CEED

THE VICTORIAN
CENTRE OF EXCELLENCE
IN EATING DISORDERS

COMMENCING FAMILY LED REFEEDING AND RECOVERY

CEED RESOURCES 2026

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Introduction

This resource has been developed to support families who are beginning to navigate their way through family led refeeding and recovery from anorexia nervosa and atypical anorexia nervosa. It is intended as a practical guide, combining clinical knowledge and lived carer experience and wisdom, in one reference.

We recognise that families often find themselves in a position they never expected — suddenly responsible for taking charge of meals, confronting distressing behaviours, and navigating a health system that can feel complex and overwhelming. This resource aims to provide clarity, reassurance, and practical strategies, while reinforcing a central truth: no family causes an eating disorder, but families can be the most powerful agents in recovery.

Throughout these pages you will find information about the nature and impacts of eating disorders, principles of Family Based Treatment (FBT), strategies for managing distress, guidance on nutrition and meal support, and insights from other families who have walked this path. While every young person's recovery journey is unique, the consistent message is that recovery is possible for everyone and that early intervention makes a profound difference.

We encourage families to read this alongside the professional support you will receive from your treatment team. It does not replace medical or clinical advice, but rather equips you with tools and confidence to play your essential role in your child's recovery.

Acknowledgements

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Anorexia nervosa and atypical anorexia explained

What is anorexia nervosa?

Anorexia nervosa is a serious and potentially life-threatening mental illness, with both mental and physical complications. A person experiencing anorexia nervosa restricts their food intake below the level they need to thrive. This results in weight loss and a body size that is too low for their expected weight, age, sex, stage of development and physical health. The person has a distorted body image and is terrified of gaining weight.

There are two sub-types of anorexia nervosa: restricting type and binge-eating/purging type. A person with the restricting subtype has significantly reduced their intake of food, usually via dieting or fasting and/or excessive exercise. A person with the binge-eating/purging subtype has significantly reduced their food intake and will also have recurrent episodes of binge eating or purging (e.g., by self-induced vomiting, laxative use).

What is atypical anorexia nervosa?

Your child may have received a diagnosis of atypical anorexia nervosa (classified under the umbrella term of OSFED aka Other Specified Feeding or Eating Disorder). This diagnosis occurs when the person has lost a significant amount of weight (via the methods described above) and exhibits the same mental and physical symptoms of anorexia nervosa, however their weight may have remained in the ‘normal’ or ‘overweight’ BMI range. Although the term ‘atypical’ might indicate this diagnosis is uncommon or unusual, a 2023 Australian study found that more than 50% of people presenting for treatment for a restrictive eating disorder were diagnosed as having an ‘atypical’ presentation.

A diagnosis of atypical anorexia nervosa is just as serious as a diagnosis of anorexia nervosa. Multiple studies have shown that the physical complications, mental distress and distorted body image in people with atypical anorexia nervosa are often worse, because the person has often been unwell for a longer period of time before being diagnosed with an eating disorder. There is debate within the eating disorder community about whether there are actually any meaningful differences between the two diagnoses.

It can be a very confusing experience for the unwell person and their carer/s to receive this diagnosis, especially if the person’s weight has remained at or above societally accepted weight norms. It is important to recognise that a person can experience a serious and life-threatening, restrictive eating disorder in any body size.

Please note that in this information pack, when anorexia nervosa is referred to, it is considered to be inclusive of atypical anorexia nervosa.

Causes of eating disorders

What caused the eating disorder?

There is no one identifiable cause of an eating disorder. No one is to blame for the development of an eating disorder. Parents do not cause eating disorders and people do not choose them. While some people may have experienced a traumatic event prior to developing their eating disorder, this is not the case for everyone experiencing an eating disorder.

Eating disorders are biopsychosocial illnesses, which means they are a complex combination of individual personality traits, genetics and environmental factors. These are known as predisposing factors. In anorexia nervosa and atypical anorexia nervosa, the mechanism is weight loss or an energy deficit over time, in a person who has the predisposition to developing a restrictive eating disorder. Sometimes the initial weight loss is deliberate (i.e., via dieting) and sometimes it can be accidental (e.g., over-training for sports, wisdom teeth extraction, braces).

Personality traits

Particular personality traits are more commonly associated with an increased risk of developing an eating disorder. These traits include anxiety, perfectionism, obsessiveness, low self-esteem, rigidity, and/or being driven and high achieving, harm avoidant or impulsive.

Genetics

Genetics can also play a part in a person developing an eating disorder. While a person cannot inherit mental illness, they can inherit a vulnerability to mental illness. Recent studies show that it is the heritability of complex traits that may make some people more vulnerable to developing an eating disorder. For example, genetics may influence the way people perceive food (reward-pleasure responses), and their internal responses such as appetite and metabolism. Eating disorders often run in families and when one sibling has an eating disorder, it increases the risk of other siblings also developing an eating disorder.

Dieting

The most prominent risk factor for an eating disorder is dieting. There are a number of reasons why a person might start dieting, including weight teasing or weight bullying, internalised weight bias, body comparisons, body dissatisfaction, healthy eating messages, trauma and/or pubertal weight gain. Dieting includes eliminating food groups, fasting or missing meals. Sometimes the restriction of food is disguised by a sudden interest in becoming vegetarian or vegan. Your treating team will likely ask questions about when the change in eating habits occurred to understand if it is linked with the onset of the eating disorder. In young people, food provides the nutrition required for healthy growth and development and any prolonged stall/decline in projected weight is a cause for concern (even if the young person was in a higher weight body prior to the dietary restriction).

The mind body impacts of an eating disorder

What happens to the brain during starvation?

Malnutrition has a catastrophic impact on the brain. Your loved one is probably behaving in ways that are not normal for them. This is due to the neurobiological changes that occur in someone's brain when they are undernourished.

You may have noticed one or more of the following changes:

- An increase in anxiety, rigidity and obsessional thinking
- A preoccupation with food (including poring over cookbooks, watching cooking shows, baking for family members and not eating it themselves, weighing and measuring food, using small bowls/cutlery)
- A decrease in social cognitions (the ability to understand how other people are thinking)
- A decrease in emotional regulation and an increase in emotional reactivity (fluctuating moods, frequent outbursts)
- A decrease in emotional expression (being able to recognise and/or respond with empathy)
- Reduced ability to make decisions (the brain's ability to weigh pros/cons of any decision is severely compromised by starvation)
- A reduction in flexibility and planning abilities
- An increase in compulsive and repetitive behaviours
- An increase in avoidance and/or impulsive actions
- Difficulty concentrating
- Impaired judgment and alertness
- Withdrawal
- Loss of sense of humour

Please note that the idea of changes in the brain can be quite scary however it is important to remember that these brain changes are reversible in full recovery.

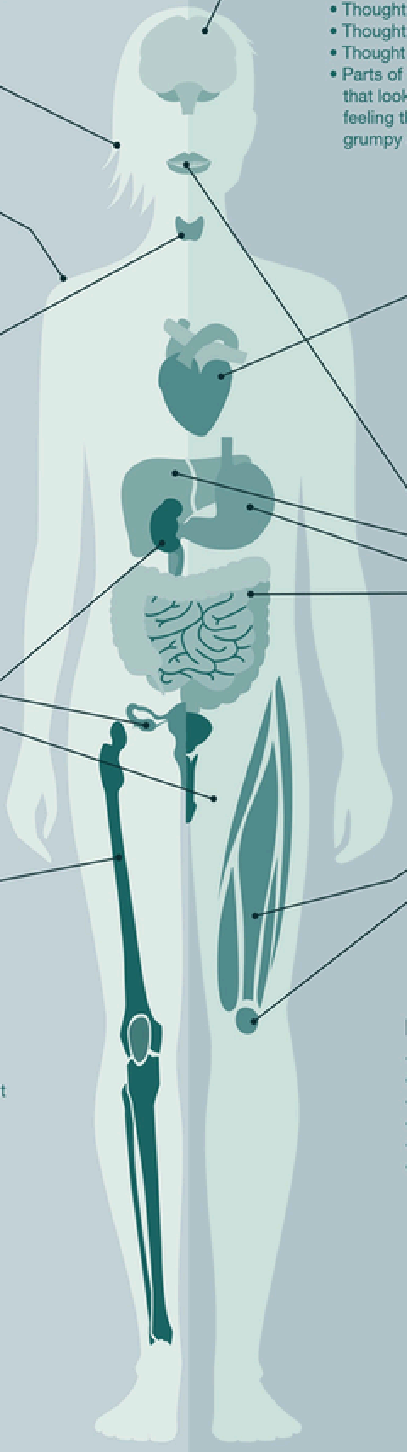
What happens to the body during starvation?

