



# Eating Disorder Service Mapping Project

A commitment under the Victorian Government's Response  
to the Parliamentary Inquiry into Issues relating to the  
Development of Body Image among Young People and  
associated effects on their Health and Wellbeing





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# CONTENTS

Executive Summary	1
Project	5
Background	5
Review of the Centre of Excellence in Eating Disorders	7
Eating Disorders	8
Prevention and Health Promotion	12
Health Services for Eating Disorders	13
Service Utilisation Data	30
Consumer and Family Support, and Community Education	38
A Responsive Service System	40
Service System Gaps	42
Appendix A	53
Glossary of abbreviations	56



## EXECUTIVE SUMMARY

This Report presents the results of a project that mapped services for people with eating disorders. The mapping exercise was a government commitment in response to recommendations of the Body Image Inquiry Report, tabled in Parliament in September 2005.

While acknowledging the importance of health promotion and health promotion activities focused on healthy eating, the Eating Disorders Service Mapping Report is focused on the range of existing health services that provide interventions for people with eating disorders. This includes programs for people with body image concerns as well as services for persons affected by the most severe eating disorders. The Report encompasses private, not-for-profit and public sector services, with a major focus on relevant state-funded mental health services.

A stepped care model is used to analyse the nature and adequacy of existing services. This approach assumes that treatment should match patient need, with the most complex and severe conditions being treated by the most specialised services and vice versa. According to this model, the less severe conditions should be treated at the primary care level, whereas specialist mental health and health services should treat moderate to severe disorders, and tertiary level specialist care focus on the most severe conditions.

Use of the stepped care model highlights issues of accessibility and availability of treatment at the different levels of care. The Report identifies service system problems at each level of care in relation to eating disorders. For instance, GPs are the key primary health practitioners, with a pivotal role in recognising problematic eating; assessing its severity, and organising appropriate treatment. It would appear however, that only a minority of GPs are willing and able to undertake this role. Community health services are another source of primary care, particularly for those with limited means, yet their staff might not be skilled in identifying and treating disordered eating. Further, community health service programs may not be in place for people with body image concerns.

Secondary level care is typically required for moderate to severe eating disorders. A person in this situation would usually be referred by primary health providers to the private or public mental health sector for mental health treatment. Paediatricians are also frequently consulted regarding children and adolescents. If the person's physical health is compromised, admission to a paediatric or general adult medical ward may also be necessary.

Although important, access to secondary care from public or private mental health services is not straightforward for the treatment of eating disorders. For instance, most private psychiatrists practise only in certain parts of metropolitan Melbourne, and bulk-billing is rare. Use of private psychologists and dietitians is costly, especially for those with little disposable income and no private health insurance cover. Additionally, private health insurance is necessary to meet the costs of private psychiatric inpatient care and day program attendance. Furthermore, fees are charged for attendance at programs run by private foundations such as the Bronte Foundation and the Oak House.

A related problem is that access to public mental health services may be difficult for people with moderate to severe eating disorders, unless they have a co-morbid condition such as depression. Although seemingly at odds with government policy, this stems from mental health clinicians' perceived lack of the needed specialist knowledge and skills, and increased service demands from other diagnostic groups.

The state-funded Primary Mental Health Teams (PMHT) are a relatively new type of public mental health service relevant to eating disorders. The PMHTs were set up from 2001 in all twenty-one Adult Mental Health Services. They assist local GPs and other primary healthcare providers to respond to mental health problems, particularly high prevalence disorders such as anxiety and depression. PMHTs also provide early intervention for young people with first episode psychosis. From 2003 to 2005, half of the PMHTs participated in a project funded by the Centre of Excellence in Eating Disorders (CEED) to build their capacity to respond to eating disorders. These teams gained additional clinical expertise about assessing and treating eating disorders, and provided consultation to GPs and other primary healthcare providers. On the other hand, only eleven of the twenty-one PMHTs took part and with staff turnover, their eating disorder skill base is diminishing.

At the tertiary level of care, there are three public specialist eating disorder services to treat adults with the most critical and complex conditions. They are located at the Austin, Monash Medical Centre and the Royal Melbourne Hospital, and have catchment areas covering sections of metropolitan Melbourne and rural/regional Victoria. These services have varying resources however, which affects what care can be provided. For instance, each has inpatient beds, but the number of beds range from two to nine. The Austin utilises beds flexibly for treatment of persons with other mental health conditions, whilst Monash can negotiate access to up to two additional beds. Further, the beds are funded at different rates across the three services. Of the three services, only the Royal Melbourne is funded for a day program as well as inpatient beds. In addition, although the Royal Melbourne and Monash provide some outpatient services, neither is specifically funded for this purpose. In brief, none of the three services has the full capacity to provide comprehensive tertiary care. Lastly, although eating disorders often emerge in early adolescence, the specialist services are for adults, typically only accepting patients from the age of 16 years upwards.

## Recommendations

The Report makes a number of recommendations about how this situation could be improved. These recommendations are as follows:

### Commonwealth funded services

- #1. That the Commonwealth Government and GP Divisions take responsibility for ensuring that GPs are adequately prepared to recognise and assess patients with disordered eating and eating disorders, whatever the patient's age, and to arrange appropriate treatment. In particular, it is noted that GPs need to be familiarised with the MBS items that enable them to share the treatment of patients with eating problems or disorders with other practitioners such as dietitians and psychologists.
- #2. That the Commonwealth Government target people with eating disorders as a client group for improved access to treatment through the recent Commonwealth initiatives under the National Action Plan on Mental Health 2006-2011.

### Community health services

- #3. That community health services develop the capacity to respond to the needs of people with mild/moderate forms of eating disorder, and to deliver promotion, preventative and early intervention programs for individuals and groups regarding body image concerns.
- #4. That Primary Mental Health Teams actively support this direction by providing primary and secondary consultation, and assistance with upskilling community health services staff as needed.

### Specialist Services

#### Mental health consultation & liaison

- #5. That C/L services and their funding be reviewed by the Mental Health Branch to ensure that these services are made available for patients with eating disorders, whether in general adult medical or paediatric wards.

#### Child and adolescent services

- #6. That in the mental health service system the role of Child and Adolescent Mental Health (CAMHS), and in the acute health system, the role of the Centre for Adolescent Health at the Royal Children's Hospital, in assessing and treating children and teenagers with moderate to severe eating disorders be affirmed.
- #7. That the responsibilities associated with this role be encouraged through additional support to CAMHS. Depending on the particular CAMHS, this extra support could include in-service training in advanced clinical interventions with the client group, primary and secondary consultation to assist in treatment management and clinical supervision. The relevant regional specialist eating disorder service would be responsible for organising this additional support (see Recommendation #14 & #11).

### Adult area mental health services (AMHS)

- #8. That all AMHS be confirmed as having a responsibility to provide assessment and treatment for people with moderate to severe eating disorders.
- #9. That specialist expertise be made available through additional eating disorder clinicians being employed by the metropolitan specialist eating disorder services to provide eating disorder-specific treatment and consultancy to their local AMHS clusters. (*Regional and Rural AMHS are part of recommendation #11* )

### Primary mental health teams

- #10. That the mandate for Primary Mental Health Teams (PMHT) be explicitly extended to include primary and secondary consultancy for GPs and other primary healthcare providers, such as community health services, in regard to people across the lifespan with mild to moderate forms of eating disorder. This should also encompass PMHT clinicians having the capacity to offer a limited number of direct clinical interventions to these clients.

### Rural Eating Disorder Services

- #11. That rural CAMHS and AMHS, (with the exception of Bendigo and Barwon), be augmented to provide a better response to people with eating disorders. This should take the form of additional clinical resources to enable provision of specialist care and secondary consultation for both CAMHS and AMHS.

### Specialist Eating Disorder Services

- #12. That all of the three regional specialist eating disorder services be strengthened and redeveloped, in the interests of expanding service availability and accessibility, and improving comprehensive specialist care.
- #13. That each of the specialist eating disorder services be adequately resourced so that all have a comparable capacity, with priority being given to non-bed based service provision.
- #14. That the role of specialist eating disorder services be extended to provide consultation and training to metropolitan CAMHS, AMHS and PMHTs, and consultation for other local healthcare practitioners and services.

### Support Services

- #15. That the work by the Eating Disorder Foundation of Victoria providing education and support to health and other community sectors, families and those affected by eating disorders, be acknowledged and receive continued support.

### Family Sensitive Practice

- #16. That all treating practitioners and services incorporate family-sensitive approaches into their treatment of people with eating disorders.

## BACKGROUND

The Body Image Inquiry Report (BIIR), tabled in Parliament in 9 September 2005, resulted from the *Inquiry into Issues Relating to the Development of Body Image among Young People and Associated Effects on their Health and Wellbeing* (Family and Community Development Committee 2005). The Report's recommendations sought to promote healthy body image amongst young people and appropriate treatment services for those experiencing eating disorders. The BIIR and the Government's Response to its recommendations provide the context for this Report.

The Government's Response to the BIIR nominated further action be undertaken in relation to particular recommendations. The proposed action that forms the basis for this document stems from Recommendation #5 which proposed the mapping of existing services for people with eating disorders. The commitment was to a comprehensive exercise that would include services from general practitioners, acute hospitals, paediatricians, community health, outpatient dietitians, private allied health, private psychiatrists, public mental health services for adults and for children and adolescents, and the specialist mental health eating disorder services. In addition, the mapping exercise was to consider how community health services could assist people with body image concerns. Also to be covered was whether eating disorder specific programs should be available in Child and Adolescent Mental Health Services, with dedicated funding.

## PROJECT

### The scope of the eating disorder service mapping project and report

As required by the Government's Response to the BIIR, the mapping project was wide-ranging. It encompassed services that respond to the milder forms of eating disorder and also those that focus on the more severe conditions. Services for adults and those for children and adolescents were included, and the interrelationships identified between services, such as common referral patterns.

This resulting Report provides an overview of the existing service system, including patterns of use and demand, and client pathways into, across and out of services. It also examines gaps in service responses, pressure points, contributing factors and possible remedies, with attention to rural as well as metropolitan areas. Principles are identified to guide improvements to the service system design. In addition, attention is paid to how staff in different parts of the service system gain access to appropriate training and consultancy advice.

As a Report commissioned by the Department of Human Services, the major focus is the accessibility and availability of state-funded health services, particularly public mental health services. It is acknowledged however, that workers in other service sectors play an important role in health promotion, early identification of body image concerns and disordered eating, provision of support and referral to treatment services. This includes schoolteachers, nurses and counsellors in the education sector, staff of gyms and other physical fitness programs, and community and welfare workers, especially in youth-oriented services.

In addition to public mental health services, the Report examines use of Emergency Departments and public hospital inpatient services, and the involvement of relevant hospital clinicians. Further, the Report takes account of the private sector, including GPs, private psychiatrists and other specialists whose services are subsidised by the Commonwealth through Medicare. It identifies Medical Benefit Schedule (MBS) items made available to GPs for use of allied health services through the Commonwealth Better Outcomes in Mental Health program. The mapping also covers private practitioner services not directly reimbursed through Medicare at the time this Report was prepared, such as registered psychologists and dietitians. Additionally, it includes private hospital psychiatric treatment programs for eating disorders and considers programs run by other private organisations such as the Bronte Foundation and the Oak House. Emerging services offered by the psychiatric disability and rehabilitation support sector (PDRS) are also included. The Report examines client pathways between these services, in terms of both referral and discharge destination.

In addition to treatment services, the Report takes account of the education, information and support programs provided by the Eating Disorders Foundation of Victoria for consumers, family carers and the wider community. It also makes reference to relevant prevention and health promotion programs funded through the DHS Public Health program.

## Objectives of the Service Mapping Project

In brief, the objectives of the Service Mapping Project are as follows:

- To map existing services and providers in the eating disorder field, including service utilisation, appropriateness and availability.
- To identify gaps and pressure points in the current service system.
- To identify how the current service system could be developed to improve service responses to people with eating disorders, such as making service access easier and referrals between services more straightforward, and enhancing the capacity of community treatment services to meet increased demand.
- To examine specific recommendations of the Body Image Report in relation to Community Health Services, and Child and Adolescent Mental Health Services.
- To also concurrently and separately review the role and performance of the Centre of Excellence in Eating Disorders (CEED), including how it could contribute to an improved service system.

## Methodology

Over fifty individuals were consulted as part of this project, representing a wide range of organisations and services. In some instances, the consultant contacted more than one individual from the same agency. Further, over the life of the project, follow-up discussions were held with certain agencies. All those approached gave generously of their time either to meet with the consultant or to have phone discussions, often providing additional documentation.

A sample of views was obtained from services of the same type, such as Child and Adolescent Mental Health Services, Adult Mental Health Services and Primary Mental Health Teams. Comment was deliberately sought from both metropolitan and rural services. The consultant also had full access to relevant documents held by the Mental Health Branch and to service utilisation data. Service utilisation data included in this Report has been de-identified in relation to the service provider, with the exception of the Royal Children's Hospital adolescent medical ward, the three regional specialist eating disorder services and the two rural services funded from 2002 for eating disorder programs.

Organisations and services consulted are listed in Appendix A. Consultations were undertaken from early April to early August 2006.

## REVIEW OF THE CENTRE OF EXCELLENCE IN EATING DISORDERS

A review of the Centre of Excellence in Eating Disorders (CEED) has been undertaken concurrently with the Service Mapping Project as a discrete activity. Whereas the focus of this report is on the provision of direct services to those with eating disorders, the CEED review was undertaken to assist the Department of Human Services in determining strengths and issues with CEED's provision of currently funded activities and, in light of the Service Mapping Project, how these should be configured into the future, in light of the changes proposed to the service landscape in this report and, more broadly, through opportunities arising from the Commonwealth's renewed commitment to mental health reform (Council of Australian Governments 2006).

The Centre of Excellence in Eating Disorders was an initiative of the Bracks Government after it took office in 1999 and was established to assist in improving treatment for people with eating disorders through education and training, consultation and research. The successful tenderer was a consortium comprising Melbourne Health (the lead agency), Women and Children's Health (now the Royal Children's Hospital), Doutta Galla Community Health Centre and the Eating Disorders Foundation of Victoria. The Centre was set up in 2002 for a three-year period. Funding has been extended to enable some consolidation of activity and a review of the Centre's performance.

Although reference to some activities of CEED are included in this Report, the findings of the CEED review have not been detailed in this report.

