EATING DISORDERS
Quick Reference & Referral Guide

*We know that eating disorders carry the **highest mortality risk** of all psychiatric conditions. Early identification and onward referral are crucial for these individuals to recover.*

HISTORY

As a general rule, ***patients who have an eating disorder rarely tell you immediately***, more often than not they will present to us with a range of different physical and mental health issues instead. It is up to us to put the pieces together and consider if an eating disorder is the underlying cause.

Key things to explore to help rule in or rule out an eating disorder:

Behaviour: Is there a reduction in the amount of food eaten, any exclusion of certain food groups, feeling out of control over what they eat, excessive exercise, vomiting, laxative use, omission of insulin in T1DM to control weight?

Their ***current and past relationship with food*** - texture, smell, taste, interest/importance of food, any recent changes?

Impact it's having on the patient's family and their life in general.

Fear: In gaining weight or getting bigger? Losing muscle mass? Fear of vomiting or choking?

Collateral history from significant others is invaluable. Has there been a change in their personality, more withdrawn, loss of interest in activities, are family/friends worried about them?

OBSERVATION

Do they look like there has been a change in weight? Signs of malnutrition? Poor dentition?

EXAMINATION

Weight, height, BMI, blood pressure & pulse (lying and standing), temperature.
Bloods & ECG (not in children unless there is a clinical need at this stage) to rule out organic disease.
Any risk of refeeding (minimal or no food over the last few days)?

RISK

By assimilating all the above information, determine level of risk to guide management.

HIGH RISK if significant physical compromise or risk of refeeding syndrome – Admit to medics/paeds.

HIGH RISK if lack of insight into their condition coupled with physical compromise. Are they capable of making objective decisions about their health? Seek information from families and significant others. Discuss directly with mental health services with a view to a Mental Health Act Assessment.

Otherwise a referral through normal pathways is sufficient.

RESOURCES

Beat: For all children and adults with an eating disorder and their families (www.beateatingdisorders.org.uk)

FEAST: For families of all children and adults with an eating disorder (www.feast-ed.org)

ARFID Awareness: For children and adults with 'Avoidant Restrictive Food Intake Disorder' and their families www.arfidawarenessuk.org

GUIDANCE NOTES ON EATING DISORDERS FOR GPs

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Eating Disorders Diagnoses & Presentations

ANOREXIA

3 features need to be present to make a diagnosis of anorexia nervosa:

1. Persistent restriction of energy intake leading to significantly low body weight (compared to what is expected for age, sex developmental trajectory, and physical health.)
2. Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain
3. Disturbance in the way that body weight / shape is experienced, undue influence of body shape and weight on self-evaluation, or persistently not recognising the seriousness of the low body weight.

Subtypes:
Restricting type
Binge-eating/purging type

BULIMIA

Diagnosis is based on:

1. Recurrent episodes of binge eating ie both of the following:
   Eating in a specific period of time (eg. within a 2 hour period), an amount of food that is definitely larger than what most people would eat during a similar period of time and under similar circumstances.
   A feeling of lack of control over eating during the episode ie. feeling that they cannot stop eating or control what or how much they are eating

2. Recurring compensatory behaviour to prevent weight gain eg. self induced vomiting, misuse of laxatives, diuretics or other medications, fasting, compulsive exercise, omitting insulin.

3. The binge eating and compensatory behaviours both occur at least once a week for 3 months (on average).

4. Self evaluation is unduly influenced by body shape and weight.

5. BMI is in healthy range or above.

BINGE EATING DISORDER

A person must display:

1. Recurring episodes of binge eating.
2. The binge eating episodes involve 3 or more of the following:
    - Eating much more rapidly than normal
    - Eating until feeling uncomfortably full
    - Eating large amounts of food when not feeling physically hungry
    - Eating alone because of feeling embarrassed by how much they are eating
    - Feeling disgusted, depressed or very guilty afterward
3. Distress about binge eating
4. Binges occur on average at least once a week for 3 months
5. NO recurring use of compensatory behaviours

Note: *Binge Eating Disorder (BED) is much less common than OVER-EATING but is much more severe than overeating. BED involves more distress about the eating behaviour, and there are usually other co-occurring psychological problems.*

ARFID (Avoidant Restrictive Food Intake Disorder)

A) Failure to meet nutritional and/or energy needs such as:

Significant weight loss
Nutritional deficiency
Dependence on oral nutritional supplements
Interference with psychosocial functioning

B) The difficulties are not due to lack of available food or by any culturally sanctioned practice.
C) There is no evidence of a disturbance in the way that body weight or shape is experienced.
D) The eating disturbance is not caused by a medical condition or another mental disorder.

