



Practical Responses to Eating Disorders

A Guide to Implementing Responses to Eating
Disorders in General Health Services

National Eating Disorders Collaboration

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The National Eating Disorders Collaboration

The National Eating Disorder Collaboration (NEDC) is an initiative of the Commonwealth Government Department of Health. Its primary purpose is to bring together all of the stakeholders in eating disorders prevention and treatment to develop a nationally consistent evidence based approach to eating disorders.

The project's objectives include:

- Provide or facilitate access to helpful, evidence based information for young people and their families on the prevention and management of eating disorders and healthy eating
- Promote a consistent evidence based national approach to eating disorders
- Develop and assist in implementing a comprehensive national strategy to communicate appropriate evidence based messages to schools, the media and health service providers.

In working towards these objectives, the NEDC is actively pursuing goals outlined in the first phase of the project:

1. Eating disorders are a priority mainstream health issue in Australia
2. A healthy, diverse and inclusive Australian society acts to prevent Eating Disorders
3. Every Australian at risk has access to an effective continuum of Eating Disorders prevention, care and ongoing recovery support.

In 2012 and 2013 the NEDC developed a National Framework for eating disorders, guidelines for communicating about eating disorders, an overview of prevention and early intervention issues and a gap analysis exploring what is happening for eating disorders at the moment and where the opportunities are for further development.

The work of the NEDC is all evidence informed, drawing on research evidence and consultation with clinicians, researchers, community based organisations, people with experience of eating disorders and their carers and other interested stakeholders.

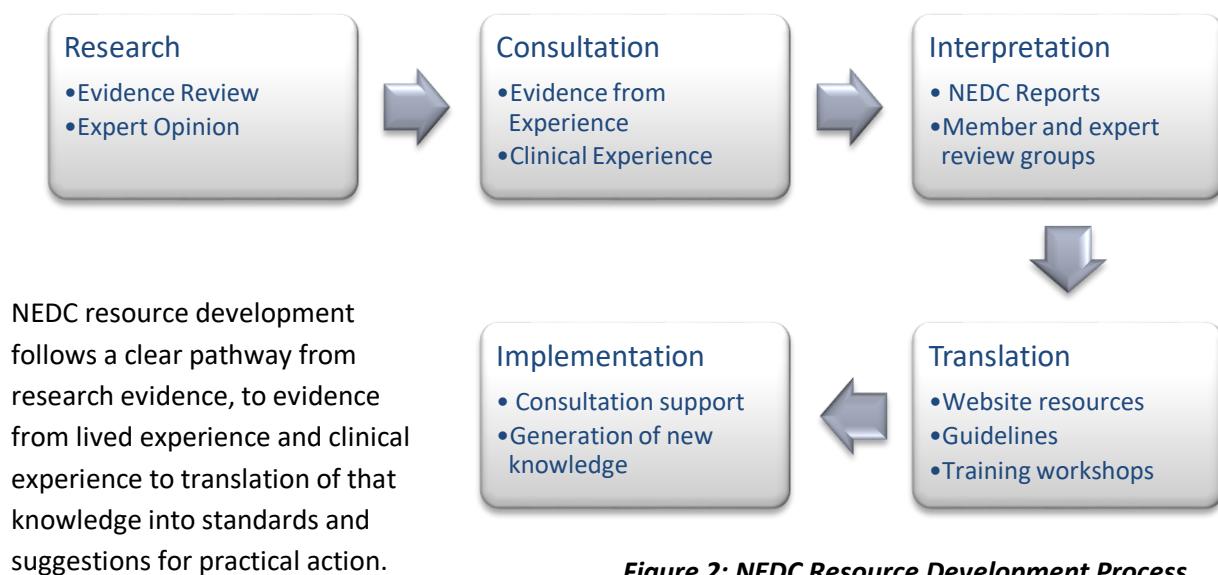


Figure 2: NEDC Resource Development Process

Purpose and Scope of the Implementation Guide

Implementation translates evidence into practice. The NEDC has developed a suite of evidence informed reports and resources that together outline evidence from research, clinical expertise and lived experience of eating disorders. This Implementation Guide explores the practical first steps required to translate that evidence into accessible and effective services for people with eating disorders. It is intended for use by people with an interest in planning, evaluating or developing services for people with eating disorders.

Approaches to implementation for eating disorders must address the complexities of eating disorders and the complexities of the health service system. Eating disorders require integrated treatment from both mental and physical health services and this represents one of the key challenges for the implementation of responses to eating disorders.

Knowledge is not enough to achieve effective implementation. Implementation science has identified steps that are critical to the process of change, filling the gap between knowledge and action. These steps start with exploration; assessing needs and matching good practice service responses with opportunities for service development.

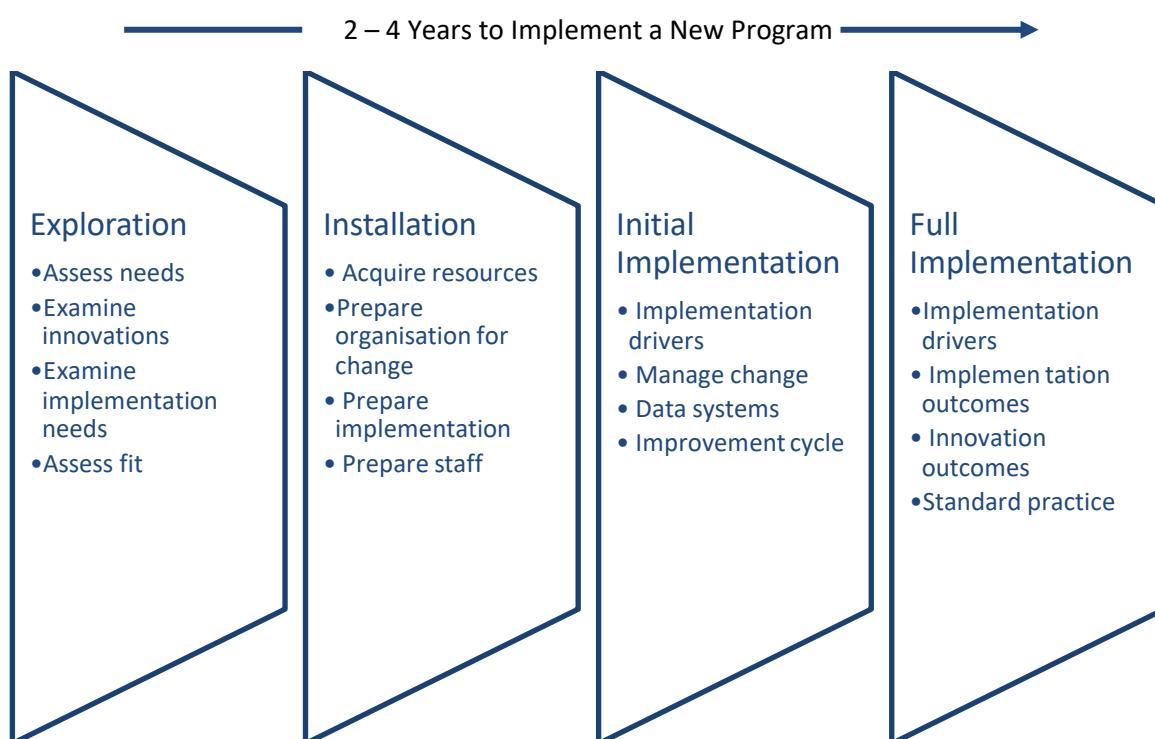


Figure 3: Implementation Stages (Metz & Bartley, 2012)

The goal of the exploration stage is to determine the feasibility of implementation of innovative approaches in specific communities or organisational settings (Metz & Bartley, 2012). During this stage the core building blocks required for change can be identified and steps put in place to ensure that there is a solid foundation for future service implementation. Critical building blocks include competency to deliver and maintain new practices, and development of organizational systems and external systems, including policy, funding and data collection.

This report focuses on the exploration stage and the core competencies and organizational systems required to deliver a cost effective response for people with eating disorders. Core competencies for individual practitioners are outlined in the NEDC Workforce Development Blueprint and service development consultation papers, therefore the focus of this report is primarily on the steps that health systems and service providers can take to implement new approaches to eating disorders.

The optimal approach to reducing the impact of eating disorders on individuals, their families, the health system and the wider community, would be the adoption of the national standards schema principles within a full continuum of care (see page 11 of this report for an outline of the standards schema and Appendix 2: Implementing Treatment Standards for a full version of the National Standards Schema).