Every organ of the body is affected by malnutrition including brain, hair, skin, heart, endocrine system, gut, kidneys, muscles/joints, kidneys, metabolism, bones and bone marrow. This is why we can't take an approach of 'just wait and see'. It is imperative that treatment is undertaken as early as possible, to reverse these effects. This will likely mean that treatment has to take precedence over all of your child's other life commitments including school, work, sport and holidays.

What is the life impact of an eating disorder?

- Eating disorders are a medical and psychiatric crisis
- Eating disorders have the highest mortality rate of any mental illness
- Eating disorders severely impact all areas of a person’s life
- Eating disorders can become a chronic illness
- Early intervention is the best chance of recovery for your child

Medical Complications of Malnutrition



HAIR

- Hairs thins and is easily broken
- Hair falls out
- Fine downy hair grows to keep you warm

BRAIN

- Brain shrinks
- Hard to make decisions
- Hard to concentrate on tasks and to learn
- Feeling: irritable, moody, withdrawn, tired, anxiety, depression, self-harm, suicide
- Thoughts that won't go away
- Thoughts of hurting yourself or wanting to die
- Thought patterns about your body, food and eating changes
- Parts of the brain may not work well: that look after growing, being hot or cold, feeling thirsty, hungry or sleepy, feeling sad or grumpy as well as not feeling like sex

SKIN

- Dry skin
- Cracking skin
- Easily bruised
- Poor circulation with dusky fingers and toes
- Skin is much slower to heal
- Sores from lying in one position for too long

HEART

- Slow heart beat
- Low blood pressure
- Heart beat feels out of rhythm
- Racing heart beat
- Lightheadedness and fainting
- Heart changes size and shape
- Parts of the heart don't work as well as usual
- Swelling of ankles

ENDOCRINE

- Pubertal delay
- Growth failure and stunting of adult height
- Low production of reproductive hormones
- Periods may become light, irregular or stop altogether
- Fertility is impaired for both girls and boys
- If do become pregnant, more likely to give birth early and to have abnormally small babies
- Abnormal functioning of the thyroid gland
- Increase in stress hormones

GUT

- Enamel loss and dental caries (teeth rot)
- Swollen salivary glands
- Constipation
- Slow digestion, food moves slowly through the gut with tummy pain
- Bloating, feeling full
- Feeling sick in the stomach
- Stomach acid burning
- Liver damage

KIDNEY

- Dehydration, low level of body fluids
- Kidneys fail

MUSCLE & JOINTS

- Weak muscles and joints
- Muscles shrink

BONES & BONE MARROW

- Reduced peak bone mass
- Weak, thin bones
- Bone pain
- Bones break easily
- Bones remain weak and thin as an adult
- Bone marrow stops working, not as many blood cells are made

METABOLIC

- Slowed metabolic rate
- Slowed processing of food into energy
- Low blood sugar levels
- Body salts, vitamins and minerals are not balanced
- Fatigue
- Low body temperature and feeling cold

Austin ACED 2018

National Eating Disorders Collaboration

Eating disorders: myths debunked

Myth	Truth
Eating disorders are not serious; they are a life-style choice or about vanity.	Eating disorders are serious and potentially life-threatening mental illnesses. A person with an eating disorder experiences severe disturbances in their behaviour around eating, exercising and related self-harm because of distortions in their thoughts and emotions.
Eating disorders are a cry for attention or a person 'going through a phase'.	Due to the nature of an eating disorder a person may go to great lengths to hide behaviour, or may not recognise that there is anything wrong. Eating disorders are not a phase and will not be resolved without treatment and support.
Families, particularly parents, are to blame for eating disorders.	There is no evidence that a particular parenting style causes eating disorders. Although a person's genetics may predispose them to developing an eating disorder this is certainly not the fault of their family.
Dieting is a normal part of life.	Eating disorders almost invariably occur in people who have engaged in dieting or disordered eating. Dieting is also associated with other health concerns including depression, anxiety, nutritional and metabolic problems, and, contrary to expectation, with an increase in weight.
Eating disorders only affect white, middle-class females, particularly adolescent girls.	Eating disorders can affect anyone. They occur across all cultural and socio-economic backgrounds, and can affect people of all ages, from children to the elderly, and all genders.

Family Based Treatment / Family Led Refeeding

What is FBT (Family Based Treatment)?

FBT is a community-based, outpatient treatment model for young people with anorexia nervosa or atypical anorexia nervosa, who are medically stable. You as the primary carer/s will be supported by your child's care team and empowered to renourish your child back to full physical health at home. FBT is initially a very high-intensity treatment, with many appointments at the beginning, tapering over time as your child recovers. The treatment manual estimates that the treatment could be between 6-18 months, however for some people the course of recovery will be longer.

There are three phases of treatment:

Phase I: Refeeding and weight restoration

Parents take full control of all meals, interrupt problematic eating disorder behaviours, excessive exercise etc. and help their child to eat enough food to return them to complete physical health.

Phase II: Returning control of eating to the young person

A gradual return of control back to the young person (in an age-appropriate way), with continued scaffolded support by primary carer/s.

Phase III: Addressing adolescent issues and treatment completion

A supported return to age-appropriate independence once all eating disorder behaviours are gone.

Core Principles of FBT

No one is to blame for the development of the eating disorder

Treatment takes an agnostic stance. FBT does not blame anyone for causing the anorexia and does not focus addressing the underlying cause of it. Instead, the stance taken in FBT is that your child has a life threatening illness, so you and your treating team need to return your child to health as quickly as possible.

Separate the young person and the illness

In FBT anorexia is externalised, meaning anorexia is viewed as being separate to the young person. The young person is not to blame for the anorexia, but the illness has become so powerful that they are not able to make choices in line with their health and recovery, therefore requiring the help of their parents to be able to recover.

The family is the best resource to bring about recovery

In FBT parents are viewed as the agents for change and that they are the best resource to bring about their child's recovery. This means that treatment focuses on empowering parents to take charge of restoring their child's health.

Hospitalisation is a short-term solution to the problem

Hospital plays a role when the young person is medically unstable, but sustainable, long-term change occurs in an outpatient setting. We know that nutritional recovery and symptom management to ensure safety can occur outside of hospital and is the initial focus of treatment in FBT.

Each family member has a specific role

Anorexia affects everyone within a family. In FBT, it is important for the whole family to attend, as each member plays a specific role for that young person. Parents take a leadership role in taking control of the problem, while siblings continue in their role as a sibling but with a deeper understanding of their unwell sibling's predicament.

Weight gain is key

Why is weight gain so important?

One of the primary goals of treatment, especially in the early stages of recovery, is weight gain. Full recovery will not be possible without regaining weight back to a level that is consistent with your child's lifetime weight trajectory. This might mean that you are restoring your child back into a larger sized body, because that is where their weight needs to be for complete physical and mental health.

Weight restoration is not the only factor in recovery from anorexia, but it is an important and crucial initial goal of treatment. Your child's brain will not be able to recover from the impacts of malnutrition until their body is fully weight restored. Often, the brain recovery lags some weeks/months behind the recovery of body weight, which is why weight restoration is the first priority of treatment.

My child has anxiety/depression, shouldn't this be addressed first?

Malnourishment can lead to a range of psychological concerns including lowered mood and heightened anxiety. It can also exacerbate pre-existing mental health conditions. We know that malnourishment compromises the ability of a person with an eating disorder to engage in individual led psychological treatment (e.g., addressing anxiety/depression) because the brain is not cognitively able to engage. As such, it is recommended that a child engages in family led treatment with an initial focus on restoring weight, to reverse the effects of malnourishment on the brain. If the child is still experiencing other mental health concerns once they have reached their ideal weight, this can be addressed in the later stages of treatment or even in individual treatment after completing FBT.

How is the target goal weight established?

