

Department of Health

health

Victorian eating disorders strategy



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Minister's foreword

Eating disorders encompass a complex set of disorders, with the most severe eating disorders associated with significant mortality and morbidity. Eating disorders can cause life-long health issues that can affect all domains of a person's life – their physical, psychological, social and emotional health and wellbeing.

Mirroring this complexity is the multilayered system of prevention programs, frontline health responses, treatment and support services. This complexity calls for a dedicated strategy to develop a shared understanding of the issues and a unified direction going forward.

The *Victorian eating disorders strategy* (the strategy) sets a joint agenda for working across the connected areas of prevention, early identification, treatment and support for people with eating disorders of all ages, stages and genders, and their families and carers.

The strategy considers eating disorders in the broader sociocultural context, which is thought to influence key risk and protective factors. The experience of leaders in the field and consumers and carers tells us that we must focus on preventing eating disorders and disrupting their development through prompt identification and engagement in care.

We know that identifying when and how to support someone to get help can be difficult. It can also be challenging to access the right treatment and support for the duration it is needed, and through the successes and setbacks of recovery. Our collective challenge is to enable flexible approaches that actively support early and sustained engagement. A clear continuum of coordinated care and support is needed.

We are proud of our commitment to recovery-oriented practice in mental healthcare in Victoria. The strategy draws on the principles of Victoria's *Framework for recovery-oriented practice* that I released in 2012. At the heart of this is embracing a culture of hope, collaborative partnerships and meaningful engagement with individuals and their families and carers. Partnerships and engagement are also at the centre of a future system for eating disorders that has strong integration between prevention efforts, early frontline responses, treatment and support services.

This is affirmed by the *National eating disorders framework: an integrated response to complexity*, developed by the National Eating Disorders Collaboration in 2012. This work was undertaken with consumers, carers and leading experts, many of whom were from Victorian services, and it resulted in a set of national principles that have been adopted in this strategy.

In Victoria, we see these principles translated in our eating disorders services. Victoria has been at the forefront of diversifying treatment options. Investment of \$4.9 million over four years is enabling the ongoing operation and development of the Body Image and Eating Disorders Treatment and Recovery Service (BETRS) provided by Austin Health in partnership with St Vincent's and the Wellness and Recovery Centre (WRC) delivered through Monash Health. These service innovations represent a shift to intensive community-based care. Along with the Eating Disorder Program delivered by Melbourne Health, they support people leaving hospital, and provide a more intensive response to prevent hospital admissions.

Our investment of more than \$3 million to establish an intensive eating disorders program at The Royal Children's Hospital (RCH) has expanded the RCH family-based treatment program. This approach empowers families and carers to be able to implement treatment at home while being supported by a multidisciplinary team. The RCH is also providing leadership in identifying and responding to emerging trends in young people presenting with eating disorders.

While these new programs have greatly increased service access for many people affected by significant eating disorders, they cannot address all of the different levels of need in the community. Local health services have an important role in planning and delivering treatment and care for their local communities. There are pockets of exceptional practice, where strong service collaboration is being locally driven by area mental health services to address the needs of people with eating disorders. We want to build on this so that people and their families and carers can more consistently access treatment and support near home whenever possible.

The strategy sets out actions recommended by the Victorian Eating Disorders Taskforce (the taskforce), to build on existing strengths in the Victorian prevention, treatment and support sectors. I would like to thank members of the taskforce and Ms Christine Fyffe MP, its chair, for the considered recommendations provided. I would also like to acknowledge the people with a lived experience of eating disorders who have written to me or generously shared their time and personal experiences to inform this strategy.

I look forward to realising the opportunities for strengthened collaboration between our committed eating disorder sector, health services and broader sectors to join up efforts to prevent and reduce the impact and duration of eating disorders, and improve the health outcomes of those affected.

A handwritten signature in black ink, reading "Mary Wooldridge". The signature is fluid and cursive, with a long horizontal stroke at the end.

Hon. Mary Wooldridge MP
Minister for Mental Health

Chair's introduction

It is my pleasure to introduce the *Victorian eating disorders strategy* (the strategy), which brings together the dedicated work of the Victorian Eating Disorders Taskforce (the taskforce) appointed by the Minister for Mental Health, the Hon. Mary Wooldridge MP.

My introduction to eating disorders began when I talked with parents about the very difficult, day-to-day struggles they experienced when supporting a young person in the family suffering from this debilitating disorder. Through my involvement with the taskforce, and further opportunities to talk with people affected by these disorders and those close to them, it was evident that while eating disorders most commonly emerge in young people, this is a group of illnesses that can affect anyone of any age, all genders, and from diverse backgrounds and walks of life.

What I have learnt is that this disorder is marked by complexities. There is no one common story about how an eating disorder develops – it can be a hidden problem, with people not getting the help they need due to a range of factors that may include fear, not identifying as having a disorder or feeling like no one understands. There is also no single consistent pathway into treatment and support, and no 'one-size-fits-all' response in providing care. For someone struggling to overcome an eating disorder, it can take time to find an approach that is right for them.

However, we do know that minimising delays in diagnosis and treatment is key to maximising outcomes and reducing the potential long-term impacts – early intervention is important whenever this disorder may occur in the lifespan, both for those who experience a single episode and for those experiencing relapsing problems.

This strategy seeks to build on the understanding of eating disorders gained through the taskforce, and to take action to renew the system accordingly. It brings into focus the need to raise awareness and have clear, responsive and reliable ways for people with an eating disorder, their families, friends and frontline health professionals to access and refer to help.

The strategy sets the overarching directions that will support the system to develop in a more consistent and responsive way, so that no matter where a person with an eating disorder lives, what type of eating disorder they have or how old they are, they can get the right treatment and support they need for their health and recovery.

I wish to extend my thanks to the members of the taskforce for their work and the collaborative approach to producing considered recommendations for this eating disorders strategy. I also wish to express my appreciation to the Hon. Mary Wooldridge MP, Minister for Mental Health, who has supported the development of this strategy in a genuine effort to improve the experience of people at all stages of eating disorders, from preventive work through to diagnosis, early intervention and intensive treatment, support and recovery.



Christine Fyffe MP
Chair

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The need for an eating disorders strategy

The health of the community is a priority for the Victorian Government. Disorders and diseases with high mortality and morbidity, such as eating disorders, are of key concern, and must be addressed by government policies at all levels, including: sociocultural factors in whole-of-population approaches; more targeted policies for at-risk groups; and specific health policies to guide development of integrated systems for people with complex conditions.

The personal cost of eating disorders

Eating disorders are serious mental illnesses that can have significant impacts on the physical health of individuals affected. Eating disorders are taken seriously as they can be fatal due to medical complications associated with the disorder. Suicide has also been identified as a major cause of death for people with a range of eating disorders (National Eating Disorders Collaboration 2012, p. 15).

The high morbidity associated with eating disorders can have lifelong impacts. People who develop eating disorders in childhood or adolescence may experience interrupted physical, educational and social development and a long-term risk of significant medical complications (National Eating Disorders Collaboration 2012, p. 15). Adults with eating disorders can experience significantly higher levels of anxiety disorders, cardiovascular disease, chronic fatigue, depressive disorders, neurological symptoms and suicide attempts (National Eating Disorders Collaboration 2012, p. 14).

These costs are documented in a report commissioned by the Butterfly Foundation in 2012. The report, *Paying the price: the economic and social impact of eating disorders in Australia*, points to the personal cost of these disorders for individuals and their families including significant lost productivity incurred through premature death and impaired ability to work to one's full potential as a result of the physical and mental health impacts (Butterfly Foundation 2012).

Delays in diagnosis and treatment

While it is well known that early identification and prompt responses to eating disorders must be a priority to reduce the duration of untreated illness and optimise chances of recovery, these disorders often go undetected until the illness becomes more obvious and symptoms have become more entrenched. The *National framework for eating disorders: an integrated response to complexity* (the national framework) calls for 'early identification and prompt intervention, based on appropriate, multidisciplinary approaches, to reduce the severity, duration and impact of the illness' (National Eating Disorders Collaboration 2012, p. 17). The best outcomes are achieved by people who receive person-centred treatment early in illness and early in episode.

