Addressing the Treatment Gap in UK Eating Disorders, Learning from International Strategies

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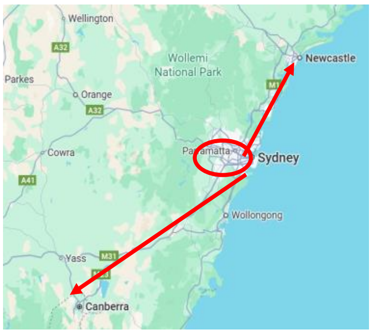
Churchill Fellow 2024

Report November 2025

the CHURCHILL fellowship

Travelling in Australia

Visiting Sydney, Newcastle, and Canberra



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Travelling in New Zealand

Visiting Auckland,
Christchurch,
and Wellington

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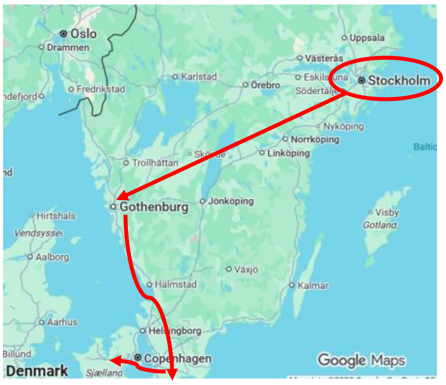
Travelling in Sweden

Visiting Stockholm, Gothenburg, and Lund, returning via Copenhagen



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1. GLOSSARY

ACEDS – Adult Community Eating Disorder Service (UK)

ACT – Acceptance and Commitment Therapy

AN – Anorexia Nervosa

ARFID – Avoidant and Restrictive Food Intake Disorder

ASD – Autistic Spectrum Disorder

BED – Binge Eating Disorder

BN – Bulimia Nervosa

BUP - Barn- och ungdomspsykiatri, child and adolescent mental health (Sweden)

CBT-E – Cognitive Behavioural Therapy for eating disorders

CEDI – Centre for Eating Disorders Innovation (Sweden)

CYPMH – Children and Young People's Mental Health

DBT – Dialectical Behavioural Therapy

ED – Eating Disorder

EDCSNZ – Eating Disorders Carer Support New Zealand

EDE-Q – Eating Disorders Questionnaire (Outcome Scoring Tool)

FBT – Family Based Therapy

IAPT – Improving Access to Psychological Therapies (NHS Talking Therapies England)

IOI – InsideOut Institute

LHD – Local Health District (Australia)

Medicare – National benefits reimbursement programme for healthcare (Australia)

MEED – Medical Emergencies in Eating Disorders

NEDC – National Eating Disorders Collaboration (Australia)

NHSBN – NHS Benchmarking Network (UK)

NSW – New South Wales

SCA – Stockholms Centrum for Ätstörningar, Stockholm Centre for Eating Disorders)

SEED – Severe and Enduring Eating Disorder

Socialstyrelsen – National Board of Health and Welfare (Sweden)

Whāraurau - New Zealand's national centre for workforce development for the infant, child, and adolescent mental health and addictions sector

2 EXECUTIVE SUMMARY

Eating disorders have psychological, genetic and social causes and carry significant risks around physical health and psychological wellbeing. Eating disorders cause serious physical and psychological harm and can be fatal. Anyone can develop an eating disorder, and they affect all ages, genders, and backgrounds. Eating disorders are a condition with one of the fastest growing prevalence rates in healthcare. Latest prevalence estimates suggest around 6% of the UK population (circa 3 million people) may suffer from a diagnosable eating disorder. Eating disorders are now common conditions, however, only around 35,000 people are able to access specialist eating disorder services in the UK each year. This makes eating disorders one of the largest treatment gaps in UK healthcare.

UK services have improved for children and young people's eating disorders care as a direct result of the focus, investment, and workforce development that was made possible by successive national strategies for children and young people's mental health. There are many other precedents for successful national mental health strategies in the UK and many areas have been transformed by well-conceived and implemented strategic plans. This includes strategies for first episode psychosis care, perinatal mental health, community mental health, and psychological therapies. However, in the absence of a national strategy, the most substantial UK treatment gap is evident for adult eating disorders care which is currently subject to capacity restrictions and high acuity thresholds.

The rising morbidity of eating disorders in the UK is not unusual and is experienced by most developed countries. My Churchill Fellowship learns from 3 countries who have responded to the national healthcare emergency for eating disorders by developing confident national strategies to address rising demand and create effective solutions. I visited Australia, New Zealand and Sweden and met with government policy teams, national clinical leaders, service providers, and patient and carer representatives to understand the process of developing national eating disorders strategies and the benefits that can be expected from developing a coordinated national approach.

Australia (2023), Sweden (2024), and New Zealand (2025) have all implemented assertive national strategies for eating disorders as a response to rising demand and increasing patient acuity. There is clear political support for eating disorders in each country. The strategies were developed following comprehensive engagement processes in each country and sought to take an evidence-based approach to improving care. The new national strategies took around 2 years to develop in Australia and Sweden and around 7 months in New Zealand.

There is much learning in each of the strategies and also in their potential for use in addressing the UK eating disorders treatment gap. The main opportunities for the UK NHS in pursuing the development of a national plan or strategy for eating disorders can be directly linked to the benefits being delivered in Australia, New Zealand, and Sweden and are;

- Strategies provide a clear vision and purpose in how to best respond to rising demand and bridge the treatment gap in eating disorders
- Strategies help define clinical standards and improve compliance

- National strategies have succeeded in taking eating disorders from being seen as a specialist condition to one now seen as a common condition where generalists can also provide a response. Eating disorders have become “everyone’s business” in the Australian healthcare system.
- National plans can be used to fix known access problems and increase capacity, this is a common feature in all 3 countries.
- Australia and Sweden have introduced clear stepped care models which identify how care can be delivered at all stages of the care pathway and at all levels of acuity. This addresses areas that are known gaps in the UK such as;
    - health promotion and prevention
    - support to primary care
    - first line therapies via digital care
    - early intervention and initial response
    - effective treatment via community responses of different intensities, including day care, along with support from inpatient and residential care
    - recovery support and relapse prevention
- Each country has also targeted developing the eating disorders specialist workforce, and crucially, the wider healthcare workforce who have a role to play in understanding and supporting an effective clinical network for eating disorders.

I saw a huge amount of innovation on my fellowship, all of which could be transported to the UK and would deliver benefits and improvements in clinical practice. The country specific sections of my report outline many of these innovations and probably most memorable for me were;

- the role of eating disorder coordinators and lead clinicians working as local clinical leaders
- the use of digital therapies (often supervised) to offer rapid first line interventions and also relapse prevention
- the support provided to primary care in building confidence and capability in the consulting room
- the use of day care as an effective alternative to acute inpatient care
- the novel approaches applied to therapies for severe and enduring eating disorders
- large scale skills and workforce development in the general healthcare workforce
- targeted attempts to address health inequalities and the needs of minority populations.

All three countries also embraced the importance of lived experience in their strategy development and subsequent implementation work, and it was important to check in on the voices of carers and service users. All spoke positively about the need for a national strategy and the purpose that it had brought to efforts to bridge the treatment gap.

The UK is a country that has delivered huge advances in mental health care over the last 25 years and it should be proud of its track record. All of these advancements have been delivered with the help of clear strategies and detailed implementation plans that have helped to transform care. My fellowship outlines the case and evidence for embarking on a similar strategic transformation in eating disorders, it is one that is much needed, would deliver considerable benefits, and would be eminently achievable.

3. INTRODUCTION

I was awarded a Churchill Fellowship in 2024 to explore how the UK could learn from international strategies for meeting the growing demand for eating disorders care. Eating disorders have grown in prevalence in recent years and are the mental disorder with the highest mortality rate. The increasing incidence of eating disorders is happening in all developed countries and has created a substantial treatment gap as countries and health systems address the challenge of rising demand. This problem is particularly stark in the UK where an estimated 3 million people[1] will experience an eating disorder at some point in their life, but the capacity to meet this demand is limited. Access rates into UK specialist eating disorder services are low with only around 1% - 2% of population eating disorder prevalence able to access specialist care each year. This positions eating disorders as the health condition with the largest treatment gap in UK healthcare. The annual UK costs of eating disorders are estimated by economists at £9b per annum[2] and there is a strong economic case for national intervention given the impact on the UK economy and the personal cost on individuals and families living with eating disorders.

