Clinical Guidance

Community Restrictive Feeding Guidance for Children and Young People (CYP)

Summary
This guide is to support clinicians working in primary care and community services to provide support for children presenting with restricted feeding.

Document Detail	
Document type	Clinical Guideline
Document name	Community Restrictive Feeding Guidance for Children and Young People (CYP)
Document location	GT*i* Clinical Guidance Database
Version	1
Effective from	12th June 2026
Review date	30th June 2029
Owner	Head of Service, Community Paediatrics Department, Community Specialist Feeding Clinic
Author(s)	Principle Authors: Dr Gina Harland, Dr Kavitha Gunasuntharam, Dr Jo Cryer, Dr May Yip (Main author) Contributors: Dr Gina Harland, Sheatha Abumehdi, Constanza Peña-Gonzalez, Deborah Thompson, Jamie Leung, Miranda Macaulay, Claire McMahen, Dr Chloe Maccaulay, Dr Nicola Hanson, Dr Kavitha Gunasuntharam, Dr Jo Cryer, Dr May Yip
Approved by; date	Paediatric Clinical Guidelines Committee, 10th June 2026
Superseded documents	
Related documents	
Keywords	ARFID, avoidant restrictive food intake disorder, restrictive eating
Relevant external law, regulation, standards	

Change History		
Date	Change details, since approval	Approved by

Summary of Guidance

1. Identify that the child has a restricted feeding pattern. This may be:
    a. Inadequate intake with faltering growth
    b. Missing whole food groups and where nutritional deficiencies are a concern
2. If growth is a concern, refer to Dietitian:
    a. If on the Community Paediatric pathway for ASD assessment (awaiting assessment of Autism)/ developmental concern – refer to Community Dietetics
    b. If not, refer to Hospital Dietetics
3. Consider baseline nutritional bloods:
    - Full blood count, Ferritin
    - B12, Folate
    - Vitamin D, Bone Profile
    - Zinc, Coeliac Screen, and TFTs (Thyroid Function tests)
    - LFT to include albumin, renal profile
4. Advice to family:
    a. See universal strategies handout: https://www.evelinalondon.nhs.uk/resources/patient-information/meal-time-strategies.pdf
    b. Advise a multivitamin

CYP Presenting to Primary Care in Lambeth/Southwark with Restrictive Feeding

Child presenting with Restrictive Feeding

↓

History/Examination
Height/Weight/BMI/HR/BP

↓

Red Flags requiring inpatient admission[3] — YES → Discuss with acute paediatrician on call

↓ NO

Features to suggest Anorexia Nervosa — YES → Refer to SLAM

↓ NO

Restrictive eating risk stratification

[3]RCPSYCH Medical Emergencies in Eating Disorders **Red Flags:**
- Recent loss of weight of ≥1kg/week for 2 weeks (consecutive)
- %mBMI <70%
- HR <40
- Core temperature <35.5

Score 0: No Risk	Score 1: Some Risk	Score 2: Moderate Risk	Score 3: High Risk	Score 4: Very High Risk
Adequate diet (>20 foods across 4+ food groups (fruit and vegetables, carbohydrates, protein, dairy, fats). **And** Normal growth (growing along centiles eg. Consider reviewing 'red book') and development. Participates in social events with minimal adjustments. Family coping well.	Mild selectivity (eg.10 foods across 4 groups) **And** Normal growth (growing along centiles eg. Consider reviewing 'red book') Mild micronutrient concerns but can take a multivitamin.	Moderate selectivity <10 foods across 2–3 groups; vitamin/mineral deficiencies, supplements unsuccessful. **And/Or:** Weight (> 2 centiles below height or growth plateau > 3/12 or concern with growth) Family unable to participate in social eating despite adjustments. Significant parental stress during mealtime	<5 foods across 1–2 groups; multiple deficiencies; supplements not tolerated) **And/Or:** Significant growth faltering (>3 centile drop, no height growth >6 months). Unable to attend school/ participation (ie. feeling tired all the time) significantly impacted by feeding causing stress to family.	Weight > 3 centiles below height **And/Or:** Severe malnutrition or metabolic instability; risk of refeeding syndrome. Enteral feeding indicated; multiple deficiencies with detrimental impact on physical health
Score 0: No Risk Do not arrange Blood Tests unless additional clinical concerns. No additional referrals required.	Arrange Blood Tests[1] **Universal Strategies for all (please signpost Resources/Strategies for parents and carers)** Consider referral to Positive Meal Times[2] (18 months-4 years) or HENRY[3] (<5 years) Review in primary care in 3-6 months Advise Supplements (OTC or prescription) Consider discussion with the paediatrician in the primary care network (PCN)			
	Score 1: Some Risk No referral required	**Score 2+3: Moderate-High Risk** Refer to General Paediatricians and Dieticians: Evelina Hospital Dietetics or Community Dietetics if developmental delay/additional needs (referral form on Evelina website)		**Score 4: Very High Risk** Refer to dietician urgently and consider if acute hospital admission is required

