EATING DISORDER POLICY - For Boarding Schools

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Aim:

By having a boarding school policy on eating disorders (EDs), educational professionals are able to identify, manage and support students, whilst enabling the whole school to confidently help staff help students with vulnerabilities, whilst knowing their precise responsibilities.

Purpose:

• To make aware of a whole-school approach to tackling eating disorders, with primary level preventative measures, secondary level management and aftercare.
• To instil greater confidence in members of staff, in identifying early signs of eating disorders, offering skill sets needed to support the student, whilst also knowing how best to be supported themselves through recommended communication pathways.
• To be informed of key considerations, in facilitating the student moving forward towards appropriate and timely treatment plan for the overall well-being.
• To equip staff with legal rights in safeguarding all students with/without eating disorder vulnerabilities, while having the correct knowledge in dealing with parents / guardians effectively.
• EDs Policy document can also serve governors, parents, Independent /LEA officers and external inspectors (eg: Ofsted), to assess at a glance what “eating disorder prevention/management measures” they can expect to see applied at the school.

Four Types of Eating Disorders & Their Clinical Descriptions:

1) **Anorexia Nervosa:** A disturbance in the way the student experiences her/his body and a refusal to maintain body weight above a minimal normal weight for age and height, leading to a body weight 15% below expected (diagnose @BMI 17.5). In females there is the absence of at least consecutive menstrual cycles.

2) **Bulimia Nervosa:** Recurrent episodes of binge eating with a feeling of lack of control over the eating behaviour and persistent over concern with body shape and weight. The student also regularly engages in self-induced vomiting, use of laxatives/diuretics, excessive exercising or rigorous dieting and fasting to counteract the effect of binge eating.

3) **Binge Eating Disorder:** Recurrent episodes of binging that are a cause of distress with a feeling of lack of control over the eating behaviour but without compensatory behaviours used to prevent weight gain.

4) **EDNOS (Eating Disorders Otherwise Not Specified):** Making up for 79% of all eating disorders. EDNOS is atypical anorexia or bulimia where a student is struggling with eating disorder thoughts, feelings or behaviours, but does not have all the clinical symptoms of anorexia, bulimia, or binge eating disorder as defined above. This can also include “Chewing and Spitting”, Orthorexia, Avoidant / Restrictive Food Intake Disorder and so on.
Primary Preventative Measures for the Boarding School:

- This is the whole-school ethos in tackling and supporting students with eating disorders.
- Make a proactive agenda to inform all staff about the ED Policy & where to access it.
- Ensure school ED Policy is in the School, Staff and Student Handbooks with appropriate tone. All new parents should be given a copy to inform.
- Create and maintain positive climate, around the School, House and Classrooms with trigger free images.
- All staff should be trained on ED identification. Members of Staff, need to reflect positive Role Modelling, mindful of own body image and any -language patterns that reflects poor body image.
- Be mindful of hidden message with any activities requiring low weight to enhance performance in sports, dance, acting, or modelling
- Promote well-rounded achievements, as well as academic/sports excellence.
- Primary role of PSHE Curriculum. Some useful topics to cover are :
  - Positive Body Image & Confidence
  - Self-esteem, Self-care & Balanced Achievements
  - Resilience & Effective Coping Skills
  - Stress, Depression & Emotional Management
  - Time & Exam Management skills
  - Myths about Body Image & Diets
  - Society’s pressure to achieve ideal Shape & Weight

*Avoid DIRECT topics on Eating Disorders and triggering images in front of vulnerable students. Instead have student support systems in place - if exploring any topics above in Talks, Workshops or Discussions.

