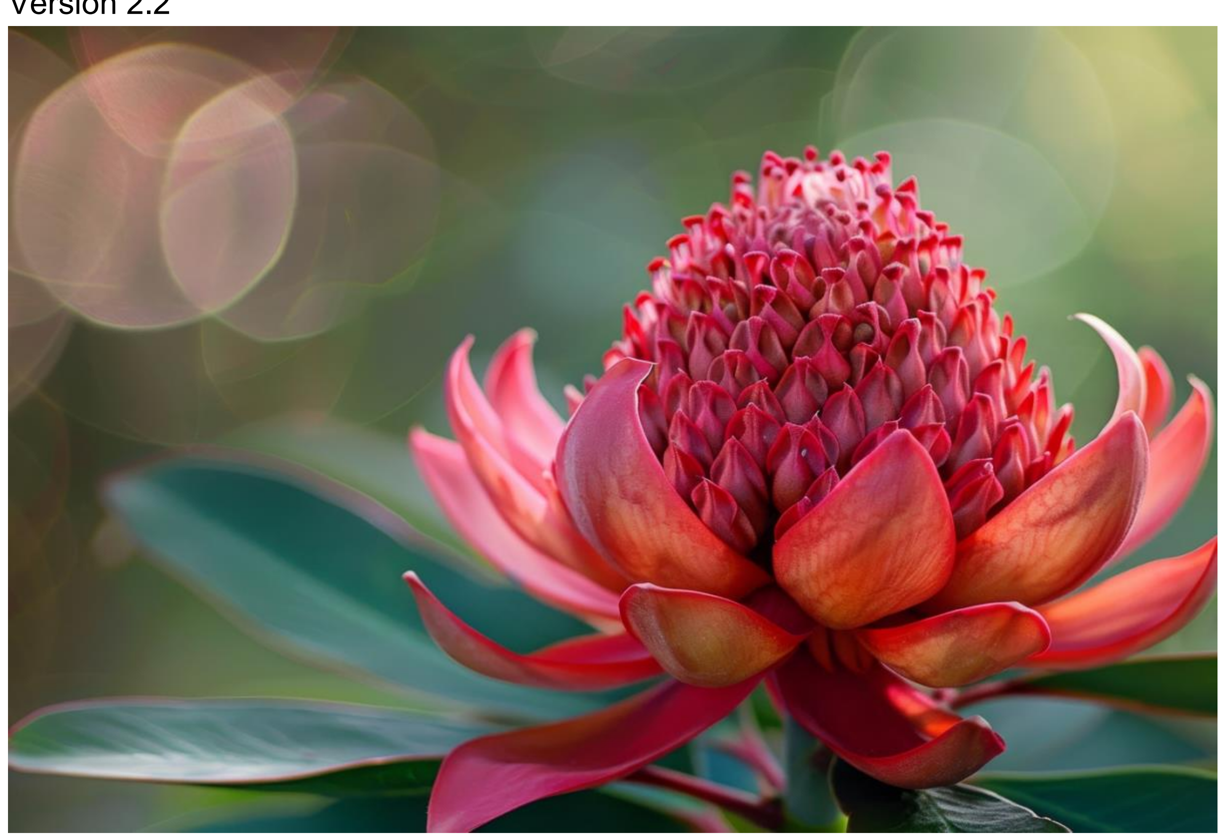
Model of Care – Eating Disorders Residential Treatment Centre

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

Version 2.2



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Acknowledgement of Country

Canberra Health Services acknowledges the Ngunnawal people as traditional custodians of the ACT and recognises any other people or families with connection to the lands of the ACT and region. We acknowledge and respect their continuing culture and contribution to the life of this region.

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Approvals

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1. Introduction

This Model of Care (MoC) for the Eating Disorders Residential Centre (The Centre) sets out the evidence- informed framework describing the right care, at the right time, by the right service and in the right location across the continuum of care for eating disorders treatment. It builds on components of the ACT Territory Wide Model of Care for Eating Disorders (TWMoC). 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-informed care to every participant, every day through integrated clinical practice, education and research; and
- Contains information about how participants enter and exit the service, service co-ordination and the linkages required for seamless treatment.

A MoC is a dynamic document and will be reviewed and updated as required 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.

Detailed information on specific processes of how care is provided is outlined in the Centre Operational Procedure, and relevant CHS policies, procedures and guidelines.

1.1 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 2024 report commissioned by the Butterfly Foundation, 'Paying the Price, Second Edition: the economic and social impact of eating disorders in Australia', suggests that around 4.45% of the Australian population is affected by an eating disorder at a clinical level, an increase of 21% since 2010[1].

It is widely accepted that people with eating disorders often do not seek help, with estimates that fewer than 30% of people with eating disorders seek help[1]. Factors include ambivalence toward treatment often being a feature of an eating disorder, stigma and shame, or lack of recognition or acknowledgement of the symptoms by either the person or health professionals. When a person does seek help for their eating disorder it is typically 4-10 years after the onset of the disorder[2]. 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, the management of eating disorders can be extremely complex[3].

Clinical consensus suggests that the best treatment for eating disorders is a multidisciplinary approach that can ensure participants have access to the combined medical, dietetic, and psychological interventions required to maximise their chances of recovery. Treatment should

be offered in the least restrictive setting that is best suited to the individual's needs and preferences[3]. 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[4]. Due to funding, resource, and time constraints treatment is often fragmented, and the integration of medical and mental health services remains underdeveloped. This leads to a lack of clarity about which clinical system should be primarily responsible for people with eating disorders[4].

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.

While all eating disorders are important, the TWMoC[5] focuses on participants with the diagnoses of Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder, as defined by the International Classification of Diseases 11.

Anorexia Nervosa

Anorexia Nervosa is characterised by a persistent pattern of restrictive eating, and/or other behaviours aimed at either establishing or maintaining abnormally low body weight or inducing rapid weight loss (e.g. more than 20% of total body weight within 6 months). It is typically associated with extreme fear of weight gain and excessive preoccupation with body weight or shape. Even when people with Anorexia Nervosa are underweight, they will continue to engage in behaviours to lose weight or prevent weight gain.

Bulimia Nervosa

Bulimia nervosa is characterised by 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

Binge Eating Disorder is characterised by repeated binge eating episodes where large amount of food is consumed in a short period of time. People with Binge Eating Disorder do not engage in any compensatory behaviours. During binge eating 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.

2. Vision and principles

To ensure consistency across services provided by CHS, the MoC aligns with the CHS Vision and values. This section provides an overview of the CHS Vision, role and values, and a clear vision and principles for the Centre which underpin the MoC.

2.1 Canberra Health Services vision, role and values

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:

- CHS Vision: Creating exceptional health care together
- CHS 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.

