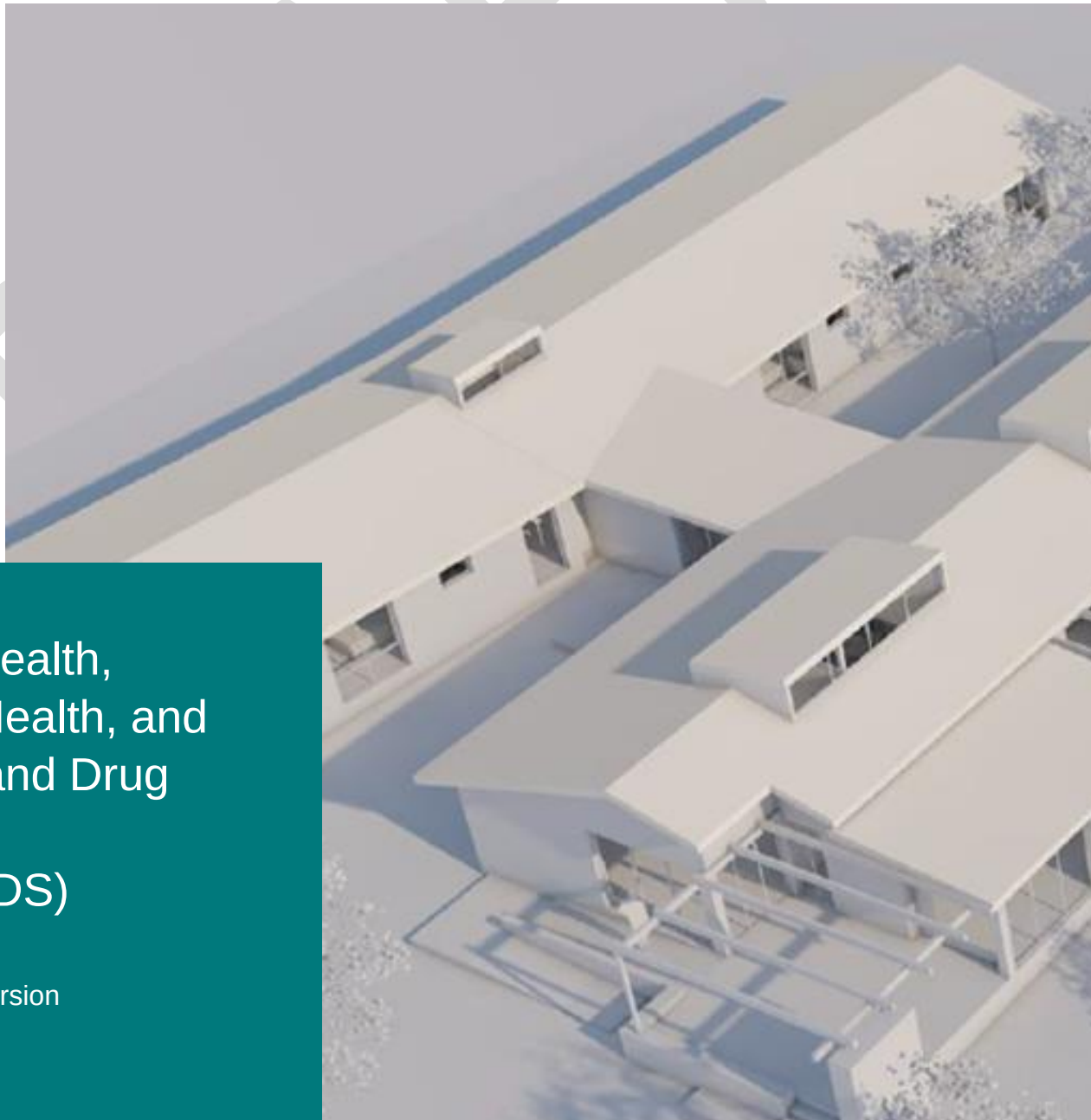
ACT Government | Canberra Health Services

Eating Disorders Residential Treatment Centre Model of Care



Mental Health, Justice Health, and Alcohol and Drug Services (MHJHADS)

Month Year Version

Contents

Approvals

Position	Name	Signature	Date
Executive Director MHJHADS	Katie McKenzie		

Document version history

Version	Issue date	Issued by	Issued to	Reason for issue
1	8/12/2023	Alex Cobb (CAMHS Senior Manager)		

*Once this document has been approved please remove the DRAFT watermark.

Introduction

This Model of Care (MoC) for the Eating Disorders Residential Centre (The Centre) sets out the evidence-based framework for describing the right care, at the right time, by the right person / team and in the right location across the continuum of care. A clearly defined and articulated MoC helps ensure that all health professionals are 'viewing the same picture', working towards common goals and most importantly evaluating performance on an agreed basis.

This MoC:

- outlines the principles, benefits and elements of care,
- provides the basis for how we deliver evidence-based care to every participant, every day through integrated clinical practice, education and research; and
- contains information of participant flows (the areas from where participants enter and exit the service) and service co-ordination, that is the linkages required for seamless participant treatment.

A MoC is a dynamic document and will be updated over time to support new evidence and improved ways of working. Any updates will include relevant change management principles and processes to ensure clear engagement and communication.

This MoC should be stored on the Canberra Health Services (CHS) 'Models of Care' intranet site. It will be reviewed and updated regularly through consultation and the relevant communication.

Eating Disorders

Eating disorders are serious illnesses that cause high levels of psychological distress for people who experience them. A person with an eating disorder has an increased risk of developing long term mental and physical illnesses, an increased risk of premature death due to medical complications and an increased risk of suicide. Eating disorders can occur at any stage of life, although the incidence peaks nationally between the ages of 12-25. A 2012 report commissioned by the Butterfly Foundation, Paying the Price: the economic and social impact of eating disorders in Australia (Paying the Price), suggests that around 4% of the Australian population is affected by an eating disorder at a clinical level[1].

There has also been a significant increase in the number of eating disorder presentations and of the acuity level of these presentations throughout the COVID-19 pandemic[2]. Research from the early months of the pandemic reported a significant increase in symptoms across all eating disorder

1 Butterfly Foundation, 2012. Paying the price: the economic and social impact of eating disorders in Australia, Butterfly Foundation, Melbourne.

2 Miskovic-Wheatley et al., 2022. *The Impact of the COVID-19 pandemic and associated public health response on people with an eating disorder symptomatology: An Australian Study*, Journal of Eating Disorders 10:9 https://doi.org/10.1186/s40337-021-00527-0

diagnoses[3], reactivation of symptoms[4], significant increase in hospital admission for children[5], and interference with the recovery process[6]. As this pandemic moves from initial crisis to more sustained change in our way of life, it is crucial to understand potential consequences of this pervasive experience for those in our community most at risk, especially for those with pre-existing mental and physical health concerns, such as for those with a lived experience of eating disorders.

The treatment and care of people with eating disorders usually involves multidisciplinary input from a range of health practitioners and services. The resulting complexity can create complications that impact timely access to, and engagement with, treatment. Gaps in the system and difficulties navigating it may result in disjointed care for people and delays in accessing care.

It is widely accepted that people with eating disorders often do not seek help, with estimates that only 5 to 15 percent of people with eating disorders access treatment[7]. When a person does seek help for their eating disorder it is typically 4-10 years after the onset of the disorder[8]. This means that when people with an eating disorder do present to health services, they do so with varying symptoms and fluctuations in severity, acuity, complexity, and risk. As a result, managing eating disorders can be extremely complex[3].