Setting goal recovery weights is a complicated process. Many factors are considered including age, height, previous lifetime weight/height trajectory (i.e., growth percentiles), family genetics, and expected pubertal growth. Remember that the goal will not be to return your child back to the weight they were prior to the onset of the eating disorder as they are now older and therefore should be in a larger body than when they were younger. Also, adolescence is a time for rapid, ongoing weight gain. It is normal to gain weight right through until our early 20's and beyond, and we encourage families not to get 'stuck' on a particular number, but rather to be flexible about how much weight might be needed for your young person to fully recover.

While it can be helpful to have the initial target weight in mind, it is important that this number is held flexibly, knowing that sometimes young people need to go well beyond it for recovery. It can be useful to focus on the concept of 'state not weight', meaning that you are looking for cognitive changes/improvements as an indicator that you are approaching the right weight for your child (e.g., improved mood, return of humour etc).

How fast should weight gain be?

Studies show that faster weight gain is better if you can manage this. The longer your child's brain is affected by malnourishment, the greater the chance of a longer course of illness. Research indicates that approximately 2kg of weight gain in the first 4 weeks of FBT is predictive of recovery 12 months later (Madden, Misckovic-Wheatly, Wallis et al., 2015). If this hasn't happened yet, please don't lose hope. Many children recover fully even when early weight gain is slower.

Weight gain is hard work, and nobody wants to be doing this any longer than is necessary. An extended course of refeeding is exhausting for both the young person and their family. The aim is to gain a minimum of 500g – 1kg each week until the target weight is achieved.

It can be helpful to think about how far you have to go. If your child has 10kg of weight to restore, this first phase of treatment will take ~10 weeks when gaining 1kg a week, while weight recovery will take the best part of a year if your child is only gaining a few hundred grams a week.

Weighing

Your child's weight will be measured each week in therapy. Their weight progress will be openly discussed in the therapy session with you and your child. This aims to help everyone understand how things are progressing, make plans for the following week, and help your child get used to the idea that weight restoration is essential.

Weighing at home should cease, and scales removed from the home. Weighing at home often contributes to increased stress for your child and runs the risk of becoming obsessive.

It can be helpful to know that BMI is not a particularly useful measure for children/adolescents. Instead, your treating team will likely focus on weight, height and your child's respective growth percentiles for weight and height.

Separating the illness from the child

Often families and supports struggle with their young person suddenly engaging in behaviours or actions that are out of character, and it may feel like a new person has taken over. They might be engaging in lying, hiding secrets, frustration, irritability and even aggression. Parents and carers report their young person can be irrational, and it can be hard to understand why they are engaging in self-destructive behaviours (e.g., refusal to eat, exercise, purging, laxative use, self-harm). For both the young person, and their loved ones this can be hard to understand or see from different perspectives.

Externalisation or externalising the eating disorder is a therapeutic strategy that helps us see the illness as a separate identity and an external influence on the person, so blame is not unduly placed upon the person. The person is not the problem, the problem (Anorexia) is the problem. Through externalisation, it can create understanding, empathy and distance between the illness being the problem, not your loved one. This helps shift blame, frustration and anger away from your child, and towards the illness itself. Some families consider the illness as its own identity and form, with a voice, thoughts and actions that are not aligned with your child. This can reduce feelings of guilt, judgement and shame from your loved one, supporting them to see that you know there is more to them than their eating disorder, and that they are not the problem.

Through externalisation, parents and supports can model distancing the illness from the young person, so the young person can also internalise this message for themselves. It may provide a space for the young person to open up communication and see that everyone is working together towards the same goal of recovery. Although it might be difficult in the beginning, research has shown that externalisation helps the young person see anorexia nervosa as a separate part of them (Voswinkel et al., 2021). This study showed that by externalising the illness from themselves, they were able to identify what the eating disorder was saying and over time challenge this. Parents and supports can provide clarity over which thoughts and behaviours belong to the young person, or the illness.

It is important to recognise that eating disorders are ego-syntonic, meaning that individuals perceive their eating disorders as a part of their personal identity. For some young people, externalisation could be experienced as dismissive, or invalidating at times, highlighting the importance of being curious and non-judgemental with your loved one. Be mindful that we cannot blame everything on the eating disorder, however, be curious, open and try to understand how the illness is influencing your loved one. Some families and young people find it useful to name their eating disorder to support with externalisation (e.g. Ed, Ana etc).

What does recovery mean?

Recovery is different for everyone, including the journey and time it takes to get there. It is a unique process, that encompasses a range of experiences, including thoughts, feelings, weight restoration and behaviours towards food and body image. Often families find it difficult to know when their loved one has 'recovered' and it can be helpful to remember that it is not a linear process. Recovery is a return to functioning and life. While this can still include ongoing challenges, we are aiming for participation in developmentally normal activities, such as school, socialising with friends/family, engaging in sport and activities of interest. With a return to normal physical growth, the young person is able to achieve their growth potential. For females this will include return of menses, but it's important to remember that this is only one of many signs of physical healing and not an indication that goal weight has been reached. Some girls never lose their period during illness, so its presence or absence should not be used as the sole measure of recovery. Every child's journey looks different, and progress is about the overall restoration of health, not just one marker.

Eating disorder cognitions can be one of the last things to shift despite a return to physical health. Some young people describe ongoing eating disorder thoughts and pre-occupation with food and weight gain, however they are able to not act on these thoughts. Families are able to see the behaviour shifting gradually over time, and often working towards a RAVES model (Regular, Adequate, Variety, Eating Socially & Spontaneously). Additionally, while they might need increased support, they are able to eat a variety of foods without fear of weight gain and/or calories. An improved relationship with their body typically occurs after weight restoration and being adequately nourished.

Some families and supports find it helpful to recall experiences with their loved one before they become unwell, to understand what recovery might look like for them.

Getting started

Four strategies to get parents started

1. Take the lead in deciding ***what*** and ***how much*** your child needs to eat for each meal and snack

2. Provide 3 main meals and 3 snacks per day and ensure all meals are eaten

3. Interrupt and stop any excessive exercise or physical activity your child is doing

4. Prevent or address other behaviours that lead to weight loss such as purging, secretive exercise or laxative use

(Wallis & Alford, 2021)

The first two weeks at home

To help get refeeding started and give carers an opportunity to see early progress, it is recommended that the primary carer/s take two weeks off work to stay at home and provide intensive support as their child begins eating again. This period is not expected to achieve full recovery. It is intended to build momentum and confidence while acknowledging the scale of the task ahead. Sometimes this approach is referred to as 'hospital in the home.'

Work together with your mental health clinician to establish a plan of who will be carrying out each of the tasks for refeeding: planning the meals, doing the grocery shopping, preparing and cooking the meal, serving, supervising and supporting full completion of each meal and snack. Your child cannot be responsible for any of these tasks at the moment and should not be accompanying you to the supermarket or choosing/preparing their own meal.

The idea of 'hospital in the home' is that you are trying to replicate the same feeding schedule that would happen if they were in an inpatient setting, with each meal and snack served at the same scheduled time each day. The expectation is that your child will eat everything that you serve to them.

As with any other serious physical illness, your child will need to cease all physical activity and rest. They may need you to intervene to help them with this.

What do I feed my child?

For eating disorders, food is considered the ‘medicine’ and is **non-negotiable**. As the parent you will need to provide at least three generous meals and three snacks per day. Each meal consists of two courses and a nourishing drink. To achieve full weight restoration as quickly as possible, you need to feed your child a high calorie diet, ensure he/she eats everything you provide (“100% of the food, 100% of the time”) and prevent any compensatory behaviours.

