# National Eating Disorders Collaboration

## Consultation Papers

# Consultation Papers

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# Treatment Standards

**Exploring opportunities to implement the National Standards Schema for Eating Disorders**
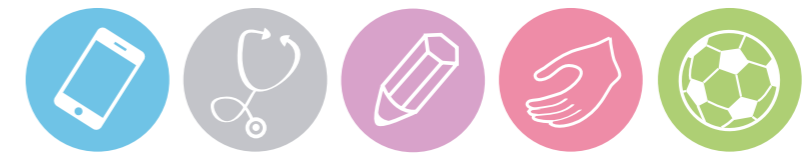
# Implementing National Standards for Eating Disorders

The National Eating Disorders Framework standards schema includes seven core principles and four implementation principles which, if implemented together, provide the foundation for an effective and consistent system to address eating disorders.

The principles of prevention and treatment focus on access to comprehensive, coordinated approaches that provide individually tailored pathways that can be consistently implemented. The principles are predicated on the need to be informed by evidence from research and the lived experience.

*Practice Principles*

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

*Implementation Principles*

- Evidence informed and evidence-generating approaches
- A skilled workforce
- Communication to ensure an informed and responsive community
- Systems support integration, collaboration and on-going development
- The national standards stress the necessity for access to a suite of services, regardless of a person's geographic location, age, or economic circumstances.
- Services provided by multiple disciplines: The most effective treatment for eating disorders addresses all aspects of the illness through a multi disciplinary team.
- A suite of services: a range of treatment and support options is required to enable the provision of individually tailored interventions that are congruent with the person's circumstances and experience.
- A stepped model of service:  varying levels of intensity of service are required to meet the differing needs of individuals at each stage of illness, delivered as an integrated sequence of care to reduce the risk of relapse and recurrence.
- Services for adults and children: the vulnerability to illness continues long after weight restoration and potentially throughout life. There is therefore a need for services that are sensitive to adults seeking support and for health services to provide treatment for adults as well as youth.

The national standards stress the necessity for access to a suite of services, regardless of a person's geographic location, age, or economic circumstances.

- **Services provided by multiple disciplines:** The most effective treatment for eating disorders addresses all aspects of the illness through a multi disciplinary team.
- **A suite of services:** a range of treatment and support options is required to enable the provision of individually tailored interventions that are congruent with the person's circumstances and experience.
- **A stepped model of service:**  varying levels of intensity of service are required to meet the differing needs of individuals at each stage of illness, delivered as an integrated sequence of care to reduce the risk of relapse and recurrence.
- **Services for adults and children:** the vulnerability to illness continues long after weight restoration and potentially throughout life. There is therefore a need for services that are sensitive to adults seeking support and for health services to provide treatment for adults as well as youth.

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

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

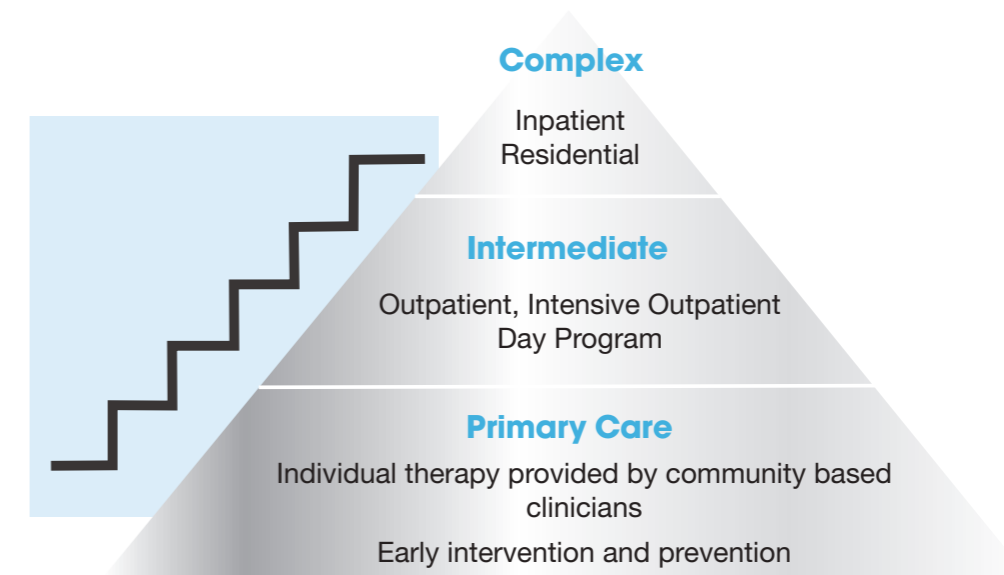*(National Eating Disorders Framework, NEDC, 2012)*



**Figure 1: A stepped model of care with flexible movement between levels of intensity**

The principles outlined in this paper are sourced from the National Eating Disorders Framework: An Integrated Response to Complexity (2012) which can be found on the NEDC website www.nedc.com.au.  The National Eating Disorders Framework and this paper are informed by and consistent with a number of National policies including:

- Fourth National Mental Health Plan (2009)
- National Mental Health Standards for Mental Health Services (2010)
- National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (2000)

## World Charter for Eating Disorders

In addition to the core principles of prevention and treatment, the World Charter for Eating Disorders is recognised as the international benchmark for the rights of those experiencing or impacted by an eating disorder. The World Charter promotes five key rights:

- Communication/partnership with health professionals
- Comprehensive assessment and treatment planning
- Accessible high quality fully funded specialised care
- Respectful, fully informed age appropriate, safe levels of care
- Accessible appropriate support education and resources for carers

## A Stepped Model of Care

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

While hospitalization is essential in the most severe cases, most people with eating disorders may be treated successfully by appropriately trained health professionals in outpatient and community settings. Intermediate levels of treatment, provided through outpatient programs, intensive outpatient programs, day programs and residential programs, are essential to ensure the continuum supports the essential step up and step down access to treatment during the course of illness. Without these intermediary levels of treatment, more people will require hospitalization.

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

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

| Principle: |
| --- |
| **A full continuum of care** |
| Eating disorders require a stepped model of care involving voluntary agencies, primary care professionals, local psychiatric services and specialised services.<br><br>A clearly identifiable continuum of care is required which includes flexible care options to meet the physical and mental health needs of people presenting with varying levels of risk, severity, complexity and acuity. |

**Potential indicators to demonstrate implementation of this principle include:**

- ☐ Every health region has community based eating disorders program(s)
- ☐ Every health region has identified primary and secondary health services with the capacity and capability to respond to eating disorders
- ☐ Flexible access pathways are articulated between levels of service
- ☐ Individuals with complex needs have access to case coordinators who are skilled in eating disorder care

# Meeting the Needs of Individuals

The experience of an eating disorder is specific to the individual and their family and this must be reflected in treatment approaches.

All types of eating disorders present within a wide range of severity. Progression along the continuum is not linear and response to treatment is individual and variable. The complex interaction between distorted eating behaviours, psychological distress, physiological disturbance and societal factors, results in a dynamic illness that can change the way in which it manifests throughout the course of illness.

This dynamic and individual presentation of illness makes eating disorders one of the most difficult psychopathologies to treat. No single treatment will be effective for every person with an eating disorder. A person with an eating disorder requires treatment that is specific to their disorder and specific to their individual circumstances.

There is a need to develop a suite of safe treatment options that can be delivered in a flexible approach with scope for individual choice. The provision of a range of treatment options is expected to increase both engagement with treatment and the effectiveness of treatment.

A person centred approach requires collaboration between patients, their families or supporters, and health professionals. Participation in decisions that personally affect them presents challenges for the person with an eating disorder. Family and professional support is required to enable the person to actively engage in their own treatment decisions. Education and support for family, carer and consumer participation is an integral part of the eating disorders service model.

| **Principle:** |
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| **Person and family centred care that addresses the needs of individuals** |
| Individual treatment plans are developed within a person-centred, family and culture sensitive and recovery oriented framework. Services are delivered with a strengths-focussed approach, supporting long-term recovery, tailored to meet individual decision making capacity and needs as they develop over the course of the illness. |

**Potential indicators to demonstrate implementation of this principle include:**

☐ People with eating disorders are able to make choices within available treatment options

☐ Policies and protocols enable staff to identify and work with family members or carers

☐ An individual treatment plan is developed for each person taking into consideration their experience, strengths and resources

☐ Planned treatment includes long term strategies for recovery including step up and step down treatment options, criteria for re-admission, and post treatment follow-up

☐ Professional support is provided to enable people to actively engage in their own treatment decisions

☐ A range of service options is available to meet the needs of adults who do not have family support, such as case coordination and residential programs

# Safe Treatment Approaches

Safe treatment for eating disorders addresses all of the aspects of illness: physical, behavioural and psychological. It is unsafe to treat one dimension without the others.

Sustained engagement with eating disorders services is an essential feature of an eating disorders model of care. Unlike some mental illnesses, such as mild to moderate depression, eating disorders do not respond to short term treatment. A longer course of treatment with recovery support is required to address all aspects of the illness and reduce the risk of relapse and chronicity.

Within the continuum of care, there is a need to link treatment across departments and to link inpatient and outpatient programs so that there is an ongoing treatment plan rather than isolated incidents of treatment. If treatment is biased towards one aspect, such as distorted eating behaviours, then these behaviours may be improved but the eating disorder may manifest in alternative ways.  Weight gain, loss or stabilization alone is not a cure for eating disorders.

Safe treatment for eating disorders therefore addresses all of the aspects of illness: physical, behavioural and psychological. It is unsafe to treat one dimension without the others.  This has implications for the organisation of eating disorders services, with a need for the provision of collaborative care on an ongoing basis.

The majority of eating disorder patients require long-term multi disciplinary care, potentially provided across different levels of care and different service agencies.

| **Principle:** |
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| **Safety and flexibility in treatment options** |
| Safe treatment for eating disorders addresses all of the aspects of illness: physical, behavioural and psychological. People have access to a range of safe treatment options which meet different needs at each stage of risk, illness and recovery.  Flexible and appropriately supported entry, exit and transition between services supports individually tailored care planning.  When transitioning from child and adolescent services to adult services appropriate support is provided to the individual and their family; and |

**Potential indicators to demonstrate implementation of this principle include:**

☐ Assessment takes multiple parameters into consideration. Single parameters, such as weight, are never used to determine treatment or discharge.

☐ Treatment plans for people with eating disorders always addresses the need for physical, psychological and nutritional intervention

☐ Access criteria for services support simultaneous and sequential service delivery from multiple providers

☐ Treatment plans support a long term approach facilitating a step up/down approach and sustained recovery support

☐ Evidence based treatment is provided in a sufficient evidence based dosage taking into consideration the type of disorder, duration of disorder, comorbid conditions and outcomes of previous treatment interventions

☐ People with persistent or complex illness, people with low BMI (<17.5), and people who do not respond to treatment have access to more intensive and longer treatment with access to at least 50 sessions of therapy

☐ Hospitalization for patients occurs before the onset of medical instability

☐ Duration of inpatient treatment is flexible to meet individual needs

☐ All health care settings have mechanisms to facilitate access to more intensive levels of specialist treatment in response to a patient's changing needs.

☐ Individuals receive scheduled follow up after treatment. Monitoring of physical and mental health is recommended for an average of 5 years post treatment.

☐ Transition and discharge plans are developed in collaboration with the individual, the family and all service providers

☐ Recovery support is accessible and included in all treatment plans

☐ People with long term illness have access to a full range of health and community services to meet their needs

## Multidisciplinary Treatment

All patients with eating disorders must be treated for the physical, psychological, nutritional and functional aspects of their eating disorder. These four components of treatment must work together, with progress in one domain enabling and supporting progress in each of the other domains. Therefore the capacity to work collaboratively in assessment, treatment planning and treatment review is essential for safe treatment.

A patient with an eating disorder needs a multi disciplinary response to their immediate presenting health problem and to the full spectrum of the eating disorder.

| Principle: |
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| **Partnering to deliver multi disciplinary treatment in a continuum of care** |
| Treatment is provided by a multi disciplinary team who work in partnership with the person, their family and other health and support providers, including treatment of co-morbid issues. The multi disciplinary team will assist clients to meet physical, mental, nutritional, occupational and social needs. Individuals with an eating disorder require individual care plans and access to a designated case coordinator. |

**Potential indicators to demonstrate implementation of this principle include:**

☐ Policies support multi disciplinary care at all levels of treatment

☐ Shared standards and clinical guidelines are implemented across disciplines

☐ Protocols support a coordinated team approach engaging the person, their family and support network and multiple service providers

☐ Individual care plans are followed by all service providers

## Facilitating Access

Person centred approaches promote accessibility and flexibility: equitable service provision that is provided in a timely and accessible manner to meet the needs of the patient. Information, support and treatment should be provided as early as possible in the course of illness and as a timely response whenever the person is motivated to engage in change. Eating disorders have an impact on the individual's ability to engage with treatment. The transient nature of illness awareness requires the capacity for an immediate treatment response.

Failure to access long term coordinated treatment early in the course of illness or episode directly contributes to the persistence of illness and the potential for other health complications and their impact on the patient's quality of life.

The NEDC has identified improved access to services for people in all locations in Australia as a high priority with action required in the following areas:

• Geographic access to services
• Clear signposting of referral /care pathways
• Reviewing entry and exclusion criteria to ensure that the combined medical and psychological aspects of eating disorders do not exclude patients from treatment
• Utilising technology in the delivery of care including video conference, email, telephone, online services, DVD/telephone counselling formats, whilst retaining the opportunity for face to face services

| Principle: |
| --- |
| **Equity of access and entry** |
| People have access to treatment and support services when and where they are needed, early in the illness and early in each episode of illness. The requirements of regional and rural areas are recognised and technological solutions to providing accessibility are included. The entry requirements and the costs, subsidies or fee rebates for treatment take into consideration the long term and complex nature of eating disorders and the need to ensure they are accessible and affordable to all. Clearly identified entry points, ideally located in the community, assist people to make informed decisions about treatment options and enable them to engage with accessible and affordable services; |

**Potential indicators to demonstrate implementation of this principle include:**

☐ Referral processes and entry criteria for access to services enable early intervention

☐ Access to eating disorders specific services is available in all areas including rural and regional

☐ Information and service entry points are easily identifiable at national and local community level

☐ Entry and exclusion criteria for access to services enable access early in the course of illness or episode

☐ People with severe and enduring eating disorders have access to a full range of treatment and support services

☐ Individuals and families have access to information and resources, including self help early intervention resources

# Tertiary Consultation

People with eating disorders require specific interventions designed to address the complexity of eating disorders, delivered by health professionals with an appropriate level of skill and knowledge of the disorders. People are best treated closest to home and family. Referral to tertiary services outside the local community or region should be a last option for most patients.

There are a limited number of eating disorders experts/specialists in Australia. Most people receive treatment at non-specialist primary and secondary levels of care. To assist them in treating people with eating disorders there is a need to provide them with access to additional expertise in eating disorders when this is required.

It is important to ensure that appropriate expertise is available at every level of care and every incidence of care. Wherever treatment occurs in the continuum of care from early intervention to recovery support clinicians require access to tertiary level expertise for consultation, supervision, guidance and referral.

Tertiary consultation is the recommended mechanism to ensure that all health professionals, including General Practitioners and specialists in other health fields, have access when they need it to an appropriate level of specialist expertise. Tertiary consultation is intended to resource and empower local treatment providers. A key issue for non-specialist clinicians is knowing that information and support are available at an early stage in planning treatment. Tertiary consultation may be provided in person however it is most likely to be delivered by video or teleconferencing.

> **Principle:**
> **Tertiary consultation accessible at all levels of treatment**
>
> Access to expert consultation is required at the earliest possible point to ensure appropriate and early intervention. Wherever treatment occurs in the continuum of care from early intervention to recovery support there must be access to tertiary level expertise for consultation, supervision, guidance and referral if required.

**Potential indicators to demonstrate implementation of this principle include:**

☐ Clinicians from all disciplines required in the multi disciplinary team have access to expert advice, case review and supervision when required regardless of their geographic location

☐ Expert advice is available for every clinician and every patient regardless of their geographic location or source of service provision

☐ Every health region has formal connections with a tertiary service that is resourced to provide training, supervision and shared care

# Support for Families and Carers

Families can play a critical role in identifying eating disorders symptoms, supporting help seeking and engagement, and supporting treatment and recovery between meetings with clinicians. In most instances it is preferable to manage eating disorders on an outpatient basis in a community location where the person can remain close to family and social relationships and this places an even greater emphasis on the role of family. Parent and carer skill building interventions may be both a primary form of treatment intervention and an adjunct to treatment approaches.

In the context of the extensive demands that management of eating disorders place on families, there is a need for effective intervention strategies that improve the effectiveness of families as moderators of treatment outcomes and ease the stress on family members.

Family education and support is integral to long term treatment of eating disorders and the prevention of eating disorders and other mental health problems in family members. Families require education, resources and support to enable them to sustain the role through the treatment and recovery process.Increased support may be required at acute stages of illness, when the person with an eating disorder is a younger child, or when the family is more socially isolated.

> **Principle:**
> **Support for families and carers as integral members of the team**
>
> Families and carers, where available, are recognised as integral members of the treatment and support team and receive support, skills and strategies, education and information to enable them to support the person with an eating disorder and to maintain personal good health. Where such support of a family or carer is not available, this gap in the team and support structure is taken into account and addressed by the service providers.

**Potential indicators to demonstrate implementation of this principle include:**

☐ Family education and support is accessible for all families, as an integral part of treatment plans

☐ Policies and protocols enable staff to identify and work with family members or carers

☐ Family or other nominated support person are supported to act as members of the treatment team

☐ Families, including partners, children and siblings, have access to education and support to manage their own stress and mental health

# Prevention and Early Intervention

*(Note: the prevention and early intervention principle in the National Eating Disorders Framework encompasses standards for all levels of prevention. The discussion here is limited to early intervention treatment. More information on prevention and early intervention may be found in the NEDC consultation paper 'Developing Practical Approaches to Eating Disorders: Prevention and Early Intervention'.)*

The complexity, long duration, impact on quality of life and high mortality risks associated with eating disorders, and the resulting high overall burden of disease costs, justify a preventive health care approach with a focus on prevention and early intervention.

Individuals who are identified and treated early in the course of an eating disorder have a better chance of recovery compared to those with a longer history of illness. People who have had an eating disorder for less than 2 years are likely to respond more quickly to treatment and experience fewer physical health consequences. Prevention, early identification and prompt intervention to reduce the severity, duration and impact of the illness have been described as the ideal standards of care for eating disorders.

There is evidence for the effectiveness of the following early intervention treatments:

- ☐ FBT for adolescents in the early stages of anorexia nervosa
- ☐ CBT and CBT-e for adults with bulimia nervosa and binge eating disorder and for adults with high levels of risk associated with disordered eating and body dissatisfaction
- ☐ Indicated (selective) prevention programs based on the principles of cognitive dissonance, psychoeducation evidence and CBT for people with high levels of risk associated with disordered eating and body dissatisfaction

| Principle: |
| --- |
| **Prioritization of prevention, early identification and early intervention** |
| Prevention, early identification and prompt intervention are necessary to reduce the severity, duration and impact of the illness. Early intervention for eating disorders includes strategies that enable people to access services as soon as they are needed: early in the development of the illness, early in help seeking and early in recurrent episodes of illness, with immediate access to treatment and support. |

**Potential indicators to demonstrate implementation of this principle include:**

- ☐ People in high risk groups are screened as part of routine health checks in primary care
- ☐ Frontline clinicians are trained and skilled to screen, assess, diagnose and refer people with eating disorders
- ☐ People in very high risk groups and those with early symptoms have access to early intervention programs (e.g. guided self help, online programs)
- ☐ Entry criteria for access to treatment services enable early intervention
- ☐ Treatment and early intervention services are assertively promoted in order to raise awareness and facilitate early access

# A Skilled Workforce

The safe treatment of eating disorders requires access to skilled professional treatment for psychological, physical and nutritional aspects of their illness. The evidence based component of treatment is located in the skill of the staff working with the patient. Therefore all patients with eating disorders need to be treated by someone who is trained to deliver this treatment. People with an eating disorder come in to contact with a wide variety of clinicians from medical and allied health fields. Every agency or program that provides health services to people at risk of developing an eating disorder should have a core capacity, defined through program infrastructure such as policies and clinician competencies, to provide appropriate services to the people with eating disorders and their families.

Evidence from research and from NEDC consultations suggests that the majority of health professionals are not sufficiently trained in the assessment and treatment of eating disorders and do not feel confident to undertake this role.

| Principle: |
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| **A skilled workforce** |
| An effective system is founded on a skilled and supported workforce. All health professionals receive training in eating disorders to raise their awareness of the serious nature of eating disorders and to enable them to identify, assess and contribute to the treatment of eating disorders. Training includes the development of attitudes and practices that support early identification and intervention and a person centred and recovery oriented approach. General Practitioners are recognised as being the first point of contact in many instances and are educated on how to interview the patient and their family to facilitate an early diagnosis. Training includes attitudes and practices that support early identification, intervention, recognition of the ambivalence and fear that is prevalent in this population and a recovery oriented approach. |

**Potential indicators to demonstrate implementation of this principle include:**

- ☐ Core competencies are defined for all relevant professions
- ☐ Everyone who works with people at high risk of developing an eating disorder has access to training appropriate to their role
- ☐ All health professionals and allied professionals who work with high risk groups are trained in screening, assessment, referral and support for people with eating disorders
- ☐ All health professionals who provide treatment are trained in the delivery of evidence based treatment and have access to tertiary support and supervision
- ☐ Non health professionals who work with high risk groups have training in eating disorders mental health first aid or equivalent
- ☐ Health professionals with eating disorders expertise are employed in every primary health care region

*For a more detailed discussion on workforce competencies please see the NEDC Consultation Paper 'Developing Practical Approaches to Eating Disorders: Workforce Development.*

# An Informed Community

*(Note: the communication principle in the National Eating Disorders Framework encompasses standards for communication with a broad range of audiences. The discussion here is limited to communication related to treatment. More information on communication about eating disorders may be found in the NEDC publication 'Clarity in Complexity: An Eating Disorders Communication Strategy' and in the consultation paper 'Developing Practical Approaches to Eating Disorders: Prevention and Early Intervention'.)*

Communication with the community, with frontline professionals and between health professionals is essential to support early intervention treatment for and recovery from eating disorders.

Communication is required in four domains:

**Awareness:** Communication with the general community and specific sub-groups at high risk of developing eating disorders to raise awareness of eating disorders as serious and complex illnesses and raise awareness of risk factors for eating disorders.

**Professional Knowledge:** Communication with health professionals and professionals who influence the health decisions of others, especially young people, to equip them to recognise risk factors for eating disorders, screen and assess for eating disorders and respond appropriately to people seeking help.

**Prevention Programs:** Communication to support the uptake of evidence based prevention and early intervention programs

**Access:** Supporting help and information seeking by ensuring that people have access to consistent, evidence based information.

