Service Model: South Australian Statewide Specialist Eating Disorder Services
Acknowledgments
The development of this proposed Service Model for Statewide Specialist Eating Disorders Services is the result of a collaborative effort from many people across the sector in South Australia.

We would like to gratefully acknowledge the many contributors whose time, effort, experiences and expertise have helped shape this document – in particular the generosity of people with a lived experience and their families who shared their stories and experiences, as well as clinicians and professionals who are passionate about improving the range of eating disorder services available to people across South Australia.
Foreword from the Chair

This report, outlining a proposed approach to a state-wide model of care for eating disorder services, has been developed in consultation with many consumers, carers, public and private providers and includes input from the non-government sector.

SA Health is committed to improving services for people with eating disorders and the process of refining the model and determining how best to implement it will continue.

The report will be distributed to stakeholders involved in consultations. The implementation of the model will involve detailed preparation and planning. With continued collaboration of the many stakeholders, it is envisaged that South Australia can fulfil the Vision statement on page 22:

“...develop a system of care ... that is accessible, equitable, appropriate, integrated and comprehensive, ensuring that people affected by eating disorders will have their needs met through the provision of appropriate integrated and quality services delivered by a range of public, private and non government agencies”.

Dr Margaret Honeyman QSO
Chief Psychiatrist
SA Health
Executive Summary

This proposed service model describes, at a macro level, the ideal continuum of care for Statewide Specialist Eating Disorders Services in South Australia.

The proposed model is a result of a project commissioned by SA Health, and has been informed by national and statewide reviews, as well as workshops and interviews with key stakeholders, including consumers, carers and clinicians. In developing this framework, best practice guidelines and the evidence base have been reviewed and incorporated into the description of the proposed service model.

There have been some highly divergent views in terms of what model would best work in the South Australian context, but in essence, all stakeholders were keen to see a broader range of specialist services available across the spectrum, and this proposed service model attempts to reflect the range of perspectives expressed.

Eating disorders are highly complex illnesses, with significant psychological and medical consequences. Presentation of eating disorders varies amongst consumers, and treatment requires a sustained, flexible and multidisciplinary approach. Defining a statewide service model is complex, and a number of challenges have been identified as part of this project. However, recommendations for the future directions for statewide specialist eating disorders services are clear:

- The sector is committed to providing high quality services for clients with eating disorders. It is accepted that once the proposed service model is agreed and endorsed, this will be followed by an action and implementation plan, associated with a detailed budget.

- In essence, it is recommended that a specialist statewide service is established that operates in a highly responsive manner across the sector, providing assessment, treatment, consultation and liaison, supervision, support and outreach to the range of hospital and community based services.

- This proposed service model recommends enhanced specialist eating disorder services across the spectrum of:
  - Promotion and prevention
  - Early intervention
  - The range of treatment and support options that focus on recovery as an outcome.

- Extra capacity and resources will need to be allocated to expand the range of services available and improve access to specialist eating disorder services across the state, in particular the introduction of day programs and the creation of a specialist, across all ages, eating disorder service, described as a ‘one stop shop’.

- There is support to ensure services and interventions to support families and carers are improved, ranging from dedicated and tailored workshops as well as coaching and strategies to reduce stress and distress for families caring for a person with an eating disorder.

- Opportunities exist for gains in both primary and secondary care, however these will require an ongoing commitment to support change over time.
• There is a need to provide training and support for General Practitioners, often the first point of access to services.

• Access to services is often compromised and not equitable if an individual is unable to engage with allied health services (such as psychologists and dietitians) via the private sector. The current cap of 5 – 12 sessions for allied health interventions via Medicare is also a limitation which impacts on the ability to access ongoing treatment.

• Service development at a tertiary level must be addressed as a priority, as it currently frequently results in people becoming very unwell before accessing specialist services and sometimes choosing to travel interstate to explore treatment options.

• Promotion and prevention strategies that are informed by evidence must be adopted by the sector to ensure consumers, carers, professionals and the public know the services and options available and how these can be accessed, across all stages of the continuum.

• Attention must be given to integrating services across the sector and state, particularly focusing on early intervention.

• A ‘hub and spoke model’ will provide increased specialist expertise and support for both generalist services and rural and remote areas. This needs to be supported by active use of telemedicine options such as video-conferencing and teleconferencing as part of an outreach service.

• Upskilling of the workforce will be required across all areas of the continuum, and this will require formal training in evidence informed therapies and interventions for eating disorder management particularly in the acute, maintenance and recovery phases, including relapse prevention planning.

• There is also an identified need to work more closely with the range of associated professions or services (e.g. schools, dentists, fitness industry) to provide education and awareness of eating disorders.

• A commitment to ongoing research and workforce development is required to continue to build knowledge of and application of best practice treatment models and interventions.

This model proposes a high level, statewide approach that allows flexibility for locally based services to adapt according to their specific needs. This also aligns with a ‘hub and spoke’ model, where specialist services sit at the centre operating as the ‘hub’ and generalist services operate as the ‘spoke’.

Once the proposed service model is adopted by SA Health, it will need to be adequately resourced and then implemented incrementally, cognisant of the required workforce development needs and the culture shift which will be required from current practice models.
Table of Contents

Acknowledgments................................................................................................................................. 2
Foreword from The Chair .......................................................................................................................... 3
Executive Summary ................................................................................................................................. 4
Table of Contents ................................................................................................................................... 6
Acronyms .................................................................................................................................................. 8
Introduction ............................................................................................................................................ 9
The National Context ............................................................................................................................... 10
The South Australian Context .................................................................................................................. 11
Project Overview ..................................................................................................................................... 11
Project Objectives .................................................................................................................................. 12
Approach .................................................................................................................................................. 12
Eating Disorders ..................................................................................................................................... 12
  What causes eating disorders? .................................................................................................................. 13
  Prevalence and burden of disease .......................................................................................................... 13
  The Impact of Eating Disorders on Parents and Carers ....................................................................... 14
  Support for Parents and Carers .............................................................................................................. 15
Classifications of Eating Disorders ........................................................................................................ 15
Clinical guidelines .................................................................................................................................... 16
  Anorexia Nervosa (AN) .......................................................................................................................... 17
    Description ........................................................................................................................................... 17
    Diagnostic criteria for Anorexia Nervosa (DSM IV) ............................................................................ 17
    Treatment for Anorexia Nervosa (AN) ................................................................................................. 18
    Children and Adolescents with Anorexia Nervosa ............................................................................ 19
  Bulimia Nervosa (BN) ............................................................................................................................ 20
    Description ........................................................................................................................................... 20
    Diagnostic criteria for Bulimia Nervosa (DSM IV) ............................................................................. 20
    Treatment for Bulimia Nervosa (BN) ................................................................................................. 21
    Children and Adolescents with Bulimia Nervosa .............................................................................. 21
  Eating Disorders Not Otherwise Specified (EDNOS) .......................................................................... 21
    Description ........................................................................................................................................... 21
    Treatment for Eating Disorders Not Otherwise Specified (EDNOS) .................................................. 22
Proposed Eating Disorders Service Model ............................................................................................... 22
  Vision Statement ...................................................................................................................................... 22
Guiding Principles ..................................................................................................................................... 23
Current Service Delivery .......................................................................................................................... 24
  Weight Disorder Unit ............................................................................................................................. 24
  Utilisation Data ....................................................................................................................................... 25
Flinders Medical Centre Paediatric Ward ................................................................................................. 31
Women’s and Children’s Hospital – Eating Disorders Program ............................................................. 31
  Utilisation data ......................................................................................................................................... 32
Women’s Health Statewide ...................................................................................................................... 33
Flinders University Services for Eating Disorders .................................................................................... 33
Private Services ......................................................................................................................................... 34
  Psychiatry ................................................................................................................................................ 34
  Psychology Services ............................................................................................................................... 34
  Dietitians ................................................................................................................................................ 34
  Error! Bookmark not defined.
Non Government Organisations .......................................................................................................35
ACEDA ...........................................................................................................................................36
Lifehouse Australia (SA) ................................................................................................................36
The Proposed Future Model .................................................................................................................36
Key components of the continuum ..................................................................................................37
Responsibility Matrix ........................................................................................................................39
Referral Pathway ...............................................................................................................................41
Services across the Continuum .............................................................................................................42
Generalist Services ............................................................................................................................42
Eating Disorder Liaison Clinicians ..................................................................................................42
Medical Inpatient Services ...............................................................................................................42
Child and Adolescent Inpatient Services .........................................................................................43
Specialist Eating Disorders Services ..............................................................................................44
Specialist Eating Disorders Service ................................................................................................44
Specialist Eating Disorders Team ..................................................................................................44
Bed based program .......................................................................................................................45
Day Program Services ...................................................................................................................47
Hub and Spoke model ....................................................................................................................48
Training needs ...................................................................................................................................48
Summary ...........................................................................................................................................49
Appendix One – Previous Reviews ........................................................................................................50
Southern Adelaide Health Service - Review of the Weight Disorder Unit .......................................50
Review of The Eating Disorders Program – Women’s and Children Hospital .............................51
Body Image and Eating Disorders Project .......................................................................................52
Appendix Two: Project Reference Group Membership ........................................................................53
Appendix Three: Contributors and Workshop Participants ..........................................................54
Appendix Four – ANZAED Position Statement for Inpatient Eating Disorders ..............................58
Appendix Five: References ....................................................................................................................60
**Acronyms**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
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<tr>
<td>AMH</td>
<td>Adult Mental Health</td>
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<td>AN</td>
<td>Anorexia Nervosa</td>
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<td>AOD</td>
<td>Alcohol and Other Drugs</td>
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<td>APA</td>
<td>American Psychiatric Association</td>
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<tr>
<td>BN</td>
<td>Bulimia Nervosa</td>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<tr>
<td>CBT</td>
<td>Cognitive Behaviour Therapy</td>
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<td>C&amp;Y</td>
<td>Child and Youth</td>
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<td>CYWHS</td>
<td>Children, Youth and Women’s Health Service</td>
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<td>CNAHS</td>
<td>Central Northern Adelaide Health Service</td>
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<td>DBT</td>
<td>Dialectic Behaviour Therapy</td>
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<td>EDNOS</td>
<td>Eating Disorder Not Otherwise Specified</td>
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<td>EOED</td>
<td>Early Onset Eating Disorder</td>
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<td>FMC</td>
<td>Flinders Medical Centre</td>
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<td>FTE</td>
<td>Full Time Equivalent</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>MDT</td>
<td>Multidisciplinary Team</td>
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<td>MH</td>
<td>Mental Health</td>
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<td>NGO</td>
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<td>National Institute for Clinical Excellence</td>
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<td>Royal Australian and New Zealand College of Psychiatrists</td>
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<td>WCH</td>
<td>Women’s and Children’s Hospital</td>
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<td>WDU</td>
<td>Weight Disorder Unit</td>
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Introduction

This document describes, at a macro level, the ideal continuum of care for statewide specialist eating disorders services in South Australia.

It is the result of a project commissioned by SA Health, and has been informed by national and statewide reviews, as well as workshops and interviews with key stakeholders, including consumers, carers and clinicians.

In developing this framework, best practice guidelines and the evidence base have been reviewed and incorporated into the description of the proposed service model.

Eating disorders are highly complex illnesses, with significant psychological and medical consequences. Presentation of eating disorders varies amongst consumers, and their treatment requires a sustained, flexible and multidisciplinary approach. Defining a statewide service model is complex, and a number of challenges have been identified as part of this project. However, future directions for statewide specialist eating disorders services are clear:

- Extra capacity and resources should be allocated to expand the range of services available and improve access to eating disorder services across the state.
- Priority should be given to the establishment of a day program and a specialist community based eating disorders service.
- Opportunities exist for gains in both primary and secondary care, however these will require ongoing commitment to support change over time.
- Service development at a tertiary level must be addressed as a priority, as it currently frequently results in people becoming very unwell before accessing specialist services and sometimes choosing to travel interstate to explore treatment options.
- Promotion and prevention strategies that are evidence based must be adopted by the sector to ensure consumers, carers, professionals and the public know the services and options available and how these can be accessed, across all stages of the continuum.
- Attention must be given to integrating services across the sector and state, particularly focusing on early intervention.
- A ‘hub and spoke model’ will provide increased specialist expertise and support for rural and remote areas.
- Upskilling of the workforce will be required across all areas of the continuum.
- A commitment to ongoing research is required to continue to build knowledge of and application of best practice treatment models and interventions.

