Mental Health Commission

GOVERNMENT OF WESTERN AUSTRALIA

Western Australian Eating Disorders Framework 2025-2030: Consultation Draft Priorities Paper

September 2024

This resource was prepared by:

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Acknowledgement of Country

The Mental Health Commission acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of this country and its waters. The Mental Health Commission wishes to pay its respects to Elders past and present and extend this to all Aboriginal people seeing this message.

Feedback

Any feedback related to this document should be emailed to: strategicpolicy@mhc.wa.gov.au.

Accessibility

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If English is not your first language, you can get free translation support through the Translating and Interpreting Service (TIS National) by phoning 131 450.

Recognition of Lived Experience

We recognise the individual and collective expertise of those with living and lived experience of mental health, alcohol and other drug issues and suicidal crisis, including their families and carers.

Acknowledgement of the National Eating Disorders Strategy 2023-2033

The Mental Health Commission acknowledges the extensive work of the National Eating Disorders Collaboration in developing the National Eating Disorders Strategy 2023-2033. The Western Australian Eating Disorder Framework 2025-2030 will aim to build on and align with the National Strategy.

Disclaimer

The information in this document has been included in good faith and is based on sources believed to be reliable and accurate at the time the document was developed. While every effort has been made to ensure that the information contained within is accurate and up to date, the Mental Health Commission and the State of Western Australia do not accept liability or responsibility for the content of the document or for any consequences arising from its use.

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Key terms

Key terms and preferred language explained below.

Key terms	Meaning
Aboriginal people	Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. Reference to Aboriginal people throughout this document is respectfully inclusive of Torres Strait Islanders.
Co-occurring conditions	Co-occurring conditions, or comorbidity, is the co-occurrence of two or more physical or mental health problems. People experiencing eating disorders are at an increased risk of experiencing co-occurring psychiatric or medical conditions. The most common co-occurring psychiatric disorders include mood disorders, anxiety disorders, post-traumatic stress disorder and trauma, substance use disorders, personality disorders, sexual dysfunction, non-suicidal self-injury, and suicidal ideation. Common co-occurring medical conditions include type 1 and 2 diabetes, polycystic ovarian syndrome, osteopenia and osteoporosis, hypotension, gastrointestinal problems, joint pains, headache and migraine, and menstrual problems.[1]
Culturally responsive	An approach that recognises and respects the unique backgrounds, beliefs, values, customs, knowledge, lifestyle, and social behaviours of all individuals. Fostering culturally responsive environments can enable the creation of culturally appropriate information, programs, screening tools, interventions, and treatment models.
Disordered eating	Disordered eating sits on a spectrum between normal eating and an eating disorder and may include symptoms and behaviours of eating disorders, but at a lesser frequency or lower level of severity.
Early intervention	The identification of symptoms and implementation of support and treatment for a person as soon as symptoms are recognised. Prioritising early intervention initiatives can significantly reduce the severity and duration of eating disorders.
Eating disorders	Eating disorders are serious, complex, and potentially life-threatening mental illnesses. They are characterised by disturbances in behaviours, thoughts and feelings towards body weight and shape, and/or food and eating.
Equity of access	People have access to affordable treatment and support services when and where they are needed, and regardless of where they live.[2]
LGBTQIA+	The term LGBTQIA+ is used to refer to lesbian, gay, bisexual, transgender, queer, intersex, asexual people, or people otherwise diverse in gender, sexual orientation and/or innate variations of sex characteristics. However, it is recognised that many people and populations have additional ways of describing their distinct histories, experiences and needs beyond this acronym.
Lived experience of an eating disorder	A person who has previously or is currently experiencing an eating disorder (diagnosed or undiagnosed) or disordered eating or body image concerns.

[1] National Eating Disorders Collaboration. *Co-occurring conditions* [website article] Retrieved July 2024 from: https://nedc.com.au/eating-disorders/types/co-occurring-conditions
[2] National Eating Disorders Collaboration (NEDC) 2023. *National Eating Disorders Strategy 2023-2033*. NEDC

Mental health professional	An umbrella term for those professions that can provide psychological support and evidence-based psychological treatment for people experiencing an eating disorder, including psychologists, social workers, occupational therapists, psychiatrists, counsellors, mental health nurses, nurse practitioners, and psychotherapists.
Prevention	In the context of eating disorders, prevention refers to initiatives that aim to reduce modifiable risk factors and/or enhance protective factors, to reduce the likelihood that a person will experience an eating disorder.
Psychosocial and recovery support	Psychosocial support refers to services and programs which support the psychological and social needs of the person experiencing the eating disorder and their families/significant others and the community. Recovery support refers to services and programs which support a person to engage with or sustain recovery or improved quality of life and assist families/significant others and community in their caring role.
Recovery/recovery-oriented	There is no singular or consensus definition of recovery. For many people, recovery from an eating disorder signifies an end to eating disorder thoughts, feelings or behaviours, and improved physical and psychological wellbeing. For others, recovery may be an ongoing process of moving forwards or maintaining a personally defined state of wellbeing or quality of life.
Risk and protective factors	A range of biological and genetic, psychological, and behavioural and sociocultural factors which may increase (risk factors) or decrease (protective factors) the likelihood of developing an eating disorder.
Social and Emotional Wellbeing (SEWB)	The traditional Aboriginal understanding of health is holistic and does not refer to the individual but encompasses the social, emotional, and cultural wellbeing of the whole community. The social and emotional wellbeing (SEWB) of Aboriginal people is strongly influenced by their connection to family, Elders, community, culture, Country, and spirituality. These connections work together to provide a culturally safe environment for Aboriginal people and helps individuals to maintain and enhance their SEWB.
System navigation	The provision of assistance to individuals, families, significant others, carers, and community members to easily locate the information, advice, treatment, care and support they require in a timely manner.
Transition support	The provision of coordinated and tailored information, guidance, and practical support to individuals, families/significant others, and carers to assist in the transition between public and/or private programs and services, and between the community and hospital, particularly in regional areas.
Trauma-informed	An approach that recognises the high prevalence of trauma experiences among people experiencing eating disorders, and the impact that the trauma can have on the person and their recovery from an eating disorder.

About the Consultation Draft Priorities Paper

The Western Australian Eating Disorders Framework 2025-2030 (Framework) will aim to lay the foundation for a statewide coordinated approach for a comprehensive, equitable, and culturally responsive system of care for those impacted by eating disorders.

Following the 2021 State Government election commitment, Western Australia has seen an unprecedented increase in community-based eating disorders treatment and services. The Framework will build on these recent investments in eating disorder programs and services in Western Australia and will utilise the National Eating Disorders Strategy 2023-2033 (National Strategy) as its foundation. Additionally, the Framework will align to the Western Australian Mental Health, Alcohol and Other Drugs Strategy 2025-2030 (WA Strategy), which is due for release in 2025.

The Consultation Draft Priorities Paper has been developed to guide the community consultation process. It has been informed by national and state consultation undertaken by the National Eating Disorders Collaboration in the development of the National Strategy, along with previous Mental Health Commission consultation that has guided eating disorders service and program development specific to Western Australia. It has also been informed by a review of current programs and services and gap analysis; guidance from the Western Australian Eating Disorders Framework Advisory Group; and targeted engagement with members of the community and government, non-government and private organisations and service providers.