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**Principle:**

**Communication to ensure an informed and responsive community**

Consistent and appropriate messages are provided to make sure that the community is aware of eating disorders as serious mental and physical illnesses.  Such messages also educate the community to reduce the stigma that hampers help seeking. Eating disorder prevention integrates with wider physical and mental health promotion strategies to provide consistent health information that promotes wellbeing.  Frontline professionals and adults with a duty of care and who influence young people (e.g. parents, school counsellors, teachers, and youth workers) are trained to recognise and respond appropriately to eating disorders;

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**Potential indicators to demonstrate implementation of this principle include:**

☐ Eating disorders are consistently represented in health information resources as serious, complex illnesses that can be treated

☐ Accurate information on the risks of dieting is consistently represented in health information resources

☐ Families are actively encouraged to develop mental health literacy

☐ Clinicians and professionals who intersect with people at high risk of eating disorders are actively encouraged to access training in screening, assessment, referral

# A Consistent Approach

Working collaboratively across disciplines and service providers in multi disciplinary treatment requires new approaches within health services.

Ensuring that approaches to eating disorders are consistent and able to work effectively together across the continuum of care will require the adoption of common standards and practice principles.

Implementation of shared clinical guidelines, decision support tools, clinical routines and protocols will build system-based competence for the multi disciplinary and multi agency, treatment of eating disorders.

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**Principle:**

**Systems support integration, collaboration and on-going development**

Policy and systems support collaboration between physical and mental health services, private and public health services, health promotion, prevention and treatment, health and community services and between professional disciplines.  On-going processes of review and shared learning support the consistent implementation of evidence based approaches.  People with personal experience of eating disorders are involved at all levels of policy development, planning, and systems development.

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**Potential indicators to demonstrate implementation of this principle include:**

☐ Eating disorders are recognised in health policy and practice as a separate group of serious and complex psychiatric disorders requiring evidence based prevention, treatment and support

☐ Health service policies include all aspects of treatment and support including:

☐ Early intervention and timely access to services

☐ Multi-disciplinary treatment

☐ Family support and education

☐ Long term access to recovery support

☐ Case coordination

☐ Discharge and long term medical monitoring

☐ The principles of the National Eating Disorders Framework guide development and review of services and service planning

## Grounding Practice in Evidence

Safe treatment options should be evidence based, founded on the best available evidence from the established research evidence base and the consensus of expert opinion published in clinical practice guidelines. It should also take into consideration emerging promising practices from current treatment research and the lived experience.

For eating disorders, evidence informed approaches means more than implementing known best practices.  In part as a result of the complexity of eating disorders, evidence supporting the efficacy of treatments is limited. The NEDC Evidence Review (2010) confirmed that there are very significant gaps in the evidence base for eating disorders and addressing these gaps is a high priority for the development of the eating disorders sector.

**Evidence informed and evidence generating approaches are:**

1. Based on and referenced to the best available research
2. Informed by the expertise of people with personal experience of eating disorders, their clinicians and carers
3. Consistent with the national eating disorders framework
4. Regularly monitored and reviewed, including review by service users, to ensure safety, appropriateness and implementation of standards
5. Evaluated on an on-going basis at an appropriate level to generate new evidence
6. Contribute to data collection on the incidence and progression of eating disorders

| Principle: |
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| **Evidence informed and evidence-generating approaches** |
| Research and evaluation are integral to the design and delivery of health promotion, prevention, early intervention, and treatment approaches. Basing approaches on evidence ensures that people have access to the most effective approaches, all approaches develop in response to emerging evidence, and new approaches that contribute to emerging, practice informed evidence are encouraged. People with personal experience of eating disorders are involved at all levels of service development and evaluation. |

**Potential indicators to demonstrate implementation of this principle include:**

☐ Treatments provided for people with eating disorders are supported by evidence as suitable for the specific presentation of eating disorder

☐ Staff are trained in the delivery of evidence based treatments for eating disorders and in person-centred approaches

☐ Data is collected on the prevalence of eating disorders, access to prevention and treatment interventions and outcomes of intervention

☐ All services are evaluated on a recurrent basis

☐ People with eating disorders and their families have the opportunity to participate in service evaluation and development

## National Standards Schema

### Practice Principles

Seven core principles and four implementation principles have been identified which, if implemented together, will provide the foundation for an effective and nationally consistent system to address eating disorders.

The principles of prevention and treatment focus on access to comprehensive, coordinated approaches that provide individually tailored pathways that can be consistently implemented. The principles are predicated on the need to be informed by evidence from research and the lived experience.

Standards of care must apply to those at risk of developing an eating disorder where the goal is prevention, those with early symptoms of an eating disorder where the goal is early intervention; those with acute illness, where the goals of treatment are recovery and relapse prevention; and to those with a severe or enduring disorder, where goals of care may be modified to encompass improvements in quality of life.

o **Person and family centred care that addresses the needs of individuals**
Individual treatment plans are developed within a person-centred, family and culture sensitive and recovery oriented framework. Services are delivered with a strengths-focussed approach, supporting long-term recovery, tailored to meet individual decision making capacity and needs as they develop over the course of the illness; and

o **Prioritization of prevention, early identification and early intervention**
Prevention, early identification and prompt intervention are necessary to reduce the severity, duration and impact of the illness. Early intervention for eating disorders includes strategies that enable people to access services as soon as they are needed: early in the development of the illness, early in help seeking and early in recurrent episodes of illness, with immediate access to treatment and support; and

o **Safety and flexibility in treatment options**
Safe treatment for eating disorders addresses all of the aspects of illness: physical, behavioural and psychological. People have access to a range of safe treatment options which meet different needs at each stage of risk, illness and recovery.  Flexible and appropriately supported entry, exit and transition between services supports individually tailored care planning.  When transitioning from child and adolescent services to adult services appropriate support is provided to the individual and their family; and

o **Partnering to deliver multi disciplinary treatment in a continuum of care**
Treatment is provided by a multi disciplinary team who work in partnership with the person, their family and other health and support providers, including treatment of co-morbid issues.  The multi disciplinary team will assist clients to meet physical, mental, nutritional, occupational and social needs. Individuals with an eating disorder require individual care plans and access to a designated case coordinator; and

o **Equity of access and entry**
People have access to treatment and support services when and where they are needed, early in the illness and early in each episode of illness. The requirements of regional and

rural areas are recognised and technological solutions to providing accessibility are included. The entry requirements and the costs, subsidies or fee rebates for treatment take into consideration the long term and complex nature of eating disorders and the need to ensure they are accessible and affordable to all. Clearly identified entry points, ideally located in the community, assist people to make informed decisions about treatment options and enable them to engage with accessible and affordable services; and

o **Tertiary consultation accessible at all levels of treatment**
Access to expert consultation is required at the earliest possible point to ensure appropriate and early intervention.  Wherever treatment occurs in the continuum of care from early intervention to recovery support there must be access to tertiary level expertise for consultation, supervision, guidance and referral if required; and

o **Support for families and carers as integral members of the team**
Families and carers, where available, are recognised as integral members of the treatment and support team and receive support, skills and strategies, education and information to enable them to support the person with an eating disorder and to maintain personal good health.  Where such support of a family or carer is not available, this gap in the team and support structure is taken into account and addressed by the service providers;

## Implementation Principles

To implement each of the practice principles, action will be required in four domains:

o **Evidence informed and evidence-generating approaches**
Research and evaluation are integral to the design and delivery of health promotion, prevention, early intervention, and treatment approaches. Basing approaches on evidence ensures that people have access to the most effective approaches, all approaches develop in response to emerging evidence, and new approaches that contribute to emerging, practice informed evidence are encouraged. People with personal experience of eating disorders are involved at all levels of service development and evaluation.

o **A skilled workforce**
An effective system is founded on a skilled and supported workforce. All health professionals receive training in eating disorders to raise their awareness of the serious nature of eating disorders and to enable them to identify, assess and contribute to the treatment of eating disorders.  Training includes the development of attitudes and practices that support early identification and intervention and a person centred and recovery oriented approach. General Practitioners are recognised as being the first point of contact in many instances and are educated on how to interview the patient and their family to facilitate an early diagnosis. Training includes attitudes and practices that support early identification, intervention, recognition of the ambivalence and fear that is prevalent in this population and a recovery oriented approach; and

o **Communication to ensure an informed and responsive community**
Consistent and appropriate messages are provided to make sure that the community is aware of eating disorders as serious mental and physical illnesses.  Such messages also educate the community to reduce the stigma that hampers help seeking. Eating disorder prevention integrates with wider physical and mental health promotion strategies to provide consistent health information that promotes wellbeing.  Frontline professionals and adults

with a duty of care and who influence young people (e.g. parents, school counsellors, teachers, and youth workers) are trained to recognise and respond appropriately to eating disorders; and

o **Systems support integration, collaboration and on-going development**
Policy and systems support collaboration between physical and mental health services, private and public health services, health promotion, prevention and treatment, health and community services and between professional disciplines.  On-going processes of review and shared learning support the consistent implementation of evidence based approaches. People with personal experience of eating disorders are involved at all levels of policy development, planning, and systems development.

## A continuum of care

The essential service elements of a continuum of care which has the capacity to address both prevention and treatment taking into consideration the high degree of variation in individual and family needs are identified as:

**Prevention**
- Primary prevention strategies targeting:
  - □ The whole community (universal)
  - □ Groups known to be at higher risk (selected) or
  - □ Individuals at very high risk who may be showing early signs of mental ill health (indicated)
- Secondary prevention strategies to lower the severity and duration of an illness through early intervention, including early detection and early treatment
- Tertiary prevention intervention strategies to reduce the impact of mental ill-health on a person's life through approaches such as rehabilitation and relapse prevention

**Treatment**
- Primary health care
- Community based clinical outpatient treatment
- Intensive outpatient treatment
- Day programs
- Residential programs
- Inpatient treatment
- Recovery oriented community based support programs

**Support Services:  continuum elements of relevance at all stages from prevention to recovery**
- Education and support for families and carers
- Non clinical counselling
- Peer support
- Information and referral support

# Document Two

# Planning Treatment Services

**Exploring opportunities to implement
community based service**

# Estimating Service Needs

There is inadequate data in Australia on the number of people presenting for treatment of eating disorders.

There is a high level of missed diagnosis for eating disorders due in part to professional lack of experience in working with patients with eating disorders and in part to the nature of eating disorders which may disguise or delay recognition of symptoms. Research suggests that only about 22% of people with eating disorders receive treatment specifically for their disorder, although most will receive treatment for related issues.

In many instances treatment in primary care is provided for weight loss/gain, mood disorders and for the physical consequences of eating disorders without reference to the underlying eating disorder. In inpatient treatment, patients may be treated for medical instability or comorbid mental health issues without reference to their eating disorder.

More people are diagnosed with binge eating disorder or 'Other Eating and Feeding Disorders' (previously called EDNOS) in Australia than either of the other eating disorders diagnoses but very little data has been collected on their access to health services. People with these disorders are at equal risk of experiencing the adverse effects of eating disorders as those with more specific eating disorders.

Estimating service needs therefore requires a combination of data on:

- Current activity levels on services providing treatment for patients with eating disorders
- Demographic data on high risk populations in the region
- Prevalence calculations based on the best available research

## Current Activity Data

Existing data on patients with diagnosed eating disorders provides the first indicator of service need.

Data may be available on primary diagnosis and presenting problems on admission to inpatient and outpatient services provided by hospitals in the region e.g.

- Emergency department services for medical stabilisation or self harm
- Admissions to medical wards including acute care wards and ICU
- Admissions to psychiatric wards
- Admissions to eating disorder programs
- Outpatient services
- Dietitian time per eating disorder admission

Current activity data may be expanded by survey of community based clinicians (e.g. GPs, psychologists, and dietitians) although these results may also be limited due to the low level of diagnosis in primary care.

## Identifying 'at risk' populations

Eating disorders can occur in any population within Australia; both males and females; in children, adolescents, adults and older adults; in all socio-economic groups; and from all cultural backgrounds.

However, across this broad demographic, certain groups have been identified as being at higher risk:

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

Some groups in the community who may not be identified as having a high statistical risk of developing eating disorders, experience specific health issues and vulnerabilities when they do experience an eating disorder that need to be taken into consideration. These groups include:

- Younger children
- Pregnant women
- People with specific health conditions – diabetes, PCOS, infertility
- Males
- Indigenous communities

*Needs analysis for the region would take into consideration current data on:*

o Population of children and youth and identification of high concentration of young people in specific areas (e.g. a university campus). Approximately 15% of young females will experience an episode of eating disorder at some level of severity. Between 50 and 80% of children and young people hold high risk beliefs about weight and diet and will engage in dieting behaviours

o Rate of obesity. Up to 30% of people seeking treatment for obesity engage in binge eating with between 10 and 20% meeting the criteria for binge eating disorder

o Rate of mood disorders or substance misuse. The majority of people with eating disorders will also experience episodes of anxiety or depression and are more likely to seek treatment for these conditions than for their eating disorder. There is a relationship between bulimia nervosa and substance misuse.

o Rate of diabetes especially in children, adolescents and young adults. The manipulation of diabetes medication to lose weight has life threatening consequences.

## Calculating prevalence

Eating disorders are relatively common when compared with other priority health issues. Every community will include people with experience of an eating disorder and most health regions will require some eating disorders specific treatment programs and a broad development of eating disorder skill and knowledge in health professionals.

*Calculation of prevalence should take into consideration:*

o **Community prevalence**
Eating disorders are estimated to affect approximately 9% of the total population with prevalence in any one year of around 2.94% in males and 5.11% in females.

o **Prevalence in women**
Australian research has identified a lifetime prevalence of 15% for eating disorders in women and 20% for subclinical presentation

o **Rates of recurrence**
People who have experienced an episode of an eating disorder are at high risk of a recurrence of the same or a related illness. Relapse is a significant issue for people with eating disorders, with rates of relapse ranging from 22% to 51% across studies of Anorexia Nervosa and Bulimia Nervosa. While Approximately 50% of individuals with anorexia nervosa and bulimia nervosa will recover, 20%–30% will continue to experience persistent subclinical symptoms, and 20%–25% will have a severe and enduring disorder. Approximately 18% of people with binge eating disorder may experience a long term eating disorder of clinical severity.

o **Changes in diagnosis**
People may experience an unstable pattern of illness, with alternation between periods of remission and new episodes of illness. Approximately half of individuals with anorexia nervosa will experience bulimia nervosa or binge eating disorder at a later stage in life. The presentation of people with bulimia nervosa and binge eating disorder may also change over time to 'Other Eating and Feeding Disorders' (OSFED).

## Planning within a continuum of care

### Approaches to Planning for Eating Disorders Treatment

The implementation of eating disorder service models should be considered in the context of State and National health policies, resource availability, organisational capability, operational factors and local community environments.

Responses to eating disorders in Australia have developed in an ad hoc way in response to local issues. This has resulted in a fragmented approach to treatment that does not effectively support flexible treatment across the continuum of care. The fragmented approach also creates barriers to sharing knowledge and increases the effort and costs involved in establishing new services.

To avoid further fragmentation, the planning for a new eating disorder service, or enhancement of existing services, should involve as many stakeholders as possible. This enables the region to draw on a broad range of expertise and ensure that the service integrates into existing systems.

Planning should include representatives of mental health and medical services.

*The range of agencies that should be considered in eating disorder service planning includes:*

- Medicare Local or other primary health care planning representatives
- Local Health District (LHD or other state health planning regions)
- All general hospitals in area
- Child and adolescent (youth) mental health services
- Community mental health services (adult)
- Eating disorder specialist services in area (public and private health)
- Eating disorder specialist referral services out of area
- NGOs providing eating disorder support services and/or consumer representation in area
- NGOs providing eating disorder outreach support services and/or consumer representation from out of area
- State government eating disorder tertiary support (NSW = CEDD; QLD = EDOS; VIC = CEED)
- Community partners e.g. community health centres, youth health centres (e.g. headspace) and individual practitioners (GPs, psychologists, dietitians) with an interest in eating disorders

### A Stepped Continuum of Care

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

The continuum of care involves voluntary agencies, primary care professionals, local mental health services, medical services and specialised eating disorder services.

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

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

## Locating Services in the Continuum

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

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

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

For people with severe anorexia nervosa (e.g. extreme or rapid weight loss and medical complications) intensive treatment is required to stop the progress of the illness. Hospitalization should occur before the onset of medical instability. Weight levels should not be used as the sole criterion for access to or discharge from inpatient or intensive treatment programs.

Most people with bulimia nervosa and binge eating disorder do not require hospitalization. Indications for the hospitalization of patients with bulimia nervosa and binge eating disorder include failure to respond to outpatient treatment, suicidality, serious concurrent general medical problems, or comorbid psychiatric or substance disorders that would otherwise require hospitalization.

## Planning Flexible Care Pathways

Eating disorders are dynamic illnesses that can change the way in which they manifest throughout the course of illness. All types of eating disorders present within a wide range of severity. Progression along the continuum is not linear and response to treatment is individual and variable. There is a need to develop a suite of safe treatment options that can be delivered in a flexible approach with scope for individual choice.

While it is not possible to predict the illness pathway for each individual there are some broadly identifiable risks for each type of disorder and the identification of different care pathways for different types of eating disorders may be appropriate. Planning for patient movement between levels of care should take into consideration:

o **Children and Adolescents with an eating disorder diagnosis**

All children and adolescents diagnosed with an eating disorder should be assessed by Child and Adolescent Mental Health Services.

o **Anorexia Nervosa and related atypical presentations**

People with anorexia nervosa can lose weight rapidly and become medically unstable. The risk of medical complications is high. Adults with a diagnosis of anorexia nervosa should ideally be referred by their primary care clinician to an eating disorders specialist service

for adults for a full eating disorders assessment. Treatment may be required at a complex or intermediate level of service.

o **Bulimia Nervosa, Binge Eating Disorder and related atypical presentations**

For adults with Bulimia Nervosa and Binge Eating Disorder, specialised CBT outpatient programs are indicated as the first line of treatment. Pathways are required up to intermediate intensive programs for people with more complex needs. Patients with medical compromise, risk of self harm or suicide require access to inpatient treatment.
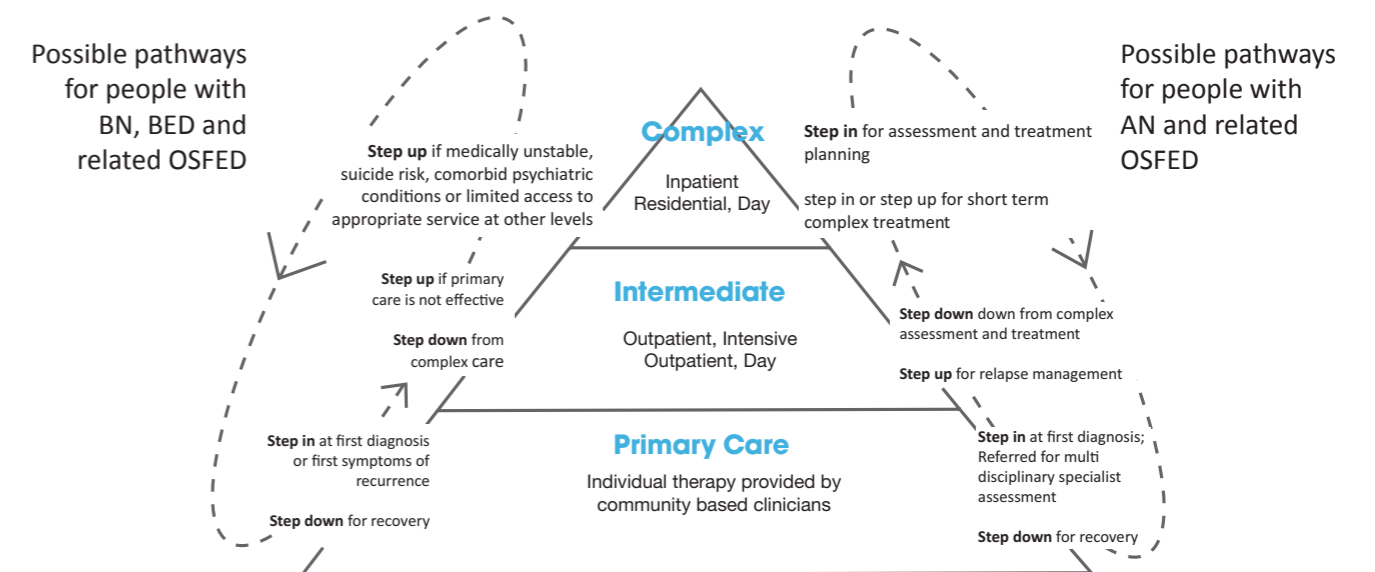


## Service Mapping

The development of treatment responses for eating disorders should aim for the best mix of access to care using currently available or currently planned resources. Planning should take into consideration:

- Eating disorders specific programs (public and private) within the region including range of services and service capacity
- Eating disorders specific programs out of area that accept referrals including range of services and service capacity
- General hospital admissions for eating disorders treatment
- Patient pathways to eating disorders and general hospital services
- Eating disorder support services
- SWOT analysis specific strengths, weaknesses and opportunities within the region including:

  ☐ clinical expertise or interest in training in eating disorders treatment
  ☐ potential care partnerships including partnerships with NGO and community partners
  ☐ professional networks able to support shared treatment
  ☐ access to GP, psychologist and dietitian services in local communities
  ☐ services with the potential to provide multi disciplinary treatment e.g. existing medical centres, youth health centres (e.g. headspace, university clinics), women's health centres, sports medicine centres, eating disorder or body image programs (e.g. NGO services), mental health services (e.g. mood disorder clinics).