When the proposed service model is adopted by SA Health, it will need to be adequately resourced and then implemented incrementally, cognisant of the required workforce development needs and the culture shift which is required from current practice models.
The National Context

Nationally the Australian Government has a number of initiatives focusing on specialist Eating Disorder Services. In October 2008 the Minister for Health and Ageing, the Hon Nicola Roxon MP, announced up to $500,000 to establish a National Collaboration on Eating Disorders to help develop a comprehensive, coordinated national approach to eating disorders. This collaboration has brought together eating disorder experts in research, education, health promotion, public health, mental health and the media. The aim of the collaboration is to assist with the development of a comprehensive and coordinated national approach to the prevention and treatment of eating disorders.

Subsequently, in March 2009 the Minister for Youth, the Hon Kate Ellis MP, announced the establishment of a new National Advisory Group on Body Image. The Advisory Group was tasked with developing a new Voluntary Code of Conduct on Body Image and provide advice to the Government on a national response. In October 2009 the Advisory Group presented the Minister with the proposed National Strategy on Body Image, which contained 16 recommendations, ranging for supporting a national and strategic approach, to endorsing a Voluntary Industry Code of Conduct on Body image.

In March 2010, the National Eating Disorders Collaboration, led by the Butterfly Foundation developed a National Framework “Eating Disorders: The Way Forward” which provided an evidence based and sector informed overview to guide the development of responses to the promotion, prevention and treatment of Eating Disorders in Australia. As the first National Framework for Eating Disorders, this report identified a range of evidence based strategies that could contribute to a reduced incidence of eating disorders in Australia and increased availability of effective treatment and support to enhance the health and quality of life of people who have an eating disorder. The full suite of guidance documents includes:

- Eating Disorders Prevention, Treatment and Management: An Evidence Review
- Eating Disorders Information and Support for Australians

The National Framework has been developed around four key aspects of the continuum of care:

- Promotion and Prevention
- Identification and Early Intervention
- Treatment Standards and Strategies
- Consumers and Carers.

Over 2010 – 2013, the National Eating Disorders Collaboration has been funded a further $3 million by the Federal Government in order to further work across the following working groups:

- National Standards Working; Prevention and Early Intervention; Social Messaging; Professional Development; Information and Resources; Collaboration and Membership; Consumer and Carers; as well as a Clinical Reference and Youth Reference Group.

These strategic documents and initiatives have been reviewed as part of this project and provided a useful guide to inform the development of eating disorders services within the South Australian context. Any future developments in the South Australian context should take into account the guidelines and resources developed as part of the national process.
The South Australian Context

There have been a number of previous attempts to review and improve Eating Disorder services in South Australia. In 2007, an Eating Disorder Service Review and an internal review of the Weight Disorder Unit were conducted by Southern Mental Health. Additionally, in 2007 an external review was undertaken of the Eating Disorders Program at the Women and Children’s Hospital. Whilst both of these reviews led to some internal changes, not all of the recommendations were fully adopted. A summary of the recommendations of these reviews is contained in Appendix One.

In November 2007 a Body Image Roundtable was attended by key clinicians and related workforce groups interested in developing South Australia’s response to eating disorders, poor body image and unhealthy weight. A key recommendation from the Roundtable Forum included the development of a proposal to scope existing services and issues for the prevention and treatment of eating disorder and poor body image in South Australia.

An additional report from the Thinker in Residence, (Kickbusch, May 2008) highlighted the importance of incorporating the whole spectrum of eating disorders when developing strategies and programs targeting healthy weight. It recommended that all programs concerned with healthy weight issues take body image into account. While recognising that strategies such as South Australia’s “Eat well, be active Healthy Weight Strategy” have been developed to address the increase in body weight of the population, consideration of the impact of these strategies on people’s negative body image needs to be taken into account in future planning activities.

In 2009 the Mental Health and Health Promotion branches of the Department of Health agreed to jointly fund a nine month Body Image and Eating Disorders Project. The objectives of this project were to develop a statewide report for consideration by the Director, Mental Health Operations providing recommendations for the prevention and treatment of eating disorders and positive body image for South Australians, ensuring that age, gender and cultural considerations be taken into account.

The Body Image and Eating Disorders Project Final Report contained nine recommendations and was presented to the Mental Health Executive in March 2010. (A summary of the recommendations is contained in Appendix One). Feedback on this report indicated there was a need to refine the recommendations, and in particular define the service model for the state. A clearly articulated future service model was required that would be in line with best clinical practice. Subsequently an external consultant was engaged to undertake this piece of work.

Project Overview

The focus of this project has therefore been to build on previous reviews and work undertaken to inform the development of a service model for the delivery of statewide specialist eating disorder services within South Australia.

This project focused on those services funded by the Department of Health and is inclusive of services currently provided by Public health services including the Flinders Medical Centre Weight Disorder Unit, the Women and Children’s Hospital – Eating Disorder Program, as well as other services provided privately.
Project Objectives

The overarching objective of this project was to propose a future service model which describes the ideal framework for statewide specialist eating disorder services within South Australia. This includes:

- Describing the underlying philosophy and key components of a future service model eating disorder services.
- Making recommendations about areas of future investment into for eating disorder services.
- Ensuring that the proposed model of service delivery is consistent with national and international directions in relation to contemporary and agreed best practice for eating disorder services.

This framework considers the needs of young people (under 18 years) and adults, and is inclusive of generalist and specialist services. The proposed service continuum includes a description of the key components of the model, including a high level service description that could be used to inform enable costing as part of the implementation phase.

Approach

The SA Department of Health engaged an external consultant, whose work was overseen by the Project Manager, Review of Statewide Specialist Eating Disorder Services within South Australia.

A Project Reference Group was established to provide guidance, advice, strategic leadership and operational and service expertise. Membership of the Project Reference Group is provided in Appendix Two. Meetings, workshops and interviews with a range of key stakeholders were undertaken as part of a broad consultation process, resulting in more than 150 participants sharing their perspectives on what would constitute the ideal service model for statewide specialist eating disorders services for South Australia (Refer to Appendix Two).

Additionally, a number of national and state documents, strategies and reviews informed the development of this proposed model.

Eating Disorders

Eating disorders are a group of psychiatric disorders that involve a poor body image, abnormal eating behaviours, overemphasis on the importance of weight and shape, and the use of extreme weight control behaviours (Watson & Elphick 2009). Eating disorders are highly complex mental illnesses that also involve significant physical impairment and medical complications. They are often severe and debilitating, affect predominantly young women, and have significant consequences for physical health and quality of life.

The following section provides an overview of eating disorders including:
- Causes
- Prevalence and burden of disease
- The impact of eating disorders on Parents and Carers
- Classifications of eating disorders (including diagnostic criteria)
- Treatment.
What causes eating disorders?

Eating disorders are often complex and chronic disorders. There are many risk factors that have been identified in contributing to the development of eating disorders. Some of these include:

- Genetic/biological factors
- Low self esteem
- Perfectionism
- Obsessionality
- Depression
- Body dissatisfaction
- Appearance teasing
- Need for external approval
- Environmental factors: media, family, friends, peers.

Research undertaken at Flinders University has found that perfectionism and self esteem, in addition to concerns about weight and shape, significantly increase the likelihood of someone developing BN (Steele, Corsini & Wade, 2007).

The media and fashion industries are often cited as contributing to an increase in social pressure (especially on young women and men) to look a certain way. For women thinness is the dominant ideal they are most often aspiring to whereas for men, a lean and muscular body is seen as the most desirable. Among adolescents there has been an increase in dieting behaviour in both young women and men and while not all people who diet develop an eating disorder it is considered a clear risk factor (Cooke & Sawyer, 2004).

Prevalence and burden of disease

Consistent data measuring the prevalence of eating disorders is difficult to find. Accurate data is made even more difficult as people often deny they have an eating disorder or delay seeking treatment. A recent study measuring the prevalence of lifetime eating disorders in an adult Australian twin cohort found a 1.9% lifetime prevalence of AN, with an additional 2.4% who met the criteria for ‘partial AN’ (absence of amenorrhea). Of the women in the cohort, 2.9% met the criteria for BN, an additional 2.9% of women met the criteria for binge eating disorder (Wade et al., 2006). These results are consistent with other research.

A study measuring the changes in community prevalence of eating disorder behaviour in South Australia over a ten year period found a significant increase in current regular use of all three eating disorder behaviours (binge eating, purging, strict dieting or fasting) in both women and men. It found that between 1995 and 2005 the increase in these behaviours was more than double. It also found that EDNOS (inclusive of binge eating disorder) was the most common diagnosis (Hay et al., 2008).

Lifetime prevalence rates in women are 4.3% for AN and partial syndrome AN, and 4 – 7% for BN (Madden et al., 2009). Onset is primarily during adolescence, when eating disorders are the third most chronic illness in women. Eating disorders have the highest lifetime mortality rate of any psychiatric disorder (up to 20%) and mortality rates are 12 times higher for women with an eating disorder than for unaffected women. For females between the ages of 15 – 24 Bulimia Nervosa and Anorexia Nervosa were the 8th and 10th leading causes of the burden of disease. This is consistent with South Australian burden of disease data.
A recent national study on The Burden of Eating Disorders in 5 – 13 year old children in Australia (Madden et al., 2009) reported an annual incidence rate for Early Onset Eating Disorders (EOED) of 1.4 per 100,000 children from a cohort of 101 children who were managed either as outpatients or in hospital for EOED. Given this was the first prospective study of its kind, a conclusion was not drawn as to whether or not the incidence of eating disorders in younger children is increasing, but it does stress that it is imperative research attention should be directed towards understanding why such young children are developing severe eating disorders and how effective identification treatment can be targeted earlier.

In adults, outcomes are poor – less than 50% of adults recover within 5 years of diagnosis. In children, evidence-based treatments, including Maudsley family therapy, have improved recovery rates to 70% after 12 months and 90% after 5 years (Madden et al., 2009).

The Impact of Eating Disorders on Parents and Carers

There have been a number of studies conducted in recent years on the impact of eating disorders on parents, family members and other carers. Living with and caring for a person with an eating disorder can be a very stressful experience for parents, carers, siblings and other family members and friends. There are several common themes that have emerged from recent studies on carers. Difficulties cited as common experiences for carers included being left out of the treatment process, lack of information about eating disorders; and where to find help and feeling they are being blamed for their child (in most cases their daughter) developing an eating disorder (Highet & Thompson, 2004; McMaster et al., 2004).

For many parents and carers, being excluded from the treatment process is described as very frustrating and distressing. Many parents have found they are not kept informed about treatment options and progress and were not able to provide any input or have their role as primary carers valued (Highet & Thompson 2004, Honey et al 2008). Parents want to be included in the treatment of their children and there in growing evidence of the importance of this, especially in young children and adolescents. The NICE guidelines recommend the involvement of family in the treatment of children and adolescents with an eating disorder (NICE 2004).

A lack of information, amongst the general public as well as health professionals has been identified by carers as a barrier to early detection of eating disorders and the ability to find appropriate help.

For many parents, accessing information about eating disorders was frustrating, time consuming and confusing (Hight & Thompson 2004). Information that parents have identified as being useful is general information about eating disorders and their impact on the individual as well as the family, why their child is behaving in certain ways, advice about strategies to use at home, post-discharge planning and follow up, coping strategies and positive ways to think about the illness and counselling and support options for parents (Honey et al 2008).
In addition, eating disorders can often have a significant impact on the family unit. The increased stress can have a negative effect on family relationships, meals and food choices can be severely disrupted as well as the general routine of the family. Social interaction can also be affected both with members of the family unit as well as the extended family and friends (Hillege, Beale & McMaster 2006).