Secondary Management of Eating Disorders:

- Boarding school’s key role is in supporting and acting as a central resource but not in treating the student with the exception of the roles school Doctors, nurses and Pastoral staff will play in continuing their role in monitoring, assessing and or emotional support.
- Eating disorder management and treatment requires a team of people & professionals working together in multi-disciplinary capacity (student, parents, HM, doctors, ED Specialist, CAMHS..). Care Plan meetings can take place at the school, with minutes filed on record.
- When a student identified with an eating disorder, primary treatment plan will come from an eating disorder specialist or CAMHS.
- Consent from student is vital. The following should be done with the agreement of the student and with the awareness and consent of the parents: Weighing, monitoring, blood tests, levels of sports activity & any exclusion for safeguarding student.
Early Signs – What to Look Out For:

NOTE: As many of the following may be hard to separate from symptoms from normal aspects of adolescent behaviour – care must be taken to observe collection of signs & symptoms with proper assessments and or test to verify presence of ED.

<table>
<thead>
<tr>
<th>Behavioural</th>
<th>Psychological</th>
<th>Physiological</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Secrecy &amp; lies</td>
<td>• Morbid fear of fat</td>
<td>• Weight loss/weight fluctuations</td>
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<tr>
<td>• Eating vast amount of food</td>
<td>• Mood swings</td>
<td>• Tiredness</td>
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<tr>
<td>• Vomiting after meal</td>
<td>• Irritability</td>
<td>• Lethargy</td>
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<tr>
<td>• Laxatives/ diuretics use</td>
<td>• Depression</td>
<td>• Dizzy spells</td>
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<tr>
<td>• Fasting/skipping BF /lunch</td>
<td>• Anxious</td>
<td>• Thirsty</td>
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<tr>
<td>• Excessive exercise</td>
<td>• Body image disturbance</td>
<td>• Swollen glands</td>
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<tr>
<td>• Keen on extra sports</td>
<td>• Distorted Body-Image</td>
<td>• Sore mouth</td>
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<tr>
<td>• Socially recluse</td>
<td>• Self-consciousness</td>
<td>• Bruised Knuckles</td>
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<tr>
<td>• Aggressive or violent</td>
<td>• Low Self-esteem</td>
<td>• Frequent bone fractures</td>
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<tr>
<td>• Substance abuse</td>
<td>• Lack of focus</td>
<td>• Slow/lack of growth</td>
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<tr>
<td>• Stealing</td>
<td>• Lack of interest</td>
<td>• Absent period- Amenorrhea</td>
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<tr>
<td>• Self-mutiliation</td>
<td>• Lacks assertiveness</td>
<td>• Gastrointestinal complaints</td>
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<tr>
<td>• Obsession with purity &amp; Being clean</td>
<td>• Avoids conflict</td>
<td>• Medication (antidepressant)</td>
</tr>
<tr>
<td>• Sexually inhibited</td>
<td>• Compulsive</td>
<td>• Growth &amp; secondary sexual development poor , minimal or absent</td>
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<tr>
<td>• Impulsive</td>
<td>• Obsessional</td>
<td>• Many dental issues</td>
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<tr>
<td>• Craves Sameness</td>
<td>• Perfectionist</td>
<td>• Poor cardiovascular system</td>
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<tr>
<td>• Dependency</td>
<td>• Poor impulse control</td>
<td>• Low Electrolytes</td>
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<tr>
<td>• Hard working</td>
<td>• Inability expressing feelings</td>
<td></td>
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<tr>
<td>• Diligent</td>
<td>• Often guilty or ashamed</td>
<td></td>
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<tr>
<td>• Autistic</td>
<td>• Psychiatric history</td>
<td></td>
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<tr>
<td>• Seeks rituals</td>
<td>• Sense of failure</td>
<td></td>
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<tr>
<td>• Difficulty Prioritising</td>
<td>• Fear of sexuality / biological maturity</td>
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<tr>
<td>• Eating small range of food</td>
<td>• Feels alienated</td>
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<tr>
<td>• Avoids eating with people</td>
<td>• Suicidal thoughts</td>
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<td>• Wearing baggy clothing</td>
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Urgent Warning Sings For Immediate Boarding School Consideration & Hospital Admission Referral (results from “Risk Assessment” and /or Test results from the school medical team or student’s own GP clinic):

