Australia & New Zealand Academy for Eating Disorders

Summer 2011-2012
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Contents

Editor's Report	1
President's Welcome	1
DSM V Update	3
Report for the senate	4
Supportive Meal therapy & Quiz 2011	5
ANZAED Conference report	6
EDRS report	7
Member Profile - Anthea Fursland	8
International Conference	9
NEDC update	10
New Zealand profile	11
Quiz results	12
AZNZAED 2012 conference details	12

Editor's Report

Warren Ward

Dear ANZAED Members,

Welcome to 2011/2012 Summer Newsletter, which is our most jam-packed newsletter to date. In this issue we have a profile on our new President Anthea Fursland. We also have a report on DSM 5, New Zealand update, as well as info on NEDC and EDRS. We even have a quiz!

I would like to thank our new Development Director Jeremy Freeman for putting together a much improved newsletter. Thanks also to Jeremy and Chris Thornton for our new website which I encourage you to visit at anzaed.org.au.

Remember this is your newsletter, so feel free to visit our website and write a letter to the editor or an article for our next quarterly newsletter.

Kind Regards

President's Welcome

A warm welcome to all of you, returning members and new members. It is my great pleasure to greet you in this newsletter, my first as ANZAED President.

We have had a busy few months since our last newsletter!

Annual Conference

In August we had our Annual Conference in Coogee Beach, NSW. My thanks to the Conference Convenor, Phillipa Hay, and her Scientific Planning Committee: Jeremy Freeman, Sloane Madden and Stephen Touyz. It was a wonderful conference, and I was not the only person to comment on the impressive standard of the workshop, paper and poster presentations. Please see Phillipa Hay's account of the conference on page 4.

AGM and Elections to the Executive

At our AGM, Chris Thornton bowed out as President after his two-year term. I would like to repeat my thanks and admiration for the way Chris has moved ANZAED forward under his leadership. He will continue on the Executive in the position of Past President, so we will have the benefit of his experience for a further term. I can only hope to continue his stalwart work.

As President-elect, I automatically assumed the Presidency for the next two years. Elected as Office Holders were: Sloane Madden as President-Elect, Warren Ward continuing as Honorary Secretary and Beth Shelton as our new Treasurer. Adrienne Alexander, Naomi Crafti, Shane Jeffrey, Simon Wilksch and Andrew Wallis continue as members of the Executive and I am delighted to welcome five new members: Susan Hart, Gabbi Heruc, Rachel Lawson, Susan Paxton, and Michelle Williams. Thanks and

farewell to Geoff Buckett, Phillipa Hay, Andrew Kennedy, Chris Martin and Roger Mysliwiec.

Development Director

Most of you will know that, because of ANZAED's recent growth and the recognition of our need for a higher level of support for continued expansion, the Executive decided to create the position of Development Director. We have appointed Jeremy Freeman, so - welcome, Jeremy! He has already hit the ground running and we hope he will help us develop further and increase the range of member services.

Our thanks to EDFV, who have provided us with administrative support for the past three years.

New Website

If you haven't yet seen our new website, please log on to www.anzaed.org.au. A huge thanks to Chris Thornton and Jeremy Freeman for developing and refining the new website. We hope you will find it much more user-friendly, and we welcome postings and feedback.

In line with this, we are working to simplify online registration for membership and conferences. Watch this space!

Professional Development

ANZAED continues to be involved in the ANZ ED PD group and holds the position of chair of that group. The group was formed in 2010 to support the development of the eating disorders workforce throughout Australia and New Zealand. The group held a face-to-face meeting the week of the ANZAED Annual Conference. We are involved in helping to coordinate a visit to Australia by Professor Glenn Waller. This trip is to coincide with his trip to Sydney to present at the biannual conference organized by CEDD and The Children's Hospital Westmead.

ANZAED also supports its members by arranging discounts for members attending certain PD events. Any ED workshop or conference wishing to obtain ANZAED sponsorship/support should contact Jeremy.

National Eating Disorders Collaboration (NEDC)

The importance of ANZAED's voice in the field of eating disorders has been recognised by the offer of an ANZAED seat on the NEDC Steering Committee (which I hold, as President). Several Executive members are active in the Steering Committee.