Support for Parents and Carers
As noted above, eating disorders can often have a significant impact on the family unit. Carers frequently report that they often lack the skills and resources required to care for their family member or friend with an eating disorder (Treasure, J. 2008). This concern was also echoed by family members and carers via workshops and meetings as part of the consultation phase of this project.

Understanding the family context is important due to the impact of the illness on the family. In eating disorders, the study of caregiving distress is an evolving area (Kyriacou et al., 2007). A recent study on understanding how parents cope with someone with AN found that over 70% of carers scored at or above the suggestive threshold for anxiety, and 38% for depression. Over 50% of carers scored at or above the clinical score for anxiety and 13% for depression. In considering the range and mix of services for the proposed statewide model of care, attention must be paid to the need to address this.

In light of the severity of the illness and the impact on carers and families, it is becoming increasingly recognised that professionals need to address carer needs and provide families with the resources necessary to enable caregiving as well as help create a familial environment which is conducive to positive changes in the familial environment (Kyriacou et al., 2007).

In order to equip the family with feelings of empowerment and the resources to support their family member in the treatment setting, the family must be regarded as a key resource, and be included and valued in the treatment process. The Maudsley model for working with families suggests building an alliance between the carers, client and MDT, and to educate both the clients and carers about the illness. To support this, a new approach has been developed and evaluated that demonstrates positive results in equipping carers with the skills and knowledge to be a ‘coach’ and help the person with an eating disorder break free from the traps that block recovery (Treasure, J. 2008). The approach includes both workshops and self help interventions for carers, and should be considered as a key component of the mix of services and support options made available for carers of people with an eating disorder.

In developing this proposed statewide model of care, there is support to ensure services and interventions to support families and carers are improved, ranging from dedicated and tailored workshops as well as coaching and strategies to reduce stress and distress for families caring for a person with an eating disorder.

Classifications of Eating Disorders
There are several types of eating disorders, and this model focuses primarily on people diagnosed with:

- Anorexia Nervosa
- Bulimia Nervosa and
- Eating Disorders Not Otherwise Specified (which includes Binge Eating Disorder).
Anorexia Nervosa (AN) and Bulimia Nervosa (BN) are the most widely known and understood eating disorders. They both occur predominantly among women (approximately 90%) and for both AN and BN clients over evaluate their weight and shape and their self worth is based largely on this and their ability to control it (Fairburn & Harrison, 2003).

People with eating disorders often have significant co-morbidities. Depression and anxiety are highly prevalent (Russell, Fuscaldo & Ealey, 2008) however other common comorbidities include Obsessive Compulsive Disorder, Borderline Personality Disorder, Post Traumatic Stress Disorder, suicidality and drug and alcohol misuse.

There are many myths and misconceptions surrounding eating disorders. These include the notions that eating disorders are a ‘cry for attention’, dieting gone wrong, caused by vanity, and just a phase (Watson & Elphick, 2009). The impact of these attitudes means that people with eating disorders may delay seeking help or may be misdiagnosed. Both of these are common occurrences.

Clinical guidelines
There are several international clinical guidelines relevant to the treatment of eating disorders that have informed this proposed service model. These include:

- Royal Australian and New Zealand College of Psychiatrists (RANZCP 2004) Clinical Practice Guidelines for the Treatment of Anorexia Nervosa
- National Institute for Clinical Excellence (NICE 2004) Clinical Guidelines

In addition, there are a number of guidelines from associated fields relevant to the treatment of eating disorders. These include:

- Dietitians Association of Australia (DAA) Practice Recommendations for the Nutritional Management of Anorexia Nervosa in Adults (2009)

Perspectives vary on the ideal mix, match, range and type of treatment interventions for eating disorders, therefore this proposed model has been informed by expert clinical opinion, consumer and family views and clinical best practice guidelines.

Clinical practice guidelines are systematically developed statements that assist clinicians and clients in making decisions about appropriate treatment for specific conditions. They are derived from the best available research evidence, using predetermined and systematic methods to identify and evaluate the evidence relating to the specific condition in question. Where evidence was lacking, the guidelines have generally be developed incorporating statements and recommendations based upon the consensus statements developed by an expert guideline development group.

Guidelines are not a substitute for professional knowledge and clinical judgment, but can be used as the basis to set standards to assess the practice of health care professionals as well as:
• Form the basis for education and training of health care professionals
• Help to assist consumers and carers in making informed decisions about their treatment and care
• Improve communication between health care professionals, consumers and carers.
• Help identify priority areas for further research.

Although the quality of research in eating disorders is variable, the methodology used to develop the guidelines used to inform this proposed model reflects current international understanding on the appropriate practice for core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders.

It should also be noted that a large scale evidence review has been conducted as part of the previously mentioned National Eating Disorders Collaboration. This review incorporates the prevention and management of eating disorders and was presented to the Australian Government Department of Health and Ageing in December 2009. This report does not replicate this work, but has been significantly guided by the national frameworks and positions.

Anorexia Nervosa (AN)

Description
The symptoms of AN include weight loss which is maintained at below normal levels for age and height. This is a result of restriction of food intake and for many over exercising.

Some people with AN also use self-induced vomiting and misuse laxatives (Fairburn & Harrison, 2003). There is a high level of co-morbidity associated with AN including depression and anxiety, irritability, impaired concentration and obsessive behaviour (Fairburn & Harrison, 2003). Clients also tend to become socially isolated and withdrawn. AN usually starts in mid teenage years and for some is short-lived and only requires a brief intervention. For others the disorder becomes more entrenched and intensive treatment is required. AN has the highest mortality rate of any psychiatric disorder in young women, with suicide being the most common cause of mortality (Birmingham et al, 2005). For young women AN is particularly serious and is associated with 12 times the annual death rate for all causes of death for females aged 15 – 24 years in the general population (Sullivan, 1995).

A recent national study on the burden of eating disorders in 5 – 13 year old children in Australia (Madden et al., 2009) identified limitations in applying DSMIV criteria for anorexia nervosa to young children; reported a higher proportion of boys affected by early onset eating disorders (EOED) than men, and described the significant psychological comorbidity and high frequency of hospitalisation associated with EOED. Potentially life-threatening medical complications were common at presentation, suggesting possible missed diagnosis and a need for education of health professionals. The study underlined the severity of EOED and highlighted the need for joint medical and psychiatric specialist management.

Diagnostic criteria for Anorexia Nervosa (DSM IV)

Experts advise that the DSMIV criteria are not always adequate for capturing the disorder. Trans-diagnostic models (Fairburn, 2005) and revised proposals for DSM-V are being examined in the international eating disorder fraternity. The current DSM- IV diagnostic criteria for AN is:
• Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g. weight loss leading to maintenance of body weight less than 85% of that expected)
• Intense fear of gaining weight or becoming fat, even though underweight
• Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight
• In postmenarcheal females, amenorrhea (i.e. the absence of at least three consecutive menstrual cycles), although it should be noted that this criterion will be removed in DSM-V.

Treatment for Anorexia Nervosa (AN)
There is a considerable lack of evidence for the treatment of AN with an exception of the treatment of children and adolescents where the Maudsley approach is often cited as best practice (NEDC 2010). This is partly due to the difficulties in conducting research in this area due to the low prevalence and high morbidity associated with AN. However, there are some aspects of treatment which are clear; the use of a multi disciplinary team is required for the most effective treatment of AN, medical complications need to be addressed and early identification is essential to enable the best outcomes. The involvement of family members in treatment for children and adolescents with AN is central.

The RANZCP, NICE and APA guidelines suggest a multidisciplinary team is required for optimal treatment of AN. Ideally the team would include a specialist in physical medicine (general practitioner, physician or paediatrician, depending on the patient’s age), psychiatrist, dietitian, nurses, and other allied health specialists such as psychologists, family therapists, social workers, occupational therapists and physiotherapists. Weight loss must be curbed if not reversed and treatment offered for physical problems associated with starvation. Baseline and repeated assessments are essential, including regular monitoring to vital signs, weight and dietary intake. In addition, dietary advice should be included in all treatment programs (RANZCP 2004).

For patients with AN which is not so severe as to require inpatient treatment, outpatient or day patient treatment may be suitable depending on the availability of appropriate services (RANZCP 2004). However, inpatient treatment or day patient treatment should be considered for people with AN whose disorder has not improved with outpatient treatment or for whom there is a significant risk of suicide, self-harm or high or moderate physical risk (NICE 2004). For people requiring inpatient treatment this should be provided within reasonable distance from their home to enable the involvement of family, carers and friends and avoid difficulty in transition between primary and secondary care services (NICE 2004).

Studies of consecutively admitted inpatients with anorexia nervosa found that “lenient” behavioural programs that use initial bed rest and the warning of returning the person to bed if weight gain does not continue are as effective as, and in some situations possibly more effective than, “strict” programs in which meal-by-meal caloric intake or daily weight is tied precisely to a schedule of privileges (e.g., time out of bed, time off the unit, permission to exercise or receive visitors). Some evidence suggests that the use of a supervised graded exercise program may be of benefit in the inpatient treatment of anorexia nervosa (APA Practice Guidelines 2010).

In relation to treatment approaches it is not clear whether one approach is more effective than another. The RANZCP guideline states that a consensus prevails that, particularly where after-care may be inadequate or unavailable, individuals should achieve close to normal weight as an inpatient.
Additionally, evidence suggests where this is not occurring there are higher rates of readmission. The evidence also clearly shows that outpatient CBT works much better once weight gain has been achieved in hospital settings.

There is also emerging data to support the use of CBT for adults (APA 2006). Good outcomes for outpatient CBT and other therapies ranges from 0-36% (McIntosh et al., 2005; Dare et al., 2001; Ricca et al., 2010); hospitalisation for weight gain alone also seems largely unsuccessful, where 30-50% of patients relapse within one-year of discharge (Channon, Desilva, Hemsley, & Perkins, 1989; Eckert, Halmi, Marchi, Grove, & Crosby, 1995; Pike, 1998), but the addition of follow-up outpatient CBT where patients have gained weight in hospital has a relapse rate over the 12-month period of only 22% (Pike, Walsh, Vitousek, Wilson, & Bauer, 2003). This evidence may be relevant across both inpatient and day patient treatment settings but to date the work has been done in relation to inpatient settings.

**Children and Adolescents with Anorexia Nervosa**

In relation to the treatment of children and adolescents, all three guidelines indicate the value of including family therapy for children and adolescents, using an approach where families become actively involved in a blame-free atmosphere, in helping patients eat more and resist compulsive exercising and purging (APA 2006). The RANZCP guidelines, while acknowledging the value of family therapy for children and adolescents, do not recommend a specific approach (RANZCP 2004). The NICE guidelines also recommend the inclusion of carers in any dietary education and meal planning for children and adolescents (NICE 2004). They recognise the need for children and adolescents to be admitted to age-appropriate facilities which have the capacity to provide appropriate educational and related activities (NICE 2004).

The NICE practice guidelines (NICE 2004) note that for children and adolescents' with anorexia, of particular importance, is the involvement of families and carers. Support from education and peers may also involve a role in recovery. Specifically:

- In nutritional management of children and adolescents with AN, carers should be included in any dietary education or meal planning.
- Admission of children and adolescents with AN should be to age appropriate services (with the potential for separate children and adolescent services) which have the capacity to provide developmentally appropriate treatment interventions and support.
- Family members, including siblings, should normally be included in the treatment of children and adolescents with eating disorders. Interventions may include sharing of information, advice on behavioural management and facilitating communication.
- Children and adolescents should be offered individual appointments with a health care professional separate from those with their family members or carers.
- Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia.
- In children and adolescents with AN, the need for inpatient treatment and urgent weight restoration should be balanced alongside the social and educational needs of the young person.
- In children and adolescents with eating disorders, growth and development should be closely monitored - where development is delayed or growth is stunted despite adequate nutrition, paediatric advice should be sought.
There is a small but consistent evidence base, which indicates that family based treatments are important in the treatment of adolescents with anorexia nervosa (Nice 2004). Consensus as to what constitutes the best form of family intervention has not been achieved, but two factors stand out as potentially important. They are:

- Family interventions should have a focus on the eating disorder and how this impacts on family relationships, emphasising in the early stages of treatment the necessity for parents to take a central role in supporting their child’s efforts to eat.
- Both separated (parents and child meet separately with the therapist) and conjoint forms (parents and child together with the therapist) of family therapy may be beneficial.