## EATING DISORDERS

### What is meant by Eating Disorders?

This Report focuses largely on services for people with moderate to severe forms of eating disorder. However, it also considers programs for people with disordered eating which does not meet diagnostic criteria for an eating disorder, including people with body image concerns.

The Tolkien II Report is one source of information about conditions that meet diagnostic criteria for eating disorders. This Report was released in April this year by Professor Gavin Andrews, Professor of Psychiatry at the University of New South Wales and St Vincent's Hospital in Sydney, and his team (Andrews and The Tolkien Team 2006). The Tolkien II Report drew together experts (typically two psychiatrists and a psychologist) in each of the main mental disorders to identify the nature of the condition, its prevalence, and the core components of a stepped care approach to treatment, costed in terms of existing and ideal coverage.

In relation to eating disorders, the Tolkien II Report identifies anorexia nervosa and bulimia nervosa as the two most common eating disorders, noting they occur predominantly amongst females (Hay, Touyz et al. 2006). They are characterised by 'abnormal patterns of eating behaviour and weight regulation, and by disturbances in perceptions of weight and body shape' (Hay, Touyz et al. 2006).

The clinical symptoms of anorexia nervosa are body weight being maintained below a minimally normal weight for age and height, 'an intense fear of gaining weight or becoming fat, amenorrhoea for at least three consecutive menstrual cycles and disturbed experience of one's body weight or shape.' For bulimia nervosa, the diagnostic criteria are 'recurrent episodes of binge eating, feelings of lack of control during these episodes, and compensatory behaviours (such as exercising, purging or fasting) to prevent weight gain' (Hay, Touyz et al. 2006).

Other types of disordered eating which do not fulfil the diagnostic criteria for either anorexia or bulimia nervosa are called 'Eating Disorders not Otherwise Specified', or 'EDNOS' for short (Fairburn, Cooper et al. 2003: 520). Behaviour may include severely restricting food intake, and irregular use of bingeing and purging to control body weight. Lastly, there are people who also do not meet the diagnostic criteria for anorexia and bulimia nervosa, but have a distorted perception of their bodies and a preoccupation with body image. Some but not all may go on to develop a diagnosable eating disorder.

### How Common are Eating Disorders?

Experienced clinicians consulted through this project agreed that good estimates of the prevalence of eating disorders in Victoria are hard to find. Estimates often make use of overseas data, and vary in terms of the age range used to gauge prevalence. For example, Victoria's Burden of Disease Study included eating disorders in its recently published analysis of 2001 data (Public Health Group 2005). Its estimate of the prevalence

of bulimia nervosa as being 0.7 percent is based on a study of Swiss females aged 14 to 17 years (Public Health Group 2005: 42). On the other hand, the Study's estimate of the prevalence of anorexia nervosa as being 0.5 percent focuses on females older than 15 years (Public Health Group 2005: 42) and the estimate is taken from an Australian study (Gilchrist, Ben-Tovim et al. 1998). The Burden of Disease Study assumed the incidence amongst males is ten percent of the rate in females (Public Health Group 2005: 42).

The previously mentioned Tolkien II Report bases its estimates on survey data from Australasia. This Report notes that the most common disorders, anorexia nervosa and bulimia nervosa occur predominantly amongst females. It identifies the annual population prevalence rates for anorexia nervosa as 0.1 percent and for bulimia nervosa as 0.5 percent (Hay, Touyz et al. 2006). Overall, these estimates indicate that eating disorders have a low prevalence compared to other mental disorders such as depression and anxiety disorders.

In addition, the Tolkien II Report gives estimates of lifetime treated prevalence, that is, the proportion of those treated for these disorders during their life. It estimates that 22 percent of people with anorexia nervosa and 13 percent of people with bulimia nervosa receive treatment for these conditions over their lifetime (Hay, Touyz et al. 2006). These low rates of treated prevalence may well indicate issues with access to treatment. In terms of outcomes, follow-up studies of people with anorexia nervosa show that after four years, only 44 percent were rated as having good outcomes, 28 percent as between good and poor, 24 percent were rated as poor, and approximately 5 percent of patients had died from the disorder (Hay, Touyz et al. 2006). In relation to bulimia nervosa, the authors comment that the long-term prognosis is relatively unclear.

A useful local source of prevalence estimates is a secondary analysis of data from the Victorian Adolescent Health Cohort Study. This analysis was commissioned in 2005 by the Centre of Excellence in Eating Disorders (CEED), and undertaken by Professor George Patton of the Centre for Adolescent Health at the Royal Children's Hospital in Melbourne. Whilst the full report is still forthcoming, an unpublished summary provided in June 2006 is informative and its findings worth noting.

The Adolescent Health Cohort Study is a longitudinal study of the health status of two thousand young Victorians who have been followed from the age of 14 years, beginning in 1992. The Study is particularly valuable for indicating the extent of problematic eating amongst young people. Firstly, it is based on a community rather than a clinical sample, so potentially captures a broader spectrum of eating problems and not just the most severe end. Secondly, the cohort being followed up was recruited at the age of 14 years, before the peak age of onset of anorexia and bulimia nervosa, which according to the summary report occurs in the mid to late teens. Lastly, the data collected on symptoms of eating disorder, whilst reliant on self-report, were defined at a partial syndrome level ie. fulfilling at least two of the diagnostic criteria for anorexia or bulimia nervosa respectively. For example, one of the symptoms of anorexia nervosa is an intense fear of gaining weight, and for bulimia nervosa, recurrent binge eating. The criteria used were thus looser and encompassed more of the group than if only those who met the full set of diagnostic criteria were included.

The summary report found that of females between the ages of 15 and 18 years in the Cohort, 7 percent showed at least two symptoms of bulimia nervosa and 5 percent at least two symptoms of anorexia nervosa. In all, over one in ten (11 percent) of the young women experienced some form of problematic eating during this time. This contrasted with the males in the Cohort, of whom less than 1 percent were similarly affected.

Co-morbid conditions were also present for the females in the Cohort with eating problems as teenagers. As young adults, they had twice the rate of ongoing problems with depression and anxiety, presumably in comparison with young women in the Cohort without a history of problematic eating. To quote the summary report: 'this was particularly so for those with bulimic syndromes where a half of those with a teenage disorder had persisting depressive and anxiety symptoms in their mid-twenties at a level of concern to a general practitioner.' Further, of those with at least two symptoms of anorexia nervosa in their teens, two-thirds were still underweight (BMI less than 20) in their mid-twenties.

In the opinion of experienced paediatricians and mental health clinicians in Victoria, there is an increase in the number of young people with eating disorders presenting for treatment, and a drop in the age of first presentations. They also noted however, that it is difficult to determine how much this may reflect increased public awareness of the signs of eating disorders.

In summary, whilst estimates may vary, there seems general agreement about the key characteristics of eating disorders. One is that in epidemiological terms, eating disorders have a low prevalence across the population as a whole. That is, few people exhibit an eating disorder. Of those with a diagnosable eating disorder, bulimia nervosa is more common than anorexia nervosa. Further, those who do have an eating disorder are typically female and importantly, develop this condition in their teenage years.

Age of onset obviously has major ramifications in terms of the impact on the young person's education, social life and physical development, and the effect on other family members. The Victorian Adolescent Cohort Study also suggests that one in ten teenage girls aged 15 to 18 years may have problematic eating behaviours, even though these do not represent a diagnosable eating disorder, nor necessarily develop into this condition.

Additional features of eating disorders are that they have a long duration, the proportion treated is relatively low and complete recovery is rare. Mortality rates are comparatively high, with one report claiming that eating disorders have the third highest mortality rate for adolescents (Highet and Thompson 2004: 2). The Royal ANZ College of Psychiatrists' clinical guidelines for anorexia nervosa note that 'the estimated mortality rate is 12 times that of similar aged women in the community and double that of women suffering other psychiatric disorders' (Royal ANZ College of Psychiatrists 2004: 660). Those with eating disorders may also manifest other mental health problems, such as anxiety and depression, as well as physical health problems.

## The Impact of Eating Disorders on Families and Other Carers

In recent years, the impact of eating disorders on other family members has attracted attention. A particularly useful study for the purposes of this Report is the qualitative research undertaken by two researchers from beyondblue in Melbourne, and released in 2004 as 'The Experiences and Needs of Carers and Families Living with an Eating Disorder' (Highet and Thompson 2004). Selected findings from this research study have also been published in a relevant professional journal (Highet, Thompson et al. 2005).

The research study's findings were based on in-depth qualitative discussions with twenty-four families with a member with an eating disorder (Highet and Thompson 2004: 12). Most were parents of adolescent girls with an eating disorder, but friends or a partner of adults with eating disorders were also included (Highet and Thompson 2004: 12). The discussions were recorded, transcribed and key themes identified. The core findings are reported here as they have relevance to service planning and delivery. The generic terms 'families' or 'family member' are used for simplicity.

Firstly, family members recalled that they were slow to recognise the signs that their relative was developing or already had a diagnosable eating disorder. This highlights the importance of community education and better public awareness of this condition, especially preparing workers in key roles such as school teachers, coaches and gym instructors.

Family members were not the only ones to miss emerging symptoms. Many said that health professionals were similarly ill-prepared to recognise a pattern of behaviour as indicating an eating disorder (Highet and Thompson 2004: 46). This meant a lack of early intervention. Once the disorder was identified, family members went into a state of shock, denial and grief (Highet and Thompson 2004: 24-25). The importance of good quality education, information and support at this time was noted, although most said they did not receive it.

Family members often experienced a delay in getting access to the right treatment services. Several factors were involved. They included lack of knowledge on the part of the family and sometimes of healthcare professionals about what services were available (Highet and Thompson 2004: 45, 47). Healthcare professionals could also be reluctant to refer the patient on for psychiatric or psychological help, seeing the problem as purely physical (Highet and Thompson 2004: 46). Stereotypical attitudes were also encountered, with the assumption that the person could voluntarily 'snap out of it' (Highet and Thompson 2004: 46-47).

Families identified service eligibility criteria as a further barrier to early treatment, particularly if access was reliant on being below a certain Body Mass Index (BMI) (Highet and Thompson 2004: 45, 47). Waiting lists for treatment were particularly frustrating, especially for public sector services (Highet and Thompson 2004: 47-48). Cost was an obstacle in accessing private services, particularly for families without private health insurance, as these services were expensive (Highet and Thompson 2004: 35, 48). Rural families were at a particular disadvantage because of the lack of locally-available services (Highet and Thompson 2004: 49).

Even when access to treatment was achieved, the researchers found that families experienced being excluded from the treatment process (Highet and Thompson 2004: 50). They complained about not being informed of treatment options and progress, and not having their opinions sought, despite being in the primary carer role (Highet and Thompson 2004: 50. 52). Families also commented on treatment programs being oriented to adolescent girls, which was difficult for males of all ages but also for adult women with eating disorders (Highet and Thompson 2004: 51. 52). On the other hand, families emphasised the value of joining support groups with other carers with similar experiences.

## PREVENTION AND HEALTH PROMOTION

In the past, VicHealth has funded programs focusing on promoting healthy eating and increasing awareness of the importance of positive body image. An example is Deakin University's Body Image and Better Health Program, which was part of the overall Food and Nutrition Program from 1994 to 1997. Currently, VicHealth does not have any funded programs underway in this area.

Promoting healthy eating is a priority for state-funded public health programs. The recent state budget included extra funding for community programs that focus on body image and the relationship between obesity prevention and eating disorders. The programs seek to send positive messages about healthy eating, without emphasising its relationship to minimising obesity.

Initiatives include the 'Kids go for your life' program, which is in its third year of operation. It is being delivered in key childhood settings, including primary schools, kindergartens, child care centres and maternal and child health centres. The program focuses on promoting healthy eating, with schools being encouraged to ensure this is reflected in the curriculum, canteen food and the school environment as a whole. Following the success of this program in rural towns such as Colac, 'Kids go for your life' is now being expanded through an initiative for primary schools called 'Healthy Start in Schools'. This includes funds to establish and maintain a kitchen garden program.

Another initiative under the 'Go for Your Life' banner will target teenagers and promote healthy body image messages.

Relevant public information campaigns to raise community awareness include educating teenagers about the dangers of fad dieting. Called 'Fad diets won't work – community conversations', these are being run across the state as forums for teenagers to learn about the problems of fad dieting and talk about their own experiences. A report on the comments and recommendations from teenagers and community members involved in the forums is due for completion in October 2006. The results of the project will be used to help schools, health services, and youth agencies, improve their approach to problems of fad dieting and obesity.

Funding is also being extended to two existing community projects at Moreland and East Geelong/Bellarine, which focus on healthy eating amongst children and adolescents. Five new projects have now been funded in other socio-economically disadvantaged areas. These projects will focus on boosting levels of physical activity and healthy eating by adults and other target groups.

## HEALTH SERVICES FOR EATING DISORDERS

Treatment services are usually categorised according to the level of specialisation of the service and its practitioners, which typically matches the degree of severity of the condition. The first level is primary care, represented by general practitioners and community health services. The next is a more specialised level of care including both health and mental health services. The third or tertiary level comprises mental health services, which specialise in providing treatment for people with the most severe eating disorders.

The following chart outlines the levels of care and the practitioners and services, which are located at each level of care.

### Chart Outlining a Stepped Care Model for People with Mild, Moderate or Severe Eating Disorders

Service Level	Service Function	Service Providers
Primary care	1st level screening for severity and risk Treatment of mild/moderate eating disorders Referral to specialist care for treatment of moderate to severe eating disorders	General Practitioners Community Health Services Private psychologists and dietitians
Specialist secondary care	Treatment for moderate and severe eating disorders, including inpatient admission if needed.	General medical and paediatric inpatient & outpatient services Private psychiatrists, psychologists & dietitians Private psychiatric inpatient care & day program for eating disorders. Public mental health services for children & adolescents, and for adults. Bendigo rural eating disorder service. Private organisations eg. Bronte Foundation, Oak House
Specialist tertiary care	Treatment for severe eating disorders, including inpatient admission if needed	Specialist eating disorder services at Austin Health, Monash Medical Centre and Royal Melbourne Hospital

## Primary Care

### General Practitioners

General Practitioners are the primary health care providers most frequently used by the public at large. For instance, the Australian GP Statistics and Classification Centre, which monitors GP activity through the Bettering the Evaluation and Care of Health (BEACH) program, recently released its 2004-05 activity report. It estimates that about 85 percent of Australians visit a GP in any one year (Australian Institute for Health and Welfare 2005: xiv). GPs are also the most accessible practitioners at this level of care, with the exception of some outer Melbourne metropolitan suburbs and certain rural areas.

