VICTORIAN ALCOHOL & DRUG ASSOCIATION

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Victorian Eating Disorders Strategy

Discussion Paper Submission

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VAADA Vision

A Victorian community in which the harms associated with drug use are reduced and general health and wellbeing is promoted.

VAADA Objectives

To provide leadership, representation, advocacy and information to the alcohol and other drug and related sectors.

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Introduction

The Victorian Alcohol and Drug Association (VAADA) welcome the opportunity to comment on the development of a new Eating Disorders Strategy in Victoria. As is recognised in the discussion paper, and further through this document, there is a strong correlation between substance use, abuse and dependence, disordered eating behaviours and eating disorders. The identification of this relationship and reference to it in the State-wide Strategy is a key first step in reducing the impact of eating disorders and increasing preventative efforts.

This identified pattern of co-occurring mental health and substance use issues is one of multiple cohorts that will hopefully benefit from reform to Victoria's Mental Health system and the vision of the Royal Commission for mental health care to be person-centred, led by those with lived experience as individuals, families and supporters; holistic -offering a more biopsychosocial model of care and for integrated treatment, care and support for individuals and their families who are affected by co-occurring mental health and substance use issues.

As illustrated below, VAADA, identify several opportunities within our sector that could aid in the development of a responsive, inclusive and integrated system that supports individuals with, or at risk of, an eating disorder across the continuum of care.

VAADA welcome further opportunities to collaboratively support the development of the strategy with the aim of reducing prevalence and minimising harm associated with co-occurring eating disorders and substance use.

Summary of Recommendations

The following recommendations are suggested to enhance the availability of care for individuals with disordered eating behaviours and disorders that present to the AOD sector.

Recommendation 1: *Develop of an eating disorder health promotion and prevention strategy that intersects with other health early development, education and welfare sectors that reflects stages of development, risk factors and high profile populations.*

Recommendation 2: *Introduction of routine eating disorder screening and assessment tools in AOD comprehensive assessment.*

Recommendation 3*: Capability and resourcing uplift for the residential AOD services to assess, monitor and support individuals with any disordered eating behaviours.*

Recommendation 4*: Review of eating disorders screening and assessment in Adult and child mental health and wellbeing services.*

Recommendation 5: *Access to primary and secondary consultation via eating disorders specialists for the AOD sector*

Recommendation 6: *Ensure that eating disorder treatment options are available for all and that the requirement of abstinence is not a barrier to treatment access.*

Recommendation 7: *Explore opportunities for individuals with co-occurring eating disorders and substance use issues to receive integrated treatment via the AOD service system that currently provides a biopsychosocial approach to care and therapeutic interventions that align with best practice for eating disorders.*

Recommendation 8: *Inclusion of the AOD sector as part of broader system for mental health and wellbeing support for eating disorders to ensure the needs of those with co-occurring mental health and substance use issues are met.*

Recommendation 9: *Increased focus and development of all health and wellbeing sectors to provide a biopsychosocial model of care that enhances the capacity for all services to provide best practice responses for eating disorders*

Recommendation 10*: Increased cross-sector investment and collaborative development of eating disorders in LGBTQI, Performance and Image Enhancing Drug (PIED) and Amphetamine user populations*

Recommendation 11*: Enhanced capacity for early identification and intervention in the Youth AOD sector.*

Response to Discussion Questions

1. Thinking about what Victoria's system of care for people affected by eating disorders should ideally look like by 2031, what three areas would you like to see prioritised? Why have you nominated these?

The following 3 areas have been listed as priorities in the context of the AOD sector and the needs of individuals with co-occurring eating disorder and substance use issues.

Priority 1: Enhanced eating disorder specialist care and workforce development initiative for the Adult and Child and Youth Mental Health and Wellbeing system

As reflected within the discussion paper, the public mental health system offers a limited focus on eating disorders that is either integrated together with all other diagnoses or delivered via 'specialist' eating disorder programs. It appears that these responses do not fully cater to the needs of all with eating disorders and that the system is currently skewed to providing treatment at the acute end of need.

The integrating of eating disorders into 'routine practice' within mental health services limits the ability for assurance of equity of service delivery and response across the public mental health system, particularly in consideration of regional/remote versus metropolitan services. Simultaneously, limited resources are also a barrier to equity of care and access when 'specialist' eating disorder services are established on a catchment based system, reducing access and requiring those in regional/rural communities to travel for care.

Further, whilst some initiatives have been funded to enhance eating disorder specialists, the recruitment to these roles is often difficult, in light of the limited opportunities for post graduate eating disorder specialisation within the psychiatry, allied health and nursing professions.

