Government of **Western Australia**
North Metropolitan Health Service
Mental Health

Eating Disorders: What might stepped care look like?

Anthea Fursland

AHHA Mental Health Network Meeting
June 28, 2017

Background – eating disorders

- Are **serious complex mental illnesses** with a **high rate of psychiatric and medical comorbidity**.
- Are associated with **intense psychological distress, fear and self-hatred** (Butterfly Foundation, 2016)
- Have **one of the highest impacts on health related quality of life of all psychiatric disorders** (AIHW, 2008)
- Carry the **highest mortality rate (10-20%), from suicide or physical illness** (Arcelus, et al., 2011)
- Represent the **12th leading cause of mental health hospitalisation costs** within Australia

(Deloitte Economics, 2012)

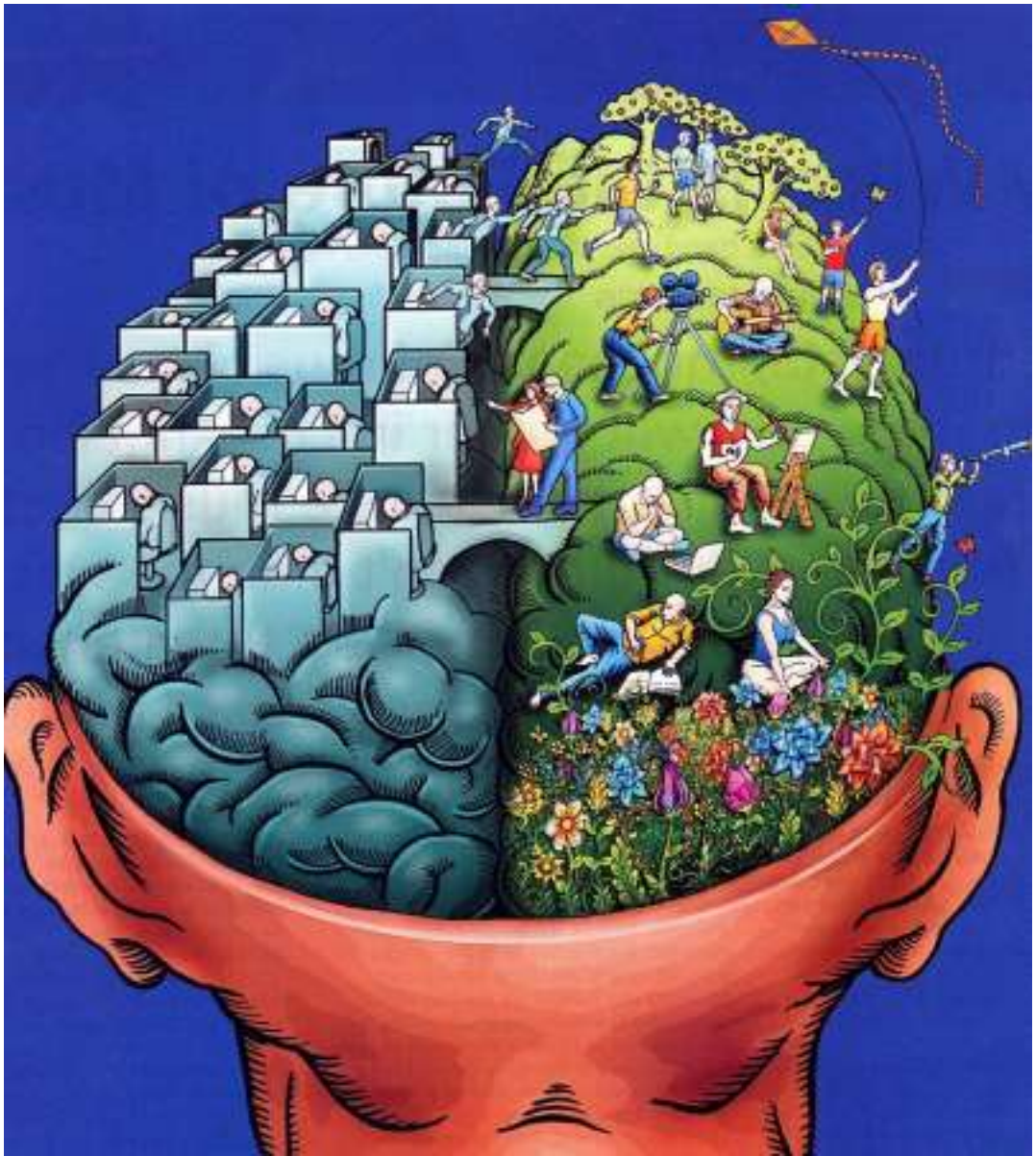
- Approximately **1 in 20 Australians currently has an eating disorder** (Hay, Mond, Buttner, & Darby, 2008)
- Eating disorders are not self-limiting illnesses. **Treatment is required to reduce the severity, duration and impact** of illness (AED, 2011)
- Person-centred and evidence based care, delivered **early in illness** by health professionals with appropriate knowledge and skill in eating disorders, can lead to full clinical recovery and improved quality of life for most people (Hay *et al*., 2014)
- Despite this it is estimated that only **one in ten people with eating disorders receive appropriate treatment** and even fewer receive early intervention. (Noordenbos, 2002)

Starvation Syndrome - Keys Study

Physical: Weight loss 24%, heart volume deceased 20%, pulse slowed 33%, base metabolism rate down 40%, strength down 30%, body temp down, feeling cold, weak and tired, dizzy, bloating

Personality: Apathy, depression, tiredness, irritability, moodiness; poor concentration; narrowing of interests; loss of sexual interest; reduced spontaneity; poor decision-making

Starvation Syndrome - Keys Study



Social activities: Deterioration in group spirit; reluctance to make group decisions or plan activities; social interaction became stilted; loss of interest in education/career activities; loss of libido