GPs have two main roles in relation to people with eating problems, including diagnosable eating disorders. One is that GPs are typically the first point of contact for a person with disordered eating. Consequently, GPs have a critical role in recognising and assessing both the severity of the condition and also the associated degree of risk to the person's health. Secondly, the GP plays an important role in determining what treatment is provided and by whom. Depending on the severity of the disordered eating, the GP could be the lead treating practitioner, or might refer the person to a more specialised treatment service, which in turn may require a GP referral. GPs are therefore both a gateway to other services and also a gatekeeper for entry into the secondary and tertiary health sectors. GPs also see people from across the age spectrum, so may pick up malnourishment in older people as well as anorexia nervosa in a teenager.

Disordered eating often has consequences for the patient's general health. GPs may therefore also refer patients to a paediatrician or other medical specialist, depending on the age of the patient and the nature of the health problem. In treating a patient with an eating disorder, GPs may also involve practitioners such as dietitians and psychologists. GPs registered with the Commonwealth Better Outcomes in Mental Health Care (BOMHC) program can use the Access to Allied Psychological Services (ATAPS) component of the program to refer a patient for up to twelve sessions with a registered psychologist, or other health professional trained in psychological interventions such as psycho-education or cognitive behavioural therapy (Kohn, Morley et al. 2005: 5). Furthermore, using the Chronic Disease Management item under the Enhanced Primary Care program, a GP can refer a patient for up to five sessions with two allied health professionals, such as a dietitian and a psychologist.

As part of the original Better Outcomes initiative, which began in 2001, the Commonwealth Government also funded a General Practice Psychiatric Support Line, run from Sydney, and covering all states and territories except SA. The aim was to provide phone-based consultation for GPs, with triage by a psychologist and access to a psychiatrist as needed. The service started in March 2004. In 2005, it was reported that in the first six months, there were 726 case discussions between a GP and the psychiatrist. Patients with eating disorders comprised just 1.2 percent of these cases (Bradstock, Wilson et al. 2005: 90). According to the General Practice Division of Victoria (GPDV), there has been relatively low uptake of this service by GPs in Victoria. Further, rural GPs have not used the phone service more frequently than those in metropolitan areas, and BOMHC-trained GPs are as likely to use it as those without this training. It would appear GPs prefer more direct consultation rather than over a phone or faxline.

Data are not available on how many people with eating disorders are seen by GPs. The Report on General Practice Activity in Australia 2004-05, generated from the BEACH program, does not include relevant diagnoses such as anorexia or bulimia nervosa, or EDNOS (eating disorders not otherwise specified). Anecdotally however, it is estimated that most GPs have one or two patients with some form of eating disorder in their practice.

Under the recently released five-year National Action Plan on Mental Health 2006-2011, the Commonwealth has committed additional funding for programs which will benefit GPs (Council of Australian Governments 2006: 9-10). This includes reform of the Medical Benefits Schedule (MBS) to enable GPs to refer patients to psychologists and other allied health professionals. It is understood the Commonwealth is also reviewing the training requirement for GPs, which had been a prerequisite for making use of the BOMHC program MBS items. To date, GPs have had to undergo this training to be registered with BOMHC, but not to make use of the Chronic Disease Management item. Further, funding has been allocated for the employment of mental health nurses in GP and private psychiatric practices. Lastly, more funding is to be made available to GP Divisions in rural and remote areas to underwrite contractual arrangements for allied health professionals, who can then take referrals from GPs.

#### Chart outlining Commonwealth funding for GP use in treating mental health problems such as eating disorders

Program	Item	What is covered?
Enhanced Primary Care	Chronic Disease Management 2005	<ul style="list-style-type: none"> <li>• Medicare item for case conferences, GP Management Plan (GPMP), Team Care Arrangement (TCA) for eligible patients.</li> <li>• GP refers patient for up to five rebated sessions to Medicare Australia-registered allied health professionals eg. dietitian &amp; psychologist, for patients with chronic and complex needs who have a GPMP and TCA in place.</li> </ul>
Better Outcomes in Mental Health Care (BOMH)	GP Psychiatric Support Helpline  Funding to GP Divisions for Access to Allied Psychological Services (ATAPS)	<ul style="list-style-type: none"> <li>• Helpline for GPs, staffed by psychologists &amp; psychiatrists.</li> <li>• BOMH registered GP refers patient for up to 12 sessions with a psychologist or other allied health practitioner (funded by GP Division).</li> </ul>
More Allied Health Services (MAHS)	Funding to rural GP Divisions to improve GP access to allied health professionals, including mental health professionals.	<ul style="list-style-type: none"> <li>• Services from allied health professionals for rural communities.</li> </ul>

Program	Item	What is covered?
Commonwealth National MH Reform program 2006-2011	<p>Increased funding to rural and remote areas for mental health services.</p> <p>Practice Incentive Payment (PIP) to allow Mental health nurses to work in GP surgeries &amp; private psychiatrists' practices.</p> <p>Medicare rebates for sessions with psychologists &amp; other allied health professionals on referral from GPs and private psychiatrists</p>	<ul style="list-style-type: none"> <li>• To be defined</li> <li>• Mental health nurses to assist in follow-up of patients, medication management &amp; referral.</li> <li>• To be defined.</li> </ul>

## Community Health Services

Community health services (CHS) are defined as agencies that receive Community Health Program funding and deliver a range of primary health and support services to meet local community needs.

Victoria has around one hundred community health services operating from about 250 sites across the state. These fall into two organisational types: 39 are independent or standalone services and the other 61 services are integrated with other health services including metropolitan, regional and rural hospital and small rural health services.

CHS plan their services and programs based on the demographics and burden of disease of their local community. Programs therefore vary according to local need and may include:

- Allied health including dietetics
- Community health nursing
- Counselling
- Health promotion
- General practice
- Dental
- Social support
- Drug treatment
- Youth services

Many CHS and programs are targeted at disadvantaged people and communities, with the objective of reducing inequalities in health. Most clients of CHS are:

- People on a low income, older people and children,
- Suffering or at risk of chronic and complex health problems,
- Concession Card holders (over 80% of clients for Community Health Program services).

*Community Health Services – creating a healthier Victoria (Department of Human Services 2004)*

Ballarat Health provides an example of a current eating disorders community health funded program that is being delivered through a local hospital. A clinic supported by a \$15,000 grant from Primary Health Branch is being trialled and will document a multi-disciplinary care planning and review process for community-based clients with eating disorders, referred to Ballarat Health Allied Health by GPs. This project based community health initiative grew from local identified need in that each week, Ballarat Health Services Dietetics Department reported seeing on average between 1 and 3 community-based clients with significant eating disorders. With the majority of referrals from GPs in the local area, clients are described as experiencing eating disorders within the moderate to moderately- severe range and are predominantly female ranging in age from 13 to 46.

The BIIR recommended that Community Health Centres be utilised more effectively for the delivery of body image programs (Recommendation #4). The Government response supported the use of community health centres as ideal settings to provide multidisciplinary services to address body image issues. Further it set out an expectation that outcomes of the service mapping exercise could assist in providing information about the range of body image programs available for incorporation in the activities of community health centres.

Community health services can have particular advantages for people with eating problems. One is that they cover the age range, so services can be provided to adolescents as well as adults. Another is that a number employ dietitians, which is particularly helpful for people who cannot afford private practitioners. Also, community health counselling services are now being enhanced, with practitioners being expected to have undergone improved training (Primary Health Branch 2005). Training for counsellors in this sector includes family therapy skills training which can augment practitioners skill base to work with this client group. Furthermore, in the 2006-07 state budget, funding was committed for extra counselling positions in community health centres to support people with mental health problems.

Given the expense of allied health, medical care and counselling services, which form the basis of treatment for and response to individuals with disordered eating and body image concerns, it is important to reinforce that community health services give priority to treating those on low incomes.

It is difficult however to tell the extent to which people with disordered eating make use of community health services, as the medical diagnosis of people who attend is not recorded. Consequently, it is not possible to quantify the services provided to this client group.

Young people are also not well represented in counselling figures for community health services. This may in part reflect an issue with counselling staff confidence and capacity to deal with body image and disordered eating. It is intended that when counselling service policy redevelopment is completed, it will focus more on young people. Access to secondary consults and clinical support would assist counselling staff confidence in implementing their new direction.

There are 12 community health services funded through the Women's Health Program in Victoria (VWHP). They include 9 regional services, and three statewide services. Established in 1987, the Victorian Women's Health Program was developed to provide services 'by women for women'. The dual strategy of delivering gender-specific health services whilst working to improve mainstream services remains a key aspect of women's health. Women's Health Services are based on an understanding of health within a social context.

These community-based services have shown awareness that body image and eating disorder problems are particularly pertinent gendered health concerns. Some have included body image and eating disorders into their programs and activities. For example, this year, as part of Body Image and Eating Disorders Awareness Week, Women's Health East will be conducting a competition for students to design a magazine cover that promotes positive body image. In rural areas, Barwon Southwest Women's Health is assisting the Cloverdale Community Centre to run a young persons' program entitled "Eat Good - Feel Good". Primary Health Branch of DHS funds these as health promotion activities.

## Secondary Care

The next level of care includes services in the private and public sectors. Also, as eating disorders have both physical and mental health dimensions, secondary care encompasses physical health as well as mental health care.

## Public Hospital Emergency Departments and General Medical Wards

People with eating disorders may present to the Emergency Departments of public hospitals. Those with associated medical problems may be admitted to general medical wards. Both situations raise the importance of the availability of mental health liaison and consultation, given that general nursing and medical staff have little specific training in treating patients with eating disorders.

The following table draws on acute hospital service utilisation data from 2000-01 to 2005-06. It shows the number of Emergency Department presentations, and of inpatient admissions (separations), for patients with a primary diagnosis of eating disorder. The numbers do not represent individual patients, as any particular patient could present more than once to an Emergency Department and could have more than one inpatient admission. The number of presentations and admissions over time do not demonstrate a discernible trend upwards or downwards.

### Emergency Department presentations by people with a primary diagnosis of eating disorder (VEMD data base)

Year	No. Emergency Dept presentations with Eating Disorder*	Percentage of overall Emergency Dept presentations
2000-01	118	0.010
2001-02	153	0.016
2002-03	195	0.020
2003-04	129	0.012
2004-05	142	0.012
2005-06 (3 quarters)	153	0.016

*\*Note: A patient could have presented more than once to the Emergency Dept.*

### Number of public hospital admissions (separations) for patients with a primary diagnosis of eating disorder (VAED data base)

Year	No. Admissions of Patients with Eating Disorders*	Percentage of overall admissions
2000-01	1404	0.13
2001-02	1402	0.13
2002-03	1449	0.13
2003-04	1266	0.104
2004-05	1430	0.114
2005-06 (3 quarters)	593	0.114

*\*Note: A patient could have had more than one admission.*

Paediatricians also take an active interest in treating eating disorders. A particular example is the RCH Centre for Adolescent Health (CAH), which runs a Healthy Eating Clinic to treat young people aged 12 to 18 years with emerging as well as established eating disorders. Paediatricians take the lead role in this Clinic, which treats adolescents with a range of eating problems, from body image concerns to eating disorders. Referrals come mostly from GPs and the majority of patients are female, with males comprising around 10 percent. Paediatric services, unlike public mental health services, do not focus on a particular catchment area. Consequently, referrals are accepted from across the state, in addition to the local western metropolitan and rural regions.

The RCH Healthy Eating Clinic uses a multidisciplinary approach and focuses on early intervention. Medical appointments are reimbursed through Medicare. Outpatient treatment includes weekly appointments. According to figures provided by the Clinic, there are around 190 on its outpatient list, with 56 new patients in 2004 and 57 in 2005.

Patients aged 15 years and over from the western metropolitan and related rural regions are typically referred onwards to Orygen Youth Health, a public mental health service for young people aged 15 to 24 years from that catchment area.

Inpatient care is provided as needed by the RCH adolescent medical ward. The number of admissions and patients has grown, as demonstrated in the following table. The rate of re-admission has also increased.

Table showing numbers of admissions, individual patients and re-admission rates for patients with eating disorders admitted to the Royal Children's Hospital in the four years from 2002-03 to 2005-06 (VAED data base)

Financial Year	2002-03	2003-04	2004-05	2005-06
Admissions (separations)	59	34	50	103
Number of individual patients	34	22	37	46
Re-admission rate	1.74	1.55	1.35	2.24

According to the Clinic, these changes reflect an increased number of patients with more complex and chronic conditions. Data supplied by the Clinic show that in both 2004 and 2005 calendar years, about half of the admissions (31 out of 69) came from the western metropolitan and rural regions. In the same two years however, as a result of new service linkages, admissions increased almost sevenfold from the Inner Southern CAMHS (from 3 in 2004 to 20 in 2005). This service does not have on-site paediatric beds at the Alfred Hospital. Without further analysis outside the scope of the current project, it is difficult to assess the extent to which the increase in admissions to the RCH of patients with eating disorders reflects changes in referral patterns compared to the greater severity of clinical presentations. Whilst the higher re-admission rate for 2005-06 suggests more severe conditions, this rate can also be influenced by other factors such as the availability and quality of post-discharge care.

The Mental Health Branch funds the RCH to provide mental health consultation/liason (C/L) services to patients of the hospital in the latter's role as the statewide tertiary paediatric hospital. The RCH is currently undertaking a review of these C/L activities to determine the best investment for future C/L functions as part of the development of a new integrated mental health program. It could be anticipated that C/L support to paediatric patients with eating disorders would be part of this review.

## Private Practitioners and Services

Private practitioners encompass Commonwealth-subsidised private psychiatrists, as well as psychologists and dietitians who specialise in managing eating disorders. The Royal ANZ College of Psychiatrists has a list of members in private practice who identified eating disorders as an area of interest in response to a College survey. Of the 85 private psychiatrists on this list, the majority practised in metropolitan Melbourne, and only three in rural areas. However, as the list only involved those who responded to the survey, there might well be other private psychiatrists treating patients with eating disorders.

The Eating Disorder Foundation of Victoria (EDFV) keeps a data base of private practitioners including registered psychologists and dietitians, as well as GPs, who elect to be identified as providing treatment for people with eating disorders. Whilst EDFV do not recommend particular practitioners, if someone rings the EDFV Helpline for a referral, they are given three names and questions to ask about what the practitioner can provide.

