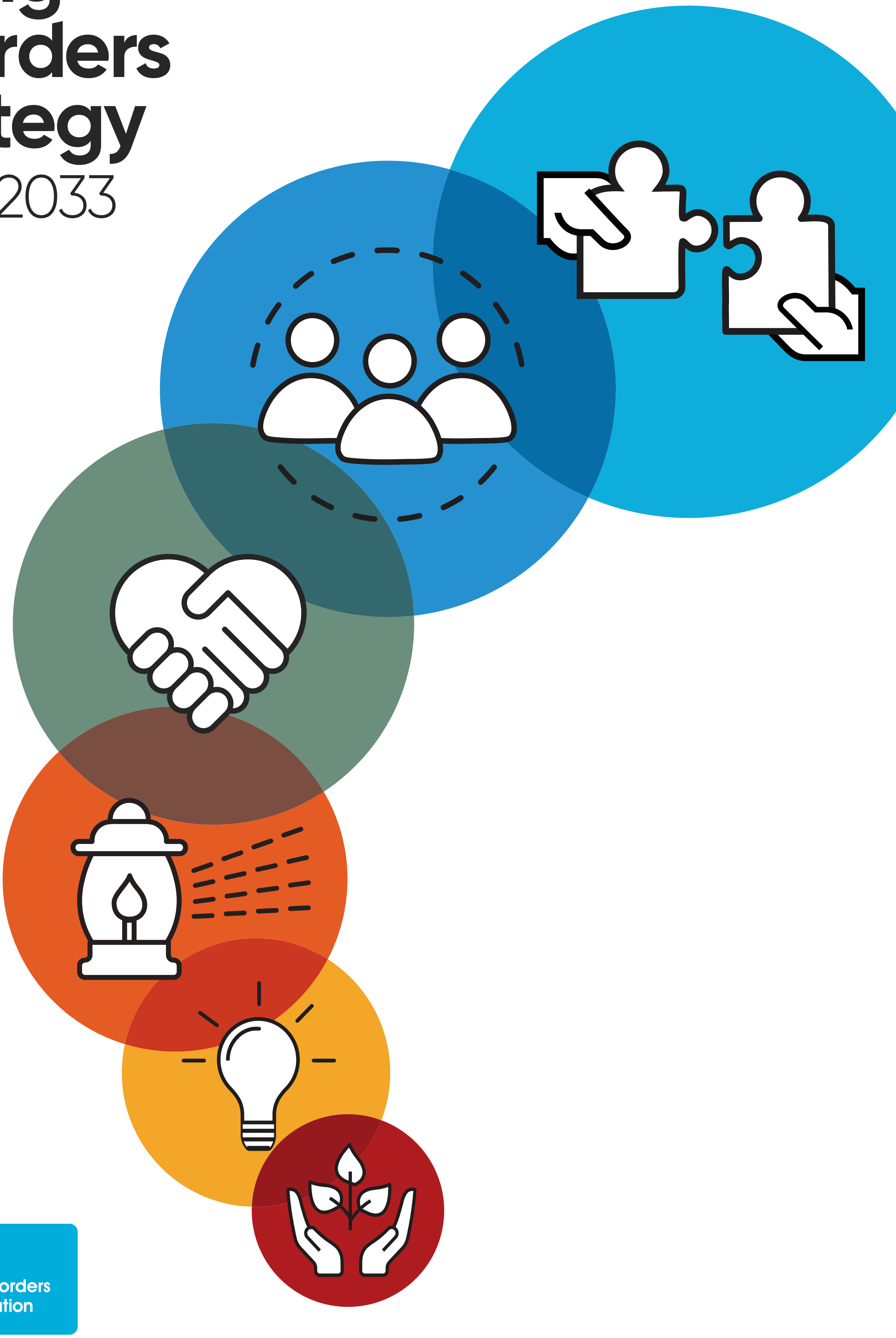
National Eating Disorders Strategy

2023–2033



National
Eating Disorders
Collaboration

NEDC acknowledges the traditional custodians of lands throughout Australia. We pay our respects to Aboriginal and Torres Strait Islander Elders, past and present, and acknowledge the important role of Aboriginal and Torres Strait Islander peoples, their cultures and customs across Australia.

Recommended citation: National Eating Disorders Collaboration (NEDC). National Eating Disorders Strategy 2023-2033. NEDC; 2023.

The development of the National Eating Disorders Strategy 2023-2033 was funded by the Commonwealth Department of Health and Aged Care.

The National Strategy was co-led and co-written by Louise Dougherty, NEDC Strategy and Policy Lead and Dr Beth Shelton, NEDC National Director.

If you require this document in a different format for accessibility, please email info@nedc.com.au.

Provide feedback on the National Strategy via https://s.nedc.com.au/ns_evaluation or QR code below.

About the National Eating Disorders Collaboration (NEDC)

NEDC is a national sector collaboration dedicated to developing and implementing a nationally consistent, evidence-based system of care for the prevention and treatment of eating disorders. NEDC is funded by the Australian Government Department of Health and Aged Care. Over the past decade NEDC has created a large body of comprehensive, evidence-based information and resources which establish standards for prevention and treatment of eating disorders. NEDC implements these standards in system-building projects, workforce development and consultation.

To inform its work, NEDC engages a broad range of stakeholders, including people with lived experience of eating disorders and their families and supports, clinicians, researchers, and other experts. NEDC has more than 10 000 members. NEDC also provides expert consultation and guidance on evidence-based provision of eating disorder services to policymakers and to national, state/territory and regional health, mental health and community organisations. NEDC's work is led by National Director Dr Beth Shelton and Chair Professor Phillipa Hay, and a Steering Committee of national sector leaders and experts. NEDC's contract is administered by the Butterfly Foundation on behalf of the Commonwealth Government.

NEDC Steering Committee

Professor Phillipa Hay (Chair)
Belinda Caldwell (Deputy Chair)
Dr June Alexander
Rachel Barbara-May
Professor Leah Brennan
Dr Susan Byrne
Dr Anthea Fursland
Amy Hannigan
Dr Laura Hart
Adjunct Associate Professor Gabriella Heruc
Professor Michael Kohn
Associate Professor Sloane Madden
Associate Professor Sarah Maguire OAM
Dr Siân McLean
Professor Richard Newton
Emeritus Professor Susan Paxton
Adjunct Associate Professor Kim Ryan
Dr Elizabeth Scott
Madeleine Sewell
Emeritus Professor Stephen Touyz
Professor Tracey Wade
Dr Andrew Wallis

Learn more about NEDC's work

www.nedc.com.au

Support services

If the content of this document brings up concerns for you, or you are concerned about someone else, please contact:

Butterfly Foundation National Helpline	☎ 1800 ED HOPE (1800 33 4673) ✉ **support@butterfly.org.au** 💬 **Webchat**
Eating Disorders Victoria Helpline	☎ 1300 550 236 ✉ **hub@eatingdisorders.org.au** 💬 **Webform**
Eating Disorders Families Australia	☎ 1300 195 626 ✉ **admin@edfa.org.au**
Beyond Blue for mental health	☎ 1300 22 4636 💬 **Webchat**
Lifeline	☎ 13 11 14 💬 **Webchat**
Kids Helpline	☎ 1800 55 1800 ✉ **counsellor@kidshelpline.com.au** 💬 **Webchat**
Suicide Call Back Service	☎ 1300 659 467 💬 **Webchat**
MensLine Australia	☎ 1300 78 99 78 💬 **Webchat**
13 YARN to talk with an Aboriginal or Torres Strait Islander Crisis Supporter	☎ 13 92 76
QLife	☎ 1800 184 527 💬 **Webchat**

If you or someone you are with is in immediate danger, please call triple zero (000).

Contents

Acknowledgements

NEDC wishes to thank the many people who have contributed valuable insights and expertise to inform the development of the National Eating Disorders Strategy 2023-2033 (National Strategy). These contributions were essential to the development of the National Strategy.

Lived experience contributions

The National Strategy aims to create meaningful change to improve experiences and outcomes for people with or at risk of eating disorders, and their families, supports and communities. Lived experience input has been a central tenet throughout the development of the Strategy, with lived experience embedded across the project team and the National Strategy Reference Group, Working Groups and Advisory Groups. NEDC is grateful for the lived experience expertise shared via these groups. NEDC is also grateful to the many hundreds of people who shared their lived experience via our public survey and through focus groups, and to the people who generously shared their stories via video to accompany this Strategy.

National Strategy Reference Group

The National Strategy Reference Group provided expert advice on the development of the National Strategy, ensuring that it reflects evidence-based policy and best practice.

Dr Beth Shelton (Chair)	National Director, NEDC
Louise Dougherty	Strategy and Policy Lead, NEDC
Dr Sarah Trobe	National Manager, NEDC
Dr June Alexander	Life Stories Diary; Lived Experience Advocate and Mentor
Kevin Barrow	CEO, Butterfly Foundation
Professor Leah Brennan	School of Psychology and Public Health, La Trobe University; Director of the Centre for Eating, Weight and Body Image
Dr Susan Byrne	Clinical Director, The Swan Centre
Belinda Caldwell	CEO, Eating Disorders Victoria
Belinda Chelius	CEO, Eating Disorders Queensland
Laurence Cobbaert	Chair and Research Lead, Eating Disorders Neurodiversity Australia
Dr Anthea Fursland	Clinical Psychologist
Amy Hannigan	Team Leader, Queensland Eating Disorder Service
Peta Marks	Chief Operating Officer, Australian Eating Disorders Research and Translation Centre
Dr Siân McLean	President, Australia and New Zealand Academy for Eating Disorders; Senior Lecturer, La Trobe University
Fintan O'Looney	Clinical Nurse Specialist, WA Eating Disorders Outreach and Consultation Service
Emeritus Professor Susan Paxton	School of Psychology and Public Health, La Trobe University

Michelle Roberton	Manager and Senior Clinician, Victorian Centre of Excellence in Eating Disorders
Jane Rowan	Executive Director, Eating Disorders Families Australia
Sara Sarraf	Manager, Mental Health Policy, Mental Health and Wellbeing Division, Victorian Department of Health
Madeleine Sewell	Eating Disorders Health Professional, CAMHS Eating Disorder Service, Perth Children's Hospital
Professor Tracey Wade	Matthew Flinders Distinguished Professor of Psychology; Director, Flinders Institute for Mental Health and Wellbeing, Flinders University Services for Eating Disorders, and Blackbird Initiative
Dr Andrew Wallis	Clinical Specialist Social Worker, SCHN Eating Disorder Service Network Lead
Dr Tania Withington	Program Manager, Eating Disorders Program, Child and Youth Mental Health Service, Children's Health Queensland Hospital and Health Service

Aboriginal Advisory Committee

The members of the Aboriginal Advisory Committee lent three Aboriginal voices and perspectives to providing feedback on the National Strategy, in the spirit of decolonisation. The members acknowledge that they do not speak for all Aboriginal people, nor Torres Strait Islander people, and strongly advocate for more work to be done with, by and for Indigenous people experiencing or at risk of eating disorders and their communities.

Professor Aunty Kerrie Doyle	Gadigal/Winninnini/Budgeri/Irish woman, Deputy Pro-Vice Chancellor, Associate Dean, Indigenous Health, School of Medicine, Western Sydney University
Dr Elizabeth Dale	Worimi woman (Gathang), Clinical Psychologist, Senior Lecturer and Academic Program Director, School of Medical, Indigenous and Health Sciences, University of Wollongong
Michelle Halliday	Wiradjuri woman, Research Associate, Western Sydney University

Working Groups

Five Working Groups (Prevention; Identification and Initial Response; Treatment; Psychosocial and Recovery Support; Workforce) and one sub-group (Lived Experience Workforce Advisory Group) were convened to contribute to the development and refinement of key concepts and specific content sections within the National Strategy. Working Group members are listed in the Appendix.

Jurisdictional perspectives

NEDC wishes to thank all of those who participated in the in-depth consultations held with eating disorder service development organisations/stakeholders in each state/territory of Australia, and with national and state-based eating disorder lived experience organisations, to inform the National Strategy.

The concurrent development of the National Eating Disorders Strategy 2023–2033 and the Victorian Eating Disorders Strategy presented a valuable opportunity for national and state collaboration, supporting a bilateral response to eating disorders. NEDC and the Mental Health and Wellbeing Division in the Victorian Department of Health collaborated to explore state and federal roles, responsibilities, and opportunities for integration.

NEDC National Strategy Project Team

Louise Dougherty, NEDC Strategy and Policy Lead

Dr Beth Shelton, NEDC National Director

Dr Sarah Trobe, NEDC National Manager

Hilary Smith, NEDC National Manager

Dr Emma Spiel, NEDC Workforce Development Coordinator

Bella Burns, NEDC Primary Health Lead

Evangeline Gardiner, NEDC Research Lead

Foreword

> “We need hope like we need air. Hope is a function of struggle – we develop hope not during the easy or comfortable times but through adversity and discomfort.”
>
> **Ryan Holiday**

The National Eating Disorders Strategy 2023–2033 encompasses a rich history of perseverance, struggle, and courageous conversations. *‘Hope’* resonates throughout this document, where pearls of collective wisdom, integrity, principles, and commitment have developed a roadmap to embed a system of care for ALL people living with ANY eating disorder in Australia. *‘Hope’* is the commitment by Government to improve access to treatment, support, and care for people impacted by eating disorders in Australia. And holding *‘hope’* means calling us all to account that ***eating disorders are everyone’s business*** and can no longer be experienced and treated in isolation.

While it’s impossible to ignore the profound impact and burden on our community, especially over the past few years, which have influenced the increase in eating disorders, perhaps decades of lived experience have given me the privilege to share a bird’s-eye view of how far we have come over the years. Many of us have survived and found a way through a broken and fragmented system, out of desperation to access or deliver treatment. Still, in continuing to navigate a way forward, partnerships are being established with those most impacted to find solutions, improve access to care, and do no harm.

The significance of how far we’ve come is evident in the National Strategy, which has courageously challenged the stereotypical perception that eating disorders are only driven and influenced by weight, shape, and food. The wisdom and knowledge contained within the National Strategy makes clear that ***‘one size has never fit all’*** – the intersectionality of multiple factors and complexities must be recognised, and must inform how we diagnose and treat eating disorders. Eating disorders do not discriminate and impact all ages, genders, sexuality, and cultures, nor are they experienced in isolation. They are often accompanied by co-existing health and mental health challenges, trauma, disability, and neurodiversity.

To genuinely improve our system, the roadmap has shifted the priority from patient-centred to person-centred care, identifying the need for evidence-based treatment while recognising other essential needs, such as psychosocial support and social determinants of health and wellbeing. So, *‘hope’* is the publication of a National Strategy outlining strategies to ensure that **no one** impacted by an eating disorder in our nation will be forgotten or left behind.

In closing, I wish to thank and acknowledge:

Minister Butler and Assistant Minister McBride, for your genuine commitment to improving the lives of all Australians impacted by eating disorders.

To the eating disorder workforce, which has undoubtedly mastered the art of perseverance and continues to hold hope for the people they care for.

To the diverse, courageous lived experience community that I am so proud to walk with. Thank you for your wisdom and advocacy, which continues to reshape and influence how we improve the lives and healing of our peers.

And finally, to the small yet mighty National Eating Disorders Collaboration team, who have worked tirelessly to bring this all together. Your courage and determination to ensure ALL expertise co-led the development gives authenticity, heart, and purpose to the National Eating Disorders Strategy 2023–2033.

S. Calvert

Shannon Calvert
Lived Experience Educator
and Advisory Consultant

Foreword

The Australian Government is committed to improving the lives of all Australians with an eating disorder. We know that eating disorder have one of the highest mortality rates of any mental illness and have devasting impacts on individuals and their loved ones. Whilst, eating disorders are complex and recovery is difficult, with timely, coordinated, and appropriate care, full recovery is possible.

To ensure all people with eating disorders have access to high quality treatment and support for their recovery, coordinated action across all parts of the system of care is needed. A holistic response is required, that integrates physical health, mental health and eating disorder-specific services.

The Australian Government is committed to reforming the mental health system and improving outcomes for those with an eating disorder. The National Eating Disorders Strategy 2023-2033 (Strategy) will provide an important framework to implement this reform. The Strategy is the product of extensive consultation and nationwide expertise. The Strategy will provide a clear roadmap to enable us all to work towards the shared goal of ensuring that people experiencing or at risk of eating disorders can access a high-quality, connected system of care, wherever they live and whatever their circumstances.

Beyond the health system, greater community knowledge and shared action is also required. We need to equip the community to recognise eating disorder warning signs, intervene early and connect people to care. As a community, we also need to work together to reduce eating disorder risk factors and enhance protective factors in all settings, including where people live, work and play.

We thank those people with lived and living experience of an eating disorder who have contributed to the development of the Strategy. It is your willingness to share your personal experiences that ultimately improves the eating disorder system of care.

We invite you to read and engage with the National Strategy, and to support its activation and implementation – we all have a role to play.

The Hon Mark Butler MP
Minister for Health and Aged Care

Emma McBride

The Hon Emma McBride MP
Assistant Minister for Mental Health and
Suicide Prevention, Assistant Minister for
Rural and Regional Health

Letter from NEDC National Director

Welcome to the National Eating Disorders Strategy 2023-2033.

Over the past several years, NEDC has listened carefully to the views and insights of people with lived experience, clinicians, researchers, governments, community providers, service development leaders and public health experts across Australia about what is needed to improve the experiences and outcomes of people with or at risk of eating disorders and their families, supports and communities. The National Eating Disorders Strategy 2023-2033 brings together this depth and breadth of knowledge and ideas into a roadmap for meaningful change.