ANZAED and NEDC have formed our own type of collaboration! NEDC decided to run its 2011 Annual Conference in conjunction with the ANZAED Annual Conference in August, the day before the ANZAED Clinical Training Day. We heard from several ANZAED members who attended the NEDC day that they learned much from talking to and hearing from people with lived experience, whom they had only known previously in the role of patients.

ANZAED response to Medicare changes

Chris Thornton met with The Hon. Mark Butler MP, Minister for Mental Health and Ageing, with Christine Morgan from the Butterfly Foundation. This was in response to changes in the Better Access to Mental Health scheme, in particular the reduction of maximum sessions from 18 to 10. Minister Butler was receptive to our concerns, particularly how the reductions had unintended consequences for severe conditions such as eating disorders. Following the meeting with Mark Butler, a submission was made to the Senate, outlining ANZAED's concerns in more detail. See Chris' report below. The submission, together with the Hansard record of proceedings are also on our website.

To conclude…

As you can see, this has been a busy year for ANZAED and I expect many of you have been busy, too. The end of the year is a time when our energy tends to lag. I hope you have time over the holidays to refresh and renew your enthusiasm for the hard and important work you do. Enjoy the break, and come back invigorated!

My best wishes for the coming year and I look forward to working with you in 2012.

Anthea Fursland
President, ANZAED

DSM V

A useful development for eating disorders or tinkering around the edges?

By Stephen Touyz & Sloane Madden

When DSM V is launched in early 2013 it will be almost two decades since DSM IV was introduced in 1994. In the two decades preceding DSM IV, Bulimia Nervosa had not yet been described, so what great developments in classification have the last two decades spawned? In essence DSM V represents a gradual evolution of the thinking presented in DSM IV rather than the seismic shift some were advocating"

So what's new in DSM V?

Binge Eating Disorder

With DSM V now seeing Binge Eating Disorder graduating from the Appendix to the main body of the manual, this will hopefully drag some of the amorphous "NOS" hordes along with it. And surely it is a good thing to clearly recognise that people who have out-of-control binges with associated disgust, embarrassment &/or guilt and distress about this problem have a mental illness and should be treated as such – hopefully more helpfully than via obesity or weight control measures alone.

Anorexia Nervosa

Some small changes in diagnostic criteria should have some significant impact on clinical diagnosis.

Amenorrhea is gone as an inclusion category. This category was unhelpful in relation to males, pre-pubescent, menopausal females and women menstruating solely through being on the contraceptive pill. Amenorrhoea is simply one of many markers of malnutrition and in many ways was superfluous given the weight related criteria incorporated in the diagnosis of AN.

"*Refusal to maintain weight*" is replaced in DSM V by "***Restriction of energy intake relative to requirements***". The term refusal was thought to imply a deliberateness to an individual's action, requiring the clinician to have a clear understanding of a persons motivation to make a diagnosis of AN. As any clinician knows this is not only difficult but has the capacity to imply blame. The ability to make this judgement on the basis of both behaviour and corroborative history represents a significant move forward and matches the way clinicians using the diagnostic criteria for their patients

Weight Criteria

DSM IV refers to non-"**maintenance of body weight at or above a minimally normal weight for age and height**", It gives examples of "***weight loss.. or failure to make expected weight gain…leading to body weight less than 85% of expected***".

DSM V simply states "***weight that is less than minimally normal, or, for children and adolescents, less than that minimally expected***", omitting the example/guideline of 85% bodyweight. In contrast, ICD10 is more specific, requiring body weight in AN to be of at least 15% below the normal or expected weight for age and height.

This loosening of weight criteria in DSM V has a number of possible ramifications. It does leave more responsibility on the clinician to make the judgement about how critical the low weight is, which may be a problem for less experienced clinicians, greater flexibility does allow criteria such as weight history, body type, physical compromise to be more seriously considered as decision points.

This is particularly helpful in children where amount and rate of weight loss predict risk of severe medical complications rather than absolute weight. Similarly it is psychological pathology (abnormal body image and fear of weight gain) which are generally better predictors of severity than weight at presentation. It may have been useful for DSM V to include stage of illness as a factor, to discriminate between conditions of initial onset, recovery, relapse and chronicity .

