



National  
Eating Disorders  
Collaboration

# National Practice Standards for eating disorders

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# 1. ACKNOWLEDGEMENT

The National Eating Disorders Collaboration (NEDC) is a collaboration of people and organisations with an expertise and/ or interest in eating disorders. It brings together expertise, research evidence and experience to develop a nationally consistent, evidence-based approach to the prevention and management of eating disorders in Australia.  
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Collaboration, defined as the act of 'voluntarily and cooperatively working together to achieve a common goal' is the core operating principle of the National Eating Disorders Collaboration (NEDC).

The contribution from NEDC stakeholders, interest groups and members to these standards and the reports they are drawn from has been invaluable in shaping our understanding of the opportunities and challenges of implementing eating disorders prevention and treatment initiatives and has enabled the NEDC to develop a more complete and accurate picture of what is happening with regards to eating disorders in Australia.

The NEDC also acknowledges the considerable work that has already been undertaken by a number of state governments and academic institutions on professional development for a skilled eating disorders workforce and identification of opportunities for improved service for people with eating disorders. We would particularly like to acknowledge the contribution of the Australia and New Zealand Academy of Eating Disorders (ANZAED) and the following state based eating disorder organisations: Centre for Eating and Dieting Disorders (NSW), Eating Disorder Outreach Service (QLD), Eating Disorder Training and Evaluation Centre (WA), and the Victorian Centre for Excellence in Eating Disorders.

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# CONTENTS

<b>1. Acknowledgement</b>	<b>1</b>
<b>2. Context</b>	<b>3</b>
2.1 Eating Disorders in Australia	3
2.2 Purpose and Scope of Standards	4
<b>3. Framework</b>	<b>5</b>
<b>4. Standards</b>	<b>6</b>
4.1 Integrating with core practice	7
4.2 Providing appropriate information and communications	7
4.3 Supporting Practice and Systems	8
4.4 Delivery of quality, evidence-based care	8
<b>5. Workforce Core Competencies</b>	<b>9</b>
5.1 Identification	10
5.2 Initial Response	11
5.3 Shared Care	12
5.4 Recovery Support	13
<b>6. An Integrated Stepped Care Approach</b>	<b>14</b>
<b>7. References</b>	<b>15</b>

## 2. CONTEXT

### 2.1 EATING DISORDERS IN AUSTRALIA

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

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

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

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

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

Eating disorders are relatively common when compared with other priority health issues affecting approximately 9% of the total population with prevalence in any one year of around 2.94% in males and 5.11% in females (NEDC, 2012).

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

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

Implementation translates evidence into practice. The NEDC has developed a suite of evidence informed reports and resources that together outline evidence from research, clinical expertise and lived experience of eating disorders.

## 2.2 PURPOSE AND SCOPE OF STANDARDS

This set of standards is intended to strengthen the workforce and to outline the values, attitudes, knowledge and skills required of individuals, services and systems to successfully respond to eating disorders. Implementing the practice standards will promote a coordinated and consistent approach to professional development and service improvement.

This document is to be read in conjunction with the relevant state and federal legislation and Australian professional codes of conduct or practice, including:

- **National Eating Disorders Framework** National Eating Disorders Collaboration (NEDC) (2012). An Integrated Response to Complexity: National Eating Disorders Framework. Report to the Australian Government Department of Health and Ageing, March 2012. NEDC: New South Wales, Australia.
- **Clinical Practice Guidelines** Hay, P., Chinn, D., Forbes, D., Madden, S., Newton, R., Sugenor, L., Touyz, S. & Ward, W. (2014). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. *Australian & New Zealand Journal of Psychiatry*, 48(11): 1,62. Available from: [www.ranzcp.org/](http://www.ranzcp.org/)
- **Service Implementation Guide** National Eating Disorders Collaboration (NEDC) (2014). Practical Responses to Eating Disorders: A Guide to Implementing Responses to Eating Disorders in General Health Services. Available from [www.nedc.com.au](http://www.nedc.com.au)
- **Stepped Care Approaches to Eating Disorders** National Eating Disorders Collaboration (NEDC) (2017). A guide to a stepped care approach for eating disorders in community integrated approaches to care. Resource available from [www.nedc.com.au](http://www.nedc.com.au)
- **Insights in Recovery Guide** Butterfly Foundation (2016). Insights into Recovery from Eating Disorders: A consumer- informed guide for health practitioners working with people with eating disorders. Sydney, Mental Health Commission of NSW. [www.thebutterflyfoundation.org.au](http://www.thebutterflyfoundation.org.au)
- **National Framework for Recovery-oriented Mental Health Services** The Department of Health (2013). National framework for recovery-oriented mental health services: Policy and theory. Canberra: Commonwealth of Australia. Available from: [http://www.health.gov.au/internet/main/publishing.nsf/Content/B2CA4C28D59C74EBCA257C1D0004A79D/\\$File/recovpol.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/B2CA4C28D59C74EBCA257C1D0004A79D/$File/recovpol.pdf)