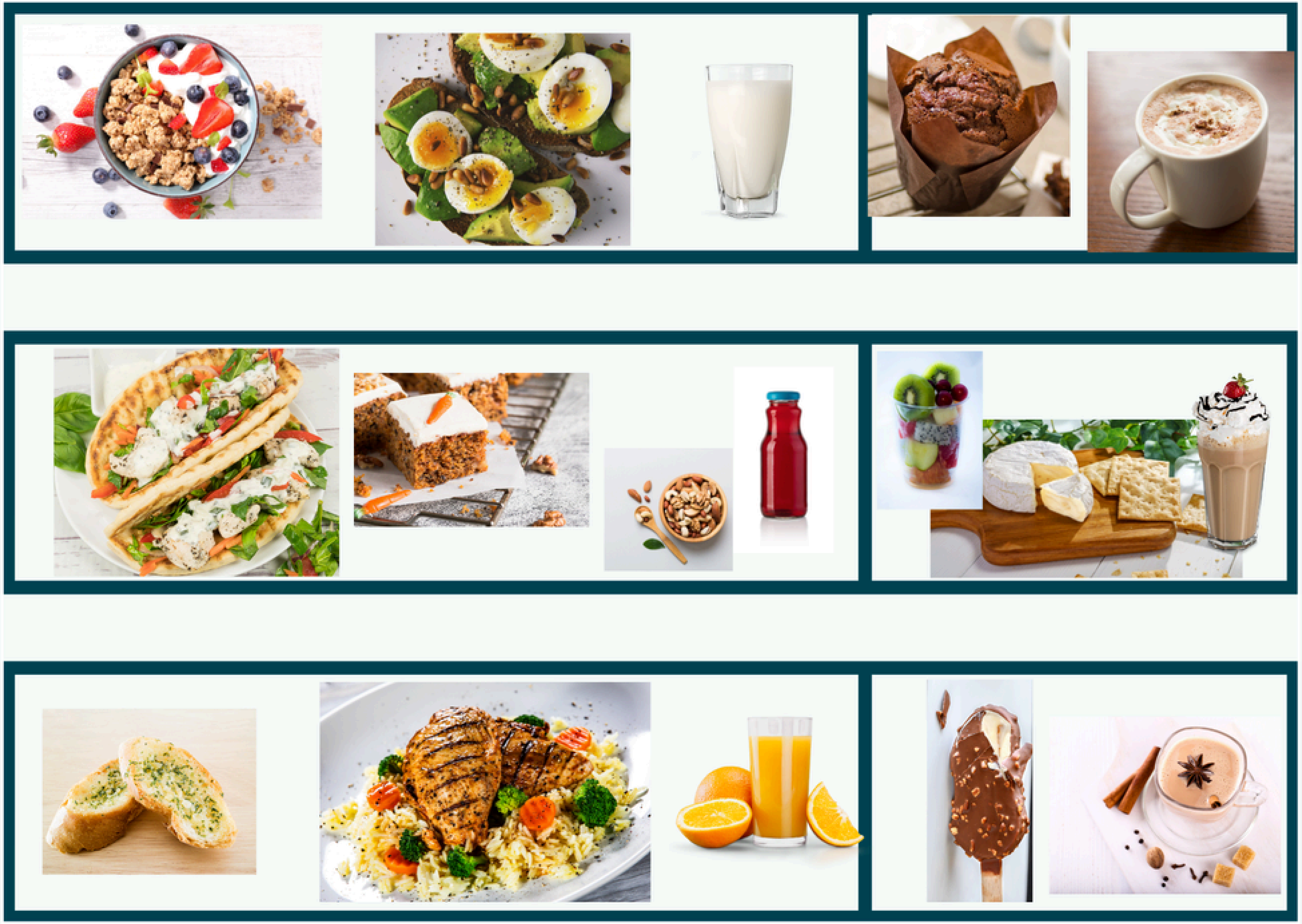
Families differ in terms of how they work out what to feed their child. Some families intuitively up the caloric density and portions, other families may need to take a more structured approach. There is a visual representation of minimum foods needs for ongoing weight restoration handout in this pack that many families find helpful. Remember to serve up what your child **needs** rather than serving what you think your child will eat.

It is often recommended that families try to minimise the volume of the food their children are required to eat by increasing the caloric value of the foods you serve. In order to do this, you can be strategic by serving full fat products, plenty of fats and oils, foods rich in proteins and carbohydrates. Page 22 includes some handy tips from a carer about how to calorie boost meals and snacks.

It is recommended to provide a variety of foods and include feared foods right from the beginning of treatment.

Many families get caught in the trap of thinking that serving “healthy food” will get their child better. It is important to remember that anorexia is a fear of food, usually high-caloric-density foods. Not only will serving “healthy food” take too long to weight restore your child (leaving them at significant risk for a prolonged period of time) but will not challenge this fear. A good sign of recovery is that your child can eat everything they ate prior to anorexia and eat everything without fear.

Minimum food needs for ongoing weight restoration



Minimum food needs for ongoing weight restoration May 2024

Calorie boosting tips from a carer

Butter and margarine:

- Melt over cooked vegetables, stir through cooked rice, cooked pasta and soups.
- Spread thickly on bread, toast, crumpets, bagels.
- Butter both sides of toasted sandwiches.
- Spread on sweet and savoury biscuits.

Plant-based oils, e.g. olive oil:

- Add oil to any cooked dishes especially vegetables.
- Add to stir fry vegetables or fried rice.
- Brush oil on meat after grilling food for the rest of the family and use oil-based salad dressings.

Avocado:

- Spread on toast or crackers.
- Add to smoothies.
- Try to include in sandwiches or puree and eat as a dip or add to other pureed foods.

Mayonnaise and dips, e.g. hummus, tzatziki:

- Use as a spread in salad sandwiches.
- Mix with tuna or egg to use on dry biscuits or in sandwiches.
- Use as a salad dressing or serve with fish cakes or fish fingers.

Cheese:

- Add grated cheese to soups, pasta, casseroles, mashed potato, scrambled eggs, tinned spaghetti or baked beans or melted on vegetables.
- Use cream cheese in dips or spread on biscuits and bread.

Cream:

- Add to milk, breakfast cereals, desserts, custard, yoghurt, sauces and soups.
- Substitute for milk in recipes for cakes and muffins.

Milk:

- Use full cream milk rather than the reduced fat options.
- Make soups and puddings with milk instead of water.
- Add 1 tablespoon of milk powder (full cream) per cup of milk to create a higher energy and protein milk to use for drinks and cooking.

Sauces:

- Use gravies and sauces where possible on vegetables and meat dishes.

How do I feed my child

Planning and preparing

Work out ahead of time who will be responsible for doing the food shopping, who will prepare each meal and who will sit with your child during the meal as well as support them afterwards (when distress is often high). Plan together with your partner and ensure that you are both on the same page. It can be helpful to work out what each of your strengths are and play to those.

Be prepared that meals may (and probably will) take a long time at first. Ensure that you have the time to be able to sit with them.

Eat at a predictable time and ensure that no more than 3-4 hours lapses between any meal/snack. Waiting for a meal increases your child's distress, so it can really help to be punctual in the early stages of treatment.

Your child should not be involved in **any** choice or preparation of food. Their only job is to turn up to the meal table and eat. While it feels paradoxical, this reduces anxiety significantly.

Make sure you have extra food at hand before the meal to replace any food disposed of by the child.

During meals, you will need to sit with your child to **support or distract them**. Getting into debates with the eating disorder can be unhelpful. Instead, consider the use of games, light-hearted conversation, television, iPad as a means of distraction.

The "magic plate"

Many parents have found the term "magic plate" helpful in enabling them to conceptualise what they have to do. Magic plate means that caregivers/parents make all decisions about food and nutrition until the child is well enough to take back this responsibility. You plan the meals and snacks, you do the shopping, you do the preparation, you decide the amounts, and you put it on the plate. The only job for the child in all this for now is to eat what is given to him/her. Most parents honour historical dislikes, but strive to reintroduce foods that were previously accepted but became "hated" or feared during the course of the illness.

Typically, parents see distress and resistance at first, but this subsides once the eating disorder works out that your child has no choice in the matter. Counterintuitively, being relieved of the choice of what, when and how much to eat ultimately eases the child's anxiety and they are able to eat what is presented.

How do I get my child to eat?

Research tells us that meals are more effective when families have a behavioural focus on eating (verbal and physical prompting) rather than trying to ‘convince’ the child to eat or provide the child with choices. Verbal prompts may be **direct**: ‘pick up the sandwich and eat it’, ‘take another bite’ or **non-direct**: ‘keep going’, ‘why don’t you eat some more pasta’. Non-verbal prompts can be pushing the plate towards the child, putting the spoon into their hand etc. **Direct** eating prompts are the most effective at getting an adolescent with anorexia nervosa to eat.

Display confidence. It is important that you come to the table with confidence that you know what your child needs. Often children will say things like ‘is this the right amount’ or ‘are you sure this is what I need to eat?’. It is important that you can confidently say, ‘yes, this is exactly what you need’.

We know that negotiating with the anorexia is a lose-lose proposition. Anorexia only ever negotiates for less. Notice when you start to enter into negotiations with anorexia and try to stop.

