AMA Victoria Submission to the Victorian Eating Disorders Strategy

13 November 2022
The Australian Medical Association (Victoria)

Informing our Responses

The Australian Medical Association (AMA) Victoria would like to firstly thank the Victorian Government for the opportunity to provide feedback on the development of the *Victorian Eating Disorders Strategy*.

We have reviewed the Discussion Paper with our members and consulted doctors with relevant medical expertise and significant experience engaging with existing eating disorders services.

Our overarching perspective is that the current system of care in Victoria should be better coordinated, funded, and the available services expanded. We welcome the Discussion Paper's existing focus on increasing prevention and early detection.

Vision

AMA Victoria sees the following three main priority areas for the care of people affected by eating disorders, in order of most important to least important:

1. Ensuring a coordinated and evidence-based eating disorder system of care in Victoria
2. Increasing the number of specialist inpatient eating disorder services and beds for people with severe eating disorders
3. Funding prevention and early detection of eating disorders

Ensuring a coordinated and evidence-based system of care

A coordinated and evidence-based eating disorder system of care should be implemented in Victoria.

Eating disorders present challenges to the traditional treatment structure for mental illnesses due to their complex physical and mental components.[1, 2] Evidence shows that brief, individual episodes of treatment are insufficient to achieve recovery from an eating disorder.[3] Additionally, studies have shown that disruption of care occurs when individuals transition between treatment settings (such as from hospitals to the community) and can cause a deterioration in patients' health.[2] Thus, expert consensus supports a longer, stepped intervention for eating disorders occurring along a continuum of coordinated, multidisciplinary care. This addresses the psychological, physical, behavioural, nutritional, occupational, and social aspects of eating disorders.

Additionally, eating disorder care in Australia is often patchy, inconsistently delivered, difficult to navigate, and not evidence-based.[2] Data shows that eating disorders were only managed in less than 1% of primary care encounters between 2000 and 2016.[4] Furthermore, only 30% of these people received treatment, and of these people, only 20% received evidence-based treatment.

The Victorian Government should ensure high levels of coordination between physical and mental health services, private and public services, health and community services, and between disciplines. Care must be able to be intensified or de-intensified according to patients' individual needs. Importantly, family and supports should also be considered critical components of the care team. The Victorian Government should also continue ensuring Victorian partnerships in the National Eating Disorders Collaboration so that a nationally consistent and evidence-based system of care for eating disorders is developed. It should also invest particularly into improving the coordination of patient transitions between services.

Increasing funding for inpatient services and beds

While specialist inpatient care and active outpatient care may both be effective for eating disorder care, the option of hospital admission must still be available for patients at risk of medical and/or psychological compromise.[5-7]

Inpatient treatment in specialist eating disorder units has been shown to be beneficial for improving eating disorder pathology and is associated with improved outcomes at follow-up.[8] Additionally, data for anorexia nervosa indicate that individuals prematurely discharged from inpatient treatment prior to achieving reasonable weight restoration are more likely to require rehospitalisation.[9]

However, currently, the Australian Eating Disorders Research and Translation Strategy 2021-31 reports that there are only 15 public and 35 private designated funded eating disorder beds in Victoria. The Strategy also states that access to eating disorder specific inpatient beds are limited, and that inpatient treatment is usually provided as part of a medical, mental health or general service, and is not funded as a designated eating disorder service or bed.[10] After patients are admitted, Victorian data also shows that there is still significant variability between length of stay in Victoria's public hospitals.[11] This lack of inpatient beds and services has been felt by patients, who identify service-related constraints including long waitlists as a key barrier to access to care for eating disorders.[12] Victorian audit data on the length of hospital stays recommends that hospitals should "seek to minimise the time patients spend in hospital, without compromising health outcomes".[11] AMA Victoria cautions around the reduction in hospital length of stay, referring the Government to prior evidence that shows economically-driven agenda for shortening the length of hospital stays can compromise patients' ability to achieve clinically satisfactory results.[13]

Thus, it is important that the Victorian Government balances economic needs with its responsibility to ensure a clinically-appropriate length of stay is available for those who need it when they need it.