I currently work as an Associate Non Executive Director with Lancashire and South Cumbria NHS Foundation Trust, a large mental health, learning disability, and community service provider in the North West of England. Prior to this I led the work programme of the NHS Benchmarking Network for over 20 years and collaborated with many national organisations to collect and analyse data on how healthcare is provided. During this time I was fortunate to be able to report on many successful policy developments in mental health that succeeded in transforming how care was provided. This included national programmes for psychological therapies, perinatal mental health, first episode psychosis, and children and young people's mental health. All of these areas succeeded in delivering broad based, rapid access services that fundamentally reshaped people's ability to access care, have a positive experience, good outcomes, and ability to recover. The common thread in all of these successes is the existence of a clear national strategy, supported by a framework of standards, investment, and workforce development.

UK governments have not yet embraced the formal commitment to a national eating disorders strategy. NHS England produced commissioning guidance in 2018, the National Public Health Service for Wales also set out its ED Framework following a Welsh Government service review in 2018. More recently the Scottish Government also published a National ED Specification in 2024, although all of these documents stopped short of committing to full strategic goals and assertive development of the ED sector to bridge the treatment gap.

Eating disorder care would benefit from a national strategy and I am confident that a structured national approach would be able to transform access to care and people's chances of full recovery. Eating disorders are treatable and in many developed countries are increasingly being recognised as a national healthcare priority given their rising prevalence and economic impact.

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[1] NHS England, National Commissioning Guidance for Eating Disorders, 2018

[2] Ernst and Young, Hope Virgo, The costs of eating disorders in the UK 2019 and 2020, 2021

My fellowship learns from 3 countries where national strategies have been developed and there is a demonstrable national commitment to address the treatment gap in eating disorders. In each country I was fortunate to be able to meet with organisations that lead on national policy development and a wide range of organisations and people working to improve access to care and achieve positive experiences for people affected by eating disorders. This report outlines what I saw and experienced in Australia, New Zealand, and Sweden and how we might learn from national and local approaches in each of these countries. I was impressed by what I saw in each country and have tried to capture this within my report.

Each country has both strengths and acknowledged development areas within their approaches and I have tried to be transparent about this in my assessment. There is probably no perfect healthcare system and no “one size fits all” solution to how we might bridge the treatment gap in eating disorders. However, the learning in my fellowship has a clear message that an optimistic and joined up national approach can make a real difference to eating disorders care.

A final note on the structure of this report. I have included a chapter at the beginning which outlines what eating disorders are as well as how the UK NHS currently responds. The case for change from this evidence is substantial. I then describe how each country I visited has chosen to address their own rising prevalence and associated treatment gap. For each country I have outlined the policy arrangements in place and then the good practice and innovations I saw through meeting with a wide range of organisations. I have showcased the work of each of these organisations and then summarised key learning by country. The final section attempts to conclude on what might be most helpful in translating for use in the UK. I am not alone in working in this area and many organisations have made similar recommendations around how the UK approach could be improved. Chief amongst these are the Parliamentary and Health Service Ombudsman, All Party Parliamentary Group on Eating Disorders, Health and Social Care Committee, Royal College of Psychiatrists Faculty of Eating Disorders, and a large number of campaigning and advocacy organisations including BEAT, Dump the Scales, SEED, and RedCan. All of these organisations have done fantastic work and I have learned from each of them. I am grateful to the Churchill Fellowship in supporting me in witnessing great international practice first hand in Australia, New Zealand, and Sweden and hope you find this report helpful in considering how we might begin to address the UK treatment gap in eating disorders.

4. ACKNOWLEDGEMENTS

I had the pleasure of meeting a lot of people over the course of my research. I remain hugely grateful to the Churchill Fellowship for enabling this and equally grateful to the people who gave their time and goodwill to help my work. I can't list every person I met but appreciate everyone who spent time with me and would like to pay particular reference to the following people who helped me in each country.

To my family, Tracey and Alice who are just the best.

In the **UK** – I am grateful for the help of Julian Emms (CEO of Berkshire Healthcare NHSFT) and Dr Geraldine Strathdee (England's former National Clinical Director for Mental Health) who acted as my referees and are always available for advice and help. In my own organisation, Lancashire and South Cumbria NHSFT, I would like to thank my Chair, David Fillingham, Chief Executive Chris Oliver, Medical Director Dr Gareth Thomas, Director of Communications Fiona Holgate, and Laura Heywood who manages our Eating Disorders service for 1.8 million population. At the NHS Benchmarking Network I would like to thank Sarah Atkinson and Kirsten Windfuhr along with the wider NHSBN team. Access to NHSBN data was instrumental to my ability to establish the evidence for the case for change in UK eating disorders care. Over the last two years I have worked closely with members of the Royal College of Psychiatrists working group on Eating Disorders and have learnt much from many experts including Dr Agnes Ayton, Dr Ashish Kumar, Dr Jonathan Campion, Dr David Ochando, and Dr Mritynjai Kumar, along with excellent support from Joanna Popis.

I briefed NHS England's mental health policy team on my work at several points and would like to thank Professor Prathiba Chitsabesan, Professor Dasha Nicholls, Claire Murdoch, Dr Adrian James, Sarah Brown, Jane Saunders Bain, Anika Sharma, Dr Adaeze Bradshaw, Simona Baracaia, Marlon Brown, and Thelma Goddard. At the Scottish Government I would like to thank Stephen McLeod and Chloe Dufus. At the Global Leadership Exchange I would like to thank Steve Appleton for his help in connecting me with people around the world and for his wider leadership role in global mental health.

I admire the work of the many campaigning and advocacy groups working to ensure eating disorders achieves the appropriate recognition and policy response and would like to thank Hope Virgo, Rt Hon Wera Hobhouse MP and the wider team at the All Party Parliamentary Group on Eating Disorders, Gemma Oaten and team at SEED, James Downs, Vanessa Longley and Jonathan Kelly and team at BEAT.

In **Australia** I am particularly grateful to Dr Grant Sara (New South Wales Health) and Professor Sarah Maguire (InsideOut Institute) for welcoming me, organising my schedule, and supporting me throughout my stay. At New South Wales Ministry of Health I would also like to thank; Elizabeth Wood, Cherie Power, Dr Murray Wright, Michelle Tonkin, and the InforMH team including; Sarah O'Neill, Charmaine Turton, Jeff Tang, John Uesi, Lawrence Ma, Nancy Jong, and Anthony Landers.

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5. THE UK EATING DISORDERS TREATMENT GAP (AND WHY WE NEED CHANGE)

Eating Disorder classifications

Eating Disorders are a group of conditions associated with dysregulated eating that have psychological, genetic, and social causes and carry significant risks around physical health comorbidities. Eating disorders cause serious physical and psychological harm and can be fatal. Anyone can develop an eating disorder, and they affect people of all ages, genders, ethnicities and backgrounds.

The main presenting conditions within eating disorders are:

Condition	Brief Taxonomy	Estimated Prevalence within ED Population
Anorexia Nervosa	Severe restriction of food and / or compensatory actions to control weight	3%
Bulimia Nervosa	A cycle of loss of control of eating and compensatory actions including purging	12%
Binge Eating Disorder	Eating very large quantities of food without feeling in control of these actions	40%
Avoidant / Resistant Food Intake Disorder (ARFID)	Restricted eating due to avoidance of certain foods due to sensory or experiential factors	5%
Other Specified Feeding and Eating Disorder (OSFED)	Other eating disorders not specified above	40%

UK Eating Disorders Prevalence

There hasn’t been a comprehensive epidemiological study of eating disorders in the UK, for this reason a range of proxy measures are instead routinely cited to estimate condition prevalence. A number of population survey tools have reported steep rises in condition prevalence across all demographic groups. The 2019 Health Survey for England using the SCOFF screening tool, found that 16% of adults reported eating disorder symptoms in the previous 12 months, a figure nearly three times higher than the previous survey in 2007. The growth in symptoms includes men and working age adults and illustrates that condition prevalence is widening and not restricted to tropes around prevalence being solely focused on young women. Proxy measures such as hospital admission rates for eating disorders also show substantial increases over the last 25 years with the period since the 2020 pandemic being particularly striking in terms of growth rates. Nearly all UK hospital admissions for eating disorders are emergency admissions due to the need for medical intervention to stabilise patients.