Remain calm and compassionate. Keep in mind that your child’s anger and outbursts come from a state of anxiety. Remaining calm, confident and compassionate will help move them out of this fear state. You can empathise with how difficult the meal is for your child, while being firm about eating -e.g., “I’m sorry you feel....”; “I can see this is hard...”.

Notice and try to stop any eating disorder behaviours as quickly as possible (e.g., breaking food into small pieces, leaving crumbs, eating with a teaspoon). Allowing these behaviours strengthens the eating disorder. Your consistency in placing boundaries around these behaviours demonstrates to the eating disorder that the only option is to eat the food served.

Although meal times can be very difficult, try to make them as normal as possible by engaging in conversation and using distractions.

You are not expected to eat as much as your child but it is important to eat with your child and eat the foods that your child is fearful of. This modelling demonstrates to your child that all foods are okay and safe.

Talk to your clinician about what to do if your child doesn’t complete their meal or entirely refuses. If a meal is not completed it is important that the missed calories are made up for. It can be helpful to have a Plan A, Plan B and as many additional plans you need to ensure that eating is non-negotiable.

Post meal supervision and support

After mealtimes distress can remain very high for your child. It can be helpful to think about what kind of support they may need afterwards. This could involve activities to distract or soothe (that are relatively sedentary). They may also benefit from hot water bottles or warm blankets, as bloating and stomach discomfort is common during the early stages of refeeding.

Managing purging and exercise

How can I keep my child from exercising/purging?

If compulsive exercise or purging is a component or your child's illness, you may need to create additional rules and routines. Below are some ways that families do this:

- Supervising your child for 30 minutes, at a minimum, after meal times is usually recommended as this can be when the urge to compensate for eating is the strongest.
- Bathroom visits may need to be supervised, including having the door open (or removed). While uncomfortable for everyone, it is important for purging behaviour to be interrupted.
- Showers only in the morning before eating, as showering after meals can sometimes be used as an opportunity for purging or exercise.
- Keeping bedroom doors open.
- You may need to stay with your child constantly. For some parents, this looks like staying with their child until they have fallen asleep, as they may exercise when everyone has gone to bed. Parents may need to sleep in their child's bedroom or have them sleep on a mattress in your bedroom, to ensure they aren't engaging in any compensatory behaviours overnight.

Managing my child's distress

Why is it so difficult for my child to eat and how do I manage their distress?

Your child's brain has been 'hijacked' by the eating disorder and is now misidentifying food as a threat. When someone is unwell with an eating disorder, the brain recognises food as dangerous. Therefore, when your child is presented with food during refeeding their brain goes into flight/fight/freeze mode. This can often result in extreme behaviours that will seem completely out of character for them. You might notice your child is violent when there has been no prior history. Some carers find it helpful to consider how they would feel being presented with their greatest fear 6 times a day, this is where the distress comes from.

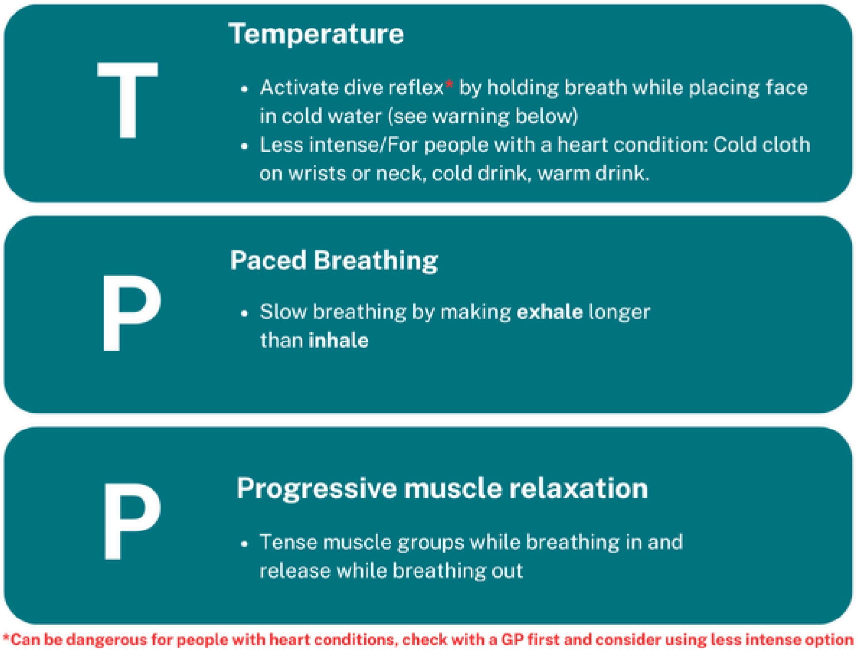
Every meal and every snack are an eating opportunity and an exposure to the thing your child fears most. This will cause distress — we expect this in order to engage in recovery. Your role is to help them to do this hard thing, multiple times every day, until their fear response eases. In early treatment, we anticipate that distress will increase before it reduces, this is due to the eating disorder being challenged.

In addition to food being perceived as dangerous by your child, they have learnt to cope with uncomfortable emotions through engaging in restriction, exercise or purging. Distress will increase as your child's strategy of regulating their emotions has been taken away, **and** they are being confronted by their greatest fear. When a young person loses a sense of their control, the eating disorder increases the negative thoughts, and will send signals to get back the control as soon as possible. Through providing some support with distress tolerance, you are showing your child that you are safely in control and supporting them with their recovery.

Your child will need your unconditional love and support to get through this distress. They need to feel they are safe and that you know what they need to recover and that you can tolerate their distress.

Distress management strategies for young people

Distress can fluctuate throughout treatment although is typically higher around meal times. For some young people distress may be felt more in the food preparation time, for others distress may be at the highest **during** meals. A lot of young people struggle with extreme distress **post** meal times and it can be helpful to have strategies that work for them. You may need to use a combination of strategies, at different stages of distress. Remember that distress is an expected part of treatment, so it is likely there will still be some distress even with strategies in place. Here are some ideas to explore together:



T **Temperature**

- Activate dive reflex* by holding breath while placing face in cold water (see warning below)
- Less intense/For people with a heart condition: Cold cloth on wrists or neck, cold drink, warm drink.

P **Paced Breathing**

- Slow breathing by making **exhale** longer than **inhale**

P **Progressive muscle relaxation**

- Tense muscle groups while breathing in and release while breathing out

*Can be dangerous for people with heart conditions, check with a GP first and consider using less intense option

Keeping distress down

Activities	Colouring, knitting, cleaning, TV, YouTube, movies, conversation, crafts, lego, organising things, colouring, walking/light exercise (if medically cleared to do so
Opposite emotions	Something that triggers a different emotion: Funny YouTube clips, comedy sketch, Sitcom, jokes
Thoughts	Something that uses our brain: Puzzles, sudoku, homework, board games, counting anything, audiobooks, podcasts
Sensations	Strong physical sensations will overcome strong emotional sensations: Ice cube, cold drinks, hot drinks, stress ball, rubber band around wrist, “Wreck-it journal”, pluck hairs

Looking after myself

How do I cope with my own distress?

It is natural that any parent/support will find refeeding exceptionally difficult, and seeing your child so upset can bring up a range of your own emotions. We understand that this could be one of the hardest things you have ever had to do and it is normal to feel overwhelmed and scared. As a parent, you understandably want to support your child and reduce their fear, and it can feel incredibly counterintuitive to present food to them when their distress is so high. It might be tempting to find ways to reduce their distress, and for some parents they try letting their child choose foods, negotiate amounts or skip meals/snacks completely. Unfortunately, while this might reduce distress momentarily, it will not be helpful in the long run and prolongs the distress of your child trying to manage their eating disorder on their own.

Many parents feel exhausted at the end of each day and often feel like there isn't a spare moment to themselves. While it is difficult, it is important to find some time for self-care in order to take care of yourself. To continue treatment as long as necessary, you will need your energy and having space for you can help you pace yourself for recovery.

We encourage you to seek your own support, from family and/or friends, your own professional psychological support, and through the various professional carer support networks (Eating Disorders Families Australia, Eating Disorders Victoria, Butterfly) or via carer support groups on Facebook and online. There is a list of eating disorder and carer support organisations included in this pack. Finding a support system reduces the feelings of isolation for parents and families.

Siblings

How has anorexia nervosa affected my other children?