# The Clinical Treatment Continuum for Eating Disorders

| Level of Care | Entry | Outpatient | Intensive Outpatient | Day Program | Residential Program | Inpatient |
|---|---|---|---|---|---|---|
| **Core Elements** | ☐ Well publicised soft entry points<br>☐ Community outreach<br>☐ Opportunistic screening<br>☐ Initial assessment<br>☐ Information<br>☐ Engagement support<br>☐ Referral pathways<br>☐ Patient advocacy<br>☐ Holding response<br>☐ Monitoring<br>☐ Recovery support<br>☐ Family support | ☐ Regularly scheduled appointments with a therapist and dietician, working collaboratively with the GP and other primary care providers<br>☐ Individual, family and/or group therapy<br>☐ Appointments at intervals to suit patient, but typically weekly at start of treatment<br>☐ Services co-located or networked | ☐ Regular individual therapy and dietician appointments PLUS<br>☐ Group meetings and supported meals<br>☐ Family education and support<br>☐ May include support therapies and recreational activities<br>☐ Program attendance two to three times per week for at least three hours per session<br>☐ All services co-located | ☐ Regular individual therapy and dietician appointments PLUS<br>☐ Group meetings and supported meals<br>☐ Family education and support<br>☐ Includes support therapies and recreational activities<br>☐ Program attendance five days week, for six to eight hours a day.<br>☐ All services co-located | ☐ Regular individual therapy, nutritional counselling and psychoeducation.<br>☐ Group meetings and supported meals<br>☐ Family education and support<br>☐ 24 hour clinical supervision and support; a long-term treatment option with a high level of support and supervision.<br>☐ All services co-located; may be located in hospitals or as separate community based centre | ☐ Regular individual therapy, nutritional counselling and psychoeducation.<br>☐ Group meetings and supported meals<br>☐ Family education and support<br>☐ 24 hour clinical supervision and support<br>☐ Medical monitoring and treatment<br>☐ Re-feeding services<br>☐ Treatment for co-morbid psychiatric conditions<br>☐ Joint admissions under both medical and psychiatric care |
| **Service Context** | Primary health care<br>NGOs<br>Tele-support services<br>Emergency departments also play a key role | Services best delivered in community locations<br>Service Providers include: primary care (e.g. Medical Centres); hospital outreach; NGOs; private providers<br>All services must be networked with Tertiary Consultation-Liaison and Hospital Inpatient services | | | | Hospital or eating disorders treatment centre with inpatient and medical facilities |
| **Tertiary Support** | **Tertiary consultation-liaison**: services integrate triage, outreach, tele-psychiatry and inpatient and outpatient specialist treatment with community based health care.<br>**Case coordination**: specialist eating disorders nurses or clinicians liaise between primary care and hospital care and provide people with rapid access to support and advice. | | | | | |
| **Recovery Support** | Step up/step down model of service access with rehabilitation and relapse prevention to ensure that people have access to the right level of care as part of a long term treatment plan | | | | | |

| | Outpatient | Intensive Outpatient | Day Program | Residential Program | Inpatient |
|---|---|---|---|---|---|
| **Patient Status[1]**<br><br>*Any one assessment factor indicates need for more intensive level of treatment* | ☐ Medically stable;<br>☐ Weight >85%;<br>☐ Good motivation for change;<br>☐ Self sufficient; can reduce ED behaviours in unstructured setting;<br>☐ No current risk of suicide or self harm<br>☐ No comorbid disorders<br>☐ Family or others able to provide support;<br>☐ Lives near treatment centre | ☐ Medically stable;<br>☐ Weight >80%;<br>☐ Fair motivation for change;<br>☐ Self sufficient; can reduce ED behaviours in unstructured setting;<br>☐ No current risk of suicide or self harm<br>☐ No comorbid disorders<br>☐ Family or others able to provide support<br>☐ Lives near treatment centre | ☐ Medically stable;<br>☐ Weight <85%;<br>☐ Partial motivation for change;<br>☐ Needs structure to reduce ED behaviours<br>☐ No current risk of suicide or self harm<br>☐ No comorbid disorders or disorders well managed<br>☐ Family or others able to provide limited support;<br>☐ Lives near treatment centre | ☐ Medically stable to extent that intravenous fluids, naso-gastric feedings or daily laboratory tests are not needed ;<br>☐ Weight <85%;<br>☐ Poor to fair motivation for change;<br>☐ Needs supervision for activities of daily living<br>☐ No current risk of suicide or self harm<br>☐ No comorbid disorders or disorders well managed<br>☐ Severe family stress or absence of family or other support<br>☐ Treatment centre too distant for patient to participate from home | ☐ Medically unstable; weight <80% or acute weight loss with food refusal;<br>☐ Very poor to poor motivation for change;<br>☐ Needs supervision during and after all meals<br>☐ Specific suicide plan with high lethality or intent<br>☐ Comorbid disorders requiring inpatient treatment<br>☐ Severe family stress or absence of family or other support;<br>☐ Treatment centre too distant for patient to participate from home |

**Notes:**

Treatment for eating disorders is a long term process. Therapeutic change occurs most successfully in an outpatient or day-patient setting. Where successful early detection at the onset or deterioration of problems occurs, hospitalisation is mostly not necessary.

All patients must be treated for the physical, psychological, nutritional and functional aspects of their eating disorder. Best practice eating disorders management requires an integrated, multidisciplinary network of primary and specialist care. Eating disorders treatment should be delivered by trained and experienced practitioners.

[1] Adapted from APA Level of Care Guidelines 2010

# Treatment Approaches

No single treatment approach has been shown to be effective for every person with an eating disorder therefore the selection of approaches must always take into consideration the individual, their family and social context, the diagnosis, the stage and longevity of illness, and comorbid conditions. A person with an eating disorder requires treatment that is specific to their disorder and specific to their individual circumstances.

Multi-modal treatment approaches are recommended that address the psychological, physical, behavioural, nutritional and functional aspects of eating disorders.

## Aims of Eating Disorders Treatment

The overarching aims of treatment for all eating disorders are:

1. Reduction in eating disorders behaviours
2. Restoration of nutritional health
3. Treatment of physical complications
4. Enabling family support through the provision of family education, counselling and therapy as appropriate
5. Enhancement of the patient's motivation to engage in treatment and recovery
6. Provision of education regarding healthy nutrition and healthy relationship with food and development of regular and healthy patterns of eating
7. Helping patients to identify and change dysfunctional thinking, attitudes, beliefs and emotions and development of new coping mechanisms
8. Reduction in extreme weight and shape concerns
9. Treatment of associated psychiatric conditions, including low mood, anxiety and impulse regulation
10. Prevention of relapse.

The goals and length of treatment for a particular person are dependent on their presentation and should be tailored to their individual needs.

## Safe Treatment

Safe treatment addresses all aspects of illness and is optimally delivered by a multi disciplinary team.

Essential components of safe treatment include:

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

- **Physical Health Assessment and Treatment**
  Regular assessment of physical health risks is essential with medical treatment where required. Physical assessment and treatment can also be useful in the identification and management of compulsive exercise and improvement of body awareness and body responsiveness.

- **Engagement**
  A critical issue for people with eating disorders is engaging them in treatment so that they can make use of available services. Engaging patients with an eating disorder in change is difficult and intensive treatment programs have high drop-out rates. Motivational Interviewing (MI) in the form of a brief, pre-treatment intervention is associated with higher completion rates in subsequent intensive treatment for an eating disorder. MI can be a useful intervention to engage individuals with severe eating disorders prior to participation in intensive treatment. (Weiss, Mills, Westra & Carter, 2013)

- **Mental Health Interventions**
  The best available evidence to date supports the use of the following therapies delivered in an evidence based dosage. The minimum course of treatment for eating disorders supported by evidence is at least 20 sessions, usually delivered over a 4 to 6 month period (ANZAED, 2011). Shorter periods of treatment are not supported by research evidence and are inadvisable except as a preventative approach.

  *Anorexia Nervosa*

  o **FBT for Adolescents** - On the basis of current evidence Family based treatment (FBT) FBT should be made available for adolescents with anorexia nervosa, in line with the recommendations of key eating disorder guidelines (American Psychiatric Association, 2006; NICE, 2004). The Children's Hospital at Westmead in NSW has found that an average of 30 sessions of Maudsley Family Based Therapy is effective in improving outcome for children and adolescents with anorexia nervosa. Provision of this number of sessions has halved rates of readmission to their inpatient unit (Rhodes & Madden, 2005; Wallis, Rhodes, Kohn & Madden, 2007).

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

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

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

  *Bulimia Nervosa and Binge Eating Disorder*

  o **Cognitive behaviour therapy (CBT)** should be offered to adults with bulimia nervosa. The course of treatment is recommended to be 20 sessions(Fairburn, Marcus & Wilson, 1993; Mitchell, Agras & Wonderlich, 2007; NICE, 2004), delivered over a minimum of 4-5 months as either individual or group therapy (Hay, & Touyz, 2012). This treatment dosage is effective for approximately 40–60% of individuals receiving treatment (Hay & Touyz, 2012).

  o **Interpersonal Psychotherapy (IPT)** should be considered as an alternative to CBT for adults. An evidence based dosage would be delivered over a longer time period of between 8-12 months to achieve results comparable with CBT.

- **Nutritional Interventions**
  Dietary advice improves outcomes for people with anorexia nervosa (RANZCP, 2011) and may enhance nutrition for people with bulimia nervosa and binge eating disorder. A nutritionally

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

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

• **Other Interventions**
Individuals may also require physical activity interventions, such as physiotherapy or exercise to assist in the management of mood and physical conditions such as osteoporosis, and occupational therapy or education support.

• **Weight disorders and obesity**
There is evidence that obesity is a serious and common outcome for people with bulimic eating disorders and binge eating disorder. Patients who are overweight may require help in addressing weight-loss. However, this is very variable and many patients at the end of therapy conclude that they are comfortable with their weight, albeit that their BMI has not changed. Weight stabilisation with normalisation of eating patterns and attitudes and beliefs about eating and eating behaviour may be a better initial goal than weight loss. For those who have a BMI higher than 30 and/or complications such as diabetes, initial stabilisation for the eating disorder may be followed by a supported weight loss program, mindful that weight loss need only be very modest, around 5-10% of body weight, to help prevent diabetes and cardiovascular disease.

# Treatment Approaches

*The following table summarizes the principle evidence based approaches to treatment that are currently in use which are discussed in more detail in the relevant chapters of the National Eating Disorders Framework. The table does not purport to include all possible forms of prevention or treatment.*

| Common to all eating disorders | Specific to Anorexia Nervosa | Specific to Bulimia Nervosa | Specific to Binge Eating Disorder | Specific to Other Specified Feeding and Eating Disorders |
|---|---|---|---|---|
| • GP monitoring weight and medical complications<br>• Local eating disorder support provided through community based organisations.<br>• Psychotherapy.<br>• CBT-E<br>• Mindfulness Therapy<br>• Anxiety / stress management<br>• Nutritional management/ monitoring/ support<br>• Psychoeducation<br>• Supportive family education<br>• Combined treatments e.g. psychotherapy + nutritional rehabilitation + medication | • Family based treatment<br>• Motivational Interviewing<br>• Interpersonal Psychotherapy (IPT)<br>• Specialist (Formerly Nonspecific) Supportive Clinical Management<br>• Nutritional rehabilitation/refeeding<br>• Adjunctive medication e.g. antipsychotics | • CBT guided self-help<br>• Mindful eating/ nutritional management<br>• Crisis intervention<br>• Family based treatment for children and adolescents<br>• Adjunctive medication e.g. antidepressants | • CBT guided self-help/ pure self-help<br>• Interpersonal Psychotherapy (IPT)<br>• Behavioural weight loss e.g. Lifestyle, Exercise, Attitudes, Relationships & Nutrition (LEARN) program<br>• Adjunctive medication e.g. antidepressants<br>• Obesity treatment/ obesity medication<br>• Combined treatments e.g. Psychotherapy + behavioural weight loss + medication | • Treatment follows the eating disordered behaviours most like AN, BN or BED |

# Building capacity for early identification

The safe treatment of eating disorders requires access to skilled professional treatment for psychological, physical and nutritional aspects of their illness. Depending on individual need outpatient treatment may include the provision of services by a range of health care providers including general practitioners, paediatricians, dietitians, physiotherapists and social workers working together as a team or networked for the provision of shared care.  A general practitioner is frequently the first point of contact and is an important member of the multi disciplinary team. Community case management models may be required to coordinate multi disciplinary outpatient services.

The range of eating disorder services to be provided in the community includes:

- Provision of information
- Promotion of prevention resources
- Initial diagnoses and assessment
- Provision of targeted prevention and early intervention to people at high risk
- Treatment of mild to moderate eating disorders in outpatient programs and through 'virtual' local multi-disciplinary teams
- Ongoing medical monitoring as part of a shared care arrangement
- Transition support, follow up and recovery support for people who have received treatment elsewhere
- Family education and support
- Patient education, social and peer support

## A Skilled Workforce

The evidence based component of treatment is located in the skill of the staff working with the patient. Therefore all patients with eating disorders need to be treated by someone who is trained to deliver this treatment.

Evidence from research and from NEDC consultations suggests that the majority of health professionals are not sufficiently trained in the assessment and treatment of eating disorders and do not feel confident to undertake this role.

Safe treatment also involves a multi disciplinary team approach. The National Framework identifies a core team of psychologists, medical practitioners, dietitians and mental health nurses supported by an accessible network of other professionals including social workers, dentists, physiotherapists, occupational therapists, other allied therapists and specialists for comorbid conditions.

Some disciplines are important members of the treatment team for different groups of patients. For example, a school teacher may be an important member of the team for children and adolescents. Patients with diabetes may require a diabetes educator on the team.

People in every community require access to accurate diagnosis and appropriate referral and support provided at both the primary and secondary levels of care. General medical practitioners, emergency department staff, dietitians, counsellors and psychologists (including school psychologists) should have the technical knowledge and skill to identify risk, screen and conduct initial assessments and provide a short term 'holding response' while expert treatment is sourced.

Every agency or program that provides health services to people at risk of developing an eating disorder should have a core capacity, defined through program infrastructure such as policies and clinician competencies, to provide appropriate services to the people with eating disorders and their families.

There are currently no defined competencies or skills sets for the treatment of eating disorders. The NEDC has identified the development of competency statements for eating disorders as an important step in the priority area of workforce development to address gaps in eating disorders prevention and treatment. In this context, competencies are defined as those measurable skills, abilities and attitudes that are required to deliver evidence based assessment and treatment for eating disorders.

The following key areas of skill have so far been identified for different groups of health professionals:

**Screen, Assess and Refer**

All health professionals who have a responsibility for assessment and diagnosis and who come into contact with the high risk groups for eating disorders should be able to demonstrate knowledge in the following areas:

1. Demonstrate knowledge of evidence relating to eating disorders
2. Identify and screen people at risk
3. Conduct assessment and document clinical history
4. Refer patients appropriately

**Contribute to Treatment and Management of Eating Disorders**

In addition to demonstrating knowledge of screening, assessment and referral, all health professionals who contribute to treatment for people with eating disorders should be able to demonstrate the ability to:

5. Work collaboratively with patients and their families
6. Develop and implement a treatment plan
7. Deliver evidence supported treatment modalities for eating disorders (e.g. CBT, FBT, Guided Self Help)
8. Contribute to collaborative interdisciplinary treatment
9. Support recovery

*Note: For a more detailed discussion on competencies please refer to the NEDC consultation paper 'Developing Practical Approaches to Eating Disorders: Workforce Development'.*

## Identifying Workforce Capabilities

A clinically informed and well networked range of support providers will add capacity to a region's response to eating disorders even when eating disorders services cannot be developed.

An assessment of the need for workforce capability development would include identification of:

☐ Access in the region to all of the professionals required in the multi disciplinary team

☐ Current levels of experience assessing and treating people with eating disorders

☐ Current levels of training in eating disorders

☐ Attitudes and beliefs about eating disorders

☐ Interest in developing capabilities in the treatment of eating disorders

## Visibility of Entry Points

There appears to be an important role in the eating disorders model of care for services which can connect community and health system activity, and physical and mental health services to support long term treatment and functional outcomes. Essential activities in this area include:

☐ Entry points

☐ Community outreach

☐ Early intervention programs

☐ Case coordination and liaison

☐ Recovery support services

☐ Family support services

A challenge for any service system seeking to provide early intervention care for eating disorders is identification of people at high risk at the earliest possible stage in the development of eating disorder behaviours and thinking. One of the most difficult things for people seeking help is determining the entry point.

Clear identification of entry points and up-skilling of staff in potential entry points are both important strategies to support an eating disorders model of care. Ideally, the entry point for eating disorders is flexible with access to treatment pathways through any of the people who act as first point of contact.

Service models should incorporate assertive outreach activities for prevention and facilitation of early identification. The following activities should all be considered as part of a preventive health approach to eating disorders:

☐ Professional networking

☐ Community education to raise awareness and publicise entry points

☐ Implementation of selective prevention programs

☐ Delivery of or facilitation of access to introductory level professional training

## The role of Emergency Departments

People who present for treatment in general hospitals for conditions related to an eating disorder have serious and potentially life threatening illnesses. Emergency staff should arrange mental health treatment to begin while the person's medical needs are being dealt with. The next step on from emergency medical treatment should be a full eating disorders assessment and a referral or transfer to an eating disorders specialist program or an eating disorder specialist clinician.

For patients who are already receiving treatment for their eating disorder it is essential that the current episode of emergency treatment is integrated with the ongoing treatment plan. If the patient is not receiving treatment for their eating disorder the present incident may be the start of their eating disorders treatment, or the start of treatment for this episode of illness. In these circumstances it is important that:

☐ A full eating disorders assessment is conducted before the person is discharged.

☐ A referral or transfer plan is in place to ensure the next stage of eating disorders treatment

☐ The patient receives follow up contact to ensure their safety and encourage uptake of referrals.

Emergency Departments require procedures and training in triage, risk identification and medical management for eating disorders to ensure an admission pathway for patients with severe illness and to prevent premature discharge.

## Early Intervention for Bulimia Nervosa and Binge Eating Disorder

Guided self help refers to a Cognitive Behavioural Therapy (CBT) approach in which the person makes self directed progress through a book or program while receiving support through regular sessions of professional guidance. Typically, six to eight support sessions of approximately 30 minutes are required.

It is suitable for people with bulimia nervosa and binge eating disorder and has been shown to be effective for around 20% of people with these disorders.  It has been shown to be suitable for people as young as 13 years of age. Guided self help is not suitable for people with anorexia nervosa.

Guided self help may be implemented by a wide range of mental health providers and may be delivered in face to face sessions or through telephone or online services. As a brief, cost effective intervention, guided self help may provide a good frontline treatment for people with bulimia nervosa and binge eating disorder before more intensive treatments are considered.  Implementation of guided self help programs may address problems associated with the lack of skilled eating disorders therapists, particularly in regional areas.

Guided self help models may be delivered in primary care and in other non-specialist settings and are therefore readily scalable and appropriate for delivery through Medicare Local networks.

Guided self help should not stand alone as a service response to eating disorders. People using guided self help may also require comprehensive assessment and access to the full range of services required for safe treatment, including access to medical treatment and nutritional counselling.

# Developing intermediate level services

Most people with eating disorders should be managed in an outpatient setting. Hospitalisation can be essential where physical impairment is significant however; it is not the optimum environment for sustained change in eating behaviours.  Community based treatment is the preferred option for the treatment of eating disorders, taking into consideration the potentially long term nature of the illness and treatment, the importance of family and social relationships during treatment and the need to generalize new behaviours to everyday living situations.

Wherever possible, services other than inpatient care should be provided in community locations with flexible entry and exit processes to allow for individual variation in access to treatment. The development of community based intermediate level services addresses gaps between primary care and inpatient hospital treatment providing access to:

- Eating disorder specific treatment delivered by skilled clinicians
- Sufficient frequency of treatment to support change
- Safe environment in which to change and learn new behaviours
- Treatment within own community
- Flexible step up/step down options for long term treatment

The scope of outpatient eating disorder programs includes but is not limited to services provided by:

- Prevention and early intervention programs
- Outpatient and outreach programs
- Intensive outpatient programs
- Home visiting

Outpatient service models may include self help programs and groups, individual counselling, individual psychotherapy, therapeutic groups and recovery oriented community based programs. Outpatient clinics providing both assessment and treatment need to be staffed by a mix of experienced practitioners linked to shared care GP community teams.

## Intensive Outpatient Programs

Flexible models of Intensive Outpatient Programs (IOP) may be the best service development option for any region which does not currently have community based treatment programs specific to eating disorders.

In this context an IOP would be a flexible step up/step down service offering varying levels of intensive intervention between the parameters of moderate intensity (2 sessions per week of approximately 3 hours e.g. after school/work hours program) to a full day program (8 hours per day 5 or 6 days a week).

The minimum components of an IOP would be:

- ☐ Assessment
- ☐ Treatment planning
- ☐ Regular individual therapy and dietician appointments PLUS
- ☐ Group meetings and supported meals

- ☐ Family education and support
- ☐ Program attendance two to three times per week for at least three hours per session
- ☐ May include additional support therapies (e.g. body image therapy, art therapy, occupational therapy) and/or recreational activities (e.g. yoga, gentle exercise)
- ☐ Ongoing monitoring for medical and psychiatric risk
- ☐ Facilitated referral to other services for step up and step down treatment as required

The typical service capacity for an IOP would be between 8 and 20 patients. Outpatient programs providing both assessment and treatment need to be staffed by a mix of experienced practitioners. IOPs require a multi disciplinary team including psychologists, dietitians and mental health nurses. GPs should be engaged to work as part of the team or on a shared care basis to provide medical monitoring and referral for treatment as required.

## Service Location

All services would preferably be co-located. The treatment team should have the opportunity to collaborate in assessment, treatment planning, treatment review and discharge planning.

IOPs should be located with or networked with existing points of entry to the health system including GPs, education health services, youth health services, women's health services, mental health services, medical weight loss programs, and eating disorder support services.

Eating disorders programs can be co-located with services that address the broader health issues of people at risk of developing eating disorders. There are a number of options for co-location of eating disorders programs with existing services including:

| Help Seeking Behaviour<br>People with eating disorders may: | Opportunity for co-location of: |
|---|---|
| First seek treatment from GP | An ED outpatient clinic provided in a primary care medical centre. This would be particularly relevant for a multi-service medical centre that already provide psychological, medical and nutritional services. |
| Seek treatment for a mood disorder | An ED outpatient service treating both mood disorders and EDs, separately or as comorbid conditions |
| Seek treatment or advice for overweight or obesity | A BED and BN outpatient program delivered at a medical weight management centre |
| Seek treatment from youth services | An ED early intervention program provided as a service of a youth health centre or university health centre |
| Seek treatment from women's services | An ED outpatient program and tertiary prevention program delivered at a women's health centre |
| Seek treatment for sport or fitness related issues | Sports clinics |
| Have a comorbid medical condition e.g. diabetes | An ED education and support group delivered as part of a diabetes education program |

It is essential that there is also provision for people who do not meet these characteristics with particular reference to services suitable for males.

### Target groups

Intermediate level services such as IOPs are appropriate for people who are motivated to change, are able to self regulate and implement changes in their lifestyles and who have an effective support structure (e.g. family, school etc.). Identified need for more structure however can reduce ED behaviours in unstructured setting

Intermediate services are not suitable for people who:

- Are medically unstable
- Weigh less than 80% of minimum BMI or have experienced very rapid weight loss
- Have an identified current risk of suicide or self harm
- Have an identified comorbid condition which requires a more intensive level of treatment
- Have poor motivation to change

Target groups for admission to community based intermediate level programs would include:

- Step in: early intervention for people in the early stages post onset of their eating disorder
- Step up: intensive support for people who have not responded to treatment at a lower level of intensity (e.g. guided self help or individual therapy provided in primary care)
- Step down: recovery support and tertiary prevention for people who have successfully participated in more intensive treatment or who are experiencing early symptoms of a recurrence of a previous treated disorder

The assessment process for the IOP should include facilitated referral to other services for patients who meet these exclusion criteria.

### Integration with other initiatives

☐ Service and referral development may be undertaken by the Medicare Local or other service coordination body for the region

☐ Psychological services may be provided within the ATAPS model

☐ Mental health nurses may be funded by the Mental Health Nurse Incentive Program

☐ Dietitian services may be funded locally through Community Health Centre or other initiatives of state government

☐ Resources may be accessible for regional areas through the Mental Health Services in Rural and Remote Areas

☐ Re deployment of existing resources for eating disorders treatment should be considered where appropriate

**For a more detailed exploration of planning for an Intensive Outpatient Program refer to Document three.**

## Intensive treatment options

### Day and Residential Programs

Day programs, residential programs and 'hospital at home' programs all offer potentially cost effective, community based alternatives to hospitalization for those who are medically stable. For people in remote rural and regional communities, residential programs can offer an accessible alternative to hospitalization that reduces the cost and stress of travel.

Day programs have been shown to be effective for older adolescents and adults (Kong, 2005) who need a higher level of structure and support than may be provided in an outpatient or intensive outpatient program. Typically people who require a day or residential program have a poor to fair level of motivation for change and require supervision for meals and activities of daily living.

