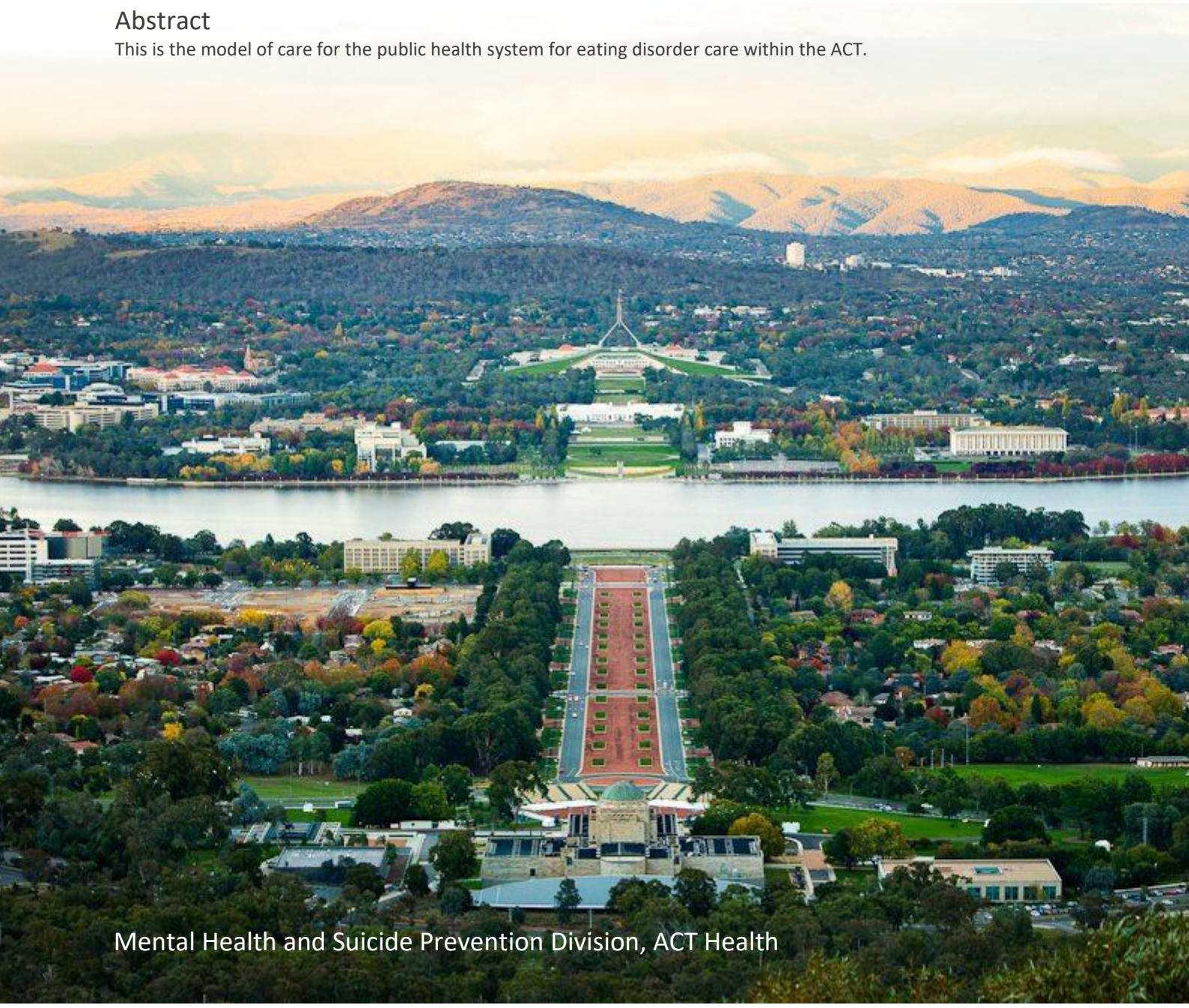
ACT Government | ACT Health

Territory-wide Model of Care for Eating Disorders

VERSION 1.0

Abstract

This is the model of care for the public health system for eating disorder care within the ACT.



Mental Health and Suicide Prevention Division, ACT Health

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Approvals

Position	Name	Signature	Date
EPHSED Project Steering Committee	EPHSED Project Steering Committee	N/A	08/12/2022

Document version history

Version	Issue date	Issued by	Issued to	Reason for issue
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Foreword

Eating disorders are serious illnesses that cause high levels of psychological distress for people who experience them. A person with eating disorders has increased risks of developing long term mental and physical illnesses, an increased risk of premature death due to medical complications and an increased risk of suicide. Eating disorders can occur at any stage of life, although the incidence peaks nationally between the ages of 12 and25[1].

A 2012 report commissioned by the Butterfly Foundation, *Paying the Price: the economic and social impact of eating disorders in Australia* (Paying the Price), suggests that around 4% of the Australian population is affected by eating disorders at a clinical level[1].

The treatment and care of people with eating disorders usually involves multi-disciplinary input from different health practitioners and services. Timely access to care and engagement with treatment can be impacted by the complexity of this care. Gaps in the system and difficulties navigating it may also result in disjointed care for people and delays in accessing care.

The ACT Government is committed to improving eating disorder services in the ACT across the full spectrum of care, to provide the best treatment and care for people with eating disorders when they need it, where they need it. As part of this commitment, in October 2018 the ACT Government released the *Position Statement on Eating Disorders*[2].

The Position Statement outlines guiding principles for the ACT Government's commitment to strengthen the eating disorders services system and provides an overview of how the ACT Government could work towards this.

The Position Statement led to a successful budget bid submission from which the Expanding Public Health Services for Eating Disorders (EPHSED) in the Territory project began. The development of the Territory-wide Model of Care for Eating Disorders (TwMoC) is a key deliverable under this project.

This TwMoC document outlines the guiding principles for the ACT Government's commitment to strengthening the eating disorders services system and provides an overview of the integrated, stepped model of care for all public eating disorder services in the ACT.

1 Butterfly Foundation, 2012. Paying the price: the economic and social impact of eating disorders in Australia, Butterfly Foundation, Melbourne.

2 ACT Health Directorate, 2018, ACT Eating Disorders Position Statement, ACT Government, ACT

Acknowledgements

The TwMoC has been developed by ACT Health in consultation with other ACT government directorates, non-government organisations, community members and clinicians across the ACT. ACT Health acknowledges that this work has been completed over a significant period, and would like to recognise and thank the following stakeholders for their contributions to this work:

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Introduction

Model of Care

A Model of Care (MoC) is an evidence-based framework describing the right care, at the right time, by the right person or team and in the right location across the continuum of care[3]. A clearly defined and articulated MoC helps ensure that all health professionals are 'viewing the same picture,' working towards common goals and, most importantly, evaluating performance on an agreed basis[4].

A MoC can vary in its area of focus and can be developed for an event (e.g., injury, procedure), a condition or disease grouping (e.g., diabetes, renal) or a population group or subgroup (e.g., children and young people). A MoC:

- outlines the aims, principles and elements of care
- provides the basis for how we deliver evidence-based care to every patient, every day through integrated clinical practice, education, and research
- contains information of patient flows (the areas from where patients enter and exit the service) and service co-ordination (the linkages required for seamless patient treatment).

Models of care are dynamic and can be changed over time to support new evidence and more efficient ways of working. Implementation and evaluation of the model, along with the required change management are essential[5].

Eating disorders

Eating disorders are a group of mental illnesses that can have significant impacts on the physical, psychological and social wellbeing of individuals and families affected. Children and adolescents with eating disorders can experience interrupted physical, educational and social development and are at a long-term risk of significant medical complications[6] and mental health issues.

The mortality rate for people with eating disorders is significantly higher than that of the average population, and among the highest for all mental illnesses. Eating disorders also have very high rates of comorbidity, including higher rates of anxiety disorders, cardiovascular disease, chronic fatigue, depressive disorders and suicide attempts[7].

3 Dept of Health, *Clinical Services Framework 2010 – 2020*, Govt of WA, 2009, p.5.

4 P. Davidson, E. Halcomb, L. Hickman, J. Phillips, and B. Graham, 'Beyond the Rhetoric: What do we mean by a Model of Care,' *Australian Journal of Advanced Nursing,* vol.23, No.3, 2006, p.49.

5 Agency for Clinical Innovation, 'Understanding the process to develop a Model of Care,' vol. 1.0, Chatswood (NSW), May 2013, p.3.

6 National Eating Disorder Collaboration, 2012. National Eating Disorders Framework: an integrated response to complexity, NEDC, Sydney

7 National Eating Disorder Collaboration, 2012. National Eating Disorders Framework: an integrated response to complexity, NEDC, Sydney

These diseases cause distress, anxiety and burden to sufferers, their family, carers, partners and friends. The Paying the Price[8] report by the Butterfly Foundation summarises the personal costs of eating disorders to individuals, their families and support networks. In addition to the large personal costs, the report also highlights significant lost productivity incurred through premature death and an impaired ability to work.

Misconceptions about eating disorders

Eating disorders are often poorly understood and underestimated. This includes beliefs that eating disorders are the results of vanity, dieting attempts gone wrong, a cry for attention or a 'phase'[9].

Eating disorders are commonly seen as only affecting adolescent girls, although they can develop at any age and affect a person of any gender and cultural background. Contrary to these beliefs, population studies suggest that up to a quarter of people suffering with anorexia nervosa and bulimia nervosa are male, although this is expected to be under-representative of the true number because of the negative stigma associated with eating disorders in males[10].

These misconceptions can affect the responses and explanations that people with eating disorders receive when they present for help from general practitioners and health care professionals. This can lead to a failure to recognise and treat eating disorders, and cause distress and withdrawal for individuals who need help.

Navigating the system and gaps in service

Across Australia and overseas, there are gaps in the range of services for people with eating disorders and regional differences in access to and delivery of services. Particularly between urban and rural areas, and between patients accessing private versus public services.

Additionally, the needs of children and adolescents differ from those of adults and the transition of care between age sectors is a period of high risk.

The integration of medical, mental health and allied health interventions also remains underdeveloped. A lack of clarity about which clinical system should be primarily responsible can lead to an absence of clinical leadership, poorly developed care pathways and inadequate coordination of care[11].

8 Butterfly Foundation, 2012. Paying the price: the economic and social impact of eating disorders in Australia, Butterfly Foundation, Melbourne.

9 Headspace, 2014. MythBuster: eating disorders. Available at: https://headspace.org.au/assets/Uploads/OR19863-MythbusterEatingDisorder-2017WEB.pdf

10 National Eating Disorder Collaboration, Who is affected? Available at: https://www.nedc.com.au/eating-disorders/eating-disordersexplained/something/who-is-affected/

11 NSW Ministry of Health, (2013). NSW Service Plan for People with Eating Disorders 2013-2018. Available at: http://www.health.nsw.gov.au/mentalhealth/publications/Publications/service-plan-eating-disorders-2013-2018.pdf

Complexity calls for a dedicated focus

People with eating disorders often present with varying symptoms, which can have fluctuations in severity, acuity, complexity and risk. Despite this complexity, there are evidence-based models of care that are available to help people recover from an eating disorder.

Evidence and expert consensus support access to a multidisciplinary approach to medical, dietetic and psychological interventions to maximise the chances of a full recovery.

Recovery is possible

Most people with an eating disorder who receive this type of multidisciplinary treatment, delivered in a timely approach and with personal commitment, can make a full recovery. However, this process can be challenging and may require prolonged treatment and engagement.

The provision of care over long periods is needed for recovery. Prolonged care can maintain or minimise the decline in physical and psychosocial functioning and contain escalation and demand on non-specialist parts of the health system.

Evidence shows that the sooner treatment for an eating disorder is started, the shorter the recovery process will be. Delays in diagnosis and access to care can prolong the illness and make it worse.

Seeking help at the first warning sign is more effective than waiting until the illness is established[12]. Early identification and prompt responses to eating disorders must be a priority to reduce the duration of untreated illness and improve the chances of recovery.

Practitioner knowledge and competence

The effectiveness of treatment and early identification of eating disorders relies on the knowledge and skill of the health workforce. During the care of people with eating disorders there are assumptions that patient management is the domain of experts outside the health workforce. This is evident in the referrals to specialist tertiary services of patients with mild illness that are made by health practitioners who have limited experience with the management of eating disorders[13].

The health workforce needs to be supported to understand the best models of care for eating disorders and to identify and respond safely to the needs of people with eating disorders. However, it can be difficult for teams to maintain their skills or be familiar with referral pathways if a limited number of people with eating disorders are seen.

12 Victoria Department of Health, 2014. Victorian Eating Disorders Strategy, Victoria Department of Health, Melbourne.

13 NSW Ministry of Health, (2013). NSW Service Plan for People with Eating Disorders 2013-2018. Available at: http://www.health.nsw.gov.au/mentalhealth/publications/Publications/service-plan-eating-disorders-2013-2018.pdf

Stepped model of care

Stepped models of care are an evidence-based, staged approach to the delivery of mental health services, containing a hierarchy of interventions from the least to the most intensive, matched to the individual's needs. It is about ensuring that people can access the most appropriate services for their mental health needs at any given time, including the ability to step up and step down to different levels of care as they move along their recovery journey.

Stepped care models provide an approach to mental health support that is person-centred and supports people across the spectrum of needs.

A number of state and policy documents have been developed to guide models of care for eating disorders, including service plans and strategies. Each of these documents describe the key principles and domains required to appropriately manage eating disorders and have helped inform the development of this document and the stepped model for the ACT.

The TwMoC outlines the need for public ACT eating disorder services to be developmentally appropriate and flexible across the continuum of care, from early engagement to ongoing treatment while enabling the ability to address fluctuations in risk and condition. To do this, there are four pillars that are needed across the health system for the management of eating disorders, which are:

- community-based interventions
- specialist outpatient treatment
- hospital-based interventions
- tertiary specialist inpatient treatment.

Figure 1 has been adapted from the NSW Service Plan[14] and the HSE Model of Care for Ireland[15,] and shows the stepped model for eating disorders which has been adapted for use in the ACT under the TwMoC.

Level 1 is the primary care component of the model comprising of GP's, dietetics, primary care teams, paediatrics, student health and schools. This is an outpatient level focusing on:

- case recognition and physical risk monitoring
- support
- self-help and education
- private practitioners
- NGOs
- family and carer support
- targeted prevention
- very early intervention.

14 NSW Ministry of Health, (2013). NSW Service Plan for People with Eating Disorders 2013-2018. Available at: http://www.health.nsw.gov.au/mentalhealth/publications/Publications/service-plan-eating-disorders-2013-2018.pdf

15 National Clinical Strategy and Programmes Division and National Mental Health Division Ireland, (2018). Eating Disorder Services: HSE Model of Care for Ireland. Available at: hse-eating-disorder-services-model-of-care.pdf

Level 2a is the mental health service and early intervention component of the model of care. It encompasses Adult Mental Health Services (AMHS), CAMHS outpatient, Headspace, and private practitioners. It is an outpatient level focusing on evidence-based first-line treatments and monitoring (in some locations), long term support, comorbidity, and stepdown care.

