QuEDS, Metro North Mental Health Service

QuEDS Guide for Community Mental Health Clinicians

Developed by Queensland Eating Disorder Service (QuEDS).

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For more information, contact:

QuEDS, Metro North Hospital and Health Service, 2 Finney Road, Indooroopilly, Qld, 4068,

Email: QuEDS@health.qld.gov.au

Phone 3100 7500 for general enquiries, or 3114 0809 for QuEDS Intake Line

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Treatment at a Glance

1. **Engage**
    a. Align with “healthy part” of consumer against the eating disorder
    b. Include families, carers and other clinicians
    c. Provide education re: effects of “starvation” on the brain/cognition and body
    d. Use motivational interviewing techniques
    e. Utilise Mental Health Act if indicated
2. **Establish medical safety**
    a. Establish shared care with GP
    b. Provide GP with ‘*QuEDS Indicators for Admission to Adult Inpatient Beds (>18yrs)’*– Appendix III
    c. Co-ordinate communication within the community treating team/consumer/ carers and supports.
3. **Ensure adequate nutrition**
    a. Enquire about specifics of recent oral intake – meals/snacks/supplements (e.g. entire consumption over past 24hr)
    b. Provide or arrange support during mealtimes
    c. Consider increasing nutrition intake with liquid high calorie supplements e.g. Ensure, Sustagen, flavoured milk/soymilk drinks (e.g. Breaka, Up & Go etc)
    d. Consider arranging Dietetic input to increase the nutritional adequacy of the meal plan
4. **Enlist in evidence-based treatment**
    a. Psychotherapy: Cognitive Behaviour Therapy (CBTe), Specialist Supportive Clinical Management (SSCM), Maudsley Model of Treatment for Adults with Anorexia Nervosa (MANTRA), Family Based Therapy (FBT <18yrs)
    b. Pharmacotherapy: High-dose Fluoxetine for Bulimia Nervosa, Lis-dexamphetamine for BED
5. **Consider referral to specialist eating disorder service for:**
    a. Assessment and treatment recommendations,
    b. Consultation to the community team, and
    c. For evidence-based therapy

    Public options include: QuEDS and Specialist Eating Disorder Services based at SCHHS, GCHHS, CHHHS.

    Private options**:** contact Butterfly Foundation for ED professionals and services
6. **Encourage contact with community-based support services**
    a. Eating Disorders Queensland (EDQ) – provide individual counselling, support groups, education, Supportive Meal Therapy etc
    b. Butterfly Foundation – provide online services

Background

Eating disorders (ED) are associated with significant psychiatric and medical morbidity. Common eating disorder diagnoses include: Anorexia Nervosa (AN), Avoidant Restrictive Feeding Intake Disorder (ARFID), Bulimia Nervosa (BN), Binge Eating Disorder (BED), Other Specified feeding and Eating Disorder (OSFED), Unspecified Feeding or Eating Disorder (UFED) and other atypical eating disorders. For further information see *DSM-5 Diagnostic criteria for Eating Disorders* (Fact Sheet available on Inside Out website - see link in Useful Resources).

Effective ED management requires close collaboration between clinicians working in psychiatric, medical and community settings. The overarching principle that guides the management of patients with eating disorders within Queensland Health (QH) is that patients have access to the level of health service as determined by their medical and mental health needs. Individuals have the right to access medical and mental health services across the continuum of care including community, inpatient and specialist services (National Eating Disorders Collaboration; NEDC, National Practice Standards, 2012).

Individuals with eating disorders have the highest mortality rate of any mental illness, however, only 25% of Australians with an eating disorder access health services (Butterfly Foundation, 2017). Warning signs of the onset, or relapse, of an eating disorder include disturbances to menstrual cycle, fainting, dizziness, lethargy, swelling of cheeks, hypothermia, rapid weight loss, large weight fluctuations and preoccupation with eating, food and body shape (NEDC). Medical complications may include electrolyte disturbance, hypoglycaemia, neutropenia, and cardiovascular instability including fatal cardiac arrhythmias.

Almost 1 million people in Australia are estimated to have an eating disorder with the economic cost in Australia conservatively estimated at $69.7 billion per year*)* (Butterfly Foundation, 2012)*.* Eating disorders affect 9% of the Australian population, and 15% of females, at some time in their life. Rates of suicide are 32 times higher in people with anorexia nervosa than in the general population. Although mortality rates for bulimia nervosa and other eating disorder are not as clearly documented, it is likely they are similarly elevated (3).

Eating disorders occur in all genders, all ages, and at any weight. Individuals may be at high medical risk, as indicated by medical parameters (see appendix III), even if they are at normal weight or overweight.

People with eating disorders and their families often report significant difficulties accessing treatment. One reason for this is the stigma associated with eating disorders, even amongst health care professionals (4,5).

Engagement

Engagement with consumer

Individuals with eating disorders are often ambivalent about change, and denial is a prominent feature of the illness. The ego-syntonic aspects of an eating disorder may contribute to treatment avoidance.

The initial mental health clinician appointment can help the consumer gain a comprehensive understanding of their illness. Psychoeducation, motivational interviewing, and externalising conversation can be used to reveal the cost of the eating disordered behaviours and motivate the individual to engage in treatment.

Initial phase of engagement:

- create rapport and establish a therapeutic alliance;
- provide psychoeducation;
- establish common goals;
- develop safety and recovery plans with the consumer;
- align with the 'healthy part' of the person rather than battling with the eating disorder.

A consumer diagnosed with an eating disorder is likely to require long-term support. The average length of time to full recovery is seven years.

It is normal for motivation to fluctuate over the course of the illness.

If the consumer is admitted to hospital, it is important to maintain the therapeutic alliance by

- visiting the consumer in hospital,
- attending multi-disciplinary team reviews/communicating with the treating team,
- being involved in discharge planning, and
- advocating for the consumer's/carers' involvement in discharge planning.

