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## Eating Disorder Policy

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**This policy should be interpreted in the context of other relevant College Policies and Procedures, particularly BCA Safeguarding Child Protection and Safeguarding Policy (December 2017), BCA Safeguarding Annual Audit December (December 2017) and the Single Equality Scheme (October 2017).**

### **Purpose**

Providing high quality education that gives our students the knowledge, skills and experience to be successful in their chosen career.

### **BCA Equality and Diversity Ethos Statement**

This policy and procedure is subject to The Equality Act 2010 which recognises the following categories of individual as Protected Characteristics: Age, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex (gender), Sexual orientation, Disability, Socio-economic Disadvantage

## **Definition**

Any person regardless of age, gender, cultural or racial background can suffer from eating disorders. Eating disorders are a way of coping with feelings that are making the person unhappy or depressed which may be difficult to face up to and talk about. The student may experience a range of emotions e.g. anger, sadness, guilt, loss or fear. An eating disorder is an indicator that the student may need help in coping with life and sorting personal problems; and may benefit from professional intervention.

## **Introduction**

Eating disorders (ED) comprise of 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 college staff, anorexia nervosa and bulimia nervosa are frequently chronic conditions, with substantial long-term physical, mental and social consequences and which recovery can be difficult. The impact of a person's eating disorder on home, family and college life is often considerable and family members and friends may carry a heavy burden over a long period of time.

The etiology of eating disorders is considered to be multi factorial. 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 student that you have concerns about to the Student Welfare Manager.

## **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 behaviour 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 college staff.

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

### **Bulimia**

Bulimia nervosa (BN) is characterized by recurrent episodes of binge eating and secondly by compensatory behaviour (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/m<sup>2</sup>. People with BN tend not to disclose their behaviour 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.

People with BN are generally managed with a combination of self-help, antidepressant medication and cognitive behavioural therapy.

### **A typical 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 behaviours. 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**

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 student unless they are not thought competent to give consent or do not have 'capacity'. Those who need to be informed may include a combination of the following people, depending on the student's wishes. Ideally it would include the parents, College Designated Safeguarding Person, Student Welfare Manager, Principle and external agencies i.e. GP, Social Care, Counsellors, CAMHS.

With the student's consent, a core team of professionals (multi-agency) will co-ordinate to manage the condition on a regular basis. Team around the child (TAC) meetings should take place with a member of the college attending.

Within the realms of confidentiality and on a 'need to know' basis college staff will be informed on progress and on what support can be put in place for the student suffering.

### **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.
- Inform the Student Welfare Manager and decide together, where and when it would be best to talk to the student
- 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 student to start talking about their issues may be one possible outcome.
- Engagement in a supportive, empathetic way is crucial to enabling the student to reveal fears about weight, dieting, excessive exercise or purging behaviour.
- Encourage the student to seek support and help from their GP, parents, college counsellor etc. and ensure that the student is aware of issues about confidentiality.

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

- 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.

### **Strategies to prevent the spread of eating disorders within the college**

- Close monitoring of students who have been in contact with another student with an eating disorder.
- Informal discussion groups within the curriculums, led by Heads of Department or Student Welfare Team
- Eating disorders to be part extracurricular activity and presentations, raising awareness and understanding within the student body and around the college
- Encouraging an open attitude to eating disorders, where students and staff feel comfortable to discuss and raise concerns where necessary.

### **Further information**

[www.eatingdisorderssupport.co.uk/helpline](http://www.eatingdisorderssupport.co.uk/helpline)

[www.mumsnet.com/teenagers/eating-disorders](http://www.mumsnet.com/teenagers/eating-disorders)

[www.childline.org.uk/](http://www.childline.org.uk/)