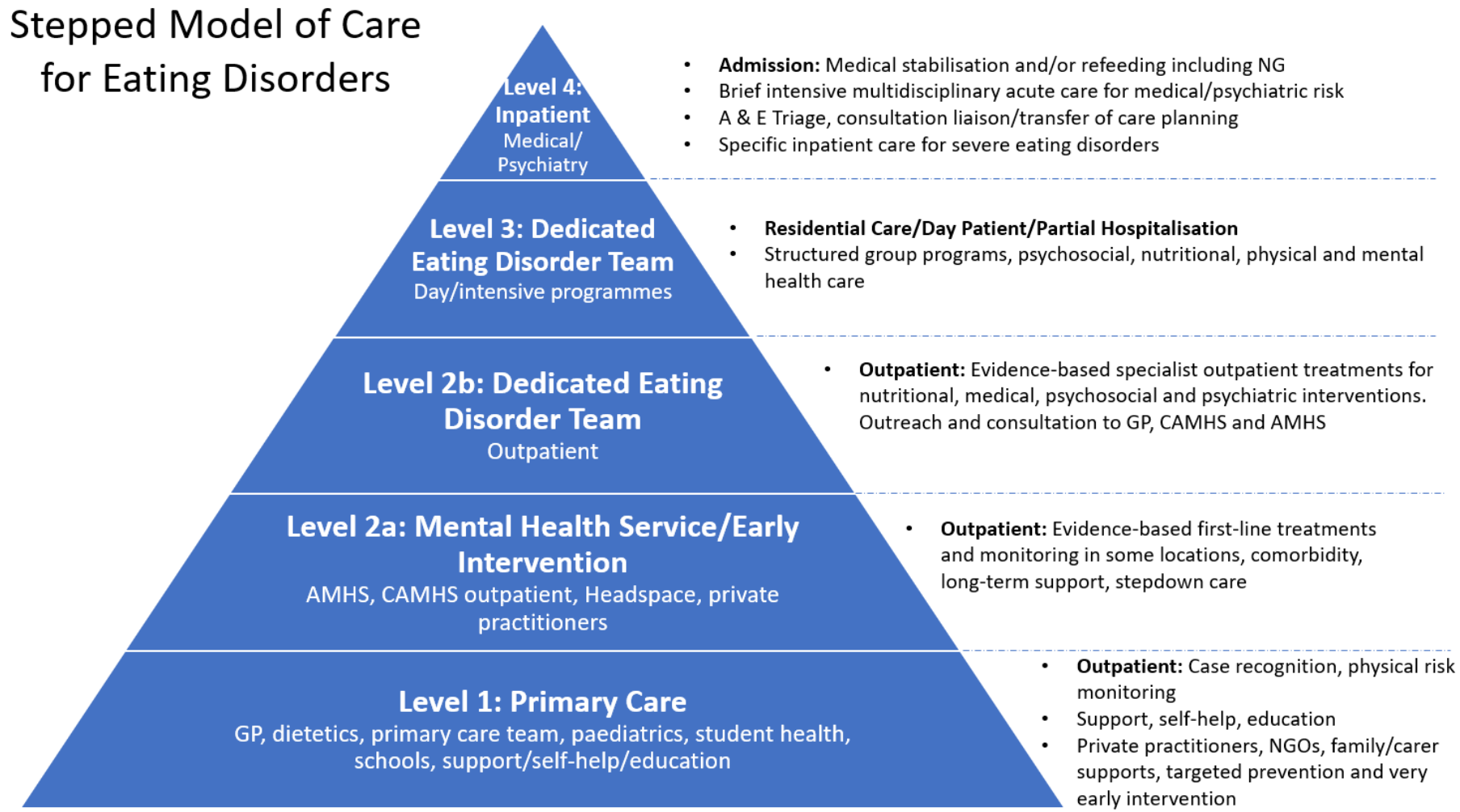
Level 2b of the model is a dedicated outpatient eating disorder team. This level of care delivers evidence-based specialist outpatient treatments for nutritional, medical, psychosocial, and psychiatric interventions. It comprises of AMHS and CAMHS as well as outreach and consultation with a person's GP.

Level 3 of the model is a day program or intensive program with a dedicated eating disorder team. This level includes residential care, day patients and partial hospitalisation with a focus on structured group programs and psychosocial, nutritional, physical, and mental health care.

Level 4 of the model of care is admission to inpatient medical or psychiatric care. This level of care may include:

- medical stabilization and/or refeeding including NG
- brief intensive multidisciplinary acute care for a medical or psychiatric risk
- Acute and Emergency (A&E) triage
- consultation liaison or transfer of care planning
- specific inpatient care for severe eating disorders.

Figure 1

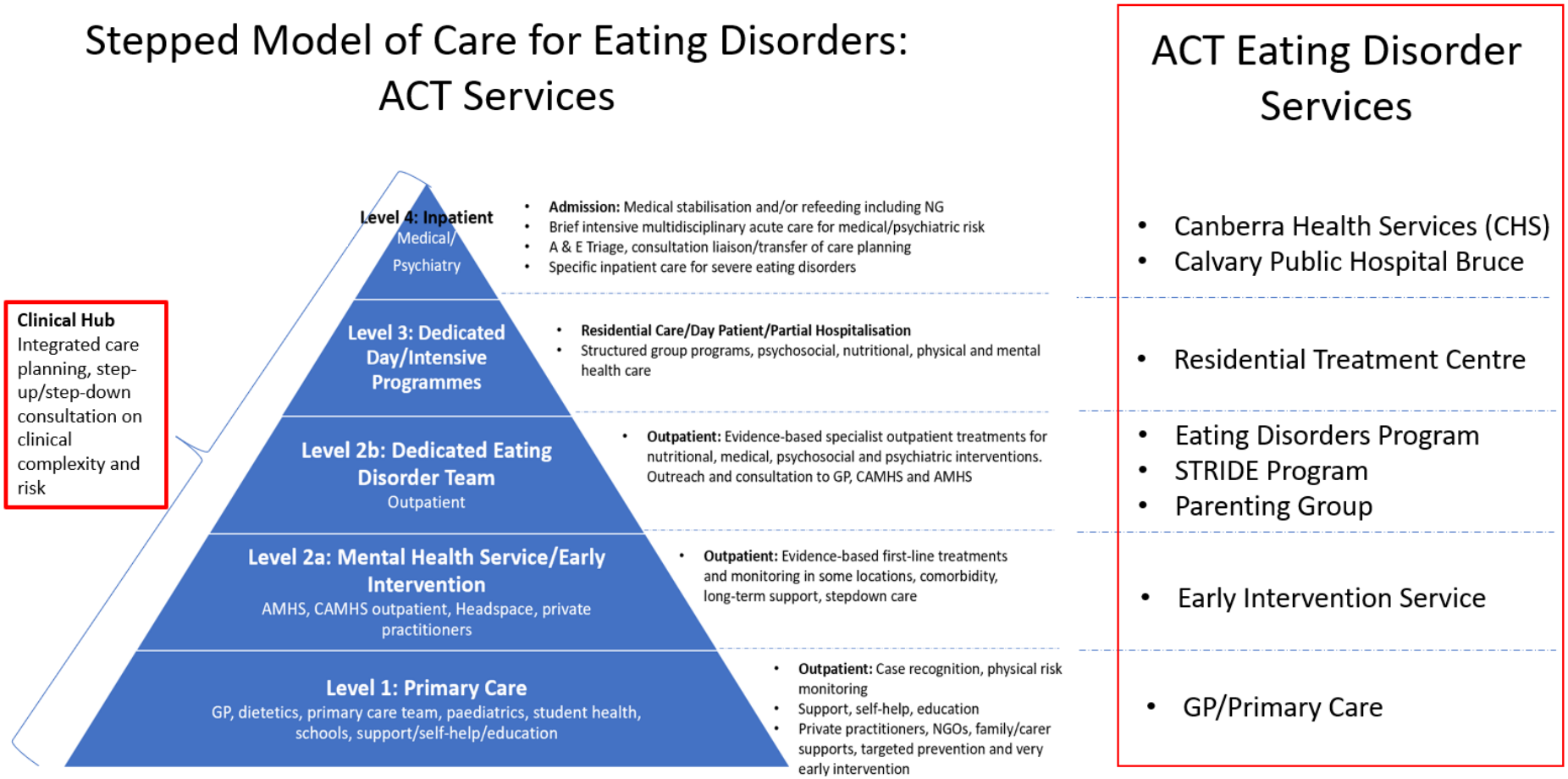

Stepped Model of Care for Eating Disorders
Level 4: Inpatient
Medical/ Psychiatry
• Admission: Medical stabilisation and/or refeeding including NG
• Brief intensive multidisciplinary acute care for medical/psychiatric risk
• A & E Triage, consultation liaison/transfer of care planning
• Specific inpatient care for severe eating disorders
Level 3: Dedicated Eating Disorder Team
Day/intensive programmes
• Residential Care/Day Patient/Partial Hospitalisation
• Structured group programs, psychosocial, nutritional, physical and mental health care
Level 2b: Dedicated Eating Disorder Team
Outpatient
• Outpatient: Evidence-based specialist outpatient treatments for nutritional, medical, psychosocial and psychiatric interventions. Outreach and consultation to GP, CAMHS and AMHS
Level 2a: Mental Health Service/Early Intervention
AMHS, CAMHS outpatient, Headspace, private practitioners
• Outpatient: Evidence-based first-line treatments and monitoring in some locations, comorbidity, long-term support, stepdown care
Level 1: Primary Care
GP, dietetics, primary care team, paediatrics, student health, schools, support/self-help/education
• Outpatient: Case recognition, physical risk monitoring
• Support, self-help, education
• Private practitioners, NGOs, family/carer supports, targeted prevention and very early intervention

ACT: Stepped Model of Care

It is expected that all future ACT eating disorder services will be positioned in the stepped care model as stipulated below in Figure 2.

- The Clinical Hub will be across all levels of care for integrated care planning, step up and step down consultation, and for consultation on clinical complexity and risk.
- General practitioners and primary care will be positioned at Level 1, or the primary care level.
- The Early Intervention Service will be positioned at Level 2a, or the mental health service and early intervention level.
- The STRIDE program, Parenting Group and Eating Disorders Program are the ACT services for Level 2a, the dedicated outpatient eating disorder team level of care.
- An ACT Residential Treatment Centre is positioned at Level 3, the residential care or day patient level of care.
- Canberra Health Services (CHS) and Calvary Public Hospital Bruce (CPHB) are the ACT eating disorder services at Level 4, the inpatient level of care.

Figure 2


Stepped Model of Care for Eating Disorders: ACT Services
Clinical Hub
Integrated care planning, step-up/step-down consultation on clinical complexity and risk
Level 4: Inpatient
Medical/ Psychiatry
Admission: Medical stabilisation and/or refeeding including NG
Brief intensive multidisciplinary acute care for medical/psychiatric risk
A & E Triage, consultation liaison/transfer of care planning
Specific inpatient care for severe eating disorders
Level 3: Dedicated Day/Intensive Programmes
Residential Care/Day Patient/Partial Hospitalisation
Structured group programs, psychosocial, nutritional, physical and mental health care
Level 2b: Dedicated Eating Disorder Team
Outpatient
Outpatient: Evidence-based specialist outpatient treatments for nutritional, medical, psychosocial and psychiatric interventions. Outreach and consultation to GP, CAMHS and AMHS
Level 2a: Mental Health Service/Early Intervention
AMHS, CAMHS outpatient, Headspace, private practitioners
Outpatient: Evidence-based first-line treatments and monitoring in some locations, comorbidity, long-term support, stepdown care
Level 1: Primary Care
GP, dietetics, primary care team, paediatrics, student health, schools, support/self-help/education
Outpatient: Case recognition, physical risk monitoring
Support, self-help, education
Private practitioners, NGOs, family/carer supports, targeted prevention and very early intervention
ACT Eating Disorder Services
Canberra Health Services (CHS)
Calvary Public Hospital Bruce
Residential Treatment Centre
Eating Disorders Program
STRIDE Program
Parenting Group
Early Intervention Service
GP/Primary Care

Eating disorders are complex disorders that require flexible, individualised care solutions across a range of settings and in a coordinated way. The TwMoC uses a stepped care model with the aim of ensuring that people with eating disorders have streamlined access to the right services in the ACT to address their needs over time.

As shown in Figure 2, under the Expanding Public Health Services for Eating Disorders (EPHSED) project, there are multiple new service and treatment options available to people with an eating disorder. Each of these services have been positioned within the TwMoC to ensure each level of acuity and intervention required for an eating disorder is available within the ACT, to reduce any duplications across services, and to ensure all gaps are covered.

As seen on the left-hand side of Figure 2, the Clinical Hub provides the opportunity for clients and services to link in with other supports as required, and for individuals to be stepped up or down the model as clinically appropriate. The use of the Clinical Hub within the stepped care model places an emphasis on integration and coordination of public eating disorder services in the ACT.

Further detail on how each service, their model of care and how they operate within the TwMoC stepped model of care is provided in this document.

Clinical Hub: Model of Care Component

Integrated service that operates across the full Stepped Model of Care

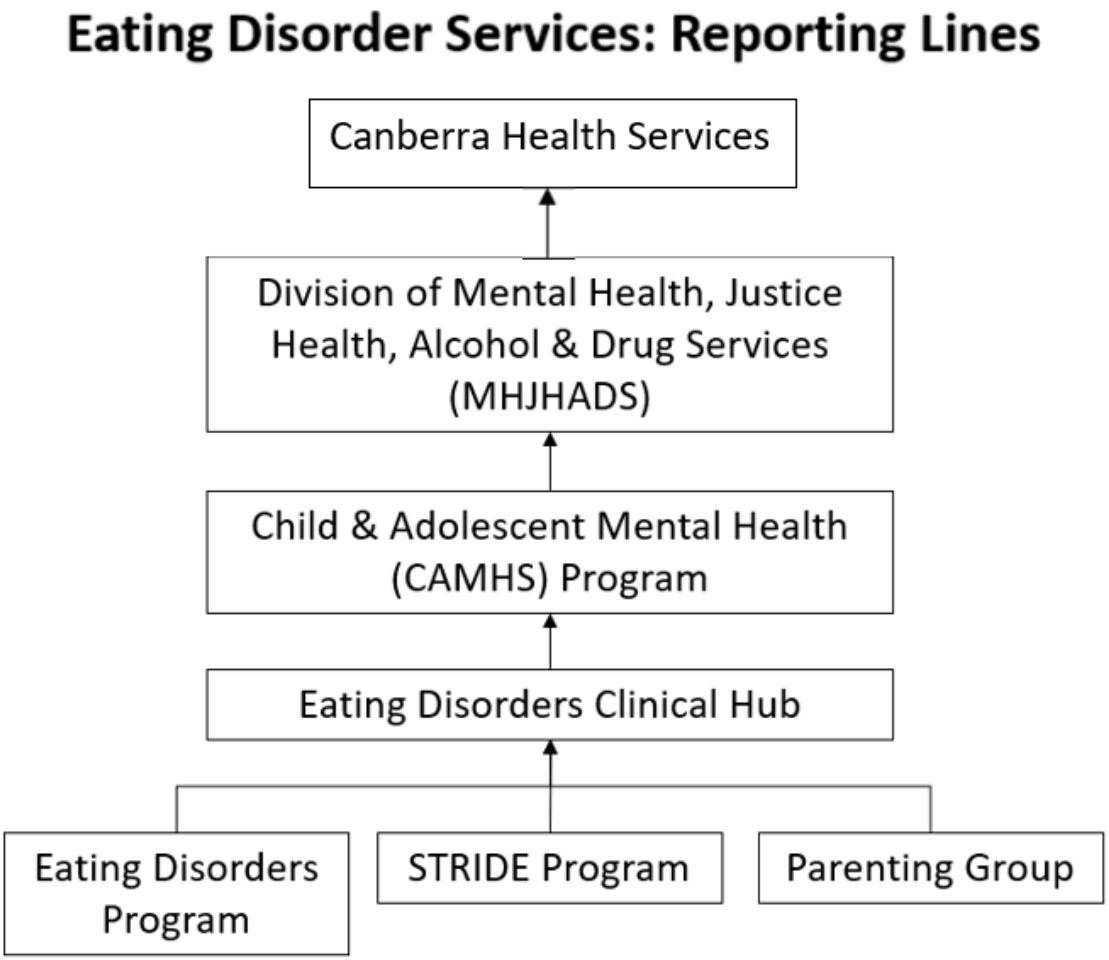
Governance

The Clinical Hub (the Hub) is the centralised point of access for public eating disorder services in the ACT. The Hub is part of the Child and Adolescent Mental Health (CAMHS) Program within the Division of Mental Health, Justice Health, Alcohol and Drug Services (MHJHADS) of Canberra Health Services (CHS).