Neveretheless, it is likely that the lack of strict weight criteria will increase the number of people diagnosed with AN in lieu of EDNOS.

Bulimia Nervosa

Frequency of Binging: Binge eating and inappropriate compensatory behaviours need only occur at least *once a week* (DSM V) rather than ***twice a week*** *(DSM IV) over a 3* month period. This adjustment is based on research evidence that people who binge once a week have the same level of, eating disorder pathology, the same level of functional impairment, similar rates of psychiatric comorbidity and the same response to treatment as people who binge/purge more often. This criterion will

probably increase the numbers of people diagnosed as BN.

The subtyping in DSM IV (Purging vs non-purging) is gone. This should not be of great consequence, as the non-purging subtype is rarely seen and indeed has received relatively little attention in the literature. If anything the non-purging subtype more closely resembles Binge Eating Disorder…

EDNOS

This category, renamed ***Feeding and Eating Conditions Not Elsewhere Classified*, (?FECNEC), has a number of informal subcategories described for possible future inclusion. These include: *Atypical Anorexia Nervosa*** (higher weight), ***Subthreshold Bulimia Nervosa*** (low frequency or limited duration), ***Subthreshold Binge Eating Disorder*** (low frequency or limited duration), ***Purging Disorder*** (in the absence of binge eating**), Night Eating Syndrome**, and the even more residual category ***Other Feeding or Eating Condition Not Elsewhere Classified*.**

Many expect and indeed hope that the prevalence of EDNOS/FECNEC will reduce due to the changed criteria in AN, the loosening of binge criteria in BN and the inclusion of BED. However in contrast, in his recent trip Chris Fairburn talked about the large group of "transdiagnostic" individuals who inevitably will vacillate between symptom patterns, and for whom a more specific diagnosis such as AN or BN is neither possible nor helpful.

So what other implications are there of these changes:

- With changes to diagnostic criteria potentially altering the inclusion and exclusion criteria in research studies, the smallish changes to AN and BN should not make a huge differences while the two year roll-in will allow researchers time to prepare.
- The increased definitions of the old EDNOS category should allow for greater tailoring of treatments, and facilitate the development of approaches for conditions such as purging disorders and night eating syndrome.

  What do you think? Have a look at the proposed changes at the APS website http://www.dsm5.org/ProposedRevision/Pages/FeedingandEatingDisorders.aspx, and go to http://www.anzaed.org.au/blog.html and share your opinion.

A REPORT FROM THE SENATE

Chris Thornton, Canberra

As noted in this year's AGM, ANZAED has been liaising with the Australian Federal Government regarding their decision to decrease Medicare funding for treatment for mental health issues by psychologists from a maximum of 18 sessions to 10 sessions. ANZAED prepared a submission to the Senate Enquiry into these changes that was read by the senators. A copy of this document is at www.anzaed.org.au.

Our immediate past president, Chris Thornton, has also, in conjunction with The Butterfly Foundation, has held two meetings with the Australian Minister for Mental Health, The Honourable Mr Mark Butler. In these meeting Minister Butler expressed concern for the unintended consequences that the decision will have on the ability to provide Evidence Based Treatment for eating disorders within the private sector.

The senate enquiry largely supported ANZAED's broad concern as to the impact on the changes to mental health, and eating disorders were cited as a key example in the Senate report. It is unclear however, if the recommendations of the enquiry will impact government policy in the short term.

ANZAED has a clear role to continuing to lobby the Federal and State Government to highlight to them the impact of their decisions on the treatment of the eating disorders. ANZAED is grateful to Christine Morgan and The Butterfly Foundation for the opportunity to meet with the Minister to present a combined clinician and consumer perspective.

Supportive Meal Therapy

An article and quiz based on a paper presented at the 2011 conference by Johanna Dalton, Royal Brisbane & Women's Hospital

Supportive Meal Therapy (SMT) is a process whereby the clinician eats a meal with the patients and models appropriate eating behaviour, while fostering an environment that is conducive to nutritional restoration. Although this mealtime support is a common and time consuming aspect of treatment, there is very little evidence to support how this should be implemented.

The eating disorder unit I am currently Nurse Unit Manager of (Royal Brisbane and Women's Hospital) was experiencing extreme stress, confusion and burnout by staff and also patients. At the 2011 ANZAED Conference in Coogee it was obvious that our problem was not unique.

