THE VICTORIAN
CENTRE OF
EXCELLENCE IN
EATING
DISORDERS

Eating Disorders Care and Recovery Checklist for Carers

The **Eating Disorders Care and Recovery Checklist** has been developed in consultation with the members of CEED's Carers Advisory Group. The carers were very clear about the value of an overview of the 'usual' process or stages of care that they might expect when their young person is diagnosed with an eating disorder through to recovery.

The resource has been developed based on the Eating Disorders Care and Recovery Framework (over the page) to ensure all components of treatment and recovery that are important for each person are accessed, throughout the longitudinal process of the recovery.

The central issue that the resource is intended to address is that many parents are not informed at the time of diagnosis by the service providers of the whole of life approaches to eating disorders treatment and recovery that are important throughout the longitudinal journey.

Too often the activation of different components of the care process occurs when the young person has deteriorated to the point of crisis or the parents have become so exhausted and distressed about their young person that they are in greater need for additional support – this may be the only time they are informed of additional services and care.

The objectives of this resource are to:

- inform carers/parents of the recommended components of care and treatment to maximise their young person's recovery outcomes;
- provide carers with an ideal blueprint for the steps involved, their role and access to resources;
- equip parents to be more active or directive in the care planning and coordination of the treatment of their young person to reduce the need for escalation of symptoms and risk to trigger access to services.

The qualifier for this resource is that not all experiences of eating disorders treatment and recovery will follow this trajectory or order of stages. However, it is intended to signpost the important steps and components for carers/parents.

Eating Disorders Care and Recovery Framework

Eating Disorders Care and Recovery Checklist for Carers

STAGES OF CARE	TASK/ACTION	DONE	DATE
IDENTIFICATION - early identification of disordered eating through to an eating disorder is very important.			
Initial concerns about person due to changes in their relationship with food, mental and physical wellbeing or eating behaviours;	Talk about your concerns with person – expect denial and resistance		
	Keep an eye on person's eating and weight control behaviours – increase family meals and limit compensatory behaviours such as physical activity		
	Check out www.feedyourinstinct.com.au		
	Encourage/take person to GP for assessment with Feed Your Instinct GP report – expect resistance		
	Source quality information about eating disorders: www.nedc.com.au www.butterflyfoundation.org.au www.eatingdisorders.org.au		
SCREENING Screening to clarify suspicion that an eating disorder might exist rather than to make a diagnosis.	See school nurse, GP or health professional to screen for possible eating disorder e.g. warning signs in FeedYourInstinct, SCOFF screening tool		
	Be firm in talking about your concerns to make sure health care provider is aware of your observations – if concerns not taken seriously, seek a second opinion from another service		
	If no sign of an eating disorder – keep an eye on person and go back to health care provider if things change		
	If sign of eating disorder – health care provider will need to do a full assessment as per the guidelines in the Feed Your Instinct GP report		
ASSESSMENT Formal mental and physical health, and psychosocial assessment.	Mental Health assessment – to identify signs of depression, anxiety, suicide, self-harm, eating disorder		
	Physical Health assessment – to identify signs of physical impacts of eating disorder e.g. BP, HR, BMI, body signs		
	Psychosocial assessment – to identify signs of withdrawal from activities,		

	levels of support, family wellbeing, school/work		
DIAGNOSIS Accurate and early diagnosis of eating disorder based on outcomes of the assessment	See GP, physician, paediatrician for assessment results and possible diagnosis of eating disorder		
	Get accurate information about the eating disorder and its preferred treatment, care and recovery pathway		
	Identify other health care providers who could provide treatment and care		
	Decide on the required level of medical and mental health monitoring with GP – e.g. weekly appointments		
CARE PLANNING - Goal of the **Care Team** is to bring together all health care providers who are involved in the care of person – meet, email communications, shared decision making.			
Care Team may be made up of carer/parent, GP, psychologist, psychiatrist, dietitian and/or school contact. Some of these members may be co-located in a service e.g. CAMHS or may be discrete independent practitioners. Goal of **Care Plan** is to make sure the agreed care plan is in place and effective to make sure the person can access care components that are important for optimal recovery.	Decide on preferred health care provider or service who can coordinate care and be available to carer for support and communication		
	Ensure care coordinator brings together other health care providers who may provide other aspects of care to create **Care Team** to discuss and agree on roles and expectations		
	Ensure Care Coordinator documents and disseminates the **Care Plan** to members of the Care Team, including parents/carers and person (if appropriate) – including plans for contact, communication, and review.		
	Ensure avenues of support for the parents, siblings, family of a person with an eating disorder are documented in a **Carer/Family Support Plan.**		