2.2 Centre vision and principles

The Centre focuses on providing best practice, evidence-informed treatment to all participants, irrespective of their clinical presentations. The Centre MoC is underpinned by a set of general principles for treatment for all eating disorders that are universally accepted in contemporary best practice clinical care, as described in detail in National Eating Disorder Collaboration (NEDC) National Strategy 2023-2033[6], the Australia and New Zealand Academy for Eating Disorders[7], RANZCP clinical practice guideline[8], and the National Safety and Quality Health Service Standards. The CHS Partnering with Consumers Framework outlines the approach to effective partnerships with carers, families, kin and supports.

The principles that inform the program and treatment delivered by the Centre are[9]:

Person-centred and collaborative approach to decision making

The Centre staff collaborate with participants and their carers/families in a least restrictive environment to develop a treatment plan that is tailored to meet the individual needs of each participant. The treatment plan and admission goals are specific to each individual and may vary widely between different participants.

Atheoretical, pragmatic, and eclectic approach to treatment of eating disorders

The Centre's program is informed by a variety of treatment approaches and best available evidence. It does not rigidly adhere to a specific model of treatment or theoretical assumptions about the aetiology of eating disorders. Treatment is practical and flexible based what will best meet the needs of the participant.

Strengths focused, recovery orientated, trauma informed, and values driven care

Treatment is focused on the strengths of the participants rather than their deficits. Participant's values are respected and inform their treatment plan. Participants are treated as experts in their own recovery journey and identify their own goals for treatment that will allow them to live a meaningful life.

Collaboration with families, carers, treating clinicians

Throughout a participant's admission at the EDRTC, where consent is provided, carers, family, and other supporters are invited to be involved in the participant's care and decision making.

A culturally affirming and inclusive approach

EDRTC endorse a culturally affirmative approach to care for Aboriginal and Torres Strait Islander people and those from culturally and linguistically diverse backgrounds. The Centre promotes sensitive, respectful, and inclusive practice for members of the Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + (LGBTQI+) community, people with disability and people with neurodiversity.

Commonwealth Government guidance on key elements to be considered for eating disorders residential treatment centres include:

- Eating disorders are psychological conditions with medical consequences
- A high level of support and supervision is required
- The importance of the social milieu/environment
- Focus on developing increased autonomy with objective measurements of progress
- Providing a home like environment with hands-on preparation experience
- Bringing participants back into a healthy relationship with food
- The power of lived experience.

2.3 Stepped Model of Care for Eating Disorders

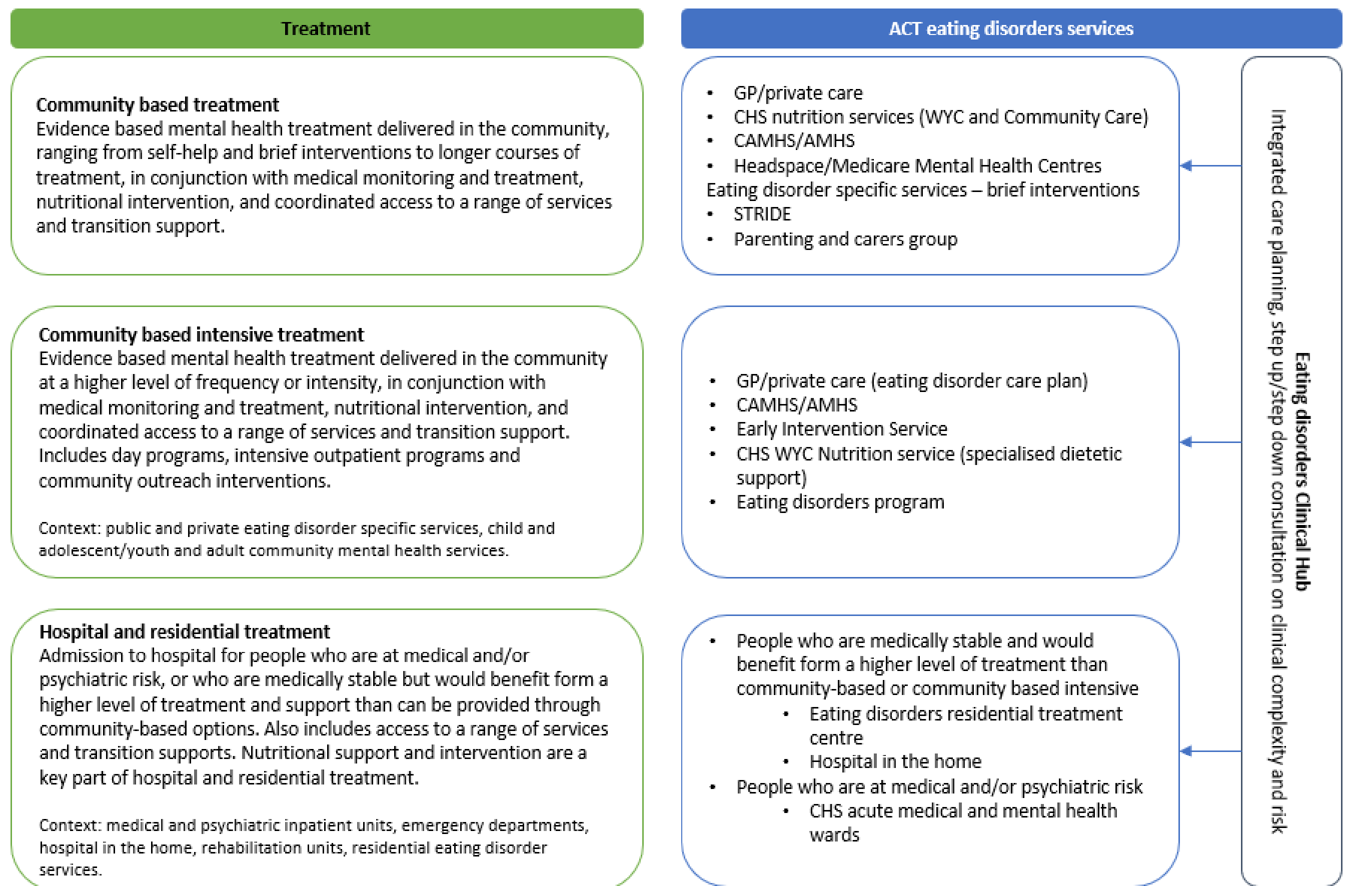
The ACT Government is committed to the provision of contemporary, co-ordinated, evidence-informed and accessible services for people with eating disorders in the ACT. The EDRTC opened in August 2024 and complements the other public eating disorder specific services in the Territory such as the Eating Disorders Program, the Early Intervention Service, the Clinical Hub, the STRIDE clinic and the Parenting/Carer Groups. 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 fills the critical gap between acute inpatient hospitalisation and outpatient programs to provide an opportunity for a more intensive program based on meal support therapy, therapeutic groups, and individual therapy

The “Stepped Care” model for eating disorders, which has been successfully established in other jurisdictions[10], 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-informed treatment in emergency departments and hospital wards.