This report suggests some practical first steps towards this goal that have the potential to deliver immediate short term benefits and create a sound foundation for future development of responses to eating disorders in Australia.

Implementing Responses to Eating Disorders



Figure 4: Building Capability: first steps to implementation of effective responses to eating disorders

Identifying Immediate Needs

In 2013, a gap analysis conducted by the NEDC identified significant gaps in the continuum of care available to patients with eating disorders in Australia. No single health planning district has been identified to date that delivers a full continuum of care for people with eating disorders. The gap analysis found that 85% of people seeking treatment for an eating disorder experienced difficulty getting access to appropriate treatment.

Eating disorders are rarely identified as a priority for mainstream medical and mental health systems resulting in lack of service planning, lack of early identification of people at risk and lack of access to treatment. The lack of planning for eating disorder services has contributed to a lack of community based eating disorder programs, reducing access to treatment, especially for people in regional and rural areas.

Significant gaps were identified in the knowledge and skill of health professionals to identify and treat eating disorders. Of frontline clinicians involved in the gap analysis consultation, 97% indicated that they had little or no training in eating disorders and lacked confidence to provide treatment.

The gap analysis report identified improved access to professional development in eating disorders as a national priority for action, including implementation of core competencies and facilitated access to existing training for all health professionals and other professionals who work with high risk groups. (*A summary of gap analysis findings and recommendations appears in Appendix 1*).

Regional Consultation Outcomes

Between 2013 and 2014, the NEDC continued to consult with health service providers in all states and territories with an emphasis on consultation in regional cities and towns serving as the health planning centre for a rural area. These consultations confirmed the findings of the gap analysis and highlighted four priority areas for development:

Referral pathways

Integrated care pathways that could provide a framework for sustained recovery for both children and adults.

Knowing what was available for people with eating disorders and who to refer patients to, emerged as a consistent regional need. Where eating disorders services are only provided through private health, the issue of accessible and affordable pathways for people without private health insurance was identified as a factor in determining referral pathways.

Professional development

Access to training and opportunities for expert supervision or case conferencing was identified as an essential contributor to confidence and readiness to treat people with eating disorders. Staff turnover in health services was identified as an ongoing challenge, requiring continuous access to training in order to up-skill new workers in eating disorders as they joined health services. The use of technology, such as video conferencing was also identified as an approach to improve access to case conferencing and expert support.

Collaboration for multidisciplinary treatment

While many people in a health region may be working with patients with eating disorders, connections between these professionals are frequently missing resulting in partial or fragmented treatment for the patient and an increased sense of burden by individual clinicians. Local professional networks to build interdisciplinary and inter organisational relationships were identified as an achievable strategy to address this issue. Nomination of GPs as case coordinators for adult patients and development of coordinator roles within secondary health services. Allocation of resources for the collaborative case conferencing and coordination aspects of integrated treatment.

Development of community based eating disorder programs

Implementing eating disorder specific groups, clinics and programs within general health services that address gaps in the continuum of care particularly for early intervention and for adult treatment and recovery support

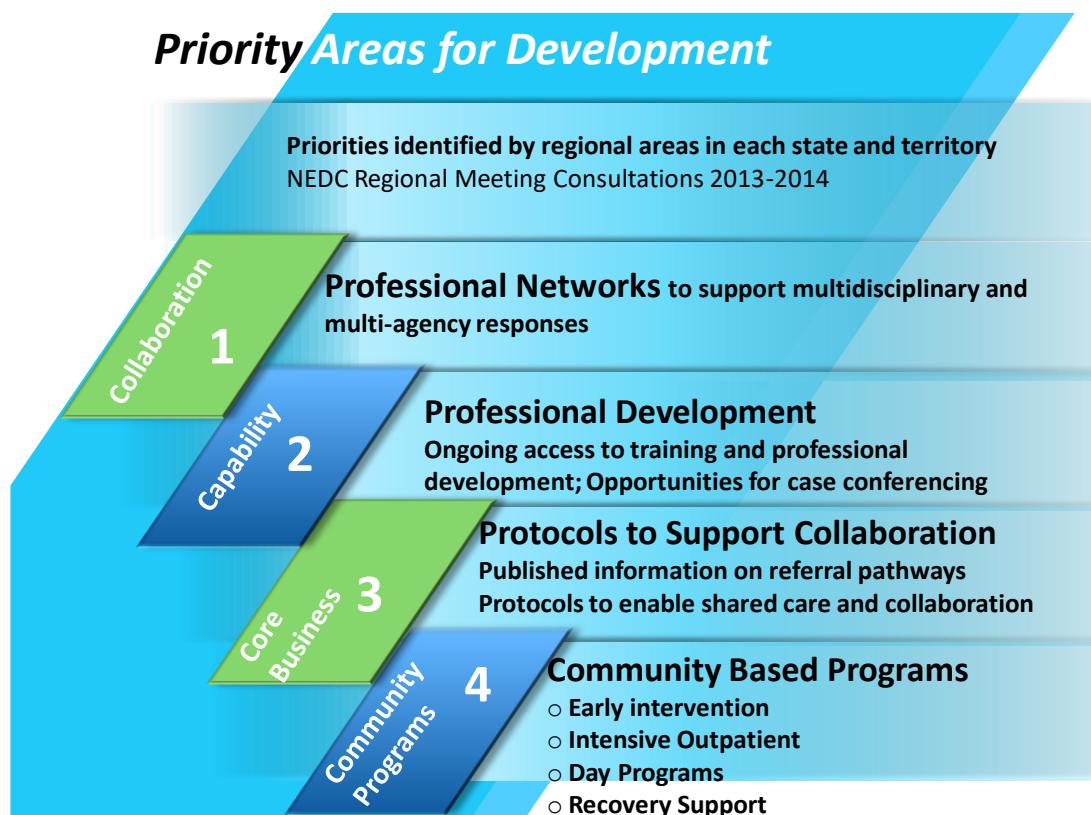


Figure 1: NEDC Consultation Outcomes: Priorities identified by regional areas

Optimal standard for care that supports recovery from eating disorders is treatment that is specific to the illness, delivered in an evidence based dosage as part of an integrated process of safe intervention and support that addresses all aspects of the illness, physical, psychological, nutritional and functional. This is a multidisciplinary and frequently a multi agency response that requires coordination and collaboration over time to ensure the best possible outcomes.

Action is required in all areas across the continuum of care from prevention to recovery support and in all states and territories to address priority gaps. Each state and territory has taken a different approach to the development of eating disorders services and therefore the next steps in development will look somewhat different in each area.

Since the inception of the NEDC in 2009 a number of states have taken significant action to address the needs of people with eating disorders. The New South Wales Eating Disorders Service Plan and the South Australian Eating Disorders Service Plan have both come into effect in this time. Victoria and Queensland have continued to implement their established responses to eating disorders including the provision of state wide tertiary support for primary and secondary health care providers.

Despite these initiatives, there continue to be insufficient eating disorder specialist services to meet the needs of everyone in Australia who experiences an eating disorder. The majority of specialist services are located in metropolitan areas and are not easily accessible for people from regional and rural communities. To the extent that people with eating disorders are receiving treatment, most receive that treatment in non-specialist primary and secondary health care services in the public and private health sectors.

There is an immediate need to improve access to eating disorders treatments in order to reduce inequities in regional access to all levels of treatment, improve access to early intervention, recovery support and treatment for mild to moderate presentations of eating disorders in community settings and improve access to intensive outpatient programs (including day programs and residential programs) in all states and territories.

To improve access to treatment and treatment outcomes for people with eating disorders all health services need to be equipped to provide a basic level of safe, evidence based response to patients with eating disorders:

- Identify and screen people at risk of eating disorders
- Communicate safely about eating disorders and weight and shape related issues
- Refer patients to appropriate treatment and support services
- If providing ongoing treatment for the patient, have sufficient knowledge of eating disorders to work in a shared care arrangement with other health professionals who are treating the eating disorder

Principles for eating disorder service planning include ensuring that:

- Every health service working with high risk populations has the capability to be a point of entry to eating disorder care
- Every health region has the capacity and capability to provide all necessary services for people who have, or are at risk of developing, an eating disorder
- Eating disorder outpatient programs are accessible, taking into consideration specific local issues such as distance,
- Access to treatment is on a flexible basis with support for a stepped approach to care, enabling patients to transition between primary and more intensive levels of treatment

Eating Disorders Overview

Eating disorders are a group of serious psychiatric illnesses which includes anorexia nervosa, bulimia nervosa, binge eating disorder, and other eating and feeding disorders (APA, 2013). Each of these disorders involves distinct behaviours and beliefs specific to the diagnosis and treatment varies depending on the diagnosis. However, people with all types of eating disorders share disturbed eating behaviours and distorted beliefs, with extreme concerns about weight, shape, eating and body image. Symptoms can also include driven exercise.