'Unofficial' diagnoses for specific presentations

These terms are commonly used in services and by the public. They are not official diagnostic categories but do describe different types of eating disorders that are supported by eating disorders services.

Orthorexia : Avoidance of foods that are perceived as unhealthy leading to a very limited range of foods and resulting low weight and/or malnutrition

Bigorexia : Obsessive focus on increasing muscle mass and compulsive muscle-building activities

T1DE : Insulin omission among people with Type 1 diabetes, as a means of reducing/managing weight.

Medical Risk Assessment

Risk Assessment Framework for Young People With Eating Disorders (taken from Junior MARSIPAN guidance)

	RED (High Risk)	AMBER (Alert to High Concern)	GREEN (Moderate Risk)	BLUE (Low Risk)
BMI & Weight	Percentage median BMI<70% (approx below 0.4th BMI centile) Recent loss of weight of 1kg or more/week for 2 consecutive weeks	Percentage median BMI 70-80% (approx between 2nd and 0.4th BMI centile) Recent loss of weight of 500-999g/week for 2 consecutive weeks	Percentage median BMI 80-85% (approx 9th-2nd BMI centile) Recent weight loss of up to 500g/week for 2 consecutive weeks	Percentage median BMI>85% (approx above 9th BMI centile) No weight loss over past 2 weeks
Cardiovascular health	Heart rate (awake)<40 bpm[a] History of recurrent syncope; marked orthostatic changes (fall in systolic blood pressure of 20mmHg or more, or below 0.4th-2nd centiles for age, or increase in heart rate of >30 bpm)	Heart rate (awake) 40-50 bpm Sitting blood pressure: systolic <0.4th centile (84-98mmHg depending on age and gender[b]); diastolic <0.4th centile (35-40mmHg depending on age and gender[a]) Occasional syncope; moderate orthostatic cardiovascular changes (fall in systolic blood pressure of 15mmHg or more, or diastolic blood pressure fall of 10mmHg or more within 3min standing, or increase in heart rate of up to 30bpm)	Heart rate (awake) 50-60bpm Sitting blood pressure: systolic <2nd centile (98-105mmHg depending on age and gender[a]); diastolic <2nd centile (40-45mmHg depending on age and gender[a]) Pre-syncopal symptoms but normal orthostatic cardiovascular changes	Heart rate (awake) >60 bpm Normal sitting blood pressure for age and gender with reference to centile charts[a] Normal orthostatic cardiovascular changes

	Irregular heart rhythm (does not include sinus arrhythmia)		Cool peripheries; prolonged peripheral capillary refill time (normal central capillary refill time)	Normal heart rhythm
ECG abnormalities	QTc>460ms (girls) or 400ms (boys) with evidence of bradyarrhythmia or tachyarrhythmia (excludes sinus bradycardia and sinus arrhythmia); ECG evidence or biochemical abnormality	QTc>460ms (girls) or 400ms (boys)	QTc<460ms (girls) or 400ms (boys) and taking medication known to prolong QTc interval, family history of prolonged QTc or sensorineural deafness	QTc<460ms (girls) or 400ms (boys)
Hydration status	Fluid refusal Severe dehydration (10%): reduced urine output, dry mouth, decreased skin turgor, sunken eyes, tachypnoea, tachycardia[c]	Severe fluid restriction Moderate dehydration (5-10%): reduced urine output, dry mouth, normal skin turgor, some tachypnoea, some tachycardia[c], peripheral oedema	Fluid restriction Mild dehydration (<5%): may have dry mouth or not clinically dehydrated but with concerns about risk of dehydration with negative fluid balance	Not clinically dehydrated
Temperature	<35.5°C tympanic or 35.0°C axillary	<36°C		
Biochemical abnormalities	Hypophosphataemia, hypokalaemia, hypoalbuminaemia, hypoglycaemia, Hyponatraemia, hypocalcaemia	Hypophosphataemia, hypokalaemia, hyponatraemia, hypocalcaemia		
Disordered eating behaviours	Acute food refusal or estimated calorie intake 400-600kcal per day	Severe restriction (less than 50% of required intake), vomiting, purging with laxatives	Moderate restriction, bingeing	
Engagement with management plan	Violent when parents try to limit behaviour or encourage food/fluid intake, parental violence in relation to feeding (hitting, force feeding)	Poor insight into eating problems, lacks motivation to tackle eating problems, resistance to changes required to gain weight, parents unable to implement meal plan advice given by healthcare providers	Some insight into eating problems, some motivation to tackle eating problems, ambivalent towards changes required to gain weight but not actively resisting	Some insight into eating problems, motivated to tackle eating problems, ambivalence towards changes required to gain weight not apparent in behaviour

