Eating Disorders policy

This policy has been developed with the support of the Hertfordshire CAMHS eating disorders team.

1. Introduction

   Tring Park School endeavours to always encourage a positive body image and healthy relationship with food and eating. This policy aims to enable students to seek help when needed, rather than to punish pupils affected by eating disorders, to protect sufferers and provide support where health is at risk. School staff play an essential role in preventing eating disorders and in supporting pupils, peers and parents of pupils currently suffering from or recovering from eating disorders. EDs are the result of a myriad of factors. Current research shows clearly that early detection and intervention in eating disorders results in a better outcome for sufferers. This policy will enable concerned parties to identify affected pupils and offers procedures to follow if further steps are necessary. The immediate and long-term health of the pupil remains the primary goal for the school. This is understood to include physical as well as psychological wellbeing.

2. Scope

   This document describes the school's approach to eating disorders. This policy is intended as guidance for all staff including non-teaching staff and governors. It is available to all staff in the Policies folder on staff resources, as part of the staff handbook and on the school's website. As part of inset training any new staff will be introduced to the policy. This policy is also included in the Parent/Pupil Handbook and is in each departmental Handbook.

3. Aims

   - To increase understanding and awareness of eating disorders
   - To alert staff to warning signs and risk factors
   - To provide a structure and defined roles for staff dealing with pupils suffering from eating disorders.
   - To provide support to pupils currently suffering from or recovering from eating disorders and their peers, parents and carers.
   - To allow pupils suspected of suffering from an ED quick access to appropriate help and support both inside school and through counselling and GP contact. This aims to minimise both short and long-term effects of the disorders.

The School nurses in the Medical Centre will measure weights and heights for all

pupils twice yearly and will use BMI and weight for height centiles as a guide to indicate intervention, but will at all times use previous history and background of each individual when preparing a care plan (see appendix 1). Every individual will be treated and discussed as an individual and each Care Plan will be tailor made to the needs of that pupil.

At no time will anyone other than the designated School nurse or school appointed professional discuss details with the pupil directly and all matters relating to this must be dealt with by the medical professional.

If staff or pupils observe any behaviour of concern, they should report that to their course director, houseparent, the DSP team or directly to the Medical Centre staff. No one should approach the individual directly and it is essential that this area is dealt with sensitively and by a trained person. Concerns should be noted and passed on to the school nurses. Feedback is very important in identifying pupils of concern. At all times, the individual will be cared for and the primary goal is about supporting and facilitating recovery. For this reason, the importance of confidentiality will be stressed to all concerned.

The United Nations Convention on the Rights of the Child, Article 12 enshrines the principle of self-determination. The school nurses should treat any information in confidence, unless the student consents to it being disclosed. However, the nurse also needs to consider the interests of the pupil and where there is significant risk the information will need to be disclosed.

Examples of such situations include:

- Abuse
- If the young person is likely to harm themselves, or others are at risk from harm (this includes severe restriction of food/starvation)
- If the young person may be involved in serious criminal activity.

Confidentiality should not be a barrier to effective communication with families and staff involved with the student. Often, staff can be given information in general terms, without breaching confidentiality. Similarly, the concerns of staff and families can be heard whilst maintaining the privacy of the student. Where confidentiality is an issue, every effort should be made to negotiate with the pupil about what information can and cannot be shared. If a decision is made to share information, the young person should be told.

For all Sixth Form students, a minimum BMI of 17.5 and a maximum BMI of 27 is advised. For Dance course students, the highest recommended BMI is 25. Students who fall outside of those ranges may trigger action as their health may be at risk. When assessing low weight, weight for height centiles are used rather than BMI for pupils under 18.

Pupils with either a very low or high BMI will be placed on the Observation List.

4. The following is the school protocol for action:

Stage	Action
Observation	If it has been noticed that weight loss has been identified (as little as a one kilogram loss in any one term) a pupil will be placed on the Observation List. If a student has been identified as having gained more than 2 kilograms in any one term, without an increase in height, they will be placed on the Observation List (it is recognized that this might be different for girls and boys). Pupils will be offered information packs and leaflets to help them understand the importance of good nutrition and making appropriate choices at meal times. It might be decided that a food diary should be kept. Parents may be notified with agreement of the pupil or if there is a sufficient level of concern from the School nurse. Pupils will have a meeting with the school nurse with special responsibility for Eating Disorders. The student will be counselled, weighed and then recalled for weighing one week later (or as felt appropriate by the assessing nurse). Dining Room staff and the student's houseparent will be requested to make 'distant observation' of food eating habits and report these to the designated school nurse.
Referral	At this stage, medical intervention becomes necessary and an appointment will be made with the school doctor. Pupils may be referred to the CAMHS eating disorder clinic or other private eating disorder specialist. A blood test and ECG may be advised to indicate any co-morbidity or rule out any underlying pathology that might help explain any decrease or increase in weight. Amenorrhoea/changes in menstrual patterns will be noted. Parents and carers will be contacted and involved in treatment wherever possible.
Treatment	External medical professional organisations (for example CAMHS ED team or other private eating disorder specialists) will be contacted for appointments.