Clinical consensus suggests that the best treatment for eating disorders should centre on a multidisciplinary approach that can ensure participants have access to the combined medical, dietetic, and psychological interventions required to maximise the person's chances of recovery. These studies also suggest that, where possible, treatment should be offered in the least restrictive setting that is best suited to the individual's needs and preferences[9]. Treatment complexity can complicate timely access and engagement in treatment, necessitating a flexible care model that should include community-based outpatient, residential services, day program and inpatient treatment options.

Locally, nationally, and internationally, it is recognised that there are gaps in the range of services available for people with eating disorders[10]. Due to funding, resource, and time constraints the eating disorder treatment sector is often fragmented, and the integration of medical and mental health

3 Termorshuizen JD, Watson HJ, Thornton LM, Borg S, Flatt RE, MacDer- mod CM, Harper LE, van Furth EF, Peat CM, Bulik CM. Early impact of COVID-19 on individuals with self-reported eating disorders: a survey of~ 1,000 individuals in the United States and the Netherlands. Int J Eat Disord. 2020;53(11):1780–90.

4 Graell M, Morón-Nozaleda MG, Camarneiro R, Villaseñor Á, Yáñez S, Muñoz R, Martínez-Núñez B, Miguélez-Fernández C, Muñoz M, Faya M. Children and adolescents with eating disorders during COVID-19 confinement: difficulties and future challenges. Eur Eat Disord Rev. 2020;28(6):864–70.

5 Haripersad YV, Kannegiesser-Bailey M, Morton K, Skeldon S, Shipton N, Edwards K, Newton R, Newell A, Stevenson PG, Martin AC. Outbreak of anorexia nervosa admissions during the COVID-19 pandemic. Arch Dis Childhood. 2021;106(3):e15.

6 Castellini G, Cassioli E, Rossi E, Innocenti M, Gironi V, Sanflippo G, Felciai F, Monteleone AM, Ricca V. The impact of COVID-19 epidemic on eating disorders: a longitudinal observation of pre versus post psycho- pathological features in a sample of patients with eating disorders and a group of healthy controls. Int J Eat Disord. 2020;53(11):1855–62.

7 The Butterfly Foundation 2014. *Investing in Need: Cost-Effective interventions for eating disorders*, Butterfly Foundation, Melbourne.

8 Gilbert, N, Arcelus, J, Cashmore, R, Thompson, B, Langham, C & Meyer, C 2012. Should I ask about eating? Patients' disclosure of eating disorder symptoms and help-seeking behaviour. European Eating Disorders Review, 20, 80-5.

9 Hay P, Chinn D et al (2014). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. Australian and New Zealand Journal of Psychiatry, 48(11), 1-62.

10 NSW Ministry of Health, (2013). NSW Service Plan for People with Eating Disorders 2013-2018

services remains underdeveloped. This leads to a lack of clarity about which clinical system should be primarily responsible for people with eating disorders[4].

While all eating disorders are important to the ACT Government, the Territory-wide model of care for eating disorders11 (TWMoC) focuses on participants with the four most common diagnoses, as detailed below[12]:

Anorexia Nervosa (AN): A person with Anorexia Nervosa places severe restriction on the amount and type of food they consume, leading to a body weight that is lower than the minimum expected for their age, gender, and general health. Even when people with Anorexia Nervosa are underweight, they will still possess an intense fear of gaining weight and will engage in behaviours to avoid weight gain.

Bulimia Nervosa (BN): A person with Bulimia Nervosa engages in repeated episodes of binge eating, which are followed by behaviours to compensate for these episodes (e.g. self-inducing vomiting, extreme exercise, laxative abuse) as a way of controlling weight. These compensatory behaviours can include vomiting, exercise, fasting, drugs or medications. These behaviours are often concealed and people with Bulimia Nervosa can go to great lengths to keep their binge eating and compensatory behaviours secret. Many people with Bulimia Nervosa experience weight fluctuations; they can be in the normal weight range, be slightly underweight or be in the overweight range.

Binge Eating Disorder: A person with Binge Eating Disorder will repeatedly engage in binge eating episodes where they eat a large amount of food in a short period of time and do not engage in any compensatory behaviours. During these episodes they will feel a loss of control over their eating and may not be able to stop even if they want to. People with Binge Eating Disorder often feel guilty or ashamed about the amount and the way they eat during an episode. Binge eating often occurs at times of stress, anger, boredom, or other forms of emotional distress.

Other Specific/Unspecified Feeding and Eating Disorders (OSFED/USFED): A person may present with many of the symptoms of other eating disorders, but not meet the full criteria for that diagnosis. In these cases, the disorder may be classified as atypical or low frequency/limited duration under the overall heading of an OSFED. This does not mean that the person has a less serious eating disorder. All disorders in this category are serious mental illnesses that cause significant distress and psychological impairment, and which are listed as diagnoses in the DSM-5 OSFED category.

The ACT Government is committed to improving eating disorder services in the ACT across the full spectrum of care and providing the best treatment and care for people with eating disorders when and where they need it. The Residential Treatment Centre forms part of ACT Government's commitment to strengthening the ACT eating disorder services system and creating a holistic system of care.

Principles

11 ACT Health Territory-wide Model of Care for Eating Disorders Version 1.0 (2022)

12 The National Eating Disorders Collaboration. (2013) Eating Disorders in Australia Fact Sheet: Available at: https://www.nedc.com.au/assets/Fact-Sheets/Eating-Disorders-in-Australia-ENG.pdf

Our vision and role reflect what we want our health service to stand for, to be known for and to deliver every day. The vision and role are more than just words, they are our promise to each other, to our participants and their families and to the community. We all have a role to play in delivering on this promise:

- Vision: Creating exceptional health care together
- Role: To be a health service that is trusted by our community

Our values together with our vision and role, tell the world what we stand for as an organisation. They reflect who we are now, and what we want to be known for. They capture our commitment to delivering exceptional health care to our community. Our values:

- We are reliable - we always do what we say
- We are progressive - we embrace innovation
- We are respectful - we value everyone
- We are kind - we make everyone feel welcome and safe.

Our Strategic Plan sets out our path forward as an organisation for the next three years. It is values driven—it outlines how we will deliver against our vision of 'creating exceptional health care together' for our participants, their families, and carers.

Our Partnering with Consumers Framework provides clear principles for a shared understanding of our approach and what is required from all team members for effective partnerships with participants and carers in line with our organisational values. The principles have been developed in collaboration with our consumer and carer organisations and underpin this Framework.

The Centre focuses on providing best practise, evidence-based treatment to all participants, irrespective of their diverse clinical presentations. This model of care is underpinned by a set of general principles for treatment for all eating disorders that are universally accepted in contemporary best practise clinical care, as described in detail in the Australia and New Zealand Academy for Eating Disorders[13] and RANZCP clinical practise guideline[14] and Guidance from the Commonwealth Government on the establishment of Residential Eating Disorder Treatment Centres:

- Person-centred informed decision making
- Supporting and Involving family/carers and significant others in shared decision making
- Recovery-orientated practice
- Least restrictive treatment context
- Multi-disciplinary approach
- Stepped and seamless care
- A culturally affirming approach, including Aboriginal and Torres Strait Islander communities and people from culturally and linguistically diverse backgrounds

13 Heruc, G., Hurst, K., Casey, A. *et al.* ANZAED eating disorder treatment principles and general clinical practice and training standards. *J Eat Disord* **8,** 63 (2020). https://doi.org/10.1186/s40337-020-00341-0.

14 Hay, P. et al (2014). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. Australian and New Zealand Journal of Psychiatry, 48(11) 1-62 https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/eating-disorders-cpg.aspx

- Promote sensitive, respectful, and inclusive practice for Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + People (LGBTQI+) community
- Trauma informed principles of treatment
- Strong integration with general practitioners (GPs)

Following consultation with stakeholders, the Commonwealth Government has provided guidance about key elements to be considered for this model of care:

- Eating disorders are psychological conditions with medical consequences
- High level of support and supervision
- The importance of the social milieu/environment
- Focus on developing increased autonomy with objective measurements of progress
- Home like environment with hands-on preparation experience
- Bring participants back into a healthy relationship with food
- Power of lived experience

Stepped Model of Care for Eating Disorders

The ACT Government is committed to the development of contemporary, co-ordinated, evidence-based and accessible services for people with eating disorders in the ACT. This includes the prioritisation of early intervention and the establishment of an effective "Stepped Care" model.