We developed training on SMT and utilised pre and post questionnaires to assess the staff knowledge and attitudes. We were aiming for an increase in knowledge and a less invested attitude from staff post the training. Recent research, including that of Josie Geller, suggests that low investment in changing the patient can encourage the patient to change.

We found that staff felt more confident, less invested and had more knowledge after the training – and therefore were much more willing to eat with the patients.

We now have more staff than ever that are able to provide SMT and generally less confusion over the guidelines. The patients seem reassured by this and although SMT remains a very trying time for the patients, the table environment seems less tense.

Check your knowledge and approach/attitude with these sample questions. Answers on back page…

QUICK QUIZ

1. **A patient asks to have a bread roll in addition to the dinner prescribed on their meal plan. Would you**

a) allow them to get a bread roll
b) allow them to get a bread roll and then discuss in the ward round
c) do not allow them to get a bread roll and explain that no changes to the meal plan will occur without dietitian approval

2. **You have been allocated to have lunch with the eating disorder patients but don't feel hungry by the time lunch comes around. Would you**

a) Eat an adequate well balanced meal
b) Tell the patients you aren't hungry and eat an apple as it's all you feel like
c) Attend lunch and apologise to the patients by telling them you aren't hungry – you've already eaten.

3. **You ask a patient to stop cutting their toast with a knife and fork. They ignore you and continue to eat inappropriately. Would you**

a) Stop the meal, and insist that they stop using the cutlery immediately or leave the table.
b) Repeatedly remind the patient to stop using the knife and fork throughout the meal hoping that they will eventually stop
c) Having raised it initially, continue with the meal and not mention it again at the table.

4. **Is it your job to ensure that patients eat all of their food during supportive meal therapy?**

a) Not at all
b) A little bit
c) Not sure
d) Mostly, yes it is.
e) Absolutely, I am there to ensure they finish their meal

See back for answers

2011 ANZAED Conference: Coogee

By Phillipa Hay, Conference Convenor

ANZAED held its 9th Annual Conference for Eating Disorders from Aug 24th to Aug 27th in The Crowne Plaza Coogee Beach Hotel. There was a fabulous vibe at the meeting with over 250 attendees at the conference and pre-conference training days. Sydney turned on the weather and we were treated to warm days of sunshine, postcard views during cocktails, as well as a wonderfully diverse scientific program which included oral presentations, posters, workshops, discussion forums and debates.

We had two thought-provoking keynotes. On the first day Professor Caroline Meyer, from Loughborough University in the UK, talked about excessive exercise and eating disorders, and on the second day Professor Perminder Sachdev, from the University of New South Wales, spoke on insights from neuroscience on anorexia nervosa. Both keynotes presenters participated in small group discussions as well.

The Clinical Training Day, preceding the conference, involved four workshops. The two excellent advanced workshops were: Acceptance and Commitment Therapy (ACT) by Chris Thornton, Dr Carla Walton & Anjanette Casey; and Managing Compulsive Exercise by Prof. Caroline Meyer. For the first time we offered two introductory workshops, in conjunction with the Australian National Eating Disorders Collaboration (NEDC). These were: an Introduction to Eating Disorders, by senior Centre for Excellence in Eating Disorders CEED staff Dr Beth Shelton and Michelle Roberton; and Working with Carers, by Dr Naomi Crafti of Eating Disorders Foundation Victoria EDFV.

The conference closed on a somewhat lighter note with a very entertaining debate on “Can dieting ever be safe?”. Dr Geoff Buckett and Professor Jan Russell set the scene for forthright and lively argument from dietitians present.

Also our congratulations go to the Paul Foulkes Clinician prize winner: Linsey Atkins; and the Peter Beumont Young Investigator prize winner: Amy Lampard, from the School of Psychology University of Western Australia, for her paper: *The Role of Dietary Restraint in the Persistence of Binge Eating in a Clinical Sample*. The standard of the young investigator papers continues to rise and is fantastic reassurance the future is in good hands, as does the excellent roll up to the AGM and strong interest in Executive positions.

We had a great response to feedback but if you misplaced your form and had feedback please just send comments in an email to Jeremy jeremy.freeman@anzaed.org.au.

