Queensland Health Guideline

Eating Disorders: Inpatient care on adult wards

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Eating disorders: Inpatient care on adult wards

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Acknowledgement

Acknowledgement of Country

Queensland Health respectfully acknowledges the Traditional Owners and Cultural Custodians of the lands, waters and seas across Queensland. We acknowledge the cultural and spiritual connection that Aboriginal and Torres Strait Islander peoples have with the land and sea. We respectfully recognise Aboriginal people and Torres Strait Islander people as two unique and diverse peoples, with their own rich and distinct cultures, resilience and strengths. We specifically acknowledge the unique history and cultural heritage of Aboriginal and Torres Strait Islander peoples as the First Peoples of Australia, and the ongoing impacts of colonisation and intergenerational trauma. We pay our respects to Elders past and present. We are dedicated to the inclusion of cultural knowledge and values as critical factors in the development, implementation and evaluation of strategies and actions to support Aboriginal and Torres Strait Islander peoples.

Recognition of lived and living experience

Queensland Health recognises people with lived experience of mental illness, problematic alcohol and other drug use, and/or mental health crisis and suicidality, their families, carers and support persons. Their contribution to driving and informing reforms to the mental health, alcohol and other drug service system is critical and valued.

Acknowledgement of content

The guidelines were developed by Queensland Eating Disorder Service (QuEDS), supported by subject matter experts, including clinicians and individual and carer representation, together with input from the peak body Eating Disorders Queensland. The endorsement of these guidelines has involved a rigorous process with expert clinicians, researchers and stakeholders who have convened to review the research and consensus statements related to the content. We would like to acknowledge their considerable contribution, review of current evidence and expert clinical guidance. Please see Appendix 5: Guideline contributors for a list of individual contributors.

Purpose

Eating disorders are serious mental health conditions characterised by severe disturbances in eating behaviours, thoughts and emotions often leading to significant physical health consequences and psychological distress. These disorders are clinically recognised and require comprehensive treatment including medical, nutritional, and psychological interventions.

Health services are required under legislation, service directives and national standards, and expected under duty of care, to provide safe, effective and quality treatment and care. This guideline brings together an evaluation of the current literature and evidence concerning medical risk factors in individuals with eating disorders that supports clinical decision making in emergency departments, medical wards, and mental health units for those who present to hospitals. It aims to support standardised care in the various Hospital and Health Services across Queensland and to ensure equitable care and access to all Queensland residents.

This guideline is intended to offer recommendations for medical assessment and monitoring, nutritional assessment, and treatment as well as the critical nursing interventions when providing care for individuals with eating disorders or at risk of eating disorder. It also includes the psychological approaches for the multidisciplinary team (MDT) that can support the treatment in the acute care settings including the integral role of providing compassionate care whilst monitoring vital signs during the acute refeeding period.

This guideline provides guidance on the appropriate application of relevant legal frameworks, including the *Mental Health Act 2016* (MHA2016) and the Guardianship and Administration Act (GAA) to inpatient eating disorders care. In addition, the guideline reinforces that human rights are a mandatory and overarching consideration that must guide all clinical decisions and interactions, ensuring care remains respectful, person centred and recovery oriented.

Scope

This guideline applies to all Queensland public hospital and health services for use with individuals presenting with eating disorders or at risk of eating disorders.

This guideline outlines best practice according to where the assessment and treatment is taking place rather than age-based care. This guideline is for use in adult emergency departments, medical wards, and adult mental health units (including young adult wards). It is recommended that the Assessment and treatment of children and adolescents with eating disorders in Queensland [1] guideline is utilised when an individual under age 18 presents to a paediatric emergency department, paediatric ward or Child and Youth Mental health inpatient unit.

How to use this document

The guideline is divided into three main sections. **Section 1: Background** provides a foundation for clinicians to develop an overall understanding of eating disorders and their prevalence. It outlines the key principles of eating disorder care that underpin the following two sections of the guideline. Finally, Section 1 provides a summary of the relevant legislation applicable to inpatient eating disorder care. All staff involved in the inpatient care of individuals with eating disorders will benefit from an understanding of the content laid out in section one.

Section 2: Standard guidelines for inpatient eating disorder care provides clinicians with systematic recommendations for evidence-based care. This section is broken up into sub-sections for specific disciplines (medical, dietetic and nursing) followed by a sub-section for all staff. This is intended to support all members of the multi-disciplinary team to have the information and guidance required for their role in the assessment, treatment, and support of individuals whilst they are in adult hospital settings.

Section 3: Additional considerations for special groups supplements section two in guiding care for individuals with co-occurring relevant medical or mental health conditions. This outlines additional considerations as well as amendments to the standard guidelines that may be required to provide safe and effective care.

1 Background

1.1 What are eating disorders?

Eating disorders are serious mental health conditions characterised by severe disturbances in eating behaviours, thoughts and emotions often leading to significant physical health consequences and psychological distress. According to the International Classification of Diseases Eleventh Revision (ICD-11) [2] the major eating disorder diagnoses include :

- anorexia nervosa (AN)
- bulimia nervosa (BN)
- binge eating disorder (BED)
- avoidant restrictive food intake disorder (ARFID)
- other specified feeding and eating disorders (OSFED) including atypical anorexia nervosa (AAN)

Less common eating disorders include:

- rumination-regurgitation disorder
- pica
- feeding or eating disorders, unspecified [2].

Eating disorders are marked by specific patterns such as extreme food restriction, excessive exercise, binge eating or purging which are accompanied by intense preoccupation with weight and shape (with the exception of ARFID, pica and rumination disorder). These disorders are clinically recognised and require comprehensive treatment including medical, nutritional, and psychological interventions.

The aetiology of eating disorders is multifaceted and therefore the treatment plans should be individualised accordingly. The biological risk factors include genetic heritability, differences in information processing, and hormonal changes. Some of the psychological factors include individuals with certain personality traits, co-occurring mental health conditions, experiences of trauma, and significant life stress. Social and cultural factors that may contribute include the cultural promotion of thinness or muscular physique that are considered more desirable, peer pressure and social comparisons and environments that foster appearance or achievement ideals or where there is dysfunctional interpersonal dynamics [3].

Disordered eating encompasses a range of irregular eating behaviours that may not meet the full criteria for a clinical diagnosis but can still have negative impacts on an individual's health and well-being. Disordered eating behaviours can be problematic and can lead to the development of an eating disorder and therefore should be identified where possible to offer early interventions and support.

Individuals with higher weight are at risk of developing eating disorders compared to the general population but their distress and clinical risk are regularly under recognised and at times minimised. These individuals often experience societal weight stigma which can be evident within the healthcare settings. In 2021-2022 the National Eating Disorders Collaboration (NEDC) developed a guideline to support clinicians provide best practice care for individuals with higher weight and to address aspects of stigma [4].

There is a wealth of evidence that supports psychological therapies for eating disorders that are available in Queensland through an Eating Disorder Management Plan, the Queensland Eating Disorder Services (QuEDS), local Eating Disorder Specialist Services (EDSS), non-government organisations such as Eating Disorders Queensland, and the Butterfly Foundation. These evidence-

based and evidence informed therapies are aimed at identifying and modifying maladaptive thought patterns and behaviours related to food, body image and self-worth [5]. There is also evidence that Dialectical Behavioural Therapy (DBT) can be used effectively to treat individuals with eating disorders and co-occurring severe emotional dysregulation.

1.2 The data on eating disorders

Eating disorders are a significant health concern in Australia, affecting a substantial portion of the population. According to data published in 2024, around 10.5% of Australians will experience an eating disorder at some point in their lives, which translates to over 2 million individuals and represents a significant increase from 2012 [6]. The most prevalent eating disorder is BED affecting approximately 2.5% of the population, followed by BN (1.5%) and then AN (0.5%). Eating disorders are particularly prevalent among adolescents with the highest incidence occurring in females aged 15-24 years. It is highly likely that the Covid-19 pandemic has been the biggest contributor to the increased prevalence of eating disorders or disordered eating in the past decade [7].

According to the National Study of Mental Health and Well-being conducted by the Australian Bureau of Statistics in 2020-2021 more than 1 in 5 individuals emphasised the significance of their weight and/or shape as being extremely important in forming their self-perception [8]. These findings underscore the pervasive impact of body image concerns particularly among younger females, highlighting the need for targeted interventions and support to promote positive body image and mental wellbeing [8, 9].

Eating disorders have a significantly higher mortality rate compared to other mental illnesses in Australia and the overall death rate is estimated to be around 5.1 deaths per 1000 person years. The highest rates occur in those with AN where 1 in 5 individuals will die prematurely from complications of this illness, including from suicides. Overall, this is estimated to contribute to a reduced life expectancy by 10-20 years for individuals with AN [10].

Alarmingly, only one-third of individuals with eating disorders in Australia receive appropriate treatment highlighting the need for improved access to care [6]. Baiano and colleagues conducted a systematic review of the health-related quality of life outcomes for those individuals with eating disorders to look at the impact more broadly [11]. They found that quality of life measures for individuals with eating disorders are extremely low compared with the general population who do not have an eating disorder and that this is irrespective of the diagnostic category.

The economic and social costs are substantial, estimated at $69.7 billion per year, including direct medical costs and indirect costs such as loss of productivity. The Butterfly Foundation have estimated that this cost is greater than the cost of depression and anxiety combined [6].

It is not fully known how many individuals present to emergency departments in Queensland for treatment of the medical compromise associated with eating disorders. However, Dooley-Hash and colleagues found that 16% of adults presenting to emergency departments screened positive for an eating disorder, regardless of their reason for visiting the emergency department [12]. This study highlights that people living with an eating disorder may present to places where there is an opportunity to identify eating disorders and provide risk assessments, referrals, and resources even if the individual is not seeking care specifically for their eating disorder.

1.3 Principles of eating disorder care

The care of individuals with eating disorders should be guided by a set of overarching principles that define the approach, values, and standards underpinning all aspects of treatment. These principles support safe, effective, and compassionate care and are aligned with contemporary best practice, including trauma-informed, culturally safe, and recovery-oriented models of care. The assessment,

diagnosis and treatment of eating disorders should ideally include a comprehensive, multidisciplinary approach that emphasises collaborative care, early intervention, inclusivity, family engagement, and patient-centred care.

1.3.1 Care is timely, accessible and delivered in the least restrictive environment

Eating disorders are serious mental health conditions that require timely, evidence-based, and person-centred care. While early intervention is associated with improved outcomes, this guideline focuses on the provision of care in adult inpatient settings, where individuals are often medically and psychologically compromised. As such, early intervention is acknowledged as a broader system priority, but not the primary focus of this guideline.

Inpatient care should be delivered in the least restrictive environment possible, with a strong emphasis on preserving autonomy, dignity, and human rights. The MHA2016, and the GAA2000 provide a legislative framework to guide clinicians in applying least restrictive care. Involuntary treatment and restrictive practices must only be used when necessary and in accordance with legislation (see section 15 Legislation).

The location of care should be determined by the individual's clinical needs, not solely by diagnosis or weight and clinicians are encouraged to refer to the recommended assessment parameters to guide this decision in Table 1. Assessment and admission indicators. Individuals with eating disorders may require care in medical, mental health, or specialist eating disorder units. Wherever possible, care should be provided close to home and in environments that support continuity and engagement [9, 13].

1.3.2 Person-centred, recovery-oriented care

Individuals should receive care that is tailored to their unique needs, values, and preferences, with an emphasis on informed choice and shared decision-making. Person-centred care recognises the individual as the expert in their own lived experience and actively involves them in all aspects of their care planning and treatment. The National Framework for Recovery-Oriented Mental Health Services defines recovery as "*being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues*" [14].

In the inpatient setting, where individuals may be medically compromised and acutely unwell, the tension between medical necessity and individual autonomy must be carefully navigated. Clinicians should strive to maximise choice and collaboration even when safety concerns necessitate more intensive intervention. This includes providing clear, transparent information about treatment rationale, involving individuals in goal setting wherever possible, and regularly reviewing the need for restrictive interventions. Clinicians should consider individual sensory needs to support comfort, reduce distress, and promote engagement in care. Recovery-oriented care supports individuals to maintain hope, build on existing strengths, and develop the skills and resources needed for sustained wellbeing beyond discharge [9].

Treatment goals are to be collaboratively developed and reflect the individual's own aspirations for recovery, not solely symptom reduction or weight restoration. Clinicians should acknowledge that recovery is possible and that the individual's capacity for autonomy and self-management may be temporarily impacted by the effects of malnutrition or acute illness, but is not permanently diminished [15].

1.3.3 Trauma-informed care

Trauma is highly prevalent among individuals with eating disorders, with research indicating that between 50-70% of individuals in eating disorder treatment report a history of traumatic experiences, and many meet criteria for post-traumatic stress disorder (PTSD) [16, 17]. The presence of trauma and PTSD has been shown to negatively impact treatment engagement, increase dropout rates, and affect treatment outcomes [16]. As such, trauma-informed care is an essential component of safe and effective eating disorder treatment.

Trauma-informed care acknowledges the widespread prevalence of trauma, recognises the signs and symptoms of trauma in individuals, families, and staff, and actively seeks to avoid re-traumatisation [18]. This approach is delivered in a collaborative, emotionally safe environment that is sensitive to the individual's needs and provides opportunity for choice. Core principles include safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment and choice, and attention to cultural, historical, and gender issues [13].

In the inpatient setting, trauma-informed care requires particular attention to practices that may be experienced as intrusive, distressing, or disempowering. This includes obtaining informed consent for weighing and physical examinations, understanding the potentially traumatising effects of medical interventions such as nasogastric feeding (NGF), minimising the use of involuntary treatment and restrictive practices, and providing choice and control wherever clinically safe to do so [16, 17]. Clinicians should routinely assess for trauma history and PTSD symptoms and consider how trauma may be influencing eating disorder symptoms, emotional regulation, and engagement with treatment. Neurodivergence should also be considered in this context (see section 3.7 Considerations for neurodivergent individuals), as sensory sensitivities, communication differences, and prior experiences may shape trauma responses and increase vulnerability to distress. Strategies to minimise trauma associated with nasogastric tube (NGT) insertion are outlined in section 3.7.3 NGT placement considerations.

Where indicated and once medically stable, trauma-focused treatments may be integrated into the treatment plan during admission when the individual is willing and motivated to engage. Active suicidality and immediately life-threatening medical conditions are contraindications to initiating trauma-focused treatment. When immediate medical stabilisation or acute risk management is the priority, trauma-focused treatment should be incorporated into discharge planning to ensure continuity of care [15, 17, 19].

1.3.4 Inclusive of family and other supports

Family and other supports play a vital role in the recovery of individuals with eating disorders across the lifespan. It is important to recognise that not all individuals will have family involvement, and for some, family relationships may be a source of distress or trauma. "Family and other supports" is therefore broadly defined to include chosen family, friends, partners, and other significant relationships as identified by the individual, including nominated support persons appointed under the MHA2016 (see MHA2016 Nominated Support Persons Brochure [20]). The individual's preferences regarding who is involved in their care should always be respected, and clinicians should work to identify and engage appropriate supports even when traditional family structures are not available or appropriate [15].

Family-inclusive care recognises and values the strengths, knowledge, and expertise that family and other supports bring, and actively engages them as partners in treatment [9]. Family and other supports should be involved in care planning, treatment decisions, and discharge planning, as directed by the individual and in accordance with privacy and consent requirements.

In the inpatient setting, family and other supports should be provided with psychoeducation about eating disorders, the treatment approach, and how they can best support their loved one's recovery. Clinicians should recognise that family and other supports may be experiencing significant distress, burden, and feelings of helplessness, and should provide appropriate support and referral to carer-specific services where available. Family-inclusive approaches have been shown to improve treatment outcomes, reduce carer distress, and support sustainable recovery [9, 15].

1.3.5 Culturally safe and inclusive care

Care is tailored to everyone's unique identity, including cultural, spiritual or religious background, ethnicity, age and stage of life, gender identity, and sexual orientation. Culturally safe care goes beyond cultural competence to actively challenge power imbalances, recognise the impact of colonisation and systemic discrimination, and ensure that care is delivered in ways that are respectful of and responsive to the individual's cultural needs and values [21].

For Aboriginal and Torres Strait Islander peoples, clinicians recognise the ongoing impacts of colonisation, intergenerational trauma, and disconnection from country, culture, and community. Eating disorder treatment should be informed by an understanding of the complex relationship between colonisation, loss of traditional food practices, and contemporary health challenges including eating disorders [15, 21]. Where possible, care should involve Aboriginal and Torres Strait Islander health workers, incorporate connection to culture and country, and be delivered in partnership with Aboriginal and Torres Strait Islander community organisations.

For individuals from culturally and linguistically diverse backgrounds, care should be provided with access to professional interpreters, culturally appropriate assessment tools, and sensitivity to cultural beliefs about food, body image, and mental health. Clinicians should be aware that stigma related to mental health may be particularly pronounced in some cultural communities and should work to provide care that is respectful, confidential, and non-judgemental [9].

For individuals who identify as LGBTIQA+, care should be gender-affirming and recognise the impact of minority stress, discrimination, and trauma on eating disorder development and recovery. Clinicians should use correct pronouns and names, be aware of the specific vulnerabilities of this population, and ensure that the inpatient environment is safe and inclusive [9, 15].

For neurodivergent individuals, care should include adapting communication, sensory environments and treatment approaches to meet the unique needs of the individual. See section 3.7 Considerations for neurodivergent individuals for further information.

For individuals with intellectual disability, local Intellectual Disability Mental Health teams are available to provide specialist consultation and support alongside standard care.

Recent studies highlight that substance use disorders commonly co-occur in individuals with eating disorders, underscoring the need for clinician awareness, routine screening and referral to appropriate services [22, 23]. This is particularly relevant to consider in inpatient settings given the additional nutritional, medical and psychosocial risks associated with this co-occurrence.

Eating disorders in older adults are increasingly recognised and may present with significant weight loss or malnutrition that warrants comprehensive assessment including consideration of underlying medical conditions and co-occurring mental health conditions. Although less commonly identified than in younger cohorts, eating disorders in later life are associated with considerable morbidity and require attentive and holistic clinical assessment [24].

1.3.6 Supporting self-management, empowerment and agency

Supporting individuals to develop skills in self-management and to exercise agency in their recovery is central to sustainable outcomes. This involves actively listening to the individual, respecting their lived experience, fostering a sense of ownership and control over their wellbeing, and building practical skills that can be applied beyond the inpatient setting [9].

In the inpatient context, where the severity of illness may necessitate more intensive medical and nursing intervention, there is an inherent tension between the need to provide life-saving treatment and the goal of supporting self-management and autonomy. Clinicians must navigate this tension thoughtfully, recognising that the individual's capacity for self-management may be temporarily impaired by the effects of malnutrition, medical instability, or acute psychiatric symptoms, but that this does not negate their fundamental right to be involved in their care [15]. To support this involvement, clinicians should provide clear, accessible explanations about treatment options, the rationale for interventions, and the expected steps in care, thereby promoting shared decision-making to the extent possible.

Individuals should be supported to participate in decision-making about their care, provided with clear explanations to understand the rationale for interventions, and to practise skills in meal planning, emotional regulation, and distress tolerance. Discharge planning should focus on building confidence and capability for self-management in the community, with clear pathways to ongoing support and stepped care [9, 15].

1.3.7 Functional and holistic recovery

Recovery from an eating disorder encompasses more than the resolution of symptoms or restoration of physical health. Functional and holistic recovery involves supporting individuals to return to or develop meaningful social, educational, occupational, and relational roles, and to build a life that is rich, connected, and aligned with their values and aspirations [9].

Inpatient care provides an opportunity to begin the process of functional recovery by addressing the cognitive, emotional, and behavioural impacts of malnutrition and acute illness. As individuals become medically stable and begin to engage with psychological therapies, attention should turn to practical skills and meaningful activities that support re-engagement with life beyond the eating disorder. This may include vocational planning, educational support, social skills development, and connecting with peer support or community resources [15].

Clinicians should recognise that functional recovery is a gradual process that extends well beyond the inpatient admission. Discharge planning should ensure that individuals have access to appropriate step-down care, community supports, and opportunities to continue building their recovery in environments that support autonomy, connection, and purpose. The goal is not simply to stabilise acute symptoms, but to support individuals to move towards lives that are meaningful, fulfilling, and free from the constraints of the eating disorder [9, 15].

1.4 Legislation

The provision of inpatient care for individuals with eating disorders in Queensland is governed by a range of legislative and regulatory frameworks that establish standards for safety, quality, human rights, and mental health treatment. Key legislation and standards include:

- *National Safety and Quality Health Service Standards* (second edition) [25]
- *Mental Health Act 2016* (Qld) (MHA2016) [26]
- *Human Rights Act 2019 (Qld)* (HRA2019) [27]

- *Guardianship and Administration Act 2000* (Qld) (GAA2000) [28]
- *Hospital and Health Boards Act 2011* (Qld) [29]
- *Public Sector Act 2022* (Qld) [30]
- *Public Records Act 2002* (Qld) [31]
- *Right to Information Act 2009* (Qld) [32]

1.4.1 Human rights considerations

Respect for human rights is fundamental to supporting the recovery of people living with mental illness. The HRA2019 [27] requires proper consideration to be given to human rights when making a decision that may affect or limit an individual's human rights. The provision of treatment and care in inpatient units must be in keeping with human rights considerations as per the HRA2019, including, but not limited to, access to health care, respect, privacy, cultural considerations, and humane treatment.

1.4.2 Capacity to consent to treatment

In Queensland, assessing an adult's capacity to consent to treatment for an eating disorder involves evaluating the individual's ability to understand and make informed decisions about their treatment. If an adult lacks capacity, involvement may be required from substitute decision-makers or other legal mechanisms under the MHA2016 [26] and the GAA2000 [28], guided by principles of least restrictive practices.

Most individuals can demonstrate that they have capacity with respect to their eating disorder treatment and are therefore able to be treated voluntarily and generally in the community. Often, a lower Body Mass Index (BMI) is associated with significant malnutrition and a diminished mental capacity to consent to treatment. This is linked to a lack of insight into the seriousness of the illness and what to expect with treatment as well as the risks of not undertaking the treatment. However, BMI is not a definitive indicator of mental capacity, and some low weight individuals may still retain full capacity and similarly, an individual within a healthy weight, or in a higher weight range can still lack capacity.

1.4.2.1 Presumption of capacity

Under Queensland legislation, an adult is presumed to have capacity to decide whether to agree to or decline healthcare, unless proven otherwise. Capacity means a person is capable of:

- understanding the nature and effect of decisions about a matter, and
- freely and voluntarily making decisions about a matter, and
- communicating the decisions in some way.

Capacity of an adult to make decisions may differ according to the type of decision, the complexity of the decision, and the support from the adult's existing support network.

For young people under 18 years of age, capacity to consent to healthcare is assessed on an individual basis and is not determined by age alone. A young person may have capacity to make decisions about their healthcare where they demonstrate sufficient maturity and understanding to comprehend the nature, purpose, risks and benefits of the proposed intervention, alternatives, and the consequences of not receiving treatment (Gillick competence), and can communicate their decision.

