Be Aware!!

Young people with Type 1 Diabetes Mellitus have an increased risk of eating disorders.

Intentional reduction or omission of insulin to achieve weight loss is a common strategy used by young people with diabetes and eating disorders.

Young people with Type 1 Diabetes Mellitus and eating disorders may have associated problems of poor glycaemic control including hyperglycaemia and hypoglycaemia, and an increased risk of diabetic complications.

RECOMMENDATIONS

Experienced multidisciplinary Diabetes and Mental Health teams should jointly manage young people with Type 1 Diabetes Mellitus in whom eating disorders have been identified.

In practice, inpatient treatment of young people with diabetes and eating disorders should be conducted in consultation with a specialist unit or by a multidisciplinary team in an outreach diabetes centre in close liaison with the appropriate tertiary centre.
PREGNANCY AND EATING DISORDERS

The majority of females who suffer from eating disorders are at a childbearing age. Those with AN will by definition, be amenorrhoeic. However, it is possible for a female to ovulate without menstruating, and thus fall pregnant. Most women with eating disorders, although they have anovular cycles, are fertile.

Clinicians who care for pregnant adolescents should consider the possibility of an eating disorder in an adolescent who:

1. Is very anxious about her weight or shape, for example refuses to be weighed
2. Has an inappropriate view of a healthy weight for her height or weight gain in pregnancy
3. Has a low BMI
4. Fails to gain weight at two consecutive prenatal visits
5. Has a history of periods of amenorrhoea, infertility, previous still birth, premature delivery or past infant feeding problems
6. Has poor circulation; cold or purple fingers
7. Has a history of dental caries (due to frequent vomiting)

POTENTIAL PROBLEMS AND COMPLICATIONS

AN: The patient may have excessive concerns about weight gain and body shape changes associated with pregnancy or lactation. These thoughts may persist even in one who has recovered to a healthy weight. Mothers with a history of AN have a higher rate of miscarriage and caesarean section. A low pre-pregnancy weight and low weight gain in pregnancy is associated with low infant birth weight and a higher incidence of malformations such as cleft lip and palate. These can be prevented by adequate weight gain in pregnancy.

BN: can occur in a woman with any BMI. It is characterised by periods of excessive eating followed by compensatory behaviours such as purging, fasting or exercising. Women with BN have a higher rate of miscarriage, hypertension during pregnancy and Caesarean section.

MANAGEMENT OF EATING DISORDERS & PREGNANCY

Referral to a tertiary treatment setting with specialist eating disorder clinicians is recommended, as this is likely to be a high-risk pregnancy both obstetrically and from an eating disorder perspective.

If a mother is managed locally the following is recommended:

1. Team to include:
   - Obstetrician and paediatrician
   - Mental health professionals (e.g., psychiatrist, psychologist, mental health nurse)
   - Dietician
2. Regular communication between all team members to set treatment goals, such as rate and amount of weight gain
3. Case management by the mental health professional (e.g., psychologist).
4. Regular monitoring of weight (as for all pregnant women). The patient with an eating disorder may not want to know their weight. This is acceptable as long as they are gaining adequate weight. If there is inadequate weight gain, the patient should be informed. Risk to the foetus should be communicated in a caring, understanding and empathic way but in a way that also emphasises the steps that need to occur to minimise harm to the unborn

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For children & adolescents use BMI centile charts. See section "Assessing Growth & Determining Healthy Weight Range".
child. Address the patient’s fears of gaining weight empathically – refrain from using scare tactics to encourage her to eat. Instead focus on “eating for the baby” or “gaining weight for the baby so that the baby can grow normally”.

5. Nutrition support and enteral feeding may be required if the patient is unable to gain sufficient weight to allow normal growth of the developing foetus. The decision to intervene should be based on the pattern of weight gain throughout the pregnancy, requirements for weight gain, the development of the foetus and the ability of the patient to care for the unborn child in utero.

6. Provide education about the expected weight gain for pregnancy, the importance of weight gain and adequate nutrition for the baby’s normal growth and development.

7. Assist the patient to eliminate (or at least reduce) eating disordered behaviours such as restrictive eating, bingeing or purging.

8. Emphasis should also be placed on ongoing management of the eating disorder to allow for adequate breastfeeding and future modelling of healthy eating behaviours for the child.

9. Ensure there is a continuing care plan implemented post discharge for parenting support and eating disorder management.