The ACT stepped care model aligns with the NEDC stepped system of care for eating disorders outlined in the NEDC National Strategy 2023-2033[7]. This diagram shows how ACT services map across the levels of treatment as described in the National Strategy. ACT services mapped to the stepped system of care for eating disorders in the NEDC National Strategy 2023-2033[7].

Figure 1. ACT eating disorders services mapped to the stepped care model.



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

3. Benefits to be realised

The MoC aims to achieve the following:

- Awareness and understanding of the role and function of the Centre

- Positive participant experience with participants receiving the right care in the right place at the right time
- Positive carer, family, kin, supporter and participant engagement in care delivery
- Positive 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, outlined in the evaluation section.

4. Description of Service

The Centre is classified as a sub-acute inpatient health facility run by Canberra Health Services (CHS). The Centre operates 24 hour, 7 days a week. MHJHADS understand and respect that people choose to describe themselves in relation to mental health services and systems in a variety of ways such as participant, client, consumer or patient. All patients in the Centre are referred to as 'participants' in this model of care and whilst staying at the Centre, reflecting active participation in their recovery journey.

The Centre is an approved mental health facility under the Mental Health Act with the following exemptions:

- Chapter 6 (Emergency Detention) of the *Mental Health Act 2015*
- Section 309 (Assessment whether emergency detention required) of the *Crimes Act 1900*
- Chapter 8 (Correctional patients) of the *Mental Health Act 2015.*

This means that a person on an involuntary mental health order can participate in the program provided they agree to full participation as per the eligibility criteria and treatment program.

The Centre focuses on the psychological and physical recovery and improved psychosocial functioning of participants by providing specialist nutritional and therapeutic interventions with medical monitoring and 24/7 nursing support for a period up to three months. This provides an opportunity for participants, carers, families, kin and supporters to envision their recovery journey and relationship with food when they are back in their own homes.

All services detailed in this MoC are tailored to the specific needs of this cohort 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 MoC includes the following service components:

- Combination of meal support and therapeutic interventions informed by evidence-based interventions and tailored to the participant's treatment needs and goals
- Strong focus on dietetics/nutritional support
- Physical health monitoring
- Carer, family, kin and supporter involvement

- Strong links to other established care providers and community-based services.

4.1 Care setting

The Centre is in the suburb of Coombs, ACT, mirroring a residential home providing a peaceful nature outlook and accessibility for participants and their carers, families, kin and supporters. Artwork supports the therapeutic role of the Centre in welcoming participants and supporting peer to peer interactions in a culturally safe space that is homely rather than institutional.

The Centre layout:

- The Centre has 12 beds laid out in a combination of single and double bedrooms
- Room allocation is decided by the CNC and Nursing team leader considering the participant's medical and psychological need and ensuring respect for gender, trauma informed care, culture, and sexual safety
- A commercial kitchen and participant kitchen. The participant dining room is designed to enable participants, carers, families, kin and supporters, peer support workers, and health professionals the opportunity to sit together at meals replicating regular mealtimes when participants are in their usual environments and supporting nutritional rehabilitation.
- Outdoor spaces and functional herb and vegetable gardens
- Shared living spaces, therapy rooms and meeting rooms
- Clinical spaces.

4.2 Care and treatment

Participants receive care 24 hours a day, 7 days a week. The multidisciplinary team (MDT) includes medical, nursing and allied health staff and other health practitioners.

Participants receive meal support therapy and are expected to participate in the group therapy program. They are offered physical health support, and interventions to support development of interpersonal skills, emotional regulation and identity beyond the eating disorder. Group and individual sessions are trauma informed and aim to identify factors that maintain the eating disorder and develop skills to address these factors, including the development of emotional regulation, interpersonal skills and the development of self-worth and identity outside of the eating disorder. Section 7 describes the therapeutic supports provided during the program.

In addition to treatment, participants will participate in housekeeping as agreed in their care plan. This is to simulate the home-like environment and foster a cohesive 'community' feel between participants at the Centre.

4.3 Staged treatment

The program is delivered in a staged approach, Stability, Challenge and Connection.

Each participant undertakes a distinct recovery journey. The treating team works collaboratively with the individual to develop a personalised treatment plan tailored to their specific needs and goals. While recovery trajectories differ from person to person, the program is broadly structured

around three progressive stages: Stability, Challenge, and Connection based on a framework for recovery in trauma therapy.[11] Participants transition through these stages at varying rates, depending on their clinical progress and individual needs. Not all participants will progress through all three stages.

Stability Stage

Participants begin in the Stability phase at admission. The focus is on medical stability, psychological safety, and settling into the program and new environment. Participants are asked to focus on completing meals and snacks and attending the group program. During the stability stage, access to leave from the facility is limited.

Challenge Stage

Once participants are medically stable and settled into the program, they will progress to the Challenge Stage. The goal is for participants to work with their treating team to challenge their eating disorder behaviours and beliefs. This will be different for each participant based on their individual goals and needs. These challenges may be based in the Centre or 'Challenge leave' may be granted for participants to engage in challenges in the community or at home. Challenges may also occur in session with a therapist or dietitian.

Connection Stage

The goal of the Connection Stage is for participants to prepare for discharge by beginning to participate in activities from their usual life. Where possible, participants can spend weekends at home, leaving the centre on Friday afternoon and returning late on Sunday evening, or early Monday morning. Participants can consolidate the skills they have developed at the Centre in their usual home environment, with the support of their treating team during the week to help problem solve any challenges or difficulties faced while at home.

5. Participant population and eligibility

5.1 Eligibility criteria

The target population for the Centre are participants with a primary diagnosis of an eating disorder, who meet the criteria for medical and psychiatric suitability, who can be safely medically monitored and managed in the Centre but require further nutritional, psychological and psychosocial support to achieve long term recovery and are willing to participate in all aspects of the program.

It is important that participants are medically stable as the intent of the Centre is to focus on the psychological therapy component of treatments, rather than physical/medical treatments. People who are assessed as not able to be safely managed at the Centre will be referred for further medical and psychiatric assessment and management prior to admission. Nasogastric feeding is not utilised and clients who require this level of care are not accepted for admission to the Centre. However, some medical interventions such as weighing participants, using oral nutritional supplementation, performing physical exams and conducting occasional blood and urinalysis tests are expected to take place consistent with eating disorder treatment guidelines

and the CHS Operational Guideline – *Providing Physical Health Care Across Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS).*

The Centre focuses on participants with the diagnoses of Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder, as defined by the International Classification of Diseases 11.

The service is sex/gender inclusive.