In terms of private hospital psychiatric services, the Melbourne Clinic currently has a separate and specific eating disorder program, while another hospital, the Albert Road Clinic, can provide individualised treatment and responses for young people with eating disorders in its adolescent inpatient and day programs.

The program at the Melbourne Clinic comprises two components: an eight bed inpatient service and a day program. Referral has to be from either a psychiatrist or GP, and the minimum age is over 16 years for the inpatient service and 16 or over for the day program. The average age is from 18 to 25 years. The majority of patients are female and from the metropolitan area. Daily fees are charged for each service component, and private health insurance is recommended for both.

The Melbourne Clinic inpatient service uses a multi-disciplinary approach, and whilst eating is supervised, nasogastric feeding is not used. The service does not take people with severe eating disorders where major medical intervention is required. The average length of stay is 40 days, and post-discharge care is provided on an out-patient basis by private psychiatrists. There are around 15 to 16 on a waiting list for admission. Whilst waiting, they are seen by private psychiatrists as outpatients. The day program only takes patients with a BMI (Body Mass Index) of 16 or above. It runs 3 days per week and is open-ended in terms of length of attendance.

## Other Private Services

Other private, fee-charging services include the Bronte Foundation in Oakleigh, the Oak House in Surrey Hills, and the Mandometer Clinic in Brighton. The latter is part of the Karolinska Institute in Stockholm, Sweden, which runs a three month residential program in Sweden. The Melbourne Mandometer Clinic follows up Australians who have completed this treatment overseas.

The Bronte Foundation started in Melbourne in May 2004. Based in Oakleigh, in southeastern metropolitan Melbourne, the Foundation is open 9am to 5pm, 5 days per week and provides individual counselling as well as family education and support. Staff include five psychologists, two dietitians and a family advocate. Depending on clientele, day program activities may also be available including time-limited groups run on specific

issues such as self-harm, and the use of relaxation techniques. Most clients are female, aged between 14 and 25 years and have either anorexia or bulimia nervosa. According to the Foundation, clients have included children as young as 10 years and an adult of 52 years.

When visited in May as part of the current project, the Foundation reported that there are around 45 to 50 clients on its books at any one time, with a waiting list. Clients have individual counselling sessions twice weekly with a psychologist and once with a dietitian. Families have a weekly group session. Clients are largely self-referred after hearing about the Foundation from media outlets or the EDFV. Referrals from health practitioners such as GPs are rare, although the Foundation requires that all of their clients be concurrently treated by a GP. According to the Foundation, the timeframe for improvement is usually 18 months to 3 years. Costs can be defrayed to some extent through private health insurance, which can cover up to 5 sessions with a psychologist and two with a dietitian. Family support sessions are free. However, the Foundation estimates the average overall cost of participating in the program as around \$30,000. Some clients come from the country areas and the Foundation can arrange low cost accommodation. An identified gap is supported accommodation for participants whilst undertaking the program, especially those from the metropolitan area who may be living alone.

The Oak House is located in Surrey Hills in eastern metropolitan Melbourne, and has been operating for several years. It is staffed by four full and part time psychologists, three part-time dietitians, a family therapist who is also a dietitian, and a part-time social worker. Clients are typically female, and range in age from 10 year to 55 years, with most aged between 20 and 30 years. When visited in May for the present project, the senior psychologist noted that there were 75 clients. The Oak House caters for clients with anorexia or bulimia nervosa, EDNOS or binge eating disorders. Clients have to be medically monitored by a GP, and sometimes also a paediatrician for the younger age groups. The Oak House can suggest GPs with an interest in eating disorders, and also liaises with a private psychiatrist practising at the Melbourne Clinic. Clients are largely self-referred, but referrals also come from GPs and clinical services.

Different programs are run for the younger and older age groups. For those with anorexia nervosa who are over 19 years, the program comprises two weekly individual counselling sessions with a psychologist and a dietitian. A range of therapeutic approaches is used, such as cognitive behaviour therapy (CBT), narrative therapy or interpersonal therapy, depending on the client and the nature of the problem. For instance, CBT is likely to be used with clients with bulimia nervosa. Structured groups are also provided, such as a 6 week program on 'mindful eating' and a 12 week transitional program on 'sense of self'. Family education sessions are provided as well as monthly sessions for friends and siblings. According to the senior psychologist, there is an eighteen month to two year recovery timeframe. For adolescents, the program uses the Maudsley model (Lock, Le Grange et al. 2001), which requires intensive family involvement and runs for twelve months. There are weekly family sessions.

As well as attending for individual and family sessions, Oak House clients can spend the day at the facility and have 'snack support' from volunteers and staff. Volunteers include students undertaking professional courses such as social work or psychology, or former

clients who have recovered from an eating disorder. The Oak House is also active in running education sessions at local schools and provides information packs for schools, GPs and dietitians.

University psychology departments often run psychology clinics as part of their training programs for clinical psychology students. Swinburne Psychology Centre in Hawthorn and Victoria University Psychology Clinic in St Albans are examples. Services can include low-cost counselling and specific time-limited programs for people with body image concerns and eating problems.

The School of Psychological Science at La Trobe University has been particularly active in developing and trialing on-line and face-to-face programs to assist people with body image concerns. Professor Susan Paxton has led these initiatives, with funding from charitable and corporate sponsors being used to run and evaluate the programs. One program for 18 to 35 year-olds focused on people with high body image concerns and disordered eating. An eight week group program was developed, using either face-to-face or on-line delivery, and a control group. A manual was produced to guide the sessions. Overall, there were 100 participants and there was no charge. When contacted in June for this project, Professor Paxton reported that the outcomes were currently being written up. She noted that at the two month follow-up, those who were part of the face-to-face group had done better than the on-line group, although both did better than the control group. At this point, there is no plan or funding to run the program again, although it is one that could suit a community health service venue.

The second program, which has been running for two years, is for adolescent girls aged 12 to 18 years and called 'My body, my life'. Again the target group is people with heightened body image concerns and eating problems. It is a six session program which is only available on the internet. There are from 5 to 8 in each group program, which is facilitated over 90 minutes once a week. Already 80 to 100 girls have undertaken the program which is advertised through school counsellors, school newsletters and the internet. An earlier program was successful in training GPs to provide a guided self-help program, delivered by GPs in their practice, for people with bulimia nervosa (Banasiak, Paxton et al. 2005).

### Child and Adolescent Mental Health Services (CAMHS)

Victoria has thirteen Child and Adolescent Mental Health Services (CAMHS) across the state. Each provides assessment, treatment and consultation for children and teenagers with serious emotional disturbance who reside within the service's defined catchment area. The targeted age range is from birth to 18 years.

CAMHS have a particularly important role in diagnosing and treating eating disorders, as most eating disorders emerge in the teenage years. Core features of the usual CAMHS approach to clients with eating disorders are a multidisciplinary team approach, work with families and collaborative work with paediatricians. For example, Monash CAMHS undertake joint assessment and treatment planning with the Monash paediatric service. A collaborative approach is also used by the Austin CAMHS with the paediatric unit at the Austin. Similarly, the CAMHS based in Warrnambool has established strong links with local paediatricians to ensure comprehensive assessment and treatment.

In other parts of the state, especially in rural areas rather than large regional towns, the quality of the service provided can be hindered by the lack of experienced CAMHS clinicians, and limited time available from psychiatrists. An example is Gippsland, which has three segments of roughly the same size in terms of population, but covering a wide geographical area.

The Royal Children's Hospital CAMHS responds to referrals of children and adolescents with emotional and psychological problems from the western metropolitan and rural catchment area, with outpatient satellite clinics at Werribee, Hoppers Crossing and Broadmeadows. These referrals may include young people with disordered eating.

Following the redevelopment of the RCH, the twelve RCH CAMHS inpatient beds, currently located at the Western Hospital Footscray, will be re-located to the RCH and sited next to the adolescent medical ward. There will also be an increase of four additional mental health beds. As part of the redevelopment planning process, the RCH is currently developing a proposal for an integrated model of paediatric and mental health care, including for patients with eating disorders. The provision of an on-site day program with step-up/step-down functions is also under consideration.

### Orygen Youth Health - Young People's Eating Disorder Clinic

ORYGEN Youth Health is a Melbourne Health program that describes itself as a comprehensive early intervention youth mental health service. ORYGEN is funded through Melbourne Health to provide public specialist mental health services that in all other parts of the state are provided in part by CAMHS (15-17 year olds) and Adult AMHS (those 16 + years).

Orygen Youth Health ran an outpatient clinic for young people with eating disorders, aged from 15 to 24 years, who resided the north-west and western metropolitan regions and the semi-rural area beyond Werribee. While it ceased intake to this type of diagnostic specific clinic based service in September 2006, Orygen has an ongoing responsibility and commitment to providing mental health treatment to young people including those with eating disorders.

For 2005-06, Orygen reported that it had treated 85 continuing care clients with diagnosed eating disorders.

The Orygen eating disorders clinic was operational during the consultations undertaken for this service mapping exercise. At that time it was staffed by a part-time psychiatrist, and two half-time and one full-time psychologists. Due to the resignation of the clinic's dietitian, dietetic sessions were sought from other public or private dietitians. The clinic staff provided case management and individual psychological therapy on an outpatient basis. Also, family sessions covering psycho-education and problem solving were offered. If inpatient care was needed, admission usually was sought at the Royal Melbourne Hospital eating disorder unit.

Orygen eating disorder clinic was focused on early intervention rather than delivering a commitment to long-term treatment. Referrals sources were from GPs, the Centre for Adolescent Health and family members. Rarely if at all, were referrals received from Primary Mental Health Teams, Child and Adolescent Mental Health Services or Adult Mental Health Services.

An additional interest of the Orygen eating disorder clinic was its participation in a multi-centre trial, funded by a pharmaceutical company, to test the effectiveness of an atypical anti-psychotic for people with anorexia nervosa. In May 2006, the trial had been underway for around 12 months.

### Adult Mental Health Services (AMHS)

There are twenty-one adult mental health services (AMHS) across Victoria. Like CAMHS, each has a defined geographical catchment area. The service components of an AMHS comprise acute inpatient beds, community residential rehabilitation beds, and community treatment teams. The teams comprise crisis assessment and treatment (CATT), continuing care (CCT) and mobile support and treatment teams (MSTT). In rural areas, multi-function satellite teams rather than discrete single function teams typically undertake community treatment. They are usually referred to as integrated community teams.

The target group for AMHS was first outlined in the 1994 document called *The Framework for Service Delivery* (Health & Community Services 1994). People with severe eating disorders were included as shown in the following definition: 'Adult public mental health services will provide assessment, treatment and support services to people with serious mental illness and/or an associated significant level of psychosocial disability. This includes clients suffering from functional psychoses, both acute and persistent, **severe mood or eating disorders...**' (Health & Community Services 1994: 26). The inclusion of severe eating disorders was reiterated in the 1996 service guidelines for general adult community mental health services (Psychiatric Services Branch 1996: 11).

In contrast to these two earlier documents, the 2002 *New Directions for Victoria's Mental Health Services – the Next Five Years* policy document did not specify the diagnostic groups to be included in the target group for AMHS (Metropolitan Health and Aged Care Services Division 2002). Instead, those most affected by mental illness were identified as the priority group for public mental health services (Metropolitan Health and Aged Care Services Division 2002: 13). However, the recent report *Improving Mental Health Outcomes in Victoria* prepared by the Boston Consulting Group and released in July 2006, returns to identifying particular diagnostic groups (The Boston Consulting Group 2006). This report categorises mental illness into three tiers according to prevalence, illness severity and seriousness of disability (The Boston Consulting Group 2006: 11, 18, 20) Tier 1 encompasses people with milder disorders and associated disability, Tier 2 represents those with moderate disability and includes people with eating disorders, and Tier 3 covers those with severe disorders and/or serious disability, including severe eating disorders (p.11).

The report identifies the state as having the major responsibility for service provision for people in Tier 3, but as sharing responsibility with the Commonwealth for those in Tier 2. Examples are Commonwealth-funded MBS items for GPs to use in treating people with mental health problems, including eating disorders, and the secondary consultation provided by state-funded PMHTs for GPs. This highlights the importance of collaboration between the Commonwealth and Victorian governments in funding services for Tier 2 clients, particularly in responding to treatment gaps for people with eating disorders.

In this regard, the recently-announced Commonwealth initiatives will be considered in more detail later in the current Report, especially in terms of priority being given to people with eating disorders (Council of Australian Governments 2006: 9-10).

### Primary Mental Health and Early Intervention Teams

There are twenty-one primary mental health and early intervention teams (PMHTs) throughout Victoria. Managed by Adult Mental Health Services (AMHS), they were established from the year 2001 as an initiative of the new Bracks Government. The teams were intended to improve the capacity of primary care providers such as GPs and community health services to recognise, assess and treat people with high prevalence disorders, in particular anxiety and depression. They were also charged with improving early intervention for young people, particularly those with first episode psychosis.

PMHTs span primary and secondary care. Whilst managed by AMHS, they are designed to enhance the capacity of the primary care system to respond to people with mental health problems and disorders. The teams also have the remit to provide a limited number of clinical interventions.

In September 2003, the Centre of Excellence in Eating Disorders (CEED) undertook a two-year project to build the capacity of PMHTs in improving primary care for people with eating disorders. This Secondary Consultation and Education Project was undertaken in each of the catchment areas of the three tertiary eating disorder services. An Eating Disorder Coordinator (a clinical specialist in eating disorders) was appointed in each of the three areas and worked with one metropolitan and one rural PMHT. Up to five additional PMHTs were included in the second year of the project.

The project aimed to upskill Primary Mental Health Teams in providing primary and secondary consultation for GPs, and other local practitioners. The focus was on how to identify and respond to the treatment needs of people with eating disorders. In all, around half of the PMHTs were part of the project, which finished in 2005. An evaluation of the project, undertaken by the University of Melbourne's Program Evaluation Unit, was completed in May 2006 (McKenzie and Dunt 2006). The evaluation did identify a number of benefits of the project, in two of the three areas covered. These included capacity-building in the PMHTs involved and formation of local networks of professionals with an interest in treating eating disorders (McKenzie and Dunt 2006: 31).

### Rural Eating Disorder Services

In 2002, the Mental Health Branch provided funding to Bendigo and Barwon to trial and evaluate programs for people with eating disorders. Each area had identified problems in the accessibility and availability of services for this client group. An evaluation of the two different models used was published recently (Endocott, Kidd et al. 2006).