Residential services providing 24 hour treatment and support in a hospital or specific residential setting may provide medical treatment and re-feeding as well as the mental health elements of integrated programs. These services meet the needs of people with severe illness, who have a low level of motivation for change and potential risks to safety. They are also required when no lower level of service is available within the community.

One criterion for admission to a residential program is lack of access to treatment at a lower level of intensity within the local community. Regional areas are often those that most need residential treatment centres. Travelling to treatment for people in rural and remote areas places additional stresses on the patient and their family which compound the impact of illness. Travelling also disrupts day to day life to the extent that there may be few opportunities to put newly acquired behaviours into practice. People in rural and remote areas may benefit from a higher level of intensive treatment delivered in a residential setting with telemedicine support provided after they return home

Residential and day programs both provide a step down from the intensity of inpatient treatment, with an opportunity for consolidation of the gains made during inpatient treatment in a more normalized environment. They may also provide a step up from outpatient treatment, and offer more structure and a level of intensity appropriate for people who require intensive psychological support but do not require medical stabilization. Residential and day programs may also reduce the demands on families and carers providing opportunities for carer respite. Both types of programs have the potential to integrate the delivery of treatment and support, including psychological, nutritional, medical, psychiatric, and complementary therapies, in a safe, supportive, and homelike environment.

Delivered in a non institutional setting that facilitates the development of daily living and coping skills for the transition to self management, residential treatment for eating disorders provides:

☐ An intensive level of therapeutic intervention and medical monitoring

☐ 24/7 Support for the personal work of recovery

☐ Role modelling by staff and peer workers

☐ Peer support

☐ May provide integrated treatment for underlying causes and comorbid conditions

### Entry and Exclusion Criteria for Hospital Treatment

"I have been in and out of hospitals for years but I have also been refused treatment a lot because I don't meet their entry criteria. I am excluded from physical treatment because I have a mental illness; excluded from eating disorders because I have a physical condition and excluded from eating disorder programs because of comorbidities."

**(Consumer who has had an eating disorder for 27 years)**

The entry and exclusion criteria for admission to hospitals wards do not prioritize the admission of people with multiple needs. There is case history evidence of people with eating disorders who have both physical and psychiatric symptoms being refused treatment on the basis that they do not meet either the criteria for admission to a medical ward or a psychiatric ward. A history of self harm or substance misuse may also be used to refuse treatment in medical units even when there is no current evidence of these behaviours.

Mechanisms that support shared care and collaborative approaches should be reviewed or developed e.g. protocols to:

☐ Admit patients under shared care arrangements

☐ Admission and exclusion criteria enable seriously ill patients with both medical and psychiatric needs to access treatment

☐ Access tertiary services, including those outside the LHD, for consultation support, case supervision  and hospital admission when required

☐ Ensure that assessment in hospitals leads to an appropriate level of treatment. Where seriously ill patients cannot be admitted, transition is facilitated to more appropriate services

### Assessment and Discharge Planning

A full eating disorders assessment must take all factors into consideration including the person's history, current eating disorders treatment plan, physical indicators, eating disorder behaviours, high risk conditions such as pregnancy or diabetes, and the social circumstances that the patient will be discharged to including an assessment of carer capacity to provide support in the current circumstances.

Ongoing treatment post discharge from hospital or other intensive forms of treatment is essential. Plans must ensure that the patient is linked in with key eating disorder clinicians in the community for ongoing treatment and support and have appropriate care or support systems in place at home. Discharge plans should include information to help patients and their families understand the warning signs of relapse, and readmission plans.

Ideally, a patient should experience their care as connected and coherent delivered in a logical and timely fashion that is consistent with their medical and personal needs (Haggerty, et al., 2003).

Transition and discharge plans should be developed in collaboration with the individual; the family and all service providers and include:

o A re-admission plan with agreed criteria for re-entry and prioritized admission

o A follow up plan with agreed criteria for monitoring

o An appointment with an appropriate treatment or support service as the next step in the treatment plan

o Information to be shared and details of primary contacts for on-going collaboration

o Referral to recovery support or the next level of treatment required by the individual. Again this may be provided as part of an eating disorder specific service or may be provided by primary or secondary care services or by community agencies. No one should leave treatment without an appointment arranged with an appropriate service as the next step in the treatment plan. For people who are deemed to be fully recovered, establishing a connection with a community agency providing recovery support is advisable so that the person has ready access to help if the need arises.

### Eating Disorder Coordinators/Coordination Teams

There are a limited number of eating disorders experts/specialists in Australia. Most people receive treatment at non-specialist primary and secondary levels of care. To assist them in treating people with eating disorders there is a need to provide them with access to additional expertise in eating disorders when this is required.

Integrated treatment for patients who require both medical and psychiatric care continues to present challenges to health services. Permanent or virtual eating disorder coordination teams able to work across units can provide a solution to this issue.

Clear communication between nursing, medical, psychiatric and allied health professionals is vital to ensure a clear and consistent approach is maintained. Eating disorder coordination teams can facilitate the development of joint program plans, treatment goals and non-negotiables, clinical roles and responsibilities and regular meeting schedules to review treatment plans.

Individual eating disorder liaison clinicians or multi disciplinary eating disorder coordination teams can contribute to:

☐ Processing and triage of referrals

☐ Building a network of skilled clinicians as a 'virtual team'

☐ Providing clinical advice and support to clinicians

☐ Developing clinical pathways to public and private services

☐ Facilitating professional development and training

☐ Regular liaison meetings with tertiary specialist services (via teleconference/video conference for rural and remote areas)

☐ Liaison with primary care providers

☐ Undertaking a case management/key worker role, or provide assessment and treatment advice to case manager/key workers

☐ Regular monitoring of identified individuals receiving health services

☐ Coordinating and facilitating referrals to the specialist eating disorder service where further assessment/treatment options need to be considered

Depending on the level of service demand and the size of the team, an integrated eating disorders Consultation Liaison Team, could also provide:

☐ More comprehensive clinical support to clinicians

☐ Outpatient and post discharge follow-up services

### Eating Disorder Team Outreach Approaches

An outreach focus, providing team support from one central location to public and private health services within a region, has been shown to be successful through The Eating Disorders Outreach Service of Queensland (EDOS). This service approach supports clinicians in the treatment and management of eating disorder, providing services in four key areas:

- Facilitation of intake to specialist eating disorder inpatient and outpatient programs
- Service capacity development through the provision of support to primary and secondary care clinicians working with eating disorders patients
- Education and training including assessment, treatment and prevention workshops and facilitation of networking between clinicians
- Consultation liaison and the development of decision support resources

The model requires a minimum of two permanent specialist clinicians (social workers and psychologist), dieticians, a nurse, specialist psychologist, a psych registrar and a team manager. There is evidence that this approach can be successful in facilitating patient access to local general medical and psychiatric facilities (Painter, Ward , Gibbon , Emmerson, 2010) .
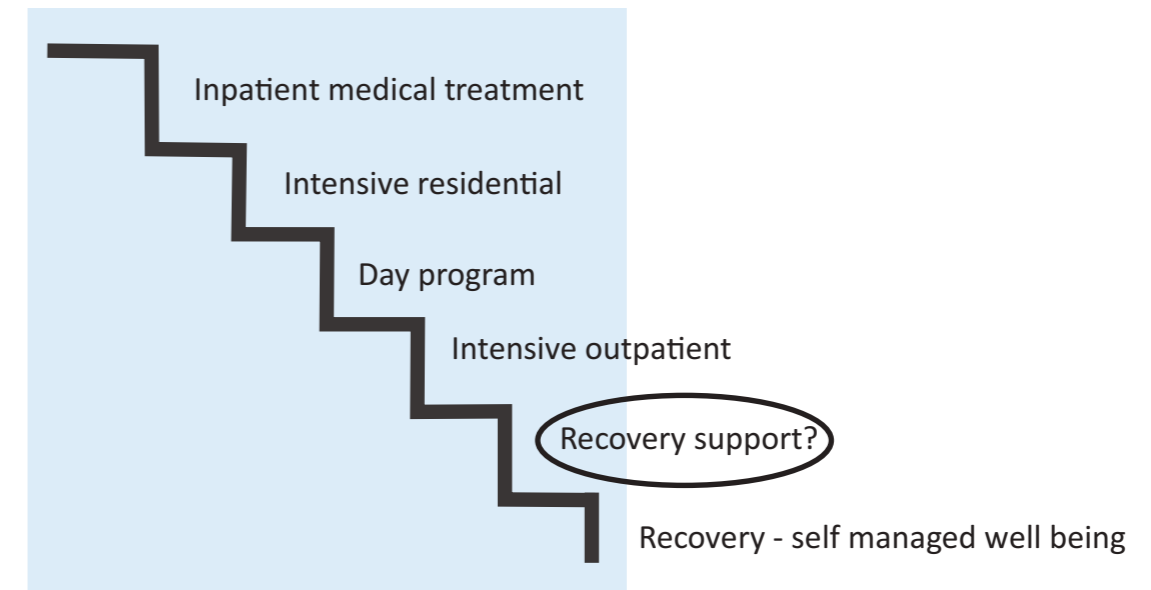
### Case Coordination

Case coordination is a useful and cost effective approach to transition management between episodes of treatment and integration of treatment with community support for improved recovery outcomes.

Eating disorder liaison roles that interface with primary, secondary and specialist services are one possible approach to outreach, to provide or facilitate access to:

- Processing and triage of referrals with support from the specialist team
- Regular liaison meetings with specialist services (via teleconference/video conference for rural and remote areas)
- Oversight of clients engaged with child and adolescent or adult mental health key workers
- 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 manager/key workers
- 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

## After Care – Implementing Support for Recovery

Sustaining recovery is a significant issue, with rates of relapse ranging from 22% to 51% across studies of people with anorexia nervosa and bulimia nervosa (Keel, Dorer, Franko et. al, 2005). Recovery support provided after treatment is essential and should be included in service planning, and in individual treatment and discharge planning.



Inpatient medical treatment

Intensive residential

Day program

Intensive outpatient

Recovery support?

Recovery - self managed well being

### Defining Recovery

The Australian National Mental Health Recovery Framework defines recovery as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues' (Commonwealth of Australia, 2013).

Recovery is a process of ongoing personal development (Andresen , Oades, Caputi, 2003; Schrank & Slade, 2007) in response to the whole experience of illness including the impact of treatment, stigma, isolation, and interrupted development, not just recovery from the symptoms of illness (Andresen et al., 2003; Davidson, O'Connell, Tondora et. al, 2006; Watson, 2012).

The desired outcome of recovery from eating disorders is a combination of remission of symptoms and improved resilience and wellbeing (NEDC, 2012).

The National Eating Disorders Framework includes a definition of recovery which takes into consideration both physical and psychological aspects of eating disorders:

- Diagnosis – no longer meeting diagnostic criteria
- Behaviour – no longer engaging in eating disorder behaviours
- Physical health – weight within healthy BMI range
- Psychological – positive attitudes to one's self, food, the body, expression of emotions and social interaction
- Practical – quality of life including capacity for engagement in work or education, and leisure
- (Bardone-Cone, Hardy, Moldonado et al., 2010)

Access to competently provided effective treatments is a vital support for recovery from eating disorders. Within the National Mental Health Recovery Framework and the related workforce core capabilities, all mental health services, including treatment services, are expected to demonstrate competence in the core skills for recovery, including respect, advocacy, collaboration and knowledge of recovery.

Recovery oriented practice is based on person centred and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness, and recovery. Recovery oriented practice develops and maintains the integrity of a person's 'self', working respectfully and empathically with the whole person in a strengths based and solution focussed framework.

## Aftercare - Providing Support for Recovery

Recovery from an eating disorder is possible at any age or stage of illness but can take many years and episodes of treatment. Access to support in the community after treatment assists recovery (Lannfelt et. al, 2014; Leung et.al, 2012).

Recovery from eating disorders is a process combining effective treatment for remission of symptoms and support to strengthen the person to improve their motivation, resilience and wellbeing. Eating disorders impact on all aspects of a person's life, including their identity, relationships, and roles. Supporting people to strengthen or develop their well being across all of these domains is an important part of personal recovery that enables more effective clinical outcomes.

Restoration of healthy behaviours, psychological health and personal recovery must happen in the context of daily living. During and after treatment, people need to learn how to respond to their normal living environments. This takes time, education, encouragement and support. It must be carried out as close to home as possible to enable people to continue or resume their normal life activities and relationships. Flexible access to ongoing support on a step in/step out basis is required wherever possible.

Person centred and recovery oriented care is the first principle of the national standards schema for eating disorders. The standards schema includes recovery support as a separate element on the continuum of care with the provision of "access to ongoing support including individual professional support, group support, peer support and self-help education" (NEDC, 2012).

Establishing a pattern of regular eating, a healthy relationship with food and the ability to self-monitor behaviours and thinking are fundamental to successful eating disorders treatment. These issues are addressed in evidence based treatment for eating disorders (e.g.CBT-E) however there is a need to sustain these patterns of thinking and behaviour for the long term and in the context of daily life.

People with mental illness experience a loss of identity, quality of life, hope, social connection and physical health. Recovery services help people to overcome these losses by strengthening functional capacity, autonomy, and a sense of personal effectiveness so that the person can set personal goals, make positive choices and restore independent living and quality of life.

Psychological and practical aspects of recovery may take longer to achieve than other indicators of recovery, with the development of new skills and behaviours occurring in the context of daily living

rather than in a treatment setting. For people who develop eating disorders in adolescence, there may be gaps in the development of the functional and social skills required to support a healthy, self directed life as an adult.

## Service Aims

Recovery focussed services assist people to learn, develop strengths and achieve hope, identity, personal responsibility, choice, and social inclusion (e.g. Amering & Schmolke, 2009; Andresen, et.al, 2003; Kogstad, et.al, 2011; Slade, 2009).

The aims of recovery support services will vary depending on the type of service and the target population but may include:

- **Recovery support:**
  - o To promote general psychological wellbeing and provide support and guidance to enable the person to do the work of recovery
  - o To facilitate recovery planning for self directed recovery after treatment
  - o To enhance motivation to engage in treatment and recovery
  - o To support self efficacy and self advocacy
  - o To provide access to peer support

- **Recovery education:**
  - o To provide education and promote development of functional skill development in key areas including stress management, coping skills and food related skills such as meal planning and preparation
  - o To sustain treatment outcomes and support the transfer of new behaviours to daily life

- **Family support: To enable family support through the provision of education, group support and counselling**

- **Relapse early intervention:** To contribute to the prevention of relapse and recurrence and support early re-intervention when required. The aim of recovery education, peer and professional support is to reduce the incidence and impact of relapse and recurrence, however some people will experience many setbacks during their recovery and facilitated re-entry to treatment is an important component of recovery oriented service.

# Recovery oriented support services

| Aims for Target Populations | Service Element |
|---|---|
| **High risk populations**<br><br>Aim: To prevent the onset or escalation of eating disorder symptoms by reducing modifiable risk factors and increasing protective factors | **Outreach and engagement:** engaging people at risk who would otherwise not receive support particularly during the pre-contemplation and contemplation stages of change.<br><br>**Prevention and early intervention:** providing information and access to evidence based prevention and early intervention strategies |
| **People with eating disorders**<br><br>**Aim:** to reduce the impact and duration of illness by facilitating access to treatment and support | **Motivational enhancement** and promotion of access to and engagement with treatment services<br><br>**Support for participation and self advocacy:** education and support for self-advocacy empowering people to actively engage in their own treatment decisions<br><br>**Social support:** As Peer support activities to overcome the social isolation of illness |
| **People recovering after treatment for an eating disorder**<br><br>**Aim:** to support self efficacy and the transfer of new behaviours to daily life in order to sustain the outcomes of treatment<br><br>To contribute to the prevention of relapse and support early re-intervention when required | **Recovery guidance:** guidance through the processes of recovery, including recovery planning, addressing barriers to recovery and recovery monitoring<br><br>**Recovery education:** developing the functional and self management skills required to sustain recovery<br><br>**Continuity of care:** providing access to professional support between episodes of treatment and facilitation of continuity of care |
| **Families, carers and professionals**<br><br>**Aim:** To enable family and professional support for people with eating disorders<br><br>To increase rates of early identification and early intervention<br><br>To support family and carer well being | **Family education and support:** enabling families and carers to be active agents supporting treatment and recovery<br><br>**Family peer support and individual counselling:** overcoming isolation and contributing to the well being of carers and family members<br><br>**Professional information, training and networking:** assisting primary care clinicians and other professionals to identify and respond appropriately to people with eating disorders |
| **Community**<br><br>**Aim:** to raise awareness of eating disorders in order to reduce social risk factors and provide a supportive environment for people during recovery | **Community information and education:** mental health literacy training and communication initiatives to support local community responses to eating disorders |

## Recovery Education

The Mental Illness Fellowship of Australia (2010) has concluded that consumer and carer education and support are critical for mental health recovery and have recommended that peer-based education programs to increase mental health literacy and improve self-management skills be embedded in all mental health policies.

Recovery education provides an alternative to more conventional rehabilitation programs for people recovering from severe mental illness. The principles of adult education support the development of the knowledge, skills, values and behaviours needed for recovery and self management of the process of recovery.

Recovery education functions similarly to mainstream adult education facilities, providing a range of course options which individual students can access on a flexible basis to meet their personal needs. People with eating disorders experience interrupted development and loss of relationships; they need to develop functional skills especially in relation to food and stress tolerance.

Recovery education may provide a solution to some of the issues in the provision of long term access to recovery support for people with eating disorders. The service model fits within the policy framework for mental health recovery and enables the implementation of services based on mixed funding including fee for service.

Recovery education could potentially be used to:

- Providing frontline early intervention and facilitating early help seeking
- Deliver psychoeducation as a prevention/early intervention strategy
- Develop functional skills in areas such as stress management and planning meals
- Provide families and carers with training
- Provide health and other professionals working with vulnerable populations with knowledge and skills in eating disorder identification, assessment, early treatment and recovery support

The Body Esteem Program in Western Australia provides an example of effective community based approaches to recovery education. Two twenty (20) week peer facilitated programs are provided for different target groups: people with experience of anorexia nervosa and bulimia nervosa; people with binge eating disorder. The program has been evaluated and has been found to be effective in engaging women in treatment, improving coping and living skills for recovery.

# Developing systems to support treatment

Provision for long term coordinated treatment and support is required for people who experience a persistent eating disorder. Sustained engagement with coordinated treatment and support should be available for a period of at least 24 months to reduce the risk of relapse.

The National Mental Health Services Standards emphasize the importance of collaboration and integration for effective delivery of mental health services (Standards 8, 9 and 10.6, 2010). Improved coordination between primary care and specialist care is a goal of the Fourth National Mental Health Plan (Priority area 3, 2009).

A collaborative multi-disciplinary team approach requires mechanisms to support professional networking across traditional treatment and professional boundaries. The multi-disciplinary team must work across both physical and mental health; between public and private health services; across specialist disciplines and between health, education and social services.

## Shared Protocols

Coordination of care between service providers is enhanced with the development of shared protocols that are implemented by all services and professions providing treatment.

☐ Delineation of clinical roles and responsibilities including documentation of the care coordination components of health care providers' roles to support a team approach

☐ Shared assessment and discharge protocols

☐ Referral protocols that include agreed referral pathways, criteria for referral, mechanisms for referral and minimum information required for referral completion

☐ Shared care, joint treatment planning and multidisciplinary team meeting protocols

☐ Clear communication between nursing, medical, psychiatric and allied health professionals

☐ Information provision protocols to ensure consistent information and communication to patients and between health care providers

☐ Treatment protocols

☐ Collaborative care meetings to plan and review treatment including  documentation on the care coordination components of health care providers' roles to support a team approach

☐ Appointment of case managers for patients with complex needs

☐ Discharge documentation protocols to facilitate transition between health care providers

☐ Protocols for inclusion of key contacts in discharge planning to contribute to continuity of care ensuring links between past, current and future episodes of care (Haggerty, JL et al. 2003)

# Planning Treatment Responses for Eating Disorders

| Planning Questions | Specific to Anorexia Nervosa |
|---|---|
| **Identifying need:** which high risk groups need to be targeted? How many people do we expect to need service? Who needs to be involved in service review and service planning? | |
| **Continuum of care:** which services are already in place for eating disorders? Where are the priority gaps that need to be filled in the continuum? | |
| **Primary and emergency care:** who has the opportunity to provide care? Who needs to be trained? What information resources would help to support screening, assessment and referral? | |
| **Intermediate level services:** does our region need intermediate services between primary and hospital care? What type of program would best meet needs and fit with existing service systems? Who should have responsibility? | |
| **Tertiary support:** do we have adequate access to tertiary support and treatment? If not, how can we improve access to existing services? How can we build tertiary capacity into our region? | |
| **Developing systems:** which policies, protocols and partnerships agreements would need to be reviewed or developed to support eating disorders treatment? | |
| **Value add:** what are the priority objectives or value-add for our region in improving responses to eating disorders? | |

# Document Three

# Planning an Intensive Outpatient Service

# Planning an Intensive Outpatient Service

Most people with eating disorders can be successfully treated in the community by appropriately trained health professionals. Receiving treatment in the community helps the person with an eating disorder to remain close to family and friends, continue to engage with education or work where possible, and generalise new behaviours into everyday situations. It also makes it easier for people to stay connected with treatment, and their treatment team, for the long term when this is needed.
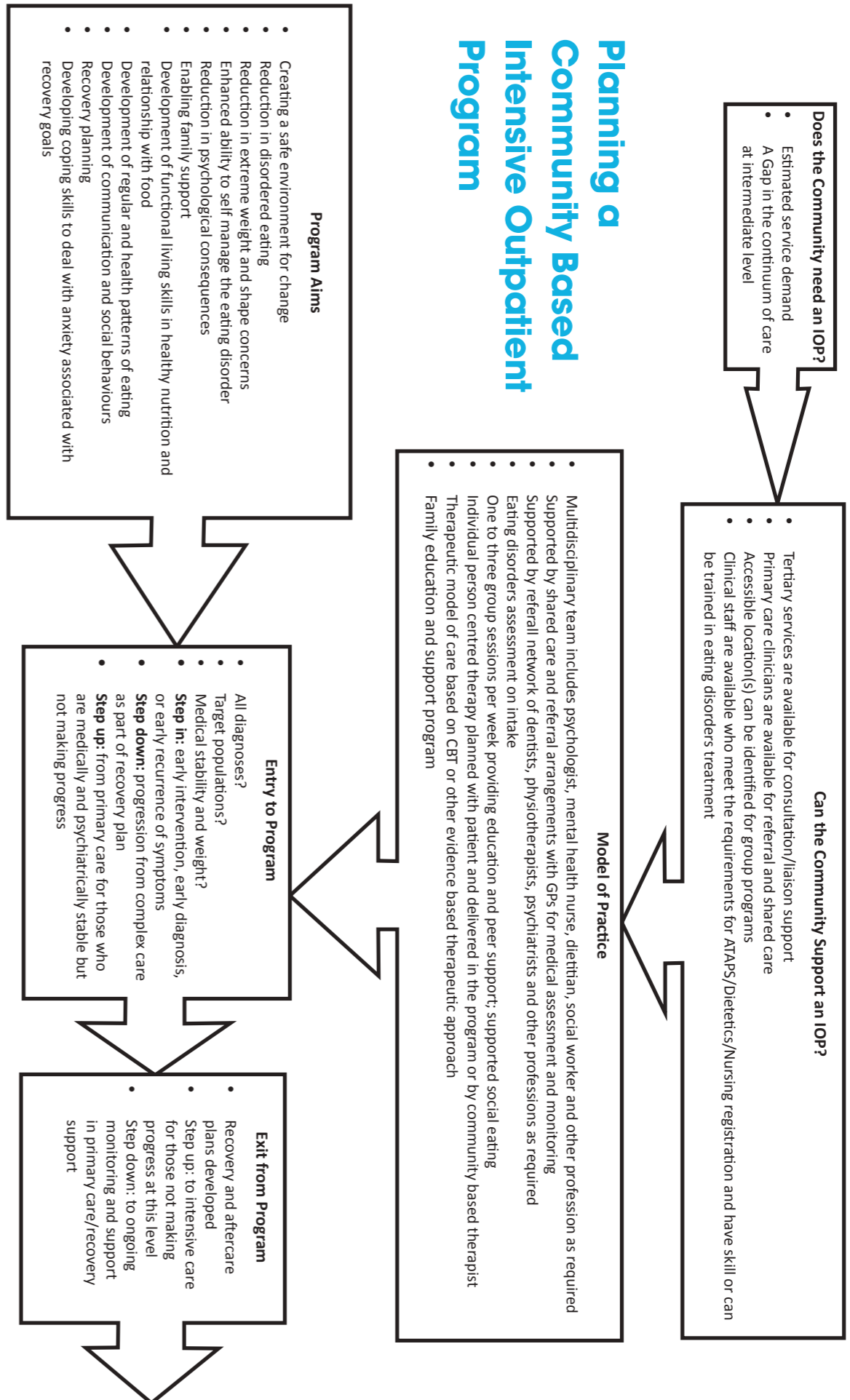
Individual outpatient appointments are often not enough to help people with eating disorders address the physical, psychological, nutritional and functional aspects of their illness. Participation in an eating disorders program with a multidisciplinary team who can integrate responses to all of the experiences of an eating disorder is a better option for people who are medically stable but who need a structured support program to help them to recover.

