



GOVERNMENT OF
WESTERN AUSTRALIA

Infant, Child and Adolescent (ICA) Taskforce Implementation Program

Eating Disorders: A Model of Care

Version 3.0 | 1 December 2022





Table of contents

1	Introduction	3
2	Background: Case for change	8
2.1	Eating disorders	8
2.2	Case for change	9
3	Overview of the Eating Disorders Model of Care	11
3.1	What is an Eating Disorders Model of Care?.....	11
3.2	Model of Care's outcomes	12
3.3	Considerations for different communities and populations	13
4	Eating Disorders Model of Care in practice	14
4.1	Who is this Model of Care for?.....	14
4.2	Who will provide care to children, families and carers?	15
4.3	How will care be provided to children, adolescents, families and carers?.....	21
4.4	Where will care be provided to children, adolescents, families and carers?	28
4.5	What might a consumer journey look like?	29
5	Delivering the Eating Disorders Model of Care	32
5.1	Reconfiguration of EDS	32
5.2	Key relationships and partnerships	32
5.3	Workforce	33
5.4	Infrastructure.....	34
5.5	Other delivery considerations.....	35
6	Terminology	37

1 Introduction

In Western Australia (WA), the prevalence of eating disorders among children and adolescents has increased rapidly since 2017. Despite this, mental health supports for this cohort remain limited, with children and adolescents often having to wait until they reach crisis point to receive care. When this occurs, children typically receive care at an in-patient unit, such as in Ward 4A at Perth Children's Hospital (PCH) and from the Child and Adolescent Mental Health Service's (CAMHS) Eating Disorders Service (EDS), located in Perth. Children and families with lived experience, clinicians and system leaders have identified a need to enhance the capability of the Infant Child and Adolescent (ICA) public mental health system to address the needs of children with or at-risk of eating disorders, with an emphasis on community-based care, service partnership, and targeted specialist support.

A Model of Care broadly defines the way health care is delivered. It outlines the care and services that are available for a person, or cohort as they progress through the stages of a condition or event.¹The Mental Health Commission (MHC) has developed this document, the **Eating Disorders Model of Care**, to define how mental health care for eating disorders and disordered eating will be delivered in WA's future ICA mental health system. Under this Model of Care, children and adolescents with eating disorders and disordered eating needs will have access to a range of general and specific supports that are evidence-based, person-centred and promote early intervention. This will be achieved through:

- **The Community Infant, Child and Adolescent Mental Health Service (ICAMHS) providing the majority of care to children and adolescents, within regions close to their homes.** The main service of the future ICA public mental health system – *area-based networks of ICAMHS teams* – will provide all children and adolescents with an eating disorder or disordered eating needs access to multi-disciplinary teams, capable of providing a range of supports to children and adolescents in community-based settings. These teams will receive training to build expertise and be led by 'Eating Disorder Practice Leads' that specialise in caring for children and adolescents with eating disorders and disordered eating needs.
- **Increased access to the expertise and care of the statewide EDS.** EDS provides specialised and intensive supports for children and adolescents with eating disorders. To enable equitable access to specialised care, EDS will expand its reach by working in partnership with all Community ICAMHS Hubs and local clinics, including providing supervision, case-by-case advice, and shared care.
- **Increased capabilities within the system.** With expert input from the statewide EDS, Community ICAMHS will work with primary care services, community services, and other

¹ NSW Agency for Clinical Innovation, (2013), Understanding the process to develop a Model of Care. An ACI Framework, Sydney.

services (including private clinicians) that care for children and adolescents. This will help the broader system to improve its capability to respond to the needs of children and adolescents with eating disorders and disordered eating behaviours.

This Model of Care was developed through the establishment of a Working Group that was responsible for designing the key features of the Eating Disorders Model of Care, with support from relevant good practice models in other jurisdictions. The Working Group provided a forum for people with knowledge and experiences of ICA mental health services to share their expertise to inform the design and development of this Model of Care. It included a broad range of voices including children, families and carers with lived and/or living experience of mental health issues, clinicians, and other system leaders. To ensure a broad reach, a survey was subsequently designed and shared with a cross-section of stakeholders across the ICA mental health system. A structured review process was followed so that the Model of Care could be reviewed and iterated based on feedback from the Working Group and other advisory groups, to inform further development and finalisation of the Model of Care.

Service Guarantee, and ICA Culturally Safe Care Principles underpin this Model of Care

A Service Guarantee has been developed to outline what children, families and carers should expect to experience in their interactions with the ICA mental health system. The Service Guarantee has eight principles, outlined in Figure 1 (refer to page 5). These principles apply to all ICA mental health services and are intended to guide how all models of care, including the Eating Disorders Health Model of Care, are implemented. Alongside the Service Guarantee, ICA Culturally Safe Care Principles have been developed to guide and enable the delivery of culturally safe and appropriate care to Aboriginal and Torres Strait islander children, families, and carers across all ICA mental health services, including this Model of Care. A summary of the ICA Culturally Safe Care Principles is provided in Figure 2 (refer to page 6).

Figure 1 | Service Guarantee Principles



Figure 2 | ICA Culturally Safe Principles

1	Spiritual: <i>We respect you, your connection to inner-self and your culture.</i>
2	Accessible: <i>Your journey of healing begins now.</i>
3	Responsive: <i>You are precious and your time matters.</i>
4	Trauma-informed: <i>Let us better understand the journey walked to now.</i>
5	Wrap-around: <i>Let us walk this journey side by side.</i>
6	Empowering: <i>Your story, your health – you are the driver.</i>
7	Connected to the community: <i>Your relationships and place in the community matter to us.</i>
<div style="background-color: #f4a460; padding: 10px; border-radius: 10px;"> <p>ICA CULTURALLY SAFE CARE PRINCIPLES</p> <div style="display: flex; align-items: center; justify-content: center; margin: 10px 0;">  </div> <p>Child, family, carer</p> </div> <p>SOCIAL AND EMOTIONAL WELLBEING DOMAINS</p>	
1	Connection to community: <i>Opportunities for individuals and families to connect, support each other and work together.</i>
2	Connection to mind and emotions: <i>The ability to manage thoughts and feelings.</i>
3	Connection to body: <i>Feeling physically strong and healthy and able to physically participate as fully as possible in life.</i>
4	Connection to family and kinship: <i>Connections to family and kinship systems are central to the functioning of Aboriginal and Torres Strait Islander societies.</i>
5	Connection to culture: <i>Connection to a culture provides a sense of continuity with the past and helps underpin a strong identity.</i>
6	Connection to Country: <i>Connection to Country helps underpin identity and belonging.</i>
7	Connection to spirit, spirituality and ancestors: <i>Spirituality provides a sense of purpose and meaning.</i>

Purpose of this document

The purpose of this document is to describe how mental health care for eating disorders and disordered eating will be delivered across the ICA mental health system. It is not intended to define specific approaches, provide clinical advice, or outline specific workforce, infrastructure, or other resource requirements. Further, it is not intended to provide guidance for specific regions, districts, or communities. For these communities, this Model of Care provides an overarching framework that can be adapted to address local needs. It is also recognised that this Model of Care is a living document; it will evolve over time to reflect new research, and findings from monitoring and evaluation activities.

A note on language and terminology

The intention of this document has been to use language that is clear and inclusive. However, it is recognised that there is not always consensus around the language associated with infant, child, and adolescent mental health. For this Model of Care, the term children, adolescents, families, and carers have been used and is inclusive of all children, adolescents, family, carers, supporters, and community members with eating disorders and disordered eating.

Throughout this document, the **reference to eating disorders is inclusive** of those with a **diagnosed eating disorder, those with disordered eating, and those at risk of developing an eating disorder**. As an example, eating disorders may include binge eating disorder, bulimia nervosa, anorexia nervosa and other specified feeding or eating disorder (OSFED). Section 6 contains a list of the key terminology used within this document.

The term 'Aboriginal peoples' has been used throughout the document and is intended to refer to all Aboriginal and Torres Strait Islander peoples.

2 Background: Case for change

This section provides a summary of eating disorders and the key reasons why change is required.

2.1 Eating disorders

Eating disorders are distinct and complex mental illnesses that affect all elements of a child or adolescent's physical, social, and emotional health and functioning.² The impact of eating disorders on a child, adolescent, family and community is lasting, and is linked to increased risk of life-threatening disease and death. Mental health care for eating disorders requires a different approach to treatment, due to the overlap of mental health and physical health support needs.³ As such, treatment and recovery need to be considered from both the mental and physical health components, particularly due to the consequences that nutrition can have on developing brains.