The Bendigo Eating Disorder Service is based on a stepped-care model (Von Korff, Glasgow et al. 2002). The service seeks to build the capacity of primary care to assess and treat the milder, less complicated conditions, as well as make secondary care more accessible for people with severe eating disorders. A proportion of the MHB funding has been used to employ additional clinicians with expertise in treating eating disorders,

who were 'embedded' in the adult mental health service. The ED clinicians include a sessional psychiatrist, and two psychologists, one full-time and the other part-time (a part-time dietitian proved difficult to recruit).

Referrals are made to the Bendigo mental health service triage system, and screened for severity and risk. The Primary Mental Health Team assesses those aged from 17 years upwards and the Bendigo CAMHS assesses the younger referrals. GPs are supported in treating milder forms of eating disorders through backup from the PMHT, and secondary consultation from an ED clinician.

Adults with severe disorders are provided with time-limited individual treatment by one of the ED clinicians. This is not available for CAMHS clients, where it is expected that a family approach will be used, in line with the Maudsley model for treating eating disorders (Lock, Le Grange et al. 2001). On the other hand, the ED clinician provides secondary consultation and clinical supervision for CAMHS clinicians in treating clients with eating disorders aged under 17 years. Where adult clients receive individual sessions with an ED clinician, the AMHS continues to be responsible for providing case management for the client and after hours services as needed. Shared care arrangements are made with GPs for ongoing care. The tertiary eating disorder service at the Royal Melbourne Hospital is used for adult inpatient admissions, should this be necessary.

In Barwon, the Barwon GP Division set up the Disordered Eating Service (DES) as a collaborative project with a group of local service providers including GPs, private psychiatrists and the Barwon Health mental health service. The aim was to provide specialist assessment for people with disordered eating, with referral to local private practitioners for treatment, including private psychiatrists as well as GPs. In this regard, the Barwon project differed from the Bendigo model. The Barwon DES operated more as a self-contained specialist clinic, whereas the Bendigo EDS sought to build capacity in the primary care sector as well as provide specialist treatment for adults with severe disorders.

By locating the Barwon DES with the GP Division, it was hoped that stigma would be reduced for people seeking treatment for disordered eating. For instance, consumers and their family members could make a direct approach themselves, rather than having to be referred by a practitioner. The service also sought to encompass mild as well as moderate to severe eating disorders, and to encourage early presentation and intervention.

Staff of the DES included a clinical psychologist, a family therapist and a dietitian. Educational workshops were also run for GPs, school nurses and the general public. Initially, the service focused on providing assessment and referral, but from early 2004, treatment was provided for patients with eating disorders where close monitoring was required {Endocott, 2006 #607: 59}. The GP Division had also shifted from a focus on eating disorders, to case management of complex clients.

## Tertiary Care

In the case of eating disorders, tertiary care has two characteristics. One is that it comprises specialist adult mental health care for the most severe forms of eating disorder. The other is that it is disorder-specific.

### Public Specialist Tertiary Eating Disorder Services

There are three regional specialist eating disorder services, which are based in metropolitan Melbourne. They operate from Austin Health's Banksia House in the north east, Monash Medical Centre in the south and the Royal Melbourne Hospital in the inner west. All of the services are for adults, and typically do not accept referrals for clients under 16 years. Each has a different level and set of service elements, which will be described in turn.

#### Austin Health

The Austin Health service is currently based at Banksia House, on the former Repatriation Hospital site. It is due for re-location to a new facility presently under construction at the Mental Health Precinct on the Austin's Burgundy Road site.

Austin Health is funded for nine specialist eating disorder beds. These beds are also used for patients with mood disorders. In addition, the beds are co-located in the same building as six mother/baby beds. This could present difficulties should a male patient with an eating disorder need admission. Most referrals are from GPs, with some from private psychiatrists and a local AMHS in the area covered by the Austin service, which covers the north east of the state. Patients have to be at least 16 years or older.

The Austin service is not funded to provide outpatient services or a day program. According to the Austin staff, follow-up after an inpatient admission is usually provided by the patient's GP or a private psychiatrist. Referral may also be made to the Melbourne Clinic's eating disorder day program. If the funding were forthcoming, staff of the Austin specialist eating disorder service would prefer to be able to offer outpatient services, including a day program running 3 days a week as an alternative to admission, and as a step-down transition program following discharge.

#### Monash Medical Centre

The Monash specialist eating disorder service has three core components – an outpatient service, inpatient beds and secondary consultation to GPs and private psychiatrists. Educational sessions are also run with community groups, such as carer support groups. Mental Health Branch funding is however, only for the inpatient component.

The outpatient service is based at the Community Mental Health Clinic in Clayton, close to Monash Medical Centre, where the beds are located. The senior clinical psychologist works in the outpatient clinic two days per week, and the psychiatrist responsible for the eating disorder service contributes a weekly session. Clinical psychology students also provide clinical interventions under supervision. The Clayton Clinic is also used as the location for a weekly intake meeting for new referrals, with two to three referrals per week,

either from GPs or self-referrals. The weekly intake meeting is run by the psychiatrist and senior psychologist from the eating disorder service. According to the senior psychologist, there is a one to two month waiting list for assessment, and if assessed as suitable for outpatient treatment, a further two to six month wait might be necessary before treatment can be initiated.

Referrals to the Monash specialist eating disorder service come from across the Southern region and associated rural areas. Around six new clients are taken on for outpatient treatment each month. According to the senior psychologist, approximately half of the outpatients have bulimia nervosa, about a quarter anorexia nervosa and the others have mixed diagnostic presentations. The outpatient clinic runs a three to six week treatment program, with two sessions per week, and also a twenty week program comprising twenty sessions. Patients are usually not referred for treatment at their local CMHS as according to the senior psychologist, there are insufficient clinical psychologists on staff to treat eating disorders.

While the present Austin facility houses the eating disorder unit and its mother/baby unit in the same building, Monash's eating disorder beds are co-located in the same unit as its mother-baby beds (six in number). The inpatient component at Monash Medical Centre comprises two specialist eating disorder beds, with some flexibility to increase this capacity to four beds (should the mother/baby component of the unit not require all of its bed complement). There is a waiting list for admission. The desirability of this co-location arrangement is questionable, especially should a male patient with an eating disorder require admission.

The senior psychologist oversees a structured program for inpatients, based on cognitive behavioural therapy principles. An occupational therapist conducts activities such as meal planning, and a dietitian provides nutritional rehabilitation. If patients with eating disorder have major medical problems, they will be admitted to a general medical ward for treatment.

### Royal Melbourne Hospital

The specialist eating disorder service based at the Royal Melbourne Hospital has four service elements: an outpatient service, an inpatient unit with dedicated eating disorder beds, an on-site day program, and provision of secondary consultation. Mental Health Branch funding is for the inpatient and day program components.

As a regionalised specialist tertiary service, the catchment area for the Royal Melbourne Hospital service includes the western metropolitan region and rural areas to the west of the state. Referrals require involvement of a medical practitioner so tend to come from GPs, and private psychiatrists, but are also accepted from AMHS. Patients from the Orygen Youth eating disorders clinic requiring hospitalisation are admitted to the RMH service.

The outpatient component encompasses three half-day sessions provided at the Royal Melbourne Hospital Parkville site. The outpatient service is for people referred for specialist treatment for eating disorders, and also for former inpatients following discharge. It is staffed by psychiatrists, a psychiatric registrar and a dietitian.

The funding for the outpatient service constrains what can be provided in length and frequency of appointments, and in the range of staff from different disciplines.

In addition, there is an intensive day program for six to eight patients. This is run on site five days per week, 9am to 3.30pm, with one day per week from 10am to 7pm so that an evening meal can be included. Usually a quarter of those attending are recently discharged inpatients and three quarters are outpatients, but this year it is reported that the proportions have been half in half.

The day program has a multidisciplinary staff team comprising a full-time mental health nurse as coordinator, a consultant psychiatrist (0.2), clinical psychologist (0.2), and social worker (0.4). A dietitian works half-time with the day program and half-time in the inpatient unit. The day program provides a structured eight week group program, with an additional two week part-time component, which has a step-down function. Education, support and therapy is also provided for families, including a family meal support group.

The service also has an eight bed inpatient unit, comprising four single and two double rooms all with ensuite facilities. Unlike the other two specialist services, the RMH beds are exclusively for patients with eating disorders, with patients aged 16 years or over.

## SERVICE UTILISATION DATA

The use of public mental health services by people with a diagnosis of eating disorder was examined for the reporting year 2005-06, using the RAPID statewide database. These data presented a snapshot of people who used the services over this particular timeframe. Before commenting on the patterns identified, two caveats are in order. One is that because clients with a diagnosed eating disorder were relatively few in number, the data would more affected than other data sets by the rigour with which clinicians recorded their clinical activity. As an example, if fewer than ten clients received continuing care, not recording one or two would make a bigger impact than if there were sixty clients using that service element.

Another and related qualification is that accuracy of the data is reliant on clinicians having recorded a client's clinical diagnosis. It is worth noting that in the past, some mental health clinicians have been reluctant to register clients on the statewide database, let alone record definitive psychiatric diagnoses, especially for children or adolescents. The data are therefore likely to be less rather than more inclusive, and probably an under-estimate of the numbers of clients with eating disorders using public mental health services.

As already foreshadowed, service utilisation data have been de-identified in terms of the service provider, with the exception of the three specialist eating disorder services, and the two rural eating disorder services.

## Child and Adolescent Mental Health Services (CAMHS)

Looking first at child and adolescent mental health services (CAMHS), the following table shows use of CAMHS by clients with an eating disorder diagnosis for 2005-06.

Table showing the use of CAMHS by clients\* with a previous or current eating disorder diagnosis and/or at least one contact with an eating disorder service in the reporting year, as recorded on RAPID for 2005-06. Figures for Barwon CAMHS and Bendigo (Loddon South Mallee CAMHS) are excluded.

2005-06						
CAMHS Metro	CAMHS Inpt	% CAMHS inpt	CAMHS C'ty	% CAMHS C'ty	IMYOS	% IMYOS
CAMHS 1	2	2%	29	2.8%	2	3.1%
CAMHS 1	0	0	22	2.3%	0	0
CAMHS 3	9	5.4%	36	3.8%	0	0
CAMHS 4	11	7%	19	1.6%	0	0
CAMHS 5	14	7.5%	35	3.3%	4	7.4%
CAMHS Rural						
CAMHS 1	2	9.5%	9	2%	0	0
CAMHS 2	0	0	20	5.7%	0	0
CAMHS 3	0	0	6	1.6%	0	0
CAMHS 4	0	0	9	2%	0	0
CAMHS 5	0	0	6	1.5%	0	0
CAMHS 6	0	0	2	1.2%	0	0

*\*Note: Individual clients can be counted more than once if they received more than one type of service or services across campuses.*

The data show that every CAMHS had at least one client with a diagnosed eating disorder. In terms of hospital admission for this clinical group, CAMHS inpatient beds are only one of two possible services used, the other being admission to a paediatric ward.

Overall, it could be said that a relatively high proportion of the CAMHS clientele had an eating disorder. Six CAMHS had from one to two percent of its community treatment service clients with an eating disorder, and another six CAMHS had over two percent (but less than six percent) with this condition. There was only one CAMHS which had less than one percent of clients with an eating disorder using its community treatment service.

## Adult Mental Health Services (AMHS)

The following table shows the use of metropolitan AMHS adult mental health services, by people with a diagnosed eating disorder.

Table showing use of public adult mental health services in the metropolitan area by clients\* with a previous or current eating disorder diagnosis and/or at least one contact with an eating disorder service in the reporting year, as recorded on RAPID for 2005-06.

2005-06												
AMHS (metro)	Adult CAT	% CAT	Adult Acute Inpt	% Acute Inpt	Adult Cont Care	% Cont Care	MSTT	% MSTT	Adult Integ Cty Serv	% Integ Cty Serv	PMH Team	% PMH Team
AMHS 1	16	1.5%	6	1.6%	14	1.2%	1	0.8%	N/A	-	0	0
AMHS 2	17	1.3%	11	0.9%	5	0.5%	0	0	N/A	-	2	6.1%
AMHS 3	38	1.7%	13	1.5%	17	2.3%	1	0.8%	N/A	-	0	0
AMHS 4	21	1.4%	7	1.2%	15	1.3%	4	1.3%	N/A	-	0	0
AMHS 5	45	2.5%	10	2.2%	15	1.7%	2	1.9%	N/A	-	2	2%
AMHS 6	20	1.2%	6	1.7%	9	1.2%	4	2%	N/A	-	2	1.9%
AMHS 7	33	2.9%	10	2.1%	8	1.1%	0	0		-	1	1%
AMHS 8	56	7.8%	26	6.3%	26	1.7%	5	5.2%	N/A	-	12	9.8%
AMHS 9	15	1.1%	7	1.9%	12	0.9%	1	0.9%	N/A	-	7	5.3%
AMHS 10	24	1.4%	7	1.6%	17	1.2%	3	1.6%	N/A	-	3	2%
AMHS 11	16	1%	11	2.4%	19	1.7%	1	1.1%	N/A	-	1	0.6%
AMHS 12	21	1.3%	13	2.3%	22	1.5%	0	0	N/A	-	9	3.2%
AMHS 13	15	1.1%	8	2.3%	11	1.1%	2	1.9%	N/A	-	0	0

*\*Note: Individual clients can be counted more than once if they received more than one type of service or services across campuses. Also, only client numbers for the main AMHS service types are included in this table. Use of the following service types are not included: dual diagnosis, early psychosis, homeless outreach and C/L services, bed-based services such as prevention and recovery care, community care units and secure extended care, and services for clients aged 64 yrs and over.*

The next table shows utilisation of rural AMHS for 2005-06 by people with a diagnosis of eating disorder.

Table showing use of public adult mental health services in rural areas by clients\* with a previous or current eating disorder diagnosis and/or at least one contact with an eating disorder service in the reporting year, as recorded on RAPID for 2005-06. Figures for Bendigo AMHS and Barwon AMHS are excluded here as they are reported separately in this section.