1.4.2.2 Capacity under the Mental Health Act 2016

The MHA2016 also defines capacity for the purposes of consenting to treatment of a mental illness. A person has capacity to consent to be treated for their mental illness if:

- the person can understand in general terms:
  - that the person has a mental illness, or symptoms of an illness, that affects mental health and wellbeing, and
  - the nature and purpose of the treatment for the illness, and
  - the benefits and risks of the treatment and alternatives, and
  - the consequences of not receiving treatment, and
- the person can make a decision and communicate it in some way.

If it is demonstrated that a person does not meet one of the above factors, the presumption of capacity will be rebutted (i.e., the person will not have capacity for the purposes of the MHA2016 [26]). A person may be supported by another person to understand the matters relevant to providing consent under the MHA2016.

1.4.3 Involuntary treatment under the Mental Health Act 2016

Involuntary treatment may be required for individuals with eating disorders if:

- the person has a mental illness, and
- the person does not have capacity to consent to treatment, and
- because of the person's illness, the absence of involuntary treatment is likely to result in imminent serious harm or serious mental or physical deterioration, and
- there is no less restrictive way for the person to receive treatment.

The MHA2016 [26] defines "treatment" of a person who has a mental illness as including anything done, or to be done, with the intention of having a therapeutic effect on the person's illness, including the provision of a diagnostic procedure. It is important to acknowledge that in working with individuals with eating disorders, treatment includes the provision of nutrition, vitamins and at times the supervision required to support the delivery of nutrition.

1.4.3.1 Less restrictive way

Under the MHA2016 [26], involuntary treatment cannot be used if there is a "less restrictive way" for the person to receive the necessary treatment. “Less restrictive way” includes:

- use of an advance health directive
- consent from a personal guardian or attorney
- consent from a statutory health attorney
- for a young person under 18 years of age – with the consent of the child or young person’s parent or legal guardian.

If no less restrictive way is identified and involuntary treatment under the MHA2016 [26] is required, regular reviews are undertaken by the Mental Health Review Tribunal to safeguard the individual's rights. Family and other supports are encouraged to be involved in these reviews.

1.4.4 Urgent health care under the Guardianship and Administration Act 2000

Section 63 of the GAA2000 [28] also allows for urgent health care of an adult without consent where the adult has impaired capacity, and either:

- the health care should be carried out urgently to meet imminent risk to the adult's life or health; or

- the health care should be carried out urgently to prevent significant pain or distress to the adult, and it is not reasonably practicable to get consent from a person who may lawfully give consent.

A health provider must not proceed without consent if aware of a known objection to health care in an advance health directive.

Urgent treatment to prevent significant pain or distress must not be provided without consent where the health provider knows the adult objects, unless:

- the adult has no, or minimal understanding of what the health care involves and why it is required; or
- the healthcare is likely to cause the adult no distress, or the temporary distress that might be caused is outweighed by the benefits to the adult of providing the health care.

The health provider must certify in the adult's clinical records as to the various things enabling the health care to be carried out.

1.4.4.1 Substitute decision-makers

For non-urgent healthcare of an adult who lacks capacity, consent of a substitute decision maker is required. Section 66 of the GAA2000 [28] sets out the order of priority for substitute decision making.

Where appropriate, a guardian may be appointed under the GAA2000 [28] to make decisions about personal matters, which may include health care. The order made by Queensland Civil and Administrative Tribunal will specify the type of personal decisions a guardian can make. The Public Guardian can be appointed by Queensland Civil and Administrative Tribunal as a guardian of last resort.

Before providing treatment, a health practitioner must take reasonable steps to confirm whether an individual has an advance health directive or a substitute decision-maker appointed. The practitioner must ensure that the correct substitute decision-maker is identified and consulted to provide informed consent before treatment proceeds.

1.4.5 Restrictive practices

Reducing restrictive interventions and working towards the elimination of restrictive practices in mental health services is a national priority that is supported by local, state, national and international frameworks, policies and legislation. Queensland Health is committed to minimising and, where possible, eliminating the use of restrictive practices across all settings.

Restrictive interventions are a last resort measure that must only be used when all other available clinically appropriate interventions have been considered, there remains an imminent risk of harm and the potential impacts of using the restrictive intervention have been considered. Occasionally there may be a need to provide life-saving treatment that requires the brief use of restraint, and this includes both physical and mechanical restraint. When considering this practice medical officers should make themselves aware of the relevant legislation and policies. Such practices should only be employed as a last resort. Restrictive practices must be applied in adherence with relevant legislation. In addition, the use of restrictive practices may lead to trauma or may compound trauma for some [33]. As such, it is important for staff to use restorative care practices to rebuild patients' sense of safety and trust after experiencing restrictive practices [33].

1.4.6 Additional resources

Additional information and resources to support decision making and application of legislation:

- Guide to informed decision-making in healthcare; 2nd Edition [34]
- Advance Health Directives and less restrictive way of treatment [35]
- Treatment criteria, assessment of capacity, less restrictive way and advance health directives - Chief Psychiatrist Policy [36]
- Mechanical restraint - Chief Psychiatrist Policy [37]
- Physical restraint - Chief Psychiatrist Policy [38]
- Consent to mental health treatment and care by the Public Guardian [39]

1.5 Supporting documents

This Guideline relates only to assessment and care of eating disorders. It should be considered in conjunction with other policies, standards, procedures, guidelines and protocols as relevant, including, but not limited to, the following:

- Assessing and responding to violence framework [40]
- Assessment and treatment of children and adolescents with eating disorders in Queensland [1]
- Co-occurring substance use disorders and other mental health disorders: Policy position statement for Mental Health Alcohol and Other Drugs Services [41]
- Domestic and family violence capability framework, guidelines and toolkit [42]
- Information sharing in mental health alcohol and other drugs care [43]
- Less restrictive way guidelines [44]
- Multimorbidity quality improvement strategy [45]
- The National Safety and Quality Health Service Standards (second edition) [25]
- Queensland multicultural policy and action plan [46]
- Suicide prevention practice guideline [47]
- Therapeutic visual observation for Mental Health and Alcohol and Other Drugs Services [48]
- Transition of care for young people receiving child and youth mental health services [49]
- Working with parents: Guidance for mental health alcohol and other drugs services [50]

2 Standard guidelines for inpatient eating disorder care

2.1 Multidisciplinary care

The treatment of eating disorders in inpatient settings requires an integrated, multidisciplinary approach [15]. This ensures a breadth of knowledge, skill and experience in assessment and treatment of the medical, nutritional and psychological sequelae of an eating disorder. The following sections provide specific guidance for medical, dietetic and nursing staff followed by guidance applicable to all disciplines. It is essential that the multidisciplinary team, regardless of their discipline, work in collaboration with each other, as well as the individual and their family and other supports, to ensure safe and effective care.

It is important to recognise that guidelines cannot provide detailed direction for managing every individual in every situation and do not replace clinical judgement. Variation in practice should be carefully considered by the multidisciplinary team and the rationale clearly documented in the health record. If further guidance is required, a subspecialist consultation with a local EDSS or QuEDS should be considered.

For individuals with significant and sustained risk concerns or complexity clinicians should follow local complex care review pathways. If the need for further escalation is identified from local complex care review, a referral may be made to the Office of the Chief Psychiatrist for a secondary consultation (see Referral pathways for complex care meetings [51]).

2.2 Guidance for medical officers

Eating disorders pose significant medical risks affecting multiple body systems and untreated can lead to severe malnutrition which results in multi-organ failure and increased mortality rates. Individuals with eating disorders are more vulnerable to the development of serious infections and other medical sequelae and therefore it is vital that when an individual presents to an emergency department in Queensland with possible medical complications of an eating disorder that all these multi-organ functions are initially examined carefully.

2.2.1 Assessment of eating disorders in adult emergency departments and indicators for admission

Key factors in assessing medical risk include evaluating BMI with concerns raised in those whose BMI is low but also where rapid weight loss as demonstrated by greater than 1kg/week loss over several weeks or where there is more than 10% over a 4-week period (irrespective of the BMI). Low nutritional intake, particularly over a prolonged period, significantly elevates risk of malnutrition and increases the risk of developing refeeding syndrome (see section 2.3 Guidance for dietitians and nutritional support). If an individual has fluid or electrolyte imbalances and/or is engaging in compensatory behaviours like purging or excessive exercise medical risk may be further elevated. It is important to recognise the elevated risk of malnutrition when an individual has co-occurring medical conditions, such as diabetes, or when they have co-occurring substance use as this will impact the nutritional status beyond restriction.

Eating disorders are associated with high rates of psychiatric comorbidity, particularly mood and anxiety disorders, resulting in significant psychological morbidity including depression, anxiety and low self-

esteem [23]. In addition, semi-starvation and malnutrition themselves can cause or exacerbate these symptoms, as demonstrated in the Minnesota Starvation Experiment [52]. Affected individuals will often be experiencing increased obsessive thoughts and fears about food and body image which can lead to social withdrawal and isolation. Additionally, there is a heightened risk of substance use which may require further assessment and support [22]. Emotional instability and difficulties managing emotional distress are common which further impact relationships and daily functioning. There is substantially increased risk of death by suicide secondary to the eating disorder, and clinicians should therefore follow established suicide-prevention frameworks in line with Queensland Health guidance [47]. Where an individual presents with co-occurring mental health conditions, appropriate referral to mental health supports should be facilitated – whether through public services, general practitioners (GP) or private providers – with consideration also given to social work involvement to support family and other supports and address broader psychosocial needs where required.

Further detail regarding assessment and admission indicators are shown in Table 1 below.

In collaboration with the individual, and their family and other supports, the recommended goals of inpatient medical treatment are to:

- establish medical stability
- carefully monitor for the emergence of refeeding syndrome and provide appropriate treatment where needed
- support the MDT in the engagement of families and other supports
- support the dietitians to provide nutritional resuscitation and rehabilitation with initiation of weight restoration as appropriate
- monitor for the reversal of cognitive effects of starvation so the individual can benefit from psychotherapy
- ensure, where possible that the individual can consume adequate nutrition and contain compensatory behaviours both on and off the ward prior to discharge
- engage appropriate allied health clinicians to provide discipline specific assessments and interventions to support safe and timely care
- arrange appropriate follow-up care in the community.

Table 1. Assessment and admission indicators

<table>
<tr><th colspan="2">Complete usual triage emergency department assessment</th></tr>
<tr><td colspan="2">Minimum assessment to be completed for all individuals with a diagnosed OR suspected eating disorder:
• measure blood pressure and heart rate at rest plus postural changes (sitting and standing with 2 minutes in between)
• collect blood tests including full blood count, electrolytes, liver function tests, glucose, phosphate, magnesium
• measure height and weight (do not rely on self-report) and calculate current BMI
• obtain an objective measure of any weight changes within the past 4 weeks
• assess oral intake and fluid status over the past 4 weeks, and particularly the past 5 days
• complete mental health screening assessment by including a risk assessment of suicide and consult Mental Health ED team accordingly
• Consider further assessment for sepsis (increased risk in this population) particularly where there are other signs of infection present *</td></tr>
<tr><td>INDICATOR OF ADMISSION TO ADULT MEDICAL WARD
(If any one of these factors is present)</td><td>INDICATOR OF ADMISSION TO AN ADULT MENTAL HEALTH WARD
(If any one of these factors is present)</td></tr>
<tr><td>• Systolic BP <80mmHg
• Systolic Postural BP drop of >20mmHg (2 minutes apart)
• Resting Heart Rate <40bpm or >120bpm*
• New ECG changes including QTc >460ms or ST/T wave abnormalities.
• Temperature <35.5°C
• Glucose (venous) <3.0mmol/L
• Potassium <3.0mmol/L
• Sodium <125mmol/L
• Magnesium <0.7mmol/L
• Phosphate <0.7mmol/L
• eGFR <60ml/min or 25% drop within 1 week
• Albumin <30g/L
• LFTs (AST or ALT) > 2x upper limit of normal
• Neutrophils <1.0 10/L
• BMI <13.0 kg/m²
• >10% total body weight loss over 4 weeks** or, more than 1kg/ week for over 4 weeks**

If none of the above parameters are identified during assessments in the emergency department then please refer all individuals to psychiatric emergency for a mental health assessment prior to discharge.</td><td>• Systolic BP 80-90mmHg
• Resting Heart Rate 40-50bpm
• Temperature 35.5-36.0°C
• Potassium 3.0-3.5mmol/L
• Sodium 125-130mmol/L
• BMI 13-15.0 kg/m2
• >25% total body weight loss in 6 months or less**
• Oral intake of less than 1000kcal/day for >4 weeks or more**
• Significant deterioration or lack of progress in community despite access to eating disorder treatment
• Suicide risk that is acutely higher as compared with individual baseline or as compared with community population.</td></tr>
<tr><td colspan="2">Additional notes for table reference:
• Importantly, clinical judgement should always be applied alongside the interpretation of the data points presented in this table.
• Currently, there is insufficient evidence to determine whether postural tachycardia should be an indicator for admission in isolation.
• Individuals who have blood glucose of 3.0–4.0mmol/L or postural tachycardia are exhibiting features of clinical deterioration and require increased monitoring in the community with nutritional support.
• Individuals with systolic BP of 80-90mmHg on Mental Health wards require Q-ADDS amendment review every 72 hours minimum to ensure compliance with local procedures on MET calls
• There will be circumstances when the BMI <15 is not considered reasonable for an admission based on that criteria alone or having achieved that but for the vast majority of individuals, the treatment they need is psychological and dietetic treatment in the community and accessing this at a weight less than 15kg/m2 is problematic due to the significant cognitive effects of starvation and would therefore leave most individuals at significant risk of deterioration
• For young people under 18 years of age, the admission guidance outlined in Assessment and treatment of children and adolescents with eating disorders in Queensland [1] may have been used to guide a referral, or may need to be consulted to support transfer to a child and adolescent mental health inpatient unit.</td></tr>
</table>

* Refers to the concerns regarding risk of infection
** Measured, objective or verifiable

2.2.2 The role of medical officers in enacting legislation for eating disorder inpatient treatment

Medical officers play a critical role in the assessment of capacity, determination of treatment pathways, and enactment of the legislative provisions (refer to section 1.4 Legislation). This responsibility requires careful clinical judgment, comprehensive documentation, and adherence to both the MHA2016 [26] and GAA2000 [28] frameworks, with particular attention to the principles of least restrictive practice and respect for human rights.

2.2.2.1 Key responsibilities of medical officers

- **Assessment of capacity:** Medical officers must assess whether an individual has capacity to consent to treatment. Capacity should not be assumed based solely on BMI or physical appearance as it reflects a cognitive process. Importantly, cognitive impairment related to malnutrition or starvation can occur at any body weight and should be carefully considered in the assessment. The clinical state of individuals with eating disorders can change rapidly, particularly during refeeding and medical stabilisation. Medical officers are responsible for regularly reassessing capacity and reviewing the need for involuntary treatment, with consideration given to transitioning to voluntary treatment as soon as clinically appropriate. When considering application of MHA2016, [26], determination of an individual's capacity to consent to treatment of a mental illness can pose challenges for medical officers unfamiliar with eating disorders due to the nuance of assessing the risks of treatment and no treatment in the context of the need for physical health treatments. In this instance, additional support may be required (e.g. by contacting local EDSS or QuEDS).
- **Determination of involuntary treatment criteria:** When an individual lacks capacity, medical officers must assess whether the criteria for involuntary treatment under the MHA2016 [26] are met, including consideration of less restrictive alternatives to provide necessary treatment and care. If a Treatment Authority is made the medical officer must consider the individual's views, wishes and preferences and ensure the individual is supported to use and understand their rights under MHA2016 [26].
  - In circumstances where there is a delay in accessing MHA2016 [26] assessment and the risk is imminent urgent care provision under the GAA2000 [28] may be utilised (see below) to enable treatment for medical risk, including nutrition. In this scenario an assessment for the application of the MHA2016 should be completed at earliest opportunity and reviewed regularly.
  - Under the MHA2016 [26] treatment encompasses anything done or to be done with the intention of having a therapeutic effect on the person's mental illness. This may include all components required for the management of an eating disorder, including nutrition, hydration, electrolyte replacement, vitamin supplementation and the provision of nursing and MDT supports necessary to ensure both the delivery and the maintenance of the adequate nutritional intake, including the management of compensatory behaviours.
- **Use of urgent health care provisions:** Medical officers may need to invoke Section 63 of the GAA2000 [28] when urgent healthcare is required. All such decisions must be clearly documented in the individual's health record, including the rationale for determining that treatment was urgent and that it was not reasonably practicable to obtain consent.
- **Application of least restrictive principles:** In all decision-making, medical officers must prioritise the least restrictive approach consistent with the individual's safety and treatment needs. When restrictive practices are necessary, they should be used for the shortest possible duration and subject to regular review.

2.2.3 Medical monitoring and management of complications during admission

Once a decision is made to admit an individual to an adult medical bed Consultation Liaison (CL) Psychiatry teams may be available to provide regular and frequent (daily if required) support to the medical team to assist them with the behavioural and psychological management. If CL teams are not available, then QuEDS or local EDSS are able to assist clinical teams with support.

Medical monitoring is a cornerstone of treatment in both the inpatient (medical/mental health ward) and community setting. The table below outlines appropriate medical monitoring from initial presentation to hospital and a guide to reducing frequency as clinically indicated throughout the admission.

Ensure the ward or hospital Dietitian has been advised of the admission (see section 2.3 Guidance for dietitians and nutritional support).

Table 2. Recommended medical officer orders: Medications, pathology and observations

Orders		Frequency at commencement	Reduction after initial refeeding period (7 days)
Medications	Thiamine	300 milligrams (mg) intramuscular or intravenous daily first 3 days	100mg oral daily after first 3 days
	Multivitamin	Daily	Daily
Pathology	TFTs B12/folate	Initial bloods	Not required unless abnormal on initial bloods
	FBC, e/LFTs, Phosphate, Mg, eGFR	Daily for at least the first 7 days	Twice weekly on weigh days
	Electrocardiogram (ECG)	Daily	Twice weekly if ongoing concerns - can be ceased if results continue to be within normal range but should be cautious where prolonged QTc has been identified or where medications may affect results.
Observations	Blood glucose levels (BGL; capillary)	If on NGF: 4 times daily (QID) + 0200hrs If on oral meal plan: 0200hrs, 0600hrs plus 1-2hrs post main meals	Twice daily (BD) Can cease if BGLs continue to be within normal range
	Postural BP + HR	QID	BD
	Temperature	QID	BD
	Fluid balance chart	Including IV, NG, oral food/fluid. Include output if medically indicated	Required for duration of admission
	Height	Objectively measured on presentation in ED and repeat the following day once in the early morning.	

If the local hospital and health service has access to PowerPlan support, then this monitoring will be ordered if the eating disorder PowerPlan is selected, as will 'orders' for vitamin and mineral supplementation, enteral feeding plans et cetera.

2.2.3.1 Management of medical complications

Individuals admitted for treatment of medical instability secondary to eating disordered behaviours may be medically compromised due to substantial periods of undernourishment or due to electrolyte derangement. Medical complications in the acute refeeding period may include risk of developing refeeding syndrome including electrolyte derangement, hydration shifts, cardiac symptoms,

gastrointestinal tract symptoms, hypoglycaemic episodes and/or risks of continued undernutrition if adequate nutrition is not promptly established.

- Electrolyte disturbance, manage according to the following guideline: Prescribing Guidelines for HYPO-Electrolyte Disturbances in Adults [53]
- Hypoglycaemic episodes often occur in the refeeding stage of severely malnourished individuals. Low BGLs (<4.0mmol/l) should be managed according to the Insulin Subcutaneous Order and Blood Glucose Record – Adult [54]. This clinical form includes guidelines for Medical Officers responding to blood glucose alerts and hypoglycaemia management in diabetes where the BGL is less than 4 mmol/L.

  Note: wherever the above document recommends giving fast acting carbohydrate, a slow acting carbohydrate should be given in addition as individuals with eating disorders are often malnourished with inadequate glycogen stores and may experience reactive hypoglycaemia following fast acting carbohydrate ingestion.
- Manage constipation as clinically indicated with stool softeners (e.g. Movicol). Stimulant laxatives (including Senna) should be avoided. Seek specialist assessment as required.

There are occasions when an individual will continue to experience medical instability and weight restoration may not track as expected despite following these guidelines. In these instances, it is recommended that clinical MDTs contact QuEDS or their local EDSS for secondary consultation.

2.2.3.2 Glucagon-like-peptide-1 (GLP-1) receptor agonists

Give the emerging use of GLP-1 receptor agonists and the limited evidence regarding their interaction with eating disorders, clinicians should exercise caution and undertake a careful risk-benefit assessment when initiating or continuing these medications in individuals with, or at risk of, an eating disorder. NEDC has published some initial education and guidance on GLP-1 use (see Eating disorders and glucagon-like peptide-1 receptor agonists (GLP-1 RAs) [55]) which clinicians are encouraged to consult particularly in inpatient settings or where individuals present already prescribed these agents. Ongoing screening for eating disorder symptoms and close monitoring are recommended during treatment, with consideration of discontinuation or modification if concerns arise, in collaboration with relevant specialist services.

2.2.4 Transfer of care from medical wards to mental health wards and/or discharge transition planning

Medical stability may be defined as the individual having received a minimum of 7 days of continuous nutrition in line with dietetic recommendations, having achieved and sustained goal nutrition for at least 24 hours and are no longer meeting criteria for medical ward admission. Clinical judgement remains essential and, in some cases, determined collaboratively by the treating medical and mental health teams – residual concerns regarding medical instability or persisting parameters may still warrant consideration with decisions regarding suitability for mental health settings made at the local level.

Therefore, once the initial seven-day refeeding period has passed, and the individual receiving care has received goal nutrition for a minimum of 24 hours, the MDT, in collaboration with the individual, their family and other supports, and the local CL team, should carefully consider the most appropriate setting for ongoing care.

The following factors should prompt consideration of transfer to a local mental health unit setting:

- the individual continues to meet criteria for mental health unit (see Table 1. Assessment and admission indicators)

- significant cognitive features of starvation syndrome persist requiring intensive, supported nutritional restoration
- the individual does not show adequate insight into the effect of the eating disorder and readiness to work towards eating regularly and adequately
- the individual is currently engaging in unmanageable compensatory behaviours that put them at risk of immediate deterioration if discharged
- the individual's BMI is below 15kg/m^2
- the individual is suffering from debilitating psychological distress that is unable to be supported in a community mental health setting
- the individual does not have the community supports in place to commence or re-commence evidence-based treatment for eating disorders.

Clear goals for admission should be collaboratively developed with the individual, their family and other supports and the mental health unit MDT.

If none of the above criteria apply it would be appropriate to discharge the individual from the medical setting. It is recommended that they step down to weekly medical monitoring with their allocated GP and an appropriate community team ensuring these plans are developed in collaboration with the individual and a copy is provided to them (verbally and in writing).

