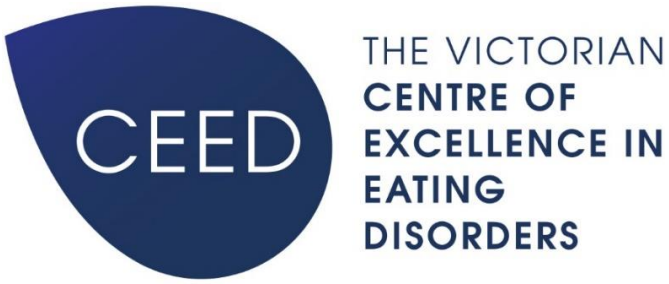

Submission to the Royal Commission into Victoria's Mental Health Services System

The Victorian Centre of Excellence in Eating Disorders (CEED) is a state-wide program of Victoria's specialist mental health service established in 2002 to improve the quality of services available to people with eating disorders and their families.

CEED's mission is to support the establishment of a clear and accessible system of care for people experiencing eating disorders. We envisage a system of care in Victoria that facilitates early identification, and provides a responsive service of appropriate care from early intervention services, primary health services, community based care, through to intensive treatment support including inpatient beds.

CEED provides leadership and support through clinical case consultation, training, resource and service development, to build quality and sustainable eating disorder treatment responses within the public specialist mental health service. We have also developed a range of early intervention strategies including interactive online resources.

CEED welcomes the establishment of the Royal Commission into Victoria's Mental Health System, as well as the Victorian Government's advance commitment to implement all of its recommendations. The Royal Commission will be an important catalyst for change, helping to improve the lives of people living with mental illness, and also the lives of their families and carers.

We welcome the opportunity to make a formal submission to the Royal Commission.

Eating disorders are among the most complex and life threatening mental health conditions that have the highest mortality rate of any mental illness. Since CEED's establishment we have strengthen the service response for young people experiencing eating disorders, however acknowledge many gaps in the system still exist and to date adult services have not been provided with the resources to provide adequate treatment for those with eating disorders.

CEED puts forward the following recommendations line with a vision for a world class system of care for Victorian's of any age or demographic.

1. **That Eating Disorders are understood as a Mental Health conditions with medical consequences**, requiring a mental health service system response with medical back-up for acute and life threatening presentations and ongoing medical monitoring of the physical health consequences of the eating disorder. This will need robust service collaboration and development of clear service pathways.

   Currently there are good collaboration and pathways in a number of child and youth mental health services and paediatrics which could be improved and bolstered to be more timely and seamless. GP recognition and appropriate responses to all ages with eating disorders is

patchy but improving. In adult health there is significant problems particularly in emergency hospital presentations and acute care. CEED becomes aware of this from our complex case consultation service.

Where severe malnutrition in a person with a history of persistence inability to meet their physical health does not constitute an alert for the need for either a medical admission or generate a request for mental health assessment and planning.

That families of unwell individuals who are refusing to engage with treatment services, do not have access or support from mental health services about the care of that person

A recent case demonstrates some of these challenges in the system. The situation involved a 26 year old woman living with her parents, who has a 14 year history of anorexia nervosa, and is currently extremely underweight but refusing to seek medical or psychiatric help. Her parents who were extremely worried, after observing her poor food intake and deteriorating health over a long time period, arranged via the GP for an ambulance to take her to an emergency department. After a long wait in Emergency the woman was assessed as medically stable (despite severe degree of malnutrition) and sent home after agreeing she would eat at home and attend a psychologist. There was no discussion with her parents about how to best support their daughter and what follow up was planned. The parents and GP continued to be concerned and perplexed about how they could arrange appropriate refeeding and medical care.

2. **People with eating disorders are supported to get treatment early**. Early identification and treatment of eating disorders is associated with significantly better outcomes, yet people with eating disorders often wait many years before getting support. Early in life intervention is crucial as eating disorders are the third most common condition in adolescent females (after obesity and asthma) and 10% of girls under 18 years have an eating disorder. Hart et al 2011 research indicated that 70% of people with eating disorders do not seek or have access to treatment. Alongside a skilled workforce trained to identify of signs and symptoms, early intervention tools developed by CEED have been associated with improved health seeking behaviour. These two early identification online resources (www.feedyourinstinct.com.au and www.reachoutandrecover.com.au) are designed to reduce the time between noticing warning signs, seeking advice and accessing treatment. Funding for these valuable resources is required to maintain an online presence, and continue improving rates of early identification and help seeking.