Activity and exercise	High levels of uncontrolled exercise in the context of malnutrition (>2h/day)	Moderate levels of uncontrolled exercise in the context of malnutrition (>1h/day)	Mild levels of uncontrolled exercise in the context of malnutrition (<1h/day)	No uncontrolled exercise
Self-harm and suicide	Self-poisoning, suicidal ideas with moderate to high risk of completed suicide	Cutting or similar behaviours, suicidal ideas with low risk of completed suicide		
Other mental health diagnoses		Other major psychiatric co-diagnosis eg. OCD, psychosis, depression		
Muscular weakness – SUSS Test Sit up from lying flat Stand up from squat	 Unable to sit up at all from lying flat (score 0) Unable to get up at all from squatting (score 0)	 Unable to sit up without using upper limbs (score 1) Unable to get up without using upper limbs (score 1)	 Unable to sit up without noticeable difficulty (score 2) Unable to get up without noticeable difficulty (score 2)	 Sits up from lying flat without any difficulty (score 3) Stands up from squat without any difficulty (score 3)
Other	Confusion and delirium, acute pancreatitis, gastric or oesophageal rupture	Mallory-Weiss tear, gastro-oesophageal reflux or gastritis, pressure sores	Poor attention and concentration	

BMI – body mass index; bpm – beats per minute; ECG – electrocardiogram;
OCD – obsessive-compulsive disorder; SUSS – Sit Up, Squat Stand

a. Patients with inappropriately high heart rate for degree of underweight are at even higher risk (hypovolaemia). Heart rate may also be increased purposefully through the consumption of excess caffeine in coffee or other drinks.
b. Jackson, L. V., Thalange, N. K. & Cole, T. J. (2007) Blood pressure centiles for Great Britain. Archives of Disease in Childhood, 92, 298-303.
c. Or inappropriate normal heart rate in an underweight young person.

Refer to the document "Junior MARSIPAN: Management of Really Sick Patients under 18 with Anorexia Nervosa" (published in 2012 by the Royal College of Psychiatrists) for full guidance on the management of children and young people with anorexia.

SLAM (South London and Maudsley) Risk Management Guidance For Eating Disorders in Adults

SYSTEM	Test or Investigation	Concern	Alert
Nutrition	BMI	<14	<12
	Weight loss per week	>0.5kg	>1.0kg
	Skin Breakdown	>0.1cm	>0.2cm
	Purpuric		+
Circulation	Systolic BP	<90	<80
	Diastolic BP	<70	<60
	Postural drop (sit –stand)	>10	>20
	Pulse Rate	<50	<40
	Extremities		Dark blue cold
Musculo-skeletal (squat Test and Sit up test)	Unable to get up without using arms for balance	+	
	Unable to get up without using arms as leverage		+
	Unable to sit up without using arms as leverage	+	
	Unable to sit up at all		+
Temperature		<35C <98.0F	<34.5 <97.0F
Bone Marrow	WCC	<4.0	<2
	Neutrophil count	<1.5	<1.0
	Hb	<11	<9.0
	Acute Hb drop (MCV and MCH raised – no acute risk		+
	Platelets	<130	<110
Salt /water balance	K+	<3.5	<3.0
	Na+	<135	<130
	Mg++	<0.5-0.7	<0.5
	PO4--	<0.5-0.8	<0.5
	Urea	>7	>10
Liver	Bilirubin	>20	>40
	Alkpase	>110	>200
	AsT	>40	>80
	ALT	>45	>90
	GGT	>45	>90
Nutrition	Albumin	<35	<32
	Creatinine Kinase	>170	>250
	Glucose	<3.5	<2.5
Differential Diagnosis	TFT		
	ESR		
ECG	Pulse rate	<50	<40
	Corrected QT intervals (QTC)		>450 msec
	Arrythmias		+

Table 1.

