Mental Health

Eating Disorders

Dr Kate Murphy, QuEDS
Dr Caroline Clancy | MN GPLO

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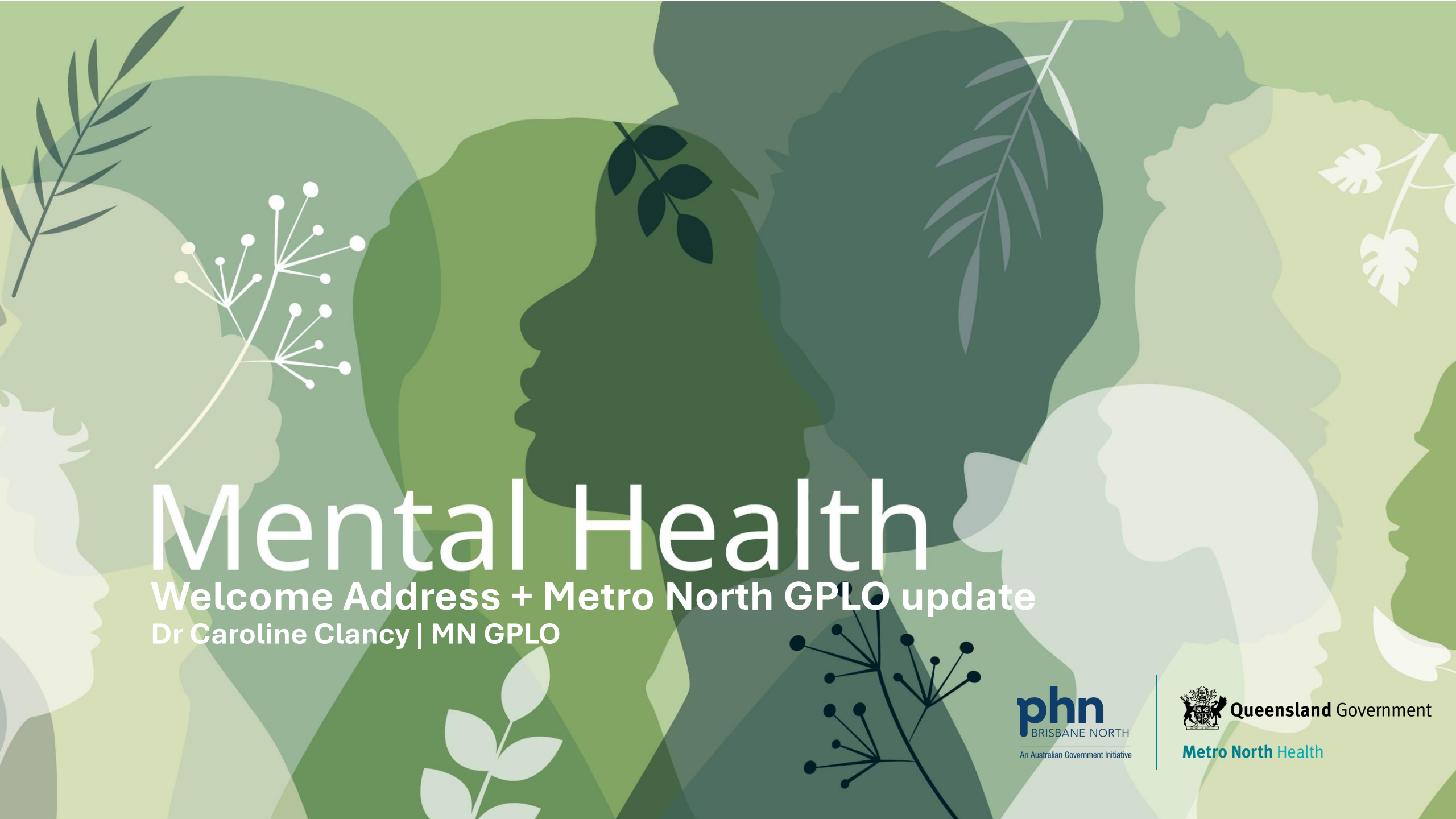
Metro North Health



Mental Health

Welcome Address + Metro North GPLO update

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TONIGHT

6:00pm	Registration, Stalls & Dinner
6:30pm	Welcome & GPLO Update
6:45pm	Main Presentation: Eating Disorders
8:15pm	Questions
8:25pm	Evaluation
8:30pm	Workshop Close

Metro North Hospital and Health Service and Brisbane North PHN respectfully acknowledge the Traditional Owners of the land on which our services and events are located. We pay our respects to all Elders past, present and future and acknowledge Aboriginal and Torres Strait Islander people across the State.

General Practice Liaison Officer Program

General Practice Liaison Officer Program

0499 112 282

MetroNorthGPLO@health.qld.gov.au

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GPLO Program Page

GP and primary care education | Metro North Health

Refer your patient

The information contained on these pages is for GPs and health professionals to help refer patients and find services available at Metro North Health.

Latest updates

Virtual Ward

The Virtual Ward phone number has recently changed, to refer a patient to Virtual Ward, please contact **1300 001 966** in hours (0800-1600hrs). If your patient is accepted by the Virtual Ward Consultant, please complete the Virtual Ward referral form (MN341) found on QHEPS.

Rapid Access Clinics

Rapid Access Clinics and Services – Local GPs can refer patients requiring escalation of care to these services for urgent assessment and treatment within a few days to provide an alternative to an emergency presentation.

Specialist outpatient services

Specialist outpatient referrals are coordinated through the Metro North Health Central Patient Intake Unit for hospitals in the region.

Find outpatient referral guidelines by speciality or referred condition below:

Search by referred speciality **Go** Search by referred condition **Go**

GP Referrals Enquiry Line: **1300 364 938**

- Smart Referrals
- How to refer your patient
- Brisbane North Health Pathways
- Health Provider Portal
- Update GP practice details
- GP Liaison (GPLO) Program
- GP and primary care education & events
- Specialists list

Does your patient reside in the Metro North Health catchment?

GP and primary care education

- Referral Tools (updated 2025)

Presentations and further resources from past education events

- Caboolture Hospital education
- Cardiology (updated 2025)
- Championing Generalism Workshop (updated 2026)
- Diabetes
- Gastroenterology and Hepatology (updated 2025)
- Gender Services
- Genetics
- Gynaecology (updated 2024)
- Haematology and Oncology
- Heart Failure
- Immunology & ENT (updated 2024)
- Kidney Health
- Maternity (updated 2025)
- Men's Health (updated 2024)
- Mental Health (updated 2025)

Medicare Mental Health- referring a patient

Australian Government
Department of Health, Disability and Ageing

medicare Mental Health

- Patients can be referred via the Health Link icon within medical records software
- Ability to upload a copy of the Mental Health Care Plan with this referral
- GP will receive automatic notification (to your inbox) that referral has been received by MMH phone service (MMHps)
- MMHps will contact the patient to help them find the right service for their needs (saving GP time)
- GP will be advised of the outcome (including if unable to contact the patient) via Medical Objects (to your inbox)

Medicare Mental Health services provide free, confidential mental health and wellbeing support for anyone in Australia.

Anyone can use our services, even if you have never reached out for mental health support before. You don't need a referral or appointment.

Depending on your preferences, you can access Medicare Mental Health services by:

- **visiting a local Medicare Mental Health Centre or Kids Hub** (formerly 'Head to Health Kids') for face-to-face support
- **calling 1800 595 212** to speak with a trained professional for advice and connection to appropriate supports.

Medicare Mental Health Check In

Medicare Mental Health Check In provides free guided digital support for you to take care of your mental health and wellbeing early. Working one step at a time, this service will help you build practical skills and confidence to feel more prepared for life's ups and downs.

Whether you prefer to move at your own pace or connect with a trained practitioner along the way, Medicare Mental Health Check In is here for you.

It's completely free for people living in Australia, no referral or diagnosis needed.

Brisbane North PHN Mental Health Services Map

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REFERRALS

Urgent Support

For acute or hospital presentations please call 1300 MH CALL on 1300 64 22 55. In an emergency present to your nearest emergency department or call 000.

Medicare Mental Health

Medicare Mental Health can connect people with mental health services in the Brisbane North and Moreton Bay region and is the preferred gateway for accessing Brisbane North PHN-commissioned mental health services.

Medicare Mental Health phone line 1800 595 212 can be accessed by consumers, their families, carers, as well as GPs, service providers and other health professionals.

The Medicare Mental Health phone line will operate 8:30 am – 5:00 pm, Monday to Friday (excluding public holidays). Services incur no out-of-pocket cost.

To make a referral to Medicare Mental Health for service navigation support, you can:

- call 1800 595 212
- submit a secure eReferral using the HealthLink SmartForm, embedded in GP practice software, or via the Health Professional portal form.referral.intake.org.au/?phn_code=PHN301

IAR-DST

The Initial Assessment and Decision Support Tool (IAR-DST) provides a standardised, evidence-based and objective approach to support clinical decision making. The IAR-DST is built into the My Mental Health Services eReferral or can be accessed at: iar-dst.online/#/

- **LEVEL 1:** SELF MANAGEMENT
- **LEVEL 2:** LOW INTENSITY
- **LEVEL 3:** MODERATE INTENSITY
- **LEVEL 4:** HIGH INTENSITY
- **LEVEL 5:** SPECIALIST AND ACUTE

PSYCHOLOGICAL THERAPIES

Sunshine Parenting Program
Peach Tree Perinatal Wellness
sunshine@peachtree.org.au

Support for mothers of infants aged 0-12 months experiencing mild postnatal depression and/or anxiety symptoms through a 6-week group program.

18 years and older

Self or health professional referral

IAR LEVEL 2

Shark Cage
Peach Tree Perinatal Wellness
programs@peachtree.org.au

A 7-week group program which helps women to increase their knowledge around healthy and unhealthy relationships.

18 years and older

Internal referral only

IAR LEVEL 2

Peer 2 Peer Meets
Peach Tree Perinatal Wellness
programs@peachtree.org.au

A peer-led 6-week group designed to help birthing parents make sense of and understand their birth experience.

18 years and older

Internal referral only

IAR LEVEL 2

Problem Management Plus
World Wellness Group
07 3333 2100

Group face-to-face support for people who identify as culturally and linguistically diverse to help manage stress and adverse situations over the course of 7-sessions.

18 years and older

Self or health professional referral

IAR LEVEL 2

Brisbane MIND
Contact Medicare Mental Health to find a provider
1800 595 212

Short-term psychological therapy for Healthcare or Pension card holders. Eligible clients must identify in one of the following under serviced groups:

- culturally and linguistically diverse communities
- LGBTIQ+ communities
- people who have experienced trauma or abuse
- people at risk of suicide
- residents of Bribie Island and Kilcoy.

12 years and older

Health professional referral

IAR LEVEL 3

Psychology in Aged Care (PAC) Wellbeing
Change Futures
07 3857 0847

Respectful, trauma-aware support for older adults living in residential aged care provided through individual counselling and support groups.

65 years and older

Referral can be made directly with Change Futures

IAR LEVEL 3

Norfolk Island Mental Health and Wellbeing
Norfolk Island Health
0011 6723 22687

NIHARCS Health and Wellbeing steering committee work collaboratively with the Norfolk Island community to develop, implement and evaluate a health promotion plan based on best practice health promotion values and principles and The Ottawa Charter for Health Promotion as defined by the World Health Organisation.

Contact the service directly

IAR LEVEL 3

Medicare Mental Health Centres
1800 595 212
Inner North Brisbane – Lutwyche (Community)
Caboolture (STRIDE)
Redcliffe (Community)
Strathpine (Neami National)

Free, walk-in mental health support, assessment and care for adults in distress or with ongoingmental health care needs through immediate, short and medium-term care. Low intensity to severe and complex psychosocial support. No Medicare card, appointment or GP referral is required.

18 years and older

Self or health professional referral

Safe Spaces
Bardon (Community): 07 3004 0101
Caboolture (STRIDE): 07 5232 1590
Redcliffe (Redcliffe Youth Space): 0435 827 817
Strathpine (Neami National): 07 3493 6710

Free, safe and welcoming after-hours, peer-led alternative to Emergency Departments (EDs) for people in emotional distress or suicidal crisis. Calling ahead is encouraged as sites can reach maximum capacity at times.
7 days a week, from 5pm – 9pm (times may vary on weekends and public holidays)..

All ages

No appointment or referral needed

CHILDREN AND YOUTH

Headspace
Richmond Fellowship Queensland
National Youth Mental Health Foundation
Caboolture: 07 5428 1599
Indooroopilly: 07 3157 1555
Nundah: 07 3370 3900
Redcliffe: 07 3897 1897
Strathpine: 07 3465 3000
Bribie Island: 07 5428 1599

Early intervention support services including one-to-one counselling, supportive family psycho-education and support groups for young people.

12-25 years

Self, parent or professional referral in centre or online

IAR LEVEL 2-3

Brisbane MIND4KiDS
STRIDEKids (Bardon): 07 3447 6500
yourtown (Deception Bay): 07 3888 0758

Short-term psychological therapy for children of families covered under a HealthCare or Pension card who have, or are at risk of developing an emotional, behavioural or mental health condition.

Not for formal diagnostic or assessment purposes, or for treatment of disability, developmental or learning disorders.

11 years and under

Health professional referral

IAR LEVEL 2-3

Norfolk Island Psychology Services
Norfolk Island Health
0011 6723 22687

Short-term psychological therapies for children, young people (0-25 years) and their families living on Norfolk Island.

25 years and under

Self, parent or health professional referral

IAR LEVEL 2-3

Specialist Youth Mental Health Services
Brisbane Youth Service
07 3620 2400

Led by a child and adolescent psychiatrist and psychologist, the service provides comprehensive mental health assessments, therapeutic interventions, and connections to additional support services to ensure that young people (aged 12-25 years) receive specialised, coordinated care that is tailored to their needs.

12-25 years

Self or health professional referral

IAR LEVEL 3-4

ASHA
Redcliffe Area Youth Space
07 3283 8769

Mobile outreach support to vulnerable young people (12-25 years) in the Moreton Bay North region who are experiencing or at risk of developing severe and complex mental health concerns and multiple and complex associated psychosocial concerns.

12-25 years

Internal referral only

IAR LEVEL 4

FIRST NATIONS

Project Yarn Circle
Youth 2 Knowledge
charles@y2k.com.au

Six, weekly sessions to Aboriginal and Torres Strait Islander school students that focus on the promotion of mental health resilience and cultural connection with the aim to reduce suicidality.

12-17 years

Contact the organisation for referral information

Yarns Heal
Queensland Council for LGBTI Health
07 3017 1777

A culturally responsive community-based suicide prevention program designed for Aboriginal and Torres Strait Islander peoples from the Lesbian, Gay, Bisexual, Transgender, Intersex, Queer + (LGBTIQ+) communities designed to improve emergency and follow up care for suicidal crisis, and to provide evidence-based treatment for suicidality.

18 years and older

No referral needed

IUIH Social Health Services

ATSICHS
Mob Link: 1800 254 354
Northgate clinic: 07 3240 8900

Trauma-informed, healing aware, and culturally safe multidisciplinary team of psychologists, counsellors, care coordinators and case managers providing evidence-based social and emotional wellbeing services for Aboriginal and Torres Strait Islander people living in the Brisbane north region.

8 years and over

ATSICHS GP referral required

MATSICHS
Mob Link: 1800 254 354
Caboolture clinc: 07 5428 5855
Deception Bay clinc: 07 3884 1999
Margate clinic: 07 3480 8100
Strathpine clinic: 07 3897 0500

A specialised service for Aboriginal and Torres Strait Islander people delivered within a broader comprehensive primary healthcare model including primary mental health services, alcohol and other drug treatment services and suicide prevention services.

All ages

Self or health professional referral

IUIH First Nations The Way Back Support Service
Intitute for Urban Indigenous Health
07 3832 3600

A voluntary, free program designed to support First Nations clients for up to six (6) months, following a suicide attempt or suicidal crisis. The service aims to enhance social connectedness, improve access to clinical and community support, and empower individuals to self-manage and boost mental wellbeing..

15 years and over

Referral only from TPCH, RBWH, Redcliffe and Caboolture Hospital following a suicide attempt or crisis

IAR LEVEL 3-4

ALCOHOL AND OTHER DRUGS

Life Back Program
Lives Lived Well
1300 727 957

A client-focused, community-based nonresidential day treatment program for people who are wanting to address their substance use concerns. Services are delivered during business hours from service hubs in Caboolture, Morayfield, Redcliffe and Strathpine.

2 years and older

Self or health professional referral

Brisbane Youth Service
07 3620 2400

A drug and alcohol program along with a counselling service for young people experiencing concerns with substance use and mental health problems, ensuring the specific needs of youth, women, families with children, and Aboriginal and Torres Strait Islander people are met.

12-25 years

Mental Health providers

Queensland Injectors Health Network (QuIHN)
1800 172 076
07 3620 8111

Initial screening, brief interventions, counselling and group programs aimed at responding to the need for outpatient rehabilitation services for members of the community experiencing co-occurring mental health and substance-related disorders.