### Pregnancy
- It is important to consider the possibility of pregnancy in any female of reproductive age.
- Pregnancy can occur without menstrual periods if a female is still ovulating.
- It is necessary to inform all patients of the risk of pregnancy, especially those who are sexually active, and work out practical ways of avoiding pregnancy.
- The use of contraception in a still growing female may result in premature epiphyseal closure with effects on final adult height.

### POST NATAL – INFANT FEEDING
Research on lactation and breast-feeding by women with eating disorders is scant and anecdotal. It is reported that they are less likely to breast feed, more likely to be concerned about their milk supply, to believe that their infant has an adverse reaction to their milk and to introduce bottle-feeding.

The effects of an eating disorder on infant feeding will vary with the type of eating disorder and whether the mother is currently symptomatic. Ways in which it may affect feeding include:

1. Breast-feeding with a low maternal bone mineral density leading to increased risk of fracture due to osteoporosis.
2. Effects of postural hypotension and fainting while holding the baby.
3. Increased tiredness and lethargy due to biochemical derangement.
4. Interference with the mother’s ability to detect satiety and hunger in her infant.
5. Limitation of feeds to prevent the infant becoming “fat”; inappropriate concerns about the infant weighing too much.
6. Prolonged exclusive breast-feeding to prevent infant from becoming “fat”.
7. Resultant failure to thrive in the infant.
8. Use of extended breast-feeding combined with mother’s food restriction to increase her post partum weight loss.
9. Increased incidence of post partum depression.

10. Poor maternal nutrition, especially energy, fat, calcium, iron and zinc, may affect breast milk constituents.

11. Maternal use of alcohol, drugs and laxatives in those with active symptomatology.

12. Spurious diagnoses of allergy or other reactions to milk components.

13. Less facilitating, more intrusive and conflicted feeding, and increased expression of negative emotion toward infant.


Postnatal Care
New mothers with a history of an eating disorder should be regularly monitored for possible infant feeding difficulties and failure to thrive.
Eating disorders are rare before about the age of 8 years and appear to have a complex causality and more serious course than in adolescents. The most common presentation in this age group is AN. Other presentations may include BN, food avoidance emotional disorder (FAED), selective eating, restrictive eating, food refusal, functional dysphagia or pervasive refusal syndrome (see section under Further Information).

Treatment of eating disorders in pre-pubertal children requires particular knowledge and skill. These children are more prone to severe physical complications and there is a high incidence of persisting morbidity. A rapidly initiated, intensive and comprehensive treatment program is required and should be conducted by child-oriented professionals who have expertise in eating disorders.

Children with an eating disorder require immediate consultation with child-oriented professionals who have expertise in eating disorders. (See ‘Useful Resources’ section).
OBESITY

Obesity, while not considered a mental illness, and not included in the DSM IV classification of ‘eating disorders’, is a major public health concern. Both obesity and eating disorders are prevalent weight-related conditions with potentially serious consequences.

It is known that dieting is a risk factor for disordered eating. Studies have shown that girls who diet frequently are 12 times more likely to binge eat when compared to girls who do not diet. Boys have been found to have 7 times the risk of binge eating if dieting. Adolescents who diet and use unhealthy weight control strategies are at an increased risk of developing an eating disorder or becoming overweight or obese.

A large population-based study of adolescents found that more than half of adolescent girls and nearly one third of adolescent boys use unhealthy weight control practices, such as skipping meals, fasting, smoking cigarettes, vomiting and taking laxatives. The study also showed that one half of girls and one quarter of boys expressed dissatisfaction with their bodies. Excessive social pressure to be thin has also been found to increase unhealthy weight control practices and clinical eating disorders.

There is some concern that attempts to address only one problem, such as obesity, may inadvertently lead to other problems (such as eating disorders).

There is a role in assisting in prevention of both obesity and eating disorders through advocating for a healthy, balanced approach to eating and physical activity.

RECOMMENDATIONS

Whether developing interventions for eating disorders or obesity, the broad spectrum of eating and weight concerns should be taken into account. A coordinated, partnership approach is required.

Healthy Behaviour Messages to Convey For All

- Promotion of healthy lifestyle behaviours.
- Eating regular meals and snacks.
- Increasing awareness of the body cues for hunger and satiety.
- Enjoying physical activity.

Aim to Address Risk Factors in Partnership with Others

Risk factors may include dieting, self esteem, media, parental role modelling, teasing, weight-related attitudes of significant others, food availability in the school and home, and sociocultural and media messages regarding eating, activity and body image.
The incidence of eating disorders in the Aboriginal population is unknown. There are key principles for consideration when treating young people from this population.