Engagement with family, carers and supports

Family, carers and supports should be recognised as integral members of the treatment and support team. As valued team members they deserve support, skills and strategies, education and information to enable them to support the person with an eating disorder and to maintain personal good health (National Standards Schema, NEDC, 2012).

See Shared Care page 12

Externalisation

Separating the illness from the 'healthy part' of the person, that desires recovery, can be a powerful tool in establishing rapport.

Examples of externalising questions/phrases:

- How much of your day is controlled by the eating disorder?
- It seems like the eating disorder has been giving you a really hard time this week and it's impacting on your work.
- Do you feel like you or the eating disorder is in control at the moment?
- What does the eating disorder tell you about yourself?
- It sounds like you're in two minds at the moment, with the healthy part of you wanting one thing and the eating disorder wanting something else. Is that how it feels?

Motivational interviewing (MI)

A motivational interviewing style can be useful to assist the individual to explore and resolve ambivalence and elicit behaviour change.

MI strategies include:

- Anticipate ambivalence
- Express empathy
- Roll with resistance
- Support self-efficacy
- Conduct a decision analysis: what are the positives and the negatives of giving in to the eating disorder versus engaging in treatment and recovery?

The role of non-negotiables in motivational interviewing

Non-negotiables

- Must be agreed upon by the team (and consequences for non-adherence), documented and communicated to consumer, carers etc.
- Enhance safety i.e. ensure the consumer does NOT die from a capacity-impairing life-threatening illness,
- Increase the therapeutic alliance between the clinician and the individual,
- Must NOT be punitive, judgemental or shaming,
- Decrease risk of team splitting,
- Provide a safety net within which the consumer can move towards recovery with the support of the clinician – i.e. the consumer can decide which additional treatment/support they would like assistance with e.g. support with nutrition, evidence-based psychological treatment such as CBT-e.

It is essential to clarify at the beginning of community treatment/engagement:

- What is NOT negotiable e.g. engaging in regular medical monitoring and hospital admission if criteria for this are met,
- Consequences if non-negotiables are NOT adhered to e.g. arranging admission under Mental Health Act if capacity is impaired and consumer deemed to be at risk,
- Reasons for non-negotiables i.e. to ensure the consumer doesn't die from a capacity-impairing life-threatening illness.

Psychoeducation

Psychoeducation is an important adjunct to therapy and can assist the consumer to learn more about eating disorders, the short and long-term effects of starvation and compensatory behaviours, and treatment options. There are excellent resources on these topics and more on the Centre for Clinical Interventions website. See link in *useful resources* – page 19.

It is helpful to educate the consumer, their supports, and other clinicians about are the reversible effects of starvation on the brain.

Starvation Syndrome refers to the physiological and cognitive effects of starvation, whether due to reduced intake or compensatory behaviours (purging, over-exercise) that reduce the availability of energy/nutrients to the body. Starvation affects many systems in the body however, most are reversible when weight is regained and or compensatory behaviours are ceased.

Much of our knowledge about sequelae of starvation comes from the Ancel Keys/Minnesota study, see links in *useful resources* on page 19 for more information.

Medical effects of starvation:

- Even if blood tests appear normal, the person with prolonged starvation/malnutrition will have reduced intracellular stores of essential electrolytes, vitamins and glucose which are all required for normal cardiac functioning. This can result in *refeeding syndrome* if food is reintroduced too quickly. Refeeding syndrome is a potentially life-threatening and should be treated in hospital, due to the risk of heart failure, coma & seizures. Cardiovascular changes due to inadequate nutrition include bradycardia (low heart rate), tachycardia (high heart rate), postural drop in blood pressure, postural increase in heart rate, and ECG changes such as prolonged QT interval. The more pronounced these changes, the higher the risk of a fatal cardiac arrhythmia and/or cardiac arrest. Fainting is a symptom of cardiovascular insufficiency.
- Oedema (swelling in ankles) may occur due to low serum levels of protein, albumin or globulin
- Neutropenia and anaemia may occur secondary to inadequate energy/nutrients to the bone marrow
- Osteoporosis, amenorrhoea (loss of periods) and possible infertility occur due to hormonal changes
- Constipation and gastrointestinal symptoms are common and exacerbated by inadequate gut stimulation, muscle wasting, and electrolyte deficits
- Compensatory behaviours can cause other specific medical complications:
    - Vomiting - low serum levels of potassium/chloride and high bicarbonate levels
    - Laxatives - low potassium levels and low bicarbonate.

Effects of starvation on the brain and food/eating behaviours:

Many of the symptoms of an eating disorder are caused and perpetuated by starvation. Including:

- Obsessive preoccupation and ritualised behaviours around food, calories, weight, and numbers.
    - Food specific behaviours may include – increased interest in food (e.g. looking up recipes or taking photos of food), hoarding of food, playing with food, eating very quickly/slowly, increased hunger, binge eating, increased use of condiments.
- Emotional changes such as increased apathy, depression, irritability, anxiety, depression, and difficulty regulating emotions.
- Changes in thinking such as impaired concentration, judgement and decision-making, and increased rigidity and obsessional thinking.
- Social changes such as withdrawal and isolation, loss of humour, feeling socially inadequate, neglect of personal hygiene and strained relationships.

Establishing a Safety Plan

A safety plan is especially important if the consumer suffers from impaired decision-making, reduced insight or motivational difficulties. A safety plan should include non-negotiable arrangements for medical monitoring, and a clear description of actions to be taken by the Community Mental Health Clinician/treating team if medical monitoring does NOT occur or medical/psychological condition deteriorates. A safety plan may also include a Community Treatment Authority to ensure life-preserving medical monitoring occurs.

