Treatment of Avoidant/Restrictive Food Intake Disorder: Referral Errors and Delay in Treatment

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INTRODUCTION

Avoidant/restrictive food intake disorder (**ARFID**)

- Eating or feeding disturbance not attributed with food disparity or cultural practices resulting in:
  - Significant weight loss
  - Nutritional deficiency
  - Dependence on enteral feeding or oral nutritional supplements
  - Marked interference with psychosocial function [1]
- Introduced in Diagnostic and Statistical Manual, Fifth Edition (DSM-5) in 2013
  - Lack of interest in eating not due to weight or body image concern
  - Discomfort or avoidance of sensory characteristics of foods
  - Anxiousness due to adverse experience related to eating (e.g., choking)

Table 1. *Prevalence Rate of ARFID in Selected Studies*
Abbreviations: MEDPC, multidisciplinary eating disorder program/clinic; PAG, pediatric and adolescent gynecology clinic (female only).

Study	Setting	N	Age, years	Prevalence, %
Clinical Samples				
Ornstein, 2013	Pediatric clinic	215	8-21	14.0
Fisher, 2014	MEDPC	712	8-18	13.8
Forman, 2014	MEDPC	700	9-21	12.4
Nicely, 2014	Eating disorder day program	173	7-17	22.5
Norris, 2014	MEDPC	205	N/A	5.0
Williams, 2015	MEDPC	422	0.33-18.25	32.0
Cooney, 2018	MEDPC	369	<18	8.4
Krom, 2019	MEDPC	100	0-10	64.0
Goldberg, 2020	PAG clinic	190	8-18	3.7
Bertrand, 2021	Pediatric clinic	401	0-18	2.7
Non-Clinical Samples				
Hay, 2017	Population survey	5737	>15	0.3
Goncalves, 2018	Primary school survey	330	5-10	15.5
Chen, 2019	Primary school survey	4816	8-12	0.5

OBJECTIVE

To investigate institutional referral patterns and treatment outcomes of patients diagnosed with ARFID

METHODS

Institutional Review Board approval

- Electronic health record retrospective review
- Aged 0-17 years with an ARFID diagnosis between January 1, 2015, and June 30, 2022
- Patients diagnosed with another eating disorder were excluded (e.g., anorexia nervosa, bulimia nervosa, unspecified eating disorder)

Statistical Analysis: SAS 9.4

- Descriptive demographic analysis
- Exact binomial 95% confidence bounds (prevalence rate)

RESULTS

Figure 1

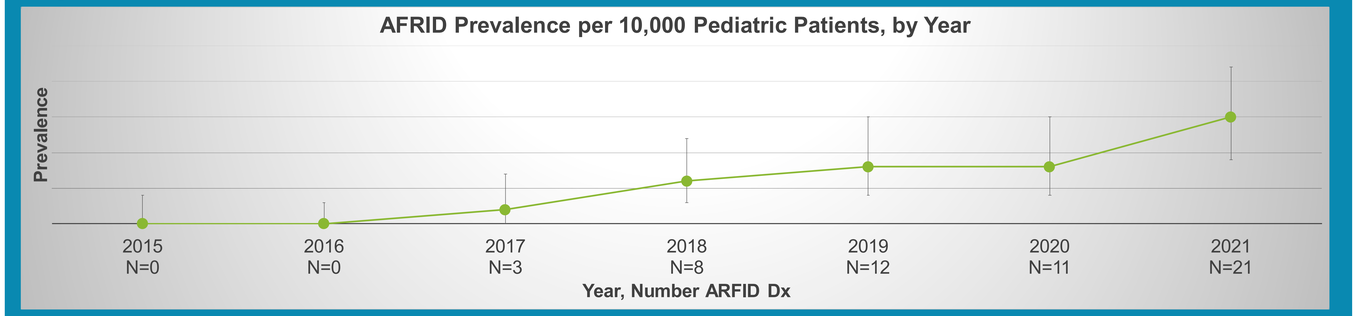

Figure 2

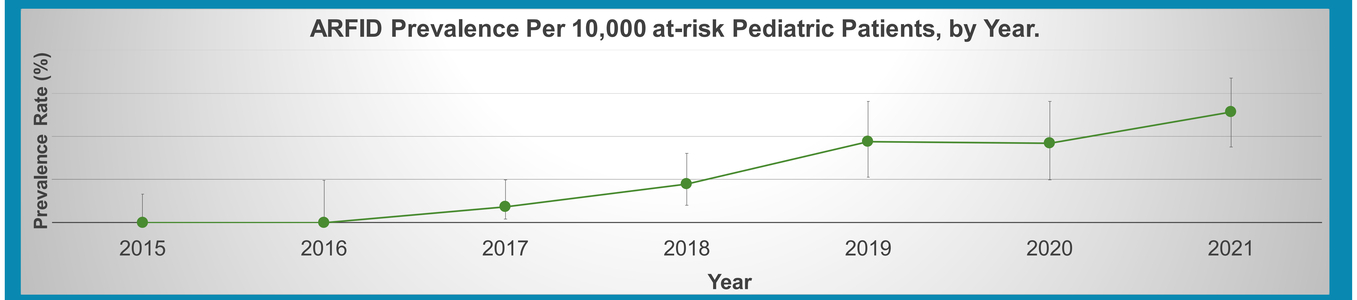

Table 2

Department Referral	Referrals	Referred out after intake n (%)	Treated	Symptoms Improved after Treatment, no. improved/no. treated (%)	
				First Episode	Second Episode
Behavioral Health	36	6 (17)	29*	20/29 (69)	6/8 (75)
Nutritional Therapy	17	7 (41)	10	3/10 (30)	N/A
Occupational Therapy	14	3 (21)	11	7/11 (64)	0/3 (0)

Referral Pattern and Treatment Outcomes by Service
17 referred to Behavioral Health only, 4 to Behavioral Health and Occupational Therapy, 7 to Behavioral Health and Nutritional Therapy, and 8 to all three services, for a total of 36 patients referred to Behavioral Health. Of these, 1 patient did not receive treatment related to ARFID. The remaining 19 patients were referred to Nutritional Therapy and/or Occupational Therapy.

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References & More Information
https://www.surveymonkey.com/r/JJTIN

DISCUSSION

Treatment Outcomes

- Similar for patients receiving behavioral health treatment (69% and 75%) or occupational therapy (64%)
- Significantly lower positive outcomes (30%) for patients receiving only nutritional therapy
  - Does not dismiss importance of collaborating with RDs during treatment
  - ARFID treatment teams with RD show better long-term outcomes versus without [2]
  - RDs help guide food selection by families ensuring nutritional balance
  - Therapists work from behavioral perspective to include these food options in regular eating repertoire [3]
  - Even one consultation with RD at start of treatment for ED is beneficial
    - Special dietary needs present due to other medical conditions or dietary preferences [4]

Nutritional therapy

- Not effective treatment alone for ARFID
- May provide notable patient benefits to eating disorder teams

Incorrect Referrals and Delays in Treatment

- Referral to Behavioral Health, Nutritional Therapy, or Occupational Therapy not based on standard criteria.
  - Lack of pattern is a significant problem.
  - Inappropriate referrals (n = 16, 29%) lead to immediate referrals to other services after intake (Table 2).
- Struggle with diagnosis and management of symptoms by PCP.
  - In-depth training in eating disorders by all PCPs not practical.
    - Training expense for one specific area not feasible for small health systems.
    - Short recorded lectures vs investing in rigorous training to improve PCP's confidence and accuracy of screening [5]
  - Use of ARFID screeners
  - Improved access to integrated behavioral health professionals

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