The Consultation Draft Priorities Paper is divided into three sections:

- Section 1: Background information including information about eating disorders, eating disorders facts, the national stepped system of care and services available in Western Australia. This background is provided as context to support understanding in review of the draft Vision, Guiding Principles, Focus Areas and Strategic priorities;
- Section 2: Draft Vision, Guiding Principles, Focus Areas, and Strategic Priorities - provided for feedback; and
- Section 3: Next Steps – outlining proposed next steps in the finalisation of the Framework following the consultation process.

Question prompts

The Mental Health Commission is seeking feedback on this Consultation Draft Priorities Paper to inform the development of the Western Australian Eating Disorders Framework 2025-2030.

Question prompts have been included in **Section 2** to guide feedback and gather insights.

Submissions may be provided by completing this survey.

All feedback must be submitted by **5pm on 20 September 2024**.

Additional information, or alternate forms of providing feedback can be sought from the Mental Health Commission Eating Disorders Project Team by emailing strategicpolicy@mhc.wa.gov.au or calling (08) 6553 0600.

Section 1: Background Information

About Eating Disorders

Eating disorders are a group of serious and complex mental health conditions characterised by problems associated with disordered eating, body weight control and severe concern with body weight and shape.[3] Commonly recognised eating disorders include:

- anorexia nervosa – characterised by the persistent restriction of food and water intake, intense fear of gaining weight and disturbance in self-perceived weight or body shape;
- bulimia nervosa – characterised by repeated binge eating episodes followed by compensatory behaviours like self-induced vomiting or laxative misuse;
- binge eating disorder – characterised by repeated episodes of binge eating, often with a sense of loss of control while eating;
- avoidant-restrictive food intake disorder – characterised by abnormal eating or feeding behaviours that result in the intake of insufficient quantity or variety of food to meet adequate energy or nutritional requirements;
- other specified feeding or eating disorder – people with this disorder present with many of the symptoms of anorexia nervosa, bulimia nervosa or binge eating disorder, but may not meet the full criteria of one or more of these disorders.[4]

While eating disorders are more common among young people, particularly females, they can occur in people of any age, weight, shape, neurotype, gender identity, sexuality, cultural background or socioeconomic group.[5]

The risk and protective factors associated with eating disorders involve a range of biological, psychological, and sociocultural factors.[6] Awareness of these factors is essential when designing programs and services to ensure better outcomes across prevention, early identification and intervention, treatment and support.

[3] Australian Institute of Health and Welfare. (2018). *Australia's Health 2018*, *3.13 Eating disorders.* Australian Government. Retrieved from https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/table-of-contents
[4] Fairweather-Schmidt, K., & Wade, TD. (2014). DSM-5 Eating disorders and other specified eating and feeding disorders: is there a meaningful differentiation? International Journal of Eating Disorders 47:524–33.
[5] National Eating Disorders Collaboration (NEDC) 2023. *National Eating Disorders Strategy 2023-2033*. NEDC
[6] National Eating Disorders Collaboration. *Risk and Protective Factors*. Retrieved from: https://nedc.com.au/eating-disorders/eating-disorders-explained/risk-and-protective-factors

Risk factors include biological and genetic factors (family history of eating disorders or mental health conditions), psychological and behavioural factors (dieting, perfectionist traits, anxiety, experience of trauma, abuse or neglect) and socio-cultural factors (peer pressure, teasing or bullying about body shape, pressure to succeed). Biological and social transition periods (onset of puberty, change in relationship status, pregnancy and postpartum) can also contribute to the onset of eating disorders. [7]

Protective factors are generally grouped around media literacy (developing the ability to critically assess and evaluate media), a healthy relationship with food and eating (enjoying eating, having a variety of different foods, being comfortable eating alone and with people), family factors (eating regular meals with family, belonging to a family that doesn't emphasise weight or physical attractiveness), individual factors (high self-esteem, positive body image, emotional wellbeing, problem solving skills) and sociocultural factors (involvement with sport or industry where there is no emphasis on thinness or physical attractiveness, peer or social support structures where weight and appearance are not of concern).[8]

In addition to the health and medical costs associated with the provision of care and treatment of eating disorders, there are significant social and economic impacts. People with an eating disorder can find it challenging to maintain employment and experience also report a range of factors that contribute to a marked reduction in wellbeing, often sustained over the life-course. These factors include social exclusion; trauma from inappropriate treatment or care; financial, housing and food insecurity; and distress from a worsening eating disorder or co-occurring conditions.[9]

[7] National Eating Disorders Collaboration. *Risk and Protective Factors*. Retrieved from: https://nedc.com.au/eating-disorders/eating-disorders-explained/risk-and-protective-factors
[8] National Eating Disorders Collaboration. *Risk and Protective Factors*. Retrieved from: https://nedc.com.au/eating-disorders/eating-disorders-explained/risk-and-protective-factors
[9] Deloitte Access Economics, 2024. Paying the price, Second Edition: The economic and social impact of eating orders in Australia. Australia: Deloitte Access Economics

Eating Disorders Facts

- Approximately 1.1 million Australians were living with an eating disorder in 2023 – an increase of 21 per cent since 2012.[10]
- Many more people experience disordered eating (i.e., behaviours consistent with an eating disorder such as restrictive dieting, binge eating, vomiting, laxative use) that do not meet criteria for an eating disorder.[11]
- In 2022, approximately 114,000 Western Australians were impacted by an eating disorder.[12]
- In 2023, there were an estimated 1,273 deaths nationally due to an eating disorder.[13]
- Nearly one-third (31.6%) of Australian adolescents engage in disordered eating behaviours within any given year.[14]
- The average age of onset for eating disorders is between 12 and 25 years of age.[15,16]
- Women are twice as likely as men to experience an eating disorder.[17]
- Recent data suggest that the prevalence of binge eating disorder may be nearly as high in men as women[18], and that the percentage of men among people with eating disorders could be higher as their experiences may be overlooked or misdiagnosed.[19]
- There is limited research on the prevalence of eating disorders among Aboriginal and Torres Strait Islander peoples and gender non-binary and transgender people. However, emerging research suggests that Aboriginal and Torres Strait Islander peoples experience eating disorders and body image issues at a similar or higher rate than non-Aboriginal people[20], and that gender non-binary and transgender people have a two to four-times greater risk than their cisgender counterparts.[21,22,23,24]
- Less than one in three (30%) of those with eating disorders seek help.[25]

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[10] Deloitte Access Economics, 2024. *Paying the price, Second Edition: The economic and social impact of eating orders in Australia*. Australia: Deloitte Access Economics

[11] Hay P, Mitchison D, Collado AEL, González-Chica DA, Stocks N, Touyz S. Burden and health-related quality of life of eating disorders, including Avoidant/Restrictive Food Intake Disorder (ARFID), in the Australian population. J Eat Disord. 2017;5(1):1-10

[12] Based on population statistics from the Australian Bureau of Statistics (December 2022), National, state and territory population.

[13] Deloitte Access Economics, 2024. *Paying the price, Second Edition: The economic and social impact of eating orders in Australia*. Australia: Deloitte Access Economics

[14] Sparti C, Santomauro D, Cruwys T, Burgess P, Harris M. Disordered eating among Australian adolescents: prevalence, functioning, and help received. Int J Eat Disord. 2019;52(3):246-54

[15] Hart LM, Granillo MT, Jorm AF, Paxton SJ. Unmet need for treatment in the eating disorders: a systematic review of eating disorder specific treatment seeking among community cases. Clin Psychol Rev. 2011;31(5):727-35.