Mental Health Act

A consumer may be required to be placed under the Mental Health Act *2016* (MHA) to access and receive life-saving monitoring and treatment if their capacity is impaired. The community Mental Health Clinician, as part of the treating team, is required to have a thorough understanding of the (MHA) as they may be required to;

1. Attend the Mental Health Review Tribunal (MHRT) or explain the processes surrounding this to the patient and or their support persons
2. Provide access to, and information on, Nominated Support Persons and Independent Patient's Rights Advisors
3. Support the GP, family members and other support persons in accessing information on the MHA as required
4. If an Authorised Mental Health Practitioner, they may be required to complete a Recommendation for Assessment (RA). An RA may be enacted if within 7 days of completing an assessment the treatment criteria may apply and there is no least restrictive alternative for treatment and care.

The RA allows for the person be detained at an AMHS or public sector health service facility for up to 24 hours from when the assessment period starts.

A Treatment Authority (TA) can be initiated by an Authorised Doctor following assessment, if the treatment criteria apply and there is no less restrictive way for the person to receive treatment and care for their mental illness. The TA must be either confirmed or revoked by an Authorised Psychiatrist within 72 hours.

When considering the necessity for enacting the MHA, it is important to consider the following:

- anorexia nervosa has the highest mortality rate of any mental illness
- the symptoms of an eating disorder and the cognitive effects of starvation can have a profound effect on a person's decision-making capacity while their IQ remains unaffected.
- adequate nutrition to the brain over an extended period can reverse these cognitive effects and restore capacity.

A Treatment Authority - community category, should be considered in circumstances where a person's eating disorder impairs their ability to consider risk, to attend medical monitoring, or to safely nourish themselves. Many recovered consumers have reported that a TA, community category, at the point of discharge from hospital, was very helpful in supporting them to continue engaging in treatment after leaving hospital. Some consumers reported that ceasing the TA at discharge gave their eating disorder 'permission' to relapse.

Establishing Medical Safety

Medical Monitoring

Monitoring should be performed at regular intervals guided by the level of clinical concern - this may range from twice weekly to no less than once a month. It is recommended that physical and psychiatric parameters are assessed against the *QuEDS Indicators for Admission to Adult Inpatient Beds (>18yrs)* which outlines thresholds for both psychiatric and medical admission (see appendix III). The community clinician should ensure the GP is aware of these criteria.

It is essential the consumer with an eating disorder has a GP willing to undertake monitoring and maintain communication with the mental health team on a regular basis. This allows the community mental health clinician and/or therapist to focus on therapeutic alliance, rapport building, and psychological interventions. When there is some variation to this (for example, if a psychologist is providing in-session weight monitoring as a part of therapy), good communication between team members is required to ensure regular monitoring occurs and is documented.

For those individuals who are difficult to engage, or who do not attend GP appointments regularly, it may be appropriate for the mental health medical and/or nursing clinicians to undertake the medical monitoring, whilst continuing to encourage and assisting the individual to engage with a GP.

Medical monitoring is essential and includes:

- Asking about fainting, dizziness, chest pain, palpitations, and other physical symptoms
- Asking about food intake, vomiting, exercise and laxatives
- Measuring postural heart rate (lying and standing measured two minutes apart). Medical practitioners do not routinely perform this simple examination, and it can be helpful to explain to them that this is an indicator of cardiac risk in a malnourished person whose resting blood pressure and blood tests are normal
- Measuring postural blood pressure (lying and standing measured two minutes apart), temperature, weight, and ECG (as clinically indicated) and weight monitoring
- Arranging regular blood tests including electrolytes (sodium, potassium, magnesium, phosphate), kidney and liver function tests, serum glucose, and full blood count
- Arranging for an initial and then annual bone mineral density scan to detect osteopenia or osteoporosis in the case of malnutrition and if a person's menstrual periods have stopped for longer than six months.

Criteria for admission and readmission

It is important that all members of a treating team, including the individual and their family/supports are aware of the admission and/or readmission plan, the plan is adhered to and decision making is transparent. Specific components of the plan may be individualised and clearly documented including 'after hours' and 'emergency' processes. Where possible, involve the individual and their support network when formulating the plan.

It is recommended that the plan includes readmission criteria which align with the *QuEDS Indicators for Admission to Adult Inpatient Beds (>18yrs)* - Appendix III. Admission should also be considered if family members believe this is necessary or the consumer is NOT engaging/progressing.

For those consumers with a co-morbid personality disorder, substance use disorder, or frequent presentations to emergency services, an *Acute Management Plan* (AMP) may also be appropriate. It is recommended that baseline mental state, risks and alerts, signs of deterioration, and suggested management for all comorbidities including medical complications are outlined individually in an Acute Management Plan (AMP).

Shared Care

The Benefits of Shared Care

Expert consensus and cohort studies recommend a multidisciplinary approach, as no single clinician and professional discipline alone can provide the necessary treatment for a person to recover from an eating disorder (NICE, 2017). Shared care improves collaboration and communication within the treating team, improves risk management and unites the treating team in a common goal. Improved coordination of care may prevent medical deterioration, excessive admissions and lead to better recovery outcomes. The community mental health clinician has an important role in facilitating the multidisciplinary team to communicate and work together. This approach can prevent 'splitting' in the treatment team.

Where an individual does NOT have a current General Practitioner (GP), assistance can be sought from the Primary Care Liaison Officer, QuEDS, or the Butterfly Foundation to locate a GP with eating disorder competency. Once a GP has been identified, liaise with them to discuss the consumer's needs and requirements for shared care including the roles/responsibilities of each person involved. If the consumer's GP is not adequately supportive or informed re: treatment of people with eating disorders, then it is appropriate to seek a replacement GP. All clinicians involved need to be willing to provide shared care. It is helpful for the mental health clinician to accompany the consumer to their first GP appointment and provide the GP with the *QuEDS Guide to Admission and Inpatient Treatment for Adults with Eating Disorders* and other resources for medical monitoring (see appendices I - III).

