clinical Commissioning Group
CPA	Care Programme Approach
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CMHT	Community Mental Health Team
DH	Department of Health
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
EDNOS	Eating Disorder Not Otherwise Specified
FBC	Full Blood Count
GP	General Practitioner
GSH	Guided Self Help
ICD-10	The International Statistical Classification of Diseases and Related Health Problems - 10th Revision
LFT	Liver Function Test
NICE	National Institute of Clinical Excellence
NGH	Northern General Hospital
SHSC	Sheffield Health and Social Care NHS Foundation Trust
SEDS	Sheffield Eating Disorders Service
SSRI	Selective Serotonin Reuptake Inhibitor
SYEDA	South Yorkshire Eating Disorders Association
EDA	The formerly named Eating Disorders Association, which is now called B-EAT.
TFT	Thyroid Function Test
U&E	Urea and Electrolytes
YCED	Yorkshire Centre for Eating Disorders

APPENDIX A - EATING DISORDERS REFERRAL GUIDELINES FOR ADULTS 16+

**Eating Disorders Referral Pathway for Adults 16+**  
**Initial Assessment by GP / Practice Nurse**  
(Children and Young People under 16 years – Refer to CAMHS)

**People with eating disorders are often ashamed of their problem and reluctant to seek help.**

**Target Groups:** Young people with low BMI, academic related stress, depression and / or self harm, women with gastrointestinal problems / repeated vomiting / Type 1 Diabetes / women reporting erratic periods or amenorrhoea, or adults who exercise compulsively.

If you suspect the patient has an eating disorder, the following two questions are recommended:

1. **Do you think you have an eating problem?**
2. **Do you worry excessively about your weight?**

And / or screen using the **SCOFF** questionnaire:

- Do you make yourself **S**ick because you feel uncomfortably full?
- Do you worry you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ne stone in a three month period?
- Do you believe you are too **F**at when others say you are too thin?
- Would you say that **F**ood dominates your life?

Two or more 'yes' answers should prompt you to take a more detailed history.

**Assess:** History and duration of eating difficulties, eating patterns and purging behaviours, body mass index – BMI (Kg / m<sup>2</sup>), attitude to weight and shape, menstrual history, mental state / psychiatric co-morbidity, physical health, blood tests (FBC, U&Es, LFT, TFT). Exclude other causes of weight loss and make diagnosis.

**GPs should take responsibility for the initial assessment and co-ordination of care for people with eating disorders presenting in primary care.**

**Atypical Eating Disorder (EDNOS)**

Fulfils some of the criteria for BN and / or AN.

**Binge Eating Disorder (BED)**

Binge eating in absence of compensatory behaviours.