2.2.4.1 Leave program

The leave guidelines have been developed to support timely progress towards the admission goals of medical/nutritional rehabilitation. The goals of leave are to assess ability to eat off the ward, to help manage compensatory behaviours and to support the transition to continuing treatment/recovery in the community.

Decisions regarding leave should be based on clinical judgement and individual circumstances and determined collaboratively by the treating medical and mental health teams. Engagement with the individual and, where appropriate, their family and other supports is essential to this process. Clinical care remains person-centred and individualised, with leave considered as part of the overall treatment and risk management plan rather than applied according to fixed timeframes.

The leave program should be reviewed regularly at MDT meetings or ward rounds. Clinical judgement remains central to decision-making, supported by expert advice (i.e. EDSS or QuEDS) as required, and should be exercised in a flexible, recovery-oriented manner that balances medical safety, psychological wellbeing, therapeutic engagement, and individual recovery needs.

While leave is generally not recommended during periods of medical instability, it is acknowledged that the ward environment and the process of receiving nutrition can be highly distressing for individuals receiving treatment for an eating disorder. In some circumstances where there is clear therapeutic rationale, brief, highly supported escorted leave may be considered clinically appropriate following documented multidisciplinary risk-benefit discussion and with appropriate supervision and monitoring in place.

Table 3. Recommended leave program

Level	Leave conditions	Recommended criteria to access level
0	No leave	• Until individual has established 7 continuous days of medical stability
1	2 x 30 minutes daily escorted with staff/ support staff or appropriate family and other supports (not during	• Medical stability for 7 continuous days as outlined below • Systolic blood pressure (BP) ≥ 90mmHg and postural systolic BP drop of no more than 20mmHg • Heart Rate ≥ 50

Level	Leave conditions	Recommended criteria to access level
	meal/ snack times or post-meal supervision)	• Neutrophils ≥ 1.5 • BGLs above 3.5mmol/l • All electrolytes in normal range • Individual is demonstrating sufficient psychological stability to safely access community leave • 100% oral consumption of Step 1 and/or Step 2 (See section 2.2.5 for details) • Efforts to reduce compensatory behaviours noted • Participation in group program/meal challenges where offered (Specialist Eating Disorder Beds only)
2	2 hours of continuous unescorted leave, with details agreed in the MDT, off the ward for a meal or snack	• All criteria as outlined for Leave Level 1 • Successful use of leave allocated for Leave Level 1* • Increase of 1 BMI Band from admission (if weight restoration is goal of admission)
3	5 hours of continuous unescorted leave, with details agreed in the MDT, off the ward for a consecutive meal and snack	• All criteria as outlined for Leave Level 1 • Successful use of leave allocated for Leave Level 2* • Increase of 2 BMI Bands from admission (if weight restoration is goal of admission)
4	Overnight unescorted leave, with details agreed in the MDT, off the ward for a consecutive meal and snack	• All criteria as outlined for Leave Level 1 • Successful use of leave allocated for Leave Level 3* • Commencement of linkage with community supports
* i.e. remains medically stable, able to eat as prescribed whilst on leave and nil compensatory behaviours noted. In order to meet admission goals, if BMI Band does not increase within three weeks or compensatory behaviour is not adequately contained, one or more of the following will be considered by the MDT: • review of leave (reduce or cancel in collaboration with the individual • supervised toilet/shower • increased supervision on ward (+/- transfer to HDU/PICU) • increased nutrition.		

2.3 Guidance for dietitians and nutritional support

2.3.1 Medical admissions

The provision of nutrition is the cornerstone of addressing medical instability and should be commenced as soon as possible once the individual is accepted for an inpatient bed. Recommendations regarding nutrition provision and the route of nutrition provision should be determined through a person-centred assessment and MDT care planning. These recommendations should be communicated with the individual and their supports, including the rationale for the recommended route of nutrition provision and the plan for incremental nutrition increases.

If the degree of medical instability indicates the need for a medical admission, it is recommended that nutrition provision be via continuous enteral feeding, with consent by the individual. Nutrition provision via continuous enteral feeds decreases the likelihood of electrolyte abnormalities, hypoglycaemic events and reduces time to goal energy and length of admission while, for some, also alleviating pressure [56-58]. Complications of oral meal plans at this stage include gastrointestinal discomfort; increased risk of post-prandial hypoglycaemic events and hypoglycaemia during prolonged fasting (i.e. overnight); difficulties in meeting required nutrition to achieve medical stability and commence nutritional repletion process requiring increased duration of admission. A 2024 systematic review [59] suggested that NGT feeding, even if faced in the first instance with prejudices and fears by individuals, family and clinicians, is useful not only for effective and necessary weight restoration, but also alleviates their stress from feeding and, in general, it is psychologically well tolerated. An additional 2024 systematic review and thematic synthesis [60] reported that many individuals “felt saved when providers took responsibility” (e.g. implementing clear boundaries around dietary change). Handing over control was sometimes viewed as a necessary step towards recovery.

Oral meal plans require significant input by trained nursing staff to support adequate nutrition consumption and documentation of such.

2.3.2 Enteral feeding options

If enteral nutrition is endorsed by the MDT, and consented to by the individual, the following protocol is recommended based on best available evidence [57].

2.3.2.1 Nutrition option 1: Continuous enteral feeding

1. Commence 24hr continuous NGF at 6000kJ/1500kcal per day using a 1.5kcal/mL (6kJ/mL) fibre-free complete enteral feed (e.g. Nutrison Energy)
2. Consider use of Iso source Soy Energy (or equivalent allergen free formula) if diagnosed with anaphylactic reaction to fish or dairy
3. For additional enteral feeding protocols see standardised eating disorder enteral feeding regimens by the Collaboration of Dietitians in Eating Disorders (COD-ED) available on the following website Health Professionals | Nutrition Education Materials Online (NEMO) | Queensland Health [61]
4. If NGF is interrupted, consider provision of an equivalent catch-up bolus. If volume of loss is unknown, then provide catch up bolus of 150ml.

Table 4. Enteral feeding regimen

Day	Regimen – 24hr continuous enteral feeds	Energy (kJ/kcal)
Day 1, 2	40ml/hr Nutrison Energy (or equivalent)	6000/1500
Day 3, 4	55ml/hr Nutrison Energy (or equivalent)	8000/2000
Day 5, 6	70ml/hr Nutrison Energy (or equivalent)	10000/2500
Day 7 onwards	80ml/hr Nutrison Energy (or equivalent)	12000/3000

2.3.2.2 Nutrition option 2: Oral nutrition provision

Should enteral feeding be delayed or not consented to it is recommended oral nutrition provision is commenced as per the protocol below.

Commence oral liquid diet at 6000kJ/1500kcal per day (see default meal plan below).

Table 5. Oral liquid nutrition plan – interim use only

Meal	Supplement Prescribed
Breakfast 0730hrs	1 bottle/tetrapak Resource plus/Ensure plus/Fortisip Compact (or equivalent)
Morning tea 1000hrs	½ bottle/tetrapak Resource plus/Ensure plus/Fortisip Compact (or equivalent)
Lunch 1230hrs	1 bottle/tetrapak Resource plus/Ensure plus/Fortisip Compact (or equivalent)
Afternoon tea 1530hrs	½ bottle/tetrapak Resource plus/Ensure plus/Fortisip Compact (or equivalent)
Dinner 1730hrs	1 bottle/tetrapak Resource plus/Ensure plus/Fortisip Compact (or equivalent)
Supper 1930hrs	½ bottle/tetrapak Resource plus/Ensure plus/Fortisip Compact (or equivalent)
Late Supper 2130hrs	½ bottle/tetrapak Resource plus/Ensure plus/Fortisip Compact (or equivalent)

2.3.3 Barriers to adequate nutrition provision

Despite the essential nature of nutrition provision to reverse the medical side effects of an eating disorder, individuals experiencing eating disorders may not consent to nutrition provision via enteral feeds or consume adequate nutrition prescription orally due to the nature of the illness. In these instances, the MDT should consider how they can further support the individual to accept and retain nutrition (See section 2.4 Guidance for nursing staff and 2.5 Guidance for all health staff).

2.3.3.1 Other Considerations

When prescribing nutrition please consider the following:

- use low fibre, energy dense feeds/supplements (1.5kcal/ml or 6kJ/ml), to minimise gastrointestinal disturbance.
- calculate fluid requirements based on ~40ml/kg (unless medical management of hydration status indicates otherwise). Fluid dysregulation is common secondary to behavioural and medical reasons and regular clinical assessment of hydration status is suggested [62].
- limit oral water intake to 250ml/day whilst receiving enteral nutrition. No other oral liquid or food, apart from that required for medication or hydration purposes, is to be taken.
- no food should be brought in from outside/home, unless agreed within an ARFID care plan (see section 3.1 Considerations for Avoidant Restrictive Food Intake Disorder).
- avoid diet foods, lollies, chewing gum, excessive condiments, artificial sweeteners, tea and coffee.
- hypoglycaemia management – acutely treat as per hospital guidelines, noting likely inadequate carbohydrate stores therefore short then long-acting carbohydrate may be appropriate. Team to review possible causes – e.g. compensatory behaviours, inadequate meal plan, glycaemic index (GI) of meal plan, evidence of higher-than-expected energy requirements. Adjust meal plan and monitoring accordingly.
- where discussion of weight is clinically indicated, this should be considered by the full multidisciplinary team, with agreement on who is best placed to communicate this and how it will be approached in a sensitive and appropriate manner.

2.3.3.2 Accelerated refeeding protocols

In some instances, it may be indicated to commence individuals on higher feeding rates than detailed previously. For example, if refeeding risk (see Appendix 2: Key definitions) is low or individual has recently completed a refeeding protocol (<10 days prior). Alternatively, feeds can be progressed in 2000kJ/500kcal increments every second day until goal energy of 12000kJ/3000kcal is reached. This decision to commence accelerated protocol is the decision of the MDT and in these cases medical monitoring should be as per standard protocol.

2.3.4 Ceasing enteral feeding

If medically stable and goal energy has been provided for 48 hours, the following options may be considered:

- continuing NGF to maintain medical stability if transferring to a mental health unit OR
- commencing an oral meal plan, topped up with overnight feeds to meet goal energy OR
- commencing 3 step oral meal plan at goal energy – use COD-ED resources for standard meal plans available on the following website Health Professionals | Nutrition Education Materials Online (NEMO) | Queensland Health [61].

It is recommended that the NGT remain in place until not required for 3 consecutive days, collectively decided with the individual.

If goal energy has been provided for 48 hours yet not medically stable, then consider:

- continuing 24hr NGF until medical stability is reached OR
- progressing to a combination of overnight NGF with a three-step meal plan to meet goal energy (see 2.3.5 Three-step meal plan).

Where there is non-acceptance of NGT feeds or concerns about tampering with feeds:

- care should be given to ensure that nutrition is delivered with a recovery-orientated compassionate and least restrictive framework with clear, consistent communication, preservation of dignity and ongoing efforts to support the individual's engagement and autonomy
- bolus may reduce opportunity for tampering with feed, reduce length of time of feeding when individual is distressed, push bolus, reducing number of episodes to twice/day and increase volume as tolerated up to 1000mL per bolus [63]
- delivering a constant and controlled supply of nutritional replacement via continuous NGT feed is the safest way of minimising refeeding risk in the severely ill patient.
- this includes when:
  - the individual meets criteria for admission to medical ward, indicating clinical or biochemical instability and/or life-threatening malnutrition
  - the individual is unable to achieve sufficient oral fluid and nutritional intake from food and/or sip feeds to stabilise and restore physical health
  - oral meal plans and/or bolus feeding may be used in specialist units where staff are all highly trained.

2.3.4.1 Direct admission to Mental Health

If admitted directly to a mental health unit, an oral meal plan is usually recommended due to the reduced risk of refeeding associated with mental health unit parameters. The dietitian should still ensure a thorough nutrition assessment is completed including risk of refeeding syndrome. When developing meal plans, ensure this is in collaboration with the individual, where possible allowing choice of meals and snacks within the context of the calculated nutritional requirements and the food service system which is in place. Dietitians are encouraged to refer to the COD-ED documents 'Recovery focused dietetic care for mental health unit for eating disorders' [64] and 'Negotiating meal plans for individuals with an eating disorder in the inpatient setting' [65] for additional information on the nutrition rehabilitation process. Table 6 details a default meal plan which may be utilised prior to a dietitian review. Meal plans provided to the individual and clinicians do not require caloric/KJ information, as this is information is contraindicated in the provision of nutrition therapy which focuses on moving away from numbers.

2.3.5 Three-step meal plan

The intermittent nature of an oral meal plan exposes individuals experiencing malnutrition to a higher risk of hypoglycaemic episodes. Consider commencement of a three-step meal plan at 8000kJ/2000kcal to ensure adequate nutrition and minimise risk of hypoglycaemic episodes secondary to underfeeding. Decrease duration of overnight fasts by introducing late supper and early pre-breakfast snacks and avoid excessive use of high GI snacks and fluids as these may precipitate hypoglycaemic responses. When commencing three-step meal plan consider the following:

- ensure supplement replacement option is of equivalent energy content for each meal and snack

- copies of meal plan should be available for individual and staff
- progress prescribed nutrition in 2000kJ/500kcal increments every two days until goal energy (based on nutrition restoration goals) is reached
- usual protocol is to progress nutrition to ~12MJ/day, however, nutrition goals may be altered according to weight restoration or maintenance requirements of the individual
- calculate fluid requirements based on ~40ml/kg (unless medical management indicates other)
- ensure there is a clear and documented decision by the MDT if step three is being to be utilised to support nutrition.

The process for the three-step meal plan is as follows:

- **Step one:** Consume 100% of prescribed meal in allocated time*, if <100% consumed proceed to step two
- **Step two:** Consume 100% of liquid supplement in allocated time*, if <100% consumed proceed to step three
- **Step three**: Remainder of liquid supplement to be delivered via nasogastric bolus (if part of the approved MDT treatment plan).

Table 6. 8000kJ/2000kcal default/example three-step meal plan

Meal	Time	Step one	Step two	Step three
Breakfast	**0730 hrs**	1 cereal with 150ml milk AND 1 fruit (or fruit juice) AND Yoghurt	250ml Sustagen/Resource plus/Ensure Plus or 120ml Fortisip Compact	Via NGT
Morning tea	**1000 hrs**	175-200g yoghurt OR portion pack cheese and crackers AND 2 sweet biscuits	250ml Breaka/Milk/Sustagen	Via NGT
Lunch	**1230 hrs**	1 Main meal option (sandwich, hot meal, salad)	250ml Sustagen/Resource plus/Ensure Plus or 120ml Fortisip Compact	Via NGT
Afternoon tea	**1530 hrs**	175-200g yoghurt OR 2 sweet biscuits + 150ml milk	250ml Breaka/Milk/Sustagen	Via NGT
Dinner	**1730 hrs**	1 Main meal option (sandwich, hot meal, salad)	250ml Sustagen/Resource plus/Ensure Plus or 120ml Fortisip Compact	Via NGT
Supper	**1930 hrs**	150ml glass milk/ 200 ml soy milk and 1 fruit OR 2 sweet biscuits	250ml Breaka/Milk/Sustagen	Via NGT
Later Supper	**2130 hrs**	150ml glass milk OR 200ml soymilk and 1 fruit or 2 sweet biscuits	250ml Breaka/Milk/Sustagen	Via NGT

* Allocated time frames: 30 minutes for meals, 20 minutes for snacks, and 10 minutes for liquid supplements.

2.3.5.1 Implementation of meal plan

When implementing three-step meal plan consider the following:

- recommend provision of Supportive Meal Therapy (SMT; see section 2.4.5 Supportive Meal Therapy) to support oral intake. Oral meal plans require significant input by nursing staff who are trained in SMT to support adequate nutrition consumption and documentation of such.
- menu items to be adjusted according to local foodservice and in consultation with the dietitian, individual, family and other supports
- nutrient intake to be divided over a minimum of three meals and three to four snacks
- low energy foods should be limited (e.g. max three serves fruit per day, soup)
- coffee, tea and other caffeinated drinks should be limited to three cups per day
- at least one hot main meal should be included each day to work towards a regular eating pattern
- avoid diet products, chewing gum, lollies, excessive use of condiments, and artificial sweeteners as these can impact appetite regulation
- no food or fluids to be brought in from home unless planned in nutrition prescription
- food preferences should be assessed with careful consideration into the rationale for avoidance and impact on nutritional rehabilitation and recovery from their eating disorder
- in early stages of refeeding a low-fibre meal plan with use of oral nutrition supplements (ONS) for mid-meals may be better tolerated with regards to early satiety and gastrointestinal discomfort
- consider excessive reliance on high GI food and fluids which may precipitate hypoglycaemic episodes and electrolyte disturbance
- consider food quality with adequate variety for nutritional adequacy
- communicate clearly with individual when they can expect to see the dietitian and when meal plans can change.

2.3.6 Nutritional complications

Confirm allergies and intolerances through clinical history and recommended testing (serum allergen specific IgE) plus referral to immunology/allergist. All formal diagnoses must be adhered to, and clinical judgement should be used for other restrictions.

Individual characteristics may increase nutritional requirements, examples include young male, breastfeeding mother, athlete. In these instances, goal nutrition may need to be increased. Tolerance, rate of weight restoration and progression towards medical stability should be monitored closely.

If average weight gain of 1kg/week is not achieved with goal energy provided (where weight restoration is required), or there are episodes of medical instability, an assessment of the current management and support to minimise compensatory behaviours should occur, while recognising this may be not due to the actions of the individual. This could include:

- increasing level of support and supervision at meals and post meals
- reviewing of leave provisions
- consideration of supervision outside of meals times for instance when showering and toileting
- consideration of 1:1 nursing supervision where needed
- encouragement of restful behaviours
- addition of a “med pass” to meal plan (e.g. 60ml QID Resource 2.0/Fortisip Compact) to increase energy by 2000kJ/500kcal per day.

2.3.6.1 Hypoglycaemic episode management:

If hypoglycaemic events occur, consider the following as possible causes:

- compensatory behaviours
- inadequate meal plan
- use of excessive high GI snacks or fluids in meal plan (maybe as step two of three-step meal plan)
- evidence of higher-than-expected energy requirements (e.g. exercising overnight).

Acutely treat hypoglycaemic episodes as per local hospital and health service guidelines and followed by a low glycaemic index meal or snack.

2.3.7 Discharge nutrition

Begin to discuss and plan discharge nutrition requirements and meal plans when the individual commences the leave program. Leave provides an opportunity to trial foods which will be commonly consumed outside of the hospital. Further information on alignment of the nutrition plan with leave levels can be found in the COD-ED document Recovery focused dietetic care for mental health unit for eating disorders [64].

When developing discharge meal plans consider the following:

- take the time to ensure meal plans are developed in consultation with the individual and if possible, their families and other supports and communicate this both verbally and in written form
- meal plans should keep in mind dietary preferences, practices and beliefs, long term goals of achieving adequate nutritional status, increased nutritional variety and a healthy body weight for the individual (i.e. BMI >20kg/m2)
- meal plans provided to the individual and the clinicians do not require caloric/KJ information, as this is information is contraindicated in the provision of nutrition therapy which focuses on moving away from numbers
- discharge meal plans can include liquid ONS – purchase/supply should be promptly arranged to ensure discharge is not delayed

Examples of meal plans providing 10MJ and 12MJ are available from COD-ED [61]. These meal plans include vegetarian choices. A blank meal plan template allows the individual and dietitian to individualise a meal plan for discharge.

2.4 Guidance for nursing staff

2.4.1 Core principles of nursing management

As 24-hour providers of inpatient care, nursing staff play a critical role in the monitoring, management and support of individuals with an eating disorder [66]. Nurses are involved in all aspects of admission and the delivery of the four key components of inpatient management:

- medical and nutritional resuscitation (often occurs in the emergency department)
- medical and nutritional rehabilitation (often occurs in the medical wards)
- medical and nutritional stabilisation (often occurs in the mental health wards)
- providing psychological support (occurs throughout admission).

During inpatient care, an individual's eating disorder cognitions are often at their most intense, as the eating disorder may be striving to maintain control. The way in which an individual may manage the

distress related to these cognitions is by engaging in actions or behaviours that aim to compensate for dietary changes.

A core component of the nursing role is to create a safe, supportive, and non-judgemental environment in which individuals feel comfortable sharing their experiences. This enables collaborative identification and management of these behaviours and their associated triggers. Through this collaborative process, supported by a therapeutic relationship grounded in validation and compassion, nurses can utilise strategies such as positive reinforcement, de-escalation techniques, and motivational approaches to enhance engagement and work towards the treatment goals. Another important aim of this process is to support individuals in identifying and developing alternative coping strategies, and work towards reducing these behaviours.

2.4.1 Key nursing considerations

Individuals affected by eating disorders experience a complex interplay of both medical and psychiatric factors that impact their physical health, psychological wellbeing, and overall functioning. The severity of these illnesses should not be underestimated as the potential complications are serious and can be life threatening. Of the available data, approximately 20% of deaths occur by suicide [67] and over 50% of deaths are the result of medical complications [68].

Inpatient care hence requires careful supervision and support to ensure nutritional, physical and psychological safety and medical stability are achieved and maintained. A core part of the nursing role is to ensure that close monitoring and observation for signs of deterioration are managed and escalated appropriately, and that interventions and processes are approached carefully and accurately as outlined throughout this section. This approach balances medical safety with a recovery-oriented, person-centred framework. The goal is not only to interrupt eating disorder behaviours, but to support the individual in building the internal capacity, autonomy, and identity required for sustained recovery.

Transparency and collaborative problem-solving with the individual during this process is imperative, to ensure all aspects of care provision is approached in a recovery-focussed, trauma informed way. It is important to understand that during inpatient care, an individual's eating disorder cognitions are often at their most intense, as previously mentioned. This may change the way in which individual’s accept care and the required interventions. Ensuring that this is approached with compassion, validation and genuine curiosity in understanding their experience, is core in centring the consumer in their care and working towards developing a strong therapeutic relationship. An important way in which this can be achieved is ensuring that required interventions and their rationale, is clearly explained to each individual prior, and their preferences are explored jointly.

2.4.2 Continuous observations - continuous therapeutic visual observation

Higher levels of support and supervision may be required for individuals at increased medical or psychiatric risk or experiencing uncontrolled compensatory behaviours. Terminology for increased observation, support and supervision varies across settings. The term continuous observation has been used to describe what has traditionally been referred to as nurse special, constant observation, and one-to-one nursing. In this context, continuous therapeutic visual observation refers specifically to the observation level ordered under therapeutic visual observations within a mental health, alcohol and other drugs (MHAOD) service setting.

The role of the nurse undertaking continuous observations or continuous therapeutic visual observations is to support the individual and maintain safety by:

- providing constant supervision (which may include supervised bathroom use)

- providing SMT and post meal support (note that continuous therapeutic visual observation prohibits service provision to any other individual)
- monitoring and documenting dietary intake, and
- monitoring behaviours of concern and providing therapeutic interventions to promote reduction or cessation.

Continuous observations and continuous therapeutic visual observations should balance necessary supervision and support with the need to consider an individual's age, developmental stage, gender, cultural background, language and history of trauma.