Historic estimates by the charity BEAT position UK prevalence at 1.25 million people living with an eating disorder. These estimates use international comparisons drawn from the period 2005 – 2015 and apply these to the UK context. However, the last 10 years have seen substantial growth in prevalence and latest estimates from the UK Royal College of Psychiatrists Faculty of Eating Disorders are that between 2 and 3 million people in the UK have a diagnosable eating disorder. This is broadly consistent with NHS England's 2018 commissioning guidance for eating disorders which estimates a 6% lifetime prevalence for eating disorders, around 3 million people.

Eating disorder services in the UK

The main response in terms of the care offering from the NHS is through specialist eating disorder services which are typically located within specialist mental health provider organisations. These are NHS Mental Health Trusts in England, Health Boards in Wales and Scotland, and Health and Social Care Trusts in Northern Ireland. The NHS also commissions additional, largely inpatient, capacity from the private sector who provide around half of the specialist eating disorder beds available in the UK. The following summary outlines the scale of current provision levels along with observations around suitability.

Primary Care – General Practice is effective in its core role of effective first line healthcare for the UK population along with structured long-term conditions management, and gatekeeping access to secondary care. Access to specialist secondary care services (apart from urgent / emergency care) generally requires a GP referral. However, despite the many strengths of UK primary care services, the NHS does not have a structured service offer for eating disorder patients in primary care and the most common response from GPs will be refer to secondary care eating disorder services. There is a general lack of clarity on eating disorder treatment protocols and acuity thresholds in primary care which leads to inconsistent practice and experiences for patients and families. Core UK medical education only includes 1-2 hours of training on eating disorders so most GP practices will be ill equipped to respond to eating disorder patients without structured national support initiatives.

First line response – digital support and self-care. Digital and self-care options are currently poorly developed in the UK and the UK NHS does not have a standardised offer for eating disorder patients to receive remote first line care from digital platforms or alternative guided self-care supports.

NHS Psychological Therapies – most eating disorders have a psychological cause and most treatments in specialist care involve psychological therapy. The NHS has made substantial investments and achieved huge success in expanding access to mainstream psychological therapy in the last 20 years with initiatives such as IAPT/ NHS Talking Therapies being used by more than 1 million people in England each year. However, the NHS currently excludes eating disorder patients from accessing NHS Talking Therapies due to concerns about patient's physical health co-morbidities.

Specialist Community Eating Disorder services – these services are well established and offer the most typical specialist care response to someone suffering with an eating disorder. Services provided to adults and children and young people are typically separate (just 5 "ageless" / integrated services exist in England) and are quite different in terms of their capacity and access arrangements.

Specialist Community Eating Disorder Services for Children and Young People – these services are typically connected with wider Children and Young People's Mental Health (CYPMH) services with 70% of NHS CYPMH services reporting a specialist eating disorder service within their offer, typically serving young people up to the age of 18. NHS CYPMH services without a specialist ED team may also offer support within wider CAMHS / CYPMH teams. Specialist eating disorder teams with CYPMH services are a relatively new offer which have been made possible by significant expansion of CYPMH as a result of successive national strategies to expand mental health support for young people. These strategies have generally been successful in expanding CYPMH availability with NHS capacity expanding by a multiple of three over the last 15 years. Three times as many young people are now seen by CYPMH services which have benefited from a parallel increase in baseline investment and workforce levels. Specialist eating disorder teams have been a significant gain from this strategic expansion of the CYPMH offer along with a number of other capabilities including crisis services, support for school mental health, and a gradual expansion of the offer of support for neurodiverse young people.

The net result of UK country level CYPMH expansion strategies are that young people with eating disorders now have generally rapid access to support. This is probably best illustrated in England where a national target of ensuring that young people with an eating disorder can access care within 4-weeks of referral has transformed the care experience with most young people now being seen within 2-weeks, or 1-week for urgent referrals. CYPMH eating disorder teams generally have a good multi-disciplinary team skill-mix and work to recognised therapeutic approaches focused on family-based therapy. This improvement should be celebrated and 14,000 children benefited from these services in 2023/24. It should be noted that these services generally finish when a young person reaches 18 years of age and young people would be expected to transition into Adult eating disorder services. Adult services are provided only at around one third the level that CYPMH eating disorders are when assessed on a per capita basis.

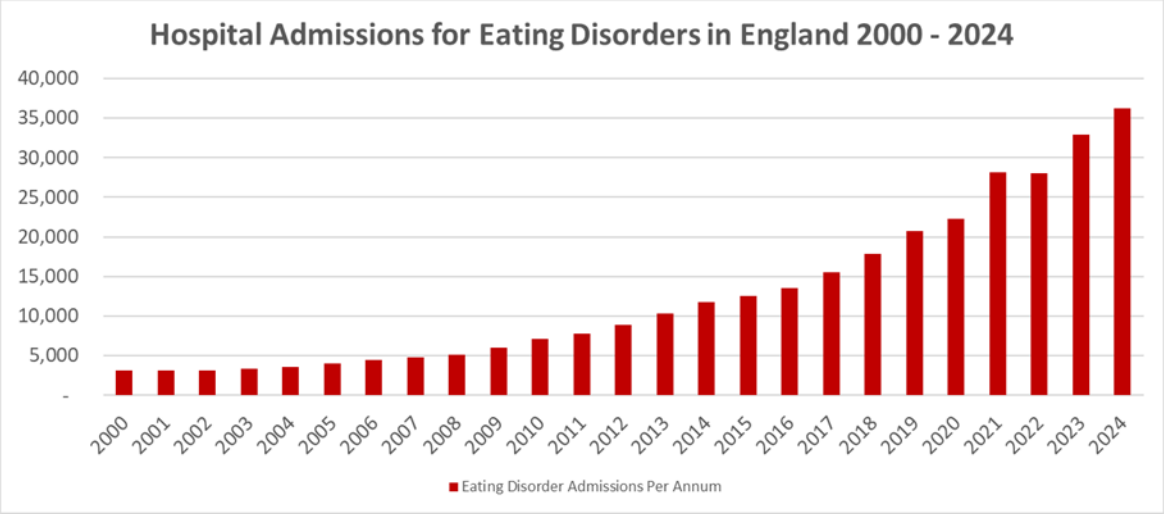
Specialist Community Eating Disorder Services for Adults (ACEDS) – these services are typically provided by all NHS mental health providers but vary significantly in terms of their size, coverage, and ability to support people with an eating disorder. Although there is some framework guidance on what the capabilities of these services should be, the lack of a national strategy and associated standards, resources, and workforce development means that services are typically small when compared to other community based mental health services. Analysis from NHS Benchmarking Network data shows that Adult Community Eating Disorders account for only around 1.7% of national community mental health team caseloads and have largely been omitted from a general expansion of community mental health services that has taken place in recent years (driven by national strategies to expand community based mental health care). Where teams do exist, they typically have a good multi-disciplinary team and offer support for most eating disorders, although ARFID is often an exclusion criteria. The core therapeutic offer is based on CBT-E with other therapies available in most providers. The major issue with ACEDS is that they generally operate with limited capacity which is reflected in the acuity level of patients accepted into services and waiting times to access care which averaged 8 weeks based on latest UK data from NHSBN. A total of 20,000 patients received treatment from ACEDS in 2023/24, a rate of 60 per 100,000 adult population, equivalent to 1 in 100 of people who may experience an eating disorder based on NHS England's 6% lifetime prevalence guidance. However, high acuity levels and long waiting times compromise most ACEDS who are mainly focused on acute case management at the expense of wider work to develop the rest of the eating disorders system including early intervention and prevention. Many services also operate with notable workforce gaps, for example, half of specialist ACEDS operate without a Consultant Psychiatrist, a glaring structural anomaly that points to the gaps that could be filled by a successful national strategy.