Establishing a collaborative working relationship with families with a young person with anorexia nervosa presents a particular challenge that requires time and expertise to balance the competing needs of different family members. However, whilst there is an emphasis on family interventions, the young person’s rights and responsibilities must not be overlooked. Issues such as confidentiality and consent must be considered carefully and not simply overridden by clinicians or parents. For this reason, young people should be offered individual appointments with a therapist separate from those with their family members or carers. For children and adolescents, it is also particularly important to ensure adequate physical monitoring and rapid commencement of treatment.

**Bulimia Nervosa (BN)**

**Description**

Bulimia Nervosa is characterised by episodes of food binge eating and purging and people with bulimia nervosa can develop severe and dangerous metabolic disturbances when purging behaviour is vigorous.

Unlike AN, for people with BN their body weight may not be noticeably low. People with BN usually feel ashamed or are distressed by their lack of control over their eating and are therefore easier to engage in treatment than AN. However there is usually a delay of many years in seeking help. There is a subgroup of sufferers of BN who engage in substance misuse and self harm (Fairburn & Harrison, 2003).

**Diagnostic criteria for Bulimia Nervosa (DSM IV)**

An episode of binge eating is characterised by the following:

- Eating, in a discreet period of time (e.g. within a 2 hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
- A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas or other medications; fasting; or excessive exercise.
- The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for 3 months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of Anorexia Nervosa.
Treatment for Bulimia Nervosa (BN)

The great majority of people with bulimia nervosa can be treated in an outpatient setting and it is considered there is a very limited role for the inpatient treatment of bulimia nervosa, unless a primary concern is the management of suicide risk or severe self harm (NICE 2004). As a first possible step, people with bulimia nervosa should be encouraged to follow an evidence-based self help program. Healthcare professionals should consider providing direct encouragement, guidance and support to people undertaking an evidence-based self help program as this may improve outcomes. This may be sufficient treatment for a limited subset of clients. As an alternative or additional first step to using an evidence-based self help program, adults with BN may be offered a trial of an antidepressant drug.

Cognitive behaviour therapy for bulimia nervosa (CNT-BN), a specifically adapted from of CBT should be offered to adults with bulimia nervosa. The course of treatment should be for 16 – 20 sessions over 4 to 5 months (NICE 2004). When people with BN have not responded to, or do not want CBT, other psychological treatments should be considered.

Children and Adolescents with Bulimia Nervosa

NICE guidelines (2004) recommend that adolescents with BN may be treated with CBT-BN adapted as needed to suit their age, circumstances and level of development. Again, for children and adolescents, family therapy should be considered whenever possible (APA 2006).

Eating Disorders Not Otherwise Specified (EDNOS)

Description

EDNOS refers to other types of disordered eating which does not fulfil the diagnostic criteria for AN or BN. Behaviours may include severely restricting food intake, over exercising and binge eating and purging. Many have had AN or BN in the past (Fairburn & Harrison, 2003) and some may go on to develop either AN or BN in the future. This is the most common form of eating disorders. Eating Disorders Not Otherwise Specified (DSM IV) is characterised by the following:

- For females, all of the criteria for Anorexia Nervosa are met except that the individual has regular menses.
- All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual’s current weight is in the normal range.
- All of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory behaviours occur at a frequency of less than twice a week or for a duration of less than 3 months.
- The regular use of inappropriate compensatory behaviour by an individual of normal body weight after eating small amounts of food.
- Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
- Binge eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviours characteristic of Bulimia Nervosa.

In the absence of evidence to guide the management of atypical eating disorders (EDNOS) other than binge eating disorder, it is recommended the clinician considers following the guidance on the treatment of the eating problem that most closely resembles the individual’s eating disorder (NICE 2004).
Treatment for Eating Disorders Not Otherwise Specified (EDNOS)
There is a lack of evidence to guide the management of EDNOS (other than binge eating disorder). However, for adults with Binge Eating Disorder, Cognitive Behavioural Therapy that has been specifically adapted (CBT-BED) should be offered (NICE 2004). There is also evidence to support the efficacy of self-help and guided self-help CBT programs as an initial step (APA 2006).

Proposed Eating Disorders Service Model
Significant discussions and workshops have occurred with service providers and special interest groups to assist in both agreeing to and describing the pathway of care within the service model for statewide specialist eating disorders services.

The following section details the guiding principles that should underpin service delivery, describes the key components of the service model and provides an overview of the suggested roles and functions of teams involved in various aspects of service delivery across the continuum of care.

Vision Statement

“To develop a system of care in the state of South Australia that is accessible, equitable, appropriate, integrated and comprehensive, ensuring that people affected by eating disorders will have their needs met through the provision of appropriate integrated and quality services delivered by a range of public, private and non government agencies”. 
## Guiding Principles

The following have been proposed by the sector for a comprehensive suite of principles (not in order of priority) underpinning the delivery of eating disorder services across the continuum of care:

<table>
<thead>
<tr>
<th>The consumer and their families/caregivers are at the centre</th>
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<tbody>
<tr>
<td>Access to a wide range of local and community services, that sit alongside (and are supported by) secondary and tertiary services</td>
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<tr>
<td>Equity of access to and level of service between public and private sectors, regardless of geographical location or eligibility</td>
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<tr>
<td>Services are provided by the multidisciplinary team in partnership with the consumer and their family (including the early development of a comprehensive care /relapse prevention plan)</td>
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<tr>
<td>Services are guided by the aim of supporting each consumer towards long-term recovery, tailored to meet individual needs.</td>
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<tr>
<td>Services are provided as close to the consumers home as possible, taking into account the availability and location of specialist services (where these are needed)</td>
</tr>
<tr>
<td>Primary health practitioners have a crucial role in providing effective, evidence based early interventions and supporting consumers in their ongoing recovery</td>
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<tr>
<td>Services are delivered with the inherent values of:</td>
</tr>
<tr>
<td>• Accountability</td>
</tr>
<tr>
<td>• Integrity</td>
</tr>
<tr>
<td>• Confidentiality</td>
</tr>
<tr>
<td>• Support/empathy</td>
</tr>
<tr>
<td>• Recognise and treat as an individual with dignity and respect</td>
</tr>
<tr>
<td>Quality services are built on</td>
</tr>
<tr>
<td>• Evidenced informed practice</td>
</tr>
<tr>
<td>• Clinical experience, expertise and practise wisdom</td>
</tr>
<tr>
<td>• Responsiveness</td>
</tr>
<tr>
<td>• Commitment to recovery</td>
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<tr>
<td>• Research and evaluation</td>
</tr>
<tr>
<td>Staff will be supported to access a wide range of learning opportunities that inform innovation and build a competent and capable workforce.</td>
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<tr>
<td>Services are coordinated and integrated for seamless service delivery, ensuring easy transition between services (age and range) and continuity of care</td>
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<tr>
<td>Concurrent recognition of assessment and treatment of both psychological and physical needs</td>
</tr>
<tr>
<td>Services are appropriate for each service users age, gender and culture and provided in environments that minimise the risk of psychological and physical harm</td>
</tr>
<tr>
<td>Developmental needs of children and adolescents are recognised, and a commitment is made that services, wherever possible, are separate from adults</td>
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2 For many people, the concept of recovery is about staying in control of their life despite experiencing a mental health problem. Putting recovery into action in this context means focusing care on supporting recovery and building the resilience of people with eating disorders, not just on treating or managing their symptoms. There is no single definition of the concept of recovery for people with eating disorders, but the guiding principle is hope – the belief that it is possible for someone to regain a meaningful life, despite a serious eating disorder. Recovery is often referred to as a process, outlook, vision, conceptual framework or guiding principle. (adapted from http://www.mentalhealth.org.uk/help-information/mental-health-a-z/Recovery)
Current Service Delivery

Weight Disorder Unit

The Weight Disorder Unit provides outpatient and inpatient services. Specialised inpatient treatment programs are an integral part of ongoing multidisciplinary and psychotherapeutic management. The Weight Disorder Unit provides care for people who are unable to progress with treatment without tertiary specialist assistance. Weight Disorder Unit inpatient programs are offered to consumers on a voluntary, and rarely detained basis. They must be medically stable enough to leave an acute medical environment and have continued monitoring of physical conditions.

The Weight Disorder Unit with a combination of its adult, child, adolescent, psychiatrists and multidisciplinary staff members provide a consultation and liaison service across all areas of Flinders Medical Centre. Liaison with paediatric and adolescent medicine services, intensive care medical services, acute medical wards, general hospital wards and the Emergency Department provide a seamless integration for delivery of eating disorders care wherever the person may be in the hospital. An important role of the Weight Disorder Unit at Flinders Medical Centre is the provision of expert advice and liaison outside the hospital. General practitioners, specialists and non medical staff know that the Flinders Medical Centre will provide expert advice and assistance for managing consumers with eating disorders.

The Unit was established in 1977 and is a statewide service based in the Flinders Medical Centre. It has a specialist inpatient unit comprising six beds located on a general medical ward. The inpatient program consists of a two week assessment, a six week bed program (with the option of this being extended) and a target weight program. The inpatient programs are matched to an appropriate stage of motivation for individuals to be able to undertake specific tasks such as weight gain, controlling purging or progressing psychological work in a contained psychiatric environment.

The unit is staffed by a multidisciplinary team, and dedicated FTE funding (applied to a mix of inpatient and community/clinic work) was reported as being:

- 0.54 FTE – Social Worker
- 1.01 FTE – Clinical Nurse
- 1.01 FTE – Clinical Nurse Coordinator
- 0.4 FTE – Visiting Medical Specialist

As part of the multi-disciplinary team, dietician services (0.4 FTE), nursing, occupational therapy, psychiatric consultation and liaison are delivered via the general hospital services, and these roles are not currently funded as dedicated Eating Disorder Specialist FTEs.

Generally clients in the Weight Disorder Unit are female and over the 18 month period (July 2009 – Dec 2010, the average age of admission was 24.61 years. The WDU recognises that eating disorders often begin in early adolescence and exacerbate to a significant level of severity in late adolescence.

Service models struggle with the arbitrary cut off between children up to 18 and adults over 18 and there is the opportunity to recognise the value of providing continuity of care across the ‘youth spectrum’ of 15 – 25 years when people are transitioning between paediatric and adult services. As such, the WDU has accepted clients from 15 upwards so they can be treated by the same team and provided with continuity of care.
Referrals are generally made by a General Practitioner (GP) to the WDU and then by necessity seen by a specialist mental health clinician, usually a psychiatrist and other members of the MDT before they are offered admission to the Weight Disorders Unit.

Waiting lists vary and it can take up to six weeks to get an initial appointment for assessment, however all clients are triaged when they are initially referred and may be seen either immediately or within a period of days if their clinical condition is deemed urgent.

Clients have access to the multi-disciplinary team on an outpatient basis (which is the preferred and main treatment provided to the majority of clients, and the Community MH Nurses also run a fortnightly clinic at Elizabeth. Clients are only admitted to the inpatient programs if there has been a deterioration of their condition or if they have not been able to gain weight on an outpatient basis.

The Weight Disorder Unit also has a group program for inpatients and recently discharged outpatients who require brief additional support after discharge. There is one group run each day for five days a week and topics include relaxation, early warning signs, perfectionism, lunchtime cooking group, healthy eating and overcoming disordered eating. At the time of this project, staff and consumers reported that often these groups did not run daily due to staffing and capacity issues.

Consumers, carers and other stakeholders consulted as part of this project were supportive of reviewing the current model of service delivery to ensure a strengthened recovery focus as well as community based support following discharge from the service. In particular, it was felt the current bed based model should be reviewed to ensure best practice treatment interventions and models were in place, particularly around removing/reviewing restrictions on personal hygiene practices, allowing for education based activity to be continued and recovery based practice. Additionally, consumers and carers unanimously supported a transitional approach back into the community as part of discharge planning.