Eating disorders are highly complex, serious mental illnesses with significant physical complications and impairment including chronic heart and kidney disease, osteoporosis and diabetes and diseases associated with obesity. Chronic physical complications can occur early in the course of illness (Katzman, 2005). The overall mortality rate for eating disorders is up to 20% (Arcelus, Mitchell, Wales, & Nielsen, 2011).

Most people with an eating disorder present with binge eating disorder or other eating and feeding disorders (Hay, Mond, Buttner, & Darby, 2008). These disorders are as clinically severe as anorexia nervosa and bulimia nervosa (Hay, Buttner, Mond, et. al, 2010), with an elevated mortality rate and increased risk of suicide comparable to that of anorexia nervosa (Crow, Peterson, Swanson et.al, 2009).

All eating disorders are serious illnesses with high levels of psychological distress, risks of long term mental illness, medical complications and an increased risk of premature death due to medical complications and to an increased risk of suicide. Eating disorders have been shown to have one of the highest impacts on health related quality of life of all psychiatric disorders (AIHW, 2008).

Eating disorders most frequently start in childhood and youth and impact on education, identity formation and physical growth. With a high risk of recurrence and chronicity, eating disorders can impact on health and quality of life for the whole life span. For families, the impact may include caregiver stress, loss of family income, disruption to family relationships and a high suicide risk (NEDC, 2010).

Eating disorders are relatively common when compared with other priority health issues affecting approximately 9% of the total population with prevalence in any one year of around 2.94% in males and 5.11% in females.

The rate of eating disorders in the Australian population is increasing (Hay, et al., 2008). This trend is most evident in binge eating disorder and has paralleled the increase in childhood obesity (O'Dea, 2005).

Eating disorders are a distinct group of complex illnesses with treatment requirements that are different to other types of mental illness. The complexities of eating disorders require a long term multi-disciplinary team approach, integrating medical, nutritional and psychological treatment delivered in a supportive environment.

Good Practice Approaches to Eating Disorders

The National Eating Disorders Framework standards schema includes seven core principles and four implementation principles which, if implemented together, provide the foundation for an effective and consistent system to address eating disorders. (Refer to Appendix 3: Implementing Treatment Standards for the full national standards schema).

The principles of prevention and treatment focus on access to comprehensive, coordinated approaches that provide individually tailored pathways that can be consistently implemented.

Practice Principles

- Person and family centred care that addresses the needs of individuals
- Prioritization of prevention, early identification and early intervention Prevention, early
- Safety and flexibility in treatment options
- Partnering to deliver multi-disciplinary treatment in a continuum of care
- Equity of access and entry
- Tertiary consultation accessible at all levels of treatment
- Support for families and carers as integral members of the team

Implementation Principles

- Evidence informed and evidence-generating approaches
- A skilled workforce
- Communication to ensure an informed and responsive community
- Systems support integration, collaboration and on-going development

A Stepped Model of Care

Eating disorders require a stepped model of care delivered within a clearly identifiable continuum which includes flexible care options to meet the physical and mental health needs of people presenting with varying levels of risk, severity, complexity and acuity.

The necessary continuum of care includes six core components with access at all levels to tertiary consultation and support:

1. Primary, secondary and tertiary prevention
2. General outpatient support provided in both hospital and community settings with flexible access to a range of services delivered with variable frequency of access, with particular emphasis on relapse prevention / early intervention
3. Intensive outpatient support for people living with their family or other support structures who require intensive clinical support
4. Day programs, providing a more structured program, including group therapy
5. Residential programs, providing 24 hour support ideally located in the community. This level of care provides a step down or step up level following or before hospitalisation and is imperative for those who may not have a significant support structure in their homes
6. Inpatient services for medical intervention and stabilisation; intensive, structured inpatient programs to address severity and co-morbidity.

Evidence Based Treatment

The National Mental Health Services Standards (Standard 10.5, 2010) require that treatment and support reflect the best available evidence. Safe, evidence based treatment for eating disorders addresses all aspects of the illness; physical, psychological, nutritional and functional.

The treatment of eating disorders requires a multidisciplinary approach delivered as an integrated and sequenced continuum of care. This may involve multiple service providers. Partial approaches to treatment, addressing some aspects of illness but not others, contributes to relapse and the ‘revolving door’ of escalation of severity and recurrent need for treatment.

Essential components of safe treatment include:

Risk Assessment

Patients must be screened for physical health risks and risk of suicide. Medical stabilization, where required, must be provided before or simultaneously with other interventions.

Physical Health Assessment and Treatment

Regular assessment of physical health risks is essential with medical treatment provided where required.

Engagement

Engaging patients with an eating disorder in change can be difficult. Motivational Interviewing (MI) can be a useful intervention to engage individuals with severe eating disorders prior to participation in intensive treatment. (Weiss, Mills, Westra & Carter, 2013)

Mental Health Interventions

Patients require evidence based psychotherapy, delivered in an evidence based dosage. The minimum course of treatment for eating disorders supported by evidence is at least 20 sessions, usually delivered over a 4 to 6 month period (ANZAED, 2011). Shorter periods of treatment are not supported by research evidence and are inadvisable except as a preventative approach. For people with more complex or persistent illness, where early intervention is not possible or not successful, a longer course of treatment is required.

Anorexia Nervosa

- **Maudsley Family Based Therapy (FBT) for Adolescents**

(American Psychiatric Association, 2006; NICE, 2004). An average of 30 sessions of FBT has been found to improve outcomes for children and adolescents with anorexia nervosa (Rhodes & Madden, 2005; Wallis, Rhodes, Kohn & Madden, 2007).

- **Specialist supportive clinical management (SSCM) for Adults** – SSCM provides an integrated, non-specialized therapy for anorexia nervosa which has demonstrated efficacy with adults in research trials (McIntosh, et al., 2006).

- **Cognitive-behavioural therapy (CBT) for adults** – CBT has shown promising results in the prevention of relapse (Hay, Touyz and Sud, 2012) delivered as a minimum of 20 sessions with an expectation of a further period of therapy after review.

- **Cognitive analytical therapy and focal psychodynamic therapy** should be considered as treatment options for adults with anorexia nervosa (NICE, 2004).

Bulimia Nervosa and Binge Eating Disorder

- **Cognitive behaviour therapy (CBT)** should be offered to adults with bulimia nervosa. The course of treatment is recommended to be 20 sessions (Fairburn, Marcus & Wilson, 1993; Mitchell, Agras & Wonderlich, 2007; NICE, 2004), delivered over a minimum of 4-5 months as either individual or group therapy (Hay, & Touyz, 2012).
- **Interpersonal Psychotherapy (IPT)** should be considered as an alternative to CBT for adults. An evidence based dosage would be delivered over a longer time period of between 8-12 months to achieve results comparable with CBT.

Nutritional Interventions

Dietary advice for a nutritionally balanced intake may restore body weight, body composition and biochemistry and improve medical status (RANZCP, 2011). Nutritional interventions should include monitoring of food consumption, binge eating and purging behaviour, and education about the medical, physical and psychological consequences of bingeing or weight loss behaviours (Hart, Jorm, Paxton et. al, 2009).

Family Education

Family and carers require education and support to enable them to support treatment and maintain their own health. In addition to this essential general level of family education and support, skill based training for parents or carers has been effectively used as an adjunct to treatment (Zucker, Marcus, & Bulik, 2006).