Specialist Eating Disorder Day Care – day care acts as a bridge between community and inpatient services and can serve as an effective step-up and step-down care option and provide a viable alternative to the need for acute inpatient admission. Services are provided by specialist multi-disciplinary teams although in very small numbers in the UK. Day care services declined in the 2010s with many providers reducing these services but have in recent years been reintroduced by some Provider Collaborative organisations as a valuable part of the care model. There is limited national data on these services due to their small scale and this is a major opportunity for the future in building a comprehensive care model in the UK.

Specialist Inpatient Eating Disorder Services for Children and Young People – a small number of specialist inpatient eating disorder facilities for CYPMH exist, alongside a broader tendency for young people with eating disorders to be admitted to more general CYPMH inpatient services. Admissions tend to have long lengths of stay (113 days in the UK in 2024) and be high cost. The workforce data for CYPMH inpatient facilities does not demonstrate the same richness in skill-mix as seen in community based care with the most frequently employed staff group being unregistered nursing staff. Other key roles such as specialist therapists including clinical psychology and occupational therapy are also evident in much lower numbers than in community based care. Care packages typically focus on feeding and weight gain alongside wider therapeutic objectives to address the young person's eating disorder. Admission numbers are typically low due to long lengths of stay and young people are much more likely to be admitted to Paediatric inpatient facilities for acute eating disorder treatment.

Specialist Inpatient Eating Disorder Services for Adults. There are around 450 specialist Adult eating disorder beds provided in the UK. Around half of these are provided by the NHS and hosted by specialist mental health providers, the other half are provided by private sector mental health providers (commissioned by the NHS). Around half of NHS mental health providers have specialist Adult ED beds so patient and carer journeys can be long due to lack of local bed availability. It is estimated that the 450 beds support a maximum of 1,500 admissions a year with capacity restricted due to long lengths of stay. Length of stay averaged 95 days in 2023/24 and is a function of high acuity levels and the therapeutic offer, with average patient BMI on admission being low at 14 (NHS Benchmarking Network). Like in specialist CYPMH inpatient care, Adult ED inpatient care pathways also focus on weight restoration with some therapeutic care for the eating disorder. Similarities with CYPMH also exist in that skill-mix is generally much lower than in eating disorder community teams despite the high acuity level of patients. These beds are amongst the most expensive in UK mental health services with an average cost for NHS providers in 2023/24 of £101k per admission. The low admission rates and high patient acuity raise legitimate questions about the effectiveness of the current specialist eating disorders inpatient model for both adults and young people.

Other Eating Disorder Admissions, Paediatric and Medical Admissions – the low throughput of NHS commissioned eating disorder facilities is part of the reason why there is a significant mismatch between capacity and demand for eating disorders inpatient care. Data from NHS Digital / NHS England in 2023/24 revealed there were 36,183 admissions for patients with eating disorders (primary and secondary diagnosis) in England. Only a maximum of 2,000 of these admissions were to specialist CYPMH and adult eating disorder beds with the remainder overflowing into adult medical and paediatric beds within acute hospitals. This means that around 95% of hospital admissions for people with an eating disorder were into an acute hospital setting for medical review, stabilisation, and urgent medical care. This de-facto model of acute hospital care for eating disorders is not part of any national strategy but a result of "failure demand" for urgent care due to limitations on specialist care available for eating disorders. The growth rate for all eating disorder admissions in England can be seen in the chart below and provides further evidence on rising demand levels and lack of optimisation of preventative work and community based care. Admissions have doubled since 2018 and tripled since 2014.



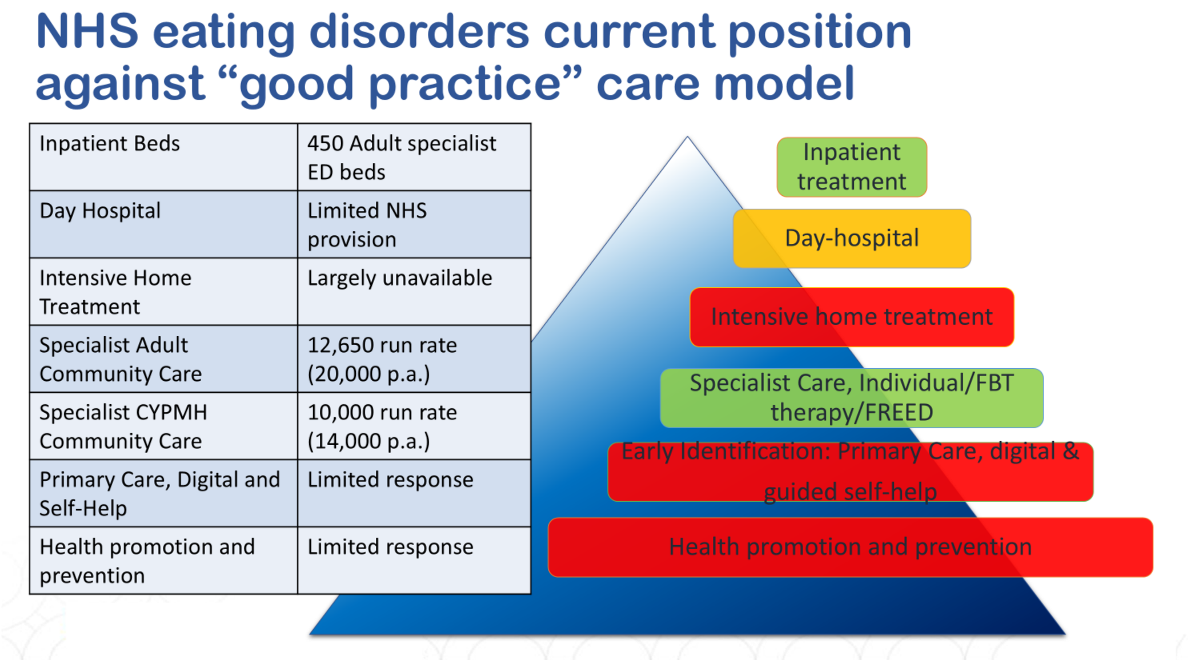
Hospital Admissions for Eating Disorders in England 2000 – 2024 (NHS Digital / NHS England)

The result of this unplanned overflow into acute hospitals is sub-optimal care due to the lack of a consistent place and team to support many people admitted with an eating disorder. This also adds to pressure on a stretched NHS where eating disorders compete for space in an NHS urgent care system which is often overwhelmed. Most eating disorder admissions are avoidable if earlier parts of the care pathway could function effectively and at a sufficient scale to meet demand. The UK system is often characterised by; insufficient capacity, late response, and avoidable late stage urgent care. Substantial improvements are possible to the current situation although this will need a strategic response given the scale of rising eating disorders demand and the need to develop capacity and connect the approach at many levels of the system.

The graphic below attempts to summarise the elements of a good practice stepped care system of managing eating disorders with the following elements:

- Health promotion and prevention
- Early intervention; primary care, digital and guided self-help
- Specialist community care; children and young people, and adults
- Intensive home treatment
- Day care
- Specialist inpatient care

The current position of the UK model of care and services is mapped against each stage of a stepped care approach and confirms the availability of; specialist community care for CYP and adults, limited day care, and specialist beds for acute admissions. With the exception of CYPMH community care, each of these elements of the model has issues with capacity, fidelity to clinical models, access and effectiveness. Equally notable is the absence of capability and response of other key elements of the pathway including; health promotion and prevention, early intervention in primary care, digital and guided self-help, along with the lack of alternatives to hospital care including intensive home treatment and day care.