15 years and over

Corrective Services for people post release, and mental health professionals

Qld Aboriginal & Islander Corp. AoD Dependence Services (QAIAS)
07 3358 5111

Group, face-to-face individual and outreach services, including brief interventions for substance use in community counselling, increasing motivation to engage in treatment, outpatient services, telephone information and aftercare support. People with co-existing AOD and mental health issues can access mental health nurses.

Most service users are Aboriginal and/or Torres Strait Islander, however non-indigenous people may also access support.

12-25 years

Corrective Services for people post release, and mental health professionals

ADIS
24/7 Alcohol and drug support
1800 177 833

24/7 support for people with alcohol and other drug concerns, their loved ones and health professionals to talk about their concerns, receive information, counselling and referral.

All ages

Self referral

SUICIDE PREVENTION

The Way Back Support Service
Inner City (Community): 07 3510 2727
Redcliffe/ Caboolture (Richmond Fellowship Queensland): 1300 180 608

Community based psychosocial support to people at risk of suicide following a suicide attempt or suicide crisis. Clients are able to access up to three months of non-clinical support coordination and care navigation which facilitates their access to community services that meet their needs.

15 years and older

Referral only from TPCH, RBWH, Redcliffe and Caboolture Hospital following a suicide attempt or crisis.

Family & Friends Support Program
IUIH: 07 3832 3600
Community: 07 3510 2727
Richmond Fellowship Queensland: 1300 180 608

The Family & Friends Support Program is designed to create a community that supports and values those who are caring for someone experiencing a suicidal crisis or following a suicide attempt.

18 years and older

Health professional, community service or self-referral

Regional Suicide Prevention
Kurbingui Youth Development
07 3156 4800

Social and emotional wellbeing support services for people who are experiencing a suicide crisis, have recently made a suicide attempt or have lost a loved one to suicide provided by social and Emotional Wellbeing Practitioners.

This is a specialised service for Aboriginal and Torres Strait Islander people.

All ages

Self or health professional referral

Brisbane MIND Suicide Prevention
Contact Medicare Mental Health to find a provider
1800 595 212

Short-term psychological therapy for Healthcare or Pension card holders who are at non-acute risk of suicide defined by:

- Suicidal behaviours within the past 3 months or
- Suicidal ideation within past 1 month with thoughts of means, some planning but no intent.

Includes recent suicide attempt or self-injury, but does not include superficial injury without intent to end life.

12 years and older

Health professional referral

Aftercare
Queensland Council for LGBTI Health
07 3017 1777

Evidence-based emergency and follow up care for people who belong to the LGBTQI+ Brotherboy and Sistergirl communities who are:

- currently experiencing suicidal ideation and/ or
- have recently been hospitalised in relation to suicidality and/or
- are impacted by the suicidality or loss by suicide of someone they know.

18 years and older

Self or health professional referral

SPECIALIST SERVICES

Transwomen's Youth Wellbeing
Open Doors Youth Service
07 3257 7660

Provides peer led mental health and wellbeing support for young transgender women aged 12 - 24 years. Services include one-on-one case management and counselling, as well as social support groups that foster community and social connection.

12-24 years

Self or professional referral

Open Doors Youth Service
07 3257 7660

Provides a safe space for Sistergirl and Brotherboy young people to connect and thrive through group, face-to-face, outreach and online support.

12 - 24 years

Self or professional referral

Recovery Warriors
Eating Disorders Queensland
07 3844 6055

A monthly group that includes activities and strategies for coping and staying connected. This group is alternates between online and in-person.

Participants are introduced to various therapeutic and support interventions as well as providing ongoing recovery skills and reminders to help their recovery pathway.

16 years and older

Internal referral only

School Readiness Program
Youthrive
North Lakes/ Everton Hills: 07 3850 3232

Children aged 3-5 years identified as experiencing developmental delay receive structured, multidisciplinary interventions facilitated by a Speech Pathologist, Occupational Therapist or Psychologist..

3-5 years

Internal referral only

IAR LEVEL 2-3

School Readiness Program
Institute of Urban Indigenous Health (IUIH)
Koobara Aboriginal and Torres Strait Islander Kindergarten: 07 3265 7171
C&K Caboolture Community Kindergarten and Preschool: 07 5499 1588

In a kindergarten setting (Koobara and C&K Caboolture) allied health professionals, such as Speech Pathologists and Occupational Therapists, work with children aged 3-5 years identified as experiencing developmental delay receive structured, multidisciplinary interventions..

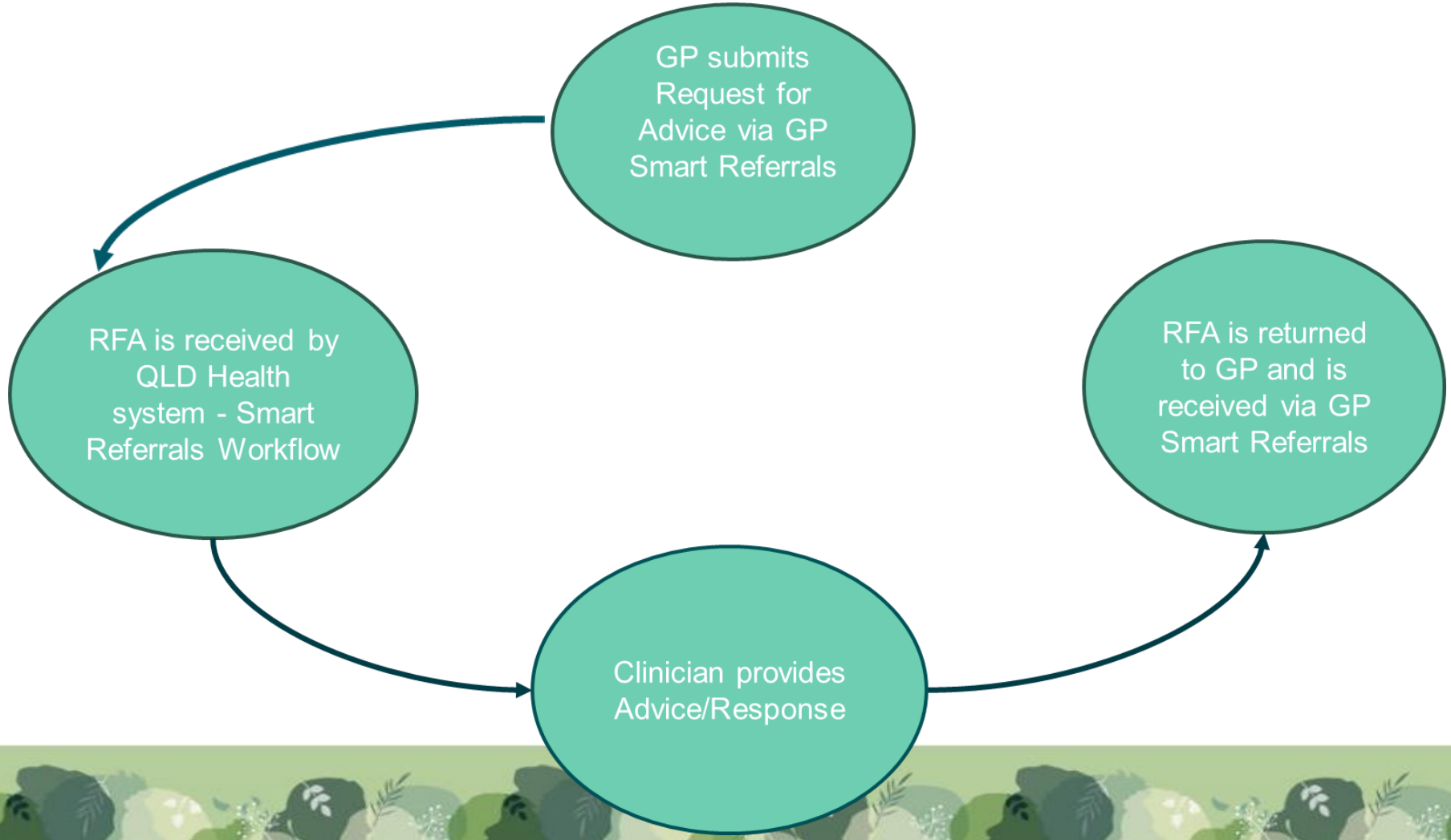
3-5 years

Internal referral only

IAR LEVEL 2-3

Request for Advice (RFA) Pathway

Outpatient Strategies



Request for Advice (RFA)

Specialty	Catchment*	Exclusion Criteria
Gender Services	Statewide	• Patients under 18 years • Psychiatric advice only (medical advice relating to hormone therapy treatment is offered as part of this service)
Metro North Persistent Pain Centre/ Tess Cramond Pain and Research Centre	Metro North Central Queensland Central West Darling Downs West Moreton	• Excludes patients under 16 years • Excludes outside catchment
Neurology	Metro North	• Excludes patients under 16 years • Excludes outside catchment • Patients currently seen by Metro North Neurology (call Registrar via switch or use "Update Request" in GP Smart Referrals)
Paediatric Medicine	TPCH	• Out of catchment for TPCH • Excludes patients over 16 years
Paediatric Medicine	Redcliffe	• Out of catchment for Redcliffe • General behavioural issues
Rheumatology	Metro North	• Out of catchment for Metro North • Patients currently seen by Metro North Rheumatology (call Registrar via switch or use "Update Request" in GP Smart Referrals)
Thoracic Medicine – Interstitial Lung Abnormalities (ILA)	Metro North	• Excludes patients under 16 • Excludes Outside Metro North referral catchment • Patients known to TPCH Thoracic Medicine
Thoracic Medicine – Lung Nodules	Metro North	• Excludes patients under 16 • Excludes Outside Metro North referral catchment • Patients known to TPCH Thoracic Medicine
Urology	RBWH	• Out of catchment for RBWH

Clinical Advice Line 1800 569 099 M-F 0830-1600

Connecting GPs directly to Metro North specialties

Specialty	Catchment*	
General Medicine and Rapid Access Clinic	TPCH	Metro North Persistent Pain Centre/ Tess Cramond Pain and Research Centre Clinical advice available Monday – Friday 9:00am – 12:00pm Metro North Central Queensland Central West Darling Downs West Moreton • Excludes patients under 16 years • Excludes outside catchment
		Metro North Virtual Ward Metro North Central West Norfolk Island • Excludes patients under 16 years • Excludes Residential Aged Care residents (Call RADAR - 1300 072 327)
Caboolture Hospital Discharge Support Services Supporting adult patients who have been discharged in the last 30 days. Specialties include: • General Surgery • General Medicine	Caboolture	Healthy Ageing Assessment Rehabilitation Team (HAART) Kallangur Satellite Hospital Patients may be ineligible if: • Currently accessing equivalent services in public or private sector • Reside outside of catchment area • Medically unstable requiring inpatient assessment or currently an inpatient • Only require therapy for maintenance of chronic condition • Residential aged care facility residents
		Rapid Access to Community Care Metro North • Excludes Patients under 16years • Excludes Acute mental health, alcohol or drugs related. • Excludes Residential Aged Care Facility Residents (Call RADAR - 1300 072 327)
Haematology	Metro North	
Heart Failure Service and Rapid Access Clinic	Redcliffe RBWH TPCH	**RBWH Post Operative Discharge Support Services** Supporting adult patients who have had a procedure at RBWH and have been discharged in the last 30 days. Surgical specialties include: • General Surgery (hepatobiliary, upper GI, hernia, thoracic, colorectal) • Plastics • Urology • Orthopaedics (elective lower limb surgery only) RBWH • Excludes paediatric patients • Excludes surgical patients outside these specialties • Patients over 30 days since discharge from RBWH • Patients who have had their procedure at another facility
Inflammatory Bowel Disease	Redcliffe Caboolture	
		Redcliffe Post Operative Discharge Support Services Supporting adult and paediatric patients who have had a procedure at Redcliffe Hospital and have been discharged in the last 30 days. Surgical specialties include: • General Surgery • Orthopaedics • Urology • Gynaecology • Ear, Nose and Throat • Endoscopy Redcliffe • Neonates • Excludes surgical patients outside these specialties • Patients over 30 days since discharge from Redcliffe Hospital • Patients who have had their procedure at another facility
		Sexual Health Metro North • Excludes Patients under 14 years
		Surgical Rapid Assessment Unit (SRAU) RBWH • Excludes patients under 16 years • Non-urgent elective general surgical conditions
		Trauma Service (RBWH) Metro North • Excludes patients under 16 years • Single system injury suitable for other services (ie. isolated limb or pelvic fractures)
		Termination of Pregnancy Metro North • Excludes Outside Metro North referral catchment
		Vestibular Rapid Access Service TPCH • Out of catchment for TPCH

Sneaky Services

Search term in **BOLD**

- Paediatric **audiology** – Caboolture (MN catchment)
- **Physiotherapy**
- TPCH: MSK, pelvic floor, vestibular, pulmonary rehab, lymphoedema, oncology
- RBWH: MSK, pelvic floor, vestibular, pulmonary rehab, neonatal, hydrotherapy, lymphoedema
- Redcliffe: MSK, pelvic floor, hand
- Caboolture: MSK, paediatric, hand therapy, haem/onc
- **Orthopaedics** scoliosis clinic – RBWH
- **Occupational therapy** cognition clinic (concussion, cognitive impairment) – TPCH
- Concussion clinic (Neurology) – RBWH -> refer under "**Neurology**" with no condition
- ICU follow up clinic – Redcliffe (accepts patients from any ICU) | **Post-acute care**
- Comprehensive Diagnostic **Breast** Clinic – RBWH (MN catchment, TPCH location)
- Paediatric **gynaecology** from 14yo – RBWH
- Antibiotic allergy assessment/de-labelling clinic – RBWH, Redcliffe | **Infectious diseases**

HealthPathways

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Brisbane North

Search HealthPathways

Community HealthPathways

Brisbane North

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Brisbane North HEALTHPATHWAYS

Health Alert

There is a large outbreak of Ebola disease caused by Bundibugyo virus in the Democratic Republic of Congo (DRC) and Uganda. On 17 May 2026, the WHO declared the outbreak a public health emergency of international concern (PHEIC). No human case of Ebola disease has ever been reported in Australia. Read more...

21 May 2026 – Clinician alert: diphtheria

Case numbers continue to rise from a large outbreak of diphtheria, primarily among Aboriginal and Torres Strait Islander peoples in the Northern Territory and Western Australia.

Clinicians should consider diphtheria when a patient presents with a clinically compatible illness, especially if they have had direct or indirect contact with a remote Aboriginal community. Ensure all patients are up to date with diphtheria vaccinations. Notify your local public health unit immediately of any suspected diphtheria cases.
See the Australian Immunisation Handbook and the Queensland Health website for more information.

Pathway Updates

Updated – 24 July
Alcohol Intervention and Withdrawal

Updated – 20 July
Recurrent Epistaxis in Children

Updated – 17 July
Breast Symptoms and Breast Cancer

Updated – 30 June
Mastitis and Breast Abscess

Updated – 30 June
Superficial Foreign Body in Eye

VIEW MORE UPDATES...

- HEALTH PROVIDER PORTAL
- METRO NORTH HHS
- PRACTICE SUPPORT WEBSITE
- LOCAL RESOURCES
- CLINICAL RESOURCES
- QUEENSLAND HEALTHPATHWAYS PORTAL
- EDUCATION FOR GPS AND STAFF
- NHSD

Mental Health

HealthPathways- Eating Disorders

Background

About eating disorders in adults

Assessment

Practice point

Seek collateral information

Patients with eating disorders may be difficult to engage, as they often don't realise the need for treatment or deny the reality of the problem. When possible, seek the patient's consent and obtain collateral information from family or carers.

1. Consider an eating disorder in people who present with any suggestive features.
2. Seek the patient's consent to obtain collateral information from:
   - family, carers, or significant others.
   - other health providers. If relevant, seek patient's permission to access their Queensland Health mental health record via the Health Provider Portal (i.e., The Viewer).

   Patients with eating disorders may be difficult to engage as they often don't realise the need for treatment, or deny the reality of the problem.
3. Explain limits of confidentiality to the patient.
4. Consider using one of the available screening tools to determine the likelihood of an eating disorder – note that routine screening of adults is not recommended:
   - SCOFF questionnaire
   - Eating disorder screen for primary care (ESP)
   - Binge-eating disorder screener – 7 (BEDS-7)
5. Take a history. This may be done over several appointments to build a rapport and avoid overwhelming the patient. An EDE-Q questionnaire may facilitate the process. Ask about:
   - weight – note that this is not the most reliable measure of severity.
   - physical activity and food-related behaviours.
   - signs or symptoms of severity and physiological changes.