**GENERAL PRINCIPLES**
Aboriginal health principles as outlined by NSW Health (Ensuring Progress in Aboriginal Health, 1999, NSW Health) have been developed to guide NSW public health workers and the Aboriginal Community in addressing Aboriginal health. These principles include:

- **A whole-of-life view of health** meaning a holistic and social view of health encompassing the physical, emotional, cultural and spiritual well being of individuals and communities.
- **A practical exercise of the principles of self-determination.**
- **Working partnerships** between health care providers and the wider Aboriginal community.
- **Cultural understanding** of Aboriginal kinship and family groups, languages, spiritual beliefs and ways of living in urban, rural and remote settings.
- **Recognition of trauma and loss** as a direct result of colonisation and dispossession which is further compounded by racism, social and economic disadvantage and the loss of access to land.

**INTERVIEW / ASSESSMENT TECHNIQUES**

- Choose an appropriate setting that will not engender fear/anxiety. Although sometimes difficult in acute settings, an open non-threatening space is ideal.
- Greet with a loose handshake without invading personal space (the amount of personal space is greater for Aboriginal people than non-indigenous).
- Provide an unhurried and clear explanation of who you/others are and your/their role.
- Give fleeting eye contact to avoid making the patient feel judged (the amount of eye-contact should be intuitively gauged by how much you are receiving). Avoiding eye contact may be culturally appropriate for some people.
- Sit side-by-side with the patient to allow closeness without intimidation.
- Talk slowly and wait for the patient to consider the response.
- In the reverse of normal practice, start with yes/no questions to alleviate any pressure on the individual to immediately ‘open up’.
- Explore the patient’s family network and spiritual beliefs about their problem before investigating their symptoms. Aboriginal people have a strong relationship with their community and spirituality and this should be understood before investigating symptoms.

**GENERAL CONSIDERATIONS**

- Commence with non-threatening statements, not questions.
- Involve the family and gather a simultaneous corroborative history. In a sense, the whole family may share the “illness”. The definition of “family” may be broader and far wider than non-indigenous communities. The family may also shed light on the cultural significance of the illness.
- Often there are individuals in the family who are given the responsibility to care for the individual. It is important to involve these carers as they have the clearest picture of the patient and their history.
- If the patient is uncommunicative regarding their illness, use a story about a fictitious third person that reminds you of the illness the person is experiencing. This can often overcome shyness or shame within the community.
- Be aware of sensitive areas including bereavement, ceremonial business (e.g., initiations), breaking of taboos and sexuality/fertility.
- Be patient and don’t expect full verbal histories when first meeting the individual and their family.

**MANAGEMENT**

- Always involve the family and carers in treatment plans.
- Always involve Aboriginal mental health workers, Aboriginal Liaison Officers or generalist Aboriginal health workers.

This section is intended to be read in conjunction with other sections in this document and should not be used as a sole management plan.
CULTURALLY AND LINGUISTICALLY DIVERSE SERVICES

BARRIERS TO ACCESSING MENTAL HEALTH SERVICES
Ethnic minority groups are usually under-represented in psychiatric services in Western nations. Differential access to services may be due to lack of knowledge about service availability, different explanatory models of illness and solutions, stigmatisation of mental illness, culturally unresponsive clinical practices and different pathways to care or referral.

Clinical services that are not culturally responsive may increase disengagement from treatment once services have been accessed. Engagement of culturally and linguistically diverse (CALD) services provides information to families to facilitate access to services, promotes positive attitudes to mental health and improves continuity of care.

STANDARD PROCEDURES FOR THE USE OF HEALTH CARE INTERPRETERS
It is N.S.W Government Policy for health care providers to seek the assistance of professional interpreters in order to ensure that Australians from non-English speaking backgrounds (NESB) have equal and appropriate access to services. The Health Care Interpreters’ Service (HCIS) was established to assist health care providers to carry out their professional responsibilities in a cross-cultural situation.

The benefits of using the HCIS is that it gives families the opportunity to ask questions about the health system, the treatment and/or procedure recommended and the risks involved, and to receive the information to make an informed choice to provide consent before treatment commences.