For further information on evidence based treatments and modalities refer to the Implementation Toolkit: Planning Treatment Programs (Appendix 3A)

Safe	<p>Safety and flexibility in treatment options: Safe treatment for eating disorders addresses all of the aspects of illness: physical, behavioural and psychological.</p> <p>Partnering to deliver multidisciplinary treatment in a continuum of care: Working in partnership with the person, their family and other health and support providers</p> <p>Evidence informed and evidence-generating approaches: Research and evaluation are integral to the design and delivery of health promotion, prevention, early intervention, and treatment approaches.</p>
Accessible	<p>Equity of access and entry: Access to services when and where they are needed, early in the illness and early in each episode of illness. Clearly identified entry points in the community, assist people to engage with accessible and affordable services</p> <p>Communication to ensure an informed and responsive community: Eating disorder awareness and prevention integrates with other physical and mental health promotion strategies to provide consistent health information that promotes wellbeing.</p>
Linked in a continuum of care	<p>Continuum: Eating disorders require a stepped model of care delivered within a clearly identifiable continuum with six levels of care and access at all levels to tertiary consultation and recovery services.</p> <p>Prioritization of prevention, early identification and early intervention: Prevention, early identification and prompt intervention reduce the severity, duration and impact of the illness</p> <p>Systems support integration, collaboration and on-going development: Policy and systems support collaboration between physical and mental health services, private and public health services, health and community services and between professional disciplines.</p>
Skilled	<p>A skilled workforce: All health professionals receive training in eating disorders</p> <p>Tertiary consultation accessible at all levels of treatment: Access to tertiary level expertise for consultation, supervision, guidance and referral if required</p>
Supporting sustained recovery	<p>Person and family centred care that addresses the needs of individuals: supporting individual approaches to long-term recovery</p> <p>Support for families and carers as integral members of the team: Families and carers receive support, education and information to enable them to support the person with an eating disorder and to maintain personal good health.</p>

Integrated Responses to Complexity

The national standards schema for eating disorders stresses the necessity for access to an integrated suite of services, regardless of a person's geographic location, age, or economic circumstances.

Brief, individual episodes of treatment are not generally sufficient to achieve recovery from an eating disorder. A longer course of intervention is required to address all aspects of the illness and reduce the risk of relapse and chronicity. People may require recurrent episodes of treatment, at different levels in the continuum of care and from different service providers.

Vulnerability to illness continues long after treatment and potentially throughout life. There is therefore a need for services that are sensitive to adults seeking support and for health services to provide treatment for adults as well as youth.

People with eating disorders need to be able to step up and down through an integrated continuum of services, experiencing their care as connected and coherent. These episodes of treatment need to work together to support incremental change towards recovery. Isolated episodes of treatment without coherence between episodes undermine the outcomes of treatment and the confidence of the person in their recovery.

Safe treatment for eating disorders addresses all aspects of the illness – physical, psychological, nutritional and functional – with treatment and support delivered by clinicians from different disciplines and frequently by different health service agencies.

An integrated response to eating disorders is characterized by:

- A stepped suite of services:** a range of treatment and support options delivered in varying levels of intensity to meet the differing needs of individuals at each stage of illness, and support transition from intensive treatment to self management
- Multidisciplinary treatment:** services provided by multiple disciplines and health services working collaboratively together
- Coordinated episodes of treatment:** planned and supported transition between programs and service providers; people with complex needs have access to a case coordinator
- Prioritization of early intervention:** Flexible entry and exit at all levels of the continuum of care in a step in/out and step up/down process with re-entry pathways to support relapse prevention and minimization of the impact of recurrence.
- Services for adults and children:** Services and referral pathways that address the needs of people of all ages including the transition between adolescence and adult services and the need of adults for aftercare and recovery support

The full continuum and scope of services for people with eating disorders may be provided within a single specialist eating disorders service however, services delivered through general primary and

secondary health services will require collaboration between several services all of which deliver a part of the safe response to eating disorders.

Eating disorders present challenges to the traditional organisation of treatment for mental illnesses. There is a need for integration and collaboration between physical and mental health services, private and public health services, prevention and treatment, health and community services and between professional disciplines.

The risks of non-integrated care

Eating disorders are long term illnesses for many people. Up to 50% of people with anorexia nervosa and bulimia nervosa have symptoms for at least five years (Wade, Bergin, Tiggemann et.al, 2006) and a recent longitudinal study found that 44% of people still met diagnostic criteria ten years after treatment for an eating disorder (Lannfelt, Molin, Linne von Hausswolff-Juhlin et.al, 2014). Recovery can take many years and episodes of treatment.

Isolated episodes of treatment without consideration of how the person accesses or re-enters treatment when it is required contribute to the development of severe symptoms before each episode, effectively creating a roller-coaster journey between improvement and deterioration and increasing the risk of chronicity and need for intensive treatment. Relying on people and their families to navigate the health system and negotiate their own re-entry to treatment places additional stress on people when they are at their most vulnerable and contributes to failure to access treatment when it is needed.

For the patient, failure to access coordinated intervention early in the course of illness or episode of illness directly contributes to the persistence of symptoms, the potential for medical complications and reduced quality of life. Partial treatment, inconsistencies in messages from treating clinicians and unsupported gaps between episodes of treatment all contribute to the risk of relapse or recurrence of illness.

For the community and the health care system, failure to provide a sufficient integrated response to eating disorders contributes to reduced effectiveness and increased costs of health care and to an increased economic burden due to long term illness. The economic cost in Australia is conservatively estimated at \$69.7 billion per year of which \$19.9 billion is the cost of health services. The burden of disease costs for eating disorders estimated to be \$52.6 billion in 2012, are comparable to the estimates for anxiety and depression of \$41.2 billion, and for obesity at \$52.9 billion (Deloitte Access Economics, 2013).

Strengthening System Responses to Eating Disorders

Systems are required to support integration of services provided at different levels of care, in different settings from community services to tertiary services, and potentially in different health regions or even different states.

A collaborative multi-disciplinary team approach requires the implementation of mechanisms to support professional networking across traditional treatment and professional boundaries. A collaborative approach to systems leadership is required to support collaborative practice at all levels of service provision.

Early Identification and Intervention

Eating disorders are not self limiting illnesses and early identification and prompt intervention based on appropriate multidisciplinary approaches are required to reduce the severity, duration and impact of the illness (AED, 2011).

An early intervention response to eating disorders is characterized by:

- **Prevention:** People in very high risk groups and those with early symptoms have access to early intervention programs (e.g. guided self help, online programs)
- **Screening:** People in high risk groups are screened and referred for early intervention treatment
- **Referral pathways:** service entry points are easily identifiable; referral processes and entry criteria enable early access to treatment
- **Community programs:** access to eating disorders specific services is available in all areas including rural and regional
- **Entry and exclusion criteria** for access to services enable access early in the course of illness or episode

The risks of non-identification

International and Australian studies have found very low rates of identification of people with eating disorders in health care settings (Hay, Marley & Lemar, 1998, Mond, Myers, Crosby et. al, 2010) resulting in delayed presentation of the seriously ill to specialist services (Madden, Morris, Zurynski, Kohn, & Elliot, 2009).

When no specific action is taken to identify, refer and treat people with eating disorders, there are significant consequences for the individual person's health and for the cost effectiveness of health services.

Lack of access to appropriate treatment, contributes to the severity and chronicity of the disorder and the need for medical and psychiatric intervention. In contrast, early intervention delivered by health professionals who are trained to deliver eating disorders treatment has been shown to improve rates of recovery, improve quality of life, reduce recurrence and therefore reduce the demands on the health system.

People who have had an eating disorder for less than 2 years are likely to respond more quickly to treatment and experience fewer physical health consequences. Without early intervention, the long term prospects are relatively poor. Recovery from an eating disorder is a long-term process, lasting on average for 1-6 years but affecting up to 25% of people as a severe and enduring illness.

Managing Risk

Risk management helps to minimize the impact of adverse events, reduce avoidable costs, and maximize opportunities for most effective use of resources. Risk management has become an essential practice for health services. Identifying the existing and potential impact of eating disorders on health service provision is an important first step towards implementation of effective approaches to eating disorders.

The primary area for consideration of risk is clinical care and safety with implications for service reputation and effective use of resources:

Clinical care and safety standards

- Clinical communication, especially communication about weight and shape, is safe and appropriate for people with or at risk of developing an eating disorder
- Health professionals demonstrate core competencies in eating disorders knowledge and skill relevant to their professional role
- Patients at risk of eating disorders are identified
- Screening and/or assessment tools are used
- Referrals pathways are established to appropriate eating disorder services/specialists
- Protocols support collaborative shared care with other clinicians and health services
- Treatments provided are evidence based and delivered in sufficient dosage to be effective
- Referral and discharge planning ensures that treatment is delivered as part of an integrated long term plan

Leadership standards

- Eating disorders are identified as a priority issue in risk management, policy, service planning, and protocols
- Designated roles have responsibility for implementing responses for patients with eating disorders
- Services are evidence based and evaluated
- Consumers with experience of eating disorders are actively involved in service development and evaluation

The key risk management questions for service providers are:

1. Are we working with or do we have responsibility for people at risk of eating disorders?
2. Do we effectively identify people who have or are at risk of developing eating disorders?
3. Are our current responses to people with eating disorders meeting evidence based standards for effective treatment?
4. Are eating disorders included in our risk assessment and service planning?