Shared Care: Roles and Responsibilities

Community Mental Health Clinician (QH)

- Coordinate the community treatment plan
- Establish shared care with the nominated GP:
    - Communicate the consumer's needs with GP via fax/email (see appendix I and II)
    - Communicate with the GP, in a timely manner, any changes in treatment/monitoring requirements
    - Forward to the GP, every 91 days, a copy of *care review summary, risk assessment*, and *care plan*, and documents that outline the *readmission criteria* for the individual (including a readmission weight, where possible developed in collaboration with family and community supports)
    - Maintain accurate GP and other service provider details in CIMHA
    - Ensure GP is aware their responsibilities should the individual fail to attend for medical reviews (e.g. recalling the patient, contacting community mental health clinician).
- Provide psychoeducation
- Undertake your responsibilities under the Mental Health Act 2016, where relevant
- Be a resource for family members
- Facilitate medical monitoring:
    - Upload medical monitoring information from GP to CIMHA as an attachment under *physical examinations and investigations* clinical note type
- Ensure attendance at appointments with GP, therapist, dietitian, and other professionals involved in the person's care
- Facilitate communication within the team and with other agencies involved in the individual's care
- Update alerts on CIMHA if an AMP is in place
- Collaborate with Child Youth Mental Health Services (CYMHS) for young people transitioning from child and youth services to adult mental health services in line with the *Queensland Health Guideline "Transition of care for young people receiving child and youth mental health services" (QH-GDL-365-5:2015).*

In your individual sessions it is recommended that you ask the consumer about:

- Medical symptoms such as fainting, chest pain, palpitations, fatigue, and loss of menstrual period
- Daily nutrition including, specifically, what and how much the person is consuming each day for breakfast, morning tea, lunch, afternoon tea, dinner, and supper
- Compensatory behaviours including vomiting, over-exercise, and laxatives
- 'Eating disorder cognitions': obsessive concerns about weight, shape, calorie intake, body checking etc

As motivation improves encourage the consumer to:

- Consider evidence-based treatments such as Specialist Supportive Clinical Management (SSCM), Cognitive Behaviour Therapy-enhanced (CBTe), or Maudsley Anorexia Nervosa Treatment for Adults (MANTRA), Day Programmes or Residential care.
- Engage with non-government support services including:
    - Eating Disorder Qld (EDQ) who provide peer mentors, individual counselling, recovery groups, Supportive Meal Therapy etc
    - Butterfly Foundation – online support, endED Butterfly House – residential care
    - Other regional organisations e.g. End-ED (Sunshine Coast based)

General Practitioner (GP)

- Provide medical monitoring on weekly basis, or more, or less frequently as clinically indicated. Monitoring should include temperature, lying and standing heart rate and blood pressure (with 2min gap), E/LFTs, Mg, FBC, ECG (as clinically indicated), and weight and BMI monitoring
- Review medical monitoring parameters against the *QuEDS Indicators for Admission* (Appendix III)
- If the consumer's physical parameters fall within the indicators for medical admission, then:
    - liaise with the treating team immediately.

  If outside of business hours,
    - contact the local acute care team to discuss a treatment plan or,
    - send the consumer directly to the local emergency department with the *QuEDS Guide to Admission and Inpatient Treatment* and admission letter
- Complete and forward the fax form for physical monitoring to the treating team following each medical review (See Appendix II).
- Advise treating team if consumer does NOT attend s

Consumer

- Contact the GP and pre-schedule appointments at the recommended frequency determined by the treating team
- Attend appointments with the community mental health treating team
- Attend appointments with other community specialists as required for treatment (e.g. dietitian)
- If unable to attend appointments for any reason contact the relevant team member and reschedule
- Utilise the provided meal plans, resources and supports provided as able with support from the community team.

Family, carers and supports

Family, carers and supports should be recognized as integral members of the treatment and support team. They should receive support, skills and strategies, education and information to enable them to support the person with an eating disorder and to maintain personal good health (National Standards Schema, NEDC, 2012).

Encourage family/carers to engage with a non-government support service such as Eating Disorders Queensland (EDQ) and to access resources via the following websites: National Eating Disorders Collaboration, The Butterfly Foundation, and the Centre for Clinical Interventions.

Private Mental Health Practitioner

- Provision of evidence-based psychological therapy for eating disorder or co-morbid diagnoses
- Provision of supportive psychological therapy
- Communication/liaison with the community team re: management plan.

Recovery Plan

Develop a recovery plan in conjunction with the consumer and their supports, considering the consumer's goals and how they would like to progress. A recovery plan should always ensure the consumer can access an evidence-based treatment such as CBT-e if they are at a stage of their recovery where they are motivated to participate in such treatment. (see Evidence-based interventions page 15)

Nutrition

Ideally, a thorough nutrition assessment and meal plan/progression should be undertaken by an Accredited Practising Dietitian. The Community Mental Health Clinician should also ask, at every appointment, about the individual's nutritional intake. This will allow you to assess their risk currently and into the future and assist with treatment planning. Ask the individual what they have eaten for breakfast, morning tea, lunch, afternoon tea, dinner and supper (and quantities). Support and encourage the individual to develop a regular eating pattern including three meals and three snacks per day. Once you have assessed their intake it may be appropriate to suggest some changes (usually an increase) in their nutrition. Assist the individual to make one small modification to their diet at each session and review their attempts at the next appointment.

For example:

- *"I see that you are eating three meals per day, but for you to stay safe/avoid admission/ reverse the effects of starvation/achieve your recovery goals you will need to increase your intake. What change do you think you could try this week?"*
- *"Last week you spoke about trying to add a small pot of yoghurt to your breakfast each day. How did you go with that? What was difficult about it? How did you overcome that challenge?"*

Supportive Meal Therapy

Supportive meal therapy is the provision of practical and emotional support during mealtimes, focused specifically on helping the patient to consume the food on their meal plan and redirecting behaviours that sabotage eating and recovery.

