Government of Western Australia
North Metropolitan Health Service
Mental Health, Public Health and Dental Services

Disordered Eating in Aboriginal Populations

Aboriginal Health Conference 2019
Perth, WA

WA Eating Disorders Outreach & Consultation Service (WAEDOCS)

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Acknowledgement

We respectfully acknowledge the past and present traditional owners of this land on which we are meeting, the Noongar people. It is a privilege to be standing on Noongar country.

Introduction to WAEDOCS

About us

State wide service aimed at:

- Ensuring patients with eating disorders have access to optimal best practice care & where possible are managed close to home.
- Multidisciplinary part time team based in D Block SCGH (3.0 FTE)

What WAEDOCS does not do

- Case manage patients
- Have admitting rights to inpatient settings
- Receive referrals for <16 years
- In general, we don't deal directly with carers or significant others

We provide

- Specialist consultation liaison, clinical mentoring & support
- Clinical training & education Monday to Friday 9am - 4pm

Prevalence of Eating Disorders

- Study of 14-20 year olds from Western Australian Pregnancy Cohort (Raine Study) (N 1,383; 49% male). Prevalence at different ages:

	AGE 14	AGE 17	AGE 20
Males	1.2%	2.6%	2.9%
Females	8.5%	15.2%	15.2%

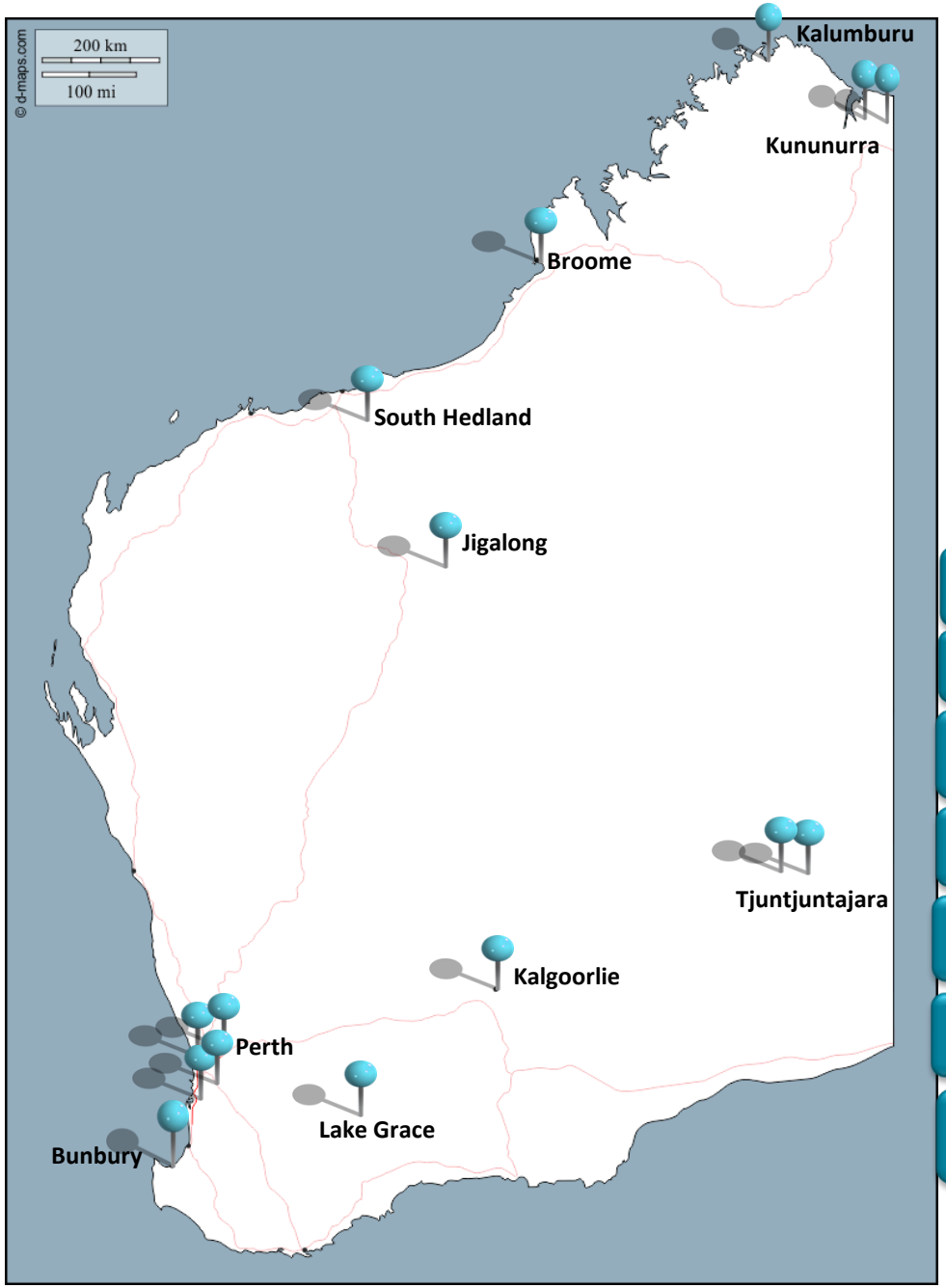
Allen et al. 2013

- "For First Australians eating disorder symptoms are **at least as frequent as for non-indigenous Australians"**….

Hay & Carriage, 2012

- Aboriginal Australians are known to be **more likely to be overweight, obese or underweight than the rest of the population.**