[16] Volpe U, Tortorella A, Manchia M, Monteleone AM, Albert U, Monteleone P. Eating disorders: What age at onset? Psychiatry Res. 2016;238:225-7

[17] Deloitte Access Economics, 2024. *Paying the price, Second Edition: The economic and social impact of eating orders in Australia*. Australia: Deloitte Access Economics

[18] Hay P, Girosi F, Mond J. Prevalence and sociodemographic correlates of DSM-5 eating disorders in the Australian population. J Eat Disord. 2015;3(1):1-7

[19] Strother E, Lemberg R, Stanford SC, Turberville D. Eating disorders in men: underdiagnosed, undertreated, and misunderstood. Eat Disord. 2012;20(5):346-55

[20] Burt A, Mitchison D, Dale E, Bussey K, Trompeter N, Lonergan A, et al. Prevalence, features and health impacts of eating disorders amongst First-Australian Yiramarang (adolescents) and in comparison with other Australian adolescents. J Eat Disord. 2020;8(1):1-10

[21] Gordon, A. R., Moore, L. B., & Guss, C. (2021). Eating disorders among transgender and gender non-binary people. In Eating Disorders in Boys and Men (pp. 265-281). Springer, Cham

[22] Diemer EW, Hughto JMW, Gordon AR, Guss CS, Austin B, Reisner SL. Beyond the Binary: Differences in Eating Disorder Prevalence by Gender Identity in a Transgender Sample. Transgender Health. 2018;3:1, 17-23

[23] Giordano S. Eating yourself away: Reflections on the 'comorbidity' of eating disorders and gender dysphoria. Clinical Ethics. 2017;12(1):45-53. doi:10.1177/1477750916661977

[24] Feder S, Isserlin L, Seale E, Hammond N, Norris ML. Exploring the association between eating disorders and gender dysphoria in youth. Eat Disord. 2017; JulSep;25(4):310-317. doi: 10.1080/10640266.2017.1297112

[25] Deloitte Access Economics, 2024. *Paying the price, Second Edition: The economic and social impact of eating orders in Australia*. Australia: Deloitte Access Economics

- The number of persons presenting at a Western Australian hospital with an eating disorder has increased by 85 per cent (from 329 hospitalisations in 2017-18 to 608 hospitalisations in 2022-23).[26]
- The national economic and social cost of eating disorders has grown to $66.9 billion in 2023 – a 36 per cent increase since 2012.[27]
- The total national health care cost in 2023 was estimated to be $251.4 million.[28]
- People with an eating disorder lose an additional 10 days of work per year. [29]
- The average caregiver to a person with an eating disorder provides 12.4 hours of care per week.[30]

[26] Mental Health Commission, unpublished. *Draft Western Australian Eating Disorders Framework 2025-2030 Discussion Paper*. Mental Health Commission, Government of Western Australia.
[27] Deloitte Access Economics, 2024. *Paying the price, Second Edition: The economic and social impact of eating orders in Australia*. Australia: Deloitte Access Economics
[28] Deloitte Access Economics, 2024. *Paying the price, Second Edition: The economic and social impact of eating orders in Australia*. Australia: Deloitte Access Economics
[29] Deloitte Access Economics, 2024. *Paying the price, Second Edition: The economic and social impact of eating orders in Australia*. Australia: Deloitte Access Economics
[30] Deloitte Access Economics, 2024. *Paying the price, Second Edition: The economic and social impact of eating orders in Australia*. Australia: Deloitte Access Economics

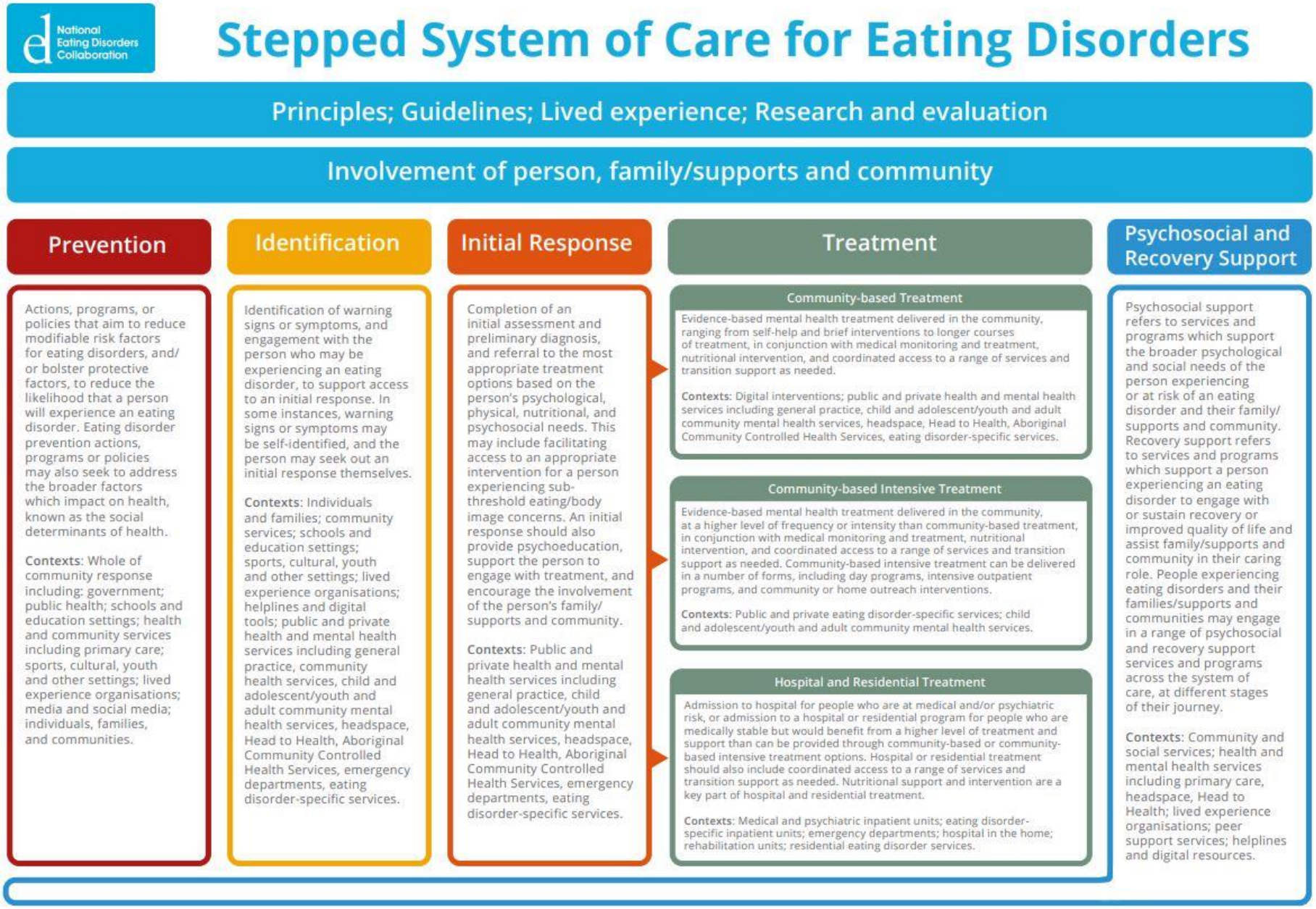
Stepped System of Care for Eating Disorders

The National Strategy, developed by the National Eating Disorders Collaboration for the Commonwealth Government, was released in August 2023. The National Strategy was developed following extensive consultation with stakeholders to build and embed a system of care that meets the needs of people experiencing or at risk of eating disorders, and their families and communities. The National Strategy includes a Stepped System of Care for Eating Disorders and provides an evidence-based foundation for the Western Australian Eating Disorders Framework 2025-2030. The 'stepped care' approach comprises a hierarchy of interventions and is a key concept within mental health policy and service provision.