	In most cases for pupils under the age of 18 family-based therapy is the recommended course of treatment, and the student may be best cared for in the home environment where food and meal supervision can be undertaken by parents. Food and meal supervision is not possible in a boarding school. This decision to go home would be made in close collaboration with the Principal, the DSP, the school doctor and the Directors of Department. It will be a team decision made in the best interests of the pupil and the family. The Junior marzipan risk assessment is used to assess the level of risk of elements of an eating disorder. If pupils have any of the elements within the Amber or Red section the risk to health by remaining in school is considered too high and it is recommended that pupils return or remain at home. If the school nurses consider that health is at risk, reduced activities may be advised and treatment will continue with counselling, advice and support. If a pupil has amenorrhea as a result of weight loss then they may be restricted from dancing or physical activity until they have regained enough weight to reinstate their menstrual cycle. If a pupils is under the care of an eating disorder specialist team then the school will be advised by the clinicians. Regular visits with the medical staff are advised and, if felt appropriate by the designated school nurse, target weight will be set and monitored regularly.

The Principal, DSP, Directors and parents are informed that a student is on this list with the consent of the pupil or when there is considered to be a safeguarding risk.

If a pupil remains on any list for more than one month, it will flag further investigation by the designated school nurse. It is our goal that a child is removed from the list or the list progression is reversed over a suitable period of time.

Those pupils who have private medical insurance may be able to claim the cost of referral to a specialist clinic dependent on the policy.

Regular training with regard to eating disorders will be offered to staff, students and parents. Additional nutrition training will be offered to pupils by a specialist dietician throughout the academic year.

This policy will be reviewed by senior staff annually and by medical staff as often as necessary. The policy and any updates or revisions are to be available in Staff Resources, Department Handbooks, and Parent and Pupil Handbooks and will be highlighted to all new staff.

Appendix to Eating Disorders Policy

1. Information about Eating Disorders:

Anyone can get an eating disorder regardless of their age, sex or cultural background.

People with eating disorders are preoccupied with food and/or their weight and body shape, and are usually highly dissatisfied with their appearance. The majority of eating disorders involve low self-esteem, shame, secrecy and denial.

Anorexia nervosa and bulimia nervosa are the major eating disorders. People with anorexia live at a low body weight, beyond the point of slimness, and in an endless pursuit of thinness by restricting what they eat and sometimes compulsively over-exercising. In contrast, people with bulimia have intense cravings for food, secretively overeat and then purge to prevent weight gain (by vomiting or use of laxatives, for example).

Risk Factors:

The following risk factors, particularly in combination, may make a young person particularly vulnerable to developing an eating disorder:

Individual Factors:

- Difficulty expressing feelings and emotions
- A tendency to comply with others' demands
- Very high expectations of achievement

Family Factors:

- A home environment where food, eating, weight or appearance have a disproportionate significance
- An over-protective or over-controlling home environment
- Poor parental relationships and arguments
- Neglect or physical, sexual or emotional abuse
- Overly high family expectations of achievement

Social Factors:

- Being bullied, teased or ridiculed owing to weight or appearance
- Pressure to maintain a high level of fitness / low body weight (e.g. sport or dancing)

Warning Signs:

School staff may become aware of warning signs which indicate a pupil is experiencing difficulties that may lead to an eating disorder. These warning signs should always be taken seriously and staff observing any of these

warning signs should refer immediately to the named Medical Sister with responsibility in this area.

Physical Signs:

- Weight loss EDs are not only present in those with low BMIs, any change in weight should be noted and tracked over a period of time.
- Dizziness, tiredness, fainting
- Feeling Cold
- Hair becomes dull or lifeless
- Swollen cheeks
- Calloused knuckles
- Tension headaches
- Sore throats / mouth ulcers
- Tooth decay
- Amenorrhoea
- Swollen stomach, constipation

Behavioural Signs:

- Restricted eating – excluding food groups; changing dietary habits i.e. becoming vegetarian or vegan; refusing to eat specific food groups. Any changes should be noted and tracked over time to distinguish between fads and more serious underlying conditions.
- Skipping meals
- Scheduling activities during lunch
- Strange behaviour around food
- Wearing baggy clothes
- Wearing several layers of clothing
- Excessive chewing of gum/drinking of water
- Increased conscientiousness
- Increasing isolation / loss of friends
- Believes s/he is fat when s/he is not
- Secretive behaviour
- Visits the toilet immediately after meals
- Disproportionate use of laxatives and /or diuretics
- Excessive exercise
- Self-harm

Psychological Signs:

- Preoccupation with food
- Sensitivity about eating
- Denial of hunger despite lack of food
- Feeling distressed or guilty after eating
- Self-dislike: fear about their shape, fear of gaining weight
- Paranoia: thinking everyone is staring because of size; thinking everyone knows what is really going on.
- Fear of gaining weight: self-worth is equated to having a low weight.
- Constantly changing what the “ideal” weight would be. A sufferer could decide to lose a stone only to lose another and continually move the ideal weight to a level which is unobtainable, showing (wrongly) in their

minds how worthless the person is if they can't even attain this ideal.