Food preoccupation: Preoccupation with food talk; collection of recipes; food planning; dawdling over meals; increase in gum chewing, smoking, nail-biting

Background – stepped care

- From 2016, stepped care approaches have provided the basis for Primary Health Network (PHN) planning and commissioning of mental health services in regional areas (Australian Government, 2016)
- It is defined by the Australian Government as:

  "*an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. While there are multiple levels within a stepped care approach, they do not operate in silos or as one directional steps, but rather offer a spectrum of service interventions*" (Australian Government, 2016)

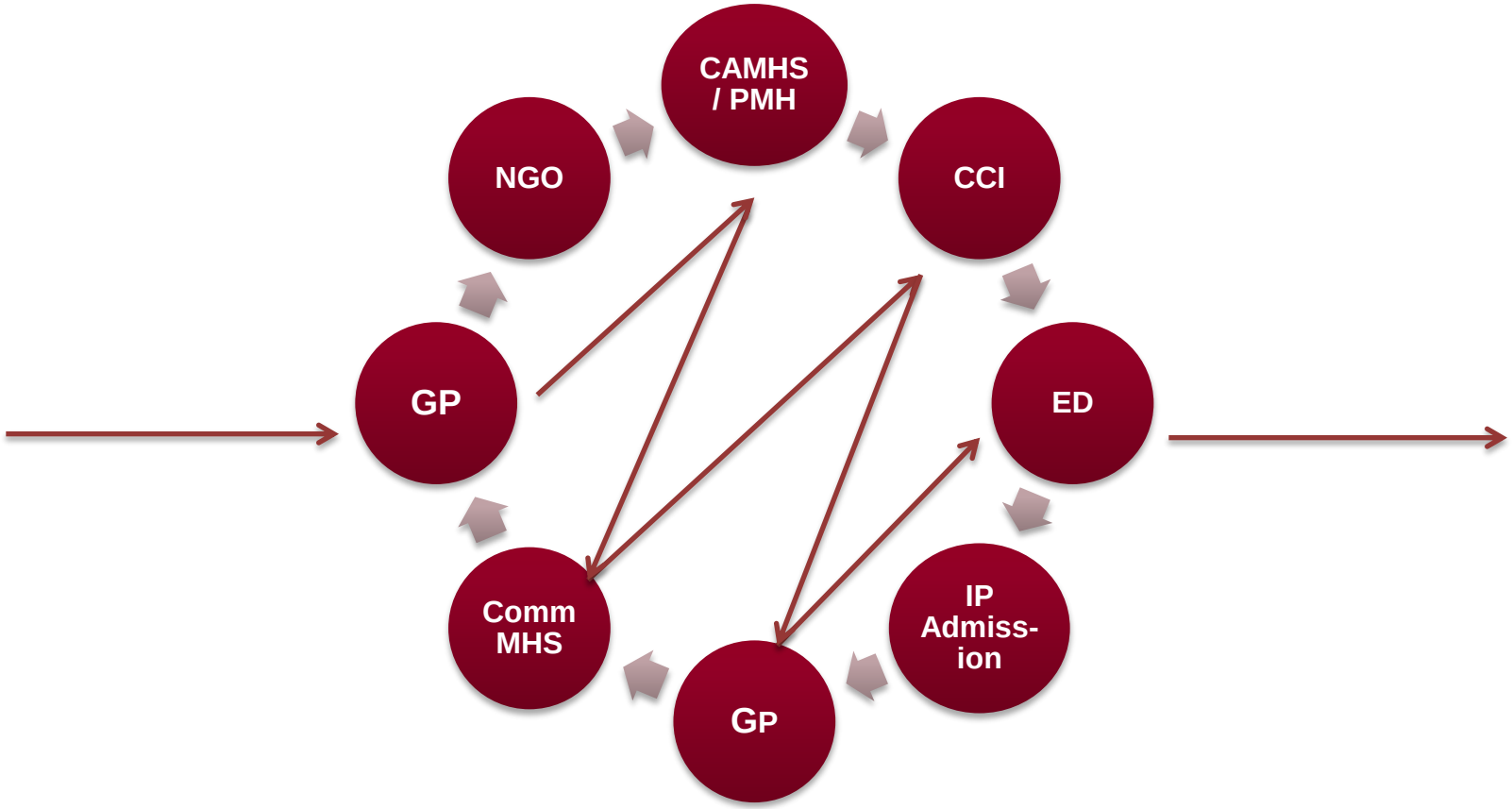
- **Decisions about stepped care approaches must be informed by the evidence and the potentially high risks associated with treatment failure at lower levels of intensity**.
- Stepped care starting at the lowest level of intensity (e.g., guided self-help) may be suitable for a person with mild bulimia nervosa or binge eating disorder. It would not be appropriate for a person diagnosed with anorexia nervosa as the medical consequences of treatment failure may be life threatening. (Wilson, Fairburn, Agras et al, 2000)

Background – WA

For people over the age of 16:

- There is only one public specialist service: the Centre for Clinical Interventions, a psychological outpatient service.
- There is no comprehensive specialist public eating disorders service – no beds/ multidisciplinary outpatients / day program or outreach service.
- With peak onset age 15-24 and average duration 7 years, around 85 % of patients with an ED are over age 16.

Lack of consistent pathways to care: a particular problem for patients ambivalent about seeking care due to the effects of their illness and impaired perceptions re: their health



Inconsistent approaches and limited access to suitable care options creates frustration and lack of trust for all.

Crisis of Confidence blocks efficient care: Lack of access to reliable specialist medical care/support discourages GPs and MH services from managing ANY patients with eating disorders, reducing outflow options and increasing inpatient LOS