The routine mental health service clinician appointment is a perfect opportunity for the consumer to practice eating with your support. Model a positive relationship with food and appropriate eating behaviours by eating a balanced meal with them. Although the consumer may be aware of the need to eat to maintain medically stability, they may also be fearful of food. Be prepared, consistent, calm, assertive and kind. Talk about the proposed task and enquire what the individual finds helpful and supportive. Coach the individual to eat, break the task into small steps, and provide distraction during the meal or snack with light conversation. Avoid discussing food/diets during the activity and avoid eating "diet" foods. Shared meals are an opportunity to get to know the consumer, their interests, hobbies, and aspirations for the future. Demonstrate compassion, reflect that it is hard, acknowledge their feelings and the challenges of the task. Remind the individual of the bigger picture, that nutrition is needed to stay alive/medically stable, out of hospital and achieve their life goals. Refer to the *QuEDS Supportive Meal Therapy* fact sheet Appendix IV.

Visit the Eating Disorders Queensland (EDQ) website for

- *The Shared Table* online learning for clinicians and family/community supporters
- opportunities to join EDQ group based *supportive meal therapy sessions*.

Nutritional supplements

The inclusion of high-energy, liquid nutritional supplements in the meal plan (e.g. Ensure, Sustagen, Resource, Fortisip, or flavoured milk/soymilk) can be very helpful for persons who are daunted by the volume of food required for their nutritional rehabilitation. An underweight/malnourished patient will not recover (physically or cognitively) on a 'normal' diet; they may need to eat up to 150% of a 'normal' diet to restore weight and health. Supplementing with nourishing drinks can also be useful for people who experience bloating/gastric discomfort or poor appetite. Ideally, such supplements should be introduced with input and advice from an Accredited Practising Dietitian.

Interpreting weight changes

It is important not to *over-interpret* small changes in weight. Daily fluctuations in weight of up to 1-2 kg are normal and don't necessarily reflect real changes in nutritional status; they may reflect fluid changes, bowel movements, changes in weighing techniques, and other variables. Changes of at least 3kg (i.e. one whole BMI band) in either direction or ongoing trends in weight change are more likely to be significant. Interpret weight changes in the context of known oral intake (collateral corroboration can be useful here) and medical indicators of nutrition (temperature, postural HR and BP, neutrophils, LFTS, glucose, phosphate, magnesium, menstruation). Focussing too much on weight (and even telling the person their weight) can exacerbate eating disorder thoughts and behaviours. Weight is best interpreted in context of longer-term nutritional status, medical monitoring and progress.

Evidence-based interventions

Psychotherapy

The evidence-based psychological treatments for eating disorders include:

- For Anorexia Nervosa in adults:
    - Cognitive Behaviour Therapy-enhanced (CBT-e)
    - Specialist Supportive Clinical Management (SSCM)
    - Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA)
- For Anorexia Nervosa in people under 18 years living with their families:
    - Family-Based Treatment (FBT), also known as Maudsley Family Therapy
- For Bulimia Nervosa and Binge Eating Disorder:
    - Cognitive behaviour therapy – enhanced (CBT-e)
    - Interpersonal Therapy (IPT)
    - Guided Self-Help (GSH)

Pharmacotherapy

Evidence for pharmacological treatments for eating disorders are as follows:

- Anorexia Nervosa - there is no strong evidence for medication
- Bulimia Nervosa – fluoxetine 60-80mg (start at 20 mg and titrate up slowly by 20mg every 2 weeks)
- Binge Eating Disorder – lisdexamfetamine 50-70mg (approved by the Therapeutic Goods Administration in 2018)

Specialist Eating Disorder Services

Provide evidence-based and supportive psychological therapies to complement care provided by public community mental health.

Queensland Health Eating Disorder Services/Private Eating Disorder Services

Services may include:

- Assessment and treatment recommendations
- Individual evidence-based therapy
- Group programmes
- Day programmes
- Specialist eating disorder beds or facilitation of inpatient admission
- Provision of consultation to community teams

Qld Health Specialist Eating Disorder Services include (contact details page 17):

- QuEDS – for services outside Gold Coast, Sunshine Coast, North Queensland
- SC-EDS (Sunshine Coast Eating Disorder Service)
- GCHHS-AEDP (Gold Coast HHS Adult Eating Disorder Programme)
- N-QuEDS (North Qld Eating Disorder Service – based in Cairns and Hinterland HHS)

Private Eating Disorder Services

- Contact Butterfly Foundation for listing of private specialist eating disorder clinicians/services

Non-government organisations

Eating Disorders Queensland (EDQ) and Butterfly Foundation are NGOs that provide a range of the following services.

Services may include:

- Individual counselling in evidence-based therapies and supportive counselling
- Online support
- Group programmes
- Supportive meal therapy
- Residential programmes – e.g. Butterfly Foundation, EndED Butterfly House.

EDQ provides services for carers, including:

- Individualised coaching
- Family coaching
- Carer Peer Mentor Program
- Carer Connect Support Group
- Fostering Recovery workshops.

Other Management Considerations

Comorbid diagnosis/complex cases

Individuals with eating disorders present with high levels of psychological distress and can have a wide range of medical and psychiatric comorbidities. Common psychiatric comorbidities include major depressive disorder, obsessive-compulsive disorder, post-traumatic stress disorder (PTSD), anxiety disorders, substance use disorder, and borderline personality disorder.

Complex case reviews conducted by the treating team with a specialist eating disorder service in attendance may assist formulation and implementation of optimal care plans for people with eating disorders and other co-morbidities.

Supervision and Consultation

Working with individuals with an eating disorder can be rewarding, but also very challenging at times. Challenges include high medical risks, high levels of stress/anxiety experienced by the person and their family and/or support network, and the person's ambivalence and fears around engagement and treatment. It is not uncommon for clinicians to feel anxious and to experience intense countertransference reactions. For these reasons, regular supervision and consultation is recommended for clinicians and teams working with people with eating disorders. Further education and training, as well as peer support, will help clinicians to manage the challenges which frequently arise.