This planning checklist considers some of the factors that are needed to deliver a successful eating disorders program for adults in the community. These factors have been selected to assist in risk management for the program. For example, effective assessment and entry criteria, staff training, and building good connections with other services in order to facilitate rapid referral of patient's who do not respond to treatment in the program, all contribute to risk management

The checklists cover the common elements that are found in intensive outpatient programs (IOP). These programs offer an intermediate level of treatment and support between individual outpatient treatment and intensive treatment in residential or inpatient programs, offering a flexible step up from outpatient treatment or a step down from more intensive treatment.

Typically an IOP would offer two to three sessions per week, often in the evening to enable people to work or go to school. An IOP may provide an intensive early intervention approach or support for recovery for people who have already received intensive treatment.

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# Planning a Community Based Intensive Outpatient Program

**Does the Community need an IOP?**

- Estimated service demand
- A Gap in the continuum of care at intermediate level

**Can the Community Support an IOP?**

- Tertiary services are available for consultation/liaison support
- Primary care clinicians are available for referral and shared care
- Accessible location(s) can be identified for group programs
- Clinical staff are available who meet the requirements for ATAPS/Dietetics/Nursing registration and have skill or can be trained in eating disorders treatment

**Model of Practice**

- Multidisciplinary team includes psychologist, mental health nurse, dietitian, social worker and other profession as required
- Supported by shared care and referral arrangements with GPs for medical assessment and monitoring
- Supported by referral network of dentists, physiotherapists, psychiatrists and other professions as required
- Eating disorders assessment on intake
- One to three group sessions per week providing education and peer support; supported social eating
- Individual person centred therapy planned with patient and delivered in the program or by community based therapist
- Therapeutic model of care based on CBT or other evidence based therapeutic approach
- Family education and support program

**Program Aims**

- Creating a safe environment for change
- Reduction in disordered eating
- Reduction in extreme weight and shape concerns
- Enhanced ability to self manage the eating disorder
- Reduction in psychological consequences
- Enabling family support
- Development of functional living skills in healthy nutrition and relationship with food
- Development of regular and health patterns of eating
- Development of communication and social behaviours
- Recovery planning
- Developing coping skills to deal with anxiety associated with recovery goals

**Entry to Program**

- All diagnoses?
- Target populations?
- Medical stability and weight?
- **Step in:** early intervention, early diagnosis, or early recurrence of symptoms
- **Step down:** progression from complex care as part of recovery plan
- **Step up:** from primary care for those who are medically and psychiatrically stable but not making progress

**Exit from Program**

- Recovery and aftercare plans developed
- Step up: to intensive care for those not making progress at this level
- Step down: to ongoing monitoring and support in primary care/recovery support

## Collaborative Planning

The implementation of eating disorder service models should be considered in the context of State and National health policies, resource availability, organisational capability, operational factors and local community environments.

Eating disorders require a stepped model of care delivered within a clearly identifiable continuum to meet the physical and mental health needs of people presenting with varying levels of risk, severity, complexity and acuity. The continuum of care involves voluntary agencies, primary care professionals, local mental health services, medical services and specialised eating disorder services. Planning for a new eating disorder service, or enhancement of existing services, should involve as many stakeholders as possible so that the new service has strong support and fits within the continuum of care.

**Action: Form a planning or advisory group to support the scoping, development and implementation of the new program.**

The range of agencies that should be considered in eating disorder service planning includes:

☐ Medicare Local representatives

☐ Local Health District (LHD) representatives including representatives of service planning, mental health, and general medicine

☐ Child and adolescent (youth) mental health services

☐ Community mental health services (adult)

☐ Eating disorder specialist services in area (public and private health)

☐ Eating disorder specialist referral services out of area

☐ NGOs providing eating disorder support services and/or consumer representation in area

☐ NGOs providing eating disorder outreach support services and/or consumer representation from out of area (e.g. Butterfly Foundation)

☐ State government eating disorder tertiary support (NSW = CEDD; QLD = EDOS/EDA; VIC = CEED/EDV)

☐ Potential community partners e.g. community health centres, youth health centres (e.g. headspace) and individual practitioners (GPs, psychologists, dietitians) with an interest in eating disorders

☐ Key people who may be involved in managing and delivering the service

☐ External consultants (e.g. National Eating Disorders Collaboration) if required

## Target Client Group

Three possible ways of looking at target groups for the service are type of eating disorder, stage of illness and demographics:

### Type of eating disorder

☐ Anorexia nervosa and related atypical presentations– day programs and IOP may be useful as step down services for people with AN

☐ Bulimia nervosa and binge eating disorder and related atypical presentations – IOP may be useful as a step up from outpatient treatment or as an intensive approach to early intervention

### Stage of Illness

☐ Early intervention: People of all ages in the early stages of illness who require early intervention

☐ Step down: People who have received intensive eating disorders treatment and need support for recovery

☐ Step up: People who have not responded to individual outpatient treatment

☐ Step in: People who are experiencing early signs of relapse or recurrence

### Demographics

Eating disorders can occur at any age. They occur in both men and women and in all cultural and ethnic communities. Consideration should be given to offering a program that is open to anyone with an eating disorder. Alternatively, the program may target a specific demographic group such as:

☐ Young people aged 15 to 25 - this is the age group who are most likely to experience a first episode of illness and may benefit from early intervention

☐ People seeking help for other mental illnesses such as mood disorders - people often seek help for these disorders before they disclose their eating disorder. Treating the eating disorder at the same time as other health issues can improve the outcomes of treatment.

☐ People seeking help for medical conditions including women seeking help with fertility and menopause issues and both males and females seeking help with weight loss.

☐ Specific communities, such as Aboriginal or Torres Strait Islander communities

☐ Specific health communities, such as people with diabetes

☐ Males or females - it is sometimes easier, particularly for males, if they can access treatment in a program that addresses their specific gender related issues

**Who is our program primarily for?**

**Co-locating** the service with existing health or support services can assist your target group to access the service. Consider potential community partners e.g. NGOs, existing health centres (e.g. youth, women's or men's health centres; sport or university clinics; body image programs; mental health services)

## Program Aims

Eating disorders programs can help people to reduce symptoms of eating disorders, address underlying triggers and maintenance factors in their lives, educate about body image, healthy exercise and nutrition and prevent or minimise the impact of relapse. The target group for the program will influence the choice of aims of the program. Possible aims include:

**Therapeutic aims**
- ☐ Enhancement of motivation and hope to support engagement with treatment and recovery
- ☐ Reduction in eating disorders behaviours
- ☐ Restoration of nutritional health

**Education aims**
- ☐ Education on healthy nutrition and healthy relationships with food and development of regular and healthy eating patterns
- ☐ Psychoeducation
- ☐ Development of new coping strategies
- ☐ Development of life skills (e.g. cooking)

- ☐ Empowering people to identify and change dysfunctional thinking, attitudes, beliefs and emotions Enabling people to self manage their eating disorder
- ☐ Reduction in extreme weight and shape concerns
- ☐ Education and skill development for families enabling family support

**Prevention aims**
- ☐ Recovery goal setting and planning
- ☐ Prevention of relapse or recurrence through monitoring, early help seeking and early access to support
- ☐ Facilitating the development of social connections and participation in meaningful roles
- ☐ Enhancing identity and strengths

**What will the program achieve?**

**Does the target group have any specific needs or interests that could be included in the program?**

## Safe effective programs

The national standards schema for eating disorders prioritizes the delivery of safe services that address the needs of individuals:

*Person and family centred care that addresses the needs of the individual: supporting individual approaches to long term recovery.*

*Safety and flexibility in treatment options: safe treatment for eating disorders addresses all of the aspects of illness: physical, behavioural and psychological.*

### Assessment processes

Recovery oriented services are delivered with a strengths-focussed approach. Assessment and treatment planning are based on the person's circumstances and personal goals. Assessment takes multiple parameters into consideration, including psychological, physical, nutritional and social factors, rather than relying on any single parameter. Assessment and planning should take into consideration:

*Personal goals and strengths*
- ☐ The person's own account of their presenting problem and their understanding of their eating disorder
- ☐ The person's aims in participating in the program
- ☐ Motivational assessment in relation to eating disorder (stage of change)
- ☐ Personal strengths and elements of self worth and self esteem

- ☐ Family resources for involvement in treatment
- ☐ Social connections
- ☐ Education and/or employment
- ☐ Recovery goals:
  - ☐ Safety
  - ☐ Health and normal eating
  - ☐ Identity and body acceptance
  - ☐ Family functioning and relationships
  - ☐ Education and work
  - ☐ Social connection

*Risk assessment*
- ☐ Screening for risk of suicide or self harm
- ☐ Physical health assessment - general medical health care is essential. If it is not delivered as part of the program, it should be delivered by other services on a collaborative, shared care basis
- ☐ Nutritional status assessment

*Weight, shape and relationship assessment*
- ☐ Eating and weight control behaviours
- ☐ Details of typical eating and drinking patterns
- ☐ Identity and body image: thoughts feeling and beliefs about weight and shape
- ☐ Usual shopping and cooking arrangements
- ☐ Family relationships

**How will assessment be conducted?**

☐ Which assessment tools will be used?

☐ Existing assessments from our service/system?

☐ Tools provided by a state or national eating disorder group?

☐ Develop our own assessment tools?

☐ Who will conduct the assessment?

☐ When will assessment occur?

**Flexible treatment options**

Flexible treatment ideally offers the client options about the way they engage with the program.

Which treatment options will we provide in order to meet the program aims and needs of the target group? e.g.

☐ Individual therapy sessions

☐ Group therapy sessions

☐ Guided self help

☐ Psychoeducation

☐ Individual nutritional counselling

☐ Group nutritional education

☐ Shared and supported meal times

☐ Family education

☐ Family support

☐ Peer group support

☐ Life skill development (e.g. cooking, coping skills, problem solving, relaxation, social skills)

☐ Support therapies (e.g. body awareness, art therapy, occupational therapy)

☐ Physical activity interventions (e.g. physiotherapy, gentle exercise)

**Individual treatment plans:** an individual treatment plan is a working summary of personal goals and the strategies that will be used to work towards those goals. It is an agreement between the service and the person about what they want to work on. Even with a fixed program that does not provide individual choices, an individual plan can help the person to relate what they are experiencing in the program to what they really want to achieve.

**Guided self help** involves an individual working through a program (usually a book that they can purchase) based on cognitive behavioural principles with regular sessions with a clinician. The clinician provides guidance, encouragement and support while the person works at their own pace through the steps in the program.

Guided self help has been shown to be an effective first step in early intervention for people with bulimia nervosa and binge eating disorder. Self help can be an important part of a comprehensive treatment plan. Face to face sessions are usually short (about 25 minutes) and can be delivered every week or at longer intervals over several months by a range of different health professionals

## Program Content

### Psychoeducation

Psycho-educational programs usually address aspects of the following content areas:

☐ Eating disorders
  ☐ The nature, symptoms and consequences of disordered eating and eating disorders
☐ Body Image
  ☐ Normal diversity and changes in body shape and physiology including normal weight fluctuation
  ☐ Cultural influences on body image and eating behaviour, and changes over time; weight-based discrimination
  ☐ Unrealistic and unhealthy body image ideals promoted in the media
  ☐ Strategies for building a positive body image
☐ Healthy eating:
  ☐ Balanced diet, set point weight theory, normal digestion and metabolism,
  ☐ Consequences of food restriction, excessive dieting, binging and purging
  ☐ Understanding the relationship between feelings and eating e.g. hierarchy of food fear, mood and nutritional intake
  ☐ Healthy weight management strategies

☐ Thinking and coping: framing and restructuring unhelpful thinking e.g.

    ☐ Unhelpful thinking styles such as perfectionism, black and white thinking, OCD

    ☐ Cognitive distortions: over evaluation of weight, shape and eating

    ☐ Coping skills e.g. distress tolerance, mindfulness, positive affirmations

    ☐ Hope – role models for recovery

☐ Recovery action planning

    ☐ Personal recovery planning

    ☐ Using self help resources

    ☐ Accessible tools (e.g. Recovery Record app, WRAP app)

## Where will the program source content and materials for education programs? e.g.

☐ Guided self help resources

☐ Evidence based manualised psychoeducation/prevention programs

☐ Other eating disorders services or state based eating disorder services

☐ Develop own content

## Nutritional assessment and support

The following activities focused on food and nutrition may enhance the therapeutic content of the program:

☐ Nutritional assessment and development of individual meal plans at commencement of program

☐ Group nutritional education sessions

☐ Individual nutritional counselling sessions

☐ Group life skills education in planning and preparing meals

☐ Supported mealtimes

Enabling people to prepare and eat healthy meals in a supportive environment can contribute to the development of healthy relationship with food and reduce the stress of eating in a social environment. Supported meals can provide positive role modelling within a supportive group setting, and improve interpersonal and communication skills.

Providing meal support can include three phases of activity:

☐ Planning and preparing nutritious meals

☐ Shared, supported meals (approximately 30 minutes)

☐ Post meal activities to support participants in managing any emotions or anxiety post meals. In a day program post meal activities might include individual activities such as journaling, reading or listening to music or group activities such as recreational activities or relaxation sessions. In a brief IOP session, activities may include participation in education and life skills development.

## Activities that support recovery

For eating disorders, recovery is defined as both clinical recovery (remission of symptoms) and personal recovery (National Eating Disorders Framework, 2011). While there is no single definition of personal recovery, the National Mental Health Recovery Framework (2013) defines it as 'being able to create and live a meaningful and contributing life in a community of choice'.

Practices that may contribute to personal recovery include:

☐ Self determination: individual treatment planning and monitoring in which the person with an eating disorder leads the process of recovery by defining their goals and taking responsibility for their own progress

☐ Choice: opportunities to select between activities and treatment options to best meet individual needs and contribute to achieving personal goals.

☐ Reflection and self directed learning: developing skills (e.g. through journaling) to monitor what happens in life in order to understand the stressors and triggers that increase illness and the coping strategies that reduce it; having access to information and self help resources.

☐ Participation and social connection; opportunities to participate in a range of social contexts, to contribute to service development and to take on leadership and mentoring roles in peer support. Mutual support plays a key role in recovery.

☐ Skill development: having access to opportunities to develop skills and strengths outside the framework of illness (e.g. access to vocational education and recreational activities)

☐ Supportive environment: a physical environment, professional culture and language that supports the development of hope, safety and trust contributes to the motivation required for personal recovery.

Some of these practices may be beyond the scope of a community based program however the program should consider how it can help to connect people with other community services and resources that can support recovery.

## Support for families

The national standards schema for eating disorders prioritizes support for families and carers:

**Support for families and carers as integral members of the team:** Families and carers receive support, education and information to enable them to support the person with an eating disorder and to maintain personal good health.

**Families** may include people in many different relationships including parents, partners, children, siblings, extended family, close friends and supporters. For most people the supportive environment for recovery is created by family.

### How will the program work with families?

The range of supports for families may include individual or group sessions that are provided as an integral part of the program or provided by another service working collaboratively with the eating disorders program.

Examples of how the program can work with families include:

☐ Protocols to support identification of the key people that the service users wants to have included in their treatment

☐ Providing informationProviding referrals to other programs and services suitable for families

☐ Individual or group education sessions about eating disorders

☐ Skill development to support treatment

☐ Personal stress management and mental health

☐ Family communication skills

☐ Peer support, opportunities to meet and network with other families

## Program Duration and Intensity

### When will program session be held?

☐ Every day/all day sessions (day program)

☐ Two or three days per week/all day sessions – which days?

☐ Two or three days per week/two to three hour sessions (IOP) – which days?

### How many sessions of therapeutic intervention will the program provide?

Evidence based recommendations for the number of sessions reflect the needs of different target groups and range from:

☐ Guided self help - from 4 to 8 sessions

☐ CBT/CBTe - 20 sessions for people with bulimia nervosa or binge eating disorder

☐ CBT/CBTe - 50 or more sessions for people stepping down from intensive treatment for anorexia nervosa (delivered through the program or in partnership with a psychologist or psychiatrist)

### How long will the program run for?

Some typical program options include:

☐ An open program with a set cycle of activities but no set duration; participants attend all sessions but only for as long as they need to

☐ An open program with flexible options for individuals e.g. starting with full participation and scaling down to a minimum participation (e.g. one session per week) as the person recovers

☐ A 6 to 12 week open program cycle which participants are encouraged to fully participate in but may enter or leave at any stage

☐ A 6 to 12 week cycle of incremental sessions which participants can only join in the first week of the program Other program duration

**Example:** a ten week program delivered on two evenings a week for two hours would be able to provide between 10 and 20 sessions of therapy plus nutritional counselling and education.

**Day programs** are indicated for people with severe illness and poor to fair motivation for change

**IOP programs** are indicated for people with mild to moderate illness and good motivation to change

**When will family sessions be held?**

☐ Evenings (e.g. after work)

☐ Saturdays

☐ In parallel with program sessions

# Staffing

The national standards schema for eating disorders prioritizes multi disciplinary treatment:
**Partnering to deliver multi disciplinary treatment in a continuum of care:** a multi disciplinary team working in partnership with the person, their family and other health service providers

Typically the core team members for an IOP or day program would include:

☐ Psychologist(s)

☐ Mental health nurse(s)

☐ Dietitian(s)

An expanded team to meet the needs of specific target groups might also include:

☐ General Practitioner (GPs should be engaged to work as part of the team or on a shared care basis)

☐ Social worker

☐ Occupational therapist

☐ Physiotherapist

☐ Family therapist

☐ Educator

In addition a broader network of professionals who may work with the program to meet the needs of individual service users might include dentists and specialists working with comorbid conditions.

**Coordination:** programs will require leadership from a coordinator and administrative support. How can this be factored into the staff team?

**Professional Development**

All staff delivering treatment should be trained in the delivery of that treatment for people with eating disorders (e.g. training in CBTe).  What training will be provided?

☐ Introduction to eating disorders (e.g. CEDD, CEED or EDOS training or equivalent)

☐ CBT or CBTe training (or other selected therapy)

☐ Guided self help training

☐ Meal support training

☐ Local training programs.....

☐ Other training.....

**Funding**

Existing opportunities for program funding may be found in the following initiatives. Program content and staff qualifications will influence what the program is eligible to access e.g.:

☐ Psychological services may be provided within the BAMHS (early intervention) or ATAPS model

☐ Dietitian services may be funded locally through Community Health Centre of other state or territory government initiatives

☐ Mental health nurses may be funded by the Mental Health Nurse Incentive Program

☐ Peer support and recovery support activities may qualify for funding under the Personal Helpers and Mentors program

☐ Resources may be accessible for regional areas through the Mental Health Services in Rural and Remote Areas program

☐ Re deployment of existing resources for eating disorders treatment should be considered where appropriate

☐ Fee for service

To secure funding from specific funding initiatives staff must have the relevant registrations to be able to deliver services.

| Program Component | Activities | Quantity (duration/ recurrence) | Staff Requirements | Resource Requirements |
|---|---|---|---|---|
| **Individual Activities** | ☐ Pre program assessment<br>☐ Therapy<br>☐ Nutritional assessment<br>☐ Nutritional counselling<br>☐ Progress review<br>☐ Post program assessment<br>☐ Recovery and discharge planning<br>☐ Other…. | | | |
| **Group Activities** | ☐ Therapy<br>☐ Psychoeducation<br>☐ Life skills education<br>☐ Supported meals<br>☐ Supporting therapies<br>☐ Recreation<br>☐ Other…. | | | |
| **Family Activities** | ☐ Individual support<br>☐ Group education<br>☐ Peer group support<br>☐ Other…. | | | |
| **Coordination and Administration** | ☐ Coordination<br>☐ Administration<br>☐ Case Review<br>☐ External collaboration<br>☐ Supervision<br>☐ Evaluation | | | |

## Program cycle

| Program | Individual Appointments | Group Session Topics | Staff Requirements/Funding |
|---|---|---|---|
| **Week 1** | | | |
| **Week 2** | | | |
| **Week 3** | | | |
| **Week 4** | | | |
| **Week 5** | | | |

Add weeks to match duration of program

# Access Pathways

The national standards schema for eating disorders prioritizes equity of access and entry to services: Equity of access and entry: Access to services when and where they are needed, early in the illness and early in each episode of illness. Clearly identified entry points in the community assist people to engage with accessible and affordable services.

## What will the program entry criteria be?

Community based programs are appropriate for people who are motivated to change, are able to self regulate and implement changes in their lives and who have an effective support structure (e.g. family, school etc). Possible entry criteria include:

☐ Diagnosed eating disorder

☐ Good to fair motivation for change

☐ Medically stable and in the care of a GP

☐ IBW>85% BMI> 18.5

☐ A level of independent eating and self sufficiency

☐ Need for structure to reduce eating disorder behaviours

☐ Family and/or social support with willingness to participate in the program where appropriate

☐ Lives near treatment centre or can readily access on a frequent basis

## Will the program accept people who are also receiving treatment for an eating disorder or comorbid condition through another service provider?

Access criteria would ideally support simultaneous and sequential treatment delivery from multiple service providers. Protocols and agreements for shared collaborative care need to be in place to support this approach.