[1] **Blood Tests in primary care**:
- Full blood count, Ferritin
- B12, Folate
- Vitamin D, Bone Profile
- Zinc, Coeliac Screen and TFTs
- LFT to include albumin, renal profile

[2] **Positive Meal Times**:
- 18 months – 4 years
- Virtual Workshop of 4 sessions
- If parents attend 3 of 4 sessions they will be offered a 1-1 one off session with a dietician
- Referral Form and Criteria via Evelina website

[3]**HENRY**:
- <5 years old
- In person workshops
- Parents/Carers book place via email
- Details of workshops and how to book place via Evelina website

Consider referral to ARFID MCCAED SLAM service
- If concerns around body image/queries around eating disorders
- Referrals via MCCAED website (up to date blood tests required)

Referral to Community Specialist Feeding Clinic
Referrals only from **health care professionals** when universal offer completed but difficulties persist (in score 2-4 risk group).
Universal offer includes:1) Health professional has discussed and implemented universal strategies with family 2) Family have already gone through Positive Mealtimes/ HENRY programme

Referral criteria:
- Universal offer implemented as above
- Child 3-18 years old
- Referrer has completed food diary, parent questionnaire and referral form (available on Evelina website)

Multivitamins

BDA Multivitamin & Mineral Supplement Options and Advice for those with restricted eating: available here

- Resource with multivitamin preparation tips and how to support introduction of these supplements to children with restricted eating.

Some examples of multivitamin preparations available to purchase are listed below. Iron may not be present in multivitamin preparations and may need to be supplemented separately. Multivitamin and iron supplements are available from pharmacies, supermarkets and online retailers. **Patients (or parents/carers) should be advised to purchase from a reputable source, and to ask a pharmacist if they need advice.**

Over The Counter Examples		
Liquid 	**Sprinkles** 	**Drops** 
E.g. Wellkid (4-12 years old) Liquid contains Vitamin A, b1, B2, B3, B5, B6, B7, B9, B12, C, D, E, Iron, Copper, Iodine and Zinc	E.g. Nutrigen Sprinkles (2-12 years old) - Contains Vitamin A, B1, B2, B3, B6, B9, B12, C, D, E, Iron, Zinc, Copper, Iodine	E.g. Natures Aid Drops (3months-5 years) Mini drops multivitamin- contain Vitamin A, B1, B2, B3, B5, B6, B12, C and D Mini drops iron – contain iron, vitamin C, B12 and folate

Healthy Start Children's Vitamin Drops

Healthy Start children's vitamin drops are free for all children in Lambeth and Southwark under 4 years of age, and free for eligible families with a child under 4 years of age in Bexley, Bromley. Greenwich and Lewisham. Families may apply or check eligibility at: **https://www.healthystart.nhs.uk/**

Per dose (5 drops), Healthy Start drops contain:

- 400units colecalciferol
- 233micrograms vitamin A
- 20mg vitamin C

Healthy Start drops are halal, vegetarian and free from milk, egg, gluten, soya and peanut residues.