The "Stepped Care" model, which has been successfully established in other jurisdictions[15], is composed of four key pillars that work together to allow people to flexibly step-up and step-down into services according to their needs. These four pillars include:

1) generalist mental health services, including primary care and community programs;

2) specialist eating disorders interventions, including outpatient clinics and day programs;

3) local hospital management, including general medicine and paediatric wards; and

4) intensive tertiary supports, including multidisciplinary teams and models of care to support evidence-based treatment in emergency departments and hospital wards.

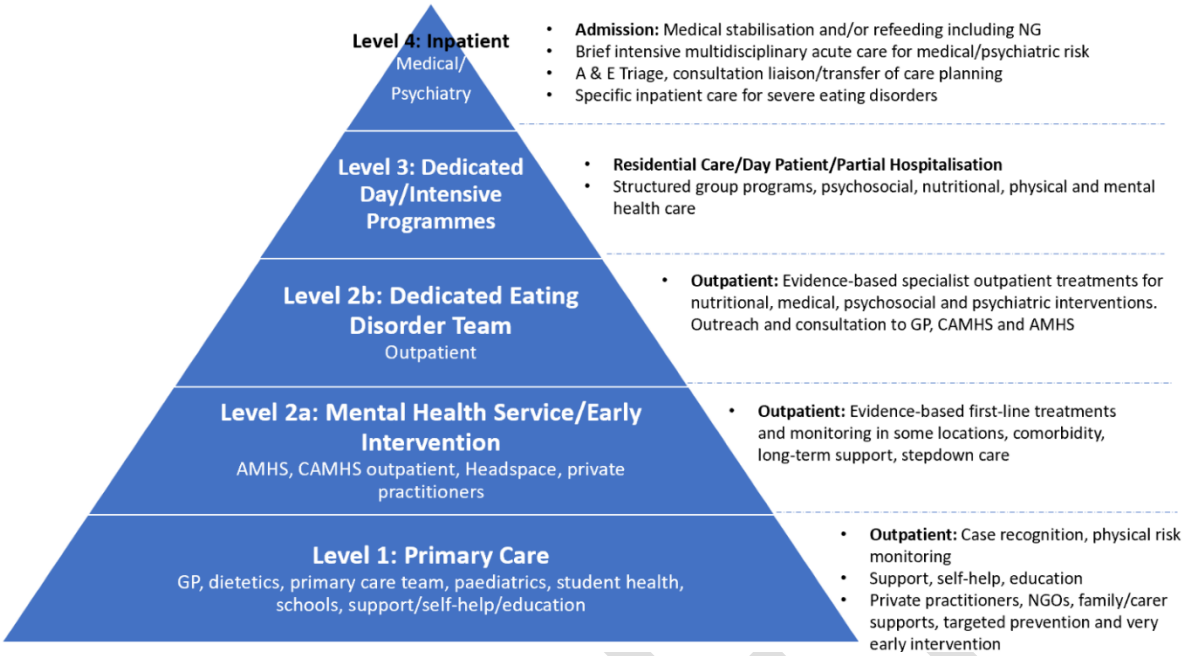
Please see Figure 1 below for the ACT's stepped care model, which has been adapted from the NSW Service Plan[16] and the Health Service Executive (HSE) Model of Care for Ireland[17].

15 NSW Ministry of Health, (2013). NSW Service Plan for People with Eating Disorders 2013-2018

16 NSW Ministry of Health, (2013). NSW Service Plan for People with Eating Disorders 2013-2018. Available at: http://www.health.nsw.gov.au/mentalhealth/publications/Publications/service-plan-eating-disorders-2013-2018.pdf

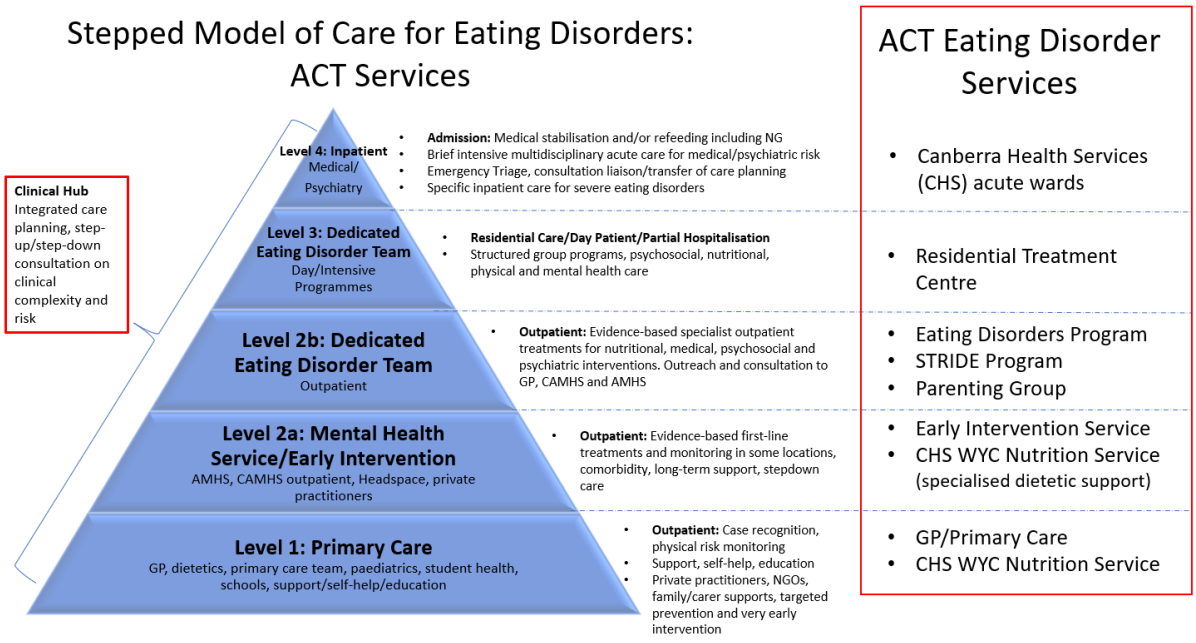
17 National Clinical Strategy and Programmes Division and National Mental Health Division Ireland, (2018). Eating Disorder Services: HSE Model of Care for Ireland. Available at: hse-eating-disorder-services-model-of-care.pdf

Figure 1:



It is expected that all future ACT eating disorder services will be positioned in the stepped care model as stipulated below in *Figure 2*.

Figure 2:



Establishing this model requires interventions to be available across the service spectrum of "Stepped Care" to ensure clients receive care appropriate to their level of need.

Further detail of all the other ACT eating disorder services can be found in the TWMoC.

This component of the model of care focuses on *Level 3: Dedicated Day/Intensive Programmes* for the Residential Treatment Centre.

Benefits to be realised

The implementation of the MoC aims to achieve the following:

- Improved awareness and understanding of the Centre role and function
- Improved participant experience with participants receiving the right care in the right place at the right time
- Improved carer and consumer engagement in care delivery
- Improved staff experience and satisfaction
- Increased positive feedback and reduced complaints received by the CHS Consumer Feedback and Engagement Team
- Trauma informed, diverse and culturally safe care is provided
- Timely admissions to and discharges from the Centre

The range of benefits associated with the Centre will be assessed qualitatively and quantitatively.

