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Eating Disorders and the Dietitian Decision-Making Tool

for adults experiencing an eating disorder

The National Eating Disorders Collaboration (NEDC)
is an initiative of the Australian Commonwealth
Government Department of Health

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About this tool

The Eating Disorders and the Dietitian Decision-Making Tool provides a step-by-step guide to support dietitians working in the community or private practice in the safe and effective identification of and response to eating disorders in adults.

Many clients who experience eating disorders may present with complications or comorbidities associated with their illness e.g. GI complaints, or may seek dietetic services for issues that may mask their illness e.g. weight loss. There is an increased mortality risk in all eating disorder presentations, and early identification and intervention are critical to setting the client on a path to the best possible recovery outcome.

The tool contains three sections:

- The first section provides a **one page overview** of the dietitian's role and recommended steps in the identification and assessment of, and response to an adult client who may be experiencing or is at risk of developing an eating disorder. It is presented as a flow chart, moving from top to bottom and uses colour coded sections. This page can be used as a stand-alone tool.
- The second section provides an **in-depth explanation** of the dietitian's role and recommended steps in the identification and assessment of, and response to an adult client who may be experiencing or is at risk of developing an eating disorder. Comprehensive detail is provided across the following five components:
 - *Know* – the behavioural, physical and psychological signs and symptoms of eating disorders; the high risk groups for eating disorders; and the protocols for supporting a person with a mental illness or a person requiring urgent medical attention.
 - *Observe* – the key warning signs and risk factors of an eating disorder.
 - *Ask* – using the Nutrition Care Process to complete a comprehensive nutrition assessment of a person with a suspected eating disorder.
 - *Listen* – to what the client and parents, carers or friends might say.
 - *Act* – following the completion of the above steps, identify and complete the necessary pathway required to support the client through prevention, illness and recovery.
 - In case of emergency
 - Immediately following emergency
 - When managing eating disorders is within your scope of practice
 - When managing eating disorders is beyond your scope of practice
 - When the client does not appear to have a current eating disorder
- The third section lists useful resources for clients, carers and clinicians; and references.

Eating Disorders and the Dietitian

Decision Making Tool

for adults experiencing an eating disorder

KNOW

Know about the behavioural, physical and psychological signs and symptoms of eating disorders.

Know the high risk groups for eating disorders (e.g. young people, people with history of food insecurity, women, athletes, people who are pursuing intentional weight loss, etc).

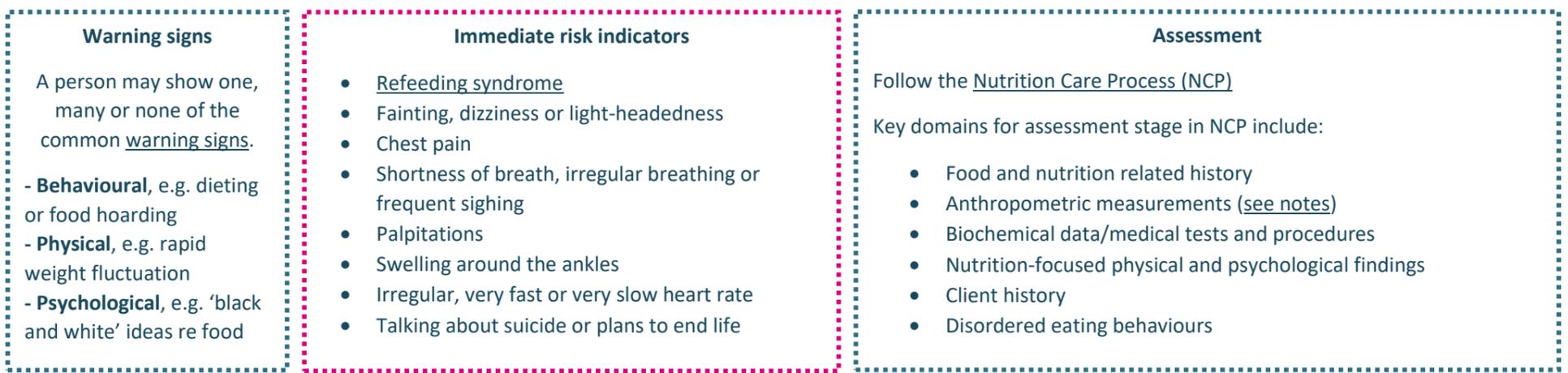
Know your organisation's protocols for supporting a person with a mental illness or a person who needs urgent intervention, including trauma informed practice and suicide risk assessment. Know local services.

