



Eating Disorders Policy

Introduction

Eating disorders (ED) comprise a range of symptoms encompassing physical, psychological and social features. Whilst the acute physical complications of these disorders may provoke great concern in family members and school staff, anorexia nervosa and bulimia nervosa are frequently chronic conditions, with substantial long-term physical and social sequelae, from which recovery can be difficult. The impact of a person's eating disorder on home, family and school life is often considerable and family members and friends may carry a heavy burden over a long period of time.

The aetiology of eating disorders is considered to be multifactorial. Whether or not a person develops an ED will depend on their individual vulnerability, biological predisposition and exposure to provoking risk factors and the operation of protective factors. The majority of studies show that eating disorders run in families. Severe life stresses have been implicated in the development of ED, approximately 70% of cases being triggered by severe life events.

Early intervention is paramount: please refer any pupil that you have concerns about to the Medical Centre or school counsellors.

Anorexia Nervosa

About 1 in 250 females and 1 in 2000 males will experience anorexia nervosa (AN), generally in adolescence or young adulthood; the mean age of onset is 16 to 17. Approximately 45% of patients with AN recover completely; 35% improve; 20% develop a chronic eating disorder, and 5% die from AN. Anorexia nervosa is a syndrome in which the individual maintains a low body weight as a result of a pre-occupation with body weight, construed either as a fear of fatness or pursuit of thinness. In anorexia, weight is maintained at least 15% below that expected. Weight loss in anorexia is caused by avoiding fattening foods, sometimes supported by excessive exercising, vomiting or misuse of laxatives. The condition generally starts with dieting behavior that may evoke no concern. After a while the commitment to dieting increases often with a number of secondary features such as social withdrawal, the development of obsessions along with physical effects such as the cessation of periods in females and lack of interest in sex in males. The diagnosis of anorexia nervosa is made on the basis of the history (preferably with corroboration from a relative or friend) along with physical examination. This may include blood tests and other investigations. The diagnosis of AN in its typical form is relatively straightforward, the main obstacle being the person's own willingness or otherwise to disclose his or her own motives, symptoms and behaviours.

In the acute stages of AN, anxiety and depression are common. AN has the highest mortality rate of any psychiatric disorder in adolescence. Typically, people with AN rarely actively seek help and are usually persuaded to seek help by family members, friends or teaching staff.

Most people with AN should be managed on an out patient basis with appropriate psychological treatment provided by the school counsellors or local eating disorder service.

Bulimia

Bulimia nervosa (BN) is characterized by recurrent episodes of binge eating and secondly by compensatory behavior (vomiting, purging, fasting, use of weight reducing drugs, exercising or a combination of these) in order to prevent weight gain. Binge eating is accompanied by a subjective feeling of loss of control over eating. Binge eating and purging are commonly associated with extreme subjective guilt and shame. The prevalence of BN has been estimated between 0.5% and 1% with an even class distribution; 90% of people diagnosed with BN are female. About 50% of people with BN recover, 20% are likely to continue with the full form of BN and 30% have a course of illness characterised either by remissions or relapses or persistent but sub-diagnostic BN.

There is considerable overlap between the long term disabling consequences of BN and those of AN. Mood and anxiety symptoms are very common, as is self harm in the form of scratching or cutting. A significant proportion of those with BN have a history of disturbed interpersonal relationships. The symptoms of low self esteem and body image disturbance can all have a negative effect on social relationships, which in turn may be damaged by a lifestyle that may be chaotic and characterized by impulsivity. Initially, those with BN are generally secretive about their bulimic episodes, though some may leave obvious signs of their disorder such as empty food packaging and occasionally bags of vomit for friends or family members to discover. In BN the body mass index is maintained above 17.5kg/m². People with BN tend not to disclose their behavior nor seek out treatment readily, although they may be more likely to do so than those with AN.

The diagnosis is made on the basis of the history, often corroborated by a parent or friend. The physical symptoms are generally less severe than those experienced by patients with AN, but include fatigue, feeling bloated, abdominal pain, constipation and erosion of dental enamel. In females, periods may be irregular.

Physical examination may be normal but calluses may be seen on the back of the hand as a consequence of induced vomiting, and dental problems may be observed. People with BN are generally managed with a combination of self help, antidepressant medication and cognitive behavioural therapy.

Atypical eating disorders, including binge eating disorder

A number of people suffer from eating disorders that closely resemble AN and BN, but are considered atypical.

Binge eating disorder is a recently described condition; people with this condition engage in uncontrollable episodes of binge eating but do not use compensatory purging behaviors.

The onset of AED is typically in the teenage years or early 20s. The physical problems that people with AED tend to present with are those of obesity along with low self esteem.