## 3. FRAMEWORK

The following practice principles are described in the National Eating Disorders Framework (NEDC, 2012). When implemented together, these principles provide the foundation for an effective and nationally consistent approach to eating disorders.

### **Recovery-oriented person and family-centred care**

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

### **Prioritisation of early identification and early intervention**

Early identification and prompt intervention are necessary to reduce the severity, duration and impact of the illness. People have access to services as soon as they are needed: early in the development of the illness, with immediate access to treatment and support

### **Safe treatment options**

Safe treatment for eating disorders addresses all of the aspects of illness assisting people to meet their physical, psychological, behavioural, nutritional, occupational and social needs. 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

### **Flexible treatment and recovery pathways**

People have access to a range of safe treatment options which meet different needs at each stage of risk, illness and recovery. Clearly identified entry points, ideally located in the community, assist people to make informed decisions about treatment options and engage with accessible services. Community-based recovery support is integrated into treatment pathways

### **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 provided. 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; and

### **Support for families and carers as integral members of the team**

Families and carers are recognised as integral members of the treatment and support team. They 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.

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

### **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 for eating disorders. People with personal experience of eating disorders are involved at all levels of research, service development and evaluation; and

### **A skilled workforce**

All health professionals working with high-risk populations and all professionals required to work in the multidisciplinary team 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; and

### Accessible tertiary consultation

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

### Evidence-based community communication

Consistent and appropriate messages are provided to make sure that the community is aware of eating disorders as serious mental and physical illnesses. Eating disorder prevention integrates with wider physical and mental health promotion strategies to provide consistent health information that promotes wellbeing; and