OBSERVE, ASK & LISTEN

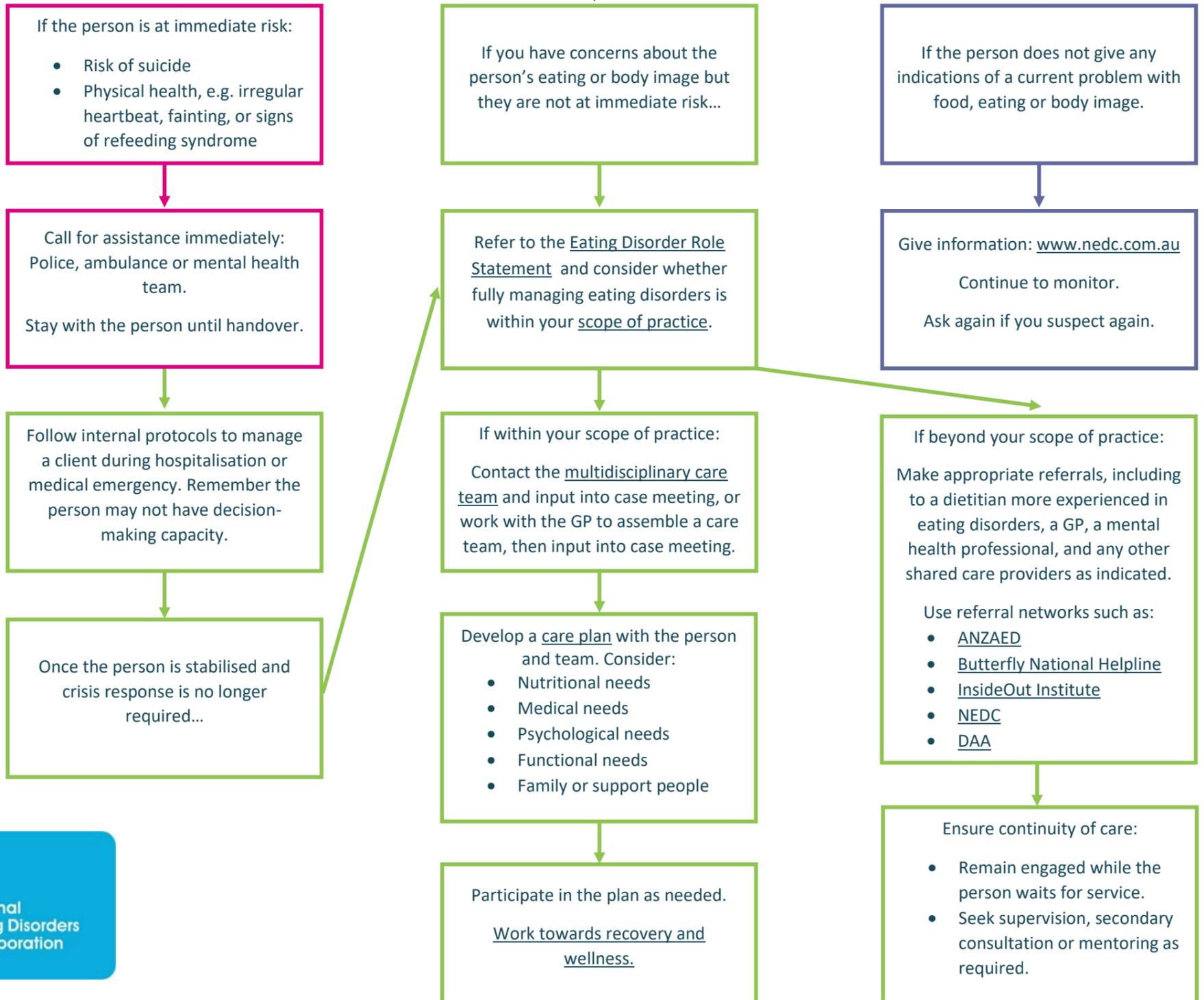
Observe warning signs and risk indicators, remembering the client may not overtly mention them. Explain your concerns.

Ask about their eating, food and related behaviours. Use an assessment tool that includes the possibility of an eating disorder.

Listen to what the client (or their carers) tell you and assess risk: Is the person physically and psychologically safe?



ACT



KNOW

Find out about the behavioural, physical and psychological signs and symptoms of eating disorders.



The defining feature of an eating disorder is the central role that preoccupation with food, eating and body weight/shape play in the person's life, to the extent that it interferes with normal physical, psychological, social and/or occupational functioning. For some people this involves exerting a significant amount of control and restriction over what they eat, for others it may involve a regular feeling of loss of control. For many people, it involves a combination of the two, known as the binge-restrict cycle. This may be observed in a person experiencing any eating disorder and is not limited to specific diagnoses or weight.

Some of the key signs likely to be observed or reported in dietetic practice include:

Behavioural

- Constant, repetitive or cyclical dieting, skipping meals, or fasting
- Avoiding or refusing certain foods or food groups
- Replacing meals with fluids
- Inappropriate hydration behaviours
- Making lists of 'good' and 'bad' foods
- Changes in food preferences, claiming no longer to like a food they previously enjoyed
- Obsessive or unusual rituals around food preparation and eating, insisting meals must be at a certain time, only using a specific knife/fork/spoon/plate/bowl/cup
- Avoiding social situations that involve food
- Cooking for others but not consuming food themselves
- Focus on shape and weight, weight loss, diet tips, images of thin or muscular people
- Frequent weighing or checking body parts (e.g. pinching, looking at reflection)
- Secretive or deceptive behaviour around food
- Eating slowly, using teaspoons, cutting small pieces of food, rearranging food on plate
- Disturbed hunger/satiety
- Denial of hunger

Physical

- Sudden or rapid changes in weight – loss, gain or fluctuation
- Sensitivity to cold
- Menstrual disturbance or delayed menarche
- Signs of vomiting: swollen cheeks/jaw, callused knuckles, damaged teeth, bad breath
- Fainting or dizziness
- Fatigue or inability to perform normal tasks

Psychological

- Preoccupation with weight, shape and appearance, food or activities related to food
- Sensitivity to comments about shape, weight, eating or exercise habits
- Depression, anxiety or low self-esteem
- Feelings of being unable to control eating or behaviours around food
- 'Black and white' thinking (e.g. food rules, rigid thoughts about food being 'good' or 'bad')
- Feeling anxious and or irritable around meal times

[List of warning signs adapted from [this fact sheet](#) by Eating Disorders Victoria]

Know the high risk groups for eating disorders (e.g. young people, people with history of food insecurity, women, athletes, people who are pursuing intentional weight loss, etc).