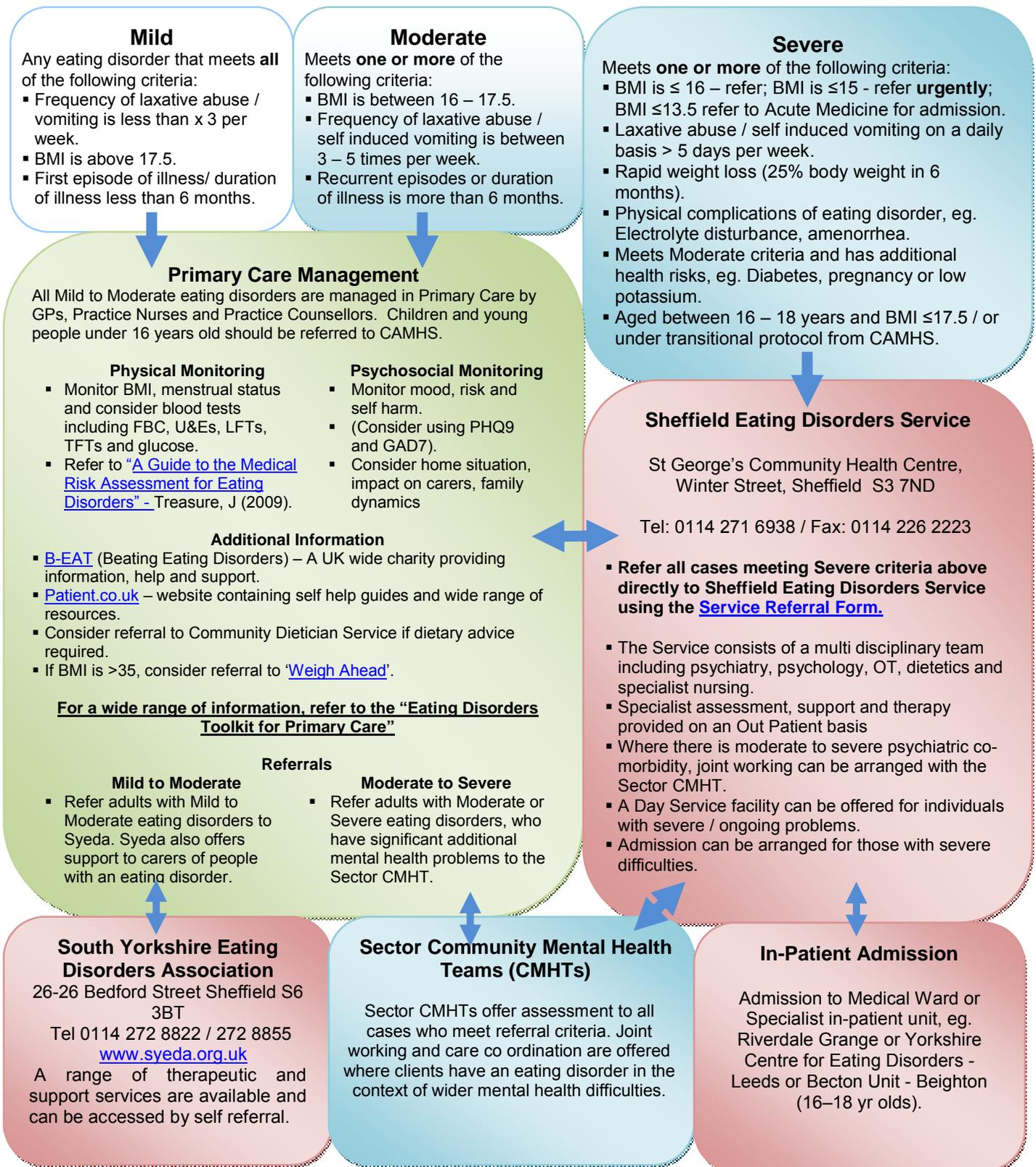
**Bulimia Nervosa (BN) DSM-IV**

- Recurrent episodes of binge eating.
- Recurrent compensatory behaviours, eg. self induced vomiting; misuse of laxatives or excessive exercise.
- Above behaviours occur, on average, at least twice a week for 3 months.

**Anorexia Nervosa (AN) ICD-10**

- Food restriction, vomiting or other means leading to weight loss (85% less than expected weight or a body mass index of 17.5 or less.
- Abnormal attitudes to food and weight. Body- image disturbance.
- Endocrine disturbance. Loss of menstrual periods in females. Loss of sexual function in males.

# Eating Disorders Toolkit for Primary Care and Adult Mental Health Services



**NB: The patient's GP remains responsible for monitoring physical health throughout treatment**

Actions by Primary Care

Diagnosis / Risk

Referral / Secondary Care

**APPENDIX B – SHEFFIELD EATING DISORDERS SERVICE REFERRAL FORM**

Date: ..... For Office Use Only – Insight No: .....