Qualitative benefits:

- Participant experience surveys
- Evaluation feedback from families and carers
- Staff experience and satisfaction surveys, and
- Compliments or complaints received by the CHS Consumer Feedback and Engagement Team, Human Rights Commission (HRC), Official Visitor, Public Advocate, consumer advocacy services, participants, carers and other stakeholders

Quantitative benefits:
CHS has an obligation to report both locally and nationally on its performance. Data pertaining to specific key performance and quality indicators include:

- The total number of participant admissions
- The total number of participants discharged from the Centre
- The total number of bed days
- The Length of Stay (LOS)
- Readmission rates within 30 days
- Outcome measures such as the National Outcome Casemix Collection (NOCC)
- A number of other quality indicators, including but not limited to:
    - Adverse clinical events resulting in significant harm, morbidity or mortality.

Description of service

The Eating Disorders Residential Treatment Centre (The Centre) is an inpatient health facility run by Canberra Health Services (CHS). It has a homelike, residential feel where participants receive intensive psychosocial support for their recovery. To enhance the care and treatment of eating disorders in the ACT, the Centre is expected to fill the critical gap between acute inpatient hospitalisation and outpatient programs, as stipulated in the stepped model of care, to provide an opportunity for a more intensive psychological and therapeutic recovery model. All patients in the Centre are referred to as 'participants' in this model of care and whilst staying at the Centre.

The Centre operates as a 24 hour, 7 days a week specialist service for people with eating disorders. This is a new service for the ACT and complements the other public eating disorder specific services in the Territory such as the Eating Disorders Program, the Early Intervention Service, the Clinical Hub, the STRIDE clinic and the Parenting/Carer Group. It is intended the Centre sits within the stepped model of care and participants can transition between these services as required and as determined via the Clinical Hub.

The Centre focuses on the psychological recovery of participants by providing specialist, intensive nutritional, psychological treatment with 24/7 nursing support for a period up to three months. The Centre aims to improve psychosocial functioning in a residential setting which simulates a supportive home-like environment. This provides an opportunity for participants, families and carers to envision their recovery journey and relationship with food when they are back in their own homes.

People admitted to the Centre are required to meet the criteria for medical and psychiatric stability to facilitate a safe and effective admission and ongoing care. Nasogastric feeding is not utilised and clients who require this level of care are not be accepted for admission to the Centre. However, some medical interventions such as weighing participants, using oral supplementation, performing physical exams and conducting occasional blood and urinalysis tests are expected to take place.

While all eating disorders are important to the ACT Government, the Residential Centre focuses on participants with the four most common diagnoses of AN, BN, BED and OSFED/USFED.

The target population for the Centre are participants with a primary diagnosis of an eating disorder (as detailed above) over the age of 16 who can be safely medically monitored and managed in the Centre but require further nutritional, psychological and psychosocial support to achieve long term recovery. The Centre comprises of 12 beds, which are a combination of both single and double rooms with ensuite bathrooms.

The Centre is open to anyone assessed as eligible for admission, with the person's state of residency factored into wait list management and triage assessments.

Care setting

The Centre is located in the residential suburb of Coombs, ACT. This location was selected as it aligned with the environmental considerations of a residential suburban setting, peaceful nature outlook and accessibility for participants and their families/carers. It is of high importance that the Centre is not located on hospital grounds or simulates a clinical setting, as the Centre needs to reflect its purpose of mirroring a residential home.

The Centre includes 7 bedrooms with 12 beds laid out in a combination of single and double bedrooms. Each room has an ensuite bathroom which is shared by maximum of two participants.

As nutritional rehabilitation is core to eating disorder recovery, the kitchen is an important structural component to this Centre and includes a participant kitchen and commercial chef kitchen. The participant kitchen and dining room is designed to enable participants, families/carers, peer support workers, and health professionals to prepare and eat meals together – replicating regular mealtimes when participants are in their usual environments.

Throughout the design process of the Centre, accessibility for participants, staff and any visiting family/carers with a disability or mobility issues have been considered and designed accordingly. Art supports the therapeutic role of the Centre in welcoming participants, and building peer to peer interactions in a culturally safe space that is domestic rather than institutional.

Safewards

The Centre aligns with the Safewards model and interventions for use in mental health inpatient units. The Safewards model is designed to reduce conflict and containment or restrictive practices within in-patient units by identifying and addressing the causes of behaviours in staff and participants that may result in harm (conflict) and reduce the likelihood of this occurring. Staff are trained to use a range of methods to manage participant behaviours in a concerted effort to reduce restrictive or coercive interventions. This also requires staff to review their own behaviours and responses to conflict and the strategies used to manage challenging behaviours.

Participant journey

Admission

Admission criteria

The admission criteria for the Centre are as follows:

- The service is sex/gender inclusive.
- Age >16 years (dependent on developmental maturity).
- Eating Disorder (DSM-5-TR) diagnosis of Anorexia Nervosa, Bulimia Nervosa, Binge Eating or Other Specified Feeding or Eating Disorder (OSFED) which is causing significant psycho-social functional impairment.
- Commitment to not engage in self harming or suicidal behaviours while participating in the program.
- Classified as voluntary patient. Must be willing and able to consent to treatment at the Centre and ready to make behavioural change with a high level of support.
- Agrees to contribute to a recovery orientated environment and participate in all aspects of the program including meal support, group and individual activities.
- No active alcohol or illicit substance dependence. If non-illicit substance dependence is present the participant must be willing to abstain from substance use for the duration of their time in the program (including whilst on leave) and not at risk of withdrawal (participants at risk of withdrawal may be admitted after appropriate detoxification). Prior to admission, participants will be informed that, as a Canberra Health Service site, the Centre is a smoke free environment and the Centre will adhere to the *CHS Procedure – Managing Nicotine Dependence.*

- Residential treatment is the most appropriate and evidence-based mode of treatment at the time (as determined via the Eating Disorders Clinical Hub). Factors considered may include response to past treatment, social support system, and environmental stressors making treatment at home prohibitive (eg severe family conflict, lives alone). For younger clients, residential treatment will be considered for participants for whom Family Based Treatment (FBT) is not clinically indicated.
- Manageable dietary restrictions (religious and/or cultural dietary considerations will be catered for). Allergies and sensory sensitivities will be considered on a case by case basis.
- Medically stable as detailed in the Centre Operational Guideline and can be safely monitored and managed in the Centre.