ABOUT THIS PAGE

Sources

Page information

Topic ID: 552190

CPD REPORTING

Add learning notes

Create a CPD report

SEND FEEDBACK

Eating Disorders in Children and Youth

Assessment

1. Consider an eating disorder in patients who present with any suggestive features. Young persons with an eating disorder may appear well and may be reluctant to talk about their disordered eating. Establish a supportive, non-judgemental environment.
2. Explain the limits of confidentiality to the patient, and always consider obtaining collateral information.
3. Consider using a screening tool.
4. Take an age-appropriate history and ask about:
   - weight – obtain previous records for percentiles, being mindful that weight is not the most reliable measure of severity
   - physical activity and food-related behaviours
   - signs or symptoms of severity
   - psychosocial factors
   - co-morbidities and medications.
5. Perform an age-appropriate examination:
   - At every visit, check general appearance and alertness, and record baseline parameters.
   - Check for signs of recurrent vomiting.
   - Consider on-the-spot blood glucose level (BGL) (glucometer) test.
   - Check pubertal development if appropriate. Follow recommended protocol and consider a chaperone.
   - Complete a mental state examination, including risk of suicide and self-harm.
6. Arrange baseline investigations.
7. Determine if the patient is high risk or medically unstable.
8. Consider the specific diagnosis based on the comparison of eating disorders table, or for more detailed information, the DSM-5-TR Diagnostic Criteria for Eating Disorders.
9. Assess for risk of refeeding syndrome.
10. Consider assessing for other complications of disordered eating.

Mental Health / Eating Disorders / GP Eating Disorder Care Plan (EDP)

GP Eating Disorder Care Plan (EDP)

Find Eating Disorder Help

The connect·ed searchable directory includes an ever-growing list of Credentialed Eating Disorder Clinicians – health professionals recognised for their training, skills and experience in providing eating disorder care.

Listed dietitians and mental health professionals (such as psychologists, social workers, occupational therapists (OTs), mental health nurses, nurse practitioners, psychiatrists and general practitioners (GPs) who provide psychological evidence-based treatment) are trained in providing eating disorder treatment.

Listed GPs are trained in providing screening, assessment and diagnosis of eating disorders and referral to appropriate services for treatment.

The search options allow you to find and connect with ANZAED Credentialed Eating Disorder Clinicians from around Australia. You can also search via appointment availability, in person or Telehealth services, languages spoken and other options as needed.

Search by location | Search by clinician | Search Telehealth providers

City/Postcode

Within (Km)
10km

Name contains

Credentialed Profession — Select

Gender — Select

Languages spoken — Select

Areas of interest — Select

Practice sector — Select

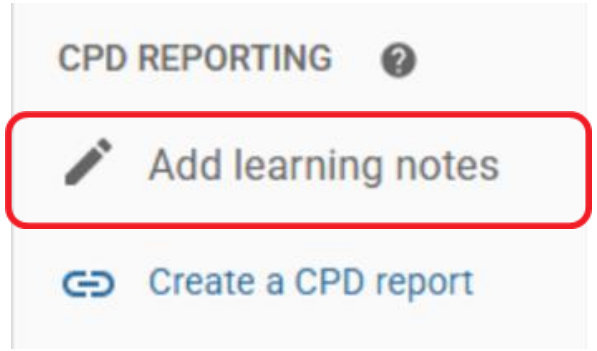
Management

1. Document all results of the assessment in the patient's GP Eating Disorder Care Plan, including:
   - patient needs, goals, actions.
   - referrals, required treatment and services.
   - review date.
2. Discuss the assessment with the patient, including the eating disorder diagnosis or provisional diagnosis.
3. Identify and discuss referral and treatment options with the patient, including appropriate support services (e.g., psychological services, dietitian, specialist mental health services).
   - All health practitioners who are providing services under these MBS items must have appropriate training, skills, and experience in the treatment of patients with eating disorders. See Inside Out – Medicare for Health Professionals: Approved Treatments for Those on an EDP and Training Options.
   - The Australia and New Zealand Academy for Eating Disorders (ANZAED) accredits dietitians and mental health professionals who have skills in eating disorder treatment. However, not all clinicians with appropriate skills are credentialed. Find an ANZAED-credentialed provider (ANZAED expanded its eating disorder credential to include GPs).
   - Patients with an EDP will be eligible for up to 20 dietetic services, and up to 40 Medicare-subsidised psychological services, in a 12 month period, depending on their treatment needs.
   - Consider early referral for specialist assessment (e.g., psychiatrist or paediatrician), as specialist review is required for the patient to continue accessing Medicare-subsidised psychological services beyond 20 sessions.
   - The Queensland Eating Disorders Service does not provide ongoing case management, and is therefore not able to provide a review under the Medicare EDP requirements.
4. Agree on goals of treatment with the patient, and any actions they will take.
5. Provide psychoeducation and written information to the patient and their family or carers.
6. Make a plan for crisis intervention and/or relapse prevention, if appropriate.
7. Make arrangements for required investigations, referrals, treatment, appropria

TQRCG

Creating a CPD report from Health Pathways

[Access Smart Search from HealthPathways (short version) | Videos & Movies on Vimeo]



Otitis Media in Children	Child and Youth Health	Brisbane North Community HealthPath...	10 mins	
Atrial Fibrillation (AF) and Flutter	Cardiology	Brisbane North Community HealthPath...	9 mins	learn risk factors for AF
ADHD in Adults	Mental Health	Brisbane North Community HealthPath...	8 mins	
Pre-conception Consultation	Pregnancy	Brisbane North Community HealthPath...	8 mins	

CPD report continued...

Learning notes | CPD reports

All Reports / ED education event / Add pages

Add pages to your report

mental

Clear all

Date range 01/07/2025 - 27/07/2026

12 of 12 | 20

Page	Category	Site	Total time	Learning notes
Bipolar Affective Disorder	Mental Health	Brisbane North Community...	26 mins	
ADHD in Adults	Mental Health	Brisbane North Community...	8 mins	
GP Eating Disorder Care Plan (EDP)	Mental Health	Brisbane North Community...	5 mins	
Eating Disorders in Adults	Mental Health	Brisbane North Community...	5 mins	
Psychosis - Established	Mental Health	Brisbane North Community...	3 mins	

Save Changes

Save and export as PDF

CPD activity report for

Caroline Clancy

HealthPathways

ED education event

Date range: 01/07/2025 - 27/07/2026

Report total time: 57 mins

Pages and total time

Site: Brisbane North Community HealthPathways

Bipolar Affective Disorder	26 mins
ADHD in Adults	8 mins
GP Eating Disorder Care Plan (EDP)	5 mins
Eating Disorders in Adults	5 mins
Depression in Older Adults	3 mins
Psychosis - Established	3 mins
Suicide Risk in Young People	2 mins
Eating Disorders in Children and Youth	1 mins
Eating Disorders	1 mins
Developmental Dysplasia of the Hip (DDH)	1 mins
Anxiety in Adults	1 mins
Psychotropic Medications in the Perinatal Period	1 mins

Keep up with the latest – GP Link e-newsletter

- Latest **LOCAL health service & GP news** - new services, supports & hospital information
- Published **weekly**
- **Sign up here:**

phn BRISBANE NORTH
An Australian Government Initiative

GP LINK
Your local source of GP news

Mental Health

Eating Disorders update 2026

Dr Kate Murphy, QuEDS

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

ADULT EATING DISORDER UPDATE 2026

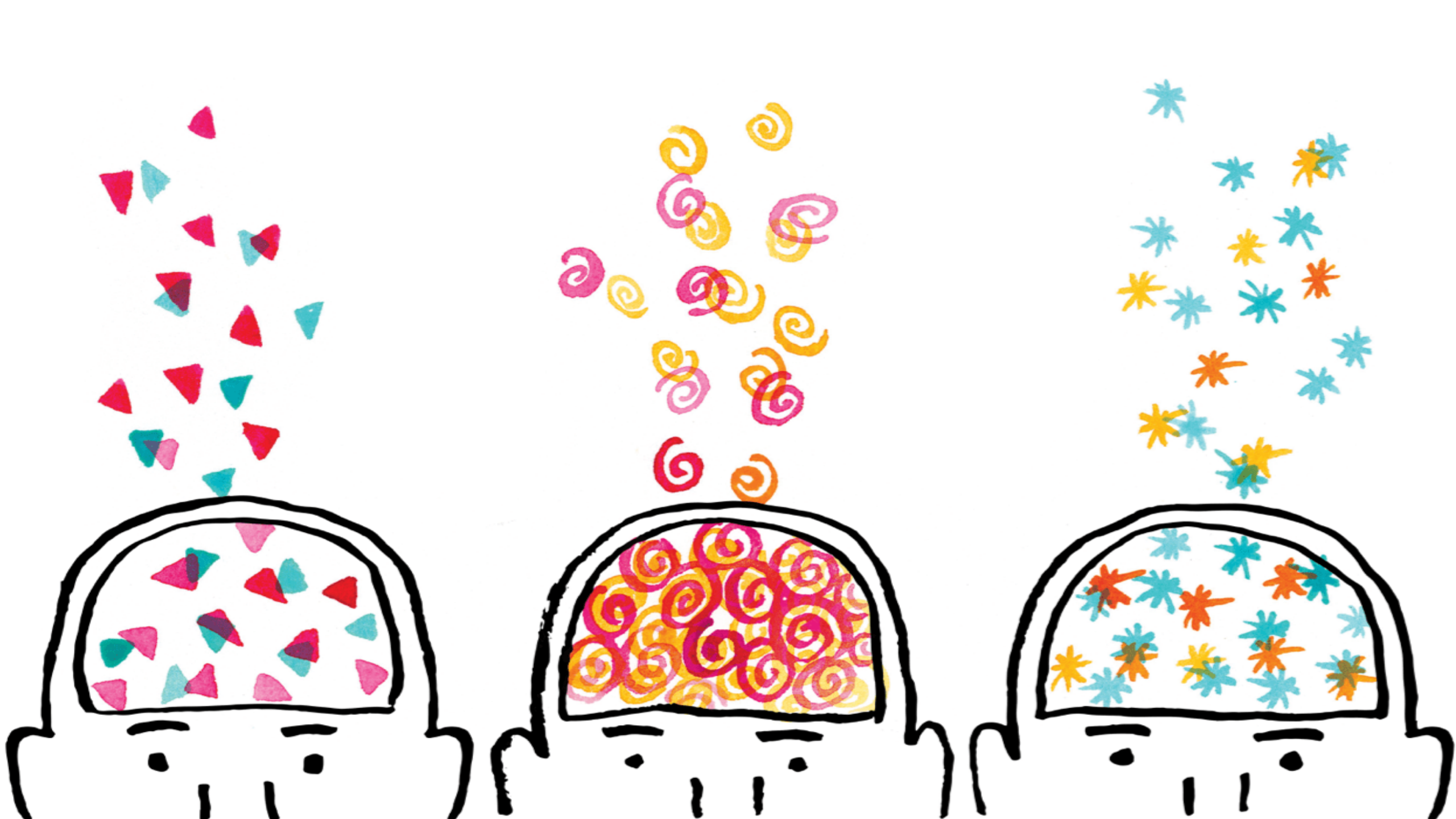
Dr Kate Murphy – Director and Consultant Psychiatrist

Queensland Eating Disorders Service (QuEDS)

Metro North Health | Queensland Government

Metro North Mental Health acknowledges the Traditional Custodians of the land upon which we live, work and walk, and pay our respects to Elders past, present and emerging.

Metro North Health | Queensland Government



Butterfly

LET'S TALK eating disorders

1800 334 673
Webchat

7 days/week
8am – midnight
(AEST/AEDT)

QuEDS

- **Queensland Eating Disorder service** – operationally under Metro North – based at Windsor (service development, education and intake) and Indooroopilly (Treatment), clinics at Spring Hill Community Mental Health clinic
- Statewide service and support to the Eating Disorder Specialist Services (EDSS) - Gold Coast, Metro South, West Moreton, Darling Downs, Sunshine Coast, Townsville, North Queensland
- We offer:
- **- Specialist assessment clinic** (MDT – medical/ dietitian/ nursing) – diagnostic clarification, treatment recommendations – generally a 1-off assessment 90minutes minimum and support to GP
- **- Treatment** – evidence based individual intervention (CBTe, SSCM, MANTRA, CBT-t) and group options (Day program (SMT + therapy) and Schema therapy)
- **- Consultation services** – Individual peer support/ MDT support to any professional teams who are providing clinical services to patients with eating disorders/ malnutrition online
- **- Education** – inpatient training, community training, CBTe and SSCM, medical education, dietitian masterclasses, annual forum, SMT etc
- **- Supervision** – individual and group supervision within discipline and across the MDT – to both public and private providers of care
- **- Research** – full time research officer with multiple projects and including wider stakeholders

QuEDS Contact Details

Referrals, intake, assessment clinic, general enquiries
Ph: (07) 3114 0809, Email: quedsfax@health.qld.gov.au

Consultation services (incl peer support)
Ph: 3114 0809, Email: quedsconsultationservices@health.qld.gov.au

Education
Ph: 3114 0809, Email: quedseducation@health.qld.gov.au

Treatment (individual treatment, group therapy)
Ph: 3100 7500, Email: quedstreatment@health.qld.gov.au

Dietetic-specific questions, peer support, education
Ph: 3114 0809, Email: quedsdietitians@health.qld.gov.au

Resources for Clinicians

- **NEDC** *eLearning (including Eating Disorder Core Skills for Mental Health Clinicians)*
- **Eating Disorders Queensland (EDQ)**
- **Centre for Clinical Intervention (CCI)** *fact sheets*
- **Butterfly Foundation** *National Helpline (8am – midnight)*
- **Inside Out** *resources; fact sheets; training modules (not free)*
- **The Shared Table** *SMT Training (iLearn or free online)*
- **QuEDS** *Education & Training (Join the QuEDS Mailing List), Consultations Services, Peer Support*

***** please note that a lot of these websites (particularly CCI) have great resources (easy to understand fact sheets., etc.) that can be given to consumers and their families as part of providing them with psychoeducation*****

Carers, Loved Ones and Kin Supports

Eating Disorder Families Australia (EDFA)

National Organisation

Support, advocacy & education https://www.edfa.org.au/

Families Empowering And Supporting Treatment for Eating Disorders (F.E.A.S.T)

Global NGO

Support, online forums, resources

https://www.feast-ed.org/

Eating Disorders QLD (EDQ)

NGO, QLD

Support, counselling, groups & resources

https://eatingdisordersqueensland.org.au/

Online Resources

- **NEDC**

https://nedc.com.au/eating-disorder-resources/families-supports

- **The Centre for Clinical Interventions (CCI)**

CCI Information Sheets and Workbooks for Mental Health Problems

- **The Victorian Centre of Excellence in Eating Disorders (CEED)**

WORKING WITH FAMILIES AND SUPPORTS OF ADULTS WITH AN EATING DISORDER – April 2024

- **Butterfly Foundation**

Families - Butterfly Foundation

Butterfly National Helpline

Ph: 1800 ED HOPE

Prevalent, Costly, Far-Reaching

(Deloitte Access Economics, 2024)

The number of Australians **living** with an eating disorder in 2023

1.1 million

The number of Australians who **died** from an eating disorder in 2023

1273

The number of Australians to experience an eating disorder in their lifetime

10.5%

Prevalent, Costly, Far-Reaching

(Deloitte Access Economics, 2024)

The economic and social cost of eating disorders in Australia in 2023

$66.9 billion

Less than 1 in 3 people seek help for their eating disorder

Average time to recover after seeking treatment

1–6 years

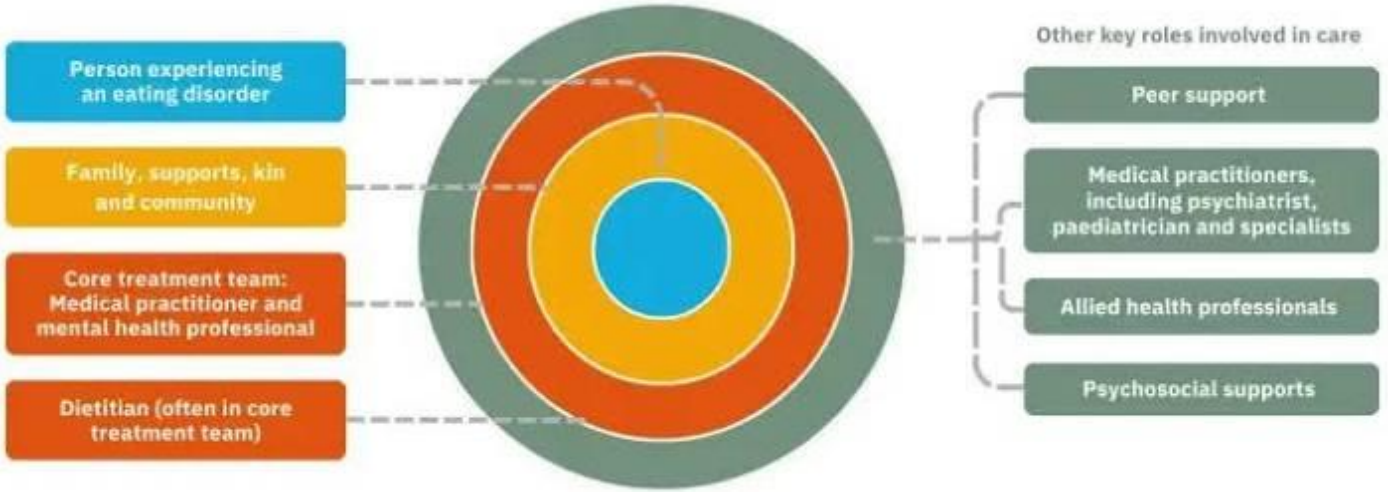
Do you think that these statistics are accurate?