Funding prevention and early detection of eating disorders

Current evidence shows that eating disorders can be prevented, and early identification and intervention strongly predicts better treatment outcomes and minimises financial cost.[2, 10, 14] The Victorian Government should fund research aimed towards identifying screening tools to detect illness. Additionally, clinician diagnostic skill in relevant first responders should be improved. Research shows that professionals with limited experience and poor understanding of eating disorder management may delay recovery or harm patients.[15]

Service Provisions

1. **To what extent do the gaps and issues in the service continuum for eating disorders align with your understanding?**
2. **Are there any further gaps and issues?**
3. **Should the strategy prioritise any of these gaps or issues? What evidence do you have to justify this focus?**
4. **What currently works well or could work well for consumers, their families, carers and supporters and / or providers?**

Evidence suggests that clinician expertise in eating disorders produces better outcomes. For example, in child and adolescent anorexia nervosa, specialised outpatient eating disorder teams have been associated with faster recovery, higher patient satisfaction, lower costs, lower rates of inpatient admission and better case identification and access compared to care by generalist services. It is important, however, to note that expert supervision of novice therapists can produce similar outcomes to those of experienced therapists.

AMA Victoria also notes with concern in the context of clinician expertise that is lamentable that the identified "partners" in the development of the strategy include "Eating Disorders Victoria, the Centre for Excellence in Eating Disorders, Tandem, the Victorian Mental Illness Awareness Council (VMIAC) and the National Eating Disorders Collaboration", with clinicians not explicitly stated.

Priority Populations

1. **In the discussion paper we have listed a series of groups that may need a greater focus in the strategy. Is this list appropriate?**
2. **If not, which other higher risk groups do we need to prioritise in the strategy for targeted action?**

The identified priority populations are largely appropriate. Attention to socioeconomically diverse groups should also be given, as the economic burden of services has been identified as a barrier to care access.[12]

References

1. National Eating Disorders Collaboration. Stepped System of Care for Eating Disorders. 2022.
2. Heruc G, Hurst K, Casey A, Fleming K, Freeman J, Fursland A, et al. ANZAED eating disorder treatment principles and general clinical practice and training standards. Journal of Eating Disorders. 2020;8(1):63.
3. National Eating Disorders Collaboration. National Practice Standards for Eating Disorders. NEDC; 2020.
4. Ivancic L, Maguire S, Miskovic-Wheatley J, Harrison C, Nassar N. Prevalence and management of people with eating disorders presenting to primary care: A national study. Australian & New Zealand Journal of Psychiatry. 2021;55(11):1089-100.
5. Madden S, Hay P, Touyz S. Systematic review of evidence for different treatment settings in anorexia nervosa. World J Psychiatry. 2015;5(1):147-53.
6. Hay PJ, Touyz S, Claudino AM, Lujic S, Smith CA, Madden S. Inpatient versus outpatient care, partial hospitalisation and waiting list for people with eating disorders. Cochrane Database of Systematic Reviews. 2019(1).
7. Hay P, Chinn D, Forbes D, Madden S, Newton R, Sugenor L, et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. Aust N Z J Psychiatry. 2014;48(11):977-1008.
8. Morris J, Simpson AV, Voy SJ. Length of Stay of Inpatients with Eating Disorders. Clinical Psychology & Psychotherapy. 2015;22(1):45-53.
9. Pike KM. Long-term course of anorexia nervosa: Response, relapse, remission, and recovery. Clinical Psychology Review. 1998;18(4):447-75.
10. InsideOut Institute. Australian Eating Disorders Research & Translation Strategy 2021-2031. A national project funded by the Australian Government, Department of Health; 2021.
11. Victorian Auditor-General. Hospital Performance: Length of Stay. Victorian Auditor-General's Office; 2016.
12. National Eating Disorders Collaboration. Barriers to Care 2022 [Available from: https://nedc.com.au/eating-disorders/treatment-and-recovery/barriers-to-care/.
13. Baran SA, Weltzin TE, Kaye WH. Low discharge weight and outcome in anorexia nervosa. The American journal of psychiatry. 1995.
14. Linardon J, Brennan L, de la Piedad Garcia X. Rapid response to eating disorder treatment: A systematic review and meta-analysis. International Journal of Eating Disorders. 2016;49(10):905-19.
15. Garner DM. Iatrogenesis in anorexia nervosa and bulimia nervosa. International Journal of Eating Disorders. 1985.