National Eating Disorders Collaboration

Evidence Experience Expertise

Eating disorders: Key considerations for service providers

Background

Eating disorders are serious mental illnesses that are estimated to affect over one million Australians in any given year (1). Eating disorders have detrimental impacts upon a person's life and result in serious medical, psychiatric, and psychosocial consequences. Without early intervention and treatment, eating disorders are likely to persist long term, lead to physical health complications, and reduce quality of life and life expectancy (2). A systematic review of the Australian and international literature found that among people with a diagnosable eating disorder, only around 23% accessed eating disorder treatment (3).

The National Eating Disorders Collaboration (NEDC) is an initiative of the Australian Government dedicated to developing and implementing a nationally consistent, evidence-based system of care for the prevention and treatment of eating disorders.

Over the last ten years, NEDC has produced a series of evidence-based guidelines and frameworks to support healthcare services to understand their role in identifying, responding to and/or treating eating disorders. This culminated in the release of two key documents in 2018: NEDC's National Practice Standards for eating disorders (4), which outline the values, attitudes, knowledge and skills required of individuals, services and systems to successfully respond to eating disorders; and NEDC's Workforce Core Competencies (5), which set out the capabilities that all health professionals should meet for the safe and effective identification of and response to eating disorders in an Australian context.

Key concepts underpinning NEDC's National Practice Standards for eating disorders and Workforce Core Competencies include:

- Eating disorders are core business for all medical and mental health services working with people who have, or are at high risk of developing an eating disorder.
- A stepped system of care is required to ensure that people can access a range of treatment and support options in varying levels of intensity to meet their needs.

The following sections expand on these two key concepts.

Eating disorders as core business

Eating disorders have traditionally been left out of mental health planning and policy, which has resulted in the exclusion of people experiencing eating disorders from services. However, it is increasingly being recognised that eating disorders should be considered core business within health services (4, 6).

To support health professionals to understand their role, NEDC has defined the five key **functional groups** who may be required to identify and/or respond to eating disorders. These functional groups are defined by the role they play in relation to the patient with an eating disorder and not by profession. A brief description of these groups is given below. For more information, including the specific competencies required for each functional group, refer to NEDC's Workforce Core Competencies (5).

The five functional groups

Early identifiers

Early identifiers have a duty of care for the wellbeing of people in high-risk groups for eating disorders and who are most likely to act as the first point of contact for people with eating disorders and their family and supports. The role of early identifiers is to proactively engage people at risk to promote early help seeking.

Initial responders

Primary health care professionals who provide the first level of intervention, such as screening, initial assessment, provisional diagnosis, and referral. Where safe and appropriate after a thorough eating disorder assessment, professionals in this group may also provide guided self-help for people with bulimia nervosa and binge eating disorder.

Shared care providers

Health professionals who provide treatment or support for the consequences of an eating disorder (e.g., medical monitoring and treatment) or for co-occurring conditions. Professionals in this group are part of the interdisciplinary and interagency treatment team but are not providing therapy specific to the eating disorder.

Eating disorders treatment providers

Health professionals delivering eating disorder-specific treatment that is safe (addressing all aspects of illness) and delivered through a collaborative multidisciplinary care team approach.

Recovery support providers

People providing ongoing support to a person who has experienced or is experiencing an eating disorder to reduce the risks associated with relapse and recurrence of illness and to support ongoing recovery. Recovery support may also be required for family and supports. This group includes the professions most likely to act as early identifiers, initial responders, and treatment providers. It may also include peer workers.

Stepped system of care

Stepped care is defined as "an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to a person's needs. Within a stepped care approach, a person is supported to transition up to higher-intensity services or transition down to lower-intensity services as their needs change" (7).