**Before completing, please ensure that your patient meets the criteria detailed in the related referral criteria document - Referral cannot be processed unless all boxes are completed**

**ESSENTIAL INFORMATION**

Referrer Details (if not GP)		GP Details	
<b>Name:</b>		<b>Name:</b>	
		<b>Job Role:</b>	
<b>Address:</b>		<b>Address:</b>	
<b>Postcode:</b>		<b>Postcode:</b>	
<b>Tel No:</b>		<b>Tel No:</b>	
<b>Fax No:</b>		<b>Fax No:</b>	
<b>Email:</b>		<b>Email:</b>	

Patient Information		
<b>Name:</b>	<b>D.O.B.</b>	<b>NHS No</b>
<b>Address:</b>		
<b>Postcode:</b>	<b>Telephone:</b>	

<b>Weight (Kg):</b>	<b>Height (m):</b>	<b>BMI:</b>
<b>Binge Eating:</b>	Yes / No	At present, how many times in a week?
<b>Self-induced vomiting:</b>	Yes / No	At present, how many times in a week?
<b>Laxative abuse:</b>	Yes / No	At present, how many times in a week is the recommended dose exceeded?
<b>Exercise:</b>	Yes / No	At present, what exercise & how many times in a week?

**Blood Results Required:**

- Please enclose copies of recent U&Es, FBC and bone densitometry if available

**PLEASE NOTE:**

**THIS SHEET MUST BE ACCOMPANIED BY FURTHER INFORMATION AS DETAILED OVERLEAF TO PROVIDE BACKGROUND INFORMATION AND AN OVERVIEW OF REASON FOR REFERRAL**

**REASON FOR REFERRAL AND BACKGROUND INFORMATION**

Please summarise below or attach referral letter to provide us with other relevant information including reason for referral, duration of problems, development of difficulties, family and social circumstances, previous treatment, views of treatment, other relevant psychological or physical issues, (e.g. diabetes, depression) and any other relevant information (e.g. life events).

Is the client aware of the referral? Yes / No

Is the client already in contact with the Mental Health Services? Yes / No

Current CPA Level: Care Co-ordinator:

Please list other services / agencies involved:

Please note this information is essential for us to process this referral and prioritise our waiting list. Failure to supply this information will lead to a delay in accepting the referral.

**WHEN COMPLETED, FAX OR POST THIS FORM TO SEDS OR THE APPROPRIATE CMHT:  
(Please refer to Eating Disorders Referral Guidelines at Appendix A for details of who to refer to)**

- Sheffield Eating Disorders Service    Tel: 0114 271 6938                      Fax: 0114 226 2223
- Community Mental Health Teams (CMHTs):
- South West      Argyll House              Tel: 0114 271 8654              Fax: 0114 271 8640
- South East      Eastglade                      Tel: 0114 271 6451              Fax: 0114 271 6450
- North              Northlands                      Tel: 0114 271 6217              Fax: 0114 271 6214
- West                The Yews                        Tel: 0114 271 6100              Fax: 0114 271 6106

For Office Use Only – Insight No: .....

**APPENDIX C – EATING DISORDERS SELF HELP QUESTIONNAIRE**

(NB: This questionnaire should be given to the individual client for self assessment).

**How do I know if I've got an eating disorder?**

This questionnaire asks about the sort of difficulties people with eating disorders experience and can give you an idea of how serious your problems are. It will not tell you whether or not you definitely have an eating disorder as it is only a rough guide.

Think about the last week and read each question, circling the number underneath that most applies to you.

**In the last week:**

- 1. Have you been deliberately trying to restrict the amount of food you eat to change your shape or weight?

Not at all	Slightly	Moderately	Markedly			
.....0.....	.....1.....	.....2.....	.....3.....	.....4.....	.....5.....	.....6.....

- 2. Have you gone for long periods of time (8 hours or more) without eating anything in order to change your shape or weight?

Not at all	Slightly	Moderately	Markedly			
.....0.....	.....1.....	.....2.....	.....3.....	.....4.....	.....5.....	.....6.....