> *"The Stepped System of Care refers to a full continuum of coordinated, effective, evidence-based services and supports, which are matched to a person's needs, and increase or decrease in intensity according to the person's changing psychological, physical, nutritional, and psychosocial needs. Progression along the continuum is not linear, and a person may require recurrent episodes of treatment and support, at different levels in the stepped system of care and from different service provider"* [31]

The Framework acknowledges the extensive work of the National Strategy. For a deeper understanding of the Stepped System of Care for Eating Disorders, including detailed definitions, please refer to page 34 of the National Strategy.

[31] National Eating Disorders Collaboration (NEDC) 2023. *National Eating Disorders Strategy 2023-2033*. NEDC


National Eating Disorders Collaboration
Stepped System of Care for Eating Disorders
Principles; Guidelines; Lived experience; Research and evaluation
Involvement of person, family/supports and community
Prevention
Actions, programs, or policies that aim to reduce modifiable risk factors for eating disorders, and/or bolster protective factors, to reduce the likelihood that a person will experience an eating disorder. Eating disorder prevention actions, programs or policies may also seek to address the broader factors which impact on health, known as the social determinants of health.
Contexts: Whole of community response including: government; public health; schools and education settings; health and community services including primary care; sports, cultural, youth and other settings; lived experience organisations; media and social media; individuals, families, and communities.
Identification
Identification of warning signs or symptoms, and engagement with the person who may be experiencing an eating disorder, to support access to an initial response. In some instances, warning signs or symptoms may be self-identified, and the person may seek out an initial response themselves.
Contexts: Individuals and families; community services; schools and education settings; sports, cultural, youth and other settings; lived experience organisations; helplines and digital tools; public and private health and mental health services including general practice, community health services, child and adolescent/youth and adult community mental health services, headspace, Head to Health, Aboriginal Community Controlled Health Services, emergency departments, eating disorder-specific services.
Initial Response
Completion of an initial assessment and preliminary diagnosis, and referral to the most appropriate treatment options based on the person's psychological, physical, nutritional, and psychosocial needs. This may include facilitating access to an appropriate intervention for a person experiencing sub-threshold eating/body image concerns. An initial response should also provide psychoeducation, support the person to engage with treatment, and encourage the involvement of the person's family/supports and community.
Contexts: Public and private health and mental health services including general practice, child and adolescent/youth and adult community mental health services, headspace, Head to Health, Aboriginal Community Controlled Health Services, emergency departments, eating disorder-specific services.
Treatment
Community-based Treatment
Evidence-based mental health treatment delivered in the community, ranging from self-help and brief interventions to longer courses of treatment, in conjunction with medical monitoring and treatment, nutritional intervention, and coordinated access to a range of services and transition support as needed.
Contexts: Digital interventions; public and private health and mental health services including general practice, child and adolescent/youth and adult community mental health services, headspace, Head to Health, Aboriginal Community Controlled Health Services, eating disorder-specific services.
Community-based Intensive Treatment
Evidence-based mental health treatment delivered in the community, at a higher level of frequency or intensity than community-based treatment, in conjunction with medical monitoring and treatment, nutritional intervention, and coordinated access to a range of services and transition support as needed. Community-based intensive treatment can be delivered in a number of forms, including day programs, intensive outpatient programs, and community or home outreach interventions.
Contexts: Public and private eating disorder-specific services; child and adolescent/youth and adult community mental health services.
Hospital and Residential Treatment
Admission to hospital for people who are at medical and/or psychiatric risk, or admission to a hospital or residential program for people who are medically stable but would benefit from a higher level of treatment and support than can be provided through community-based or community-based intensive treatment options. Hospital or residential treatment should also include coordinated access to a range of services and transition support as needed. Nutritional support and intervention are a key part of hospital and residential treatment.
Contexts: Medical and psychiatric inpatient units; eating disorder-specific inpatient units; emergency departments; hospital in the home; rehabilitation units; residential eating disorder services.
Psychosocial and Recovery Support
Psychosocial support refers to services and programs which support the broader psychological and social needs of the person experiencing or at risk of an eating disorder and their family/supports and community. Recovery support refers to services and programs which support a person experiencing an eating disorder to engage with or sustain recovery or improved quality of life and assist family/supports and community in their caring role. People experiencing eating disorders and their families/supports and communities may engage in a range of psychosocial and recovery support services and programs across the system of care, at different stages of their journey.
Contexts: Community and social services; health and mental health services including primary care, headspace, Head to Health; lived experience organisations; peer support services; helplines and digital resources.

Eating Disorder Programs and Services in Western Australia

In recent years, the State and Commonwealth Governments have significantly increased investment in eating disorders services in Western Australia. New statewide eating disorders programs and services, including the three Western Australian Eating Disorders Specialist Services (WAEDSS), the expansion of the Body Esteem Program and Cockburn Mental Health Clinic, are progressively being implemented and are making a significant and positive impact. Further gains are expected as these services become fully operational. A number of private services also provide high-quality care for people experiencing eating disorders and disordered eating in Western Australia.

However, program and service gaps remain across the stepped system of care, particularly for priority populations including children and young people, LGBTQIA+ people, neurodiverse people, Aboriginal and culturally and linguistically diverse people, and people living in regional areas.

Currently, the following eating disorders specific programs and services are available in Western Australia:

- Kara Maar (South Metropolitan Eating Disorder Specialist Service)
- North Metropolitan Eating Disorder Specialist Service
- East Metropolitan Eating Disorder Specialist Service
- Western Australian Eating Disorders Outreach and Consultation Service (WAEDOCS)
- Perth Children's Hospital Child and Adolescent Mental Health Service Eating Disorders Program
- Centre for Clinical Interventions
- Body Esteem Program (Luma)
- The Swan Centre
- Esus Centre
- Ramsay Clinic (Hollywood Hospital).

Additional non-specific programs and services are provided by:

- Community mental health programs, services and organisations
- GPs, dietitians and clinical psychologists
- Lived Experience (Peer) workers
- Western Australian Country Health Service (WACJS)
- Public and private hospitals.

Section 2: Draft Vision, Principles and Focus Areas

Framework: Draft Vision and Guiding Principles

Key issues and themes were identified through stakeholder engagement, review of previous consultations and mapping of existing services in Western Australia. This has informed the draft Vision, Guiding Principles, Focus Areas and Strategic Priorities of the Framework. The draft Guiding Principles and Strategic Priorities have largely been drawn from the National Strategy and modified to reflect the Western Australian context. They also align with the principles of the Western Australian Eating Disorders Specialist Services Model of Service and the Infant, Child and Adolescent Taskforce: Eating Disorders Model of Care.

Vision

The Vision will identify what the Framework hopes to accomplish over the long term. It should define where we want to be in the future. The draft Vision is:

All Western Australians experience optimal mental health and wellbeing to reduce the impact of eating disorders in our community.

