

**Supportive Meal Therapy Guidelines**

We want to build a supportive and safe environment that enables our clients to enjoy a meal in a social setting.

**PRE-GROUP REQUIREMENTS**

1. All clients must either (a) see Georgina (the dietitian) before the first SMT session, or (b) if you already have a treating Dietitian or psychologist, discuss the following points with this clinician prior to attending group.

* Development of a safety plan for triggers that could occur during group
* Agreement on meal being provided by client
* Completed medical monitoring form
* Review of participation agreement & consent form

1. Forms required to be completed before the first SMT session include:

* Signed safety plan
* Signed participation agreement
* Signed consent form

1. Medical monitoring form (if required as per GP)

**GROUP OUTLINE**

* Every Thursday 12.55-2pm
* The participation agreement points will be reiterated before the group commences
* The kitchen will be closed to staff not involved and other clients
* Participants must be 18 years or older
* The group is open to any person and we encourage equality and diversity here at Balanced. Please be aware that the group may have diverse body types, genders, ethnicities, sexual orientations, and ages (18+)

**SMT GROUP RUN SHEET**

12.55pm group participants arrive

12.55-1.05pm introductions, clinician to read through guidelines and

1.05-1.10pm brief grounding exercise (guided meditation)

1.10-1.40pm eat - max time 30 minutes

1.40-2pm activities

**What is SMT?** SMT stands for Supportive Meal Therapy.

It is the process of a clinician eating a meal with you to support you in completing your meal.

The clinician models helpful eating behaviours\* whilst fostering an environment that assists with your nutritional restoration, provides consistency and aims to reduce anxiety.

**The goal of SMT** is to provide a safe, supportive, and consistent environment, which maximises the opportunity for nutritional intake and minimises anxiety associated with mealtimes

**\*Helpful Eating Behaviour**

* Demonstrating adequate portioning, adequate food variety and pace of eating while engaging in neutral conversation during and after the meal

**^Unhelpful behaviour**

These behaviours can keep you stuck in the eating disorder cycle for example:

* Comparing or commenting on meals
* Breaking or picking food into smaller pieces
* Pulling food apart
* Hoarding food
* Disposing of food (including intentionally crumbling, dropping or wiping content from provided meals), choosing low calorie or diet food items, eating very slowly, chewing and spitting food or regurgitating and re-swallowing food, shaking or jiggling your body, or pacing.

**Table rules**

* Use the bathroom prior to the meal
* No excessive cutlery or serviettes
* Meals will be checked by clinicians prior to starting the meal
* All food is to remain on the plate
* Unhelpful behaviours are to be avoided and will be addressed if needed
* Eat your food in the way it has been provided e.g. keep a toasted sandwich as one, do not pull apart
* All food/drink items agreed upon must be consumed and this will be checked by the clinician supervising
* If meals are incomplete, you will be reminded that the signed participation agreement states that an oral nutrition supplement will be provided in place of the incomplete meal
* All participants must remain at the table until the SMT time has finished unless there is an agreed-upon exception
* All participants are required to participate in the post-meal activities



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| **PATIENT/PERSON RESPONSIBILITIES** | |
| PRE-MEAL | * You will be reminded of the table rules and unhelpful behaviours, non-negotiables and outline of the session * Discuss any queries with your meal chaperone prior to the meal * Try to attend the bathroom prior to the meal start time * Arrive at the agreed dining area at the designated meal times * Ensure long sleeves are pulled back, and clothing with excessive folds or pockets are not worn to the meal table |
| DURING | * Follow the table rules~ and complete the prescribed meal as per your meal plan * Try to not delay starting eating (can lead to excess stress in the last few minutes * Pace yourself throughout the meal, time updates will be provided to help you pace yourself over the time allowed * Focus on your own eating, behaviours and recovery goals * Try not to engage in unhelpful behaviours^ * Take guidance from the staff when provided, these are made with your recovery goals in mind * Unhelpful behaviours^ will be addressed at the table in a thoughtful and concerned manner * All meals must be completed, if this does not occur, the prescribed nutrition will be delivered as per your non-negotiables |
| POST-MEAL | * Remain seated and do not leave the staff until the allocated time is completed * Try engaging in distraction activities and conversation which can help to prevent and reduce post meal distress and anxiety |



**Client Intake Form**

**Title** (please circle): Ms Miss Mrs Mr Dr Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Postal Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Email Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Telephone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mobile** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicare Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Position** \_\_\_\_\_\_\_ **Expiry /**

**Occupation**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Place of Employment**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to you** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Information Release Form**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorise *Balanced: Mind Body Life Pty Ltd* to discuss my treatment as needed with the following people or organisations (e.g. GP, Psychiatrist, Dietitian, Work/University, Anglicare):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Group Meal Support Consent Form**

**Conditions of Supportive Meal Therapy**

**Service:** As part of your assessment and treatment, *Balanced: Mind Body Life Pty Ltd* will collect and record personal information relevant to your current situation.

**Access:** You may access the material recorded in your file upon request, subject to the exceptions in National Privacy Principle 6, copies of which are available on request.

**Confidentiality:** All personal information gathered by Balanced remains confidential ***except:***

* If your file is subpoenaed by a court; or
* Failure to disclose the information would place you or another person at risk; or
* Your prior approval has been obtained (e.g. in order to discuss your care with your GP).

**Participation agreement:** Clients must agree to and sign the Supportive Meal Therapy Participation Agreement (see next page)

**Cost:** The price of the group is $15 per session, to be paid in one sum of $60 for four sessions. Because the group is ‘closed’ (i.e., it will be the same group of clients for the four sessions), this fee is non-refundable.

**Cancellation of Attendance:** Text message reminders for group meal support are sent out two days prior. If you are unable to attend, please call the practice on 0475 000 679 so we know not to expect you on that day.

If there is anything written on this page that you do not understand, please discuss it with a staff member before you sign.

**Consent:** I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read and understood the above Consent Form. I agree to these conditions for the meal support services provided by Balanced.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_



**Supportive Meal Therapy Participation Agreement**

Before participating in the meal support group, we ask that you agree to:

* provide a meal approved by the dietitian at Balanced or the clinician treating your eating disorder that is consistent with your personal goals
* remember that everyone has different goals, and therefore meals will vary and you must feel confident enough to manage this
* consume your meal within 30 minutes, or
* if all of your meal is not finished you will consume an oral nutritional supplement that we will provide (25% 50% 75% or 100% of supplement dependent on how much of your meal you ate)
* accept that if you refuse to complete your meal and/or supplement unfortunately you will not be able to attend the next session
* avoid connecting outside of the group (i.e. exchanging numbers) throughout the duration of SMT
* avoid conversation that is likely to trigger others (some examples outlined in this handbook)
* be supportive to others in the group
* abide by any further agreements set in session with a clinician prior to the group session
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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If there is anything written on this page that you do not understand or disagree with, please discuss it with a staff member before you sign.

**Consent:** I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read and understood the above non-negotiables. I agree to these conditions for the meal support services provided by Balanced.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

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