Exclusion Criteria

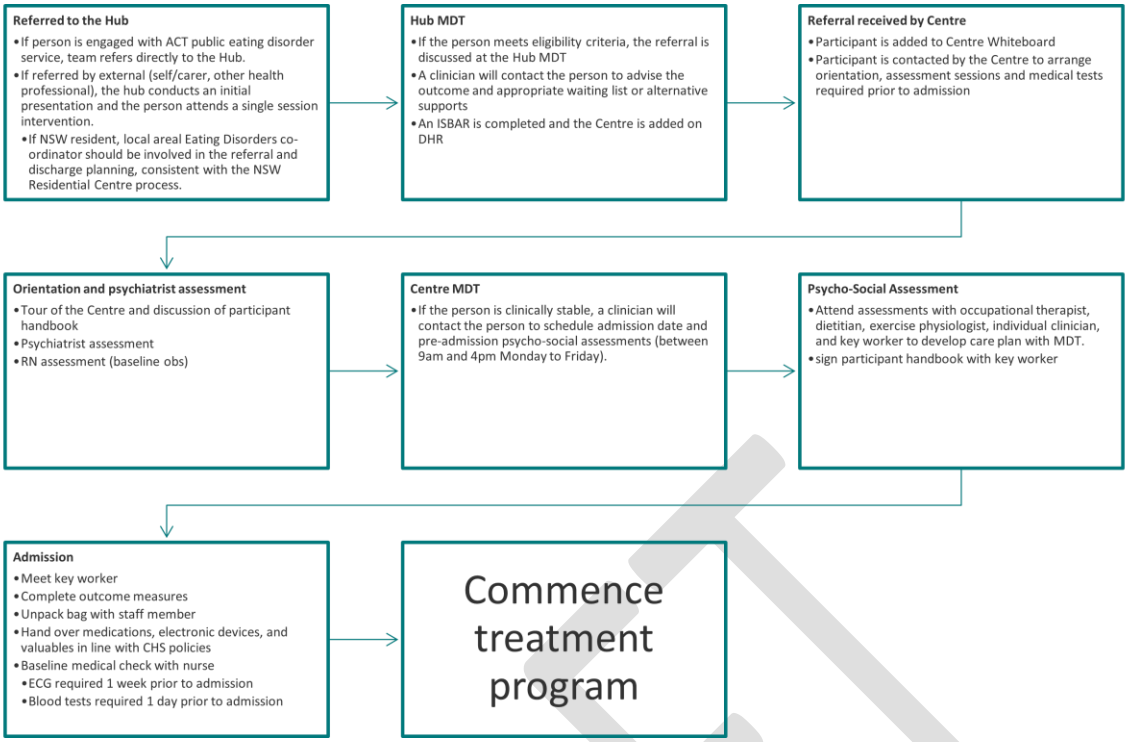
Exclusion criteria are as follows:

- Primary diagnosis of feeding disorder such as Avoidant Restrictive Food Intake Disorder, pica, rumination disorder
- Requires a level of medical care that cannot be provided at the Centre (e.g. parenteral feeding, daily blood tests, observations multiple times per day, at risk of re-feeding syndrome)
- A lower level of care would be beneficial
- Participant does not consent to the participant agreement

Referral and Admission Pathway

All referrals to the Centre are through the Eating Disorders Clinical Hub and admitted by the Centre Consultant Psychiatrist. A detailed description of the referral and admission pathway is in the Centre Operational Guideline. A summary of the participant journey is in figure 3.

Figure 3. Referral and Admission Pathway Flow Chart



Services

All services detailed in this model of care are tailored to this specific cohort's needs and are intended to complement the treatment schedule implemented by the Centre. All service elements have been incorporated following extensive consultation with relevant stakeholders.

The Centre model of care includes the following service components:

- Combination of individual and group therapy sessions, informed by evidence based intervention and tailored to the participant's treatment needs
- Strong focus on dietetics/nutritional support
- Use of alternative therapies
- Physical health monitoring
- Family/carer involvement
- Peer workforce
- Strong links to other established care providers and community based services

The following service component is still under consideration and could operate at the Centre, dependent on further scoping work and budget commitments:

- Day program

Care and Treatment

Participants receive care 24 hours a day, 7 days a week. The multidisciplinary team includes a psychiatrist who is responsible for all admissions and discharges and provides psychiatric

management. All staff work shifts to support the care program. Medical support is provided by a Nurse Practitioner and nursing staff. It is intended that participants may visit their general practitioner for routine care that cannot be managed at the Centre throughout their stay as required. Allied health staff includes psychologists, dieticians, social workers, occupational therapists, exercise physiologists and complementary practitioners which may include roles like Yoga Coach, Drama Therapist, Art Therapist etc. Food services work closely with the dietitian and other statutory regulated health practitioners to support hands-on treatment in the kitchen. The program is supported by mental health support workers, some of whom may have a lived experience and be part of the peer workforce.

Consistent with the principles of Enhanced Cognitive Behaviour Therapy for Eating Disorders (CBT-E), the treatment program is designed to support regular eating of 3 meals and 3 snacks each day. Most of these are on site but to develop flexibility, spontaneity and normalising social eating, some meals and snacks are off site during excursions or as part of behavioural experiments (exposure). Most treatment occurs in groups with all clients present during most groups. Participants also have the opportunity for individual consultations with their primary clinician/s, dietitian and psychiatrist as indicated in their care plan.

In addition to treatment, participants are expected to partake in household chores. This is to simulate the home-like environment and foster a cohesive 'community' feel between participants at the Centre.

Phased Treatment

A phased system treatment approach is utilised, with 6 phases: Welcome Phase, Phase 1-4 and Graduation Phase prior to discharge. The phased treatment approach is consistent with other eating disorders residential treatment centres in Australia and the United States of America. The phases inform a participant's care plan, including level of support required for portioning and post meals, participation in group activities and leave. Participants at the Centre are likely to be in different phases. Each phase has goals and guidance for progressing to the next phase. Movement between phases are also individualised and discussed by the participant and MDT during review sessions.

The phases of care are detailed in the Centre's Operational Guideline.

Group Therapy

This model of care focuses on the use of the social milieu as a powerful agent for change. To fully realise this, group therapy is the main (but not the sole) modality of the treatment program. The group modality fosters social connection and allows for peer feedback and reflection as well as accountability and support between participants. Group therapy sessions includes evidence-based therapies for eating disorders and their comorbidities. Some group sessions may be conducted in smaller or multiple group formats, informed by the social milieu. Attendance at group sessions is informed by the participant's phase of care and agreed to by the Multi Disciplinary Team (MDT).

Individual Therapy

In addition to group psychotherapy, each participant engages in individual psychotherapy sessions with an allocated primary clinician as agreed to in their care plan. Psychological treatment is strongly evidence-based and formula driven. Evidence based treatments for eating disorders include Enhanced Cognitive Behaviour Therapy for Eating Disorders (CBT-E), Dialectical Behaviour Therapy (DBT), Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA), Specialist Supportive Clinical Management (SSCM), Interpersonal Psychotherapy (IPT), Motivational Enhancement, Family Based Therapy (FBT).

Dietetics

Participants meet with the Centre dietitian, who conducts an assessment and make individualised recommendations for the participant's meal plan which are reviewed throughout the participant's time at the Centre. The recommendations consider the participant's treatment goals, allergies and sensory sensitivities as well as available meal options and the social milieu.

The dietitian provides individual nutrition sessions for participants as well as facilitating group sessions including psychoeducation, food appreciation and preparation and outings such as to grocery stores.

Meal Support

The Centre's setting provides a home-like, therapeutic community so that participants can envision recovery at the Centre and when they are back in their own homes. This therapeutic community allows participants an opportunity for hands-on experiences such as portioning food and preparing meals as well as sitting together at a communal dining table for meal in a controlled environment. Families and carers are encouraged to participate in mealtime with their loved one in addition to meal preparation activities as appropriate.

In addition to meal preparation, participants are encouraged to go on outings to grocery stores to select food items for meal preparation, and on outings to cafes and restaurants as a group. These types of exposure replicates activities which would be undertaken in the participant's regular life and helps to address any anxiety and concern whilst still admitted to the Centre.

This model of care aims to bring participants back into a healthy relationship with food through nutritional change that is achieved through behavioural interventions (nutritional counselling, skills training and exposure and response prevention)[18]. Through the use of strategies such as hands on experience in the kitchen, group outings to public places such as cafes and restaurants, encouragement and support from peer workers with lived experience, and individualised treatment plans participants are given the necessary tools to aid recovery. These tools, in combination with the appropriate amount of time in treatment, aim to minimise the risk of relapse upon returning home.

Physical health support

18 Waller, G. & Raykos, B. (2019). Behavioral Interventions in the Treatment of Eating Disorders. Psychiatric Clinics of North America, 42(2). 10.1016/j.psc.2019.01.002

The Centre is staffed by nursing staff 24 hours per day. Nurses conduct observations each morning after participants wake up and before breakfast and at other times if indicated. On site blood tests and urinalysis to monitor medical stability is expected to be required at least monthly, however the frequency may increase as clinically indicated, for example to monitor psychiatric medications. A Nurse Practitioner is available during business hours and can conduct medical examinations, order diagnostic tests and prescribe PBS medications. Nursing staff liaises with a participant's GP and co-ordinate care with CHS and other health care providers for the management of chronic health conditions or pregnancy.