The benefits to health care providers include:
- Facilitation of accurate diagnosis and patient’s understanding of treatment
- Adherence to treatment (including medication)
- Ability to offer health promotion and prevention programs
- Effective management of chronic illness
- Reduction of hospitalisation rates
- Savings in unnecessary diagnostic tests, procedures, and health personnel time
- Prevention of misunderstandings that could result in legal action
- Translation of instructions to the family and special diets necessary for the treatment of the patient can be carried out by the HCIS

It is essential that Health Care Interpreters are present during interviews or discussions with the family with regard to the following situations or issues:
- Admission
- Medical histories, assessments and treatment plans
- Medical instructions
- Consent for procedures, treatment and research
- Psychiatric assessment and treatment
- Counselling
- Psychological assessment
- Discharge procedures and referrals
- Sexual assault, physical and emotional abuse
- Health education and promotion programs
- Explanation of medication
- Mental Health Review Tribunals and Magistrate’s enquiries

In situations of admission or discharge, where a HCI is not available on site, the Telephone Interpreting Service (TIS) may be a viable option. In cases of emergency, when a HCIS or TIS interpreter may not be available and a non professional interpreter or family member is relied upon, service providers must ensure that the HCIS is called as soon as possible to ensure that accurate information has been communicated and the medical history is accurate.

**HEALTH CARE INTERPRETER SERVICE**

<table>
<thead>
<tr>
<th>Sydney West Area Health Service</th>
<th>Northern Sydney/Central Coast Area Health Service</th>
<th>Sydney South West Area Health Service/Western Zone</th>
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</thead>
<tbody>
<tr>
<td>Ph: (02) 9840 3456</td>
<td>Ph: (02) 9926 7560</td>
<td>Ph: (02) 9828 6088</td>
</tr>
<tr>
<td>Sydney South West Area Health Service/Eastern Zone</td>
<td>South East Sydney/Illawarra Area Health Service</td>
<td>Hunter New England Area Health Service</td>
</tr>
<tr>
<td>Ph: (02) 9515 9500</td>
<td>Ph: (02) 4274 4211</td>
<td>Ph: (02) 4924 6285</td>
</tr>
<tr>
<td>All country areas of NSW (except Greater Murray &amp; Southern)</td>
<td>Illawarra region</td>
<td>Greater Murray &amp; Southern</td>
</tr>
<tr>
<td>Ph: 1800 674 994</td>
<td>Ph: (02) 4274 4211</td>
<td>Ph: 1800 247 272</td>
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</tbody>
</table>

**INTERPRETING SERVICES**

<table>
<thead>
<tr>
<th>Translating &amp; Interpreting Service</th>
<th>Doctor’s Priority Line</th>
<th>Hospital Priority Line</th>
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<tbody>
<tr>
<td>Ph: 13 14 50 (Free Service)</td>
<td>Ph: 1300 131 450</td>
<td>Ph: 1300 655 030</td>
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<td></td>
<td>(Free for Private Practitioners including GPs)</td>
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**PATIENT RIGHTS & RESPONSIBILITIES**

All families of NESB should be informed about the HCIS and their ability to access a professional health care interpreter. All health facilities need to display the contact phone number for the HCIS and the TIS. A copy of the HCIS pamphlet and patient rights and responsibilities pamphlet should made available to the family in the appropriate language. Families from a NESB should be informed of their rights to make a complaint if they are dissatisfied with a Health Service or the HCIS.

**ACCESS TO INFORMATION ABOUT EATING DISORDERS**

Written information should be provided to the family in the appropriate language. This should be seen as complementary to the HCIS and not replace the use of an Interpreter. Written and audio information about eating disorders can be accessed from: [www.chw.edu.au/prof/services/psychmed/healthykids/](http://www.chw.edu.au/prof/services/psychmed/healthykids/)

**NSW TRANSCULTURAL MENTAL HEALTH SERVICE**

The service offers a free consultation and assessment service to health professionals providing mental health care to patients from CALD backgrounds living in NSW. The Transcultural Mental Health Service can be contacted on: **Tel (02) 9840 3897.**
NSW SERVICE FOR THE TREATMENT & REHABILITATION OF TORTURE & TRAUMA

The service assists survivors of torture and refugee trauma and provides resources to individuals who work with them to provide appropriate, effective and culturally sensitive services. The service can be contacted on: Tel (02) 8778 2000 Liverpool branch and (02) 9646 6666 Auburn Branch.

NSW REFUGEE HEALTH SERVICE

The service offers free health assessment clinics, advice and referral for people who have recently arrived from overseas on humanitarian grounds and provides consultation and support to mainstream health care workers working with refugees. The service can be contacted on: Tel: (02) 8778 0770.