Qld Health Specialist Eating Disorder Services are available to advise on management of eating disorders cases, and provide education, resources and other supports for clinicians.

Queensland Health Eating Disorder Services

Queensland Eating Disorder Service (QuEDS)

(For health services outside Gold Coast, Sunshine Coast and North Queensland)

Services provided: Phone Intake and Advice, Specialist Consultation (Assessment) Clinic (based at RBWH), Consultation, Training and Treatment (CBT-e, SSCM, Day Program)

Access to RBWH specialist beds if inpatient treatment goals aren't met with QuEDS Consultation Service input.

Contact: 07 3114 0809 or email: QuEDS@health.qld.gov.au

Gold Coast Adult Eating Disorder Program (GCHHS-AEDP)

Services provided: Assessment, Consultation, Training and Evidence-based Outpatient Treatment

Contact: 07 5635 6200

Referrals 1300 MHCALL

Sunshine Coast Eating Disorder Program (EDS-SC)

Services provided: Assessment, Consultation, Training and Evidence-Based Outpatient Treatment

Referrals and contact: 07 5202 9500 or email: SC-MHAS-EDS@health.qld.gov.au

North Queensland Eating Disorder Service (N-QuEDS)

Services Provided: Assessment, Consultation, Training and Evidence-based Outpatient Treatment

Contact: TBA when service opens in Cairns late 2020.

Useful Resources

- QuEDS website (includes QuEDS Guide to Admission and Inpatient Treatment):
  https://metronorth.health.qld.gov.au/rbwh/healthcare-services/eating-disorder

- DSM-5 Diagnostic Criteria for Eating Disorders
  https://insideoutinstitute.org.au/assets/dsm-5%20criteria.pdf

- Queensland Health Guideline – Transition of care for young people receiving child and youth mental health services.
  https://www.health.qld.gov.au/__data/assets/pdf_file/0020/151085/qh-gdl-365-5.pdf

- Child Health Qld (CHQ) statewide guideline (QH-GDL-961:2020) "Assessment and Treatment of Children and Adolescents with Eating Disorders in Queensland" for hospital treatment protocols (Medical and Mental Health) - available on QH intranet at:
  https://www.health.qld.gov.au/__data/assets/pdf_file/0040/956569/qh-gdl-961.pdf

- Eating Disorders Queensland. NGO supporting consumers, carers and community:
  https://eatingdisordersqueensland.org.au/

- Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders 2014.
  https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/eating-disorders-cpg.aspx

- National Eating Disorder Collaboration's (GP Information Kit and other resources, eLearning e.g. medical management):
  http://www.nedc.com.au/health-professionals

- Inside Out Institute for Eating Disorders (e-learning – e.g. Community treatment)
  https://insideoutinstitute.org.au

- Centre for Clinical Interventions' fact sheets for consumers:
  https://www.cci.health.wa.gov.au/Resources/For-Clinicians/Eating-Disorders

- Butterfly Foundation national helpline and other resources
  https://butterfly.org.au/
  Phone: 1800 334 673

- Starvation Syndrome Information:
  - https://archive.wphna.org/wp-content/uploads/2016/01/2005-Mad-Science-Museum-Ancel-Keys-Starvation.pdf
  - https://insideoutinstitute.org.au/resource-library/the-effects-of-starvation

- Video of Associate Professor Warren Ward, Director of QuEDS, presenting on "Identification, Assessment and Treatment of People with Eating Disorders"
  https://player.vimeo.com/video/280804574

- Contact QuEDSEducation@health.qld.gov.au to express your interest in attending QuEDS facilitated educational events including:
    - ✓ Inpatient Management full day seminar
    - ✓ Community Management half-day seminar
    - ✓ EDN/MHPN breakfast meetings
    - ✓ Annual QuEDS Dietitians Masterclass
    - ✓ CBTe 2-day training
    - ✓ QuEDS annual full day forum
    - ✓ QuEDS also offers tailored training sessions on request

Recommended clinician treatment manuals

- Cognitive Behaviour Therapy and Eating Disorders by Christopher Fairburn, 2008 Guilford Publications
- Cognitive Behaviour Therapy for Eating Disorders; A Comprehensive Treatment Guide by Glenn Waller et al, 2007 Cambridge University Press

Recommended guided self-help manuals

- Overcoming Bulimia Nervosa and Binge Eating: A self-help guide using Cognitive Behavioural Techniques, 3rd Edition 2012, Little Brown Book Group by Peter Cooper
- Overcoming Binge Eating, Second Edition, 2013 Guilford Publications by Dr Christopher Fairburn
- Beating Your Eating Disorder; A Cognitive-Behavioural Self-Help Guide for Adult Sufferers and Their Carers, 2010, Cambridge University Press by Glen Waller at el
- 8 Keys to Recovery from an Eating Disorder Workbook by Carolyn Costin, WW Norton & Co,2017

Recommended apps

- Recovery Record: a patient and clinician food and feeling log app based on CBT
- Rise up and recover: Recovery Warriors log and emotions tracker

APPENDICES

Appendix I – Shared Care Fax Template

Metro North Hospital and Health Service

Queensland Government

FACSIMILE

TO:	**Fax:**	**FROM:**	**Fax:**
	Name:		**Phone:**
	Organisation:		**Name:**
	Date:		**Position:**

CONFIDENTIAL COMMUNICATION

SUBJECT: SHARED CARE for [NAME] [DOB)

Dear Dr

I am writing to establish SHARED CARE for [NAME] [DOB] which will include conducting regular medical
monitoring.
The consumer will require medical review [FREQUENCY], including

- Bloods (LFTs,electrolytes, FBC, magnesium, glucose) ,
- physical observations (lying and standing blood pressure and heart rate),
- weight and BMI.

The Mental Health Service will review [NAME] on a regular basis and communicate with you any changes in treatment. Every 91 days you will receive a care review summary, a risk assessment and a care plan outlining admission crietria for [NAME].