There was also strong support that, during an inpatient stay, the need for weight restoration should be balanced alongside the educational and social needs of the individual.

All stakeholders were clear that there is a need for inpatient/intensive residential beds as part of a comprehensive suite of services, and supported the extension of specialist eating disorders services to be available in the community. Examples of this include step-up/step-down services via day programs, outreach and residential services.

**Utilisation Data**

Systems used to record WDU activity include the metropolitan Adelaide mental health system CBIS, Flinders Medical Centre’s ATS Casemix system and a database designed in Excel. There is still activity going on to clarify these processes and some of the data included in this report, but it was considered the most accurate information that was available at the time of compiling this report.
In summary, utilisation is reported in 3 specific categories.

- The six bed inpatient ward with an average of 9.5 admissions per month (1 Jul – 31 Dec 2010),
- The outpatient clinic which sees an average of 55.9 clients per month (1 Jul – 31 Dec 2010), and
- A community based service with a client list of 198 (as at 18 May 2011)

**WDU Inpatient Unit**

The six bed inpatient ward is the only specialised inpatient treatment setting in South Australia. For the 18 month period to December 2010, the WDU had an average of 9.5 admissions per month (40.3% were first time admissions), with an average length of stay of 20.7 days (including trial leave days).

![Figure 1: Admissions and Discharges](image1)

![Figure 2: Average Length of Stay](image2)
Client Demographics
The graphs below describe the mix of inpatients admitted into the WDU ward. Information includes referral sources, gender, region of residence (current address, not necessarily at the time of admission), and average age at the time of admission.

Referral Sources
In the 18 month period to December 2010, the vast majority of referrals came from GPs (87%), with a small amount of referrals from families or self referral, mental health services, public hospitals.

Age at Admission
The average age at admission to the WDU for the 18 month period to December 2010 was 24.61 years.
Gender

For the 18 month period to December 2010, the vast majority of admissions to the WDU were female.

Region of Residence upon Discharge

Within the 18 month period to December 2010, the reported region of residence was on average:

- **South**: 47.6%
- **Country**: 14.1%
- **West**: 16.5%
- **East**: 8.54%
- **North/North-East**: 9.76%
- **Interstate**: 3.7%

Note: This represents location of residence as at 17 February 2011 and not necessarily at the time of admission
**WDU Outpatient Clinic**

The Outpatient clinic is held within the inpatient ward with services provided by consultants, mental health nurses, psychiatric registrars, dietitian and social work. They held an average of 55.9 consultations per month for the 18 month period to December 2010.

Data recording/collection is not as straightforward as the inpatient unit with a number of different reporting processes, and this continues to be a work in progress.

**WDU Community/Mobile Team**

The community or mobile team is based in the FMC Flats and provides services by consultants, registrars and mental health nurses. They had a current client list of 203 in January 2011. The average number of clients seen per month (for the 18 month period to December 2010) was 41.4.

**Current Clients and Contacts**

There are a number of clients who remain ‘active’, and the team are in the process of reviewing their lists and so the numbers will change. The number of contacts has been divided into ‘client participating’ in maroon and ‘non-participating’ in yellow.
WDU Community/Mobile Team Client Demographics
The average age of community clients (at January 201) was 27.83 years, ranging between 7 - 61 years of age. Of the 203 current clients at this time, 190 were female and 13 were male.

WDU Community Team Referral Sources
A snapshot of referral sources in January showed that 41.9% of referrals to the community team came from GP’s, 29.6% from inpatient settings and 19.2% from mental health facilities.

WDU Community Team Areas of Residence
A snapshot of clients in January showed a majority of clients came from the Southern suburbs and many from country areas.

<table>
<thead>
<tr>
<th>Region</th>
<th>% of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>South</td>
<td>44.1%</td>
</tr>
<tr>
<td>Country</td>
<td>19.3%</td>
</tr>
<tr>
<td>East</td>
<td>13.4%</td>
</tr>
<tr>
<td>West</td>
<td>10.9%</td>
</tr>
<tr>
<td>North/North-East</td>
<td>10.89%</td>
</tr>
<tr>
<td>Interstate</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

Figure 9: Community Team Referral Sources

Figure 10: Community team region of residence
Flinders Medical Centre Paediatric Ward

Young people requiring medical stabilisation are also admitted to the Paediatric Ward at Flinders Medical Centre. Further information is being sought on this service, including occupancy data and treatment interventions, and will be added to this report as this becomes available.

Women’s and Children’s Hospital – Eating Disorders Program

The Women’s and Children’s Hospital (WCH) provides inpatient and outpatient services to young people with eating disorders (up to the age of 18) and their families. Referrals can be made through several avenues including GP, parents, school, Child and Adolescent Mental Health Services (CAMHS) or other health professionals.

There are up to three beds available in the Adolescent Ward (which is a medical ward) however these beds are not designated for eating disorder clients. A ‘virtual’ multi-disciplinary Eating Disorders Team comprising a gastroenterologist, nursing staff, dietitian, consultant family therapist and a school teacher from Hospital Education Services oversees the inpatient care of clients. The team meet twice weekly to coordinate their care. None of these positions are formally designated to working with clients with eating disorders. The family therapist is able to work with clients with eating disorders due to personal interest and the goodwill of management. There is a general philosophy that the young person belongs out of hospital and that they are there for physical resuscitation and to commence a process that continues after they have been discharged via outpatient clinics. There is a staged program for which there are protocols and guidelines.

There are multiple entry points into the Program including the Department of Gastroenterology, Emergency Department, Department of Psychological Medicine or CAMHS. There is also additional variability depending on whether the client is a public or private client.

Very few clients are admitted to Boylan Ward; a designated psychiatric inpatient facility for children and adolescents. Clients with eating disorders are only admitted to Boylan Ward for two reasons; if they have co-morbid psychiatric conditions and it is unsafe for them to be managed on an open ward or if they have repeated admissions for eating disorders and require a more specialised nursing program.

Feedback from stakeholders considered the ideal future model for eating disorder services, addressing the specific needs of child and young people, would incorporate implementation of the recommendations of WCH Eating Disorder Review, and would also need to be cognizant of the client group that are transitioning from child and youth services to adult services at (or around) the age of 18 years.

Consistency of treatment is important. As a family member I wanted to be involved in the treatment planning for more daughter, and appreciated having consistent contact with skilled, non-judgmental professionals who had my child’s best interest at heart to help them, and our family, recover from this devastating illness.

Family member
The recommendations of the review were unanimously supported by the multi disciplinary team and included:

- A shared model for the service should be developed to integrate the various aspects of treatment of eating disorders, with the protocol to be revised to guide management
- Develop a psychological management protocol that is complementary to the medical protocol
- A more comprehensive approach to the psychological management of children should be developed, including case management, individual and group therapy
- Appointment of an adolescent physician (1.0 FTE)
- Dietitian and Family Therapist time to be increased as part of the MDT for enhanced therapeutic work with children and families
- Mental health professional/clinician (1.0 FTE) to be appointed to the programme to expand the range of treatments available and provide case management functions
- More psychiatric involvement with at least one psychiatrist claiming ownership and clinical responsibility
- Separate outpatient facility for adolescents, that has a clear Maudsley stream available as well as other treatment options such as general family therapy
- Separate inpatient service for adolescents with eating disorders and functional disorders – possibly in near vicinity or off campus
- Improved early identification and notification of early onset eating disorders
- Improved transition services from inpatient into the community
- Responsibility by psychiatrists, power to detain under the Mental Health Act (enforce treatment where situation is life threatening)
- Gastroenterology to provide a consult service only.

**Utilisation data**

Utilisation data for WCH Adolescent Ward and Boylan Ward from July 2009 – January 2011 show that the average admissions per month are 3.5 and 0.5 respectively over this 18 month period, as per the graph below.
Outpatient and community data was not able to be accessed during the timeframe of the project and is continuing to be sourced. This will be added to this report when it becomes available.

The average length of stay was 17.91 bed days for WCH and 6.4 bed days for Boylan Ward as per the figure below.

For the 18 month period of July 2009 – Jan 2011, monthly occupancy for WCH ranged between 8 bed days to 102 bed days, averaging 49 bed days per month. Over the same period, monthly occupancy for Boylan Ward ranged between 2 and 17 bed days averaging 3.2 bed days per month.

**Women’s Health Statewide**

Women’s Health Statewide provides counselling for women who have disordered eating behaviour. It is a service funded via CYWHS. There is one counsellor (0.6 FTE) position working specifically in the area of eating disorders. There are certain eligibility criteria for women to be able to access this service including being over 18 years of age and having a Health Care Card or being in financial difficulty. The service is located in North Adelaide and is available to women across the state. Clients are referred through a variety of sources including self referral, parents/carers, partners, friends, GP or other therapists. There is no time limit on counselling and the average length of treatment is between six months and two years. The counsellor is also able to provide phone counselling for parents and carers and consultation to health and education professionals.

**Flinders University Services for Eating Disorders**

The Flinders University School of Psychology offers a range of treatment and intervention approaches as part of its research program which varies depending on available funding. The following programs are currently available.

**Research: An Evaluation of web-based multimedia intervention for carers of people with anorexia nervosa.** The interactive web program aims to give carers information and skills to help them help their relative, cope with care-giving and reduce distress. The information provided through the program includes:

- Information on how to communicate with a person with anorexia; how to support them at meal times, facilitate weight gain and re-establish healthy eating
- How to manage crises and conflict
- How to assess and manage risk.

Flinders University has also been awarded a National Health and Medical Research Council grant for a randomised controlled trial of three treatments for anorexia nervosa in adults. From 2010 to 2012, free therapy for anorexia nervosa is offered in South Australia as part of this treatment research, provided by clinical psychologists. Three different treatments will be compared, all of which have been previously shown to improve the symptoms of anorexia nervosa: cognitive behaviour therapy, motivational and cognitive therapy, and specialist supportive therapy.

Additionally, the School of Psychology is conducting a randomised controlled trial evaluating two group interventions for body image concerns. Both programs aim to teach and practise skills that have previously been shown to help young women feel better about themselves and their bodies. Participation in the research study is available to young females aged 17 to 25 who have current body-related concerns.

There is also a current trial of a "guided self-help" treatment for individuals experiencing problems with perfectionism. Perfectionism can be associated with a range of problems. These may include specific difficulties such as anxiety, depression and some eating disorders. Research suggests that cognitive behaviour therapy designed to treat perfectionism is effective in improving the symptoms of these disorders. This treatment involves working through a guided self-help manual in eight weekly sessions with a trainee therapist at Flinders University.

**Private Services**

There are a limited number of Private services available for people (and their families and carers) with eating disorders. These largely fall into the categories of Psychiatrists, Psychologists and Dieticians. The following section provides a brief overview of some of the current specialist providers.

**Psychiatry**

There are a limited number of private psychiatrists who provide outpatient treatment services specialising in the treatment of eating disorders in South Australia, and these are largely based in the central city area. Referral can be made by clients and their families directly, via GPs, or from public hospital services.

**Psychology Services**

Advanced Psychology Services is the only private clinical psychology service that specialises in treatment for eating disorders (and related problems) and provides outpatient services for adults, adolescents, and children. The treatment offered is as per the outpatient services guidelines in the proposed model of eating disorder treatment services document (i.e., NICE guidelines for adult AN, CBT for adult/adolescent BN FBT for AN adolescents). The service currently operates two days per week.

Service utilisation breakdown is of clients is 60-65% adult, and 35-40% under 18 years of age, with the demand for services for all ages increasing, particularly adolescents.

The typical referral pathway is through one of 5 routes:
- GP/psychiatry direct referral
- Clients or parents of clients contacting us directly (e.g. internet search, or word of mouth)
- Discharged from inpatient unit
ACEDA
- Referral from other service providers (e.g. dietician).