This Strategy is for people who care about, and are responsible for, improving Australia's response to eating disorders. In an important sense, this is everyone. A whole of community response to reducing risk, identifying eating disorders, and prompting timely response is needed. National and state governments and regional leaders have a critical role in providing leadership, enacting standards, and resourcing the system of care. The community, health, and mental health care sectors, public and private, are key to providing effective and coordinated treatment and care. Eating disorder sector lived experience and service development organisations have an essential role in supporting people with lived experience, providing information and resources to the broader community, developing the workforce, and helping to build the system of care. Researchers contribute new knowledge to help us understand what works, and how to translate this into practice. People with lived experience drive change across all aspects of the system of care, including through leadership, co-produced research, system and service co-design, and participation in the Lived Experience workforce.

This Strategy is not a bureaucratic exercise. It is designed to be useful to you – the reader; stakeholder; system-builder; advocate. It is a tool to help people at all levels and in all settings to work in a coordinated and sustained way to transform a fragmented system with some excellent elements into a full and coordinated system of care for all. The Strategy provides a clear formulation of the full eating disorder stepped system of care and sets out minimum national standards and priority actions to guide coherent system change. While there can be no single blueprint for regional approaches to eating disorder care, the Strategy provides national standards and priority actions to meet with local knowledge in the creation of context-sensitive, practical solutions. The Strategy can help guide policy and planning, goal setting, action, and evaluation at every level.

I invite you to read and use the Strategy. Read it all or go straight to a specific area of interest in the system of care. How are the standards and actions relevant to your setting/s and responsibilities? NEDC will be actively supporting the implementation of the Strategy with collaborative sector initiatives, consultation, and resources to support workforce development and evaluation.

The idea of system-building can feel abstracted or detached from people's on-the-ground experiences. Reflections from people with lived experience of eating disorders are embedded throughout the Strategy, providing real-world insights and serving as a reminder that each and every action can make a meaningful difference to those who seek care and support.

The National Eating Disorders Strategy 2023-2033 is a call to action and a roadmap for all stakeholders. Together, we can build a nationally consistent, effective, equitable and coordinated system of care that meets the needs of people experiencing or at risk of eating disorders and their families/supports and communities.

Dr Beth Shelton
NEDC National Director

Sector support

The national and state eating disorder service development and lived experience organisations, and the Australian Eating Disorders Research and Translation Centre, are unified in support of the National Eating Disorders Strategy 2023–2033 and will be working together to achieve the Strategy's aims over the next decade.

Service development organisations

ANZAED
AUSTRALIA & NEW ZEALAND ACADEMY FOR EATING DISORDERS

ANZAED

The Australia & New Zealand Academy for Eating Disorders is pleased to support the National Eating Disorders Strategy 2023–2033.

ANZAED strongly endorses the vision, purpose, principles, and proposed actions outlined in the Strategy and is optimistic for the implementation of integrated, coordinated, and evidence-based care across the whole system of care.

We commit to working with state-based and national organisations to achieve the important aims of the National Strategy that seek to improve outcomes for all those affected by eating disorders.

CEED THE VICTORIAN CENTRE OF EXCELLENCE IN EATING DISORDERS

CEED

With great confidence, the Victorian Centre of Excellence in Eating Disorders (CEED) recommends the National Eating Disorder Strategy 2023–2033. CEED shares the vision for an Australian community that delivers an equitable and effective response to people who experience eating difficulties and body concerns, and their families and supports. CEED aspires to prevent, and reduce the impact of eating disorders, and will continue collaborating to bring this vision to reality.

Children's Health Queensland Hospital and Health Service | Queensland Government

CYMHS EDP

Children's Health Queensland, Child and Youth Mental Health Service, Eating Disorder Program offers service development and capacity building activities and evidence-based clinical services across Queensland. The Eating Disorder Program vision is closely aligned to the National Eating Disorder Strategy aiming to achieve equitable, accessible and effective care for children and young people with eating disorders, and their families regardless of location and personal context. The Eating Disorder Program looks forward to engaging with the implementation of the Strategy in the years ahead.

INSIDEOUT
Institute for Eating Disorders

InsideOut

We welcome the National Eating Disorders Strategy 2023–2033 to provide a roadmap in establishing eating disorders as a national priority. Embedding evidence, evaluation and quality improvement measures across the system of care will improve wellbeing and better support the millions of Australians living with an eating disorder and their families.

Metro North Health | Queensland Government

QuEDS

The Queensland Eating Disorder Service (QuEDS), Metro North Mental Health HHS support the National Eating Disorder Strategy 2023–2033 and will seek to broadly contribute to the implementation of the standards outlined in this document to improve outcomes for people experiencing or at risk of eating disorders, and their families/supports and communities.

WA Eating Disorders Outreach & Consultation Service (WAEDOCS)

WAEDOCS

WAEDOCS welcomes the Strategy as an opportunity for growth of equitable high-quality care for individuals experiencing or at risk of developing eating disorders. We view this initiative as an opportunity to develop a thriving workforce able to positively impact the lives of people experiencing eating disorders and their families. We also support the National Training Framework that seeks to embed eating disorder content within all relevant tertiary and vocational training for the future workforce.

Lived experience organisations

Butterfly Foundation

As the national charity representing the voice of lived experience for eating disorders and body image issues, Butterfly Foundation is heartened to see the culmination of comprehensive work to develop the National Eating Disorders Strategy 2023–2033, and would like to congratulate the team at NEDC. Butterfly is committed to supporting the Strategy, including advocating for funding and share of voice, to support the sector in delivering these critical requirements to better support those with lived experience of an eating disorder and their families and carers.

EDFA

Eating Disorders Families Australia (EDFA) endorses and embraces the National Eating Disorders Strategy 2023–2033, and is committed to working collaboratively to realise the Strategy's objectives over the next decade. We aim to contribute to an accessible system of care that recognises the critical role of carers and families through an integrated, stepped approach. We are committed to fostering community understanding, empathy, and holistic support for all individuals and families impacted by eating disorders.

EDNA

Eating Disorders Neurodiversity Australia (EDNA) is a not-for-profit organisation created in 2022 that aims to increase awareness of the intersectionality between eating disorders and neurodivergence. In addition, EDNA's team members are passionate about promoting a neurodiversity-affirming approach to eating disorder care through lived experience-led endeavors. The National Strategy recognises the urgent need for increased recognition of lived experience expertise and its inclusion in co-participatory research as well as person-centered treatment design, particularly for underserved and/or high risk populations such as neurodivergent individuals. Acknowledgement of intersectionality and efforts towards inclusivity in both prevention and clinical efforts are pivotal aspects of moving forward to achieve better outcomes for all affected by eating disorders.

EDQ

Eating Disorders Queensland had the opportunity to give feedback on the National Eating Disorders Strategy 2023–2033 and will be working together to achieve the Strategy's aims over the next decade. We look forward to being part of an approach that highlights the voices of lived experience, helps eradicate weight stigma and ensures that we, as a service provider, meet the client on their journey and respond to their needs.

EDV

Eating Disorders Victoria is excited to support the launch of the National Eating Disorders Strategy 2023–2033, and we commend the NEDC for championing this once-in-a-generation opportunity for national reform. Having represented the voices of Victorians in the development of the strategy, we are confident the approach works cohesively with our efforts at a state level to improve the system of care. We look forward to welcoming resulting initiatives that support and reinforce the expectation of full recovery for all, notably through improved early intervention and person-centred and lived experience informed care.

Australian Eating Disorders Research and Translation Centre

The Australian
Eating Disorders
Research and
Translation Centre

AEDRTC

The AEDRTC supports the National Eating Disorders Strategy 2023–2033 as an important companion document to the Australian Eating Disorders Research Strategy 2021–2031. Improving the system of care for people with eating disorders and their loved ones requires a multi-pronged approach encompassing co-produced research, translation and implementation of evidence, embedded in service and system reform.

OVERVIEW

Overview

About eating disorders

Eating disorders are serious, complex mental illnesses accompanied by physical and mental health complications which may be severe and life threatening. They are characterised by disturbances in behaviours, thoughts and feeling towards body weight and shape, and/or food and eating. Although more common among adolescents and young people, particularly females, eating disorders can occur in people of all ages, gender identities, sexual orientations, neurotypes, all body shapes and sizes, all socioeconomic groups, and from any cultural background.

While national epidemiological survey data for eating disorders is lacking, more than one million Australians are estimated to be experiencing an eating disorder in any given year (1, adjusted for current population). Globally, the prevalence of eating disorders has risen over the past decade (2, 3), suggesting that Australian prevalence estimates may be an underestimation of the true prevalence.

There are substantial human, social and economic costs associated with eating disorders. These costs can include severe mental and physical health impacts, reduced quality of life, reduced social and economic participation, and premature death either by suicide or due to medical complications of the eating disorder (3-7). Eating disorders not only affect the person with the illness, but also their family/supports, many of whom suffer their own mental health consequences, as well as lost earnings through the need to provide care, and relationship breakdown as a consequence of the stress associated with providing care (7-11). In 2012, the social and economic cost of eating disorders in Australia was estimated at $69.7 billion (1), a figure which is likely to now be considerably higher as a result of the rise in prevalence rates over the last decade.

About the National Eating Disorders Strategy 2023–2033

While considerable progress has been made towards better meeting the needs of people experiencing or at risk of eating disorders, and their families/supports and communities, many people still face challenges in accessing a minimum standard of evidence-based care.

To build on investment and progress to date, and guide sector development and policy decision-making for the next decade, the National Eating Disorders Collaboration (NEDC) was tasked by its members and by eating disorder sector leaders to develop a National Eating Disorders Strategy 2023–2033 (National Strategy). Implementation of the National Strategy will help to ensure that people are able to access an effective, equitable and coordinated system of care.

The development of the National Strategy was funded by the Australian Government Department of Health and Aged Care.

Vision

- Eating disorder care is embedded in the health systems of all states/territories and regions.
- People experiencing or at risk of eating disorders and their families/supports and communities can access an effective, equitable and coordinated system of care.
- The prevalence of eating disorders is reduced, and recovery outcomes and quality of life are improved for people experiencing eating disorders and their families/supports and communities.

Purpose

To articulate the key components, standards and actions that are required to achieve an effective, equitable and coordinated system of care that meets the needs of people experiencing or at risk of eating disorders and their families/supports and communities.

Principles

The following principles guide the National Strategy and the system of care for eating disorders (adapted from 12, 13):

Lived experience guidance and leadership

The expertise and insights of people who are experiencing or who have experienced an eating disorder and their families/supports and communities are embedded in health system leadership and in service planning, design, delivery, and evaluation.

Prevention focus

All levels of government and community act together to reduce eating disorder risk and bolster protective factors, so that fewer people develop an eating disorder.

Early identification and intervention

People have access to 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.

Recovery-oriented person and family-centred care

Care and treatment sit within a recovery-oriented, person and family-centred, and strengths-based approach.

Evidence-based and evidence-generating approaches

Approaches to treatment and care are evidence-based, and research and evaluation is conducted to generate new evidence, particularly where the evidence is lacking for specific population groups.

Evidence-based individualised treatment options

Treatment for people with eating disorders is based on evidence and individualised to meet the person's needs.

Flexible treatment and support pathways

People have access to effective treatment and support options, which meet different needs at each stage of risk, illness and recovery.

Equity of access and entry

People have access to affordable treatment and support services when and where they are needed, and regardless of where they live.

Trauma-informed care

Care and treatment are approached from a trauma-informed lens which recognises the high prevalence of trauma experiences among people experiencing eating disorders, and the impact that the trauma can have on the person and their recovery from an eating disorder.

Culturally safe, sensitive, and competent practice

Eating disorder practice is culturally safe, promotes respect, social justice, and equity, and recognises different models and understandings of mental health.

Scope

The National Strategy is a system-building strategy. The focus is on defining what is needed in an effective, equitable and coordinated system of care for eating disorders, and on feasible, grounded steps for building it.

The National Strategy is not a clinical guideline and does not provide recommendations or information about specific models of clinical care. It focuses on the components and functions that need to be present and delivered within the system of care. Links to clinical guidelines for eating disorders and other resources are available here.

Similarly, while the National Strategy highlights some research gaps which relate to components of the system of care, it is not a research strategy. The National Strategy sits beside the Australian Eating Disorders Research and Translation Strategy 2021–2031 (14), forming complementary roadmaps to provide direction and reference for the sector – one for system of care-building, and one for research. An effective system of care requires research – from basic science through to translational research – to be embedded at all levels, with ongoing evaluation to continuously inform and improve services and outcomes.

Areas for further focus

There is broad recognition across the sector of the diverse range of experiences of eating disorders, disordered eating and body image concerns, and that significant work is required to better understand these experiences for different population groups, including tailored models of care and support.

In particular, while Aboriginal and Torres Strait Islander peoples experience eating disorders at the same or higher rates than non-Indigenous Australians (15, 16), the appropriateness and responsiveness of the Western system of care to meet the needs of Aboriginal and Torres Strait Islander peoples is yet to be formally assessed.

There is a need for more understanding about how the eating disorder construct fits within Aboriginal and Torres Strait Islander conceptualisations of social and emotional wellbeing and approaches to healing and care, including the development of culturally appropriate diagnostic tools and treatment approaches (16, 17). Further research with, by and for Indigenous people is needed to understand how both Indigenous and Western models and systems of care can best operate to provide care that is culturally safe, relevant, and effective. This may then inform the development of guidelines and other key health documents specific to eating disorder care for Aboriginal and Torres Strait Islander people. Such guidance should be driven by community, enabled by government, adopted by the wider health and social sectors, and should embed an understanding of the need for solutions and approaches which can work and be adapted for each community. Culturally informed research paradigms and strategies are emerging to guide future work (see Dale et al. 2021 (18); Australian Eating Disorders Research and Translation Strategy 2021–2031 (14)).

Until this deeper understanding emerges, the implementation of any standards and actions within the National Strategy must align with principles and practices that drive access to services that are prevention-focused, strengths-based, culturally safe and responsive, equitable and free of racism (see National Aboriginal and Torres Strait Islander Health Plan 2021–2031 (19)). This consideration should underpin the implementation of all standards and actions contained within this Strategy.

Development of the National Strategy

The National Strategy draws together lived experience, clinical, and research expertise. NEDC engaged in extensive national consultations with stakeholders to identify what is required to build and embed a system of care that meets the needs of people experiencing or at risk of eating disorders, and their families/supports and communities. The different types of expertise shared provided the foundation for the development of the National Strategy.

The National Strategy development and consultation process included:

In-depth consultations

Consultations with eating disorder-specific services across Australia generating an understanding of the past and current service system

Eating disorder service development organisations/key informants and national and state-based eating disorder lived experience organisations

62
stakeholders

80
participants
Consultation at the 2022 ANZAED conference

Online survey
People with lived experience of an eating disorder or disordered eating/body image concerns and professionals

1031
respondents

6
lived experience focus groups

43 participants
Exploring the experiences of underserved and higher risk population groups

2
commissioned papers

On **eating disorders and neurodivergence** and exploring considerations for approaches to **eating disorders among Aboriginal and Torres Strait Islander peoples**

Working Groups and Advisory Groups

5
working groups and one sub-group

129 participants
Providing content-based expertise into each component of the system of care and into workforce considerations

- **Prevention**
- **Identification and Initial Response**
- **Treatment**
- **Psychosocial and Recovery Support**
- **Workforce**
- **Lived Experience Workforce Advisory Group**

National strategy reference group
23 members
Comprising eating disorder sector leaders to advise on National Strategy development and implementation

Aboriginal Advisory Committee

Guidance & Expertise

National Eating Disorders Collaboration Steering Committee

Document structure

The National Strategy is organised into four sections, outlined below:

Section One

The reform context for mental health and eating disorders

This section describes the broader mental health reform context that the National Strategy exists within, as well as the specific reform context for eating disorders.

Section Two

The stepped system of care for eating disorders

This section introduces the stepped system of care for eating disorders, which is the key concept around which the National Strategy is based.

Section Three

Standards and actions

This section outlines the standards and actions required to achieve a system of care for eating disorders which meets the needs of people experiencing or at risk of eating disorders, and their families/supports and communities.

The standards articulate minimum standards required for each component of the stepped system of care, and the actions describe what is needed to achieve these standards. Standards and actions for the workforce are also included, in recognition of the integral role of the workforce across the system of care.

Section Four

Strategy progress indicators

This section outlines examples of high-level indicators to help evaluate progress towards the standards and actions outlined in the National Strategy.

Standards at a glance

The National Strategy sets out minimum standards required for each component of the system of care and articulates specific priority actions for each standard. The standards and actions are directly informed by extensive consultation with people with lived experience, clinicians, researchers, community providers, service development leaders, public health experts, and government.

The standards and their corresponding priority actions are outlined in Section Three of this document. The standards are also listed below to enable an 'at a glance' view.

Prevention

Standard 1

The principle of 'do no harm' in relation to eating disorder risk is applied to public policy and practice.

Standard 2

The principle of 'do no harm' in relation to eating disorder risk is applied to research activities.

Standard 3

There is increased community capacity and expertise to prevent eating disorders through a 'do no harm' approach which acts to reduce risk and bolster protective factors.

Standard 4

Home and family, school, work, health, online, and sports, fitness and performance environments bolster protective factors and reduce risk factors.

Standard 5

Prevention programs are evidence-based and accessible, meeting the needs of people from different ages and backgrounds.

Standard 6

Weight stigma is challenged and reduced, working towards elimination.

Identification

Standard 1

There is whole-of-community awareness of the signs and symptoms that may indicate a developing or existing eating disorder, and the pathways to care.