## What will the program exclusion criteria be?

Community based programs at an intermediate level of intensity are not suitable for people who are:

☐ Medically unstable

☐ Weigh less than 80% of their minimum BMI or have experienced very rapid weight loss

☐ Have an identified current risk of suicide or self harm

☐ Have an identified comorbid condition which requires a more intensive level of treatment

☐ Have poor motivation to change or participate in the program

## How will the program respond to people who cannot join the program?

☐ If you people are not eligible for your service or you have a waiting list, how will you refer people to other services?

☐ If you have a waiting list, how will you prioritize who is accepted into the program?

## Pathways into the program: how will people get access to the program?

☐ Referral from GP

☐ Self referral

☐ Referral from other health professionals (e.g. dietitian, psychologist, dentist, school counsellor)

☐ Other

### How will you accept and process referrals?

## Communication: How will people know about the program?

A challenge for early intervention for eating disorders is the large number of people who do not seek help in the early stages (insert statistic). If the aim of the program is early intervention then program activities could include assertive outreach.

☐ Who will you promote the service to? e.g. GPs, psychologists, health centres, dietitians, school counsellors, weight loss centres, sports centres, youth services, mental health services, hospitals

☐ What information will people need in order to be able to access the service?

☐ How will you promote the service?
  ☐ Through professional networks
  ☐ Print media (e.g. brochures, posters)
  ☐ Website specific to the program
  ☐ Information on other service websites
  ☐ Other.......

☐ How will people contact the service?
  ☐ Existing referral centre/processes
  ☐ Telephone
  ☐ Email
  ☐ Other.....

☐ What resources do you need to develop to support promotion of the service?

# Program Connections

Eating disorders are dynamic illnesses that can change the way in which they manifest throughout the course of illness. Progression is not linear and response to treatment is individual and variable.

Eating disorders require a stepped model of care delivered with a clearly identifiable continuum from primary and outpatient care to intensive inpatient care and recovery support. Safe, effective treatment is linked into other services within the continuum of care to enable people to progress flexibly from on level of treatment to another at different stages of their illness.

Strategies that can assist to connect the program into the continuum of care include:

☐ Making effective use of the planning/advisory group networks (see page 5)

☐ Establish referral pathways out of the program:

    ☐ How will the program facilitate access to more intensive levels of specialist treatment in response to the patient's changing needs?

    ☐ How will the program facilitate access to less intensive levels of long term support (e.g. ongoing medical monitoring; peer support; recovery tools)

☐ Discharge planning developed in collaboration with the individual, their family and all related service providers. These plans should include a recovery action plan. A full assessment should be completed before discharge. The assessment should take into consideration behaviours, social circumstances and carer circumstances.

☐ Scheduled follow up for people who have left the program

☐ Established links to tertiary consultation for case consultation or supervision

    ☐ How can the program link to regional or state tertiary services?

    ☐ How can the program link to national or interstate tertiary services?

The national standards schema for eating disorders prioritizes access to expert support for all eating disorders programs:

**Tertiary consultation** *accessible at all levels of treatment: access to tertiary level expertise for consultation, supervision, guidance and referral if required*

# Practical Implementation

The implementation of eating disorder programs has to be considered in the context of State and local service policies and procedures. Where local policies and procedures exist these should be used, or adapted for use.

The national standards schema for eating disorders prioritizes the implementation of systems and protocols that support collaborative responses to eating disorders:

**Systems support integration, collaboration and on-going development:** *policy and systems support collaboration between physical and mental health services, private and public health services, health and community services and between professional disciplines.*

The delivery of treatment by a multi disciplinary, and potentially multi agency team, requires systems and protocols to support:

☐ Delineation of clinical roles and responsibilities

☐ Agree referral pathways, criteria for referral, mechanisms for referral and minimum information required for referral completion

☐ Entry, exit and withdrawal of service criteria

☐ Client rights and responsibilities

☐ Joint program treatment planning (where applicable)

☐ Communication between all team members

☐ Family identification and engagement in treatment

☐ Information sharing protocols

☐ Collaborative care meetings to plan and review treatment

☐ Partnership agreements and protocols

☐ Assessment protocols

☐ Referral and transition protocols between services and agencies

☐ Protocols to support a coordinated team approach engaging the person, their family and support network

☐ Protocols to enable staff to identify and work with family members or carers

Other implementation resources that may be required include:

☐ Manuals

☐ Are the therapies or education content to be used manualised?

☐ Do you need to develop a practice manual for the program?

☐ Do you need guidelines for meal support?

☐ Program Timetables and staffing rosters

☐ Information and promotion resources

☐ Promotion resources

☐ Service location and facilities

## Evaluation

The national standards schema for eating disorders prioritizes the evaluation of services:
*Evidence informed and evidence generating approaches: research and evaluation are integral to the design and delivery of treatment.*

☐ Will you adopt a formative or summative evaluation?

☐ Who will conduct the evaluation?

☐ What are the key evaluation questions: what do you want to find out?

☐ Who will have access to evaluation reports?

☐ What data will you collect and how will you record it?

☐ What needs to happen to ensure ethical evaluation practice and participant privacy and confidentiality?

## Indicators of Recovery

Measures of program outcomes and impact will depend on the aims and content of the program. The following checklist has been developed from definitions of recovery promoted in the National Eating Disorders Framework (NEDC, 2011) which are based on research and consumer perspectives on recovery. The checklist has been cross referenced to the general literature on mental health recovery. Standardized tools should be used to measure outcomes wherever possible.

*Remission from symptoms of illness*
- Absence of or reduction in eating disorder behaviours
- Absence of or reduction in eating disorder cognition
- No longer meeting diagnostic criteria

*Physical health*
- Weight restoration or stabilization
- Restoration of nutritional health
- Medical treatment for physical consequences of illness

*Self acceptance*
- Self esteem and self respect
- Body acceptance
- Relaxed attitude to food
- Ability to experience and express emotion
- Awareness and utilization of personal strengths
- Well developed and stable sense of own identity and strengths

*Self management*
- Motivation to recover
- Understanding of illness
- Self direction and personal responsibility
- Capacity for reflection and change
- Stress and anxiety management skills
- Recovery action plan
- Competency (functional life skills e.g. cooking, meal planning)

*Social connection*
- Social competence: ability to form and maintain close relationships; communication skills
- Cordial and supportive family relationships
- Functional social life
- Valued social roles and activities e.g. work, education
- Participation

*Resilience/coping strategies*
- Hope, optimism and sense of purpose
- Problem solving and planning skills
- Conflict resolution skills
- Subjective assessment of quality of life (reference)
- Supportive networks and ability to ask for help
- Access to practical necessities

**Why do we think this program will work?**

| What are the main problems for the target group and what is currently available for them? | How do the elements of our program address these problems? | What outcomes do we expect the program will achieve for participants? |
|---|---|---|
|  |  |  |

# Document Four

# Intervention for Prevention

**Exploring opportunities to implement the coordinated approaches to eating disorders prevention**

# Developing a Prevention Strategy

Prevention strategies need to fit into the work of the organisation and meet the needs of specific groups at risk of developing an eating disorder. Each sector may take a slightly different approach to prevention however, there are some basic steps to developing a healthy, supportive environment for people at risk of developing an eating disorder that are relevant in all contexts:

## 1. Identify need

The first step is to identify which high risk groups your organisation works with and the most appropriate strategies to address their needs. The age, gender, activities and cultural needs of different high risk groups can all have an impact on the approach needed to reduce the risk and impact of eating disorders. The way in which your organisation interacts with high risk groups will also influence the type of strategy you adopt.

*Page 84 provides background information on identifying needs.*

## 2. Develop understanding

Eating disorders are serious and complex illnesses that affect people's physical and mental well being with potentially lifelong consequences. They are also fairly common with about 9% of the population experiencing an eating disorder at some point in their lives. Despite this they are often misunderstood. The first step to prevention is to develop understanding in your organisation by getting the facts about eating disorders.  Skill the adults (professionals, parents and volunteers) who intersect with high risk groups to identify eating disorder symptoms, promote help seeking, and model appropriate attitudes and behaviours.

*Page 86 provides information on common myths and training opportunities*

## 3. Focus on things which can be changed

There are risk factors for eating disorders which cannot be changed including biological and inherited risk factors. However there are protective factors and risks which can be changed. Useful issues to focus on include:

a.  Modifiable risk factors for eating disorders such as dieting, disordered eating, body dissatisfaction and the internalization of body ideals

b.  Social environment factors such as body bullying and 'fat talk', expectations about appearance, support for healthy eating

*Page 88 provides information on modifiable risks*

## 4. Establish objectives

Strategies that have a clear purpose and objectives are easier to implement and evaluate. The specific objectives for each organisation may vary but some of the general objectives for eating disorders prevention include:

a.  Promoting health and well-being

b.  Enabling early identification and early help seeking

c.  Increasing awareness of eating disorders as serious illnesses

d.  Developing a healthy culture that respects diversity

e.  Raising awareness of and reducing the incidence of body bullying and fat talk

f.  Increase awareness of warning signs and intervention strategies

*Page 92 provides more information on the purpose of eating disorders prevention*

## 5. Support help seeking

For people who are already experiencing early signs of eating disorder, getting quick access to help is an important step to reduce the impact and duration of illness. Organisations can support access to early help by providing information resources and facilitating access to early intervention programs. Many people need support to recognise that they are at risk. Facilitating access to mental health literacy and mental health first aid training for all adults who work with high risk groups can support early identification of risk and help seeking.

*Page 93 provides information on early identification and help seeking*

## 6. Facilitate access to prevention and early intervention programs

Increase protective factors for the people you work with by providing access to evidence based prevention and early intervention programs delivered by trained professionals. If you work with groups of young people, consider delivering prevention workshops as part of your regular program. If you work with individuals or other groups at risk, consider how you can facilitate access to external prevention and early intervention programs. If you are already providing other health or self esteem related programs that target the same high risk groups, consider adding evidence based prevention and early intervention resources to the existing initiative.

*Page 94 provides information on evidence based prevention programs*

## 7. Communicate safely

If the way in which you work with people at risk includes communication about weight and shape then it is important to check the safety of your communications. This may include evaluation of explicit messages ( e.g. in information resources, learning curriculum, media ) and implicit messages included in the cultural practices and standards of your organisation (e.g. policy, dress codes).  The objective is to deliver programs and health messages that are safe and consistent, ensuring that initiatives for general health, mental health, body image and obesity prevention are mutually safe and supportive.

*Page 98 provides information on evaluating your communication messages*

**8. Embed good practice in culture**

Creating a safe environment for people at risk of eating disorders requires a consistent, coordinated response over time. Develop supportive environments that take an integrated and safe approach to promoting good health by making good physical and mental health and respect for body diversity important issues in all the practices of your organisation. Review policies, protocols and training requirements and embed the principles of safe communication, support for mental health and mental health literacy, and access to eating disorders prevention and early intervention programs in the culture of the organisation.

*Page 102 provides information on developing healthy environments*

# 1. Identifying 'at risk' groups

Are eating disorders and the risk factors for developing an eating disorder something that you or your organisation should be concerned about?

If your organisation works with people at high risk of developing an eating disorder – directly by providing them with a service or employing them, or indirectly by influencing them – then you are in a position to contribute to the prevention of eating disorders.

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

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

Some groups in the community who may not be identified as having a high statistical risk of developing eating disorders, experience specific health issues and vulnerabilities when they do experience an eating disorder that need to be taken into consideration. These groups include:

- Younger children
- Adult males
- Pregnant women
- People with specific health conditions (e.g. diabetes, PCOS, infertility)
- Indigenous communities

If you work with or employee any of these high risk groups, or influence any of these high risk groups by providing information related to weight, shape and self esteem, then implementation of a prevention strategy should be considered.

The way in which your organisation interacts with high risk groups will also influence the type of strategy you adopt. For example, health or counselling services may consider screening people at risk and referral to eating disorders services. If you work with groups of young people then providing

prevention workshops may be the most appropriate strategy. These and other options are discussed in later chapters in this consultation paper.

## The Timing for Prevention

As for other mental illnesses which develop in adolescence, childhood is the critical period for primary preventive efforts and the development of resilience; adolescence and young adulthood is the stage when early intervention strategies may be required. However, for eating disorders, different approaches to prevention seem to be more effective for different age groups.

- **Young Families**
  The behaviours, attitudes and beliefs that contribute to vulnerability to eating disorders are established early in life and are reinforced by the person's social environment.

- **Children and Adolescents in the Middle School Years**
  Research suggests that there is a marked increase in body image and eating concerns in young people while they are between school years 7 and 8 (Wertheim, Koerner, & Paxton, 2001) and that intervention at late primary school and early high school represents an opportunity for prevention of the development of body image problems (Paxton, 2002).

  Some issues such as body dissatisfaction affect males and females at different ages. Body dissatisfaction is a risk factor for both depressive mood and low self-esteem in girls in early adolescence and in boys in mid adolescence. Prevention of body dissatisfaction must begin early and should be considered as a component of both obesity and eating disorder prevention programs.

- **Older Adolescents and Young Adults**
  There is a high prevalence of body dissatisfaction and related eating disorder problems in university age women. At this stage indicated prevention interventions are usually required. The goal of these interventions is to reduce body dissatisfaction and disordered eating behaviour that are already present. Typically, individuals who have high weight and shape concerns volunteer to participate in this type of program or are referred by a health professional.

While knowing about the key periods for onset of eating disorders and risk factors can help in planning a prevention strategy, eating disorders can occur at any age. Early intervention should occur as soon as warning signs are noticed regardless of the person's age or health history.
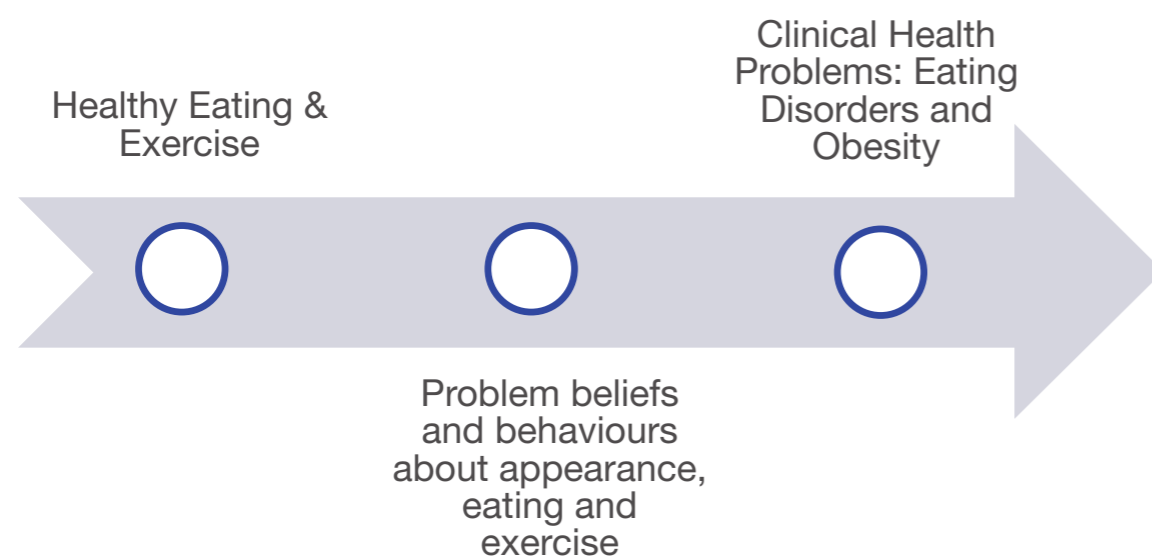
## 2.    Develop understanding

Eating disorders are often poorly understood and underestimated in contemporary society. There are mistaken beliefs that eating disorders are about vanity, a dieting attempt gone wrong, an illness of choice, a cry for attention, or a person "going through a phase".  Eating disorders are also frequently believed to affect only adolescent girls. These types of misconceptions are not limited to the general public, but also affect the responses and explanations people receive when they present for professional help, contributing to a failure to identify and treat people with these illnesses.

There is a prevalent myth, reinforced by media images, that the only eating disorder of concern is anorexia nervosa and that therefore a person must be severely underweight to have an eating disorder. Most people with an eating disorder present with binge eating disorder or atypical symptoms. These disorders are as clinically severe as anorexia nervosa and bulimia nervosa. Because they are harder to see and less well known in the community, people with these eating disorders are also less likely to get treatment.

Another common myth is that eating disorders are 'the opposite of' obesity. Although the weight status of these individuals can be different, eating disorders and overweight have more in common than is usually believed. For example disordered eating is a shared pathway into both eating disorders and obesity and people who are overweight or obese are at higher risk of developing an eating disorder than the general population.

Obesity and eating disorders may be viewed as occurring at the same end of a spectrum. At one end, health promoting beliefs, behaviour and practices buffer against these conditions; at the opposite end of the spectrum, weight related syndromes and eating disorders are potential outcomes.

Healthy Eating & Exercise

Problem beliefs and behaviours about appearance, eating and exercise

Clinical Health Problems: Eating Disorders and Obesity

Other prevalent myths influence the way we think about weight, shape and self worth. A common myth is that how we look is more important than other aspects of who we are. Another is that anyone can be slim if they work hard enough.

### Who needs to develop understanding?

The most important target audience are the adults who intersect with people at high risk of developing eating disorders. This includes primary care clinicians, educators, sports coaches, fitness instructors, youth workers and parents, and in the workplace managers and supervisors. It may also include peer leaders for adult and older adolescent groups.

*Engaging Parents*

Parents are consistently identified as the most influential group for children and young people and are therefore a primary target audience for prevention and early identification messages. Family interactions shape the views that young people have of their bodies and appearance and their understanding of healthy relationships with food. Families have also been identified as a young person's first point of reference for health information.

It is therefore important that parents gain an understanding of eating disorders and how family activity can positively influence mental health.

### Sourcing evidence based information

Mental health first aid training provides one evidence based option for developing an accurate understanding of eating disorders.

☐ Mental Health First Aid for Eating Disorders http://www.mhfa.com.au/

Information resources and workshop sessions have also been developed by a number of eating disorder services for parents, teachers, managers and others, on eating disorders and on body image.

☐ The Butterfly Foundation www.thebutterflyfoundation.org.au
☐ Centre for Eating and Dieting Disorders (CEED, NSW) http://www.cedd.org.au/
☐ The Victorian Centre of Excellence in Eating Disorders (CEDD) http://ceed.org.au/
☐ Eating Disorders Victoria (EDV) http://www.eatingdisorders.org.au/
☐ Eating Disorders Association (QLD) http://eda.org.au/

Individual expert presenters can be identified through:

☐ The Australia and New Zealand Academy  for Eating Disorders (ANZAED) http://www.anzaed.org.au/

Evidence based fact sheets on eating disorders and information on eating disorders services is available from:

☐ National Eating Disorders Collaboration (NEDC) www.nedc.com.au.

## 3.    Focus on things which can be changed

No single cause of eating disorders has been identified. Like most other psychiatric illnesses and health conditions, a combination of several different factors may increase the likelihood that a person will experience an eating disorder at some point in their life.

A modifiable risk factor is something that can be changed through intervention in order to reduce the probability of disease.  The modifiable risk and protective factors for eating disorders occur within the context of everyday life – family and peer relationships, school and workplace cultures, recreational and sport activities, media and social influences. There is a complex interaction between biological, psychological, social, environmental, cultural, and economic factors.

Some of the risk factors for eating disorders relate to body weight and shape and the way in which our society responds to weight. Identified risks include a higher BMI, a high level of concern about weight and shape and exposure to appearance based criticism including bullying, teasing and 'fat talk'. These experiences may prompt people to engage in unhealthy attempts to lose weight. A few of the most common factors are described here.

### Extreme weight loss behaviours

Eating disorders almost invariably occur in people who have engaged in dieting or disordered eating. Research has suggested that the vulnerabilities that people inherit (genetic) may be amplified by environmental stressors and then "switched on" by the effects of dieting and disordered eating.

### Disordered eating

Disordered eating is the single most important indicator of onset of an eating disorder. Disordered eating is a disturbed pattern of eating that can include fasting and skipping meals, eliminating food groups, restrictive dieting accompanied by binge eating and excessive exercise. Disordered eating can also include purging behaviours such as laxative abuse and self-induced vomiting.

Disordered eating can result in significant mental, physical and social impairment in adolescents that may last for years and affect their whole lives. Risks include:

- Depression and anxiety
- Increased risk of suicidal thoughts
- Social isolation and reduced quality of life
- Malnutrition and dehydration – people can be malnourished even when they are of normal weight
- Academic failure especially due to poor concentration
- Long term weight gain and increased risk of obesity
- Increased risk of osteoporosis later in life

Disordered eating is increasing, and many studies show that disordered eating is now normative in Australian society.  Between 50% and 80% of children and young people hold high risk beliefs about weight and diet and will engage in dieting behaviours. Up to 30% of people seeking treatment for obesity engage in binge eating with between 10 and 20% meeting the criteria for binge eating disorder.

### Dieting

The term 'dieting' refers to a broad range of eating behaviours and thoughts that are unhealthy and potentially harmful from a physical and psychological standpoint. Examples include overly restrictive eating (i.e., excessively low calorie intake, cutting out entire food groups), strict and rigid food rules, and dietary changes that are not practical or sustainable long-term. Dieting can be distinguished from healthful dietary practices and cognitions, such as having a balanced diet, aiming to eat the recommended serving of fruits and vegetables, being flexible about food choices, and engaging in practical and sustainable dietary practices. In Western countries, approximately 55% of women and 29% of men report having dieted to lose weight at some point in their life.

While moderate changes in diet and exercise have been shown to be safe, significant mental and physical consequences may occur with extreme or unhealthy dieting practices. Adolescents who diet and develop disordered eating behaviours carry these unhealthy practices into young adulthood with a range of health consequences. Even modest levels of dieting alter brain activity and being underweight or malnourished alters the processes of normal development having an impact on physical health, and a person's ability to learn, work or participate in social or physical activities such as sport.

Dieting is associated with the development of eating disorders. It is also associated with other health concerns including depression, anxiety, nutritional and metabolic problems, and, contrary to expectation, with a longer term increase in weight.

The act of starting any diet increases the risk of eating disorders in adolescent girls. Research shows that young people who engage in unhealthy dieting practices are almost three times as likely as their healthy-dieting peers to score high on measures assessing suicide risk.

Studies in Australia and New Zealand have found:

- Approximately half of adolescent girls have tried to lose weight and practise extreme weight loss behaviours such as fasting, self-induced vomiting and smoking
- As many as 75% of high school girls feel fat or want to lose weight
- Young people who diet moderately are six times more likely to develop an eating disorder; those who are severe dieters have an 18-fold risk
- Among girls who dieted, the risk of obesity is greater than for non-dieters

'The brain is undergoing a great phase of development from 12 to 25 and it needs a proper balance of oils and nutrients.  If you impair that critical phase, moods become less regulated, you have more difficulty understanding other people and you become less flexible in your thinking'
**Janet Treasure**

### Internalisation of the thin socio-cultural ideal

Evidence shows that socio-cultural influences play a role in the development of eating disorders, particularly among people who internalise the Western beauty ideal of thinness. The most predominant images in our culture today suggest that beauty is equated with thinness for females and a lean, muscular body for males. People who internalise this 'thin ideal' have a greater risk of developing body dissatisfaction which can lead to eating disorder behaviours. People who internalise and adopt the Western beauty ideal of thinness as a personal standard have a higher risk of developing an eating disorder.