The Hub governs the following ACT public eating disorder services:

- Eating Disorders Program (EDP)
- Short Term Recovery Interventions for Disordered Eating (STRIDE) Program
- Parenting Groups.

Please see below for a visual representation of this governance structure:



Description of service

The Hub is a specialist community based centralised service for children, adolescents and adults who are experiencing an eating disorder as their primary presenting issue. The Hub's core business includes assessment and treatment, consultation and liaison, education and training and system integration to strengthen eating disorder services across the Territory.

The Hub will function as the central referral point for eating disorder services in the ACT. It will provide and support a range of coordinated eating disorder services within the Territory that shift the focus of eating disorder management away from acute inpatient treatment and towards a flexible, appropriate, and efficient Stepped Care treatment model.

By bringing together the resources and expertise on pathways and treatment options for eating disorders, the Hub provides a holistic, integrated, central point of care that will coordinate timely treatment for people on the spectrum of eating disorders.

The Hub has a key focus on improving care coordination, system integration and communicating the care pathways for eating disorders. The Hub is not an eating disorder treatment or therapy service, but instead has a coordination and service support focus.

Clients will have access to a trained clinician during the intake and assessment process for the Hub, but no ongoing sessions or therapy will be scheduled with Hub staff. The Hub is made up of multi-disciplinary mental health professionals who work within a recovery and person-centred framework.

The Hub will also provide clinical consultation to clinically managed people with eating disorders assigned to community teams in the ACT, while increasing the clinical capacity of the EDP and supporting the non-government organisation (NGO) providers for both the Early Intervention Service and Residential Centre in the ACT community. Together, these system enhancements and service integration strategies will better support people with eating disorders across their spectrum of needs.

The establishment of the Hub helps to embed eating disorders as 'core business' for mental health and other health services and will deliver eating disorders competency and training throughout CHS. The reviewing, updating and implementing of the TwMoC and will be scheduled every three years under the MHJHADS Governance Committee.

The Hub also has a consultation and liaison role where teams within CHS and CPHB, general practitioners and community-based services will be able to seek specialist eating disorders advice if they are treating or managing a person with eating disorders. This in-reach and outreach capacity helps to reinforce transition pathways between inpatient and outpatient services in the community.

The Hub accepts referrals from anyone within the greater Canberra region who are concerned about themselves or someone else who is exhibiting disordered eating behaviours, or who has a primary diagnosis of an eating disorder and requires care. Upon receiving a referral, the Hub undertakes a detailed initial assessment to determine the best care pathway for that individual. This may include referring clients to other public ACT eating disorder services, such as the Early Intervention Service, the Residential Centre, the EDP and inpatient care or back to their GP or other community supports. In addition to referrals, the Hub will be responsible for establishing and leading STRIDE Clinic and Parenting Workshops.

The aim of the Hub is to review identified issues and address eating disorder service gaps in the ACT, ensuring people with eating disorders have access to evidence-based care when they need it. It promotes recovery and aims to improve health outcomes for people with an eating disorder and reduce demand on acute health services.

If the individual who requires care resides outside the ACT, the Hub will collaborate with them to step them down to appropriate services in their local area or to direct them to a database of service providers in their local area.

General principles for treatment

Treatment principles

In addition to the National Practice Standards for the Mental Health Workforce (2013), the Hub will implement the treatment principles and general clinical practice and training standards published by The New Zealand Academy for Eating Disorders (ANZAED) in November 2020.

The National Practice Standards for the Mental Health Workforce (2013) are[16]:

1. Rights, responsibilities, safety, and privacy
2. Collaborating with people, families, and carers in recovery-focused ways
3. Meeting diverse needs
4. Working with Aboriginal and Torres Strait Islander people, families, and communities
5. Access
6. Individual planning
7. Treatment and support
8. Transitions in care
9. Integration and partnership
10. Quality improvement
11. Communication and information management
12. Health promotion and prevention
13. Ethical practice and professional development responsibilities.

The ANZAED Eating Disorder Treatment General Principles are[17]:

1. Early intervention is essential
2. Coordination of services in fundamental to all service models
3. Services mut be evidence based
4. Involvement of significant others in service provision is highly desirable
5. A personalised treatment approach is required for all patients

16 Victorian Government Department of Health on behalf of the Safety and Quality Partnership Standing Committee, *National Practice Standards for the Mental Health Workforce*, Victorian Government Department of Health, 2013, accessed 3 August 2021.

17 G Heruc, K Hurst, A Casey et al., 'ANZAED eating disorder principles and general clinical practice and training standards', *Journal of Eating Disorders*, 2020, 8(63), Doi: https://doi.org/10.1186/s40337-020-00341-0

6. Education and/or psychoeducation is included in all interventions
7. Multidisciplinary care is required
8. A skilled workforce is necessary.

The ANZAED Eating Disorder Treatment General Clinical Practice Standards are[18]:

1. Diagnosis and assessment
2. Multidisciplinary care team (MDT)
3. Positive therapeutic alliance
4. Knowledge of evidence-based treatment
5. Knowledge of levels of care
6. Relapse prevention
7. Professional responsibility.

As well as the general clinical practice standards, the ANZAED practice and training standards for dietitians providing eating disorder treatment cover expectations for:[19]

- Screening
- Professional responsibilities
- Nutrition care process
  - Nutrition assessment
  - Nutrition diagnosis
  - Nutrition intervention
  - Monitoring and evaluation.

As well as the general clinical practice standards, the ANZAED practice and training standards for mental health professionals providing eating disorder treatment cover expectations for[20]:

1. Coordination of services
   1.1 Communication within the multidisciplinary care team
   1.2 Communication with patients
   1.3 Communication with family and significant others
2. Establishing a positive therapeutic alliance
3. Professional responsibility
4. Knowledge of levels of care
5. Mental health assessment
6. Mental health diagnosis

18 Heruc et al., 'ANZAED eating disorder principles and general clinical practice and training standards'

19 G Heruc, S Hart, G Stiles et al., 'ANZAED practice and training standards for dietitians providing eating disorder treatment', *Journal of Eating Disorders*, 2020, 8(77), Doi: https://doi.org/10.1186/s40337-020-00334-z

20 K Hurst, G Heruc, C Thornton et al., 'ANZAED practice and training standards for mental health professionals providing eating disorder treatment, *Journal of Eating Disorders*, 2020, 8(58), Doi: https://doi.org/10.1186/s40337-020-00333-0

7. Mental health intervention

   7.1 Knowledge of evidence-based treatment

8. Managing risk

   8.1 Monitoring and evaluation.

Services

The Hub is responsible for delivering the following key services:

- A central referral point or pathway for all eating disorder services in the ACT.
- A key consultation or liaison role with service providers across the ACT, with the aim of supporting consistent provision of information about referral pathways, care escalation and treatment options, including hospital-based services and outreach programs.
- The provision of advice, consultation, networking and support for clinicians collaborating with people with eating disorders.
- The development and facilitation of training programs for clinicians seeking guidance on evidence-based interventions and psychoeducation as treatment and support pathway options.
- Ongoing and regular consultation with peak bodies focused on eating disorders, such as The Butterfly Foundation.
- Undertaking research into evidence-based models of care as part of the development of the expansion of eating disorder services in the ACT.
- The provision of STRIDE Program and Parenting Groups.

Central referral point or pathway

Any individual who wishes to access care for disordered eating behaviours or a diagnosed eating disorder will be required to contact the Hub to submit a referral.

The centralisation of this function assists in streamlining care, standardising intake and referral processes and simplifies the community messaging on how to access care for an eating disorder in the ACT.

Liaison with ACT service providers

The Hub will develop partnerships with primary care providers, NGOs, community groups, clinical bodies and education providers who interface with eating disorder care in the ACT. These partnerships will focus on creating working relationships, additional care options and pathways in and out of the public health system and into other organisations, as appropriate.

The formation and maintenance of these partnerships is integral in providing a public eating disorder service that covers the full spectrum of care and life span.

Provision of advice, consultation, networking and support for clinicians

The Hub functions as a liaison point for all ACT public clinicians collaborating with clients with disordered eating behaviours or eating disorders. This includes the provision of advice and consultation, which could include case reviews, attendance of team meetings and ad hoc clinical advice.

The Hub is also able to provide support to clinicians who request it on a case-by-case individualised basis.

Training programs for clinicians

A core function of the Hub is to develop the capacity of clinicians to best deliver the TwMoC. The Hub will provide clinical leadership, service coordination, clinical liaison, and escalation of care pathways. It will develop clinicians' knowledge and clinical confidence of eating disorders through training, education and peer supervision.

The Hub will implement the ANZAED training standards published in November 2020[21]. In line with the *National Mental Health Practice Standards 2013* all clinicians will be encouraged to participate in ongoing training and development, including clinical and peer supervision, clinical reviews, and multidisciplinary team meetings[22].

Regular consultation with peak bodies

The Hub undertakes regular consultation with peak bodies which may include (but are not limited to):

- The Butterfly Foundation
- National Eating Disorders Collaboration (NEDC)
- InsideOut
- Eating Disorders Families Australia (EDFA)
- Carers ACT
- Health Carers & Consumers Association (HCCA)
- Capital Health Network.

Eating disorder research

The Hub undertakes research and development projects regarding eating disorders in the ACT as part of its operation. This includes supporting University students who are seeking to use data in research and the evaluation of programs.

The Hub recognises the importance and value of research to progress evidence-based prevention and treatment interventions for eating disorders. The Hub is committed to supporting quality research that aims to improve the lives of those with eating disorders.

The Hub is a clinical service and is not currently funded to undertake research. Any research involving the Hub will be dependent on research grants and the current capacity of the Hub workforce.

Any research studies involving the Hub are expected to include an element of mutual support for the Hub. For example, this support could involve data sharing between the Hub and the research team,

21 Heruc et al., 'ANZAED eating disorder principles and general clinical practice and training standards'

22 Victorian Government Department of Health on behalf of the Safety and Quality Partnership Standing Committee, *National Practice Standards for the Mental Health Workforce*

or the sharing of resources and information in the form of workshops between the Hub and the research team.

Short Term Recovery Intervention for Disordered Eating (STRIDE) program

The STRIDE program is staffed by provisional psychologists under the supervision of clinical psychologists and provides short-term therapy to eligible clients. Eligibility for the STRIDE Program includes the following:

- primary presenting issue is an eating disorder (Anorexia Nervosa, Bulimia Nervosa, Other Specified Eating Disorder)
- BMI between 15 and 40 (people who present with a BMI below 15 usually require a higher level of care than can be provided at STRIDE)
- if the client is a young person (under 18) their family must be willing to be active participants in their child's treatment
- if the client is an adult (over 18) then they must be motivated to engage in treatment for their eating disorder
- a current resident of the ACT
- regularly engaged with their GP for medical monitoring
- medically stable.

The STRIDE program also assists in expanding the future workforce of eating disorder clinicians by providing student psychology placement opportunities in the ACT.

Treatment initiatives may be trialled and evaluated through the STRIDE program as deemed appropriate.

The Parenting Group

The Parenting Group provides psychoeducation and support in implementing the first phase of a Maudsley family-based therapy approach in the home. The group is for parents and carers who have a loved one under the age of eighteen whose treatment recommendation is this treatment option.

Collaborative Care Skills Workshops (CCSW)

Professor Janet Treasure and her team at South London and Maudsley Mental Health Trust developed Collaborative Care Skills Workshops (CCSW) based on a comprehensive model of carer coping. These workshops were designed to improve carers' well-being, coping strategies, and critical thinking skills by modifying communication patterns and teaching carers the basic principles of motivational interviewing. The CCSW is currently under development with the Hub, with staff attending training shortly.

Care setting

The Hub is currently located at the Canberra Hospital in Garran, ACT. This location allows Hub staff direct access to Canberra Hospital patients and staff, strengthening the connection with inpatient services on campus.

Future planning includes consideration of co-locating the Hub with other public eating disorder services in the future. If so, accessibility for those (both clients and visiting family and carers) with a disability or mobility issues will be considered and designed accordingly.

Patient pathway

All requests for assistance with disordered eating habits or eating disorders will require a full referral to be submitted to the Hub.

To make a referral to the Hub:

- call (02) 5124 4326
- email chs.edch@act.gov.au
- fill in the online referral form at www.canberrahealthservices.act.gov.au/services-and-clinics/services/eating-disorders-clinical-hub

The appropriateness of the referral will be determined by phone calls with the individual, their family or carer and their current treatment team (if applicable). If the referral to the Hub is not appropriate, other appropriate services will be suggested, such as:

- an eating disorder Mental Health Plan
- visiting your GP
- seeing a private practitioner
- accessing eating disorder communication materials.

If the referral to the Hub is appropriate a Single Session Intervention (SSI) appointment will be scheduled. Once the SSI has been attended a clinical discussion will take place to decide on an appropriate treatment option for the individual.

Appropriate treatment options may be:

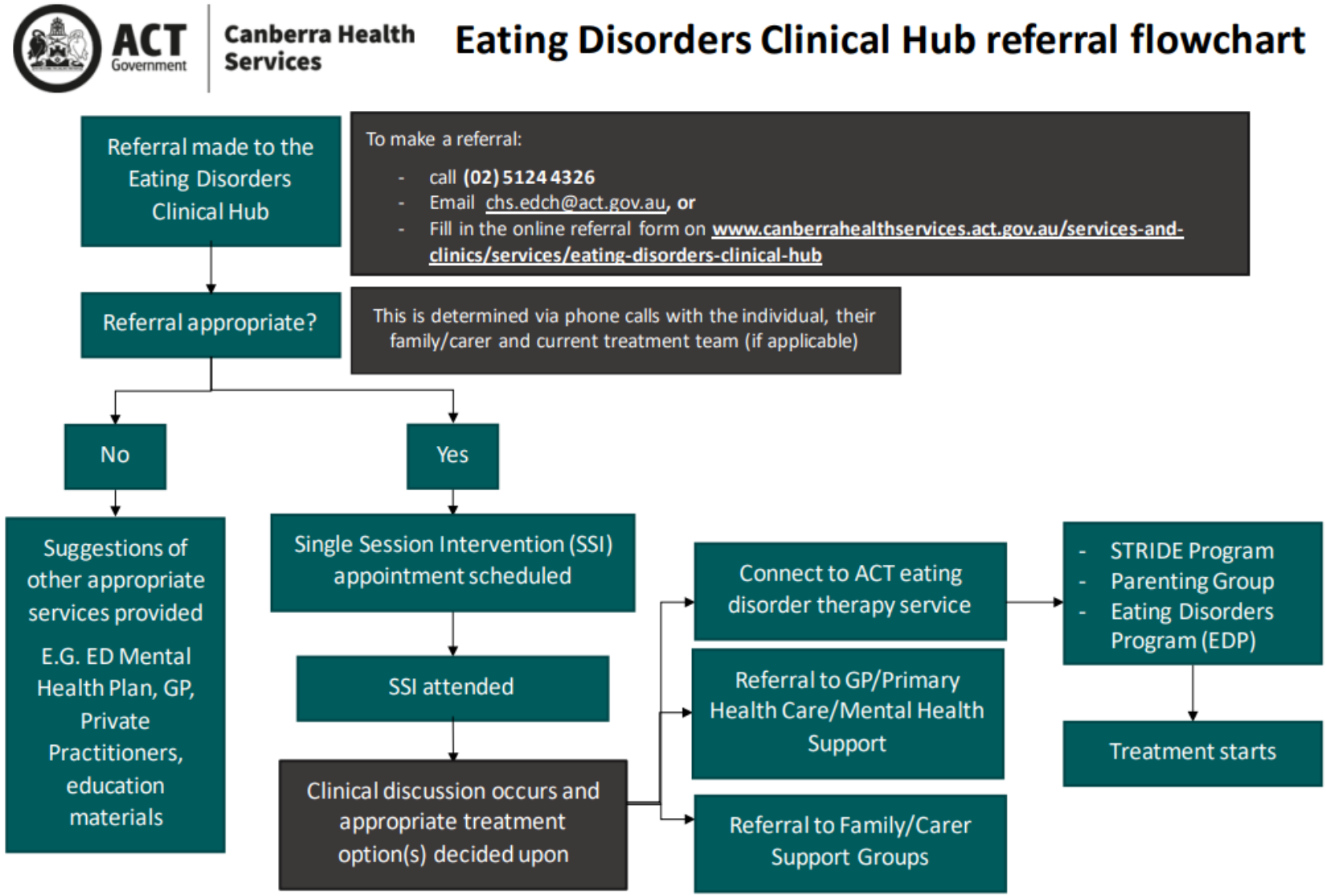
- a referral to a GP, primary health care service or mental health support service
- referral to family and carer support groups
- connecting to an ACT eating disorder therapy service like the STRIDE program, Parenting Group or Eating Disorders Program (EDP).