Childhood and adolescence is recognised as a period of heightened risk for the development of eating disorders across all genders. Epidemiological studies have estimated that 75 per cent of anorexia nervosa and bulimia nervosa cases, and 50 per cent of binge eating disorder and other eating disorders onset before the age of 22.⁴ Common behaviours associated with eating disorders and the trajectory of physical health result in higher risk for emergency department (ED) presentations. Eating disorders, including disordered eating, are further compounded by co-occurring mental and physical conditions such as depression, personality disorders, obsessive compulsive disorder, anxiety, and neurodevelopmental conditions.⁵ The psychological, social, and physical impacts of eating disorders among these young people and their families and carers are severe, and often impact family dynamics and relationships. Children and adolescents with eating disorders can also have high mortality, suicide, and disability rates.⁶

² South Australia Health, Statewide Paediatric Eating Disorders Service: A Model of Care, Version 9, 2020

³ National Eating Disorders Collaboration, Stepped system of care for eating disorders, <https://nedc.com.au/support-and-services/system-of-care/>

⁴ Gemma Johns, Bridget Taylor, Ann John and Jacinta Tan; Current eating disorder healthcare services – the perspectives and experiences of individuals with eating disorders, their families and health professionals: systematic review and thematic synthesis; The Royal College of Psychiatrists 2019

⁵ National Eating Disorders Collaboration, Comorbidity, <https://nedc.com.au/eating-disorders/eating-disorders-explained/types/comorbidity/>

⁶ Bailey et al. Mapping the evidence for the prevention and treatment of eating disorders in young people, Journal of Eating Disorders, 2014, 2:5

2.2 Case for change

Presentations for eating disorders are increasing across WA, however, there remains a critical gap in the provision of supports, particularly in regional areas

The prevalence of eating disorders in children and adolescents in WA is increasing significantly. In recent times, EDS and the Child Adolescent Health Service's (CAHS) inpatient unit have recorded significant increases in eating disorder admissions. Between 2017 and 2020, there was a 168 per cent increase in eating disorders admissions to CAHS inpatient units and a 200 per cent increase to WA Country Health Service's (WACHS) hospitals.⁷ Further, referrals to EDS grew by 42 per cent between 2014 and 2019; with a 47.9 per cent single year increase in 2020. Studies have also demonstrated that the COVID-19 pandemic has had an impact on eating disorder presentations. As an example, findings from one study showed that the number of annual eating disorder presentations among children and adolescents increased by 62 per cent in 2020 from the two years prior.⁸

In regional and remote areas, there is growing demand for eating disorder supports. To illustrate, eating disorder presentations to WACHS' EDs increased from four in 2017 to 12 in 2020, and admissions to WACHS CAMHS increased from nine in 2016 to 29 in 2020. Despite the growing need for more eating disorder mental health supports in regional and rural areas, most supports, including EDS, are Perth based. This needs to change going forward to ensure that there is equitable access to eating disorder mental health care for all children and adolescents across WA.

The continuity of care between hospitals, EDS, and community-based services is often fragmented

The current system of services for eating disorders is focused on inpatient units for physical recovery and mental health services for severe mental ill-health. As a result, the continuity of care between inpatient units, EDS, community, and mental health services is often fragmented, and a greater burden is placed on hospital based and intensive support services. To resolve this, a greater focus on collaboration among mental health and physical health clinicians, and community-based services, and partnering with families and carers, is needed to support improved continuity of care and reduce the demand for hospital based and intensive support services.

Individuals aged 16-to-17-years of age, with an eating disorder, experience major challenges with accessing supports

Individuals aged 16-to-17-years of age, with eating disorders, are often unable to access inpatient services through PCH due to the age limit of the hospital. Further, they must be

⁷ Mental Health Commission, Ministerial Taskforce into Infant, Child and Adolescent Mental Health: Taskforce Insights Series Paper 1 (unpublished)

⁸ Butterfly Foundation. (2022). The reality of eating disorders in Australia. <https://butterfly.org.au/wp-content/uploads/2022/08/The-reality-of-eating-disorders-in-Australia-2022.pdf>

referred to EDS by 16 years of age to be eligible to receive mental health treatment until they are 18 years of age.⁹ This cohort is particularly vulnerable and transitions between services can be particularly unsettling for young people. To address the gap in care for 16-to-17-year-old children with eating disorders, the WA government allocated \$31.7 million to expand the WAEDSSs. This service is designed to provide community based treatment to individuals aged 16 years and over with an eating disorder.¹⁰ Additional work and accompanying resources are required to optimise inpatient care for all ages, with particular consideration of those aged 16 and above.

⁹ Perth Children's Hospital. (2022). Eating Disorders Service. <https://pch.health.wa.gov.au/Our-services/Mental-Health/Eating-Disorders-Service>

¹⁰ Mental Health Commission. (2021). Frequently Asked Questions. WA Eating Disorder Specialist Services. https://www.mhc.wa.gov.au/media/3964/faq-wa-eating-disorders-state-wide-services_web.pdf

3 Overview of the Eating Disorders Model of Care

This section provides an overview of the Eating Disorders Model of Care, including its objectives, limitations, and its intended outcomes for children, adolescents, families, carers, staff within the ICA mental health system, and the broader WA community.

3.1 What is an Eating Disorders Model of Care?

The Eating Disorders Model of Care outlines how Community ICAMHS, the statewide EDS and WAEDSSS will use a stepped care approach to deliver care for children and adolescents aged 0-to-17-years old, who experience or are at risk of developing an eating disorder or disordered eating and have mental health presentations. Specifically, this Model of Care outlines how:

- Community ICAMHS will provide care for children and adolescents with eating disorders and disordered eating mental health needs. At times, this may involve the statewide EDS providing case by case advice.
- Community ICAMHS and the statewide EDS will provide joint care for children and adolescents with an eating disorder and disordered eating, using an evidence-based and person-centred approach.
- Community ICAMHS and the statewide EDS will interact and partner with hospital-based services to support children and adolescents with eating disorders, so that both their physical and mental health needs are met.
- Community ICAMHS, the statewide EDS and WAEDSSs will partner with other services integral to the mental and physical health of children and adolescents with eating disorders. These services may include general practitioners (GP), primary care and community service providers.
- Community ICAMHS and the statewide EDS will contribute to developing the capacity of the broader system to respond to the needs of children with eating disorders.

NOTE: The Eating Disorders Model of Care **may be subject to change** as new developments emerge and additional operational planning and service design activities are undertaken, in regard to the respective responsibilities of WAEDSSs, EDS and PCH. This includes clarifying who provides care to adolescents aged 16-17 years of age. Given these circumstances, this document predominantly focuses on describing the role of EDS. Once the roles of EDS and WAEDSSs are confirmed, this document should be updated accordingly to include both EDS and WAEDSSs throughout.

Objectives

The objectives of the Eating Disorders Model of Care are to:

- Outline how children, adolescents, families and carers will **access and receive mental health care** for eating disorders and disordered eating behaviours within the ICA mental health system.
- Outline the **high-level workforce, infrastructure, and delivery considerations** to implement this Model of Care.
- Guide the **future operational design of services** that will deliver mental health care for eating disorders.

Limitations


This Model of Care is intended to provide a framework that broadly defines how care will be provided. As such, it is not intended to:

- **Define specific treatments, supports, therapies or interventions, or clinical guidelines.** It is understood that these decisions are subject to an individual's needs, the clinical judgment of a health worker, and the input of a parent or carer.
- **Provide guidance on future service provision for specific regions, districts, or communities.** It is understood that future service providers will tailor the Model of Care to the respective needs of the communities they serve and the unique context in which they operate.
- **Provide specific workforce, infrastructure, or other requirements** to deliver this Model of Care. This will be the focus of future streams of work involving the MHC and other partners of the WA Government.

3.2 Model of Care's outcomes

The Eating Disorders Model of Care is intended to deliver a range of outcomes, outlined in Table 1 below.

Table 1 | Eating Disorders Model of Care intended outcomes

Outcomes that mental health care for eating disorders is seeking to achieve for...	
 Children, adolescents, families, and carers	Children and adolescents can access continuous care for eating disorders that is close to home and tailored to their needs .
	Children and adolescents receive supports that are focused on their physical, emotional, and psychological recovery .
	Children and adolescents develop a healthy relationship with food and are able to maintain healthy exercise behaviours .
	Parents and carers have the skills and capacity to support the recovery of their child and participate in care provision.

Outcomes that mental health care for eating disorders is seeking to achieve for...



Staff working in eating disorders

Physical and mental health clinicians adopt a **partnership approach** to deliver **holistic and coordinated care** to children and adolescents with eating disorders.

Staff are provided with **opportunities to increase their capabilities and understanding of eating disorders** amongst children and adolescents.