Table 1. Eligibility criteria

ACT residents	Interstate residents
• Age ≥16 years (dependent on developmental maturity). People aged under 16 may be managed as an inpatient at the Canberra Hospital or outpatient by the eating disorders team in consultation with the Division of Women, Youth and Children.	• Age ≥16 years (dependent on developmental maturity).
BMI >14 • An ACT resident with a BMI below 14 and a diagnosis of severe and enduring Anorexia Nervosa will be assessed on a case-by-case basis	BMI >15
• Participants are available prior to potential admission to undertake preadmission assessments	• Are engaged with an Eating Disorders treatment team within their local area who are available for consultation, liaison and discharge care following the residential care admission. • Engaged with adequate support to enable safe travel to and from the ACT.

All participants
• Residential treatment is determined to be the most appropriate treatment as determined by the EDRTC intake MDT and the admission assessments including a psychiatric review, physical health evaluation and a dietitian assessment. • Active engagement with a GP for medical monitoring and continuity of health care • Primary diagnosis of an Eating Disorder including Anorexia Nervosa, Bulimia Nervosa or Binge Eating Disorder (ICD 11) which is causing significant psycho-social functional impairment. • Agree to the participant agreement which outlines expectations of the participants while admitted to EDRTC • Consumers have capacity to agree to and participate in treatment at the Centre and are ready to make behavioural change with a high level of support. • No active alcohol or illicit substance dependence

All participants
• Manageable dietary restrictions (e.g. religious and/or cultural dietary considerations, allergies, and sensory sensitivities will be accommodated following a dietitian assessment.) • Medically stable as detailed in the Centre Operational Procedure and can be safely monitored and managed in the Centre.

5.2 Exclusion criteria

Exclusion criteria are as follows:

- Primary diagnosis of feeding disorder such as Avoidant Restrictive Food Intake Disorder, pica, rumination disorder. People who present with feeding disorders such as Avoidant/restrictive food intake disorder (ARFID) as their primary presentation will be referred to more appropriate services
- Requiring a level of medical care that cannot be provided at the Centre (e.g. parenteral and enteral feeding, daily blood tests, observations multiple times per day, at risk of re-feeding syndrome)
- Presentations where an eating disorder is not the primary issue
- Recent self-harm and/or suicidal behaviour
- Complex comorbid mental health presentations that exceed the management capability of EDRTC
- Active alcohol or substance dependence
- Inability to participate in the group program
- A higher or lower level of care would be beneficial as determined in collaboration with the participant and Hub clinical team
- Participant does not consent to the participant agreement.

6. Participant journey

6.1 Referral and admission pathway

Referral and enquires about EDRTC from the community are received through the Eating Disorders Clinical Hub who forward them to the EDRTC Intake team for triage and referral management. Referrals for patients who are a current inpatient receiving treatment for an eating disorder in TCH or NCH can be discussed directly with the EDRTC psychiatrist and/or the eating disorder transitional clinician.

Referral management considers the assessment findings, triage category and compatibility with the current participant milieu. Physical, dietetic and psychiatric assessment by EDRTC staff will be completed prior to admission. Engagement and readiness to address eating disorder concerns through the nutritional and therapeutic program is also assessed. Discharge planning commences upon admission so that timely referrals to community supports can be made.

Detailed description of the referral and admission pathway is in the Centre Operational Procedure. A summary of the participant journey is in Figure 2.

Figure 2. Eating Disorders clinical Hub referral flowchart

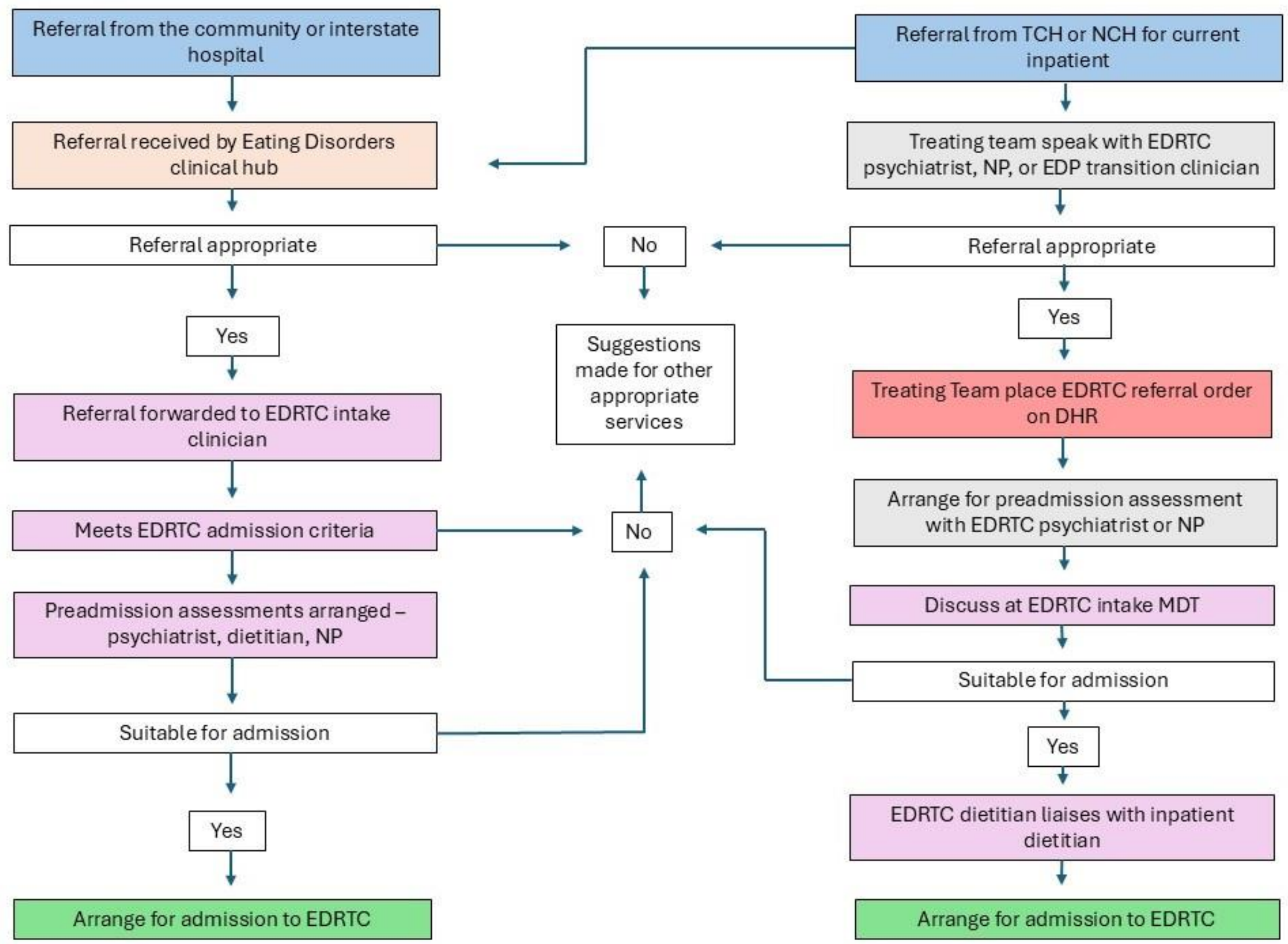
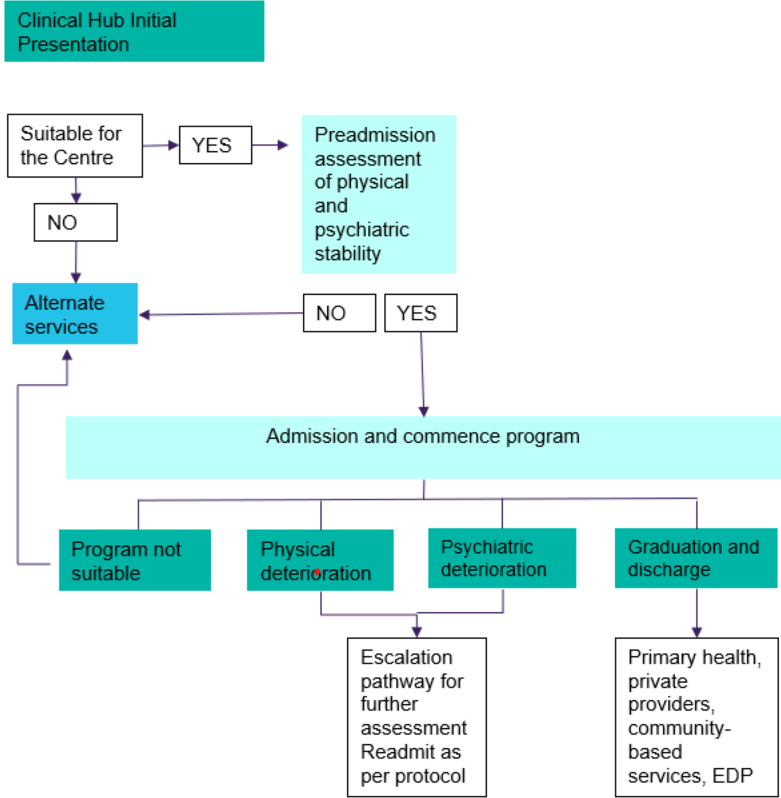