Once an appropriate treatment option has been decided, treatment can start for that individual.

For a visual representation of the pathway from the Hub referral to treatment please see Figure 3 below[23]:

23 Current Eating Disorders Clinical Hub Referral Flowchart as of October 2022.

Figure 3


ACT Government
Canberra Health Services
Eating Disorders Clinical Hub referral flowchart
Referral made to the Eating Disorders Clinical Hub
To make a referral:
- call (02) 5124 4326
- Email chs.edch@act.gov.au, or
- Fill in the online referral form on www.canberrahealthservices.act.gov.au/services-and-clinics/services/eating-disorders-clinical-hub
Referral appropriate?
This is determined via phone calls with the individual, their family/carer and current treatment team (if applicable)
No
Yes
Suggestions of other appropriate services provided
E.G. ED Mental Health Plan, GP, Private Practitioners, education materials
Single Session Intervention (SSI) appointment scheduled
SSI attended
Clinical discussion occurs and appropriate treatment option(s) decided upon
Connect to ACT eating disorder therapy service
Referral to GP/Primary Health Care/Mental Health Support
Referral to Family/Carer Support Groups
- STRIDE Program
- Parenting Group
- Eating Disorders Program (EDP)
Treatment starts

Admission criteria

Admission criteria for referral to the Hub includes:

- being a resident of the greater Canberra region
- primary presenting concern of disordered eating habits or a diagnosis of an eating disorder.

The Hub accepts referrals from anyone within the greater Canberra region who is concerned about themselves or someone else who is exhibiting disordered eating behaviours, or who has a primary diagnosis of an eating disorder and requires care.

Upon receiving a referral, the Hub undertakes a detailed intake, triage, and assessment process to determine the best care pathway for that individual. This includes referring clients to other public ACT eating disorder services (such as the Early Intervention Service, the Residential Centre, the EDP and inpatient care), referral to their GP or other community supports, or the provision of self-help materials and resources. For some eating disorder services, individuals may be able to make a self-referral directly to the service instead of to the Hub.

Potential clients are not required to have a regular GP they visit in the community as an admission criterion for the Hub assessment. As part of the intake process, if a potential client is identified as not having a regular GP engaged in their care or treatment, the Hub will collaborate with that individual to engage a GP prior to progressing to Hub assessment.

General enquiries

The Clinical Hub can provide general information on:

- self-help resources
- NGOs within the ACT who provide support for families and carers with a loved one who is experiencing eating disorders or disordered eating behaviours
- general practitioners within the ACT
- private health care options in the ACT for eating disorder treatment
- public health care options in the ACT for eating disorder treatment.

For general enquiries and the provision of requested information, this can be provided verbally via the phone or in writing via email. The Hub staff member will be required to record this interaction for data reporting and future service planning purposes.

Referral to services

If the initial contact results in progression to a referral to the Hub, as determined by the Hub staff member, a full referral form and details of the person's regular GP (if known) will be requested at this stage. If the person does not have a regular GP, the Hub will assist in linking the person in with a suitable GP or other health professional.

Initial presentation

The person will then be booked into an Initial Presentation (IP) session. The IP may occur in the initial phone call (if appropriate) or booked for an alternative time. It is at this point that the Hub will request blood work if this has not previously been provided with the referral.

> **Note**: If the referral is for a person who is a current inpatient at Canberra Hospital or at Calvary Public Hospital Bruce, the Transitional Clinician or Duty Officer can conduct the IP while the person is still admitted to hospital, prior to discharge. This will expediate the referral process, ensuring timely access to care.

After completion of the IP, the Hub will determine if the person requires either a Single Session Intervention (SSI) or is referred externally to primary care or an appropriate private practitioner. If the person is referred externally, the Hub is to close the referral with the understanding that the person is welcome to re-refer later if further assistance is needed.

Single Session Intervention

If the person is deemed suitable to require an SSI, the Hub will schedule this at the time of conducting the initial presentation. Not all SSIs will indicate the need for a partnership or referral to an ACT public eating disorder service.

Following completion of the SSI, in collaboration with the client, consideration of their presentation, and in line with evidence-based interventions available, the person will be informed of their recommended treatment pathway. This may be a referral to primary care or to a GP, to a private practitioner or to an ACT public eating disorder service such as the STRIDE Program or EDP.

Risk management and step-up procedures and arrangements

The Hub strives to deliver the right care for all clients, in the right setting at the right time. Robust risk assessment and management policies will be developed for this purpose.

Specific areas that will be addressed in policies include:

- the principle of consent to treatment, particularly regarding minors
- the management of particularly vulnerable clients, including sexual safety (sexuality, age, gender)
- implementing trauma informed approaches
- responding to and the management of mental state deterioration (psychological and mental wellbeing) and suicide risk
- physical or medical risk (decompensation) management including risks around refeeding syndrome.

In the cases of medical or psychiatric deterioration, transfer to hospital will be organised. For non-life-threatening situations, the Hub may call the client's GP or treating physician to determine the escalation pathway. For life threatening situations, this is to be organised immediately via ambulance.

Discharge process

Discharge from the Hub is dependent on the discharge pathway identified for the individual. If the client is identified as suitable for stepping up into inpatient care or down to GP or primary care, the discharge from the Hub will occur upon entering that care pathway.

Similarly, if the client is identified as requiring a step down to a service that is located outside of the ACT, the discharge from the Hub will occur upon the referral to that service.

If the client is identified as suitable for the EDP, the STRIDE Program or the Parenting Group, discharge from the Hub will not occur until the client has completed therapy with the EDP, the STRIDE Program, or the Parenting Group.

This is to ensure accurate data capture and reporting processes on client engagement with public eating disorder services at the outpatient level. This also ensures continuity of care for the client throughout their treatment journey, as the Hub can have oversight of client progress and can address any client deterioration as appropriate.

Follow-up care

Throughout a client's treatment journey, Hub staff will consult with the client's initial referrer (if appropriate), GP and their current treating team on progress made and the client's discharge or step down care plan. This will ensure appropriate follow-up care in the client's own geographical area of residence is available and ready upon the client's discharge date if the Hub cannot provide this.

There may be clients from rural and remote areas who do not have dedicated follow-up care. A gap analysis should be conducted prior to discharge as part of the discharge planning process to ensure clients are linked with appropriate services, which may include Telehealth support. A comprehensive policy will be developed outlining discharge and follow-on care arrangements and procedures.

Workforce

The Hub will employ a multidisciplinary workforce to ensure that clients receive access to the medical, dietetic, and psychological interventions that are required to maximise the chance of a full recovery at any stage of the client's eating disorder journey.

The Hub workforce may include:

- a Clinical Hub Manager
- a Service Coordinator Clinician
- a Transition Clinician
- a Therapist
- a Dietician
- a Medical Consultation Liaison.

Student Clinicians

The Hub will work with the ACT Health Clinical Placement Office to provide a teaching environment to intern psychologists, nurses, medical and allied health students. Students will be informed of the professional supervision required as per their discipline and education level specific requirements.

Inpatient Care: Model of Care Component

Level 4 of Stepped Model of Care

Description of service

In Australia, admission to hospital for acute medical care is the standard approach when an eating disorder becomes life-threatening. When life is at risk, for example, due to extremely low weight, admission to hospital for medical treatment is the appropriate response.

When people with eating disorders are at high psychiatric risk, they may be admitted to psychiatric wards to manage and contain such risk. In these acute care inpatient contexts, the focus is on life-saving interventions including medical stabilisation and weight gain.

People with eating disorders can present to Emergency Departments, and these departments have a key responsibility in facilitating patient entry into treatment. Health practitioners working in Emergency Departments need continued and up to date training in the triage, risk identification and medical management of people with eating disorders. As such, clinically informed assessment is essential, and procedures to ensure locally supported treatment and referral pathways need to be established.

In general, inpatient services can be provided on general medical wards or mental health units. The effective management of a patient with an eating disorder requires collaborative multidisciplinary care including medical, nursing and allied health disciplines. Consultation liaison and telemedicine support from specialist services can help to ensure evidence-based treatment plans for patients and linkages to appropriate referral pathways.

This model of care document is not intended to replace or replicate inpatient management guidelines which have been developed by both Canberra Hospital and Calvary Public Hospital Bruce for the medical and psychiatric management of patients with an eating disorder. Instead, the inpatient component of the TwMoC is intended to formalise the entry and exit pathways for inpatient hospital services, strengthen the integration of specialist eating disorder teams during an admission, and provide improved support and care coordination for those who require inpatient treatment for their eating disorder.

Care setting

Currently in the ACT, ACT Health inpatient medical stabilisation is available at the Canberra Hospital and Calvary Hospital. For people aged under 16 years, inpatient management is in the Paediatric ward. For people 16 years and over, inpatient management at the Canberra Hospital is in the Adult General Medicine Ward.

If medically stable, patients can be admitted to Calvary Public Hospital Mental Health Acacia Ward or the Adult Mental Health Unit at the Canberra Hospital. This is for treatment of acute psychiatric and suicidality risk, rather than access to an eating disorder specific program.

Admission to inpatient services is often accessed through a presentation to the Emergency Department (ED).

Patients with immediate life-threatening manifestations of eating disorders (e.g., anorexia or bulimia nervosa) should be assessed in the emergency department and the admission destination will be a clinical decision. When other medical instability indicators are present and the patient is not at imminent risk of death, admitting the patient to hospital (regardless of setting) is the recommended approach. Clinical judgement regarding the best available setting will always be exercised.

General principles for treatment

Upon admission to hospital for an eating disorder, a number of general principles are followed.

1) Multidisciplinary treatment approach

Eating disorders are complex illnesses that are best managed using a multidisciplinary approach. A coordinated team approach is essential for developing and implementing a holistic management plan for the admission. The team provides a united front which ensures effective communication with the person and their family or carer as well as providing assurance in a period of crisis and distress for the family or carer.

2) Engagement with the patient

A person with an eating disorder (and, anorexia nervosa or bulimia nervosa) has an intense fear of putting on weight and most of the difficult behaviours that are associated with this illness are driven by this fear. An admission to hospital is highly stressful for the person and an empathetic, non-judgemental approach is necessary to facilitate engagement. The person requires a containing but caring approach that ensures safety but also focuses on providing positive experiences and growth for the person.

3) Engaging the person's family or carer in treatment is essential

If the person consents, their family or carers should be involved in all aspects of care of the person and be considered part of the treating team. A person's family or carers are an essential resource whose ongoing support and encouragement is necessary to support the person's recovery. The person's family or carers require support and guidance to build their confidence and competence in supporting their loved one and should be provided with opportunities to practice in different contexts such as meals on the ward and during ward leave.

4) Aims for admission

The purpose of an inpatient admission of the person is to provide a safe and therapeutic environment where the person is supported to reduce medical risks, move towards a healthy weight, and re-establish regular eating patterns.

The aims for admission are:

- medical stabilisation and nutritional improvement
- containment of eating disorder behaviours (including compensatory behaviours such as vomiting and over exercising)
- to establish a trajectory of weight gain as indicated
- associated mental health support.

Management of an inpatient admission

People with an eating disorder may feel uncomfortable disclosing information about their behaviours, making the detection of disordered eating symptoms difficult. Some individuals with an eating disorder will deny their symptoms.

It is important to keep objective measures such as weight and physical markers under review if an eating disorder is suspected. Family or carers should be included in the assessment process wherever possible. Staff should endeavour to interview family members and carers of adults as part of the assessment procedure, with prior consent from the patient.

Persons with an eating disorder will often not disclose eating disorder symptoms at presentation but will present for treatment for a variety of other, often related, physical signs and symptoms. Comorbid psychiatric illnesses are common for people with an eating disorder and therefore should be assessed for in addition to the physical manifestations of the disorder.

When considering a referral to hospital, it is important for the referrer to discuss the situation with the treating team and the proposed treatment service. Specialist services should be consulted. If urgent medical assistance is required, presentation to the emergency department should be the first contact point.

Upon admission to the ward, patients will receive care 24 hours a day for the length of their admission. Patients will be cared for by a multidisciplinary team, which should include but is not limited to medical, nutritional, nursing and psychological care.

Most patients who are admitted to hospital for their eating disorder will be critically ill upon admission, therefore the admission needs to be considered medical as well as psychiatric regardless of the ward the patient is admitted to.

The key tasks of the in-patient medical team are to:

- safely refeed the patient
- avoid refeeding syndrome caused by too rapid re-feeding
- avoid underfeeding syndrome caused by too cautious rates of re-feeding
- medically manage refeeding syndrome if this occurs
- handover patient care to the psychiatry team once patient is medically stable
- consultation with endocrinologist if presence of prolonged amenorrhea or other hormonal dysregulation secondary to underweight or malnutrition
- manage, with the help of staff, the behavioural problems common in patients with anorexia nervosa, such as resisting nutrition
- manage family/carer concerns
- occasionally treat patients under treatment orders (using the mental health act 2015), with the support of psychiatric staff
- arrange handover of the patient to the next step in staged care.

Care protocols can differ depending on the hospital, ward, presentation type and acuity of illness, though care will be tailored to each patient's specific needs as determined by clinical staff.

Refusal of care

If a patient has an acute and potentially life-threatening illness and is refusing treatment or is unable to consent to treatment, then a decision must be made regarding the degree to which the patient should be involved in the medical decision-making process and their decision-making capacity.

It may become necessary to use the ACT Mental Health ACT 2015 to enable medically necessary treatment. Anorexia Nervosa is a serious mental disorder where inpatient re-feeding is at times an essential and direct treatment for this illness. In rare situations, where there is a life-threatening physical risk and an unwillingness or inability to agree to treatment, treatment orders may be indicated and should be discussed with the psychiatric care team.