A community that is aware, together with frontline health professionals who can identify eating disorders, are central to support people to seek help and provide earlier diagnosis, thus reducing critical delays in treatment.

Navigating the system and gaps in services

Challenges entering and navigating the service system, which invariably involves a vast array of services, can complicate timely access and engagement in treatment. Care can become disjointed if the multiple services needed are not properly coordinated.

People can find it challenging as they navigate between and within different service systems: public and private services, hospital and community services, youth into adult services, and between rural and metropolitan-based specialist services. Families and carers may be coordinating care for their loved one, often at the same time as they are trying to understand how to best support them through the challenges of treatment.

Treatment and support options vary in intensity, specialisation and type. Flexibility to intensify treatment in response to changing needs is vital to ensure that individuals can sustain their engagement or build on treatment gains made.

Responding to complexity

Managing eating disorders can be extremely complex. People with eating disorders often present with varying symptoms, and the illness may follow a variable course, often with fluctuations in severity, acuity, complexity and risk.

The range and severity of associated conditions (for example, depression, anxiety, fertility problems, kidney failure and high blood pressure) can also complicate diagnosis and management (National Eating Disorder Collaboration 2012).

This complexity is demonstrated in the average length of hospital stay. The Victorian 2012–13 data shows that the average hospital stay for someone admitted with an eating disorder in Victoria is 13 days (Department of Health 2013). This is in contrast to the average patient hospital stay in Australia, which is 2.9 days (Butterfly Foundation 2012, p. 58).

Despite the complexity, evidence-based models of care are available that can help people recover from an eating disorder. The workforce needs to be supported to take up these models of care and deliver them through multidisciplinary team approaches in a more consistent and systematic way.

Reducing eating disorders

Given the high morbidity of eating disorders, opportunities to reduce their impact or prevent their development need to be found and maximised. There is, however, still much to learn about how eating disorders develop, how to prevent them, and where prevention efforts are best focused. Issues such as when early intervention is required, which models of early intervention should be employed and in what settings also need to be clarified.

Currently, there are multiple services and settings that use different forms of prevention. These range from whole-of-population approaches to improve mental health and wellbeing, resilience and health literacy, through to prevention activities specific to eating disorder risk and protective factors.

Despite the existence of a number of resources for targeted interventions, uptake, availability and prioritisation of these resources across the state, is inconsistent. Further, for prevention programs to be effective, they must be appropriate for the setting and audience, including factors such as age, gender and cultural background. Given this, Victoria needs to adopt more consistent and accurate approaches, with a clearer understanding of outcomes sought.

Complexity calls for a dedicated focus

To decrease the prevalence and impact of eating disorders and achieve ongoing improvement of our eating disorder services, the Victorian Government established the Victorian Eating Disorders Taskforce (the taskforce). The taskforce made recommendations for the prevention, early detection and treatment of eating disorders. This strategy is the result of their work.

The strategy provides a foundation for building on collaborative effort across the whole community, and on the high-quality services in Victoria, so that we can improve service access and ensure early intervention and prevention are integral to the overall approach to eating disorders.

This strategy considers not only those with current or recurring eating disorders but also those at risk of developing an eating disorder and broader population-based initiatives that may help prevent eating disorders.

This requires strong leadership, governance and support for local service participation. It also requires whole-of-government commitment to ensure a consistent, holistic and integrated response across the areas of prevention, early detection, treatment and support.

What are eating disorders?

The term 'eating disorders' refers to a range of illnesses that include anorexia nervosa, bulimia nervosa and binge-eating disorder. Eating disorders have varying levels of severity. The most severe eating disorders have relatively low prevalence, but are serious mental illnesses that can have severe and potentially fatal physical impacts. People with eating disorders respond best when assertive medical and mental health assessment and treatment are provided early.

Eating disorders such as bulimia nervosa and binge-eating disorder may be less severe but more common. Eating disorders can also occur alongside higher-prevalence disorders such as anxiety and depression. For example, in Western Australia, a study that screened people receiving outpatient mental healthcare for anxiety and depression found that 7.3 per cent of people had a diagnosable eating disorder previously undetected (Fursland and Watson 2013).

Eating disorders should be distinguished from disordered eating. Fasting, skipping meals, restrictive dieting, laxative misuse and misuse of diet pills are examples of disordered eating (National Eating Disorder Collaboration 2010, p. 11). People with disordered eating are considered in this strategy through whole-of-population and targeted prevention approaches.

The exact cause of eating disorders is unclear, but it is widely accepted they are likely to result from a complex interplay of multiple biological, psychological, sociocultural and other external factors.

Contrary to popular belief, eating disorders are not confined to young women. They can affect people from all backgrounds, ages and genders. For example, the national framework refers to increasing diagnosis of eating disorders in older women (National Eating Disorder Collaboration 2012, p. 16) and younger children (Nicholls et al. 2011).

Often eating disorders begin to develop in adolescence, but this varies according to gender and the type of eating disorder. For example, binge-eating disorder generally occurs in early adulthood (National Eating Disorder Collaboration 2010b, p. 8) and anorexia nervosa tends to develop in younger adolescence (Gonzalez et al. 2007).

While the onset of different eating disorders occurs at different ages, delay between onset and first presentation is common across all eating disorders. For example, while bulimia nervosa usually occurs in later adolescence, people may not seek help until several years later.

There are some known risk factors, including:

- personality characteristics such as body dissatisfaction, low self-esteem, perfectionism, obsessive-compulsiveness and negative emotionality (National Eating Disorder Collaboration 2010b, p. 11)
- life experiences such as post-traumatic stress, neglect and childhood sexual abuse (National Eating Disorder Collaboration 2010b, p. 11)
- cultural factors such as participation in aesthetic sports (such as dancing)
- dieting (National Eating Disorder Collaboration 2010b, p. 10) and depressive symptoms (Patton et al. 1999 p. 765).

How are eating disorders treated and managed?

Full recovery from an eating disorder is possible (Bardone-Cone et al. 2010). The national framework suggests effective treatment of eating disorders requires integration and collaboration between:

- physical and mental health services
- public and private health services
- professional disciplines
- various treatment approaches for comorbid conditions
- families and clinicians as essential members of the treatment team.

Advice from experts, including consumers and carers, emphasises that treatment must be developmentally appropriate. Transitions for young people as they move into adult-based services need to be well managed and supported. Other important transitions for consumers occur between physical and mental health services; hospital-based and community services; and private and public services. Managing transitions is critical to preventing people from falling through the gaps and making sure individuals' needs are met with continuity as they change.

To truly provide timely intervention and support for affected individuals and their families and carers, eating disorder treatment responses must be organised and managed across multiple service systems – primary health and mental health services; general and acute medical services (including paediatricians and physicians); and specialist mental health services, which include clinical mental health services and mental health community support services. Key aspects of treatment include psychosocial support, advocacy, and mutual support and self-help. Services are provided by a mix of public and private sector agencies or professionals.

Services also focus on engaging and supporting families and carers, who often play a vital role in the recovery of those with an eating disorder. Caring for someone with an eating disorder can significantly affect many aspects of families' and carers' lives such as relationships, social interactions, ability to work and finances if intensive intervention is required. Many carers report high levels of distress and burn out (Treasure et al. 2001), so support for carers and other family members is vital.

Services and settings

There are a range of services and settings involved in eating disorder prevention activity and in working with people across the spectrum from identifying risk factors and early warning signs through to more complex disease.

Treatment and support services: State-funded general health and specialist mental health services (including mental health community support services), general practice, and primary care services, and private mental health programs and professionals are among key treatment and support services involved in assessment, intervention, emergency responses, ongoing monitoring, case management and support to participate in daily activities for meaningful recovery.