- NATIONAL EATING DISORDERS STRATEGY 2023-2033
- Call to action for all health practitioners
- Supported by government
- Lays out a framework for health care providers to follow in order to have systems in place to identify individuals who have eating disorders or who are at risk of developing and ED to provide the best stepped care approach
- Early identification and prevention are key to support change
- Lived experience as experts

- https://journals.sagepub.com/doi/full/10.1177/10398562241249906


Stepped System of Care for Eating Disorders
Principles; Guidelines; Lived experience; Research and evaluation
Involvement of person and family/supports/community
Prevention
Identification
Initial Response
Treatment
Psychosocial and Recovery Support

THE CARE TEAM



Identification and initial assessment by GP/ clinic nurse

Diagnostic clarification and treatment recommendation

- Private psychiatrist and/or programs
- Queensland Eating Disorder Service (QuEDS)
- Eating Disorder Specialist Services (EDSS) *Gold Coast, Sunshine Coast, Cairns, Metro South, Townsville, West Moreton, Darling Downs*
- Child and Youth Mental Health Eating Disorder program (EDP)

Consultation/ peer support/ formal education and supervision

- QuEDS
- EDSS
- Australia and New Zealand Academy of Eating Disorders - ANZAED

General information for individuals/ families and key supports

- Eating Disorders Queensland (EDQ)
- Butterfly Foundation
- Inside Out
- National Eating Disorder Collaboration (NEDC)
- Eating Disorder Families Australia (EDFA)

Treatment services
QuEDS, EDSS, CYMHS EDP
Private providers – Eating Disorder Management Plan (EDMP)
EDQ/ Inside out e-therapies

<u>Inpatient/ residential:</u>
New Farm clinic
Robina Hospital Program
Cooinda Hospital/ Buderim Private
Wandi Nerida
H-floor RBWH

Shared care

QuEDS are not a case management service

If you consider case management appropriate – either directly related to the eating disorder or a co-occurring mental health condition, please contact local MH-Call

All QuEDS input is voluntary and requires consent – patients can be on a Treatment Authority but their attendance at QuEDS is voluntary

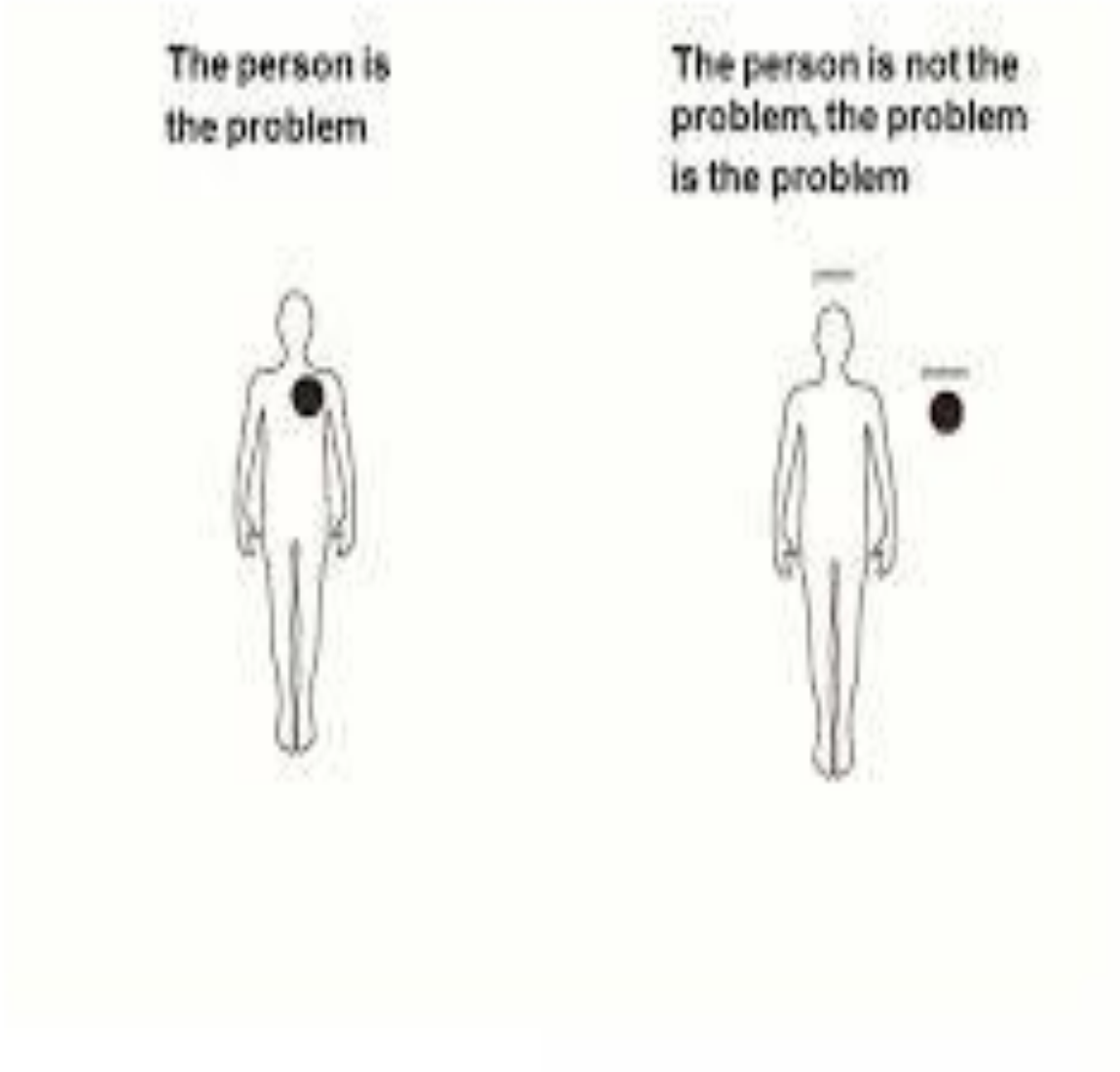
All patients sign up to the non-negotiables of care

This includes regular medical monitoring by their own GP – depending on weight, nutritional intake and medical stability – weekly, fortnightly or monthly – we will make recommendations based on our assessment

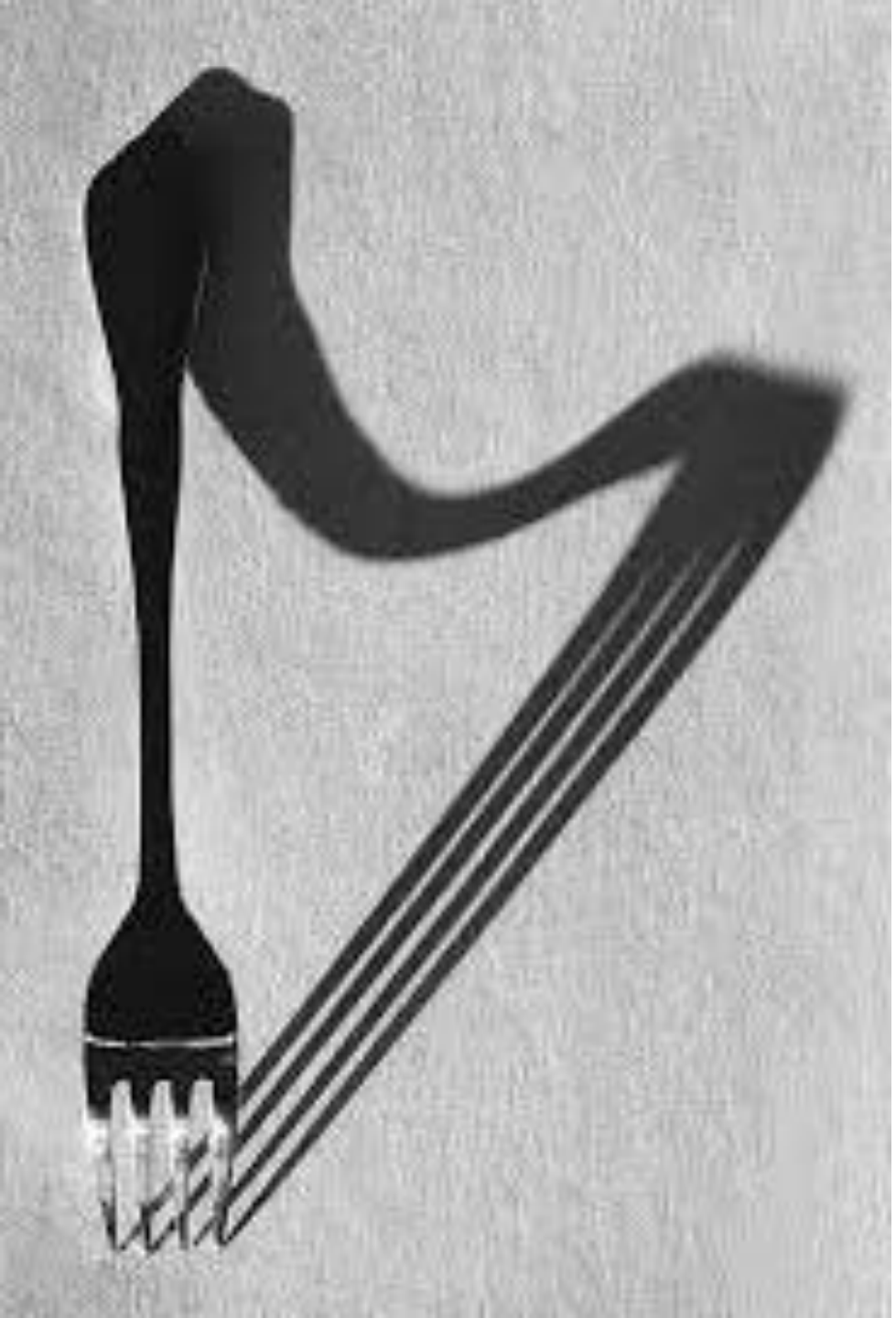
We cannot safely engage in therapy if medical risk is not safety-netted and therefore it is a requirement of care


PAUSE
FOR
THOUGHT

What are Eating Disorders?



Externalising



“Voices” of an Eating Disorder

You’re disgusting

You don’t deserve to eat

You’re weak if you eat

If you do eat you MUST get rid of it

You’ll only find happiness if you lose more weight

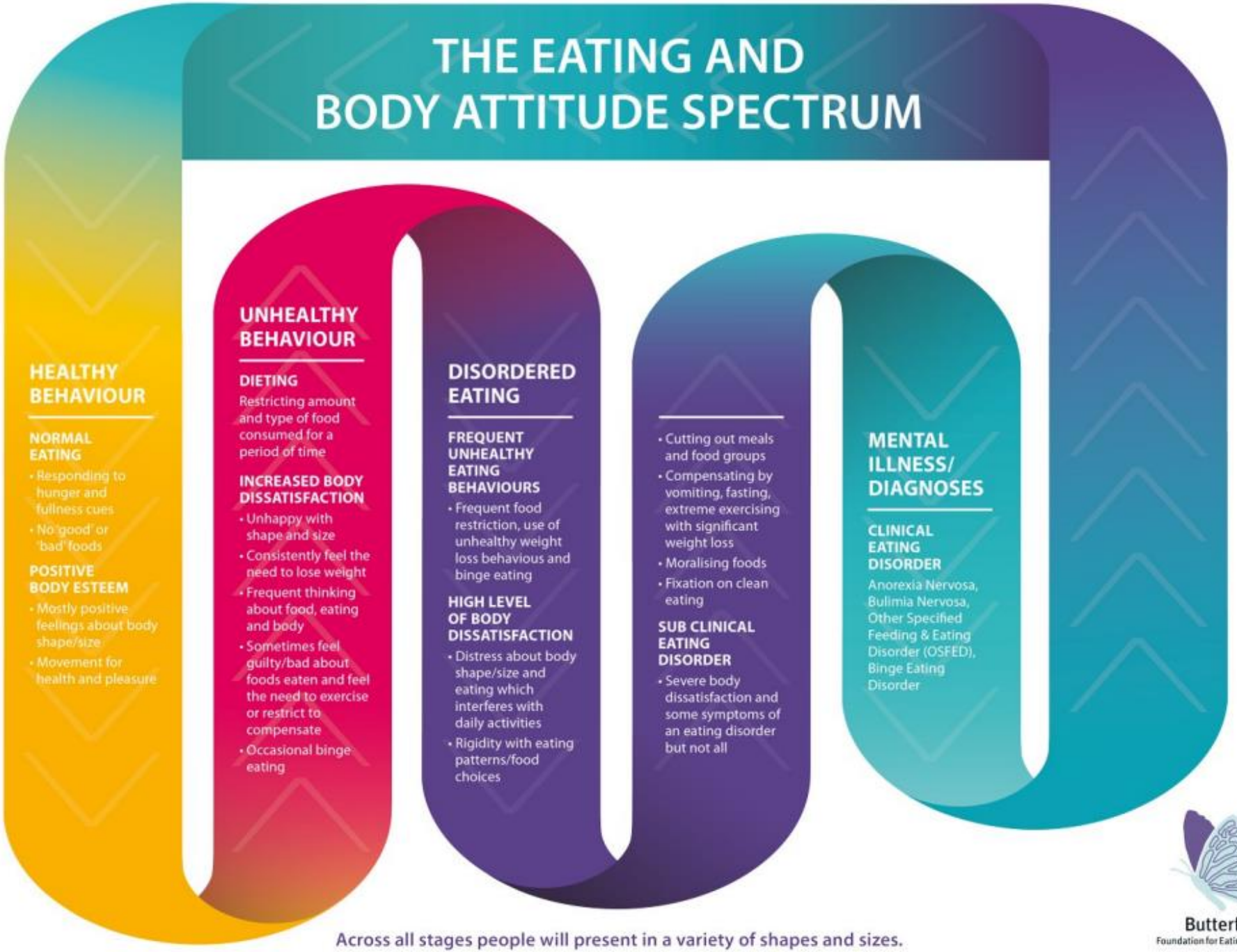
If you eat you will be fat

No one will like you/love you if you gain weight

If I lose weight, I’ll feel more in control

The less I eat, the more I’ve achieved

My self worth is determined by the number on the scales



(Butterfly, 2025)

“No matter your size, shape, abilities, gender identity, sexuality, cultural or linguistic background, economic status, profession or location, anyone can experience an eating disorder.”

(*Butterfly Foundation*, 2025)

HIGH RISK GROUPS

- More than half of all people with an ED are in larger bodies with rates of eating disorders increasing most in people with higher weight.
- LGBTQIA+SB community
- ~27% amongst Aboriginal & Torres Strait Islander peoples
- People seeking weight loss,
- People with co-occurring mental health condition,
- People in competitive occupations (including sports),
- Transition periods
- Restrictive diets
- Neurodivergent individuals
- History of trauma

Eating Disorders in Males

(NEDC, 2022)

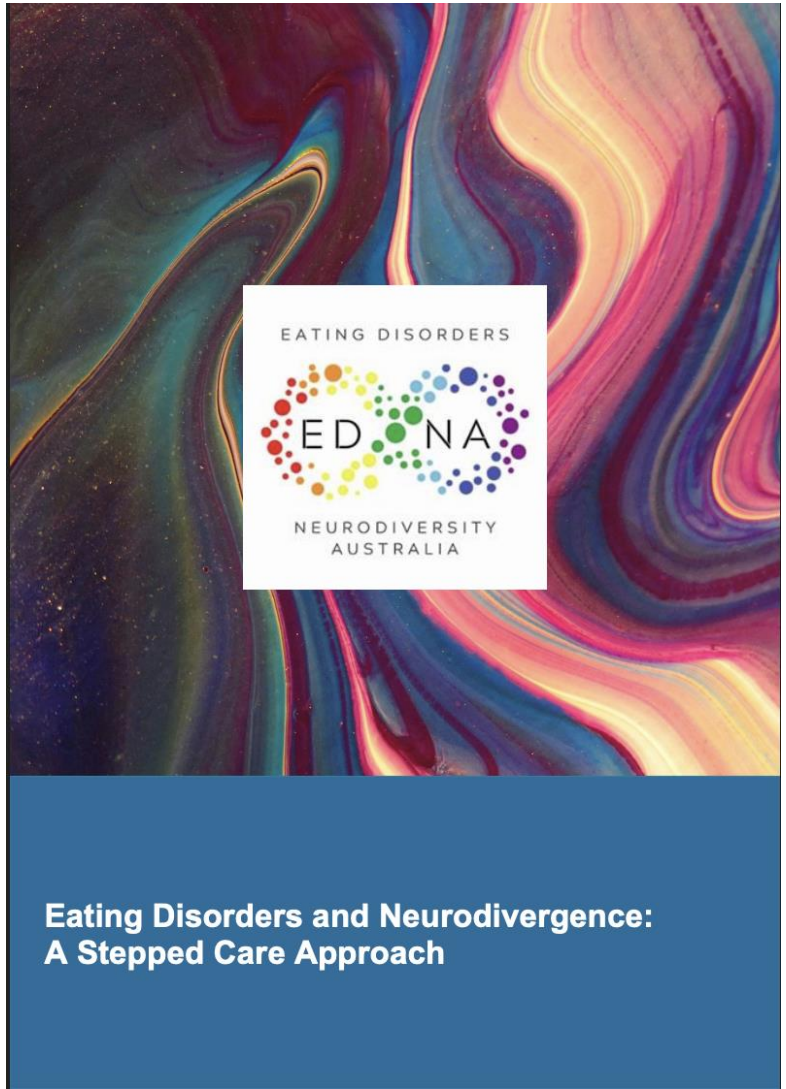
"33% of Australians experiencing an eating disorder identify as male. This is likely to be higher, due to underreporting attributable to gender stereotyping and misdiagnosis" (Deloitte, 2024)

- May present as muscularity-oriented disordered eating
- 55% of 12-18yr old males want to change their body
- May be missed by health professionals
- Majority of studies on eating disorders are based on female samples
- Delayed help-seeking
- Stigma

Resources, tips and advice specifically for LGBTQIA+ individuals experiencing eating disorders and body image concerns.