<table>
<thead>
<tr>
<th>Physiological / Medical</th>
<th>Psychiatric</th>
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<tbody>
<tr>
<td>• Student Weight Loss &gt; 30% of body weight over 3months</td>
<td>• Self-mutilation</td>
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<td>• Severe dehydration</td>
<td>• Risk of suicide</td>
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<tr>
<td>• Heart Rate &lt; 40bpm</td>
<td>• Severe depression</td>
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<tr>
<td>• Temperature &lt; 36 degrees C</td>
<td>• Psychosis</td>
</tr>
<tr>
<td>• Systolic blood pressure &lt; 70 mm Hg</td>
<td>• Outpatient treatment ineffective</td>
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<tr>
<td>• Serum Potassium &lt; 2.5mEq/l (even with oral potassium replacement)</td>
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<tr>
<td>• Related somatic illness (eg; infection)</td>
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NB: High risk students are given priority for urgent admissions e.g. students who are self-harming; with suicidal actions; are anorexic with rapid weight loss due to starvation.

What to do when you become aware of a student with an ED?

1. Helpful approach for non-therapists:
   - Be compassionate and understanding.
   - Actively listen without judgement.
   - Stay calm and away from the need to rescue or fix the problem.
   - Demonstrate your empathy, whilst appreciating the complexity of ED mind-set.
   - Appreciate there exists at any time, duality of intentions for recovery & conflict against changing.
   - Keep your boundaries, yet show you are willing to help the student move forward.
   - Do not offer exclusivity or confidentiality! - Explain “why” & “when” for disclosure. Emphasis safeguarding that student, rather than it being about trust issue.
   - Avoid comments using the following words, with student with ED vulnerability:
     * Specific weight – *shape or dress size – *Amount of food or type of food eaten - * “Looking well!” comments

2. Have specific Criteria for Home Study or exclusion from activities (e.g. sports, school trips)
3. Whether you are a Housemaster, Housemistress, Teaching Staff, Support Staff, PE Teacher, Pastoral Support, School Counsellor or Medical Staff at the boarding school - immediately inform your Designated Child Protection Officer (DCPO) or Care Co-ordinator.
4. You may wish to do this via your line management or go directly.
5. DCPO / Care Co-ordinator, may carry out “Risk Assessment” to protect the student’s welfare.
6. Inform the House Staff, so they can monitor the well-being of the student closely.
7. Avoid getting in to daily accountability or assigning another student for this task exclusively.
8. Avoid dealing with this situation alone, as it can be very demanding and consuming. DCPO or Line manager must decide the nature of the student’s case as urgent, pressing but not urgent or something that needs regular monitoring without any outside referrals at this stage ( Input from the Medical Team will help with this assessment).
9. Chronic or transient Cases requiring detailed help requires, Boarding school GP, student’s own Doctor or Child and Adolescent Mental Health Team (CAMHT) to be notified, in order for correct ED assessment to be carried out. S/he will then determine, whether the student needs medical intervention with prescribed medication, referral to Psychiatrist /ED Counsellor or both for effective recovery.
10. School Counsellor/Pastoral Lead Staff, can also help to support the student as well as the frontline staff, in regular contact with the student.
11. Frontline staff, dealing with student with ED, should be given additional support via regular Supervision, sessions with OT or school counsellor.

Here some eating disorders advice & support resource:

Who to Contact At School:

1) Primary Contact: ______________________ Designated Child Protection Officer/Care Co-ordinator
   Telephone #: ______________________________ E-mail: ______________________________

2) Secondary Contact: ____________________________ = Line Manager
   Telephone #: ______________________________ E-mail: ______________________________

Keeping Accurate Student Case Notes on Record:

For the purpose of Whole-school approach, effective dissemination of information and keeping all staff directly in contact with the student – keeping timely case notes on that student record is advised. This also helps to share responsibilities in verifying signs of any disorderly eating, weight loss, or eating disorder at the early stage. Everyone with access to student case notes should be up to date with Data Protection Act, School Confidentiality Policies and Disclosure procedures. All written communications should be signed by the education professional that last made the entry and counter signed by DCPO. As a good practice, monthly face to face meeting with all school staff concerning that student should take place to share information collectively. Joint care /Case meeting can be arranged regularly to share and consult this information, so everyone is up-to-date and able to raise any urgent concerns during the course of ED assessment phase, management, or aftercare once the receives treatment and may be returning back to boarding.