2005-06												
AMHS (rural)	Adult MH CAT	% MH CAT	Adult MH Acute Inpt	% MH Acute Inpt	Adult MH Cont Care	% MH Cont Care	Mob Supp & Treat	% MSTT	Adult Integ Cty Serv	% Integ Cty Serv	PMH Team	% PMH Team
AMHS 1	N/A	-	11	2.4%	N/A	-	N/A	-	44	1.4%	5	3%
AMHS 2	N/A	-	3	1.1%	N/A	-	3	3.4%	21	1.1%	0	0
AMHS 3	17	1.6%	7	2.7%	4	0.6%	0	0	N/A	-	6	4%
AMHS 4	12	0.9%	2	0.5%	15	1%	1	0.6%	N/A	-	2	3.4%
AMHS 5	11	1.5%	5	2.5%	10	1.5%	0	0	N/A	-	1	0.9%
AMHS 6	7	0.8%	3	1.4%	8	1%	0	0	N/A	-	1	0.4%

*\*Note: Individual clients can be counted more than once if they received more than one type of service or services across campuses. Also, only client numbers for the main AMHS service types are included in this table. Use of the following service types are not included: dual diagnosis, early psychosis, homeless outreach and C/L services, bed-based services such as prevention and recovery care, community care units and secure extended care, and services for clients aged 64 yrs and over.*

Three features of AMHS service utilisation warrant mention. One is that all AMHS had at least some clients diagnosed with an eating disorder over the period 2005-06. In other words, there was no AMHS in either the metropolitan or rural area which had no eating disorder clients at all. The second feature is that there was relatively minor variation across AMHS in the proportion of clients with an eating disorder. For example, in seventeen out of twenty-one services (77 percent), between one and two percent of clients using continuing care services had a diagnosed eating disorder. Three AMHS had less than one percent of these clients receiving continuing care, and one had more than two percent. Lastly, it was noticeable that clients with eating disorders used all the main service elements in an AMHS, that is, primary mental health care, crisis assessment and treatment, acute inpatient care, continuing care, mobile support and treatment and integrated community care (the latter replaces CATT and MSTT in three rural services). Put another way, with only minor exceptions, all of the core service elements of each AMHS had a proportion of clients with eating disorders.

The following chart shows the number of AMHS and CAMHS which have different proportions of clients with an eating disorder using their community-based treatment services.

Type of Service	Number of services with less than one percent of clients with a eating disorder	Number of services with between one and two percent of clients with a eating disorder	Number of services with more than two percent and less than six percent of clients with a eating disorder
AMHS community continuing care	3	17	1
CAMHS community assessment and treatment	1	6	6

### Specialist Tertiary Eating Disorder Services

In examining service utilisation data for the specialist eating disorder services, the pattern of use of outpatient treatment in 2005-06 accords with expectations, given how funding has been allocated. That is, the service specifically funded for non-bed based services, the Royal Melbourne, treated 170 clients in this manner. The Monash eating disorder service, even though not specifically funded for non bed-based services, also had a number of clients (54) treated as outpatients. On the other hand, the Austin specialist eating disorder service, which is also not funded for non bed-based services, had no clients recorded as receiving outpatient treatment in 2005-06.

In relation to bed use in 2005-06, the following table shows different patterns of utilisation across the three services.

Table showing potential bed occupancy and actual bed occupancy for patients with eating disorders admitted to the three tertiary specialist eating disorder services in 2005-06, based on data from the statewide database (RAPID)

Tertiary specialist eating disorder service	Potential bed occupancy (beds x 365.25 days)	No. Admissions	Average Length of Stay	Actual bed occupancy	% Actual compared to potential occupancy
Austin Health - Banksia House (9 designated ED beds)	9 x 365.25 = 3287.25	52	18.5	962	29%
Melbourne Health - Royal Melbourne Hospital (8 designated ED beds)	8 x 365.25 = 2922 days	58	43.1	2499.8	85.6%
Southern Health - Monash Medical Centre (2 designated ED beds with access to 2 other beds)	2 x 365.25 = 730.5	28	34.7	971.6	133%

There are several features to note in how beds designated for eating disorder were used by the three services in 2005-06. Firstly, in terms of actual versus potential bed occupancy, the Royal Melbourne's rate of 85.6 percent occupancy accords with standard expectations. However, Monash's 133 percent bed occupancy rate indicates that this service has too few designated eating disorder beds, and is relying on access to other specialist beds to meet the need to admit people with eating disorders.

In contrast, the data show that in 2005-06, the Austin markedly under-utilised its eating disorder beds for patients with this condition. Only 29 percent of available bed occupancy was used for patients diagnosed with an eating disorder. This low percentage is striking as it contrasted with the way the other specialist eating disorder services used their beds, and is well below standard expected occupancy rates. Also important to note is that only 32 percent of those admitted to the Austin's designated eating disorder beds were diagnosed with this disorder. Beds were therefore being used to admit patients with other conditions. Further, in 2005-06, the north east adult acute inpatient unit at the Austin admitted more patients with an eating disorder diagnosis (26 or 6.3 percent) than any other adult acute inpatient unit in the state. The number of patients admitted to the Austin's local area service beds was almost three times the number admitted to the equivalent area adult inpatient service at Monash and the Royal Melbourne. This would suggest that at the Austin, these area adult inpatient beds are at times being used in lieu of specialist eating disorder beds, and that the latter are not fully accessible to patients with eating disorders.

Secondly, the table also demonstrates considerable variation across the three specialist eating disorder services in terms of average length of stay (henceforth LOS). The data indicate for 2005-06, the Austin discharged its patients with eating disorders much more quickly than the other two specialist services. The Austin's average LOS (18.5 days) was just over half as long (53 percent) as that at Monash (34.7 days), and only 43 percent of the average length of stay for patients at the Royal Melbourne (43.1 days). It is not clear why there would be such a marked difference in the Austin's average LOS. This could be affected by several factors, including the level of acuity and complexity of the eating disorders being treated, operational criteria for discharge and the availability and nature of follow-up care. Identifying the particular factors involved in each service would require more detailed investigation.

### Rural Specialist Eating Disorder Services

Service utilisation data for 2005-06 show the impact of the two rural specialist eating disorder projects – the eating disorder service at Bendigo, and the disordered eating service at Barwon Health. As these services began in 2002, the service statistics for the year 2000-01 were taken as a baseline for comparative purposes.

Table showing use of Barwon and Loddon South Mallee (Bendigo) adult mental health services in rural areas by clients\* with a previous or current eating disorder diagnosis and/or at least one contact with an eating disorder service in the reporting year, as recorded on RAPID for 2005-06 (figures for 2001-02 are given in brackets).

2005-06												
AMHS	Adult MH CAT	% MH CAT	Adult MH Acute Inpt	% MH Acute Inpt	Adult MH Cont Care	% MH Cont Care	Mob Supp & Treat	% MSTT	Adult Integ Cty Serv	% Integ Cty Serv	PMH Team	% PMH Team
Barwon AMHS	N/A	-	14 (10)	2.8%	14 (5)	1.9%	0	0	31	1.2%	12	9.8%
Loddon South Mallee AMHS	32 (10)	1.3%	7 (2)	1.5%	23 (9)	1.4%	3 (0)	2.1%	N/A	-	21 (N/A)	4.5%

*\*Note: Individual clients can be counted more than once if they received more than one type of service or services across campuses. Also, only client numbers for the main AMHS service types are included in this table. Use of the following service types are not included: dual diagnosis, early psychosis, homeless outreach and C/L services, bed-based services such as prevention and recovery care, community care units and secure extended care, and services for clients aged 64 yrs and over.*

Table showing the use of Barwon and Loddon Mallee South (Bendigo) CAMHS by clients with a previous or current eating disorder diagnosis and/or at least one contact with an eating disorder service in the reporting year, as recorded on RAPID for 2001-02 & 2005-06. Figures for 2001-02 are give in brackets.

2005-06						
CAMHS Metro	CAMHS Inpt	% CAMHS inpt	CAMHS C'ty	% CAMHS C'ty	IMYOS	% IMYOS
Barwon CAMHS	0	0	0 (1)	0	1 (0)	0.3%
Loddon South Mallee CAMHS	0	0	17 (6)	2.4%	0	0

*\*Note: Individual clients can be counted more than once if they received more than one type of service or services across campuses.*

The data indicate that the introduction of the Bendigo Eating Disorder Service has enhanced access to secondary level care for people with eating disorders in the catchment area. The CAMHS and AMHS service components as well as the specialist eating disorder service are providing services to more people with an eating disorder. Put another way, the data indicate that overall, public mental health services have become more accessible to people with eating disorders in Bendigo through the introduction of the eating disorder service. The number of clients with a diagnosed eating disorder using each of the different AMHS service elements tripled in most instances, as did use of CAMHS community assessment and treatment (from 6 to 17).

The increase in use of adult service elements included adult inpatient care (from 2 to 7), the CAT service (from 10 to 32), continuing care (from 9 to 23) and mobile support and treatment (from none to 3). The PMHT recorded twenty-one clients using this service element in 2005-06 (the PMHT did not exist in 2000-01). In addition, forty-four clients made use of the eating disorder service in itself.

Turning to the Barwon Disordered Eating Service (henceforth DES), the number of assessments undertaken by the DES (186) from between December 2002 and March 2005 showed that there was a high level of unmet need in the Barwon area. Of the 186 patients assessed, 55 percent were diagnosed with anorexia or bulimia nervosa and 80 percent of this group had not previously been treated for an eating disorder (Endocott, 2006 #607: 59). On the other hand, from the baseline year of 2000-01 to 2005-06, there is no change in the number of Barwon CAMHS clients with eating disorders recorded on the statewide database. The number remains at one client.

In comparison with Bendigo, service utilisation data for Barwon CAMHS and AMHS show a more uneven impact from the introduction of the DES. The most striking result is for CAMHS as already mentioned, with the data showing that the number of clients using CAMHS has remained the same at one client. This is unexpected, given that eating disorders usually develop in the mid to late teens. On the other hand, more adult clients with an eating disorder used AMHS service elements. Of the four elements that make up the Barwon AMHS, three show an increase in the number of clients with eating disorders, whereas there was a decrease for the fourth (from 3 to none for the mobile support and treatment service). The increases range from a 14 percent rise in the number of acute inpatients (from 10 to 14), a doubling of clients using the community integrated service (from 15 to 31) and a near tripling of those using continuing care (from 5 to 14). However, the Barwon disordered eating service did not include a specialist eating disorder treatment component in its model. Consequently, in Barwon there was no new access to a public specialist treatment for eating disorders, as in the Bendigo model.

The evaluation of the two eating disorder projects stressed the importance of an eating disorder service providing specialist treatment as well as specialist assessment (Endocott, Kidd et al. 2006: 61). Specifically, the evaluation noted that 'it is not realistic to expect an EDS to only provide assessment and care planning. This causes frustration both for those referring into the service and the service providers' (Endocott, Kidd et al. 2006: 62). Clearly, if a specialist eating disorder service does not offer treatment, it may do little more than enhance primary care for people with disordered eating, without covering treatment gaps at the secondary and tertiary levels of care for the more severe eating disorders.

## CONSUMER AND FAMILY SUPPORT, AND COMMUNITY EDUCATION

### Psychiatric Disability and Rehabilitation Support Services (PDRSS)

The psychiatric disability and rehabilitation support sector appears to have had little involvement in providing services specifically for people with eating disorders. The exception is Pathways Geelong, whose involvement was instigated by a request from a local psychiatrist for outreach support to three or four clients with eating disorders. This was extended to a house being made available through the Housing and Support program in Geelong.

Pathways identified gaps in terms of psychosocial rehabilitation for people with eating disorders, and also gaps in individual and family interventions. In late 2005, the agency obtained funding from a local philanthropic trust for three years for an additional position. Pathways now has one full-time support worker and a part-time clinical psychologist working with people with eating disorders, with some eleven to twelve active clients receiving a range of services from outreach support, to sessions with a clinical psychologist using cognitive behaviour therapy.

### Eating Disorders Foundation of Victoria (EDFV)

The Eating Disorders Foundation of Victoria (EDFV) is the peak non-government body, funded by state government, which provides information and support to people with eating disorders and their families and friends. The Foundation is also actively involved in educating the community, including school staff, gym and fitness workers, and community and welfare workers, and advocates for service improvements.

EDFV runs a 1300 Helpline Monday to Friday from 9.30am to 5pm (to 8.30pm on Wednesdays), which is a major source of information and referral for people seeking help with an eating disorder. The Helpline is staffed by volunteers, who undergo a six week training program, and are supervised by a full-time volunteer coordinator. A database is maintained of private practitioners who elect to be identified as interested in treating people with eating disorders. The database includes GPs, registered psychologists and dietitians.

Callers to the EDFV Helpline seeking referrals are given the names of three practitioners and a list of questions to ask about what treatment is offered. A family support worker offers one-off appointments for family members to explain how the service system works and referral processes. Psycho-educational groups for families are also provided. As well, EDFV encourages the formation of support groups, especially in rural areas. There are already a number of support groups across Victoria, including Bendigo, Ballarat and Leongatha in South Gippsland as well as two in metropolitan Melbourne. EDFV provides an eleven day training program for group convenors.

In addition, EDFV provides education about eating disorders, and employs a full-time education officer for this purpose. A major focus is raising awareness amongst groups of workers whose roles are important for early intervention. These include primary and secondary school teachers, gym instructors, sports coaches, health and welfare workers, and youth workers. EDFV continues to provide training for these key groups about recognising the early signs of eating disorders and how and where to refer for help. It charges \$100 per hour to the host organisation, regardless of the number of participants, and adds \$20 for travelling to rural areas.

With funding from CEED, EDFV produced and disseminated resource manuals for schools and the physical fitness industry. A further initiative under development aims to provide collated information to assist GPs in their management of patients with an eating disorder, such as identifying the specific MBS items to use in referring patients to psychologists and dietitians. Three web-based tools were being trialed at the time the current Report was being prepared.

EDFV runs education seminars for consumers, carers and the general community, has library resources and maintains a panel of speakers who can talk about their experience of recovery at relevant functions. Through the EDFV website, a moderated chat room is being developed for consumers to share their experiences. EDFV also has a regular newsletter with information on meetings of carer and consumer group meetings, educational events and other items of interest to those with eating disorders and their relatives and friends.

Eating Disorder Networks have been established in Bairnsdale and Gippsland, and are active in linking relevant practitioners and generating community support for improved services.