Does the service work with people ‘at risk’ of eating disorders?

Eating disorders can occur in any population within Australia; both males and females; in children, adolescents, adults and older adults; in all socio-economic groups; and from all cultural backgrounds. However, across this broad demographic, certain groups have been identified as being at higher risk:

- Adolescents and young adults (ages 12-25)
- Females including women with fertility issues and older women
- People engaging in competitive sport, fitness or dance
- People seeking weight loss treatment
- People with a personal or family history of eating disorders

Some groups in the community experience specific health issues and vulnerabilities when they develop an eating disorder that need to be taken into consideration. These groups include:

- Younger children
- Pregnant women
- People with specific health conditions – Type 1 Diabetes, PCOS,
- Indigenous communities – binge eating, extreme dieting behaviours and the core cognitive features of eating disorders, weight and shape concerns, occur at equal or higher rates in Indigenous populations to those found in other populations (Hay & Carriage, 2012).

Does the service effectively identify people at risk of eating disorders?

People with eating disorders use a wide variety of health and support services but do not specifically talk about their eating problems. Research suggests that only about 22% of people with eating disorders receive treatment specifically for their disorder, although most will receive treatment for related issues.

Early intervention critically depends on early detection of risks and symptoms (McGorry & Yung, 2003; Marshall, Lockwood, Lewis, & Fiander, 2004). Individuals who are identified and treated early in the course of an eating disorder have a better chance of recovery compared to those with a longer history of illness (Berkman, Lohr, & Bulik, 2007; Gilbert, Arcelus, Cashmore, et.al, 2012; Haines, Ziyadeh, Franko,et.al, 2011; Steinhausen, 2009).

The range of health issues associated with eating disorders which may be seen by health service providers includes depression, anxiety, gastrointestinal disorders, menstrual and fertility problems, high blood pressure, kidney failure, overweight or obesity, osteoporosis, Type II diabetes and dental problems.

Common health presentations include:

- Emotional problems
- Weight loss
- Gastro-intestinal problems
- Infertility issues
- Injuries caused by overexercising
- Fainting or dizziness
- Feeling fatigued or not sleeping well
- Feeling cold most of the time regardless of the weather
- Swelling around the cheeks or jaw, calluses on knuckles, damage to teeth and bad breath (signs of vomiting)

Screening to Improve Early Identification

Although people with eating disorders may not volunteer information about eating problems many would welcome questions from health care providers about eating behaviours. Asking about eating habits and a person's relationship with food and exercise fits well with the current recommendations to GPs for general preventive screening (RACGP, 2012).

Opportunistic screening for eating disorders is a simple, safe and inexpensive approach that has the potential to enhance general health in patients who are screened as well as identifying people who have or are at high risk of developing an eating disorder. Evidence based resources exist to support screening including the simple five question SCOFF and the Eating Disorders Screen for Primary Care (ESP) tools.

One study found that the best individual screening questions are:

- Does your weight affect the way you feel about yourself?
- Are you satisfied with your eating patterns?

(Cotton, Ball, & Robinson, 2003)

Screening is likely to identify people with disordered eating. This is the regular engagement in destructive eating or weight loss behaviours including binging and purging and is the most common step before development of a full eating disorder. While not sufficient to meet the current diagnostic criteria for a clinical disorder, disordered eating constitutes a serious health problem in its own right contributing to medical and mental health problems and significantly increasing suicidal thoughts and behaviours in adolescents. A study of young Australian women with subclinical levels of disordered eating has found that even minor levels of illness have a significant impact on health and quality of life for the long term (Wade, Wilksch, & Lee, 2012).

Disordered eating affects a much higher number of people in the community than eating disorders. Approximately 20% of females experience subclinical disordered eating and this is probably a conservative calculation when compared with other studies suggesting that up to 80% of teenagers may engage in dangerous eating behaviours at some time.

Additional information on screening appears in Appendix 4: Implementing Prevention Programs

Why Prioritize Eating Disorders?

- Eating disorders are relatively common, affecting about 9% of the population across the lifetime
- Eating disorders overlap with three priority areas for preventing health care: mental illness, obesity and diabetes
- Eating disorders are frequently undetected and under treated leading to health complications and chronicity
- Disordered eating contributes to depression, obesity, gastrointestinal and dental health problems
- There are no 'quick fix' treatments available. The best evidence based approach is early intervention.

Eating Disorders - a Priority Issue for Medical and Mental Health Services

Risk	Consequences of Risk	Contributory Factors
Risk category: Clinical Care and Patient Safety		
Non identification of people with or at risk of ED	<ul style="list-style-type: none"> Increased risk long course of illness and chronicity Increased impact on physical and mental health Increased health care costs Reduced effectiveness of treatment for related conditions (e.g. obesity, dental erosion, fertility, depression) 	<ul style="list-style-type: none"> Lack of staff knowledge of ED Lack of screening processes for people in high risk populations
Non provision of evidence based treatment in sufficient dosage to be effective		
Non provision of safe treatment that addresses physical, psychological and nutritional aspects of illness	<ul style="list-style-type: none"> Increased risks of chronicity of physical and/or mental health issues Failure to sustain treatment outcomes Relapse/ recurrence and need for further treatment Operational costs of delivering recurrent treatment Mortality including risk of suicide 	<ul style="list-style-type: none"> Lack of staff knowledge of ED Lack of funding for evidence based dosage of therapy Lack of collaboration/coordination between disciplines
Discharge/exit from treatment without plans for continuity of care and recovery	<ul style="list-style-type: none"> Risk of relapse/recurrence Risk of patient death Impact on family health 	<ul style="list-style-type: none"> Focus on acute episode rather than recovery Lack of alternative health services to refer to Lack of collaboration/coordination between service providers
Refusal of hospital treatment	<ul style="list-style-type: none"> Rapid deterioration Risk of death Risk of long term physical health consequences Impact on family health 	<ul style="list-style-type: none"> Lack of staff knowledge of ED Failure to implement shared care arrangements between psychiatric and medical departments Lack of either psychiatric or medical facilities within the hospital

Risk	Consequences of Risk	Contributory Factors
Risk Category: Leadership		
Increasing rates of ED in community	<ul style="list-style-type: none"> Increased complexity and chronicity of ED and/or physical consequences Increased demand for complex health care Increased costs of health care 	<ul style="list-style-type: none"> Lack of screening and early identification for people with ED Focus on obesity without reference to ED risks
Lack of ED programs in community	<ul style="list-style-type: none"> Failure to access services early in illness Failure to sustain outcomes after treatment 	<ul style="list-style-type: none"> Lack of planning for ED service provision Lack of collaboration/coordination between care providers Inadequate data collection on ED
Services fail to meet consumer and community expectations	<ul style="list-style-type: none"> Complaints and loss of reputation Increased risk long course of illness and chronicity 	<ul style="list-style-type: none"> Failure to include ED in policy, service planning and role responsibilities Staff attitudes and misconceptions about ED Lack of consumer participation in service planning, development and evaluation

Developing Core Capabilities to Minimize Risk

All health services that work with populations who are vulnerable to eating disorders, can manage risk and improve service effectiveness for patients with eating disorders by addressing five core areas of capability.

The goal of this approach is to ensure that the service is equipped to meet the needs of people with, or at risk of developing eating disorders at the level of early identification, assessment, referral to appropriate services and collaboration with other service providers in shared care approaches.

1. Core Responsibility

The key to ensuring that health services respond appropriately to people with eating disorders is to make it ‘core business’, specifically including eating disorders at a governance level in policies and procedures, service plans, position descriptions, and governance responsibilities. This would include ensuring that the specific needs of people with eating disorders are addressed in clinical guidelines, patient assessment protocols, treatment planning, program content and discharge planning.

The first step to developing safe responses for people with eating disorders is to ensure that eating disorders are identified on the risk register and are addressed in risk management and service development plans.

The second step is to examine the relevance of eating disorders and associated risks to the population who use the health service, estimating the need for responses to eating disorders based on knowledge of high risk populations, existing service data, and general prevalence data.

Planning for the development of eating disorders services is explored in more detail in Appendix 3A ‘Planning Treatment Services’ and in Appendix 3B ‘Planning an Intensive Outpatient Service’.