From an AOD sector perspective, the need for enhanced public mental health eating disorder services is required to ensure those with co-occurring AOD and eating disorder needs can receive integrated treatment, care and support across AOD and MH sectors. Many individuals accessing the community based AOD specialist sector do not have resources available to access private care for their eating disorder and therefore are limited in their options for treatment. Further, individuals may have experienced stigma from primary care providers as a result of their substance use and therefore be reluctant to disclose disordered eating behaviours; further limiting treatment options. Without an enhanced public mental health system for eating disorder treatment, across the spectrum of disordered eating diagnoses and levels of acuity, the AOD sector is often left to manage and/or coordinate care for individuals with eating disorders and substance use. Whilst some areas of the AOD sector may have skills to provide this care, the funding and nature of episodic periods of care limit the capacity of the AOD sector to do this work as core business.

To this end, any workforce development and capacity building initiatives to enhance eating disorder capability in Adult and Child mental health services must be offered across AOD and MH systems. Several successful models of cross-sectoral initiatives currently exist such as; Tripeaks (a partnership between VAADA (AOD sector), the Centre for Excellence in Child and Family Welfare and the Victorian Healthcare Association); Family violence advisors across MH and AOD sectors and the Victorian Dual Diagnosis Initiative (VDDI). There is obvious opportunity for these existing partnerships to be built on to include an eating disorder specialty.

Priority 2: Introduction of universal screening for disordered eating behaviours and eating disorders amongst populations who are at elevated risk including the alcohol and drug sector

There is currently a scarcity of screening and assessment for eating disorders across mental health and allied sectors such as the AOD sector. This lack of screening and assessment is in spite of the knowledge that there are common vulnerabilities to the development of an eating disorder and existing populations within the community that have higher rates of co-morbid ED and other conditions or concerns.

Multiple research studies have concluded that routine screening for comorbid substance use and mental health issues is best practice in being able to minimise harms and improve treatment outcomes (Marel et al 2016). This evidence applies to comorbid ED and substance use issues equally. Yet the introduction of routine screening for comorbid substance use and mental health disorders in both mental health and AOD sectors in Victoria has not to date included a focus on disordered eating behaviours. Where screening and assessment for disordered eating does occur it appears only to focus on the presence or absence of a 'disorder'. For the many individuals who have yet to receive diagnosis, are fearful of negative reaction to disclosure or are not aware that their behaviours are of concern, this style of screening will not identify their needs.

This issue is explored further on Page 5.

Priority 3: Investment and resourcing to support a continuum of responses across the spectrum of prevention, early intervention, treatment and recovery.

Research into eating disorders outlines several key factors that illustrate the need for a continuum of responses. Firstly, disordered eating behaviours are rarely a single point in time phenomenon for individuals and the course of illness can be protracted over many years. Secondly, high risk periods for the development of an eating disorder across the lifespan are evident (NEDC 2021). Whilst there is no direct causal factors for eating disorder development, multiple risk factors have been identified (Butterfly Foundation 2022; Mayhew et al 2018). With this knowledge, investment in prevention and early intervention is essential in reducing the burden of illness and addressing the cause of the change in eating behaviours before it escalates to a disorder.

Investing in early intervention and prevention would also result in increased community dialogue about eating disorders. As has been observed through other health promotion style programs like Beyond Blue, increased dialogue about the problem reduces stigma, increases the literacy of the community and could consequently create a culture in which those struggling with eating disorders feel enabled to ask for help as do their families and supporters.

Eating Disorders Victoria, and other eating disorder foundations across Victoria must be acknowledged for the work they do in promotion. However, the establishment and implementation of this strategy across a broad range of intersecting health and community services, along the spectrum of prevention, early intervention, treatment and recovery and within different high risk age profiles, will be essential to reducing the impact of eating disorders. This will require cross-sector AOD and mental health resourcing and support.

Evidence shows that the longer the pattern of disordered eating goes without intervention, the more entrenched and difficult the recovery (Butterfly Foundation 2017; NEDC 2021). Ensuring that there is a 'stepped care system' of eating disorder treatment, care and support is therefore essential to reducing the harms for the individual and their family. This 'system' requires person centred care for individuals with disordered eating at any stage of their need, supporting best practice interventions for eating disorders (Hay et al 2014; NICE 2017). People with eating disorders, like other mental health issues will require different services at different stages throughout their and are entitled to access these services close to where they live, when they need them.

Recommendation 1: Develop of an eating disorder health promotion and prevention strategy that intersects with other health and wellbeing systems, early development, education and welfare sectors that reflects stages of development, risk factors and high profile populations.