Based on the known risk factors for eating disorders, high risk groups who may benefit from screening for eating disorders include young people, women, athletes, people with a family history of eating disorders, people seeking help for weight loss, and people who have had an interrupted relationship with food (for example due to food insecurity or due to illness).

Some clients in dietetic practice may be at risk of an eating disorder but go "under the radar". These include people of normal or higher body weights, or people whose presenting issue is assistance with weight management, as this is highly normalised in our culture.

Some health conditions can also increase risk of developing an eating disorders, particularly if the treatment for that condition involves restricting caloric intake or limiting/avoiding certain food groups. Examples include diabetes (Type 1 and 2), coeliac disease, polycystic ovarian syndrome, food allergies, and pregnancy. If you are providing support to a client experiencing one of these conditions, it is important to screen for a possible eating disorder and monitor on an ongoing basis. You may need to adjust your clinical approach to ensure that it does not increase eating disorder risk, and might consider secondary consultation or referral to an eating disorder clinician.

Know your organisation's protocols for supporting a person with a mental illness or a person who needs urgent intervention, including trauma informed practice and suicide risk assessment. Know local services.



Check with your employer or practice manager if you are not already aware of the systems and processes that your service or practice has in place to support a client who needs urgent/crisis intervention. This should include processes to support the client, processes to document and monitor intervention, and processes to support the clinician or other staff providing emergency assistance (i.e. you and/or your colleagues).

If your practice doesn't have these protocols in place, you can get some tips on how to develop these and what to include from the [National Practice Standards](#) for Eating Disorders and the NEDC guide on [Implementing Treatment Standards](#) (click link then scroll down).

To find local services in your area, use referral networks such as [ANZAED](#), [Butterfly National Helpline](#), [InsideOut Institute](#) and the [NEDC](#).

OBSERVE

Observe warning signs and risk indicators, remembering the client may not overtly mention them. Explain your concerns.

Warning signs

A person may show one, many or none of the common warning signs.

- **Behavioural**, e.g. dieting or food hoarding
- **Physical**, e.g. rapid weight fluctuation
- **Psychological**, e.g. 'black and white' ideas re food

Immediate risk indicators

- Refeeding syndrome
- Fainting, dizziness or light-headedness
- Chest pain
- Shortness of breath, irregular breathing or frequent sighing
- Palpitations
- Swelling around the ankles
- Irregular, very fast or very slow heart rate
- Talking about suicide or plans to end life

Key warning signs and risk factors that you are most likely to observe in dietetic practice are shown on the previous page. Bear in mind:

- Clients seeking help for weight loss or pursuing weight loss dieting are the highest risk group for the development of an eating disorder. This may occur for clients in bodies of any size, shape or weight.

To start a conversation when you suspect a client may experience challenges with food, eating or body weight and shape, try one or some of these:

- "Many people worry about food and weight. Do you worry about these things?"
- "Are you satisfied with your eating patterns?"
- "Do you eat in secret?"
- "Do you ever make yourself sick because you feel too full?"
- "Do you ever feel you lose control over how much you eat?"
- "Have you recently lost over 5kg?"
- "Do you think you're fat when other people think you're too thin?"
- "Would you say food dominates your life?"

If the client answers 'yes', proceed to assessment.

A non-judgemental approach which normalises the client's experience, may help the client to understand that other people also experience these challenges, and may support engagement throughout and beyond the screening and assessment phase. Maintain professional communication style and avoid language that glamorises or stigmatises disordered eating behaviours, or blames the client or their family for their difficulties with food and eating.

Refeeding Syndrome

Refeeding Syndrome is a potentially lethal condition that may occur when aggressive nutrition is recommenced in someone who has metabolically adapted to starvation. During starvation, the body conserves energy and protein by decreasing heart rate, blood pressure, metabolic rate, protein/enzyme production, and gut activity. After this adaptation period, if parenteral, enteral, or aggressive oral nutrition support is provided, abrupt metabolic changes occur. These include increase in heart rate, blood pressure and metabolic rate; change in hormone levels; stimulation of protein synthesis and replenishment of body energy stores (ATP, glycogen); reduced serum levels of K, PO₄, Mg, Zn and Na. These changes can cause thiamine deficiency and severe or fatal alterations in the function of muscles, nerves and brain.

Refeeding syndrome is most likely to occur in an inpatient setting, and close monitoring is required.

Refer to your hospital's guidelines for the prevention and management of refeeding syndrome. Example guidelines from NSW Health are available online for paediatric and adult settings.

Other critical physical risk indicators

Signs of impaired heart function:

- Fainting, dizziness or light-headedness
- Chest pain
- Shortness of breath, irregular breathing or frequent sighing
- Palpitations
- Swelling around the ankles
- Irregular, very fast or very slow heart rate
- Irregular blood pressure and/or significant postural changes

Blood test results indicating medical emergency:

- Neutropenia (low white cell count)
- Raised liver function
- Low glucose, K, Mg, PO₄

Immediate psychiatric risk

If a person discloses that they have current or recent thoughts of suicide or self-harm, marked feelings of hopelessness, or have been engaging in reckless or risky behaviours, follow Mental Health First Aid guidelines:

- Listen without judgement; give the person space to talk
- Ask open-ended questions to find out more about the suicidal thoughts
- Use direct language; don't be afraid to use the word 'suicide'
- Take what the person says seriously
- Take action. Stay with the person. Work together to ensure their safety.
- Get the professional assistance you need

IF ANY OF THE ABOVE ARE PRESENT, GO TO THE EMERGENCY RESPONSE SECTION OF THIS DOCUMENT. CALL FOR ASSISTANCE AS SOON AS POSSIBLE. STAY WITH THE PERSON. SEEK DEBRIEFING ONCE YOU HAVE HANDED OVER.