Goal

The Goal will define what the Framework aims to achieve. The draft Goal is:

To prevent and reduce the prevalence and impact of eating disorders for individuals, families and communities in Western Australia.

Purpose

The Purpose describes the 'why' of the Framework. The draft Purpose is:

To provide a framework to guide a coordinated approach to address eating disorders in Western Australia from 2025 to 2030, that supports a comprehensive, equitable, and culturally responsive system of care.

Guiding Principles

The Guiding Principles will underpin the Focus Areas and Strategic Priorities of the Framework. The draft Guiding Principles are:

- Person and family-centred care, which recognises the unique and differing needs of individuals
- Recovery-oriented care, recognising that there is no single or consensus definition of recovery
- Lived experience guidance and leadership
- Evidence-based and evidence-generating approaches
- Timely and flexible treatment and support pathways
- Equity of access including for priority groups and within regional and remote areas
- Trauma-informed care that acknowledges co-occurring conditions
- Culturally safe, sensitive, and competent practice.

Focus Areas

The Focus Areas identify the key areas for action and change. The draft Focus Areas are:

1. Strengthen **prevention and early intervention** programs and services in the community, particularly in **regional areas**.
2. Improve access to **system navigation** and **transition support** between programs and services, as well as **psychosocial support** across the care continuum.
3. Increase **education, training and system navigation** support to health and mental health **professionals** and **Lived Experience (Peer) workers** in community and health services.
4. Improve equitable access to **trauma-informed, specialised** bed-based care within **hospitals** and the **community** that addresses the complexities of **co-occurring conditions**.
5. Build an **evidence-base for eating disorders** programs and services, with a focus on **research, data and evidence-generation** across the care continuum, particularly for priority populations.

Questions

Vision, Goal, Purpose

(a) Do you have any feedback on the draft Vision, Goal or Purpose?

Guiding Principles

(a) Do the draft Guiding Principles adequately outline the key principles to guide the Framework and the system of care for eating disorders?
(b) Is there anything you would add or change?
(c) Are there any additional issues that need to be considered regarding the Guiding Principles?

Your views on the five Focus Areas will be sought at the end of the document, in the Overview section

Focus Areas

Focus Area 1: Strengthen prevention and early intervention programs and services in the community, particularly in regional areas

Key issues

Investment in health promotion and prevention programs and services will assist to keep people well by raising awareness and increasing knowledge of eating disorders This is especially important for people who live in regional and remote areas where services are traditionally harder to access. An increase in prevention and early intervention will help to reduce the demand on emergency departments, hospitals and specialist services into the future.

The following key issues have been identified:

- In recent years, there is an emerging evidence-base of initiatives that provide opportunities to enhance health promotion and prevention and guide investment.
- There are growing concerns in the community regarding the impact of social media on body image, with research demonstrating an association between social media use and increased body dissatisfaction and disordered eating[32]. Improving media literacy, particularly among young people, can have a positive impact on body image.
- Promotion and prevention initiatives with a focus on building resilience, awareness of the impacts of media and education to support a more positive body image experience can occur in any setting, however may be targeted to those most at-risk, particularly in school and community contexts.
- A lack of information and education on eating disorders and their seriousness can result in high levels of stigma. Efforts to reduce stigma is required to encourage help seeking support.
- Misconceptions persist around who experiences eating disorders and how they present, and often fail to acknowledge the breadth of eating disorders and disordered eating. Historically, there has been a focus on acute presentations of anorexia nervosa, however eating disorders and disordered eating exist on a spectrum and can present in different ways. Fostering a greater community awareness and challenging misconceptions around eating disorders will help to create environments where people can seek help and access the support they need.
- Providing people including individuals, families and communities with easy-to-access information and location-based navigation support, will mean that people receive the care and support they require, at an earlier stage of their condition.
- Early identification and timely access to appropriate treatment can significantly improve health outcomes. Addressing barriers to access and increasing the availability of community support programs, psychosocial and recovery support, and peer support services, with a focus on regional and remote areas can better support people when they first become unwell in the community or step down from more intensive treatments to community-based services. Early identification and early intervention may also occur in school settings, mental health and health settings and community-based services.

[32] Holland G, Tiggemann M. A systematic review of the impact of the use of social networking sites on body image and disordered eating outcomes. Body Image. 2016 Jun;17:100-10. doi: 10.1016/j.bodyim.2016.02.008

Draft strategic priorities

Aligned to Focus Area 1 and the key issues, the following draft strategic priorities have been identified:

1.1 Ensure public policy and initiatives related to education, health promotion, food and nutrition, physical activity, weight management/dietary control, advertising and media do not inadvertently contribute to eating disorder risk.
1.2 Deliver a comprehensive range of evidence-based health promotion initiatives to create supportive environments and reduce stigma, enhance protective factors and reduce risk factors.
1.3 Strengthen awareness in the Western Australian community of eating disorders, including common signs and symptoms and the importance of early intervention.
1.4 Facilitate access to innovative, evidence-based programs to support individuals prior to receiving treatment.
1.5 Ensure access to person-centred timely treatment in the community, at the level of intensity people require, as close to home as possible (including digital options and virtual care pathways).
1.6 Strengthen access to early intervention and community-based intensive treatment options, including psychosocial supports, for those in regional and remote areas.

What this might look like

Actions aligned to Focus Area 1 strategic priorities may include:

- Developing eating disorder communication guidelines to support best practice in public health campaign messaging and broader health communications.
- Delivering evidence-based media literacy, social media and body kindness-based programs within schools, or community organisations.
- Delivering evidence-based eating disorder literacy training for people who engage with children and young adults.
- Developing identification kits or resource packages and make available in relevant community settings.
- Developing and implementing innovative digital programs to support people in the interim prior to receiving treatment.
- Strengthening Lived Experience (Peer) and psychosocial support programs for people, their families and/or significant others in community mental health services.
- Designing and implementing rapid, early intervention programs in community mental health services.
- Developing place-based, community-led approaches to prevention, screening, and early intervention in regional areas.
- Strengthening regional access to community-based intensive treatment options, delivered close to home or virtually.

Questions

Focus Area 1: Strengthen prevention and early intervention programs and services in the community, particularly in regional areas

a) Do the key issues identified reflect those relating to prevention and early intervention, particularly in regional areas?
b) Do the draft strategic priorities address the key issues relating to this Focus Area?
c) Do the examples of 'What this might look like' adequately reflect key actions to demonstrate how the priorities could be implemented in practice?
d) Is there anything you would add or change?
e) What do you think are the highest priorities in Focus Area 1?

Focus Area 2: Improve access to system navigation and transition support between programs and services, as well as psychosocial support across the care continuum

Key issues

The provision of coordinated, accessible and tailored information, guidance, and navigation support to individuals, their families and/or significant others can assist them to locate the information, advice, treatment, care and support they require in a timely manner. Additionally, the provision of transition support is important for moving from one hospital to another; transitioning from metropolitan to regional services; stepping up or down to more or less intensive treatment options; and moving between public and private services. The provision of psychosocial support for individuals and carers, including peer support workers across the continuum, can assist people to remain well in the community.