The broader ICA mental health system

There is a greater focus on **community education, prevention, and early intervention**, particularly in schools, regarding eating disorders.

There are **clear pathways** for all services, including hospitals, primary care, and community services, to **access information on eating disorders**.

3.3 Considerations for different communities and populations

It is acknowledged that there are historical barriers to accessing care and supports for eating disorders for different communities and populations, and that care is often not catered specifically to their unique social, cultural, or other needs. This Model of Care is designed to be inclusive, accessible and of benefit to different communities and populations across the state. These include, but are not limited to:

- regional, rural and remote children, families and carers
- Aboriginal and Torres Strait Islander children, families and carers
- ethnoculturally and linguistically diverse (ELD) children, families, and carers
- LGBTQIA+ children.

It is recognised that as part of implementing this Model of Care, there will need to be a level of adaption to ensure that the care delivered meets the needs of different communities and populations.

4 Eating Disorders Model of Care in practice

This section describes the Eating Disorders Model of Care in detail. It focuses on providing information around: who this Model of Care is for; who will provide care; how care will be provided; and where care will be provided.

4.1 Who is this Model of Care for?

This Model of Care is primarily for children and adolescents aged 0-to-17-years of age who have an eating disorder, emerging eating disordered needs, or experience disordered eating behaviours.¹¹ These children and adolescents may present with the following:

- experience paediatric avoidant eating patterns
- be medically stable but physically at risk due to an eating disorder or disordered eating diagnosis
- be medically unstable or biochemically unstable and require stabilisation
- experience presentations and distress associated with eating disorders, such as eating issues, body image issues, and excessive exercise
- be at risk of self-harm, or suicide, and have presentations associated with eating disorders and disordered eating
- have neurodevelopment disorders or conditions.

Within the above profile of need, there may be variation in terms of the scale or complexity of needs. Accordingly, the Model of Care seeks to provide care to all children and adolescents. While this Model of Care targets those aged 0-to-17-years of age, there should be some flexibility in the age cohort. For example, Community ICAMHS and statewide EDS should be able to provide supports to children aged 18-years-of-age and beyond, particularly those who are in high school. This will be important in ensuring continuity of care, particularly at a time that is often challenging for adolescents.

Aboriginal and Torres Strait Islander children, families and carers

It is recognised that the care provided to Aboriginal and Torres Strait Islander children, adolescents, families and carers experiencing an eating disorder, needs to address their physical, mental and social health and wellbeing in a cultural context. The care and supports

¹¹ There is a degree of flexibility assumed within this Model of Care, so that Community ICAMHS and EDS can provide care for those 18 years of age where appropriate.

Community ICAMHS, EDS and WAEDSSs provide needs to be culturally appropriate and respectful of Aboriginal communities’ traditional healing and medicine practices and delivered in accordance with the ICA Culturally Safe Care Principles.

ELD children, families and carers

It is acknowledged that the care provided to ELD children, adolescents, families and carers needs to be accessible and respectful of the cultural, linguistic, religious and spiritual needs of ELD communities. Community ICAMHS, EDS and WAEDSSs should consider the specific needs of ELD children, adolescents, families and carers who are experiencing an eating disorder, and adapt their practices and approaches accordingly.

Regional and remote children, families and carers

It is recognised that all levels of care for eating disorders needs to be accessible to regional and remote children, families and carers across WA, and be tailored to local communities’ context and needs. To achieve this, detailed operational planning and service design needs to be conducted in collaboration with these communities.

4.2 Who will provide care to children, families and carers?

Community ICAMHS and the statewide EDS will work together to provide care to children and adolescents with an eating disorder or disordered eating behaviours, using a stepped care approach. It is recognised, however, that providing care to children and adolescents with eating disorders requires involvement and support from families and carers and is the responsibility of a broad range of health and social care services. It is also acknowledged that WAEDSSs are funded to provide Community based care to adolescents aged 16-years-of-age and over.¹² To this end, this Model of Care focuses on describing the care provided by ICA public mental health services, specifically: *Community ICAMHS, EDS, WAEDSSs, hospital-based services and primary care and community services*. This is summarised in Table 2 and described in turn below.

Table 2 | Overview of how care will be delivered

Service	Description
Community ICAMHS	Children and adolescents with eating disorders and disordered eating behaviours will receive the majority of their care from a Community ICAMHS’ multidisciplinary team. An Eating Disorders Practice Lead from a Community ICAMHS Hub will support ICAMHS clinicians to conduct assessments and provide supports. ICAMHS clinicians will also provide care coordination. In addition, Community ICAMHS will provide peer support options to the child, family and carers.

¹² The role of WAEDSSs may be subject to change, as further operational planning and service design activities are conducted. It is also acknowledged that WAEDSSs has been allocated \$31.7 million from the WA Government to expand the service to support 16-17 year-olds.

Service	Description
EDS	The existing EDS will expand its scope of practice to work in partnership with Community ICAMHS. This includes providing training and supervision, educational resources, case-by-case advice, and shared care. The EDS will also provide specialised and intensive supports to children and adolescents at PCH ¹³ . The EDS will have a research and excellence function that will contribute to building the system’s capability and capacity to identify and manage eating disorders among children and adolescents.
WAEDSSs¹⁴	WAEDSSs will provide community-based care to adolescents aged 16-years-of-age and over, referred after their 16th birthday, and whose needs are not better met by Community ICAMHS.
Hospital-based services	Children with eating disorders may at times need to receive care in a hospital-based setting, such as in-patient unit. When this occurs, Community ICAMHS, EDS and WAEDSSs will work in collaboration with PCH, and other metropolitan and regional hospitals to provide mental health care to children and adolescents, either by providing case by case advice or shared care.
Primary care and community services	Community ICAMHS, EDS and WAEDSSs will work with primary care and community services to provide shared care and case by case advice to enable these services to respond to and better support the needs of children with eating disorders. Community ICAMHS and EDS will also support these services to expand their capabilities to support children with eating disorders.

4.2.1 Community ICAMHS

Depending on the region’s needs, Community ICAMHS will have dedicated eating disorders expertise embedded within its Hubs. This will be in the form of an Eating Disorder Practice Lead that will supervise and support mental health clinicians and physical health clinicians within Community ICAMHS Hubs and local clinics to provide treatments and care coordination to a child, family and carer. At times, these Practice Leads may undertake assessments and deliver supports, particularly to children with complex needs. They will also provide outreach support to the Community ICAMHS local clinics. Community ICAMHS Hubs that do not have an Eating Practice Lead will be able to draw on the closest Hub with a Practice Lead, as needed.

As eating disorders have both a psychological and medical aspect, the supports provided must address both needs. Community ICAMHS will deliver both types of supports in a multidisciplinary team, using a person-centred and evidence-based approach.¹⁵ Depending on

¹³ Further work and investment are required to optimise inpatient care for those aged 16 years and over experiencing an eating disorder.

¹⁴ The role of WAEDSSs may be subject to change, as further operational planning and service design activities are conducted.

¹⁵ More information on the types of psychological and medical supports that Community ICAMHS will provide are listed in Section 4.3.

the child, adolescent, family and carers needs, support from Community ICAMHS will look like one of the following:

1. Community ICAMHS mental health and physical health clinicians will **provide supports** to a child, family and carer, drawing on the Eating Disorders Practice Lead for expertise as required.
2. Community ICAMHS Eating Disorders Practice Lead and clinicians **will draw on the statewide EDS to provide case by case advice** that supports ICAMHS clinicians to provide supports. As required, this may include seeking advice from EDS' dieticians on how to address the nutritional aspects of a child/adolescent's eating disorder. This will be particularly important as Community ICAMHS Hubs will not have an embedded dietician, therefore, advice and support in this area will predominantly come from EDS.
3. Community ICAMHS Hub's mental health and physical health clinicians, and other services integral to eating disorders, such as statewide EDS, WAEDSSs and GPs, will deliver **supports, using a shared care approach**. In these shared care arrangements, Community ICAMHS will lead care provision and care coordination. Exceptions to this will occur when a child/adolescent is medically unstable and cared for in hospital. In these circumstances, the hospital's medical team will lead care provision.