NHS eating disorders current position against "good practice" care model

Inpatient Beds	450 Adult specialist ED beds
Day Hospital	Limited NHS provision
Intensive Home Treatment	Largely unavailable
Specialist Adult Community Care	12,650 run rate (20,000 p.a.)
Specialist CYPMH Community Care	10,000 run rate (14,000 p.a.)
Primary Care, Digital and Self-Help	Limited response
Health promotion and prevention	Limited response

6. AUSTRALIA

Acknowledgement of country

As a visitor to Australia, I acknowledge the tradition of custodianship and law of the Country on the lands I visited. I pay my respects to those who have cared and continue to care for Country and pay respects to elders past, present and emerging.

Circular Quay and Central Business District, Sydney, New South Wales

Introduction

I visited Australia during March and April 2025 and organised my schedule around 3 main reference points:

1. National Government policy on eating disorders and the role of the National Eating Disorders Collaboration (NEDC)
2. How state level eating disorders policy and care is managed in New South Wales
3. How innovation and implementation of eating disorders policy takes place with reference to the work of the InsideOut Institute in Sydney.

The acknowledgements section of this report highlights the significant help I received from many people in Australia. Central to everything that happened in Australia was the help I received from my friend Dr Grant Sara who is a Consultant Psychiatrist and leads the work of mental health analytics in his role as Director of InforMH in the Systems and Analytics Branch of the New South Wales Ministry of Health. Grant introduced me to key people and organisations to ensure my work was productive and enjoyable. I am also extremely grateful to Professor Sarah Maguire and Caroline Hill at the InsideOut Institute for Eating Disorders. Sarah and Caroline allowed me to spend a week with their team where I saw the most fantastic innovations in eating disorders care alongside a commitment to put these into practice through partnerships and implementation support. At the National Eating Disorders Collaboration I am grateful to Dr Sarah Trobe for her help in explaining the development and implementation of the national strategy for eating disorders.

Australia’s healthcare system and mental health

The following summary is sourced from Professor Grant Sara’s contribution to the NHS Benchmarking Network’s 2022 report on International Mental Health Benchmarking. Australia has a universal healthcare system. Within Australia’s federated system of government, responsibility for health care is shared between national and state level governments. Private health insurance is also incentivised through the taxation system but is not mandatory. Around half of Australians currently have private health insurance.

Mental health services are funded and organised as part of general health services: state governments provide admitted, outpatient and emergency hospital care and community mental health care, which are free at the point of service. The Australian Government subsidises primary care and office-based “private” psychiatry and psychology services through the Medicare Benefits Schedule, with demand managed through out of pocket “gap” payments. Private hospitals provide around one quarter of mental health beds but typically do not provide emergency or involuntary care. Together these arrangements mean that state and territory governments provide the bulk of care for people living with severe and enduring conditions such as schizophrenia, while primary care and private hospital services provide most care for common mental health conditions such as anxiety and depression. Of the $13.2 billion spent nationally in 2022-23, state and territory governments spent 60% ($8.0 billion), the Australian Government 35% ($4.6 billion), and private health insurance funds and other third-party insurers 4.7% ($622 million).

State and territory government services are typically organised into regions (typically called Local Health Districts or Networks) with population-wide responsibilities for defined geographical areas. The Australian Government also funds regional planning bodies (Primary Health Networks) which directly commission some community-based mental health services.

Federal Government

I met with officials from the Department of Health and Aged Care to discuss the national approach to eating disorders. The national / federal “Commonwealth” government confirmed a clear interest for many years in eating disorders and a recognition of the work done by states and territories to develop local strategic initiatives to address the treatment gap.

Australian Government
Department of Health and Aged Care

We the Department of Health and Aged Care, proudly acknowledge the Traditional Owners and Custodians of Country throughout Australia and pay respect to those who have preserved and cared for the lands on which we live, work, and benefit from each day.

The federal government approach appeared to respect and harness initiatives at state and territory level whilst responding to growing political support for a national approach to eating disorders. Political support for eating disorders had been evident for many years across the main political parties in Australia.

The team I met with at Department of Health and Aged Care were all clearly on top of the National Eating Disorders Strategy (2023-2033).

There was much common ground in our shared discussion about rising demand, and the need for a coordinated response to both higher levels of morbidity and the need to connect different parts of the healthcare system to enable an effective response.

The team described a range of initiatives designed to create momentum in Australia and fill gaps within the national healthcare system.

These initiatives were part of a strategic shift in moving eating disorders from being a highly acute and specialist / tertiary concern, to a position where eating disorders were recognised as a common condition requiring a broad based or generalist response, with specialist care available when required.

It was interesting for me to hear about how the federal government system worked and the complex set of relationships required with states and territories and the large number of stakeholders operating within Australian healthcare.

Yradhang Building, Department of Health and Aged Care, Canberra

Key initiatives put in place included:

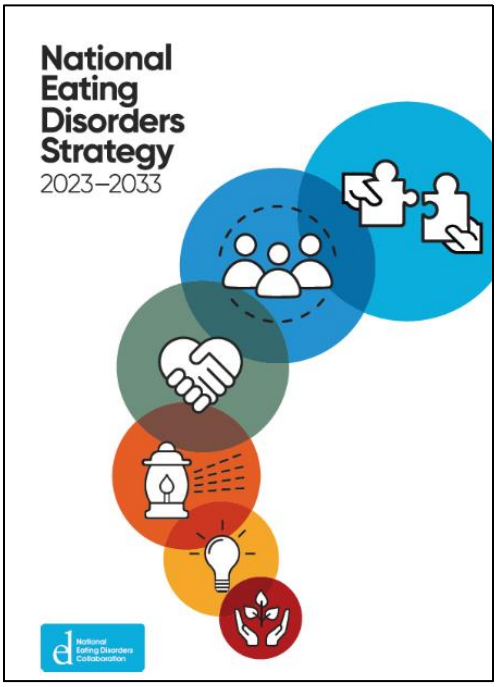
- Funding the National Eating Disorders Collaboration to develop and advance the national strategy – NEDC are funded to the extent of $1m per annum to support and oversee the development of Australia's national strategy for eating disorders.
- Stimulating the culture of eating disorders being "everyone's business in Australian healthcare" – this impetus is tangible in Australia although it doubtless took time to encourage and establish. The breadth of sectors and professionals involved in eating disorders identification, support and care is impressive especially given the challenges in coordination inherent in an insurance-based system of healthcare.
- Commitment to prioritisation of eating disorders through the Medicare reimbursement system – government support for reimbursement of healthcare costs through Medicare insurance is a tangible area of support and encouragement of the provider market to respond to policy expectations. National Medicare reimbursement is set at a high level for eating disorders episodes with support for up to 40 sessions of psychological therapy interventions and 20 sessions of Dietician support. In practice care pathway completion rates are much lower than these levels and funding gaps exist to provider charging levels requiring self-payment for some patients but federal government intention on condition prioritisation is clear.
- Establishment of a competitive grants process to fill gaps in the Australian eating disorders system – there are many examples of successful innovations as a result of this process including InsideOut Institute's national e-clinic service.
- Direct federal funding for an eating disorders residential facility in each jurisdiction – this initiative has real momentum following the establishment of the first facility in Tasmania, I was also fortunate to visit the new facility in New South Wales in Hunter New England Local Health District.
- Support for national early intervention and helpline services via the Butterfly Foundation which is funded annually to run a phone line for consumers and carers to link them with

care. The InsideOut Institute are also funded to work with “headspace” to develop early intervention pathways for people with EDs.