The following key issues have been identified:

- For people experiencing eating disorders and those who care for them, finding the right information and navigating the system of care can be challenging. In the absence of timely and accessible information and support, people can delay seeking help, which may result in requiring more intensive care at a later stage.
- A continued focus on transitional support for 16–17-year-olds as they move from child to adult services, particularly in regional and remote areas, is a high priority. High-quality transition care and support with developmentally appropriate interventions has the potential to improve a young person's outcomes.[33]
- Providing support when and where it is required can positively impact a person's experience with the system and their overall health outcomes, enabling them to become well sooner.
- As part of a multidisciplinary team, Lived Experience (Peer) support workers play a significant role in the provision of support in the community. People experiencing eating disorders, their families and/or significant others may also seek to engage in a range of psychosocial and recovery support services and programs across the system of care, at different stages of their journey.
- The National Disability Insurance Scheme (NDIS) is an important component of the system of care, however publicly available data suggests only a small number of people living with eating disorders have NDIS access. While the interface between eating disorders and psychosocial disability remains challenging, there is an opportunity to better support people with longstanding eating disorders and co-occurring conditions through the NDIS.[34]

[33] Livanou M, Heneghan A, Bouliou E, Hill G, Mills K, Naylor Roll S, Smalley Z, The J, Treasure J. Co-producing an inclusive-care model for young people transitioning from adolescent eating disorder services to adult care: A qualitative study protocol for Transition for Eating Disorder Youth intervention. Eur Eat Disorders Rev. 2023;1–12

[34] National Eating Disorders Collaboration (NEDC) 2023. *Summary paper: NDIS engagement for people with eating disorders*. NEDC

Draft strategic priorities

Aligned to Focus Area 2 and the key issues, the following draft strategic priorities have been identified:

2.1 Promote person-centred care that is inclusive of families/significant others.
2.2 Support people experiencing or at risk of eating disorders and their families/significant others to easily locate and navigate services in a timely manner.
2.3 Support continuity of care for people experiencing or at risk of eating disorders and their families/significant others to transition between services and levels of treatment, through clear communication and tailored care navigation.
2.4 Support people transitioning between hospital services and community-based services.
2.5 Facilitate opportunities for people and their families/significant others to access timely and responsive individual advocacy, to provide a voice to those impacted by eating disorders.
2.6 Ensure there is continuity of care and transition support for 16–17-year-olds as they transition from child to adult services.
2.7 Strengthen and facilitate access to psychosocial, Lived Experience (Peer) support groups, recovery support services and programs and the NDIS for people experiencing eating disorders and their families/significant others.

What this might look like

Actions aligned to Focus Area 2 strategic priorities may include:

- Creating a centralised hub of state-specific information, resources and system navigation guidance, and individual and systemic advocacy.
- Developing a system navigation resource for GPs and other health professionals to support people, their families and/or significant others find the help they need.
- Eating disorder-specific public inpatient and outpatient settings providing accessible information on treatment options, criteria for admission and admission pathways.
- Providing accessible information on available support services and programs through health and mental health services.
- Providing more step-down support for people returning to regional areas following a hospital admission.
- Transition coordinators supporting all patients moving between programs and services, with a particular focus on people with co-occurring conditions and those in regional areas.
- Undertaking cross sector consultation to identify opportunities and develop solutions to strengthen care for 16–17-year-olds transitioning from child to adult services.
- Expanding Lived Experience (Peer) support programs in the community (including online programs and programs for young people).

Questions

Focus Area 2: Improve access to system navigation and transition support between programs and services, as well as psychosocial support across the care continuum

a) Do the key issues identified reflect those relating to system navigation, transition support and psychosocial support?
b) Do the draft strategic priorities address the key issues relating to this Focus Area?
c) Do the examples of 'What this might look like' adequately reflect key actions to demonstrate how the priorities could be implemented in practice?
d) Is there anything you would add or change?
e) What do you think are the highest priorities in Focus Area 2?

Focus Area 3: Increase education, training and system navigation support to health and mental health professionals and Lived Experience (Peer) workers in community and health services

Key issues

Increasing education, training and system navigation support to health and mental health professionals will mean that when a person seeks help, professionals will be better equipped to provide the individual with the support they need.

The following key issues have been identified:

- In Western Australia, there are high quality, evidence-based programs and services being delivered across government, non-government, community and the private sector. However, for some health and mental health professionals who do not specialise in eating disorders, the system can appear fragmented and challenging to navigate. Integrating services, improving communication, and establishing flexible pathways and individualised treatment options can better equip professionals to meet the needs of people experiencing eating disorders and those who support them.
- There has been a view that eating disorders are a 'specialist' clinical area which has led to a lack of understanding and confidence in the health and general mental health workforce to assess and treat eating disorders. Educating, upskilling, and providing opportunities for supervision will empower the broader health and mental health workforce to better support people with eating disorders.
- The coordination and delivery of education and training, and the provision of opportunities for clinical supervision can build capacity of the health and general mental health workforce in identifying and treating eating disorders in the community. Building skills, knowledge and confidence can enable this workforce to better support the people they care for. Education and training that broadens the focus beyond acute presentations of anorexia nervosa and challenges common misconceptions and stigma can create safer environments and enable people to access the care and support they require.

Draft strategic priorities

Aligned to Focus Area 3 and the key issues, the following draft strategic priorities have been identified:

3.1 Provide education, training and support to health and mental health professionals to deliver best practice care, including those working in Primary Care.
3.2 Provide coordinated, evidence-based and consistent approaches to the dissemination of information, provision of professional development and consultation liaison to support health and mental health professionals in early identification and intervention.
3.3 Ensure programs and services across the continuum of care are inclusive of the full range of eating disorder presentations.
3.4 Strengthen clinical coordination and improve communication between health and mental health professionals, within the multidisciplinary team, and between services.
3.5 Embed eating disorders as a workforce priority in mainstream health and mental health services.
3.6 Build capacity of the health and mental health sector to ensure the provision of best practice care.
3.7 Build capacity of a skilled and diverse Lived Experience (Peer) workforce to operate across the system of care.

What this might look like

Actions aligned to Focus Area 3 strategic priorities may include:

- Delivering eating disorders education, training and supervision for health and mental health professionals to facilitate:
  - greater understanding by emergency department and general hospital staff of co-occurring conditions, and the provision of trauma-informed care in the context of eating disorders;
  - increased knowledge, skills and confidence for GPs to support assessment, early intervention and system navigation;
  - increased awareness of the breadth of eating disorder presentations;
  - high-quality, ongoing clinical supervision for GPs, nurses, dietitians and Lived Experience (Peer) workers, enhancing capacity for reflective practice and continuous improvement.
- Developing and disseminating communication tools to better support interactions within the multidisciplinary team, and between services (for example, structured referral and transition letters, care plans and discharge summaries).
- Expanding clinical consultation liaison services to meet the needs of health and mental health professionals.
- Facilitating eating disorder sector engagement with the broader health and mental health sectors to strengthen training and professional development opportunities (including in trauma-informed care, culturally safe practice, transdiagnostic approaches and co-occurring conditions).
- Developing statewide eating disorder Lived Experience (Peer) workforce infrastructure to assist organisations to grow their workforce to provide timely access to support in the community.

Questions

Focus Area 3: Increase education, training and system navigation support to health and mental health professionals and Lived Experience (Peer) workers in community and health services

(a) Do the key issues identified reflect those relating to education, training and system navigation support for health professionals?
(b) Do the draft strategic priorities address the key issues relating to this Focus Area?
(c) Do the examples of 'What this might look like' adequately reflect key actions to demonstrate how the priorities could be implemented in practice?
(d) Is there anything you would add or change?
(e) What do you think are the highest priorities in Focus Area 3?