For mental health units see Therapeutic Visual Observation for Mental Health and Alcohol and Other Drugs Services [48]

2.4.3 Nursing responsibilities

Table 7. Nursing responsibilities approaches and rationales

NOTE: Human rights and dignity to be maintained. Consider individual's gender preferences of nursing, privacy and coverage of exposed areas, and trauma history, when undertaking interventions that require close supervision, physical contact or disrobing.	
Approach	**Rationale and recommendations**
Activities of daily living (ADL)	
Direct supervision may be required (including when patient is using the shower or bathroom). When clinically indicated, it is important to ensure that staff maintain direct visual contact with the individual, this may include being physically present in the room.	Due to medical, physical and psychological risks. Unsupervised ADLs may provide an opportunity to engage in compensatory behaviours. Particularly important during post meal period, when urge to purge or otherwise compensate may be at its highest.
Bed allocation	
Offer shared room with shared bathroom (rather than single room) – consider high visibility bed near nursing station.	Increased visibility assists to decrease opportunities for compensatory behaviours and increase support as required. Reduced access to sinks and water can reduce opportunity for nutrition loss and excess fluid consumption.
BGL	
Observe individual wash and dry hands before peripheral test (finger prick). Completed 2 hours POST meal or QID +/- 0200 hours. If hypoglycaemia occurs overnight, consider if nutrition is inadequate for needs, or is being diverted. **<3.0mmol/L[†]** **Capillary BGLs <4.0mmol/l (see section 2.2.3.1 Management of medical complications)**	BGL's results can be altered if hands are contaminated (eg: moisturiser, sugar-water or jam). BGL's are tested 2 hours POST meal to identify postprandial hypoglycaemia (which occurs after nutrition is absorbed by the body). The longest period of time between meals/snacks is overnight, this is when BGL drops are most likely to occur.
Bowel Chart, Oedema Check, and Fluid and Food Balance Charts	
Record objective and observed food, fluid intake / output and bowel chart. Avoid use/prescription of senna-based and other stimulant laxatives. No laxatives from home (including laxative/diuretic teas).	Food charts can assist to identify difficult meals/snacks, patterns or issues with food services. They can also assist dietitian with menu planning and are essential to estimate the individual's nutrition intake and energy balance. Fluid can be used to artificially inflate weight, known as "fluid loading". Quality and frequency of bowel movements may be impacted by inadequate or inconsistent nutrition or hydration. Objective

[†] Arrange urgent RMO/ward call review if parameters meet any of the listed criteria

Approach	Rationale and recommendations
	(sighted, not reported) observation assists in determining what, if any, intervention is required. Restoring nutrition can result in fluid shifts and oedema. Oedema may also artificially inflate weight. The abrupt cessation of laxatives can result in rebound oedema and electrolyte imbalances.
ECG	
As prescribed by the treating team. Also necessary if significant BP postural changes (>20mmHg) are observed or chest pain reported. **Any arrhythmia or ECG changes†**	Heart muscle can be weakened and function impaired with inadequate or inconsistent nutrition. ECGs can detect cardiac compromise or changes and assist in treatment planning and intervention. V QTc prolongation may be related to electrolyte imbalances (especially hypokalaemia) or QT-prolonging drugs. Prioritise electrolyte repletion and repeat ECG after correction. Note the requirement to expose abdomen or chest area can be confronting and distressing.
Height	
On admission in emergency department.	Measured early morning, ensure individual is standing at fully height, legs straight, feet flat, ankles against the wall.
Leave	
Initially no leave from ward due to medical risks. As per QuEDS leave guidelines or treating team direction (see section 2.2.4.1 Leave program	Leave should align with nutritional goals and should therefore be used to support the individual to demonstrate the ability to maintain medical and nutritional safety off the ward. Leave may need to be ceased if weight goals or medical stability are not maintained. A comprehensive risk assessment and mental state examination to be completed and clearly documented prior to and on return from leave, with any concerns or changes escalated to the treating team. Note, leave can be a time of increased stress which may impact individual's mental and physical health risk profile.
Meal plan and SMT (see section 2.3.5.1 Implementation of meal plan and section 2.4.5 Supportive Meal Therapy)	
Meal plan as prescribed by dietitian (no changes by other staff or individual). Maintain 100% supervision throughout all meals and snacks. Eat a reasonable meal/snack with the individual.	The meal plan is prescribed to meet the individual's nutritional requirements. Changes may result in undernourishment and can reinforce eating disorder cognitions. The time around meals/snacks period can be distressing. Supervision and support are required to support the individual during this time. SMT provides an opportunity to role model healthy eating and acceptable behaviours during and following meals/snacks.
NGT	
Ensure NGT and line always remain visible, and syringes are not accessible by the individual. PH aspirate to test placement preferred. Fine bore with regular flushes as prescribed.	Strong eating disorder cognitions may result in interference with the tube and/or nutrition. To reduce radiation exposure and delays in renourishment pH aspirate is the preferred method to test placement, noting individual hospital policies and procedures may differ. Discuss removing NGT with MDT if nutrition goals are consistently met via oral route only (meal plan/liquid supplements) for 3 days.
Pathology	
FBC, e/LFT, Phosphate, Mg, B12/folate, TFTS and any others as indicated by clinical concerns and findings.	Bone marrow, neutrophils and leucocytes can be suppressed by inadequate nutrition, leading to a weakened immune system.

Approach	Rationale and recommendations
	Increased LFT's occur in both restrictive and high calorie/high carbohydrate intake, as well as in refeeding syndrome. Electrolyte balances may be disturbed by inadequate or inconsistent nutrition.
Property search (refer to Chief Psychiatrist Policy - Searches and Security [69])	
Conducted on admission, transfer or return from leave, and then as otherwise clinically indicated. Consider property search after visitors who may intentionally or accidentally/inadvertently bring contraband onto the ward. Refer to local searches and safety procedure.	Personal belongings may contain contraband or harmful items which may be used to serve eating disorder behaviours, such as NGTs or syringes, medications, condiments, laxatives, weights, gum or sweeteners. Individuals have increased psychiatric risks, including self-harm and suicide.
Therapeutic Visual Observations	
No less than 15 min between visual checks. Continuous observations may be required.	Individuals have increased psychiatric and medical risks, including falls, cardiac compromise, self-harm and suicide. Therapeutic visual observations should be performed by clinicians with the appropriate training and skills, due to the nature of risks, this may be best suited to a Registered Nurse. Consider one-to-one nurse patient ratio continuous supervision including supervised bathroom/toilet use. Curtains open at the patient's bedside until evening time.
Vitals	
Temp < 35.5c‡ **Pulse < 50bpm or > 120bpm‡** **Systolic BP below 90mmHg‡** **Postural drop > 20mmHg‡** Initially QID Respiratory Rate, Temp + postural HR and BP. Reduce frequency as clinically indicated (Note: continue postural HR and BP throughout admission). To complete postural observations: 1. Measure sitting BP and HR 2. Ask individual to stand, wait 2 mins 3. Complete standing BP and HR.	Heart muscle can be weakened with inadequate or inconsistent nutrition. Significant postural changes can indicate that the heart is struggling to compensate for normal postural changes. Low BP, HR, RR or temp are indicators of medical instability. Ensure the correct cuff is used for blood pressure monitoring. A paediatric, small adult or large cuff may be required.
Weighing (see Appendix 2: Key definitions for discussion and rationale of blind weighing).	
Unsighted ('blind') in emergency department and in early morning following any ward transfer. Then, routinely twice weekly (e.g. Monday and Thursday). Complete early morning, post urination and pre-breakfast, with removal of jewellery and wearing only a hospital gown. Refer to local HHS guidelines for property search policies and procedure as well as Chief Psychiatrist Policy - Searches and security **[69]**. Do not allow the individual to see their weight, cover the display panel or use a weigh chair- aka 'blind' weight. Do not provide ANY feedback on the result (including weight, BMI or trajectory, and general comments such as 'good', 'that's better' et cetera).	Tracking weight trends can help dietitians fine-tune and individualise meal plans (this includes altering the meal plan level, dependent on the individual's overall progress, including approaching discharge and goal weight). A consistent approach ensures the individual's weight is accurately recorded over time. Weighing individuals' early morning, post-void decreases the opportunity to modify weight by drinking a lot of water. Weighing individuals in a hospital gown ensures consistency with the weight of clothing worn at each weigh in. Weighing individuals in a hospital gown also decreases the opportunity to conceal objects to modify weight. It is important to be aware that individuals may hide objects on their person (in hair, underwear et cetera).

‡ Arrange urgent RMO/ward call review if parameters meet any of the listed criteria.

Approach	Rationale and recommendations
	'Blind' weighing can help decrease anxiety on weigh days and may reduce subsequent engagement in ED behaviours and increase ability to effectively engage with treatment. Progress is evaluated by looking at trends in weight change rather than a single weight in time. This is why reporting on the weight as an isolated number is unhelpful.

2.4.4 Support strategies for common eating disorder behaviours

A core component of the nursing role is to create a safe, supportive, and non-judgemental environment in which an individual feels comfortable sharing their experiences. This enables collaborative identification and reduction of these behaviours and their associated triggers. Through this collaborative process, supported by a therapeutic relationship grounded in validation and compassion, nurses can utilise strategies such as positive reinforcement, de-escalation techniques, and motivational approaches to enhance engagement and work towards the treatment goals. Another important aim of this process is to support individuals in identifying and developing alternative coping strategies, and work towards reducing these behaviours.

It is common for individuals to feel both a desire to recover and a strong pull toward eating disorder behaviours at the same time. Acknowledging this ambivalence can reduce shame and support more open engagement. All behaviours are understood as attempts to cope with distress, regain control, or reduce anxiety. Interventions should aim to address both the behaviour and the underlying need it is serving. Nurses work collaboratively with individuals to understand the function of behaviours and support the development of alternative coping strategies that align with the individual's recovery goals. When behaviours persist or escalate, this may indicate increased distress or unmet needs and provides an opportunity for further support and review. Address with curiosity.

Common behaviours may include, but are not limited to:

- excessive exercise/Incidental exercise (pacing, leg jiggling, excessively tidying bedspace)
- vomiting
- chewing/spitting
- syphoning/diverting/decanting enteral feeds or food
- chewing gum
- excessive use of sweeteners, salt or condiments
- modifying weight (fluid loading, carrying or sewing weights/heavy items in clothing, undergarments or hair).

If any behaviours are noticed or suspected, clearly document these and all interventions attempted (whether helpful or not). If behaviours persist despite support, involve the broader team to increase support, review strategies, and ensure safety. If concerns are ongoing, treating team may seek further support and guidance through consultation with EDSS or QuEDS.

Table 8. Identifying and responding to common behaviours

Behaviour	What to look for	What to do
Exercise	Pacing around the ward Sit-ups or leg raises in bed	Use calm, curious, and non-assumptive language to explore the behaviour (e.g. 'I noticed you've been moving a lot. What do you think that's about?'), while still maintaining clear and consistent boundaries. Explain that limiting

Behaviour	What to look for	What to do
	Moving legs constantly Excessive movement in bed bay (e.g. constantly tidying up, or making the bed)	movement supports medical stability and aligns with their goal of recovery (whatever these are for them personally, focus on full recovery) and returning to meaningful activities. Re-direct back to bed rest if on medical ward, use wheelchair or shower chair if required. Use distraction to avoid patient re-engaging in the behaviour. Consider PRN if unable to settle. Document all interventions clearly.
Inaccurate weights	Placing weights (e.g. coins) into hospital gown, undergarments, or in pockets or hair Wearing heavy clothing or jewellery Water loading	Dress in a new hospital gown immediately prior to weighing. Supervise bathroom use and avoid showering in evening and morning of weigh days. Remind the individual that fluid loading is dangerous and can be identified in their blood and urine tests. False weight readings are likely to lengthen and complicate admissions. Consider removing any fluid holding items from the individual's bed area (e.g. vases, water jugs), as these can be utilised to decant feeds or food, or fluid load. Individuals may use salt, vegemite et cetera to assist with fluid loading the night before weigh day, so these items should also not be accessible outside of mealtimes.
Interfering with NGT	Cutting holes in the tube Turning the machine on and off Changing the rate Disconnecting the line Redirecting feeds Syphoning feeds Removing NGT	Only nursing staff are to touch the NG machine. NGT and line to remain visible. Check the NGT regularly to ensure that the machine is turned on, running at the correct rate and there is no evidence of damage to the line. Remove sharp objects (pens, pins, scissors) or syringes to be left at the individual's bedside. Tape all connection points and bungs – check regularly to ensure these remain untouched. Disconnect feeds when showering. Consider covering the feed bag (e: with a pillowcase) if the individual finds this helpful. Ensure the face of the machine remains visible at all times. Position machine at the head of bed and away from arm reach. If NGT removed or displaced, replace NGT as soon as possible and re-commence nutrition. Document timeframes or quantity of nutrition missed or lost.
Purging	Intentional vomiting Regurgitation/rumination Excessive exercise Using laxatives, enemas or diuretics inappropriately Visitors may intentionally or accidentally/inadvertently bring contraband onto the ward	Monitor the bed and bathroom space for signs of vomiting e.g. clothing, bed linen, luggage, sinks. Encourage individual to attend to their toilet needs prior to mealtime. Continuous observation, including bathroom use, for 60mins post main meal and 30mins post snacks (see section 2.4.5 Supportive Meal Therapy). No extra fluids (these can be used to support vomiting). If contraband is found or suspected- consider more frequent property searches.

Behaviour	What to look for	What to do
Disposing of food	Throwing food in the bin Hiding food/feeds in containers (poppers, shampoo bottles, water bottles) or on the bottom of the plate or table et cetera Intentionally dropping food or crumbs	Avoid direct confrontation. Try gently reminding the individual that food is their medicine, and that adherence to the meal plan will ensure a smooth admission and discharge from hospital. Where appropriate replace lost food with replacement nutrition as per meal plan or at direction of dietitian.
Avoidance of nutrition	Arriving late to the table Chewing/spitting Cutting food into small pieces Eating excessively slowly Attempting to hide food Distraction/avoidance Asking to swap meal items Removing NGT See section 2.4.5 Supportive Meal Therapy for more information.	Watch closely to ensure that the individual has swallowed their food/NGT remains in situ. If NGT is removed or displaced, replace NGT as soon as possible and re-commence nutrition. Have awareness that in response to the distress and strong eating disordered cognitions that are often occurring during mealtimes, individuals may attempt to manage this by distracting nursing staff, for example by excessive talking. It is okay to engage in the conversation with gentle prompting to "*take another bite now"* throughout. Remain consistent with the treatment plan (e.g. the meal plan). It is not helpful to the consumer for you to engage in conversations around changes during these times. Reduce likelihood of this by ensuring talking through the plan and expectations prior to meals. (see section 2.4.5 Supportive Meal Therapy), and gently reminder consumers of this.
Body and shape checking/ recording	May include pinching or repeatedly touching parts of the body, such as the abdomen, arms and thighs, or feeling for protruding bones; assessing the change to fit of rings, bracelets and watchbands, or clothing; measuring circumference of wrists, thighs or arms with hands and may include marking the distance between with a pen.	Address these behaviours in a supportive manner, noting that body checking and recording perpetuates and maintains a preoccupation with weight and shape. Individuals may mark the space between two hands cupped around a limb and use this to measure changes in weight and shape. Encourage individual to wash this off if observed. Encourage the removal of jewellery.

2.4.5 Supportive Meal Therapy

For individuals with an eating disorder, meals and snacks are a time of heightened anxiety and distress [66]. Individuals often display maladaptive coping mechanisms to cope with the uncomfortable and distressing thoughts and emotions. These coping mechanisms may include (but are not limited to) avoiding or rushing the meal/snack, hiding or dropping food, exercising or other forms of purging.

SMT is a vital and effective strategy to support individuals during this time. SMT is more than simply sitting with, or observing, the individual eating. Instead, is it a way of providing emotional and practical support to the individual with an eating disorder. It aims to acknowledge and address the struggles faced before, during and after meals and snacks.

The key goals of SMT are to:

- facilitate and maintain regular and adequate nutrition
- facilitate weight restoration or maintenance
- increase self-confidence around consuming an adequate portion
- increase variety of foods consumed
- normalise and role model "normal" eating behaviours
- decrease fear of foods and ritualistic behaviours

There are three phases to SMT:

- pre-meal support
- supervised meal
- post-meal support.

All phases are critical in reaching the goals of SMT.

2.4.5.1 Pre meal support

Prior to a meal:

- talk through the SMT documentation – refer to local SMT documentation or contact QuEDS to assist with the development of same
- confirm individuals' meal preferences and check against the meal plan
- set clear expectations (e.g. completing 100% of the meal in the time frame, not negotiating on prescribed meal plan at the table, not leaving the table)
- brainstorm strategies with the individual for during and after the meal to support with managing challenging thoughts and emotions, along with potential urges to engage in maladaptive coping mechanisms (e.g. purging). Example strategies may include exploring topics of conversation for distraction (e.g. pets, travel, tv shows), and sensory modulation (e.g. use of heat packs)
- prompt to go to the bathroom.

2.4.5.2 Supervised meal

To support the individual to complete 100% of the prescribed oral meal plan in the timeframe allocated involves three steps (see section 2.3.5 Three-step meal plan). It is important to note, there is to be no variations from the dietitian's prescribed meal.

- **Step one:** involves a 30-minute timeframe to complete meals (breakfast, lunch and dinner), and a 20-minute timeframe for snacks (morning tea, afternoon tea and supper).
- **Step two:** individuals unable to complete 100% step one, will be provided an oral nutritional supplement.
- **Step three:** individuals unable to complete step two will be prescribed delivery of nutrition via NGT.

2.4.5.3 Post-meal support

Post-meal support occurs one hour post meals and 30 mins post snacks. Often post meal is when individuals distress can be heightened due to physical and psychological challenges and discomfort. Strategies to support this include:

- providing validation and reassurance
- development of distress tolerance skills e.g. distraction activities (board games, music, podcasts, et cetera)
- consider input from psychologists and occupational therapists for strategies to be implemented during this time including sensory modulation screening (e.g. heat packs, essential oils, music)
- see Supportive Meal Therapy (SMT) – Guidelines for Staff/Meal Chaperones [70].

In instances where meal supervision and post meal support are not available, it is recommended that individuals complete their meal/snack in the sight of staff (e.g. near the nursing station) or with a family member or other support person who has received guidance in the principles of SMT (see The Shared Table | Carer training program [71].

2.5 Guidance for all health staff

2.5.1 Important points to remember about the support of an individual affected by an eating disorder

- No one chooses to develop an eating disorder. No one is to blame, especially not the individual.
- Challenges accepting assistance and motivation for change can be part of having an eating disorder. Understanding and acceptance of the difficulties is essential for effective care.
- Long standing feelings of ineffectiveness or low self-worth are often core features of having an eating disorder. Avoidance of criticism is crucial and a consistent, collaborative approach necessary.
- Recovery is possible with appropriate support. Staff can play an important role in holding hope for recovery and supporting the individual to persist with treatment. Recovery is, however, a gradual process that extends beyond the inpatient admission and continues in community-based treatment settings. Inpatient care provides an important foundation for recovery by addressing acute medical risk and beginning nutritional rehabilitation.

2.5.2 Therapeutic interventions to support individuals with eating disorders during the acute assessment process

- Provide a clear explanation for the purpose of admission and explain what medical risk factors are present to assist the individual, family and other supports understand restrictions that may be put in place (e.g. limits on physical activity).
- Provide clear communication of expectations, both in verbal and written form, take the time to ensure a shared understanding of the rationale for treatment protocol, and encourage the involvement of families and other supports in both the assessment and treatment process. A written plan should be provided to the individual to reflect the plans made.
- Recognise that hospitalisation can be a highly stressful and potentially traumatising experience for individuals, families and other supports. Apply trauma-informed principles including clear communication, predictability, choice where possible, and prioritising emotional safety.
- Recognise that specific considerations may be required, and beneficial, when implementing a care plan for individuals with a severe and/or long standing presentation in a higher level of care; this may be to include more flexible goalsetting, higher levels of collaboration between individual and clinical staff, and an increased emphasis on quality of life, medical stability, and adequate nutritional rehabilitation as well as more tailored treatment planning.
- Recognise that without eating disorder-informed approaches integrated into the inpatient program, eating disorder symptoms and psychiatric sequalae may be inadvertently reinforced or may worsen during admission.

2.5.3 Allied health interventions and psychological supports that can be provided throughout inpatient care

- Implement a highly consistent and coordinated multidisciplinary approach across all treatment elements and phases. Remember that psychological or therapeutic interventions to support individuals with eating disorders are predicated on the collaborative development of treatment goals, and the clear communication of the rationale for all procedures and interventions.

- Maintain a consistent, empathetic, person-centred, non-judgemental, and nonpunitive approach at all times. For example, use correct pronouns and names and be aware of any specific differences that may be relevant to the individual to ensure that the inpatient environment is safe and inclusive. Consideration of specific vulnerabilities of this population as well as clear communication of the support available will help when balancing the need for structure and expectations re treatment goals with respect for the individual's autonomy and preferences.
- Communicate realistic expectations regarding the admission (verbally and in writing) to reduce uncertainty and minimise anxiety in the individual and the family and other supports as well as the staff team. Ensure understanding of the fact that whilst inpatient care can begin the recovery process by addressing acute medical or mental health risk, ongoing recovery requires sustained community treatment.
- Consider motivational interviewing techniques that may be helpful to increase willingness to change and address ambivalence by allowing the individual to feel more in control of their care and exercise their autonomy as much as possible.
- Identify particularly difficult times or situations for the individual and collaboratively assist with the development and use of strategies to help regulate anxiety. Document these as part of the management plan, provide the management plan to the individual in a manner that they are able to understand, and encourage the person to intervene early to avoid distress getting worse.
- Remember that eating disorder behaviours are an understandable response to a perceived threat that the individual may be experiencing. Externalising language can help in such situations and when therapeutically appropriate (e.g. "it seems like the eating disorder voice is making it difficult for you").
- Recognise that eating disorder behaviours can serve as emotion regulation strategies. When these behaviours are restricted during admission, distress can increase. This is an expected and understandable response, not treatment resistance. Strategies such as emotional regulation techniques, distress tolerance, and relaxation skills can help.
- Recognise that a collaborative multidisciplinary team that incorporates a variety of allied health practitioners (e.g. social work, psychology, and occupational therapy alongside dietetics) is optimal to eating disorder care in inpatient settings. Allied health clinicians can provide a range of individual interventions (such as disorder-specific psychoeducation and focused psychological strategies) that improve engagement in treatment, address psychosocial barriers, and facilitate comprehensive discharge planning as well as family inclusive practice.
- Additional recovery planning activities, where possible, such as therapeutic groups (adapted for the impact of malnutrition), input from appropriate lived experience speakers, and information about evidence-based outpatient therapy options can also optimises care.
- Where available, specific roles for allied health clinicians working to full scope to support people affected by eating disorders in the inpatient setting should also be considered.
    - Social workers work alongside the individual and the family and other supports to identify and address psychosocial barriers to treatment as well as enhance existing resources and strengths to support recovery. In the inpatient settings, social workers play an essential role in assisting the client and the team to build strong therapeutic relationships, navigate complex systems, and connect to community supports (interpersonal, financial, practical). Promoting social and emotional wellbeing and addressing inequity ensures multidisciplinary care is holistic, person centred and grounded in dignity and respect. As relational experts, social workers can lead the engagement of family and other supports, assess carer needs and capacity for involvement, and strengthen the natural care system to reduce carer burden and the risk of representation. For further information on family engagement see section 2.5.6 Suggestions for engaging families and other supports as well as the Social Work Structured Family Meeting protocol and

the Queensland Health guide to working with adult patients and families (for more information contact: Social Work and Welfare Clinical Education Program, Department of Health, GPO Box 48, Brisbane QLD 4001, SWWCEP-enquiries@health.qld.gov.au, phone (07) 3176 5407).