2. Capability

The delivery of safe treatment requires a skilled and supported workforce with the competency to implement the assessment, treatment or support relevant to their professional role. A priority in developing safe responses for people with eating disorders is ensuring that all health professionals are able to address eating disorder issues and the interaction of eating disorder thinking and behaviour with medical and nutritional health issues.

All health professionals who work with people at risk of eating disorders should be able to identify, screen, assess and refer patients with suspected eating disorders for appropriate treatment. Identification of eating disorders requires knowledge of the illness and warning signs as well as knowledge of pathways to access appropriate professional intervention, positive attitudes towards people with eating disorders and a belief that acting on this knowledge will have a positive outcome (Jorm, Korten, Jacomb et. al, 1997).

If the patient will continue to receive treatment from the service for related conditions, health professionals should be able to work collaboratively as part of a shared care team, demonstrating an understanding of eating disorders and their treatment and the ability to support recovery. The evidence based component of treatment is located in the skill of the staff working with the patient.

Therefore all patients with eating disorders need to be treated by someone who is trained to deliver this treatment.

Capabilities appropriate for health professionals who work with people who have or are at risk of developing eating disorders combine the core capabilities outlined by the NEDC for eating disorders with the core capabilities for the delivery of recovery oriented care:

- Respectful, hope inspiring and recovery oriented
- Collaborative – working with the patient and their family
- Demonstrate knowledge of evidence relating to eating disorders
- Identify and screen people at risk
- Conduct assessment and document clinical history
- Refer appropriately
- Knowledge of appropriate treatment options and treatment delivery
- Contribute to collaborative interdisciplinary treatment
- Support recovery
- Work collaboratively with people with eating disorders and their families or other identified support people

Family and supporters are integral to recovery. Where family will be involved in supporting treatment or recovery, their involvement is essential in treatment and discharge planning, and in education to develop their own understanding of eating disorders and their skills to support treatment outcomes.

3. Collaboration

Safe treatment for eating disorders addresses all of the aspects of illness: physical, behavioural and psychological. Safe treatment is therefore provided by multiple disciplines and often multiple service agencies. The most effective approach is a collaborative multi-disciplinary team approach which enables services to work in partnership with each other and with the person and their family.

Ideally, a patient should experience their care as connected and coherent; delivered in a logical and timely fashion that is consistent with their medical and personal needs.

The development of networks of collaborative partnerships is essential to recovery from eating disorders including partnerships with service users, their family or supporters, health professionals and community services. Positive team relationships contribute to successful outcomes for people with anorexia nervosa receiving FBT (Murray, Griffiths, Le Grange, 2013) and are important to overcome any differences in beliefs about eating disorders between clinicians, ensuring clear and consistent messages for the patient and their family.

Collaborative practice requires systems in place that support team approaches to treatment including:

- Arrangements for coordination and collaboration between mental health, medical and nutritional health services
- Protocols to facilitate referral and sharing of information

- Identification of the potential professionals in primary and secondary care services who are able to work together as a multidisciplinary team as the need arises
- Professional development strategies that support local collaborative networks
- Protocols for a team approach engaging the person, their support network and multiple service providers
- Shared standards and clinical guidelines across disciplines
- Identified links to expert eating disorder services for tertiary consultation
- Increasing use of technology for networking and to assist in shared real time case management
- Flexible coordinated pathways – case coordination, treatment and discharge planning, and collaboration between service providers both within the health and NGO systems to ensure that people have an integrated and consistent experience of treatment and support

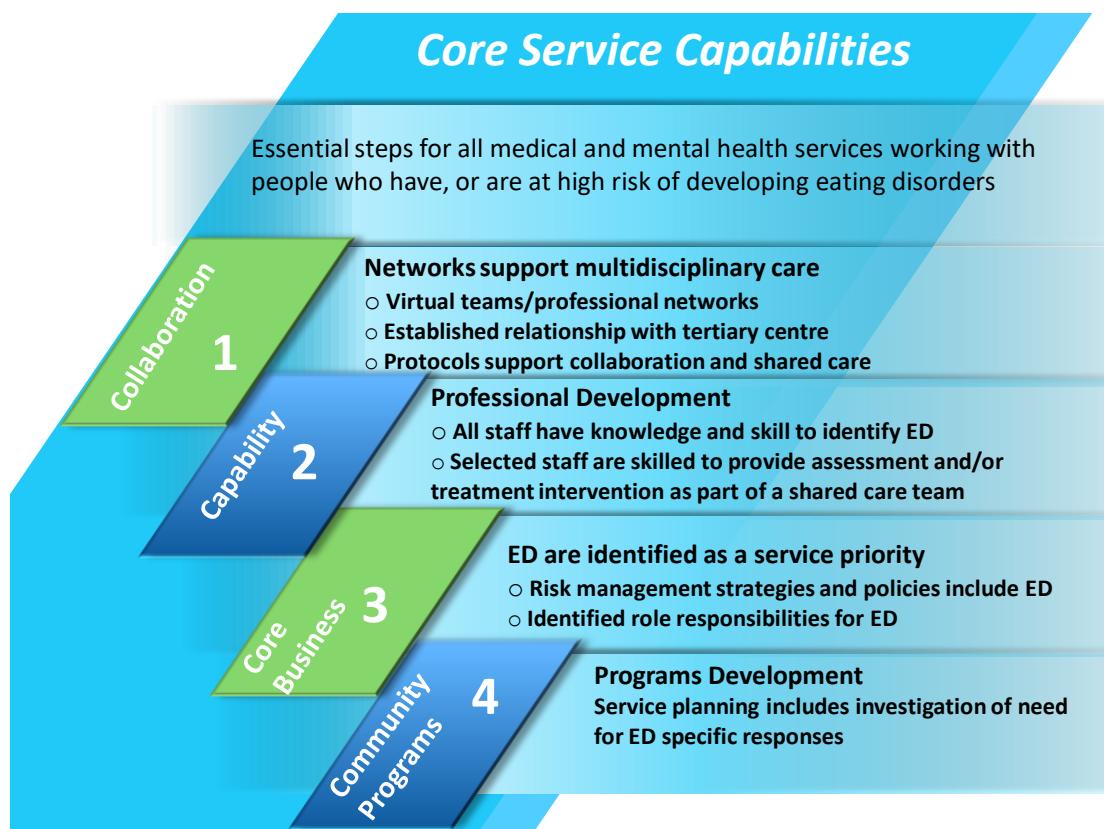


Figure 5: Steps to Building Implementation Capabilities for Eating Disorder Treatment

Implementing Eating Disorder Programs

Most people with eating disorders may be treated successfully by appropriately trained health professionals in community settings. Management of eating disorders on an outpatient basis in a community location enables the patient to remain close to family and social relationships, continue engagement in work or education where possible, and generalize new behaviours into everyday situations.

Intermediate levels of treatment, provided through outpatient programs, intensive outpatient programs and day programs, are essential to ensure the continuum supports the essential step up and step down access to treatment during the course of illness. Without these intermediary levels of treatment, more people require hospitalization.

Hospitalization is essential in the most severe cases. The complexity of eating disorders and the potential for rapid deterioration in physical health mean that close links must be maintained between community service providers and more intensive levels of specialist treatment including access to tertiary consultation and treatment services.

The complexity, long duration, impact on quality of life and high mortality risks associated with eating disorders, and the resulting high overall burden of disease costs, justify a preventive health care approach with a focus on prevention and early intervention. This early access includes intensive treatments provided early in the course of illness.

Early and timely access to treatment should be prioritized at a point between development of a high level of risk (disordered eating and/or body dissatisfaction) and the early stages of a full eating disorder (first two years after onset of eating disorder behaviours).

While the evidence for effective treatment is limited there is evidence for the effectiveness of the following early intervention treatments:

- FBT for adolescents in the early stages of anorexia nervosa
- Guided self help, CBT and CBT-e for people with bulimia nervosa and binge eating disorder or with high levels of risk associated with disordered eating and body dissatisfaction
- Selective prevention programs based on the principles of cognitive dissonance, psychoeducation evidence and CBT

Each region needs a different response to improve access to treatment for eating disorders depending on the resources that it already has.

The NEDC has identified four areas in which the continuum of care for people with eating disorders could be strengthened in most regions:

1. Intermediate level programs

Community based eating disorder specific programs that are staffed by a multidisciplinary team delivering integrated treatment and support for between one to three sessions per week. Frequently called Intensive Outpatient Programs (IOP) this flexible approach may offer interventions from early intervention to step up/down treatment options for people with eating disorders of moderate severity. Programs typically combine individual and group

education and therapy, including guided self help, CBT, and FBT. Medical assessment and monitoring is provided by the person's own GP working in a shared care arrangement with the program. IOP provide a flexible, intermediate step between primary and intensive treatment options.