In particular the organisation went smoothly (thanks again to the Program Committee: Jeremy Freeman, Dr. Sloane Madden and Professor Stephen Touyz and all the volunteers!), short poster orals were generally well received (but were a bit far from the actual posters), the early start for the AGM not so well received! (but this is hard to timetable) and whilst the discussion groups were liked we need to ensure a minimum number per room to reduce noise.

Please diary ANZAED's next annual conference in **Adelaide August 23-25**, 2012. Keynote speakers are Professor Carolyn Black-Becker and Professor Marika Tiggemann. Adelaide is an elegant cultured city known for its fine dining, wineries and Tuscan-like countryside.

NEWS FROM AROUND THE GLOBE: 2011 Eating Disorder Research Society (EDRS) meeting

Beautiful Edinburgh, Scotland was the setting for the 17th Annual Meeting of the Eating Disorders Research Society (EDRS), September 22-24, 2011. Many exciting topics were covered by researchers from all over the world, including several UNC Eating Disorders Program faculty, fellows, and students. Particularly "hot topics" included the NORA (noradrenergic) model of anorexia nervosa (AN); the ARIADNE (Applied Research into Anorexia Nervosa and Eating Disorders Not Otherwise Specified) program; and new research focusing on bone and endocrine health in AN. The NORA model posits that underlying noradrenergic dysregulation leads to high levels of anxiety and to low blood flow to a key brain area (insula) where body image is "stored". The melding of these two factors causes high levels of body-focused anxiety that promotes intense dieting. In the short term, dieting reduces noradrenaline, which "turns down" the anxiety level. But, in the long term, dieting behavior increases in order to maintain this "anti-anxiety" effect. Interesting supportive preliminary data from a brain imaging study were presented, but much more research is needed to validate or refute the model.

ARIADNE is a 5-year research program in the UK that aims to translate findings from experimental neuroscience into clinical practice toward the goal of developing optimal management strategies for patients at all stages of illness. Four (of seven total) sub-projects of the program were highlighted: (1) MANTRA (Maudsley Model of AN Treatment for Adults), which is a novel trait-focused psychological therapy for AN; (2) CREST (Cognitive Remediation and Emotion Skills Training), which teaches patients how to accept, tolerate, manage and express emotions; (3) ECHO (Expert Carers Helping Others) and OAO (Overcoming Anorexia Online), which are low intensity, distance learning interventions to reduce distress and to change self-factors that may help maintain care recipients' disordered eating thoughts and behaviors; and (4) a community-based study of mothers with eating disorders and their offspring.

The symposium on bone health in AN provided important information about (1) the roles of low levels of lean body mass and insulin like growth factor-1 and high levels of cortisol in persistent bone deficiencies even after patients regain weight; (2) the impact of AN and binge eating on infertility and polycystic ovary syndrome; and (3) the potential to stop bone loss in young girls with AN through low dose estrogen replacement.

Topics covered by UNC researchers focused on (1) a novel glucose measure that may be helpful in gauging the severity of binge eating; (2) a community-based approach to engaging Latino family members in eating disorder treatment; (3) the impact of proposed changes in the DSM-5 for binge eating frequency in the diagnosis of bulimia nervosa and binge eating disorder; (4) body image and disordered eating in women over age 50; (5) an update on the Genetic Consortium for AN (GCAN) genomewide association study; and (6) factors associated with time to recovery in AN.

In addition to all this great new science, conference attendees were treated to a "haggis ceremony" and reception at the Edinburgh Castle, and to dinner at the beautiful Royal Botanical Gardens. It will be a hard act to follow, but no doubt next year's EDRS conference in Porto, Portugal, September 20-22, 2012, will be just as exciting.

Reprinted, courtesy Dr Kim Brownley, University of North Caroline: The UNC Eating Disorders Program Blog October 21, 2011

MEMBER PROFILE:
ANTHEA FURSLAND: ANZAED PRESIDENT

Where did you study psychology?
I received my BSc Hons (Psych) at the University of London; my MSc (Clin Psych) at University of Guilford (both UK); and my PhD (Clin Psych) at the Wright Institute, Berkeley, California

Why?
I got into the field of psychology when I was working in the market research department of an advertising agency. My boyfriend thought I was wasting myself in a menial job and should go to uni – but I had no confidence as hadn't done that well in my A levels (Year 12 exams). He'd studied psychology and lent me two books to read, so I read them and thought "Why not?"