Standard 2

Professionals at key entry or referral points (e.g., general practitioners (GPs), emergency department staff, school counsellors, mental health professionals, dietitians, Aboriginal and Torres Strait Islander Health Workers and Practitioners, Alcohol and Other Drug workers, staff in sporting/performance organisations) can recognise eating disorder warning signs and symptoms and provide or support access to an initial response.

Standard 3

People who may be experiencing an eating disorder are proactively identified during interactions with the health system and in other settings.

Initial response

Standard 1

Mental health professionals at key entry or referral points can conduct an initial eating disorder assessment including psychiatric risk, make a preliminary diagnosis, provide psychoeducation, refer the person to the appropriate level of treatment and supports, and continue to engage the person and family/supports throughout any waiting time for treatment.

Standard 2

GPs and other medical professionals including emergency department staff can conduct an initial eating disorder assessment including medical and psychiatric risk, make a preliminary diagnosis, provide psychoeducation, refer the person to the appropriate level of treatment, engage the person and family/supports, and continue to provide medical monitoring/treatment throughout any waiting time for mental health treatment.

Standard 3

Dietitians can conduct an initial eating disorder assessment including a dietetic assessment, provide nutrition education and dietetic intervention, refer the person for assessment of medical and psychiatric risk and a preliminary diagnosis, and continue to engage the person and family/supports throughout any waiting time for treatment.

Standard 4

Mental health and health professionals at key entry or referral points have access to clinical and training resources to support their role in initial response.

Standard 5

Health professionals, mental health professionals and the community can easily access information about the treatment and support options available face-to-face, through telehealth, and online for their region, including brief treatment interventions and peer support programs, to assist referrals during the initial response stage.

Treatment

Standard 1

People can access timely treatment and at the level of intensity they need, as close to home as possible (including digital options) and move between levels of treatment intensity in a seamless and supported way.

Standard 2

Eating disorders clinical support, consultation and system navigation support is accessible to treatment providers (both public and private) across the system of care.

Standard 3

Treatment is person-centred and inclusive of families/supports and communities.

Standard 4

Treatment models and practices are effective and evidence-based.

Standard 5

Health and mental health services at all levels provide effective, appropriate, and flexible services to meet the needs of people with eating disorders from underserved and higher risk population groups, including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, neurodivergent people, LGBTQIA+ people, and people in larger bodies.

Standard 6

Eating disorder treatment meets the needs of people across the full range of eating disorder presentations.

Standard 7

Eating disorder treatment is provided by a multidisciplinary team, with a mental health professional and medical practitioner as a minimum. Dietitians, psychiatrists and paediatricians can often be an integral part of the multidisciplinary team, with other professionals as needed (e.g., peer support workers, exercise physiologists). In the case of self-help or brief digital therapies, the person may not have a multidisciplinary team, but should be connected to medical care to ensure safety.

Standard 8

Treatment is affordable.

Standard 9

Treatment providers are trained and skilled for the level of treatment they provide in line with national training standards.

Treatment (community-based)

Standard 1

Community-based public mental health services (including child and adolescent/youth mental health services, adult mental health services, headspace, Head to Health, Aboriginal Community Controlled Health Services) provide evidence-based treatment ranging from guided self-help and brief interventions, to longer courses of treatment as clinically indicated, for binge-eating disorder, bulimia nervosa, other specified feeding or eating disorder (OSFED) (excluding atypical anorexia nervosa), unspecified feeding or eating disorder (UFED), and sub-threshold eating disorders, and provide or refer to treatment for anorexia nervosa, atypical anorexia nervosa, avoidant/restrictive food intake disorder (ARFID), pica, and rumination disorder.

Standard 2

Treatment services routinely offer or refer to early and brief community interventions for people with binge-eating disorder, bulimia nervosa, OSFED (excluding atypical anorexia nervosa), UFED, and sub-threshold eating disorders where clinically indicated.

Standard 3

GPs and paediatricians are equipped to provide ongoing medical monitoring and treatment for people with eating disorders, in conjunction with other medical professionals as needed.

Treatment (community-based intensive)

Standard 1

People can access a community-based intensive treatment option delivered close to home or virtually (e.g., day programs, intensive outpatient programs, outreach support).

Standard 2

Community-based intensive services ensure that staff are trained in line with national standards to work within their professional scope of practice and in line with the aims of the program.

Treatment (hospital and residential)

Standard 1

There is sufficient access to hospital beds and residential care to meet the medical and psychiatric needs of children and adolescents, transition age groups (16-25), adults, and older adults.

Standard 2

All emergency departments are able to assess and provide medical and psychiatric stabilisation in accordance with national and state/territory clinical guidelines, and refer to an appropriate level of care, including inpatient admission as required.

Standard 3

All public hospitals have capacity to provide medical and psychiatric inpatient care for eating disorders, or have established and documented pathways for timely referral.

Standard 4

Regardless of setting of inpatient admission (e.g., medical ward), mental health support is provided appropriate to the goals of the admission.

Standard 5

People are supported to move between inpatient and community treatment services (both public and private) with supported pathways, service collaboration, and clear, timely communication including discharge planning.

Psychosocial and recovery support

Standard 1

People experiencing eating disorders and their families/supports have access to psychosocial and recovery support services and programs, according to their needs.

Standard 2

Staff providing psychosocial and recovery support services and programs have understanding about eating disorders appropriate to their role and context.

Standard 3

The evidence base for the efficacy of psychosocial and recovery support services and programs is further developed.

Workforce

Standard 1

Engagement in eating disorder practice by the current and future health and mental health workforce is increased and barriers are reduced.

Standard 2

Eating disorders are a workforce priority in mainstream health and mental health services.

Standard 3

There is a skilled and diverse Lived Experience workforce operating across the system of care, including in governance, leadership, consultation, and direct care roles.

Standard 4

The education, social and community services workforces are skilled and knowledgeable about eating disorders appropriate to role and function within the system of care.

SECTION 1

The reform context for mental health and eating disorders

The reform context for mental health and eating disorders

This section outlines the broader context of mental health reform within which the National Eating Disorders Strategy is positioned, followed by an overview of the eating disorder reform context. It provides a high-level overview of the shifts that are needed within the system of care for eating disorders, as background to the National Strategy.

Reform for mental health

A significant period of mental health reform is underway in Australia, building on the recommendations of the Productivity Commission's Inquiry Report on Mental Health (20), the National Suicide Prevention Adviser's Final Advice (21), and the Royal Commission into Victoria's Mental Health System (22). These inquiry reports highlighted significant challenges within the mental health system, including a lack of clarity about roles, responsibilities and funding, underinvestment in prevention and early intervention, system fragmentation and complexity, service gaps and barriers to service access, and a lack of person-centred care.

The Australian Government gave its support (in full, in principle, or in part) to all recommendations within the Productivity Commission's Inquiry Report on Mental Health and the National Suicide Prevention Adviser's Final Advice (23), and the Victorian Government committed to implementing all recommendations within the Royal Commission into Victoria's Mental Health System (24). In recognition of the need for a whole-of-government approach to achieve the required system reform, the National Cabinet committed to the development of a National Mental Health and Suicide Prevention Agreement (23). The National Mental Health and Suicide Prevention Agreement (25) was signed by the Commonwealth and all state and territory governments in 2022, and sets out the shared commitment of the Commonwealth, state and territory governments to work in partnership to achieve systemic, whole-of-government reform and deliver a comprehensive, coordinated, consumer focused and compassionate mental health and suicide prevention system for all Australians.

The general roles of the Commonwealth and state and territory governments outlined under the National Mental Health and Suicide Prevention Agreement (25) are as follows:

> "The Commonwealth is responsible for system management, funding and policy direction for primary mental healthcare, as well as physical and mental health services subsidised by the Medicare Benefits Scheme (MBS) and commissioned through the Primary Health Networks (PHNs). The Commonwealth also provides some clinical and non-clinical community based mental healthcare and subsidises private specialist mental healthcare via the MBS and the Pharmaceutical Benefits Scheme (PBS)." (25, p.10)
>
> "The States [state and territory governments] are generally responsible for providing health and emergency services through the public hospital system. This includes public hospital mental health services for people with severe and persistent mental illness, as well as specialist community-based mental health services and responding to people in suicidal distress. This also includes the system management of public hospitals, taking a lead role in managing public health activities; and providing legislative and governance arrangements for Local Hospital Networks." (25, p.11-12)

Other key reform areas and policies include the current review of the National Disability Insurance Scheme (26), the Disability Royal Commission (27), the forthcoming National Mental Health Workforce Strategy (28), the National Mental Health Research Strategy (29), the National Lived Experience (Peer) Workforce Development Guidelines (30), Vision 2030 for Mental Health and Suicide Prevention in Australia (31), the National Children's Mental Health and Wellbeing Strategy (32), the National Agreement on Closing the Gap (33), and the National Aboriginal and Torres Strait Islander Health Plan 2021-2031 (19).

Reform for eating disorders

Considerable work has been undertaken and progress made across the system of care for eating disorders, particularly over the past five to ten years. This progress has been driven by eating disorder lived experience organisations and advocates, eating disorder service development organisations and service leaders, clinicians and other health professionals, researchers, and governments and policymakers, in response to the need to improve outcomes and experiences of care. This has laid a strong foundation for continued system-building reform. Examples of progress and investment include:

- The publication of the National Agenda for Eating Disorders 2017–2022 (34), consolidating existing evidence and consensus-based expert opinion into a series of priorities and actions for health system reform;
- The introduction of Eating Disorders Treatment and Management Plans under the MBS to support access to an evidence-based intensity and duration of eating disorders treatment for people with anorexia nervosa and people with other eating disorders who meet the eligibility criteria (35);
- Increasing recognition of eating disorders as part of core business for public sector mental health services (36-38);
- Greater understanding of the full range of care and treatment services that people may require over the course of illness and recovery (including a comprehensive model of the system of care for eating disorders (39));
- Increased provision of care and treatment services (40), including residential care (41, 42);
- The development of guidelines and training standards to support eating disorder expertise to be embedded across the system of care, including the Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Treatment of Eating Disorders (43), the Management of Eating Disorders for People with Higher Weight: Clinical Practice Guideline (44), the National Practice Standards for Eating Disorders (including workforce core competencies) (12), the Australia and New Zealand Academy for Eating Disorders (ANZAED) Clinical Practice and Training Standards (45-47), and the National Framework for Eating Disorders Training (13);
- The establishment of the ANZAED Eating Disorder Credential to support workforce development and increase the accessibility, quality and consistency of treatment (48);
- The establishment of the Australian Eating Disorders Research and Translation Centre to coordinate a national approach to eating disorder research and translate findings into practice, drawing on the identified priorities within the Australian Eating Disorders Research and Translation Strategy 2021–2031 (14);
- State/territory strategic planning, such as the NSW Service Plan for People with Eating Disorders (37) and the Victorian Eating Disorders Strategy (49) (to be superseded by the forthcoming new Victorian Eating Disorders Strategy).

Despite this progress and investment, and the existence of pockets of excellence, the personal and social costs of eating disorders remain too high. Many people experiencing or at risk of eating disorders and their families/supports and communities still face significant challenges in accessing a minimum standard of evidence-based care. This constitutes a national crisis in care for people experiencing eating disorders and their families/supports and communities.

System challenges and barriers include workforce shortages and system pressures, service gaps, a lack of coordination and continuity of care across services and settings, and a lack of data to support service planning and evaluation. These challenges are compounded for people living in regional, remote and very remote areas of Australia, and for people from underserved and higher risk population groups.

NEDC's consultations with people with lived experience and their families/supports and communities, clinicians, researchers and other stakeholders to inform the development of the National Strategy highlighted that evidence-based eating disorder care needs to be embedded in the Australian health system and gaps in treatment and support must be addressed. Eating disorders are a mainstream health concern and must be met with an organised, funded, whole-of-health system response which involves and integrates general health, mental health and eating disorder-specific services. This requires both 'top-down' and 'bottom-up' change.

What needs to change?

Based on these consultations, the significant shifts needed to enable an effective, equitable and coordinated system of care for eating disorders can be characterised as follows:

- From a fragmented system with pockets of excellent practice and many gaps, to an adequately resourced and coordinated system which consistently meets the needs of people experiencing or at risk of eating disorders and their families/supports and communities.
- From an approach based on the historical view that eating disorders are a 'specialist' clinical area for one diagnosis (anorexia nervosa), to activation of a whole-of-health system response integrating medical and mental health across primary, secondary and tertiary care for all eating disorder diagnoses.
- From stereotypes and a lack of understanding of eating disorders, to recognition that eating disorders can be experienced by any person, at any stage of their life.
- From a predominant focus on acute treatment services, to a stepped system of care including community-based treatment and support delivered as early in illness as possible.
- From public mental health and health services considering service provision for eating disorders as a choice, to service provision for eating disorders as 'core business' with appropriate roles, accountabilities and resourcing.
- From services operating as isolated silos, to services providing an integrated and seamless experience of care for people experiencing or at risk of eating disorders and their family/supports and community.
- From eating disorders practice being viewed as fundamentally separate from the broader area of mental health, to being an integral part of mental health practice.
- From a system of care which does not cater to the needs of underserved and higher risk population groups, to an inclusive and tailored system of care which meets diverse needs.

Enablers of change

The following enablers can help drive the changes needed across the system of care.

Lived experience leadership and expertise

The important role of eating disorder lived experience in driving sector reform should be recognised and enhanced across the system of care. Lived experience organisations and individual lived experience voices provide leadership and expertise, and are crucial conduits for lived experience approaches, needs and perspectives.

Service planning and care pathways

States and territories should have an eating disorder plan for providing a complete stepped system of care within their state/territory, including roles and responsibilities, and strategies and accountabilities for addressing system gaps. Bilateral agreements between the Commonwealth and states/territories provide the basis for coordinated service roles and accountabilities. Local regions should have well-articulated care pathways across the system of care, with integration of public and private services and across child and adolescent/youth and adult services. Services should facilitate care navigation and ensure coordination with other services across the system of care. Joint regional planning and local solutions are critical to ensuring that people can access the care they need face-to-face or online, as early in illness as possible and as close to home as possible. Primary Health Networks have a key role in this and in workforce development and service coordination/navigation.

Strategic system-building and service development

Ongoing strategic system-building and service development work is needed to continue to build and embed the system of care at national, state/territory and regional levels. There is large variation in the extent of system-building work that has been conducted across states/territories, ranging from decades of intentional system-building activities in some jurisdictions, to more recent engagement in system-building activities in others (50).

Focus areas for strategic system-building and service development work include policy and planning, embedding eating disorder expertise as part of core business within public sector health and mental health services, delivery of workforce development initiatives, and provision of navigation/ coordination roles.

Existing models for system-building services/roles include:

- Centralised state/territory service development, training and consultation organisations
- Regional multidisciplinary eating disorder ‘hubs’ within public sector mental health services
- Eating disorder coordinators situated in public mental health services, Primary Health Networks or other health/community settings
- Lived experience organisation initiatives.

Research, data collection and evaluation

Service/program planning and delivery should reflect best evidence, drawing on research, clinical and lived experience expertise. National, state/territory and service level data for eating disorders should be routinely collected, and used to support service planning, evaluation, quality improvement, workforce development, knowledge translation, and innovation. All funded programs and services should routinely evaluate outcomes to measure effectiveness, continue to build the evidence base, and inform continuous quality improvement and innovation.

Understanding the needs of underserved and higher risk population groups

The needs of underserved and higher risk population groups across the system of care must be better understood, including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, neurodivergent people, LGBTQIA+ people, people in larger bodies, people with co-occurring conditions, and people with longstanding eating disorders. Co-produced research should be conducted to inform the development or tailoring of programs and models of care for specific population groups. These programs and models should be evaluated to ensure that the needs of different population groups are met.

Workforce development

Eating disorder expertise must be embedded and accessible across the full stepped system of care, appropriate to setting. For example, people working in higher-risk community settings and primary care settings need to be willing, able, confident and supported to identify emerging eating disorders and support initial assessment and referral; community-based mental health services need capacity to provide evidence-based treatment for people experiencing binge-eating disorder, bulimia nervosa, other specified feeding or eating disorder (OSFED) (excluding atypical anorexia nervosa), unspecified feeding or eating disorder (UFED), and sub-threshold eating disorders, and provide or refer to treatment for people experiencing anorexia nervosa, atypical anorexia nervosa, avoidant/restrictive food intake disorder (ARFID), pica, and rumination disorder; eating disorder-specific services need capacity to provide treatment for people across the range of eating disorder diagnoses and levels of complexity. The Lived Experience workforce needs to be supported and expanded across the system of care.

Workforce planning and training can be done in a targeted way with reference to the NEDC National Training Framework (13) and ANZAED Clinical Practice and Training Standards (45-47). Introductory training is accessible online, and treatment model training online/face-to-face in all jurisdictions. Ongoing access to clinical consultation and supervision should be available in all regions. Eating disorders content should be embedded within all relevant tertiary and vocational training for the future workforce, and clinical consultation and supervision should be available in all regions.

National Strategy

The National Eating Disorders Strategy 2023-2033 is a key enabler to support the changes needed across the system of care for people experiencing or at risk of eating disorders, and their families/supports and communities. It is designed to align with the roles and responsibilities for Commonwealth and state and territory governments within the broader mental health system (as outlined within the National Mental Health and Suicide Prevention Agreement (25)), as well as the roles and responsibilities of other stakeholders.

Implementation of the National Strategy will help to ensure that people experiencing or at risk of eating disorders, and their families/supports and communities can access an effective, equitable and coordinated system of care.