Cinelli & O'Dea, 2012



WAEDOCS Aboriginal Data 2016-2019

No. of patients = 15

No. of associated consultations = 298

- Kimberley
- Pilbara
- Perth Metro
- South West
- Eastern Wheat belt
- Goldfields-Esperance region
- Great Victoria Desert

Key Points about Eating Disorders (ED's)

- EDs stand at interface of both physical & mental health
- EDs include **anorexia nervosa** (self-starvation because of intense fear of weight gain), **bulimia nervosa** (binge eating & compensatory behaviours such as vomiting) & **binge eating disorder**.
- Anorexia nervosa has the highest mortality of any mental illness – burden of suffering for patients & families is profound
- NO comprehensive specialist public ED service in WA for people age ≥16 (around 85 % of patients are >16 yrs)
- Starvation rapidly causes brain atrophy of crucial networks involved in self-perception, emotion regulation & decision-making
- Early access to quality care is vital to improve prognosis (& thus long term health costs)
- **GPs have a critical role –** in early detection & intervention, psycho-education, care coordination & collaboration

Disordered Eating vs an Eating Disorder

- Disordered eating
  - A descriptive phase not a diagnosis
  - Patterns similar to eating disorders but may be lesser in severity or frequency
  - Restrictive eating patterns or binge eating or avoiding certain food groups or exercise regimes
  - May place someone at risk of developing an eating disorder

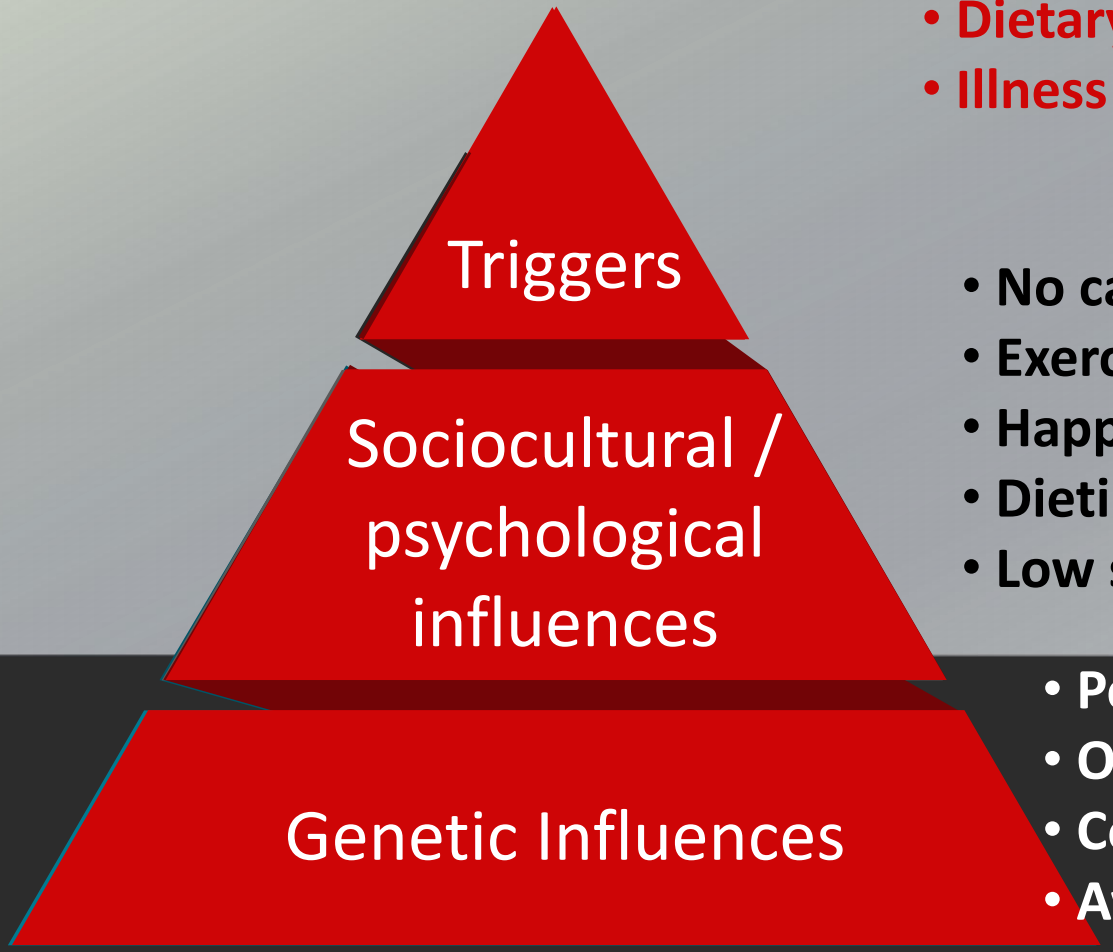
- Eating disorder
  - Similar patterns to disordered eating
  - Defined DSM 5 / ICD criteria
  - Higher intensity & frequency