Participants also have access to an exercise physiologist, who can develop and review an individualised movement plan. The exercise physiologist facilitates group sessions including gentle movement/stretching and psychoeducation.

Alternative Therapies

Complementary psychosocial interventions that have shown evidential promise (such as permaculture[19] and animal therapy) may also be utilised at the Centre. The Centre is expected to have a functional herb and vegetable garden for participants to utilise and care for. Animal therapy activities may also be included in the Centre's program as per the relevant CHS guidelines and procedures.

Other activities that improve general functioning and quality of life like creative art therapy and music therapy are included in the Centre's program as part of a holistic recovery-based approach. The use of these activities complements the therapy interventions by focusing on the restoration of the whole person beyond the eating disorder.

Family/Carer Inclusion

In recognition of the critical role that families and carers play in the management and recovery of a loved one's eating disorder, the Centre has a strong focus on integrating families and carers throughout their loved one's stay at the Centre. This may include, as appropriate, attending multidisciplinary team and family meetings, attending and assisting at mealtimes, specific family/carer visit times and peer worker sessions.

Workshops/information sessions are held at the Centre for all families and carers who would like to participate. These sessions provide families and carers with practical skills on how to cope with and appropriately manage their loved one's eating disorder both in the Centre and upon discharge to their own home. The workshops/information sessions provides an opportunity to connect families and carers, allowing families and carers to share knowledge and experiences, and provide lived-experience support to each other during this time. It is important for families and carers to feel they are appropriately equipped with the right skills via education and training from the Centre to assist their loved one in their recovery journey post discharge, as this improves the participant's chances of sustaining their recovery long-term.

19 Sempik, J. (2010). Green care and mental health: gardening and farming as health and social care. Mental Health and Social Inclusion 14, 3. Aug

Progress Monitoring and Review

Multidisciplinary Team Meeting (MDT)

The MDT meets at least weekly to review and update participants' care plans. Participants are included in the MDT discussions. Carers and members of a participants' outpatient care team may be invited to attend an MDT with the participant's consent.

Care Plan

As part of the admission process, participants take part in a multidisciplinary assessment which informs the development of a care plan with their clinician and/or the MDT. The care plan includes:

- Treatment goals
- Phase of care
- Distress tolerance plan
- Meal plan
- Movement plan
- Use of electronic devices
- Agreed leave

The care plan is reviewed and updated at each MDT.

Flag system

The Centre recognises that recovery from an eating disorder can be challenging and that participants may have difficulty engaging in elements of the program at times. To effectively support participants to complete the program and provide a safe, recovery oriented environment for all participants at the Centre, the Centre utilises a "flag system". The Flag System is a communication term that is used by Centre staff to discuss any concerns about the participants' recovery progression and/or if they have engaged in behaviours that are considered inappropriate during their participation. A flag system has been utilised in Day Programs in Australia.

The Centre has a 3-flag system. Participants are issued "flags" for consistent difficulty adhering to their care plan and the Participant Agreement. If Centre staff are concerned about progress and observe consistent difficulty meeting recovery goals such as not attending therapy sessions, not adhering with their nutritional plan, weight interfering behaviour, inappropriate personal device use and inappropriate conduct with others. Their Key Worker and/or the Care Team issues a flag and problem solves to get back on track.

First Flag – This is issued by the key worker. After receiving the first flag, the Key Worker will problem solve with the participant to assist them to fulfil their participation goals.

Second Flag - This is issued by the key worker or the MDT. Participants who reach two "flags" are required to have a formal review with the MDT to discuss their progress in the program. Further assistance to meet program expectations and their own personal goals are negotiated.

Third Flag - This is issued by the MDT. Once a participant reaches three “flags” they are reviewed by the MDT and are required to suspend their participation at the Centre. This is to enable participants to review their ability and motivation to engage at the Centre. If they would like to resume their participation, a plan and evidence for addressing challenges needs to be demonstrated.

If a participant’s returns to the Centre one “flag” is removed from their file. However, they will still have two “flags” pending. Early discharge from the Centre occurs if they receive another “flag” due to difficulty adhering to their recovery goals (again totalling three flags), and all previous attempts to identify and resolve difficulties in committing to and persevering with their recovery goals have been exhausted. They may require alternate treatment services at that time. It may be possible for a participant to re-commence participation at a later stage.

Certain behaviours at the Centre will lead to discharge from the Centre as the behaviour may indicates that a different care setting is more appropriate. Such behaviours may include weight control behaviour that results in a deterioration in physical stability, serious self-harm, alcohol/drug/medication misuse, violent or aggressive behaviours toward others, criminal activity whilst on the Centre premises.

It is noted that any clinical decision in response to the flag system will take into consideration the most up to date MHJHADS triage scale to assess risk in the context of a mental illness. Responding to deterioration and discharge planning will occur as outlined below.

Responding to deterioration

Medical

Nursing staff take observations of participants daily before breakfast and as otherwise indicated. If there are signs of medical deterioration that cannot be managed safely as per the Centre Operational Guidelines and other relevant CHS policies, staff call for an ambulance to transport the participant to the Emergency Department.

Psychiatric

Centre staff are available to provide support to participants who are emotionally distressed. If there are signs of psychiatric deterioration that cannot be managed safely as per the Centre Operational Guidelines and other relevant CHS policies, Centre staff call emergency services to transport the participant to the Emergency Department.

Transfer and Discharge

Discharge planning commences from the point of admission. A participant may be discharged for a number of reasons including completion of the program, the participant chooses to withdraw from the program, the participant has received three flags or the participant requires step up to a more acute setting. From admission, Centre staff work with a participant to identify an outpatient team who they will engage with post discharge and keep that team updated regarding progress and discharge planning. The engagement and support of family and carers in collaborative planning for discharge is a strong focus of the MDT. Where possible and with consent, a participant’s family/carers and

outpatient team are invited to attend a discharge planning MDT. Community supports for the participant and carer will be discussed as part of discharge planning.

It is possible that a participant at the Centre may step up to a more acute environment during an admission if there is a deterioration in their mental or physical state in line with the *National Safety and Quality Health Service– Recognising and Responding to Acute Deterioration Standard*. In this situation a participant is discharged from the Centre and then follows the admission process if they wish to return to the Centre following discharge from the acute setting.

A divisional Key Performance Indicator (KPI) is to ensure a discharge summary is sent to the person's GP within 48 hours of discharge. A copy may also be provided to others such as carers or a nominated person when consent is provided by the consumer. The discharge summary outlines ongoing care arrangements that have been organised. Community Mental Health providers are involved in discharge planning and contacted (in accordance with pre-arranged care plans) to commence or continue with ongoing care.

Interdependencies

Aboriginal Liaison Officers

Aboriginal Liaison Officers (ALO) across the whole of MHJHADS are available to provide emotional, social, and cultural support to Aboriginal and Torres Strait Islander people and their families when they are admitted to the Centre, according to the participant's wishes.

ACT Public Eating Disorder Services

Participants may be referred from or to the Centre to ACT public eating disorder services via the Clinical Hub. ACT public eating disorder clinicians may be involved in MDTs, discharge planning and ongoing post discharge support.

Acute Hospital Wards

There are times a participant may be transferred or discharged to the Emergency Department at The Canberra Hospital or North Canberra Hospital, or to a specific medical or psychiatric ward. Transfers of this nature are facilitated by the Centre's treating Consultant, or their delegate, and the CNC. Transfers are provided by ACTAS.