  - Psychologists may contribute to an individualised treatment plan via comprehensive assessment (including screening and recommendations to address co-occurring issues), psychological risk assessment and safety planning as indicated, individualised formulation of developmental and maintaining factors. Where possible individual or group program sessions may focus on developing understanding of the eating disorder mindset, psychoeducation, coping with distress (e.g. during weight restoration), exploring identity and values and discharge-planning.
  - Occupational therapists can assist individuals with progressing towards independence in managing their ADLs. This may include a functional assessment, support in building new skills and coping mechanisms and support re-engagement in life as they regain strength and nutrition during treatment. Interventions may include sensory modulation, such as the use of weighted blankets, proprioceptive activities, tactile fidgets, visual stimuli, scents and music. An occupational therapist can also support individuals to develop strategies such as breathing exercises and relaxation training to support with digestion, self-regulation and parasympathetic engagement and therapy programs to support therapeutic engagement and with increasing activity tolerance.
  - If available, additional allied health clinicians can also play an important role during inpatient treatment for an eating disorder. For example, and as indicated by the individual care needs, an exercise physiologist could provide an opportunity to support exercise adjustments and prescription if appropriate, a physiotherapist could be utilised to assess strength and assistance needs or support pelvic floor dysfunction if necessary, and a speech pathologist could provide intervention to address dysphagia and swallowing supports if required.

- Provide additional information to support the individual and family and other supports in learning more about eating disorders (see Appendix 4: Resources and support options).

2.5.4 Suggestions for engaging the individual in shared decision making, establishing collaborative treatment plans, and prioritising patient preferences in care

- Provide a “what to expect during admission” handout and/or orientation guide to all individuals, families and other supports.
- Identify the primary nurse and doctor, dietitian, liaison psychiatrist or psychiatric nurse practitioner, and social worker.
- The treatment approach should be collaboratively designed with the individual as much as possible, including structured support to facilitate the acceptance of nutrition. The medical necessity of nutritional rehabilitation should be explained clearly to both the individual and family and other supports.
- Acknowledging that when capacity is impaired or medical risk is acute, more intensive intervention may be required to ensure safety.
- For individuals receiving involuntary treatment under MHA2016, ensure they are aware of and understands their rights, as per the Statement of rights for patients of mental health services [72].
- Reinforce that the individual is considered an active participant in the treatment process by introducing strategies such as initiating a daily diary/cognition and mood record for noting eating

and emotional patterns, associated thoughts, feelings, and behaviours to enhance in preparation for transfer to outpatient therapy.

- Consider the development and delivery of structured groups to promote participation in recovery focused goals and strategies such as distress tolerance skills, mindfulness, relaxation, and art or music therapy that can both help with emotional regulation during the admission and offer additional preparatory tools for continuing treatment in the outpatient setting.
- Once medically stable, as per the definition, consider appropriateness for transfer to a mental health unit as soon as possible as these specialised settings may have higher patient to staff ratios, clinicians with expertise in complex psychopathology as well as therapeutic skills and resources that allow for adequate supervision of meals and behavioural contingencies to support nutritional restoration.

2.5.5 Suggestions for supporting staff to build and maintain an effective therapeutic alliance

- Prioritise a consistent multidisciplinary team approach to support engagement with treatment and provide clear, predictable care. Reinforce the importance of each staff member following care plans to minimise the potential for division or conflict within the care team and with the individual or family and other supports.
- Ensure an understanding across the treatment team that nutritional rehabilitation can increase the individual's distress and provoke treatment interfering behaviours. This can be challenging for individual staff and for team dynamics. Training to help staff recognise that behaviours such as food refusal, distress at mealtimes, or difficulty initiating eating are often manifestations of eating disorder symptoms and severe anxiety can help. Skills development to assist staff in responding with empathy, validation, and compassionate support to persist with the treatment plan is also important as clear boundaries, consistent actions, and therapeutic structure are essential components of safe and effective eating disorder treatment.
- Acknowledge that helping the person challenge eating disorder behaviours can at times leave staff feeling ineffectual, increasing the potential for blame/criticism of the individual or therapeutic nihilism/resignation that nothing is helping. Support staff to request assistance if experiencing low self-efficacy or expressing low confidence in their ability to help.
- Recognise that a proactive service response and resources are required for teams to adequately deal with the reactions staff may experience when working with people affected by eating disorders in an inpatient setting. Daily debriefing, care plan progress reviews, team and individual clinical supervision, and specific staff training may be required.
- Encourage staff to seek support from line management, supervisors, and colleagues as caregiving burden is common among teams working with individuals with eating disorders in intensive treatment settings.
- Provide and encourage attendance at professional development and educational training that has a focus on acute eating disorder presentations and the processes that explain and promote an effective response to symptoms in an inpatient setting.

2.5.6 Suggestions for engaging families and other supports during treatment in the inpatient setting

- Provide education and training for staff regarding the importance of awareness of, and sensitivity to, families and other supports.

- Inform the families and other supports about who exactly they should contact if they have concerns or questions, having this be a consistent team member is recommended.
- Inform families and other supports that it's common for an individual to find the inpatient setting difficult and for there to be an increase of eating disorder behaviours, eating disorder-related anxiety and distress in response to treatment.
- If the individual is consenting to the involvement of family and other supports, contact should aim to be rapid, consistent, and regular in order to enable the development of a timely and consistent approach to family inclusive treatment.
- Respect the individual's right to privacy and confidentiality. While families and other supports can always provide information to the treating team, information can only be shared with them if the individual consents (except in specific circumstances outlined in privacy legislation). Aim to work with the individual to identify who they would like involved in their care.
- While information sharing with informed consent is preferable, sharing information without consent may be considered on a case-by-case basis to a person who has "sufficient interest" in the health and welfare of a individual if it is considered necessary for the individual's treatment and care or to prevent serious risk to life, health or safety (see Information sharing | Queensland Health [43]).
- Recognise that educating families and other supports about their loved one's diagnosis, involving them in the development of the care plan, and including them in the treatment, may have been neglected by other health professionals and that all family and other supports can require ongoing information, resources, and support.
- Recognise that the eating disorder problem may try and isolate the individual by withholding consent to involve family and other supports but remember that they can still provide information to the treating team. Educate and help staff to understand that it is not breaking confidentiality to be given information.
- Recognise that admission can be a stressful experience for both the individual and the family and other supports.
- Provide clear information to families and other supports about treatment expectations and essential elements of the treatment plan at the start of admission and throughout the stay.
- Recognise that hospitalisation can also offer a brief respite for family members and other supports and assist them in restoring their emotional resources that will be needed to continue to care for the individual following discharge.
- Acknowledge that addressing eating disorder behaviours can leave families and other supports feeling exhausted and ineffectual, increasing the potential for criticism of the individual or therapeutic nihilism/resignation that the individual can't be helped.
- Encourage family and other supports to recognise that accepting and endorsing staff efforts to manage and treat symptoms may be the best thing they can do during the individual's inpatient stay. Practicing self-care is also very important. Later in the hospitalisation, families and other supports can also be provided with access to education and training in effective meal support and refeeding strategies (e.g. The Shared Table carer training program [71]).
- Establish realistic expectations and ensure that families and other supports receive regular updates and consistent messaging re the admission via a designated team member.
- Be cautious about how inpatient stay is discussed. Rather than seeing it as a failure, reinforce that this level of care is a necessary at this time and that it can be an important stage of treatment and that while a hospital stay will not cure the disorder, it can be a very helpful step in the recovery process.

- Remind families and other supports that the nutrition being provided is the assistance that is needed at this point in time. Emphasise that when individuals do not eat adequately it is very difficult to stabilise and treat psychiatric symptoms.
- Prepare family and other supports as well as the individual for discharge. This will help to contain anxiety and discuss about the need for ongoing treatment in an outpatient setting aimed at recovery and avoidance of future readmissions.
- Link families and other supports to community services and ongoing support options as soon as possible and include in discharge planning when appropriate.

2.5.7 Planning for transition to community care

- Involve the individual in discharge planning from the outset, supporting them to identify their goals for ongoing recovery and the type of support that would be most helpful.
- Identify accessible referral options for specialist evidence-based outpatient treatment and assist the individual and family and other supports to discuss and decide on the most appropriate outpatient treatment plan.
- Proactively facilitate referral to outpatient treatment as this may be difficult for the individual due to both low help seeking and ambivalence as well as accessibility barriers e.g. cost, location, availability and waiting list.
- Provide information about non-government support services (e.g. Eating Disorders Queensland – see Appendix 4: Resources and support options).

2.5.8 Supporting General Practitioners, care coordinators, and community clinicians providing ongoing care

- Start discharge planning at the beginning of the admission by ensuring that the individual has a GP and if not, assist them to connect with one prior to discharge.
- Ensure engagement with treating community clinicians from the outset, from assessment for admission to discharge. Ensuring cohesive treatment between inpatient teams and community teams is essential to support recovery.
- Provide information throughout the admission, even if the GP or care coordinator are not yet able to act on this information.
- On discharge, handover as much as possible to the relevant community team and share insights on what helped and what did not help with this individual.
- Where possible, facilitate warm handovers including direct communication between inpatient and community teams prior to discharge.
- If the individual is under a Treatment Authority, provide a copy (or equivalent summary) of the written information given to the individual outlining their authorised treatment and care plan, including any conditions or obligations related to community treatment.

2.5.9 Supporting individuals with longstanding eating disorders

- The term longstanding eating disorder does not denote a fixed diagnosis or absence of recovery, but instead reflects the duration, complexity, and individual trajectory of an individual’s experience.
- Individuals with a longstanding eating disorder have experienced an eating disorder over many years, often with persistent symptoms and limited response to multiple treatment interventions.

Longstanding eating disorders are often complex, with impacts across physical health, psychological wellbeing, and social and occupational functioning.

- Individuals may have evolving and diverse support needs over time, requiring flexible, person-centred approaches. Care planning should recognise that goals may extend beyond symptom reduction, and include quality of life, dignity, autonomy, and personal meaning, alongside safety and clinical considerations.
- The NEDC Holding Hope Guide and Workbook Series provide guidance to support individuals, families and other supports, and multidisciplinary teams to develop collaborative, person-centred care plans, with a focus on dignity, choice, and compassionate care, particularly in complex or non-linear recovery journeys [73].

2.5.10 Self-care for clinicians

- Working with individuals with eating disorders is highly rewarding and meaningful; however, it can also be complex and at times evoke feelings of uncertainty, frustration or not knowing what to do in challenging situations.
- Clinicians are encouraged to regularly check in with themselves, prioritise self-care and seek support where needed, including accessing local wellbeing resources.

Engagement with specialist eating disorder services, such as QuEDS or local equivalents is recommended to access clinical advice, education, supervision and opportunities for debriefing.

3 Additional considerations for special groups

3.1 Considerations for Avoidant Restrictive Food Intake Disorder (ARFID)

Diagnosis for ARFID is outlined in the ICD-11 [2], as symptomology of significant nutrient deficiency, dependence on enteral nutrition, significant psychosocial impairment and/or significant weight loss. Weight changes or low BMI are not required for a diagnosis of ARFID, and it is important to note that individuals with ARFID live in all body shapes and sizes. Individuals with ARFID do not restrict their food intake due to concerns about weight or body shape, which distinguishes ARFID from other eating disorders. ARFID may be co-diagnosed with other feeding and eating disorders, including pica, rumination disorder, and binge eating disorder. Food insecurity, cultural practices or other medical conditions need to be considered when diagnosing.

Australian prevalence data suggests young adults and adults present at a rate of 0.3% in the general population [74] and 1.98% in an adolescent population [75], this is similar to prevalence of AN.

ARFID is defined by limited volume or variety of food or fluid intake motivated by one or more of the following phenotypes [76, 77]:

- **sensory sensitivity:** heightened sensitivity to the sensory properties of food (e.g. taste, texture, appearance, smell),
- **fear of aversive consequences:** fear of choking, vomiting, or gastrointestinal pain secondary to food-related trauma – often acute in onset, maybe associated with an anxious predisposition, food avoidance may broaden over time to include entire food groups, or
- **lack of interest in food or eating:** secondary to low appetite, evidenced by low dietary volume, and associated with medical, nutritional, and/or psychosocial impairment.

A clinician can screen for ARFID using the Nine Item ARFID Screen, a validated tool to assess for the presence of ARFID [78].

ARFID is heterogeneous in presentation and requires both medical and psychological management [79]. The medical risk of individuals with low weight ARFID is similar to those with AN [80] and may require inpatient treatment if they become medically unstable or there is limited progression of community treatment. Admission to a medical or mental health unit for nutritional resuscitation and rehabilitation may be required to achieve medical stability, support severe micronutrient deficiencies and address starvation-induced cognitive changes to enable effective engagement in community-based treatment.

Evidence suggests that individuals with ARFID present with a high rate of co-occurring medical and psychiatric illnesses, including disorders of the gut brain interaction (DGBI), obsessive compulsive disorder, generalised anxiety, autism spectrum disorder, attention deficit hyperactivity disorder (ADHD), cognitive impairment and learning disorders [81].

3.1.1 Admission

Detailed psychological, medical and nutritional assessments including causation of limited nutritional intake, micronutrient deficiencies, medical sequelae and medical/psychological comorbidities should

inform treatment/management plan. A multi-pronged assessment and support/treatment may include clinicians from the following services: specialist eating disorder, CL, general medicine, gastroenterology, speech pathology, occupational therapy, psychology, and dietetics. Micronutrient deficiencies will vary due to the nature of the individual's type of restriction; dietetic and medical assessment should include extensive micronutrient pathology (including but not limited to iron, calcium, vitamin B12, vitamin D, folate, vitamin A and excess B6).

3.1.1.1 Goals of Inpatient Treatment

Goals of inpatient treatment of ARFID remain the same as with other eating disorders with additional considerations as follows:

- assess and address micronutrient deficiencies and excesses,
- exclude possible medical causes of limited oral intake (e.g. gastroenterology review, swallow assessment),
- emphasis is on adequate nutrition for discharge vs variety of nutrition – this may be achieved through use of liquid ONS or if required via enteral feeds,
- continue vitamin, mineral supplementation until deficits addressed and/or oral meal plan provides for all macronutrient and micronutrient requirements.

Individuals with ARFID presentations may require extra support to deal with:

- heightened sensory sensitivity to ward environment, NGF and oral feeding,
- fear of vomiting, choking, gastrointestinal symptomology
- constipation and abdominal pain
- anxiety, with/or without obsessive-compulsive behaviours
- poor appetite, early satiety
- lack of hunger and fullness cues
- Inability to complete volume of meal due to sensory fatigue, and
- significantly reduced acceptance of foods and fluids.

3.1.2 Standard nutritional management guidelines - considerations

It is recommended that medically unstable individuals with ARFID are managed according to standard guidelines for inpatient eating disorder care (see section 2) to facilitate progression to medical stability and nutritional rehabilitation.

Prompt clinical assessment by the dietitian (with appropriate reviews) is essential to inform the nutrition plan. Assessment of malnutrition should extend to micronutrients. Members of the treating team should consult, with consent, with families and other supports early in the admission to guide management and refeeding options.

The three-step meal plan (see section 2.3.5 Three-step meal plan) may be inappropriate, but all efforts should be taken to facilitate adequate nutrition intake prior to discharge with a combination of preferred foods plus ONS and multivitamin and mineral supplementation if necessary.

Transition to oral intake requires planning and clinical judgement with consideration of:

- admission goals
- motivations for avoiding foods

- consideration of individuals preferences
- flexible timing for introduction of oral intake (e.g. small meals/snacks over top of 24 hr continuous NGFs early in refeeding or as first step post 7 days nasogastric refeeding protocol)
- provision of preferred foods in oral meal plan (e.g. special meals - these may need to be provided from outside hospital, such as from home or hospital canteen)
- use of liquid supplements (ONS) in oral meal plan (as part of step one of three-step meal plan)
- slower progression of oral meal plan (e.g. snacks over top of 24hr continuous NGFs, overnight NGFs, use of liquid supplements to meet requirements, smaller serve sizes)
- commencing nutritional rehabilitation with increased volumes of preferred foods whilst nutritional deficiencies are addressed by vitamin/mineral and liquid supplements
- the need to ensure adequacy at mealtimes, before introducing novel foods or conducting food challenges
- the phenotypic presentations require varied exposure techniques
- service capabilities (e.g. consider occupational therapist involvement in sensory training).

3.1.3 Community treatment

Formulation of a community treatment plan should be initiated early in admission with the individual and if consent provided, in consultation with families and other supports and finalised prior to discharge. Consensus on recommendations propose a multi-disciplinary multi-modal approach [82]. Therapy to facilitate reduced avoidance and restriction of oral intake is best actioned via treatment in the community setting. Complete extinction of ARFID symptomology may not be the goal of treatment or viable due to neurodivergence or co-occurring conditions such as DGBI [83].

In addition to usual QuEDS recommendations, consider:

- referral to psychologist/mental health practitioner with experience in treatment of eating disorders and ideally Cognitive Behaviour Therapy for ARFID (CBT-AR) [84]
- referral to dietitian, for management of nutrient deficiencies and enteral nutrition management, if required, in addition to dietetic support to CBT-AR
- referral to clinicians with expertise to support additional sensory needs and expertise in the individual's co-diagnoses to build an appropriate and supportive MDT.

Early data suggests the presentation of ARFID could lead to development of weight and shape concerns with possible transition to other eating disorders diagnoses [85]. While ARFID symptomology will need to be addressed, the cognitions leading to these other diagnoses should be addressed first in evidence-based eating disorder treatment.

Individuals diagnosed with ARFID cannot currently access the Medicare Benefits Schedule item - *Eating Disorder Treatment and Management Plan* however, may be eligible for a *Mental Health Treatment Plan* and/or *Chronic Disease Management Plan*.

3.2 Considerations for individuals who are post bariatric surgery.

Individuals with eating disorders who have undergone bariatric surgery face a complex interplay of nutritional and psychological challenges. Some may experience exacerbated eating disorder symptoms or new manifestations of disordered eating patterns after surgery, potentially leading to malnutrition and

compromised health. Understanding this interaction is limited to overlapping symptoms and evolving presentations [86].

3.2.1 Post-surgical eating behaviours and diagnostic challenges

Loss of control (LOC) eating, including binge eating, is typical in post-bariatric surgery (PBS) individuals with a history of BED or objective binge episodes [87]. Studies show that 10–39% of patients develop LOC eating within two years post-surgery, sometimes as early as 4–6 months [86]. Grazing, though hard to define, is also prevalent, affecting 18.6–46.6% of PBS individuals. Postoperative changes, like reduced stomach capacity, can alter how LOC eating presents, making diagnosis challenging [88, 89]. Night eating syndrome and grazing are also prevalent but often underdiagnosed, as they can be mistaken for normal postoperative behaviours [86]. Research on excessive dietary restriction remains limited.

3.2.2 Nutritional and psychological risks

After bariatric surgery, majority of individuals may face elevated risks of malnutrition due to reduced stomach capacity, altered nutrient absorption, and dietary restrictions. A local study found that vulnerable micronutrients in the first 12 months after bariatric surgery include folate (after sleeve gastrectomy and gastric bypass) and vitamin B1, and potentially vitamin D, vitamin A and selenium after gastric bypass [90]. Longer-term at-risk nutrients include vitamin B12 and iron [90]. Inadequate protein intake may occur in the short-term perioperative period but can last longer in the setting of post-surgical complications or disordered eating [91]. Concurrent, rapid weight loss and dietary changes may exacerbate body image concerns, perpetuating ED symptoms.

3.2.3 Evidence gaps

Despite heightened awareness, research on eating disorders in PBS populations remains scarce. Current evidence indicates the following:

- **malnutrition risks:** nutritional deficiencies are common and necessitate vigilant monitoring
- **eating disorders:** BED exhibits a notable prevalence, potentially manifesting differently PBS, and is frequently associated with psychological and behavioural stressors [92]
- **limited robust data:** most studies are limited in scope, highlighting the necessity for extensive, longitudinal research to inform diagnostic and therapeutic approaches.

3.2.4 Challenges in diagnosis and treatment

The overlap of eating disorder symptoms with post-surgical adaptations complicates diagnosis. Distinguishing between adaptive eating behaviours (e.g. altered satiety and food tolerances) and pathological patterns is critical. Effective diagnosis and treatment require multidisciplinary care that includes nutritional, psychological, and medical assistance.

Further research is essential to improving understanding and outcomes to ensure comprehensive, evidence-based care for PBS individuals with eating disorders.

3.2.5 Admission

A comprehensive psychological, medical, and nutritional evaluation should include key at-risk micronutrient assessments and are specific depending on the classification of bariatric surgeries that have taken place:

- **sleeve gastrectomy:** ferritin, vitamin B12, folate, copper, ceruloplasmin, 25-OH vitamin D, vitamin B1, vitamin B6, RBC zinc along with haemoglobin, parathyroid hormone, albumin, and C-reactive protein
- **Roux-en-Y or single anastomosis gastric bypass:** all tests for sleeve gastrectomy plus vitamin A, retinol-binding protein, RBC zinc, serum selenium, and red blood cell glutathione peroxidase (RBCGPx)
- **historical biliopancreatic diversion:** all tests for sleeve gastrectomy and Roux-en-Y/single anastomosis, with the addition of vitamins E and C.

A complete blood profile is recommended before bariatric surgery to address any deficiencies, then prior to revisional surgery, thereafter 6- and 12-months post-surgery in the first year, then annually, or more frequently if deficiencies are present. Additional tests may be requested based on clinical judgment, including but not limited to alcohol withdrawal assessments. Research suggests that individuals who have undergone bariatric surgery have a high prevalence of alcohol use disorder and are at increased risk for alcohol withdrawal." [93, 94]. This multi-faceted assessment and treatment approach may involve collaboration with specialists in the following areas: eating disorder services, CL, general medicine, gastroenterology, psychology, and dietetics.

Goals of inpatient treatment remain the same as with other eating disorders with additional considerations as follows:

- provide adequate nutrition for medical stabilisation and nutritional rehabilitation
- identifying and addressing micronutrient deficiencies
- exclude possible medical/surgical causes of limited oral intake re. gastroenterology
- continue vitamin and mineral supplementation until acute deficits are addressed and the oral meal plan commences. The oral meal plan is unlikely to meet requirements, it is recommended to take long-term bariatric multivitamins, calcium, and vitamin D as per the American Society for Metabolic and Bariatric Surgery guidelines [95].