3. A **skilled work force** in which all health professionals receive training in eating disorders to raise awareness of the serious nature of eating disorders, and to enable them to identify, assess and contribute to the treatment of eating disorders. Eating disorders require treatment that is specific to the illness and the level of severity. Increasing access to professional training through services such as CEED is a vital component of improving outcomes for people living with eating disorders. The workforce covers all levels of care; primary care to specialist hospital care, the range of roles from detection, treatment and interventions and community support post treatment, and all professional groups. The education and training content and systems required are complex and varied. E.g Brief online introductory programs to assist primary care detection, university under and post graduate training appropriate to the professional group, and training in treatment

modalities which require intensive training and ongoing practice development, supervision and support of workers.

4. Eating disorders are associated with the highest mortality rate of all mental health disorders. Moderate to severe Eating disorders: Anorexia Nervosa (AN) and AN like presentations, other eating disorders with comorbid mental health presentations and presentations where treatment at lower tier of service has not succeeded, typically require a complex, coordinated service response due to the mental health treatment needs and associated psychiatric and physical risks) and **should be classified as core business for Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS)**. CAMHS/ AMHS need to be adequately resourced to provide this complex service response, in particular in resourcing a community-based treatment response. There is often a lack of recognition and acceptance of eating disorders as major mental illnesses that warrant and should have equal rights to access to and appropriate treatment in mental health. The incidence for Anorexia Nervosa, the least common of eating disorders has a similar prevalence to Schizophrenia in females (1-2% of the population). There are promising examples of improved practice in adult mental health services in planning for and providing a pathway and services for eating disorders. E.g. NorthWestern Mental Health Service has created Eating Disorders Coordinators in each of it 5 AMHS with the role of improving the service response and skills of colleagues as well as a clinical caseload. Triage service now screens and triages to the appropriate AMHS if community-based care is the intensity appropriate compared with previously all eating disorders clients placed on a waiting list for the specialist hospital based service.

5. That **service leaders are responsible and accountable** for implementing a system of care for people with eating disorders that is accessible and provides treatment based on the current evidence. Service leaders are responsible for ensuring the community and primary care is informed about entry points, treatments and the importance of early access to care. (See 4. above).
6. **A focus on the missing middle.** A stepped system of care relies on all levels of the service system (frontline professionals, primary health care providers, secondary level, and tertiary level). Alongside improved responses from AMHS (tertiary level) services, an enhancing response from primary health networks to support access to treatment for people with bulimia nervosa, binge eating disorder and subthreshold eating disorders is desperately needed. This will not only provide much needed service to people living with eating disorders but will reduce the pressure on AMHS services and acute medical services.

   The federal government has been providing funding for services by the Butterfly Foundation with one of the latest being a treatment service planned for Glen Iris. Whilst funding is welcomed for increased services, planning for these service needs to be part of a clear system of stepped and integrated care, but such planning collaboration is lacking. Victoria could work to ensure collaborative planning takes place in the development of this new and any further services. Also, starting in November 2019 a plan to fund increased sessions (up to 40) for complex eating disorders under Medicare's Better Access to Mental Health Services (the final terms are in planning stage) will commence. This provides an opportunity and it is essential to ensure; as above, there is good coordination of services between state funded and the federally funded services along with adequately trained and qualified workforce to work in and provide these services.

7. That **families and carers are recognised as important partners** in treatment. Families and carers play a valuable role in supporting clients stay engaged with treatment, the implementation of treatment and provide long term care and support. Family and carers should be involved in treatment from the outset, and throughout the course of treatment.

   Developments in services that assist this aim include the Collaborative Carer Skills Workshops (CCSW) that CEED has worked with Deakin University to disseminate training of workshop facilitators across Victoria. CCSW is the evidence-based practice carer skills and psychoeducation group program that increased skills in supporting their loved one and decreases carer stress and burden. Also in line with government policy on mental health workforce and carer inclusion, there have been the beginning of Carer Consultants as part of the mental health workforce specifically for eating disorders. CEED commenced this with the creation of a Carer Consultant as part of the team, and this role has assisted the establishment and support of positions in CAMHS, CYMHS and in one of the specialist Eating Disorders services.