What led you into your special interest area of ED's?
I got into Clinical, and in my last placement (in 1980!!) I chose Atkinson Morley Hospital, as it had been a Therapeutic Community - and, being a child of the 60s, I thought that would be fun. Little did I know it was also the regional ED centre (part of St. George's) – and was headed up by Arthur Crisp (who was then one of the few people in the UK writing about EDs). I went to work in the public sector and became known as an 'expert' on EDs – just because I knew a little. I did further training at the Women's Therapy Centre, supervised by Susie Orbach, and was in a consultation group lead by Marilyn Lawrence.

What is the best thing about your job?
The variety. Before coming to Perth I had been a clinician for 25 years and involved in supervision/consultation. I was also Chair of ED Best Practices for a large insurance company (26 clinics). But I had never been involved in research, and working at CCI, I'm fortunate to be involved in the research/practice interface. I've enjoyed disseminating CBT-E in Australia, creating the CCI web modules, researching and publishing our outcomes with Sue Byrne, being a therapist in a large RCT…I'm involved in such interesting areas and I feel incredibly lucky.

What is the worst thing about your job?
Not having enough staff to see the patients quickly enough - as it is now, we have a long waiting list.

What do you enjoy doing when you're not being a psychotherapist?
I love planning and cooking meals, eating out, and drinking red wine with my partner!

Was any particular mentor significant or vital in your career?
Arthur Crisp wasn't really a mentor, but his respectful stance and his developmental approach influenced the way I look at people with eating disorders - I recommend his chapter in Garner & Garfinkle, and his book, 'Let Me Be'. Marilyn Lawrence helped me understand anorexia nervosa better, through consultation and her book, 'The Anorexic Experience'.

You have trained in some interesting places…what did you get most out of each of these?
My original training was really in Behavioural Psychology so my secret's out - I'm a behaviourist at heart! Then I got interested in Feminist Psychotherapy (trained at the Women's Therapy Centre) and in psychodynamic psychotherapy (trained at the Tavistock Clinic) – and most of the clinical work associated with my PhD was in Object Relations theory. So I came to CBT rather late in the game, and through rather a circuitous route! But I believe that my behavioural beginnings and my development through

feminist and psychodynamic theory and therapy mean that I bring a wealth of understanding to my current work.

What books are on your bedside table now?
Half-blood Blues (Esi Edugyan) and The Cat's Table (Michael Ondaatje)

What is your favourite piece of music?
Shine on you crazy diamond. Why? It's Pink Floyd – brilliant and haunting; a sad story about their former lead singer, Sid Barrett, who went 'crazy'.

What is your favourite food?
I love spicy foods – curries and Thai food, but I also love modern Spanish cuisine.

What makes you passionate?
Belief in the value of what I'm doing – whether it's creating a tasty dish or doing my best to help someone overcome their eating disorder. Love. Justice. A great pair of shoes!

What inspires you?
My dislike of mediocrity.

How would you describe yourself in three words?
Short. Tenacious. Fun-loving.

Where do you hope to still travel?
Macchu Picchu, Luxor, St. Petersburg, Buenos Aires, Croatia, Vietnam…

What is your earliest memory?
Living in Jamaica, when I was three.

What do you hope to achieve as President of ANZAED?
I would like to see ANZAED continue to grow in prominence and influence as the frontline organisation of professionals, contributing to state and federal ED policies, and becoming even more involved in advocacy and the development of ED training across Australia and New Zealand. I believe we need to be more responsive to events such as models dying from starvation, but not just be reactive – we need to promote positive messages of health and raise awareness in the broader community.

International Conferences

F.E.A.S.T

First international F.E.A.S.T. (Families Empowered and Supporting Treatment of Eating Disorders) conference - Warrenton, Virginia, U.S.- November 3-4, 2011
http://www.feast-ed.org/Alexandria2011.aspx for more info.