- Upskilling of the Australian healthcare workforce to expand understanding of eating disorders and ability to provide support and care (including primary care). There are a large number of eating disorders training and development initiatives in play in Australia which can demonstrate real scale in uptake. The headspace project is developing the workforce at a national level whilst a number of state-based service development organisations (e.g. CEED, QuEDS, WAEDOCS, InsideOut Institute) are funded by state governments to drive workforce development for their public mental health services.
- Involvement of patients and carers in strategy development and implementation.
- Commitment to evaluation of eating disorder strategy and policies – evaluations will take place at both state and territory level and also at fixed points for the national strategy rollout.
- Investment in the Australian Eating Disorders Research and Translation Centre

Australia National Eating Disorders Strategy 2023-33

Australia launched a confident national strategy for eating disorders in 2023 to achieve better access to care and better outcomes for the 1.1 million Australians with an eating disorder. The 10-year national strategy follows on from several state-wide strategies that had begun the process of addressing the eating disorders treatment gap. Particularly notable are the strategies developed in New South Wales and Victoria, Queensland also has a range of ED-specific actions within their broader MH Strategy ‘Better Care Together’, with momentum also evident in other states and territories. This state level momentum has continued and state level strategies such as the New South Wales Service Plan (2021-25), and Victoria ED strategy (2024-31) now align with the national strategy’s goals and delivery aspirations.


National Eating Disorders Strategy
2023–2033

National Eating Disorders Collaboration

One of my key learnings from Australia was the importance of political support and commitment to making strategies happen and then achieve meaningful implementation. Successive Australian Health Ministers and Prime Ministers have publicly stated government support for an eating disorders national strategy and have helped raise public awareness and support for their national approach. Notable in their public support have been Health and Aged Care Minister Mark Butler and Prime Minister Anthony Albanese. Many other politicians including Minister Greg Hunt, and Minister Emma McBride have campaigned for improved mental health and eating disorders care and my sense was that this has become a bipartisan political issue with much common ground for politicians, policy makers, and healthcare planners.

The weight of political support is considerable and includes green and independent MPs as well as the two main parties in the Australian Labor Party and the Liberal Party of Australia. Central to this political support is the issue of lived experience with many people personally impacted by eating disorders and committed to advocate for change and improved experience and outcomes for patients and families.

Strategy Formulation Process

The national strategy has many antecedents including accomplished state level approaches. The national strategy development process was led by NEDC working in partnership with the eating disorders sector with a wide range of stakeholders involved in its production. The process took two years to accomplish and developed a coalition for change and a message that things needed to improve in Australia. The National Eating Disorders Collaboration helped coordinate the national strategy development and act as custodians for its implementation.

National Eating Disorders Collaboration (NEDC)

NEDC are the federally funded organisation tasked with overseeing the delivery of Australia's national strategy for eating disorders. NEDC is a national collaborative platform for experts by lived experience, clinicians, leaders, researchers, and service providers. NEDC aim to generate unified, evidence-based sector positions and consistent national standards in support of the National Eating Disorders Strategy 2023-2033, and translate these into practical action for the prevention, identification, treatment, and support of eating disorders. NEDC were established in 2009 and are hosted by the Butterfly Foundation. There is also a highly relevant 15-year development history of active work taking place across states and territories and an increasing prioritisation of eating disorders within the federal government.

I met with Dr Sarah Trobe, Director of NEDC to hear about the development process for the national strategy and how the implementation had progressed since the 2023 launch. Sarah and team are energised to progress the implementation of the national strategy through a wide series of partnership and implementation actions.

Sarah outlined how the idea and momentum for a national strategy came from the eating disorders sector due to the need to respond to rising demand levels and generate consistent standards for all states and territories. NEDC worked with sector leaders in all states and territories to conduct a service mapping exercise and actively learn from the experiences of sector leaders. NEDC established a national reference group with broad based membership including first nations peoples, service users and carers. The stepped system of care was refined through the process, for example in adding 'prevention' and 'psychosocial and recovery support' to become integral parts of the framework. A working group was established for each of stages in the stepped care system (plus a supplementary group for workforce development). The stepped care system helps to bring clarity to the national strategy and also its associated implementation actions to help build the national system of care. What is particularly impressive around the workforce strategy is the focus on the whole workforce, not just ED specialists. The success of the stepped care aspirations for a broad based national response to eating disorders relies on the upskilling and confidence building in the full healthcare workforce.

NEDC support the implementation process of a number of health system change projects led by other organisation across the country that are essential on the journey to make eating disorder's "everyone's business" in Australia. NEDC's relationships with state-based service development organisations helps to translate national standards and the national strategy to local regions. The state-based organisations are key to implementation as they know their local system and NEDC provides support to help equip them to do what they need to do.

Stepped Care Model

The stepped care approach helps bring much needed clarity to how the whole eating disorders care system is designed to work in Australia. The highlights of each of the six stages of the stepped care approach are summarised below.

Australian Stepped Care Model for Eating Disorders

Prevention – aiming to reduce modifiable risk factors to help slow or reduce demand growth, connecting into the social determinants of health, and raising awareness and understanding in support of whole community responses to the risk factors around eating disorders. This includes using "Eating Disorder Safe" principles in developing a dialogue within families and elsewhere around relationships with food and body image, the impact of the food industry and external influences such as social media.

Identification – raising awareness of identification of warning signs and early symptoms of eating disorders to enable a more agile and scaled up initial response in local communities (e.g. including schools, sports clubs, and primary care).

Initial response - widening access to skills in initial diagnosis and early response to enable a person experiencing the early stages of an eating disorder to receive care in an accessible and empathetic manner (e.g. from primary care, school and CYP mental health services, and if appropriate from community mental health care).

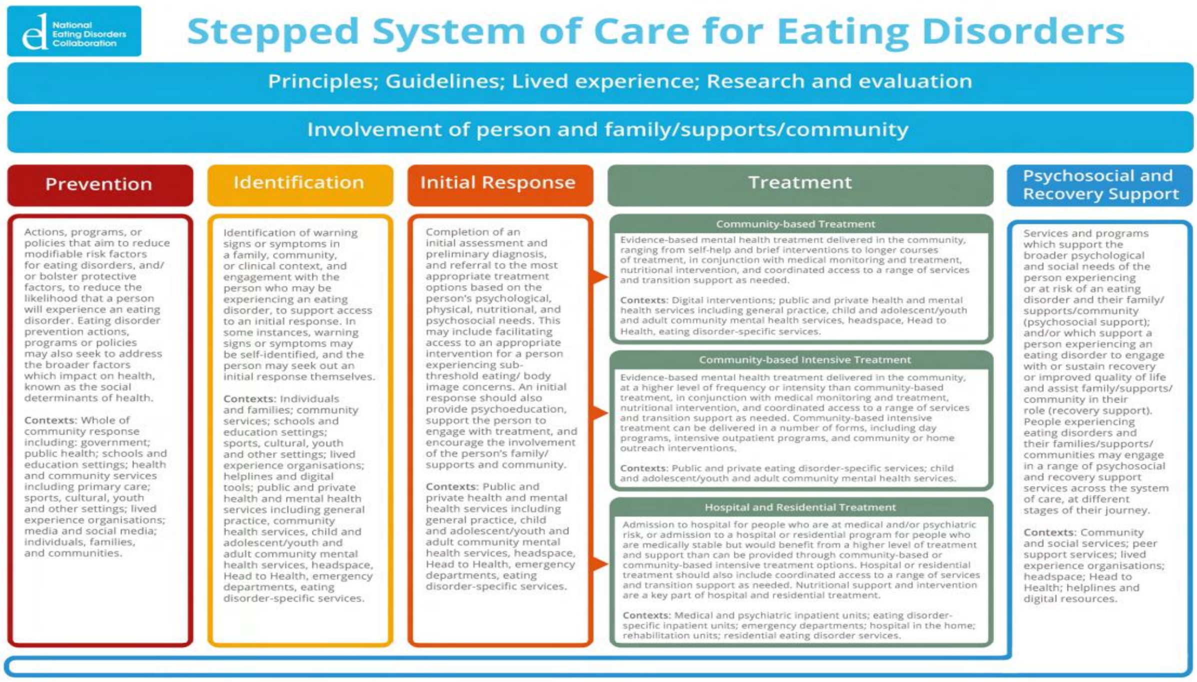
Treatment – enabling a full therapeutic response to the eating disorder symptoms from providers offering community based treatment of different intensities, and if required from specialist day care and inpatient services (this is focused on ensuring a coherent line up of service offers to be able to respond effectively to different levels of patient acuity).