Consent

The transition from childhood to adulthood can cause confusion about rights and responsibilities. Potential difficulties arise from the need to inform parents and carers about risk, but maintain as far as possible the young person's rights to confidentiality. The government specifically addresses issues relating to consent and confidentiality. Young people aged 16 to 17 are regarded as adults for the purposes of consent and are, therefore, entitled to the same duty of confidentiality as adults. Children under the age of 16 who have the capacity and understanding to make decisions about their own treatment are also entitled to make decisions about the use and disclosure of information they have provided in confidence. However, where a competent child is refusing treatment for a life threatening condition, the duty of care would require confidentiality to be breached.

Procedures for Care of Students with eating disorders:

(Please refer to the section on consent before disclosing information about pupils to other people without the pupil's consent. Ideally this consent should be written and signed by the pupil.) When a problem is reported, various people may need to be involved to provide the best help for the individual; this should only be with the consent of the pupil unless they are not thought competent to give consent (please refer to the section on consent for clarification). Those who need to be informed may include a combination of the following people, depending on the pupil's wishes. Ideally it would include the parents, College Safeguarding Officer, Headmaster or Deputy Headmaster, College Counsellor, Housemistress/master, the student's tutor, and Medical Centre staff.

Any student who seeks help through the Medical Centre needs to understand that medical confidentiality will be honoured.

With the pupil's consent, a core team of medical and House staff will co-ordinate to manage the condition. This will occur by formulating a personal care plan and ensuring that the relevant people are aware of it. The team will meet as frequently as is thought necessary, depending on the severity of the pupil's condition. The care plan may need to include a realistic educational plan for the affected student, being flexible while balancing realistic workloads, deadlines and the College's responsibility to ensure the student fulfills important learning goals. Consideration should be given to any potentially stressful decisions/situations in the student's life (e.g. exams, UCAS, career decisions). The care plan will include eating patterns and exercise and will be discussed with the pupil and core team and frequency of follow up will be arranged according to the severity of the pupil's condition.

A member of the team will be designated to communicate with parents (usually House or Medical Officer) depending on the pupil's ability to consent and respect for confidentiality.

Referral for counseling will be strongly encouraged and may be made a condition of continued school attendance (depending on the severity of the condition). The following agencies may be involved: College Counsellor, Eating Disorders Association and Adolescent Psychiatry Unit.

Exercise restriction may be imposed in some pupils if deemed necessary on medical grounds.

Management and Care Plan will be kept in the student's confidential medical record.

The College and Medical Team will not be able to manage some students with eating disorders. For such pupils it will be better for them to be managed at home or as a hospital in-patient. Depending on the ability of the pupil to give consent, this decision would be made by involved members of staff.

The policy will be available on the web site for all staff, students, parents and the College Council. It is important that parents are aware that the College has a policy on eating disorders and it will be explained to parents of students affected.

Broaching the subject: advice that may be useful when first addressing the student causing concern:

- Take time to sort out what you have observed to make you feel that there is a problem. Once you are reasonably sure there is cause for concern do not be deflected by family members, or friends who may try to brush it aside or tell you that you must be mistaken.
- Think about who would be the best person to approach them – friend, family member, another teacher, possibly more than one person?
- Decide where and when it would be best to talk.
- Avoid talking about your own or another person's experiences – this may elicit a competitive response from the sufferer.
- Responses to the confrontation may range through outright denial and fury, through to grateful relief. However, the person confronted may change their mind about their initial response once they have had time to think about it, so be prepared for that too.
- Be realistic about what you want the outcome of the confrontation to be. Stopping the damaging eating behaviour overnight is not realistic, but encouraging the person to start talking about their issues may be one possible outcome.
- Engagement in a supportive, empathetic way is crucial to enabling the person to reveal fears about weight, dieting, excessive exercise or purging behavior.
- Encourage the pupil to see the Medical Centre staff and Counsellors and ensure they are aware of issues about confidentiality.

Practical and emotional support for other students concerned with a peer suffering with an eating disorder:

- Provision of training and education regarding the subject of eating disorders.
- Consider the needs of the student's immediate friendship group. They may be feeling a loss in their friendship circle or confusion about how to relate to their friend.
- Encourage student's friends to continue usual activities with the person experiencing the eating disorder.
- Remind friends that they are not responsible for their friend's eating disorder or recovery.
- Be mindful of other students' reactions to the eating disorder.

Strategy to prevent the spread of eating disorders within the school:

- Close monitoring of students who have been in contact with another student with an eating disorder.
- Informal discussion groups within the Houses, led by Housems.
- Eating disorders to be part of PHSE, raising awareness and understanding within the student body.
- Encouraging an open attitude to eating disorders, where students and staff feel comfortable to discuss and raise concerns where necessary.

Training and Education strategy for staff and pupils:

- Education focused on eating disorders will be delivered via PHSE lessons, as well as through more informal discussion groups within the Houses.
- Training is offered for staff – this is refreshed at regular intervals to ensure knowledge is kept up to date.
- Eating disorders will feature in INSET for teaching and non-teaching staff.

Information:

www.b-eat.co.uk

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