Early identification and response services: Health professionals in frontline services like primary care, general practice or emergency departments are often a first point of contact for the community seeking assistance for health concerns, and are well placed to identify emerging or re-emerging eating disorders. Depending on the setting, this involves initial assessment, supporting engagement in further assessment, early intervention, initiating and supporting referral, ongoing medical monitoring, care coordination or emergency responses.

Prevention settings: Preventative health activities that target key protective and risk factors occur in a range of settings including health services, education settings and workplaces. Depending on the setting, eating disorders prevention activity may include general resilience building, as well as activities to target risk and protective factors of specific eating disorders.

Statewide support and workforce development services: Statewide support services provide community awareness, education and advocacy, helplines and web-based support and information and peer support. The Victorian Centre of Excellence in Eating Disorders is responsible for supporting workforce capability in Victoria's specialist mental health services to treat eating disorders. This is complemented by Eating Disorders Victoria, which offers training for carers, clinicians and primary health professionals.

Table 1: Examples of services and settings

Examples of treatment and support services	Examples of early identification and response services	Examples of settings where prevention activity may occur
Primary health services	Primary health services	Primary health services
General practitioners	General Practitioners	headspace
headspace	headspace	School health/welfare services
Specialist mental health services including mental health community support services and acute community intervention services	School health/welfare services	Womens health/welfare
Private mental health services	Womens health/welfare	Out-of-home care
Community paediatric services	Maternal and child health services	Youth services
Hospital-based acute medical and mental health bed-based services	Youth services	Sports and fitness programs
Hospital-based outpatient services	Specialist mental health services including mental health community support services and acute community intervention services	TAFE health/welfare services
Specialist eating disorder beds and intensive community-based programs	Emergency departments	University health/welfare services
Emergency departments	Private mental health services	
Peer-support services	Private mental health clinicians	
	Alcohol and other drug services	
	Community paediatric services	
	Dental services	
	Gynaecology services	
<p>Examples of statewide support and workforce development services</p> <p>Victorian Centre of Excellence in Eating Disorders, Eating Disorders Victoria, Butterfly Foundation, National Eating Disorders Collaboration, helplines (EDV Helpline, Butterfly Helpline, Kids Helpline)</p>		

Building on current strengths in Victoria

While there are opportunities to improve, Victoria is recognised as a national leader in investing to advance and expand intensive models of community-based care in specialist mental health services. Victoria has also taken the lead in acknowledging that, for people with eating disorders, earlier responses provided through intensive community-based treatment and support are integral to improving people's outcomes.

In addition to intervening earlier in illness and in episode, the Victorian commitment to preventing or disrupting illness development is demonstrated by this strategy's unique focus on prevention alongside treatment and support for people with current illness.

The strategy calls for strong collaboration and organisation between the multiple services and settings already playing an important role in preventing, identifying, treating or supporting people with eating disorders and their families and carers.

The strengths of the current system provide a strong base on which to build. Eating disorder considerations can also be included in mainstream understandings of prevention and treatment issues.

There is, however, always more to learn and do as innovation occurs. A stronger understanding of the outcomes of all activities, across the spectrum of prevention, efforts to promote earlier intervention and delivery of treatment and support, is needed to support current efforts and approaches.

Treatment and support services

There has been a record increase in investment in eating disorder services for Victoria since 2010. This has supported the development of models of care to provide more intensive treatment options in the community as alternatives to acute inpatient care whenever possible.

An innovative family-based model that targets the needs of children and young people with eating disorders, and builds on community-based and early responses to eating disorders, has been established at The Royal Children's Hospital with new investment of \$3 million over three years.

An additional \$4.9 million over four years was allocated in 2012–13 to further develop intensive community-based treatment models for young people and adults through the Wellness and Recovery Centre which includes the Monash Butterfly Day Program (Monash Health), and the Body Image and Eating Disorders Treatment and Recovery Service (Austin Health in partnership with St Vincent's). Melbourne Health is also funded to provide a specialist eating disorder service.

Annual investment of more than \$4 million funds specialist eating disorder beds attached to each of these services, and forms part of the continuum of highly intensive and specialist responses for people with eating disorders in Victoria. Medical and specialist mental health inpatient services within tertiary facilities are also part of the continuum of more intensive treatment responses.

Victoria's state-funded general health and specialist mental health services are an integral part of the service system needed to meet the range of medical and mental health needs someone with an eating disorder may have. Providing medical monitoring and support through GPs or paediatricians is pivotal to supporting local responses. Collectively, primary care and local health services (general health and specialist mental health) are well placed to respond to health and mental health concerns that commonly co-occur with eating disorders. For example, GPs are often an easily accessible, pivotal point of continuous contact or relationship for someone with an eating disorder. People may return to their GP for reviews, mental health plans and referral to specialists. Presenting problems may include a range of physical health complications, depression and anxiety. Further, local responses to people's acute, subacute and continuing care needs can also be addressed through emergency and crisis responses and case management services provided by local general health and mental health services.

There are excellent examples of practice in Victoria where area mental health services and their medical counterparts have developed integrated, local responses for their community with the support of the Victorian Centre of Excellence in Eating Disorders.

Mental health community support services are part of Victoria's state-funded specialist mental health service system. Key features of the newly commissioned mental health community support services in Victoria include reorganised intake processes, individualised packages of support and developmentally informed models of care in youth residential rehabilitation services. A new planning function for mental health community support services will support responses to locally identified needs in each region. There is an opportunity over time, to assist these services to identify and respond to complex mental health conditions with co-occurring physical health issues like those that are present in people with eating disorders.

To support early help seeking and engagement in the community, a number of helplines and web-based supports are available. The Eating Disorders Victoria helpline team provides phone and email-based helplines and drop-in support during the week. Likewise, the Butterfly Foundation provides a national support line and web-based counselling services; and e-headspace is a youth-friendly point of contact.

Private providers including GPs, health professionals funded through the Commonwealth's Medicare Benefits Schedule and private hospitals are all part of the system of care for people with eating disorders. Eating Disorders Victoria maintains a list of GPs, private mental health professionals and dietitians who treat eating disorders in Victoria. The establishment of Eating Disorders Victoria Psychology enables people to access private psychologists with specific experience and skills in eating disorders. Online professional development resources also support private health professionals with interest and skill in treating eating disorders. The Victorian Centre of Excellence in Eating Disorders offers the Eating Disorders Online Learning Program, which was designed by the Centre for Eating and Dieting Disorders NSW for health professionals working with eating disorders. A number of private professionals have accessed this learning program since it was first offered by the Victorian Centre of Excellence in Eating Disorders in 2012.

Supporting people as they move between and within services and sectors is an important aspect of delivering effective and safe treatment. For example, the Health Pathways Victoria initiative was established as part of the roll out of Primary Health Networks, (formerly Medicare Locals). The Barwon Health Pathways, launched on 1 August 2013, and Health Pathways Melbourne, launched on 4 June 2014, provide a collaborative and structured approach to coordinating patient care across the acute and primary care interface. The Barwon Health project has included consideration of the needs of people with eating disorders.

Victoria also funds 30 Primary Care Partnerships to improve access to services and continuity of care. Primary Care Partnerships also focus on chronic disease prevention, integrated health promotion, and partnership development.

Early identification and response services

Effective service responses and pathways that support optimal health outcomes in people with eating disorders rely on early identification, followed by prompt responses from frontline health services to emergent, current or recurring signs of illness. Experts unanimously agree that it is vital to get this frontline response right.

Eating Disorders Victoria has developed a GP and primary care education package that is accredited by the Royal Australian College of General Practitioners. Training is offered to GPs, practice nurses and other allied health professionals within the primary health sector, and is delivered by a team of experts including the Victorian Centre of Excellence in Eating Disorders.