Figure 3. Participant journey through the Centre program



6.2 Discharge planning

The maximum length of stay is three months. Graduation and discharge planning commences from admission to the program. Discharge may occur if the participant:

- Has completed the program
- Chooses to withdraw from the program
- Finds the program is not meeting their needs
- Is unable to meet the expectations outlined in the participant agreement
- Has a change in care level such as requiring hospitalisation (may be readmitted as condition resolves)

To ensure a smooth discharge and seamless transitions between care, Centre staff in collaboration with the participant, will:

- Identify, engage and meet with a suitable post discharge care provider or outpatient team in the participant's geographic area
- Develop an individualised discharge plan
- Engage cares, family, kin and supporters
- Explore crisis prevention strategies, tailored to challenges the participant may face on discharge
- Connect with peer support and service navigation where possible
- Provide appropriate clinical handover
- Engage in collaborative care planning with appropriate community organisations.

6.3 Treatment Non negotiables

“Non-negotiables” are aspects of treatment, behaviours and intentions that are a key part of sustaining recovery. They need to be in place for even then most challenging days to help progress towards recovery.

The Participant Agreement covers the non-negotiable expectations that must be agreed to for admission to proceed. If a participant is consistently unable to meet the essential recovery commitments, such as nourishment, participation, respectful engagement, and maintaining a safe environment, it may be a sign that this program isn’t the right fit at this time. In such cases, Centre staff will work with the participant to explore alternative supports or pathways, which may include transitioning out of the program.

7. Therapeutic interventions

7.1 Individual therapy

Where appropriate, participants may be offered individual therapy sessions with an allocated primary clinician as agreed to in their care plan.

Psychological treatment is primarily supportive in nature; however, it may also be based on evidenced informed treatments for eating disorders and other mental health disorders, including:

- Enhanced Cognitive Behaviour Therapy for Eating Disorders (CBT-E)
- Specialist Supportive Clinical Management (SSCM)
- Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA)
- Motivational Enhancement.
- Dialectical Behaviour Therapy (DBT)
- Radical Open Dialectical Behaviour Therapy (RO-DBT)
- Interpersonal Psychotherapy (IPT)
- Compassion-focused therapy (CFT)
- Mindful Self-Compassion (MSC)

Dietetics:

- All participants meet with the Dietitian for individualised assessment and meal plan recommendations. The frequency and focus of dietetic appointments are tailored to the participant’s stage in the program.

7.2 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 a key 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. Some group sessions may be conducted in smaller or

multiple group formats including participant led groups, informed by the social milieu. All participants at the Centre are expected to attend group sessions.

Group therapy sessions include:

- Psychological skills group, psychoeducation groups, process groups, creative art therapy, music therapy and others
- Psychosocial interventions such as horticulture therapy, animal therapy and others

The use of these activities complements the core therapy interventions by focusing on the restoration of the whole person beyond the eating disorder and is consistent with Enhanced Cognitive Behaviour Therapy for Eating Disorders (CBT-E) principles of expanding other domains of self-worth and improving quality of life.

7.3 Meal support therapy

This MoC 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)[12]. Consistent with the principles of eating disorders treatment, the program is designed to support regular and adequate eating of three meals and three snacks each day. Using strategies such as hands on experience in the kitchen, group outings to public places such as cafes and restaurants, encouragement and support from staff, 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.

CHS Food services work closely with the dietitian and other health practitioners to support food preparation, self-plating and portioning in the kitchen.

7.4 Physical health support

Physical health assessment, monitoring, diagnostic and other testing, management of complex physical comorbidities and medication management is provided by nursing staff and a Nurse Practitioner (NP). All participants receive a physical assessment as part of their care planning.

The Centre uses the Early Warning System (EWS) (Adult and Paediatric) to monitor participants' physical health. Acute deterioration will be responded to as per the Centre Operational Procedure.

7.5 Carer, family, kin and supporter inclusion

The Centre recognises the critical role that carers, families, kin and supporters play in the management and recovery of a loved one's eating disorder. The Centre has a strong focus on integrating carers, families, kin and supporters throughout their loved one's stay at the Centre. This includes, as appropriate, attending MDT and family meetings, attending at mealtimes, and specific visiting times for carers, families, kin and supporters. Support is provided to carers, families, kin and supporters to assist their loved one in the recovery journey.