Community Mental Health Teams

Participants may be referred to or from the Centre to Community Mental Health Teams via the Eating Disorders Clinical Hub. Where appropriate, community teams and clinical managers are invited to participate in Centre MDT meetings and other forums to support a participant's treatment, care and their discharge planning, as well as the ongoing support of the consumer through community based clinical management.

General Practitioners

GPs play a key role in holistic care and in particular early identification of risk, response to and management of eating disorders as they are often the first point of contact for health concerns.

As part of the referral process, all participants have a GP who is responsible for medical and ongoing care once the participant has been discharged and/or stepped down to primary care supports. Centre staff are required to work closely with the participant's home GP throughout the participant's stay at the Centre to keep them informed and involved throughout treatment progression. GPs are invited to participate in discharge planning case conferences. Participants may be supported to see their regular GP practice for non-emergency situations that cannot be managed at the Centre.

Private Clinicians

Participants may be referred from or to the Centre to private clinician (e.g. psychologist, dietitian) via the Eating Disorders Clinical Hub. Private clinicians identified as part of the outpatient treating team may be involved in MDTs, discharge planning and ongoing post discharge support.

Pets as Therapy

Pet Therapy is an approved therapeutic activity at the Centre. The animals used in the therapy program are compliant with the *CHS Infection Prevention and Control - Healthcare Associated Infections Procedure* and the *CHS Guideline – Animal Visits*. Their use is monitored by the clinical team.

Service support

Bedside Data Entry, Patient Digital Journey Boards and the Digital Health Record

Clinicians (nurse, allied health, doctors, etc.) have access to computers to enter relevant participant information into the Digital Health Record, order tests, review results of investigations, send outpatient referrals, provide discharge emails to participants and GPs. This includes a combination of fixed computers located within the staff base as well as ROVERS.

Patient Digital Journey Boards are located within the staff workstation and provide real-time information regarding the participant's demographic information, location, alerts and transport needs. They are a communication tool designed to increase awareness of a participant's status at any given time and assist care planning and the discharge. Nursing staff are responsible for updating the journey board.

Communication within the ward

Staff and participants have access to telephone communications through VoIP telephones and a Digital Antenna System which provides access to carrier mobile phone networks within the building. Staff VoIP telephones and wireless internet access points (allows internal and public internet access)

are available for 30 minutes through UPS battery backup in the event of a power failure to provide continued communications during systems failure or a disaster response.

Staff also have ACSCOM duress handsets which provide mobile telephone functionality.

Food Services

Breakfast, lunch, dinner, morning, afternoon tea and supper is provided for participants. Most meals are delivered by CHS Food Services with final preparations and portioning on site at the Centre. CHS Food Services work closely with the Centre dietitian to develop the menu and ordering. Some food items may be purchased by Centre staff from a supermarket or take-away/delivery to facilitate therapeutic activities and ease the transition home by exposing participants to food items that they would encounter post discharge. The Centre follows the *CHS Operational Procedure - Bringing Food into Canberra Health Services (Adults and Children).*

There are a number of cafes available for families, parents and carers to use near the Centre.

Infection Control

The Centre complies with the National Safety and Quality Health Service (NSQHS) Standards on Prevention and Control of Healthcare Infections, CHS policy and procedure and work with the infection Prevention and Control Unit to minimise the risk of health care related infection. Processes on the ward include hand hygiene practices, standard precautions, additional precautions, environmental cleaning, isolation of participants with infectious diseases and quarantine of participants during pandemics or with listed disease requiring quarantine.

Interpreter services

Interpreters are available through the Translating and Interpreting Services (TIS) for participants and families who require assistance to communicate effectively.

Linen

Supplies are delivered by the CHS linen contractor and delivered daily. Clean linen supplies are stored in the designated linen bay. The linen supply is restocked by a trolley exchange system. Dirty linen is stored in linen hampers in the dirty utility room. Collection and transfer to a central location for collection occurs.

Consistent with providing a home like feel to the Centre, participants are able to bring personal items such as their own blanket, bedspread, or pillow and are responsible for regularly laundering the items as per infection control guidelines.

Participant Entertainment

Participant entertainment is not available in the bedrooms. Television and entertainment systems are available within the communal recreational area of the unit.

Pharmacy

Participants are responsible for supplying their own medications that has been prescribed by their GP for the expected duration of their admission. If additional medication is required, including medication changes made by the Centre Psychiatrist, Centre staff support the participant to fill a script at a Pharmacy.

Medications may be nurse or self administered through webster pack, depending on the participant's phase of care, care plan and risk assessment.

There will be some stock medications provided by Pharmacy such as Paracetamol.

Medications will be handled as per the *CHS Clinical Policy – Medication Handling.*

Printer

A multifunction printer and a pharmacy scanner are located within staff workstation.

Security

The unit is access controlled for the safety of participants, visitors and staff. Access to the unit is via intercom or swipe card access. Family and carers have access via visiting hours and by arrangements.

All staff have access to Ascom handsets when working on the ward. These devices incorporate a notification system for alarms and alerts activated within the ward. The devices also incorporate a personal duress button and mobile phone capability.

Duress buttons within the staff bases, interview room and meeting room may be used to activate the centralised hospital duress system. When the duress alarm is activated the location of the duress is notified to all Ascom handsets within the ward as well as centrally to the security service.

There is no permanent CHS security located on site. CHS Security monitor alarms and contact the centre in the case of duress alarm to ascertain if any assistance is required.

In case of an emergency, staff call police.

Stores

Supplies are provided to the Centre through CHS Supply.

Video Conferencing

Video conferencing is available within the main meeting room.

Wi-Fi

Free Wi-Fi internet and networking access is provided throughout the Centre for use by staff and visitors.

Cleaning and Waste Management

Cleaning and waste is managed per the CHS Policy for Waste Management by the cleaning contractor

Workforce

Leadership and governance of the Centre

The leadership team ensures high quality evidence based, multidisciplinary coordinated care is delivered to participants and their carers.

The CAMHS Clinical Director, in liaison with the CAMHS Operational Director, is responsible for the governance of the Centre. A CAMHS Senior Manager oversees the operations of the Centre.

The Clinical Nurse Consultant (CNC) and Allied Health Managers provide leadership and guidance within their discipline, manage operations, promote professional standards, competencies and contribute to the professional development of less experienced staff. They report to the CAMHS Senior Manager. The CNC manages the general operations of the Centre, including ensuring there are adequate resources to ensure the safe functioning of the Centre.

Workforce Profile

The staff profile requires a skilled workforce adept at assessing and treating people with an eating disorder diagnosis. Members of the Centre multidisciplinary workforce are required to work flexibly and can be called upon to redeploy across the division as required.

The Centre requires a skilled workforce and will be staffed by the following:

- Consultant Psychiatrist
    - General Practitioner
    - Nurse Practitioner
    - Nursing staff
    - Allied Health and allied health assistants
    - Peer workers

Medical

Consultant Psychiatrists: provide **c**linical leadership which includes oversight for assessment recommendations, treatment and care, decisions as per the *Mental Health Act 2015*, multidisciplinary team clinical review, discharge planning and closure decisions. It also includes input to strategic and business planning for the provision of best practice treatment and evidence-based interventions. They provide direct psychiatric care through specialised assessment interviews, review appointments,

medication prescription, diagnosis and formulation of treatment targets, therapeutic engagement and relevant interpersonal and cognitive therapy, liaison with inpatient psychiatrists regarding admission recommendations and education to the multidisciplinary team to enhance skills, knowledge and evidence-based interventions.

A Consultant Psychiatrist (Senior Staff Specialist) will be employed 0.6 FTE and cover the Centre, Eating Disorders Program, and Clinical Hub weekdays 8.30am to 4:51 pm.