Policy context

Stepped care for mental health has been, and continues to be, a key policy focus for the Australian Government. In response to the findings of the National Mental Health Commission's Review of Mental Health Programmes and Services, the Australian Government identified "refocusing primary mental health care programmes and services to support a stepped care model" as a key area for reform (8, 9). The purpose of this reform was to transition from a 'one size fits all' approach to an approach which matches the provision of services to individual need. Primary Health Networks (PHNs) were tasked with implementing this reform in primary care (9). Subsequent key policy documents and reform agendas have continued to focus on stepped care approaches to mental health, including:

- The Fifth National Mental Health and Suicide Prevention Plan (7)
- National Mental Health and Suicide Prevention Agreement (10)
- Productivity Commission Mental Health Inquiry Report (11)
- National PHN Guidance: Initial Assessment and Referral for Mental Healthcare (12)
- PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance: Stepped care (13)

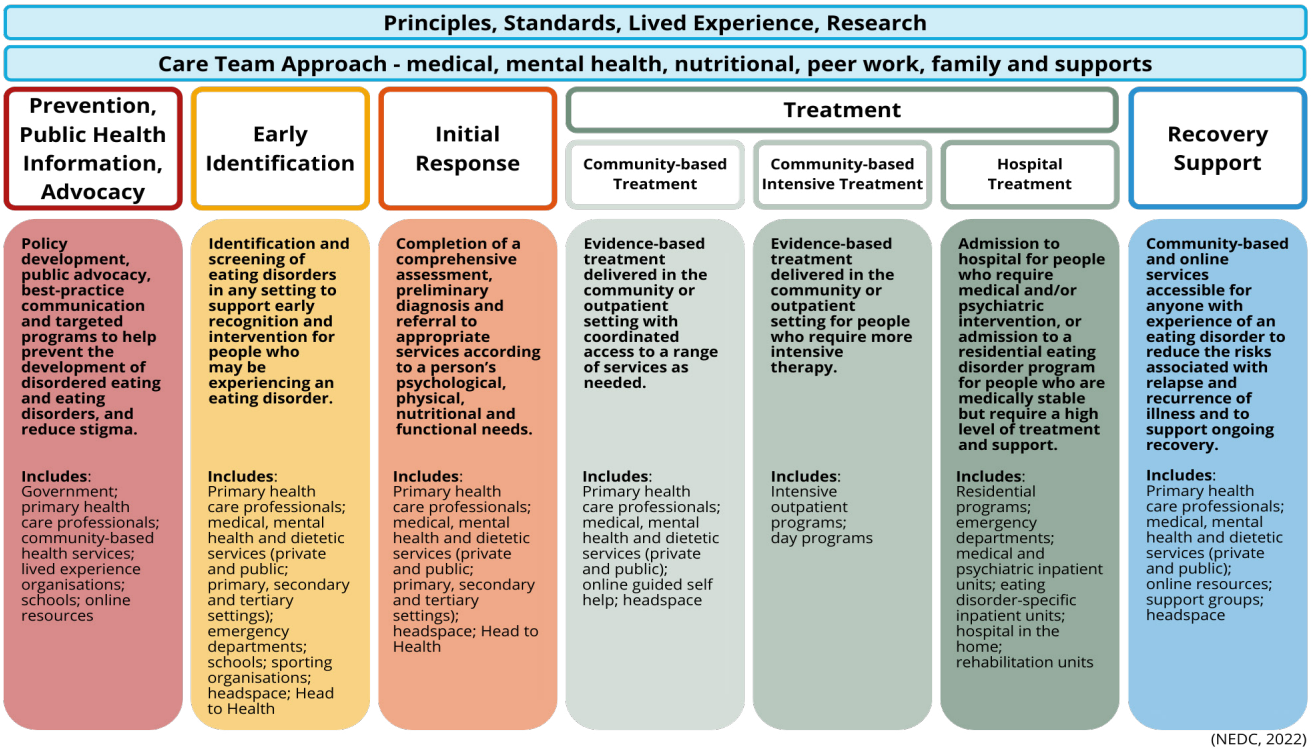
Stepped system of care for eating disorders

Eating disorders are a distinct group of complex illnesses with treatment requirements that are different to other types of mental illness due to the complex overlapping nature of mental health and physical health needs. The provision of a stepped system of care for people with eating disorders is supported by expert consensus as the ideal approach where the continuum includes a full spectrum of levels of intensity, skilled assessment of need and coordinated transition between services as the person's needs change.

The stepped system of care for eating disorders delivers coordinated, evidence-based services that increase or decrease in intensity according to a person's changing psychological, physical, nutritional and functional needs. Progression along the continuum is not linear and response to treatment is individual and variable. People may require recurrent episodes of treatment, at different levels in the continuum of care and from different service providers.

NEDC has developed a model of the stepped system of care for eating disorders, with examples of care and treatment services that people may require across the course of illness and recovery (shown in Figure 1 below).