(Body Pride Resource Hub - Butterfly Foundation, 2025)

Eating Disorders and Neurodivergence



- Feeding and eating difficulties are overrepresented in neurodivergent people (Cobbaert & Rose, 2023)
- It is understood that between 20-37% of individuals with AN are also autistic (Westwood & Tchanturia, 2017; Adamson et al., 2022).
- ARFID prevalence has been estimated to occur in 21% of autistic individuals (Koomar et al., 2021)
- Odds were four times higher for ADHDers being diagnosed with an eating disorder (Nazar et al., 2016)
- Atypical sensory processing, cognitive rigidity, social communication differences and executive function have a wide range of ramifications for eating (Cobbaert & Rose, 2023).

Eating Disorders & Aboriginal and Torres Strait Islander People

(Burt et al., 2020; Hall et all., 2020; Hay & Carriage, 2012)

- Limited research available, ~ 10 studies available.
- Eating disorders are more common prevalent among adult (27%) and adolescent (29%) Indigenous Australians.
- Higher levels of overevaluation of weight and shape.
- Binge eating disorders are as common, if not more common, among Aboriginal and Torres Strait Islander youth.
- Currently no studies available on appropriate treatment interventions or adjustments needed to be made to treatments.

Screening and identification

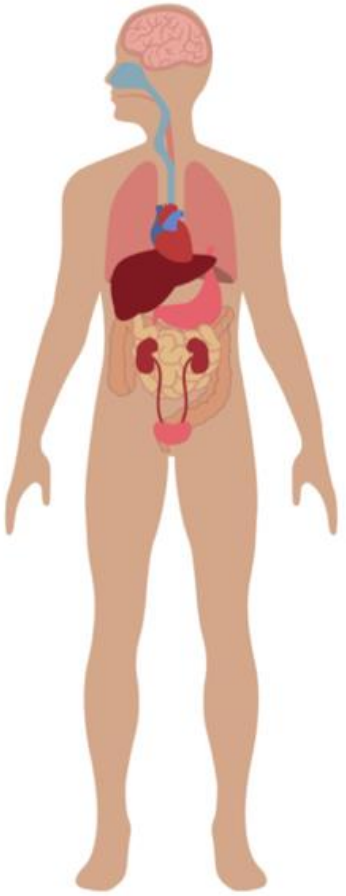
- Information available in medical settings encouraging starting the conversation
- Being mindful of weight stigma in medical settings – asking permission to weigh, blind weighs and not announcing weight, T
- Weight neutral space - try not to celebrate weight loss or suggest dieting prior to asking about disordered eating, use language such as weight change, nutrition and eating patterns
- Using your relationship to encourage gentle opening up of the content - Consider having several appointments lined up to explore this content and encourage reflection
- Using appropriate screening tools where appropriate (acknowledging that these tools are not necessarily validated in certain populations)
- SCOFF can be used but may miss BED, ARFID and those not in low weight bodies
- Offering written information
- Suggesting a formal route for diagnostic clarification
- Use of tools such as the EDE-Q
- Using the physical examination and investigations as a way to be curious, consider psychological harm as well as medical risk

GENERAL
- Marked weight changes
- Weakness/fatigue
- Dehydration
- Abnormal electrolytes (AN, BN)
- Poor concentration, irritability

SKIN, HAIR, AND TEETH
- Dry skin (AN, BN)
- Brittle nails (AN, BN)
- Hair loss (AN, BN)
- Fine downy hair growth (lanugo) (AN)
- Cold intolerance (AN)
- Tooth decay (BN)

ENDOCRINE
- Delayed growth, short stature, delayed puberty, low hormone levels (AN)
- Delayed onset of menses, loss of periods in females (AN, BN)
- Abnormal thyroid levels (sick euthyroid)
- Insulin resistance of Type 2 diabetes (BED)
- Loss of libido (AN)

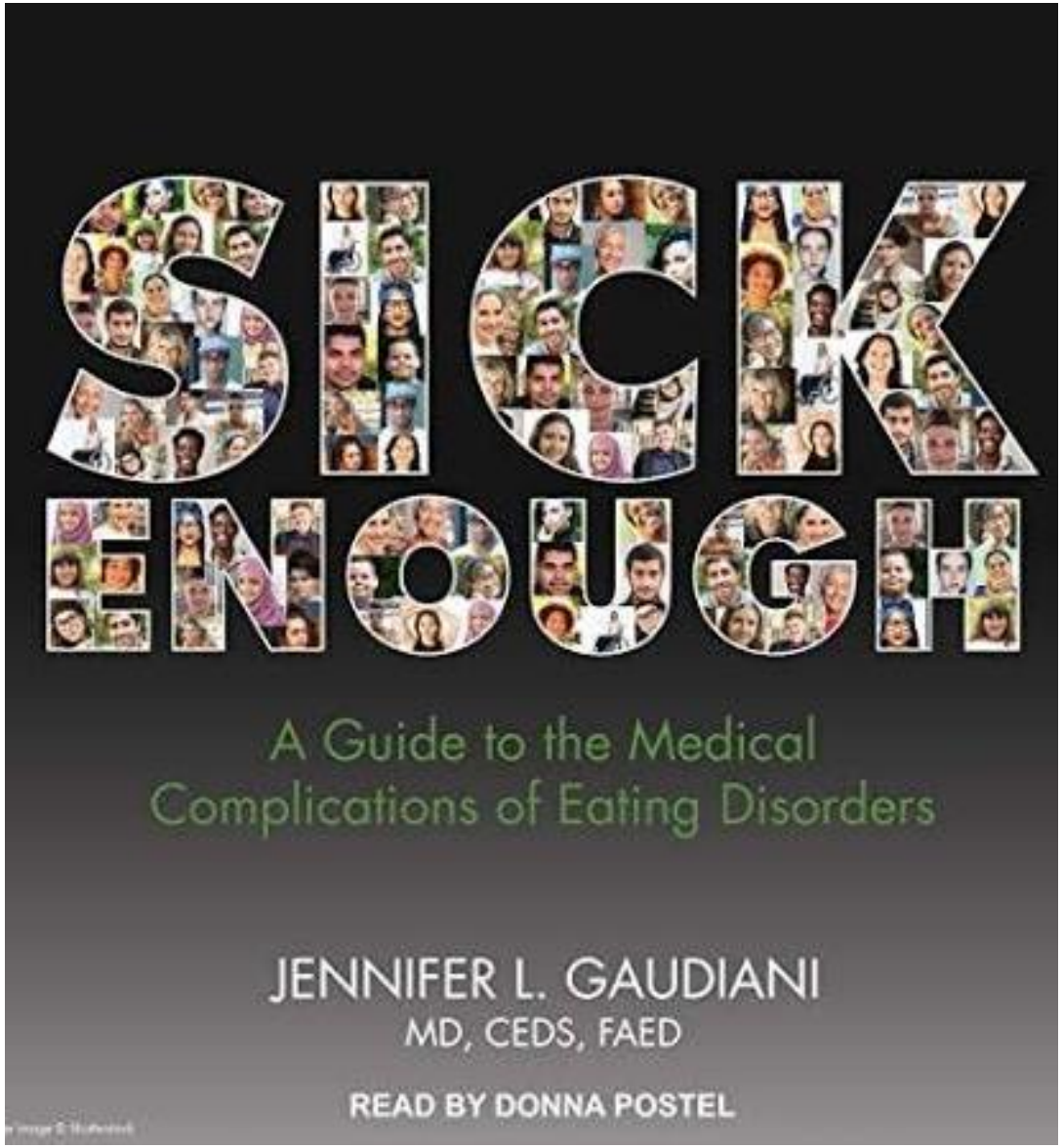
GASTROESOPHAGEAL
- Abdominal pain/bloating
- Constipation
- Reflux



PSYCHOSOCIAL
- Depression
- Anxiety
- Low self–esteem
- Over concern with weight/shape
- Shame or guilt
- Withdrawal from friends/activities

CARDIOVASCULAR
- Low pulse (AN, BN)
- Dizziness (AN, BN)
- Low blood pressure (AN, BN)
- High blood pressure (BN/BED)
- Arrhythmia/irregular heartbeat (AN, BN)

MUSCULOSKELETAL
- Low bone density, osteopenia, osteoporosis (AN)
- Stress fractures (AN, BN)
- Decreased muscle mass (AN)



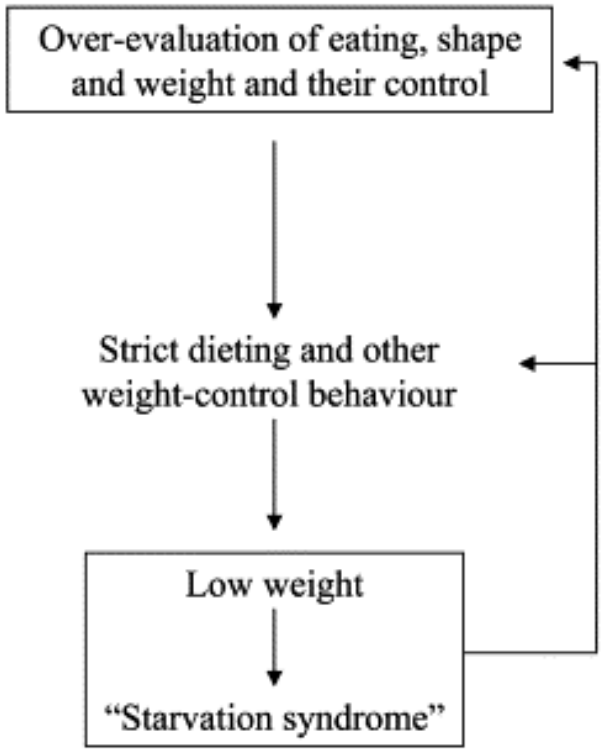

PAUSE
FOR
THOUGHT

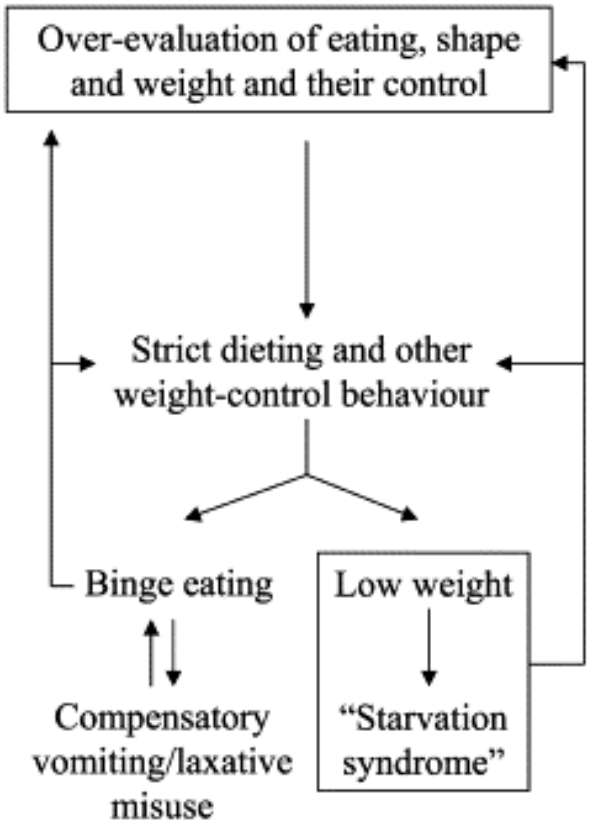
Core Symptomology

Over-evaluation of **control** of eating, shape, or weight

Changes in **behaviours**, **thoughts**, and **attitudes** to food, eating, weight, or body shape

Severe disturbances in eating behaviours that **interfere** upon an individual's **functioning**

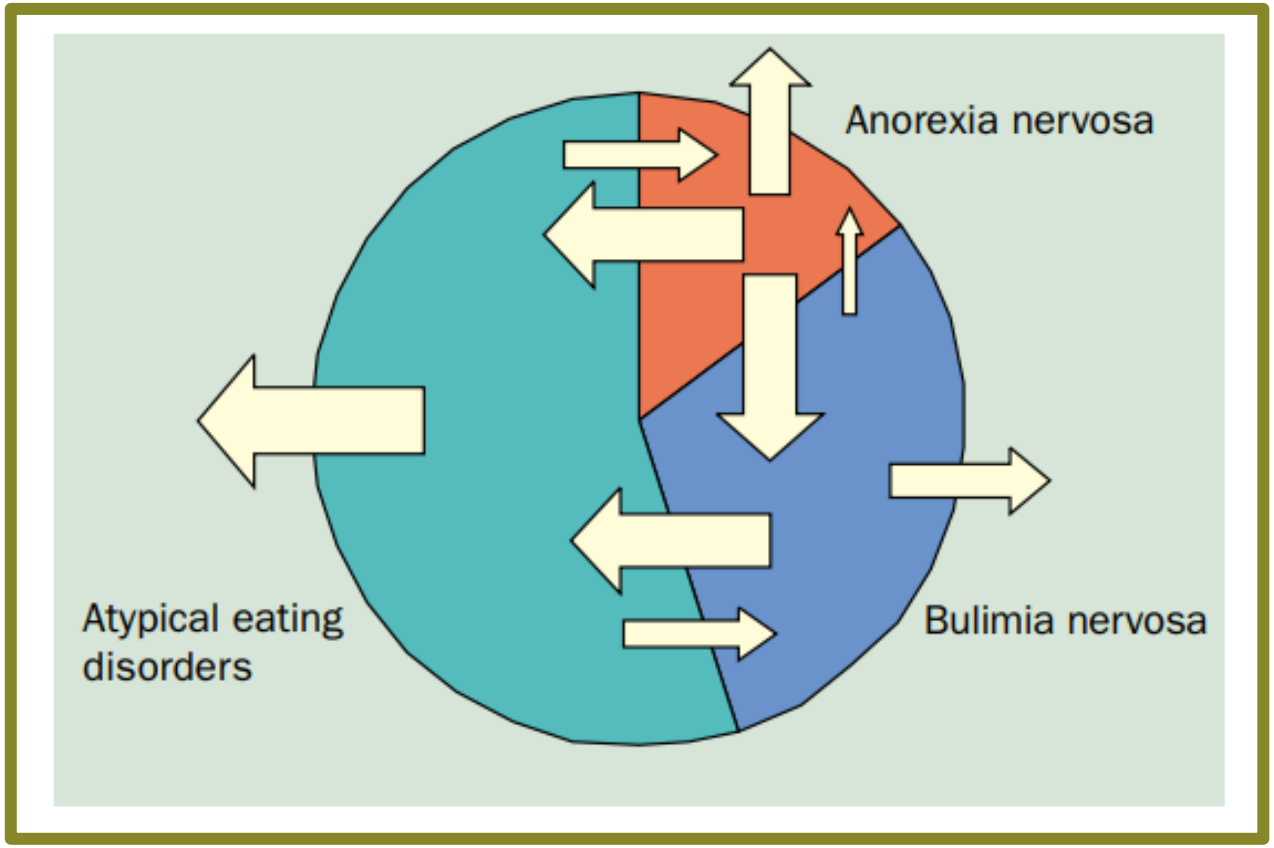




Cognitive transdiagnostic model of Eating Disorders

FAIRBURN ET AL

The Transdiagnostic Perspective



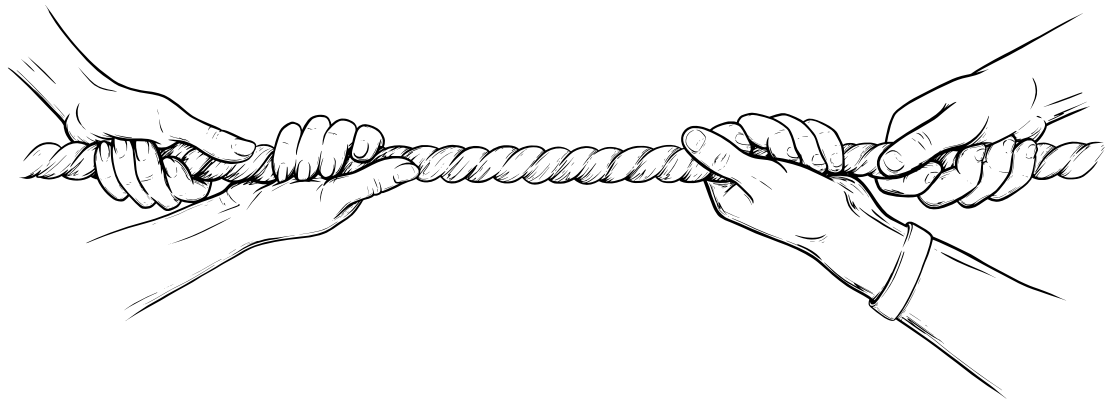
(Cooper, 2015)

Diagnostic Flux…

- Schematic representation of temporal movement between the eating disorders (Fairburn & Harrison, 2003)
- Migration between eating disorder diagnoses has been shown to occur in **53%** of cases over a 30-month period (Milos et al., 2009)

Severe, Complex, and Often Misunderstood

- Egosyntonicity
- Perception that the eating disorder is a valued part of the self, or serves a valued function in day-to-day life



Maladaptive coping strategy

Numbing from emotions

Providing distraction

Helping to feel in control

Informing a meaningful identity

Case Presentation - Jenny

For discussion:

WHAT DIAGNOSES ARE GOING THROUGH YOUR MIND?