Inpatient support

The Hub can provide a consultation and liaison role to teams within CHS and CPHB who are currently treating a patient with an eating disorder. The key integration point for inpatient hospital services into public, specialised eating disorder clinical support is provided via the Hub.

This in-reach capacity helps to reinforce transition pathways between inpatient and outpatient services in the community, to support the patient and their family or carers during this time and to support clinicians when treating these patients.

This support can include:

- attending multi-disciplinary meetings
- providing support and advice to treating clinicians
- involvement in discharge planning
- facilitating in-services or educational sessions to staff on management of patients with an eating disorder.

Where possible, the Hub can also assist in the facilitation of complex case discussions for multiple stakeholders.

CHS and CPHB clinicians are encouraged to contact the Hub when providing care for a patient with an eating disorder. For further information on the Hub please the Model of Care Component on page 18.

Transitional clinician

The Hub staffing includes a Transitional Clinician position. The Transitional Clinician is a temporary position and provides a coordination function for clients and families following an admission to hospital in the context of an eating disorder.

The Transitional Clinician is an in-reach clinician, who provides resources and expertise in eating disorder services and assists patients and families in pathways and treatment plans after their hospital admission. The Transitional Clinician can also assist patients and their families unfamiliar with eating disorder services to connect with these services.

The capacity of the Transitional Clinician and the level of support they can provide is dependent on overall Hub capacity and current operational activities and priorities.

Care pathway - Canberra Hospital

Emergency Department presentation

Inpatient services for eating disorders at Canberra Hospital can be accessed when the patient presents to the Emergency Department (ED).

Upon presentation to the ED, the patient will be reviewed for medical stability and immediate medical care needs. If the patient can be stabilised and does not require an admission to the ward, they will be discharged with a discharge letter provided to the patient's primary GP.

It is recommended that the ED staff contact the Hub once a patient with an eating disorder presents to the ED. The Hub can provide specialised support to staff, the patient and the patient's family and carers at this point, and upon discharge if this is the patient's first presentation to hospital for their eating disorder.

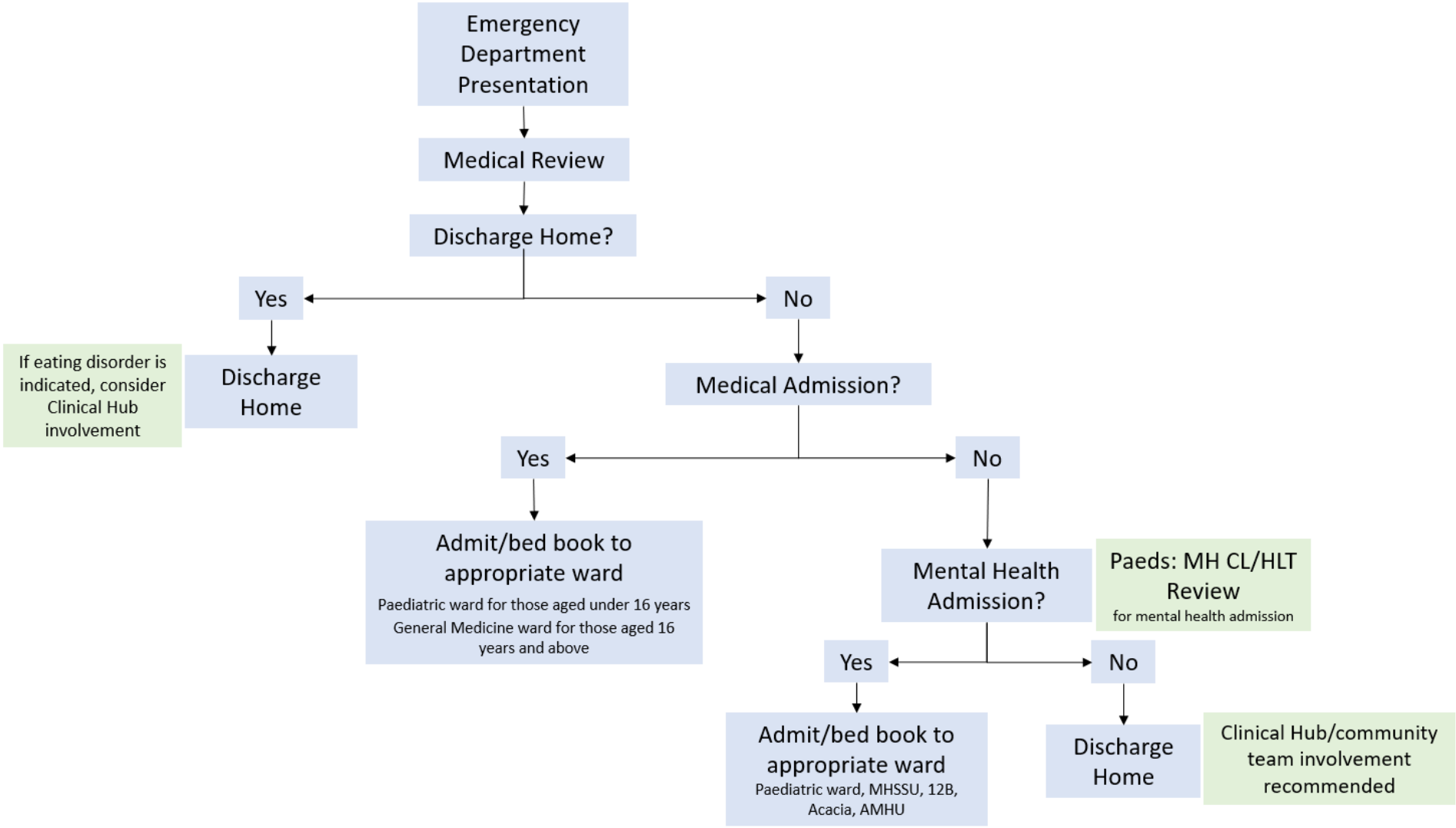
If the patient requires a medical admission to the ward, ED staff will facilitate this as per usual hospital processes. This is a clinical decision on whether to admit to the ward.

If the patient is not appropriate for a medical admission, they will be reviewed for eligibility for a mental health admission if indicated. For paediatric patients, the Mental Health Clinical Liaison (MH CL) or the CAMHS Hospital Liaison Team (HLT) will be involved in this review.

If deemed appropriate, the patient will be booked to the appropriate ward for ongoing care. Upon transfer to the ward, the patient will be managed according to the most appropriate guideline.

The pathway from the Canberra Hospital ED into inpatient hospital admission is as per Figure 4 below:

Figure 4


Emergency Department Presentation
Medical Review
Discharge Home?
Yes
No
If eating disorder is indicated, consider Clinical Hub involvement
Discharge Home
Medical Admission?
Yes
No
Admit/bed book to appropriate ward
Paediatric ward for those aged under 16 years
General Medicine ward for those aged 16 years and above
Mental Health Admission?
Paeds: MH CL/HLT Review
for mental health admission
Yes
No
Admit/bed book to appropriate ward
Paediatric ward, MHSSU, 12B, Acacia, AMHU
Discharge Home
Clinical Hub/community team involvement recommended

Direct admission

Where possible, a planned admission to the appropriate ward should be facilitated. Direct admissions should be facilitated during working hours wherever possible and if the clinical situation allows. This decision is often made if the patient does not respond to outpatient treatment or meets medical instability parameters and requires an escalation of care.

If the patient is being referred for inpatient care by their GP or other health care provider, a referral to ED can be facilitated by contacting the ED Admitting Officer prior to the patient presenting to the hospital. If the health care provider expects the patient will require a medical admission, they can contact the Consultant on call on the General Medicine ward at Canberra Hospital in addition to the ED Admitting Officer.

This process enables the health practitioner to expedite the admission process for the patient, if appropriate and agreed to by CHS hospital staff, but does not guarantee an admission and does require the relevant hospital staff to accept the patient for referral.

In cases where the patient is rapidly deteriorating and there are concerns regarding physical wellbeing and medical instability, the patient should be directed to present to the ED for assessment and triage.

Admission criteria

On presentation to the ED, all patients will be triaged and assessed by ED staff which includes a thorough medical history and examination. Persons with an eating disorder will often not disclose eating disorder symptoms at presentation but will present for treatment for a variety of other, often related, physical signs and symptoms (please see Table 1). Co-morbid psychiatric illnesses are frequent in patients with an eating disorder and therefore should be actively screened for.

Table 1: Characteristics of Patients with an Eating disorder

Hallmark symptoms of an eating disorder	Physical signs and associated abnormalities	Co-morbid mental health presentations
• Low body weight or failure to achieve expected weight gains • Fear of weight gain • Body image disturbance • Severe body dissatisfaction and drive for thinness • Preoccupation with food, weight, and shape • Restricted dietary intake • Self-induced vomiting • Misuse of laxatives, diuretics, or appetite suppressants • Excessive exercise • Amenorrhoea/oligo-menorrhoea or failure to reach menarche • Loss of sexual interest	• Dehydration • Hypothermia • Syncope (e.g., low blood pressure, postural drop) • Cardiac arrhythmias • Suicide attempts • Infection • Renal failure • Bone marrow suppression • Gastrointestinal dysfunction • Acute massive gastric dilation from bingeing • Enlarged parotid gland from purging • Electrolyte imbalance • Self-harm (cutting) • Effortless vomiting	• Major Depressive Disorder • Anxiety Disorder • Obsessive Compulsive Disorder • Substance abuse/ dependence • Self-harm and suicidal ideation • Borderline Personality Disorder

Hallmark symptoms of an eating disorder	Physical signs and associated abnormalities	Co-morbid mental health presentations
• Binge eating with loss of control and eating unusually large amounts of food • Self-imposed dietary restrictions – vegan/dairy free/gluten free		

Patients attending the ED who are suspected of having an eating disorder (based on the characteristics outlined in Table 1 or other clinical indicators) should be referred for either inpatient or community management as appropriate. RANZCP also have clinical practice guidelines for eating disorders which can be a useful tool. An in-patient admission is indicated for patients who are at significant risk of mental or physical harm.

Consultation with a senior clinician is strongly advised as it can be difficult to decide whether a patient meets criterion for medical admission, especially if the patient has impaired decision-making capacity or lacks insight into their illness. Clinical judgment regarding the best clinical setting should always be exercised, although when in doubt admission to hospital is the recommended action.

CHS adult ward

A consistent multi-disciplinary team approach is essential for patients with an eating disorder. Patients with eating disorders require a consistent, firm but understanding, non-judgmental, and non-punitive approach to management.

For an adult who has been admitted to the ward at CHS, the following activities may be undertaken upon admission:

- Establishment of 'Goals of Admission,' which is developed in consultation with the patient and establishes a clear plan for the purpose of admission and what medical risk factors are present.
- Establishment and collaborative implementation of the care plan involving the patient and, wherever possible and appropriate, with family and carers.
- Discussion and agreement on physical activity restrictions.
- Discussion on any ward leave, if appropriate.
- Discussion of supervision requirements, particularly for meal support and supervision.
- Ensuring appropriate support for families or carers - the Hub is also available to support the patient and their family or carer as appropriate.
- Development and agreement of a 'treatment agreement.'
- Establishment of regular opportunities for debriefing, reviewing patient alignment to and progress against the care plan, and facilitating strategies for distress tolerance for both staff and patient - the Psychology Department and the Hub is available to support staff and the patient and their family or carer as appropriate.

CHS paediatric ward

For a child or young person to be admitted to the paediatric inpatient service for their eating disorder they must be aged under 16 years and require inpatient treatment.

To assist with the decision to admit, staff will undertake an assessment regarding the young person's medical instability, their need for nutritional restoration, whether a mental health admission is indicated and nutritional rehabilitation requirements. To optimize patient outcomes and shared decision making, the admitting team's multidisciplinary reviews should include:

- pediatrician or registrar
- psychiatrist or registrar
- allied health professionals
- nursing staff
- carers and family.

If admission to the paediatric ward is indicated, the following reviews and assessments may be undertaken:

- History of the young person's presenting illness.
- Past and co-existing psychiatric history.
- Social and family history.
- Physical assessment of the young person.
- Medical investigations.
- Consideration of re-feeding syndrome.

Further assessments that may be undertaken include:

- dietitian assessment
- psychiatric assessment
- psychological intervention.

The medical management of the young person is likely to include:

- medical stabilisation
- daily bloods
- supplementation
- considerations for nasogastric tube feeding.

The family/carer of the young person should be involved in the care planning for the young person, and preferably involved in any multi-disciplinary meetings.

Care pathway – Calvary Public Hospital Bruce

Emergency Department presentation

Inpatient services for eating disorders at Calvary Public Hospital Bruce can be accessed when the patient presents to the Emergency Department (ED).

Upon presentation to the ED, the patient will be reviewed for medical stability and immediate medical care needs. If the patient can be stabilised and does not require an admission to the ward, they will be discharged and local community-based treatment or advice from a Community Mental Health service will be sought.

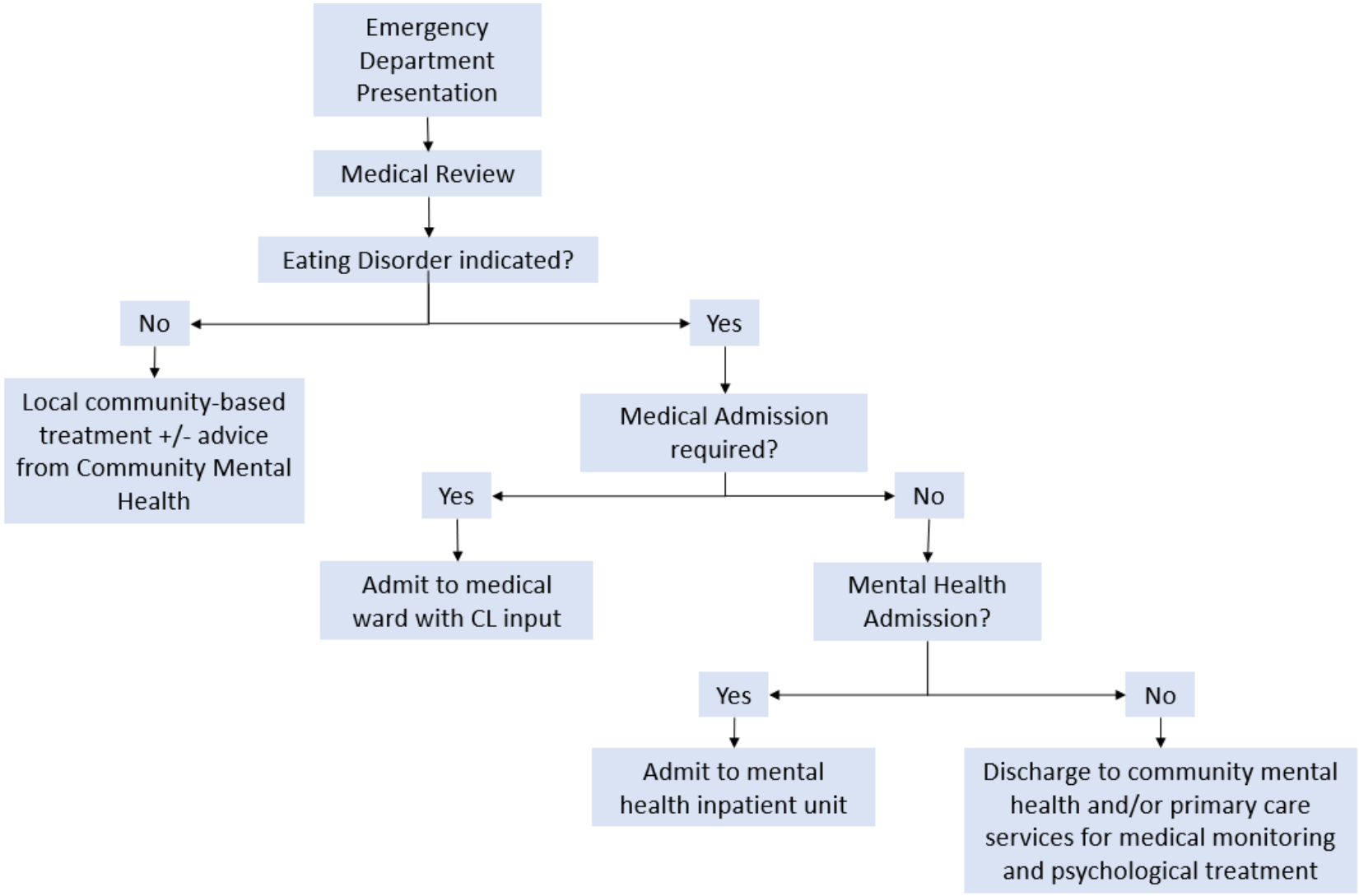
If medical admission is required, the patient will be admitted to the medical ward with CL input.