Stepped System of Care for Eating Disorders



(NEDC, 2022)

The following paragraphs describe in more detail each element of the stepped system of care.

Prevention, public health information and advocacy

Prevention, public health information and advocacy has an important role in preventing the development of disordered eating and eating disorders. Individuals and organisations across a broad range of sectors can contribute to this, including but not limited to governments, lived experience organisations, health professionals, schools, and online settings.

Early identification

Early identification and screening of eating disorders is important to support early recognition and intervention for people who may be experiencing an eating disorder. This can occur with primary health care professionals or in medical, mental health and dietetic services (private and public; primary, secondary and tertiary settings), emergency departments, schools, sporting organisations and headspace.

Initial response

Initial response involves the completion of a comprehensive eating disorders assessment, provisional diagnosis and referral to appropriate services according to a person's needs. This can occur in medical, mental health and dietetic services (private and public; primary, secondary and tertiary settings) and can be conducted by primary health care professionals, mental health professionals, and dietitians, as examples.

Treatment

Treatment extends across three levels of the stepped system of care, with the treatment intensity increasing across these three levels. Decisions about the level of treatment required must be informed by the evidence for eating disorders and the potentially high risks associated with treatment failure at lower levels of intensity. As such, the lowest level of treatment may not be an appropriate starting point for treatment. For example, hospital services may be required as soon as someone is identified as having an eating disorder.

The first treatment level is community-based treatment, which refers to evidence-based treatment delivered in the community or outpatient setting, with coordinated access to a range of services as required. This can occur in medical, mental health and dietetic services (private and public) and be delivered by appropriately skilled primary health care professionals. It can include the provision of online guided self-help, where appropriate. Community-based treatment can be used as a step in at first diagnosis or first occurrence of symptoms, or a step down from community-based intensive treatment or hospital treatment.

The second level of treatment is community-based intensive treatment, when treatment at a higher frequency and intensity is required. This can be delivered in the community through intensive outpatient programs and day programs. Peer workers may also be involved alongside community-based intensive treatment. Community-based intensive treatment can be used as a step in at first diagnosis or first occurrence of symptoms, a step up when a patient is not responding to community-based treatment, or as a step down from hospital treatment.

The third treatment level is hospital treatment, when admission to hospital is required for people who require medical and/or psychiatric intervention, or admission to a residential eating disorder program for people who are medically stable but require a high level of treatment and support. This can be delivered in emergency departments, medical and psychiatric inpatient units, eating disorder-specific inpatient units, hospital in the home, rehabilitation units and eating disorder-specific residential programs. Hospital treatment can be used as a step in at first diagnosis or first occurrence of symptoms when a person is at medical and/or psychiatric risk. People can also step up to hospital treatment for medical and/or psychiatric intervention to manage complications and risk, or if the patient requires a structured eating disorder program.

Recovery support

Recovery support refers to the provision of community-based and online services accessible for anyone with experience of an eating disorder to reduce the risks associated with relapse and recurrence of illness and to support ongoing recovery. These services and support can be provided by primary health care professionals, community-based mental health and dietetic services (public and private), and support groups. Online resources can also support recovery.

Principles, standards, lived experience and research

Underpinning the stepped system of care are key principles, standards and research, including the Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Treatment of Eating Disorders (15), the ANZAED Eating Disorder Treatment Principles and General Clinical Practice and Training Standards (16), the National Practice Standards for Eating Disorders (4) and the Workforce Core Competencies for the Safe and Effective Identification of and Response to Eating Disorders (5). Alongside these principles, standards and research, lived experience input throughout the design, delivery and evaluation of services within the stepped system of care is essential.

Care team approach

Across the continuum of care, a multidisciplinary care team approach is required which includes medical and mental health care professionals at a minimum, dietetic care as appropriate, and other mental health and medical input in line with the person's needs, including peer workers. Family and supports are an integral part of the care team.

Conclusion

Service providers should be aware of their roles and responsibilities in responding to eating disorders. Eating disorders should be viewed as core business, and staff should be able to demonstrate the appropriate competencies, based on NEDC's Workforce Core Competences (5). In addition, services should be aware of where their service sits in the stepped system of care for eating disorders and ensure that people experience a coordinated transition to different levels of the stepped system of care as needed.

The NEDC is available to provide tailored guidance and support to service providers.

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