21st Annual Renfrew Center Foundation Conference

Feminist Relational Perspectives and Beyond: The Next Generation.
November 11-13, 2011
Philadelphia Airport Marriott
http://www.renfrew.org/news-events/events/21stConfSaveTheDate.asp
for more information

Eating Disorders International Conference

EDIC EATING DISORDERS INTERNATIONAL CONFERENCE 2012

The Second **Eating Disorders International Conference** , Institute of Education, London from March 15th to 17th 2012.
Keynote Speakers: Terry Wilson & Andy Hill
http://www.edic.org.uk/ for more info

2012 AED Conference

2012 AED International Conference on Eating Disorders
May 3 – 5, 2012, Hilton Austin, Austin, TX USA
http://www.aedweb.org/AM/ for more info

iaedp ***Symposium***

2012: March 22-25, 2012
Charleston Marriott, Charleston, South Carolina
http://www.iaedp.com/ for more info

National Eating Disorder Collaboration (NEDC) update

Background

The NEDC project is funded by the Department of Health and Ageing (DoHA) to develop a national framework and standards for the promotion, prevention, early intervention and management of eating disorders. It is administered by The Butterfly Foundation who has responsibility to bring together key stakeholders with an interest in eating disorders, and to deliver the framework and standards to DoHA. The steering committee is chaired by Professor Pat McGorry and comprises experts and leaders in eating disorder prevention, treatment, research as well as consumers and carers.

Anthea Fursland, as ANZAED president has a position on the Steering Committee, most of whom are ANZAED members. These include current ANZAED Executive members Sloane Madden, Chris Thornton, Naomi Crafti and Susan Paxton. NEDC working groups include the Clinical Reference, Professional Development, Prevention and Early Intervention, National Standards, Social Messaging, Information and Resource, Collaboration & Membership and Evidence from Experience.

Current projects

A **National Framework** has been developed which lays out the fundamentals of how eating disorders should be managed in Australia.

The Framework includes a national standards schema comprising 7 key principles for *prevention and treatment* and 4 key principles for *implementation*:

Prevention and Treatment:

1. Tailored approaches that address the needs of individuals
2. Prevention, early identification and intervention are prioritised and resourced
3. Safety and flexibility in treatment options
4. Partnering to deliver multi-disciplinary treatment in a continuum of care
5. Equity of access and entry
6. Tertiary consultation accessible at all levels of treatment
7. Families and carers are supported as integral members of the team

Implementation:

1. Evidence informed and evidence-generating approaches
2. A skilled workforce
3. Communication to ensure an informed and responsive community
4. Health systems support integration, collaboration and on-going development.

The National Framework expands on these principles, explaining the current evidence basis and how they need to be applied.

The **Communications Strategy** provides an evidence informed strategic framework and guidance on communication about eating disorders, focusing on the need to raise awareness and ensure early identification and intervention. The four objectives of the strategy are to:

1. Enhance recognition of eating disorders,
2. Support prevention programs,
3. Promote resilience and
4. Encourage help seeking.

The strategy includes key messages about eating disorders, with an evidence base for what can and cannot be said. The strategy includes participation in current and future population health promotions and campaigns, where appropriate.

A website is currently being developed which will link to the ANZAED website and include an evidence based clearinghouse of resources, professional guidelines, professional development opportunities and access to an e-network through Facebook for professionals.

NEDC linked its annual conference to ANZAED in 2011 by conducting its National Workshop in the same week and running two training workshops through ANZAED at the Crowne Plaza Coogee as well as a workshop tailored specifically for those with a lived experience of an eating disorder, as described in the Conference report above.

To hear about or become a member of the NEDC, see www.nedc.com.au.

ANZAED members have the opportunity to review the draft National Framework and Communications Strategy and give feedback by 31 December, 2011to have an opportunity for input into the final documents at http://www.anzaed.org.au/nedc.html

NEW ZEALAND PROFILE

By Rachel Lawson

HOW IS PROVISION OF TREATMENT FOR EATING DISORDERS SET UP IN NEW ZEALAND?