SECTION 2

The stepped system of care for eating disorders

The stepped system of care

A 'stepped care' approach is a key concept within mental health policy and service provision which refers to "an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to a person's needs. Within a stepped care approach, a person is supported to transition up to higher-intensity services or transition down to lower-intensity services as their needs change." (51, p.70)

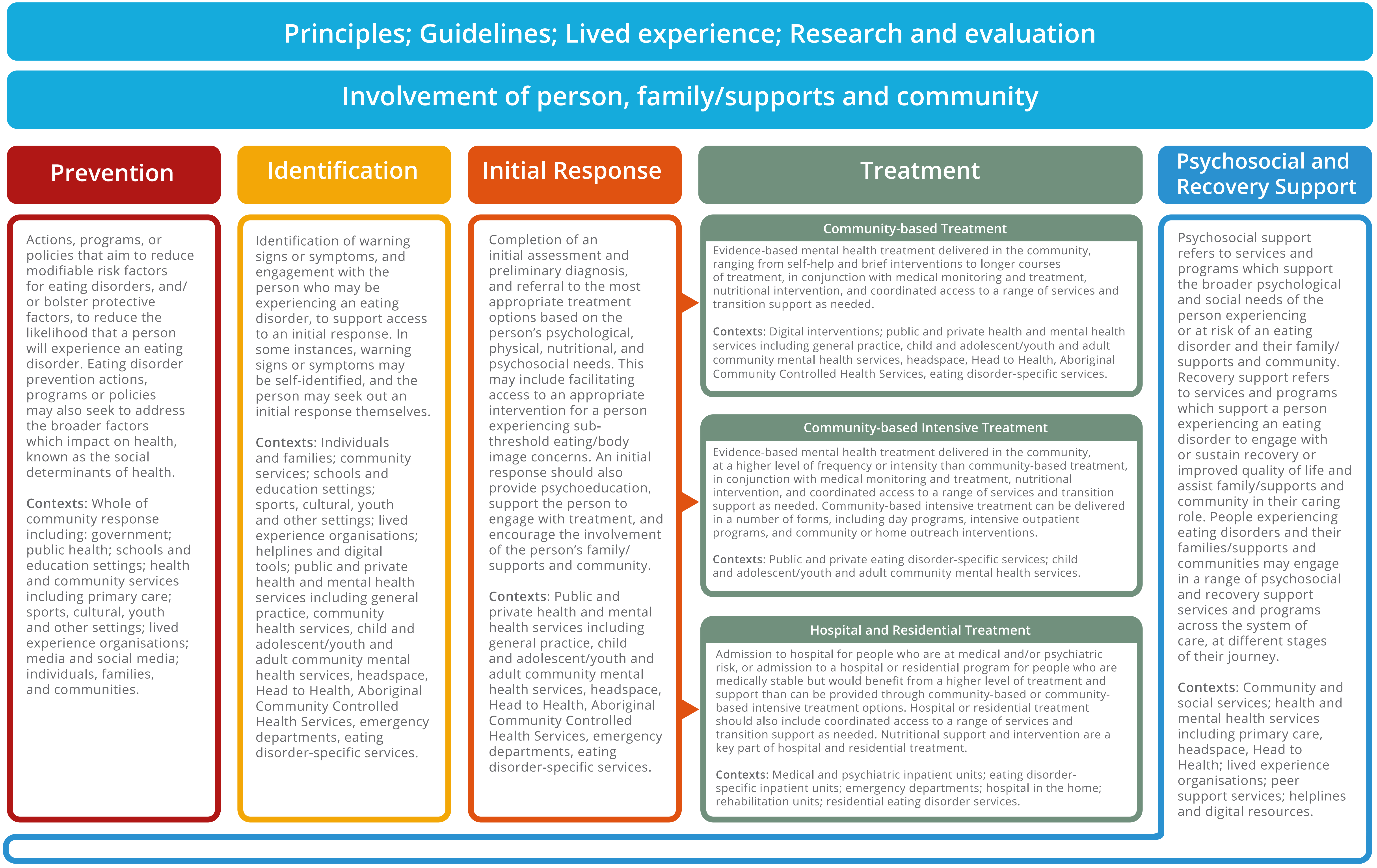
NEDC has integrated two decades of sector and lived experience consensus and service development into a model of the stepped system of care for eating disorders (page 34), designed to be embedded within the stepped care approach used across mental health policy and services. NEDC's model is tailored to reflect the specific needs of people experiencing or at risk of an eating disorder, and their families/supports and communities, who may require access to a range of different services, at different levels of intensity or frequency, across the course of illness (or risk of illness) and recovery. The purpose of the model is to depict the components that should be available in an effective system of care for eating disorders. The model has been utilised to support policy development and service planning across a number of jurisdictions.

The stepped system of care for eating disorders refers to a full continuum of coordinated, effective, evidence-based services and supports, which are matched to a person's needs, and increase or decrease in intensity according to the person's changing psychological, physical, nutritional, and psychosocial needs. Progression along the continuum is not linear, and a person may require recurrent episodes of treatment and support, at different levels in the stepped system of care and from different service providers.

The components of the stepped system of care for eating disorders are depicted on page 34 and described in more detail in Section Three.

National Eating Disorders Collaboration

Stepped System of Care for Eating Disorders



Principles; Guidelines; Lived experience; Research and evaluation

Involvement of person, family/supports and community

Prevention

Actions, programs, or policies that aim to reduce modifiable risk factors for eating disorders, and/or bolster protective factors, to reduce the likelihood that a person will experience an eating disorder. Eating disorder prevention actions, programs or policies may also seek to address the broader factors which impact on health, known as the social determinants of health.

Contexts: Whole of community response including: government; public health; schools and education settings; health and community services including primary care; sports, cultural, youth and other settings; lived experience organisations; media and social media; individuals, families, and communities.

Identification

Identification of warning signs or symptoms, and engagement with the person who may be experiencing an eating disorder, to support access to an initial response. In some instances, warning signs or symptoms may be self-identified, and the person may seek out an initial response themselves.

Contexts: Individuals and families; community services; schools and education settings; sports, cultural, youth and other settings; lived experience organisations; helplines and digital tools; public and private health and mental health services including general practice, community health services, child and adolescent/youth and adult community mental health services, headspace, Head to Health, Aboriginal Community Controlled Health Services, emergency departments, eating disorder-specific services.

Initial Response

Completion of an initial assessment and preliminary diagnosis, and referral to the most appropriate treatment options based on the person's psychological, physical, nutritional, and psychosocial needs. This may include facilitating access to an appropriate intervention for a person experiencing sub-threshold eating/body image concerns. An initial response should also provide psychoeducation, support the person to engage with treatment, and encourage the involvement of the person's family/supports and community.

Contexts: Public and private health and mental health services including general practice, child and adolescent/youth and adult community mental health services, headspace, Head to Health, Aboriginal Community Controlled Health Services, emergency departments, eating disorder-specific services.

Treatment

Community-based Treatment

Evidence-based mental health treatment delivered in the community, ranging from self-help and brief interventions to longer courses of treatment, in conjunction with medical monitoring and treatment, nutritional intervention, and coordinated access to a range of services and transition support as needed.

Contexts: Digital interventions; public and private health and mental health services including general practice, child and adolescent/youth and adult community mental health services, headspace, Head to Health, Aboriginal Community Controlled Health Services, eating disorder-specific services.

Community-based Intensive Treatment

Evidence-based mental health treatment delivered in the community, at a higher level of frequency or intensity than community-based treatment, in conjunction with medical monitoring and treatment, nutritional intervention, and coordinated access to a range of services and transition support as needed. Community-based intensive treatment can be delivered in a number of forms, including day programs, intensive outpatient programs, and community or home outreach interventions.

Contexts: Public and private eating disorder-specific services; child and adolescent/youth and adult community mental health services.

Hospital and Residential Treatment

Admission to hospital for people who are at medical and/or psychiatric risk, or admission to a hospital or residential program for people who are medically stable but would benefit from a higher level of treatment and support than can be provided through community-based or community-based intensive treatment options. Hospital or residential treatment should also include coordinated access to a range of services and transition support as needed. Nutritional support and intervention are a key part of hospital and residential treatment.

Contexts: Medical and psychiatric inpatient units; eating disorder-specific inpatient units; emergency departments; hospital in the home; rehabilitation units; residential eating disorder services.

Psychosocial and Recovery Support

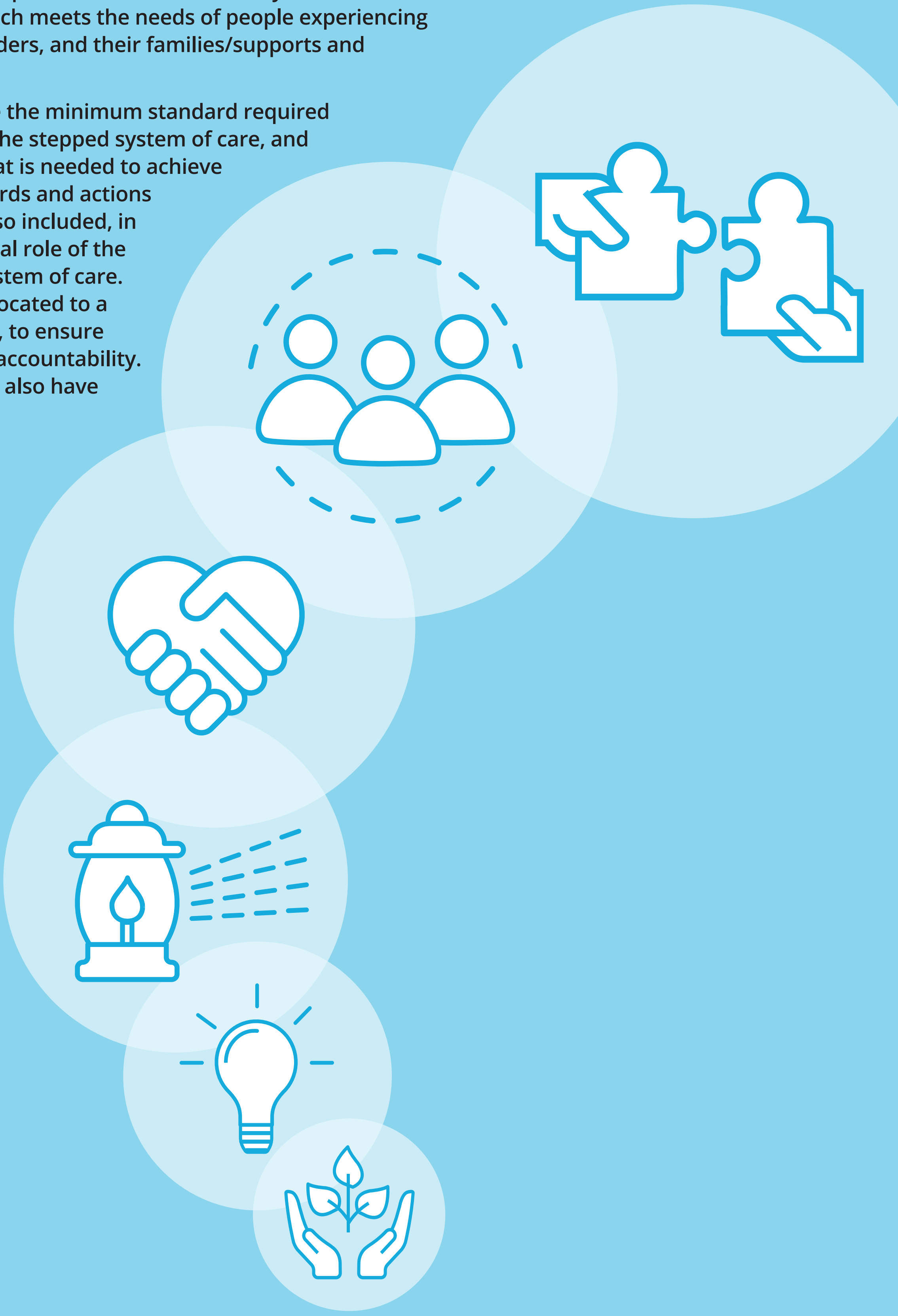
Psychosocial support refers to services and programs which support the broader psychological and social needs of the person experiencing or at risk of an eating disorder and their family/supports and community. Recovery support refers to services and programs which support a person experiencing an eating disorder to engage with or sustain recovery or improved quality of life and assist family/supports and community in their caring role. People experiencing eating disorders and their families/supports and communities may engage in a range of psychosocial and recovery support services and programs across the system of care, at different stages of their journey.

Contexts: Community and social services; health and mental health services including primary care, headspace, Head to Health; lived experience organisations; peer support services; helplines and digital resources.

SECTION 3
Standards and actions

The National Strategy articulates standards and actions required to achieve an effective, equitable and coordinated system of care for eating disorders, which meets the needs of people experiencing or at risk of eating disorders, and their families/supports and communities.

The standards articulate the minimum standard required for each component of the stepped system of care, and the actions describe what is needed to achieve these standards. Standards and actions for the workforce are also included, in recognition of the integral role of the workforce across the system of care. Each action has been allocated to a particular stakeholder/s, to ensure clear responsibility and accountability. Other stakeholders may also have a role in these actions.



Prevention

CONTEXTS | **Whole of community response, including: government; public health; schools and education settings; health and community services including primary care; sports, cultural, youth and other settings; lived experience organisations; media and social media; individuals, families, and communities.**

Eating disorder prevention refers to actions, programs, or policies that aim to reduce modifiable risk factors for eating disorders, and/or bolster protective factors, to reduce the likelihood that a person will experience an eating disorder. Eating disorder prevention actions, programs or policies may also seek to address the broader factors which impact on health, known as the social determinants of health.

The elements that contribute to the development of an eating disorder are complex, and involve a range of biological, psychological, and sociocultural factors (52-54), known as risk factors (see Table A1, Appendix). A risk factor is a variable that makes a person more likely to experience a negative health outcome. Some eating disorder risk factors (for example, age) cannot be changed, while others (such as body dissatisfaction) can be modified. There are also variables which are known to reduce the likelihood of a person experiencing a negative health outcome, known as protective factors (see Table A2, Appendix). Prevention initiatives target modifiable risk and/or protective factors.

Prevention initiatives may be directed towards a general population group regardless of their risk factor status (universal prevention), towards specific sub-groups of the population at higher-than-average risk of eating disorders (selective prevention), or towards individuals who are experiencing sub-threshold signs or symptoms of an eating disorder (indicated prevention) (55).

Effective eating disorder prevention can stop people from developing eating disorders and their associated, potentially long-term, mental and physical health consequences (56). As well as reducing the burden on individuals, families and communities, eating disorder prevention can reduce pressure on the health care system (57). Further, eating disorder prevention activities can help to promote wider mental and physical health. For example, body appreciation is associated with a range of health-promoting behaviours (58, 59), so actions to promote body appreciation can both help to prevent eating disorders and support wider health.

To date, the modifiable risk factors that have been the main targets for eating disorder prevention research and program implementation include sociocultural appearance pressures, body dissatisfaction, especially weight and shape concerns, and appearance change behaviours such as dieting and excessive exercise (56). Prevention interventions linked to these risk factors include school-based programs to address self-esteem, pressures to conform to sociocultural appearance ideals, body dissatisfaction, media, and social media literacy, dieting and body change behaviours, and interventions involving parents which aim to prevent eating disorders in children (60).

The importance of addressing the wider social and environmental factors which impact on eating disorder risk is being increasingly recognised, requiring macro-level policy responses (61, 62). This includes ensuring that policies related to nutrition, physical activity, and weight management do not contribute to eating disorder risk. Broader public policy, such as economic policy, can also impact on modifiable eating disorder risk/protective factors (for example, food insecurity (63, 64)).

One key social and environmental factor which has been highlighted in the literature as an important focus for eating disorder prevention is weight stigma (65). Weight stigma contributes to poor physical and mental health outcomes and is associated with reduced health-promoting behaviours and delays in help seeking for health issues (66-71). The evidence base highlights both the existence and impact of weight stigma within healthcare settings and among healthcare professionals (69, 72-76), including among eating disorder professionals (77). Experiences of weight stigma and weight-based discrimination may contribute to disordered eating (68, 78-81) and eating disorders (82, 83). A range of initiatives aimed at reducing weight stigma have been developed, including professional development for health professionals, development of clinical guidelines, policy shifts in some service settings, and patient advocacy tools (84-86); however, more is needed.

Learning from lived experience

Lived experience participants from the National Strategy public survey and focus groups called for increased prevention efforts that target the general public as well as specific higher-risk settings such as schools, sports environments, healthcare settings and workplaces. They suggested that these efforts should increase education and awareness and challenge harmful language and messaging around food and bodies, to build a culture which supports people to feel safe and comfortable in their bodies. Lived experience participants highlighted the importance of identifying and addressing risk factors and strengthening potential protective factors, to help prevent people from developing eating disorders. People also called for increased recognition of the unique experiences and risk factors amongst different population groups.

Click here to hear from people with lived experience about prevention

“Despite a high level of input from the medical system due to other, non-related issues of my physical and mental health… a lot of the early recognition factors of an eating disorder and potentially my risk factors [were missed].” – Lived experience participant

Standard 1

The principle of 'do no harm' in relation to eating disorder risk is applied to public policy and practice.

Priority actions

1.1 Eating disorder sector to establish eating disorder-safe principles for relevant public policy, drawing on lived experience, clinical and research expertise, and expert input from the wider public health and public policy sectors.

1.2 All levels of government to ensure that public policy and initiatives related to education, health promotion, food and nutrition, physical activity, weight management, advertising and media do not contribute to eating disorder risk, drawing on eating disorder-safe principles and expert input.

