# FEEDING & EATING DIFFICULTIES: GUIDELINES FOR ASSESSMENT & MANAGEMENT

| DOMAIN | PFD/Developmental | ARFID |
|---|---|---|
| **MEDICAL** | | |
| Primary gastro diagnosis (gastro oesophageal reflux, GORD, functional constipation). | ✓ | |
| Coughing / choking on food/drink (dysphagia). | ✓ | |
| Recurrent upper respiratory tract infections. | ✓ | |
| Congenital neurological / heart / airway disorder. | ✓ | |
| **NUTRITION** | | |
| Nutritional deficiency (limited dietary diversity). | ✓ | ✓ |
| Growth outside of expected parameters (under or over). | ✓ | ✓ |
| Growth within expected parameters. | ✓ | ✓ |
| Need for oral or enteral nutritional supplements. | ✓ | ✓ |
| **FEEDING SKILL** | | |
| Difficulty drinking, biting, chewing & manipulating food / drink in the mouth. | ✓ | |
| Holding food in mouth / overstuffing mouth / swallowing partially chewed food. | ✓ | |
| Delayed self-feeding. | ✓ | |
| Difficulty maintaining sitting position / upright posture. | ✓ | |
| Need for adaptive feeding strategies, positioning or equipment. | ✓ | |
| **PSYCHOSOCIAL** | | |
| Food avoidance based on: Sensory sensitivity to specific foods / food groups. | ✓ | ✓ |
| Lack of interest in food / eating. | ✓ | ✓ |
| Anticipatory anxiety of aversive consequences of eating. | | ✓ |
| Difficulty with mealtime participation across all social contexts | ✓ | ✓ |
| Behaviours of distress at mealtimes, need for distraction or rewards. | ✓ | ✓ |

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**Key Principles for Good Practice:**

- ✅ Think *"Why is this child struggling to eat?"* – rule out food insecurity > medical drivers >skill-based deficit > psychological drivers.
- ✅ Intervene early – delays lead to entrenched behaviours.
- ✅ Support families – guilt, confusion, and stress are common.
- ✅ Work collaboratively – single-discipline input is rarely sufficient.
- ✅ Use your local networks:

Speech & Language Therapy (SLT), Occupational Therapy (OT), Nutrition & Dietetics, Paediatrics & Gastroenterology, Child & Adolescent Mental Health (CAMHS), Eating Disorder (ED) services, local charities, school nurses, health visitors and family support workers.

**1. Recognise Feeding Difficulties Early**

**PFD (**Paediatric Feeding Disorder**)** = Include medical / nutritional / feeding skill / psychosocial factors. Medical and skills-based factors play a significant role.
**ARFID (**Avoidant Restrictive Food Intake Disorder**)** = Nutritional and psychosocial factors play a significant role.

**2. Initial Clinical Assessment (Primary Care Level) - RED FLAGS – Urgent referral needed:**

- ✅ Dysphagia, choking, coughing on fluids, aspiration or recurrent chest infections
- ✅ Severe food refusal / dehydration / feeding aversion
- ✅ Growth faltering or faltering weight trajectory, nutrient deficiencies or anaemia, missing whole food groups

**3. Early Actions for ALL Professionals - Initial checks:**

- ✅ **Growth chart review** (weight, height, BMI centiles) and dietary history (variety, quantity, feeding environment)
- ✅ **Feeding development history** (textures, milestones, skills) and screen for oral-motor and self-feeding issues - refer to SLT/OT if needed
- ✅ **Provide foundational feeding advice to families:** Mealtime routines, build trust, modelling and food exposure, pressure free approach
- ✅ **Stabilise nutrition:** Refer to community dietitian for assessment & supplementation

**4. MDT Referral & Management Pathways - Escalate if no improvement after 6-8 weeks** or complexity is identified:

- ✅ **SLT** – Oral-motor dysfunction, dysphagia and mealtime communication
- ✅ **Dietitian** – Growth/nutritional concerns and mealtime routines
- ✅ **OT** – postural management, self-feeding, sensory responses and mealtime participation (regulation)
- ✅ **Paediatrics / Gastroenterology** – Medical issues (e.g. reflux, allergies, constipation)
- ✅ **CAMHS / ED Services**– ARFID features, anxiety, family stress, eating-related trauma
- ✅ **Clinical Psychology / Psychiatry** – For comorbid mental health issues

**5. ARFID Pathway – When and Where to Refer:** If restrictive eating is severe, persistent, and NOT due to medical/skill-based issues → suspect ARFID.

- ✅ **Refer to local CAMHS or ARFID pathway** if:

Marked food avoidance due to anticipatory fear / persistent low intake despite parental efforts / significant distress around mealtimes

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**References:**


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This guidance was co-produced by people with lived experience of feeding & eating difficulties, and a panel of experts representing medical, nutritional, skill based and psychosocial domains, following a nine-month consensus process (PFD Community of Participation CoP 2025).

It should be used alongside the CoP 2025 Position Paper:
Bridging Diagnostic Grey Areas in Early Childhood Feeding Difficulties: Towards Needs-Led, Developmentally Informed Care