NICE guidelines (2004)

A guide for Medical Risk Assessment for Eating Disorders, Treasure SLAM (2004)

Medical Risk arises from a combination of the restrictive behaviours (food and in some cases fluid) and the compensatory behaviours:

- Excessive exercise with low weight
- Blood in vomit
- Inadequate fluid intake in combination with poor eating
- Rapid weight loss

Body Mass Index (weight /height in metres squared) is a proxy measure of medical risk in anorexia nervosa. As a lone marker it has limitations:

- Potential for deceit (water loading)
- Less reliable if rapid change in weight
- Less reliable at extremes of height
- Higher risk for each BMI range for men (taller)
- Children lower BMI*
- Less reliable if bulimic features
- Less reliable if fluid restriction
- Less reliable if physical co morbidity
- BMI not critical with regards to risks associated with fluid and electrolyte balance

* In children & adolescents the cut off for BMI to make the diagnosis is a weight and height below the second centile of BMI. It is possible to get centile charts off the web for the USA (the 3rd centile is depicted). *www.cdc.gov/growthcharts/*

The following is recommended for a rapid risk assessment repeated frequently as necessary:

- BMI
- Blood pressure and pulse rate
- Muscle strength (see below)
- Examination of the skin and temperature for those at high risk
- A full physical looking for e.g. infection (note can be with normal temperature) and signs of nutritional deficiency.

Tests for Muscle strength: (See table1 for scoring)

The Squat and Stand Up test

The patient is asked to squat down on her haunches and is asked to stand up without using her arms as levers if at all possible

The Sit Up Test

The patient lies flat on a firm surface such as the floor and has to sit up without, if possible, using her hands

Investigations

Frequent investigations of full blood count and chemistry are necessary (FBC, ESR, U&E, Cr, CK, Gluc, LFTs) if:

- Patient is in a high risk category from previous assessment, or
- If they have a BMI <15, or
- The BMI is less reliable due to features outline above, or
- There is a history of purging.

ECG is recommended if BMI <14 and if drugs which have an effect on QT interval are prescribed.

Refer to the document "MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa, 2nd ed" (published in 2014 by the Royal Colleges of Psychiatrists, Physicians and Pathologists) for full guidance on the management of adults with anorexia.

What Information to Include in Referrals

In your referral information, include the following details:

- **Patient's eating pattern:** Are they restricting their food intake (If so, how? eg. Are they excluding particular types of foods, or restricting their calorie intake?) Are they engaging in episodes of binge eating? Are they purging (ie. vomiting, taking laxatives, compulsive exercise, omitting insulin if diabetic), and if so, how often?
- **Physical risk indicators:** What is their current weight? How has their weight changed over the past month? Are they menstruating regularly (if female)? What are the relevant blood test results (incl HbA1C if diabetic)?
- **Body image:** How do they feel about their current body shape and weight? Is there evidence of body shape over-focus or dissatisfaction (eg. excessive weighing and/or mirror-checking, other body-checking behaviours)
- **History of eating difficulties:** When did the eating problems start? What occurred at that time that might have triggered them?
- **Family circumstance:** What is their family/living situation? Do they receive support from their family? Are their family/supporters concerned about the patient?
- **Motivation for recovery:** What is the patient seeking from services? Do they believe they have an eating disorder/problem? Have they tried to make improvements to their eating pattern? What are their goals in relation to their eating/weight/body shape?

Your HB's Local Pathways for Eating Disorders

(to be completed by services before circulating this document to their local GPs)

Team to send a referral for a child under age 18
(including tel number for team and how to submit referral):

Team to send a referral for an adult over age 18
(including tel number for team and how to submit referral):

Who to contact for a discussion about a child under age 18 who is at high risk and may require immediate treatment:

Who to contact for a discussion about an adult over age 18 who is at high risk and may require immediate treatment:

ED Transitions Teams

Every HB has an eating disorders transitions team that supports young people who have an eating disorder and are approaching their 18th birthday and who are likely to require ongoing treatment under adult services. The transitions teams engage with the young person, their family, and health professionals involved in their care and treatment to identify their ongoing needs and goals and plan appropriate treatment and support. If you refer a young person who is soon having their 18th birthday, they may be referred on to the transitions team to plan assessment under the adult service.