4.2.2 Statewide Eating Disorders Service (EDS)

EDS will use a coordinated paediatric and psychiatric medicine approach to provide statewide specialised support to children and adolescents with eating disorders, up until they are 18-years-of-age. The statewide EDS will be responsible for:

1. Providing **case by case advice to Community ICAMHS, PCH and other services** caring for children and adolescents with eating disorders. This may involve providing expert advice in regard to assessments, care plans or treatment options.
2. Providing **shared care with Community ICAMHS, PCH, and other services**. This may involve Community ICAMHS and the statewide EDS delivering different types of supports simultaneously, or both services delivering supports together, through co-facilitation of programs, or jointly conducting one-on-one consultations and group sessions. In these joint care arrangements, Community ICAMHS will lead care provision, unless the child/adolescent is being treated as an inpatient at a hospital. In these circumstances, the hospital's medical team will lead the delivery of care.
3. Deliver **specialised and intensive supports** to children, adolescents, families and carers across WA. Care could be provided in the community, in outreach and in PCH. When a child or adolescent transitions from Community ICAMHS to the statewide EDS for treatment and is not admitted into hospital, EDS will provide care coordination. This includes an EDS clinician regularly communicating with the child or adolescent's Community ICAMHS care coordinator, to support a seamless transition back into Community ICAMHS, when the child or adolescent is ready.

EDS clinicians will undertake set visits to regional and remote Community ICAMHS Hubs and local clinics each year. This may involve a mobile team of EDS clinicians travelling to different

regions throughout the year, to provide expertise and support to children, families, carers, and clinicians within those regions.

The statewide EDS’ research and excellence function

The statewide EDS will play a role in supporting, inspiring and upskilling the ICA mental health system, in particular Community ICAMHS, in the provision of care for children and adolescents with eating disorders and disordered eating behaviours. To do this, the statewide EDS will establish a research and excellence function that provides education and training to clinicians, conducts research, develops resources to guide safe inpatient, outpatient and community management of children and adolescent with eating disorders, and works towards ensuring there is contemporary and consistent service delivery across the system. This research and excellence function will be similar to the WA Eating Disorders Outreach and Consultation Service. It is envisioned that this function is comprised of a small team within EDS who is responsible for undertaking the activities listed in Table 3.

Table 3 | Overview of what EDS’ research and excellence function will provide to Community ICAMHS and the system

What will EDS’ research and excellence function provide to support Community ICAMHS?	What will EDS’ research and excellence function provide to support the system?
<p>Evidence based training and professional development programs to Community ICAMHS’ Eating Disorder Practice Leads and clinicians, to support them to undertake assessments and deliver generalised care for eating disorders.</p>	<p>Evidence based training and professional development programs to increase hospitals, community organisations and primary care providers’ capacity and capability for early intervention, identification and management of eating disorders among children and adolescents.</p>
<p>Clinical supervision and mentoring to Community ICAMHS Eating Disorder Practice Leads and clinicians. Supervision will incorporate reflective practices and be provided in one-on-one and group settings.</p>	<p>Research related to eating disorders. These research activities should inform how supports are provided and the development of the EDS’s training and education programs, and educational resources. To support research activities, the EDS should form partnerships with researchers, such as tertiary education institutions and research institutes.</p>
<p>Educational resources (e.g. articles, FAQs, etc.) for Community ICAMHS to guide safe community management of children and adolescents with eating disorders.</p>	<p>Educational resources to guide safe inpatient, outpatient and community management of people with eating disorders.</p>
	<p>Child and parent/carer friendly resources on eating disorders (e.g. information booklets, handbooks, etc.). These resources should include general information about eating disorders and</p>

What will EDS' research and excellence function provide to support Community ICAMHS?	What will EDS' research and excellence function provide to support the system?
	self-help strategies for children, parents and carers to use, particularly when waiting for care. These resources can be shared with children, families and carers via Community ICAMHS Hubs and clinics, hospitals, community services, primary care, schools, and other organisations within the system.
	Forums to facilitate system-wide collaboration. This could include hosting events and workshops that bring various parts of the system together to share knowledge and experiences, and design solutions to current challenges.

4.2.3 Hospital-based services

Children, adolescents, families and carers may receive care in hospital-based settings as an inpatient, particularly if they are medically unstable or have complications with malnutrition and require intensive nutritional resuscitation and restoration.¹⁶ PCH currently supports children with eating disorders in its medical ward (Ward 4A). There are plans for an Eating Disorder Unit to be established at PCH, however, this is subject to funding. Nonetheless, Community ICAMHS and EDS will work in collaboration with PCH to provide mental health care for children and adolescents who are admitted into PCH. This will involve EDS providing case-by-case advice and in-reach care in PCH. For adolescents admitted into adult hospitals with an eating disorder, further work and investment are required to optimise inpatient care. WAEDSS Patient Transition Co-ordinators will support transitions from adult inpatient care to appropriate community-based treatment or other services to support sustained recovery.

A note on EDS and WAEDSSs

Currently EDS will provide care for children who are referred before their 16th birthday up until they are 18 years of age, while WAEDSS will provide care for children who are referred after their 16th birthday. However, this delineation may be subject to change based on future planning amongst WA Health Service Providers (HSP).

¹⁶ Those diagnosed prior to the age of 16 years of age and presenting to PCH will be treated as both an inpatient and outpatient up to the age of 18. Those aged 16 years and over presenting for the first time will be treated in a general hospital ward which may be in a youth ward.

4.2.4 Primary care and community services

Primary care and community services may be involved in care provision for a child or adolescent with an eating disorder or disordered eating. Community ICAMHS and EDS will work with GPs and other community-based health services (including Aboriginal Community Controlled Health Organisations (ACCHOs)) to:

- Provide case-by-case advice to primary and community health services to enable them to respond to and better support the needs of children with eating disorders and disordered eating.
- Provide shared care with primary care and community services to provide holistic supports to meet the needs of the child, family and carers.
- Help to build the capacity and capability of primary care and community services to support children with eating disorders and disordered eating within community settings.

4.2.5 Stepped model of care

Community ICAMHS, the statewide EDS and WAEDSSs will use a stepped care approach to deliver care for children and adolescents with eating disorders. A stepped care approach involves providing supports that are matched to a child, adolescent, family and carer's needs and preferences. For example, supports are increased or decreased in intensity according to a child or adolescents' changing psychological, physical, nutritional and functional needs.¹⁷

How does the stepped Model of Care approach work?

Community ICAMHS will be responsible for supporting children, adolescents, families and carers 'step-up' and/or 'step-down' the intensity of their care, including supporting the transition to and from EDS or WAEDSSs. It is recognised that the stepped care approach may look different for each child, adolescent, family and carers. The following provides some examples to illustrate how the stepped model of care may work within the context of eating disorders.

Example 1: A 12-year-old child presents with highly complex disordered eating needs upon entry into Community ICAMHS. After the Eating Disorders Practice Lead undertakes the assessment with the ICAMHS clinician, the decision from the Practice Lead is to refer the child and their family immediately to the statewide EDS for intensive care. The Community ICAMHS care coordinator remains connected to the family during this time, but EDS carries out care coordination. After receiving care from EDS, the child/adolescent and family then 'step-down' into Community ICAMHS to receive ongoing support, before transitioning out to their primary care provider when ready.

Example 2: A 15-year-old young person presents to Community ICAMHS with an eating disorder that is moderate in complexity. The decision from the Eating Disorders Practice Lead is for Community ICAMHS to work with EDS in a shared care arrangement to support the

¹⁷ National Eating Disorders Collaboration, Stepped System of Care for Eating Disorders, <https://nedc.com.au/support-and-services/system-of-care/>

adolescent. This involves Community ICAMHS and EDS running respective sessions with the young person and family (*for example, the Community ICAMHS clinician delivers meal preparation sessions with the adolescent and their parents, and EDS' psychologist conducts individual therapy sessions*), and facilitating joint case conference sessions. After some time, Community ICAMHS and EDS, with agreement from the adolescent and family, decide the young person can 'step-down' the intensity of their care. Community ICAMHS now continues to provide care, with EDS only providing case-by-case advice.

Example 3: A 14-year-old young person with an eating disorder presents with needs that are moderate in complexity upon entry into Community ICAMHS. The decision from the Eating Disorders Practice Lead is for an ICAMHS clinician to provide therapies to the young person, family and carers, with support from the Practice Lead. After treatment commences, the Community ICAMHS clinician recognises that their needs are more complex than originally thought. After consulting with the Eating Disorders Practice Lead, the Community ICAMHS clinician refers the young person to EDS for more intensive care (i.e. the care they receive 'steps-up' in intensity). EDS then provides care to the young person and their family and undertakes the care coordination function.

Example 4: A 15-year-old has been receiving care for their eating disorder from Ward 4A at PCH, after being admitted upon presentation to the ED. The young person has reached a state of medical stability and is referred to Community ICAMHS for continued support. In the first instance, Community ICAMHS' clinician and the Eating Disorder Practice Lead, and EDS facilitate joint sessions, as well as provide some treatments independently. After some time, care transitions to Community ICAMHS, and clinicians within ICAMHS provide care, drawing on the EDS for case-by-case advice as needed.