Individuals with eating disorders following bariatric surgery may require extra support to deal with:

- constipation and abdominal pain
- poor appetite and early satiety
- postprandial hypoglycaemia [96, 97].

3.2.6 Standard nutritional management guidelines – considerations

For medically unstable individuals, the standard guidelines for inpatient eating disorder care (see Section 2), continued enteral feeding and close monitoring are recommended to avoid refeeding syndrome and facilitate progression to medical stability and nutritional rehabilitation.

Depending on surgical history, feeding tube placement, (i.e. NGT or nasojejunal (NJT)), needs to be considered. A surgical consultation is recommended. A prompt clinical assessment by a dietitian (with appropriate reviews) is essential to inform the nutrition plan. Treating team members should consult with family and other supports early in the admission to guide management and refeeding options.

Renourishment for PBS individuals with eating disorders must account for the reduced stomach reservoir post-surgery, which limits their ability to consume the volume of food typically required to meet energy needs. The smaller gastric capacity, coupled with altered digestion and absorption, makes it challenging to achieve adequate oral intake without causing discomfort or complications like nausea, dumping syndrome, or postprandial hypoglycaemia.

Renourishment strategies should prioritise nutrient-dense, small, and frequent meals while considering the individual's tolerance and nutritional deficiencies. Please refer to the COD-ED resource *Eating disorders post bariatric and metabolic syndrome surgery - Dietitians guide* [98] for nutritional management considerations. A modified nutritional protocol for PBS individuals who are experiencing eating disorders needs to be considered; however, there are no high-quality tested protocols.

3.2.7 Community treatment

Formulation of a community treatment plan should be initiated early in admission in consultation with individual and if consent, with family and other supports and finalised prior to discharge. Consider the following:

- referral to a psychologist/mental health practitioner with experience in the treatment of eating disorders and, ideally, Cognitive Behavioural Therapy enhanced (CBT-E)
- referral to a dietitian (preferably with experience working with individuals post-bariatric surgery)
- referral to local eating disorder service.

Please refer to the COD-ED Clinician guide for community treatment considerations.

Additional clinical resources

- COD-ED Resource – Eating Disorders Post-Bariatric and Metabolic Syndrome Surgery - Dietitians Guide [98] is available by contacting QuEDSDietitians@health.qld.gov.au
- British Obesity and Metabolic Surgery Society Guidelines – Perioperative and postoperative biochemical monitoring and micronutrient replacement for patients undergoing bariatric surgery – 2020 update [99]
- NEDC – Management of eating disorders for people with higher weight: Clinical practice guideline [100]
- NEMO – Vitamin and Mineral Recommendations after Bariatric Surgery [101]
- Royal Australian College of General Practice - The bariatric surgery patient: Nutrition considerations [102]

Further reading

- Nutritional recommendations for adult bariatric surgery patients: Clinical practice [91]
- Nutritional pyramid for post-gastric bypass patients [103]
- Recommendations for nutritional care after bariatric surgery: Recommendations for best practice and SOFFCO-MM/AFERO/SFNCM/expert consensus [104]
- The optimal nutritional programme for bariatric and metabolic surgery [105]

3.3 Considerations for individuals with co-existing disorders of gut-brain-interaction (DGBIs)

Functional gastrointestinal disorders were renamed disorders of gut-brain interaction (DGBI) in the 2016 update to the Rome Foundation's diagnostic criteria (see Appendix 2: Key definitions) to address misconceptions surrounding functional gastrointestinal disorders, specifically that DGBI are less legitimate, defined, or 'organic' than other gastrointestinal diseases [106]. Indeed, there are clear diagnostic algorithms for DGBI, and an understanding of the molecular basis of the visceral hypersensitivity that underpins these disorders. There are evidence-based treatment options including medications, dietary interventions and brain-gut therapies for the motor and sensory components. More recently, there have been advances in understanding the inherent overlap between disorders of gut-brain interaction, motility disorders, and eating disorders, and the proposed utility of DGBI treatments to improve symptoms and treatment outcomes in individuals with eating disorders [107, 108].

Up to 98% of individuals with an eating disorder suffer functional gastrointestinal symptoms [109, 110], commonly dysphagia, heartburn, early satiety, abdominal pain, bloating, and constipation. Up to 49% meet criteria for three or more DGBI, the most common being functional dyspepsia and irritable bowel syndrome [110, 111].

Eating disorder cognitions and behaviours influence perception and response to gastrointestinal symptoms and may perpetuate symptoms [83, 110, 112-114].

Determining symptom reporting motivated by the eating disorder can be difficult. Disordered eating may reflect any combination of control of weight or shape, sensory food aversions, altered interoception including appetite, gastrointestinal symptom avoidance, or fear of consequences of eating [83, 111, 114-116].

Further, gastrointestinal dysmotility is common in eating disorders, hence it does not prohibit an eating disorder diagnosis. Studies indicate 20-50% of individuals have delayed gastric emptying [117, 118], with similar rates across AN, BN and ARFID [111].

In AN, gastric dilatation occurs in up to 82%, and two-thirds may have delayed colonic transit [118-120]. The overlap between functional dyspepsia, gastroparesis and ARFID may pose the greatest diagnostic challenge, with 77% of gastroparesis individuals screening positive for ARFID [116]. Rather than focusing on the separation of these disorders, recognition of their significant overlap has enabled a shift in treatment paradigm, where best practice includes collaborative management of the gastrointestinal symptoms during eating disorder treatment, wherever possible [107].

3.3.1 Individual considerations

It is recommended that medically unstable adults with eating disorders and either suspected or confirmed co-occurring DGBI are managed according to the standard guidelines for inpatient eating disorder care, with these additional considerations:

- individuals with DGBI present with a high rate of co-occurring medical/psychiatric illness - detailed multidisciplinary assessments and treatment planning should occur
- consider gastroenterology consultation (with expertise in DGBI):
  - if gastrointestinal symptoms are new or severe - this may require investigation such as faecal studies, cross-sectional abdominal imaging, or gastrointestinal endoscopy if necessary
  - for advice on management of significant gastrointestinal symptoms
  - when gastrointestinal symptoms are preventing nutritional rehabilitation
  - if considering alternative feeding routes such as NJT

- individuals with significant functional gastrointestinal symptoms may require additional support with the impact of heightened visceral hypersensitivity on nutritional rehabilitation (e.g. feed intolerance, severe post-prandial symptoms, heightened fear of aversive consequences of eating such as pain, vomiting, or choking, learned food aversions, and broad perceived food intolerances)
- the standard arms of DGBI treatment include neuromodulators, gut-directed psychotherapy, and dietary strategies with specialist gastroenterology guidance
- psychological support may be provided by CL or individual psychology with expertise in assessment, formulation and psychoeducation in functional disorders, or DGBI more specifically where available
- consider the role of prokinetics and neuromodulators to improve gastrointestinal symptoms and therefore support the goals of the eating disorder admission [107]
- minimise or avoid opioid medications where possible – consider Persistent Pain Service consultation for individuals as indicated [121-124]
- consider route of medication administration in individuals with known rumination, regurgitation, or vomiting, including orally dispersible preparations when possible
- optimise constipation management, including consideration of pelvic floor dysfunction and obstructed defecation, to improve gastrointestinal motility and both upper and lower gastrointestinal symptoms
- manage electrolyte and haemodynamic disturbances in eating disorder individuals with excessive losses for example due to vomiting or diarrhoea, per oral route where possible
- if presenting with chronically limited dietary variety, thorough assessment and targeted repletion of micronutrient deficiencies is recommended (see section 3.1.1)
- In individuals with severe symptoms, emphasis may be directed to adequate nutrition for discharge prioritised above variety of nutrition – this may be achieved through use of ONS if necessary, with ongoing community treatment required to progress to a full diet.

3.3.2 Nutritional management considerations

Prompt clinical assessment by the dietitian, with appropriate reviews, is essential to inform the nutrition plan. Assessment of malnutrition should extend to micronutrients with targeted repletion as required.

It is recommended that medically unstable individuals with DGBI requiring admission are cared for as per the standard guidelines for inpatient eating disorder care (see Section 2) in order to avoid refeeding syndrome, and to facilitate progression to medical stability and nutritional rehabilitation. Individuals should be supported in using the least invasive feeding route for the shortest duration necessary to achieve these goals. Failure to tolerate or progress on NGF despite MDT input should prompt input from a gastroenterologist with DGBI expertise.

It is recommended that post-pyloric feeding with NJT be considered only as a temporary measure in select cases with severe post-prandial symptoms limiting individual nutritional progress. MDT and sub-speciality gastroenterology input is required, with clear parameters around expected goals and duration of treatment, replacement in case of unexplained tube failure, and a tube weaning plan, to be discussed and agreed upon by the individual and treating team before insertion. More invasive feeding routes such as gastrostomy, jejunostomy, and parenteral nutrition, without medical indication (e.g. intestinal failure), carries significantly higher morbidity risk [122, 123]. Evidence in the DGBI population suggests long-term enteral nutrition does not improve functional gastrointestinal symptoms or weight gain [125, 126] and carries risk of perpetuating harmful cognitions and behaviours for those with eating disorders. It is recommended that the consulting gastroenterologist discuss all such cases with a sub-speciality MDT including neurogastroenterology or intestinal failure clinicians, before commencing.

Transition to oral intake via the three-step meal plan may be more challenging when significant functional gastrointestinal symptoms are present, however all efforts should be taken to discharge on adequate oral intake with as few dietary restrictions as possible. Consider MDT input for dietary, medication, and psychological support of severe functional gastrointestinal symptoms preventing oral transition [123].

Transition to oral intake requires planning and clinical judgement with consideration of:

- admission goals
- motivations for avoiding foods
- flexible timing of introduction and/or slower progression of oral intake, for example:
  - small snacks or low volume high protein high energy fluids in addition to 24 hr continuous NGF regimen early in refeeding or as first step post 7-day protocol
  - extended weaning of overnight NGFs
  - increased use of liquid supplements as part of step one of three-step meal plan
  - oral diet modifications; food density, volume, texture, fibre content and FODMAP (fermentable oligosaccharides, disaccharides, monosaccharides, and polyols) load may all influence DGBI symptoms
- accommodate objectively diagnosed food allergies and intolerances in the oral meal plan where clinically necessary – this may require collateral information from the individual's other care providers
- different symptom profiles and presentations require varied exposure techniques when introducing foods that illicit fear or aversion – consider multidisciplinary involvement to support oral food transition within service capabilities, for example:
  - occupational therapist involvement for sensory retraining
  - psychology involvement for relaxation, emotion regulation, distress tolerance and pain management strategies, or
  - nursing for SMT (see section 2.4.5) at meals times.

Note: Nutrition interventions that restrict the diet in any manner (volume or variety of foods, specific dietary patterns or food eliminations) may introduce additional risk for maintaining malnutrition, reinforcing eating disorder cognitions or behaviours and, in some cases, the DGBI symptoms [114, 127, 128]. It is recommended that modifications to three-step oral meal plans occur to the minimum extent necessary to achieve nutritional rehabilitation goals, with agreement from the full treating team. Further dietary modifications or interventions for gastrointestinal symptom management should be withheld until acute malnutrition and associated risk has resolved. Current guidance recommends cautious use, if not total avoidance, of restrictive dietary approaches in individuals with an active eating disorder [127-130].

3.4 Considerations for individuals who are pregnant or in the postpartum period

It is estimated that the prevalence rate of eating disorders during pregnancy is around 5-7% [131, 132]. There are often considerable feelings of guilt and shame as well as high levels of stigma that is attached to experiencing an eating disorder while pregnant, which can prevent women from seeking help.

Pregnancy is a vulnerable period for the onset or relapse of an eating disorder and can occur at any stage throughout the perinatal period [133, 134]. The perinatal period provides an ideal opportunity for screening for eating disorders, as women are actively engaged with healthcare providers during this

time. It is recommended that women be screened for eating disorders throughout pregnancy and early identification is optimal for foetal and pregnancy health. Routine and regular screening during pregnancy may contribute to taking special preventive measures for risk groups and protecting mother-child health. There are currently no validated eating disorder screening tools specifically designed for use in the perinatal period. The Eating Disorder Screen for Primary Care is used in the general population and has not been validated in the perinatal population but may be useful for initiating conversations and may be considered for use [135].

It can be difficult to recognise signs and symptoms of eating disorder in pregnancy as pregnancy related symptoms may mask eating disorder symptoms. Some pregnancy related symptoms that may mask eating disorder symptoms include:

- cravings may mask binge eating
- recommendations of avoidance of certain foods (e.g. for food safety reason) may mask restriction
- nausea and vomiting may mask restriction and purging.

Eating disorders can also lead to a range of serious medical complications in pregnant women. Women with eating disorders during pregnancy have a higher risk of experiencing pregnancy complications such as:

- premature and preterm birth
- gestational diabetes
- maternal anaemia
- miscarriage
- foetal growth restriction
- low infant birthweight
- infant feeding difficulties [135].

The more severe or prolonged the eating disorder is at the time of trying to get pregnant or sustain a pregnancy, the more significant the medical, gynaecological and obstetrical complications and risks [136]. A lot of these risks, if due to inadequate or excessive nutrition, can be reduced with appropriate care and nutrition during pregnancy [136].

Despite the complexity and risk of managing eating disorders in pregnancy, few studies are available to guide care. The below information is supported by a systematic review, identifying only eight studies that addressed the management of AN in pregnancy [137]. Managing eating disorders in pregnancy is an area of clinical care that requires a multidisciplinary approach and includes those experienced in managing high-risk pregnancies.

Additionally, it is important to consider that some women may first recognise previously undiagnosed neurodivergence during the perinatal period, as the increased cognitive, sensory, and emotional demands of pregnancy and early parenting can unmask traits. Awareness of this is relevant in mental health and eating disorder care to avoid misdiagnosis or diagnostic overshadowing [138] (see also section 3.7 Considerations for neurodivergent individuals).

Table 9. Suggested changes to *Table 1. Assessment and admission indicators* in the context of pregnancy [137]

Medical Parameters		Considerations in pregnancy for medical admission
Pathology	Magnesium	<0.66mmol/L
	eGFR	Not used in pregnancy

Medical Parameters		Considerations in pregnancy for medical admission
	Albumin	< 26g/L
	Liver enzymes	Any abnormal liver tests, including low range sustained abnormalities
	Creatinine	>30% increase in creatinine from early pregnancy >70 mmol/L in consideration with muscle mass
Anthropometry	Weight loss and inadequate weight gain	Lack of weight gain or low weight for pregnancy. Refer to expected weight gain in pregnancy recommendations: *Guidance for Healthy Weight Gain in Pregnancy* [139] A maternal BMI in pregnancy of less than 18 kg/m² with a pre-pregnancy BMI of 18 kg/m² or less should be a flag for consideration of nutritional support
Other	Ultrasound to monitor foetal growth	Suboptimal foetal growth (typically with symmetrical foetal growth restriction less than the tenth percentile for gestation or the crossing of individual growth centiles by 30–40 points)
	Oedema	Oedema is not uncommon as the pregnancy progresses but refeeding and heart failure can also be associated with oedema in AN and as such the differential diagnosis of any oedema should be carefully considered
	Echocardiogram	To monitor for cardiac concerns relating to restrictive eating disorders due to cardiac load during delivery.

3.4.1 Weight changes

As pregnancy progresses the use of BMI to monitor weight gain becomes increasingly flawed as fluid volume increases and placental and foetal weight vary considerably. Although there is guidance from professional societies on expected pregnancy weight gain, weight gain varies considerably across individuals and it is difficult to account for weight from fluid, the uterus, placenta, and foetus. Furthermore, although weight stabilisation might be somewhat reassuring in a non-pregnant individual with AN, within the context of pregnancy this almost inevitably is associated with overall body mass weight loss.

Criteria for admission for nutritional rehabilitation typically includes weight loss; however, in pregnancy, admission might also be in the context of lack of weight gain or low weight for pregnancy. A maternal BMI in pregnancy of less than 18 kg/m² with a pre-pregnancy BMI of 18 kg/m² or less should be a flag for consideration of nutritional support.

The use of a pregnancy weight gain tracker (which is a part of standard care in many maternity services) should be used with caution and it is recommended only as a clinical tool for the treating team rather than for use with individuals. Additionally, ensuring weight is being taken with consent and with clinical purpose (rather than just standards practice) and a discussion around options for how it is taken and discussed it has occurred (e.g. offering blind weights).

- Pregnancy weight gain chart for BMI more than 25kg/m2 | NEMO Maternal Health Group [140]
- Pregnancy weight gain chart for BMI less than 25kg/m2 | NEMO Maternal Health Group [141]

3.4.2 Pathology

It is recommended to complete the standard pathology for assessing medical stability in eating disorders (full blood count, electrolytes, liver function tests, glucose, phosphate, magnesium) as well as high risk nutrients including Vitamin D, iron and B12.

Many of the blood markers used to monitor the severity of weight loss are altered by the physiological changes of pregnancy and, therefore, interpretation in the context of AN and pregnancy needs adjustment.

3.4.3 Treatment

For individuals at high risk of medical complications, such as when pregnant, an inpatient admission or an intensive outpatient or day-care treatment should be considered. An inpatient admission can facilitate medical stabilisation through safe nutrition and weight restoration, as well as the prevention and treatment of refeeding syndrome, to reverse the acute cognitive effects of severe malnutrition, whilst supporting appropriate foetal growth and development.

Inpatient nutritional rehabilitation of AN in pregnancy is very similar to treatment in the non-pregnant state. A multidisciplinary approach to inpatient management is essential. When deciding on outpatient care, day care, or inpatient care, various factors should be taken into account: the BMI, the rate of weight loss (e.g. 1kg per week or more) or, in pregnancy, a lack of weight gain or concerns with foetal growth, and the need to actively monitor medical risk parameters, the woman's current overall physical health, specific mental and physical co-occurring conditions (e.g. gestational diabetes or type 1 diabetes), and whether families and other support can support an individual and keep them from serious harm as a day patient.

An important principle is that the provision of clinical care should always align with the aim of least restrictive practice, be trauma-informed, and wherever possible be collaborative with the women and their families and other supports. Consideration should be given to the family system when admitted to hospital as they may be the primary carer of children and require additional supports.

It is recommended to refer or consult with a dietitian for nutrition advice during the perinatal period, support the establishment of regular eating, and manage nutritional deficiencies as indicated [135]. A consumer resource developed by COD-ED Eating disorders, nutrition and pregnancy [142], can be provided to the consumer to support dietetic education.

It is also recommended to refer, with consent, to local perinatal mental health services given their ability to provide perinatal specific care through from conception to the first year postpartum.

3.4.4 Standard nutritional management guidelines - considerations

It is recommended that medically unstable adults with eating disorders who are also pregnant are managed according to the standard guidelines for inpatient eating disorder care (see Section 2), with additional considerations.

If the nutritional needs cannot be met, nasogastric feeding could be considered, which remains a clinically important option in pregnancy when increased intake might also be limited by common pregnancy complications, such as reflux, heartburn, and slower digestion associated with the hormonal changes involved in pregnancy.

3.4.4.1 Supplementation

At a minimum, all individuals who are pregnant are advised to take a prenatal multivitamin containing at least 400-500mcg folate and 150mcg Iodine daily. Individuals with eating disorders might also require routine thiamine supplementation. Eating disorders in pregnancy adds the need to consider supplementation for iron, vitamin B12, vitamin D, and electrolytes if these are deficient, to improve blood concentrations.

Additionally, individuals with eating disorders are at a significantly higher risk of osteoporosis and, therefore, might begin pregnancy with compromised bone calcium reserves. If dietary calcium intake is suboptimal, increased intake of calcium-rich foods in the diet (e.g. cheese, milk, and yoghurt) should be encouraged. If supplementation of calcium is required, combining this with vitamin D should be considered to enhance absorption.

It is important to ensure that vitamin A upper limits are not exceeded if using ONS drinks or NGF. Although vitamin A requirements increase slightly in pregnancy due to tissue and organ development, it is important to avoid excess consumption. If deficiency is suspected, supplementation with beta-carotene has been preferred over retinol during pregnancy.

In individuals with eating disorders, hypokalaemia is frequent and often the result of vomiting. Thus, it is not enough to prescribe oral potassium supplementation; these individuals will also need support to stop or reduce vomiting.

Additional training for staff is offered in iLearn - Eating Disorders in Peripartum - iLearn - Internal Catalogue [143].

3.4.5 Eating disorders in the postpartum

The postpartum period is a high-risk period for eating disorder symptoms, irrespective of how the pregnancy progressed. Eating disorder symptoms may persist or worsen after birth, especially if woman's expectations about returning to pre-pregnancy size and shape are unrealistic [134].

Eating disorders have been associated with increased risk of anxiety and depression both during pregnancy and in the year following birth [144]. It is recommended to provide support for early parenting, infant feeding, settling and emotional attachment with their infant [131].

Additionally, energy and nutrient needs are further increased for those that are breastfeeding which can make it harder to meet energy requirements through diet alone.

Women with current or past eating disorders are significantly more likely to develop postpartum depression [145]. We also know that anemia during and after pregnancy significantly increased the risk of postpartum depression [146]. Therefore, prevention, identification and treatment of anemia in pregnant women with eating disorders is recommended.

The multidisciplinary team should also consider the need for higher levels of care for those who experience a relapse or worsening of eating disorder symptoms in the postpartum which may include admission to a mother and baby unit (such as Lavender Unit or Catherines House see Table 10. below).

3.4.6 Supports and treatment options

Table 10. Support and treatment options for individuals who are pregnant or in the postpartum period

Service	Information	Link / Details
Local Perinatal Mental Health Team (Community)	Individuals may be able to access public perinatal mental health services that supports emotional health and wellbeing of individuals and their families during the perinatal period.	Perinatal Mental Health | Metro North Health 1300 MHCALL
Queensland Centre for Perinatal and Infant Mental Health (QCPIMH)	Provide support to the mental health needs of parents and carers during and after pregnancy	Queensland Centre for Perinatal and Infant Mental Health | Children's Health Queensland

Service	Information	Link / Details
Mother-baby Perinatal Mental Health Unit – Inpatient	Lavender Mother and Baby Unit (Gold Coast University Hospital)	Discuss with your team
	Catherine's House (Mater Hospital Brisbane)	Discuss with your team.
Australian Breastfeeding Association	The ABA offers 24/7 support through their breastfeeding helpline, breastfeeding support groups, a podcast Breastfeeding with ABA - https://www.breastfeeding.asn.au/breastfeedingwithABA and Mum2Mum app - https://www.breastfeeding.asn.au/mum2mum-app	https://www.breastfeeding.asn.au/ 1800 686 268
COD-ED	Eating disorders, nutrition and pregnancy factsheet	COD-ED Eating Disorders and Pregnancy
COPE	Centre for Perinatal Excellence (COPE) provides non-clinical information for parents and families on eating disorders during pregnancy	COPE: Centre of Perinatal Excellence | COPE
PANDA	PANDA supports the mental health of expecting, new and growing families through a range of services and programs, for example the Survive and Thrive Podcast https://panda.org.au/articles/panda-podcasts	https://panda.org.au/ 1300 726 306
Peach Tree Perinatal Wellness	Peach Tree provide services for parents, partners, and families who are impacted by emotional and mental health challenges in pregnancy and early parenthood.	https://peachtree.org.au/
White Cloud Foundation	A tele-mental health service offering support to individual experiencing changes to their mental health. Meals for Mums – delivery of 14 nutritious meals to the mother's home (by referral only).	https://whitecloudfoundation.org/ 07 3155 3456

3.5 Considerations for individuals who have co-existing Type 1 Diabetes Mellitus (T1DM)

This section provides additional information for the inpatient management of individuals with T1DM admitted for the management of disordered eating behaviour or eating disorders and should be utilised alongside the standard guidelines for inpatient eating disorder care (see Section 2).