What To Do After Referring On

After making the referral, and while the patient/family is waiting for an assessment in specialist services, do the following:

- Give the patient/family a copy of the Appendix to this document and encourage them to read and use the resources that are relevant to them
- See the patient weekly until they have had their assessment in specialist services, monitor changes in their presentation and inform the specialist service of any specific changes
- Undertake your own further research into eating disorders using the resources listed in the appendix

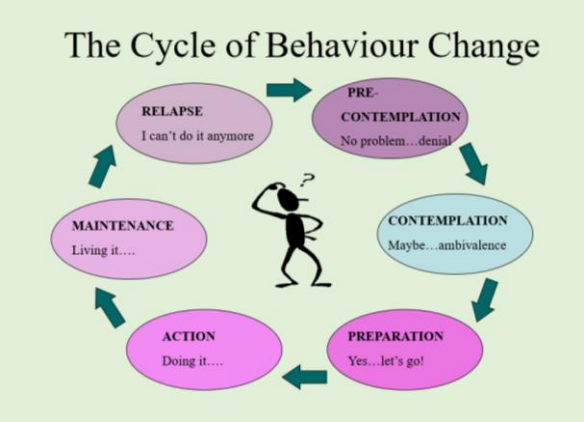
Basic Dos and Don'ts When Supporting Someone Who Has An Eating Disorder

1) Avoid making any comments about the person's weight or appearance. No matter how positive or encouraging you try to be, they will interpret what you say as meaning "You look fat"!. It's OK to give them specific praise about other aspects of their appearance eg their hair, clothes, make-up, or something they're good at doing etc

2) Avoid talking about your own or other people's eating habits. However well intentioned, hearing about other people's eating habits may strengthen their drive to compete to eat the least.

3) Avoid being drawn into discussions about weight, food, body shape etc. They are rarely helpful as the logic in the thinking of a person with an eating disorder can be biased or distorted. Try to change the subject and point out that you are avoiding these discussions with them and why.

Stages of Change and Ambivalence/Anxiety About Treatment



Ambivalence

The stages of recovery from an eating disorder follow the Stages of Change model that is similar to models of addiction. It is estimated that most patients in eating disorders services are in the Contemplation stage of recovery and therefore are highly ambivalent about whether or not they feel ready for, able to achieve, or feel the need for, recovery. Even if this is the case, patients who are in the Contemplation, and even the Pre-Contemplation stage, should be referred to specialist services as those services can offer them and their families support and intervention that are appropriate to the stage they are at.

Emotional Expression

Patients who are in the Pre-Contemplation or Contemplation stages will experience a wide range of emotions when attending appointments and discussing their concerns, eating behaviours and treatment options with you. They are likely to express anxiety, fear, guilt, shame, and anger as well as other emotions, and these emotions might be intense. It is important that you listen and validate those emotions, explaining that you understand why they feel this way while also continuing to fulfil your clinical responsibilities in a calm respectful manner.

Clinical Suspicion

The level of ambivalence that people who have eating disorders of all ages experience can make it hard for them to be fully open and direct about the nature and extent of their difficulties. As a result, it is necessary for you to piece together the evidence based on the information they do provide, information from those close to them, observations of their behaviours and medical indicators, in order to come to a clinical judgement about the nature of their condition and what their needs are. Because you will probably be working with incomplete (and often conflicting) information, it is important that you practise a high level of suspicion regarding whether someone has an eating disorder, and refer on for specialist assessment, or contact your local specialist services to discuss the patient's presentation, even if you are not certain that they have an eating disorder. The specialist service will be happy to advise.

Supporting People With An Eating Disorder Who Are Discharged From Specialist Services

Specialist services sometimes discharge people who still have an eating disorder as they are unlikely to benefit from any further treatment or support. This may be because the patient is in Pre-Contemplation or Contemplation stages, or they may have disengaged from the specialist services. Ideally the specialist service would have discussed their plan to discharge the patient with you beforehand. If the patient is willing to meet with you occasionally, you can have an important role to play in:

a) Advising the patient and their family on medical issues
b) Reviewing with them whether there has been a change in their ability/willingness to engage with specialist services and the treatment options available
c) Ensuring that the patient and family have information about the resources available

Appendix: Information & Resources About Eating Disorders For Patients, Supporters/Families & Professionals

If you have been given this information by your GP, they believe that you or someone close to you may have an eating disorder. This information will help you to understand what eating disorders are, how they affect people's lives and what you can do.