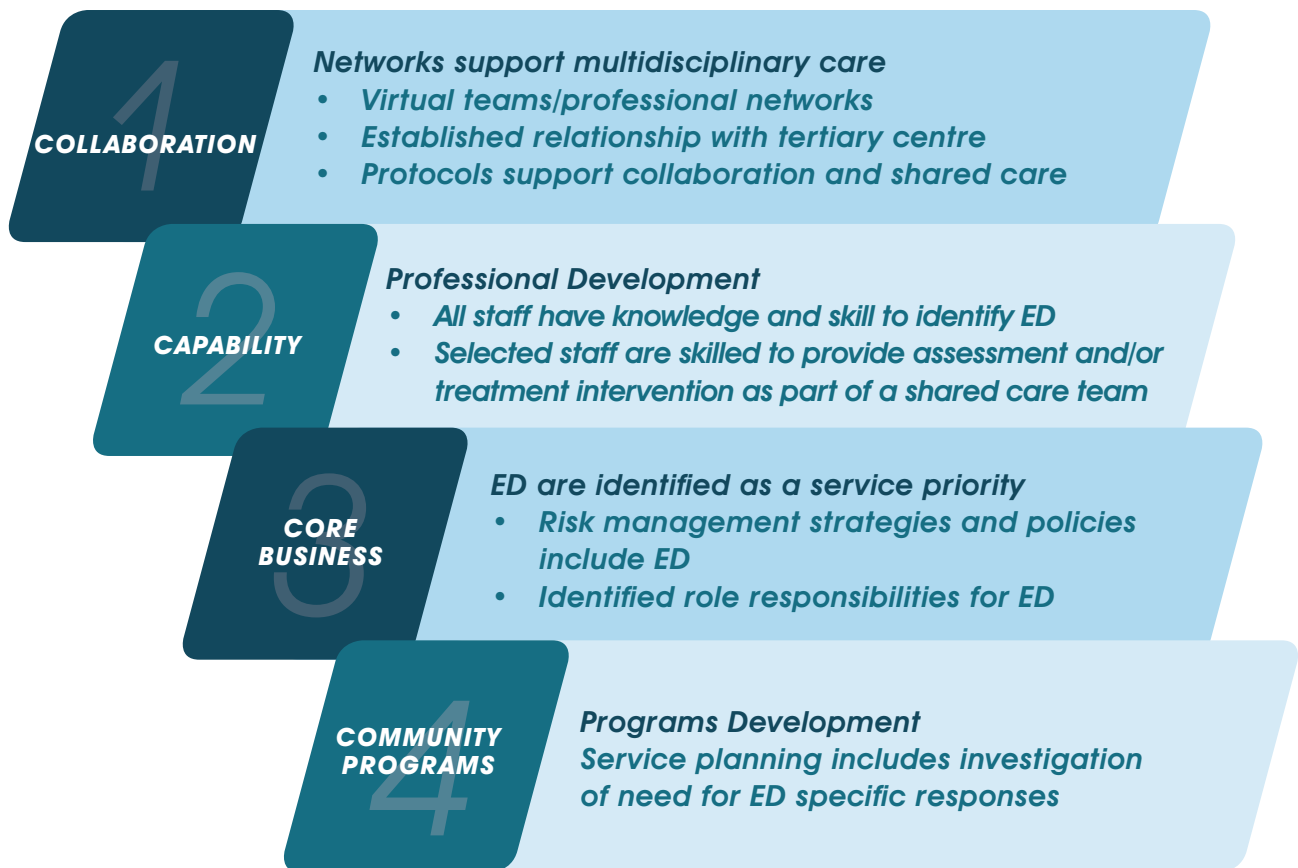
### Systems support integration and collaboration

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. People with personal experience of eating disorders are involved at all levels of policy development, planning and systems development.

## 4. STANDARDS

### Core Service Capabilities

*Essential steps for all medical and mental health services working with people who have, or are at high risk of developing eating disorders*





## 4.1 INTEGRATING WITH CORE PRACTICE

STANDARD	STANDARD IN ACTION
Eating disorders identified as being an important community health concern and serious mental health issue requiring a coordinated response.	<ul style="list-style-type: none"> <li>• Connection made with a nationally recognised eating disorders service and/or local eating disorders program providers as relevant to services delivered.</li> <li>• Identified staff member(s) to represent the organisation or practice to the eating disorders sector.</li> </ul>
Eating disorders are prioritised as part of any focus on mental health and allied physical health concerns including obesity.	<ul style="list-style-type: none"> <li>• Services run or commissioned which address mental health include eating disorders and how they will respond to them in their service documentation.</li> <li>• Relevant staff meet workforce core competencies</li> <li>• Eating disorders are included in screening and assessment tools/ processes.</li> <li>• There are identified role responsibilities for eating disorders within mental health and sufficient time allocation to undertake these roles.</li> <li>• Risk management strategies and policies relating to mental health include eating disorders.</li> </ul>
Service and system planning includes investigation of ED needs in primary care setting.	<ul style="list-style-type: none"> <li>• Eating disorders are addressed in key needs analysis, strategic and planning documentation.</li> <li>• Organisation or practice collects data regarding eating disorders to inform future needs and service planning.</li> </ul>

## 4.2 PROVIDING APPROPRIATE INFORMATION AND COMMUNICATIONS

STANDARD	STANDARD IN ACTION
Evidence-based information on eating disorders is disseminated in ways that are useful to their audiences.	<ul style="list-style-type: none"> <li>• Utilises the latest information on eating disorders from reputable sources.</li> <li>• Eating disorders information is included in internal and external resources on relevant health issues including; mental health, obesity and chronic illness.</li> <li>• Organisations or practices share eating disorders resources and/or information with their workforce and other stakeholders.</li> </ul>
Communicates about eating, weight, body image and eating disorders in a way that reduce the risk of harm.	<ul style="list-style-type: none"> <li>• Internal and external communications adhere to the Mindframe Guidelines for eating disorders.</li> <li>• Use of anthropomorphic measurements is appropriate, medically necessary and undertaken by qualified professionals.</li> </ul>