Clients must be engaged with a GP or paediatrician for medical monitoring of their health. These medical specialists can also refer on a Mental Health Care Plan so that the client is eligible for a rebate per session (for most clients this is limited to 12 sessions per calendar year but in “exceptional circumstances” this can be capped at 18 sessions per calendar year). It is noted that the gap between the rebate and the full session cost frequently limits access for clients and their families.

As an agency, Advanced Psychology services work in a multi-disciplinary approach with clients also seeing one or more of the following from both private and public sector (Flinders WDU or WCH) services: dietician, psychiatrist, paediatrician, and GP. There is also regular communication with the GP or other referrers.

**Dietarians**
A small number of Dietarians provide treatment and support to clients and their families as private practitioners.

Appetite for Change is a private practice that provides nutrition and dietetic counseling for children, adolescents and adults with eating disorders and disordered eating in an outpatient setting.

The typical referral pathway is through one of 4 routes:

- GP/psychiatrist direct referral
- Clients or parents of clients directly (e.g. via internet search or word of mouth)
- Referral from other service providers (e.g. psychologist)
- ACEDA

Clients are ideally managed collaboratively, with medical management by a GP or psychiatrist, and concurrent psychological support from either a psychologist or psychiatrist. Eating disorder clients, particularly with anorexia nervosa or more severe eating disorders frequently require weekly or fortnightly review sessions to assist with improving nutritional markers, weight status and behaviour change. Clients may claim rebates through private health funds if able to afford private health insurance. However, access can be limited by inadequate financial assistance for dietetic services for eating disorders through the Medicare Enhanced Primary Scheme. This only provides rebates for a maximum of 5 sessions per calendar year with a dietitian, leaving a gap payment per session of $25 to $100, depending on length of consult.

**Non Government Organisations**
There is clearly a place for the services that can be provided by Non Government Organisations (NGOs) in the provision of eating disorder services. This may range from advocacy, support, information sharing, advice, peer support and mentoring, family & carers support, education and training. Additionally, treatment services may be provided by credentialed and gazetted NGOs across non clinical services. There are a number of examples nationally and internationally where NGOs also employ registered clinical staff to deliver services. Two NGOs current providing eating disorder services in South Australia and their activities are described below.
ACEDA
Aceda is a non-government organisation funded through the Department of Health. Aceda’s mission statement is to assist all South Australians affected by panic and anxiety, obsessive compulsive, and eating disorders, and their supporters through education, information, support and advocacy. Aceda’s vision is for recovery, understanding, acceptance and inclusion with values that are client-centred, recovery focused and embrace lived experience with disorders. Staff of Aceda are knowledgeable of all aspects of these disorders, mostly from their own lived experience or close relationship with others with lived experience. Aceda provides non-clinical face-to-face and telephone support, self-help and support groups, as well as individual and systemic advocacy.

Lifehouse Australia (SA)
Lifehouse is a non-government organisation established to help young women deal with a variety of life controlling issues. Lifehouse have established a purpose built live-in residential care facility, where they offer a Christian based program, providing young women with support and guidance to overcome conditions and behaviours that have become life controlling. Lifehouse will accept up to 12 young women at any one time, and advise that clients with eating disorders account for approximately 80% of the people they work with.

The Proposed Future Model
The consultation process, along with a consideration of previous reviews, has identified that the current range of dedicated specialist services for South Australians with eating disorders is fragmented and does not meet the demand for service.

Current service consists of limited public and private community based outpatient services (including Psychiatrists, GPs, Psychologists and Dietician support etc), with six adult inpatient beds and a limited community based outreach team, three child and adolescent beds and an outpatient clinic, and limited community based services. Services are also largely concentrated in the Adelaide metropolitan area, with limited access to specialist services for people living in rural and remote areas.

It is readily apparent that there are different needs for service based on the severity of each individual’s illness as well and a need to focus on early intervention strategies, health promotion and prevention and strong recovery focus. Disparities between access to services for the rural and remote population have also been identified, as well as the variance in level of treatment and support that can be accessed via the public and private sectors.

This service model proposes the development of an extended and dedicated specialist service, resourced to deliver services for clients with severe, complex and enduring eating disorders, as well as the provision of support to generalist mental health services across the state (inclusive of children, adolescent and adult services) including general medical services (acute medical and GPs). This could be in the form of outreach, consultation and liaison, shared assessment and treatment planning, support and supervision.

There was clear support from all stakeholders to improve and extend the range of services available to people with eating disorders across the spectrum. There was a general consensus that a centralised ‘hub’ for tertiary specialist services would be desirable and the ‘spoke’ services would be community based services at a secondary and primary level. The model proposes a high level, statewide pathway that allows flexibility for locally based generalist services to adapt according to their specific needs.
Video and teleconferencing modalities were firmly supported as a mechanism to improve access to specialist input and services for people outside on the Adelaide metropolitan area, as well as in the provision of specialist outreach clinics, across all ages. The point of entry into services is often via the GP, and many people considered that a focus on training and upskilling of GPs is required to increase confidence and competence in understanding the complexities of eating disorders. A number of other states have developed and evaluated extensive GP toolkits and training packages that provide guidance on assessment and treatment, and this needs to be considered within the South Australian context.

The RANZCP treatment guide suggests a range of services are available to clients across the continuum including:

- Hospital inpatient treatments for medical stabilisation, and in some instances, refeeding only
- Comprehensive day programs or other non-residential programs
- Intensive outpatient treatments and support programs.

These also indicate that it is more common to be treated in intensive outpatient or day program settings (unless an individual’s life is threatened – requiring resuscitation or at risk of self harm). The treatment guidelines advocate for comprehensive treatment plans, describing these as a ‘road map’ for recovery; and requiring a collaborative and partnership based approach with the consumer, carers and clinicians. Such plans need to be flexible enough to cope with changing needs and circumstances, and should be shared with all members of the clinical teams.

**Key components of the continuum**

This document proposes a comprehensive service model of the delivery of statewide specialist eating disorder services in SA. As part of the development of the model a number of workshops were conducted (refer to Appendix Three for participants) and, further informed by a review of the evidence and stakeholder views, several areas in need of development have been identified within the current continuum of care. This model proposes how the continuum of care should develop to address these (subject to additional resources).

The key components across the eating disorder service continuum/client pathway are:

For the purposes of this framework, the minimum elements to be considered in each service component are detailed in the table below.

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**Figure 13: Components of the Eating Disorder Services Continuum**

<table>
<thead>
<tr>
<th>Promotion and Prevention</th>
<th>Early Intervention</th>
<th>Treatment and Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>Primary and secondary Services</td>
<td>Referral and Screening</td>
</tr>
<tr>
<td>Schools</td>
<td>Consult Liaison</td>
<td>Consult Liaison</td>
</tr>
<tr>
<td>Resources</td>
<td>Assessment and Care Planning</td>
<td>Treatment and Support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discharge</td>
</tr>
<tr>
<td>Service Component</td>
<td>Key elements</td>
<td></td>
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<td>---------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| **Promotion and prevention** | • Establishing collaborative cross sector approaches  
• Identifying safe and effective practice  
• Communication and information dissemination  
• Research and knowledge development (including school based)  
• Undergraduate training across all allied professional disciplines (including GPs, Dentists) |
| **Early Intervention**     | • Workforce Development  
• GP resources and training (including screening tools)  
• “Front-line” professionals (including dentists, schools, fitness industry etc) |
| **Referral and Screening** | • Screening – early recognition and identification  
• Interpretation of early warning signs (severity and need)  
• Consultation and Liaison |
| **Assessment & Care Planning** | • Medical assessment tailored to eating disorders (e.g. BMI, vital signs etc)  
• Risk assessment  
• Nutritional Assessment  
• Bio-psychosocial assessment tailored to eating disorders (e.g. cognition, behaviour etc) including  
  o Family assessment and engagement  
  o Mental health  
• Diagnosis (criteria, aetiology, applying diagnoses and formulation)  
• Assessment of risk within a family context  
• Ongoing support needs of families  
• Assessing risk of suicide or self harm  
• Physical assessment (including dental)  
• Motivation  
• Multidisciplinary team initial treatment plan and ongoing case reviews  
• Consultation and Liaison |
| **Treatment and Interventions** | • Motivational interviewing (working with ambivalence, engagement with client group, managing ego-syntonic dynamics)  
• Application of tools (CBT, DBT, ACT, Maudsley family therapy model)  
• Monitoring of weight restoration, exercise management, compensatory symptom management (e.g. self harm)  
• Meal support  
• Pharmacology  
• Basic life support  
• Enteral or parenteral feeding  
• Anxiety management  
• Individual psychotherapy and family therapy  
• Facilitating groups for people with eating disorders  
• Education sessions for people with eating disorders and their families  
• Meaningful activity  
• Relapse prevention planning  
• Preparation for discharge including transition to follow-up services  
  • Planned home visits (and/or tele/video-conferencing for rural areas)  
  • Day program engagement  
• Support and treatment from outpatient services (GP, CAMHS, AMHS,  

Responsibility Matrix

For the purpose of describing this service model, it is useful to delineate what activity is likely to occur at primary, secondary and tertiary service levels when working with people with eating disorders, rather than focusing specifically on who would be providing the services.

It is noted this will be an iterative process which will continue to be refined as resources are secured and as services evolve, therefore high level activity is described rather than specifics. This will allow for a consistent statewide approach to be adopted, whilst allowing for local or rural variation and flexibility as described in the responsibility matrix below.

<table>
<thead>
<tr>
<th>Level</th>
<th>Focus</th>
<th>Key linkages and interfaces – MDT therapeutic focus</th>
</tr>
</thead>
</table>
| Primary Care | Promotion and prevention | • General Adult and C&Y MHS  
• GPs  
• School Counsellors |
| Secondary Care/Community | Mild to moderate ED | • Child & Youth MH services  
• AMH services (community and inpatient)  
• Specialist Eating Disorder Services  
• NGOs  
• Liaison Psychiatry  
• Dieticians  
• Psychologists  
• Paediatricians/units  
• Physicians  
• Gastroenterologists  
• Adult medical units  
• University clinics |
| Secondary Care/Specialist and Intensive | Severe and enduring ED | • Child & Youth MH services  
• AMH services (Community and Inpatient)  
• Specialist Eating Disorder Services  
• NGOs  
• AOD services  
• Liaison Psychiatry  
• Dieticians  
• Psychologists |

<table>
<thead>
<tr>
<th>Service Component</th>
<th>Key elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge</td>
<td>• Self management, relapse prevention planning and support</td>
</tr>
</tbody>
</table>

Table Two: Responsibility Matrix and Key Linkages
<table>
<thead>
<tr>
<th>Level</th>
<th>Focus</th>
<th>Key linkages and interfaces – MDT therapeutic focus</th>
</tr>
</thead>
</table>
|       | - C&Y MH units  
- Adult medical units  
- Adult MH units  
- Family & carer support and engagement | - Paediatricians/units  
- Physicians  
- Gastroenterologists  
- University clinics  
- Specialist allied health professionals |
Referral Pathway

The consultation process revealed there is no clear referral pathway to specialist eating disorder services.

Past practice has usually been that all referrals for people requiring specialist eating disorder services were received from GPs to specialist inpatient services (WDU or WCH) with clients seen by a public or private practitioner (Psychiatrist, Psychologist, Dietician).

Figure 14: Proposed Eating Disorder Services Referral Pathway
Services across the Continuum
For the purpose of this proposed model, key service aspects across the continuum have been identified, incorporating generalist and specialist services. These are described in more detail in the section below.

Generalist Services

Eating Disorder Liaison Clinicians
It is proposed that General Eating Disorder Liaison Clinician roles are created that are delivered by designated mental health clinicians who are situated in either Child and Adolescent Mental Health Services or Adult Mental Health Services across the state. They will interface with primary and some secondary services, provide a link to specialist eating disorder services and the ‘one stop shop’, and provides, facilitates or be involved in:

- Processing and triage of referrals with support from the specialist team.
- Regular liaison meetings with specialist services (via teleconference/videoconference for rural and remote).
- Oversight for clients engaged with CAMHS or AMHS keyworkers.
- Liaison with primary care.
- Identifying the resources required to support individuals under the care of CAMHS or AMHS.
- Undertaking a case management/key worker role, or provide assessment and treatment advice to case managers/key workers within CAMHS or AMHS.
- Regular monitoring of identified individuals within CAMHS or AMHS, including coordinating and facilitating referrals to the specialist Eating Disorder service where further assessment/treatment options need to be considered.