ASK

Ask about their eating, food and related behaviours.



Follow the [Nutrition Care Process \(NCP\)](#)

Key domains for assessment stage in NCP include:

- Food and nutrition related history – current and previous food intake relative to activity levels; fluid intake; alcohol, caffeine; food allergies or any other conditions which may lead to avoidance of certain foods; food fears; relationship with food, eating, weight and body and when any concerns started; weighing behaviours at home; family history and relationships with food; history of disordered eating in client or family; client views on nutritional status
- Anthropometric measures – weight history including highest and lowest weight, and recent weight changes (loss, gain or fluctuation); current weight* and height; body mass index (BMI)
- Biochemical data/medical tests and procedures – heart rate, blood pressure, blood test results (K, PO₄, Mg, Na, Cl, HCO)
- Nutrition-focused physical findings – sleep patterns; heart function; bowel function; menstrual function (where relevant); physical appearance; energy levels
- Nutrition-focused psychological findings – mood; anxiety; concentration
- Client history – age; living situation; medical history; comorbidities; medications; social history; work/education history; family genetics relative to body shape and size
- Disordered eating behaviours – any history of binge eating; any compensatory behaviours such as vomiting, laxative use, diet pills, other pharmaceuticals; misuse of insulin (usually among young people with T1DM); spitting out food; over-exercise
- In children and adolescents – growth pattern indices/percentile chart using current and historical anthropometric measures* (use recommended charts from [World Health Organisation and Centers for Disease Control and Prevention](#)); calcium and bone mass; menarche; family setting, relationships with food in the home and how meals are prepared in the home.

*** A note on weighing:** some clients may find the experience of being weighed particularly distressing because of the intense fear and/or shame that they feel about their weight. This is a function of their eating disorder and must be taken seriously. If a client shows significant distress at the thought of being weighed:

- Explain the purpose of weighing – this is to get a baseline and is not a measure of the client's worth as a person;
- If the client has recently been weighed by another clinician in the care team, consider whether it is purposeful to weigh the client again. It may be appropriate to agree which member of the care team will be responsible for monitoring weight and keeping other involved clinicians informed of any changes or progress (with the client's consent);
- Give the client the option not to know their weight, for example by stepping onto the scale backwards so that the client cannot see the number ("blind weighing");
- Avoid making comments about the client's weight during the weighing process, and avoid inadvertently saying the weight aloud while taking the reading or writing notes;
- Hold any discussion about the weight results until after the assessment is complete. Discuss issues relating to weight with an understanding of the distress that the client may experience, and speak generally about progress rather than discussing specific numbers if the client requests this.

Assessment

Use an assessment tool that includes the possibility of an eating disorder.



All entry level dietitians and above can complete a comprehensive assessment of a client with a suspected eating disorder.

Assessment should cover the key domains outlined above. You could use [this template](#) from the InsideOut Institute, or could review your practice's standard assessment form to ensure that it covers the above domains fully. A comprehensive nutritional assessment template is also available to DAA members through the Eating Disorders Interest Group (EDIG).

You might also be interested to know about validated diagnostic assessment tools for eating disorders, such as the [Eating Disorder Examination Questionnaire \(EDE-Q 6.0\)](#); the [Eating Disorder Examination \(EDE 17.0\)](#); the [Binge Eating Disorders Screener \(BEDS-7\)](#); the [Eating Disorder Quality of Life \(EDQOL\)](#); the [Eating Attitudes Test \(EAT-26\)](#).

When conducting an assessment, remember to ask the client about their goals and reasons for coming to see you. For children and adolescents, you might also ask the family member or carer about their views if they are present. Teasing out any differences of opinion between the client and their family member or carer may help clarify different perspectives and provide a more comprehensive picture of eating disorder behaviours.

LISTEN

Listen to what the client (or their carers) tell you and assess risk: Is the person physically and psychologically safe?



What the client might say

The client may respond to questions about their food, eating and body image in a range of ways. Common responses include:

- Ambivalence – wanting to hold onto some parts of their disorder while also wanting to reduce others, for example wanting to maintain the sense of control that the behaviours give while no longer wanting to experience certain side-effects.
- Minimising concerns – this may occur due to low self-esteem, shame or stigma, or it may occur because the client is fearful of receiving treatment for their eating disorder. Responses might include statements like “I don’t need help, there are others who need it more” or “I don’t want to talk about any of this, I’ll be fine, I have it under control”.
- Normalising or rationalising statements – for example “everyone my age skips meals” or “at my gym no one eats carbs”.

Responses where the client appears to be trying to minimise, rationalise or hide the full extent of their illness are a symptom of the eating disorder. Confrontation or argument in this context is unhelpful. Compassionate listening and development of a collaborative relationship are important. Acknowledge the distress that they are expressing, and the challenges involved in discussing their personal experience.

What the parents, carers or friends might say

Families often get it right, and may be telling you about their loved ones’ behaviour in the face of denial from the client. For example, a family member might report that they have noticed your client start to wear baggy clothes, avoid family events involving food and take the dog for frequent long runs. The family member may sense very strongly that something is wrong, even if they can’t specifically name an eating disorder or specific disordered behaviours.

It is important to take family evidence into consideration in the face of denial from the person, as the client may be working to conceal some of these behaviours. The client’s responses to the concerns raised by their loved ones may give important clues to how ready they are to start considering recovery, which may inform your care plan and the referrals that you make.