Outside of the above hours psychiatric support is covered by an on-call MHJHADS Psychiatric Registrar based at the CH who report to the on-call consultant.

Nursing

In addition to their role in assessing and managing physical health, all nursing staff have a role in providing psycho-social support to participants and their families, key worker, facilitate group psychoeducation and skills sessions, meal support, post meal supervision, and escorted leave.

Nurse Practitioner (NP): The NP is a registered nurse, educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The NP provides clinical leadership, support and education to nursing staff. The NP can perform medical assessments, order and interpret pathology tests, prescribe medications, provide psychotherapy, and liaise with a participant's GP regarding continuous health management.

Clinical Nurse Consultant (CNC): provides nursing clinical leadership in establishing and maintaining clinical standards, ensuring best practice principles are utilised and evidenced in the delivery of nursing care. The CNC allocates resources and monitors nursing shift workloads and skill mix to ensure that clinical risk is monitored, and quality and safety systems are maintained.

Registered Nurse Level 2 (RN2): provides nursing clinical leadership and is responsible for staff and participants when in charge of a shift, direct participant care and ensure support and supervision are provided to student nurses and student enrolled nurses, under the general direction of the CNC.

Registered Nurse Level 1 (RN1): provides direct nursing care to participants.

Enrolled Nurse (EN): provides direct nursing care under the direction of Registered Nurses.

The changes in allocation of beds based on acuity and the implementation of minimum staffing levels under the Workload Management Tool, nurse-to-participant ratios, is expected to be outlined in the next ACT Public Sector Nursing and Midwifery Enterprise Agreement in 2023 and this may impact the nurse staffing profile for the unit. A review of the nurse staff profile will be undertaken once the Workload Management Tool for the Centre is known.

Allied Health

The clinicians Allied Health clinicians are managed by the Allied Health Manager.

All Centre staff Allied Health Professionals will provide psycho-social support to participants and families, facilitate groups and individual sessions, meal support, and advocacy,

In addition, allied health professionals have specific training and may perform the following:

Occupational Therapist: provide functional and sensory assessments, may conduct home visits, liaise with appropriate service providers and organises home modifications as needed for eligible clients.

Social Worker: provide psychosocial support to families, collaborates between the MDT and facilitates communication, consumer advocacy, provides information on support services and links eligible participants to appropriate service providers.

Psychologist: provides psychological expertise and support for clients who may need assistance with mental health changes related to their illness, injury, or health-related problem.

Allied Health Assistants: provide support, information, education, care planning, discharge planning and sharing of recovery stories to participants and their families.

Peer Recovery Workers: are workers with a lived experience, they provide support, information, education, care planning, discharge planning and sharing of recovery stories to participants and their families.

Dietitian: provides nutritional assessment and support, and education and information on dietary requirements. They play a key part in preventing and treating malnutrition and ensuring increased nutritional requirements are met for recovery.

Exercise Physiologist: Performs fitness and stress tests on participants to determine their strengths and limitations, and devises appropriate movement plans.

Creative Arts Therapist: Uses a combination of therapeutic activities from the arts to support participants to express themselves and enhance their recovery.

Music Therapist: Uses evidence-based music therapy methods such as therapeutic songwriting, music listening, singing and improvisation to provide group and individual interventions to support the recovery goals of participants.

Accreditation and Training

It is recognised that there are core skills needed by Centre staff to provide specialist residential like eating disorder care. The Centre promotes ongoing training and professional development for staff, including clinical supervision, education and training opportunities, engagement with the Strengths, Engagement and Development (SED) plans, training and education based on identified areas of need and areas of interest relevant to the workplace, advice from discipline leads, recommendations from Eating Disorder professional bodies, and the NSHQS standards.

All new staff are provided with the CHS Welcome Booklet and MHJHADS local orientation as an essential element of their induction to CHS, the Division and to the Centre. Nurses additionally receive a Centre Induction booklet specific to nursing practice. New CNCs are provided with the Centre CNC Orientation manual with information specific to the role.

All staff complete mandatory education specific to their discipline, role and the Centre workplace as per CHS, MHJHADS and local procedures.

It is an expectation that all staff remain current in their mandatory training and maintain currency with their annual training as identified by the organisation.

CHS is accredited in alignment with the NSQHS Standards.

Implementation

The Centre MoC is implemented with the opening of the Centre. The culture of the Centre underpins the implementation which captures the CHS values and has a focus on partnering with participants and carers. The implementation is led by the Centre CNC and Allied Health Manager with the support of the CAMHS Operational and Clinical Director and CAMHS Specialist Services Senior Manager.

The MoC is implemented by:

- Recruitment of adequate, skilled nursing staff by the CNC to support the MoC
- Recruitment of adequate, skilled allied health staff by the Allied Health Manager to support the MoC
- Recruitment of adequate, skilled Medical Staff under the direction of the Clinical Director to support the MoC
- Recruitment of adequately skilled Administration staff
- Incorporation of the MoC into Centre orientation and induction documents
- Processes and documentation used within the unit that support the principles of the model of care

Monitoring and Evaluation

The Centre is committed to ongoing improvement in collaboration with participants and carers.

Evaluation

Specific to the clinical evaluation, the federal Government has provided funding to set up a Technical Advisory Group (TAG). The TAG comprises of various eating disorder researchers and clinicians in Australia. This group has developed a minimum data set for information that is collected at each of the federally funded residential programs across Australia. Evaluation may be undertaken by Centre staff and/or in partnership with Universities with relevant ethics approvals obtained.

In the clinical evaluation of the Residential Centre, information to be collected as part of the minimum data set includes the following measures:

Measure	Frequency
BMI	Weekly
EQ-5D-3L or EQ-5D-5L Health Questionnaire	Admission and follow-up
WHO-DAS	
ED15	Weekly
EDED-Q	Start of treatment, every 4 weeks during admission, every 3 months post-discharge over 12 months
Body Image Acceptance and Action Questionnaire	
PHQ-9	
GAD-7	

Clinical Impairment Assessment	
Consumer Experience Survey (TBC)	End of treatment
Carer Experience Survey (TBC)	End of treatment

Additional measures will be administered consistent with the *Use of Mandatory National Outcome Measures – MHJHADS* policy and updated clinical guidelines, research, and CHS policy.

Records management

Following the relevant consultation, this finalised document and any further updates will be electronically stored on the Canberra Health Services intranet site – 'Models of Care', to ensure accessibility for all staff.

Abbreviations

ACTAS	ACT Ambulance Service
CHS	Canberra Health Services
DSM	Diagnostic and Statistical Manual
EDRTC	Eating Disorders Residential Treatment Centre
STRIDE	Short Term Recovery Intervention for Disordered Eating

Model of Care Development Participants

CAMHS Operational Director	Kalvinder Bains
CAMHS Clinical Director	Dr Ilona DiBella
CAMHS Senior Manager	Sarah Toohey
Acting CAMHS Senior Manager	Alex Cobb
CAMHS Consultant Psychiatrist	Dr Matthias Regner
Project Officer	Thomas Roberts
Project Officer	Kathryn Bell
ACT Health Directorate	Jessica Miko
ACT Health Directorate	Monica Upward-Garcia

ACKNOWLEDGMENT OF COUNTRY

Canberra Health Services acknowledges the Traditional Custodians of the land, the Ngunnawal people. Canberra Health Services respects their continuing culture and connections to the land and the unique contributions they make to the life of this area. Canberra Health Services also acknowledges and welcomes Aboriginal and Torres Strait Islander peoples who are part of the community we serve.

ACCESSIBILITY

If you have difficulty reading a standard printed document and would like an alternative format, please phone 13 22 81.

If English is not your first language and you need the Translating and Interpreting Service (TIS), please call 13 14 50.

For further accessibility information, visit: www.health.act.gov.au/accessibility

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