Focus Area 4: Improve equitable access to trauma-informed, specialised bed-based care within hospitals and the community that addresses the complexities of co-occurring conditions

Key issues

Each person who requires more intensive levels of treatment and support for their eating disorder, has differing needs and past experiences. An experience of trauma, co-occurring conditions including neurodiversity and other mental health conditions can impact how a person responds to treatment.

The following key issues have been identified:

- Providing dedicated multidisciplinary teams within hospital settings can ensure care is person-centred, trauma-informed and addresses the co-occurring conditions and complex needs that may be present with an eating disorder diagnosis. Utilising a specialised team to oversee all aspects of a patient's medical and psychiatric needs would allow for a more effective and holistic approach to the treatment of eating disorders in hospitals.
- Patient care coordinators, who can support emergency departments to provide rapid and thorough assessments, offer a point of contact for individuals throughout their hospital admission, and assist them in the transition to community-based services, are a key component of the multidisciplinary team.
- Creating safe, non-threatening clinical spaces within hospitals that minimise any impact on distress and do not contribute to the risk of trauma is crucial to the individual's engagement with treatment in the hospital setting and their overall recovery.
- For those who are medically stable but still require treatment, care is provided in the community through intensive day programs, specialist services or residential treatment. Residential services can provide a level of care to those who require additional support or respite, or when day programs do not meet their needs. There are currently no residential facilities in Western Australia. However, some Western Australians who experience eating disorders are utilising interstate services to access this level of treatment.
- Embedding a regional focus into existing services and programs to provide access for people living in regional and remote areas is crucial in achieving equitable access to services and programs across Western Australia.

Draft strategic priorities

Aligned to Focus Area 4 and the key issues, the following draft strategic priorities have been identified:

4.1 Explore options for the provision of community-based residential rehabilitation care within the system of care that support individuals and their families/significant others.
4.2 Identify service gaps for trauma-informed, specialised bed-based care for people across age groups and provide greater access to beds.
4.3 Embed eating disorders as core business within mental health services and hospitals, including Emergency Departments.
4.4 Ensure the system of care allows for equitable access, regardless of geographical location, gender, or age.

What this might look like

Actions aligned to Focus Area 4 strategic priorities may include:

- Undertaking needs assessments to determine the need and scope of a community based residential rehabilitation program.
- Supporting dedicated multidisciplinary teams including patient care coordinators trained in the care of patients experiencing eating disorders.
- Providing dedicated specialised eating disorder inpatient beds for adults (people aged 16 years and older).
- Strengthening the capacity of public hospitals to provide seamless medical and psychiatric inpatient care for people experiencing eating disorders or assisting them to establish and document pathways for timely assessment and supported referral.

Questions

Focus Area 4: Improve equitable access to trauma-informed specialised bed-based care within hospitals and the community that addresses the complexities of co-occurring conditions

a) Do the key issues identified reflect those relating to trauma-informed specialised bed-based care within hospitals and the community, and the complexities associated with co-occurring conditions?
b) Do the draft strategic priorities address the key issues relating to this Focus Area?
c) Do the examples of 'What this might look like' adequately reflect key actions to demonstrate how the priorities could be implemented in practice?
d) Is there anything you would add or change?
e) What do you think are the highest priorities in Focus Area 4?

Focus Area 5: Build an evidence-base for eating disorders programs and services, with a focus on research, data and evidence generation across the care continuum, particularly for priority populations

Key issues

It is critical that the development of any system-wide improvements is underpinned by a robust and sustainable data source and research base. Ensuring a commitment to data and evidence-generating approaches, particularly where information or initiatives are lacking, will help to map services and prioritise the development of initiatives of the greatest need. This is particularly the case for specific population groups, including Aboriginal people and LGBTQIA+ people.

The following key issues have been identified:

- Research is required to better understand the prevalence of eating disorders among Aboriginal people,[35] as is the development of culturally appropriate programs, screening tools, interventions and treatment models for Aboriginal people. Emerging research suggests that Aboriginal people experience eating disorders and body image issues at a similar or higher rate than non-Indigenous people,[36] however a collaborative and place-based approach is required to further understand eating disorders within the Aboriginal community and co-develop place-based solutions to the issues of greatest need.
- There is limited research into other priority population groups, including people from culturally and linguistically diverse backgrounds, neurodivergent people, LGBTQIA+ people, people in larger bodies, people with co-occurring conditions, and people with longstanding eating disorders. A better understanding of the needs of these groups can help inform the development of inclusive and tailored interventions and ensure provision of care which recognises the complex and differing needs of individuals.
- Whilst in more recent years there has been an emerging evidence-base of initiatives investment in research will help to identify further opportunities to enhance health promotion and prevention and guide investment.

[35] Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. Reference to Aboriginal people throughout this document is respectfully inclusive of Torres Strait Islanders.
[36] National Eating Disorders Collaboration (NEDC) 2023. *National Eating Disorders Strategy 2023-2033*. NEDC

Draft strategic priorities

Aligned to Focus Area 5 and the key issues, the following draft strategic priorities have been identified:

5.1 Build an evidence base for health promotion initiatives to maximise impact in preventing eating disorders.
5.2 Support mental health services to proactively identify people who may be experiencing or be at risk of eating disorders through the development of co-designed screening tools for priority population groups including those who are neurodiverse, LGBTQIA+ people, Aboriginal people, and those from culturally and linguistically diverse backgrounds.
5.3 Promote and generate data and research to build the evidence-base around eating disorders in Western Australia.
5.4 Actively monitor eating disorder activity in Western Australia.
5.5 Undertake research to better understand the needs for specific age groups and for priority population groups, across the care continuum.

What this might look like

Actions aligned to Focus Area 5 strategic priorities may include:

- Developing culturally appropriate and co-designed screening tools for Aboriginal people.
- Developing co-designed screening tools for those who are neurodiverse, LGBTQIA+ people, and those from culturally and linguistically diverse backgrounds.
- Utilising data and undertake needs assessments and modelling to inform workforce planning.
- Undertaking research on the incidence and prevalence of various types of eating disorders among Aboriginal people.
- Developing eating disorders programs and services which are place-based, culturally secure and aligned to a Social and Emotional Wellbeing (SEWB) approach.

Questions

Focus Area 5: Build an evidence-base for eating disorders program and services, with a focus on research, data and evidence generation across the care continuum, particularly for priority populations

a) Do the key issues identified reflect those relating to eating disorders research, data and evidence generation, particularly for priority populations?
b) Do the draft strategic priorities address the key issues relating to this Focus Area?
c) Do the examples of 'What this might look like' reflect key actions to demonstrate how the priorities could be implemented in practice?
d) Is there anything you would add or change?
e) What do you think are the highest priorities in Focus Area 5?

Other issues

The Focus Areas, strategic priorities and action areas outlined above, have been developed based on a review of consultations, mapping of services and engagement with an advisory group and key stakeholders. They aim to outline priority areas for change.

Questions

Other Issues

Taking into account the Five Focus Areas and associated strategic priorities outlined above:

a) Do the five Focus Areas adequately outline the overall themes and priorities to guide the Framework and a statewide coordinated approach to eating disorders?
b) Are there any additional issues that have been missed in the Focus Areas and the strategic priorities?
c) Is there anything you would add or change?
d) In your view, which Focus Area is the highest priority?
e) Do you have any further comments, queries, or feedback with regards to the draft strategic priorities and Focus Areas outlined above?