ACT

in case of emergency

If the person is at immediate risk:

- Risk of suicide
- Physical health, e.g. irregular heartbeat, fainting, or signs of refeeding syndrome



Inpatient admission is recommended if **ANY** of the following indications are present in an adult:

	Psychiatric admission	Medical admission
Weight	BMI < 14	BMI < 12
Rapid weight loss	1kg per week over several weeks OR grossly inadequate nutritional intake OR continued weight loss despite community treatment	
Systolic BP	< 90 mmHg	< 80 mmHg
Postural BP	> 10 mmHg drop with standing	> 20 mmHg drop with standing
Heart rate		≤ 40 bpm OR ≥ 120 bpm OR postural tachycardia > 20/min
Temperature	< 35.5°C or cold/blue extremities	< 35°C or cold/blue extremities
Blood sugar	Below normal range	< 2.5 mmol/L
Na	< 130 mmol/L	< 125 mmol/L
K	Below normal range	< 3.0 mmol/L
Mg		Below normal range
PO₄		Below normal range
eGFR		< 60ml/min/1.73m ² or 25% drop within a week
Albumin	Below normal range	< 30 g/L
Liver enzymes	Mildly elevated	Markedly elevated (AST or ALT > 500)
Neutrophils	< 1.5 x 10 ⁹ /L	< 1.0 x 10 ⁹ /L
Risk assessment	Suicidal ideation, active self-harm OR moderate to high agitation or distress	

Mental health crisis team assessment is recommended if you have any concerns that the person is not able to stay safe, e.g.:

- If they have a specific plan for suicide and have access to the means to carry out their plan
- If they are unwilling to hand over any items that they have a plan to use for suicide

Refer to the [RANZCP clinical practice guidelines for the treatment of eating disorders](#) for admission criteria in children and adolescents.

Sources: [RANZCP clinical practice guidelines for the treatment of eating disorders](#)
[Mental Health First Aid guidelines on suicidal thoughts and behaviours](#)

Call for assistance immediately:
Police, ambulance or mental health crisis team.

Stay with the person until handover.

INTERVENTION FOR THIS EMERGENCY PREVAILS OVER ALL OTHER ASSESSED NEEDS



For **Police/Fire/Ambulance**, call 000 from anywhere in Australia. If you are deaf or have a speech or hearing impairment, call 106 for a teletypewriter emergency call.

- Tell the operator you want Ambulance (for a person in medical emergency)
- Tell the operator you want Police (for a person at risk of harming themselves or others)
- Stay calm
- Speak slowly and clearly
- Tell the emergency services exactly where to come
- If the person is suicidal, tell the emergency services this so they can respond appropriately

For local **Crisis Assessment and Treatment Team (CATT)**, write the contact details for your local service here [NOTE: it's most likely based at your nearest major public hospital]:

For help in your State or Territory to locate and access local services:

NSW – Mental Health Line 1800 011 511

VIC – SuicideLine Victoria 1300 651 251

QLD – 13 HEALTH 13 43 25 84

TAS – Mental Health Services Helpline 1800 332 388

SA – Mental Health Assessment and Crisis Intervention Service 13 14 65

WA – Mental Health Emergency Response Line 1300 555 788 (Metro) 1800 676 822 (Peel)

NT – Northern Territory Mental Health Line 1800 682 288

ACT – Mental Health Triage Service 1800 629 354

Stay with the person

If a person is in a state of medical or psychiatric emergency, it is important that you do not leave them alone. If necessary, ask a manager or colleague for assistance to contact your client's loved ones (with consent) and to cancel your next appointment.

When talking to the suicidal person, focus on the things that will keep them safe for now, rather than the things that put them at risk. To help keep the suicidal person safe, develop a safety plan with them:

- Focus on what the person should do to stay safe, not what they shouldn't do
- Be clear about who will do what (e.g. who will call for help, how the person will self-soothe)
- Make the timeframe for the plan feel manageable – it only has to last until help arrives
- Ask how they would like to be supported (without taking on their responsibilities)

ACT

immediately following
emergency

Follow internal protocols to manage a client during hospitalisation or medical emergency. Remember the person may not have decision-making capacity.



Your organisation's protocols might include:

- Clinical policies for shared care in emergency contexts
- Scope of practice considerations
- Practice standard for your main area of clinical focus
- Supervision policies
- Risk assessment procedures

If you work in a practice that does not have these in place, consider setting them up. Remember that stepped care and continuity of care are crucial, and that your practice context should guide when you are involved in the case and when you hand it over to services that are more or less intensive or specialised than yours. More information about the eating disorders continuum of care see the [National Practice Standards for Eating Disorders](#).

A note on decision-making capacity

For some people with eating disorders, the effect of starvation on the brain may impair cognitive function to the extent that they are unable to make informed decisions about their own care and treatment. In these cases, a mental health professional may admit the client to involuntary treatment under the Mental Health Act. The criteria for involuntary admission vary in each State and Territory.

It is not usually a dietitian's role to decide if a person should be admitted for involuntary treatment. You might, however, be asked for your clinical expertise when a person's care plan is being developed, or may be involved in delivering care under a community treatment order.

Once the person is stabilised and crisis response is no longer required...



Seek debriefing within the first 24 hours after the emergency

Your clinical supervisor or line manager may be a great place to start.

If they are not available, or if they are not skilled in critical incident debriefing, find out if your organisation has an Employee Assistance Program (EAP). Your manager should be able to provide you with these details. An EAP can provide you with free, confidential counselling and its counsellors are usually skilled in critical incident debriefing.