If you are agreeable to SHARED CARE for [NAME] please complete and
return the attached medical monitoring fax every [FREQUENCY] when you see [NAME]

A useful resource which can be accessed by googling 'QuEDs' is 'A guide to admission and inpatient treatment for people with eating disorders in Qld' which will assist with medical monitoring and admission criteria.

Please note medical parameters outlined on page 2 of the document. If your patient meets any admission criteria, please ask them to present to their local hospital DEM.

Appendix II – Medical Monitoring Fax Template

Metro North Hospital and Health Service

Queensland Government

FACSIMILE

TO:	**Fax:**	[Type number]	**FROM:**	**Fax:**	[Type number]
	Name:	[Type name]		**Phone:**	[Type phone]
	Organisation:	[Type organisation]		**Name:**	[Type name]
	Date:	[Type date]		**Position:**	[Type position]

CONFIDENTIAL COMMUNICATION

SUBJECT: SHARED CARE for (NAME, DOB)

Pages [No. pages] **(inclusive)**

Date:

Frequency of monitoring:

Medical Monitoring			
Height (cm)		Weight (kg)	
BMI kg/m2		Weight change	
Blood pressure	Lying	Standing	
Heart rate	Lying	Standing	
Temperature			
FBC, LFT, Mg, Electrolytes, Glucose Please note abnormalities			

Please return fax to:

Doctors Name: _____ Signature:_____

- Refer to your local emergency department if:
  - Systolic blood pressure is below 90 mmHg or a postural drop of 20mmHg
  - Heart rate below 40bpm, or above 120bpm, or postural tachycardia above 20bpm
  - Potassium, magnesium, phosphate, glucose below normal range.
  - Neutrophils below 0.7 mmol/L

Appendix III – Indicators for Admission to Adult Inpatient Beds (>18yrs)

Table 1: QuEDS Indicators for Admission to Adult Inpatient Beds (>18yrs)

If **ONE or MORE** of these parameters is met at the time of assessment, inpatient treatment is advised (2). The list in the table is not exhaustive; therefore, any other medical problems which are of concern should be discussed with the relevant medical team.

Contact QuEDS Intake for support during business hours on (07) 3114 0809.

Medical Parameters		Medical admission indicated[β]	Psychiatric admission indicated[µ]
Physical observations	Systolic blood pressure	<80mmHg	<90 mmHg
	Postural blood pressure[#]	>20mmHg drop with standing	
	Heart rate	≤40 bpm or > 120 bpm	<50 bpm
	Postural Heart rate[#]	postural tachycardia > 20bpm[^]	
	Temp	<35.5C	<36.0C
	12-lead ECG	Any arrhythmia including: QTc prolongation, or non-specific ST or T-wave changes including inversion or biphasic waves	
	Blood sugar	Below normal range (<3.0 mmol/L)	
Pathology	Sodium	<125 mmol/L	<130 mmol/L*
	Potassium	Below normal range (<3.5 mmol/L)	
	Magnesium	Below normal range (<0.7mmol/L)	
	Phosphate	Below normal range (<0.75mmol/L)	
	eGFR	<60 $^{ml/min/1.73m2}$ or rapidly dropping (25% drop within a week)	
	Albumin	<30 g/L	Below normal range (<35g/L)
	Liver enzymes	Markedly elevated (AST or ALT >500)	
	Neutrophils	<0.7 x 10^9/L	<1.0 x 10^9/L
Nutritional	Re-feeding risk	High	
	Oral intake	Grossly inadequate nutritional/fluid intake (<1000kCal/4MJ daily) Unmanageable compensatory behavior (vomiting, exercise, laxatives)	
Anthropometry	Weight loss	Rapid weight loss (i.e. 1 kg/week over several weeks)	
	Body Mass Index (BMI)[@]	BMI <12 kg/m^2	BMI 12-14 kg/m^2
Other	Community supports		Not responding to outpatient treatment
	** Please note, any biochemical/electrolyte abnormality which has not responded to adequate replacement within the first 24 hours of admission should be reviewed by a Medical Registrar urgently*		

[β] Medical admission is recommended if BMI <12 or there are significant abnormalities of physical parameters as indicated in the table above.

[µ] Psychiatric admission is indicated if BMI 12-14, or there are other abnormalities of physical parameters that are not of sufficient severity to warrant medical admission.

[#] Postural HR and BP are measured from lying to standing with a 2minute break.

[^] Postural tachycardia is only a criterion for admission if the patient has restricted oral intake or weight loss.

[@] Body Mass Index (BMI) is Weight (kg)/ Height (m2) – see QuEDS Weight Chart – Appendix VII

NB: For Adolescent admission parameters please refer to "Assessment and treatment of children and adolescents with eating disorders in Qld" see https://www.health.qld.gov.au/__data/assets/pdf_file/0040/956569/qh-gdl-961.pdf

Or 2page summary of Adolescent Admission Parameters on QuEDS internet website https://metronorth.health.qld.gov.au/rbwh/healthcare-services/eating-disorder

For support re: adolescent eating disorder treatment (business hours) contact CYMHS-EDP Intake on (07) 3397 9077.

Supportive Meal Therapy (SMT) Handout A- for the Patient/ Person

SMT is the process where a meal chaperone/staff member eats a meal or snack with you to support you in completing their prescribed nutrition (as per the meal plan). The meal chaperone models helpful eating behaviour*, whilst fostering an environment that assists with your nutritional restoration, provides consistency and aims to reduce anxiety.

Goal: To provide a safe, supportive, consistent environment, which maximises the opportunity for nutritional restoration and minimises anxiety associated with meal times.

***Helpful Eating Behaviour** is demonstrating adequate portioning, adequate food variety and pace of eating while engaging in neutral conversation during and after the meal. These eating behaviours are helpful for your nutritional restoration and assist you with challenging eating disorder cognitions and behaviours.