If your GP has made a referral to a specialist service to assessment, this information will tell you what you can do now while you are waiting for the assessment. Treatment can start immediately with the actions that you take from today onwards, and it is best that you start this process immediately in order to secure a good outcome. Be aware that some services have a waiting list that might be weeks or months long. Some services see people for assessment soon after receiving a referral, but then place them on a waiting list before starting treatment if they are accepted into the service. Other services put people on a waiting list before assessment, but then would start treatment straight away after assessment if they are accepted into the service.

If you are attending an assessment, you can prepare for the appointment by doing the following:

a) Keep a daily list of what (and how much) you or your loved one are eating and drinking, and take this with you to the appointment
b) Make a list of which foods you or your loved one feel comfortable eating and a list of which foods you/they avoid, take these with you to the appointment

You can take someone supportive with you to the appointment. The professional you see may ask to see you on your own for some of the appointment, and we encourage your support person to re-join you when discussing what the next steps will be. If you have any questions, then contact the service beforehand, they will be happy to answer your questions. The person you see may need to weigh you during the appointment. They may need to see you a second time to continue the assessment process. Try to share as much information as you can so that the service understands fully what you are experiencing and what support and treatment will be most helpful.

BOOKS

“Rehabilitate, rewire, recover” by Tabitha Farrar (for teenagers and adults with anorexia)

Nutritional rehabilitation to heal the body and neural rewiring to shift neural pathways of restriction, exercise compulsions, and anorexia-generated thoughts and behaviours in the brain. Using experience from her own recovery, and accounts from adults whom she has worked with as a recovery coach, Tabitha Farrar takes you through the process of building your own, personalised, recovery. As well as non-traditional ideas and concepts, this book delivers a “toolkit” to help with the neural rewiring process, and action-based ideas to help you eat without restriction.

“Overcoming Binge Eating” by Chris Fairburn (for teenagers and adults with bulimia or binge eating disorder)

This bestseller provides information to understand binge eating and bring it under control, whether you are working with a therapist or on your own. Clear, step-by-step guidelines show you how to:
Overcome the urge to binge
Gain control over what and when you eat
Break free of strict dieting and other habits that may contribute to binges
Establish stable, healthy eating patterns
Improve your body image and reduce the risk of relapse

“Help Your Teenager Beat an Eating Disorder” by James Lock and Daniel le Grange (for families of teenagers with anorexia or bulimia)

If your teenager shows signs of having an eating disorder, you may hope that, with the right mix of love, encouragement, and parental authority, he or she will just “snap out of it”. If only it were that simple. This book presents evidence that your involvement as a parent is critical. In fact, it may be the key to conquering your child’s illness. It also provides the tools you need to build a united family front that attacks the illness to ensure that your child develops nourishing eating habits and life-sustaining attitudes, day by day, meal by meal. Full recovery takes time, and relapse is common. But whether your child has already entered treatment or you’re beginning to suspect there is a problem, this book gives guidance on how to take action.

“Skills-based Caring for a Loved One With an Eating Disorders: The New Maudsley” by Janet Treasure & Gráinne Smith
(for families of adults with anorexia or bulimia)

This book equips carers with the skills and knowledge needed to support those who have 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 professionals’ and carers’ ability to build continuity of support for their loved ones. Using evidence-based research and personal experience, the authors advise the reader on a number of difficult areas in caring for someone with an eating disorder. This new and updated edition is essential reading for both professionals and families involved in the care and support of anyone with an eating disorder.

“Food Refusal and Avoidant Eating in Children, Including Those With Autism Spectrum Conditions: A Practical Guide for Parents and Professionals” by Gillian Harris & Elizabeth Shea
(for families of children with autism and ARFID)

Many children with Autism Spectrum Disorder (ASD) have a restricted dietary range, and this book provides parents with advice and training on how to deal with this condition and achieve a healthier and more balanced diet. Now described as Avoidant or Restrictive Food Intake Disorder (ARFID), it is due to sensory hypersensitivity, and it can impact upon the health of the child, upon the family, and upon social integration.