Prescribing for vitamin and mineral deficiencies

For guidance on prescribing, please refer to the South East London Paediatric Formulary (accessed via Clinibee – registration required):

Deficiencies

Children with restricted eating are at risk for several deficiencies, including:

Specific deficiencies	Link to SEL Paediatric Formulary monograph
Iron/ Ferritin	IRON (ORAL SUPPLEMENTATION)
Folate	FOLIC ACID
Vitamin A, Vitamin E, Selenium	As part of a multivitamin – see MULTIVITAMIN Refer to individual preparations for ingredients
Vitamin C (ascorbic acid)	As part of a multivitamin – see MULTIVITAMIN Refer to individual preparations for ingredients If concerns of severe Vitamin C deficiencies or scurvy, consider ASCORBIC ACID Other formulations such as oral drops are available for purchase
Vitamin B12	Consider HYDROXOCOBALAMIN (IM) Other formulations such as oral tablets and oral sprays are available for purchase
Colecalciferol (Vitamin D3)	COLECALCIFEROL (VITAMIN D3) South East London Clinical Guidance for the Management of Vitamin D Deficiency and Insufficiency in Children up to the age of 18 years - excluding neonates in Neonatal Units
Zinc	ZINC

BDA Factsheets for parents and carers:

- Supplements BDA Factsheet: https://www.bda.uk.com/resource/supplements.html
- Iron BDA Factsheet: https://www.bda.uk.com/resource/iron-rich-foods-iron-deficiency.html
- Folic Acid BDA Factsheet: https://www.bda.uk.com/resource/folic-acid.html
- Calcium BDA Factsheet: https://www.bda.uk.com/resource/calcium.html
- Vitamin D BDA Factsheet: https://www.bda.uk.com/resource/vitamin-d.html

Resources/Strategies for Parents and Carers given by professionals

ARFID Awareness UK: https://www.arfidawarenessuk.org

- Resources for healthcare professionals and parents/carers including a food diary template, ARFID introduction leaflet and booklets for schools.

Evelina mealtime strategies for parents - also available as a PDF here

Creating a Routine

Children respond well to different aspects of their day when they know what to expect.

- Try to fit three meals and two snack times into your child's day.
- Limit meal times to half an hour, after this your child may not eat much more.
- When eating, talk as a family. Try to keep conversation light-hearted and not focused on food.
- Offer a healthy pudding whether or not the main meal was eaten.
- Consider a visual timetable for meal times.

Choosing what to eat

- Think about textures of foods your child likes. For example, if they like dried cereal, think of foods with similar consistencies, such as vegetable crisps.
- Give your child a choice, even if it is something as simple as "Would you like Weetabix or Rice Krispies?" or "Would you like to pour the milk or would you like me to pour the milk?"
- If your child rejects a food, offer small amounts of different food.
- Consider introducing brand new foods separate to meal times. For example, during tasting times or sensory play.
- Beware of adding to “safe foods” as there is a risk that the safe food will be dropped.

Getting used to food

Sometimes children don't engage with their food because it is unfamiliar to them. Getting them to play and be involved with making food can help.

- Try baking with your child. Get them actively involved in choosing a recipe, making it, and tasting the end product.
- Have a birthday party or picnic for some of their stuffed toys. Get them to choose a menu and help you make the food.
- Let your child help you set the table for meal times. Role play eating outside of meal times. This can reduce pressure when it comes to eating meals.

Praise and Rewards

Remember to encourage what your child is doing well throughout their day, as this builds self-esteem and confidence

- Try giving praise and attention away from meal times. If your child gets most of your undivided attention when they are being fussy at meal times, they may continue to do so – they think any attention is good attention.
- Try and arrange something fun to do after the meal. For example, "After the meal, we can watch your favourite film", something to look forward to can take the focus off of eating.
- Children learn from modelling behaviour. If you enjoy your food and finish your portions they are likely to see this as normal

Additional reading

Clinical and nutritional management of children with restricted feeding or ARFID – background and further factors covered in Community Specialist Feeding Clinic.