Planning for intensive outpatient programs is explored in more detail in Appendix 3B.

2. Intensive level programs

Day programs, residential programs and 'hospital at home' programs all offer potentially cost effective, community based alternatives to hospitalization for those who are medically stable. In this context residential services are intensive short term programs (up to 12 weeks) that integrate address all aspects of illness in an intensive program of 24 hour support. For people in remote rural and regional communities, residential programs can offer an accessible alternative to hospitalization that reduces the cost and stress of travel. A basic intensive community program (IOP) would consist of a group psycho-education program, individual counselling, family education and support, nutritional education and individual meal plans with supported social eating. The program is typically delivered over an 8 to 10 week cycle with patients able to join the program at any stage in the cycle. IOP provide opportunities for people to step up from individual primary care treatment, step down from more intensive levels of treatment

Day and residential programs are considered in Appendix 3A: Planning Treatment Services.

3. Hospital Services

The delivery of both medical and psychiatric services to patients with eating disorders continues to be a challenge for many hospitals. Appointment of an eating disorders liaison position, a multidisciplinary eating disorders coordination team or a 'virtual team' of health professionals who are knowledgeable about eating disorders and able to work together on a needs basis, may provide the most effective strategy to support people receiving inpatient treatment.

Hospital coordination and outreach teams are described in more detail in Appendix 3A: Planning Treatment Services

4. Aftercare - Recovery Support

Eating disorders are egosyntonic disorders that play a valued role in the person's life. After treatment people need to learn to live without their eating disorder.

Sustaining recovery is a significant issue for people with eating disorders, with rates of relapse ranging from 22% to 51% across studies of people with anorexia nervosa and bulimia nervosa (Keel, Dorer, Franko et.al, 2005). Access to support in the community after treatment has been found to assist recovery (Lannfelt et.al, 2014; Leung, Ma, Russell, 2012) and continuing care after treatment is therefore identified as an essential component of the eating disorders continuum of care to reduce the risk of relapse and recurrence.

Recovery support provides a low cost approach to relapse prevention that can sustain treatment outcomes and assist people to achieve full personal recovery.

A variety of approaches can be effective in supporting recovery including:

- Recovery education programs – recovery education is an evidence based and cost effective approach to mental health recovery. 20 week educational group programs have demonstrated effectiveness in improving coping and daily living skills for people with eating disorders in Australia
- Peer support groups
- Case coordination
- Family education and support
- Community education to ensure supportive environments for recovery (e.g. school, employment)

4 *Implementing Community Programs*

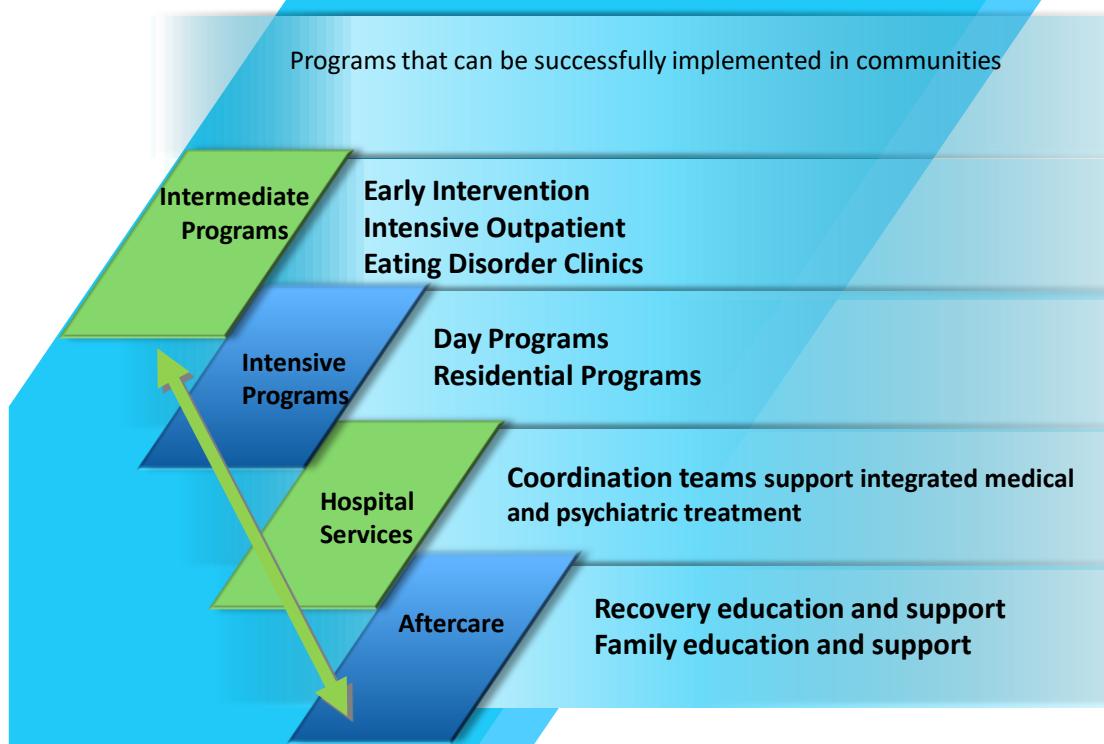


Figure 6: Flexible community approaches *integrated with* intensive treatment options

Conclusion

Eating disorders at the mild to moderate levels of severity are common illnesses. Even at more severe levels of illness, the prevalence of eating disorders in the population and the potential for physical health consequences would make eating disorders a priority in health service delivery.

Most people with eating disorders can be treated in their own community through existing primary and secondary health care services and non-government support services. To be safe and effective for the patient and cost effective for the community and the health care system, these services need the capacity to:

- Screen people in high risk groups
- Prioritize early intervention to reduce the severity and duration of illness
- Provide safe treatment for all aspects of the illness
- Deliver coordinated and integrated care across professional disciplines and between different agencies
- Provide access to community based eating disorder specific programs and recovery support

The capabilities required to implement these responses for people with eating disorders include:

- Core business:** Identification of eating disorders as core business and a responsibility of all services that work with high risk populations including both mental and medical health services
- Capability:** Training and professional development for key workers involved in the treatment and support of people with eating disorders
- Collaboration:** Identification of leadership roles and development of protocols to support collaborative interdisciplinary and inter-agency care for the duration of illness
- Community programs:** Development of early intervention, treatment and recovery support programs in the community to address gaps in the local continuum of care

Building these basic capabilities to implement effective responses for people with eating disorders is within the reach of most health services.

This approach is not sufficient to meet the needs of people with severe or extreme eating disorders nor does it meet the needs of adults who experience chronic eating disorders. Both of these groups may require skilled tertiary care at a higher level of intensity. There continues to be a need to increase the availability of eating disorder specialist services, including hospital beds, residential and day programs, for people with severe or extreme illness.

Some states have started to address the needs of these groups through the implementation of eating disorder service plans (notably, Victoria, South Australia and New South Wales). The implementation strategies outlined in this guide would support and integrate with state government plans to improve access to tertiary inpatient programs and day programs. In the absence of such plans there is still a strong justification in developing capability for early identification, early intervention and relapse prevention to minimize the risks for patients, their families and health service systems.

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National Eating Disorders Collaboration Reports

2013

A Nationally Consistent Approach to Eating Disorders: Opportunities to Implement the National Eating Disorders Framework (unpublished; NEDC member access only)

Eating Disorders Prevention and Early Intervention: A Review of Evidence Based Approaches and Opportunities to Implement Effective Strategies (unpublished; NEDC member access only)

2012

[National Framework: An Integrated Response to Complexity 2012](#)

[Communication Strategy Report: Clarity in Complexity 2012](#)

[Appendix: Eating Disorders - A Current Affair](#)

[Appendix: Healthy Weight Related Messages](#)

[Appendix: Evidence from Experience Report](#)

[Appendix References](#)

2010

[Evaluating the Risk of Harm of Weight-Related Public Messages](#)

[Eating Disorders: The Way Forward – An Australian National Framework](#)

[Eating Disorders Prevention, Treatment and Management – An Evidence Review](#)

[Eating Disorders Information and Support for Australians – Resource Review](#)

[Eating Disorders: The Way Forward – A Strategic Communication Framework](#)

Appendix 1

Identifying Priority Gaps: A Summary of Findings from the NEDC Gap Analysis

In 2013, the NEDC gap analysis found significant gaps in the continuum of care available to patients with eating disorders in Australia. Most people have, at best, access to only one part of the continuum. There are too few services for the number of people experiencing eating disorders, with no evidence of geographic planning for a full continuum of care. No single health planning district has been identified to date that delivers a full continuum of care for people with eating disorders.