2. To what extent do the gaps and issues in the service continuum for eating disorders align with you understanding?

From and AOD perspective all the gaps identified are reflective of our experience. Those of particular relevance include;

- Challenges developing and adapting services for particular groups in the community who have additional vulnerability to eating disorders
- Lack of comprehensive and coordinated approach to building and supporting workforce capability
- Eating disorders not currently viewed as core business for medical and mental health services
- Stigma
- Lack of accessible services, including outreach support

3. Are there any further gaps and issues? Should the strategy prioritise any of these gaps or issues? What evidence do you have to justify this focus?

The following gaps should be prioritised for the co-occurring eating disorder and substance use population and considered as a part of broader mental health reform.

Issue 1: Screening and assessment for disordered eating and eating disorders

There is currently no systemic way of screening and assessing for eating disorders within the public mental health nor AOD sectors.

Within Area Mental Health Services, the State-wide assessment tool does not specifically explore disordered eating behaviours. Unless concern regarding eating behaviours is explicitly stated by an

individual or their family or the individual showed signs of malnutrition, disordered eating behaviours would largely be missed. The same applies for the Victorian AOD system. The current assessment tools, whilst including a variety of mental health screening and assessment tool does not specifically address eating disorders. The current optional module for individuals presenting with mental health concerns in the AOD assessment tool is the Modified Mini Mental State, which again does not screen for disordered eating behaviours.

It is important to note that if this screening and assessment were to be implemented across AOD services, it would be important to couple it with workforce development activities that focus on regular screening of eating disorders dependent on the course of treatment the individual is participating in. This necessity reflects the often inextricable and complex relationship between disordered eating and substance use that can include; compulsive behaviours, self- soothing, coping strategies and emotional regulation. Evidence reflects the importance of investigating the functional relationship between the ED and substance use and AOD assessment provides an obvious opportunity for exploration (Gregorowski 2013).

Due to the complex interrelationship between ED and substance use, disordered eating behaviours may not be recognisable until such time an individual ceases substance use. Therefore AOD treatment settings, such as residential withdrawal and rehabilitation should be prioritised for screening, assessment and workforce development activities. These services also provide a unique opportunity to observe people where they will be interacting with food in a group setting, providing a unique opportunity for screening, assessment and intervention.

If the enhancement of identification and treatment of eating disorders within residential AOD services, amongst others, were to be realised it would require both practice and systems change. Firstly, strong collaborative care between AOD and MH systems or resourcing for more mental health clinicians (nurse practitioners, psychiatrists, MH registrars) would be required to ensure high quality integrated treatment care and support is provided within the AOD system. Secondly, the AOD sector would require access to all workforce development activities, including the provision of primary and secondary consultation for those with eating disorders. These systems of care would be necessary to provide continuity of care throughout the individuals' recovery across mental health and substance use sectors.

The increased mortality risk associated with prolonged illness from eating disorders and research illustrating higher efficacy of treatment early in prevention both support the need for improved screening,. The introduction of routine screening also provide an opportunity for enhanced capability which will minimise an identified barrier to help seeking as identified by Bryant et al 2022. Bryant et al (2021) reported that approximately 5 Australians die every day due to the effects of an eating disorder, while only one in four individuals seek help for their condition. The introduction of routine screening could significantly increase the opportunities for those who have not yet sought help to be identified.

The ROAR and Feeding Your Instinct (FYI) eating behaviours screening tools available on the Eating Disorders Victoria website could easily be adopted as modules attached to the Victorian State-wide AOD Assessment tool. It is suggested that use of tools such as these could be prompted by the addition of a few extra routine eating disorder screening questions in the AOD assessment relating to body image concerns, functionality of substance use and/or other common disordered eating behaviours.

Recommendation 2: Introduction of routine eating disorder screening and assessment tools in AOD comprehensive assessment.

Recommendation 3: Capability and resourcing uplift for the residential AOD services to assess, monitor and support individuals with any disordered eating behaviours.

Recommendation 4: Review of eating disorders screening and assessment in Adult and child mental health and wellbeing services.

Recommendation 5: Access to primary and secondary consultation via eating disorders specialists for the AOD sector

Issue 2: Integrated treatment for people with co-occurring substance use and eating disorders

Conditions of entry for eating disorder inpatient treatment can present as a barrier to those with co-occurring substance use and eating disorders. Whilst it is appreciated that an abstinence based approach is required for inpatient treatment due to risk and legal issues, the ability for individuals to safely achieve abstinence from substances and maintain treatment for their disordered eating is a barrier to achieving wellness. Requiring abstinence prior to eating disorder treatment can increase risk as eating disorder symptoms may be exacerbated in the context of change and without alternative coping strategies. The requirement of abstinence for this cohort as a condition of treatment needs to be addressed across all treatment services.