If medical admission is not required the patient will be assessed for mental health admission. If mental health admission is required, the patient will be admitted to the mental health inpatient unit.

If mental health admission is not required, the patient will be discharged to a community mental health or primary care service for medical monitoring and psychological treatment.

The pathway from the ED into inpatient hospital admission is represented in Figure 5 below:

Figure 5


Emergency Department Presentation
Medical Review
Eating Disorder indicated?
No
Yes
Local community-based treatment +/- advice from Community Mental Health
Medical Admission required?
Yes
No
Admit to medical ward with CL input
Mental Health Admission?
Yes
No
Admit to mental health inpatient unit
Discharge to community mental health and/or primary care services for medical monitoring and psychological treatment

CPHB adult ward

Multi-disciplinary management of the patient will commence immediately from admission to the ward. A psychiatrist should support the inpatient medical team, preferably one with an expertise in eating disorders.

If an expert is unavailable, consultation should involve a consultation liaison or adult general psychiatrist. The multi-disciplinary team should also include a dietitian with specialist knowledge in eating disorders, preferably within a nutrition support team, and have ready access to advice from an eating disorders psychiatrist or expert.

If specialist knowledge is unavailable, then consultation with tertiary services with outreach support will be necessary and is recommended.

It is important to establish the goals of admission from the onset. If the patient presents with a low BMI, restoration of normal weight is unlikely within one admission.

If a short medical or psychiatric inpatient admission is indicated, the likely goals of admission include:

- treatment of medical complications and restoring medical stability
- beginning nutritional rehabilitation and increasing the patient's BMI to a safer level
- stabilizing body weight
- reducing acute purging or other eating disorder behaviours sufficiently to restore medical and behavioural stability
- assisting in the development of appropriate eating behaviors to allow for continued medical stability in the community.

If the patient requires a longer admission, the goals of admission are likely to include:

- medical and physical stability
- continuing to improve the nutritional status and weight restoration towards healthy levels
- sufficient normalisation of eating behaviours to facilitate transfer to a less restrictive treatment environment, as discussed and agreed to by all relevant clinicians

Psychological therapy is another goal of longer admission, noting there may be limited utility in trying to engage the patient in psychological therapy whilst severely undernourished. Brain function is affected and engagement in psychological work can be difficult.

Despite this, psychologists can play a pivotal role in assisting the treatment team throughout admission, assisting the patient with distress tolerance (particularly around meal and weigh-in times), speaking with families, and assisting with any associated distress.

Please note that CPHB does not have a paediatric inpatient unit, and all paediatric admissions are seen at Canberra Hospital.

Discharge process

Discharge needs to be carefully planned with the patient and family and carers, preferably from the start of the hospital admission. Critically ill patients will require a long treatment trajectory, involving numerous treatment settings of which the inpatient medical admission is only one. Preparing families and carers, and the patient, will be important to contain anxiety and set realistic expectations about the need for ongoing treatment and outcomes.

Discharge planning should include the following activities:

- Identification of local treatment options outside of the hospital inpatient setting.
- Commencement of referrals (if required).
- Where possible, an invitation to the patient's GP, outpatient team, the Hub, and the EDP to attend weekly multi-disciplinary team meeting to discuss a discharge plan.
- Re-admission plan (if required).
- GP discharge letter.

Hospital in the Home

A transfer to Hospital in the Home (HITH) should be considered if other arrangements for post-admission follow up are not available or suitable. This should be a time-limited arrangement (e.g., 2-4 weeks) with the purpose of transitioning care to community services and weight stabilisation but is subject to clinical discussion and management.

A comprehensive clinical handover must occur from General Medicine to the HITH multidisciplinary team with a care plan developed and agreed to by General Medicine, the HITH clinical team and the patient and family and carers prior to the patient being discharged.

The care plan is to be a clear weekly plan and is to include planned frequency of visits to the HITH clinic, weight and BMI goal and measurement frequency and plans for "non clinic" days. For example:

- daily phone calls
- frequency and nature of blood tests
- frequency of medical and dietitian contact
- planned psychological support.

Ward readmission criteria must be decided upon and discharge planning for when the patient leaves the HITH service should also have been commenced.

Once clinically stable and discharged from the ward, patients will often attend HITH up to three times a week as an outpatient. Services that HITH can provide upon the patient attending Canberra Hospital may include:

- a medical review
- a dietitian review
- a psychologist review

- a social work review
- meal support
- the provision of dietary supplements and medications
- blood tests and urinalysis
- vital signs monitoring
- weighing and weight monitoring.

Follow-up care

The coordination of how to 'step-down' a patient from hospital to other suitable eating disorder services or home is to be established at the time of admission as part of the early discharge planning process.

Throughout the patient's admission, staff will consult with the patient, the patient's family or carer, the patient's GP, the Hub and other relevant stakeholders on progress made and the patient's discharge plan. This will ensure appropriate follow-up care in the patient's own geographical area of residence is available and ready upon the patient's discharge from hospital, and that all stakeholders are aware of their responsibilities.

There may be clients from rural and remote areas who do not have dedicated follow-up care. A gap analysis should be conducted prior to discharge as part of the discharge planning process to ensure the patient is linked with appropriate services in their state of residence, which may include Telehealth support.

Eating disorders Clinical Hub

The Hub can provide some follow-up care to patients once discharged from hospital for a period of up to 6 weeks. This support is provided by the Transitional Clinician and can include phone check-ins with the patient and their family or carer, psychoeducation, and facilitation of referrals to other public eating disorder outpatient services (if appropriate).

Engagement of the Hub to provide discharge support should be discussed with the Hub as part of the patient's discharge planning process, which should occur upon admission.

Residential Treatment Centre: Model of Care Component

Level 3 of Stepped Model of Care

Description of service

To enhance the care and treatment of eating disorders in the ACT, the Residential Treatment Centre (the Centre) is expected to fill the critical gap between inpatient hospitalisation and outpatient programs, as stipulated in the stepped model of care, to provide an opportunity for a more intensive psychological and therapeutic recovery model in a home-like environment. All patients in the Centre will be referred to as 'participants' in this model of care and while staying at the Centre.

The Centre will operate as a 24 hour, 7 days a week specialist service for people with eating disorders. This is a new service for the ACT and will complement the other public eating disorder specific services in the Territory such as the EDP, the Early Intervention Service, the Hub, the STRIDE clinic and the Parenting/Carer Group.

The Centre is a different service offering to inpatient care and not every person discharged from hospital will be eligible to attend the Centre immediately.

It is important to note that the Centre is not a medical facility and medically unstable clients will not be accepted for admission. Parenteral supplementation (such as iron infusions) or nasogastric feeding will be not used and clients who require this level of care will not be accepted for admission to the Centre. However, some medical interventions such as weighing participants, using oral supplementation, performing physical exams and conducting blood and urinalysis tests are expected to take place.

The Centre is a therapeutic service that will focus on the psychological recovery of participants by providing specialist, intensive nutritional, psychological treatment over an extended period. The Centre aims to improve psychosocial functioning in a residential setting which simulates a supportive home-like environment. This provides an opportunity for participants, families and carers to envision their recovery journey and relationship with food when they are back in their own homes.

While all eating disorders are important to the ACT Government, the Residential Centre will focus on participants with the four most common diagnoses of Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), Other Specified Feeding or Eating Disorder (OSFED), and Unspecified Feeding or Eating Disorder (USFED).

The target population for the Centre are participants with a primary diagnosis of an eating disorder (as detailed above) over the age of sixteen who are medically stable but require further nutritional, psychological and psychosocial support to achieve long term recovery.

The Centre will be open to anyone assessed as eligible for admission, with the person's state of residency factored into wait list management and triage assessments.

General principles for treatment

The Centre will focus on providing best practise, evidence-based treatment to all participants, irrespective of their diverse clinical presentations. This model of care will be underpinned by a set of general principles for treatment for all eating disorders that are universally accepted in

contemporary best practise clinical care, as described in detail in the RANZCP clinical practise guideline[24]:

- Person-centred informed decision making.
- Involving family and carers and significant others in shared decision making.
- Recovery-orientated practice.
- Least restrictive treatment context.
- Multi-disciplinary approach.
- Stepped and seamless care.
- A dimensional and culturally informed approach to diagnosis and treatment.
- Trauma informed principles of treatment.

Following consultation with stakeholders, the following principles will also be considered key to this model of care:

- Eating disorders are psychological conditions with medical consequences.
- The importance of the social milieu and environment.
- Focus on developing increased autonomy with objective measurements of progress.
- Home like environment with hands-on preparation experience.
- Importance of choice and motivation around food and eating.
- Power of lived experience.
- Strong integration with primary care physicians.

Services

The Centre may include some of the following service components:

- Individual therapy sessions.
- Group therapy sessions.
- Strong focus on dietetics and nutritional support.
- Use of alternative or complementary therapies (such as permaculture, music therapy, art therapy etc.).
- Family and carer involvement.
- Peer workforce.
- Strong links to other established care providers.

24 Hay, P. et al (2014). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. Australian and New Zealand Journal of Psychiatry, 48(11) 1-62 https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/eating-disorders-cpg.aspx

Care setting

The Centre will be in the residential suburb of Coombs, ACT. This location has been selected as it aligns with the environmental considerations of a residential suburban setting, peaceful nature outlook and accessibility for participants and their families and carers.

It is of high importance that the Centre is not located on hospital grounds or simulates a clinical setting, as the Centre needs to reflect its purpose of mirroring a residential home.

The Centre will include twelve beds laid out in a combination of single and double bedrooms. Each room will have an ensuite bathroom which will be shared by maximum of two participants.

The kitchen is an important structural component to the Centre and will include a participant kitchen and commercial chef kitchen. The participant kitchen and dining room will be designed to enable participants, families and carers, peer support workers, and health professionals to prepare and eat meals together – replicating regular mealtimes when participants are in their usual environments.

Throughout the design process of the Centre, accessibility for participants, staff and any visiting family and carers with a disability or mobility issues will be considered and designed accordingly.

Patient pathway

All referrals for appropriate participants into the Centre will be managed via the Clinical Hub. For a full referral pathway from the Hub to the Centre please see Figure 3.

Admission criteria

The admission criteria for the Centre will be determined in consultation with the service provider and other public ACT eating disorder services.

Admission process

Upon appropriate assessment and referral from the Hub to the Centre, all referrals will be placed on an intake list for onboarding, which will be actively managed by the Centre. This list will be based on upcoming client discharges, date of initial referral from the Hub, triage category, compatibility with the current participant milieu and any other factors deemed appropriate.

Upon referral to the Centre, prospective participants may be hesitant on whether the Centre is the right treatment option for them. As admission to the Centre is voluntary and prospective participants are encouraged to tour the Centre with their family or carer prior to their admission date to decide if the Centre is a good fit for their healthcare journey and needs.

Care and treatment

Participants will receive care 24 hours a day, 7 days a week. If possible, it is intended that participants will visit their GP and any private practitioners they may have already engaged in their treatment throughout their stay as required. All staff will be working shifts to support the care program.

In addition to treatment, participants will be expected to partake in household chores. This is to simulate the home-like environment, increase responsibilities and to foster a cohesive ‘community’ feel between participants at the Centre.

Phased treatment

A phased system treatment approach is likely to be used. This is to be further developed in consultation with the service provider and other public ACT eating disorder services.

Risk management/step-up procedures and arrangements

The Centre strives to deliver all participants with the right care, in the right setting at the right time. Robust risk assessment and management policies will be developed for this purpose.

Specific areas that will be addressed in policies are likely to include:

- The principle of consent to treatment, particularly regarding minors.
- Responding to and the management of mental state deterioration and suicide risk.
- Physical and medical risk management including risks around refeeding syndrome.

In the cases of medical or psychiatric deterioration, transfer to hospital will be organised. For non-life-threatening situations, the Centre is to call the participant's GP, treating physician or the Hub to determine the escalation pathway. For life threatening situations, this is to be organised immediately via calling '000' for an ambulance transport.

Discharge process

The Centre will have a maximum length of stay of three months.

It is recognised that discharge is inevitable for all participants, and staff, the participant, and their family and carers must work and plan towards discharge as part of treatment planning at the outset.

The goal is to ensure the participant is best prepared for transitioning to a lower level of care and can be successful in their next level of treatment (if appropriate). In the weeks leading up to discharge, the participant, their family or carer, GP, private practitioner and appropriate staff from the Centre and the Hub will work together to identify an appropriate transition plan.

Follow-up care

The coordination of how to 'step-down' the participant from the Centre to other suitable eating disorder services or home is to be established at the time of admission as part of the early discharge planning process.

Throughout the participant's stay, staff will consult with the participant's initial referrer and the Hub on progress made and the participant's discharge plan. This will ensure appropriate follow-up care in the participant's own geographical area of residence is available and ready upon the participant's discharge date.

There may be participants from rural and remote areas who do not have access to dedicated follow-up care. A gap analysis should be conducted prior to discharge as part of the discharge planning process to ensure participants are linked with appropriate services, which may include Telehealth support. A comprehensive policy will be developed outlining discharge and follow-up care arrangements and procedures.

Workflow and work processes

Multi-disciplinary team

Holistic multi-disciplinary treatment plans are collaboratively designed with each participant to meet their unique recovery goals. It is not a one-size-fits-all model but is formulation-based and bespoke, informed by a comprehensive multidisciplinary assessment.

A phased approach to treatment allows for an objective measurement of progress and the ability to adjust levels of supervision while increasing the autonomy and freedom of participants to make recovery-orientated choices. All members of the multidisciplinary team are expected to work together collaboratively to enable a participant's individualised recovery outcomes.

Workforce

The workforce profile at the Centre may include the following professions:

- nursing
- psychiatry
- psychology
- dietetics
- occupational therapy
- exercise physiologist
- general practitioners
- social work
- chef
- kitchen hand
- peer workforce
- administration
- art, music and drama therapists.

Eating Disorders Program: Model of Care Component

Level 2b of the Stepped Model of Care

Description of service

The Eating Disorders Program (EDP) is a free, public, specialist community-based eating disorder service available to residents of the ACT and provides therapy to clients across the lifespan of their treatment. The EDP has a multidisciplinary team working within a strengths, evidence and recovery-based framework offering specialist therapy to support tailored treatment to meet individual and family needs.

The EDP provides evidence-based therapy inclusive of all ages to people who are medically stable and are motivated to actively engage in treatment. The service is based on the principles of recovery and participation.

It focuses on delivering evidence-based therapies that are sensitive to age, gender, spirituality, and culture. The EDP team works closely and in consultation with the person, family and carers and the treating GPs.