## 4.3 SUPPORTING PRACTICE AND SYSTEMS

STANDARD	STANDARD IN ACTION
Available resources and tools are used to assist in implementing integrated community responses to eating disorders.	<ul style="list-style-type: none"> <li>NEDC documentation on nationally consistent approach to eating disorders integrated with policies, plans and models.</li> <li>Organisation or practice has systems in place for dissemination of information and professional development.</li> <li>Resources and tools are made available to staff and healthcare workforce on identification, assessment, treatment and referral.</li> </ul>
Practitioners are able to understand eating disorders and address them in ways appropriate to their role.	<ul style="list-style-type: none"> <li>Organisations and practices have the tools to provide or access ongoing training regarding eating disorders in their own regions.</li> <li>Workforce are confident in implementing knowledge in their practice.</li> <li>Information on professional development opportunities is regularly reviewed and shared with relevant internal stakeholders.</li> </ul>
Participates in collaborative, local relationships to ensure appropriate, consistent primary care for those with eating disorders.	<ul style="list-style-type: none"> <li>Referral pathways identified, established and reviewed, including access to tertiary eating disorders care.</li> <li>Collaborative care is facilitated and encouraged.</li> </ul>

## 4.4 DELIVERY OF QUALITY, EVIDENCE-BASED CARE

STANDARD	STANDARD IN ACTION
Consumers with experience of an eating disorder and their carers are involved in development, implementation and evaluation.	<ul style="list-style-type: none"> <li>A consumer representative with a lived experience of an eating disorders sits on consumer boards/committees within the organisation, practice and/or system.</li> <li>Services provided or commissioned have documented processes to receive and action feedback from those with a lived experience.</li> </ul>
Eating disorders services that provided or commissioned are evidence-based and incorporate regular review and evaluation.	<ul style="list-style-type: none"> <li>Commissioning or funding bodies have tools to compare proposals to best practice evidence.</li> <li>Organisations access eating disorders expertise for advice on services when required.</li> <li>Service delivery is in line with evidence base on treatment model, dosage and duration.</li> </ul>
Services are provided across the continuum of care for eating disorders.	<ul style="list-style-type: none"> <li>Services provided or commissioned which address mental health, obesity or chronic illness include consideration of eating disorders.</li> <li>Those seeking treatment for an eating disorder are able to access effective, early intervention within their community.</li> <li>Organisations involved in health care planning or delivery in federal, state and local jurisdictions have a plan for implementing services across the continuum.</li> </ul>

## 5. WORKFORCE CORE COMPETENCIES

Competencies refer to the demonstrable skills and knowledge that are required to work in a particular field. There are currently no defined competencies for the treatment of eating disorders in Australia.

Core competencies provide a benchmark of standards against which skills and performance can be assessed. The adoption of a competency based approach has a number of potential benefits including:

- Communicating the current evidence, principles and priorities for treatment of eating disorders
- Encouraging transparency of standards, expectations and accountability
- Promoting professional development and the improvement of current work practices;
- Assisting in the identification of training needs and the design of training activities and programs
- Promoting flexibility and the potential for individualisation of training
- Assisting with assessment for recruitment purposes (based on Leung, 2002).

These core competencies outline capabilities that all health professionals should achieve in their work with eating disorders. They are intended to complement discipline-specific practice standards or competencies of relevant professions including but not limited to; general practice, paediatrics, psychiatry, psychology, nursing, dietetics, social work and occupational therapy. They do not reflect the skills or specific competencies necessary to expertly deliver treatments specific to eating disorders care.

Different workplaces and degrees of specialised practice require different levels of competency, varying on a spectrum from professionals who are solely involved in early identification to professionals providing specialist eating disorder treatment and varying across service settings.

Four functional groups have been identified who play an important role in the identification and treatment of eating disorders. These functional groups are defined by the role they play in relation to the patient with an eating disorder and not by profession. Core competencies are those relevant to all functional groups appropriate to their role. Core competencies do not address the expert knowledge or modality skills required to deliver evidence-based medical, psychological or dietetic treatment for eating disorders.