Psychosocial and recovery support – ensuring that services and programmes are available that support the ongoing recovery of the person with an eating disorder, with a focus on symptom reduction and improved functioning. Eating disorders can become long term conditions in the absence of good recovery support and access to targeted and ongoing care can be a game changer (eating disorders are treatable and patients can fully recover).

Workforce – the workforce development process underpins all stages of the stepped care approach and aims to build required skills and competencies in both the specialist ED workforce and crucially in the wider health and care workforce. Eating disorders are now a common condition and healthcare professionals need to be able to recognise and respond effectively to patient needs.

Australia's Stepped Care System for Eating Disorders

The stepped care model and its key interconnections are also summarised in the graphic used in the national strategy document (below).



National Eating Disorders Collaboration

Stepped System of Care for Eating Disorders

Principles; Guidelines; Lived experience; Research and evaluation

Involvement of person and family/supports/community

Prevention

Actions, programs, or policies that aim to reduce modifiable risk factors for eating disorders, and/or bolster protective factors, to reduce the likelihood that a person will experience an eating disorder. Eating disorder prevention actions, programs or policies may also seek to address the broader factors which impact on health, known as the social determinants of health.

Contexts: Whole of community response including: government; public health; schools and education settings; health and community services including primary care; sports, cultural, youth and other settings; lived experience organisations; media and social media; individuals, families, and communities.

Identification

Identification of warning signs or symptoms in a family, community, or clinical context, and engagement with the person who may be experiencing an eating disorder, to support access to an initial response. In some instances, warning signs or symptoms may be self-identified, and the person may seek out an initial response themselves.

Contexts: Individuals and families; community services; schools and education settings; sports, cultural, youth and other settings; lived experience organisations; helplines and digital tools; public and private health and mental health services including general practice, community health services, child and adolescent/youth and adult community mental health services, headspace, Head to Health, emergency departments, eating disorder-specific services.

Initial Response

Completion of an initial assessment and preliminary diagnosis, and referral to the most appropriate treatment options based on the person's psychological, physical, nutritional, and psychosocial needs. This may include facilitating access to an appropriate intervention for a person experiencing sub-threshold eating/ body image concerns. An initial response should also provide psychoeducation, support the person to engage with treatment, and encourage the involvement of the person's family/ supports and community.

Contexts: Public and private health and mental health services including general practice, child and adolescent/youth and adult community mental health services, headspace, Head to Health, emergency departments, eating disorder-specific services.

Treatment

Community-based Treatment

Evidence-based mental health treatment delivered in the community, ranging from self-help and brief interventions to longer courses of treatment, in conjunction with medical monitoring and treatment, nutritional intervention, and coordinated access to a range of services and transition support as needed.

Contexts: Digital interventions; public and private health and mental health services including general practice, child and adolescent/youth and adult community mental health services, headspace, Head to Health, eating disorder-specific services.

Community-based Intensive Treatment

Evidence-based mental health treatment delivered in the community, at a higher level of frequency or intensity than community-based treatment, in conjunction with medical monitoring and treatment, nutritional intervention, and coordinated access to a range of services and transition support as needed. Community-based intensive treatment can be delivered in a number of forms, including day programs, intensive outpatient programs, and community or home outreach interventions.

Contexts: Public and private eating disorder-specific services; child and adolescent/youth and adult community mental health services.

Hospital and Residential Treatment

Admission to hospital for people who are at medical and/or psychiatric risk, or admission to a hospital or residential program for people who are medically stable but would benefit from a higher level of treatment and support than can be provided through community-based or community-based intensive treatment options. Hospital or residential treatment should also include coordinated access to a range of services and transition support as needed. Nutritional support and intervention are a key part of hospital and residential treatment.

Contexts: Medical and psychiatric inpatient units; eating disorder-specific inpatient units; emergency departments; hospital in the home; rehabilitation units; residential eating disorder services.

Psychosocial and Recovery Support

Services and programs which support the broader psychological and social needs of the person experiencing or at risk of an eating disorder and their family/supports/community (psychosocial support); and/or which support a person experiencing an eating disorder to engage with or sustain recovery or improved quality of life and assist family/supports/community in their role (recovery support). People experiencing eating disorders and their families/supports/communities may engage in a range of psychosocial and recovery support services across the system of care, at different stages of their journey.

Contexts: Community and social services; peer support services; lived experience organisations; headspace; Head to Health; helplines and digital resources.

Australia's Stepped Care Model for Eating Disorders (National Eating Disorders Collaboration) 2023-2033

The stepped care model could be largely transportable to the UK and would help in identifying required actions in areas where there is a lack of structure in the UK including; prevention, early identification and response, effective treatments, recovery support, and full workforce development. There is an absolute clarity of thinking in Australia on the benefits and importance of each element of the national strategy. We could benefit from a similar approach in the UK.

Of course, strategies are often just documents and success will be down to effective implementation and change. NEDC have successfully moved into this space and the 6 pillars of the stepped care approach have now been translated into 141 priority actions to help implement the aspirations in the strategy. The strategy implementation identifies both top-down and bottom-up initiatives as well as a range of overall coordination activities.

Three key levers have been identified to help kick start strategy implementation;

1. To activate national and jurisdictional planning and coordination
2. To kickstart sustainable local/regional system-building across Australia.
3. To increase workforce capacity to respond to eating disorders, disordered eating and body image concerns

NEDC's support for these levers is tangible and a number of immediate actions are in place to develop momentum during the early activation phase of the strategy.

- Overarching coordination
- Stakeholder activation
- Strategic communication and resources – including a "My implementation" toolkit, and professional development databases

- Embedding eating disorder content in tertiary curricula for medicine, psychiatry, psychology, nursing, occupational therapy, social work, and dietetics
- Primary Health Network (PHN) collaborations to embed eating disorder expertise in primary care.
- Targeted initiatives for underserved populations, including Aboriginal and Torres Strait Islander communities, neurodivergent individuals, people with longstanding eating disorders, and people with higher weight.
- Workforce development strategies to enhance training, supervision, and support for professionals across disciplines
- Leading the Right Care, Right Place project, seeking to establish a more accessible and integrated system of care through the introduction of an Eating Disorder Coordinator model within Primary Health Networks

There is also a national strategy "Action Hub" database hosted by NEDC where stakeholders share their progress against national strategy actions. I was struck by the progress being made across a wide range of initiatives and how the national strategy for ED has helped to encourage high levels of innovation in provider actions. The providers are to be commended for this response although crucially this was enabled by the framework of the national strategy.

The job of strategy development and implementation would doubtless be more straightforward in the UK (assuming any national ED strategy would be accompanied by standards, protocols, resources, and workforce growth). None of these areas are as predictable or as controllable in Australia with the parallel health insurance-based model, large private sector, and state and territory level governments, however, the standards framework developed by NEDC and others has been a huge stimulus for innovation. The NHS has historically struggled to develop such a degree of innovation and there is much that we can learn from Australia. Equally we should be inspired by the confidence of the Australian approach and how "making eating disorders everyone's business" has been translated into wide reaching actions and change.

A final word on the national strategy is the commitment by NEDC and states and territories to conduct evaluations of progress. The lessons learned will be readily available for use in the UK.

New South Wales Ministry of Health

I spent a week with the New South Wales Ministry of Health in Sydney and spent time with their health informatics and business intelligence team for mental health. I also met key people in the mental health team and attended a number of state and national forums taking forward work programmes in eating disorders and healthcare intelligence and insight.

NSW Health InforMH

I have worked for many years in the healthcare analytics and insight space and have always been impressed by the content generated by the InforMH team within New South Wales Health. The team are led by Director Dr Grant Sara and use data and technology to develop insight, support decision making, and improve the effectiveness of mental healthcare across the state.

I spent a week with the team in Sydney and saw their work at first hand. I was impressed by their agility and focus on getting content out to a wide range of users and supporting the evidence base for mental health service provision across the state.

New South Wales runs a state level data warehouse and also supports their 18 Local Health Districts and structured local data warehouses. A suite of reporting applications have been developed in Power BI to support clinical measurement and real time decision making.