8. Progress monitoring and review

8.1 Care Plan

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

- Risk assessment
- Treatment goals
- Stage of care
- Distress tolerance plan
- Medication
- Meal plan
- Use of electronic devices
- Agreed leave
- Sexual safety

The care plan is reviewed and updated by the care team whenever the participant transitions to the next stage of the program.

8.2 Multidisciplinary Team Meeting (MDT)

The MDT meets every 2 weeks to discuss participant's successes, challenges and requests, and review and update participants' care plans. The MDT is comprised of the participants core treating team (therapist, dietitian, key worker, psychiatrist), a representative from the EDRTC leadership team and all relevant allied health, medical, and nursing staff involved in the participant's care. Participants are included in the MDT discussions. Carers, families, kin and supporters and members of a participants' outpatient care team may be invited to attend an MDT with the participant's consent.

8.3 Responding to barriers to progress/indicators for review

The Centre recognises that recovery from an eating disorder can be challenging. Consumers may have difficulty progressing toward their care plan goals, engaging with aspects of the treatment or require a higher level of support at times. Participants agree to the EDRTC Participant Agreement prior to admission – this document outlines expectations regarding engagement in the program, treatment non-negotiables and concerns that may indicate additional support is required to stay focused on their recovery.

Discussions and plans at all stages are documented on the consumer's electronic clinical record.

Deterioration in a participant's mental or physical state may require care in a more acute environment. Detail on responding to deterioration is found in the Centre Operational Procedure. The re-admission process to the Centre is detailed in the Operational Procedure

and is dependent on the cause of deterioration and assessment of safety to return to the Centre.

9. Service support

9.1 Bedside data entry, patient digital journey boards and the Digital Health Record

Clinicians use 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 mobile 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.

9.2 Communication within the Centre

Staff and participants have access to telephone communications through Voice over Internet Protocol (VoIP) telephones and the mobile phone networks for the area. The VoIP telephones and wireless internet access points (which allow internal and public internet access) are available for 30 minutes through 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.

9.3 Food services

Breakfast, lunch, dinner, morning tea, afternoon tea and supper are provided for participants. Meal ingredients may be delivered by CHS Food Services with preparation and portioning at the Centre, or components of the meals may be pre-prepared off site by CHS Food Services and delivered to the Centre for final preparation and portioning. CHS food services work closely with the Centre dietitian to develop the menu and ordering. The Centre covers the cost of cooking group therapy; participants pay for their snacks or take aways during cafe challenges. The Centre follows the *CHS Operational Procedure - Bringing Food into Canberra Health Services (Adults and Children).*

There are cafes near the Centre for families, parents and carers, families, kin and supporters.

9.4 Infection control

The centre complies with the National Safety and Quality Health Service (NSQHS) Standard 3, Preventing and Controlling Infections. The Centre complies with all relevant CHS policies and staff work with the Infection Prevention Control Unit to minimise the risk of healthcare related infection.

9.5 Interpreter services

The Centre adheres to the ACT Government – *Language Services Policy.* Interpreters are available through the Translating and Interpreting Services (TIS) for participants and families who require assistance to communicate effectively.

9.6 Linen

Supplies are delivered by the CHS linen contractor and delivered and collected on a regular schedule. 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 designated exchange site for collection.

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

9.7 Participant entertainment

Participant entertainment is not available in the bedrooms. Television and entertainment systems, puzzles, board games and art supplies are available within the communal recreational area of the unit. Participants can bring personal devices such as laptops and mobile phones. Use of personal devices is detailed in the Centre Operational Procedure and considers safe use of devices including ligature risk, accessing suitable websites, sleep hygiene, and privacy.

9.8 Pharmacy

Participant medication is supplied by CHS Pharmacy unless otherwise agreed by the treating team. Participants are asked to bring 3 days' supply of medications to allow time for review and dispensing from the CHS pharmacy. Medications are handled and stored as per the *CHS Clinical Policy – Medication Handling.*

9.9 Printer

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

9.10 Security

Therapeutic security supports the safety of participants, carers, families, kin and supporters, and staff within the therapeutic environment ensuring a proportionate level of security is maintained.

Relational security

Relational security describes the relationships between staff and participants, including aspects relating to the quality of care and resourcing, and staff ratios. Relational security involves knowing and understanding the consumer group and the circumstances in which there is a security risk. It requires staff to have a therapeutic relationship with the participants and know their history, risk potential, current mental state, behaviour, stressors, strengths and protective

factors. Carers and families can play a role in helping to understand the history, risk potential, stressors and protective factors for each participant.

Environmental security

The physical environment supports the safety and security of participants, staff and visitors and is the primary responsibility of CHS Security. There is no permanent CHS security located on site. Environmental or physical security pertains to structural aspects of the environment that make a facility physically secure. It includes building design, composition and maintenance, access control via intercom or swipe care, Ascom handsets, security and personal duress alarms, and cameras.

Procedural security

Procedural security refers to methods used by staff to maintain security, guided by relevant CHS policies, procedures and guidelines and is the responsibility of all staff, with clinical staff taking the lead role. It includes legislation, policies and procedures regarding the management of incidents, quality and governance, information management, legal obligations, audit, research and human resources.

9.11 Stores

Supplies are provided to the Centre through CHS Supply.

9.12 Video conferencing

Video conferencing is available within the main meeting room and multi-function room.

9.13 Wi-Fi

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

9.14 Cleaning and waste management

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

10. Workforce

The Centre workforce is diverse and multidisciplinary. Staff have a range of skills, knowledge, and experience to deliver comprehensive services and therapeutic interventions. This section details the workforce model for the Centre. Tree subsections give an overview of the MDT approach, the staffing profile and the workforce training requirements.

10.1 The multidisciplinary team

Care is delivered by experienced professionals who are appropriately trained and passionate about providing care and interventions. This includes staff from different health professional backgrounds and clinical support roles. Together, the Centre staff provide comprehensive,

discipline-specific and evidence-informed interventions. An MDT approach involves collaborative efforts and combined expertise to offer access to therapeutic interventions, holistic treatment formulation and comprehensive clinical review.

10.2 Staffing profile

The Centre requires a skilled workforce adept at assessing and treating people with an eating disorder diagnosis. The Centre is staffed by the following:

- Consultant Psychiatrist
- Nurse Practitioner
- Nursing staff
- Allied Health and allied health assistants (AHA)
- Administrative staff

A psychiatrist is responsible for all admissions and discharges and provides psychiatric management. Physical health support is provided by the Nurse Practitioner and nursing staff. Allied health staff may include psychologists, accredited practicing dietitians, social workers, AHA and creative arts therapists.

The Centre provides opportunities for students to complete placements under the supervision of staff who meet relevant CHS and Australian Health Practitioner Regulation Agency (AHPRA) supervisor requirements.