Having a child with anorexia nervosa can be really tough on siblings. They can react in various ways, depending on age, own issues, personality and their own unique relationship with their unwell sibling. Common feelings may include grief, sadness, anger, neglect and isolation, and stress or worry.

Many siblings report wanting to understand anorexia nervosa better, be involved in treatment, and know how they can help their unwell sibling. In FBT, siblings are encouraged to participate in treatment sessions so they can have their questions answered, express concerns, and feel included. This involvement helps siblings understand what their brother or sister is going through and reduces feelings of confusion or isolation.

However, it’s important to clarify that siblings should not take on the role of a parent. Meal support is the responsibility of parents, not siblings. Asking siblings to supervise meals or enforce eating can create stress, damage relationships, and place an unfair burden on them. Their role is to remain a sibling, someone who offers companionship, reassurance, and normalcy.'

How can I best support my other children?

It is likely that through your child’s treatment and recovery you will find that your other children do not get the attention and time that they would ordinarily receive. Try to find a little bit of time each day to spend with them and talk to them.

Many worries for siblings come from concern for their sibling and confusion about what is going on. Try to help them understand that their sibling has an eating disorder, what that is, and that you need to spend more time with them during this period. Depending on your other children’s age, it might be helpful to provide them with books or handouts about anorexia nervosa.

Validate your other children’s feelings. Allow them to voice how they are feeling and reassure them that they are loved and cherished.

Don’t be afraid to ask for help from others. Consider who in your network may be able to best support you with your other children. Is someone available to care for your other children during meal times? Take them to school/sports/after school activities?

How are siblings involved in FBT?

Many siblings report wanting to have a better understanding of anorexia nervosa, wish to be involved in treatment and want to know how they can help their unwell sibling. In FBT, siblings are expected and encouraged to be involved in treatment.

Their involvement provides the opportunity for siblings to better understand their unwell sibling's predicament, have their own questions answered, and concerns heard. Siblings also provide a crucial role in supporting the young person. This can be as simple as watching TV together, offering a hug, or talking about things unrelated to the eating disorder. Sibling relationships can often be disrupted by the illness; It is important that they remain in the role of a sibling, rather than one of a parent.

FBT Phase II and III

Phase II

What is Phase II and when will we start?

By the end of Phase I, your child should be at or near their target goal weight, and should be eating regularly, adequately, and with wide variety without struggle. Your child should, for the most part, not be engaging in compensatory behaviours. Typically, you will see some improvements in your child's mood. Many parents report seeing a return of their child's personality. While your child's eating disorder cognitions have usually not disappeared completely (this takes some time), young people are typically able to respond to and manage these thoughts much better.

Following appropriate signs of recovery, you will discuss moving into Phase II of treatment with your FBT clinician. Phase II involves parents gradually returning control of eating back to the young person (in an age-appropriate way), with continued scaffolded support by primary carer/s. The transition from Phase I to Phase II is delicate, and can be a common time for relapse; planning this transition with your treating team is important. Sessions are usually fortnightly during Phase II and the young person will continue to be weighed each appointment. The whole family continues to attend appointments.

What does Phase II actually look like?

Many parents find that this phase is harder in some ways than Phase I. It can be difficult to hand over control, trust your child, stay vigilant about the eating disorder and do it methodically and carefully. It is not a linear process and baby steps are encouraged. For your child, taking these first steps towards independent eating, "choosing" to eat, and choosing to fight the eating disorder on their own rather than being told what to do, can be really hard and introduce feelings of guilt and anxiety.

Parents are encouraged to transition in to Phase II slowly and systematically. Often families start with small steps such as getting their child to choose between two snacks and slowly build up to larger steps such as having their child plate up their own food. If you discover that a step is too hard for now and your child wasn't ready, it is absolutely ok to step in and help your child with that step (e.g., decide what snack they will have if they are struggling to do so or add more food to their plate if they have not served themselves enough). You may also decide to backtrack to an earlier, more manageable step before moving forward again – it is a dynamic process.

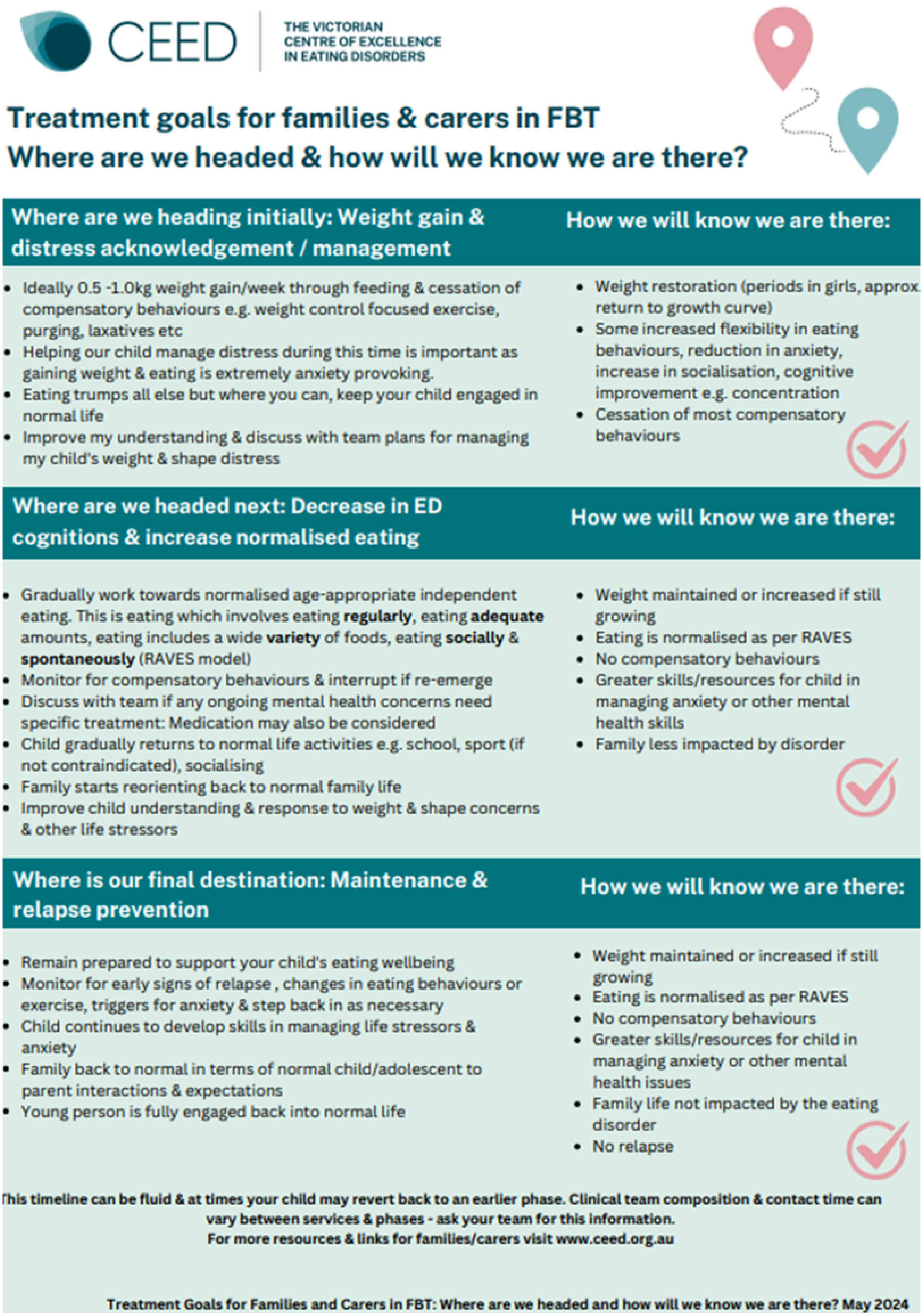
How do we do it?

- Take baby steps. Don’t rush this phase, it may take a long time.
- Accept and embrace the fact that Phase II does pose an inherent risk but is an important part of recovery.
- Be systematic in how you approach handing back control of independent eating to your child. Decide on a process and stick to it.
- Have the child/young person practice choosing and preparing their food under supervision before they are permitted to eat unsupervised.
- Assess progress regularly.
- Take back control when necessary. It can be (and is often) a 2 steps forward, one step back process. No blame should be attached to the child or yourself if these steps back are required. Keep in mind that whatever happens is simply feedback, not failure.
- Some young people will need a gentle nudge to move forward as it can feel very safe to have no choice in what and when to eat.
- Don’t force Phase II into an external timeline. Trying to push independent eating to get to go on an interstate school trip or back to school full time etc. won’t work in general.