### 1. Early Identification

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

### 2. Initial responders

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

### 3. Shared care treatment providers

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

### 4. Eating disorders treatment providers

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

### 5. Recovery Support Providers

People providing professional support to those who are learning to self-manage their recovery from an eating disorder and to families and carers – this group includes the professions most likely to act as early identifiers and initial responders as well as treatment providers.

## 5.1 IDENTIFICATION

All professionals who have a duty of care in their professional role for the health and wellbeing of people in high risk groups for eating disorders

People with or at risk of eating disorders do not typically volunteer to disclose to health professionals or directly seek help for their eating disorder. Early intervention requires identification and screening of eating disorders in primary care and non-mental-health settings. When screening, one or two simple questions should be considered for use with specific target groups.

### Knowledge

- Basic knowledge of the facts about eating disorders
- Awareness of prevalent myths and their impact
- Basic knowledge of contributing risk factors
- Awareness of high risk population

### Assessment

- Ability to recognize common warning signs
- Ability to initiate discussion about eating habits and attitudes
- Ability to use standardised screening tools for eating disorders

### Referral

- Knowledge of the first step in securing appropriate professional help in own organisation or community
- Knowledge of sources of information about eating disorders that may be used by the person at risk and/or their family

### Intervention and Support

- Within professional scope, model an understanding and supportive attitude
- Encourage and support appropriate help seeking
- Know the limits of personal expertise and when to seek advice or refer on

## 5.2 INITIAL RESPONSE

Health professionals in roles responsible for making referral and initial treatment decisions  
e.g. General Practitioners, Emergency Department personnel, Psychologists.

### Knowledge

- General knowledge of developmentally appropriate healthy eating, nutritional principles and healthy relationships with food
- Ability to recognise signs of disordered eating and associated health risks
- Ability to describe eating disorders, their progression and impact
- Awareness of the nature and prevalence of atypical presentations
- Ability to describe the range of physical issues related to eating disorders
- Ability to explain the impact of rapid weight loss and/or very low BMI on cognition
- Awareness of a variety of health conditions which can co-exist with eating disorders (e.g. diabetes, obesity, depression)
- Ability to demonstrate an empathetic understanding of the high levels of ambivalence, shame and fear of change in people with eating disorders
- Discuss the barriers to self-disclosure that a person with an eating disorder may experience and strategies to deal with these barriers

### Assessment

- Ability to take a culturally appropriate preliminary case history relevant to eating disorders
- Ability to engage parents/carers/partners and assess their concerns recognising that symptoms may be minimised by the person with an eating disorder
- Assess for risk of suicide and self-harm
- Use assessment tools and tests as appropriate for the person and the professional discipline

### Referral

- Demonstrate knowledge of services and systems in your region appropriate for the evidence-based treatment of eating disorders
- Refer people with eating disorders to relevant services to address their physical, psychological and nutritional needs
- Identify when the person should be referred directly to an eating disorders specialist service
- Identify when a person with an eating disorder needs an urgent medical assessment or psychiatric assessment and when they should be referred to a Hospital Emergency Department.

### Intervention and Support

- Provide appropriate follow-up for people referred for treatment
- Demonstrate knowledge of support services available for people with eating disorders and their families and provide information
- Ability to manage a person with an eating disorder who is waiting for treatment
- Subject to usual role, ability to provide professional guidance to people with BN and BED who are working through a self-help program

## 5.3 SHARED CARE

Health professionals who will provide treatment or support during treatment as part of an inter- disciplinary interagency team or a shared care arrangement.