4.3 How will care be provided to children, adolescents, families and carers?

The following section describes how a child, adolescent, family and carer may access and receive care from Community ICAMHS and EDS, across three broad stages: **access; support; and transition.**¹⁸

4.3.1 Access

Community ICAMHS will receive referrals to provide care to a child and adolescent with an eating disorder, and their family and carers, and manage their intake and assessment process. The following describes the key activities Community ICAMHS, and EDS will undertake within this stage.

¹⁸ Please note, where references are made to EDS, this predominately relates to intensive hospital-based and outpatient treatments. Once established, this could be inclusive of WAEDSSs, pending outcomes of HSP future planning activities.

Referral

All referrals for eating disorders will come through to the Community ICAMHS Hubs from various sources and channels (e.g. online, in-person, over the phone, etc.), including, but not limited to:

- child, parent or carer self-referral
- paediatric, tertiary, or regional hospitals
- paediatricians
- tertiary hospital EDs and inpatient wards
- GPs
- Aboriginal Medical Service (AMS) / (ACCHOs)
- schools (includes school psychologists)
- other services / organisations involved in a child, adolescent, family and carer's network.

Any referrals that Community ICAMHS' local clinics, EDS and WAEDSSs receive will be directed to the Community ICAMHS Hubs.

EDS' referral processes

Ideally, EDS should only receive referrals from Community ICAMHS, after an assessment within Community ICAMHS has been undertaken. It is acknowledged that there is the possibility that EDS may receive a referral from PCH, particularly if a child/adolescent has come through to the ED, presenting with an eating disorder and then been admitted to PCH. In these instances, EDS will provide the referral to Community ICAMHS, flagging the urgency, but it will start providing in-patient care immediately (if appropriate), regardless of if the referral has been processed.

Triage and intake

Community ICAMHS Hubs will have an intake team who is responsible for triaging and assessing the referrals it receives against intake criteria for children and adolescents with eating disorders. To support the triage process, the intake team may reach out to the Eating Disorders Practice Lead within Community ICAMHS for advice, particularly for complex cases. In some circumstances, the Practice Lead may reach out to EDS for expert advice. If the intake team has identified a child/adolescent requires an emergency paediatric medical assessment, the triage clinician will immediately direct the child/adolescent to an ED for a medical assessment to detect medical instability.

Once the referral has been triaged, the intake team will identify the most appropriate Community ICAMHS Hub or local clinic to provide care to the child/adolescent, family and carer. The intake team within the Community ICAMHS Hubs will also ensure that all children, adolescents, families and carers are receiving some level of immediate support. At the point of intake, the Community ICAMHS intake team will also assign the child, adolescent, family and carer a mental health clinician from a Community ICAMHS Hub or local clinic who will act as their care coordinator and have expertise in eating disorders.

EDS' triage processes

Where EDS receives referrals from Community ICAMHS (after the assessment has occurred), EDS' multidisciplinary team will triage the referrals at a weekly triage meeting. The multidisciplinary team meeting assesses each child/adolescent's physical health records, weight loss trajectories, and mental health complexity to determine whether the child/adolescent meets EDS' intake criteria. If referrals are marked as urgent, they will be reviewed out of the 'weekly meeting cycle' (i.e. they will be reviewed upon receipt).

Information provision and support

At the first point of engagement with Community ICAMHS, the intake team will offer the child, family and carers the option to have access to a peer support worker. It will be the child, family and carer's decision if they choose to access support from a peer support worker. At this time, Community ICAMHS will also provide information and educational resources to children, families and carers, including guidance on self-help strategies they can use while waiting for care, parent/carer support groups they can attend, and information on how they can access the 24/7 chatline if a crisis situation emerges.

EDS' role and approach to information provision and support

EDS' research and excellence function will develop information and educational resources (e.g. handbooks, guides, etc.) for Community ICAMHS and other services to share with children, parents and carers following a referral into ICAMHS. This may include information booklets on eating disorders and invitations to eating disorder psychoeducation workshops for parents and carers.

Assessment

The assessment will be holistic and focus on both the child/adolescent's mental and physical health. It will assess: a child/adolescent's general functioning and the impact of their eating disorder on social, personal, family, employment, and school functioning; their psychological health; and their medical stability. The assessment will also look to gain an understanding of the child/adolescent's wellness goals; their relationships, family and carer dynamics, and living environment. The assessment process will involve a multidisciplinary team. If the child presents with needs that are moderate in complexity, the Eating Disorders Practice Lead, a mental health clinician, physical health clinician and a psychiatrist or psychologist from within Community ICAMHS will likely conduct the assessment independently. If the child's needs are more complex, a joint assessment may be undertaken between Community ICAMHS and EDS.

EDS' role and approach to assessment

Upon request from Community ICAMHS, EDS may co-facilitate assessments with Community ICAMHS, or lead the assessment with Community ICAMHS. This will typically occur in

situations where the Community ICAMHS' intake team and/or Eating Disorders Practice Lead have identified at the triage stage that the child/adolescent may have complex needs.

When a child/adolescent is referred to EDS, the service may conduct an additional assessment, to help inform what intensive and specialised supports it should provide. EDS' assessment may involve a psychiatrist, mental health clinician, paediatrician, and dietitian and will likely have three components: a structured interview questionnaire to obtain necessary information; a clinical interview; and a physical examination. Following the assessment, the multidisciplinary team will identify suitable, treatment options.

4.3.2 Support

Children and adolescents with eating disorders, and their family and carers, can receive a broad range of evidence-based, therapeutic supports that promotes recovery and wellbeing and meets their needs, preferences and goals. The following outlines the key activities that Community ICAMHS and EDS will undertake during this stage.

Care plans

Before supports are provided, Community ICAMHS will develop care plans to outline what supports a child/adolescent will receive and how they will receive them. The Eating Disorders Practice Lead, with support from the multidisciplinary team will undertake this process, in partnership with the child, adolescent, family and carers. Depending on the child/adolescent's needs, EDS may provide expert input into the development of the care plan. The assessment/s, the child, adolescent, family and carer's needs (e.g. physical, psychosocial, educational, and cultural needs), goals, circumstances and preferences, will inform the care plan. Medical safety will be embedded into care plans for eating disorders, particularly given the interconnections between care for mental health and physical health.

EDS' role and approach to care plans

EDS may provide advice to Community ICAMHS to support the development of care plans, upon request from Community ICAMHS' Eating Disorders Practice Lead. In situations where a child/adolescent is referred to EDS to receive intensive and specialised support, it is anticipated that EDS will work closely with the Community ICAMHS' Eating Disorders Practice Lead or clinician to update the care plan to reflect the supports that EDS will provide.

Supports and treatment

Evidence based supports and treatments will be provided to a child, adolescent, family and carer. Supports will be person-centred and individualised, and children, families and carers will be involved in making decisions about the supports they receive. Community ICAMHS will provide moderate to high intensive supports, while EDS will provide more intensive supports.

The following outlines examples of the types of supports that Community ICAMHS and the EDS may provide.

Community ICAMHS' supports and treatments

Community ICAMHS may provide the following types of supports for children and adolescents, in various settings, such as in its Hubs and local clinics, in the child/adolescent's home, via telehealth, and in hospital-based settings (via either outpatient or inpatient care):

- individual or group psychotherapy
- family based treatment (FBT)
- meal preparation programs
- therapeutic meal support
- physical / medical monitoring
- psychoeducation for families and carers
- provision of and/or facilitated access to community-based parent / carer support and therapeutic groups
- social and emotional support for children, families and carers via peer support workers
- other non-clinical supports, such as facilitating access to financial, legal and social supports.

EDS' supports and treatments

EDS will provide supports and treatments in Community ICAMHS Hubs and local clinics, in EDS' clinic (outpatient settings), in the home, via telehealth, and in hospital-based settings (via either outpatient or inpatient care). They may provide the following types of supports and treatments in the form of one-on-one consultations, or structured day programs/sessions over a certain period:

- FBT
- therapeutic meal support
- intensive psychological support
- medical monitoring
- dietitian supports
- physiotherapy / exercise physiology
- therapy groups (e.g. group, family and/or peer sessions)
- support groups for children, families and carers
- psychoeducation for families and carers (e.g. education and skill training workshops)
- schooling (via teachers from School of Special Educational Needs: Medical and Mental Health).

EDS' role in providing supports and treatment

During the support stage, EDS may support the delivery of care by:

- providing case-by-case advice to Community ICAMHS
- providing joint care with Community ICAMHS and/or with PCH
- independently providing intensive and specialised care to children, families and carers.