Medical Inpatient Services
Where a medical inpatient admission is indicated, a range of requirements, issues and treatment options need to be considered based on each individual client’s age, presentation and needs. The APA guidelines note that clients will frequently present with one or more of the following features (often in combination):

- Acute medical complications of malnutrition
- Severe dehydration
- Risk of refeeding syndrome
- Electrolyte imbalance
- Physiological instability
- Cardiac abnormalities
- Hepatic or renal compromise
- Poorly controlled diabetes

The primary goals of a medical inpatient admission are therefore:

- Sufficient correction of electrolyte imbalance
- Sufficient refeeding to stabilise medical status and correct sequelae of acute starvation
- Refeeding at a point that the risk of refeeding syndrome is no longer present.
A clear protocol has been established for individuals presenting at Flinders Medical Centre which provides guidance for the management of emergency presentations of eating disorder patients to FMC, and aims to ensure appropriate assessment is made, experts are asked to provide consultation and that all eating disorder patients are reviewed by a psychiatrist in the area. The key elements include:

- Recognition of critical weights and weight loss and primary determinants of medical risk
- Admission of patients presenting after hours
- Request for Consultant Intensivist review.

These medical inpatient admissions require active collaboration and strong support from the medical team, paediatricians, psychiatric liaison, the specialist eating disorders team, private practitioners and local mental health clinicians.

Clear discharge plans and outpatient follow-up are essential for this to be successful and to reduce chance of readmission.

**Child and Adolescent Inpatient Services**

**Medical Inpatient Admissions**

Although Child and Adolescent services are primarily for individuals under 18 years of age, clinical assessment and treatment must be cognisant of the young person’s developmental stage and treatment needs, therefore some flexibility and clinical judgement may be needed when deciding the most appropriate service for individuals. Where paediatric inpatient admission is indicated, a range of requirements, issues and treatment options need to be considered based on the young person’s presentation and needs.

- Follows the medical model focussing on weight recovery – this is supported by evidence that there is a need for assertive rapid intervention for younger people due to the higher risk of rapid deterioration (NICE 2004).
- The key focus is on correction of starvation and nutritional rehabilitation.
- Access to the Women’s and Children Hospital is currently by direct referral, or via GPs or paediatrician.
- Inpatient treatment may be for a period of weeks or months, depending on the severity of illness and needs of the individual.
- A shared model for the service should be developed to integrate the various aspects of treatment of eating disorders, particularly for discharge planning when transitioning back to the community.
- The Department of Psychological Medicine at the WCH would need to develop a psychological management protocol (including case management, individual and group therapy) that is complementary to the medical protocol.
- Regular MDT team reviews should be undertaken that assess function, including interactions, use and utility of the client management protocol.
- Designated positions need to be agreed that interface closely with the specialist eating disorders team, and also work towards the transition planning to day programs or outpatient family therapy if appropriate.
- The multi-disciplinary team works together to provide a comprehensive treatment program for clients and families and also interfaces with others involved in the individual’s outpatient treatment plans, including when the young person will be transitioning to Adult services.
**Boylan Inpatient Unit**

- This unit is also considered a treatment setting option for some young people (under 18 years) whose eating disorder symptoms present in the context of a broader co-morbid presentation.
- If the young person is under the care of a CAMHS service, but may benefit from a higher level of supervision and/or there is a need to engage closely with the family, or in need of further assessment or assistance with other aspects of their life (e.g. school engagement).

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**Specialist Eating Disorders Services**

**Specialist Eating Disorders Service**

Most people with AN should be managed on an outpatient basis with psychological treatment provided by a service that is competent in giving that treatment and assessing the physical risk of people with eating disorders. The great majority of patients with bulimia nervosa can be treated as outpatients. There is a very limited role for the inpatient treatment of bulimia nervosa. This is primarily concerned with the management of suicide risk or severe self-harm (NICE 2004).

Services available for treating eating disorders can range from intensive inpatient programs in which general medical care is readily available to residential and partial hospitalisation programs to various levels of outpatient care (in which the client receives general medical treatment, nutritional counselling and/or individual, group and family psychotherapy).

There is consensus that the treatment of severe eating disorders is complex and requires multidisciplinary specialist medical, nutritional, nursing and psychological care, and this is endorsed by ANZAED (Appendix Four). The RANZCP guidelines for patients with AN which is not so severe as to require inpatient treatment (e.g. where the risk of death from suicide or physical effects is high), outpatient or day patient treatment may be suitable, but this decision will depend on availability of appropriate services.

The proposed model suggests the establishment of a Specialist Eating Disorders service with three key components that could be co-located in the community:

- Specialist Eating Disorders team - ‘One stop shop’
- Bed based program
- Day program.

This would require an enhancement of existing services, by confirming existing dedicated resources, as well as the establishment of a centralised specialist statewide eating disorder service. It would need to be closely aligned to local hospital inpatient facilities involved in medical stabilisation for people with severe anorexia nervosa. The service would be linked with a range of other providers of services including general practice, private practitioners, mental health services and hospital inpatient services.

**Specialist Eating Disorders Team**

The Specialist Eating Disorders Team, via the ‘one stop shop’, will provide outreach support to primary and secondary services to assist in building capacity and capability through consultation, liaison, support, supervision and teaching.
The team will operate using the following approach:

- Regular (at least monthly) meetings with identified community based staff which includes triage, case reviews, discussion of new referrals and ongoing clients, care planning, teaching and training as identified, as well as regular/ad hoc supervision and support to individual liaison staff as identified and required.
- Develop a shared understanding of the basic principles and fundamentals of the provision of treatment for eating disorder clients.
- Assisting with the interface with primary sectors (e.g. support of medical management provided by GPs).
- Potential to provide regular specialist outreach clinics (e.g. Dietician and Psychology services) for CAMHS and AMHS across the state.
- Flexible support for the more geographically distant services based on need (hub and spoke model) via teleconferences, videoconferences, face to face sessions providing the opportunity for supervision, case reviews, assessment, peer review, consultation and liaison, training, mentoring and support.
- Provide access to specialist consultations where a second opinion is required, as well as offering joint assessments with general community based staff and teams.
- Ensure flexibility to develop different models based on specific and individual needs as service provision evolves, particularly across children, adolescent and adult services.
- Have formal links with universities that promotes an environment where evaluation and developing knowledge will add value to developing services in the South Australian context.

"One Stop Shop"
Support has been demonstrated for a key coordinating body and a “one stop shop” approach to streamline access and entry to specialist eating disorder services. This would:

- Be accessed via a central phone number
- Offer advice/triage/assessment
- Be staffed by specialists with specific training in eating disorders (Child, adolescent and adult specialists)
- Provide community based outreach services, including case management
- Support to general mental health staff
- Support and training for families and carers
- Provide regular and consistent training/development/support/supervision – this can be offered in various forms (e.g. videoconferencing etc)
- Consultation and liaison (including for rural and remote populations)
- Coordination of service evaluation, research and a client register
- Develop and coordinate a specialist register to could include private, government, university clinics – people who are accredited and have demonstrated expertise, ongoing training and supervision in this area.

Bed based program
Informed by the best practice guidelines, the key components of the bed based service be actively supported by a specialist team and would include:

- Open to 15 years and up if appropriate developmentally
- 24 hour residential accommodation in an age appropriate homelike setting
- 24 hour staffing with clinical staff on site when clients are in residence
• Transfer to and from hospital inpatient services
• Supported and/or supervised meals
• Evidence informed treatment and relapse prevention planning by appropriately qualified staff, including group and/or individual treatment and therapy involving family where appropriate
• Close monitoring of physical and mental wellbeing of clients
• Engagement with family
• Transition planning.

Referrals could be received from the specialist eating disorder service for people who are medically stable, have a severe eating disorder, for whom outpatient treatment is either not indicated or individuals who have not responded to outpatient care, and therefore require the expertise and interventions of a residential treatment program. Specific factors considered before referring and admitting a client to the service include:

• The complexity of the client’s needs due to co-morbid physical health conditions
• The complexity of the client’s needs due to co-morbid mental illness
• The ability to maintain the involvement of the clients family in treatment, particularly when the client is an adolescent or a parent/caregiver
• Clear admission guidelines keyed to appropriate stage of Motivation and clinical complexity
• All clients admitted regardless of comorbidity and suicide risk unless acute inpatient care is indicated
• All weights and metabolic risks admitted as long as not requiring ICCU and Acute Medical Care
• A focus for intensive therapy where there is a failure to progress in the core outpatient therapy – including motivational interviewing and CBT offered by a truly multidisciplinary team while managing all levels of medical and psychiatric risk.
• Seamless integration with Paediatrics and ICCU and other specialties.

Treatment in the service would take into account the client’s Body Mass Index (BMI) and severity of eating disorder symptomology (e.g. eating disorder behaviour and cognition). Treatment must also allow for individualised care in the context of a clear program structure. In addition to group based treatment there will also be provision of individual therapeutic support where necessary.

Treatment would be provided to accommodate starvation induced effects on cognitive functioning. In some instances, where an individual presents with poor motivation, no insight and is resistant to treatment due to a severe state of starvation, the relevant provisions under the Mental Health Act 2009 could be actioned in order to commence treatment in a structured setting.

Based on best practice guidelines, the expected length of stay would be approximately six to ten weeks depending on the severity and complexity of the eating disorder.

The treatment services should be provided with the following aims as part of recovery:

• Weight restoration through nutritional rehabilitation.
• Identification and limitation of eating disorder behaviours and establishment of regular eating patterns and normal eating behaviours.
• Management of excessive exercise behaviour.
• Management of medical complications of Anorexia Nervosa.
• Psychological therapy to begin to address anorexic cognitions and core beliefs.
• Development of skills and coping strategies.
• Identification and addressing of maintaining factors contributing to the eating disorder.
• Identification and addressing of co-morbid psychiatric conditions as well as predisposing traits like cognitive rigidity and emotional recognition deficits.
• Motivational enhancement to increase stage of change to allow for transition to day program treatment if indicated.

**Day Program Services**

There is clear support for the immediate establishment of day program service to meet a range of individual needs. There is a growing evidence base that shows day programs are effective in the treatment of eating disorders (McDemott, B., et al, 2001), providing a ‘step – up’ approach for treatment from a community setting preventing the need for an initial inpatient admission, as well as a ‘step down’ approach from inpatient services as a transition back to outpatient services, reducing the risk of relapse. The service would be open to 15 years and up if appropriate developmentally.

Two types of day program could be provided:

• An intensive 5 day program that caters for clients who have more acute needs. These clients would be referred directly from the community, or could be clients who are transitioning from the residential program and are living back at home.

• A less intensive 3 day program that provides continuity of service for clients who are, or maybe moving towards outpatient services as they improve towards recovery, aiming to prevent the client requiring a higher acuity service. This service would have an emphasis on strengthening the client’s ability to take responsibility for the management of their eating disorder behaviour, including meal preparation and social eating during outings.

Treatment would be provided with the following aims:

• Further weight gain and reduction of eating disorder behaviours and cognitions
• Development of skills and competencies for the client to increasingly be able to take on more responsibility to self manage eating disorder behaviours
• Enhancement of an individual’s motivation to advanced stages of change
• Identification and addressing of maintaining factors and co-morbidities contributing to the eating disorder
• Assist the clients in integrating ongoing recovery process into their usual home and social environment.

The composition of the multidisciplinary team for both the residential treatment service and day program services requires agreement; however the team would need to consist of the following disciplines/specialities:

• Psychologist
• Psychiatrist
• Psychiatric registrar
• Adolescent Paediatrican
• Clinical Practice Consultant/ Clinical Services Coordinator
• Registered Psychiatric Nurses
• Occupational Therapist
• Dietitian
• Peer Support Workers
• Social Worker (with family therapy training)
• Peer support workers
• Family/carer consultants.