Eating Disorders Victoria and the Butterfly Foundation also offer workshops for people working with young people in primary, secondary and tertiary education settings. These workshops aim to support earlier recognition and response to early warning signs and eating disorders. This includes Eating Disorders Victoria's Should I Say Something workshop, based on the Eating disorder first-aid guidelines (2008), and the Butterfly Foundation's Early Intervention workshops which are also open to the broader community, including sports and fitness groups.

In addition to activities specifically designed to improve awareness, there are screening and assessment tools that have a more general focus on mental health, nutrition and exercise. Community health services in Victoria, for example, do holistic screening to examine all the determinants that impact on a person's health and wellbeing. The service coordination template tools (2012) include questions about nutrition, weight concerns, depression and anxiety.

The Victorian Department of Education and Early Childhood Development supports early identification and response to mental health issues in school students by providing mental health resources to schools. In addition to this, the department provided funding of \$750,000 to headspace for the SAFEMinds project. This project supports the development of additional resources for school professionals and parents to identify and respond to mental health issues in young people (such as mild mood disorders or self-harm), and professional knowledge of referral pathways for students with mental health issues.

At the broader community level, the Victorian Government will invest in mental health first aid training for community members in 2014–15. This training aims to equip people to help someone developing a mental health problem or in a mental health crisis until professional help is available or the crisis is resolved.

Prevention

Eating Disorders Victoria and the Butterfly Foundation offer targeted prevention resources and workshops focusing on general protective factors as well as protective factors specific to helping reduce the risk of an eating disorder developing. This includes student workshops in schools to promote positive body image, improve media literacy, encourage self-acceptance and social connection. In addition, the Victorian Department of Education and Early Childhood Development funded the development of the See Me media literacy resource. This resource is now available to all schools as an online resource.

Eating Disorders Victoria and the Butterfly Foundation host annual health promotion and awareness-raising events, Feed the Soul and the Plating Up the Positives respectively. Collectively, the activities of these two organisations provide important platforms to increase awareness and implement prevention and early intervention strategies.

The Victorian Department of Education and Early Childhood Development is also engaged in prevention activities through its support of children and young people to be resilient and develop protective factors for good mental health. For example, the *Resilience framework acknowledges* the skills that young people need in order to be resilient, productive members of society, including decision making, help seeking, stress management and relationship skills. The framework brings together resources to help schools build resilience in young people.

In addition to the *Resilience framework*, the Victorian Department of Education and Early Childhood Development's *Principles for health and wellbeing* underpin effective professional practice in and across the department's health and wellbeing services, early childhood services and schools. The principles seek to promote and support young Victorians' optimal health, wellbeing and educational outcomes.

At a broader, whole-of-population level, the Victorian Department of Health invests in promoting health and wellbeing through Healthy Together Victoria. This is Victoria's flagship preventative health initiative that aims to improve the health and wellbeing of all Victorians by taking a unique 'complex systems approach' to reducing population level chronic disease. This means we are trying to better connect all the elements to strengthen Victoria's health system so people stay healthier for longer.

Statewide support and workforce development services

The Victorian Centre of Excellence in Eating Disorders is responsible for supporting workforce capability in Victoria's specialist mental health services to treat eating disorders.

Drawing on the latest evidence and lived experience of eating disorders, the centre provides training and consultation for specialist mental health services. The centre also supports system development to enable treatment and care for people with eating disorders to take place through local health services whenever possible, and it is piloting co-design approaches to delivering functions such as training and education.

Statewide eating disorder support services in Victoria include Eating Disorders Victoria and the Butterfly Foundation. Other important sources of support include helplines such as beyondblue and Kids Helpline.

Experiences of individuals and their families and carers

Eating Disorders Victoria and the Butterfly Foundation connect with individuals and their families and carers through their support services, helplines and advocacy.

There are a range of possible difficulties for people with eating disorders, their families and carers when seeking treatment. The challenges go beyond the inherent difficulties of the illness itself, to include issues relating to access and navigation of the healthcare system.

The experience of individuals with a lived experience of eating disorders and their families and carers is captured through forums hosted by Eating Disorders Victoria and reflected in the Butterfly Foundation's report *Paying the price: the economic and social impact of eating disorders in Australia*.

Experiences of individuals and their families and carers in their own words

'In the early stages it was difficult to obtain treatment. Firstly, because the illness was not diagnosed by GPs and other health professionals and secondly the eating disorder psychiatrist books were full.'

'In the early part of her disease GPs and specialists (including dietitians and psychologists) failed to recognise her eating disorder even though she was significantly underweight and with amenorrhoea.'

'Being an adult male it was very difficult to be taken seriously; I had three GPs and a nutritionist all fail to diagnose the condition.'

'Living in a rural area there are no choices in treatment at all. Treatment clinics were only in Melbourne and this meant splitting the family for an extended length of time and I still had other children to consider.'

'Finding qualified psychiatrists for the treatment of patients suffering from eating disorders is a nightmare. There are very few skilled in this area of mental health and who have a solid understanding of this illness.'

'There need to be more services for people with eating disorders that are about more than weight restoration. A person's weight is not an indicator of how "well" they are. Also, as per my experience, a person who has experienced anorexia and gained weight can then find themselves with bulimia nervosa or eating disorder not otherwise specified but not be able to seek help because everyone sees the weight gain as recovery.'

'I should not have to tell my doctor that she should check electrolytes on someone who is purging daily.'

'The biggest thing that has improved my quality of life is having support. Making friends who I can connect with. This helps me feel less alone. We get to share progress and use it as motivation. And also when times are tough you have somewhere to lean.'

'When I finally got the right treatment it was highly effective. However the five years prior to this treatment was either ineffective or made the condition worse.'

'There wasn't a team. I never received a referral to a dietitian. I didn't get individual counselling. Once I was out of hospital I was on my own.'

'What I have realised over the years is that we the family also need support and care and we need to take care of ourselves. Unfortunately these illnesses can consume the people we love so much at times, we get left to pick up the pieces and have to try to live a normal life especially for the other children in the family.'

Experiences of the workforce

There are broad workforce groups involved in delivering activity relating to eating disorders prevention, early identification, treatment and support.

Some of the reflections and experiences of key workforce groups were captured through the work of the taskforce, site visits undertaken by the Chair, Ms Christine Fyffe MP and through Eating Disorders Victoria Education programs.

Reflections and experiences of the workforce

Tertiary health professionals

'It is important that treating teams feel supported to manage the range of medical and mental health issues someone with an eating disorder may have. This requires strong local leadership to build a multidisciplinary team.'

'Service provision has been disparate and requires further clarity and authority in relation to service roles and responsibilities.'

'Models of care that address ambivalence and support people to engage in treatment are needed. Adopting flexible entry, exit and re-entry approaches can support this.'

'It can be difficult for teams to maintain skills in eating disorders treatment if only a limited number of people with eating disorders are seen. This is particularly of concern in rural areas with small populations.'

Primary care professionals

'There is not much time with patients and I have already spent five days trying to find somewhere to send my patient with an eating disorder. Everywhere I try, she doesn't meet the criteria.'

'Lack of consistent referral pathways make it hard for frontline professionals to refer someone they have identified as having early warning signs or a current eating disorder.'

'I would never have considered the possibility of an eating disorder with someone coming in with anxiety or depression. I'll certainly be asking some more relevant questions now.'

'Once a problem is identified there are limited options, particularly in rural areas. It is also difficult to know how to engage the person to do something about a problem if they are not ready to address it.'

'There are a lot of young women that come to this clinic and I'm sure there are a couple that could have an eating disorder, but in general talking, they don't talk about what they are really doing to make you consider it so how do you broach the possibility of an eating disorder if they aren't wanting to talk about it?'

School health and welfare professionals

'Eating disorder education is very useful in order to learn about services and to encourage young people to seek help.'

'Learning through case studies and information presented helps to dispel the myths about eating disorders.'

'Through receiving education I felt reassured by the knowledge that I am on the right path when helping someone with an eating disorder.'