Care coordination

During the support stage, the Community ICAMHS care coordinator will regularly communicate with the child, family and carers through various ways (e.g. in-person, email communications, or virtual options, such as videoconferencing). They will also play an important role in coordinating the child, adolescent, family and carers supports and appointments, and ensuring information is appropriately shared among services. The key aim of care coordination is to facilitate a coherent and integrated approach to care across all services, that delivers on the child, adolescent, family and carers wellness goals. To do this, the Community ICAMHS care coordinator may use the following approaches:

- **Hold multidisciplinary team meetings** (including with EDS and WAEDSSs, where relevant) to enable collaboration and shared decision-making across all teams/individuals involved in care provision. Care plans and treatments should be discussed and evaluated in these meetings. These meetings will include the peer support worker and Aboriginal Mental Health Worker, if applicable to the child, family and carers. Where appropriate, these meetings may include the child, family and carers, so that they can provide input into the discussions. Actions from these meetings should be shared with all services involved in care provision (including the peer support worker and Aboriginal mental health worker), and with the child, family and carers.
- **Have regular touchpoints between Community ICAMHS and EDS (or WAEDSSs)** when the child/adolescent has transitioned to EDS or WAEDSSs for care. These touchpoints will support the 'step-down' in care from EDS or WAEDSSs to Community ICAMHS when the time is right. Children, families and carers should be involved in these discussions as appropriate.
- **Hold interagency meetings**, where required, to facilitate information sharing about ongoing care and management of the child/adolescent, and discuss any new, emerging needs. Children, families and carers should be involved in these discussions as appropriate.
- With the child/adolescent's consent, **regularly communicate with the child/adolescent's GP, paediatrician, private clinician, or primary care team** to share information and discuss care planning, treatment and management. Children, families and carers may be involved in these discussions, if appropriate.
- Regularly **communicate with schools** to help them to support the child/adolescent. Where appropriate, children, families and carers should be involved in these discussions.

Care coordination when EDS is supporting a child/adolescent

When a child/adolescent has transitioned to EDS for care, EDS will carry out the care coordination responsibilities. To enable a seamless 'step back' into Community ICAMHS (when the child is ready), the Community ICAMHS care coordinators should be invited to EDS' multidisciplinary team meetings and remain involved in some capacity.

4.3.3 Transition

When it is safe and suitable to do so, children and adolescents with eating disorders will be supported to transition into other settings, ensuring continuity of care. The following describes the key activities that Community ICAMHS and EDS will undertake in this stage.

The transition stage involves a child/adolescent, family and carer transitioning their care from Community ICAMHS to a primary care and/or community service provider; or a child/adolescent transitioning to adult community or hospital-based services for continued support, if they are approaching 18 years of age, or are 18 years of age, and have finished high school. The transition stage in this context does not refer to the transition or 'step-down' from EDS to Community ICAMHS (see commentary below which describes the transition from EDS to Community ICAMHS).

Transition from EDS to Community ICAMHS

Where a child is referred to EDS for care, they will always transition back to Community ICAMHS after receiving care, and before transitioning out to their GP or a community service provider. The transition between EDS and Community ICAMHS will be conducted with proper handovers and communication between the services.

The transition stage has been broken down into three steps: pre-transition; during transition; and post transition. The following discusses each in turn.

Pre-transition

Before the transition, the Community ICAMHS' care coordinator and others supporting the child, adolescent, family and carers (including those inside and outside of Community ICAMHS) will begin discussions on when it may be appropriate to transition care out to the community, or to an adult based eating disorders service, such as WAEDSSs, for continued support. Progress on the child, family and carer's goals/milestones and their preferences should be considered during these conversations. As part of planning for the transition, the individuals/team supporting the child/adolescent may also choose to begin to gradually reduce the intensity of support, as a way to prepare the child, adolescent, family and carer for the transition.

During transition

During the transition stage, the Community ICAMHS care coordinator will engage with relevant support services, organisations and schools to conduct warm handovers and discuss the

ongoing support needs. This may involve having meetings with all services present, or one-on-one meetings with Community ICAMHS, the service/organisation, and where appropriate, involve the child, adolescent, family and carer. The care coordinator will also provide educational support and resources to support the family and carers provide ongoing care and support to their child. Resources may include information about what they could expect in the coming weeks, months or years, strategies that the child, family and carer could use if they are struggling, and a list of services they could reach out to for support and advice.

Post transition

Post-transition, the Community ICAMHS' care coordinator will maintain contact and communication with the child, family and carers for some time. As part of these touchpoints, the care coordinator will check-in on how the child, family and carers are going, and discuss whether the supports they may currently be receiving are appropriate.

Transitioning to an adult mental health service or WAEDSSs

There may be times when an adolescent will need to transition to an adult community or hospital-based service, or WAEDSSs for continued support. For example, if an adolescent is approaching 18 years of age, or are 18 years of age, has finished high school, and requires continued support for their eating disorder (beyond what primary care services can provide). The transition process to an adult service will involve Community ICAMHS providing a referral to the appropriate service and conducting a warm handover with the clinician who will be providing care to the individual going forward. Relevant information, such as care plans, should be shared and discussed at the handover meeting. The Community ICAMHS care coordinator may stay involved in some capacity to support the transition.

It is acknowledged that there may be some circumstances where Community ICAMHS will continue to provide supports to a child/adolescent beyond 18 years of age (e.g. if they are still at school). This will be the decision of Community ICAMHS, the child/adolescent and their families and carers.

4.4 Where will care be provided to children, adolescents, families and carers?

Community ICAMHS and EDS will provide care to children, adolescents, families and carers in a range of settings and locations. Most importantly, supports, where possible, will be delivered in settings that make children and adolescents feel safe and comfortable, and are easily accessible for children, families and carers. Community ICAMHS may provide care in its Hubs and local clinics; PCH, GP practices, AMS/ACCHO centres, a child/adolescent's home, community centres, and via telehealth. EDS may provide care in the settings listed above, as well as in EDS's clinic/s and in PCH.

4.5 What might a consumer journey look like?

Children, adolescents, families and carers' journeys will be unique. Examples are provided overleaf of how a child, adolescent, family and carer with an eating disorder or disordered eating behaviours may access support. The examples provided are for illustrative purposes only, and do not present all children, families and carers situations.