T1DM specific information in this section has been adapted from and aligns with the Queensland Health guideline Inpatient management of Type 1 Diabetes and disordered eating/eating disorders in ≥16 years [147]. Any information additional to these documents will be separately referenced.

For information pertaining to community management please refer to the following Queensland Health guideline Disordered eating and eating disorders in children, adolescents and adults with Type 1 Diabetes [148].

3.5.1 Background

Research suggests up to 40% of individuals with diabetes may have disordered eating behaviour and 50-90% of individuals with T1DM and disordered eating behaviour may omit or restrict insulin to manipulate weight.

Prevalence of eating disorders such as BED, OSFED (including AAN) and BN may be twice as common in T1DM as the general population; however, current research suggests there is no difference in rates of AN co-occurring with T1DM. Mortality risk in those with the co-occurring T1DM and AN is three-fold due to the risk of acute hyperglycaemia or hypoglycaemia, malnutrition and the complications

of chronic hyperglycaemia. Inappropriate restriction/omission of insulin to manipulate weight is a common compensatory behaviour for those struggling with disordered eating behaviour.

There has been one systematic review evaluating the effectiveness of interventions for individual with T1DM and eating disorders. Inpatient therapy appeared to be the most effective treatment with long term improvements in glycaemic control, anxiety, disordered eating behaviour and psychological test scores (related to eating disorder psychopathology, depression and anxiety) following an extended inpatient stay. An intensive intervention for this group targeting both eating disorder and diabetes treatment is necessary to achieve results.

Around 50% of individuals with T1DM are using insulin pump therapy as their treatment of choice. During inpatient admission for eating disorder treatment, a collaborative decision with input from the individual and their supports in consultation with the diabetes team is required to ascertain the appropriateness of insulin pump therapy and level of support required to manage insulin administration. Alterations to usual insulin regimens may include temporary transition to multiple daily injections to ensure adequate diabetes management. This decision should be reviewed regularly with a plan for return to pump therapy when appropriate.

3.5.2 Objectives

The purpose of this section is to provide goals and clear recommendations for the inpatient management of T1DM with disordered eating behaviour or T1DM with a diagnosed eating disorder.

3.5.2.1 Goals of Inpatient Medical Treatment

In collaboration with the individual, and their family and other supports, the recommended goals of inpatient medical treatment are:

- establish medical stability:
  - including BGL stabilisation and treatment of Diabetic Ketoacidosis – consider temporary cessation of insulin pump therapy and re-establishing insulin with Multiple Daily Injection therapy
  - to carefully monitor for the emergence of refeeding syndrome and provide appropriate treatment where needed
  - to Identify and treat complications of poorly controlled diabetes
- to support the MDT in the engagement of families and other supports
- to provide nutritional resuscitation and rehabilitation including micronutrients and macronutrients with initiation of weight restoration as appropriate
- to support the establishment of appropriate nutrition and diabetes self-care behaviours, including adequate nutrition and insulin management, both on and off the ward independently prior to discharge
- consider re-establishing insulin pump therapy.
- to monitor for the reversal of cognitive effects of starvation so the individual can benefit from psychotherapy
- to arrange appropriate follow-up support in the community utilising a shared care approach – consider the individual's goals and need for increased intensity of support including regular medical monitoring (GP), diabetes/endocrine team, and eating disorder-specific therapy.

Table 11. Suggested addition to Table 1. Assessment and admission indicators for diabetes-specific physical indicators for hospital admission

Medical Parameters		Considerations in pregnancy for medical admission
Diabetes indicators	HbA1c	>10%,
		Diabetic Ketoacidosis
		episode of severe hypoglycaemia*
Insulin		Insulin omission, restriction of insulin or suspicion of this behaviour that requires inpatient re-establishment or titration of insulin regimen

** Severe hypoglycaemia - defined as person requiring third party assistance [147]*

If ANY parameter is met at the time of assessment, inpatient treatment should be considered. This list is not exhaustive, and any other medical concerns should be discussed with a medical officer. An admission for an individual with Type 1 diabetes and co-occurring eating disorder or disordered eating would be most appropriate in a medical setting due to initial medical stabilisation and insulin titration. There may be some exceptions where a mental health unit is more appropriate.

3.5.3 Multi-disciplinary team

The MDT should include staff with experience and understanding of both T1DM and eating disorders. Shared care with expertise sourced from medical, endocrine/diabetes, and psychiatry/psychology arenas is best practice. Suggested roles as follows:

- An **endocrinologist** to manage insulin titration and acute and chronic diabetes complications
- A **credentialed diabetes educator (CDE)** for diabetes self-management education throughout the admission and preparing for discharge. Ward staff may benefit from upskilling by the CDE to support individual with anxiety during insulin administration, hypoglycaemic and hyperglycaemic episodes and T1DM management
- A **dietitian** experienced in both diabetes and eating disorders for nutritional rehabilitation and diet education. Alternatively shared care or consultative care between a dietitian experienced in eating disorders and a dietitian experienced in diabetes
- A **mental health team** that may include a psychologist, psychiatrist and/or a CL team to provide advice for the team and individual on medications and psychoeducation around anxiety
- **specialised eating disorder service** involvement should be considered (e.g. EDSS or QuEDS).

Aim to meet as a treating team with the individual and their family and other supports at the beginning of the admission and regularly throughout the admission. These meetings can be useful to clarify treatment goals, set expectations, review progress and plan for discharge.

3.5.4 Dietetic considerations/responsibilities: Meal plan prescription

Note: The meal plan is a nutrition prescription that is developed by the dietitian for the individual and should only be altered in consultation with the ward dietitian.

The meal plan will be collaboratively developed with the individual (including their family and other supports if appropriate) and the following considerations additional to standard guidelines for inpatient eating disorder care (see Section 2):

- adjust menu items according to food availability within local services
- divide nutrient intake over a minimum of three meals and three snacks
- limit low energy foods (e.g. maximum three serves fruit per day, soup)
- include at least one hot main meal each day
- ensure adequate protein at each meal
- avoid use of sugary drinks (fruit juice with a meal is acceptable).

Additional considerations:

- aim for similar carbohydrate portions at meals and increase consistently with meal plan progression
- aim to keep carbohydrate (CHO) in snacks <15g initially - in cases with higher energy requirements or gastroparesis consider increasing snacks >15g CHO which will require insulin
- clearly document carbohydrate count in the meal plan in grams, 10g or 15g portions (according to individual's prior knowledge)
- carbohydrate count step one of three-step meal plan with Insulin:CHO ratio to pre-determine food insulin dose and document clearly on the meal plan (see Appendix V: Meal Plan templates in Inpatient management of type 1 diabetes and disordered eating/eating disorders in ≥16 years [147])
- carbohydrate count the step two of three-step meal plan supplement and suggest an insulin dose that is 50% of usual insulin to carbohydrate ratio (for example: if Insulin:CHO = 1 unit:15g CHO, take 1 unit of insulin per Fortisip (containing 37g carbohydrate))
- consider using lower carbohydrate supplements for step two of three-step meal plan such as Calogen (0g carbohydrate) or between meals to minimise need for additional insulin dose.

3.5.5 Diabetes team responsibilities

The insulin management plan is to be determined by treating team in consultation with the individual and their supports and ratified prior to documentation on the meal plan including:

- recommendations for timing of insulin dose including consideration of post meal insulin injection with a very fast acting insulin such as Fiasp if oral CHO intake is erratic
- *Insulin:CHO* ratio – for dietitian to pre-determine food insulin bolus dose
- *Correction Factor and Target BGL* – dietitian to note on meal plan.

3.5.6 Nutritional complications

- Confirm allergies/intolerances through clinical history and recommended testing (serum allergen specific IgE) plus referral to immunology/allergist. Check for Coeliac Disease. All formal diagnoses must be adhered to, and clinical judgement should be used for other restrictions.
- Consider gastroparesis and delayed gastric emptying which are linked with both malnutrition and as a complication of prolonged hyperglycaemia.
- Co-existing medical conditions may increase goal energy (e.g. young male, breastfeeding mother). Tolerance, rate of weight restoration and progression towards medical stability should be monitored. People with type 1 diabetes do not have different energy requirements to those without diabetes.
- If inadequate nutrition intake is suspected, or an average weight gain of 1kg/week is not achieved with goal energy provision (if this is a treatment goal), consider increasing support provided by staff to the individual to improve nutrition intake and retention via:
  - supervision at meals and post-meal
  - assessing and managing compensatory behaviours including insulin manipulation

- considering utility of leave
- supervising showers and toileting
- continuous one to one nursing supervision
- addition of a “medpass” to meal plan (e.g. 60ml QID Resource 2.0/ Fortisip Compact Protein / Calogen) to increase energy by 2000kJ – 2500kJ/500-600kcal per day with appropriate insulin dose
- review glycaemic control and increase support to individual to ensure adequate insulin delivery via injection or insulin pump.

3.5.7 Discharge Nutrition

- Negotiate individualised meal plan for discharge with individual (including family and other supports if appropriate), keeping in mind the individual’s perspective and long-term goals of achieving or maintaining adequate nutritional status and normal body weight (i.e. BMI >20kg/m2).
- Meal plan can include liquid supplements.
- Ensure provided meal plan aligns with individual’s diabetes literacy e.g. a simplified CHO counting approach may be appropriate.

3.5.8 Diabetes Education

- Assessment of current diabetes self-management knowledge is important once medically stable.
- CDE and diabetes dietitian to provide diabetes self-management education including normal eating and insulin behaviours throughout the admission.
- Consider education for family and other supports.
- In addition to standard diabetes education consider:
  - addressing fears of carbohydrates, hypoglycaemia, hyperglycaemia
  - education around insulin or treating hypoglycaemia and weight gain.

3.6 Considerations for individuals with co-occurring borderline personality disorder

The management of individuals with disordered eating who have co-occurring borderline personality disorder (BPD) can present unique challenges. The role of this section is to assist in the support of individuals who present with both eating disorder and personality disorder symptoms at times of admission.

Specifically, there are times when the psychiatric formulation views disordered eating as a maladaptive coping mechanism, to regulate emotions or have other psychological needs met. In these circumstances it is important to consider how an individual’s medical needs may be met, whilst also considering risks such as reinforcement of maladaptive behaviours, reduced opportunities to participate in community-based care, and other iatrogenic harms.

3.6.1 Inpatient medical care

Individuals with disordered eating and co-occurring BPD may require inpatient care for medical stabilisation, particularly in cases of severe malnutrition, electrolyte imbalance, or other life-threatening complications. Medical care should be provided, promptly, with referral to dietetics and CL psychiatry for nutritional and psychiatric assessment. If the individual is assessed as low risk of refeeding, a more

rapid treatment plan could be developed (refer to section 2.2 Guidance for dietitians and nutritional support).

When deviating from standard guidelines for inpatient eating disorder care as detailed in section 2, a plan should be developed involving all members of the treating team along with the individual receiving treatment. It is important that all members of the team providing care across the inpatient, community and primary setting are involved in developing the plan to minimise the risks of divisions within teams and ensure everyone agrees. The plan made should be documented alongside an Acute Management Plan (AMP), where appropriate, which should be available to all team members including The Viewer and CIMHA (Consumer Integrated Mental Health and Addiction application). These plans should be updated regularly, as diagnostic formulations and circumstances may change over time.

It is suggested that regular meetings occur to discuss presentations of people with disordered eating and BPD so that complexities can be recognised and addressed.

3.6.2 Mental health unit care

Mental health unit admissions could be considered when acute suicidality, self-harm, or severe emotional dysregulation impairs the individual's ability to engage in treatment.

- **Short and goal-directed admissions:** Extended hospital stays can reinforce dependency and regression. Admissions should focus on crisis management, skills-building, and transition to community support.
- **Dialectical Behavioural Therapy (DBT)-informed approach:** DBT is the gold-standard treatment for BPD and should be incorporated into the treatment plan where possible. Skills training in distress tolerance, emotion regulation, and interpersonal effectiveness can support eating disorder recovery.
- **Coercive approaches can lead to treatment resistance:** Motivational interviewing techniques can enhance engagement and reduce oppositional behaviours.
- **Emotional validation with limit-setting:** Individuals with BPD benefit from having their distress acknowledged while also being held accountable for treatment commitments.
- **Managing self-harm and suicidality:** Self-harm should be managed using harm minimisation strategies where appropriate and suicidal ideation needs careful assessment in accordance with local and state suicide prevention pathways.

3.6.3 Community management

Ongoing evidence based individual outpatient treatment in the community is essential for relapse prevention and long-term recovery. The following aspects should be considered during inpatient admissions and plans made collaboratively with the appropriate community team/ healthcare providers:

- **Psychological treatment approaches:** Eating disorder treatment should incorporate BPD-specific interventions, such as DBT or mentalisation-based therapy. CBT-E or Specialist Supportive Clinical Management techniques may still be effective but may not address all areas that the individual requires assistance with.
- **Care coordination:** Regular meetings of the MDT should occur, and in addition to community team members, should also include members of inpatient medical, emergency department and CL psychiatry.
- **Crisis and relapse planning:** Individuals with BPD often experience frequent crises, requiring clear relapse management plans with strategies for emotional regulation and distress tolerance.

- **Managing treatment dropout:** Providing recovery motivation and integrating peer support may assist in reducing disengagement.
- **Family and other supports:** Families and other supports should receive education about both disorders to reduce conflict and improve support strategies as well as to assist with unmet needs.
- **GP follow-up:** Regular follow-up with a GP and psychological specialists where indicated are essential for monitoring physical health, medication management, and engagement in psychological treatment.

3.7 Considerations for neurodivergent individuals

Neurodivergence (see Appendix 2: Key definitions for discussion of chosen term) refers to natural differences in brain structure, function and behaviour, including, but not limited to autism and ADHD. Research shows that neurodivergent individuals - particularly those who are autistic, have ADHD, and/or have Tourette Syndrome - are at higher risk of eating disorders [149, 150].

Traditional eating disorder interventions are often less effective and can even be harmful for neurodivergent individuals because they are designed for neurotypical people [149, 150]. Additionally, when sensory, communication, and autonomy needs are unmet in a hospital setting, neurodivergent individuals may discharge against medical advice—not because they don't recognise the need for treatment, but because the environment is unbearable.

While this section focuses on autism and ADHD, co-occurring forms of neurodivergence should also be considered when adapting communication and treatment to ensure care is accessible, inclusive, trauma-informed, and affirming.

3.7.1 Basic considerations

3.7.1.1 Language use with individuals and in written documentation

Using affirming language helps reduce stigma, build a positive sense of identity, support self-advocacy, and improve healthcare experiences—all of which are essential for eating disorder recovery.

To promote respectful and inclusive care, staff should endeavour to:

- ask neurodivergent individuals about their preferred terminology and use it consistently. Use identity-first language (e.g. autistic person) and 'autism' instead of deficit-based terms (e.g. ASD) or person-first language (e.g. person with autism), unless preferred otherwise.
- replace deficit-based terms (e.g. sensory processing disorder, fussy or picky eater, selective mutism) with neutral or strengths-based language (e.g. processing differences, selective eater, situational mutism). For more examples refer to Neurodiverse Connection: affirming language guide [151].
- replace pathologising phrases (e.g. overreacting, behavioural, non-compliant) with objective descriptions of the neurodivergent person's specific support needs (e.g. experiencing distress due to […], prefers not to make eye contact, needs requests to be framed in a non-demanding way to help mitigate demand avoidance).
- acknowledge and respect the experiences of neurodivergent individuals, understanding that their sensory perceptions (like pain) may be different from what is considered typical. Dismissing these experiences as 'wrong' (e.g. ignoring or underestimating reported pain) can be invalidating for the individual and has the potential to be a traumatic experience.

3.7.1.2 Sensory supports

Sensory processing differences can make hospital environments challenging for neurodivergent individuals. Common triggers—such as bright lights, busy areas, loud or repetitive noises, scents (e.g. hand sanitisers, perfumes), and tactile discomfort (e.g. touch aversion, hospital fabrics)—can lead to sensory overload, increasing anxiety and affecting communication, information processing, therapy engagement, and eating.

To support neurodivergent individuals' sensory needs, staff can:

- Proactively ask about modifications and accommodations such as turning off ceiling lights, offer to conduct sessions in quieter spaces. The EDNA sensory guides (for individuals and health services) can be used to help identify and guide these adjustments [152].
- Offer sensory tools or fidgets (consult an occupational therapist if possible) or check with support persons about items they can bring (e.g. noise cancelling headphones).
- Minimise exposure to sensory triggers (e.g. avoid scented products, silence electronics).
- Support safe stimming without judgment to aid emotional and sensory regulation. In this context, 'safe' refers to behaviours that don't harm the individual and/or interfere with medical treatment (e.g. pacing may not be appropriate for someone on bed rest).
- Avoid assuming movement stims are compensatory behaviours. Ask the individual what is supportive and work with the team to identify safe stims at different stages of renourishment.
- Provide access to quiet spaces like sensory rooms for retreating from sensory overload.
- Explain procedures in advance and always ask for consent before initiating touch, even for routine tasks where consent was previously given (e.g. blood pressure checks).
- Offer bathroom assistance or prompt at scheduled intervals for neurodivergent individuals who may struggle with interoceptive cues related to bladder/bowel signals. This is especially important for those on bedrest or requiring wheelchair assistance, as delays in support can increase stress or lead to medically risky attempts to walk independently.
- Record and share sensory accommodations to ensure consistency of support, using tools like Julian's Key Health Passport [153].

3.7.1.3 Communication adaptations

Neurodivergent individuals may communicate differently because of how they process information (e.g. literal thinking, alexithymia) and their social experiences (e.g. focusing on words over tone, avoiding eye contact). These differences are often mistaken for deficits, but they actually come from both sides misunderstanding each other (double empathy problem [154, 155]). In healthcare, the gap between medical language and how individuals communicate can make this even harder. The triple empathy problem [156, 157] explains how systems like healthcare may misinterpret or struggle to provide support.

To improve communication and engagement, staff can:

- Recognise that communication differences are not deficits and approach interactions with empathy. The EDNA communication guide may be a useful resource for clinicians to support bridging communication and understanding, helping ensure interactions are accessible and respectful [152].
- Proactively offer the neurodivergent individual the option to communicate in their preferred way, which may vary depending on the situation and their sense of felt safety. For non-speaking or low-verbal autistic individuals, this may include providing augmentative and alternative communication options, such as communication boards or apps.

- Remember that the ability to speak is different from the ability to understand. Always assume competence and speak directly to the individual.
- Offer a visual description of themselves, along with stating their name and role at the start of an interaction, as low eye contact may cause confusion or disorientation.
- Allow time for the neurodivergent individual to process information and, if needed, provide assessment questions in advance. Explaining the rationale for care recommendation and giving them the opportunity to ask question can help reduce distress.
- Understand that frequent staff shifts and handovers can increase overwhelm and disorientation due to ongoing processing demands and routine disruption. Providing a log for the individual to keep, where staff record the time, names, and roles during each meeting, can be helpful.
- Clearly communicate changes and transitions in advance and maintain consistent routines.
- Be specific with language and clarify actions and timing (e.g. “I’ll check in with the team and return by noon with an update”) instead of vague expressions (e.g. “I’ll check on you later”), as uncertainty can cause distress for autistic individuals.
- Offer a written summary of key points discussed and/or allow the person to keep a record of key messages during the session for later reference. Many individuals may benefit from multimodal learning (e.g. listening and reading).
- Record and share communication accommodations to ensure consistency of support, using tools like Julian’s Key Health Passport [153].
- Clinicians should maintain awareness of the potential to experience strong emotions or negative responses, protective or parental responses, feelings of helplessness, hopelessness, inadequacy, and stress regarding medical acuity (countertransference) to patients with eating disorders [158-161].
- Reflexive practice is recommended, including development of operational practices for self-reflection and seeking support (supervision and/or peer support).
- Clinicians should routinely assess for trauma history and PTSD symptoms and consider how trauma may be influencing eating disorder symptoms, emotional regulation, comorbid conditions, and engagement with treatment [33].

3.7.1.4 Mitigating the risk of meltdown and shutdown

Neurodivergent individuals can experience meltdowns or shutdowns due to sensory overload or under-stimulation, routine disruptions, and/or overwhelming emotions during a hospital admission. Unlike ‘tantrums’ (intentional attempts to influence a situation), meltdowns and shutdowns are *involuntary* responses to overwhelming stimuli and/or stress.

To reduce likelihood of meltdowns and shutdowns and support individuals if they occur, staff can:

- Apply the sensory and communication accommodations discussed above.
- Use trauma-sensitive approaches to bathroom monitoring. Neurodivergent individuals, particularly Autistic people, face higher rates of trauma and sexual abuse. Bathroom observation can be triggering and retraumatising. To protect privacy and reduce distress, staff can hold a towel for coverage or keep their back turned while maintaining verbal contact (e.g. asking the individual to hum, whistle, or tap their feet/hands for non-speaking individuals).
- Collaborate with the individual and their support persons to identify early warning signs of distress and determine supportive actions staff can take if a meltdown or shutdown occurs.

- Record a personalised meltdown and shutdown mitigation plan and ensure all treating team members follow it (see: Eating disorders and neurodivergence: A stepped care approach p.p. 87-88 for a framework for a sensory meltdown and shutdown mitigation plan [149]).