A strategic approach

This strategy takes a broad perspective of the issues and embraces an integrated response to eating disorder prevention and early identification, as well as the treatment and support required by people with eating disorders and their families and carers. It considers eating disorders as part of a broader sociocultural context that can influence key risk and protective factors such as body image and weight management.

The strategy also seeks to reorient activities from a historical focus on critical care provided through inpatient hospital treatment, to a stronger emphasis on targeted prevention and supporting a larger number of people earlier to prevent or disrupt illness progression.

This means paying more attention to integrating the role of medical care, coupled with continuity in mental healthcare to address other important aspects of recovery. People with a lived experience commonly identify that having self-acceptance, accepting one's body, having a relaxed attitude to food, having a functioning social life, and being in contact with and having the courage to express emotions are important to personally defined recovery (National Eating Disorders Collaboration 2012, p. 30).

Clinical mental health and mental health community support services that respond flexibly to individual needs are necessary to support these important aspects of personally meaningful recovery.

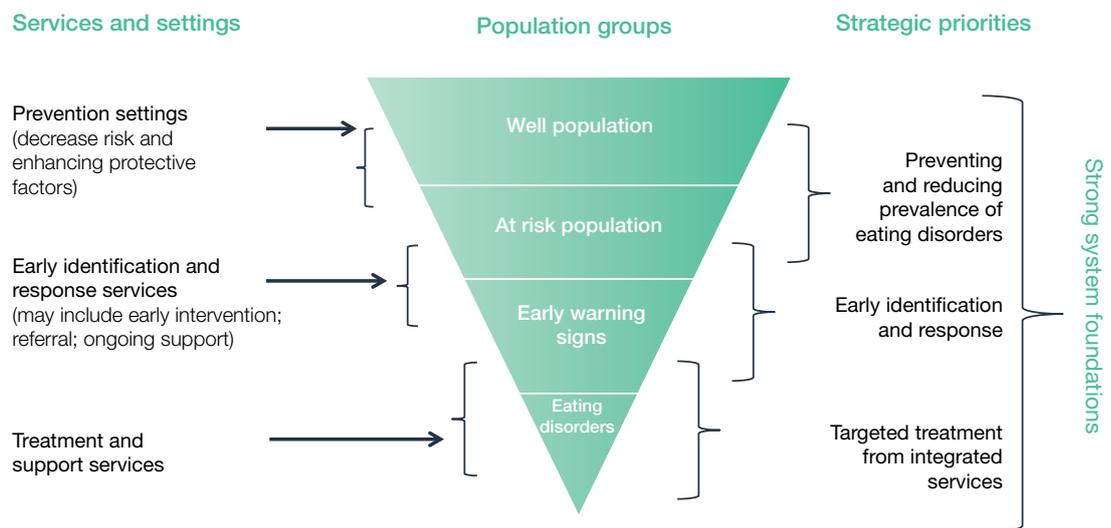
The strategy has four strategic priorities:

- preventing and reducing the prevalence of eating disorders
- early identification and response
- targeted treatment from integrated services
- strong system foundations.

Figure 2 illustrates the spectrum of population groups to be addressed through the strategy, the broad service and setting types with a role to play across the spectrum and how these relate to the four strategic priorities.

The strategy adopts the principles of the *National eating disorders framework: an integrated response to complexity* and the *Victorian Framework for recovery-oriented practice*. It is also consistent with the principles of the Mental Health Act 2014, the Carers Recognition Act 2012 and the National Standards for Mental Health Services 2010.

Figure 2: An integrated view: the Victorian eating disorder strategy



Preventing and reducing prevalence of eating disorders

The exact cause of eating disorders is unclear, but it is widely accepted that they are likely to result from a complex interplay between multiple biological, psychological, sociocultural and other external factors (National Eating Disorder Collaboration 2010b).

While the evidence base for eating disorders has developed significantly in recent years, there is still much to learn about how they develop and how best to prevent them.

Research suggests high self-esteem, emotional wellbeing and good general mental health are protective factors against eating disorders, disordered eating and negative body image (National Eating Disorder Collaboration 2010a, p. 10).

These protective factors are important for strengthening resilience. This is particularly the case in adolescence, when there are specific pressures, such as heightened body awareness, changing peer and family relationships, and developing self-identity (Eating Disorders Victoria 2014).

Prevention activities are required in two key areas: fostering protective factors at the community level and with at-risk groups; and raising awareness to demystify eating disorders.

Creating supportive environments and fostering protective factors

Prevention efforts at the community level to create supportive environments and address social and cultural factors affecting attitudes to food, physical activity and body image can influence the health and wellbeing of the whole population.

Healthy Together Victoria aims to tackle some of these issues by strengthening Victoria's health system to keep the population healthy. Clear public health messages that speak to all members of the community can support people to foster healthy relationships with food, physical activity and body image.

By investing in a prevention focus, there are opportunities to embed and leverage strategies to prevent eating disorders within broader efforts such as mental health promotion and obesity prevention.

The National Eating Disorders Collaboration has highlighted the importance of ensuring that public health messages about obesity, physical activity and healthy eating are sensitive to potential impacts on body image and disordered eating, and reflect size-acceptance issues when discussing healthy weight (National Eating Disorders Collaboration 2011).

More-targeted prevention activities should pay particular attention to building resilience and promoting specific protective factors in at-risk groups. This includes community-based and primary care services, school student support and nursing services, sport, recreation and gyms, tertiary education settings and workplaces that are most likely to come into contact with at risk groups.

At-risk groups are more likely to achieve positive outcomes with interventions targeting modifiable risk factors for eating disorders (National Eating Disorders Collaboration 2012, p33) such as body dissatisfaction, preoccupation with dieting and excessive weight control. One example is media literacy programs in schools that can promote critical evaluation of media representations of body ideals. These have been associated with a long-term reduction in risk factors for developing an eating disorder (Wilsch and Wade 2009).

Demystifying eating disorders

Historically, a lack of understanding about eating disorders has led to a number of misconceptions that have perpetuated stigma and stereotypes surrounding eating disorders.

While community awareness of eating disorders is increasing thanks to the efforts of the National Eating Disorders Collaboration, the Butterfly Foundation and Eating Disorders Victoria, stigma continues to be identified as a significant barrier to seeking help (Mental Health Australia 2014).

Some common myths about eating disorders (Eating Disorders Victoria 2014; headspace 2014) include:

- Eating disorders are a fashion, trend, phase or attention seeking.
- Eating disorders are a fad, a diet gone wrong or an attention-seeking attempt.
- It's easy to tell if someone has an eating disorder because they will be very underweight.
- The solution to eating disorders is simple – just stop.

Unhelpful misconceptions may lead to certain groups going unnoticed, undermine the seriousness of the disorder and imply that people can stop their behaviour if they really want to (headspace 2014).

Seeking help and early engagement in treatment may be compromised if people feel their problems are not valid. The voice of people with a lived experience of eating disorders consistently tells us that non-judgemental, hopeful attitudes are one of the most valued things supporting recovery (National Eating Disorder Collaboration 2010c), so busting myths is an important part of ongoing awareness.

Actions

Objective 1

Strengthen the population's healthy behaviours and attitudes to food, physical activity and body image. This includes fostering resilience and self-worth based on individual strengths and promoting diversity in body image.

- Actively encourage early childhood services, schools and workplaces to create health-promoting environments where people learn and work through participation in the Healthy Together Achievement Program, which provides benchmarks, tools and resources to promote protective factors (such as physical activity and mental health and wellbeing).
- Promote protective factors through existing health promotion curriculum and related sports and recreation activities in schools and tertiary education settings, local government and non-government youth services, and community-based sports and fitness groups. This could include the uptake of evidence-informed school-based programs and resources to support students across the prevention–intervention continuum.
- Promote the availability of the Healthy Together Healthy Eating Advisory Service, which provides advice on the provision and promotion of healthy foods through school and early childhood food services.
- Identify and support everyday people to promote healthy behaviours and attitudes to healthy eating and physical activity among their families, friends and communities via the Health Champions initiative operating in Healthy Together Communities.