The Centre follows the ACT Nursing and Midwifery Safe Care Staffing Framework (Ratios Framework) included in the ACT Public Service Nursing and Midwifery Enterprise Agreement 2020-2022.

Centre staff are required to work flexibly. As stipulated in the position descriptions and in accordance with the relevant Enterprise Agreements, staff can be called upon to redeploy across the division to meet operational demand.

The staffing profile is outlined in Appendix B.

10.3 Accreditation and training

Professional development, supervision and clinical teaching are essential to delivering high quality care, and adequate time and resources are provided to meet clinicians' learning and teaching needs. This includes opportunities for supervision and establishing and promoting linkages with other eating disorders services to support staff development.

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, 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, NEDC minimum training standards, 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. EDRTC induction focuses on familiarising new staff with the MoC, service components and work duties, and the principles of care and culture underpinning the MoC.

All staff complete mandatory education specific to their discipline, role and the Centre workplace as per CHS, MHJHADS and local procedures. Nurses additionally have a Nursing Process Guide specific to nursing practice. 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.

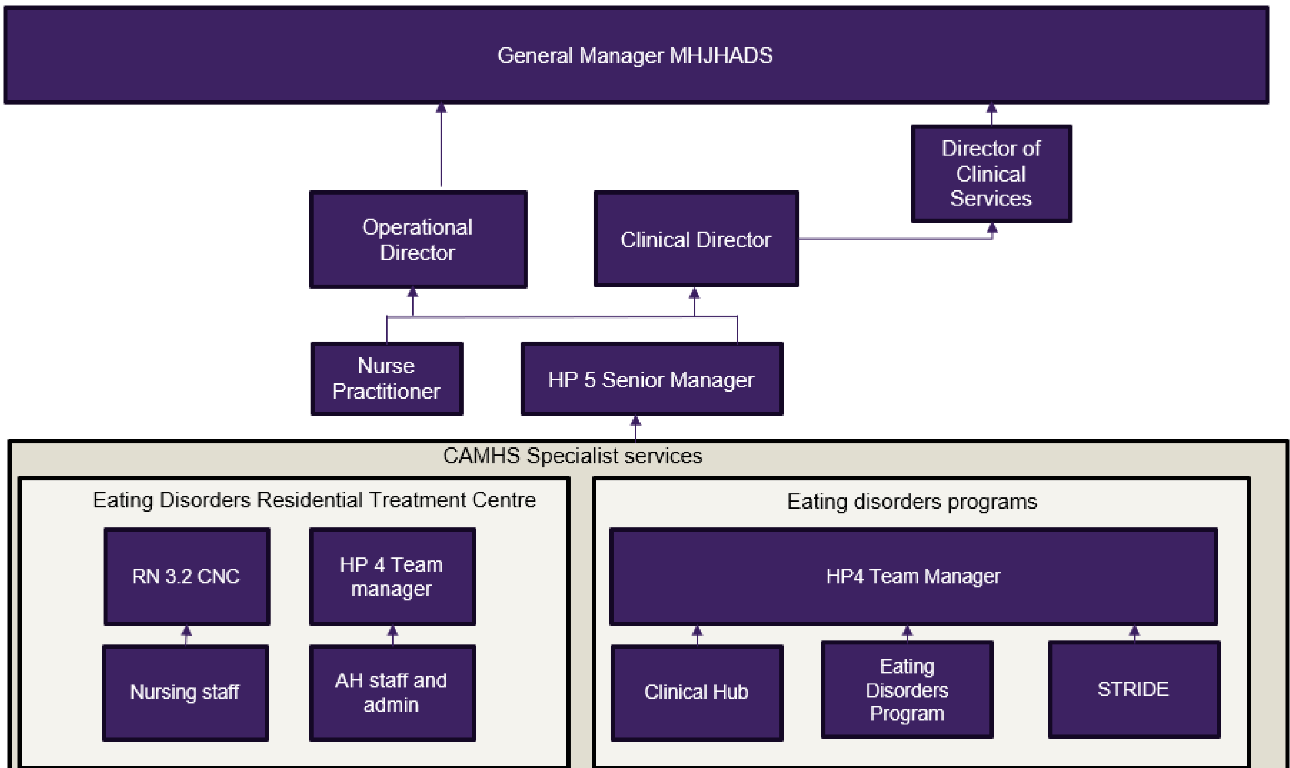
10.4 Research and collaboration

The Centre is committed to building the knowledge and evidence base in eating disorders treatment by contributing to and engaging in research and academic forums. Staff are encouraged to pursue post graduate qualifications relevant to eating disorders treatment and to participate in academic teaching and research opportunities. Quality improvement and research activities are actively sought and supported as are attendance and participation in local and national research forums and conferences. The Centre acknowledges it is part of a broader network of eating disorders services and has a role to play in contributing to national benchmarking and research activities and the body of academic literature in the field. Research and evaluation may be undertaken by Centre staff and/or in partnership with universities with relevant ethics approvals obtained.

11. Leadership and governance

The leadership team ensures high quality evidence informed, multidisciplinary coordinated care is delivered to participants and their carers, families, kin and supporters. The CHS Eating Disorder Services are under the governance of the Child and Adolescent Mental Health Service (CAMHS) as shown in the organisational chart.

Figure 4. Organisational structure for the Centre



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. All nursing staff are aligned professionally under the Assistant Director of Nursing (CAMHS), who reports professionally to the Office of the Director of Nursing. All allied health staff are aligned professionally to their professional leads, and the Office of the Director of Allied Health.

The Clinical Nurse Consultant (CNC) and Allied Health Manager 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 for the safe functioning of the Centre.

12. Interdependencies

12.1 Legislation

Centre staff are required to comply with the following overarching legislation, which collectively aims to ensure that individuals with mental health needs receive appropriate and compassionate care while protecting the rights and safety of patients and the broader community. Appropriate training is provided to ensure staff can meet this obligation. This legislation provides a legal framework that governs the operation of mental health services, setting standards for assessment and treatment while adhering to human rights principles and best practices in the mental health field. Staff must understand their responsibilities and apply service interventions in line with the following ACT legislation.

Human Rights Act 2004

The *Human Rights Act 2004* is the foundational human rights framework for the ACT. It protects and promotes the human rights of all individuals within the jurisdiction. In the context of mental health services, this legislation ensures that the rights of mental health consumers are respected and upheld. It sets the standard for the ethical and dignified treatment of individuals with mental health conditions, safeguarding their fundamental human rights. This includes rights related to privacy, dignity, freedom from discrimination, and access to adequate healthcare.