- ED's have highest mortality rates of all psychiatric disorders (cardiac arrest & suicide)

- Suicide rates = 20% more in eating disordered pts than in the general population

How it begins…

- **Weight loss**
- **Trauma (sexual, physical, verbal, bullying, bereavement)**
- **Dietary Restrictions**
- **Illness**



- **No carbs/fat**
- **Exercise more**
- **Happiness = thin**
- **Dieting is normal**
- **Low self-esteem**

- **Cultural expectations**
- **Bias against obesity**

- **Perfectionism**
- **Obsessional**
- **Competitive**
- **Avoidant**
- **Impulsivity**

- **Genetic predisposition**
- **Substance abuse**
- **Depression**
- **Over achiever**

Minnesota Starvation Study

36 Healthy, young, male conscientious objectors to WWII

Phase 1

- 3 mths 3200 kcal (~13300kJ)
- 35km/week walking

Phase 2

- 6 mths 1800 kcal
- (~7500kJ)
- 35km/week walking

25% total weight loss (1.1kg/wk)

Phase 3

- 3 mths: additional intake 2200kcal (~8300kJ)

Physical

- Reduced pulse rate / heart volume
- Reduced temperature
- Feeling dizzy / cold / weak / fatigued
- Reduced muscle strength
- Lower metabolic rate

Personality

- Apathy / Depression / Tiredness / Irritability / Moodiness
- Poor concentration
- Narrowing of interests
- Rigid thinking
- Reduced spontaneity
- Poor decision making

Social

- Deterioration group spirit
- Reluctance making group decisions
- Stilted social interaction
- Loss interest education / career

Preoccupation

- Preoccupation with food
- Collecting recipes / planning meals
- Increased gum chewing / smoking / nail biting

Implications of starvation

- Anyone will experience significant physical, psychological, emotional changes if they have significantly reduced dietary intake
- A person with anorexia nervosa will be suffering from **starvation** PLUS a **psychological disorder**
- To help a patient recover from starvation, we need to help them to **eat more & regain weight**, which is the most terrifying thing for someone with an eating disorder

Importance of prevention

✓Focus on positive **body esteem** & **healthy eating behaviours**

✓ Empower communities to support body confidence

✓ Celebrating body confidence & body acceptance.

Treatment: Identification of the illness and assessment

Importance of Screening - SCOFF

Do you ever 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 (6.3 kg) in a 3 months?