The key gap identified in the NEDC gap analysis is the lack of a systematic approach that embeds eating disorders treatment into mainstream health systems and ensures that the majority of people with eating disorders have access to evidence based care. Reference to eating disorders is largely absent from health policies and funding arrangements. Reliance on an understanding of other mental illnesses as the basis for policy development has led to initiatives that do not address the complexity and duration of eating disorders. The absence of eating disorders, particularly binge eating disorder and EDNOS, from policy, plans, data collection and access criteria for services compounds the invisibility of these serious illnesses. The outcome is a high cost in health complications, quality of life, life expectancy and in measurable financial costs.

Systems are required to support integration of services provided at different levels of care, in different settings from community services to tertiary services, and potentially in different health regions or even different states.

The gap analysis report identified the following key gaps in current approaches to eating disorders:

Access to treatment and support

- 85% of people seeking treatment experience difficulty getting access to appropriate treatment
- 60% of clinicians experience difficulty referring clients for eating disorders treatment
- There are no specialist eating disorder inpatient services for adults in TAS, NT and WA
- There are no specialist eating disorder services in regional areas
- No health planning district provides a full continuum of care
- Current funding for mental health services provides a treatment dosage that is substantially less than the evidence based treatment dosage for eating disorders
- Most treatment for eating disorders is provided through private practice and through private hospitals. Lack of recognition of eating disorders in private health insurance, Medicare benefits and other funding initiatives leads to difficulties in accessing treatment, particularly for people who are reliant on public health services
- Lack of strategies to provide integrated treatment in general health services results in a ‘revolving door’ experience for people with an eating disorder, exiting a service once medically stable and then receiving no support until they are next medically compromised

Workforce Knowledge and Skill

- Half of health professionals receive no training in eating disorders and an additional 47% receive training they believe is inadequate to equip them to treat eating disorders

- There is very limited awareness of the presentation of eating disorders other than extreme weight loss in anorexia nervosa in both health professionals and the general community

Family Support

- Lack of access to recovery and family support services in the local community increases costs and disruption to normal life and increases the risk of relapse
- Lack of integration of support services with treatment for people who access treatment from medical services, reduces effectiveness of treatment and increases family stress

Consistent implementation of prevention

- There is no consistent implementation of eating disorders prevention initiatives
- Eating disorders are not included in the development or evaluation of mental health, obesity prevention and general health promotion initiatives

Data to inform health system development

- No data has been collected on eating disorders by the Australian Bureau of Statistics
- No data has been available on eating disorders to guide the development of mental health initiatives such as Better Access to Mental Health Services

Identified National Priorities

Action is required in all areas across the continuum of care from prevention to recovery support and in all states and territories to address priority gaps. Action in all of these opportunity areas has the potential to reduce the impact of eating disorders.

The intention of the gap analysis report is to outline a systematic approach to eating disorder service development that addresses national priorities and that can inform state and territory governments as they select the specific issues to target within their existing systems. The priority areas for action identified below provide the first steps towards the development of a nationally consistent approach to eating disorders that addresses the key gaps in current service delivery.

National Priorities

1. Policy

Inclusion of eating disorders and the evidence based standards for eating disorders prevention and treatment in all relevant health policies, plans, funding initiatives, Medicare Benefits Schedule and health promotion strategies

Specific action is required to

- Increase access to psychology, psychiatry and multi-disciplinary services through the introduction of separate Medicare item numbers for eating disorders or adaption of existing access initiatives (e.g. BAMHS, ATAPS) to reflect evidence based dosage and duration of treatment.
- Prioritize mapping eating disorders population health needs and service gaps in each community health region

- Include eating disorders in the development of national hospital reform and the move to activity based costing to ensure appropriate remuneration for inpatient, residential and community treatment
- Integrate body image and eating disorders prevention at a policy level, recognising that body dissatisfaction is a risk factor for eating disorders
- Integrate eating disorders prevention strategies in health promotion and prevention initiatives that address general mental health, body esteem, nutrition, exercise and obesity

2. Workforce development

Implementation of core competencies and facilitated access to existing training for all health professionals and other professionals who work with high risk groups

For early intervention and timely treatment to occur it is essential that people who work with those at high risk of eating disorders proactively identify eating disorders symptoms and engage people in help seeking. It is essential that there are then appropriate treatments for those people to be referred to. Without an active response from health professionals, supported by a knowledgeable community, early intervention will not happen.

Workforce development is a very high priority area for action. While other strategies are required (as outlined in this report) none of these strategies can successfully address the effectiveness of responses to eating disorders without the development of a skilled workforce.

Specific action is required to:

- Facilitate access to existing education and basic training resources
- Implement core competencies for all health professionals and other professionals working with people at high risk of eating disorders
- Resource existing centres of eating disorders expertise to enable better outreach and tertiary support for primary and secondary health services, especially in regional areas

3. Consistent national standards

Develop and implement national standards, clinical guidelines and decision support tools.

Nationally consistent approaches to eating disorders in Australia can only be achieved with the consistent implementation of shared standards. An immediate opportunity exists to build on the impetus and expertise of the NEDC to review existing guidelines and decision tools and develop them into one consistent national suite of standards.

Specific action is required to:

- Review existing clinical guidelines and develop:
 - Australian clinical guidelines that cover the full spectrum of eating disorders
 - Implementation guidelines that address the uptake, usage and medico-legal implications of national standards and clinical guidelines
 - Decision support tools relevant to each discipline in the multi-disciplinary team
- Ongoing review of emerging evidence and translation into practice

4. Community access

Resourcing existing eating disorders services (government and non government) to extend the reach and capacity of services as soft entry points for rapid and appropriate assessment and referral.

Specific action is required to:

- Dissemination of existing assessment and referral tools
- Review roles and capacity of existing information and ‘point of entry’ services
- Develop collaborative links between information services and eating disorder service providers to ensure streamlined, timely referrals
- Review and build the capacity of existing information services to provide immediate access to short term professional intervention as an early intervention strategy and to maintain motivation while people wait for access to other services

5. Integrated approaches to prevention

Implement an integrated cross sector approach to address the complex and inter-related problems of eating disorders, body dissatisfaction and obesity.

Specific action is required to:

- Implement existing evidence based prevention and early intervention programs on a consistent basis, using existing mental health promotion initiatives as a platform for dissemination
- Provide training in the delivery of evidence based prevention programs for teachers, sports coaches and other professionals working with young people
- Collaborate with health promotion campaigns to develop safe and effective approaches to weight management with an emphasis on healthy lifestyle modification for children and young people
- Facilitate access to mental health literacy and mental health first aid training for parents and professionals who work with people at high risk of eating disorders
- Implement the NEDC guidelines on safe weight related messages for all weight related health promotion strategies
- Convene a national expert panel to review the role of dieting in obesity, body dissatisfaction and eating disorders and develop long term strategies to promote healthy environments
- Provide online access to professionally facilitated self-guided early intervention programs under the auspice of one or more existing eating disorders service providers

6. Data collection

Inclusion of all diagnoses of eating disorders in health and welfare data collection and mental health surveys as a first step towards developing a detailed profile of eating disorders in Australia

There is an immediate need to improve access to eating disorders treatments in order to reduce inequities in regional access to all levels of treatment, improve access to early intervention, recovery support and treatment for mild to moderate presentations of eating disorders in community settings

and improve access to intensive outpatient programs (including day programs and residential programs) in all states and territories.

However, on the basis of current data it is not possible to accurately establish benchmarks for the capacity of eating disorders services or estimate the level of future need for eating disorders specialist services.

A priority area for action is therefore more detailed data collection to support decision making.

Specific action is required to:

- Include all diagnoses of eating disorders as distinct categories in national data collection activities including the Australian Health Survey
- Inclusion of BED as a condition in the International Classification of Primary Care
- Include eating disorders as a national research priority and support a National Research Agenda for the eating disorders sector
- Develop a detailed map of existing service capacity and resources for potential development in all community health regions
- Review of the role, capacity and sustainability of current state based non government community organisations providing support to people with eating disorders and their families