### Body dissatisfaction or negative body image

Body dissatisfaction expressed as concern about weight or shape is the most potent risk factor for the development of an eating disorder. Research suggests that body dissatisfaction and concern with weight gain begin in childhood but that this pattern of thinking remains open to change making it a primary target for prevention initiatives.

Poor body image can contribute to impaired mental and physical health, lower social functionality and poor lifestyle choices. Body dissatisfaction, the experience of feelings of shame, sadness or anger associated with the body, can lead to extreme weight control behaviours and is a leading risk factor for the development of eating disorders. Body dissatisfaction is also linked to depression and low self-esteem and has been found to be widespread in adolescent girls in Australia.

A wide range of relationships can influence body esteem including:

- Family & Siblings
- Friends & Peers
- Boyfriends & Girlfriends
- Teachers /Youth Mentors
- Sport and Fitness Coaches/Dance Teachers
- Work supervisors and Colleagues
- Media & Popular Culture

### Weight related criticism

Weight related teasing, bullying and critical comments about weight, particularly when the comments are made by people who are important in a person's life such as parents and role models, have been identified as risk factors for body dissatisfaction and eating disorders.

'Fat talk' is language and dialogue that reaffirms thin and beauty ideals.  Many people use 'fat talk' as a way to normalise and vocalise their insecurities and negative feelings about their own body. It is often an automatic response and without being challenged will continue to occur.  'Fat talk' also encourages unhealthy and negative body comparisons amongst peers further intensifying people's negative body esteem.

### Self esteem

Low self esteem has been identified by many research studies as a general risk factor for the development of eating disorders. Strong self-esteem has been identified as essential for psychological well-being and for strengthening the ability to resist cultural pressures. High levels of feelings of loneliness, shyness and inferiority and the belief that one has very little social support have all been identified as risk factors for eating disorders.

### Participation in appearance related activities

Participation in weight-related social or professional sub-cultures such as sport, dancing, fitness, and modelling, has been identified as a risk factor for the development of disordered eating and eating disorders. People engaged in high levels of exercise or competitive physical activities tend to have increased rates of body dissatisfaction, disordered eating and eating disorders despite the fact that society sees them as being extremely fit and healthy.

### Breaking the Developmental Cycle of Eating Disorders

Biological, psychological and social factors all contribute to the development of an eating disorder. However, the triggers for the onset of an eating disorder are typically nutritional stress as a result of a diet (or by exercise or illness in anorexia nervosa) which occurs in the context of a stressful or difficult life event.

Prevention focuses on the modifiable risk factors that precede the development of illness in order to break the developmental sequence.  The most common modifiable risk factors for eating disorders are body dissatisfaction and dieting.

*Focus on risk factors that can be changed:*

☐ Thin ideal internalization
☐ Body dissatisfaction
☐ Peer pressure, bullying and fat talk
☐ Dieting and disordered eating

*Increase  protective  factors:*

☐ Social support
☐ Self esteem
☐ Non competitive physical activity (sport for fun)
☐ Healthy eating behaviours
☐ Respect for diversity

A short list of warning signs for eating disorders appears in appendix 4 on page 114

# 4.   Prevention for a Purpose

The overarching aims of any prevention strategy are to break the cycle of eating disorders development by identifying people at risk and high risk situations, supporting early help seeking and creating healthy supportive social environments that reduce risk and increase protective factors.

General objectives include:

- Promoting health, well-being and resilience
- Enhancing early recognition of people at risk
- Supporting early help seeking
- Increasing awareness of eating disorders as serious illnesses
- Developing a healthy culture that respects diversity
- Raising awareness of and reducing the incidence of body bullying and fat talk
- Ensuring that all communication on weight, shape and mental health is safe and appropriate
- Increasing awareness of warning signs and intervention strategies

## Supporting Good Health

Some of the risk factors and socio-environmental stressors for eating disorders are shared with other mental illnesses. Low self-esteem, stress, bullying, body dissatisfaction, risk taking, self-harm, substance misuse, disordered eating and depression frequently occur in some combination in the lives of young people. Strategies which address the risks and protective factors for eating disorders may also contribute to achieving other health and well being objectives.

## Improving Performance

Disordered eating and eating disorders directly affect a person's ability to study, work and engage in social and sporting activities. A potential benefit of prevention programs for schools, sports clubs and employers is a reduction in absenteeism and presenteeism (lower productivity).

| General Objectives | Our Objectives |
|---|---|
| Promoting health, well being and resilience | |
| Supporting early identification and help seeking | |
| Developing a healthy social environment | |
| Reducing modifiable risk factors | |
| Increasing protective factors | |
| Improving performance | |
| Raising awareness of eating disorders as serious illnesses | |
| Ensuring that all communication on weight, shape and mental health is safe and appropriate | |

# 5. Support help seeking

The ability to engage with appropriate help at an early stage in illness is regarded as a protective factor for mental health. Mental illnesses typically have their onset between the ages of 12 and 25 years and yet these age groups are the least likely to seek help from conventional health services.

People with eating disorders often do not seek help, or only seek help after a long period of illness. Evidence suggests there is an average delay of approximately 4 years between the start of disordered eating symptoms and first treatment. For some people, this delay can extend to 10 or more years.

Shortening the time between the start of symptoms and first treatment can improve health and quality of life. This is the goal of early identification strategies.

Getting professional help early depends on the capacity of community members to recognise the health problem. Lack of mental health literacy has been identified as a significant barrier to help seeking for mental illnesses generally and for eating disorders in particular.
Recognition requires knowledge of the illness and warning signs, plus knowledge of pathways to access appropriate professional intervention.  To be willing to act on this knowledge, people must perceive that help-seeking is a positive behaviour and that acknowledgement of a health problem will not incur stigmatisation.

In order to support help seeking and recovery organisations can act to improve:

- Awareness of risks , warning signs and ways to engage with people at risk
- Strategies to support a person returning to school, sport or work after treatment
- Eating disorders service and referral information

## Improving Mental Health Literacy

It is vital that adults who frequently connect with and influence children and young people, including parents, teachers, sports coaches and youth leaders, have accurate and up-to-date knowledge about eating disorders and appropriate strategies to support positive body image and nutrition.

Training in mental health first aid has been shown to be effective in increasing community knowledge of and support for people with eating disorders to seek appropriate help.

All professions which regularly intersect with people at high risk of developing an eating disorder require a basic level of mental health literacy and the knowledge and skill to identify risk factors, ask questions to encourage disclosure and refer people for appropriate help.

## The role of Primary Care Clinicians

The majority of people with eating disorders have contact with health professionals but they do not specifically talk about their eating problems. This means that many people are not diagnosed with eating disorders at an early stage because they present with apparently unrelated complaints. Common health presentations include emotional problems, weight loss, and gastro-intestinal problems.

Although people may not volunteer information about specific eating problems in health care appointments many would welcome questions from health care providers about eating behaviours. Asking screening questions may help to initiate disclosure and talk about their body dissatisfaction or disordered eating with a health professional leading to earlier access to treatment.

Improving screening and assessment for eating disorders by GPs, paediatricians, dietitians and counsellors is vital to support early intervention.

If your organisation provides clinical or counselling services, training staff in screening, assessment and referral for eating disorders is an important part of a prevention and early intervention strategy. (For more information on competencies for screening and assessment please refer to the NEDC consultation paper 'Developing Practical Approaches to Eating Disorders: Workforce Development). Opportunistic screening of people in high risk groups who present for health care and the development of pathways to early intervention treatment through primary health care are two important strategies that can be supported by organisations that provide health services.

Evidence based screening questions appear in appendix 1 on page 107

## 6. Facilitate access to prevention programs

There are a number of evidence based prevention programs which have been successfully used to reduce internalization of the thin-ideal, body dissatisfaction and disordered eating.

Most of these programs have been developed for use with groups of children or young people and have been evaluated in the context of school or tertiary education programs. There is scope to adapt these programs for delivery in other settings and this is a priority area for action to improve the impact of prevention strategies.

Prevention strategies should take into consideration the options for directly providing prevention programs and for facilitating access to external programs. Organisations which work with groups of young people may be able to provide prevention programs as an integral part of their regular programs. Organisations that work with other age groups or with individuals may be able to provide information resources and support access to external prevention programs. Opportunities to network with similar organisations should be explored to share the delivery of prevention programs.

### A Range of Evidenced Based Programs

The range of successful approaches to prevention of eating disorders that are supported by research evidence include:

- **Dissonance-based education**
  Dissonance-based approaches are informed by cognitive dissonance theory which has been successfully used in preventing substance abuse and obesity. They are based on the idea that when there is an inconsistency between an individual's health beliefs and behaviours, the resulting psychological discomfort will motivate them to change their attitude or behaviours to reduce this inconsistency. Amongst university students, dissonance based education, incorporating health education activities that build self-esteem have been shown to be more successful than psycho-educational approaches.

- **Psychoeducation**
  Psychoeducation involves teaching about eating disorders and their risks. The psychoeducation program 'Student Bodies' has been shown to be an effective strategy for young people aged 15 to 25 years.  It has also been shown to be a successful approach for adult professionals such as teachers who work with young people. Programs targeting groups younger than 15 years of age should avoid discussion of disordered eating behaviours so as to ensure young people did not learn eating disordered behaviours from the program.

- **Media literacy**
  Health education programs that develop media literacy are based on the assumption that promoting a critical evaluation of the media will reduce its credibility and persuasive influence. There is clear evidence for a relationship between media literacy and a reduction in risk factors for eating disorders in adolescent girls. This is consistent with evidence that media literacy can also reduce other risk behaviours in adolescents, such as smoking and use of alcohol. Media literacy programs are a best practice approach for the 12 to 14 year old group.

- **Cognitive Behavioural Therapy (CBT)**
  CBT principles have been used in a range of prevention initiatives for people with body dissatisfaction and a high risk of developing an eating disorder and have shown successful outcomes in random controlled trials over many years. CBT programs have been shown to be successful for older adolescents and adults.

Other types of approaches to prevention that are showing promise include:

- **Addressing peer interactions**
  The peer environment has been shown to impact upon body dissatisfaction and disordered eating.  For example, environments in which there is high attention paid to appearance, high frequency of talk about dieting and weight issues ("fat talk") or teasing about weight and shape can increase risk for these problems.  This approach has been successful for pre-adolescent boys and girls and young adolescent girls.

- **Self Esteem**
  Low self-esteem is a risk factor for body dissatisfaction, dieting, and eating disorders as well as a general risk factor for other mental health issues. Health education and health promotion programs that are based on the improvement of self-esteem have achieved success in the reduction of body dissatisfaction, dietary restraint and disordered eating.

### Delivering Effective Prevention Programs

The approach to delivering prevention programs is as important as the program content. Strategies which enhance program effectiveness include:

- **Multi-sessional programs**
  Multiple session programs produce larger effect sizes than single-session programs. Continuing reinforcement of messages through 'booster sessions' is also suggested to sustain new behaviours.

- **Programs that are interactive**

    A review of school-based eating disorder prevention programs has found interactive inter-ventions in which students learnt experientially produced more positive effects than didactic interventions that employed an information-based approach .

- **Trained program leaders**

    Evidence supports the use of a trained presenter. Programs are most effective when delivered by people who have been specifically trained to deliver eating disorders prevention programs.

- **Internet based education with moderated group discussion**

    Technology-based interventions, such as internet prevention programs, internet-assisted CBT, online consulting, and text messaging have all shown promise in assisting in the early intervention treatment of eating disorders. For older adolescents and young adults internet-based interventions structured around a cognitive behavioural approach or cognitive dissonance have been shown to be effective.

- **Consistent, coordinated approaches**

    To be most effective, prevention initiatives should be delivered consistently over time as part of a long term and coordinated approach to prevention and early intervention for eating disorders.

### Evidence Based Interventions for children and young people

Prevention programs are not all equally successful.  The following list highlights a selection of programs which are supported by research evidence:

- **Media Smart**

    For early high school (grades 7 and 8), Media Smart is an 8 session program that addresses media and peer issues in interactive class-room activities. This is a universal program for girls and boys unselected for risk factors.  Long term follow-up shows reduction in risk factors for eating disorders.

- **Happy Being Me**

    This program is an interactive school-based program specifically for grade 7 girls. This 3 session program addresses both media and peer issues including increasing understanding of the role of body comparisons, fat talk and teasing in maintaining body dissatisfaction and disordered eating.

- **The Body Project**

    The Body Project is a two-part group intervention program for adolescent girls and young women at risk of developing eating disorders. Using a cognitive dissonance approach, participants learn skills that increase body satisfaction, decrease unhealthy weight control behaviours and prevent eating disorder symptoms. They learn to make gradual lifestyle changes to achieve a healthy body weight. The program is supported by a facilitator guide and is designed to be delivered by school counsellors, nurses and teachers.

- **Student Bodies**

    Student Bodies is an online psycho-educational intervention program designed to help women establish and maintain a positive body image and to engage in healthy eating behaviours.  The program was designed as an 8-week, structured intervention program with scope for booster sessions.  Student Bodies has been shown to be effective in reduction of body mass index (BMI) and self-reported dieting. The program is suitable for older female students in upper high school and tertiary education, and has been used successfully with teachers.

Research suggests a strong link between body dissatisfaction and disordered eating and evidence based approaches to reducing body dissatisfaction form an essential part of the prevention of eating disorders. Recommendations from the National Strategy on Body Image (2009) are also appropriate for the prevention of eating disorders

- **Free to BE** – a resource for years 3 to 12 which aims to address the various factors that influence body image. This resource was developed by the Butterfly Foundation as a part of the Australian Government's National Body Image Strategy

- **Y's Girls** – an affordable curriculum resource for girls in primary school designed to be delivered by teachers, which has demonstrated promising results in improving body dissatisfaction, thin ideal internalisation, self esteem and disordered eating.

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**7-10 Years**
**Primary School**

In general, children under the age of 12 years do not need information on eatin disorders. Communication with children should focus on positive behaviours

In school prevention programs focus on:

▶ Good health
▶ Body image and self esteem
▶ General mental health literacy

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**10-14 Years**
**Middle School**

Transitional years of puberty are a critical period for intervention

In school prevention programs focus on:

▶ Self esteem
▶ Perfectionism
▶ Media literacy and 'ideal body shape' internalisation
▶ Healthy eating
▶ Risks of dieting
▶ Natural changes in variation in body shape
▶ Standing up to a peer pressure
▶ Building a peer environment that supports positive body image

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**15-18 Years**
**High School & Tertiary**

For young people aged 15 to 25 years, information on eating disorders may contribute to recognition of risk factors in themselves and others and the development of supportive community environments.

This age group may be at higher risk, having already engaged in disorder eating behaviours. Messages should be tailored to meet the needs of high risk audiences.

Messages should include ways to challenge the thin ideal

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**18-25 Years**
**Tertiary & Employment**

As for 15-18 year olds, this group may be at higher risk and require specifically targeted messages to address risk behaviours.

Awareness of eating disorders is required to enable peer and partner support.

Messages may target specific occupations and interest groups at higher risk including athletes, entertainment industry and employers of young people.

Evidence based programs that integrate eating disorders prevention and obesity prevention include:

- **The 5-2-1 Go! intervention** (Planet Health obesity prevention curriculum plus School Health Index for Physical Activity and Healthy Eating: A Self- Assessment and Planning Guide, Middle/High School Version) an integrated obesity prevention and disordered eating behaviour prevention intervention  for pre-adolescent and early adolescent girls.

- The **Healthy Weight** program (part of The Body Project) includes various techniques to discourage unhealthy dieting behaviours (e.g., calorie-counting or food deprivation) while facilitating guidance for achieving a healthier lifestyle, including regular exercise and a healthy diet.  Particular attention is paid to factors which may have led to failure of previous diet goals and participants receive nutritional information specific to their individual diet plans, in order to prevent prospective failures. Participants learn to make gradual lifestyle changes to achieve a healthy body weight.

## 7. Communicate Safely

If you work with people at high risk of developing eating disorders you may already be communicating about sensitive issues such as weight and shape, either directly through learning curriculum, training, or information resources, or indirectly through role modelling and cultural expectations.

It is important to consider the unintended consequences of messages and resources that provide weight related content.

If your organisation already has prevention strategies in place addressing issues such as healthy nutrition, self esteem development and stress reduction these can provide a useful platform for the dissemination of evidence based eating disorders prevention messages.

Coordinated and consistent messaging that promotes health outcomes for overweight and eating disorder problems is possible, particularly around prevention. One way of achieving this is to focus on the shared risk and protective factors, and to change these in a positive direction.

### Shared Risk Factors

- Being overweight in childhood
- Weight bias and stigmatisation
- Childhood weight-related teasing
- Amount of time spent watching television/using the internet/playing video games
- Media and marketing exposure
- Dieting and disordered eating
- Poor body image
- Depressive symptoms and anxiety
- Family talk about weight, parent weight-concern and weight-related behaviours (e.g. dieting)

### Shared protective factors

- Enjoying physical activity
- Positive body image
- High self-esteem
- Eating breakfast, lunch and dinner every day
- Family modelling of healthy behaviours (e.g. avoiding unhealthy dieting, engaging in physical activity, having regular and enjoyable family meals)

The way in which we communicate about weight and shape and about eating disorders can contribute to prevention and early intervention by:

- Increasing knowledge of health issues and appropriate solutions
- Correcting myths and misconceptions
- Demonstrating the benefits of behaviour change
- Prompting help seeking and individual action
- Influencing perceptions, beliefs, attitudes and social norms

### Evaluating the Safety of Existing Resources and Health Programs

The following checklists and table summarize the key principles for the development and evaluation of messages which are safe for all audiences. These provide an initial tool to identify the risks associated with a proposed or existing resource, before a more detailed analysis is initiated.

### Checklist for Safe Messages

**Positive Communication Strategies**
*Communicating about eating disorders*

- Be developmentally appropriate for the intended audience – don't talk about eating disorders with children under 15
- Provide accurate, evidence based information
- Promote help seeking and be supported by information on sources of help
- Balance representation of males and females, diverse cultures and age groups, unless specifically addressing a single target audience (e.g. teenage boys)
- Be reviewed for ambiguity and possible risk of harm before dissemination.
- Communicating about weight and shape
- Promote healthier and balanced thinking on body image, shape, eating and weight, nutrition and exercise
- Accurately convey the impact that lifestyle behaviours have on overall health
- Respect individual and cultural diversity including body diversity
- Promote and encouraging self esteem, body satisfaction, self worth and resilience
- Enable critical evaluation of media messages
- Challenge stereotypes and stigmatisation
- Promote community responsibility for safe, healthy social environments

**Unsafe Communication Strategies**
*Communicating about eating disorders*

- Describe details of how to engage in eating disorders behaviours (e.g. how to induce vomiting)
- Normalize, glamorise or stigmatize eating disorders
- Use or provide information on personal measurements in relation to people who have experienced an eating disorder (e.g. weight, body proportions, amount of exercise, number of episodes in hospital)
- Use judgemental, stigmatising or value laden language
- Use objectifying language that detracts from recognition of the personal experience of illness
- Focus exclusively on Anorexia Nervosa without consideration of other eating disorders
- Communicating about weight and shape
- Use directive words or rigid rules (e.g. do's and don'ts; "never" and "always")
- Use appearance language to address weight issues (e.g. "thin" or "fat")
- Label foods or food groups as 'good' or 'bad'
- Attribute virtues (such as success, popularity, intelligence) to people based on their appearance or weight
- Use images of extreme body weights or shapes
- Use language or images that ridicule or stereotype people based on their appearance
- Use personal physical measurements such as weight, waist measurements etc

## Risk        or        Protection

**Focus on weight or shape**
Messages focus on weight or body shape as the key issue and target for change. Images show tape measures, scales, or extreme physical shapes. The words 'weight' or 'shape' are a prominent part of the message.

**Focus on good health**
Messages take a holistic view of health, promoting physical, social and emotional wellbeing.

**Stereotypical images**
Images portray 'Western cultural ideals' e.g. thin women; muscular men; nuclear two parent families; blond fair skinned people. Images are manipulated to portray 'perfection'.

**Healthy diversity**
Images portray a range of real people of different appearances including ethnic difference; range of healthy body images; male and female images; different age groups.

**Measurement**
Messages encourage people to assess their health through measurement of physical dimensions (such as waist measurement or weight) or encourage a focus on measurement of calorie intake or hours of exercise.

**Personal achievement**
Messages encourage people to engage in healthy eating and exercise to achieve personal goals that relate to doing things that the person wants to do in their lives, or experiencing positive feelings.

**Rules**
Messages promote simplistic rules that everyone must follow e.g. labels foods as 'good' or 'bad'

**Informed choices**
Messages provide evidence based information to help people make healthy individual choices about food, exercise, and help seeking.

**Fear/stigma**
Messages motivate people to act based on fear of illness or social exclusion. Messages attribute success or popularity to people based on their weight or appearance.

**Self worth**
Messages promote self esteem and encourages change based on self-worth

Key messages to communicate about eating disorders appear in appendix 2 on page 108
Key messages about weight and shape appear in appendix 3 on page 111

# 8. Develop healthy environments

The risks for eating disorders develop over time and are reinforced by daily activities. A consistent approach is required for prevention that ensures that all the messages people receive contribute to resilience. The benefits of participating in a single prevention workshop can be overshadowed, for example, by the daily reality of weight related bullying or perceived pressures to be thin. For this reason, holistic strategies are recommended that influence the whole of an organisations approach to well being and body diversity.

This consultation paper has been developed for people working in many different settings including schools and tertiary education centres, sports clubs, dance schools and fitness centres; health services, youth services, and employers across a broad spectrum of industries. All of these groups are referred to in the paper as 'organisations'. Prevention strategies can be implemented by individuals in all of these different contexts but they are most likely to be successful when they have the support of the organisation behind them. This paper explores what organisational support for prevention might look like in practice.

## Whole of School Approaches

A number of different approaches have been investigated in Australia to address the specific issue of negative body image. Conclusions support a 'whole of school approach' based on four key elements: taught curriculum, staff training and development, school environment and policy, and partnerships with parents and services.

The National Strategy on Body Image (Commonwealth of Australia, 2009) provides a checklist on whole of school approaches to promote positive body image which includes many of the same recommendations. The following edited list of recommendations may contribute to the prevention of eating disorders in a whole of school context and may be adapted for implementation in other contexts such as sports programs.

## Checklist for a Whole of School Approach

*Policy*

- Include a statement in the school mission about providing a body image friendly environment and celebrating diversity.
- Prohibit appearance-related teasing, including cyber-bullying in school policy.
- Ensure that there is no weighing, measuring or anthropometric assessment of students in any context.
- Provide an opportunity for all students to engage in regular physical activity in a non-competitive, non-weight-loss focused, safe and secure environment.
- Provide a balance of food options from all food groups in the canteen.
- Display public material and posters that include a wide diversity of body shapes and sizes and ethnicity.

*Workforce Development*

- Train all relevant teaching staff in the early identification and referral of students with serious body image concerns and eating disorders

- Provide all teachers with training and information about eating disorders, their impact on the wellbeing of young people and ways that risk factors are reinforced by social environments.
- Train teachers to use body friendly language in their interactions with students.