Additional staff mix requirements could be assessed as appropriate, and could include (but not be limited to) General Practitioners, physiotherapists, play therapists and teachers.

Staff members, as part of the specialist team, may work across all services to provide continuity and to facilitate transition across the services.

**Hub and Spoke model**

Feedback indicates that although some clinics are provided outside of the metropolitan area, currently these are inconsistent and irregular. There is the potential for a specialist eating disorders team to provide support and input in a “hub and spoke” model of supervision and training for all identified primary, secondary and NGO services involved in eating disorders, particularly in rural and remote areas.

Part of the role for a specialist eating disorder service team should be to enhance the level of clinical support, supervision and training/mentoring for all community based services. This support may include being available for joint assessments and input/support for the small group of intensive clients unable to be managed by community services (the ‘spoke’) without support from the specialist team.

The two key factors required for an effective ‘hub and spoke’ approach to eating disorder service delivery are:

- Ensure dedicated resources or designated mental health clinicians in all of the ‘spoke’ services.
- Scheduling planned meetings and video conferences at regular intervals regardless of whether or not the ‘spoke’ service has current clients, maintaining relationships and ensuring that time is allocated for supervision and training and reflective practice.

From the ‘hub’ perspective, this may also be described as a consultative service that will be provided by senior medical staff, nurses and/or other allied health professionals who are part of the specialist team, and who have specialist knowledge, expertise and experience in the management and treatment of eating disorders across all age groups.

**Training needs**

Eating disorder management is complex and requires skills in evidenced based treatment such as psychotherapy, family therapy and other therapeutic interventions. To gain these skills a process of training, supervision and clinical experience is required. Additional attention needs to be paid to further reviewing the workforce development, training and skills required for competent and capable clinicians specialising in working with clients with eating disorders.
Summary
Eating disorders are highly complex illnesses, with significant psychological and medical consequences. Presentation of eating disorders varies amongst consumers, and treatment requires a sustained, flexible and multidisciplinary approach.

This discussion document for a service model for statewide specialist eating disorder services in SA, has described, at a macro level, the ideal continuum of care. The proposed model is the result of a project commissioned by SA Health, and has been informed by national and statewide reviews, as well as workshops and interviews with key stakeholders, including consumers, carers and clinicians.

In developing this framework, best practice guidelines have been considered and the evidence base has been reviewed and incorporated into the description of the proposed service model. The National context and strategic intent for delivering high quality and evidence based treatment services have been considered within the South Australian context in terms of the proposed service development towards fully integrated future services.

In essence, it is proposed to establish a statewide specialist service that operates in a highly responsive manner across the sector, providing assessment, treatment, consultation and liaison, supervision, support and outreach to the range of hospital and community based services. This proposed service model recommends enhanced eating disorder services across the spectrum of:

- Promotion and prevention
- Early intervention
- The range of treatment and support options

The proposed model seeks to reflect primary, secondary and tertiary roles in the range and mix of services across the service continuum, which includes a specialist eating disorders team coordinating a range of services including community based treatment, day program, bed-based service, consultation and liaison, support & supervision, training and education, information and advocacy, research and evaluation.

This is an aspirational and overarching service model for statewide specialist eating disorder services requiring additional resources to fully implement. For example, extra capacity and resources are required to expand the range of services available and improve access to eating disorder services across the state, in particular the introduction of day programs and a specialist community based eating disorder team. The model proposes a high level, statewide pathway that allows flexibility for locally based services to adapt according to their specific needs. This also aligns with a ‘hub and spoke’ model, where specialist services sit at the centre operating as the ‘hub’ and generalist services operate as the ‘spoke’.

Once an agreed service model is adopted by SA Health, it will need to be adequately resourced and then implemented incrementally, cognisant of the required dedicated workforce development needs and the culture shift required from current practice models.
Appendix One – Previous Reviews

Two significant reviews have previously been undertaken on eating disorder services, with a number of subsequent recommendations.

Southern Adelaide Health Service - Review of the Weight Disorder Unit

Recommendations (July 2007)

1. Consider establishing two community mental health therapist positions (RN/PSO).
2. Consider ceasing the community nursing service to help fund two Community mental health therapist positions.
3. Multiclassify the Manager/Coordinator position (RN/PSO).
4. Consider the following improvement initiatives for the inpatient program.
   - Access
     - Document the admission criteria for the inpatient program and make it available to consumers, carers and other health professional.
     - The waiting list to be made available electronically to minimise disruptions to ward routine.
     - Better input to programs
     - Increase dietitian time.
     - Introduce physiotherapist sessions to teach patient how to exercise without affective weight loss.
   - Support group therapy to assist patients in their preparation of how they are going to manage on discharge.
   - Bed Program
     - Review criteria for outdoor and toilet privileges
     - Restrict to clients at high physical risk (potentially only achievable if community therapist positions established).
     - Discharge - all patients discharged to be linked with a community therapist who specialises in eating disorders. Private or above mentioned community mental health therapist.
5. The WDU management should sit with Mental Health Rehabilitation and Recovery Division. The
6. Undertake a trial of triage of referrals to be done by the booked assessment service.
7. Implement CBIS and collect NOCC data.
8. Enable research capability within the unit through the employment of a research officer or through the Manager/Coordinator role.
9. Develop a website in collaboration with the Eating Disorders Association of SA where consumers, carers and health professionals can obtain information and be directed towards services in their local area.
10. Prepare proposal and submit for Department of Health, through SAHS CEO, to
    - Plan and create a network of therapist positions in metropolitan Adelaide working in CNAHS and SAHS sites, relating directly with the specialist unit.
    - Work with SAHS CAMHS and CYWHS to better identify demand and models of intervention.
    - Work with Country Mental Health Services to identify demand and expert local support arrangements in some centres.
Review of The Eating Disorders Program – Women’s and Children Hospital
Recommendations (Nov 2007)

The following recommendations were made:

- A shared model for the service should be developed to integrate the various aspects of
treatment of eating disorders
- Regular team reviews should be initiated that assess function, including interactions, use
and utility of the protocol and difficulties
- Based upon the model of care chosen (i.e. augmented developmental approach or a shift to
a more psychological approach) the protocol should be revised to guide management.

1. The Gastroenterology Department should become consultants to the Eating Disorders Program.
2. The Department of Psychological Medicine at the WCH needs to develop a psychological
management protocol that is complementary to the medical protocol.
3. A more comprehensive approach to the psychological management of these children should be
developed, including case management, individual and group therapy.
4. An adolescent physician (1.0 FTE) should be appointed to coordinate medical in-patient
management and, if this model is opted for, direct the eating disorders team.
5. The dietitian time available to the program should be increased to 0.5 FTE
6. A 1.0 FTE mental health professional (psychiatric nurse or clinical psychologist) should be
appointed to the program to expand the range of treatments available and provide case
management functions.
7. A 0.5 FTE clinical nurse consultant should dedicate their efforts to supporting medical and
psychological protocols through their consultation with and interaction with Adolescent Ward
staff and if possible, provide some additional case management capability.
8. A program co-ordinator should be appointed from existing staff (or new appointees) to assist the
Director in managing the Eating Disorders Team.
9. Changes made to the Eating Disorders Team should be reviewed in two years to assess the
effectiveness of these changes.
Body Image and Eating Disorders Project
Recommendations (Dec 2009)

- A 12 month Senior Project Officer position be funded to progress the following recommendations.
- A single point of contact for information, referral advice and the provision of coordinated training is established.
- Establish a specialist service for children and adolescents.
- State-wide Specialist Eating Disorder Services within South Australia need to operate as a coordinated and integrated system.
- Establish day programs for children, adolescents and adults with eating disorders in South Australia.
- Establish a Professional Development Network for clinicians working in the area of eating disorders.
- Mental Health regional teams identify team members as ‘key contacts’ in their region for eating disorders, and this role be formalised within job and person specifications.
- That the Mental Health Training Centre facilitate a training program to up-skill clinicians in working with people with eating disorders.
- Improve services for country clients through discharge planning, use of telemedicine, Individual Psychosocial Rehabilitation and Support Services (IPRSS) packages, and providing increased support and developing the skills of country clinicians.
### Appendix Two: Project Reference Group Membership

<table>
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<tr>
<th>Name</th>
<th>Organisation</th>
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<td>Clinical Director, Southern Mental Health, Adelaide Health Service</td>
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<td>Emma-Kate Codrington</td>
<td>Consumer representative</td>
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<td>Paula Hakesley</td>
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<td>Gabriella Heruc</td>
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<td>Tracey Hill</td>
<td>Community Nurse, Weight Disorder Unit, Flinders Medical Centre</td>
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<td>Dr Margaret Honeyman</td>
<td>Chief Psychiatrist, Director Mental Health Policy, Department of Health (Chairperson)</td>
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<tr>
<td>Wayne Horwood</td>
<td>Executive Officer, ACEDA</td>
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<td>Dr Randall Long</td>
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<td>Robyn Mercer</td>
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### Appendix Three: Contributors and Workshop Participants

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Appendix Four – ANZAED Position Statement for Inpatient Eating Disorders

POSITION STATEMENT: INPATIENT SERVICES FOR EATING DISORDERS
While many patients with an eating disorder can be treated effectively as outpatients, ANZAED takes the position that there is a continued need for specialist inpatient services for those with severe illness.

ANZAED endorses the RANZCP guidelines for specialist inpatient care and indications for admission (see Appendix). These are in accord with international guidelines and are premised on the consensus that treatment of a severe eating disorder is complex and requires multidisciplinary specialist medical, nutritional, nursing and psychological care.

In addition ANZAED endorses the following principle:
The inpatient ward environment is very important to a successful outcome. Patients (and their families) may suffer psychological trauma when treated in inappropriate settings. There are well-recognized problems and risks with:
• Managing patients in high security psychiatric units where the medical difficulties of eating disorder patients can be overlooked and where their needs may be placed at a lower priority than patients who have greater behavioural disturbance
• Mixing adolescents with adults suffering acute psychoses, the latter who may have severe behavioural disturbance
• Management by professionals unfamiliar with current management and/or the potential for adverse effects of excessively punitive and coercive approaches

Access to such hospital care for people with eating disorders is widely variable across Australia and New Zealand, with some regions having no such services.

ANZAED accepts an important role as the leading bi-national professional organisation in the area to work for improved services and care and redress this current situation.

CURRENT NOVEMBER 2007 FOR REVIEW NOVEMBER 2012
Executive Committee Date: 12/11/07

References:

**RANZCP Guideline 1 Treatment setting:** For patients with anorexia nervosa which is not so severe to require in-patient treatment (e.g. where the risk of death from suicide or physical effects is high) out-patient or day-patient treatment may be suitable, but this decision will depend on availability of such services. The following are indications for admission adapted from the APA guidelines (2000):

**Physical state –**
- **adults:** heart rate (HR) <40 min, blood pressure (BP) <90/60mm, potassium <3, other electrolyte imbalance, temp <36°C and/or body mass index (weight kg/height m²) <14;
- **children:** HR <50 min, orthostatic changes: <20/min increase, HR >20mm drop in BP, BP <80/50mm, low potassium, low phosphate and/or rapid weight loss

**Mental state**
- an active plan for suicide; continuous preoccupation with eating disorder cognitions; co-operative only in highly structured treatment; presence of another psychiatric disorder requiring hospitalisation

**Eating Disorder symptoms**
- needing supervision of every meal and/or naso-gastric feeding; needing modification of extreme purging and/or exercise behaviours; severe family problems and/or requires residential placement to access treatment.

**Disclaimer:** These are not exclusive of other indications which may arise e.g. pubertal developmental delay

Executive Committee Date: 12/11/07
Appendix Five: References

ANZAED Position Statement for Inpatient services for Eating Disorders
www.anzaed.org.au


RCANZP guidelines 


- Eating Disorders Prevention, Treatment and Management: An Evidence Review
- Eating Disorders Information and Support for Australians

[www.eatingresearch.com](http://www.eatingresearch.com)