If you are in a practice that does not have an EAP, you can get support from the Suicide Call Back Service on 1300 659 467 if you have supported a client experiencing suicidality.

Practice self-care

Providing support and assistance to a suicidal person or a person experiencing a medical emergency can be physically and emotionally demanding. It is important to take care of yourself.

For some ideas and tips on professional self-care, check out these resources from [Reach Out](#), the [Black Dog Institute](#), or [Life In Mind](#).

Engage with your client once appropriate. Continue to follow the steps on the next pages.

ACT

when managing eating disorders is **within** your scope of practice

If within your scope of practice:

Contact multidisciplinary care team and input into case meeting, or work with GP to assemble a care team, then input into case meeting.



Management of a person with an eating disorder should include medical, psychological, nutritional and functional rehabilitation.

In a community/outpatient setting, a GP usually takes on the coordinating role within a multidisciplinary team. This could include doctors, paediatricians, mental health nurses, Aboriginal health workers, dentists, psychiatrists, psychologists, school counsellors, mental health workers, dietitians, social workers, occupational therapists, physiotherapists, sports coaches, teachers and youth workers.

A dietitian who can fully manage a client with an eating disorder would:

- Oversee nutritional care of inpatients and outpatients with more severe eating disorders and be aware of specialist/support services available for people with eating disorders.
- Act as nutrition resource person for the support, education, training and development of others involved in the care of eating disorder clients.
- Support best practice management of the client, and be actively involved in treatment planning, team meetings and correspondence with other health professionals within the team.

A dietitian should not undertake sole management of a client with an eating disorder, provide counselling outside their skill base or practice in this field without continuing professional development and supervision.

Develop care plan with the person and team. Consider:

- **Nutritional needs**
- Medical needs
- Psychological needs
- Functional needs
- Family or support people



Collaboration between all members of the care team is important. This should involve the client and, wherever possible, their family, carers or support people.

Eating disorders comprise a wide range of diagnoses, behaviours and levels of severity, and every client is different. In taking the below points into account, remember that person-centred care is crucial.

Cultural, socio-economic and regional/remote considerations: Some social and environmental factors may lead to differences in presentation. These include present or historical food insecurity, and cultural differences in the ways that disordered eating is understood. This should be taken into account for people living in towns with limited or interrupted food supply, and for Aboriginal and Torres Strait Islander people. Intervention and care planning must take account of the client's access to food and other resources, and be delivered in culturally respectful ways.



Tips/considerations for early recovery

Nutritional rehabilitation is a key element of treatment, no matter the weight of the person, in order to restore the body and brain to sufficient health and to be able to proceed with psychological intervention. For some clients, refeeding forms part of medical stabilisation, and this must occur before psychological intervention can commence. It is incorrect to assume that a person will "eat when they're ready" if they access therapy without nutritional rehabilitation.

Food monitoring at this early stage should focus on eating enough and on regular patterns of eating. Gauging 'enough' food for each client will vary depending on the duration and severity of malnutrition, presence of diet induced thermogenesis, the existing patterns of eating and disordered eating behaviours (including compensatory behaviours), as well as age, gender, activity levels, etc.

At this stage, hunger and fullness signals may be interrupted and are not (yet) a suitable gauge for whether the client has eaten enough. This is particularly the case for any clients who engage in restraint or restriction, which can be observed in any diagnostic category (including Binge Eating Disorder – see this explanation of the diet cycle) and in a client of any body weight.



Tips/considerations as recovery progresses

Food monitoring can progress to a focus on variety and flexibility, then on internal awareness and trust. Refer to the "Recovery from Eating Disorders for Life" Food Guide (REAL Food Guide) for a comprehensive and user friendly guide to healthy eating in eating disorder recovery. Disordered eating behaviours should also continue to be monitored.

Remember that recovery is rarely linear, and that a client may experience times during their journey towards recovery where they feel stuck. As a dietitian, you can support your client by understanding the intense feelings of fear, guilt and shame that can be part of treatment as well as part of the disorder. Respond with empathy and support your client to re-engage with recovery. Ensure that they are supported by a mental health professional to assist with any distress.

Participate in the plan as needed.

Work towards recovery and wellness.



A key part of recovery includes maintenance and relapse prevention planning. For the dietitian, this may include continuing to see the client for some after a stable weight is achieved and supporting the client to build a confident and healthy relationship with food and eating. Reinforce messages about how starving the brain will lead back to rigid thinking, low mood, anxiety and other eating disorder pathology, and work with the client to develop strategies to avoid this.

For some people, relapses are a normal part of the longer term recovery process. If you are concerned that a client is deteriorating, that is reason enough to seek medical review. It is not appropriate to 'watch and wait' in the context of eating disorders due to the serious and potentially fatal complications and the speed with which they may progress, especially in children and adolescents.

ACT

when managing eating disorders is beyond your scope of practice

Remember: All dietitians can assess and identify a person with or at risk of developing an eating disorder, and can encourage change towards 'normal/natural' eating. All dietitians can also develop a therapeutic relationship with a client, assess risk and make relevant referrals. If you are not confident in doing these things, ensure that you seek supervision. This will assist you in supporting any current clients with diagnosed or suspected eating disorders, as well as identifying future clients. Early detection and intervention are critical to setting the client on a path to the best possible recovery outcomes.

If you are a DAA member, look for the 'Guide for Accredited Practising Dietitians New to Working in the Eating Disorder Specialty' from the Eating Disorders Interest Group (EDIG) for further tips. You can also look for a supervisor with eating disorder experience through the EDIG, or through the [Australia and New Zealand Academy for Eating Disorders \(ANZAED\)](#).