Figure 3 | Consumer journey map 1

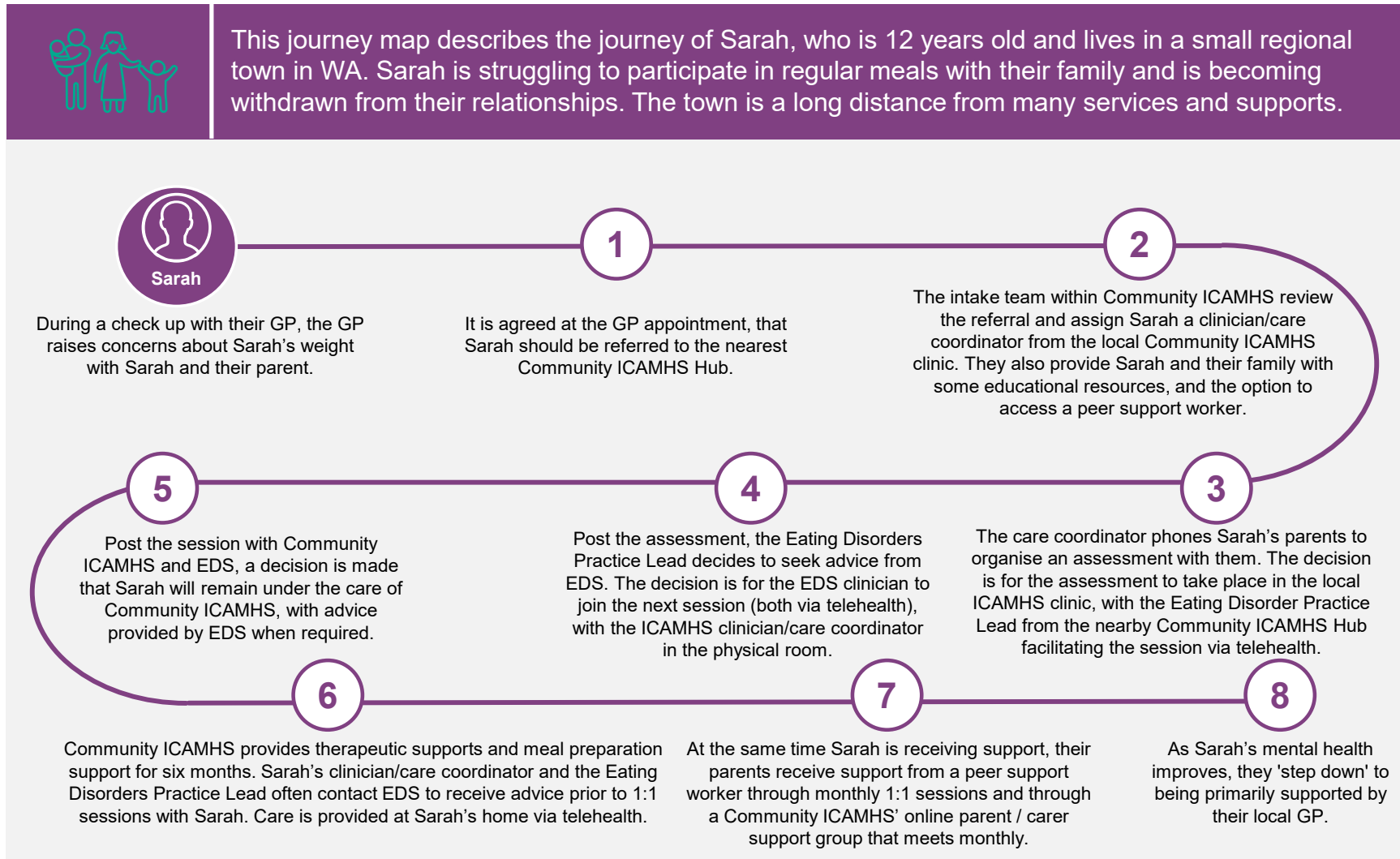
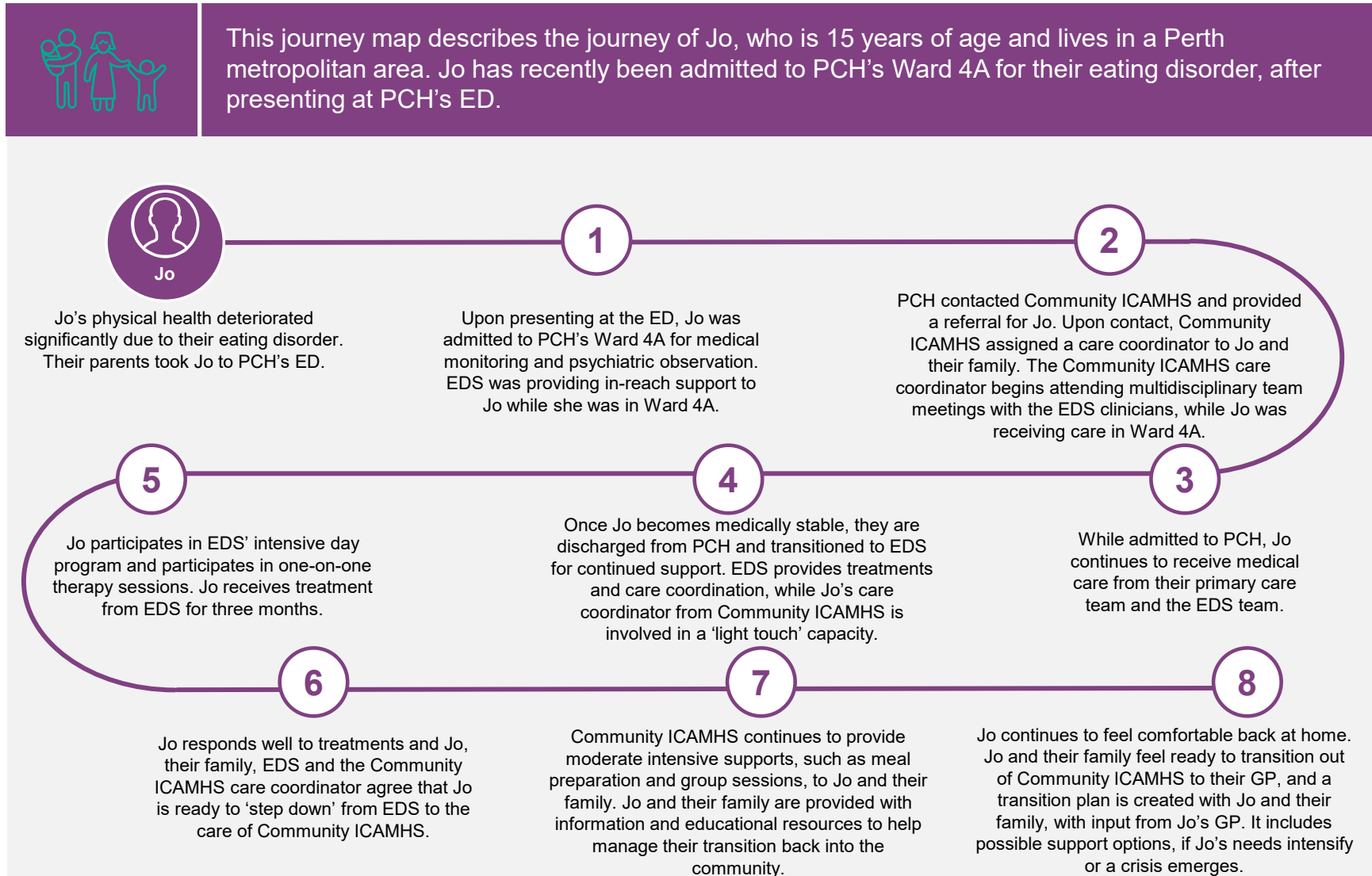


Figure 4 | Consumer journey map 2



5 Delivering the Eating Disorders Model of Care

There are various considerations that need be taken into account to operationalise the Eating Disorders Model of Care. These considerations have been outlined in this section using the following categories: *reconfiguration of EDS; key relationships and partnerships; workforce; infrastructure; and other delivery considerations.*

5.1 Reconfiguration of EDS

To support the delivery of this Model of Care, the existing EDS will need to be reconfigured to meet the expanded service requirements. The process to update the service may require time for planning, detailed service and operations design, hiring and training of a skilled workforce and the development of required infrastructure, particularly if the existing set up is no longer functional. Further, a rapid review or assessment of EDS' current functionality would be beneficial, so that existing opportunities for improvement of the service can be considered in the plan to transition to the future, enhanced service. The service should also be frequently reviewed in the early years to receive feedback and adapt to the needs of the ICA mental health system.

5.2 Key relationships and partnerships

It is recognised that there a critical relationship between Community ICAMHS, EDS and WAEDSSs to deliver care for eating disorders. As such, strong partnerships, underpinned by appropriate processes, infrastructure and agreed working practices, will be important in supporting the services to communicate, collaborate and appropriately share information in relation to a child, adolescent, family and carers care.

Other services, outside of Community ICAMHS, EDS and WAEDSSs, will at times need to be involved. The types of services and organisations involved will differ for each child, adolescent, family and carer. Some of these services and organisations may include:

- community health and social care services
- hospitals and hospital-based services
- paediatricians
- primary care (e.g. GPs, ACCHOs, AMS)
- private psychologists / psychiatrists

- schools and Department of Education School of Special Educational Needs: Medical and Mental Health (SSEN:MMH).

5.3 Workforce

The following describes the workforce requirements for Community ICAMHS and EDS.

5.3.1 Community ICAMHS' workforce

Community ICAMHS will have Eating Disorder Practice Leads embedded within Community ICAMHS Hubs.¹⁹ These Practice Leads will oversee and support mental health clinicians and physical health clinicians within Community ICAMHS Hubs and local clinics. Practice Leads will have specific expertise and knowledge of eating disorders, experience in delivering evidenced based supports and be trained in FBT.²⁰ Some of the core competencies Eating Disorder Practice Leads and clinicians within Community ICAMHS may have include²¹:

- General knowledge of the clinical features of eating disorders, common and evidence-based supports, and recovery-oriented practices.
- An understanding of how to identify eating disorder and disordered eating warning signs.
- An ability to conduct assessments for eating disorders and disordered eating and contribute to multidisciplinary team assessments.
- An ability to develop care plans and deliver person centred, evidence-based treatments for eating disorders and disordered eating, including within a multidisciplinary team.
- An ability to support the child/adolescent, family and carers facilitate their personal recovery.

Clinicians supporting children and adolescents with eating disorders and disordered eating will work in a multidisciplinary team. Multidisciplinary team members will come from a range of professional backgrounds, including psychologists, social workers, nurses, Aboriginal Mental Health Workers, and peer support workers. The Community ICAMHS Model of Care provides further detail on the multidisciplinary team, and other teams within Community ICAMHS that will provide care.

5.3.2 EDS' workforce

EDS will have a multidisciplinary team, skilled in eating disorders, to provide intensive treatments, and an expert team to run its research and excellence function. It is recognised that EDS may need to increase in size and scale to carry out its roles and responsibilities. Within EDS' multidisciplinary team, it may have the following roles (listed in alphabetical order):

- dietitian

¹⁹ Note: not every Community ICAMHS Hub may have an Eating Disorder Practice Lead. It will depend on the region's needs.