Alternatively, working with an individual in the community from a harm minimisation perspective across both eating disorders and substance use could aid in alleviating this barrier. This style of treatment would also be more in keeping with literature that recommends concurrent treatment for co-occurring eating disorders and substance use is best practice (Hay et al 2014; NICE 2017). In order for this method of treatment to be viable, AOD and other allied services would require significant workforce development including upskilling and working as part of a system that supports them to do this work through primary, secondary consultation and direct access to acute care services.

Recommendation 6: Ensure that eating disorder treatment options are available for all and that the requirement of abstinence is not a barrier to treatment access.

4. What currently works well or could work well for consumers, their families, carers and supporters and providers?

The evidence base for treatment of eating disorders favours a biopsychosocial and multidisciplinary approach (Hay et al 2014; NICE 2017). As identified through the Mental Health Royal Commission, however, the current public mental health system is not designed around such models of care and thus many individuals may receive inadequate eating disorder treatment through this system currently.

It has also been identified in the Mental Health Royal Commission that the AOD sector plays an integral role in providing treatment for those with co-occurring substance use and mental health disorders. The AOD sector is largely built on a biopsychosocial model of care and as identified earlier, the sector do not perform routine screening and assessment for eating disorders. They do however provide treatment for features of addiction such as emotional dysregulation, trauma, coping mechanisms, distress tolerance and compulsive behaviours and employ multiple therapeutic models including CBT, ACT, motivational interviewing and stage based change management that are also used as part of treatment for eating disorders (Hay et al 2014; NICE 2017).

The Mental Health Royal Commission has identified the need for mental health services to move towards a more biopsychosocial model of care and recommendations 35 and 36 of the Royal Commission require mental health services to provide integrated treatment for co-occurring substance use and mental illness. The realisation of both these recommendations will undoubtedly aid in providing better outcomes for those accessing mental health care for eating disorders. However, without further investment and support to the lower tier of the stepped care model of mental health and wellbeing (AOD sector, primary health and families), the recovery prospects of those with eating disorders remains somewhat limited and again orientated towards the acute end of need.

In light of the strength of the AOD system in providing biopsychosocial care a possibility exists for the enhancement of eating disorders for co-occurring needs to sit within the AOD sector as well as within the mental health sectors.

Recommendation 7: Explore opportunities for individuals with co-occurring eating disorders and substance use issues to receive integrated treatment via the AOD service system that currently provides a biopsychosocial approach to care and therapeutic interventions that align with best practice for eating disorders.

Recommendation 8: Inclusion of the AOD sector as part of broader system for mental health and wellbeing support for eating disorders to ensure the needs of those with co-occurring mental health and substance use issues are met.

Recommendation 9: Increased focus and development of all health and wellbeing sectors to provide a biopsychosocial model of care that enhances the capacity for all services to provide best practice responses for eating disorders

5. In the discussion paper we have listed a series of groups that may need a greater focus in the strategy. Is this list appropriate?

We welcome the inclusion of people with co-occurring mental health and substance use issues as a priority group in this strategy. It is estimated that up to 50% of individuals with an eating disorder will abuse alcohol or an illicit substance (Gregorowski et al 2013). Further those with ED who use substances demonstrate worse ED symptomatology and poorer outcomes than those with ED's alone. It has also been reported that the presence of ED in substance using patients leads to greater severity of substance abuse and poorer functional outcomes. (Gregorowski et al 2013). In light of this strong correlation between eating disorders and substance use, it is suggested that treatment for disordered eating should not be confined to the mental health sector alone, but in fact be routinely available to individuals accessing treatment via the AOD sector also. In order to appropriately address the needs of those with co-occurring eating disorders and substance use issues it is important to understand that there are different cohorts within the broader substance using population that have an increased risk of co-occurring ED and substance use and addiction and different functional relationships between their substance use and eating disorder. The following section outline these groups.