Phase III

What is Phase III and when will we start?

During Phase III, your child should be weight restored, capable of managing independent eating and re-engaged in their previous normal activities. The primary focus of this phase is to identify and address any issues that interfere with appropriate adolescent development, to ensure that the young person and your family can return to normal life without an eating disorder. With your FBT clinician, you will make plans to address these issues. Sessions are typically 4-6 weekly and weighing is phased out of treatment.



CEED | THE VICTORIAN CENTRE OF EXCELLENCE IN EATING DISORDERS

Treatment goals for families & carers in FBT
Where are we headed & how will we know we are there?

Where are we heading initially: Weight gain & distress acknowledgement / management

- Ideally 0.5 -1.0kg weight gain/week through feeding & cessation of compensatory behaviours e.g. weight control focused exercise, purging, laxatives etc
- Helping our child manage distress during this time is important as gaining weight & eating is extremely anxiety provoking.
- Eating trumps all else but where you can, keep your child engaged in normal life
- Improve my understanding & discuss with team plans for managing my child's weight & shape distress

How we will know we are there:

- Weight restoration (periods in girls, approx. return to growth curve)
- Some increased flexibility in eating behaviours, reduction in anxiety, increase in socialisation, cognitive improvement e.g. concentration
- Cessation of most compensatory behaviours

Where are we headed next: Decrease in ED cognitions & increase normalised eating

- Gradually work towards normalised age-appropriate independent eating. This is eating which involves eating **regularly**, eating **adequate** amounts, eating includes a wide **variety** of foods, eating **socially** & **spontaneously** (RAVES model)
- Monitor for compensatory behaviours & interrupt if re-emerge
- Discuss with team if any ongoing mental health concerns need specific treatment: Medication may also be considered
- Child gradually returns to normal life activities e.g. school, sport (if not contraindicated), socialising
- Family starts reorienting back to normal family life
- Improve child understanding & response to weight & shape concerns & other life stressors

How we will know we are there:

- Weight maintained or increased if still growing
- Eating is normalised as per RAVES
- No compensatory behaviours
- Greater skills/resources for child in managing anxiety or other mental health skills
- Family less impacted by disorder

Where is our final destination: Maintenance & relapse prevention

- Remain prepared to support your child's eating wellbeing
- Monitor for early signs of relapse , changes in eating behaviours or exercise, triggers for anxiety & step back in as necessary
- Child continues to develop skills in managing life stressors & anxiety
- Family back to normal in terms of normal child/adolescent to parent interactions & expectations
- Young person is fully engaged back into normal life

How we will know we are there:

- Weight maintained or increased if still growing
- Eating is normalised as per RAVES
- No compensatory behaviours
- Greater skills/resources for child in managing anxiety or other mental health issues
- Family life not impacted by the eating disorder
- No relapse

This timeline can be fluid & at times your child may revert back to an earlier phase. Clinical team composition & contact time can vary between services & phases - ask your team for this information.
For more resources & links for families/carers visit www.ceed.org.au

Treatment Goals for Families and Carers in FBT: Where are we headed and how will we know we are there? May 2024

Messages from families

From CEED Parent Survey (2015)

Advice from parents who have supported their children to recovery, to parents new to this journey

“Love them but challenge the illness”

“Be prepared to do things way outside of your comfort zone”

“Seek separate psychological help for yourself”

“Don’t argue with the child. You’re only arguing with the disorder”

“Don’t give up. Listen and trust your instinct”

“It may be stressful and confronting for the whole family. You need to look after yourself as it can very wearing”

“Work with your partner, you can’t do it alone”

“You can insist on full nutrition each meal. You can stop all exercise immediately”

“Take control of the eating disorder – do not enable the disorder”

Knowing what they know now, what would parents have done differently?

Take a firmer stand on our daughters eating and exercise right from the beginning

Sought more help from friends and family, rather than just us parents doing everything

Took control of eating earlier

Kept a very good eye on her after meals

Stopped sport

Stop the excessive exercise regime

Prioritised nutrition

Challenged her behaviour sooner

Not agreed to minor diet changes

Been more insistent about food

Encouraged open discussion

Not worked

More calm approach

Removed scales from home

Not allowed her to make so many food choices

Eating disorders and neurodivergence

Co-occurring neurodivergence and eating disorders

It is estimated that close to half of individuals who are diagnosed with an eating disorder are also neurodivergent; Autism and ADHD being the most common co-occurring diagnoses. Neurodivergent traits may leave a young person vulnerable to developing an eating disorder or exacerbate factors that maintain an eating disorder.

If your child is neurodivergent, we encourage you to share this with your treatment team. This knowledge allows you and your team to better understand your child's unique needs and make appropriate adaptations to the standard treatment to best support your child. If you think your child might by Autistic or have ADHD but does not yet have a formal diagnosis, please raise this with your treating team.

Screening and assessment

Clinicians are encouraged to screen all people presenting with an eating disorder or disordered eating for neurodivergence (i.e. complete a brief assessment). If a screening test indicates possible neurodivergence, then it may be recommended that a young person complete a more thorough assessment. It is not necessary to wait until weight has been regained to screen for Autism or ADHD. It is more important that potential neurodivergence is identified early. If it is indicated that further assessment would be beneficial, the assessment will focus on factors that were evident before the development of an eating disorder and take into account factors outside of the eating disorder.

Accommodating neurodivergent traits in treatment

If your child is neurodivergent, adjustments can be made to FBT to ensure that their specific needs are met. As parents you are likely to already have a strong sense of what your child needs and we encourage you to share this with your treating team. In discussion with you, your treating team will likely have some suggestions of treatment adaptations to accommodate your child's neurodivergent traits too. Some considerations or modifications may include:

- The physical eating environment may need to be adapted to meet sensory support needs (e.g., noise reduction, dimmed lights, reduced smells, fewer people around). A sensory profiling assessment completed by Occupation Therapist can be helpful in guiding what adjustments may be most helpful.
- Allowing access to distractions/self-regulating stimuli while eating (e.g., viewing content on an iPad, eating while stimming).
- Neuronormative food rules and mealtime expectations may need to be challenged. For example, it may not be an appropriate goal or expectation for your child to sit at a table for family meals, eat socially, eat a wide variety of foods or eat the same meal as the rest of the family.

- A greater focus on understanding and regulating emotions.
- Careful consideration of how information is communicated to best support your child.

Please note that modifying eating disorder treatment for neurodivergent individuals is an evolving field and all neurodivergent individuals, like neurotypical individuals, are unique in their needs. Continue to have discussions with your treatment team about what is and isn't working, to ensure that treatment is appropriately tailored to your child and family.

Resources

EDNA Resource: Supporting a neurodivergent individual with an eating disorder

Butterfly Foundation Resource: Autism, Eating Disorders and Me - Butterfly Foundation

Eating Disorders Victoria: Eating disorders and Autism - Eating Disorders Victoria

EDNA Resource: Neurodivergent people and eating disorders

Eating disorder support organisations

Butterfly Foundation

Butterfly Foundation is the national charity for all Australians impacted by eating disorders and body image issues, and for the families, friends and communities who support them. www.butterfly.org.au.

Butterfly Foundation has a National Helpline offering free and confidential support for anyone concerned about eating disorders or body image issues.

Butterfly Foundation also offer Virtual Support Groups, Webchat Support Groups, Webinar Workshops for Carers and Collaborative Care Skills Workshops for Carers

Eating Disorders Families Australia (EDFA)

EDFA is the only national organisation providing support, education, advocacy and counselling solely for carers and families impacted by an eating disorder. www.edfa.org.au.

EDFA offer many carer-specific support groups including: Coffee catchups, Diagnosis-specific groups (ARFID, SE-ED, Bulimia Nervosa, Binge Eating Disorder), Newbie Carers, Male Carers, and Sibling Support Group.

Regular education webinars and a video resource library.

Eating Disorders Victoria (EDV)

EDV is the trusted guide for Victorians affected by eating disorders, helping them to get the support they need to ensure the earliest possible recovery. www.eatingdisorders.org.au

EDV have a range of support options for carers including:

- Telehealth Counselling sessions.
- Telehealth Nurse consultations.
- Lived Experience Carer Coaching (for families early in help-seeking).
- Lived Experience Carer Courses.
- Collaborative Care Skills Workshops.
- Workshops, E-learning, Carer newsletters and a Podcast.