Objective 2

Develop and promote balanced social marketing approaches and media messages that foster healthy relationships with food, physical activity and body.

- Facilitate a forum bringing together experts from the fields of obesity prevention and eating disorders prevention to develop social marketing approaches and messages that support a positive health and wellbeing culture for all Victorians.
- Actively work with the media and other stakeholders to encourage adoption of these messages. This could include supporting the Commonwealth and key stakeholder groups in advocating for a national guideline for media groups for appropriate and health promoting coverage of weight related issues.

Objective 3

Support the community to critically appraise advertising, fashion and media images and messages, including those that promote the thin ideal for women, the muscular ideal for men, appearance and beauty norms, and objectification of women.

- Promote media literacy programs to schools, youth services and other community agencies. In doing so, the community, including vulnerable groups such as young people, is encouraged to review choices about media use.
- Support advocacy for the Commonwealth Government to regulate advertising and print media to clearly label digitally altered or enhanced images (male and female).

Objective 4

Schools, tertiary education settings, youth services and other community organisations are supported to provide targeted prevention for at-risk populations.

- Develop guidelines to support schools, youth services and other community agencies working with at-risk populations to select appropriate, targeted prevention programs such as those targeting body image. Guidelines need to summarise the evidence for programs that meet the needs of different age groups, genders and delivery settings. These guidelines should be readily available to the community, including but not limited to: young people; family members; schools and members of the school community; tertiary education; sports coaches; and personal trainers.
- Provide information about evidence-based programs through a mobile phone application, which is linked to relevant primary care services and networks such as headspace, Primary Health Networks and Eating Disorders Victoria.

Early identification and response

Eating disorders arise from a complex interplay of factors. While it may not be possible to prevent all eating disorders, like many other physical diseases and mental illnesses, early identification coupled with a rapid response can significantly improve health outcomes and optimise chances of recovery.

It is important that early identification and responses for people with eating disorders are understood in the following contexts: early warning signs of emergent illness in children and young people; signs of eating disorders occurring or reoccurring in adulthood; and early indicators of relapse in people with current eating disorders.

Challenges to early identification and response

A key feature of eating disorders is that the individual may not identify as having an illness.

Concealment of symptoms is also common, particularly during early stages of an illness when signs and symptoms belonging to the illness may be less easy to discern (National Eating Disorders Collaboration 2012, p. 35). It is not uncommon for people with eating disorders such as bulimia nervosa to keep their disorder hidden for up to eight to ten years, at great cost to their physical and psychological health (Gaskill and Saunders 2000). The hidden nature of eating disorders presents significant challenges to timely identification.

For children and young people with eating disorders, families and carers play a central role in facilitating first access to assessment, diagnosis and treatment. This can be very challenging when the young person does not identify with having an eating disorder, or they experience significant ambivalence.

It is critical that early concerns of families and carers are recognised and supported by frontline and specialist health service responses.

Opportunities to improve

While people with eating disorders may be reluctant to seek help specifically for their illness, attendance at health services for symptoms associated with the disorder is much more common. People with eating disorders such as bulimia nervosa and binge-eating disorders, for example, may seek help for physical complaints such as gastrointestinal problems, or mental health difficulties including anxiety or depression (National Eating Disorders Collaboration 2012, pp. 37–38).

GPs are often the first point of contact for health concerns. There is unanimous agreement that the GP's role is central to efforts to improve early identification and response to eating disorders. Dental issues and help sought for gynaecological problems may also be the first health contact for women with an eating disorder.

Similarly, pregnancy and motherhood is a major life event that can retrigger an eating disorder due to changes in body image, eating patterns or difficulties adjusting to significant change and stress often associated with this new role. Women with a history of eating disorders may be more likely to have comorbid depression and anxiety which may be exacerbated before, during or after pregnancy (Hoffman et al. 2011).

Frontline health professionals in community-based and primary care services, as well as more specialist health services, are critical to identifying eating disorders earlier. Similarly, environments where there may be at-risk groups, such as schools, sporting and recreation facilities and gyms are important settings for earlier identification to occur.

Raising community awareness or 'literacy' around eating disorders will enable community members, peers, key workforce members and families and carers to more easily identify early warning signs (Hart, Jorm and Paxton 2012). The next critical step is assisting community members to know how to respond to someone when they notice signs or symptoms, and encouraging people to acknowledge the need to seek appropriate assistance.

It is important to provide targeted information and tools about how to respond and when and where to refer people when they need more help. Earlier identification efforts need to be supported with clearly defined pathways into early and effective interventions. This includes interventions and support for people who, although they may not meet criteria for an eating disorder, are experiencing emergent problems such as disordered eating, unhealthy weight loss and negative body image.

Actions

Objective 5

Promote and enable early identification.

- Develop a checklist of eating disorder warning signs that could be included in a general mental health and wellbeing assessment that may be undertaken in secondary schools by school allied health professionals and in primary care settings. This checklist should cover identifying early warning signs, assessing the risk of an eating disorder, identifying appropriate primary care level responses, and referring consumers to more specialist medical and mental health services.
- Identify and actively promote technological ways to support GPs and other primary health providers to use the above checklist.
- Promote eating disorders literacy as part of general mental health literacy training for community members including families and peers, teachers and other school staff (for example, allied health professionals such as school nurses and student support services officers) who are in a position to identify problems early and influence help seeking. This could include, for example, inclusion of eating disorders as part of the Department of Education and Early Childhood Development mental health resources.

Objective 6

Support the development of early intervention programs targeted to people experiencing emergent problems such as disordered eating, unhealthy weight loss, and negative body image.

- Develop targeted programs and supports for people experiencing emergent problems (such as disordered eating, unhealthy weight loss, and negative body image) through GPs, primary care services such as headspace, community health centres, Primary Health Networks, and private allied health providers.
- Provide primary care practitioners, funded through the Medicare Benefits Schedule (MBS) Better Access to Mental Health initiative, with access to training, secondary consultation and services for clients with eating disorders.

Objective 7

Best possible care is available and coordinated for women with current, unresolved, or previous eating disorders affecting fertility, pregnancy and parenting.

- Ensure care is coordinated for women with current, unresolved, or previous eating disorders affecting fertility, pregnancy and parenting.
- Identify and document the most appropriate lead service to undertake the care coordination role to prevent complications associated with the eating disorder.

Targeted treatment from integrated services

For frontline health professionals, the first challenge is what to look for, followed by how to respond.

Managing eating disorders can be extremely complex. Those suffering from an eating disorder can present with varying symptoms, and the illness may follow a variable course. Some may experience a relapse and recovery cycle, while others have an enduring disease type progression. The range and severity of associated conditions (for example, depression, anxiety, fertility problems, kidney failure and high blood pressure) can also complicate diagnosis and management (National Eating Disorder Collaboration 2012).

It is important that people who have developed an eating disorder receive early treatment that coordinates a range of services and supports to attend to all aspects of the illness. According to the National Eating Disorders Collaboration, '[t]he only safe way to respond to eating disorders is to address all of the aspects of the illness, including both physical and mental illness, and the environmental context in which the illness occurs' (National Eating Disorder Collaboration 2012, p. 7).

Often, care for those experiencing eating disorders will occur over extended periods of time and across multiple life phases, requiring coordinated, age-appropriate support. The effect on families and carers over prolonged periods of time can be significant as they are often the mainstay of support for someone with an eating disorder throughout their recovery.

Person-centred care

Core considerations of person-centred care include: flexible approaches that accommodate individual needs; readiness for change; type and stage of illness; age and developmental stage; gender; cultural background; and circumstances in which people live.

There is no one-size-fits-all response to eating disorders, and different approaches work for different people. It is important that consumers and their families/carers have access to information to assist them to make informed choices about their treatment.