Once you have the above steps covered, consider whether you will remain involved in the client's care as a shared care provider (e.g. if you have a relevant speciality for a comorbid condition that the client is experiencing). See below for details about referral pathways and continuity of care.

If beyond your scope of practice:

Make appropriate referrals, including to a dietitian more experienced in eating disorders, a GP, a mental health professional, and any other shared care providers as indicated.



A core multi-disciplinary team for a person with an eating disorder should include someone who can manage each of the client's **medical**, **psychological** and **nutritional** needs. Depending on the person, the team might also include professionals to assist with **functional** needs or to manage comorbid conditions. The exact make-up of the care team will vary from person to person, and in some cases one professional may be able to fill more than one of the above roles.

Check if the client has a regular GP or other medical professional (e.g. paediatrician, psychiatrist, psychologist or other physician) and, if so, whether that clinician knows about and is managing the eating disorder. If not, encourage the client to make an appointment with their doctor to discuss their eating difficulties and seek diagnostic assessment. You could also seek the client's consent to liaise directly with their doctor.

If you need to make referrals directly, each of the following avenues are available:

- [Australia and New Zealand Academy for Eating Disorders \(ANZAED\)](#)
- [Butterfly National Helpline](#)
- [InsideOut Institute](#)
- [National Eating Disorders Collaboration \(NEDC\)](#)
- [Dietitians Association of Australia \(DAA\)](#)

Shared care

The primary risk factor for development of an eating disorder is engaging in weight loss dieting behaviour. This applies to all forms of eating disorder, and not just restrictive-type disorders. This has implications for any intervention which includes a weight loss or weight management focus. Even incidental weight loss (e.g. through illness) may initiate an eating disorder. If you're part of a shared care team for a person with an eating disorder, you will need to collaborate closely with the experienced eating disorder clinicians on the team to ensure that the client's treatment needs are met holistically and without causing further risk.

Ensure continuity of care:

- Remain engaged while the person waits for service
- Seek supervision, secondary consultation or mentoring as required.



You might be the first professional your client has ever spoken to about their eating disorder. Ensuring that you provide effective continuity of care is crucial to supporting their ongoing engagement in treatment, which is key to recovery and improved quality of life. It is important that you respond to their disclosure with professionalism and compassion – thank the client for sharing this with you, validate their emotions if appropriate and provide reassurance that you will stay involved in their care until you can link the client with the right services.

Depending on the availability of eating disorder services or clinicians in your area, you may need to remain involved in your client's care for some time while they are on the waiting list for more specialised service. These tips may help:

- Continue to encourage change towards healthy, flexible eating and away from black-and-white thoughts about food;
- Consider whether working through a [Guided Self Help](#) program may assist your client (note: not recommended for clients with suspected or confirmed Anorexia Nervosa or precipitous weight loss);
- Continue to monitor your client and look for any signs of escalation in the severity of their eating disorder or any complications – have any of the immediate risk factors emerged? Has there been an increase in the client's cognitive rigidity, or in their levels of distress around food or body image? **Any signs that concern you are sufficient justification to seek medical review.** Ask your client to see their doctor and have a full blood count taken. If their condition has deteriorated, this may be a trigger to escalate any referrals that are still wait-listed or to follow the [emergency response](#) steps outlined in this guide.
- Remember you're never alone when supporting a client with an eating disorder. As well as making use of supervision, you can access tertiary consultation from the eating disorder service in your state or territory. Click the links below to find your local contacts:

[ACT](#)

[NSW](#)

[NT](#)

[QLD](#)

[SA](#)

[TAS](#)

[VIC](#)

[WA](#)

Include transition planning well in advance of any planned transitions. Include arrangements for follow up by the initial team and support for the new team. Comprehensive transition planning and follow-through reduce the risk of clients falling through the gaps and prolonging illness.

ACT

when the client does not appear to have a current eating disorder

If the person does not give any indications of a current problem with food, eating or body image.



If you suspect a client has an eating disorder, but then after assessment it seems that they don't, there could be a few different explanations:

1. They don't have an eating disorder
2. They do have an eating disorder, but don't yet feel safe or ready to tell you about it
3. They do have an eating disorder, and are actively trying to conceal it

Respecting where the client is at and continuing to build a therapeutic alliance may support the client to discuss any eating concerns with you more openly at a future appointment. Attempting to override or coerce the client into admitting that they have an eating disorder is unlikely to help.

If after assessment you are reasonably sure that the client has an eating disorder but that they either do not see it that way or try to minimise your concerns, some motivational interviewing techniques could assist you to open the conversation. Resources for this are available through the DAA Eating Disorders Interest Group (for DAA members), or you can seek support from your supervisor.

Give information: www.nedc.com.au

Continue to monitor.

Ask again if you suspect again.



Whether your client has an eating disorder or not, you can provide information about eating disorders and where to go for further support if they find that they do have concerns. They may be more willing to do some reading of their own before they discuss their concerns with you.

There are many online resources produced by Australian eating disorder services that can help. The National Eating Disorders Collaboration site may be a good place to start, or for younger clients the mobile-friendly eatingdisordersinfo.org.au site. A fuller list of resources is available at the back of this guide.

Continue your relationship with your client and provide services as normal. Be aware that eating disorder symptoms may arise at any time, so you should continue to monitor your client for any of the [key signs](#) or [immediate risk indicators](#).

If you do suspect that your client may be showing signs of an eating disorder, ask screening questions again. It is better to continue asking using a non-judgemental approach and keep the door open to a possible disclosure of an eating disorder. The 'watch and wait' approach is never advised.