1. Performance and Image Enhancing Drugs and Eating Disorders

Performance and Image Enhancing Drug (PIED) use has been associated with eating disorder and muscle dysmorphia symptoms in gender-expansive people and transgender men (Nagata et al (2022). Further lifetime use of PIED has been found to be associated with the presence of ED symptomology in the US amongst college students (Ganson et al 2022). In terms of prevalence, the Needle Syringe Program national Minimum Data Collection 2020/21 data reflected 9% of drugs injected on one snapshot day were anabolic agents and selected hormones (Heard et al 2021). Whilst this cohort of substance users may be smaller than others, the strong correlation between body image and PIED use presents an opportunity for cross-sector harm minimisation and health promotion within LGBTQI communities which are shown to be at a higher risk of disordered eating (Calzo et al 2017). Patterns of co-occurring PIED and substance use amongst athletic and young people is also worth exploring

Recommendation 10: Increased cross-sector investment and collaborative development of eating disorders in LGBTQI, Performance and Image Enhancing Drug (PIED) and Amphetamine user populations

2. People in residential rehabilitation services

As mentioned previously, the opportunity to observe eating behaviours amongst substance users in a residential setting presents a rare opportunity to actively identify disordered eating. As reflected in a 2019 study of eating disorders in residential substance use treatment found that nearly 60% of women screened positive for eating disorder symptoms with 32% reporting a previous or current eating disorder (Robinson et al 2019). If screening for symptoms of eating disorders was routine in residential AOD settings, based on these findings one would assume that regular high rates of co-occurrence would be uncovered. If resources were available within these settings to support people with disordered eating behaviours and help them to re-learn nutritional habits, high quality integrated treatment could be provided.

3. Young people in AOD treatment settings

Several factors point to the need for specialist consideration of young people with co-occurring eating disorders and substance use. Firstly, the average age of onset for eating disorders is between 12-25 years of age (Volpe et al 2016) which is similar to the pattern of first use of substances in Australia. As illustrated by the Australian Health and Wellbeing (AIHW) dataset (2022), age of first use of alcohol is commonly between 14-16 years and cannabis as the most commonly used drug between the ages of 12-17 years. Secondly, the developmental phase of adolescence is symbolised by significant physical, psychological and emotional change. This is often accompanied by periods of emotional dysregulation for some young people, particularly those who have experienced childhood adversity (Rienecke et al 2022). This period of emotional dysregulation can result in young people seeking new ways of self-soothing and or ways to control self which can include substance use and disordered eating behaviours (Mann 2014). Data suggests that addressing the underlying psychopathology in both these disorders may be critical, and treatment in adolescence may prevent deterioration in ED and SUD symptoms (Mann 2014). Engagement with a young person is often key to successful intervention. If all youth AOD workers were skilled in eating disorder screening and brief intervention it could significantly aid in capturing early signs of disordered eating behaviours.

Recommendation 11: Enhanced capacity for early identification and intervention in the Youth AOD sector.

4. Amphetamine users and eating disorders

The function of amphetamines in terms of weight should be considered when completing assessments of AOD use. As reported by Gregorowski et al (2013), amphetamines may be used as an appetite suppressant in order to aid weight loss. In fact, one study found that those who use laxatives, diet pills or diuretics to manage their weight are at an increased risk of abuse of stimulant substances suggesting a psychological state skewed towards 'immediate solutions' and impulsivity (Gregorowski 2013). It is also interesting to note that rates of amphetamine use are higher in individuals with Anorexia Nervosa compared to Bulimia Nervosa (Gregorowski 2013). The different reasons for disordered eating in these two cohorts, may be worth further exploration in terms of those with co-occurring amphetamine use disorders. Ensuring functional assessment of anyone who uses methamphetamine could provide an important opportunity for identification of disordered eating behaviours.

5. Cannabis users and eating disorders

Cannabis is the most commonly used illicit substance amongst individuals with anorexia Nervosa. Further, studies have demonstrated an increased cannabis use in ED patients compared to a control group and reported comparative prevalence rates across ED subgroups for this class of substance (Gregorowski et al 2013. Interestingly, within the Victorian AOD service data, cannabis is the most commonly used drug amongst those accessing treatment from the sector (AIHW 2022). Whilst this pattern may be reflective of broader societal trends, the connection between the actions of cannabis for sleep, anxiety and emotional regulation; symptoms that are common amongst those with eating disorders is worth further exploration. Again, given the high rates of cannabis use in both eating disorder and AOD treatment seekers, an important window of screening, assessment and treatment exists.

Whilst there remains conjecture in the literature about the benefits of medicinal cannabis for eating disorders, one small clinical trial of Dronabinol, a synthetic cannabinoid found an increase in weight

amongst individuals with enduring anorexia nervosa (Andries et al 2014). More importantly, the perception/ expectancies that medicinal cannabis will aid in either reduction of side effects resulting from the eating disorder or actually alleviate disordered eating behaviours has been identified amongst those with eating disorders (Scharmer et al 2020). With a growth in the use of medicinal cannabis for a variety of physical and mental conditions, further exploration of medicinal cannabis for eating disorders and as a potential harm minimisation strategy for cannabis dependent individuals with eating disorders is warranted.

Further exploration of the correlation between cannabis and eating disorders is required.

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