1.3 Health promotion organisations and eating disorder organisations to collaborate on approaches to health promotion that do not contribute to eating disorder risk.

Standard 2

The principle of 'do no harm' in relation to eating disorder risk is applied to research activities.

Priority actions

2.1 Eating disorder sector to establish eating disorder-safe principles for research, drawing on lived experience, clinical and research expertise.

2.2 Research stakeholders to ensure that research activities do not contribute to eating disorder risk, drawing on eating disorder-safe principles and expert input.

Standard 3

There is increased community capacity and expertise to prevent eating disorders through a 'do no harm' approach which acts to reduce risk and bolster protective factors.

Priority actions

3.1 Eating disorder service development and lived experience organisations to partner with other sectors, industries, professional bodies and consumer groups to develop and disseminate training and supporting resources in eating disorder-safe principles for community, health and education professionals working with a diverse range of people and communities, and support their implementation.

Standard 4

Home and family, school, work, health, online, and sports, fitness and performance environments bolster protective factors and reduce risk factors.

Priority actions

4.1 Parents and caregivers to be supported through a range of health, social and community services and programs to build their own confidence and skills in fostering their child(ren)'s positive body esteem, media literacy and positive relationships with food and eating.

4.2 Early childhood education and care settings to implement whole-of-service policies and procedures to drive a culture of body appreciation and positive relationships with food and eating.

4.3 Primary and secondary schools to implement whole-of-school policies and procedures to drive a culture of body appreciation and positive relationships with food and eating, promote wellbeing and mental health literacy, including taking a harm minimisation approach across all curricula and a zero-tolerance approach to appearance or identity-based teasing and bullying.

4.4 Tertiary and vocational education settings to uphold approaches which promote body appreciation and do no harm in respect of eating disorder risk factors, particularly within their student health and wellbeing services.

4.5 Eating disorder organisations to partner with industry bodies to develop and roll out workplace initiatives for eating disorder prevention, such as through eating disorder-safe guidelines for workplaces, employee wellbeing programs and staff health/activity challenges.

4.6 Sports, fitness and performance organisations at all levels to embed a focus on eating disorder prevention within club/organisation culture, including through culture change programs and efforts to ensure inclusion of diverse bodies.

4.7 Social media platform providers and media organisations to uphold the use of inclusive language and imagery, act to ensure algorithms support the dissemination of content reflecting diverse bodies and identities, enforce bans on appearance-related abuse, harassment and discrimination, provide support and skill development to moderators and administrators, and employ a diverse workforce.

Standard 5

Prevention programs are evidence-based and accessible, meeting the needs of people from different ages and backgrounds.

Priority actions

5.1 Government to fund large-scale dissemination and evaluation of existing evidence-based prevention programs.

5.2 Government to fund research for the development and evaluation of prevention programs where gaps exist for specific age groups or for underserved and higher risk population groups.

5.3 Eating disorder service development and lived experience organisations to continue to provide evidence-based training, resources and support for people providing prevention programs or interventions (e.g., school staff, sports coaches, workplace wellbeing managers).

5.4 Eating disorder sector to develop, maintain and promote a publicly accessible list of evidence-based prevention programs for various settings and population groups.

Standard 6

Weight stigma is challenged and reduced, working towards elimination.

Priority actions

6.1 Government to enact prohibition of weight and size discrimination in anti-discrimination legislation at national and state/territory levels, where none currently exists.

6.2 Providers of tertiary and vocational health and mental health professional courses to include course content on the impact of weight stigma, and how to reduce and remove it from professional practice.

6.3 Health professional bodies across all disciplines to deliver continuing professional development activities on the impact of weight stigma, and how to reduce and remove it from professional practice.

6.4 Health promotion strategies and campaigns to orient their focus away from weight reduction or management, instead focusing on health-promoting behaviours.

Identification

CONTEXTS | Individuals and families; community services; schools and education settings; sports, cultural, youth and other settings; lived experience organisations; helplines and digital tools; public and private health and mental health services including general practice, community health services, child and adolescent/youth and adult community mental health services, headspace, Head to Health, Aboriginal Community Controlled Health Services, emergency departments, eating disorder-specific services.

Identification refers to the detection of warning signs or symptoms, and engagement with the person who may be experiencing an eating disorder, to support access to an initial response. In some instances, warning signs or symptoms may be self-identified, and the person may seek out an initial response themselves.

People experiencing or at risk of eating disorders can face individual and systemic barriers to help-seeking, such as stigma (87, 88), lack of recognition or acknowledgement of symptoms/illness (87, 89), and issues of service availability/access (87, 90). For these reasons, the people around them have an important role in recognising warning signs and symptoms and supporting help-seeking.

Community members and professionals with a role in identification include (but are not limited to) families/supports, general practitioners (GPs), teachers, school counsellors and nurses, nurse practitioners, dietitians, mental health professionals, dentists, sports and fitness professionals, physical therapists, and medical specialists. Digital tools and resources can also support identification.

Identifying warning signs or symptoms early in the eating disorder (or sub-threshold eating disorder) can help to shorten the duration of untreated illness (the time between first onset of a diagnosable illness and receiving evidence-based treatment). Shorter duration of untreated illness is associated with better treatment outcomes for eating disorders (91), reducing the impact of the eating disorder on the person and their family/supports and community.

Many people experiencing or at risk of an eating disorder are not identified early in the course of illness (or sub-threshold illness) (88, 92, 93). The average duration of untreated illness for eating disorders ranges from 2.5 years for anorexia nervosa, to 4.4 years for bulimia nervosa, and six years for binge-eating disorder (94). However, people experiencing eating disorders frequently present to primary health care settings for other concerns (92, 95), but the eating disorder is not identified, and evidence-based treatment is not accessed or provided. In addition, people frequently report negative experiences of interactions with health providers when eating disorders or related concerns are discussed (96, 97).

A lack of awareness of different types of eating disorder presentations (such as binge-eating disorder and OSFED) impacts on identification (88). This can be exacerbated by weight stigma and weight-centric approaches, resulting in eating disorders being missed or discounted (e.g., health risk factors ignored in individuals whose BMI is not in the 'underweight' range) (74), and in disordered eating behaviours being encouraged to promote weight loss (74, 98, 99).

Further, there continues to be a lack of awareness and/or understanding about the ways in which eating disorders may present differently in some population groups (such as among neurodivergent people (100), LGBTQIA+ people (101), people from culturally and linguistically diverse backgrounds, and amongst Aboriginal and Torres Strait Islander peoples (15)). For some populations, such as among athletes, warning signs may be overlooked or normalised (102). There is a lack of lived-experience informed, validated screening tools specifically tailored to different population groups.

Learning from lived experience

Lived experience participants from the National Strategy public survey and focus groups called for increased knowledge and awareness of eating disorders and their warning signs among the community and health professionals, to increase early identification of eating disorders. People reported that opportunities for early identification are missed, or symptoms minimised, due to warning signs (e.g., dieting and weight loss) being normalised and encouraged, lack of knowledge about eating disorders (especially for eating disorders outside of anorexia nervosa and bulimia nervosa) and misconceptions about what an eating disorder 'looks like'. They suggested that efforts to improve identification should provide more training and support for people who can assist in identification (e.g., friends and family, teachers, sports coaches, GPs), reduce stigma, and encourage eating disorder screening in health settings.

Click here to hear from people with lived experience about identification

"I think [identification of my eating disorder] didn't happen in a way because some of the behaviours associated with eating disorders are so normalised and common… it was seen as a normal thing to do." – Lived experience participant

Standard 1

There is whole-of-community awareness of the signs and symptoms that may indicate a developing or existing eating disorder, and the pathways to care.

Priority actions

1.1	The eating disorder sector and government to work together to galvanise public awareness of eating disorder signs and symptoms and increase understanding of the need to respond as early as possible, such as through a national public health campaign.
1.2	Eating disorder and mental health organisations to continue to provide evidence-based information about eating disorder signs and symptoms and pathways to care, tailored to a range of audiences.
1.3	Eating disorder service development, lived experience organisations and Primary Health Networks to disseminate system navigation and referral information.
1.4	Eating disorder lived experience organisations to continue to provide evidence-based resources to assist people and their families/supports and communities to identify concerns and pathways to care.
1.5	Organisational/service settings which interact with population groups at higher risk of eating disorders (e.g., LGBTQIA+ services, schools, sporting/performance organisations) to provide evidence-based information about eating disorders appropriate to the audience.

Standard 2

Professionals at key entry or referral points (e.g., GPs, emergency department staff, school counsellors, mental health professionals, dietitians, Aboriginal and Torres Strait Islander Health Workers and Practitioners, Alcohol and Other Drug workers, staff in sporting/performance organisations) can recognise eating disorder warning signs and symptoms and provide or support access to an initial response.

Priority actions

2.1	Health and mental health services to ensure staff are trained to identify eating disorders and have access to up-to-date local/regional and online treatment and support options.
2.2	Eating disorder service development and lived experience organisations to disseminate accessible online/face-to-face training, and evidence-based screening tools to support health and mental health professionals in identification.
2.3	Eating disorder service development, lived experience organisations and Primary Health Networks to disseminate information about service pathways to support system navigation and referral by health and mental health professionals.
2.4	Tertiary and vocational health/mental health education providers to ensure that curricula routinely include information about eating disorder-safe principles of care and competencies for identification and referral.

Standard 3

People who may be experiencing an eating disorder are proactively identified during interactions with the health system and in other settings.

Priority actions

3.1	Commonwealth government to ensure that the Commonwealth Initial Assessment and Referral processes/tool can support identification of the appropriate level and context of care for people experiencing eating disorders and support appropriate referral.
3.2	Eating disorder sector to develop and maintain a publicly accessible list of validated screening tools, including online tools.
3.3	Researchers and the broader eating disorder sector to further validate existing tools and/or co-design and validate new screening tools where there are gaps for specific population groups (e.g., eating disorder screening tools for Aboriginal and Torres Strait Islander peoples; children under 12, neurodivergent people, LGBTQIA+ people).
3.4	Mental health support and counselling lines to ensure staff have training to identify and guide people to appropriate eating disorder support.
3.5	Health services to screen for eating disorders among people with commonly co-occurring conditions, including in people presenting for bariatric surgery.
3.6	Mental health services to incorporate eating disorder screening into initial assessment protocols and case reviews.

Initial Response

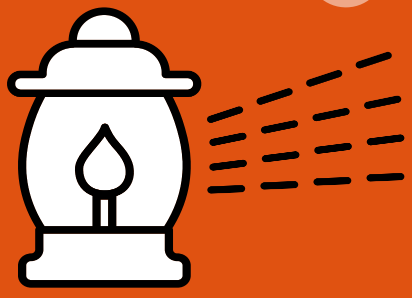
CONTEXTS | **Public and private health and mental health services including general practice, child and adolescent/youth and adult community mental health services, headspace, Head to Health, Aboriginal Community Controlled Health Services, emergency departments, eating disorder-specific services.**

An initial response comprises an initial assessment and preliminary diagnosis, and referral to the most appropriate treatment options based on the person's psychological, physical, nutritional, and psychosocial needs. This may include facilitating access to an appropriate intervention for a person experiencing sub-threshold eating/body image concerns. An initial response should also provide psychoeducation, support the person to engage with treatment, and encourage the involvement of the person's family/supports and community.

Where there is a wait to access treatment, or if the person is not yet ready to engage with treatment, the initial response may involve monitoring ongoing safety, providing education on harm reduction strategies, continuing to engage the person and their family/supports and community, and facilitating connections to peer support.

Where the eating disorder was identified by a health professional, the same health professional may also conduct the initial assessment and preliminary diagnosis, and refer to the most appropriate treatment options (or provide treatment within scope of role and training). If the person who initially identifies eating disorder concerns is not equipped to complete the required initial assessment within the scope of their usual role and their training, they should refer on to one or more additional health professionals or services.

Prompt initial response, including access to an initial assessment, preliminary diagnosis, and referral to appropriate services, is important to ensure safety, prevent deterioration and provide the best chance for positive health and quality of life outcomes (94, 103, 104).



Learning from lived experience

Lived experience participants from the National Strategy public survey and focus groups called for more accessible and equitable initial responses to eating disorders, particularly during the early stages of illness. Participants highlighted issues such as unclear pathways to care, strict assessment and diagnostic criteria, long waitlists for appointments, insufficient eating disorders training and awareness among health professionals, distrust of the health system due to previous negative experiences, and a lack of communication among health professionals. To strengthen initial response to eating disorders, people with lived experience indicated the need for additional eating disorder training for health professionals, assessment tools and processes which take into consideration a person's experiences and needs (including co-occurring conditions), and greater support for those navigating assessment and referral pathways.

Click here to hear from people with lived experience about initial response

By the time I saw someone I was already getting really unwell by that point... I just feel like the moment someone comes in and expresses a concern there needs to be really quick action. Not just 'oh well, you know there's a six week wait...' because six weeks can make a huge difference." - Lived experience participant

Standard 1

Mental health professionals at key entry or referral points can conduct an initial eating disorder assessment including psychiatric risk, make a preliminary diagnosis, provide psychoeducation, refer the person to the appropriate level of treatment and supports, and continue to engage the person and family/supports throughout any waiting time for treatment.

Priority actions

1.1 Training providers to ensure that mental health professionals are trained to conduct an initial eating disorder assessment including psychiatric risk, make a preliminary diagnosis, provide psychoeducation, refer the person to the appropriate level of treatment, and continue to engage the person and family/supports throughout any waiting time for treatment.

1.2 Mental health services to ensure staff are trained to provide an initial response according to their scope of practice and clinical role.

Standard 2

GPs and other medical professionals including emergency department staff can conduct an initial eating disorder assessment including medical and psychiatric risk, make a preliminary diagnosis, provide psychoeducation, refer the person to the appropriate level of treatment, engage the person and family/supports, and continue to provide medical monitoring/treatment throughout any waiting time for mental health treatment.

Priority actions

2.1 Training providers to ensure that general practitioners are trained to conduct an initial eating disorder assessment including psychiatric and medical risk, make a preliminary diagnosis, provide psychoeducation, refer the person to the appropriate level of treatment, engage the person and family/supports, and continue to provide medical monitoring/treatment throughout any waiting time for mental health treatment.

2.2 Health services to ensure staff are trained to provide an initial response according to their scope of practice and clinical role.

2.3 Hospitals to ensure that emergency department staff are trained to conduct an initial eating disorder assessment including psychiatric and medical risk, make a preliminary diagnosis, provide psychoeducation, refer the person to the appropriate level of treatment, engage the person and family/supports, and continue to provide medical treatment throughout any waiting time for treatment.

Standard 3

Dietitians can conduct an initial eating disorder assessment including a dietetic assessment, provide nutrition education and dietetic intervention, refer the person for assessment of medical and psychiatric risk and a preliminary diagnosis, and continue to engage the person and family/supports throughout any waiting time for treatment.

Priority actions

3.1 Training providers to ensure that dietitians are trained to conduct an initial eating disorder assessment, including a dietetic assessment, provide nutrition education and dietetic intervention, refer the person for assessment of medical and psychiatric risk and a preliminary diagnosis, and continue to engage the person and family/supports throughout any waiting time for treatment.

3.2 Services to ensure that dietitians are trained to provide an initial response according to their scope of practice and clinical role.

Standard 4

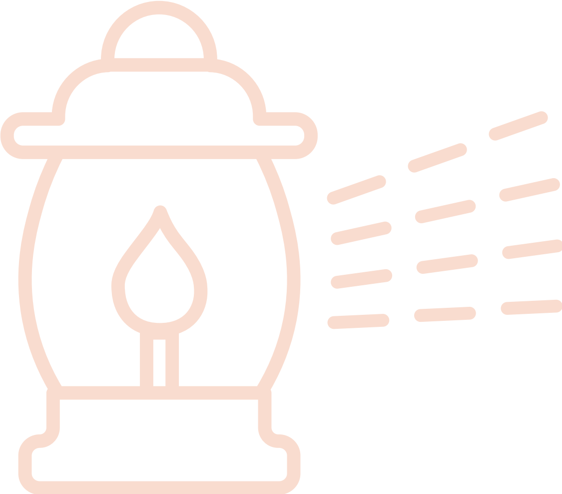
Mental health and health professionals at key entry or referral points have access to clinical and training resources to support their role in initial response.

Priority actions

4.1 Eating disorder service development organisations to continue to develop and disseminate online/face-to-face training, validated assessment tools, and psychoeducation resources to support health and mental health professionals in assessment, preliminary diagnosis, and in engaging the person and family/supports.

4.2 Eating disorder service development and lived experience organisations to disseminate information to health and mental health services about brief interventions such as single session interventions, self-help and guided self-help.

4.3 Tertiary and vocational health/mental health education providers to ensure that curricula routinely include/provide access to information about eating disorder assessment tools and treatment including brief interventions such as single session interventions, self-help and guided self-help.



Standard 5

Health professionals, mental health professionals and the community can easily access information about the treatment and support options available face-to-face, through telehealth, and online for their region, including brief treatment interventions and peer support programs, to assist referrals during the initial response stage.

Priority actions

5.1 Every Primary Health Network to provide comprehensive HealthPathways for eating disorders with up-to-date localised information about treatment options, for GPs and other health professionals.

5.2 Commonwealth, state and territory governments, and regional health planners to consider provision of funded community-based eating disorder care navigation roles or mechanisms.

5.3 Eating disorder service development and lived experience organisations to assist people experiencing or at risk of eating disorders and their families/supports to locate and navigate services by providing an online resource which contains information about the system of care and treatment options, including available services (public and private).