Based upon successful training packages the authors provide for parents and professionals, this book enables the reader to understand the condition and work with it, gradually increasing the range of food a child is able to eat. It includes case studies, points of interest and action points to make this an accessible and resourceful read.

“Anorexia and Other Eating Disorders: How to Help Your Child Eat Well and Be Well” by Eva Musby
(for families of children with autism and anorexia and bulimia)

With a wealth of practical examples and tips that have helped many tens of thousands of relieved parents, this book guides you through each stage of you son or daughter’s recovery. It provides solace and confidence, while addressing the real-life questions that parents struggle with.

The practical and emotional strategies in every chapter rest on up-to-date knowledge distilled from published research, from families, and from therapists worldwide. With her lived experience and that of the hundreds of parents she has coached, Eva Musby aims to empower families to be effective right away, from the first successful meal all the way through to recovery.

WEBSITES

F.E.A.S.T. https://www.feast-ed.org

The global support and education community of and for parents of those with eating disorders. Of particular value is their 'First 30 days' programme, which aims to transform parents into empowered caregivers in 30 days. You will receive 30 emails over 30 days with approximately 30 minutes per day of learning materials. In addition to reading, you will receive links to video and audio content from F.E.A.S.T. and from other trusted sources.

Beat website https://www.beateatingdisorders.org.uk

Beat's national helpline exists to encourage and empower people to get help quickly. People can contact Beat online or by phone 365 days a year. They listen to them, help them to understand the illness, and support them to take positive steps towards recovery. They also support family and friends, equipping them with essential skills and advice, so they can help their loved ones recover whilst also looking after their own mental health.
In particular, this page of the Beat website provides information and advice for GPs, people with eating disorders and their families/supporters about the process of having an initial appointment with a GP and making a referral:
https://beat.contentfiles.net/media/documents/gp-leaflet-website.pdf

ARFID Awareness UK https://www.arfidawarenessuk.org

They are the UK's only registered charity dedicated to raising awareness and furthering information about Avoidant/Restrictive Food Intake Disorder. As a not-for-profit organisation, they work to provide individuals, parents, carers and medical professionals with up-to-date relevant information, research and support.

MaleVoiceED https://www.malevoiced.com

MaleVoiceED is a charity which recognises and values the lived experience of males who have experienced, or are experiencing, eating and exercise related difficulties and associated conditions. MaleVoiceED is all about the awareness and support of males with eating disorders, disordered eating and comorbid conditions. It enables peer support groups to encourage recovery and delivers a portfolio of training.

Eva Musby: Helping You Free Your Child of an Eating Disorder https://www.anorexiafamily.com

Help for parents of children and teens suffering from anorexia and other eating disorders.

NICE Guidance https://www.nice.org.uk/guidance/ng69

This guideline from the National Institute for Health and Care Excellent covers assessment, treatment, monitoring and inpatient care for children, young people and adults with eating disorders. It aims to improve the care people receive by detailing the most effective treatment for anorexia nervosa, binge eating disorder and bulimia nervosa.

USEFUL FREE APPS

Recovery Record
This app allows you to record your meals and snacks, as well as your thoughts, feelings and urges through the day. It has a large range of features.

Rise Up + Recover
This app helps you record your meals and feelings.

Mindshift CBT
Specifically designed to help teens and young adults deal with anxiety in a healthy way.

CBT Thought Diary
This app is a journal that uses effective tools from Cognitive Behavioural Therapy to help you challenge your thoughts to increase your happiness and well-being.

What's Up? – A Mental Health App
Combines tools from CBT and acceptance commitment therapy (ACT) to help deal with feelings of depression, anger, stress and anxiety. It helps identify negative thinking patterns, put a current issue into perspective and rate feelings of the day.

The Mindfulness App
Helps you become more present in your life, mindfulness helps you maintain a moment-by-moment approach to life.

Stop, Breathe, and Think
A meditation app with information on the types and benefits of meditation and mindfulness

Headspace
A meditation app made simple, which has shown to help people feel less stressed, focus more and sleep better

MyCare
Information and support for carers to work towards their own recovery and well-being