Over their lifetime, people with an eating disorder may move through relapse and recovery many times, requiring quick access to suitable services in times of relapse and a preventive focus during recovery. This means recognising the episodic nature of eating disorders by providing flexible services that allow an 'easy in, easy out, easy back in' approach to treatment and care.

The therapeutic relationship is an important factor in supporting recovery (see for example Hubble et al. 1999). People may have several therapists before establishing a therapeutic relationship that is right for them. People with a lived experience consistently highlight hopeful, non-judgemental approaches of treating teams as significant contributors to recovery (National Eating Disorder Collaboration 2010c). Peer-directed programs and support are also highly valued for the important contribution they can make to recovery.

Support for families and carers

The national framework calls for person- and family-centred care that addresses the needs of individuals. It also identifies families and carers as integral members of the team supporting the person with an eating disorder.

Treating teams working in partnership with family and carers are particularly important for parents caring for a child or young person with an eating disorder. Implementing treatment at home can be very challenging and treating teams need to be able to provide support. In this context, there is also a need for increased support for families and carers who have limited family and social supports.

Appropriate family- and carer-inclusive treatment is also important for adults with eating disorders. Key support people such as parents, partners or friends should be identified and included in treatment when this is in the best interests of the person (National Eating Disorder Collaboration 2012).

Access to the range of services needed

Services for those with an eating disorder have developed organically out of existing health services. Practitioners with a particular interest or skill have developed services based on the best available information, but this has not necessarily occurred in a systematic way or in collaboration with related or similar services.

Consequently, the types of services available, access criteria and management approaches differ around Victoria, as does the knowledge and confidence of different services in assessing and treating eating disorders. There is service variability, high service demand and high thresholds for entry into services in both public and private treatment.

In Victoria much work has been undertaken to increase access to a range of treatment options available across the continuum of care, with the recent investment in intensive community-based programs at The Royal Children's Hospital, Monash Health and Austin Health in partnership with St Vincent's. These are important components of an overall eating disorder system of care as they can provide greater intensity of treatment when this is required, and support people with the most severe and complex eating disorders.

This strategy affirms the direction for more accessible health services that draw on locally available mental health, medical and primary care responses, so that whenever possible the person can remain in their local community with their usual supports during treatment. This is particularly important to enable families from rural and regional areas to remain in their local context when implementing treatment at home.

There are some excellent examples of local health service responses that are being successfully led and developed, particularly by child and adolescent or youth mental health services with paediatric services.

The challenge is to achieve high-quality responses more consistently across Victoria. This will be critical to generating earlier responses in local contexts, and mitigating the need for more intensive day patient or inpatient programs.

Service coordination and transitions

People with an eating disorder must relate to many different professionals across the multiple services they may be accessing. If care is not adequately coordinated across these services, there is a high risk that it will fail to effectively address all of the person's needs in a coherent way. Disengagement from treatment occurs as people move through different parts of the healthcare system.

Consumers, carers and the workforce alike identify that better management of transitions within and between services is needed to support people to engage and remain engaged in their treatment and support.

The strategy considers high-risk transition points as a priority. One of the key transitions is for young people moving from child and adolescent mental health services into adult-focused mental health services.

Mental health services that support adolescents and young people to remain engaged in developmentally appropriate treatment and care are vital. This may be achieved through specialist child and youth mental health services delivering treatment and care for young people with eating disorders up to the age of 25. Depending on the circumstances of the individual, including their stage of illness, development and family context, specialist adult mental health services may be better placed to respond.

Actions

Objective 8

Timely, coordinated and integrated assessment, treatment and care for children, young people, adults and older people with eating disorders and their families and carers should be in developmentally appropriate settings in both metropolitan and rural areas.

- Develop a service-level framework that details the expected roles and relationships between the multiple services with a role to play in identifying, treating and supporting people with eating disorders, across sectors and levels or tiers of care which can be locally translated.
- The service-level framework will affirm the role and responsibility of local health services to plan and deliver eating disorders care for their local population (with the support of relevant specialist eating disorder services), including:
 - Develop integrated child and youth mental health services (in partnership with paediatricians, GPs and physicians) to assess, treat, and support children and young people with eating disorders up to 25 years and their families and carers.
 - Develop integrated adult mental health services (in partnership with GPs, local physicians, and specialist adult eating disorder services) to deliver and plan treatment and support for adults over 25 years presenting with late onset, unresolved eating disorder and comorbidities.
 - Develop protocols and promote clearly described service access pathways for referral and discharge planning between primary care and specialist services and facilitate transitions throughout the service system. This includes escalating care to specialist eating disorder services to provide and lead individualised and supportive treatment and care of people with the most complex and severe eating disorders.

- Particular attention should be given to developing access to services through youth-friendly primary care settings such as headspace.
- Establish a specialist eating disorder advisory group to provide advice on appropriate access, utilisation and transitions into and from specialist eating disorder and other acute bed-based treatment to community-based care.
- Promote strong care-team approaches that draw on the necessary multidisciplinary professionals and support services available locally, and from specialist eating disorder services if required. This includes identification and documentation in each individual care plan of a lead service with responsibility for coordinating care.
- Advocate to include individuals experiencing eating disorders who have a complex presentation, enduring or recurring condition and/or comorbid illness in Commonwealth and state-funded care coordination initiatives.

Objective 9

Promote consumer choice and a consumer-centred sector.

- Actively support and promote a consumer choice and consumer centred service sector. To achieve this, the following need to be implemented:
 - a centralised ‘one-stop shop’ that provides information for consumers, families and carers about eating disorders and services
 - opportunity for consumers and carers to access timely and responsive advocacy
 - peer-directed and support programs for both consumers and families and carers.

Strengthening system foundations

There are already many examples of good work and collaboration underway in Victoria that provide a strong basis for Victorian eating disorder services to continue to evolve to best meet the public's needs.

Prevention, improved quality in service provision and more positive consumer experiences will be enabled and supported through a unified focus on the fundamentals of developing service capacity – workforce development, strong leadership and governance, and data and evidence.

Capturing the lived experience of eating disorders is a central part of data collection and evidence, and will allow services and the system to evolve to better meet consumer needs.

Actions

Objective 10

Victoria promotes and generates data and research to build the evidence base around eating disorders.

- Actively monitor eating disorder activity in Victoria, including:
 - Establish a minimum data set and reporting process that monitors service use, responsiveness, effectiveness and client outcomes for people with eating disorders.
 - Host a consumer and carer-led dialogue (every two years) to gain feedback on the experience of the service system's renewal process.
 - Determine an approach to monitor prevention efforts in Victoria.
 - Identify opportunities to measure body image and dieting characteristics in young people so that trends and changes over time can be established.
- Advocate for a national eating disorders research agenda, including:
 - Investigate the incidence and prevalence of various types of eating disorders.
 - Strengthen understanding of eating disorder prevention activities through advocating for a research agenda nationally and via research funding bodies (such as beyondblue, National Health and Medical Research Council).
 - Support strong collaboration between practitioners and researchers within Victoria, Australia and internationally.

Objective 11

Recognise workforce development for key groups (including health promotion, school and youth professionals, frontline primary care professionals and clinically trained practitioners) as a key enabler of prevention, early identification and intervention.

- Ensure eating disorders literacy is implemented as part of general mental health literacy training for key workforces, who are in a position to identify problems early and influence help seeking.
- Promote the Department of Education and Early Childhood Development mental health resources that aim to support schools to understand whole of school approaches to mental health promotion, and managing mental health issues in children and young people.

- Encourage undergraduate and postgraduate training for practitioners to incorporate eating disorders, and engage specific workforces in training about eating disorders through professional networks including:
 - Primary Health Networks
 - Royal Australian College of General Practitioners
 - Royal Australian and New Zealand College of Psychiatrists
 - Royal College of Physicians
 - Australian Psychological Society
 - Dietitians Association of Australia
 - youth workers
 - school health workforce
 - sports and fitness industry.
- Provide access to flexible and accessible secondary consultation and training to support primary care practitioners' (GPs and headspace) capacity to recognise and respond early to family/carer concerns and people showing emerging warning signs of an eating disorder.