5.4 Eating disorder organisations and mental health entry and referral services to promote the availability of eating disorder credentialed clinicians within the system of care.

Treatment

CONTEXTS | **See community-based treatment, community-based intensive treatment, and hospital and residential treatment sub-sections.**

Eating disorder treatment refers to evidence-based mental health treatment, in conjunction with medical monitoring and treatment, along with access to nutritional intervention and other services as needed. Treatment can be delivered through digital, telehealth and/or face-to face interventions. Eating disorder treatment is provided by a multidisciplinary team, with a mental health professional[1] and medical practitioner as a minimum. Dietitians, psychiatrists and paediatricians can often be an integral part of the multidisciplinary team, with other professionals as needed (e.g., peer support workers, exercise physiologists). In the case of self-help or brief digital therapies, the person may not have a multidisciplinary team, but should be connected to medical care to ensure safety.

There are three levels of treatment within the stepped system of care for eating disorders – community-based, community-based intensive, and hospital and residential (described further in the sub-sections of this chapter). Treatment intensity increases across these three levels. A person may commence treatment at any level, depending on their needs. Coordination across these levels of care, and service navigation support, are crucial to improving the outcomes and experiences of people with lived experience and their families/supports and communities.

Two key functions of the eating disorder treatment system are to respond to the broad range of eating disorders through the provision of early intervention and accessible, evidence-based community treatment, and to provide immediate treatment for people with acute health and/or mental health needs. Every region of Australia requires access to these services in line with its specific needs.

Treatment should be specific to the person's age and developmental stage, and delivered by health professionals who maintain up-to-date knowledge and skills in evidence-based approaches to eating disorders, or be delivered via digital interventions with high-quality evaluation and data to support efficacy. Treatment should be tailored to the person's individual needs and delivered using an evidence-based practice approach, which combines best research evidence, patient values and perspectives, and clinical expertise (105). It should also be inclusive of the person's family/supports and community. Families/supports and communities should be supported to access appropriate support for their role in the recovery journey. This can include access to their own mental health treatment, financial assistance, educational resources, and support groups.

Research shows that the majority of people experiencing eating disorders do not receive treatment for the eating disorder (93, 106-108). For those who do access treatment, this often occurs after many years (106) and rates of recovery are sub-optimal (6).

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[1] An umbrella term for those professions that can provide therapeutic support and evidence-based mental health treatment for people experiencing an eating disorder, including psychologists, social workers, occupational therapists, psychiatrists, counsellors, mental health nurses, nurse practitioners, and psychotherapists (13).

There is a need for more research on evidence-based delivery of existing treatment models, as well as more research on innovative treatment models to improve outcomes. In addition, there is a need to develop tailored treatment models for higher risk and underserved population groups (e.g., Aboriginal and Torres Strait Islander peoples, neurodivergent people, people with longstanding eating disorders). Ongoing work is also needed to address weight stigma, which can present a barrier to people seeking and receiving treatment, and can impact on recovery (74, 99, 109).

Learning from lived experience

Lived experience participants from the National Strategy public survey and focus groups called for equitable and accessible treatment that focuses on both psychological and physical health, and is person-centred, individually tailored, trauma-informed, and inclusive and affirming of all identities and body shapes and sizes. They highlighted the need for services to be available no matter where people live, and to be available as early in illness as possible, calling for increased staffing and funding to increase the availability of treatment and reduce waitlists. People indicated a need for admission criteria to be inclusive of different presentations and experiences, clearer referral pathways to (and between) services, increased availability of care within the public system, and for care to be delivered by a multidisciplinary team which includes family/supports.

Click here to hear from people with lived experience about treatment

“One of my biggest challenges in trying to access treatment... is not fitting the stereotype of what people think of when they think of an eating disorder... So as well as having the eating disorder, I then had to advocate for myself to get the treatment [that I needed].” – Lived experience participant

Standard 1

People can access timely treatment and at the level of intensity they need, as close to home as possible (including digital options), and move between levels of treatment intensity in a seamless and supported way.

Priority actions

1.1 Government and health and mental health service leaders to endorse eating disorders treatment as a core public health service accountability and workforce planning priority.

1.2 National, state/territory, and regional planners to ensure adequate access to treatment services in every region (including rural and remote) and for each age group (children and adolescents, transition age groups (16-25), adults, and older adults).

1.3 Treatment services within a local region (both public and private) to collaborate on service entry criteria to ensure a seamless system of care with coverage for all presentations.

1.4 All treatment services to support people and their families/supports to transition between services and levels of treatment (step-up, step-down, and within level) through clear inter-service communication and tailored care navigation.

1.5 Treatment services to allocate dedicated staff time for supporting connection with other services and clinicians, and maintaining up-to date knowledge of the local service system.

1.6 Researchers, in conjunction with service providers and people with lived experience, to conduct further research into treatment interventions including brief and/or digital interventions, as well as other innovative solutions to meet needs.

Standard 2

Eating disorders clinical support, consultation and system navigation support is accessible to treatment providers (both public and private) across the system of care.

Priority actions

2.1 Commonwealth and state/territory governments to provide funding and accountabilities to public eating disorder-specific treatment services to provide clinical support, consultation and system navigation support within their region.

2.2 Public eating disorder-specific treatment services to routinely provide clinical support, consultation and system navigation support to other health and mental health services in the system of care in their region.

2.3 Eating disorder service development organisations to continue to provide clinical support, consultation and system navigation support as part of their work.

Standard 3

Treatment is person-centred and inclusive of families/supports and communities.

Priority actions

3.1 At every service entry point, treatment services to provide people experiencing eating disorders and their families/supports with psychoeducation, information about treatment options (e.g., private or public, treatment provider, level of care) and how to navigate the system of care.

3.2 Treatment services to establish shared treatment goals with the person and their family/supports, including consideration of the person's broader psychosocial supports and needs, and any co-occurring conditions.

3.3 Treatment services to engage families/supports as early as possible in treatment and provide them with specific psychoeducation and support for their own needs.

Standard 4

Treatment models and practices are effective and evidence-based.

Priority actions

4.1 Treatment services to provide a model of care for eating disorders that is effective and evidence-based.

4.2 Treatment providers to have the required skills in line with national eating disorder clinical and training standards.

4.3 Treatment services to routinely collect data to evaluate outcomes and inform service and sector continuous quality improvement.

4.4 Researchers, in conjunction with service providers and people with lived experience, to conduct research into existing as well as innovative treatment models to improve outcomes.

Standard 5

Health and mental health services at all levels provide effective, appropriate, and flexible services to meet the needs of people with eating disorders from underserved and higher risk population groups, including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, neurodivergent people, LGBTQIA+ people, and people in larger bodies.

Priority actions

5.1 Researchers, service providers and people from specific population groups to co-design, co-produce and evaluate appropriate models of care for these population groups.

5.2 Health and mental health services to implement and evaluate models of care which meet the needs of underserved and higher risk population groups, and co-deliver training to staff to deliver these models.

Standard 6

Eating disorder treatment meets the needs of people across the full range of eating disorder presentations.

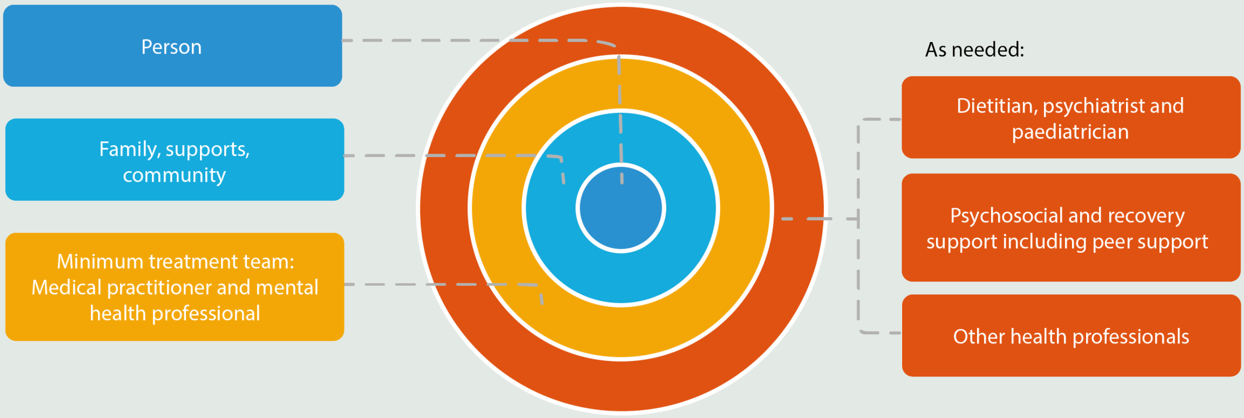
Priority actions

6.1 Regional planners to ensure that services are inclusive of and meet the needs of all eating disorder presentations, including people experiencing ARFID, people with longstanding eating disorders, and people with co-occurring conditions.

6.2 Researchers and the broader eating disorder sector to further develop and evaluate appropriate models of care to meet the needs of people across the range of eating disorder presentations.

Standard 7

Eating disorder treatment is provided by a multidisciplinary team, with a mental health professional and medical practitioner as a minimum. Dietitians, psychiatrists and paediatricians can often be an integral part of the multidisciplinary team, with other professionals as needed (e.g., peer support workers, exercise physiologists). In the case of self-help or brief digital therapies, the person may not have a multidisciplinary team, but should be connected to medical care to ensure safety.



Priority actions

7.1 Primary Health Networks and other regional health planners to consider options to support the establishment of multidisciplinary teams (including virtual teams) such as through funded community-based eating disorder care coordination/navigation roles or mechanisms.

7.2 Eating disorder service development organisations and professional bodies to continue to build networks of clinical supervisors and communities of practice for the different professions involved in eating disorder treatment.

7.3 Treatment services, service development and lived experience organisations to continue to develop and disseminate communication tools to support communication in the multidisciplinary team, and between services (for example, structured referral and transition letters, and discharge summaries).

Standard 8

Treatment is affordable.

Priority actions

8.1 Government and health services to ensure that all public mental health services provide eating disorder services consistent with the needs of their regions.

8.2 Regional planners to ensure that there are low-cost treatment options in their region for those who require them.

8.3 Training providers and relevant professional organisations to ensure that GPs and mental health professionals are equipped to utilise the Medicare Eating Disorder Treatment and Management Plan items.

Standard 9

Treatment providers are trained and skilled for the level of treatment they provide in line with national training standards.

Priority actions

9.1 Mental health and health services to ensure treatment providers meet minimum training standards in line with the National Framework for Eating Disorders Training and relevant professional guidelines.

9.2 Eating disorder training providers to align their training with the National Framework for Eating Disorders Training and obtain approval of training for those trainings relevant to the ANZAED Eating Disorder Credential.

9.3 ANZAED to continue to provide and promote the ANZAED Eating Disorder Credential for mental health and dietetic treatment providers to help develop the workforce and improve access to, and quality of, treatment.

9.4 Eating disorder service development and lived experience organisations to develop accessible online training in eating disorder-safe principles for all staff involved in the treatment of people experiencing eating disorders and their families/supports, and work with service leaders to disseminate this training.

9.5 Relevant professional bodies[2] to provide professional development opportunities for eating disorders for their members.

9.6 Services to promote opportunities for staff to learn and enhance skills through activities such as secondments, exchange programs, coaching, mentoring and peer reflective practices, and communities of practice.

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[2] For example, Dietitians Australia, Australian Counselling Association, Australian College of Rural and Remote Medicine, Australian Association of Psychologists Inc, Occupational Therapy Australia, Australian Psychological Society, Australian Association of Social Workers, Australian Clinical Psychology Association, Royal Australian College of General Practitioners, Australian College of Mental Health Nurses, Royal Australian and New Zealand College of Psychiatrists, Psychotherapy and Counselling Federation of Australia, Australian College of Nurse Practitioners.

Treatment

Community-based

CONTEXTS | Digital interventions; public and private health and mental health services including general practice, child and adolescent/youth and adult community mental health services, headspace, Head to Health, Aboriginal Community Controlled Health Services, eating disorder-specific services.

Community-based treatment refers to evidence-based mental health treatment delivered in the community, ranging from self-help and brief interventions to longer courses of treatment, in conjunction with medical monitoring and treatment, nutritional intervention, and coordinated access to a range of services and transition support as needed.

Care can be provided face-to-face and/or via telehealth or digital interventions. Treatment utilises evidence-based treatment models matched to the person's age and developmental stage and is person-centred, considering co-occurring conditions, personal or environmental circumstances, and preferences.

Community-based treatment can be used as a step-in to treatment, or a step-down from community-based intensive treatment or hospital and residential treatment. Clinical practice guidelines recommend that in general, people experiencing eating disorders should receive treatment in an outpatient setting and in the setting that is least restrictive and best suited to the person's needs and preferences (43).

Community-based treatment should be affordable, accessible, and equitable. Treatment in the community increases the overall accessibility of treatment and supports early identification and intervention. There is evidence that early intervention can improve treatment outcomes and increase the chance of full and sustained recovery from an eating disorder (106). Community-based treatment allows people to remain connected to their community, life, family, and supports, promotes activation of personal networks and resources, and can reduce treatment costs. Community-based treatment is often the first point of contact with treatment for people experiencing an eating disorder and can reduce the need for people to access hospital care (110).

NEDC's consultations with people with lived experience and their families/supports, clinicians, researchers, and other stakeholders highlighted that there is a lack of available community-based treatment in many parts of Australia and that addressing this is key to providing an adequate system of care for people experiencing eating disorders. Many public community health and mental health services still do not provide services for people experiencing eating disorders. Treatment in the private sector is a key resource, but people report encountering barriers to access including availability, long wait lists and affordability. Increased provision of treatment in the public health system, widespread use of MBS eating disorder items, and evidence-based digital treatment interventions are all important in increasing the availability of community-based treatment.

Along with increased overall availability of community-based treatment, it is essential that community-based services providing eating disorder treatment, including private practitioners, have well established links to other components of the system of care to allow a person to step up into more intensive forms of treatment, and down to community treatment as required.

An emerging area of community-based treatment for eating disorders is the provision of early and/or brief treatment interventions. There are existing evidence-based approaches to early and brief treatment, and progress towards scaling them for various settings (106). Early and brief interventions aim to provide targeted treatment such as single session interventions, self-help, guided self-help, and manualised lower intensity treatments as soon as possible after the person presents for treatment. They can be effectively used in waitlist management (111). Early and brief interventions focus on engagement and early symptom change, psychoeducation, reinstatement of adequate nutrition, the active involvement of family and supports, and ensuring medical screening and safety. There is potential for early and brief interventions to be provided in a range of health service settings and by a diverse health workforce, and there is emerging evidence that virtual treatment may be as effective as in-person treatment (112). Eating disorder treatment services should provide early intervention pathways and early and brief treatment models, and evaluate outcomes.

Click here to hear from people with lived experience about community-based treatment

"When accessing a treatment service for the first time, there can be assumptions of pronouns and sexuality which can make the service feel unsafe. From this I've felt less willing to engage in eating disorder treatment." – Lived experience participant

Standard 1

Community-based public mental health services (including child and adolescent/youth mental health services, adult mental health services, headspace, Head to Health, Aboriginal Community Controlled Health Services) provide evidence-based treatment ranging from guided self-help and brief interventions, to longer courses of treatment as clinically indicated, for binge-eating disorder, bulimia nervosa, OSFED (excluding atypical anorexia nervosa), UFED, and sub-threshold eating disorders, and provide or refer to treatment for anorexia nervosa, atypical anorexia nervosa, ARFID, pica, and rumination disorder.

Priority actions

1.1 Government and health and mental health service leaders to endorse eating disorders as a core public health service accountability for public health services.

1.2 All community-based mental health services (including child and adolescent/youth mental health services, adult mental health services, headspace, Head to Health) to ensure sufficient staff are trained and supported to provide evidence-based treatment for binge-eating disorder, bulimia nervosa, OSFED (excluding atypical anorexia nervosa), UFED, and sub-threshold eating disorders, and to provide or refer to treatment for anorexia nervosa, atypical anorexia nervosa, ARFID, pica, and rumination disorder.

1.3 Mental health services to ensure that, at a minimum, staff providing treatment for eating disorders have completed introductory training, are trained in an evidence-based treatment model appropriate to the age group/s they are treating, and have access to ongoing supervision and organisational support.

Standard 2

Treatment services routinely offer or refer to early and brief community interventions for people with binge-eating disorder, bulimia nervosa, OSFED (excluding atypical anorexia nervosa), UFED, and sub-threshold eating disorders where clinically indicated.

Priority actions

2.1 Treatment providers to be trained and supported to provide early and/or brief interventions for people with binge-eating disorder, bulimia nervosa, OSFED (excluding atypical anorexia nervosa), UFED, and sub-threshold eating disorders where clinically indicated.

2.2 Services providing eating disorder treatment to ensure staff have capacity to offer, or refer to, early and brief interventions (online or face-to-face) such as single session interventions, guided self-help or other brief manualised interventions where clinically indicated.

2.3 Service commissioners and funders to fund early intervention pathways in treatment services.

2.4 Eating disorder service development organisations and training providers to continue to provide accessible online training to health and mental professionals to deliver self-help/guided self-help interventions, and information about the existing and emerging evidence base for these.

Standard 3

GPs and paediatricians are equipped to provide ongoing medical monitoring and treatment for people with eating disorders, in conjunction with other medical professionals as needed.

Priority actions

3.1 Eating disorder organisations and training providers to continue to provide and promote tailored and accessible online training and resources for general practitioners and other medical professionals in management of eating disorders.