## The Butterfly Foundation

The Butterfly Foundation is a philanthropic organisation established in May 2003 by a parent activist committed to changing attitudes to people with eating disorders and improving access to services, especially in the public sector. The Foundation makes presentations to professional gatherings to convey the experiences of family members and consumers. It also runs fund-raising events, and uses the funds to improve consumer access to services. For example, at any one time, ten people with eating disorders and limited means are funded to attend private practitioners, such as dietitians or psychologists, and services like the Bronte Foundation or Oak House.

More recently, the Foundation generated private funding towards a day program to be run by Southern Health through South East CAMHS. Through the recent state budget, the government committed additional funding so that this program can be piloted and evaluated over three years. The Foundation is also interested in establishing a community house, run by volunteers, with the aim of providing support on a drop-in basis for people with eating disorders who lack sources of social support. Another example is the funding provided by the Butterfly Foundation for a project worker in East Gippsland to develop a proposal for a day centre and outreach support.

## A RESPONSIVE SERVICE SYSTEM

### What are the basic principles for a responsive service system?

The stepped care model used in the Tolkien II report is useful for examining services for people with eating disorders of varying severity, and deciding how services could be redeveloped. The stepped care model is based on the commonsense principle that treatment should be matched to patient need, starting with primary care for the less severe conditions, specialist treatment services for moderate to severe disorders, and highly specialised care for the most severe conditions, particularly where there are associated medical problems compromising the person's physical health.

In addition to the principle of stepped care, there are other general principles which are important in achieving a responsive service system. For instance, primary care services in particular should be local for ease of access. Specialist treatment should also be readily available and not dependent on where the person lives and their level of disposable income. Moreover, in line with contemporary approaches to delivery of health and mental health care, treatment in the community should be the first option, with inpatient care to be used only when necessary. The recently released Worldwide Charter for Action on Eating Disorders adds another principle especially pertinent to eating disorders and their emergence in the mid to late teens. The Charter states that children and adolescents should be treated in age-appropriate treatment facilities (Academy for Eating Disorders 2006).

### Treatment Approaches

It was beyond the scope of this project to define best practice in the treatment of eating disorders. Clearly there is still considerable divergence about the evidence-base for different approaches to treatment (Evidence-based Practice Center 2006), with some scepticism about whether any particular intervention makes much difference to the outcome (Ben-Tovim D I, Walker K et al. 2001) and others defending current practices (Russell and Abraham 2002).

The preferred model of care affects what services should be made available, and vice versa. For instance, if the approach requires a specified number of outpatient sessions of cognitive behaviour therapy, then staff are needed with the right qualifications and experience, as well as accessible outpatient premises. Some general comments are therefore in order, based on discussions with experienced clinicians and a brief review of the relevant literature.

Broadly-speaking, it would seem that approaches to treatment can be differentiated according to the age, type and severity of disorder of the person with the condition. The clinician's professional training and experience may also affect the significance given to physical and psychological factors in both causation and treatment.

Starting with diagnosable eating disorders, the approach developed by the Maudsley Institute in London and used at Westmead Hospital in Sydney appears to have currency for the treatment of teenage girls with anorexia nervosa (Lock, Le Grange et al. 2001). The additional criteria include living with their families and 18 years or under with an eating disorder of less than three year duration (Lock, Le Grange et al. 2001). This approach seeks to support the family, especially the parents, in taking an active role in helping the young person manage her condition. On the other hand, it is accepted that in severe cases where a person's BMI has fallen to a level which means their survival is in danger, then physical intervention must take priority, including hospital admission in order to achieve weight gain. A patent limitation of this approach is its exclusion of teenagers with eating disorders who are alienated from and not living with their family for whatever reason.

For people with anorexia nervosa, the Royal ANZ College of Psychiatrists' clinical practice guidelines recommend a multidisciplinary team approach for optimal treatment (Royal ANZ College of Psychiatrists 2004: 662). The guidelines identify diagnosis and treatment as being 'the preserve of psychiatry'. They also point out however, that 'The team would ideally include a specialist in physical medicine (eg. a general practitioner, physician or paediatrician, (depending on the patient's age), a dietitian, nurses and other allied health specialists such as psychologists, occupational therapists and physiotherapists' (Royal ANZ College of Psychiatrists 2004: 662). Others recommend dentists as well, due to the effect on dentition of repeated purging. Also seen as helpful for young patients is the provision of support and education for family members about how best to help the young person, whether in primary care (Wilhelm and Clarke 1998: 71) or at secondary and tertiary levels (Royal ANZ College of Psychiatrists 2004: 664-665).

For adults with eating disorders, Professor Christopher Fairburn, a psychiatrist from the University of Oxford, is a major researcher and clinical leader in this field (Fairburn, Cooper et al. 2003). His treatment approach is based on extensive use of cognitive behaviour therapy (CBT). Fairburn's initial research focused on the use of CBT for people with bulimia nervosa, but he now considers that this approach also works for people with anorexia nervosa and atypical eating disorders or EDNOS (Fairburn, Cooper et al. 2003: 519-520). It is understood that Professor Fairburn is presently undertaking a large NHS-funded trial in England to evaluate the use of CBT for anorexia nervosa and EDNOS, as well as bulimia nervosa.

In the review of the research literature, albeit cursory, it was noticeable that little mention was made of rehabilitation. This is surprising given that the experience of a severe eating disorder, particularly in young people, may mean missing out on key developmental experiences. The research literature consulted was also silent on issues for male patients with eating disorders. Whilst eating disorders are known to predominate in women rather than men, there was no specific reference to whether treatment approaches were effective for both sexes in the same age bracket and with similar types of eating disorder.

## SERVICE SYSTEM GAPS

### What are the current service gaps and how could these be met?

There are a number of gaps in the current service system. This section will consider each in turn and suggest ways in which they might be overcome.

#### General Practitioners

At the primary care level, perhaps only a minority of GPs are skilled in recognising eating problems or eating disorders, assessing their severity and organising appropriate treatment. This is a major issue as GPs have such a key role in the healthcare system. Some GPs may of course be sufficiently skilled to initiate treatment themselves, with or without assistance from other practitioners like dietitians and psychologists. For more complex conditions, appropriate treatment may involve referral to more specialist practitioners, such as paediatricians or private psychiatrists.

It may be that GPs have difficulty in finding the right sort of treatment arrangement. For instance, it would appear that not all GPs have the right information to make an appropriate response, such as how to make use of MBS items to cover shared care with other practitioners. Use of these items also requires that GPs identify registered psychologists and dietitians in their local area with an interest and expertise in treating people with eating disorders.

As previously mentioned, the EDFV is in the process of assisting GPs in making more use of the appropriate MBS items. In consultation with GPs and GPDV and other relevant groups, EDFV is developing web-based tools, including a patient flow-chart, and identification of the relevant MBS items, such as ATAPS for psychological interventions by psychologists and other health professionals, and the Chronic Disease Management item for dietitian sessions.

#### Recommendation #1:

It is recommended that the Commonwealth Government and GP Divisions take responsibility for ensuring that GPs are adequately prepared to recognise and assess patients with disordered eating and eating disorders, whatever the patient's age, and to secure appropriate treatment. In particular, it is noted that GPs need to be familiarised with the MBS items that enable them to share the treatment of patients with eating problems or disorders with other practitioners such as dietitians and psychologists.

#### Private Practitioners and Services

The main problems with access to private practitioners and services are availability and accessibility. Availability is an issue as private services are located predominantly in limited areas of metropolitan Melbourne, which presents major difficulties for people living elsewhere, especially in rural and regional areas. Accessibility is also affected by the cost

of services. Not all people with eating disorders can afford the private health insurance needed for private inpatient care and for day programs. Similarly, an unknown proportion does not have the disposable income to cover the cost of treatment, especially by private psychologists and dietitians, and from private psychiatrists if bulk-billing is not an option.

Two of the recent Commonwealth initiatives under the National Action Plan on Mental Health could increase access by people with eating disorders to treatment in the private sector {Council of Australian Governments, 2006 #623: 9-10}. One is reform to the MBS schedule which would enable GPs to refer more patients to private psychologists and other allied health professionals with little if any extra cost to the patient. The other is additional funding for treatment services provided in rural areas by allied mental health professionals, including psychologists, with funding allocated through GP Divisions. The difference these initiatives will make to access to treatment by people with eating disorders will be influenced by the Commonwealth's approach to their implementation, such as whether those with particular diagnoses will have priority access, and how issues such as geographical access and affordability are addressed.

#### Recommendation #2:

It is recommended that the Commonwealth Government target people with eating disorders as a client group for improved access to treatment through the recent Commonwealth initiatives under the National Action Plan on Mental Health 2006-2011.

### Community Health Services

As already indicated, community health services and centres provide services for people across the age spectrum, with a particular emphasis on those unable to afford private health services. They may include counsellors and often dietitians on their staff.

Primary Health Branch has thus far focused on the role of community health services in delivery of health promotion strategies to influence body image perceptions. This remains an important aspect for the continued work of these services.

Depending on the level of a community health centre / service's medical and allied health resources, they are also well-placed to respond to people with disordered eating at the less severe (mild to moderate) end of the continuum. Further, there are programs for people with body image concerns, such as those piloted by Professor Susan Paxton, from the School of Psychological Science at La Trobe University, which could be run by community health services, particularly those focused on services for women.

It would appear that community health services have not routinely seen themselves as providing services to this client group. The future development of counselling and health programs, and an invigorated focus on youth in this sector provides an opportunity to change this direction. This however will require new inputs, so that Government's support of Recommendation #4 in the BII Report can be actioned.

### Recommendations # 3&#4:

As part of the future development of counselling and health programs in this sector it is recommended:

- #3. That community health services be developed to respond to the needs of people with mild/moderate forms of eating disorder, and to deliver promotion, preventative and early intervention programs for individuals and groups regarding body image concerns.
- #4. That Primary Mental Health Teams actively support this direction by providing primary and secondary consultation, and assistance with upskilling community health services staff as needed.

### Public Hospital Emergency Departments and General Medical Wards

The number of Emergency Department presentations and of hospital admissions for people with eating disorders highlights the importance of mental health consultation and liaison. This is becoming more readily available in Emergency Department environments, with the distribution of additional state budget funds in 05-06 and 06-07 for enhancing the mental health response in hospital Emergency Departments.

Mental Health consultation and liaison funding levels and distribution have an historical basis. While most major metropolitan teaching hospitals receive mental health funding to address the mental health assessment and treatment planning needs of their patients, funding does not cover all wards and units 24 hours a day. Hospitals determine priority areas for utilisation of these resources. In addition, not all general public hospitals where children, adolescents and adults with eating disorders receive treatment are funded for a C&L service.

The mapping exercise confirmed that the extent of mental health input for patients with eating disorders in general medical wards varies across acute public hospitals, and even within the same hospital. For instance, at Monash there is a full-time consultation liaison mental health nurse who works with paediatric inpatients, whereas this level of mental health input is apparently not available for adult patients with eating disorders in general medical wards on the same campus. Similarly, concern was raised by RCH staff that insufficient mental health consultation liaison was provided to paediatric wards, yet the RCH receives significant funding from the state mental health budget for 'psychological and psychotherapy services', which includes C/L services. These funds are allocated to the RCH separate to funding for the RCH CAMHS, and their use is currently under review. Moreover, although the Austin is funded for mental health consultation/liaison, none of this funding goes to cover mental health input to the paediatric ward.

Given these anomalies and the implications for the quality of patient care, it would be timely for the Mental Health Branch to encourage the use of mental health consultation/liaison funding in hospitals which admit patients with eating disorders to deliver coverage to adult and/or paediatric beds. However this links to the broader issue of continued inequitable distribution of C/L funding across health services, despite some attempts to redress this historical imbalance.

#### Recommendation #5:

It is recommended that C/L services and their funding be reviewed by the Mental Health Branch to ensure that these services are made available for patients with eating disorders, whether in general adult medical or paediatric wards.

#### Child and Adolescent Services (CAMHS & The CAH)

There are two major issues for CAMHS in treating children and young people with eating disorders. One is that a particular CAMHS may not have clinicians with the right expertise to provide individual assessment and treatment, and to work with the young person and their family. The second issue relates to the target age group of CAMHS services and the junction between CAMHS and adult mental health. When a CAMHS client requires continuing treatment after turning 18, due to the complexity of their condition, a transfer to the local AMHS is needed. However, CAMHS staff report difficulties in achieving a smooth transition, with AMHS staff being reluctant to provide the same intensity of intervention as CAMHS. CAMHS clinicians observed that as a result, they usually seek to transfer care of an 18 year old to a private practitioner, although one may not be readily available, especially in rural areas.

In relation to the first issue regarding clinician expertise, it would seem that specialist eating disorder services, whose role is currently focused on adults, could take on the role of preparing and supporting CAMHS clinicians in treating young people with eating disorders. This role should include provision of primary and secondary consultation as well as ongoing supervision as appropriate. CAMHS clinicians should also be able to access advanced training to help them gain and update their knowledge and skills about current approaches to treating young people with eating disorders. Further, protocols need to be developed with the relevant AMHS to enable the latter to assume care of a young person with an ongoing eating disorder when the client turns 18.

Similar issues also apply in the different acute health sector context of the Centre for Adolescent Health (CAH) at the Royal Children's Hospital.

#### Recommendations #6 & #7:

- #6. It is recommended that in the mental health service system the role of Child and Adolescent Mental Health (CAMHS), and in the acute health system, the role of the Centre for Adolescent Health at the Royal Children's Hospital, in assessing and treating children and teenagers with moderate to severe eating disorders be affirmed.
- #7. It is recommended that the responsibilities associated with this role be encouraged through additional support to CAMHS. Depending on the particular CAMHS, this extra support could include in-service training in advanced clinical interventions with the client group, primary and secondary consultation to assist in treatment management and clinical supervision. The relevant regional specialist eating disorder service would be responsible for organising this additional support (see Recommendation #14 & #11).

## Adult Mental Health Services (AMHS)

AMHS clinicians identified a particular difficulty in treating people with moderate to severe eating disorders. This was because whilst few in number, this group of clients requires a level of expertise lacking in most AMHS. AMHS clinicians also see themselves as fully occupied responding to clients with other complex conditions, including serious psychotic disorders, and particularly those with dual diagnosis. People with moderate to severe eating disorders are typically only accepted as AMHS clients if they have a co-morbid disorder, such as major depression. The consequence is restricted access to adult public mental health services for people with eating disorders. This effectively limits opportunities for early intervention and continuing treatment in the community, seemingly at odds with government policy.