Objective 12

Support, develop and monitor service capability and capacity.

- Provide for short to longer-term measures in the Clinical mental health implementation plan 2014–17, supporting Victoria's specialist mental health workforce framework: strategic directions 2014–24, to create workforce capability in the areas of family-inclusive, trauma-informed and recovery-oriented care in order to provide high-quality services to individuals affected by eating disorders and their families and carers.
- Establish mechanisms for training and maintaining an eating disorders workforce in collaboration with specialist eating disorder services and consumers and carers who have a lived experience.
- Specialist eating disorder services ensure staffing at levels required to deliver developmentally appropriate eating disorder treatment with access to an appropriate multidisciplinary skill mix.
- Require all services providing specialist eating disorder treatment and care to demonstrate capability to support and maintain the expertise and competence of their workforce through ongoing workforce development and service delivery to a critical mass of clients.
- Support service development to provide choice in the range of interventions and treatment settings available to Victorians.
- Adopt the most recent technology for communication, service delivery, workforce development and training.

Objective 13

Eating disorder networks are established as a way of organising and coordinating a network of responses across the continuum of prevention, early identification, treatment and support activities within and across existing specialist eating disorder network areas.

- Establish eating disorder networks as a key enabler to meeting the objectives of this strategy. In a networked model there will be collaborative effort across a range of programs and services, including, but not limited to:
 - state-funded mental health service providers including mental health community support services and services supporting recovery such as occupational, vocational and housing needs
 - acute hospital emergency, medical, paediatric and allied health services
 - private health services and specialists
 - GPs
 - Primary Health Networks and Primary Care Partnerships
 - community health services
 - youth-specific services such as headspace, tertiary student health services, local government youth services
 - primary and secondary school nursing and welfare programs
- Support the role of local health services to plan and deliver eating disorders treatment and care for local populations through stronger integration with key partners including GPs, specialist eating disorder services and private providers within the network.
- Affirm the role of specialist eating disorder services within each network to provide and lead individualised and supportive treatment and care for people with complex and severe eating disorders.
- Support arrangements for greater permeability in service access so that consumers can access services from any network when recommended services, programs or interventions are not available from the network where they reside.
- Provide a structure for stronger collaboration, particularly in areas of eating disorders prevention and in the generation and application of research.

Knowing things are improving

Through implementing this strategy, the Victorian Government will build on the existing strength of our responses and improve life outcomes for people with emerging and current eating disorders.

To underline this commitment we will provide progress reports to the Victorian community against the objectives.

Changing the system will take time, and such a complex condition requires integrating multiple services and networks. However, we also know that positive change is already underway in many parts of Victoria.

An important part of supporting widespread and continued change will be to ensure that feedback is provided to inform ongoing improvement in the services being delivered. This includes co-design approaches to inform system improvement and evaluation.

Through hosting a consumer- and carer-led dialogue, feedback on service system renewal will inform progress and identify priorities for further improvements. We will also work with experts and the sector to ensure that data collected is used to inform our understanding of service access and outcomes for people with eating disorders.

Strong leadership, governance and support for local services participation will underpin these efforts going forward.

Victorian Eating Disorders Taskforce

Phase 1 taskforce membership – treatment and support

Ms Christine Fyffe, MP – Chair

Ms Rachel Barbara-May – Chief Social Worker, Alfred Child and Youth Mental Health Service. Alfred Health Eating Disorder Coordinator. National Eating Disorders Collaboration Steering Committee member

Ms Tracey De Poi – President, Eating Disorders Victoria

Ms Claire Diffey – Manager, Victorian Centre of Excellence in Eating Disorders

Ms Lenora Lippman – General Practice Victoria

Mr Paul Napper – CEO, Pathways Rehabilitation and Support Services, Barwon

Associate Professor Richard Newton – Clinical Director Mental Health, Austin Health. Co-Chair of the National Eating Disorders Collaboration working group for treatment standards.

Professor Susan Sawyer – Director, Centre for Adolescent Health, Royal Children's Hospital

Ms Anna Spraggett – Director, Board of the Butterfly Foundation

Professor David Russell – Gastroenterology, Royal Melbourne Hospital

Mr Chris Tanti – CEO, headspace

Phase 2 taskforce membership – prevention and early detection

Ms Christine Fyffe, MP – Chair of the Victorian Eating Disorders Taskforce

Ms Rachel Barbara-May – Chief Social Worker, Alfred Child and Youth Mental Health Service. Alfred Health Eating Disorder Coordinator, National Eating Disorders Collaboration Steering Committee member

Ms Rita Butera – Executive Director Women's Health Victoria

Ms Kate Carnell – Chief Executive Officer beyondblue

Professor David Castle – Professor of Psychiatry, St Vincent's Hospital

Dr Jacinta Coleman – Head Adolescent Medicine, Monash Children's

Ms Tracey De Poi – Chair, Eating Disorders Victoria

Ms Claire Diffey – Manager Victorian Centre of Excellence in Eating Disorders (CEED)

Dr Ben Goodfellow – Child Psychiatrist, Geelong Child and Adolescent Mental Health Service

Ms Kristen Michaels – Chief Executive Officer, Eastern Melbourne Medicare Local

Professor George Patton – Director of Adolescent Health Research, Centre for Adolescent Health

Ms Jerril Rechter – Chief Executive Officer, VicHealth

Professor David Russell – Gastroenterology, Royal Melbourne Hospital

Ms Anna Spraggett – Director, Board of the Butterfly Foundation

Mr Chris Tanti – CEO, headspace

Ms Alison Vickers – Manager, Secondary School Nursing Program, Eastern Metropolitan Region, DEECD

National eating disorders framework principles

Principle 1.1 Person and family-centred care that addresses the needs of individuals

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

Principle 1.2: Prioritisation prevention, early identification and early intervention

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

Principle 1.3: Safety and flexibility in treatment options

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

Principle 1.4: Partnering to deliver multi disciplinary treatment in a continuum of care

Treatment is provided by a multidisciplinary team working in partnership with the person, their family, and other health and support providers, including treatment of comorbid issues. The multidisciplinary team will be able to meet physical, mental, nutritional, occupational and social needs. Individuals with an eating disorder require individual care plans and access to a designated case coordinator.

Principle 1.5: Equity of access and entry

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

Principle 1.6: Tertiary consultation at all levels of treatment

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

Principle 1.7: Support for families and carers as integral members of the team

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

Principle 2.1: Evidence informed and evidence generating approaches

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

Principle 2.2: A skilled workforce

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

Principle 2.3: Communication to ensure an informed and responsive community

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

Principle 2.4: Systems support integration, collaboration and ongoing development

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

Victorian *Framework for recovery-oriented practice*

- Promoting a culture of hope
- Promoting autonomy and self determination
- Collaborative partnerships and meaningful engagement
- Focus on strengths
- Holistic and personalised care
- Families, carers, support people and significant others
- Community participation and citizenship
- Responsiveness to diversity
- Reflection and learning

Victorian Public Health and Wellbeing Plan

- Build prevention infrastructure to support evidence-based policy
- Develop leadership and strengthen partnerships to maximise prevention efforts
- Review financing and priority-setting mechanisms to ensure available resources are based on population need and potential for impact
- Develop effective modes of engagement and delivery of evidence-based interventions in key settings
- Strengthen local government capacity to develop and implement public health plans
- Improve health service capacity to promote health and wellbeing

Victorian Health Priorities Framework

- Universal access and a focus on those most in need
- Equitable outcomes across the full continuum of health
- Person and family centred
- Evidence-based decision making
- Capable and engaged workforce
- Responsibility for care spans the continuum
- Maximum returns on health system investments
- Sustainable use of resources through efficiency and effectiveness
- Continuous improvement and innovation
- Local and responsible governance

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