3.2 Medical professional bodies to include management of eating disorders in professional development content.

3.3 Eating disorder service development organisations to map eating disorder content in medical training, and help facilitate its inclusion as part of tertiary level training for the medical workforce.

3.4 GP settings to implement organisational strategies to manage GP workload and support GP role for eating disorders, such as optimising the role of practice nurses, and supporting GP session time allocation.

Treatment

Community-based intensive

CONTEXTS | Public and private eating disorder-specific services; child and adolescent/youth and adult community mental health services.

Community-based intensive treatment refers to evidence-based mental health treatment delivered in the community, at a higher level of frequency or intensity than community-based treatment, in conjunction with medical monitoring and treatment, nutritional intervention, and coordinated access to a range of services and transition support as needed. Community-based intensive treatment can be delivered in a number of forms, including day programs, intensive outpatient programs, and community or home outreach interventions.

Community-based intensive treatment can be used as a step-in to treatment, a step-up from community-based treatment, or as a step-down from hospital and residential treatment. Community-based intensive treatment can provide increased intensity multidisciplinary care including meal support, while allowing people to remain connected to community, family and supports. It is more cost effective than inpatient treatment. There is evidence for the effectiveness of day programs for eating disorders (110, 113-115), although there is a need for further research to determine the best format and components (114, 116). There is also a need for more research comparing outcomes for different levels of care (117, 118), as well as further research and evaluation of current and innovative models of community-based intensive treatment.

Click here to hear from people with lived experience about community-based intensive treatment

“Day program meant I was able to be home with my son a lot of the time, so that was really valuable for me to still be in my ‘Mum’ role, but also having the structure and accountability of the day program.” – Lived experience participant

Standard 1

People can access a community-based intensive treatment option delivered close to home or virtually (e.g., day programs, intensive outpatient programs, outreach support).

Priority actions

1.1 Commonwealth, state/territory governments and regional planners to support additional community-based intensive treatment options, due to significant gaps for step-up and step-down treatment.

1.2 Researchers, in conjunction with service providers and people with lived experience, to co-produce further research into existing and innovative high intensity community treatment models, including models which meet the needs of underserved and higher risk groups.

Standard 2

Community-based intensive services ensure that staff are trained in line with national standards to work within their professional scope of practice and in line with the aims of the program.

Priority actions

2.1 Eating disorder service development and lived experience organisations to collaborate with services to promote existing training resources and develop new resources in areas of practice including meal support for people experiencing eating disorders.

Treatment

Hospital and residential

CONTEXTS | **Medical and psychiatric inpatient units; eating disorder-specific inpatient units; emergency departments; hospital in the home; rehabilitation units; residential eating disorder services.**

This level of treatment refers to admission to hospital for people who are at medical and/or psychiatric risk, or admission to a hospital or residential program for people who are medically stable but would benefit from a higher level of treatment and support than can be provided through community-based or community-based intensive treatment options. Hospital or residential treatment should also include coordinated access to a range of services and transition support as needed. Nutritional support and intervention are a key part of hospital and residential treatment.

Hospital treatment is used as a step-in to treatment or a step-up from community-based or community-based intensive treatment when a person is at medical and/or psychiatric risk, or a step-up when the person requires a higher level of treatment and support. Residential treatment is used as a step-up from community-based or community-based intensive treatment if the person is medically stable and requires a structured inpatient eating disorder program, or as a step-across from hospital treatment if the person is medically stable, as part of transitioning back to community care. Hospital/residential treatment is delivered by both public and private providers.

NEDC's consultations with service development organisations, people with lived experience and their families/supports, clinicians, researchers and other stakeholders provided insights about the use of inpatient treatment for eating disorders in Australia. A distinction can usefully be made between the functions of general hospital units and eating disorder-specific units.

General hospital units (medical and psychiatric) generally provide life-saving medical and/psychiatric stabilisation, crisis care and/or nutritional intervention. They do not routinely provide psychological treatment or detailed discharge planning and follow-up. Eating disorder-specific units (including hospitals and residential services, public and private) provide comprehensive medical and psychosocial assessment inclusive of families/supports, nutrition support, behavioural change and mental health support in the context of a cohort/milieu of patients.

Hospital and residential care can provide coordinated multidisciplinary assessment, essential nutritional rehabilitation, care and treatment planning, an opportunity to break entrenched eating disorder patterns, and intensify treatment to improve outcomes and increase hope for recovery.

It is important that regardless of the setting of an inpatient admission, mental health support is provided appropriate to the goals of the admission, and there is detailed discharge planning to link the person into community care.

Click here to hear from people with lived experience about hospital and residential treatment

"I've often found the step-down from inpatient care to be abrupt and difficult - continuity of care in the form of a step-down program and better coordination of a team pre-discharge may prevent or slow down the risk of relapse" – Lived experience participant

Standard 1

There is sufficient access to hospital beds and residential care to meet the medical and psychiatric needs of children and adolescents, transition age groups (16-25), adults, and older adults.

Priority actions

1.1 State and territory governments to map the need for inpatient care for people across age groups and provide greater access to beds as required.

1.2 State and territory governments to set out the roles of dedicated eating disorder beds, and general psychiatric and medical beds in their jurisdiction.

1.3 State and territory governments to commission and implement state/territory-wide consistent clinical guidelines for admissions and inpatient care.

1.4 Private hospitals to scope capacity to offer additional beds, including the viability of public/private partnerships.

Standard 2

All emergency departments are able to assess and provide medical and psychiatric stabilisation in accordance with national and state/territory clinical guidelines, and refer to an appropriate level of care, including inpatient admission as required.

Priority actions

2.1 State and territory governments to provide funding and accountabilities for eating disorder-specific tertiary services to provide leadership, consultation, and clinical support to emergency departments in the surrounding system of care.

2.2 Eating disorder service development organisations, and training providers, in partnership with relevant professional bodies, to develop and disseminate tailored training for emergency departments in eating disorder identification, psychiatric and medical risk assessment, medical and psychiatric stabilisation, preliminary diagnosis and referral.

2.3 Eating disorder-specific services and/or local mental health services to provide clinical consultation and referral support to emergency departments and to consultation/liaison hospital staff.

Standard 3

All public hospitals have capacity to provide medical and psychiatric inpatient care for eating disorders, or have established and documented pathways for timely referral.

Priority actions

3.1 Public hospitals to ensure workforces are trained to provide medical and psychiatric inpatient care for eating disorders according to scope of role.

3.2 State and territory governments to support eating disorder-specific tertiary services to provide leadership, consultation and clinical support to public hospitals in the surrounding system of care.

Standard 4

Regardless of setting of inpatient admission (e.g., medical ward), mental health support is provided appropriate to the goals of the admission.

Priority actions

4.1 Hospital and residential services to ensure that training on eating disorder-safe principles and meal support is made available to all staff involved with eating disorder admissions.

4.2 Eating disorder service development organisations and training providers to develop and disseminate training in eating disorder-safe principles, identification, initial response and referral for hospital consultation/liaison psychiatry staff.

4.3 Hospital and residential services to ensure workforces are trained and supported to provide evidence-based acute/high-intensity care for people experiencing eating disorders.

Standard 5

People are supported to move between inpatient and community treatment services (both public and private) with supported pathways, service collaboration, and clear, timely communication including discharge planning.

Priority actions

5.1 Eating disorder-specific public and private inpatient settings to provide accessible information to the public about programs, criteria for admission and admission pathways.

5.2 Inpatient services to provide clear communication to the person and family/supports about the goals and progress of admission, develop a detailed discharge plan with the person and their family/supports, and provide this plan to the person, their family/supports and the community treatment team.

5.3 Inpatient services to communicate with community treatment providers about the goals and progress of admission and provide a detailed discharge plan.

Psychosocial and Recovery Support

CONTEXTS | **Community and social services; health and mental health services including primary care, headspace, Head to Health; lived experience organisations; peer support services; helplines and digital resources.**

Psychosocial support refers to services and programs which support the broader psychological and social needs of the person experiencing or at risk of an eating disorder and their family/supports and community. Recovery support refers to services and programs which support a person experiencing an eating disorder to engage with or sustain recovery or improved quality of life and assist family/supports and community in their caring role.

Providing psychosocial support for a person's broader psychological and social needs can impact positively on recovery, and vice versa. As such, the terms psychosocial and recovery support are used together in this section. Where the term recovery is used, it is acknowledged that there is no singular or consensus definition of recovery, and that the concept should be defined by each person in a way that reflects their own personal goals and cultural worldviews. For many people, recovery from an eating disorder signifies an end to eating disorder thoughts, feelings and behaviours, and improved physical and psychological wellbeing. This may mean engaging or re-engaging with social activities, hobbies, and daily life. For others, recovery may be an ongoing process of moving towards or maintaining a personally defined state of wellbeing or quality of life.

People experiencing eating disorders and their families/supports and communities may engage in a range of psychosocial and recovery support services and programs across the system of care, at different stages of their journey. These services and programs are generally delivered by community-based organisations, with funding from the Commonwealth and state and territory governments, as well as through lived experience organisations and the peer support workforce (a part of the Lived Experience workforce).

Psychosocial support services and programs can provide assistance with daily activities, help people to rebuild or maintain social connections, participate in education and employment, and support people to obtain financial, housing and other supports as needed. The experience of an eating disorder, or of supporting someone with eating disorder, can cause major disruptions across many parts of life (7-11). As such, psychosocial support services and programs can provide valuable assistance to people experiencing an eating disorder and their families/supports and communities, helping them to manage the impacts of the eating disorder and maintain or improve overall wellbeing.

Recovery support services and programs can help to foster hope for recovery, reduce risk of relapse, and support people to continue to engage in recovery when moving between levels of care. They can also provide harm minimisation support. For families/supports and communities, recovery services and programs can empower them to better understand eating disorders and how to support their loved one. Recovery support services and programs are often provided by lived experience organisations, who have an important role in connecting directly with and supporting people with lived experience and their families/supports and communities across all stages of their journey through the system of care.

Peer support work is a form of psychosocial and recovery support that involves connecting with others who have had similar experiences or challenges. Peer support work can take many different forms, including one-on-one conversations, support groups, and online forums. It can be delivered by people with lived experience of an eating disorder to people experiencing an eating disorder, or by people with lived experience of caring for someone with an eating disorder to other people in a caring role. Peer support work can foster a sense of community and belonging and can support people to practice recovery skills. There is an increasing evidence base for the efficacy of peer support work (119, 120), although further research, data collection and evaluation are necessary to continue to build this evidence base.

National Strategy consultations highlighted that the accessibility of psychosocial and recovery support to people experiencing or at risk of eating disorders and their families/supports is hampered by a lack of integration between psychosocial and recovery support services and clinical/treatment services, a lack of recognition or understanding of the types and value of psychosocial and recovery support, and a lack of eating disorders knowledge among the broader (non-eating disorder specific) psychosocial workforce.

Learning from lived experience

Lived experience participants from the National Strategy public survey and focus groups highlighted the importance of embedding recovery and psychosocial support that addresses the needs and goals of the person and their family/supports across the system of care. Many participants described peer support (such as through online groups or individual sessions) as a valuable source of understanding and practical support that fosters a sense of community and hope for the person and their family/supports. Participants highlighted that psychosocial and recovery support services can play an important role in supporting people to transition down from higher levels of care. People called for wider recognition across the system of care that recovery is different for everyone and is non-linear. Some participants highlighted that people not pursuing recovery should be supported to access harm minimisation services and other services to support their broader psychosocial needs. Loss of income and disconnection from education/employment, community and family were also described as areas which psychosocial support could help to address.

Click here to hear from people with lived experience about psychosocial and recovery support

“I think one of the biggest things that I’ve felt has made a difference to my journey is community-based support groups…. really being able to talk with other people who know what you’re going through…” – Lived experience participant

Standard 1

People experiencing eating disorders and their families/supports have access to psychosocial and recovery support services and programs, according to their needs.

Priority actions

1.1 Clinical services to provide information about available psychosocial and recovery support services and programs to people experiencing eating disorders and their families/supports, and facilitate connection to these services and programs as required.

1.2 Clinical services to include psychosocial and recovery support providers in the multidisciplinary care team where appropriate.

1.3 Eating disorder sector and government to investigate mechanisms for provision of psychosocial and recovery support (including through the National Disability Insurance Scheme) for people experiencing longstanding eating disorders.

1.4 Psychosocial and recovery service providers to ensure that programs and services are available for people experiencing eating disorders and their families/supports.

1.5 State/territory and regional planners to consider availability of psychosocial and recovery supports when conducting service planning.

1.6 Providers of referral databases and practice guidelines to include psychosocial and recovery support interventions.

Standard 2

Staff providing psychosocial and recovery support services and programs have understanding about eating disorders appropriate to their role and context.

Priority actions

2.1 Eating disorder service development organisations and lived experience organisations to collaborate with psychosocial and recovery support services to develop accessible online training in eating disorder-safe principles and practice, and eating disorders information and skills tailored for psychosocial and recovery support service settings.

2.2 Eating disorder service development organisations and training providers to collaborate with psychosocial and recovery support services to promote and disseminate online training in eating-disorder safe principles and practice via tertiary and vocational education settings and psychosocial and recovery support service settings.

2.3 Eating disorder sector to develop competencies and training guidelines for eating disorder peer support workers.

Standard 3

The evidence base for the efficacy of psychosocial and recovery support services and programs is further developed.

Priority actions

3.1 Services providing psychosocial and recovery support to ensure that services/programs are evaluated.

3.2 Researchers, people with lived experience and services to design, implement and evaluate innovative and effective psychosocial and recovery support interventions for eating disorders, including for underserved and higher risk groups.

3.3 Researchers and services to disseminate findings and support knowledge translation.

Workforce

There is a need for a workforce of adequate size, skill, and diversity positioned across the system of care to meet the needs of all people at risk of or experiencing an eating disorder and their families/supports and communities. Data-driven, strategic, and coordinated workforce development will enable this to happen.

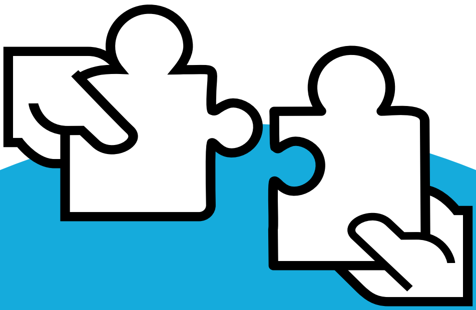
Considerable reform work is being undertaken to build the health and mental health workforces across Australia at state and national levels, in the context of major workforce shortages. This reform includes the National Lived Experience Workforce Development Guidelines (30) and the forthcoming National Mental Health Workforce Strategy (28), as well as state/territory workforce strategies. The workforce standards and actions in this National Strategy are aligned with these broader workforce initiatives and complement them by focusing on eating disorder-specific workforce issues.

Historically the eating disorders workforce has been understood as a small number of medical, mental health and dietetic professionals with a highly specific skillset, working mostly within eating disorder-specific services across public health and private practice, along with researchers whose work is dedicated to the field. It has become apparent that this workforce, though essential, will not be sufficient in size, diversity or positioning in the system of care at the scale required. A significant expansion of the eating disorder workforce is needed. The development of workforce competencies, standards and training and supervision infrastructure within the eating disorder sector over recent years means that the workforce can be built in an efficient and targeted way, based on the knowledge of the particular skills that need to be embedded in each part of the workforce across the system of care.

An important workforce growth opportunity is the expansion of the Lived Experience workforce for eating disorders. Recognition of the importance of the Lived Experience workforce in the mental health sector has grown significantly over the past five to ten years, including national investment to support those with lived experience of mental health challenges to shape the policies and programs that affect them. The Lived Experience workforce comprises people employed in paid positions that require lived experience as an essential employment criterion, regardless of position type or setting (30). This can include personal lived experience of mental health challenges, or experience of supporting someone through mental health challenges. The Lived Experience workforce includes a broad range of roles, including (but not limited to) consumer or carer consultants, peer support workers, executive governance, paid board and committee representation, education, training, research, consultancy, policy design, and advocacy in service settings (30). In these roles,the Lived Experience Workforce contributes to personal change and recovery, as well as cultural and practice change within services (30).

Eating disorder lived experience organisations, service development organisations and services are increasingly employing Lived Experience workers in leadership, training, education, service design and evaluation roles across all elements of the stepped system of care for eating disorders. Peer support work is increasingly being integrated into service settings as part of multidisciplinary teams. The development of policies and guidelines for eating disorder Lived Experience work, and increased recognition of the value of the Lived Experience Workforce within eating disorder services and as part of care teams will strengthen the workforce as a whole.

To build the skill, size and diversity of the health, mental health, and education, social and community services workforces to meet the needs of people experiencing eating disorders into the future, and to implement the standards and actions within the National Strategy, comprehensive and coordinated action at national and state/territory levels is required. Any local to large-scale action that intends to build skills in the workforce must also consider building organisational readiness through culture change and the development of policy and procedures, strategies for attracting new workers, strategies for supporting and retaining workers, and the provision of opportunities for diverse and rewarding career progression.



Learning from lived experience

Lived experience participants from the National Strategy public survey and focus groups called for an expansion of the workforce to address service and system-related issues (e.g., long waitlists, insufficient services to meet demand, poor accessibility in rural and remote areas). Some people noted the availability of an eating disorder-specific and highly dedicated workforce, however also indicated that access to this workforce is inequitable. People highlighted the need for additional training and support for specific professional groups with a key role in the system of care (e.g., GPs, education staff).