New Zealand has three speciality regional eating disorders services known as "hubs" that support their local "spokes" or districts. These speciality services are based in Christchurch (South Island Eating Disorders Service-SIEDS), Wellington (Central Region Eating Disorders Service-CREDS) and in Auckland (Regional Eating Disorders Service-REDS). These services provide treatment for eating disorders and consultation and training to their districts. Each district has an eating disorders liaison (EDL) clinician who is an expert in eating disorders, and who works closely with the hubs to co-ordinate training and provide advice to local clinicians on eating disorders. EDLs may also be involved in providing treatment to service users and their family/ whanau.

SOUTHERN REGION

The Southern region covers the South Island. SIEDS have an outpatient and inpatient service for those aged 13 years of age and upwards. The inpatient beds are available for all those across the South Island who need more intensive care. SIEDS uses telemedicine to provide teaching and case consultation to its districts and also visits each district twice a year.

The South Island also has Southern Support Eating Disorder Service. This is a contract held in primary care for the Southern part of the South Island.

The South Island also has the Eating Awareness Team (EAT). EAT provides information and support for individuals, families and professional on eating disorders.

CENTRAL REGION

The Central region encompasses the Hutt Valley; Capital and Coast (Wellington), Mid Central (Manawatu), Hawke's Bay and Whanganui DHBs, with EDL clinicians in each district. CREDS have an outpatient service, a day programme and a residential service, taking referrals from all sources, including self-referral. The residential beds are for clients 16 and upwards and are reserved for the most unwell clients or clients from the district who require a two week assessment. CREDS provide a primary, secondary, and tertiary service along with consultation/liaison and education.

MIDLAND REGION

The Midland region encompasses Lakes DHB, Taranaki DHB, Waikato DHB; Bay of Plenty DHB and Tairawhiti DHB. Each DHB has an Eating Disorder Liaison clinician who supports staff in their area working with clients with eating disorders. They also provide consultation and training to their DHB and community.

NORTHERN REGION

The Northern region encompasses Auckland DHB, Counties/Manakau DHB, Waitemata DHB and Northland DHB. REDS is based in the Auckland DHB as the "hub" service and their spokes/ districts are the other DHBs and the Midland Region DHBs. Each district has EDL clinicians. REDS is an outpatient service consisting of an adolescent, adult and an outreach consultation team. The residential and day programme services for individuals aged 15 years and older are run by Thrive. Thrive is a part of Challenge Trust. REDS also works in close partnership with Starship Hospital who provide expert inpatient care for young people up to age 15.

The Northern region also has the Eating Difficulties Education Network (EDEN). EDEN is a non-profit community agency based in Auckland. Their purpose is to promote body trust and satisfaction, size acceptance and diversity on an individual and societal level.

The Northern Region also has the Eating Disorders Association of New Zealand (EDANZ) which was set up in 2007 by a group of parents from Auckland. Their aim is to provide support, information and help to families

MAUDSLEY FAMILY BASED THERAPY (FBT)

New Zealand has nearly finished its roll out of MFBT. As we know for anorexia nervosa early detection and treatment is the key to recovery SIEDs runs a monthly telemedicine supervision group and CREDS has developed a special interest group and some telephone supervision.

For further information contact Rachel Lawson:
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Answers to Supportive Meal Therapy quiz

1. c) as the meal plan is written up by a dietician it has been carefully calculated. Too much food may result in re-feeding syndrome. Food is the medicine. It's important to be consistent. Changes outside of the ward round/team review can result in splitting.
2. a) It is important to role model healthy eating. We need to be the proof that eating does not cause rapid weight gain etc.
3. c) Low investment. Raise the issue outside of the table environment as the table is too stressful. Discuss the concerns 1:1 in private.
4. The preferred response is a) as it reflects a low investment approach from the staff member. It is up to the patient how much they eat – the nurse/allied health worker is not a "failure" if the meal is not completed.

SAVE THE DATES!

AUSTRALIA & NEW ZEALAND ACADEMY FOR EATING DISORDERS

10th Annual Conference

One decade on – Where are we now?

Friday – Saturday 24th & 25th August, 2012

Clinical Training Day Workshops

Thursday 23rd August 2012

At the Crowne Plaza Hotel, Adelaide

Keynote addresses from:

Professor Carolyn Black-Becker
Trinity University, San Antonio, Texas

Professor Marika Tiggemann
Flinders University, Adelaide

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Note that ANZAED's office is open on **Mondays** and **Wednesdays.**