As well as the primary evidence-based treatment offered through EDP, detailed below under Services, EDP can also provide supported meal therapy as a component of the treatment modality undertaken. The EDP also assists the Hub with the Parenting Groups, in addition to providing consultation and liaison with other services for eating disorder clients as appropriate.

The primary focus of the service is to provide assessment and evidence-based treatments that are supported by published research demonstrating their effectiveness for those experiencing a moderate to severe eating disorder. Services are guided by the Australian and New Zealand academy for eating disorders (ANZAED) treatment principles and general clinical practice and training guidelines.

These standards were developed to provide guidance for Mental Health and Dietetic professionals who provide eating disorder treatment. The practice standards help to ensure best practice, patient safety and optimal patient outcomes in the management of eating disorders.

The EDP works collaboratively with other relevant acute, outpatient and community-based services to improve outcomes for those living with an eating disorder.

The EDP is not a medical or crisis service, and therefore it is important that consumers continue to be reviewed by their GP. Persons can contact the Access Mental Health Service who provide crisis mental health support 24 hours a day, 7 days a week by calling 1800 629 354 or 02 6205 1065**.**

The EDP only accepts referrals from the Hub. The Hub undertakes an intake, triage and assessment process prior to sending referrals to the EDP.

Principles of care

Recovery informed, person-centred and systemically focused

Support and intervention offered through the EDP is underpinned by recovery orientated care based on the assumption that children, adolescents, and adults accessing the service can lead fulfilling lives and contribute meaningfully to their communities and society more broadly.

The service provides person-centred care and respects the person and their family's autonomy and self-determination in making informed choices regarding treatment, goals, attitudes, and rights throughout the therapeutic relationship. The focus of specific evidence-based eating disorder treatment provides hope and structured support to consumers and their family and carer to work on their identified recovery goals.

The service is systemically focused and therefore works closely with familial and external systems to support recovery.

Timely access to care

In recognition of limited accessible options to specific eating disorder treatment within the ACT, the EDP works collaboratively with other public and private services to:

- acknowledge and manage barriers to timely comprehensive care
- foster referral pathways
- actively triage referrals
- provide timely information and resources at the point of contact to the consumer.

Collaboration and continuity of care

The EDP will work to:

- offer timely and flexible follow up to adults, young persons and their families post discharge from hospital based acute services
- establish robust relationships with adult and young persons' social and family systems as well as any support systems within a community setting that will support and foster growth and recovery on an ongoing basis
- build collaborative partnerships with agencies and workers to ensure a continuity of care and promote options that are available to meet the needs of the adult or young person.

Integrated, multidisciplinary and evidence-based care

The EDP will adopt a holistic approach to treatment and care informed by evidence based therapeutic intervention and individual need, emphasising physical, social, educational, occupational and psychological and emotional wellbeing.

Embracing diversity and complexity

The EDP will display understanding and respond to gender, racial, cultural, physical and socioeconomic diversity as well as the complexities of people and their families accessing the service with informed, sensitive, and flexible practice.

Safety and quality

The EDP will deliver an evidence-based service by ensuring the ongoing development of services including staff development, engaging in quality initiatives, adhering to national quality, safety and practice standards, and the adoption of best practice. EDP will provide a safe environment for staff, consumers and their families to safely receive care within the community.

Consumer and carer involvement

The EDP works from a recovery framework and reflects the importance of the person and their family or carer's meaningful participation in their care and treatment. EDP are committed to involving a person and their family in decision affecting their health, care, and treatment. EDP is underpinned by systemic theory and family-based intervention and strives for high family and carer involvement, along with other care teams and service providers.

Telehealth

For clients who are unable to attend an appointment face to face, EDP will offer the option of a video phone call. Please note that EDP requires most therapy sessions to be conducted face to face, and this option is only available on a case-by-case basis in consultation with EDP.

Services

The EDP provides specialised evidence-based eating disorder therapy to eligible clients. These core interventions include, but are not limited to:

- Maudsley Family Based Therapy (FBT)
- Cognitive Behavioural Therapy – Enhanced (CBT-E) for both young people and adults
- Cognitive Behavioural Therapy – Ten Session Model (CBT-T)
- RAVES Eating Model
- MANTRA
- Specialist Supportive Clinical Management (SSCM)
- Adolescent and Parent Focused Therapy.

Maudsley Family Based Therapy

Maudsley Family Based Therapy proceeds through three clearly defined phases, with approximately 20 treatment sessions over a period of up to 12 months.

The Maudsley approach is an intensive outpatient treatment where parents play an active and positive role to:

- help restore their child's weight to normal levels expected given their adolescent's age and height to reflect their unique previous growth trajectory
- hand the control of eating back to the adolescent and encourage normal adolescent development through an in-depth discussion of these crucial developmental issues as they pertain to their child.

The Maudsley Approach considers the parents as a resource and is essential in successful treatment for AN.

Cognitive Behavioural Therapy – Enhanced

Enhanced Cognitive Behavioural Therapy requires 20 sessions over 20 weeks for persons who are within normal weight range.

For persons who are underweight treatment needs to be longer and 40 sessions over 40 weeks is recommended.

CBT-E is a 'transdiagnostic' personalised psychological treatment for eating disorders. At the core of all eating disorders is a dysfunctional self-evaluative system.

People with eating disorders tend to evaluate their self-worth almost entirely on their weight and shape. This overevaluation of weight and shape is the core psychopathology responsible for driving many of the clinical features we see in the eating disorders.

In the second stage of CBT-E progress is systematically reviewed, and plans are made for the main body of treatment, Stage Three.

Stage Three focuses on the processes that are maintaining the person's eating problem. Usually this involves addressing concerns about shape and eating, enhancing the ability to deal with day-to-day events and moods, and the addressing of extreme dietary restraint.

Towards the end of Stage Three and in Stage Four the emphasis shifts onto the future. There is a focus on dealing with setbacks and maintaining the changes that have been obtained.

CBT-E is a highly individualised treatment. It is designed to fit the person's difficulties and be modified considering their progress.

Cognitive Behavioural Therapy – Ten Session Model

The Ten Session Model of Cognitive Behavioural Therapy is ten sessions over 10 weeks.

It is a shortened version of CBT-E, and the person needs to be in the action stage of change and within a normal weight range.

RAVES Eating Model

The Regularity, Adequacy, Variety, Eating Socially and Spontaneity (RAVES) Eating Model is an evidence informed framework to nutrition in recovery from an eating disorder.

The process of RAVES provides a format for how to develop an eating pattern that helps support a sustainable recovery.

The RAVES eating model is incorporated across all intervention models at EDP.

MANTRA

MANTRA is a specialist integrative therapy that has been developed specifically for the treatment of anorexia nervosa. MANTRA consists of seven core modules conducted over 20-40 sessions.

MANTRA aims to address the cognitive, emotional, relational and biological factors which tend to maintain AN by working out what keeps people stuck in their anorexia, and gradually helping them to find alternative and more adaptive ways of coping[25].

25 The London Centre for Eating Disorders and Body Image. Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA). Available at: https://www.thelondoncentre.co.uk/mantra

SSCM

Specialist Supportive Clinical Management (SSCM) is an effective outpatient eating disorder treatment for anorexia nervosa. The two aims of SSCM are to:

- help clients make a link between their symptoms and their eating behaviour and weight
- to support them in a gradual return to normal eating and weight restoration.

To do this, SSCM combines two therapeutic components, clinical management, and supportive psychotherapy. The clinical management aspect prioritises the establishment of normal eating and weight restoration, provides targeted psychoeducation and advice about eating disorders, eating and weight and shape concerns.

The supportive psychotherapy framework allows client and clinician to respond to other important life issues identified by the client, including those that may impact upon the eating disorder[26].

Care setting

EDP is located at the Phillip Health Centre on the corner of Keltie and Corinna Streets, Woden.

The EDP is available Monday to Friday between the hours of 8.30am until 16:51pm. EDP does not provide acute or urgent responses to young people or adults in crisis.

EDP provide office-based appointments. The EDP does not provide outreach services to consumers, however, supports consultation to other service providers within the public and private sector community as required.

Outside these hours a person and their family can contact the Access Mental Health Service who provide crisis mental health support 24 hours a day, 7 days a week. People who require acute medical services will be directed to other appropriate services such as their GP or Emergency Department.

Patient pathway

All requests for assistance with disordered eating habits or eating disorders will require a full referral to be submitted to the Hub. For a detailed overview of the pathway from the Hub referral to treatment at the EDP please see Figure 3.

Admission Criteria

Key Eligibility Criteria

- Children, adolescents, and adults (inclusive of all ages across the lifespan).
- Have a primary presenting issue of a moderate to severe eating disorder.
- Are a resident of the ACT.
- Have a BMI between 15-40.
- Are medically stable.

26 National Eating Disorders Collaboration (2020). Specialist Supportive Clinical Management (SSCM). Available at: Specialist Supportive Clinical Management (SSCM) (nedc.com.au)

- Are motivated and willing to engage in therapy and recovery-oriented goals of treatment.

Priority will be given to persons who:

- have been discharged from an acute setting because of medical instability
- are on the triaged wait list for service and deterioration in their medical stability is informed by their GP, consumer self-report or other health professional.

Exclusion Criteria

- Medical instability as confirmed by GP or treating medical professional, which may require acute medical attention.
- A BMI below 15 which impacts capacity to effectively engage in cognitive based therapeutic intervention.
- Active suicidal ideation and self-harm as the primary presenting issue.
- Premorbid mental health conditions which impact capacity to engage effectively in evidence based therapeutic interventions (e.g., major depression, psychosis).
- Resides outside the ACT – clients who are not ACT residents can work with the Hub to be connected to local services within their residential area.
- A diagnosis of Avoidant Restrictive Food Intake Disorder (ARFID).

Referral to services

Once the Hub has completed their intake and assessment processes, if the client is recommended EDP as their treatment pathway, the Hub will make a referral to EDP.

Once this referral is received at EDP, the client will be allocated a care zone and added to the waitlist for further assessment. While on the waitlist, monthly contact is made. The client initiates this contact. If EDP does not receive contact by the client, EDP staff will follow-up with the client.

After the EDP assessment is completed, the client will commence therapy if this is clinically indicated.

Risk management/step-up procedures and arrangements

The EDP strives to deliver all clients with the right care, in the right setting at the right time. Risk management policies and procedures are well established at CAMHS and are supported by clear lines of accountability. The CAMHS risk management response is guided by policies and procedures established by CHS and MHJHADS.

RiskMan is ACT Health's platform for incident notification and risk reporting.

In the cases of medical or psychiatric deterioration, transfer to hospital will be organised. For non-life-threatening situations, EDP may call the client's GP or treating physician to determine the escalation pathway. For life threatening situations, this is to be organised immediately via ambulance.

Discharge process

From the commencement of engagement, discharge planning with the consumer, family or carer and other key stakeholders is important. There is a focus on working toward recovery and treatment

goals and consideration of transfer of care as appropriate to other services upon therapy cessation and discharge, to reduce extended gaps in care.

Follow-up care

Throughout a client's treatment journey, EDP staff will liaise with the client's initial referrer (if appropriate), GP and the Hub on progress made and the client's discharge and step down care plan.

Follow-up will be conducted within 12 months of engagement and is to be initiated by the client. This follow-up can be done by EDP or the Hub as appropriate.

Workforce

The EDP is staffed by a multidisciplinary workforce, which may include a manager, therapists, and an administrative services officer. This ensures clients receive access to the medical, dietetic, and psychological interventions that are required to maximise the chance of a full recovery throughout the client's eating disorder journey.

Early Intervention Service: Model of Care Component

Level 2a of the Stepped Model of Care

Description of service

The purpose of the ACT Early Intervention Service for Eating Disorders (EISED) is to overcome barriers to early treatment and recovery and provide highly coordinated early care, with a central focus on reducing the duration of an untreated eating disorder. The early intervention service is intended to complement, rather than replace, existing evidence-based treatments and protocols.

The provision of appropriate early intervention for people with eating disorders has been shown to improve people's rates of recovery, quality of life and reduce the need for more intensive services provided by the health system.

The ACT EISED will focus on promoting help seeking behaviour and early intervention treatment for people in the early stages of developing an eating disorder and those with an eating disorder of low to moderate severity. Improving access to early intervention is intended to improve patient outcomes and promote recovery, while reducing demand on the specialist tertiary and acute inpatient services.

The ACT EISED will be delivered by an NGO as the service provider. The service provider will work in close collaboration with ACT Health and the Hub to facilitate appropriate patient flows and connection with other public ACT eating disorder services.

All referrals to the ACT EISED will be allocated from the Hub or be received directly by the service. Discharges will be completed in collaboration with the Hub to ensure the provision of step-down supports, if appropriate.

General principles for treatment

FREED Model

The First Episode Rapid Early Intervention for Eating Disorders (FREED) model is currently the only evidence-based model of care for early intervention of eating disorders[27]. The FREED service model is associated with significant reductions in wait times and improved clinical outcomes for emerging adults with recent onset of an eating disorder. The model enables rapid access to specialised treatment which gives special attention to challenges in the early stages of an eating disorder.

FREED is a flexible evidence-based treatment approach focused on early intervention, making it much more effective than traditional treatments at reversing the changes to brain, body and behaviour caused by eating disorders. For further information, visit: First Episode Rapid Early Intervention for Eating Disorders | FREED (freedfromed.co.uk)

27 Allen, Mountford, Brown, Richards, Grant, Austin, Gellnon, Schmidt (2020). First episode rapid early intervention for eating disorders (FREED): From research to routine clinical practice. Early Intervention Psychiatry (14) 5:625-630. Doi: 10.1111/eip.12941

The ACT EISED will use the following key principles of the FREED model:

- Clients are to be over the age of 16, and clients under the age of 16 can be referred on a case-by-case basis, as determined by the Hub.
- Clients to have an eating disorder duration of three years or less or no previous engagement in an evidence-based intervention for eating disorders.
- The EISED therapy option is to be tailored to suit the client's personal circumstances and treatment requirements.
- EISED to conduct an 'engagement call' within 48 hours of receiving a referral from the Hub to confirm eligibility for the EISED, and to book into an assessment time slot.
- The initial EISED assessment must be completed with two weeks of the referral being made from the Hub.
- The client must commence treatment within four weeks of the referral being made from the Hub.
- EISED is to conduct pre and post outcome measures or surveys which can be used to demonstrate clinical outcomes.

Other principles

Further to the key FREED principles, the ACT EISED will focus on providing best practise, evidence-based treatment to all clients, irrespective of their diverse clinical presentations. This model of care will be underpinned by a set of general principles for treatment for all eating disorders that are universally accepted in contemporary best practise clinical care, as described in detail in the RANZCP clinical practise guideline[28]:

- Person-centred informed decision making.
- Involving family or carers and significant others in shared decision making.
- Recovery-orientated practice.
- Least restrictive treatment context.
- Multi-disciplinary approach.
- Stepped and seamless care.
- A dimensional and culturally informed approach to diagnosis and treatment.
- Trauma informed principles of treatment.

Care setting

The ACT EISED is intended to operate five days a week in the ACT. The ACT EISED does not provide acute or urgent responses to young people or adults in crisis.

Outside these hours people and their families can contact the Access Mental Health Service who provide crisis mental health support 24 hours a day, 7 days a week. Persons who require acute medical services will be directed to other appropriate services such as their GP or Emergency Department by calling 000.

28 Hay, P. et al (2014). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. Australian and New Zealand Journal of Psychiatry, 48(11) 1-62 https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/eating-disorders-cpg.aspx

Patient pathway

All referrals to the ACT EISED will be allocated from the Hub or be received directly by the service, with discharges completed in collaboration with the Hub. The Hub is the key integration point for the early intervention service into public, specialised eating disorder clinical support.