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

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

One point for every “yes”; a score of ≥2 indicates a likely case of anorexia nervosa or bulimia nervosa

Red flags from assessment / history

- Physical symptoms
  - Fatigue
  - Dizziness, light-headedness, chest pain
- Dieting and attitudes to food
  - Preoccupation with weight, body shape & image
  - Fear of weight gain
  - Compensatory behaviours (purging, laxative misuse, driven exercise)
- Food scarcity
  - More likely to be underweight – or, paradoxically, to binge eat
- Comorbidities – depression, anxiety, PTSD
  - Risk of self-harm and suicide
- Sudden or frequent changes in weight
  - If no medical reason, might suggest disordered eating

Treatment: Medical & Nutritional Monitoring Principles, Multi-Disciplinary Management

- ✓Medical stabilisation & regular medical monitoring
- ✓Prevention & treatment of re-feeding syndrome
- ✓Safe nutritional & weight restoration
- ✓Reversal of cognitive effects of starvation prior to outpatient psychotherapy

Treatment: Reversing physical & psychological effects of starvation

Caution in the community setting

- Extremely underweight individual (BMI <15)

OR

- Excessive, significant weight loss (as per malnutrition definitions)

OR

- Symptomatic e.g. SOB, chest pain, oedema, dizziness, syncope +/- change in biochem level

OR

- Energy intake <1000kcal / day for >2 days especially if nil oral fluid intake

Consequences of Refeeding Syndrome

REFEEDING SYNDROME

- Hypophosphatemia
- Hypomagnesaemia
- Hypokalemia
- Hypocalcaemia
- Altered glucose metabolism
- Fluid balance abnormalities
- Vitamin deficiency

Cardiac Arrhythmias / Arrest
Tachycardia / Bradycardia

Lethargy / Weakness /
Seizures / Paralysis

SOB / Respiratory Failure /
Oedema

Confusion / Altered Mental
State

Gastroparesis / Abdominal
Pain / Constipation

Treatment: Normalising eating

MEALS

- This can take different forms depending on what the diet history reveals e.g.,
  - **Establishing a regular eating pattern**
  - Being more in tune with hunger signals (will need to eat by the clock at first)
  - Increasing variety of foods chosen
  - Increasing the amount of food consumed
  - Challenging food rules

OTHER NOTES

- Need regular GP monitoring for refeeding syndrome – especially when first commencing refeeding
- Re-establishing normal eating most successful when combined with specialist psychological support

Treatment: Psychological treatment

- Treatment works most effectively with a well nourished brain
- Psychological treatment needs to be culturally informed
- Grief and relationship stress can result in disordered eating and, if untreated, this can cause long-term problems

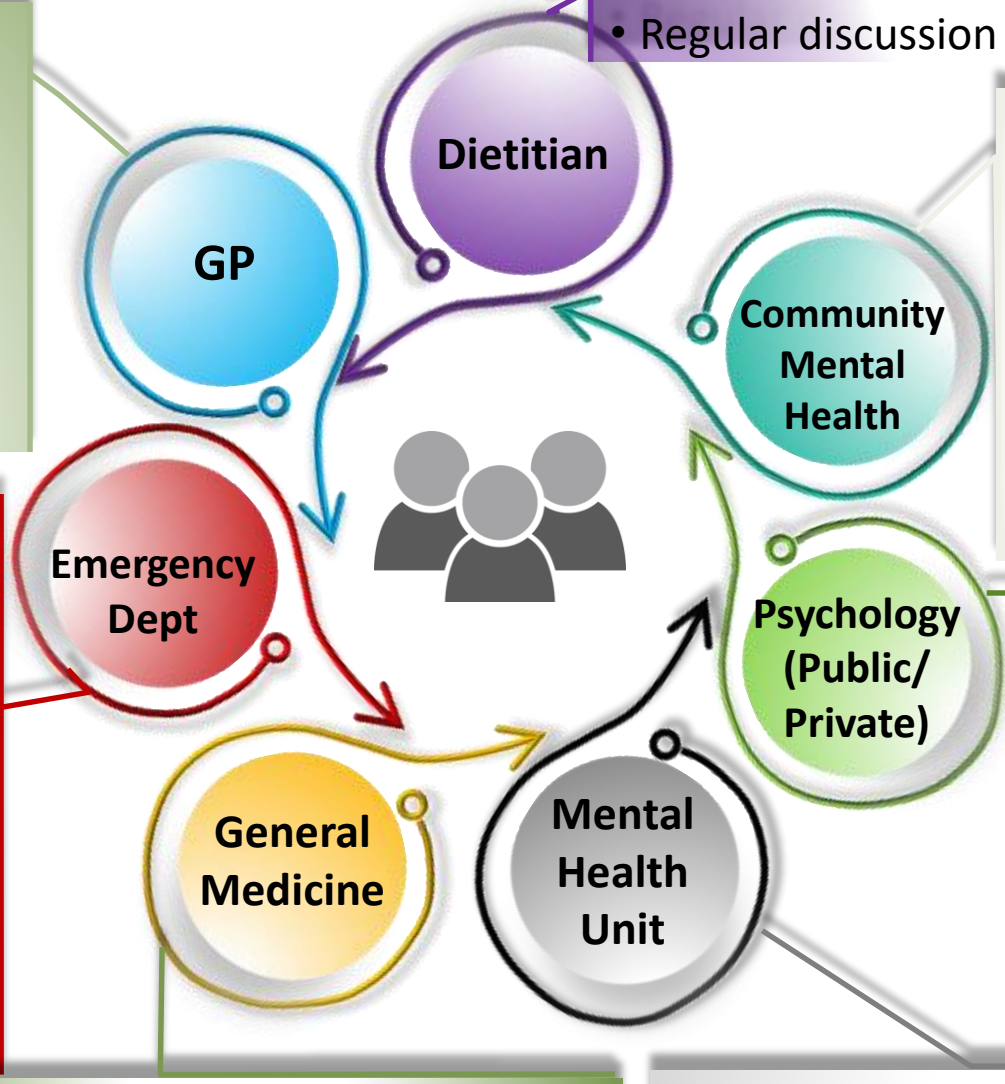
Treatment: Discharge / Transfer planning and relapse prevention