²⁰ FBT refers to family based treatment. It is a treatment option for children and adolescents with an eating disorder (typically anorexia nervosa, and in some circumstances bulimia nervosa) who are living at home with family and carers.

²¹ National Eating Disorders Collaboration. (2018). Workforce core competencies for the safe and Effective identification of and response to eating disorders. <https://www.nedc.com.au/assets/Uploads/WORKFORCE-CORE-COMPETENCIES-for-the-safe-and-effective-identification-of-and-response-to-eating-disorders.pdf>

- nurses (mental health and medical)
- occupational therapist
- peer support workers
- physician
- physiotherapist
- psychologist
- social worker
- speech therapist.

Research and excellence function

The research and excellence function will need to be staffed with an expert team, who are appropriately skilled in eating disorders. The roles within this team may include researchers, trainers, and administrative staff. They will receive ongoing input from EDS' multidisciplinary team to provide the perspective from various roles, such as practicing psychologists, or psychiatrists.

This team will focus on education, training and research on eating disorders' therapies and treatments. To support research activities, the EDS' research and excellence function should develop partnerships with tertiary education institutions and research institutes, and identify funding opportunities that could be leveraged.

5.4 Infrastructure

Physical and digital infrastructure is critical in enabling the delivering of care for eating disorders. The following describes the key infrastructure requirements.

5.4.1 Physical infrastructure

Child/adolescent friendly designed spaces in Community ICAMHS and EDS

Spaces will be child-friendly, welcoming, and culturally safe. In Community ICAMHS, this includes creating child and adolescent friendly spaces, such as indoor and/or outdoor areas for children and adolescents to relax; calming spaces; and rooms for different types of therapies, such as medical monitoring, group therapy, and meal preparation supports. These rooms should have a welcoming and home-like look and feel, with appropriate kitchen appliances to enable food preparation and group mealtimes. Like Community ICAMHS Hubs, EDS should have spaces that enable individual and group sessions and supports to be easily conducted (e.g. quiet zones, spaces for individual consultations, spaces for individual, group and meal preparation sessions, medical monitoring, etc.). In EDS, there should also be a training room, and a designated office space for the research and excellence.

Resources to support outreach care for eating disorders

Resources are required to support staff deliver care, including mobile outreach care into regional communities and home visits into a child, family and carer's home. These resources may include access to transportation (e.g. motor vehicles) and accommodation.

5.4.2 Digital infrastructure

Reliable and suitable digital infrastructure will be a key component in enabling staff to perform their roles, whether this be delivering care and treatment via telehealth, or capturing, accessing and sharing information digitally. Community ICAMHS Hubs and clinics, and EDS will provide staff with the necessary digital infrastructure. This may include: portable devices such as laptops, iPads and smart mobile phones, with reliable internet connectivity / Wi-Fi; high-quality cameras to enable videoconferencing and telehealth; and a centralised data system that all individuals involved in a child, family and carer's care (including those outside of Community ICAMHS and the child, family and carer themselves) can access to view the child's care plan, appointments, digital medical records (e.g. a summary of the supports or medications they have been provided), and their contact details and preferences (Figure 5).

Figure 5 | Centralised data system for the ICA mental health system

A recommended feature of the future ICA mental health system is that care plans, and other critical information relating to a child's care, will be accessible to GPs and other service providers, via a system wide information management system. This is to enable a seamless care experience for children, families and carers.

5.5 Other delivery considerations

There are other various considerations to support delivery of eating disorder supports, including:

- **Resolving potential gaps** – at present, there are no dedicated eating disorders beds for those aged 16 to 17 year olds presenting for the first time to an ED and requiring an admission.
- **Identifying possible, future funding sources** – funding may be sought for future services, such as inpatient beds, increased community support and treatment services.
- **Conducting further planning regarding a new Eating Disorder Unit at PCH**, noting this is subject to funding.
- **Identifying opportunities for greater collaboration across the sector**, particularly between Community ICAMHS, EDS, WAEDSSs, and adult eating disorders services or mental health services, and between the HSPs, to ensure care provision is integrated.
- **Focusing on creating equitable access to EDS and WAEDSSs for children, families and carers in regional and remote areas**. This could be through the application of suitable targets (i.e. a proportion of EDS and WAEDSSs' caseload will be children residing in regional and remote areas).
- **Recruiting staff from multiple HSPs for EDS' research and excellence function**. These staff members could work together from different locations.
- **Establish networks amongst statewide services**, for example between EDS and WAEDSSs, and with other services, to support research and the delivery of integrated care.

- **If funded, identifying opportunities for HSPs** to work with the WA Primary Health Alliance and other primary care stakeholders to consider optimal approaches for GPs and others to work with Community ICAMHS and EDS.
- **Establishing Memorandums of Understanding** among services and organisations to facilitate information sharing and care coordination.
- **Changing the language** that is used when providing care to children, families and carers to more inclusive, safe and accessible (i.e. less clinical).
- **Reviewing and evaluating service delivery** regularly to improve how care is provided.

6 Terminology

Table 4 below contains a list of the key terminology used within this document.

Table 4 | Key terms used within this document

Term	Its intended meaning and use
ACCHO	Aboriginal Community Controlled Health Organisation.
AMS	Aboriginal Medical Service.
CAHS	Child and Adolescent Health Service.
CAMHS	Child and Adolescent Mental Health Service
Carer	A person who provides care to another person, such as a child who is living with mental ill-health. They may have statutory responsibility for a child, be a family member who supports a child in their family or be another peer or community supporter.
Children/Child	Any person who is under the age of 18. This term is sometimes used to describe all infants, children and adolescents aged 0-to-17-years of age.
Clinicians	Professionals engaged in the provision of mental health services, including but not limited to Aboriginal mental health workers, administrative staff, allied health workers, nurses, paediatricians, psychiatrists, psychologists, and others.
Clinical supervision	Experienced health professionals providing guidance and oversight to less experienced health professionals.
Community ICAMHS Hub	A central 'hub' in each region within WA that leads the provision of mental health supports and is a single point of entry for all children, families and carers.
Community ICAMHS local clinic	A local clinic that can deliver care close to home for children, families and carers. The Community ICAMHS Hubs will coordinate and support these clinics.
HSP	Health Service Provider
ICA Culturally Safe Care Principles	ICA Culturally Safe Care Principles are intended to guide the delivery of culturally safe, responsive and quality health care to Aboriginal and Torres Strait Islander peoples.
ED	Emergency Department

Term	Its intended meaning and use
EDS	Eating Disorders Service.
ELD	Ethnoculturally and linguistically diverse.
Family	A child's family of origin and/or their family of choice. It may include but not be limited to a child's immediate family, extended family, adoptive family, peers, and others that share an emotional bond and caregiving responsibilities.
GP	General practitioner.
ICA	Infant, child and adolescent.
ICAMHS	Infant, Child and Adolescent Mental Health Service.
ICA mental health system	The public specialist infant, child and adolescent mental health services. This relates to services funded and provided by the WA Government.
Mental ill-health	This is a broad term that is used to include mental health issues, mental health needs, and mental illness. It relates to an experience of mental health issues impacting thinking, emotion, and social abilities, such as psychological distress, in addition to diagnoses of specific mental health disorders, such as depression and anxiety.
Model of Care	A Model of Care broadly defines the way health care is delivered. It outlines the care and services that are available for a person, or cohort as they progress through the stages of a condition or event. The following definition of a model of care can be used: an overarching design for the provision of a particular type of health service that is shaped by evidence-based practice and defined standards.
OSFED	Other specified feeding or eating disorder
PCH	Perth Children's Hospital
Peer support worker	A peer support worker is someone with lived experience who is there to support the child, families and carers. They may provide emotional and psychological supports; be in attendance at appointments; or be an advocate and/or champion for the child, family and carers.
People with lived experience	A child or young person who is or has lived with the impacts of mental ill-health and a person who is or has provided care to a child who is living with mental ill-health.
Service Guarantee	The Service Guarantee outlines what children, families and carers will expect to experience in their interactions with the ICA mental health system.
Shared care	Shared care involves two or more services working together to deliver coordinated care to children, families and carers.
SSEN:MMH	Department of Education School of Special Educational Needs: Medical and Mental Health.

Term	Its intended meaning and use
Staff	People who work within the ICA mental health system.
WACHS	WA Country Health Service.
WAEDSSs	Western Australian Eating Disorder Treatment Specialist Services.



GOVERNMENT OF
WESTERN AUSTRALIA



GPO Box X2299, Perth
Business Centre WA 6847

Level 1, 1 Nash Street
Perth WA 6000

T (08) 6553 0600