*Curricula*

- Provide developmentally appropriate teachings at every year level.

*Engaging Parents*

- Make available up-to-date printed information about how parents can support their child to develop a positive body image and a healthy relationship with food
- Provide parents with links to information about body image and eating disorders on the school website
- Present talks and information nights for parents about eating disorder issues.

  *(Adapted from the Checklist for Body Image Friendly Schools, Commonwealth of Australia, 2009)*

## An integrated workplace response to eating disorders

The WHO (World Health Organisation) and Australian government has recognised the workplace as a priority setting for health promotion. There are many positive, practical things that employers, managers and human resource managers can do to develop and support a healthy workplace and support those at risk or those experiencing eating issues or negative body image to seek help. Developing health workplace cultures includes reducing 'fat talk', eliminating appearance or weight based bullying. Similar to the 'whole of school' approach, a holistic approach in the workplace involves policy, training and communication strategies.

*Policy*

- Raise awareness of and reduce the incidence of appearance-related teasing, including cyber-bullying
- Support access to healthy food and non competitive physical activity to maintain well being
- Ensure that workplace communication resources is safe for all audiences and include a wide diversity of body shapes and sizes and ethnicity
- Promote pride in achievement and functional ability rather than appearance
- Ensure that uniforms and dress codes enforced are 'body image friendly' enabling all employees to feel comfortable whilst at work and that sends a message to all employees that diversity in body shape and size is respected.

*Workforce Development*

- Train all relevant staff in the early identification and referral of employees with serious body image concerns and eating disorders
- Provide staff with training and information about eating disorders, their impact on wellbeing, absenteeism and presenteeism, and ways that risk factors are reinforced by social environments
- Train managers, supervisors and team leaders to use body friendly language in their interactions with staff and role model positive body image

## Prevention and Early Intervention Model for Eating Disorders

| Level of intervention and target audience | Primary Prevention | | | Secondary | Tertiary |
|---|---|---|---|---|---|
| | *Universal* | *Selective* | *Indicated* | *Early intervention* | *Recovery Support* |
| | Target the whole community with an emphasis on<br>☐ Families<br>☐ Young people<br>☐ Professionals who work with families and young people e.g.<br>☐ Primary health care<br>☐ Education<br>☐ Sport and fitness<br>☐ Youth and welfare | Target groups known to be at higher risk e.g.<br>☐ Young people aged 12 to 25<br>☐ Athletes and people engaged in physical fitness and dance<br>☐ People with diabetes etc. | Target individuals at very high risk who may be showing early signs of mental ill-health e.g.<br>☐ People with a high level of body dissatisfaction<br>☐ People with disordered eating<br>☐ People seeking help for weight loss | Target people in the first two years of an eating disorder to lower the severity and duration of illness | Target people who have experienced an eating disorder to reduce the impact of mental ill-health on a person's life and the risk of relapse and recurrence |
| **Objectives** | **Community Awareness**<br>Community members are aware that eating disorders are serious illnesses<br>Community members are aware of the risk factors and early symptoms of eating disorders<br>Social and media environments minimize risk and support well being | **Prevention Programs**<br>People in high risk groups have access to the level of education and support required to minimize risk and develop protective factors. | | **Early Intervention Treatment**<br>People with early symptoms of eating disorder have prompt access to evidence based treatment interventions including CBT (CBT-e) and FBT delivered in integrated outpatient programs. | **Recovery Support**<br>People who have experienced an eating disorder have access to long term community based support |
| **Outcomes** | ☐ Reduced stigma and misunderstanding<br>☐ Improved approaches to self care<br>☐ Improved levels of early identification and early help seeking | ☐ Reduced body dissatisfaction and disordered eating<br>☐ Improved approaches to self care<br>☐ Improved levels of early help seeking | | ☐ Reduced impact of illness; patients remain engaged with education, family, employment and community<br>☐ Reduced duration and costs of illness | ☐ New behaviours integrated into activities of daily living<br>☐ Improved approaches to self care<br>☐ Improved levels of early help seeking |
| **Actions** | ☐ Integrated health messages promote healthy attitudes and behaviours to prevent obesity, body dissatisfaction and eating disorders<br>☐ Information on eating disorders and treatment is easily accessible<br>☐ Communication to key professional groups through existing organisations and communication channels<br>☐ Parent information and education programs delivered through schools and health services<br>☐ Promotion of 'whole of community' strategies to health (e.g. whole of school approaches) | *Selective*<br>☐ Prevention programs delivered to groups at high risk (e.g. in schools and sports programs)<br>☐ Prevention information and resources accessible online<br>☐ Professionals trained in delivery of prevention programs<br>☐ Professional trained in mental health first aid and screening for risk<br>☐ Parent information and education programs | *Indicated*<br>☐ Prevention programs delivered to groups at high risk (e.g. in tertiary education and sports programs)<br>☐ Online prevention programs<br>☐ Adult support programs (e.g. NGO and health centres) | ☐ Opportunistic screening and early assessment in primary care<br>☐ Rapid access referral pathways to intensive early treatment<br>☐ Integrated, multidisciplinary early intervention outpatient programs<br>☐ Local (primary and secondary care) treatment networks available in the community<br>☐ Telephone and online assessment and early intervention treatment | ☐ Community based rehabilitation and recovery support services including peer support<br>☐ Medical monitoring<br>☐ Coordination of access to supports withint he community such as employment and social interactions. |
| **Service Provider** | Health promotion initiatives:<br>☐ State and Federal governments<br>☐ Schools<br>☐ Tertiary education<br>☐ NGO services | Services working with high risk groups e.g.<br>☐ Schools<br>☐ Tertiary Education<br>☐ General and health related youth services<br>☐ Sport, dance and fitness<br>☐ Diabetes education<br>☐ NGOs<br>☐ Health services and health professional development services | | Mental health service providers:<br>☐ Public health<br>☐ Private health<br>☐ NGOs | Community based services:<br>☐ Primary health care<br>☐ NGOs |

**Notes:**
There is evidence that intensive intervention at an earlier stage of eating disorders contributes to reduced impact and more sustainable recovery. Early intervention treats disordered eating and related psychological distress and helps to establish the preventative measures needed for long-term health.

## Strategic Questions for Eating Disorders Prevention

| Strategic Questions | Opportunities and Challenges |
|---|---|
| **Identifying need:** who do we work with that might benefit from a prevention strategy? Which group is the highest priority for intervention? | |
| **Developing understanding:** who needs to know more about eating disorders in our organisation? What type of learning approach would work for this group? | |
| **Modifiable risks:** which risks can we influence? How does our social environment increase or reduce risks? | |
| **Organisation objectives:** what would we need to achieve in order to justify having an eating disorders prevention strategy? | |
| **Supporting help seeking:** how can we support people to get help early? Who needs to be trained in Mental Health First Aid or screening? Which services can we refer people to? | |
| **Access to prevention programs:** are prevention programs right for our context? Should we provide programs or facilitate access to external programs? If we provide programs, how would they fit in with other activities? Who needs to be trained to deliver or support the programs? | |
| **Safe communication:** what do we already do that might influence risk and protective factors? How can we evaluate the safety of what we do? | |
| **Embedding practice in culture:** how can we review our policy, procedures and practices to promote health and respect for body diversity? | |

## Appendix 1: Screening Questions for Eating Disorders

Screening questions for eating disorders can be as simple as the five questions in the Eating Disorders Screen for Primary Care (ESP) and SCOFF screening tools. The questionnaires do not diagnose eating disorders but identify the possible presence of an eating disorder and prompt a more detailed assessment.

### SCOFF

**S** – Do you make yourself Sick because you feel uncomfortably full?
**C** – Do you worry you have lost Control over how much you eat?
**O** – Have you recently lost more than 6.35 kg in a three-month period?
**F** – Do you believe yourself to be Fat when others say you are too thin?
**F** – Would you say Food dominates your life?

An answer of 'yes' to two or more questions indicates the need for a more comprehensive assessment. A further two questions have been shown to indicate a high sensitivity and specificity for bulimia nervosa.

**1.** Are you satisfied with your eating patterns?
**2.** Do you ever eat in secret?

### Eating Disorder Screen for Primary Care (ESP)

- Are you satisfied with your eating patterns? (A "no" to this question is classified as an abnormal response).
- Do you ever eat in secret? (A "yes" to this and all other questions is classified as an abnormal response).
- Does your weight affect the way you feel about yourself?
- Have any members of your family suffered with an eating disorder?
- Do you currently suffer with or have you ever suffered in the past with an eating disorder?

People who use screening questions should be trained in eating disorders identification and assessment.

## Appendix 2: Key Messages about Eating Disorders

| Communication to Raise Awareness of Eating Disorders | |
|---|---|
| **Promoting Recognition & Help Seeking** | |
| **Key Message:** | **Key Message Themes** |
| **Eating disorders are serious illnesses, not a lifestyle choice** | • ED are complex illnesses affecting both physical and mental health<br>• Of all mental illnesses, eating disorders pose the greatest risk of death in young women.<br>• No one can be blamed for developing an eating disorder. There are genetic, and personality vulnerabilities and social and environmental triggers. Eating disorders are caused by multiple factors – no one factor causes an eating disorder<br>• Eating disorders are severe illnesses and people can't "just stop" their eating disorder A person with an eating disorder is in distress and needs help<br>• Eating disorders are not just about food or weight, vanity, will power or control. They are fuelled by distress, anxiety, stress and cultural pressures<br>• Food and exercise are used as coping mechanisms to help people deal with other issues such as anxiety, depression, or confusion<br>• People with eating disorders require treatment for both mental and physical health: addressing the underlying psychological issues and the impact on physical health<br>• For some people, the process of recovering from an eating disorder can be long, slow and challenging for everyone involved, and requires support from a number of areas<br>• Treatment early in the development of the disorder can reduce the duration and severity of the illness.<br>• There is hope for recovery and improved quality of life at all stages of illness |
| **People from all walks of life may experience an eating disorder** | • Eating disorders affect both men and women<br>• People in all age groups can experience eating disorders<br>• People from all cultural backgrounds experience eating disorders<br>• People who engage in particular sports (e.g. gymnastics, athletics, rowing), dancers and models may be at an increased risk of experiencing an eating disorder<br>• People who are experiencing high levels of stress may experience eating disorders<br>• Women going through significant life changes such as pregnancy or menopause may experience eating disorders<br>• People who have other mental illnesses, such as anxiety or depression, may also experience an eating disorder<br>• People who have other physical illnesses, such as diabetes, may also experience an eating disorder |

| **Early intervention is crucial**<br><br>**Acting on the warning signs of eating disorders could save a life** | Information that should be included in communication about the warning signs of eating disorders includes:<br><br>• There are warning signs of eating disorders. You can be trained to recognise and respond.<br>• You can't judge whether a person has an eating disorder based on their weight, shape or appearance; A person's weight may not indicate how much danger they are in<br>• Restrictive dieting, body dissatisfaction and excessive exercise can be indicative of the development of eating disorders<br>• People at risk of developing an eating disorder may have a problem with food, and/or an intense dislike of their bodies or appearance and/or place a great deal of emphasis on weight and shape and/or display perfectionist traits and/or suffer from low self-esteem<br>• People at risk of developing an eating disorder may have a problem with food, and/or an intense dislike of their bodies or appearance and/or place a great deal of emphasis on weight and shape and/or display perfectionist traits and/or suffer from low self-esteem<br>• Many people with an eating disorder are reluctant, fearful or ambivalent about seeking help and may benefit from the action taken by people in their support network (e.g. parents, family, friends).<br>• When you see the warning signs get help as soon as possible<br>• Early intervention can prevent the development of an eating disorder or reduce the severity of illness<br>• For most people, the earlier help is sought, the more likely they are to recover<br>• Recovery is achievable and worthwhile<br>• We do have effective treatments for many types of eating disorders |

## Appendix 3: Key Messages about Weight and Shape

| Principles for Communicating about Eating Disorders |
| --- |
| **Principles** |
| Communication about eating disorders should:<br><br>• Be developmentally appropriate for the intended audience<br>• Support understanding of eating disorders as serious, complex illnesses<br>• Provide accurate, evidence based information which is supported by identification of the source of information e.g. author or publishing organisation, indication of expertise in eating disorders and a publication date<br>• Respect the experience of people who have eating disorders<br>• Assist people to make appropriate decisions about help seeking<br>• Include on-going monitoring and evaluation of the impact on audiences to ensure the continuing safety and appropriateness of content<br>• Balance representation of males and females, diverse cultures and age groups, unless specifically addressing a single target audience (e.g. teenage boys)<br>• Communication about eating disorders should always be supported by information about appropriate sources of help<br>• Be reviewed for ambiguity and possible risk of harm before dissemination. |
| **Precautions** |
| Communication about eating disorders should not:<br><br>• Describe details of how to engage in behaviours that are symptomatic of eating disorders (e.g. how to induce vomiting)<br>• Normalize, glamorise or stigmatize eating disorder behaviours<br>• Use or provide information on personal measurements in relation to people who have experienced an eating disorder (e.g. weight, body proportions, amount of exercise, number of episodes in hospital)<br>• Use judgemental, stigmatising or value laden language<br>• Use objectifying language that detracts from recognition of the personal experience of illness<br>• Focus exclusively on Anorexia Nervosa without consideration of other eating disorders |
| **Target audiences** |
| • People who have an eating disorder or disordered eating and their support network<br>• In general, children under the age of 12 years do not need information on eating disorders. Communication with children should focus on positive behaviours for good health, body image and self esteem and general mental health literacy.<br>• For young people aged 12 to 25 years, information on eating disorders may contribute to recognition of risk factors in themselves and others and the development of supportive community environments. Information on eating disorders should be supported by information on positive behaviours for good health and self esteem. |

| Communicating Safe Messages that Support Eating Disorder Prevention | |
| --- | --- |
| **Promoting Resilience** | |
| **Key Message:**<br><br>There is a strong link between dieting and Eating Disorders<br><br>**Prevention messages:**<br><br>" Skipping meals makes you feel starved so you overeat and feel bad"<br><br>"Don't be fooled by fad diet promotion in the media" | Safe messages about dieting and weight loss<br><br>Communication and health promotion strategies that include reference to dieting, or weight loss that are safe and relevant for eating disorders prevention will emphasize:<br><br>• Fad diets are dangerous to health<br>• Dieting, weight dissatisfaction, low mood, unhealthy weight control behaviours, and over-exercising are all associated with the development of eating disorders<br>• Regular use of extreme weight loss strategies may contribute to long term weight gain<br>• Promote and encourage healthy eating, weight management and exercise strategies<br>• Promote the pursuit of personal self-care goals such as addressing diagnosed health problems, and increasing energy and engagement in life.<br>• Promote a flexible approach to food that can be adapted to personal needs and energy requirements as life changes<br>• Promote a calm relationship with food and physical activity, responding to the state of the body, such as hunger, thirst and tiredness (as opposed to rigidly imposed diet or exercise regimes) |
| **Key Message:**<br><br>Appearance ideals are determined by fashion and constantly change<br><br>**Prevention message:**<br><br>"Your value doesn't depend on appearance"<br><br>"Comparing yourself to unrealistic ideals is dangerous"<br><br>"Media images have been altered and are unreal" | • Respect diversity in appearance; environments that recognise and accept diversity contribute to social and emotional wellbeing<br>• 'Fat talk' and weight related teasing are unacceptable and can contribute to the development of eating disorders<br>• Self esteem is a protective factor for eating disorders<br>• Body dissatisfaction can lead to unhealthy dieting and depression as well as eating disorders<br>• What we see in the media isn't real life. Images are chosen and manipulated to show unrealistic ideals |

| Key Message:<br><br>Everyone has a role to play to build a culture that values people for who they are, not for what they look like<br><br><br>Enhancing protective factors for eating disorders is good for everybody's health | • Risk and protective factors for eating disorders occur in everyday life, in the home and family relationships, schools, workplaces, recreational and sport activities, and media and social influences<br><br>• The way we behave as a society directly affects our mental health, especially for children and young people<br><br>• Improving mental health literacy for everyone will help to reduce the stigma associated with eating disorders and other illnesses<br><br>• The media plays an important role in communicating social values. Media promotion of body shape, weight and food as indicators of social success contributes to an unhealthy social environment.<br><br>• Improving media literacy and awareness will help to challenge and change culture<br><br>• Groups and organisations in the community have a responsibility to create safe and healthy social environments (e.g. school or workplace culture)<br><br>• Families can support their loved ones to build a positive body image and develop healthy eating behaviours<br><br>• Regular family meals, and positive talk about healthy behaviours and personal strengths may help to build resilience<br><br>• Peers can support their friends to build a positive body image and develop healthy eating behaviours<br><br>• Fitness, sport and dance instructors influence how people understand their bodies. They have an important role to play in helping people to develop body acceptance and healthy exercise practices.<br><br>• Acceptance of weight and shape diversity may reduce discrimination and stigma |
|---|---|

## Principles for Safe Messages to support Eating Disorder Prevention

### Principles

Communication and health promotion strategies that focus on issues related to eating disorders (e.g. weight, dieting, exercise, self esteem, mental health literacy) should be evidence based and safe for vulnerable people, including those who may be at risk of developing an eating disorder.

Message content can contribute to the prevention of eating disorders by:

- Promoting healthier and balanced thinking on body image, shape, eating and weight, nutritional and exercise knowledge and behaviours
- Accurately conveying the impact that lifestyle behaviours have on overall health
- Promoting nutrition and physical activity for energy and engagement
- Being delivered from a compassion-centred approach that encourages self-care rather than as prescriptive injunctions
- Respecting individual and cultural diversity including body diversity
- Promoting and encouraging self esteem, body satisfaction, self worth and resilience
- Enabling critical evaluation of media messages on the thin body ideal, 'healthy' behaviour and the nature of success
- Challenging stereotypes and stigmatisation
- Promoting community responsibility for safe, healthy social environments
- Promoting the development of policies and practices to support safe social environments (e.g. school policies on issues such as bullying or recording student weights)
- Promoting cultural change (e.g. by promoting change in media representation of body appearance, weight and health issues)

### Precautions

All messages should be reviewed and monitored for safety and efficacy for vulnerable audiences including:

- People who have or are at risk of developing an eating disorder
- People who are obese or are at risk of developing obesity
- People with health issues that may increase their risk of developing an eating disorder or obesity (e.g. diabetes)
- Children and young people

Communications about health that relate to weight, diet, exercise, or body image should avoid the use of:

- Directive words or rigid rules (e.g. do's and don'ts; "never" and "always")
- Appearance language to address weight issues (e.g. "thin" or "fat")
- Labelling foods or food groups as 'good' or 'bad'
- Attributing virtues (such as success, popularity, intelligence) to people based on their appearance or weight
- Use of images of extreme body weights or shapes
- Use of language or images that ridicule or stereotype people based on their appearance
- Measurement:
    o Avoid the use of personal physical measurements such as weight, waist measurements etc
    o Avoid the use of prescriptive or competitive targets for physical activity

### Target Audiences

Ideally, prevention messages need to reach their audience before the establishment of high risk behaviours or early signs of eating disorder. A critical period for intervention is the age group 10 to 14 years.

Messages communicated to young people should always be communicated to adults in their sphere of influence as well to ensure a consistent and supportive environment. People in spheres of influence include, but are not limited to: Families, Teachers, School Counsellors, Youth Workers, Physical activity instructors, GP's

For more information on safe and appropriate messages please refer to the NEDC report 'Clarity in Complexity: National Eating Disorders Communication Strategy' and 'Evaluating the Risk of Harm of Weight-Related Public Messages' both of which can be found in the NEDC publications section at **www.nedc.com.au**

# Appendix 4: Warning Signs for Eating Disorders

## Key Message: Early intervention is crucial

*"Acting on the warning signs of eating disorders could save a life"*

**Behavioural warning signs**

- Dieting behaviours (e.g. fasting, counting calories/kilojoules, avoidance of food groups)
- Evidence of binge eating (e.g. disappearance or hoarding of food)
- Evidence of vomiting or laxative use (e.g. taking trips to the bathroom during or immediately after meals)
- Excessive, obsessive or ritualistic exercise patterns (e.g. exercising when injured or in bad weather, feeling compelled to perform a certain number of repetitions of exercises or experiencing distress if unable to exercise)
- Changes in food preferences (e.g. refusing to eat certain 'fatty' or 'bad' foods, cutting out whole food groups such as meat or dairy, claiming to dislike foods previously enjoyed, a sudden concern with 'healthy eating', or replacing meals with fluids)
- Development of rigid patterns around food selection, preparation and eating (e.g. cutting food into small pieces or eating very slowly)
- Avoidance of eating meals, especially when in a social setting (e.g. skipping meals by claiming they have already eaten or have an intolerance/allergy to particular foods)
- Lying about amount or type of food consumed or evading questions about eating and weight
- Behaviours focused on food (e.g. planning, buying, preparing and cooking meals for others but not actually consuming; interest in cookbooks, recipes and nutrition)
- Behaviours focused on body shape and weight (e.g. interest in weight-loss websites, books and magazines, or images of thin people)
- Development of repetitive or obsessive behaviours relating to body shape and weight (e.g. body-checking such as pinching waist or wrists, repeated weighing of self, excessive time spent looking in mirrors)
- Social withdrawal or avoidance of previously enjoyed activities

**Physical warning signs**

- • Weight loss or weight fluctuations
- • Sensitivity to the cold or feeling cold most of the time, even in warm temperatures
- • Changes in or loss of menstrual patterns
- • Swelling around the cheeks or jaw, calluses on knuckles, or damage to teeth from vomiting
- • Fainting
- Psychological warning signs
- • Pre-occupation with food, body shape and weight
- • Extreme body dissatisfaction
- • Distorted body image (e.g. complaining of being/feeling/looking fat when a healthy weight or underweight)
- • Sensitivity to comments or criticism about exercise, food, body shape or weight
- • Heightened anxiety around meal times
- • Depression, anxiety or irritability
- • Low self-esteem (e.g. negative opinions of self, feelings of shame, guilt or self-loathing)
- • Rigid 'black and white' thinking (e.g. labelling of food as either 'good' or 'bad'

*(Source: Mental Health First Aid: Eating Disorders First Aid Guidelines, 2008)*

**The National Eating Disorders Collaboration** is a collaboration of people and organisations with expertise in the field of eating disorders, individuals from a range of healthcare and research sectors and people with a lived experience of an eating disorder.

Through the contribution of its members, the NEDC has the resources to lead the way in addressing eating disorders in Australia.

**nedc.com.au** brings research, experise and evidence from leaders in the field together in one place.

It's a one stop portal to make eating disorders information a lot more accessible for everyone.

## Become a member
We welcome individuals and organisations to become members of the NEDC. As a member you can get involved in one of the working groups and contribute to project deliverables. You will also be informed on collaboration activities and receive access to the members only area of the website. Join the collaboration:
**www.nedc.com.au/become-a-member**

## Sign up for the NEDC Monthly e-Bulletin
If you would like to keep up to date with what is happening in the wider eating disorders sector including the latest evidence based research on eating disorders you can register receive our monthly e-Bulletin. Subscribe to the e-Bulletin:
**www.nedc.com.au/subscribe**