SAFETY – sometimes the person's medical or mental health can become very poor, quickly – importance of regular monitoring with health care provider.			
MEDICAL SAFETY *Medical safety assessment and management*	*Ensure care plan includes regular medical monitoring and is clear who is responsible for this e.g. GP, paediatrician* *Ask for clear plan for steps to take when person exhibiting specific signs of medical instability* ***IF NEEDED**: Ensure **Safety Action Plan** is documented and disseminated to Care Team, including parents/carers and person (if appropriate)*		
MENTAL HEALTH SAFETY *Mental Health safety assessment*	*Ensure care plan includes regular mental health monitoring and is clear who is responsible for this e.g. psychologist, psychiatrist* *Ask for clear plan for steps to take when person exhibiting specific signs of mental distress/risk e.g. suicidality, self-harm, social withdrawal* ***IF NEEDED**: Ensure **Safety Action Plan** is documented and disseminated to Care Team, including parents/carers and person (if appropriate)*		
ONGOING CARE WITH ACUTE BACKUP -			
MEDICAL MANAGEMENT Medical monitoring and stability; weight gain and stabilisation;	Ensure care plan includes regular medical monitoring and is clear who is responsible for this e.g. GP, paediatrician		
	Refeed young person to a healthy weight determined by team and parents based on range of factors		
	Monitor weight regularly		
MENTAL HEALTH CARE Medication assessment and review; comorbidity management; monitoring mental health risks;	Ensure care plan includes regular mental health monitoring and is clear who is responsible for this e.g. psychologist, psychiatrist		
	Ensure team aware of any pre-existing comorbidities or concerns you have about other presenting mental health concerns; and strategies developed to manage these throughout treatment		
	Assess for need for medication – not usually beneficial but may be useful in		

	some cases		
NUTRITIONAL REHABILITATION Eating behaviours; eating disorders interventions; food varieties and patterns;	If weight gain required, ensure young person is eating sufficiently to gain weight consistently		
	Provide meal support to reduce anxiety and increase intake		
	Support regular eating schedule		
	Provide a variety of foods and eating environments to promote flexible eating		
	Access advice on nutritional intake if needed from dietitian		
	Develop school meal support strategies		
FAMILY INVOLVEMENT Treatment resource; education; empowerment; engagement; sibling support; peer and professional support;	**Carer and Family Support Plan**;		
	Families to be well informed on eating disorders through provision of comprehensive and evidence-based information		
	Carer education and support sessions be available		
	Peer support in person or online available and offered		
	Plan developed for family organisation to manage caring responsibilities		
	Financial support options for caring responsibilities discussed		
	Emotional support options for caring responsibilities discussed		
	Support options for siblings discussed		
INDIVIDUAL THERAPY Psychoeducation, eating disorders maintaining factors; interpersonal issues; emotion regulation and expression; trauma; comorbidity; body image acceptance; weight recovery; creative arts therapies;	Seek appropriate evidence-based individual therapy when a person will benefit. Many people in malnourished phase will find individual therapy less than optimal.		
	Psychological Treatment Services or Better Access to Mental Health Medicare program – see GP for Mental Health Care Plan and referral		
RECOVERY/QUALITY OF LIFE			
RELAPSE PREVENTION Managing mental and physical health;	Develop a Relapse Prevention Plan with care team which defines key markers of wellness, early and late signs of relapse; and strategies for maintaining wellness, actions for early and late relapse. Plan should include which members of a clinical team/service may become reinvolved upon relapse or if new		

	services need to be contacted		
	Have a discussion and plan for transition to adult services if needed, including the transition of records. Even if a young person is well, the transition of records to the new potential team would be desirable, or provide a summary to parents.		
RESTORED HEALTH AND EATING Living skills; self-care; weight restored;	Handover of responsibility for eating behaviours, weight maintenance, and living skills to person		
	Parents/carers/family supported to 'stand down' from caring roles		
PSYCHOSOCIAL SUPPORT Social connection; family and friends; support network;	Ensure social and emotional supports are in place to protect and support recovered person to prevent relapse.		
EDUCATION AND WORK Pathways; participation;	Ensure social and practical supports are in place within the school, education or workplace setting to support recovered person' participation.		
STEP UP/STEP DOWN PLANNING For Severe and Enduring Eating Disorders, advance care planning and structures in place to facilitate timely access to services when status changes;	Have an advanced care planning directive in place		
	Have ongoing care plan in place which stipulates what actions to implement under what conditions e.g. hospital admission		