Click here to hear from people with lived experience about the workforce

“Well, our experience... [it] was hard to find a GP with expertise in this area... When we found someone with expertise... they were brilliant, but there is not enough of them.”
– Lived experience participant

Standard 1

Engagement in eating disorder practice by the current and future health and mental health workforce is increased and barriers are reduced.

Priority actions

1.1 Eating disorder service development organisations to work with tertiary and vocational health/mental health education providers to map and increase eating disorder content in undergraduate and postgraduate courses.

1.2 Eating disorder service development organisations, lived experience organisations, and researchers, to work to reduce barriers, including stereotypes and stigma around eating disorder professional practice.

1.3 Eating disorder services to partner with tertiary and vocational health/mental health education institutions and industry to co-design student skill development pathways such as eating disorder placement networks and early intervention student clinic hubs.

1.4 Tertiary and vocational health/mental health education providers and rural/remote eating disorder service providers to partner to develop and incentivise eating disorder placements in rural/remote settings.

1.5 National and state/territory eating disorder service development organisations and lived experience organisations to collaborate to increase national coordination and promotion of training and professional development opportunities (online and face-to-face) and ensure coverage across the different professions.

1.6 Eating disorder service development and lived experience organisations to promote eating disorder sector engagement with broader mental health sector training and professional development opportunities (including trauma-informed care, culturally safe practice, transdiagnostic approaches, co-occurring conditions).

Standard 2

Eating disorders are a workforce priority in mainstream health and mental health services.

Priority actions

2.1 Government and health and mental health service leaders to endorse eating disorders as a core service accountability and workforce planning priority for public health and mental health services.

2.2 Health and mental health services to routinely include consideration of eating disorder-specific skills in workforce planning to match the scope of the service.

2.3 Health and mental health services to ensure sufficient eating disorder expertise for their team to meet the needs of people presenting with eating disorders.

2.4 Health and mental health services to ensure that data and needs assessments underpin workforce planning and development for eating disorders and that outcome data is utilised and disseminated to drive ongoing continuous quality improvement and innovation.

2.5 Health and mental health services to support clinicians to access eating disorder professional development and training, supervision, and opportunities to practice.

Standard 3

There is a skilled and diverse Lived Experience workforce operating across the system of care, including in governance, leadership, consultation, and direct care roles.

Priority actions

3.1 Organisational and service leaders to endorse and build organisational readiness to support the leadership and work of eating disorder Lived Experience workers within their organisation/service, recognising Lived Experience workers as integral partners in the system of care.

3.2 Eating disorder lived experience organisations and eating disorder service development organisations to develop standards, competencies, and training frameworks for the eating disorder Lived Experience workforce, building on existing work within the eating disorder sector and the broader mental health sector.

3.3 Organisations/services to ensure that eating disorder Lived Experience leaders and workers have clear role descriptions, policies, and procedures to support their work, and access to supervision, training, and professional development opportunities commensurate with their areas of skill, expertise and experience.

3.4 Eating disorder lived experience organisations and service development organisations to develop practical guidelines and training to upskill the broader mental health Lived Experience workforce in eating disorder awareness.

3.5 Organisations/services to pay eating disorder Lived Experience workers according to appropriate award structures.

Standard 4

The education, social and community services workforces are skilled and knowledgeable about eating disorders appropriate to role and function within the system of care.

Priority actions

4.1 Eating disorder service development and lived experience organisations to partner with the education, social and community services sector to develop and disseminate training and supporting resources in eating disorder-safe principles, and support their implementation.

4.2 Eating disorder service development and lived experience organisations to provide professional development opportunities to the education, social and community services sector.

SECTION 4

Strategy progress indicators

Strategy progress indicators

Example high-level progress indicators, which can be used to develop specific outcome measures (both qualitative and quantitative) and help evaluate progress towards the standards and actions are outlined below.

A more detailed evaluation resource is available here.

Prevention

- Population-level disordered eating rates are reduced.
- Population-level body dissatisfaction is reduced.
- Population-level eating disorder rates are reduced.
- Experience and impacts of weight stigma and associated health care inequity are reduced.
- Levels of knowledge about eating disorders in the general population are improved.
- Body acceptance and positive relationships with food and eating are increased.

Identification

- A higher proportion of eating disorders are identified.
- Eating disorders are identified earlier in illness or sub-threshold illness.
- People report improved help-seeking experiences.

Initial Response

- There is increased availability of initial eating disorder assessment and referral in health and mental health services.
- The time between identification and initial response is reduced.

Treatment

- Eating disorder recovery outcomes are improved.
- The time between initial response and treatment commencement is reduced.
- Access to short term evidence-based interventions is increased.
- Increased number of people receive care in the community.
- People with an eating disorder report a ‘no wrong door’ experience to treatment-seeking and service navigation.
- Hospital admission and readmission rates are reduced.
- More people receive care for their eating disorder within public mental health settings.

Psychosocial and Recovery Support

- Psychosocial support services and programs provide more services for people experiencing eating disorders.
- People can access recovery support services during the recovery journey.

Workforce

- There is increased availability of a skilled and diverse workforce across the system of care.
- The workforce is confident and willing to provide care to people experiencing or at risk of eating disorders.

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Glossary

Key terms used within the National Strategy are defined below. While many of the terms below have broader usage, they have been defined in relation to eating disorders.

Body image	Body image involves the thoughts, feelings and actions that relate to an individual's experience of their body. Body image experiences and thoughts can range between positive and negative. Body image is influenced by internal and external factors. Body dissatisfaction occurs when a person has persistent negative thoughts and feelings about their body and can drive people to engage in unhealthy weight-control behaviours, particularly disordered eating. This places them at increased risk of developing an eating disorder.
Co-occurring conditions	The occurrence of more than one disorder at the same time. A person with an eating disorder is at increased risk of experiencing another mental health or medical condition at the same time. Examples of common co-occurring conditions experienced by people with eating disorders include mood disorders, anxiety disorders, post-traumatic stress disorder, substance use, type 1 and type 2 diabetes, and gastrointestinal disorders (5).
Disordered eating	Disordered eating sits on a spectrum between normal eating and an eating disorder and may include symptoms and behaviours of eating disorders, but at a lesser frequency or lower level of severity. Disordered eating may include restrictive eating, compulsive eating, and/or irregular or inflexible eating patterns. Disordered eating behaviours are a risk factor for development of an eating disorder.
Eating disorder lived experience organisations	Organisations that advocate for, educate, support, and provide evidence-based information about eating disorders to people with lived experience and their families/supports, as well as to the broader community. Some eating disorder lived experience organisations also provide clinical services and/or conduct service development activities. For more information about eating disorder lived experience organisations, click here.
Eating disorder service development organisations	Organisations that focus on upskilling health professionals and services, and/or developing policy to guide health services and policymakers to plan for and effectively respond to eating disorders. Some eating disorder service development organisations also provide clinical services and/or conduct lived experience activities. For more information about eating disorder service development organisations, click here.

Evidence-based	Programs, interventions or treatment models for which there is rigorous scientific research to demonstrate effectiveness. It is important to note that eating disorders research has historically focused on experiences and outcomes for white, cisgender females. While studies reporting on experiences and outcomes for broader demographic groups have increased in recent years, more research is needed for underserved and higher risk populations (such as Aboriginal and Torres Strait Islander peoples, LGBTQI+ people, neurodivergent people). It is important to note that some evidence, particularly for Aboriginal and Torres Strait Islander peoples, may be outside of the formal academic literature, existing in non-Western systems of knowledge and expertise. Limitations of the current evidence base for underserved and higher risk population groups should be recognised, and co-produced research should be conducted to increase the evidence base for these groups.
Evidence-based practice	The integration of research evidence, clinical expertise, and patient values and perspectives, to inform care (105).
Family/supports and community	A person/people providing care and support to someone experiencing an eating disorder. This may be a family member/s (e.g. parent, child, partner, grandparent), or chosen supports such as a friend or community member. The importance of extended family and community networks for Aboriginal and Torres Strait Islander peoples should be recognised (121).
Identification	The detection of warning signs or symptoms, and engagement with the person who may be experiencing an eating disorder, to support access to an initial response. In some instances, warning signs or symptoms may be self-identified, and the person may seek out an initial response themselves.
Initial response	Comprises an initial assessment and preliminary diagnosis, and referral to the most appropriate treatment options based on the person's psychological, physical, nutritional, and psychosocial needs. This may include facilitating access to an appropriate intervention for a person experiencing sub-threshold eating/body image concerns. An initial response should also provide psychoeducation, support the person to engage with treatment, and encourage the involvement of the person's family/supports and community.
Lived experience of an eating disorder or disordered eating or body image concerns	A person who has previously or is currently experiencing an eating disorder (diagnosed or undiagnosed) or disordered eating or body image concerns.
Lived experience of caring for someone experiencing an eating disorder	A person who has previously or is currently caring for a person with an eating disorder.

Lived Experience workforce	The Lived Experience workforce comprises people employed in paid positions that require lived experience as an essential employment criterion, regardless of position type or setting. This can include personal lived experience of mental health challenges, or experience of supporting someone through mental health challenges. The Lived Experience workforce includes a broad range of roles, including (but not limited to) consumer or carer consultants, peer support workers, executive governance, paid board and committee representation, education, training, research, consultancy, policy design, and advocacy in service settings. Lived Experience is capitalised when referring to the Lived Experience workforce to distinguish between having personal lived experience and working in a professional Lived Experience role (30).
Local Hospital Networks	Separate legal entities established by each Australian state/territory government in order to devolve operational management for public hospitals, and accountability for local service delivery, to the local level. Some jurisdictions have their own local names for the areas and administrative units known nationally as Local Hospital Networks (for example, 'Local Health Districts' in New South Wales and 'Hospital and Health Services' in Queensland) (122).
Longstanding eating disorder	The term 'longstanding eating disorder' is not a diagnostic term and does not have a consensus definition. Longstanding eating disorders are sometimes referred to as 'severe and enduring eating disorders'. Again, this is not a diagnostic term and there is no consensus definition, although criteria have been suggested (123-125). NEDC has chosen to use the term 'longstanding eating disorder' as recent studies have highlighted a preference among people with lived experience for the term 'longstanding eating disorder' over the term 'severe and enduring eating disorder', which can engender a sense of hopelessness (126, 127). However, further research into preferred terminology is needed.
Mental health professional	A mental health professional is an umbrella term for those professions that can provide psychological support and evidence-based psychological treatment for people experiencing an eating disorder, including psychologists, social workers, occupational therapists, psychiatrists, counsellors, mental health nurses, nurse practitioners, and psychotherapists (13).
Prevention	Actions, programs, or policies that aim to reduce modifiable risk factors for eating disorders, and/or bolster protective factors, to reduce the likelihood that a person will experience an eating disorder. Eating disorder prevention actions, programs or policies may also seek to address the broader factors which impact on health, known as the social determinants of health.
Primary Health Networks	Independent organisations funded by the Australian government which assess the health care needs of people within their local region, commission services to address these gaps, and improve coordination of services (128).

Public sector health and mental health services	Publicly funded and managed services providing health or mental health services.
Psychosocial and recovery support	Psychosocial support refers to services and programs which support the broader psychological and social needs of the person experiencing or at risk of an eating disorder and their family/supports and community. Recovery support refers to services and programs which support a person experiencing an eating disorder to engage with or sustain recovery or improved quality of life and assist family/supports and community in their caring role.
Recovery	There is no singular or consensus definition of recovery, and the concept should be defined by each person in a way that reflects their own personal goals and cultural worldviews. For many people, recovery from an eating disorder signifies an end to eating disorder thoughts, feelings and behaviours, and improved physical and psychological wellbeing. This may mean engaging or re-engaging with social activities, hobbies, and daily life. For others, recovery may be an ongoing process of moving towards or maintaining a personally defined state of wellbeing or quality of life.
Stepped system of care for eating disorders	The stepped system of care for eating disorders refers to a full continuum of coordinated, evidence-based services, which are matched to a person's needs, and increase or decrease in intensity according to the person's changing psychological, physical, nutritional, and psychosocial needs. Progression along the continuum is not linear, and a person may require recurrent episodes of treatment, at different levels in the stepped system of care and from different services providers.
Treatment	Eating disorder treatment refers to the provision of evidence-based mental health treatment, in conjunction with medical monitoring and treatment, along with access to nutritional intervention and other services as needed. Treatment should be tailored to the person's individual needs and delivered using an evidence-based practice approach, which combines best research evidence, patient values and perspectives, and clinical expertise.

List of abbreviations

AEDRTC	Australian Eating Disorders Research and Translation Centre
ANZAED	Australia and New Zealand Academy for Eating Disorders
ARFID	Avoidant/restrictive food intake disorder
CAMHS	Child and Adolescent Mental Health Service
CEED	Victorian Centre of Excellence in Eating Disorders
CYMHS EDP	Child and Youth Mental Health Service, Eating Disorders Program
EDFA	Eating Disorders Families Australia
EDNA	Eating Disorders Neurodiversity Australia
EDQ	Eating Disorders Queensland
EDV	Eating Disorders Victoria
GP	General practitioner
MBS	Medicare Benefits Schedule
NEDC	National Eating Disorders Collaboration
OSFED	Other specified feeding or eating disorder
QuEDS	Queensland Eating Disorder Service
SCHN	Sydney Children's Hospital Network
UFED	Unspecified feeding or eating disorder
WAEDOCS	WA Eating Disorders Outreach and Consultation Service

Appendix

Working Groups

The Working Groups contributed to the development and refinement of key concepts and specific content sections within the National Strategy.

Prevention Working Group

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Psychosocial and Recovery Support Working Group

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Lived Experience Workforce Advisory Group

(a sub-group of the Workforce Working Group)

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Table A1. Eating disorder risk factors* (54, 129–133)

	Biological	Psychological and behavioural	Social and environmental
Evidence that these risk factors are causal and modifiable, and therefore targets for prevention	Weight loss, deliberate or otherwise	Body dissatisfaction and over-valuation of weight and shape	Exposure to social norms regarding body and appearance ideals
		Drive for thinness or muscularity	Exposure to pro-eating disorder online content
		Dietary restriction or dieting	Bullying and/or weight-related teasing
		Low self-esteem and feelings of inadequacy	Attachment difficulties
		Co-occurring mental health conditions, e.g., anxiety, depression, obsessive compulsive disorder	Parental dietary restriction or family dieting
		Stress	Parental attitudes to weight/shape
		Substance use disorders	Involvement in elite sport or activities promoting lean body type
Evidence that these risk factors are correlational, and should be considered in prevention initiatives	Early development	Personality traits, e.g., perfectionism, neuroticism, obsessionality, compulsivity, impulsivity, avoidance motivation, introversion, self-directedness, goal-orientation	Weight stigma
	Gut microbial		Unemployment, underemployment, socioeconomic disadvantage and food insecurity (current or historical)
	Age, i.e. greatest risk of onset is during adolescence		
	Early pubertal timing (females) or late onset puberty (males)	Heightened sensitivity to or difficulty coping with negative evaluations	Minority status and minority stress (racial, cultural, sexual, gender, ability)
	Gender, including gender diversity		Gender roles
	Health conditions which lead to a focus on weight or food intake, e.g., diabetes, polycystic ovarian syndrome, coeliac disease	Neurodivergence, e.g., Autism, ADHD, giftedness, Intellectual Disability, Tourette's Syndrome	Transitions, e.g., change of school, end of relationship, becoming a parent, menopause
	Auto-immune disease	Trauma history	Childhood adversity and family disruption
	Pregnancy and post-partum		Family history of eating disorder
Non-modifiable risk factors	Genetics		

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* People will have different levels of exposure to these risk factors, in addition to broader mental health risk factors. Risk factors which impact on Aboriginal and Torres Strait Islander social and emotional wellbeing include factors such as: interruptions to traditional food systems; racism; trauma; absence of family members; disconnection from community; services that are not culturally safe; restrictions on access to country; and lack of connection to the spiritual dimension of life (122). For further examples of risk factors which impact on social and emotional wellbeing, refer to p.8 of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing (121).

Table A2. Eating disorder protective factors* (134–138)

	Biological	Psychological and behavioural	Social and environmental
Evidence that these protective factors are modifiable, and therefore targets for prevention	Bodily attunement (i.e., awareness of bodily needs)	Positive body image	Positive family connectedness
		Positive self-image	Regular, positive family meals
		High self-esteem	Positive familial attitudes to body diversity
		Multi-faceted self-concept	Low family influence to lose/manage weight
		Self-compassion	Exposure to feminist influences/ critical social perspectives
		Body acceptance/appreciation	Self-perceived rejection of appearance ideals
	The experience of body functionality	Self-perceived rejection of appearance ideals	Weight-inclusive approaches (e.g., to healthcare)
		Media literacy	Access to social, emotional and tangible support
		Appreciation of body diversity	Involvement in sport
		Mindfulness regarding food and body related distress	Food security
		Positive self-talk	
Non-modifiable protective factors			High maternal BMI in childhood
			Being part of a large full-sibling group

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* People will have different levels of exposure to these protective factors, in addition to broader mental health protective factors. Protective factors for Aboriginal and Torres Strait Islander social and emotional wellbeing include factors such as: connection to body (e.g., through access to culturally safe, culturally competent and effective health services and professionals); connection to mind and emotions (e.g., strong identity); connection to family and kinship (e.g., culturally appropriate family-focused programs and services); connection to community (e.g., support networks); connection to culture (e.g., cultural involvement and participation); connection to country (e.g., time spent on country); and connection to spirituality and ancestors (e.g., contemporary expressions of spirituality) (122). For further examples of protective factors related to social and emotional wellbeing, refer to p.8 of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing (121).

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