Mental Health Act 2015

The *Mental Health Act 2015* provides the legal framework for the assessment, treatment, and care of individuals with mental health disorders in the ACT. Its central function is to balance patients' rights and needs with the community's protection. It aims to ensure that mental health services are delivered with a focus on the least restrictive interventions and respect for patient rights.

12.2 Services

At the service level, partnerships and collaborations with various services, organisations and agencies are essential to ensure participants receive comprehensive and holistic care. The relationships with key service partners are described in the table below.

Table 2. Relationships with key service partners

Agency	Role	Function
ACT Public Eating Disorder Services	Pre and post Centre eating disorder care.	Participants may be referred to or from 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.
Animal therapy	Therapeutic support.	Animal therapy is 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.
CHS Aboriginal Liaison Officers	Support for Aboriginal and Torres Strait Islander participants.	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.

Agency	Role	Function
CHS – Acute hospital services (includes Canberra Hospital and North Canberra Hospital)	Mental health assessment and inpatient care.	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. If transfer of the participant is required to the Emergency Department for further psychiatric assessment the shift team leader will liaise with either Mental Health Consultation Liaison or the Hospital Liaison Team. Transfers are provided by ACT Ambulance Service. The CHS Alcohol and Drug Consultation Liaison service may be utilised as needed.
CHS Community mental health teams	Community based mental health care.	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 participant through community based clinical management.
General Practitioners	Physical and mental health care pre and post Centre admission.	GPs play a key role in holistic care and in particular early identification of risk, response to and management of eating disorders. 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

Agency	Role	Function
		through MDT processes to see their regular GP practice for routine, non-emergency situations that cannot be managed at the Centre
Other government and non-government Community based organisations	Community based occupational, educational, and psychosocial services.	Clients may be engaged with or referred to a range of organisations in the ACT and surrounding region that provide support for recovery, discharge planning and transition to the community. Carers ACT and Eating Disorders Families Australia provide support for families, kin and loved ones. Educational institutions may be involved on an individual basis.
Private clinicians	Care and therapy pre and post Centre admission.	Participants may be referred to or from the Centre to private clinicians (e.g. registered psychologist, accredited practicing 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.

13. Implementation

The MoC was implemented with the opening of the Centre. It is accessible to all staff and publicly available.

14. Monitoring and evaluation

The Centre is committed to ongoing improvement and contributing to the evidence base for the role of Residential Centres in the treatment of eating disorders in collaboration with participants and carers, families, kin and supporters. The MoC and operational procedures are reviewed in line with the MHJHADS evaluation framework.

14.1 Evaluation

Specific to the clinical evaluation, the federal Government has provided funding for and established a Technical Advisory Group (TAG). The TAG comprises of various eating disorder researchers and clinicians in Australia. This group developed a data set, outlined in the table below, to guide the collection of data at each of the federally funded residential programs across Australia. Data to be collected for clinical evaluation of the Residential Centre includes the following measures:

Table 3. Minimum data set

Measure	Frequency
Body Mass Index (BMI)	Weekly
Health Questionnaire EQ-5D-3L or EQ-5D-5L (EuroQol)	Admission and follow-up as per the National evaluation strategy under development
Eating Disorder-15 (ED15)	Weekly
Eating Disorder Examination Questionnaire (EDED-Q)	Start of treatment, every 4 weeks during admission.
Body Image Acceptance and Action Questionnaire (BIAA-Q)	Start of treatment, every 4 weeks during admission.
Patient Health Questionnaire (PHQ-9)	Start of treatment, every 4 weeks during admission.
General Anxiety Disorder Screener (GAD-7)	Start of treatment, every 4 weeks during admission.
Clinical Impairment Assessment (CIA)	Start of treatment, every 4 weeks during admission.
Your Experience of Service Survey (YES Survey)	On discharge or end of treatment
Carer Experience Survey (introduction TBC)	On discharge or end of treatment

CHS has an obligation to report both locally and nationally on performance, detailed in the Operational Procedure. Additional measures will be administered consistent with the Use of

Mandatory National Outcome Measures – MHJHADS policy and updated clinical guidelines, research, and CHS policy.

Other quality indicators may include adverse clinical events resulting in significant harm, morbidity or mortality.

Table 4. Activity data

Key data	Description
Admissions	Total number of admissions. Admission source: • MHJHADS teams • Interstate • Other Age Gender Diagnosis
Discharges	Total number of discharges Discharge reason: • Completion of program • Required higher level of care • Withdrew from the program Discharge follow up: • MHJHADS team • Private provider • Interstate • Other
Centre occupancy	Percentage of inpatient beds occupied
Average length of stay	Calculated for discharged participants
Care plan	Percentage of participants with a care plan - completed
Readmission rate	Readmission to inpatient care within 28 days
Admission assessment	Percentage of participants who have undergone physical examination within 24 hours of admission – conducted by a medical officer
Participant experience	Your Experience of Service (YES) survey results on discharge
Consumer and carer feedback response.	Percentage of Feedback responded to within 35 days (National Standard response time)

Qualitative assessment:

- Evaluation feedback from carers, families, kin and supporters
- Staff experience and satisfaction surveys
- 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, families, kin and supporters.

15. Records management

Records are managed as per the *Health Records (Privacy & Access) Act 1997* (ACT) and CHS procedures. 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. The MoC will be publicly accessible through the CHS Website.

16. Abbreviations

Abbreviation	Meaning
AN	Anorexia Nervosa
ARFID	Avoidant/restrictive food intake disorder
BED	Binge Eating Disorder
BN	Bulimia Nervosa
CHS	Canberra Health Services
DSM	Diagnostic and Statistical Manual
MHJHADS	Mental Health, Justice Health and Alcohol and Drug Services
MDT	Multi-Disciplinary Team
NEDC	National Eating Disorders Collaboration
OSFED/USFED	Other Specific/Unspecified Feeding and Eating Disorders
STRIDE	Short Term Recovery Intervention for Disordered Eating
TWMoC	ACT Territory Wide Model of Care for Eating Disorders

17. Appendix A – Staffing profile

Medical Staff

Position Title	Classification	FTE 2025	Comments
Consultant Psychiatrist	Staff Specialist	0.4	

Nursing Staff

Position Title	Classification	FTE 2025	Comments
Nurse Practitioner	4.2	1.0	
CNC	3.2	1.0	
Registered Nurse	RN2	5.7	
Registered Nurse	RN1	5.7	
Enrolled Nurse	EN2	1.0	
Enrolled Nurse	EN1	2.5	

Allied Health

Position Title	Classification	FTE 2025	Comments
Team manager	HP4	1.0	
Health Professional	HP3	3.0	Includes dietician and social worker
Health professional	HP2	3.2	Includes creative arts therapist intake clinician, psychologist
Allied Health Assistant	AHA3	3.0	

Administration

Position Title	Classification	FTE 2025	Comments
Administration officer	ASO3	1.0	

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