Two possible strategies have been identified that might help resolve this problem. One is to require that AMHS identify one or two clinicians who could develop expertise in the assessment and treatment of eating disorders. Clinicians with this portfolio would undertake advanced training organised by the relevant specialist eating disorder service, with the latter also making available both primary and secondary consultation and clinical supervision. The difficulty with this option is that it would hold little attraction for AMHS clinicians who already feel overloaded and are wary of trying to be 'all things to all people'. Moreover, the likely low numbers of people with eating disorders could make it difficult for ED portfolio clinicians to maintain this expertise.

The second and preferred option is that the regional specialist eating disorder services be funded for additional clinicians, whose main role would be to provide specialist community-based treatment to AMHS clients with eating disorders. The AMHS would be expected to carry the case management role for individual clients, including assessment and individual service planning, as well as provision of after hours acute support should this be needed. In this option, the ED clinician would be based in the specialist eating disorder service, and would work with a cluster of local AMHS to provide intensive treatment for clients with eating disorders. The specialist eating disorder services would provide clinical support and supervision on a regular basis for these clinicians.

### Recommendations #8 & #9:

It is recommended that:

- #8. All AMHS be confirmed as having a responsibility to provide assessment and treatment for people with moderate to severe eating disorders.
- #9. Specialist expertise be made available through additional eating disorder clinicians being employed by the regional metropolitan specialist eating disorder services to provide eating disorder-specific treatment and consultancy to their local AMHS clusters. (Regional and Rural AMHS are part of recommendation # 11)

## Primary Mental Health and Early Intervention Teams

Primary Mental Health Teams (PMHT) are already mandated to provide education and consultancy to primary care providers such as GPs and community health services. However, their focus to date has been on the assessment and treatment of people of all ages with depression and anxiety disorders, and early intervention for young people, particular in relation to first episode psychosis.

With increased Commonwealth assistance to GPs for treating mental health problems and disorders through the National Action Plan {Council of Australian Governments, 2006 #623: 9-10}, it is timely for PMHTs to take a more active role in relation to eating disorders. This should include education and consultation for GPs in the assessment of all forms of disordered eating, and treatment of the less severe types of eating disorder. PMHTs could also provide limited direct clinical interventions.

A number of PMHTs benefited from the Secondary Consultation and Education Project run by CEED from 2003 to 2005, becoming more skilled and confident in providing direct assessment and treatment, as well as guidance for GPs and other practitioners. Only half of the PMHTs were included in this Project and besides, even for those who were involved, the benefits have not been always sustained as staff move on. As a result, PMHTs should be targeted for additional training into the future. As part of their expanded roles the metropolitan regional specialist eating disorder services and augmented rural services should undertake this training for PMHTs in their catchment areas.

### Recommendation #10:

It is recommended that the mandate for PMHTs be explicitly extended to include primary and secondary consultancy for GPs and other primary healthcare providers, such as community health services, in regard to people across the lifespan with mild to moderate forms of eating disorder. This should also encompass PMHT clinicians having the capacity to offer a limited number of direct clinical interventions to these clients.

## Rural Eating Disorder Services

Both CAMHS and AMHS in rural settings face particular problems in treating people with eating disorders. The most obvious are difficulties in attracting and keeping clinical staff, problems in staff having the right set of skills for treating people with eating disorders, and the lack of private practitioners to provide specialist treatment. On the other hand, the Bendigo Eating Disorder Project has shown that with a relatively modest outlay of extra funding, it is possible to increase access to treatment in public mental health services for people with eating disorders.

This model is based on specialist eating disorder clinicians being embedded in the rural AMHS. An outline of the service model is attached as Appendix B and shows client pathways into the service and across the different components. An outreach service is provided to outlying parts of the catchment area, including Swan Hill. As already noted in this Report, data on service utilisation show this service model has increased service access for people with eating disorders.

The apparent success of the Bendigo model provides the basis for establishing it in other rural mental health services. On the other hand, the level of additional resourcing would also need to reflect the variation in population size and dispersal in different rural regions.

#### Recommendation #11:

It is recommended that rural CAMHS and AMHS (with the exception of Bendigo and Barwon), be augmented to provide a better response to people with eating disorders. This should take the form of additional clinical resources to enable provision of specialist care and secondary consultation across CAMHS and AMHS.

### Specialist Tertiary Eating Disorder Services

The most obvious and immediate problem with the existing regional specialist eating disorder services is that they do not have a set of common service components reflecting an explicit model of care. Beginning for example with bed numbers and location, only the Royal Melbourne specialist service has an inpatient unit dedicated solely to patients with eating disorders. While it has 8 beds, Monash has only 2 beds collocated with 4 beds intended for mothers and babies. The Austin at present has a variable number of beds at any given time from a funded complement of 9. This resource is also used for mood disorder clients. These specialist beds at the Austin (along with Austin's mother/baby beds) will move to a new building later this year. This move will see a composite unit to deliver care for eating disorder, adult acute psychiatry and mood disorder clients and will therefore require careful consideration by this service of the model of care. The mother/baby service, while also moving to the same building, is to be located in a separate wing.

The Royal Melbourne Hospital is also the only eating disorder service to be funded specifically for a non-inpatient service component (a day program). As the Austin is not funded to provide outpatient treatment, it offers only minimal follow-up for those discharged from the inpatient unit. Monash however, while not specifically funded to do so, conducts outpatient services and delivers particular programs for individuals with bulimia nervosa as well as offering secondary consultation to GPs and private psychiatrists.

There seems to be general agreement amongst experienced clinicians about the model of care and associated core components of a specialist eating disorder service. In essence, the emphasis would be on early intervention through the provision of intensive treatment in the community, both on an individual and group basis, and access to an intensive day program as a step-up alternative to inpatient care. Hospital admission would be used selectively and sparingly. Post-inpatient care would involve intensive outpatient treatment, with access to day program activities. Clients should be encouraged to participate in treatment planning, and information, education and support of family members should be an integral component of service delivery.

The first core service component would be provision of clinical interventions in community settings for people with moderate to severe eating disorders. This form of treatment would enable early intervention and an alternative to inpatient admission, as well as

intensive post-discharge follow-up should admission be necessary. The second service element would be an intensive day program, either co-located with the inpatient unit or based in the community. This program would perform a step-up/step-down function.

The third service component would comprise access to inpatient beds designated exclusively for eating disorder patients, and preferably in a separate unit rather than combined with other specialist or acute mental health inpatient beds. The total number of beds required would be influenced by factors such as the targeted age range, the nature of adjacent bed and staffing configurations and related funding issues, and the availability of other complementary services.

It is important to have comparable access to inpatient specialist care for clients from all areas of the state, and from all age groups. It is also necessary to gain and maintain a critical mass of expertise and an appropriate number of beds in order to deliver the best possible treatment and care for eating disorder clients at the time of their most vulnerable and acute level of illness. An expansion of earlier intervention services and more comprehensive treatment and support responses to this group through primary care, as well as enhanced mental health workforce expertise and treatment delivered in the community, should in the medium to longer term effect some reduction of acute hospital medical admissions and the demand for mental health CAMHS and adult specialist eating disorder beds.

However, careful planning needs to be undertaken to strategically address the present distribution anomalies. Due consideration should also be given to the existing regionalised catchment basis governing bed based service access and utilisation with deliberation as to the best possible measures that might achieve more equitable arrangements.

In addition to these components, the specialist eating disorder service should have the capacity to provide consultation to other public sector services and practitioners treating people with moderate to severe eating disorders. This would include consultation and liaison to general medical inpatient and Emergency Department staff at the hospital where the service is located, as well as training and supervision for in regional catchment service clusters for community-based clinicians in CAMHS, AMHS and PMHTs. Lastly, the service should be a visible contributor whether alone or in collaboration with others, to clinical and applied research about eating disorders. Part of this activity should be investigating the best treatment options for people with eating disorders. With the involvement of the PDRS sector, a further service component could be home-based outreach support and other forms of psychosocial rehabilitation.

Currently, none of the existing specialist eating disorder services match the model outlined above. There are different ways the shortfall could be resolved. These are summarised in the following chart:

Chart showing future options for specialist eating disorder services and the associated advantages and disadvantages

Outline of Options	Advantages	Disadvantages
<p><b>Option 1:</b></p> <p>Establish one specialist ED service by consolidating all the resources into one centre at RMH.</p>	<p>Most efficient use of resources.</p> <p>Outpatient service could expand.</p> <p>Builds critical mass of expertise for quality care, secondary consultation, teaching &amp; research.</p> <p>Existing precedents such as Spectrum.</p>	<p>Loss of regional services and networks.</p> <p>Reduces regional availability of specialist service.</p> <p>One central service would be less accessible for consumers &amp; families.</p>
<p><b>Option 2:</b></p> <p>Retain 3 specialist ED services. All to attain full set of service elements – outpatient treatment, day program, inpatient unit dedicated to eating disorders, secondary consultation.</p> <p>Fund all eating disorder beds at the same level.</p>	<p>Maintains &amp; strengthens local accessibility of specialist service.</p> <p>Builds expertise in local services in region, particularly CAMHS and AMHS.</p> <p>Increases availability of comprehensive care.</p>	<p>Limited resources spread thinly.</p> <p>Time needed to get funding for comprehensive set of components in all three specialist services.</p> <p>More expert staff required than in a centralised model in an environment of workforce shortage</p>
<p><b>Option 2A:</b></p> <p>First establish RMH as a model program with all service elements.</p> <p>Evaluate &amp; adjust model before rolling out to other two services.</p>	<p>Would enable validation of core service elements.</p> <p>Staged rollout means more realistic use of limited funds.</p>	<p>One service seen as favoured over others – maybe drift of expertise.</p> <p>Danger that rollout might lose momentum.</p>
<p><b>Option 2B:</b></p> <p>Expand all three services over similar timeframe.</p>	<p>All services will start to expand. Boost to staff morale, gives hope to consumers and families.</p>	<p>Obtaining funding takes time – frustrating for staff, consumers &amp; families.</p> <p>Better resourced service could be disadvantaged as others catch up.</p> <p>Regional catchment arrangement means continued inequitable access for extended period.</p>

Firstly, consolidating all the resources into just one specialist eating disorder service could have advantages. This could include more strategic use of the available resources to enhance the capacity of CAMHS and AMHS to treat people with eating disorders in community-based settings. It would also follow the precedent set by other specialist services which focus on low prevalence disorders, such as Spectrum. On the other hand, it would further constrain the local availability of specialist eating disorder services.

The other direction is to continue the three specialist services, expand their resourcing to match the service model outlined above, and set new requirements for service provision, including clear specification of their catchment areas. As a first step, all eating disorder beds should be funded at the specialist rate.

There are at least two ways in which the capacity of the three services could be enhanced. One option is to establish the RMH specialist eating disorder service as a model program in the first instance, such as through re-allocation of other funding and use of growth funds. The model program could then be evaluated for its effectiveness, enabling adjustments to be made before seeking to roll out the model across the other two specialist services.

The second option is to start expanding all three services at the same time, acknowledging that those services which currently lack certain components will need more resources and time to put these in place.

#### Recommendations #12 -#14:

It is recommended that:

- #12. The three regional specialist eating disorder services be strengthened and redeveloped, in the interests of expanding service availability and accessibility, and improving comprehensive specialist care.
- #13. Each of the services be resourced adequately so that all have a comparable capacity, with priority being given to the development of non-bed based service provision.
- #14. The role of the specialist eating disorder services be extended to provide consultation and training to metropolitan CAMHS, AMHS and PMHTs, and consultation for other local healthcare practitioners and services.

## Consumer and Family Support, and Community Education

The expansion of services provided by Eating Disorders Foundation is a welcome development for consumers and families.

### Recommendation #15:

That EDFV be acknowledged for its contribution to consumers and families and encouraged to continue its development of support groups around the state.

## Family Sensitive Practice

Treatment services also have a responsibility to ensure that their practices are inclusive of consumers and their families. In particular, families' needs for information, education and support should become an accepted part of service delivery.

### Recommendation #16:

That all treating practitioners and services incorporate family-sensitive approaches into their treatment of people with eating disorders.

## APPENDIX A

### List of Organisations and Services Consulted

The General Practice Division of Victoria

The Centre for Adolescent Health

The Royal ANZ College of Psychiatrists

The Melbourne Clinic

The Eating Disorders Foundation of Victoria

La Trobe University, Department of Psychology (Professor Susan Paxton)

Managers of Primary Mental Health Teams

Directors of Child and Adolescent Mental Health Services

Orygen Health Eating Disorder Clinic

Managers of Adult Mental Health Services

Directors of Specialist Eating Disorder Services at Austin Health (Banksia House),  
Monash Medical Centre and Melbourne Health (Royal Melbourne Hospital)

Bendigo Eating Disorder Service

Barwon Disordered Eating Service

Pathways Geelong (Psychiatrist Disability and Rehabilitation Support Service)

The Centre of Excellence in Eating Disorders (CEED)

The Bronte Foundation

The Oak House

The Butterfly Foundation

VicHealth

Office for Youth, Department for Victorian Communities

Mental Health Branch, Department of Human Services

Public Health Program, Department of Human Services

Primary Care and Community Health Branch, Department of Human Services

Acute Health Program, Department of Human Services

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## GLOSSARY OF ABBREVIATIONS

AMHS	Adult Mental Health Services (sometimes called Area Mental Health Services)
AN	Anorexia Nervosa
ATAPS	Commonwealth Access to Allied Psychological Services
BEACH	Bettering the Evaluation and Care of Health
BMI	Body Mass Index
BN	Bulimia Nervosa
BOMHC	Commonwealth Better Outcomes in Mental Health Care
CAH	Centre for Adolescent Health
CAMHS	Child and Adolescent Mental Health Services
CATT	Crisis Assessment and Treatment Team
CBT	Cognitive Behavioural Therapy
CHS	Community Health Service
CMHS	Community Mental Health Service
COAG	Council of Australian Governments
DHS	Department of Human Services
ED	Eating Disorder
EDFV	Eating Disorders Foundation of Victoria
EDNOS	Eating Disorder Not Otherwise Specified
GP	General Practitioner
GPDV	General Practice Division of Victoria
IMYOS	Intensive Mobile Youth Outreach Service (CAMHS)
MBS	Medical Benefits Schedule (Commonwealth)
MSTT	Mobile Support and Treatment Team (AMHS)
NMHS	National Mental Health Strategy (Australia)
NHS	National Health Service (England and Wales)
PMHT	Primary Mental Health Teams
RMH	Royal Melbourne Hospital