Section 3: Next Steps

Monitoring and Evaluation

Monitoring and evaluation is essential to support the successful implementation of the Framework. A monitoring and evaluation plan is currently in development and will be referenced in the final Framework. The monitoring and evaluation plan will complement the evaluation tool developed by the National Eating Disorders Collaboration to support the implementation of the National Strategy and will align with the Western Australian Mental Health, Alcohol and Other Drugs Strategy 2025-2030 and the Outcomes Measurement Framework currently under development.

The monitoring and evaluation plan will act as a guide to monitor the implementation of the Framework and evaluate its impact on the wellbeing of people living with an eating disorder, their families and/or significant others across a range of domains.

Next Steps

The Mental Health Commission will collate feedback on the Consultation Draft Priorities Paper to finalise the development of the Western Australian Eating Disorders Framework 2025-2030 for the consideration of the Minister for Mental Health.

Appendix

Mapping WA Service Streams and National Stepped System of Care

The Western Australian Mental Health, Alcohol and Other Drugs Strategy 2025-2030 (in development) (WA Strategy) draft Service Streams outline a system-wide approach to the development of strategic priorities. The draft WA Service Streams have been developed based on extensive research, evidence and engagement. The National Strategy identifies 'stepped care' as the most appropriate approach to eating disorder treatment. Stepped care refers to a full continuum of coordinated, effective, evidence-based services and supports, which are matched to a person's needs, and increase or decrease in intensity according to the person's changing psychological, physical, nutritional, and psychosocial needs. Detailed descriptions of the components of the National Stepped System of Care can be found in the National Strategy.

The Framework will align with the WA Strategy Service Streams and the National Stepped System of Care. **Figure 1** maps the draft WA Strategy Service Streams to the National Stepped System of Care. **Figure 2** maps the Western Australian Eating Disorders Framework 2025-2030 draft Focus Areas to the WA Strategy Service Streams and the National Stepped System of Care.

Figure 1 – Mapping Draft WA Service Streams and National Stepped System of Care for Eating Disorders

Draft WA Service Streams	Prevention and Promotion	Community Support	Community Treatment	Community Bed-Based	Hospital	System-wide Initiatives
National Stepped System of Care	Prevention	Identification	Treatment - Community-based	Treatment - Residential	Treatment - Hospital	Workforce
		Initial Response	Treatment - Community-based intensive			Principles; Guidelines; Lived experience; Research and evaluation
		Psychosocial and Recovery Support*				Involvement of person, family/significant other and community

* For the purposes of strategic planning and reporting, 'Psychosocial and Recovery Support' sits under the 'Community Support' service stream. However, it is important to note that a range of support programs and services are provided at every stage of the care continuum.

Figure 2 – Mapping Western Australian Eating Disorders Framework draft Focus Areas

Draft Focus Area	Draft Strategic Priorities	WA Strategy Service Stream	National Stepped System of Care
1. Strengthen prevention and early intervention programs and services in the community, particularly in regional areas	1.1 Ensure public policy and initiatives related to education, health promotion, food and nutrition, physical activity, weight management/dietary control, advertising and media do not inadvertently contribute to eating disorder risk. 1.2 Deliver a comprehensive range of evidence-based health promotion initiatives to create supportive environments and reduce stigma, enhance protective factors and reduce risk factors. 1.3 Strengthen awareness in the Western Australian community of eating disorders, including common signs and symptoms and the importance of early intervention. 1.4 Facilitate access to innovative, evidence-based programs to support individuals prior to receiving treatment. 1.5 Ensure access to person-centred timely treatment in the community, at the level of intensity people require, as close to home as possible (including digital options and virtual care pathways). 1.6 Strengthening access to early intervention and community-based intensive treatment options, including psychosocial supports, for those in regional and remote areas.	Prevention and Promotion Community Support Community Treatment	Prevention Identification Initial response Treatment – Community-based Treatment – Community-based Intensive Psychosocial recovery and support
2. Improve access to system navigation and transition support between programs and services, as well as psychosocial support across the care continuum	2.1 Promote person-centred care that is inclusive of families/significant others. 2.2 Support people experiencing or at risk of eating disorders and their families/significant others to easily locate and navigate services in a timely manner. 2.3 Support continuity of care for people experiencing or at risk of eating disorders and their families/significant others to transition between services and levels of treatment, through clear communication and tailored care navigation. 2.4 Support people transitioning between hospital services and community-based services.	Community Support System-wide Initiatives	Psychosocial recovery and support Involvement of person, family/significant other and community

	2.5	Facilitate opportunities for people and their families/significant others to access timely and responsive individual advocacy, to provide a voice to those impacted by eating disorders.		
	2.6	Ensure there is continuity of care and transition support for 16–17-year-olds as they transition from child to adult services.		
	2.7	Strengthen and facilitate access to psychosocial, Lived Experience (Peer) support groups, recovery support services and programs and the National Disability Insurance Scheme for people experiencing eating disorders and their families/significant others.		
3. Increase education, training and system navigation support to health and mental health professionals and Lived Experience (Peer) workers in community and health services	3.1	Provide education, training and support to health and mental health professionals to deliver best practice care, including those working in Primary Care.	System-wide Initiatives	Workforce Research and evaluation
	3.2	Provide coordinated, evidence-based and consistent approaches to the dissemination of information, provision of professional development and consultation liaison to support health and mental health professionals in early identification and intervention.		
	3.3	Ensure programs and services across the continuum of care are inclusive of the full range of eating disorder presentations.		
	3.4	Strengthen clinical coordination and improve communication between health and mental health professionals, within the multidisciplinary team, and between services.		
	3.5	Embed eating disorders as a workforce priority in mainstream health and mental health services.		
	3.6	Build capacity of the health and mental health sector to ensure the provision of best practice care.		
	3.7	Build capacity of a skilled and diverse Lived Experience (Peer) workforce to operate across the system of care.		
4. Improve equitable access to trauma-informed specialised bed-based care within hospitals and the community that addresses the	4.1	Explore options for the provision of community-based residential rehabilitation care within the system of care that support individuals and their families/significant others.	Community Bed-based	Treatment – Residential
	4.2	Identify service gaps for trauma-informed, specialised bed-based care for people across age groups and provide greater access to beds.	Hospital	Treatment – Hospital
	4.3	Embed eating disorders as core business within mental health services and hospitals, including Emergency Departments.	System-wide Initiatives	Workforce

	complexities of co-occurring conditions	4.4	Ensure the system of care allows for equitable access, regardless of geographical location, gender, or age.		
5.	Build an evidence base for eating disorders programs and services, with a focus on research, data and evidence generation across the care continuum, particularly for priority populations	5.1 5.2 5.3 5.4 5.5	Build the evidence base for health promotion initiatives to maximise impact in preventing eating disorders. Support mental health services to proactively identify people who may be experiencing or be at risk of eating disorders through the development of co-designed screening tools for priority population groups including those who are neurodiverse, LGBTQIA+ people, Aboriginal people, and those from culturally and linguistically diverse backgrounds. Promote and generate data and research to build the evidence-base around eating disorders in Western Australia. Actively monitor eating disorder activity in Western Australia. Undertake research to better understand the needs for specific age groups and for priority population groups, across the care continuum.	Prevention and Promotion Community Support System-wide Initiatives	Prevention Identification Initial response Research and evaluation

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