~Table Rules

- Try to use the bathroom prior to the meal (any trips to the bathroom during or post meal will require supervision)
- No excess condiments/serviettes/excess cutlery
- Meals will be checked by the chaperone prior starting the meal
- All food is to remain on the plate
- Unhelpful behaviours^ are to be avoided and will be addressed if needed
- Eat your food in the way it has been provided
- All food/drink items provided to you must be consumed and this will be checked by the meal chaperone
- All participants must remain at the table until SMT time has finished and remain with the chaperone for the post meal time

^Unhelpful Behaviours can keep you stuck in the eating disorder cycle. These include: Comparing or commenting on meals, breaking or picking food into smaller pieces, pulling food apart, hoarding food, disposing of food (including intentionally crumbling, dropping or wiping content from provided meals), choosing low calorie or diet food items, eating gum, eating very slowly, chewing and spitting food or regurgitating and re-swallowing food, shaking or jiggling your body, or pacing.

PATIENT/ PERSON – RESPONSIBILITIES	
PRE-MEAL	• You will be made aware that you are on SMT, given a copy of your meal plan, and taken through the table rules~, helpful* and ^unhelpful behaviours • Discuss any queries with your meal chaperone prior to the meal • Try to attend the bathroom prior to the meal start time • Arrive at the agreed dining area at the designated meal times • Ensure long sleeves are pulled back, and clothing with excessive folds or pockets are not worn to the meal table
DURING MEAL	• Follow the table rules~ and complete the prescribed meal as per your meal plan • Try to not delay starting eating (can lead to excess stress in the last few minutes) and • Pace yourself throughout the meal, time updates will be provided to help you pace yourself over the time allowed • Focus on your own eating, behaviours and recovery goals • Try not to engage in unhelpful behaviours^ • Take guidance from the meal chaperone/staff when provided, these are made with your recovery goals in mind • Unhelpful behaviours^ will be addressed at the table in a thoughtful and concerned manner • All meals must be completed, if this does not occur, the prescribed nutrition will be delivered as per your meal plan
POST MEAL	• Remain seated and do not leave the meal chaperone/staff until the allocated time is completed (i.e. no teeth cleaning or accessing other rooms) • Try engaging in distraction activities and conversation which can help to prevent and reduce post meal distress and anxiety

Supportive Meal Therapy (SMT) Handout B- for the Meal Chaperone/ Staff ***(Meal Chaperone/ Staff also need to read SMT HANDOUT A)***

Note: *It is important that staff working with people with eating disorders receive support from senior staff members and colleagues (including for bathroom and meal breaks) and do not have an active eating disorder. Other support persons are encouraged to access services such as Eating Disorders Queensland (EDQ).*

MEAL CHAPERONE/ STAFF SHOULD DEMONSTRATE:

Role modelling: consuming an appropriate meal or snack with the person, demonstrating normal speed of food consumption and appropriate eating behaviours, providing non-meal related light conversation during meal times and assisting the person to identify inappropriate behaviours by providing gentle verbal redirection.
Consistency: Following a set program provides certainty and boundaries for the person, shows respect for your colleagues and fights against the eating disorder affecting the person.
Externalising: Using externalising language that challenges the eating disorder, not the person. i.e. "It looks like the eating disorder is making things hard for you today".
Support: Using an empathic and supportive tone. i.e. "Your body deserves the right to this nutrition". Do be cautious of sharing too much of your own personal information and/or opinions.

Remember it is not your responsibility to make the person eat. Your responsibility is to follow the SMT program so the person can consume and retain their nutrition. Refrain from taking an authoritative stance, try expressing empathy and validating the persons struggles while reminding them that their treatment is medically required. One redirection prompt at the table is enough, as the unhelpful behaviour^ is generally due to anxiety and may not be within the person's control.

	GOALS
Pre meal	• Assess person's mental and emotional state • Engage in anxiety management strategies
During meal	• Address any issues (e.g. inappropriate eating behaviours) in a non-threatening manner • Manage emotional lability • Provide a calm and pleasant environment
Post meal	• Support in addressing eating disorder cognitions/behaviours • Encourage relaxation and diversion activities

MEAL CHAPERONE/ STAFF – RESPONSIBILITIES	
PRE-MEAL	• Receive appropriate training and ongoing support in SMT provision • Remind of appropriate meal time behaviours relevant for that person including bathroom use prior to meal • Ensure that the person's meal provided matches the meal plan prescribed • Be familiar with the table rules~ and unhelpful behaviours^ **(see SMT handout A)** • Prepare drinks etc... Offer the person their preferences if in their meal plan and available i.e. flavour of juice or yoghurt. *Ensure the person has been provided with their pre SMT information (i.e. SMT Handout A) and prompt them to attend the bathroom.
DURING MEAL	• Inform person of starting time and total time allowed (i.e. "It's 12pm, we'll start now and have 20 minutes"), and provide one reminder when 5 minutes is left. • Do not engage in ANY negotiations around the prescribed meal plan, food intake or time allowances. Do not allow meal changes from the prescribed meal plan. • Follow the table rules~ • Model helpful eating behaviour* by eating a reasonable quantity meal/snack (a similar number of items to the patient is recommended, no diet foods). Moderate availability of condiments. • Encourage non-eating related conversation, redirect and/or discourage focus on weight, diet and food topics. • If struggling with unhelpful behaviours^, try one gentle reminder, avoiding direct confrontation. Be aware of any hyper-vigilance of/ distress at other patients' behaviour and seek assistance from staff if needed *In the event not all of the meal is consumed, step 2 of the meal plan is to be provided (followed by step 3 as required)
POST MEAL	• Remain with, and observe all people participating and engage them in activity/conversation. • Note the role of anxiety and its co-morbidity with eating disorders. Use distress tolerance techniques to assist with helpful ways of coping (i.e. using warm pack on the stomach for complaints of discomfort, sensory interventions or distraction with a game or activity. • Record intake in food and fluid charts • Notify the treating team if unhelpful behaviours^ occur, they will consider if treatment changes are required

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