3.7.2 Assessment and formulation considerations

Factors contributing to eating disorders in neurodivergent individuals differ from those in neurotypical populations. Understanding key intersectional factors is essential for developing a client-centred treatment plan:

- Gender diversity is more common among neurodivergent individuals and can affect body image. Gender incongruence, societal pressures, minority stress, and differences in interoception can contribute to distress around appearance and eating. Gender-affirming care is essential in neurodiversity-affirming care.
- Co-occurring health conditions—such as hypermobility (e.g. Ehlers-Danlos Syndrome), dysautonomia (e.g. POTS), gastrointestinal issues (e.g. IBS), chronic pain and swallowing difficulties are more common in Autistic and ADHD populations. If not addressed, these conditions can affect food intake and make following treatment harder. For guidance on supporting co-occurring health issues, refer to Clinician guide: Constellation of chronic medical conditions commonly seen in Autistic & ADHD adults and section 3.3 above.
- Psychological trauma is common among neurodivergent individuals, who face higher rates of bullying, social rejection, discrimination, poverty (including food insecurity), and neglect in medical settings. Masking and systemic barriers add to this stress, often leading to medical trauma and distrust of healthcare. A trauma-informed approach is essential.
- Neurodivergent burnout, caused by long-term stress, masking, and unmet sensory needs, leads to physical, emotional, and mental exhaustion, often making eating more difficult. While it may look like depression, traditional behavioural activation strategies can make it worse. Recovery from burnout involves reducing demands and where possible, ensuring disability supports are in place during discharge planning.
- PDA (Pervasive Drive for Autonomy/extreme demand avoidance) is a descriptive profile associated with Autism, characterised by an intense resistance to perceived demands. While not a formal diagnosis, it can be a useful framework to consider within a person's formulation—particularly in inpatient settings, where increased demands may feel overwhelming and contribute to distress. To mitigate this, prioritising relational safety. Staff can support individuals by finding common ground, minimising unnecessary demands, and working collaboratively towards treatment goals. Emphasising choice and recognising autonomy needs can support more effective engagement, rather than interpreting responses solely as "resistance" or non-compliance. For clinician resources, visit PDA Society: Research & professional practice [162].
- **ADHD and medication:** ADHD medications, like stimulants, can reduce appetite, which may make weight restoration harder. However, they can also improve focus and executive function, helping individuals engage with therapy and to follow treatment plans. The benefits and risks of ADHD medication should be assessed individually.
- **Atypical sensory habituation and masking:** Many neurodivergent individuals do not adjust to repeated sensory exposure the way neurotypical people do. Ongoing exposure to aversive stimuli can increase distress, cause dysregulation, and lead to masking rather than true acclimation. A supportive approach prioritises felt safety and nourishment by offering sensory-friendly foods and/or supplements over diet expansion.
- **Other co-occurring conditions:** Neuropsychiatric and cognitive conditions commonly observed in neurodivergent individuals may influence eating disorder presentation and require integrated or

concurrent treatment to optimise outcomes (e.g. intellectual disability, OCD, psychosis, catatonia [163, 164]). Recognising these factors within formulation can guide treatment planning and support a personalised, client-centred approach.

3.7.3 NGT placement considerations

NGT insertion can be traumatic for anyone. Neurodivergent individuals may be more vulnerable to stress and re-traumatisation due to sensory sensitivities, touch aversion, and medical anxiety. The following strategies can help reduce distress and support a safer, more positive experience:

- allow time for individual to process information about the procedure and ask questions
- perform NGT insertion in a calm environment with a support person present, helpful for co-regulation
- consider using local anaesthetics (e.g. xylocaine spray) to minimise pain during insertion and offer 8-10Fr NGT to reduce irritation
- ask the individual their preference regarding the temperature of NGT flushes
- position face taping to minimise sensory discomfort and offer hair clips to secure the tube, reducing movement and skin irritation
- use Vaseline or skin-sensitive tape as a barrier between the nostril and NGT to prevent irritation or sores.

3.7.4 Nutritional management considerations

The following considerations can guide dietetics care:

- **Understanding eating habits:** Food “rules” may stem from executive functioning differences or a need for sensory predictability, rather than being driven by weight/shape concerns. Work with the individual to understand their experiences and avoid assuming these rules are systematically eating disorder driven.
- **Food tolerability changes:** If a previously accepted food is no longer tolerated, consider neurodivergent burnout or executive functioning struggles. For example, soft or liquid foods may be easier during burnout, as chewing can be challenging due to fatigue or reduced sensory and motor capacity.
- **Interoceptive awareness:** Variations in interoceptive awareness (e.g. difficulty recognising hunger/fullness cues, hypersensitivity to stomach stretching) can influence therapy and treatment decisions. Smaller, more frequent meals can help individuals with heightened awareness avoid distress from stomach stretching.
- **Meal plan:** A limited range of foods may reflect sensory needs and intersect with eating disorder-related restriction. For strategies to meet nutritional needs without exposure-based approaches to new foods, refer to section 3.1.2 Standard nutritional management guidelines – considerations for individual with ARFID.

In addition to customising the meal plan to meet sensory needs, mealtime accommodations can improve eating capacity and experience. Consider:

- **Tray Settings:** Individuals may prefer using a small spoon or having food separated for easier access. Plastic plates may reduce aversive sounds from cutlery against ceramic surfaces.
- **Eating environment:** emphasis on social eating can increase distress and heighten sensory overwhelm. A quiet space with no social pressure, or the use of noise-cancelling headphones during meals, may create a safer environment.

Further information can be found in the EDNA Information Sheets: ‘Dietitians’ and ‘Inpatient Care’ Info Sheets [152].

3.7.5 Discharge planning and community treatment considerations

- **Neurodivergent Support Plan:** Document supportive and triggering experiences from inpatient care and create a personalised support plan for the individual. This plan can be shared with the treatment team and used in future hospital admissions.
- **Peer Support Networks:** Fostering a positive sense of neurodivergent identity is beneficial. Consider connecting the individuals with peer support groups led by neurodivergent facilitators to promote understanding, shared experiences, and reduce isolation (see EDNA Information Sheets: ‘Carers’ and ‘Neurodivergent People’ [152]).
- **Neurodiversity-Affirming Therapies:** Ensure ongoing therapy aligns with neurodiversity-affirming principles rather than attempting to “fix” or change the individual (see EDNA Information Sheets: ‘General Practitioners’, ‘Mental Health Professionals’, and ‘Dietitian’ [152]).

Continuous quality improvement

Quality and safety improvement processes in MHAOD services supports the delivery of high-quality clinical care. The Eating Disorders: Inpatient Care on Adult Wards guideline is aligned with a number of the Queensland safety priorities in mental health alcohol and other drugs care including Priority 1: Partnering for improved safety; and Priority 2: Improving the identification of deterioration or increased risk of harm [165].

MHAOD services are encouraged to apply the Queensland safety and quality improvement framework: Mental health alcohol and other drugs care in achieving and maintaining a learning culture to drive safety and quality improvement. This includes routine mechanisms for collecting and reviewing individual- and carer-reported experience measures, complaints, compliments, and feedback to support a learning culture and drive continuous improvement in the quality and safety of eating disorder care across adult inpatient wards.

Aboriginal and Torres Strait Islander considerations

When working with Aboriginal and Torres Strait Islander individuals and their families and communities, it is essential to adopt a culturally safe, trauma informed and respectful approach to the provision of health care. At all stages of engagement, consider whether the individual may benefit from the involvement of an Aboriginal and Torres Strait Mental Health Worker. The NEDC companion document First Nations perspectives: Strengthening the eating disorder safe principles can be referred to in order to address the unique cultural, historical, and social factors affecting Aboriginal and Torres Strait Islander communities, and the ways that these factors relate to Aboriginal and Torres Strait Islander people's experiences of health, food, mind and body [166].

Diversity considerations

Effective health care requires recognising and respecting the diversity of individuals, including differences in culture, language, age, disability, religion, sexuality, gender identity and geographic location when providing health care. At all stages of engagement, consider whether input is needed from health and/or other agency providers with identified roles who could provide appropriately and respectfully engage and support. Examples include services such as the Queensland Transcultural Mental Health Centre, Deafness and Mental Health Statewide Consultation and Liaison Service, Sexual Health Services.

Partnering with individuals

Individuals are partners in their own care and should be involved in decisions and planning about their current and future care needs. Individuals are to be informed of their rights to privacy and confidentiality and the limitations that are associated with this. Individuals and their families and support persons are

to be encouraged and given the opportunity to ask questions, seek clarification, and discuss aspects of treatment and care being provided. Staff are expected to share information in a clear and accessible manner that aligns with the individual's needs and to check for understanding.

Partnering with individuals, carers, families and lived experience leadership is a core component of delivering safe, quality care consistent with the Queensland safety priorities in mental health alcohol and other drugs care particularly Priority 1: Partnering for improved safety [165]. In alignment with the *NSQHS Partnering with Individuals Standard* [25], MHAOD services are expected to establish and maintain structured partnerships that support individual involvement in the planning, design, delivery, measurement and evaluation of care. HHSs are encouraged to work with local lived-experience leaders to adapt this guideline to the local context, co-develop staff education that incorporates individual and carer perspectives and embed lived-experience leadership within governance structures overseeing eating disorder care.

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Appendix 1: Provision of eating disorder care

Federal government response

The National Eating Disorders Collaboration (NEDC), supported by the Australia Government, launched the National eating disorder strategy 2023-2033 [9]. The strategy aims to address the comprehensive care needs of individuals affected by eating disorders across the country and it focuses on improving access to timely and effective treatment, enhancing public awareness and education, and ensuring ongoing support for recovery. Key objectives include the development of specialised treatment centres to provide multidisciplinary care, integrating services seamlessly from primary care to specialised interventions. This approach aims to reduce treatment delays and ensure individuals receive appropriate care tailored to their needs.

Additionally, the NEDC strategy emphasises the importance of early intervention through targeted awareness campaigns, aiming to improve recognition of early signs and symptoms among healthcare providers and the public. Education initiatives will promote evidence-based practices in diagnosing and managing eating disorders, aiming to reduce stigma and encourage early help seeking behaviour. Furthermore, the strategy underscores the need for continuous research and evaluation to advance understanding of eating disorders and improve treatment outcomes nationwide. The aim of the strategy is to build a supportive community that prioritises the well-being and recovery of individuals affected by an eating disorder, along with their families and other supports.

State government response

Better Care Together: A Plan for Queensland's state-funded mental health, alcohol and other drug services to 2027 (Better Care Together [167]) is an overarching health plan initiated by Queensland Health aimed at improving the coordination, quality, and accessibility of healthcare services across the state. It provides a robust framework for addressing the complex needs of individuals with eating disorders by promoting integrated care, cultural inclusivity, family engagement, person-centred approaches, and access to specialist services.

This plan aims to deliver comprehensive and effective care for this vulnerable population and includes the following Key Actions:

1) expanding the reach of specialist eating disorder treatment, care and support across all ages and to meet demand
2) boosting service delivery at existing specialist eating disorder service locations in Cairns, Townsville, Sunshine Coast, Gold Coast and Metro North
3) establishing two new specialist eating disorder services to provide service coverage across Metro South and West Moreton and Darling Downs regions
4) enhancing capacity in high priority locations to enable increased access for children, adolescents, and young individual.
5) increasing community-based carer and Lived Experience (peer) supports across Queensland
6) innovating approaches – implementing new early intervention programs for young individual addressing factors influencing the development of eating disorders – expanding new brief intervention models to provide earlier and more timely treatment, care, and support.

QuEDS provision and partnerships

QuEDS was established in the early 2000s (initially as the Eating Disorder Outreach Service) as there was increasing recognition of eating disorders as serious mental health conditions requiring specialist treatment. QuEDS has evolved significantly over the years to meet the growing demand for specialised care in eating disorders across the state, having had substantial funding increases of which the most recent in 2023 was following the roll out of Better Care Together [167].

In the initial stages, the Eating Disorder Outreach Service primarily operated through outpatient clinics located within the main Brisbane hospitals focusing on assessment, diagnosis, and treatment planning for individuals with eating disorders as well as education and training for health professionals. As awareness and demand grew the service expanded its reach to include regional centres and supported the development of EDSS in other divisions including the Sunshine Coast, the Gold Coast and Cairns. Following the Better Care Together funding QuEDS have additionally provided support for a further four EDSS services in Townsville, Metro South, West Moreton and Darling Downs Hospital and Health Services.

The QuEDS team now consists of approximately 30 specialist staff situated at three main sites and sits operationally under the Metro North Mental Health division and reports annually to Queensland Mental Health, Alcohol and Other Drugs Branch.

QuEDS continues to play a pivotal role in the management and treatment of eating disorders across Queensland by offering a statewide specialist assessment clinic that provides diagnostic clarification and treatment recommendations alongside a large treatment team that can offer individual evidence-based psychological therapy as well as a structured day program and therapeutic groups. The consultation arm of the service offers an MDT that includes psychiatrists, senior nurses, and allied health professionals to review and support treatment plans alongside General Practitioners (GP's), private practitioners, mental health clinicians and medical teams who are managing individuals with eating disorders.

QuEDS offers extensive planned and ad-hoc education sessions to a wide variety of practitioners including community and inpatient eating disorder management training, dietitian masterclasses, and medical staff teaching. The senior members of QuEDS provide peer support and supervision (both individual and group) to over 200 practitioners across Queensland who work in some capacity with those who experience eating disorders and are also engaged in research to support the ongoing learning and understanding of eating disorders and the treatments that are effective in promoting long term recovery.

QuEDS coordinates access to Queensland Health funded statewide specialist eating disorder beds which are situated at the Royal Brisbane and Women's Hospital and at the residential treatment service, Wandi Nerida. These specialist beds are a vital component of the continuum of care, providing a supportive environment for individuals with severe eating disorders who require medical stabilisation and intensive therapeutic interventions. Furthermore, QuEDS engages, where appropriate, with private hospitals and providers to engage individuals with inpatient, day program and outpatient treatment alongside their GP.

QuEDS collaborates closely with national stakeholders such as the NEDC, the Butterfly Foundation and the Inside Out Institute to enhance its service delivery and support framework. Through these partnerships QuEDS engages in knowledge sharing, professional development and advocacy aimed at improving awareness, prevention, and treatment of eating disorders. Partnership with Eating Disorders Queensland also provides local expertise and support networks as well as facilitating seamless transitions between community and clinical care for Queensland residents.

Appendix 2: Key definitions

Term	Definition
Adequate (nutrition)	Adequate, regular intake of macronutrients, micronutrients and fluids to maintain/improve medical stability, health and nutritional status over time. This may include nutrient supplementation including vitamins and minerals and oral nutrition support.
Blind weighing	Weighing an individual in a manner that they do not sight the measurement. This can be performed standing on scales backwards or on sitting scales. This is often recommended in inpatient settings initially due to likely weight fluctuations caused by rehydration and significant change in nutrition provision causing fluid shifts. It is recommended that the decision to blind weigh is made collaboratively between the individual and the clinical team.
BMI Band	Refers to providing information regarding weight based on BMI as a whole number rather than to a decimal place (e.g. a weight in kg which equates to a BMI 16.4 would be referred to as BMI band 16. Weight feedback using BMI banding accounts for natural fluctuations in weight and weight restoration which may assist to reduce focus on specific numbers which is often experienced by individuals recovering from an eating disorder and reduces focus on natural weight fluctuations.
Compensatory behaviours	Compensatory behaviours refer to actions undertaken by an individual to counteract or prevent weight gain after eating, often driven by distress related to body image or food intake. These can include (but are not limited to) self-induced vomiting, misuse of laxatives, diuretics or medications, fasting and excessive or driven exercise.
Family and other supports	The term “family and other supports” has been used in this document to acknowledge the diverse roles and relationships involved in supporting individuals with eating disorders. It is recognised that other terms, such as family and loved ones, carers, key supports, and other persons may also be relevant and are respected within different contexts.
Individual	The term “individual” has been used in this document to refer to a patient, consumer, service user or person living with or having experienced an eating disorder. The choice of terminology aims to maintain consistency throughout the guideline whilst promoting respectful, person-centred language and emphasising individuality.
Neurodivergence	This guideline acknowledges the importance of established diagnostic frameworks, including ICD-11 criteria for neurodevelopmental disorders including autism spectrum disorder and attention-deficit hyperactivity disorder (ADHD). At the same time, it recognises that many individuals presenting with eating disorders may demonstrate neurodevelopmental traits—such as differences in sensory processing, cognitive flexibility, interoception, or executive functioning—that are clinically relevant to assessment, engagement, and treatment planning, but may not meet full diagnostic thresholds or have been formally assessed. The term neurodivergent is therefore used in this guideline as an inclusive, descriptive term reflecting both contemporary clinical practice and lived experience language and does not imply a formal diagnosis. The inclusion of neurodivergent considerations is intended to support clinicians to recognise and respond to individual differences that may influence eating disorder presentation and care, rather than to redefine diagnostic categories. Where diagnostic specificity is required, ICD-11 terminology should be applied. Acknowledging neurodiverse traits alongside formal diagnoses allows for more person-centred, developmentally informed, and accessible care, particularly in situations where diagnostic clarity may be limited or evolving.
Nutritional resuscitation	Refers to the initial stages of re-feeding regime necessary for the individual when they are in medical crisis
Nutritional rehabilitation	Refers to nutrition provision following the initial refeeding period. This stage is categorised by weight restoration (where required), reversal of nutrient deficiencies and establishment of a regular eating pattern.
Medical stability	Medical stability may be defined as the individual having received a minimum of 7 days of continuous nutrition in line with dietetic recommendations, having achieved and sustained goal nutrition for at least 24 hours and are no longer meeting criteria for medical ward admission. Clinical judgement remains essential and, in some cases, – determined collaboratively by the treating medical and mental health teams – residual concerns regarding medical instability or persisting parameters may still warrant consideration with decisions regarding suitability for mental health settings made at the local level.
PowerPlan	A PowerPlan is a term commonly used in healthcare IT systems – especially in electronic medical records like Cerner Millennium – to describe a predefined, evidence-based set of orders or clinical actions that can be applied to a patient’s care plan.

Term	Definition
Refeeding	Refeeding refers to the structured restoration of nutrition in individuals who have experienced malnutrition or prolonged restriction. It requires careful monitoring due to the risk of metabolic disturbances, including refeeding syndrome. High-risk refeeding features include prolonged dietary restriction, rapid or significant weight loss, low body weight or existing electrolyte abnormalities and such presentations may necessitate a slower commencement of nutrition and closer medical observation.
Refeeding Syndrome	Refeeding syndrome is a potentially life-threatening constellation of metabolic and clinical complications that occur during the period of re-introduction of nutrition following a period of starvation of significant malnutrition. It is characterised by rapid shifts in fluids and electrolytes, most notable hypophosphatemia, but also hypokalaemia, hypomagnesaemia, thiamine deficiency and fluid overload – which can lead to cardiac, respiratory, neurological and haematological compromise.
Rome Foundation diagnostic criteria	Comprehensive diagnostic standards for functional gastrointestinal disorders (see Rome IV Criteria - Rome Foundation [168]
Starvation syndrome	Starvation syndrome refers to the physiological and psychological adaptations that occur in response to prolonged energy and nutrient deficiency. These changes include bradycardia, hypotension, hypothermia, gastrointestinal slowing, hormone suppression, cognitive impairment and mood disturbance. The classic features were extensively documented in Ancel Keys' Minnesota Starvation Study which demonstrated the profound and wide-ranging effects of sustained nutritional deprivation [52]. These changes are reversal with adequate and consistent nutritional rehabilitation.
Variety (of nutrition)	A balanced intake of wide variety of food from the spectrum of food groups which ensures macro and micronutrient sufficiency.

Appendix 3: Abbreviations

Abbreviation	Meaning
AAN	atypical anorexia nervosa
ADHD	attention deficit hyperactivity disorder
ADL	activities of daily living
AMP	Acute Management Plan
AN	anorexia nervosa
ARFID	avoidant restrictive food and intake disorder
BED	binge eating disorder
BGL	blood glucose level
BMI	body mass index
BN	bulimia nervosa
BPD	borderline personality disorder
CDE	Credentialed Diabetes Educator
CL	Consultation Liaison
CBT-AR	Cognitive Behavioural Therapy for ARFID
CBT-E	Cognitive Behavioural Therapy enhanced
COD-ED	Collaboration of Dietitians in Eating Disorders
DBT	Dialectical Behavioural Therapy
DGBI	disorders of gut brain interaction
ECG	electrocardiogram
EDSS	Eating Disorder Specialist Services
GAA2000	Guardianship and Administration Act 2000
GI	Glycaemic Index
GP	general practitioner
HRA2019	*Human Rights Act 2019*
ICD-11	International Classification of Diseases Eleventh Revision [2]
LOC	loss of control
MDT	multidisciplinary team
MHA2016	*Mental Health Act 2016*
NEDC	National Eating Disorders Collaboration
NEMO	Nutrition Education Materials Online
NGF	nasogastric feeding
NGT	nasogastric tube
NJT	nasojejunal tube
ONS	oral nutrition supplements
OSFED	other specified feeding and eating disorders
PBS	post-bariatric surgery
PTSD	post-traumatic stress disorder
QuEDS	Queensland Eating Disorder Services
SMT	Supportive Meal Therapy
T1DM	Type 1 Diabetes Mellitus

Appendix 4: Resources and support options

Name	Description	Website
Australia & New Zealand Academy for Eating Disorders	ANZAED eating disorder treatment principles and general clinical practice and training standards	ANZAED eating disorder treatment principles and general clinical practice and training standards | Journal of Eating Disorders | Springer Nature Link
	ANZAED practice and training standards for dietitians providing eating disorder treatment	ANZAED practice and training standards for dietitians providing eating disorder treatment | Journal of Eating Disorders | Springer Nature Link
Butterfly	Caring for someone with an eating disorder	https://butterfly.org.au/eating-disorders-body-image/concerned-about-someone-you-know/caring-for-someone-with-an-eating-disorder/
	People from multicultural communities	https://butterfly.org.au/eating-disorders-body-image/who-does-it-affect/people-from-multicultural-communities/
	Risks and warning signs	https://butterfly.org.au/eating-disorders-body-image/risks-and-warning-signs/
Eating Disorders Families Australia	Provides support, education, advocacy and counselling for families and other supports impacted by an eating disorder	https://edfa.org.au/
Eating Disorders Neurodiversity Australia	Advocates for and supports neurodivergent individuals with eating disorders Their website has a number of guides and information sheets for individuals, families and other supports and health professionals	https://www.edneuroaus.com/guides
Eating Disorders Queensland	Provides treatment and support for individuals, families and other supports	https://eatingdisordersqueensland.org.au/carers-and-key-supports/
Multicultural Mental Health Coordinators	Contact details for multicultural mental health coordinators in each Hospital and Health Service	Multicultural Mental Health Coordinators | Queensland Health
National Eating Disorder Collaboration	Eating Disorder Medicare Items	Eating Disorder Medicare Items
	Eating Disorders and Neurodivergence: A Stepped Care Approach	Eating Disorders and Neurodivergence: A Stepped Care Approach
	Information for families and other supports	https://nedc.com.au/support-and-services/families-supports
National Institute for Health and Care Excellence	NICE Guideline: Eating disorders: recognition and treatment	Eating disorders: recognition and treatment
Queensland Eating Disorder Service	Statewide specialist assessment, consultation and education	Queensland Eating Disorder Service (QuEDS) | Health | Queensland Government
Queensland Health Lived Experience (Peer) Workforce	Lived Experience worker contacts accessible via local HHS QHEPS sites	
Queensland Transcultural Mental Health Centre	Statewide service supporting individuals from culturally and linguistically diverse backgrounds to receive culturally appropriate mental health care	https://www.qld.gov.au/health/services/specialists/queensland-transcultural-mental-health-centre/about-qtmhc
World Wellness Group	Culture Care service for families and other support from multicultural backgrounds	https://worldwellnessgroup.org.au/culture-care/

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