- 3. Have you had any periods of binge eating? (ie. eating what other people would regard as unusually large amounts of food with a sense of having lost control over eating).

Not at all	Slightly	Moderately	Markedly			
.....0.....	.....1.....	.....2.....	.....3.....	.....4.....	.....5.....	.....6.....

4. Have you had a definite fear that you might gain weight or become fat?

Not at all	Slightly	Moderately	Markedly
.....0.....	.....1.....	.....2.....	.....3.....
.....4.....	.....5.....	.....6.....	

5. Have you made yourself sick, taken laxatives, diuretics (water tablets) or vigorously exercised as a way to control your weight or to counteract the effects of eating?

Not at all	Slightly	Moderately	Markedly
.....0.....	.....1.....	.....2.....	.....3.....
.....4.....	.....5.....	.....6.....	

6. Has your weight or shape influenced how you think about (judge) yourself as a person?

Not at all	Slightly	Moderately	Markedly
.....0.....	.....1.....	.....2.....	.....3.....
.....4.....	.....5.....	.....6.....	

**Total Score**

Scoring on one item alone wouldn't normally suggest you are likely to have an eating disorder, but the more items you score on the more likely this is.

3 - 12	<b>Low level</b> of difficulties – Work through this guide and consider some of the self-help references at the end of the booklet.
13 - 24	<b>Moderate level</b> of difficulties – Work through this guide, but you may also wish to consider seeking professional help.
24 - 36	<b>High level</b> of difficulties – You may benefit from seeking professional help as soon as you feel able.

Adapted from "Eating Disorders – A Self Help Guide" from Newcastle, North Tyneside & Northumberland Mental Health NHS Trust. Accessed via the Patient UK website ([www.patient.co.uk](http://www.patient.co.uk)). Reproduced with permission.

**APPENDIX D - PRIMARY CARE EATING DISORDERS ASSESSMENT FORM**

**DEMOGRAPHIC DETAILS**

Name: \_\_\_\_\_ Patient / NHS No: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Assessment: \_\_\_\_\_

**CORE DATA**

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BMI \_\_\_\_\_

**ASSESSMENT**

1. Current situation / personal and family history:

\_\_\_\_\_  
\_\_\_\_\_

2. History of eating problem:

a) How long have you been having problems?

\_\_\_\_\_  
\_\_\_\_\_

b) How did it begin?

\_\_\_\_\_  
\_\_\_\_\_

c) How did it develop?

\_\_\_\_\_  
\_\_\_\_\_

d) Current problems and maintenance factors.

\_\_\_\_\_  
\_\_\_\_\_

e) Previous help?

\_\_\_\_\_  
\_\_\_\_\_

Binge YES/NO. What is a binge:

\_\_\_\_\_  
\_\_\_\_\_

## Eating Disorders Toolkit for Primary Care and Adult Mental Health Services

Frequency:

---

---

Triggers:

---

---

Purge: Vomit / Laxatives / Diuretics / All

---

---

Do you drink alcohol:

---

---

Exercise:

---

---

### 3. Current signs and symptoms:

a) Current eating patterns:

---

---

b) Restrictive diet: YES/NO

---

---

<b>MENTAL STATE</b>
---------------------

Mood:

---

---

Medication:

---

---

Self-esteem:

---

---

Motivation:

---

---

**PHYSICAL STATUS**

Menstrual history:

---

---

Are you under / over weight?

---

---

How do you feel about your body size / shape?

---

---

Any other physical problems which you attribute to eating?