Admission criteria

The admission criteria for the ACT EISED will be determined in consultation with the service provider and other public ACT eating disorder services.

Discharge process

The discharge process for the ACT EISED will be determined in consultation with the service provider and other public ACT eating disorder services. Early discharge planning is encouraged.

Follow up care

Throughout the client's therapy journey, ACT EISED staff will consult with the client's initial referrer and the Hub on progress made and the client's follow-up care plan. This will ensure appropriate follow-up care in the client's own geographical area of residence is available and ready upon the client's discharge date, if required.

Workflow and work processes

The workflow and work processes of the ACT EISED are to be determined by the Service Provider in line with operational requirements.

Workforce

The ACT EISED workforce is the responsibility of the service provider and may include therapists, allied health professionals, peer workers and administrative support.

Primary Care: Model of Care Component

Level 1 of the Stepped Model of Care

General Practitioner involvement in the stepped care model

To assist in clarifying the desired level of General Practitioner (GP) involvement for clients when they are engaged with a higher-level therapy service, and to highlight the desired level of interaction the service should have with the GP or GP practice, please refer to the below table.

Level	Desirable GP Involvement	Desirable Service Interaction with GP sector
Level 1: Primary Care	Conduct GP appointments in the community as clinically indicated. Provision of medical information to support treatment plan within private sector.	Not applicable as client will be engaged with private sector instead of public system.
Level 2a: Mental Health Service/Early Intervention	Conduct GP appointments in the community as clinically indicated. Provision of medical information to support referral.	Engagement letter. Discharge letter.
Level 2b: Dedicated Eating Disorder Team	Conduct GP appointments in the community as clinically indicated. Provision of medical information to support referral. Involvement in care and safety and planning and discharge planning as required.	Engagement letter. Discharge letter. Involvement in care planning. Involvement in discharge planning as required.
Level 3: Dedicated Day/Intensive Programs	Conduct GP appointments in the community as clinically indicated. Provision of medical information to support referral. Involvement in care and safety and planning and discharge planning as required.	Engagement letter. Discharge letter. Involvement in care planning. Involvement in discharge planning as required.
Level 4: Inpatient Medical/Psychiatry	Provision of medical information to support referral. Involvement in care and safety and planning and discharge planning as required.	Engagement letter. Discharge letter. Involvement in care and safety and planning and discharge planning as required.

Description of primary care sector

The foundation of eating disorders care across the lifespan is community-based care. Within the ACT, the eating disorders primary care sector includes GPs and GP practices in primary care and community mental health, NGOs, community programs, services and education. Each of these services have a significant role to play in the provision of health care to people with an eating disorder, their families and carers.

The health care system relies on the primary care sector to identify and enable early intervention. GPs and GP practices play a key role in the early identification, response to and management of eating disorders as they are often the first point contact for health concerns.

Consequently, GPs and other frontline health professionals should be properly supported to identify and manage eating disorders within a primary care setting, and to provide support for clients who are engaged with higher level care for their eating disorder. This can be as simple as a phone call, but ideally would include a service engagement letter, involvement in care and discharge planning, and a discharge letter once therapy has been completed.

Community-based organisations and NGOs are also vital components of the eating disorders sector. These organisations play key roles in providing advocacy, information and support for people with eating disorders and can be a key point for referrals.

While primary care services and community organisations can provide services for people with mild to moderate symptoms, it is also important to have established networks and referral pathways from these generalist interventions to more specialist treatment for people with higher clinical needs. An assessment of when to refer for higher care and what higher care options are available can be found by contacting the Hub.

This model of care component is focused on connecting the primary care sector into the public health system and higher levels of care for eating disorders. It provides an integration framework to ensure continuous care for clients throughout their treatment journey inclusive of appropriate escalation processes, discharge planning, and ongoing management and monitoring expectations.

Principles of care

Recovery informed, person-centred and systematically focused

Support and intervention for eating disorders is underpinned by recovery orientated care based on the assumption that children, adolescents, and adults accessing care can lead fulfilling lives and contribute meaningfully to their communities and society more broadly.

The service provides person-centred care and respects the person and their family's autonomy and self-determination in making informed choices regarding treatment, goals, attitudes, and rights throughout the therapeutic relationship. The focus of specific evidence-based eating disorder treatment provides hope and structured support to consumers and their family and carer to work on their identified recovery goals.

The primary care sector works closely with familial and external systems to support recovery.

Timely access to care

The primary care sector works collaboratively with other public and private services to acknowledge and manage barriers to timely comprehensive care, to facilitate appropriate referrals and provide timely information and resources at point of contact to the consumer.

Collaboration and continuity of care

Collaboration between and within sectors and services ensures smooth transitions of care in a clinically appropriate and integrated manner, and better outcomes for clients. Collaboration between the primary care sector and higher levels of care is recommended to support clients who access multiple services.

Continuity of care is important for the primary care sector as this sector is often the discharge destination for clients stepping down from higher levels of care. The TwMoC encourages GPs to be involved throughout the client's treatment journey, which includes being informed of progress and clinical decisions while engaged in higher levels of care and involved in the discharge planning for the client.

Integrated, multidisciplinary and evidence-based care

This model of care will provide the framework for a holistic approach to treatment and care informed by evidence based therapeutic intervention and individual need, emphasising physical, social, educational, occupational, psychological and emotional wellbeing. The key to integration between sectors is the Hub, which is described further in this document.

Consumer and carer involvement

A recovery framework reflects the importance of the person and their family and carer's meaningful participation in their care and treatment. The primary care sector is committed to involving people and their families and carers in decisions affecting their health, care, and treatment.

Telehealth

For clients who are unable to attend an appointment face to face, the option of a video phone call should be made available. Best practise treatment for eating disorders requires most therapy sessions to be conducted face to face, and this option is only available on a case-by-case basis in consultation with the service provider.

General Practitioners

Overview

GPs and GP practices are often the first point contact for patients who are experiencing disordered eating behaviours or an eating disorder. GPs play a key role in the early identification and response to patients who present with these issues.

GPs can provide care and monitoring for eating disorder clients in the community, and if escalation is required, can refer to other eating disorder services as appropriate. Support on managing eating disorder clients in the community and how to identify when escalation of care is required can be provided by contacting the Hub.

The use of the Hub is promoted via HealthPathways, SmartForm on Healthlink and by the Hub's webpage. GPs are encouraged to contact the Hub at any point for assistance with their eating disorder clients.

GPs have access to professional development opportunities that assist with working with clients to manage eating disorders. This includes training and resources provided by organisations such as the National Eating Disorders Collaboration (NEDC) and the InsideOut Institute. The Hub will also provide ad-hoc training and information sessions as required.

GPs also play a pivotal role in the ongoing management of eating disorders, which often includes monitoring and regular check-ins with clients after discharge from a higher level of care such as hospital. It is important that GPs are involved throughout a client's journey when they access more

intensive care within the public or private system, and are included in discussions regarding the client's progress, clinical decisions and discharge planning.

All clinicians should understand the significant physical risks associated with eating disorder behaviour, including the risk of death, and be aware of the parameters of physical stability, as outlined in the Royal Australian and New Zealand College of Psychiatry (RANZCP) clinical practice guidelines for the treatment of eating disorders. There is a need for all patients to have a medical assessment, preferably by a medical practitioner who understands the clinical symptoms and signs indicating the risks associated with eating disorders. Ongoing medical review should be a non-negotiable element of treatment.

Private practitioners

Overview

Private practitioners, such as allied health professionals and mental health nurses in private practice are available in Canberra. Private practitioners provide therapy for those diagnosed with an eating disorder.

Referral process

If clinically indicated, a GP can provide a referral to private practitioners as required for access to Medicare benefits such as the Eating Disorder Treatment and Management Plan (EDMTP). Potential clients are also able to access private practitioner services without a GP referral, noting that this would not qualify them for Medicare rebates.

NGOs and community sector

Overview

Community-based organisations and NGOs are vital components of the eating disorders sector. These organisations play key roles in providing advocacy, information and support for people with eating disorders and can be a key point for referrals. The NGO and community sector for eating disorders in the ACT is diverse and includes organisations that delivery therapy and educational programs, provide information and online resources and provide advocacy and support to patients, families and carers.

Within the ACT, NGOs who provide these supports include organisations such as headspace, Think Mental Health, Mental Illness Education ACT (MIEACT) and the Butterfly Foundation.

NGOs who provide advocacy and support for eating disorders include Mental Health Consumer Network, Eating Disorders Families Australia and other organisations.

Further information on these organisations, their role and their offerings can be found on their respective websites.

Considerations for client care

Comorbidities

Fifty-five to 97% of people diagnosed with an eating disorder have a mental illness comorbid condition[29]. This means that eating disorder clients engaged with a GP are often seeking help for more than just their eating disorder.

The high frequency and complexity of comorbidities for clients with eating disorders make it even more important that the GP engages in the client's care journey to assist with managing (or at least providing context for) the client's comorbidities and how these may interact with the eating disorder.

Care in the community

Once a client presents to their GP with disordered eating behaviours or an eating disorder diagnosis, the GP can setup an EDTMP for that client. An EDTMP is an evidence-based, best practice model of treatment that enables the client to access up to 20 Medicare-subsidised sessions with a dietitian and 40 sessions with a mental health clinician over a 12-month period for private services.

For any patient, an EDMTP expires 12 months following the start date on the plan. After a plan expires, a patient will require a new EDTMP to continue accessing services under the EDP program. They will then be able to access up to 40 psychological treatment services and 20 dietetic services for 12 months from the start date of this new plan, if the threshold of total services allocated has not been exceeded within 365 days, including from any other mental health or dietetic care plans.

Further information on this and other Medicare Benefit Scheme (MBS) items for eating disorders can be found online at: MBS online - Upcoming changes to MBS items - Eating Disorders

29 National Eating Disorders Collaboration (NEDC). (2017). *Eating disorders prevention, treatment and management an updated evidence review.* Sydney: NEDC

Integration between sectors – Eating Disorders Clinical Hub

The key integration point for the primary care sector into public, specialised eating disorder clinical support is provided via the Hub. For further information on the integrated service provided by the Hub, please refer to the Clinical Hub: Model of Care on Page 18 of this document.

For a detailed overview of what happens once a referral has been made to the Hub, please see Figure 3.

HealthPathways

HealthPathways offers clinicians locally agreed information to make the right decisions together with patients, at the point of care. The pathways are designed primarily for GP teams, but are also available to specialists, allied health professionals, and other health professionals in the region.

For eating disorders, information on the Hub and the EDP are available on HealthPathways, with further information on referral pathways.

HealthPathways and further information can be accessed via their website: HealthPathways ACT and SNSW (communityhealthpathways.org)

SmartForms on HealthLink

Smartforms on Healthlink is an online referral system used by GPs to refer clients into the hospital setting. Due to the implementation of the Digital Health Record (DHR) within the ACT in late 2022, the utilisation of Smartforms for ACT GPs to refer into Canberra Hospital or Calvary Public Hospital Bruce will be implemented once the DHR is fully implemented.

More information on Smartforms on HealthLink can be found at their website: Home - HealthLink

Emergency Department presentation

If the client is medically unstable and requires treatment immediately, they should be directed to present to the nearest emergency department for assessment and treatment.

Escalation of care

Once a GP determines that a client requires escalation of care for their eating disorder, the Hub can be contacted if the client is medically stable.

It is advisable that for all requests for assistance and escalation of eating disorder clients, the Hub be contacted in the first instance or as soon as practical. If the client is medically unstable, the following pathways and information sources can be accessed:

- Healthpathways
- Healthlink
- Emergency Department presentation.

Return to primary care

GPs are often an integral part of the client's discharge plan for ongoing care in the community. As a client approaches discharge from another service or therapy option, it is recommended that the client's GP engages in clinical discussions and discharge planning discussions.

Upon formal discharge, often the GP is responsible for ongoing monitoring and engagement with the client as clinically appropriate. This involvement of the GP ensures a smooth transition back to the community and supports the GP with handover. This handover will be provided in written form with discharge details and outcomes.

Ongoing care and management

Ongoing care and management of clients with an eating disorder in the community upon discharge is often the responsibility of the GP. This can include activities such as medical monitoring via blood tests, weighing of clients and referrals to other services as appropriate.

GPs can consult with the Hub regarding discharged clients to assist with clinical management while the client is in the community, and determine further care pathways as required.

Model of care monitoring and evaluation

The use of monitoring and evaluation of all models of care is recommended. Both monitoring and evaluation are necessary management tools to inform decision-making and demonstrate accountability. Systematically generated monitoring data is essential for a successful evaluation.

Monitoring can be defined as the periodic assessment of programmed activities to determine whether they are proceeding as planned. At the same time, evaluation involves the assessment of the programs towards the achievement of results, milestones, and the impact of the outcomes based on the use of performance indicators.

Both activities require dedicated funds, trained personnel, monitoring and evaluation tools, effective data collection and storage facilities, and time for effective inspection visits in the field and to each service.

As this is the first time the ACT has a TwMoC document, appropriate monitoring and evaluation activities will be considered for future implementation with the revi ewing and updating of the TwMoC to be scheduled every three years under the MHJHADS Governance Committee.

Abbreviations

ACT	Australian Capital Territory
ACTHD	Australian Capital Territory Health Directorate
AN	Anorexia Nervosa
ANZAED	Australia New Zealand Academy for Eating Disorders
BED	Binge Eating Disorder
BMI	Body Mass Index
BN	Bulimia Nervosa
CAMHS	Child & Adolescent Mental Health Services
CBT-E	Cognitive Behavioural Therapy - Enhanced
CBT-T	Cognitive Behavioural Therapy – Ten Session Model
CCSW	Collaborative Care Skills Workshops
CHS	Canberra Health Services
CPHB	Calvary Public Hospital Bruce
DHR	Digital Health Record
EDFA	Eating Disorders Families Australia
EDP	Eating Disorder Program
EDTMP	Eating Disorder Treatment Management Plan
EISED	Early Intervention Service for Eating Disorders
FBT	Family Based Therapy
FREED	First Episode Rapid Early Intervention for Eating Disorders
GP	General Practitioner
HCCA	Health Carers & Consumers Association
Hub	The Eating Disorders Clinical Hub
IP	Initial Presentation
MANTRA	Maudsley Anorexia Treatment for Adults
MBS	Medicare Benefit Scheme
MDT	Multidisciplinary Team
MHJHADS	Mental Health, Justice Health, Alcohol & Drug Services
MIEACT	Mental Illness Education Australian Capital Territory
NEDC	National Eating Disorders Collaboration
NGO	Non-Government Organisation
OSFED/USFED	Other Specified Feeding or Eating Disorder/Unspecified Feeding or Eating Disorder
RANZCP	Royal Australian & New Zealand College of Psychiatrists
RAVES	Regularity, Adequacy, Variety, Eating Socially, Spontaneity Model
SSCM	Specialist Supportive Clinical Management
SSI	Single Session Intervention
STRIDE	Short Term Recovery Intervention for Disordered Eating
The Centre	The Residential Treatment Centre for Eating Disorders
TwMoC	Territory-wide Model of Care for Eating Disorders	

ACKNOWLEDGMENT OF COUNTRY

ACT Health acknowledges the Traditional Custodians of the land, the Ngunnawal and Ngambri people. ACT Health respects their continuing culture and connections to the land and the unique contributions they make to the life of this area. ACT Health also acknowledges and welcomes Aboriginal and Torres Strait Islander peoples who are part of the community we serve.

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