### Knowledge

- Discuss the importance of a family and person centred approach to treatment, as developmentally appropriate
- Explain the role of families and carers in assessment, engagement, treatment and recovery
- Demonstrate awareness of personal attitudes, values and beliefs (e.g. body shape) to manage the potential impact of collusion with a person with an eating disorder
- Describe the standards for safe treatment (National Standards Schema<sup>¶</sup>)
- Describe the medical care that may be required to treat eating disorders
- Describe the role of intensive treatments including hospital admission
- Describe the purpose of weight gain for people with malnutrition
- Be aware of the risks of re-feeding syndrome, and the need for specialist nutritional restoration
- Demonstrate awareness of the circumstances when involuntary treatment may be necessary
- Describe a range of evidence supported treatment modalities for eating disorders and their relevance to individual needs including: CBT, Guided Self Help CBT, FBT
- Discuss issues in the care of adults with long term eating disorders
- Understand how care teams are set up including the range of professions required to safely address all aspects of illness
- Describe the roles of key professions in the multidisciplinary team including: GP, Psychologist Psychiatrist, Dietitian, Dentist, Mental Health Nurse, OT, Social Workers, Paediatricians

### Assessment

- Work with an individual to identify their strengths and resources for care planning
- Discuss the importance of involving family members or supporters in assessment of children and adolescents and encouraging the involvement of family members or supporters in adults
- Contribute to the comprehensive assessment of children, adolescents and adults in relation eating disorders and take a clinical history for a person with a suspected eating disorder using culturally respectful practice
- Use assessment tools and tests as appropriate for the person and the professional discipline

### Referral

- Know the limits of personal expertise and when to seek advice or refer on
- Utilize relevant tertiary services for professional training, case conferencing, supervision and referral
- Refer people with eating disorders for treatment of comorbid conditions where appropriate

## 5.4 RECOVERY SUPPORT

Health professionals who provide treatment and/or ongoing care and support.

### Knowledge

- Describe physical, psychological and personal understanding of recovery
- Discuss the risk of relapse and the importance of recovery support
- Describe secondary prevention strategies
- Explain the range of education and support needs a person with an eating disorder and their family/support people may require

### Assessment

- Ability to conduct strengths based assessment, collaborating with the person to identify their strengths, risks for relapse and individual needs for support

### Referral

- Demonstrate awareness of community based support services and resources and refer people to appropriate services
- Recognise indications of relapse and support people to re-access treatment services

### Intervention and Support

- Within scope of usual role demonstrate ability to provide one or more of the following: information, case management, peer support, recovery education, recovery planning, counselling and meal support.

## 6. AN INTEGRATED STEPPED CARE APPROACH

The national standards schema (NEDC National Framework 2012) for eating disorders stresses the necessity for access to an integrated suite of services, regardless of a person's geographic location, age, or economic circumstances.

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

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

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

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

An integrated response to eating disorders is characterized by:

### A stepped suite of services

A range of treatment and support options delivered in varying levels of intensity to meet the differing needs of individuals at each stage of illness, and support transition from intensive treatment to self-management.

### Multidisciplinary treatment

Services provided by multiple disciplines and health services working collaboratively together.

### Coordinated episodes of treatment

Planned and supported transition between programs and service providers; people with complex needs have access to a case coordinator

### Prioritization of early intervention

Flexible entry and exit at all levels of the continuum of care in a step in/out and step up/down process with re-entry pathways to support relapse prevention and minimization of the impact of recurrence.

### Services for adults and children

Services and referral pathways that address the needs of people of all ages including the transition between adolescence and adult services and the need of adults for aftercare and recovery support.

### Stepped Care for Eating Disorders

An integrated spectrum of services that is able to deliver the right treatment at the earliest possible opportunity in the development of illness or help seeking, responding flexibly to changes in the person's needs over time.

A. An integrated continuum of services delivering collaborative care across primary, secondary and tertiary levels and across psychiatric and medical services

B. The right treatment delivered in an evidence based dosage and duration

Earliest possible opportunity, early in the course of illness, early in subsequent episodes of illness, early in relapse and recurrence and early in help seeking.



The full continuum and scope of services for people with eating disorders may be provided within a single specialist eating disorders service however, services delivered through general primary and secondary health services will require collaboration between several services all of which deliver a part of the safe response to eating disorders. Eating disorders present challenges to the traditional organisation of treatment for mental illnesses. There is a need for integration and collaboration between physical and mental health services, private and public health services, prevention and treatment, health and community services and between professional disciplines.

## 7. REFERENCES

The following resources have been used in the development of this report. Further references can also be found in key NEDC documents drawn on in the development of these standards. [www.nedc.com.au](http://www.nedc.com.au)

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