- Community engagement & monitoring
- Transparent readmission criteria
- Early access to care can ↓need for hospitalisation, ↓LOS & ↓ duration of illness.
- Use of relapse prevention plans that identify triggers- early warning signs

Collaborative Care Plan

- Initial weekly visits then once stable fortnightly to monthly
- Recommended observations / biochemistry as per WAEDOCS criteria

- Weekly visits initially providing nutrition support for ongoing restoration
- Regular discussion with GP/Psych/CMHS



- CTO / voluntary with CMHS
- Provide backup to GP/DT/Psychologist
- Weekly weight
- Facilitate re-admission to ED if needed (+/- MHA)

- Comprehensive medical and MH assessment
- Admission as per WAEDOCS guidelines
- Appropriate navigation to General Medical setting or MHU

- Weekly evidenced based psychological treatment
- Weekly weighing
- Regular discussions with GP/DT/CMHS re: attendance & progress

- Daily recommended observations & biochemistry
- Commence nutrition restoration

- Normalise eating
- Support with anxiety management / secondary MH co-morbidities

Potential Challenges for staff

- Dealing with lack of insight and poor decision-making (e.g., disengaging from treatment) as a result of starvation. Can be challenging, frustrating.
- Managing pt. fear/anxiety around refeeding and inpatient treatment with minimal/no formal psychological support.
- How to provide nutrition

Appropriate management

- Transparent plan
  - ✓ No surprises
  - ✓ Requires robust & trusting therapeutic relationship.
- Upskilling of clinicians

- Boundary setting –
  - ✓ Provides containment & safety
  - ✓ Prevents inconsistencies
  - ✓↓ negotiation
  - ✓↓ staff burnout

- Acknowledge what is being asked may be difficult

Challenges for clients & clinicians

Holistic health

Encompassing mental physical, cultural & spiritual health

Challenges of treating malnutrition & starvation

- Culturally responsive care within statewide guidelines
- Geographical isolation
- ↓ continuity in remote areas (locum GPs & nursing staff)
- ↓collaboration between services
- Medical monitoring & refeeding risk in community
- Temporary mobility
- Co-morbidities- self harm, depression, anxiety, PTSD
- Tobacco, alcohol and other drug use
- Social & emotional factors = grief; loss; trauma; abuse; violence; substance misuse, racism, homelessness
- Land central to well-being- tx right place right time
- Access to culturally appropriate, safe, specialist services
- Lack of research

Take home messages

BMI is not the sole determinant of medical instability (state not weight)

Disordered eating (e.g., irregular eating, binge eating) and weight loss of any kind (from illness, food scarcity, dieting) are potentially life-threatening and have long-term implications for physical & mental health.

The long-term effects of disordered eating and malnutrition need to be explained to patients so that they understand

Feed the brain to optimise recovery

Access to psychological treatment (for grief, relationship issues, etc.) is important but requires a well nourished brain

A healthy relationship with food is possible, so hold the hope!


Questions
Answers