1. Introduction to restricted feeding and ARFID

Definition: Avoidant/Restrictive Food Intake Disorder (ARFID) is an eating disorder characterized by a persistent failure to meet appropriate nutritional and/or energy needs with at least one of the following according to DSM V (American Psychiatric Association , 2013):

1. Significant weight loss (or lack of expected weight gain or growth in children:
2. Significant nutritional deficiencies;
3. Dependence on enteral feeding or oral food supplements;
4. Disturbances in psychosocial functioning

Exclude:

- Lacks food availability or cultural and religious reasons; not due to anorexia nervosa or bulimia nervosa and is not the result of abnormalities in the experience of body weight and shape; cannot be explained by current state of health or other co-occurring mental disorders.

Recent clinical evidence confirms that ARFID and restrictive feeding coexists with other neurodevelopmental disorders, particularly Autism Spectrum Disorder (ASD). (Kambanis PE, 2020) Children with ARFID often presents with different degrees of malnutrition and this can take years to be reversed and long term deficits in growth and nutrition could impact growth and development. (BDA ARFID Special Interest Group, June 2022)

2. Main Consequences of ARFID

Physical Complications: ARFID can lead to significant physical health issues, including (Rachel Marie James, 2024):

- **Nutritional Deficiencies**: Lack of essential nutrients can result in conditions such as anaemia, neurological sequelae, electrolytes abnormalities, scurvy, and rickets.
- **Growth and Development Issues**: Children may experience stunted growth and delayed puberty.
- **Gastrointestinal Problems**: Chronic constipation, diarrhoea or abdominal pain can occur.

Patients who are at a healthy weight or above a healthy weight can be deficient in one or more micronutrients. (Yule, et al., 2021)

3. History taking, Examination and Blood Investigations

If there are concerns about nutritional deficiencies, the following examinations and blood tests are recommended:

- **History taking (focusing on)**: Birth history (Complication at birth or during neonatal period such as nasogastric feeding, gastro-intestinal reflux), past medical and current medical history, constipation.
- **Dietary history:** Current food and type of food taken. Fluid intake.
- **Physical Examination**:
    - Assess growth parameters (height, weight, BMI)
    - Physical signs of malnutrition (easy bruising, gum bleeding)
    - Examine the conjunctiva looking for conjunctiva pallor
    - Examination and palpation of the abdomen (if palpable stools or masses).
    - Vital signs: Heart rate and blood pressure due to evidence of bradycardia and hypotension in this group of children.
- **Blood Tests (baseline as above, plus consider)**:

  Iron studies to evaluate for iron deficiency.
  Selenium
  Magnesium
  Vitamin levels (Vitamin A, E, C).
  Genetics if growth concerns or features of dysmorphism

References

American Psychiatric Association . (2013). Diagnostic and Statistical Manual of Mental Disorders. In A. P. Association, *Diagnostic and Statistical Manual of Mental Disorders*. Washington, DC, USA.

BDA ARFID Special Interest Group. (June 2022). *The Role of the Dietitian in the Assessment and Treatment of Children and Young People with Avoidant Restrictive Food Intake Disorder (ARFID)*.

Kambanis PE, K. M. (2020). Prevalence and correlates of psychiatric comorbidities in children and adolescents with full and subthreshold avoidant/restrictive food intake disorder. *Int J Eat Disord* , 53: 256–65.

Rachel Marie James, J. O. (2024). Physical health complications in children and young people with avoidant restrictive food intake disorder (ARFID): a systematic review and meta-analysis. *BMJ Paediatrics Open 2024*, 8:e002595.

Yule, S., Wanik, J., Holm, E., M.B., B., Shanley, E., Sherman, C., . . . Ziff, M. (2021). Nutritional Deficiency Disease Secondary to ARFID Symptoms Associated with Autism and the Broad Autism Phenotype: A Qualitative Systematic Review of Case Reports and Case Series. *Journal of the Academy of Nutrition and Dietetics*, 12:3.