WHAT WOULD YOUR FIRST FEW QUESTIONS BE IN THIS CASE?

WHAT EXAMINATIONS AND INVESTIGATIONS WOULD YOU WANT TO DO?

WHO MIGHT ELSE YOU INCLUDE IN YOUR ASSESSMENT?

JENNY

- Prior to June 2024
- “I was always dieting and trying to lose weight but never really stuck to it”
- “Did a lot of Tony Ferguson shakes and trying to eat health”
- “Would try doing it for a week and then stop”
- Then in June last year - started using Mounjaro prescribed by the GP
- “It took my appetite away”
- Was still eating normally but would become fuller more quickly
- Weight at that time - 104kg
- Has lost nearly 40kg now
- "Don't really eat that much and I think that I am little bit obsessed with losing weight"

- Now (12 months later)
- Weighs herself everyday on own scales for the past year
- Want to make sure its going down
- “If its going down then "nothing happens"
- If it doesn't go down - she feels disappointed and as though she needs to eat less
- Dietitian has asked her to stop weighing herself - doesn't feel great about that and hasn’t been able to stop

JENNY

- **NOW:**
- BF: Coffee
- Lunch: Fortisip
- Dinner: Fortisip
- Started having fortisip when she got sent to hospital 6 weeks ago - was having 4-5 fortisips in hospital
- Prior to fortisip she was having a bowl of cereal for dinner
- She is avoiding social situations where food is involved - last few months this has happened
- Dietitian has been working with her on adding another fortisip to her intake but she is unable to do this due to fear of gaining weight - or a worry about not losing weight
- Last ate solid food a few weeks ago

JENNY CONTINUED

- Lowest recorded adult weight: 67.4 kg (BMI: 25.68) at age 30 years.
- Highest recorded adult weight: 104 kg (BMI: 39.63) at age 29 years.
- Goal or ideal weight: 60 kg (BMI: 22.86).
- Understanding of healthy weight: “When it started this I wanted to be 60kg” but thinks that it might be less than that
- Feels like she would be "happier" if she were thin
- On further conversation regarding thoughts of suicide she talked about "making a deal with myself that this was the last time I would try to lose weight and if it didn't work then I might not live through this" - on clarification she was indicating that her suicidal thoughts/ plans might increase if she was to remain at this weight or if she gained weight
- During dieting episodes, she would drop a kilo or 2 and then go back up
- No sense of stable weight/ set point.

- Weight Observations
- Weight: 67.4 kg
- Height: 162 cm
- BMI: 25.68 kg/m²
- Change since referral: -6.6 kg
- BMI change since referral: -2.51 kg/m²

Feeding and Eating Disorders

(*American Psychiatric Association*, 2022)

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Other Specified Feeding or Eating Disorder
- Unspecified Feeding or Eating Disorder
- Avoidant/Restrictive Food Intake Disorder
- Pica
- Rumination Disorder

Regardless of diagnosis, eating disorders are associated with a wide range of physical and psychological symptoms; and increased risk of premature death due to medical complications and suicide risk.

Anorexia Nervosa

(American Psychiatric Association, 2022)

A. Restriction of energy intake relative to requirements, leading to significantly low body weight in the context of age, sex, developmental trajectory, and physical health.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way one's body weight or shape is experienced, **undue influence of body shape and weight on self-evaluation**, or persistent lack of recognition of the seriousness of the current low body weight.

Specifiers: restricting type, binge-eating/purging type

Bulimia Nervosa

(American Psychiatric Association, 2022)

A. Recurrent episodes of bingeing. An episode of binge eating is characterised by both of the following:
    1. Eating, in a discrete period of time, an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
    2. A sense of lack of control over eating during the episode
B. Recurrent inappropriate compensatory behaviour in order to prevent weight gain.
C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for three months.
D. Self-evaluation is unduly influenced by shape and weight.
E. Does not occur exclusively during episodes of Anorexia Nervosa.

Binge Eating Disorder

(American Psychiatric Association, 2022)

A. Recurrent episodes of binge eating.
B. Binge eating associated with 3 or more of the following:
    1. Eating much more rapidly than normal
    2. Eating until feeling uncomfortably full
    3. Eating large amounts when not physically hungry
    4. Eating alone from embarrassment
    5. Feeling disgusted with oneself, depressed, or very guilty afterward.
C. Marked distress regarding binge eating is present.
D. The binge eating occurs, on average, at least once a week for 3 months.
E. The binge eating is not associated with the recurrent use of inappropriate compensatory behaviour as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Other Specified Feeding and Eating Disorder (OSFED)

(American Psychiatric Association, 2022)

- Eating behaviours that cause clinically significant distress and impairment, but do not meet full criteria.
  - Diagnosis may specify why the presentation does not meet criteria (e.g. BN low frequency).

Example OSFED presentations:

- **Atypical anorexia nervosa:** All criteria met, except despite significant weight loss, weight is within or above normal.
- **Bulimia nervosa** (of low freqency and/or limited duration)
- **Binge-eating Disorder** (of low frequency and/or limited duration)
- **Purging Disorder:** Recurrent purging behaviour to influence weight or shape in the absence of binge eating
- **Night Eating Syndrome**: Recurrent episodes of night eating after awaking from sleep

Avoidant Restrictive Food Intake Disorder (ARFID)

(American Psychiatric Association, 2022; Thomas & Eddy, 2018)

Eating or feeding disturbance manifested by persistent failure to meet nutritional needs associated with one (or more):

- **Significant weight loss** (or failure to achieve expected gains)
- **Significant nutritional deficiency**
- **Dependence on enteral feeding or supplements**
- **Marked interference with psychosocial functioning**

- **No fear of weight gain or body image disturbance**
- Not due to lack of available food or cultural practice
- Not accounted for by another medical or psychiatric condition

Fear of aversive consequences

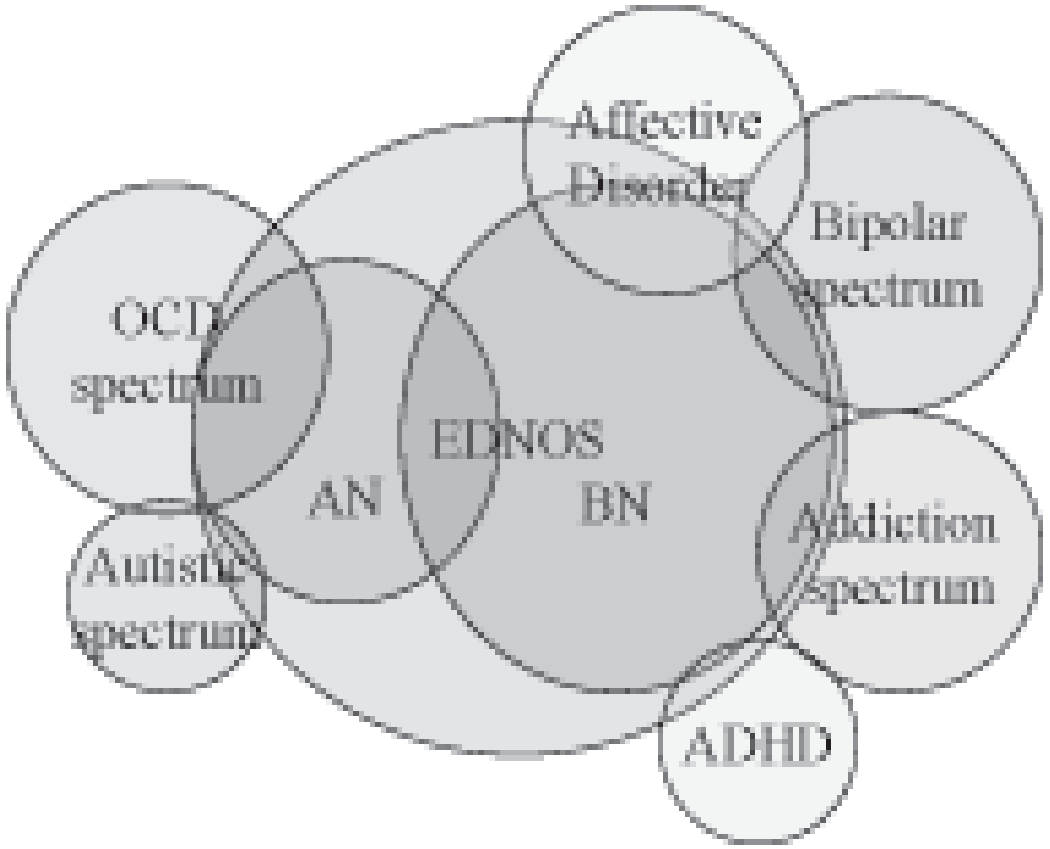
Sensory sensitivity

Lack of interest in eating

Co-occurring Diagnoses

(Treasure & Schmidt, 2008)

55% - 97% of individuals living with an eating disorder, have at least one additional co-occurring condition (NEDC, 2017)



- Trauma-related disorders
- Anxiety disorders
- Mood disorders
- Self-harm and suicidality
- Substance use disorders
- Personality disorders
- ADHD, Autism
- OCD


PAUSE
FOR
THOUGHT

Queensland Health Guideline

Eating Disorders: Inpatient care on adult wards

Queensland Eating Disorders Service (QuEDS)

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What makes this guideline different?

- Evidence-informed
- Recovery-oriented
- Statewide
- Multidisciplinary
- Co-designed with lived experience
- Least restrictive

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How was it developed?

How to use the guideline

1. Background – foundation of knowledge

2. Practical guidance for standardised care

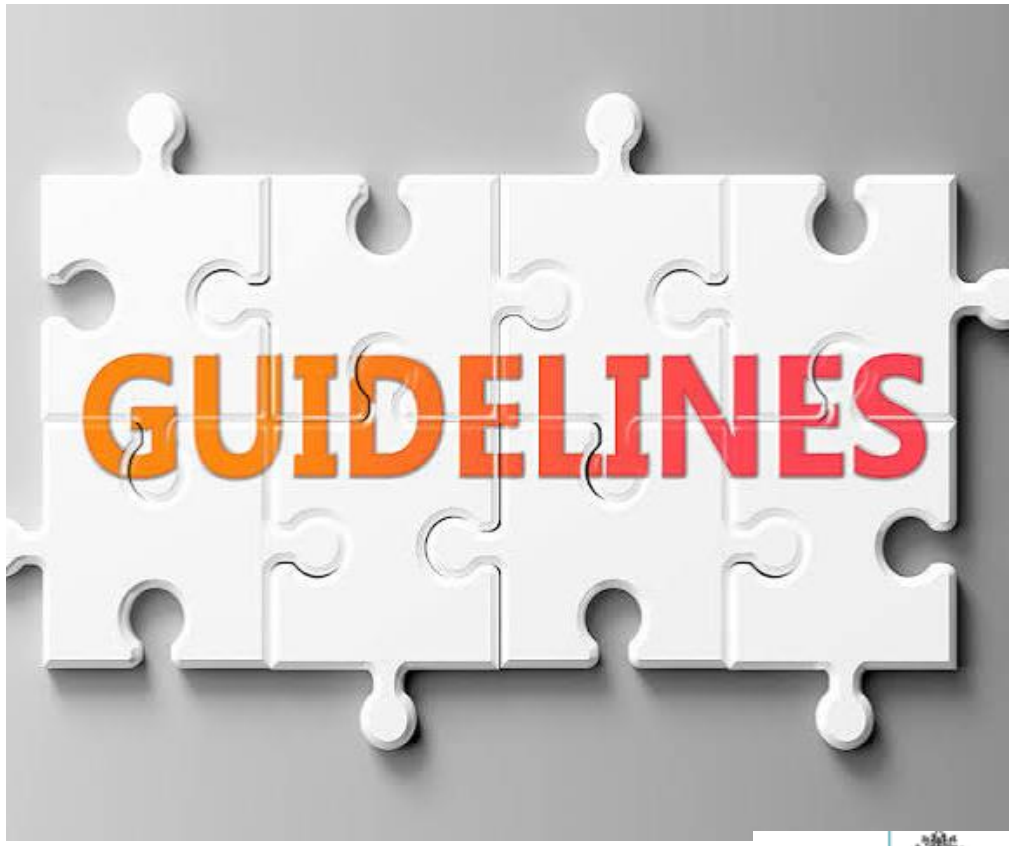
Medical officers

Dietitians/ nutrition considerations

Nursing care

Allied health/ MDT

3. Additional considerations for special groups



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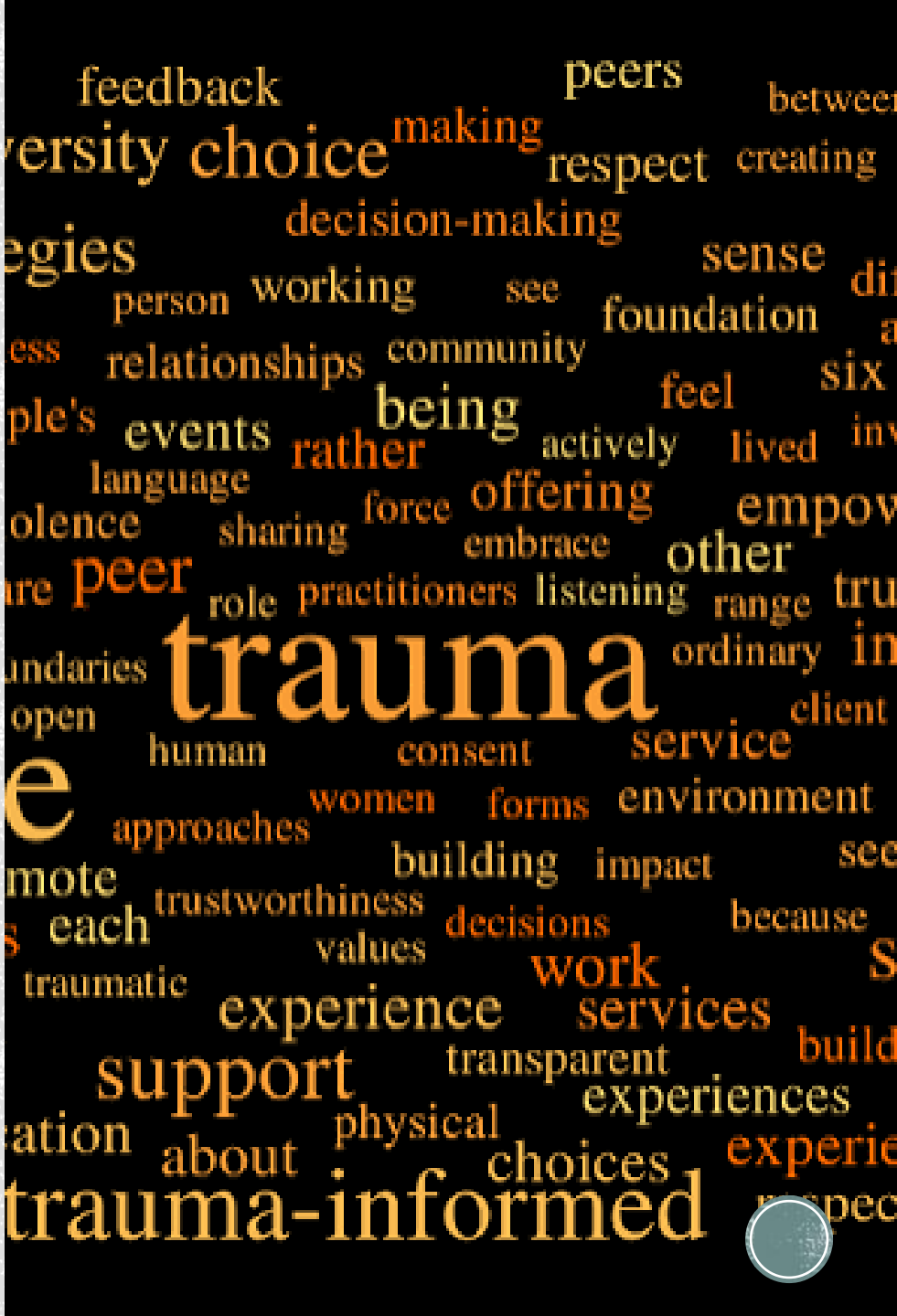
Principles of care

- Care is timely, accessible and delivered in the least restrictive environment
- Person-centred, recovery orientated care
- Trauma-informed care
- Inclusive of family and key support
- Culturally safe and inclusive
- Supporting self management, empowerment and agency
- Functional and holistic recovery



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1. Eating disorders have the highest mortality rate of any mental illness.