Resources and references

Resources for clients

Eating disorder fact sheets, including information in Arabic, Chinese, Russian, Spanish and Vietnamese: <https://www.nedc.com.au/research-and-resources/fact-sheets>

Information about the therapeutic team: <https://www.nedc.com.au/eating-disorders/treatment-and-recovery/the-thera/>

Information about recovery: <https://www.nedc.com.au/eating-disorders/treatment-and-recovery/recovery/>

Information about relapse/recurrence: <https://www.nedc.com.au/eating-disorders/treatment-and-recovery/relapse-and-recurrence/>

Seven Tips for Improving Your Body Image: <https://www.nedc.com.au/assets/Infographics/NEDC-Infographic-Tips-for-Improving-Body-Image.pdf>

Guys Get Eating Disorders Too: <https://www.nedc.com.au/assets/Infographics/NEDC-Infographic-Males.pdf>

Eating Disorder Myths: <https://www.nedc.com.au/assets/Infographics/NEDC-Infographic-Myths.pdf>

Eight Tips for Dealing with an Eating Disorder: <https://nedc.com.au/assets/NEDC-Resources/NEDC-Resource-8-Tips-for-Dealing-with-an-ED.pdf>

Resources for carers, family and friends

Caring for someone with an eating disorder: <https://www.nedc.com.au/assets/NEDC-Resources/NEDC-Resource-Carers.pdf>

Mental Health First Aid for people experiencing suicidal thoughts and behaviours: <https://mhfa.com.au/sites/default/files/mhfa-guidelines-suicide-revised-2014.pdf>

Mental Health First Aid for eating disorders: https://mhfa.com.au/sites/default/files/MHFA_eatdis_guidelines_A4_2013.pdf

Seven Tips for Families and Carers: <https://www.nedc.com.au/assets/Infographics/NEDC-Infographics-Caring-for-Someone.pdf>

Getting Help for Someone You Are Worried About: <https://www.nedc.com.au/assets/Uploads/Getting-help2.PNG>

Eight Tips for Dealing with an Eating Disorder: <https://nedc.com.au/assets/NEDC-Resources/NEDC-Resource-8-Tips-for-Dealing-with-an-ED.pdf>

Resources for clinicians

Eating Disorder Role Statement: Role Statement for Accredited Practising Dietitians practising in the area of Eating Disorders: <https://daa.asn.au/what-dietitians-do/role-statements/>

Dietitian Scope of Practice: <https://daa.asn.au/maintaining-professional-standards/dietitian-scope-of-practice/>

National Practice Standards for Eating Disorders: <https://www.nedc.com.au/assets/NEDC-Resources/national-practice-standards-for-eating-disorders.pdf>

Implementing Treatment Standards: <https://nedc.com.au/assets/NEDC-Consultation-Papers-compressed-2.pdf>

Nutritional Assessment for Eating Disorders: <https://insideoutinstitute.org.au/assets/nutrition-assessment.pdf>

"Recovery from Eating Disorders for Life" (REAL) Food Guide: <https://jeatdisord.biomedcentral.com/articles/10.1186/s40337-018-0192-4>

Mental Health First Aid for people experiencing suicidal thoughts and behaviours: <https://mhfa.com.au/sites/default/files/mhfa-guidelines-suicide-revised-2014.pdf>

Mental Health First Aid for eating disorders: https://mhfa.com.au/sites/default/files/MHFA_eatdis_guidelines_A4_2013.pdf

Stages of Change for people with eating disorders: <https://www.nedc.com.au/eating-disorders/treatment-and-recovery/stages-of-change/>

Self-care for professionals: <https://schools.au.reachout.com/articles/self-care-for-professionals>

Self-care planning for managers and supervisors: <https://www.blackdoginstitute.org.au/news/news-detail/2018/10/04/how-you-can-empower-your-team-with-self-care-planning>

Eating Disorders Screening, Identification and Referral: <https://www.nedc.com.au/assets/NEDC-Resources/Screening-identification-referral-guide.pdf>

Medicare Benefits Schedule – Changes to MBS Items – Eating Disorders: <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-EatingDisorders>

New MBS Item Numbers for Eating Disorders – Frequently Asked Questions: <https://www.nedc.com.au/assets/Fact-Sheets/MBS-Eating-Disorder-Items-FAQs-Joint-Response-2019.pdf>

DAA find a Colleague: <https://daa.asn.au/find-a-colleague/>

DAA find an APD: <https://daa.asn.au/find-an-apd/>

References used in this guide

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Department of Health, 2016. National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families. Online: <http://www.coaghealthcouncil.gov.au/Portals/0/National%20Framework%20for%20Health%20Services%20for%20Aboriginal%20and%20Torres%20Strait%20Islander%20Children%20and%20Families.pdf>

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InsideOut Institute for Eating Disorders, 2017. Refeeding Syndrome. Online: <https://insideoutinstitute.org.au/assets/refeeding%20syndrome.pdf>

Mental Health First Aid Australia, 2014. Suicidal Thoughts & Behaviours: Mental Health First Aid Guidelines. Online: <https://mhfa.com.au/sites/default/files/mhfa-guidelines-suicide-revised-2014.pdf>

National Eating Disorders Collaboration, 2014. Implementing Treatment Standards. Online: <https://nedc.com.au/assets/NEDC-Consultation-Papers-compressed-2.pdf>

National Eating Disorders Collaboration, 2018. National Practice Standards for Eating Disorders. Online: <https://www.nedc.com.au/assets/NEDC-Resources/national-practice-standards-for-eating-disorders.pdf>

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