- Moodiness: mood swings /depression. The overall temperament of the student is very important as adolescents often have severe mood swings anyhow. Changes from the norm over a prolonged period are perhaps better indicators of an underlying problem.
- Excessive perfectionism
- When challenged, refusal to accept there is a food issue
- Panic attacks

Staff Roles:

The most important role school staff can play is to familiarise themselves with the risk factors and warning signs outlined above and ensure that the designated school nurse is aware of any child causing concern.

Pupils may choose to confide in a member of school staff if they are concerned about their own welfare, or that of a peer. Pupils need to be made aware that it may not be possible for staff to offer complete confidentiality, as sharing of information might be required to protect the person in question. If you consider a pupil is at serious risk of causing themselves harm then confidentiality cannot be maintained. It is important not to make promises of confidentiality that cannot be kept even if a pupil puts pressure on you to do so. Pupils should be assured that information will only be shared with professionals who would need to know in order to provide them with treatment, support and maintain safety. It is necessary to explain procedures and steps to be taken and to reassure the sufferer that they are believed, taken seriously and will be helped.

The reintegration of a pupil into school following a period of absence should be handled sensitively and carefully and, again, the pupil, their parents, school staff and members of the multi-disciplinary team treating the pupil should be consulted during both the planning and reintegration phase.

This information should be stored in the pupil's child protection file.

Direct email for anyone who has concerns about an individual is:
medical@tringpark.com

2. NICE Guidelines

https://www.nice.org.uk/guidance/ng69/chapter/Recommendations#identification-and-assessment

3. Junior marzipan risk assessment table:

Junior Marsipan: Summary of Risk Table

	Red Risk Level (High Risk)	Amber Risk Level (Alert to High Concern)	Green Risk Level (Moderate Risk)	Blue Risk Level (Low Risk)
BMI and Weight	Percentage median BMI <70% Recent loss of weight of 1kg or more/week for 2 consecutive weeks	Percentage median BMI 70-80% Recent loss of weight of 500-999g/week for 2 consecutive weeks	Percentage median BMI 80-85% Recent weight loss of up to 500g/week for 2 consecutive weeks	Percentage median BMI>85% No weight loss over the past two weeks
Cardiovascular Health (Depending on age and gender)	Heart rate <40bpm History of recurrent syncope, marked orthostatic changes (fall in systolic BP of 20mmHg or more) Irregular Heart Rhythm (does not include sinus arrhythmia)	Heart Rate 40-50bpm Sitting BP systolic = 84-98mmHg, diastolic = 35-40mmHg Occasional syncope; moderate orthostatic cardiovascular changes (fall in systolic BP of 15mmHg or more or fall in diastolic BP of 10mmHg of more within 3mins standing or increase of heart rate of up to 30bpm	Heart Rate 50-60bpm Sitting BP systolic = 98-105mmHg, diastolic 40-45mmHg Pre-syncope symptoms but normal orthostatic cardiovascular changes Cool peripheries, prolonged periphery capillary refill (normal central capillary refill)	Heart rate >60bpm Normal sitting BP Normal Orthostatic cardiovascular changes Normal heart rhythm
ECG abnormalities	Prolonged QTc interval, evidence of tachy/bradyarrhythmia, evidence of biochemical abnormalilites	Prolonged QTc interval	Normal except expected abnormalities relating to medication or family history	Normal
Hydration Status	Fluid Refusal Severe Dehydration	Severe fluid restriction Moderate dehydration	Fluid restriction Mild dehydration	Not clinically dehydrated
Temperature	<35.5degreeC tympanic or 35.0degreeC axillary	<36degreeC		
Biochemical Abnormalities	Hypophosphataemia, hypokalaemia, hypoalbuminaemia, hypoglycaemia, hypoatraemia, hypocalcaemia	Hypophosphataemia, hypokalaemia, hyponatramia, hypocalcaemia		
Disordered Eating Behaviours	Acute food refusal or estimated calorie intake 400-600 kcal per day	Severe restriction (less than 50% required intake), vomiting, laxatives	Moderate restriction, bingeing	
Engagement	Violent when parents try to limit behaviour or encourage food/fluid intake, parental violence in relation to feeding	Poor insight, lacks motivation, resistant to changes required to gain weight, parents unable to implement meal plan advice	Some insight, some motivation, ambivalent towards changes required to gain weight but not actively resisting	Some insight, motivated, ambivalence towards changes required for weight gain not evident in behaviour
Activity/Exercise (in context of malnutrition)	High levels of uncontrolled exercise (>2h/day)	Moderate levels of uncontrolled exercise (>1 h/day)	Mild levels of uncontrolled exercise (<h/day)	No uncontrolled exercise
Self-Harm and Suicide	Self-poisoning, suicidal ideas with moderate to high risk of completed suicide	Cutting or similar behaviours, suicidal ideas with low risk of completed suicide		

Please see full guidelines for full details in each section and additional sections (other mental health diagnoses, muscular weakness and other) www.rcpsych.ac.uk/files/pdfversion/CR168.pdf

Last updated by JF 23/11/2020 Date of next review Autumn 2021