Among eating disorders, anorexia nervosa has the highest mortality rate, with suicide being the second leading cause of death. It is estimated that one in five individuals with anorexia who die do so from suicide.

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EATING DISORDERS › AWARENESS AND PREVENTION

Why Intervention Is Necessa Prevent Eating Disorder Deat

By Lauren Muhlheim, PsyD, CEDS | Updated on August 27, 2020

Print

Medically reviewed by Rachel Goldman, PhD, FTOS

We often hear about the dangers of obesity, but we hear less frequently about the risks of eating disorders. Eating disorders may seem benign, but this is a myth. Every 62 minutes someone dies as a direct result of an eating disorder.[1]

Early intervention markedly improves treatment outcome, which is one reason to ensure individuals with eating disorders receive a prompt diagnosis and access to treatment, preferably evidenced-based wherever possible.

Evidence for guidance

- "meet QuEDS guidelines for admission" ….
- Where did the recommendations come from?
- The question we kept returning to …
- Which physical health findings actually predict poor outcomes?

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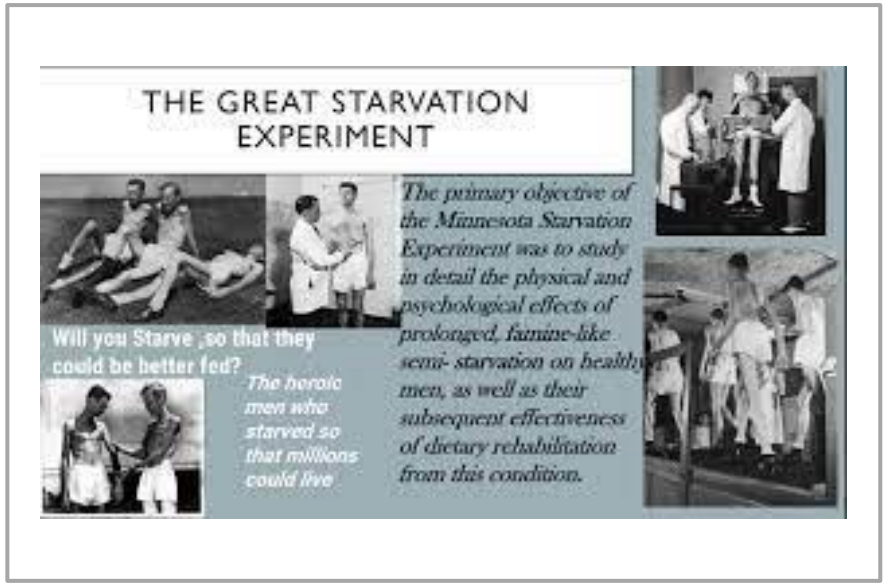

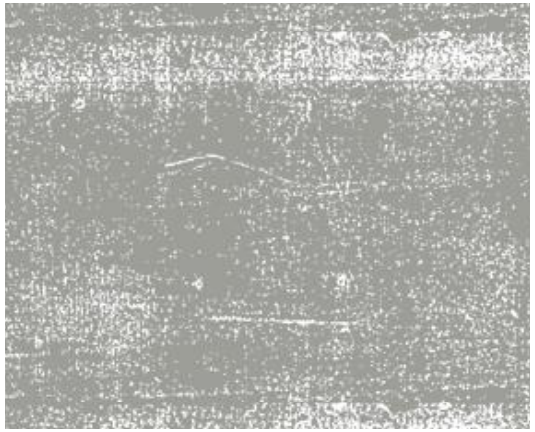

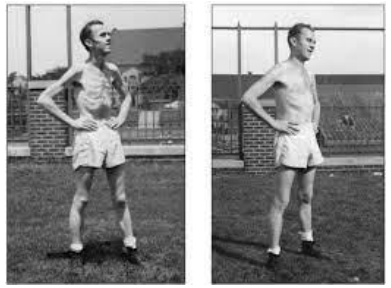

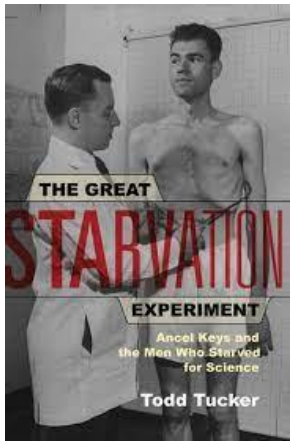

Minnesota starvation study

World Federation of Societies of Biological Psychiatry (WFSBP) consensus statement on candidate biomarkers for anorexia nervosa

Hubertus Himmerich [1 2], Johanna Louise Keeler [1], Joseph A King [3], Stefan Ehrlich [3 4]
Lisa-Katrin Kaufmann [5 6], Cynthia M Bulik [7 8], Sarah Cohen-Wo
Howard Steiger [10 11], Linda Booij [10 11], Palmiero Monteleone [1
Alessio Maria Monteleone [13], Ulrich Cuntz [14 15], Ulrich Voderho
Selamawit Alemayehu Tessema [17], Yael D Lewis [18 19], Magnus S
Jochen Seitz [21], Marta Tyszkiewicz-Nwafor [22], Olga Karpenko [23
Sergueï O Fetissov [25], Isabelle Mack [26 27], Namrata Dhopatkar
Maria M Uribe [30], Kazuhiro Yoshiuchi [31], Nadine Abuobeid [1], Di
Daniel Stein [19 34], Sevgi Bektas [1 35], Daniel J Müller [36 37], Phili
Philibert Duriez [39], Chloé Tezenas du Montcel [38 39], Elżbieta Pas

Results: Candidate biological markers that have been associated with AN include clinical (e.g. body weight), molecular (e.g. genetic, epigenetic, hormonal, immunological, metabolomic), cellular (e.g. leukocytes), neuroimaging (e.g. structure, function, connectivity), digital, cardiac and neurophysiological parameters. Some clinical and laboratory parameters are risk markers in clinical practice. Biological markers have pathophysiological relevance in understanding the biological and metabolic pathophysiology of AN and its physical health consequences. Few studies have examined pharmacogenetics or therapeutic drug monitoring as tools to monitor and guide the treatment of AN.

Conclusions: Biological markers will hopefully soon enable clinicians to intervene earlier in a more targeted manner to mitigate treatment resistance. However, the current scientific basis for most biological markers are group comparisons only. Studies on sensitivity, specificity and the prognostic value of these markers are lacking.

Cardiovascular risk factors and serious health events in individuals with eating disorders: A systematic review

Dr Kate Murphy, Dr Morgan Sidari, Dr Thomas Skerlj, Dr Kirsten McMahon, Dr Stephen Parker, Chloe Pearson, Jana Waldmann, Dr Elizabeth Eggins

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The Clinical Problem

- Eating disorders → significantly elevated mortality
- Cardiovascular abnormalities common (HR, BP, QTc)
- Unclear which markers indicate imminent risk
- Variation in admission decisions across services
- Impact on patients, families, and clinicians

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Aim of the Review

To identify cardiovascular predictors of:

Death or cardiac arrest or malignant arrhythmia

To inform guideline review

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Methods

- Systematic review (PRISMA)
- 15 databases searched (to Oct 2025)
- Inclusion: ED population + CV parameter + serious outcome
- Focus on prognostic (predictive) studies only
- AI-assisted + dual reviewer screening

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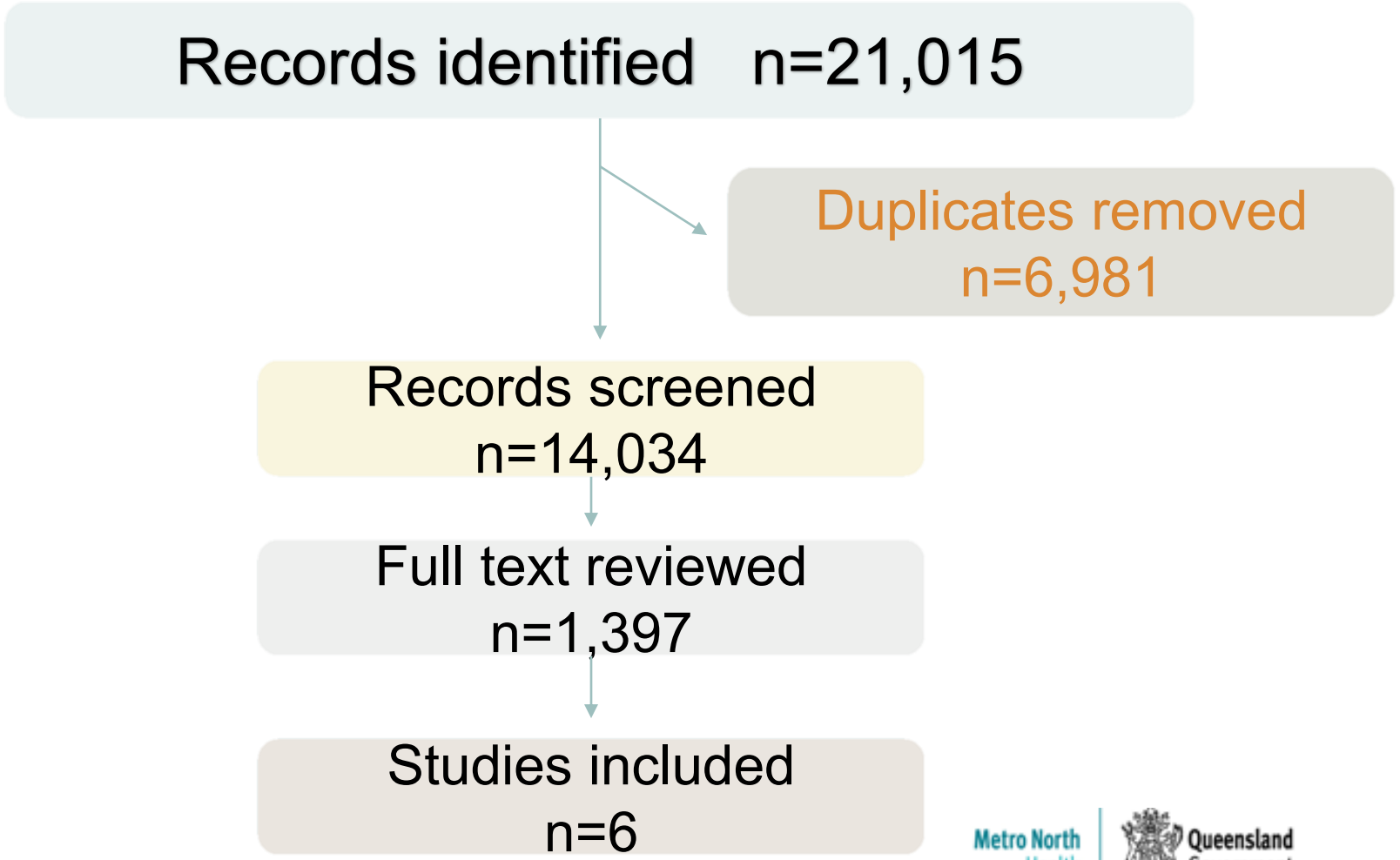
PRISMA records



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Characteristics of Included Studies

- All studies: anorexia nervosa
- Sample sizes: 3 – 6,937
- Predominantly female samples
- High heterogeneity in measures and outcomes
- All studies high risk of bias

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Summary of Included Studies

Study	Sample	Risk Factor	Outcome	Key Finding
Edakubo 2020	AN n=6937	Hypotension	Mortality	OR 8.65
Guinhut 2021	AN n=384	Cardiac complications	Mortality	HR 3.29
Frederiksen 2018	AN n=430	QTc	Mortality	No association
Facchini 2006	AN n=3	QTc	Arrhythmia	Unclear
Yahalom 2013	AN n=12	Bradycardia	Arrhythmia	No association
Okabe 1993	AN n=20	QTc/Bradycardia	Mortality	Unclear

Key Findings

Hypotension:

- OR ~8.65 for in-hospital mortality

Composite cardiac complications:

- HR ~3.29 mortality
- **Bradycardia:**
- No clear association with mortality
- **QTc prolongation:**
- Insufficient / low confidence evidence

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What Was Not Studied

No eligible studies examining:

- Postural hypotension
- Postural tachycardia
- Heart rate variability
- Dynamic changes over time
- **Significant gaps in evidence base**

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Interpretation

- Cardiovascular abnormalities ≠ equal risk
- Hypotension likely reflects physiological instability
- Bradycardia/QTc may reflect adaptation or illness severity
- Risk is multifactorial and context-dependent
- Absence of evidence ≠ absence of risk

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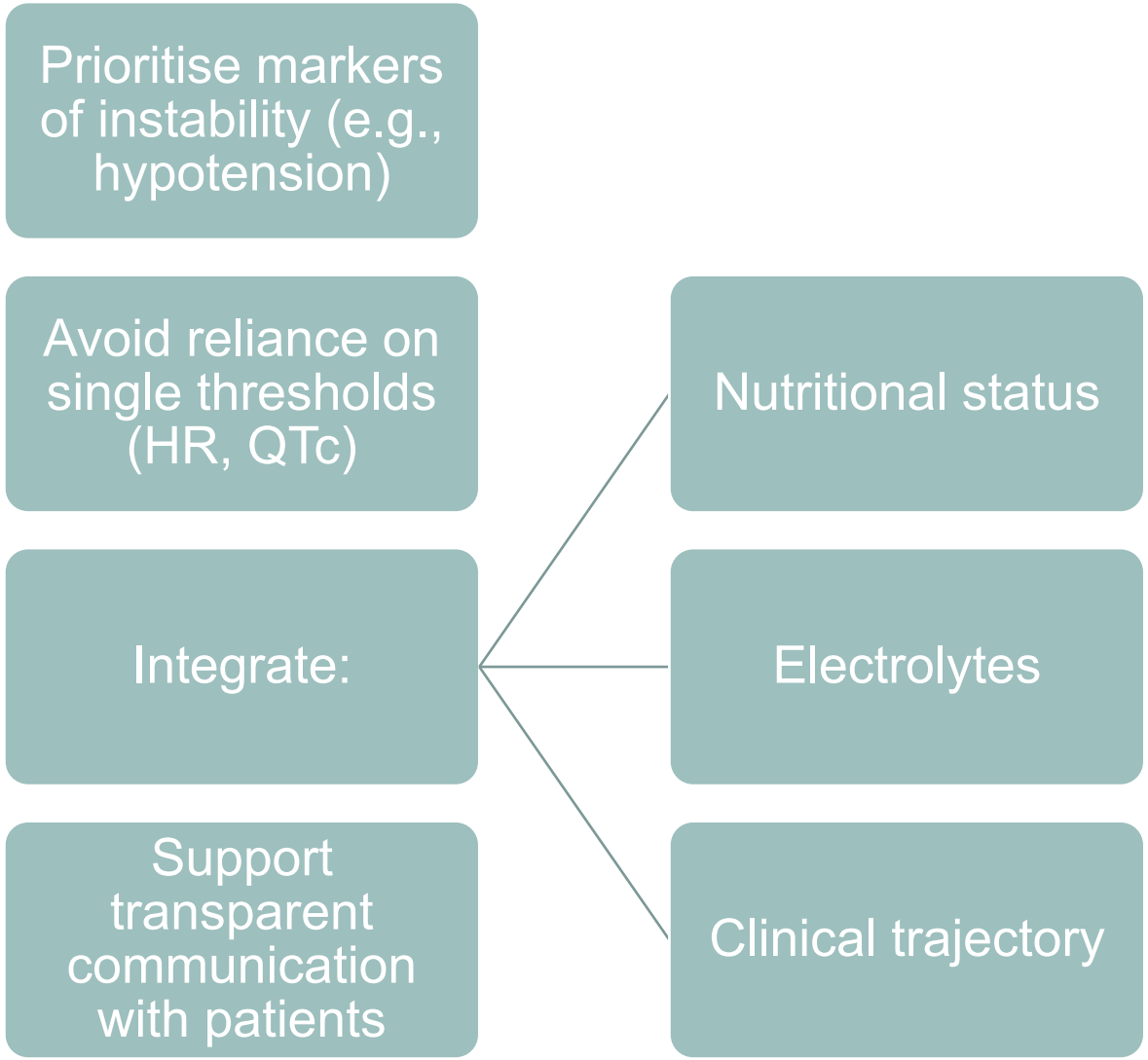
Clinical Implications