F.E.A.S.T. (Families Empowered and Supporting Treatment)

F.E.A.S.T. is a global support and education community of and for parents of those with eating disorders like anorexia, bulimia, binge eating, and more. www.feast-ed.org/

F.E.A.S.T. have a range of support options for carers including:

- F.E.A.S.T 30 Days (an innovative and unique program designed to educate and empower parents and caregivers of people with eating disorders).
- Caregiver Skills Toolkit (practical guidance and critical skills through a series of short, informative videos.
- F.E.A.S.T. Webinar Series, Blogs, Videos and Resources.

InsideOut Institute

InsideOut Institute is Australia's national institute for research, translation and clinical excellence in eating disorders. www.insideoutinstitute.org.au

InsideOut Institute offer the SupportED: Online Self-Help Program for Carers of People with an Eating Disorder. This is a free online training and skills-building program for carers. https://insideoutinstitute.org.au/resource-library/supported

Carer support organisations

Carer Gateway

Carer Gateway is an Australian Government program providing free services and support for carers.

Carer Gateway provides many services to support carers in their caring role, including: in-person and online peer support groups, tailored support packages, in-person and phone counselling, in-person and online self-guided coaching, online skills courses and access to emergency respite.

Carers Victoria

Carers Victoria is the statewide voice for family carers, representing and providing support to unpaid carers in Victoria. www.carersvictoria.org.au.

Carers Victoria offer opportunities to connect with other carers, information on respite options, workshops, and links to other relevant services for carers.

SANE

SANE is the leading national mental health organisation for people with complex mental health issues in Australia and for the families and friends that support them.

SANE offer a free counselling service that supports people affected by mental health issues. They also talk to friends, family members and health professionals about their concerns.

SANE's community forums offer a safe and supportive place with people who understand.

Tandem Carers

Tandem is the Victorian peak body representing family, carers and supporters of people living with mental health challenges. Tandem's mission is to provide leadership and coordination for the community of individuals and organisations who seek better outcomes for Victorian mental health carers. https://www.tandemcarers.org.au/.

Tandem provide information, education, and training to family and friends supporting people with mental health issues, and they support and advocate for the diverse needs of family, friends and other supporters of people living with mental health issues.

Information about financial assistance and support for carers can also be found on the Tandem website.

Eating disorders books for carers

Survive FBT: Skills Manual for Parents Undertaking Family Based Treatment (FBT) for Child and Adolescent Anorexia Nervosa – by Maria Ganci

This book is a valuable resource for parents commencing FBT and for parents struggling during treatment. It offers clear, practical advice and empowers parents to confront whatever the illness throws at them. It is also an important resource for clinicians and will help them guide their families through treatment.

Family-Based Treatment for Eating Disorders Piece by Piece: A Practical Guide for Parents – by James Lock, Aileen Whyte

The book illustrates how parents who are participating in family-based treatment (FBT) for their child's eating disorder (ED) may enhance their chances of achieving optimal outcomes for their child by more successfully navigating the challenges that often impede progress in treatment and recovery.

When Your Teen Has an Eating Disorder: Practical Strategies to Help Your Teen Recover from Anorexia, Bulimia, and Binge Eating – By Lauren Muhlheim and Laura Collins Lyster-Mensh

When Your Teen Has an Eating Disorder will empower you to help your teen using a unique, family-based treatment (FBT) approach. With this guide, you'll learn to respectfully and lovingly oversee your teen's nutritional rehabilitation, which includes helping to normalise eating behaviours, managing meals, expanding food flexibility, teaching independent and intuitive eating habits, and using coping strategies. and recovery skills to prevent relapse.

Skills-based Caring for a Loved One with an Eating Disorder: The New Maudsley Method – by Janet Treasure, Grainne Smith, Anna Crane

Skills-based Caring equips carers with the skills and knowledge needed to support those suffering from an eating disorder, and to help them to break free from the traps that prevent recovery. Through a coordinated approach, it offers detailed techniques and strategies, which aim to improve both carers and professionals' ability to build continuity of support for their loved ones.

How to Nourish Your Child Through an Eating Disorder: A Simple Plate-by-Plate Approach to rebuilding a Healthy Relationship with Food – by Janet Treasure, Grainne Smith, Anna Crane

Written by registered Dietitians, this book provides a comprehensive, visual and easy-to-follow guide to supporting your child overcome their eating disorder and to eat normally again, that does not rely on counting calories and measuring food. Their approach is rooted in family-based treatment (FBT).

One Meal at a Time: A Parent's Guide to the Early Stages of Recovery from Anorexia Nervosa – by Dr Penny Larcombe

One Meal at a Time is a compassionate guide, grounded in FBT, to help parents navigate those critical early days and weeks with confidence and care. This book offers parents practical advice and emotional support to take charge of recovery and guide their child through one of the hardest times of their life. It includes real-world examples, ready-to-use scripts, and practical strategies.

Emergency Assistance

Emergency: 000

Emergency, Police and Ambulance (24 hours)

If someone has tried to harm themselves or someone else, or you think they are about to, call triple zero (000) immediately or go with them to an emergency department.

Lifeline: 13 11 14

Crisis Support. Suicide Prevention

Connect with a Lifeline Crisis Supporter (24 hours)

Suicide Call back Service: 1300 659 467

Suicide Call-back Service (24 hours)

Kids Helpline: 1800 551 800

Kids Helpline. Anytime. Any Reason (24 hours)

13 YARN: 13 92 76

13 Yarn is the first national crisis support line for mob who are feeling overwhelmed or having difficulty coping.

13 Yarn offer a confidential one-on-one yarning opportunity with a Lifeline-trained Aboriginal and Torres Strait Islander Crisis supporter who can provide crisis support 24 hours a day, 7 days a week.

CATT Crisis Assessment and Treatment Team

A CATT is a group of people who work together and includes mental health professionals such as psychiatric nurses, social workers, psychiatrists, and psychologists. They are based in major hospitals.

A CATT responds to urgent requests to help people in mental health crisis 24 hours a day, 7 days a week. A mental health crisis can include: a psychotic episode, self-harm, feeling suicidal and feeling out of control.

To find your local CATT team, ring your closest major public hospital.

Mental Health and Wellbeing Act 2022

Families and carers

- The Mental Health and Wellbeing Act (the Act) recognises the important role played by families, carers and supporters of people experiencing mental illness and psychological distress.
- The Act supports the involvement of carers and of parents of children and young people in the assessment, treatment, care, support, and recovery of people receiving mental health and wellbeing services.
- The Act includes mechanisms for a person to appoint a nominated support person to support them to express their views and preferences if they become unwell and receive compulsory assessment or treatment.
- The Act also sets out the circumstances when a person's health or personal information may be disclosed to family members or carers.
- You can access the full Act here: https://www.legislation.vic.gov.au/in-force/acts/mental-health-and-wellbeing-act-2022/001

Complaint procedures

- Anyone can make a complaint about mental health and wellbeing services, including families, carers, and supporters.
- Complaints can be made directly to a mental health and wellbeing service provider. All mental health and wellbeing service providers must have procedures for receiving, managing, and resolving complaints.
- Complaints can also be made to the Mental Health and Wellbeing Commission.
- Complaints can be made to the Commission in relation to any matter arising from:
    - the provision of mental health and wellbeing services by a mental health and wellbeing service provider.
    - a failure by a mental health and wellbeing service provider to provide services to a consumer
    - a failure by a mental health and wellbeing service provider to make all reasonable efforts to comply with the principles of the Act.
    - the way in which a complaint was handled by a mental health and wellbeing service provider.
- Complaints can also be made by a carer, family member or supporter in relation to their experience in that role. https://www.health.vic.gov.au/chief-psychiatrist/reporting-a-failure-to-comply-with-the-mental-health-and-wellbeing-act-2022
- If further guidance is required, the Office of Chief Psychiatrist can be contacted by phone on 1300 767 299.

Want to learn more?

What are Eating Disorders?
Atypical Anorexia Nervosa
What is Starvation Syndrome
Eating Disorders: What are the Risks?
Eating Disorders and Neurobiology
Eating Disorders from the Inside Out: Laura Hill TED Talk on Anorexia
Eating disorders and my sibling
Self care for carers