---

---

Blood tests:

---

---

**TREATMENT PLAN**

Agreed healthy weight:

---

---

Problems identified:

---

---

Aims / Contract:

---

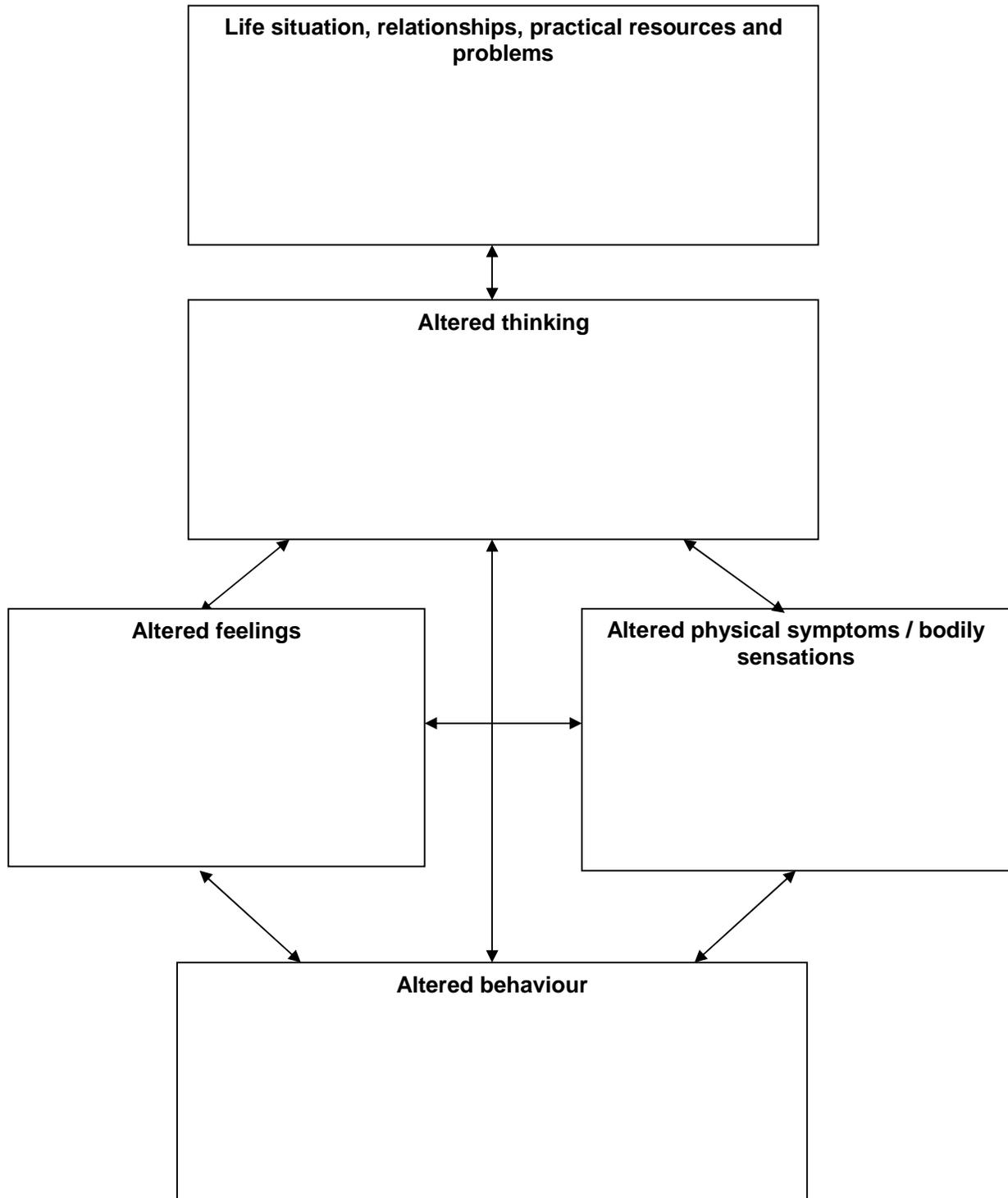
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Further referral:

---

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**APPENDIX E – THE FIVE AREAS ASSESSMENT MODEL**



Dr Chris Williams (1999 – 2009) [www.livinglifetothefull.com](http://www.livinglifetothefull.com) and [www.fiveareas.com](http://www.fiveareas.com)