Parent Involvement & considerations:

Parents need to be a firm part of the communication when dealing with or supporting student with eating disorder. Encourage student to open this communication. If student is unwilling, avoid forcing due to possible existence of toxic family dynamics at home. Parents, local guardian or next of kin must be alerted to their legal responsibility in student safeguarding and protection. DO inform and involve them, if the student is non-compliant, deteriorating further and shows resistance to getting treatment. Any Care Plan that the CAMHS/ED Specialist recommends, which the school opts to implement, also needs to have written Parental Consent. Parents may fit in to these categories:

a) Keen and willing to offer full support,

b) In denial of their child’s ED problem,

c) Defensive or refusal to take part,

d) In fear that ED is a reflection of bad parenting, &

e) Parent with maladaptive or dysfunctional eating family dynamics.

School role is only as a facilitator, go-between-resource, and encourages active partaking in treatment offered by the skilled ED experts (e.g. family therapy, attending Joint Care Plan meetings helping student settling back in after treatment with home environmental changes and so on) - NOT to be confused with your role - counselling or fixing!
Non-compliant or resisting parents, needs to be handled motivationally – as a student who refuses help and treatment. School is protected by Child Protection Law, Mental Health Act 1983 and Children’s Act 1989 (with their recent amendments) – for any refusal. School can legally override the lack of consent from one or both parties by considering Safeguarding student agenda – if that student is perceived to be in danger of harm from progressive eating disorder. **School will also have duty of care to other students who may be getting affected negatively, if this happens – notification of intension, followed by student dismissal from the boarding school may be necessary.** Note: the student is free to return, provided they abide by school terms and condition for returning, once they have successfully received treatment.

**Aftercare Management & School’s Role in Helping:**

1. Allocate the form teacher or DCPO, to liaise with hospital Care Plan coordinator, about the appropriateness of academic work (when to offer, how much, how soon, method of checking work, By whom, modality of exchanging work etc.)
2. Devise a meal/ post meal monitoring – through accompanying close friend(s), only WITH the consent of student. If student feels vulnerable, eating away from others (perhaps even in another room) but with a trusted staff may be more appropriate. Once stable & confident, student should be encouraged to eat with others from the same House at meal time.
3. Student can work with school counsellor or ED Therapist on Methods for reducing anxiety and some other basic life skills to increase resilience and reduced lapse or relapses.
4. If on medication (such as antidepressant, anxiety medications ...), school medics or Housemistress/Master can over see this - with student’s consent.
5. Recovering /Recovered student is free to continue studying with you, only on the terms and condition of marked improvement in health & psychology , supported by his/her key treatment specialist and in agreement with school policy to monitor measures of ongoing maintenance of recovery (e.g.: weight stability, healthy eating, stable electrolytes , overall wellness of the student to function as peers would)
6. In some cases intense eating disorder treatment may come to an end (e.g. from an inpatient unit), and the student may be now ready for resettlement back in to normal ways of life – including returning to boarding school. Ongoing or time –limited medical and pastoral support from within the school can still be necessary and be highly beneficial.
7. Children, Schools and Families Act 2010 (Section 3aa) May apply when determining whether it would NOT be in the student’s best interests for full-time education to be provided due to mental health deterioration.

**Keeping Up To Date & ED Policy Reviewing:**

Last review date: ________________ Next review date: __________________

Annual review of boarding school policy is ideal. Involve wide range of education professions, student representation, Parents, school medical team and counsellor representation in your review consultations if possible, before finalizing policy. Do amend policy according to any latest changes in the law – especially with **Mental Health Act** and **Children’s Act**.