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Implications for Guidelines

1. • Shift from threshold-based → risk formulation approach
2. • Acknowledge limited prognostic evidence
3. • Support least restrictive care where safe
4. • Balance risks of over- and under-admission
5. • Embed clinical judgement within structured guidance

Table 1. Assessment and admission indicators

Complete usual triage emergency department assessment

Minimum assessment to be completed for all individuals with a diagnosed OR suspected eating disorder:

- measure blood pressure and heart rate at rest plus postural changes (sitting and standing with 2 minutes in between)
- collect blood tests including full blood count, electrolytes, liver function tests, glucose, phosphate, magnesium
- measure height and weight (do not rely on self-report) and calculate current BMI
- obtain an objective measure of any weight changes within the past 4 weeks
- assess oral intake and fluid status over the past 4 weeks, and particularly the past 5 days
- complete mental health screening assessment by including a risk assessment of suicide and consult Mental Health ED team accordingly
- Consider further assessment for sepsis (increased risk in this population) particularly where there are other signs of infection present *

INDICATOR OF ADMISSION TO ADULT MEDICAL WARD (If any one of these factors is present)	**INDICATOR OF ADMISSION TO AN ADULT MENTAL HEALTH WARD** (If any one of these factors is present)
• Systolic BP <80mmHg	• Systolic BP 80-90mmHg
• Systolic Postural BP drop of >20mmHg (2 minutes apart)	
• Resting Heart Rate <40bpm or >120bpm*	• Resting Heart Rate 40-50bpm
• New ECG changes including QTc >460ms or ST/T wave abnormalities.	
• Temperature <35.5°C	• Temperature 35.5-36.0°C
• Glucose (venous) <3.0mmol/L	
• Potassium <3.0mmol/L	• Potassium 3.0-3.5mmol/L
• Sodium <125mmol/L	• Sodium 125-130mmol/L
• Magnesium <0.7mmol/L	
• Phosphate <0.7mmol/L	
• eGFR <60ml/min or 25% drop within 1 week	
• Albumin <30g/L	
• LFTs (AST or ALT) > 2x upper limit of normal	
• Neutrophils <1.0 10/L	
• BMI <13.0 kg/m²	• BMI 13-15.0 kg/m2
• >10% total body weight loss over 4 weeks** or, more than 1kg/ week for over 4 weeks**	• >25% total body weight loss in 6 months or less**
	• Oral intake of less than 1000kcal/day for >4 weeks or more**
	• Significant deterioration or lack of progress in community despite access to eating disorder treatment
If none of the above parameters are identified during assessments in the emergency department then please **refer all individuals to psychiatric emergency for a mental health assessment prior to discharge**.	• Suicide risk that is acutely higher as compared with individual baseline or as compared with community population.

Additional notes for table reference:

- Importantly, clinical judgement should always be applied alongside the interpretation of the data points presented in this table.
- Currently, there is insufficient evidence to determine whether postural tachycardia should be an indicator for admission in isolation.
- Individuals who have blood glucose of 3.0–4.0mmol/L or postural tachycardia are exhibiting features of clinical deterioration and require increased monitoring in the community with nutritional support.
- Individuals with systolic BP of 80-90mmHg on Mental Health wards require Q-ADDS amendment review every 72 hours minimum to ensure compliance with local procedures on MET calls
- There will be circumstances when the BMI <15 is not considered reasonable for an admission based on that criteria alone or having achieved that but for the vast majority of individuals, the treatment they need is psychological and dietetic treatment in the community and accessing this at a weight less than 15kg/m2 is problematic due to the significant cognitive effects of starvation and would therefore leave most individuals at significant risk of deterioration
- For young people under 18 years of age, the admission guidance outlined in *Assessment and treatment of children and adolescents with eating disorders in Queensland* [1] may have been used to guide a referral, or may need to be consulted to support transfer to a child and adolescent mental health inpatient unit.

* Refers to the concerns regarding risk of infection
** Measured, objective or verifiable

Indicators for admission

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* Refers to the concerns regarding risk of infection

** Measured, objective or verifiable

Jenny

23-year-old woman

BMI 25.7

Pulse 42

BP 86/58

QTc 455

Says: “I’m fine, I don’t need to go to hospital.”

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Jenny – more information

- 18% weight loss in 3 months
- Vomiting up to 4 times daily
- Lives alone
- Wants to leave to get back to work
- Family concerned

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PAUSE
FOR
THOUGHT

How to use the guideline to support decision making

Consider the principles of care
What are the suggested indicators of medical admission
If these are not met – does your clinical judgement, consider her to require admission despite “not meeting QuEDS criteria”
If so, given that she wants to leave … consider the legislative considerations section
Then implement the medical treatment and monitoring aspects of guideline and refer to dietitian
Make sure there are nursing considerations in the plan – e.g. level of observations etc
If not, does she need a MH assessment?
If not, what discharge arrangements/ considerations would you want to have in place?

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and enactment of the legislative provisions (refer to section 1.4 Legislation). This responsibility requires careful clinical judgment, comprehensive documentation, and adherence to both the MHA2016 [26] and GAA2000 [28] frameworks, with particular attention to the principles of least restrictive practice and respect for human rights.

2.2.2.1 Key responsibilities of medical officers

- **Assessment of capacity:** Medical officers must assess whether an individual has capacity to consent to treatment. Capacity should not be assumed based solely on BMI or physical appearance as it reflects a cognitive process. Importantly, cognitive impairment related to malnutrition or starvation can occur at any body weight and should be carefully considered in the assessment. The clinical state of individuals with eating disorders can change rapidly, particularly during refeeding and medical stabilisation. Medical officers are responsible for regularly reassessing capacity and reviewing the need for involuntary treatment, with consideration given to transitioning to voluntary treatment as soon as clinically appropriate. When considering application of MHA2016, [26], determination of an individual's capacity to consent to treatment of a mental illness can pose challenges for medical officers unfamiliar with eating disorders due to the nuance of assessing the risks of treatment and no treatment in the context of the need for physical health treatments. In this instance, additional support may be required (e.g. by contacting local EDSS or QuEDS).
- **Determination of involuntary treatment criteria:** When an individual lacks capacity, medical officers must assess whether the criteria for involuntary treatment under the MHA2016 [26] are met, including consideration of less restrictive alternatives to provide necessary treatment and care. If a Treatment Authority is made the medical officer must consider the individual's views, wishes and preferences and ensure the individual is supported to use and understand their rights under MHA2016 [26].
  - In circumstances where there is a delay in accessing MHA2016 [26] assessment and the risk is imminent urgent care provision under the GAA2000 [28] may be utilised (see below) to enable treatment for medical risk, including nutrition. In this scenario an assessment for the application of the MHA2016 should be completed at earliest opportunity and reviewed regularly.
  - Under the MHA2016 [26] treatment encompasses anything done or to be done with the intention of having a therapeutic effect on the person's mental illness. This may include all components required for the management of an eating disorder, including nutrition, hydration, electrolyte replacement, vitamin supplementation and the provision of nursing and MDT supports necessary to ensure both the delivery and the maintenance of the adequate nutritional intake, including the management of compensatory behaviours.
- **Use of urgent health care provisions:** Medical officers may need to invoke Section 63 of the GAA2000 [28] when urgent healthcare is required. All such decisions must be clearly documented in the individual's health record, including the rationale for determining that treatment was urgent and that it was not reasonably practicable to obtain consent.

- **Application of least restrictive principles:** In all decision-making, medical officers must prioritise

The Role of Medical Officers in Enacting Legislation for eating disorders inpatient care

Initial interventions for Eating Disorders

Medical stability
Nutrition and meal planning
Reversal of starvation effects
Supportive psychotherapy
Family and carers support
SMT
Psychoeducation
Motivational interviewing and building rapport

NICE Guideline (NICE, 2020)

Anorexia Nervosa

First line:
- **CBT-ED**
- **SSCM**
- **MANTRA**

Second line:
- **Focal Psychodynamic Therapy***

Bulimia Nervosa

First line:
- **CBT Guided Self Help**

Second line:
- **CBT-ED**

Binge Eating Disorder

First line:
- **CBT Guided Self Help**

Second line:
- **Group CBT-ED**

Third line:
- **Individual CBT-ED**

OSFED

Consider using treatment for the eating disorder it most closely resembles

First-line Anorexia Nervosa Treatments (Fairburn, 2008; Hay et al., 2016; McIntosh et al., 2024; Schmidt et al., 2019; Stiles-Shields et al., 2016;)

CBT-ED

Well suited for patients:

- Seeking active treatment, with guidance from therapist
- Motivated to engage
- Willing to complete homework

Contraindications:

- Compromised physical health
- Suicide risk
- Severe clinical depression
- Persistent substance misuse
- Major life events or crises
- Inability to attend treatment
- Absence of the therapist

SSCM

Well suited for patients:

- Wanting a flexible approach
- Ambivalent about change
- With little change in previous therapy
- With co-occurring personality disorders

MANTRA

Well suited for patients:

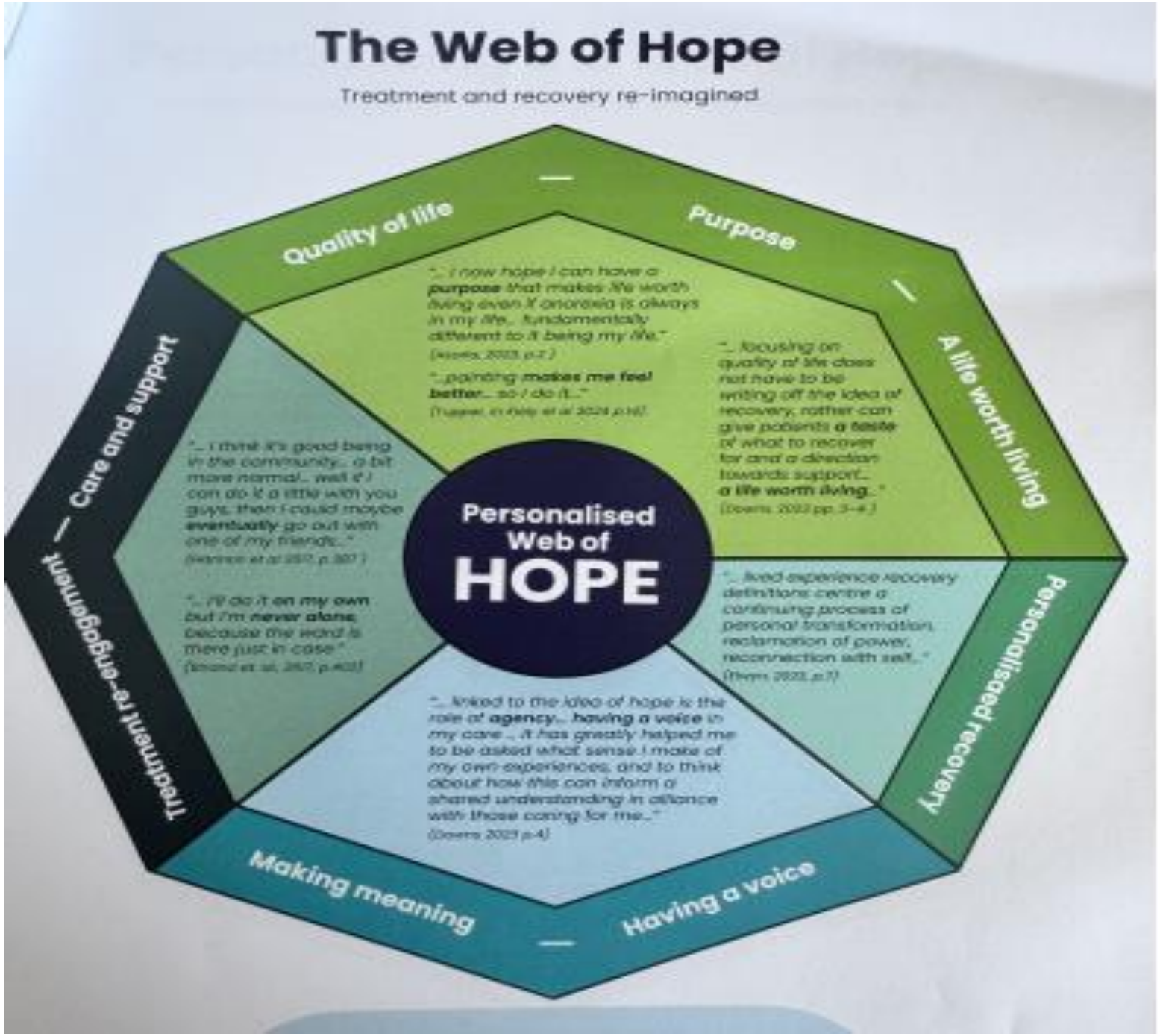
- With anxious, sensitive, perfectionistic, detail-focused and/or obsessional traits
- With longstanding illness
- Who value their illness
- Willing to complete homework

Long standing eating disorders – language and definition

- Severe and Enduring Eating Disorders (SEED) vs Long-standing Eating Disorders
- Can have long standing but not severe and vice versa – often shorter duration but very severe
- The staging model used duration 7 years
- Samples of individuals with this presentation prefer the term long standing
- They also described having the definition relatively “arbitrary” – the duration, the BMI
- PERSISTENT SYMPTOMS (functional impairment, regular MDT requirement, shape and weight concerns ongoing, dietary behaviours continue, underweight)
- ENDURING
- TREATMENT RESISTANCE (low motivation or lack of response to evidence based and evidence informed treatments)

Guidelines on approaches to long standing eating disorders

- There is research into effectiveness of evidence-based treatments in long standing ED – in 2017 compared CBTe in SE-AN vs nSE-AN – similar response in BMI and other recovery domains and this was sustained recovery
- Australia and New Zealand guidelines – focus on maintaining hope, harm minimisation and improving quality of life
- "Holding Hope" – published in June 2024 Holding Hope (nedc.com.au)
- *While recognising the ongoing discourse surrounding clinical characterisation of eating disorder stage and prognosis, this paper places its emphasis on advocating for compassionate care, primarily through palliative approaches, irrespective of prognosis. It is important to dispel the common misconception that palliative care is synonymous with end-of-life care. Rather, it embodies a comprehensive approach designed to enhance overall well-being and quality of life for individuals navigating the complex interface of physical and mental health challenges due to the impacts of longstanding eating disorders.*
- America – maintain hope +/- move away from traditional ED treatments
- Overall agreement that there needs to be optimal staff mix, adaptive, flexible, co-produced, personalised care
- +/- weight restoration and reduction of eating disorder symptoms
- Or harm reduction + improvements in Quality of Life measures


The Web of Hope
Treatment and recovery re-imagined
Quality of life
Purpose
A life worth living
Personalised recovery
Having a voice
Making meaning
Treatment re-engagement
Care and support
Personalised Web of HOPE
"... I now hope I can have a purpose that makes life worth living even if anorexia is always in my life... fundamentally different to it being my life."
(Nicola, 2023, p.2)
"...painting makes me feel better... so I do it..."
(Tupper, in Haig et al 2024 p.16)
"... I think it's good being in the community... a bit more normal... well if I can do it a little with you guys, then I could maybe eventually go out with one of my friends..."
(Hannon et al 2017, p.307)
"... I'll do it on my own but I'm never alone, because the word is there just in case"
(Strand et al, 2017, p.403)
"... focusing on quality of life does not have to be writing off the idea of recovery, rather can give patients a taste of what to recover for and a direction towards support... a life worth living..."
(Downs, 2022 pp. 3-4)
"... lived experience recovery definitions centre a continuing process of personal transformation, reclamation of power, reconnection with self..."
(Thom, 2023, p.7)
"... linked to the idea of hope is the role of agency... having a voice in my care ... it has greatly helped me to be asked what sense I make of my own experiences, and to think about how this can inform a shared understanding in alliance with those caring for me..."
(Downs 2023 p.4)

Final pause for thought, questions and reflections

Thank you for listening

Kate.Murphy2@health.qld.gov.au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