First day at New South Wales Health HQ, St Leonards, Sydney

I was particularly impressed by **MH Trace**, a tracking tool for data and key indicators across the state's mental health services that is updated hourly to enable quasi-real time reporting. The system is akin to a command centre for system and service management and generates insight on a wide range of measures including waiting list status and management.

I attended the **National Data Governance Forum** to explore how states and territories in Australia manage and coordinate data management and reporting. The Data Governance Forum kindly allocated me time at their regular meeting for a shared discussion on how eating disorders data collection, management and reporting worked across states and territories. Representatives from all jurisdictions described a consensus where eating disorders were now of higher priority with work underway on new prevalence studies, enhanced training and support to GPs, workforce development, standardisation of acute pathways, new hubs for eating disorders, and the impact of new residential services.

The **Real Time Suicide Monitoring** system had been established to link the work of mental health services, Police, coroners, local and national organisations. The New South Wales suicide register was the third to be established in Australia and was working successfully to share robust and timely data on suicide as well as acting as an aid to agencies to help manage risk and reduce suicide incidence. The system had succeeded in linking a series of datasets across health, education, transport, justice, and voluntary sector (including Lifeline) and was producing a regular series of insights and risk profiles. I was particularly impressed by the use of GIS geographical reporting to identify and monitor high risk public locations. The use of geo coded transport data had succeeded in identifying 50 locations of concern within Sydney with data available in HTML format that can be drilled down into to support suicide prevention.

The effective use of data by the InforMH team illustrated the potential for generating enhanced levels of future insight around the incidence of eating disorders and the effectiveness of interventions to improve patient outcomes. The improved health policy framework within Australia had certainly created more optimism around identifying and treating eating disorders. However, reporting on data and generating insight is fundamentally more challenging in an insurance-based healthcare system than in a publicly funded and planned system such as the

UK NHS. InforMH are doing great work in Australia to identify and profile how people with eating disorders interact with the healthcare system, but this is challenging given how eating disorders are often not the primary diagnostic coding for presenting patients. This issue helped convince me of the need for creativity in how patients are identified and reported with a need to focus on both primary and secondary diagnosis as well as the need to actively connect systems and be creative around how data supports eating disorder clinical networks.

New South Wales Ministry of Health – State Wide Eating Disorders Strategy

The long history of state and territory strategies for eating disorders was a key learning point for me during my time in Australia. Eating disorders have mattered for a long time in Australia.

I met with Dr Murray Wright, Chief Psychiatrist for New South Wales and asked where the impetus came from for the NSW ED strategy. Murray replied, “the strategy was born out of necessity” and then proceeded to identify a series of difficulties and crises in eating disorders care which necessitated a state wide response to ensure more joined up care. The backdrop for NSW mental health services included a number of structural problems including; poor access to public psychological therapies, and issues with the size of the public psychiatry workforce.

I also met with Cherie Power, Policy Officer for eating disorders in NSW Ministry of Health who explained the history, development, and rigour applied in getting eating disorders onto the agenda. The first New South Wales state eating disorders strategy was published in 2013, 10 years before the national ED strategy. The discussion over the place and value of eating disorders care had therefore already taken place in New South Wales and there was a clear state-wide commitment to support eating disorder patients and families. One of the important implications of the NSW approach was that eating disorders had moved away from being seen as a niche mental health sub-specialty into a place where it had become part of the core business of the healthcare system, eating disorders had become everyone’s business in the New South Wales health system. It is the “core business” words that really marked and ignited the massive national policy shift, to change EDs from being excluded and niche to mainstream. There is an important distinction to note here in that prior to the publication of the state wide plan, eating disorder patients would have been regarded as tertiary patients requiring specialist care, whilst under the “everyone’s business” state and national strategies, patients now all present to local services where they can expect to receive support and care. The mantra of “no wrong door” for eating disorders appears to have traction across the state and eating disorders has demonstrably moved away from being a specialist concern to a broad based network with connectivity and shared delivery across all levels of the health system.

New South Wales State Wide Eating Disorders Steering Committee

During my time in NSW I was fortunate to be able to attend the State-Wide Steering Committee for eating disorders. The Committee oversees the implementation of the NSW Service Plan for People with Eating Disorders 2021-2025, which identifies six strategic goals to drive service improvement and innovation in prevention, early intervention and treatment in NSW. NSW

Health is focussed on embedding eating disorders services as core business in local health districts and specialty health networks to ensure people can access care close to their home, families, and local support networks. This regular meeting embodied the mantra that eating disorders are everyone's business in the Australian healthcare system. The meeting was chaired by a senior Ministry of Health official (Elizabeth Wood, Deputy Secretary Health System Strategy and Patient Experience) and included representation from a full range of stakeholder organisations across the state. The meeting had representation from Ministry of Health strategy, planning, and informatics specialists, alongside a large number of provider organisation representatives including; Acute Physicians, Paediatricians, Specialist Nurses, Psychiatrists and Psychologists. Representation was also evident from primary care, LHDs, university and academic partners, delivery specialists, coordinators, and patient and carer representation. This was probably the most diverse forum I have attended in eating disorders and reinforced that Australia has made significant progress in redefining eating disorders, which are no longer a niche mental health sub-specialty, but a common condition and broad based concern.

The business covered by the NSW ED Steering Committee was also interesting and illustrates the scale and scope of the work required to make ED care mainstream and effective. The Committee provides the governance framework to ensure strategy implementation progresses.

As with any strategy and change project there were a number of infrastructure initiatives;

- Data and monitoring (InforMH)
- Workforce Development (designed and implemented by InsideOut Institute): a successful hybrid workforce development programme was now in place across the state to widen the scope of ED understanding and capabilities. At the time of reporting a total of 15,000 people had completed evidence-based eLearning programmes. Large numbers of health professionals had also attended face-to-face training. The most frequent professions taking part being psychologists, dieticians, nurses, and social workers. A further 400 clinicians had enrolled to undertake ARFID training. Given that only around 2,200 WTE clinicians work in specialist community ED services in the UK the scale of the ED learning uptake in NSW should not be under-estimated.

Sub Committee reports also updated on work around clinical standards and service delivery;

- Adult Medical Leads
- Paediatric and Youth Medical Leads
- Eating Disorders Coordinators
- Tertiary Hubs

The meeting also reported on strategic developments;

- National Eating Disorders Plan (National Eating Disorder Collaboration)
- Residential Eating Disorders Centre update (Hunter New England Local Health District)
- Evaluation of the NSW Service Plan for People with Eating Disorders 2021-2025
- Service Plan Implementation Reports

I was struck by how energised the committee's programme of work was and the senior engagement across all clinical and managerial disciplines. The presence of a senior NSW

Ministry of Health official as Chair also spoke of the significance of the work taking place in New South Wales and its importance to both state ED plan and national ED strategy.

Hunter New England Local Health District

The Australian Federal Government supports eating disorders through its national 10-year strategy and also through a series of targeted initiatives to develop infrastructure and shape clinical practice. One of these initiatives is to ensure that each state and territory has its own dedicated eating disorders residential unit. These are funded by federal government and provide residential rehabilitation focussed care to support medically stable patients who require a live-in programme targeting substantial eating disorder symptomatic change. I visited one of these residential services located 90 miles north of Sydney in Newcastle, which sits within the Hunter New England LHD in NSW. The service is in a purpose built facility named by the local Aboriginal Elders as baiyangbaiyaang, an Aboriginal name which means "butterfly the one who flutters".

I visited a few weeks before the formal opening by the Federal Assistant Minister for Mental Health Emma McBride and the NSW Minister for Mental Health Rose Jackson, and saw an impressively conceived and designed 12 bed unit offering a homelike environment for people in need of more intensive treatment who would benefit from a high intensity rehabilitation programme with wrap around care focused on recovery. I met with a number of staff at both the residential unit and the LHD Executive. I was impressed by their motivation and aim of providing the best possible response for patients with eating disorders. The LHD team included excellent medical leadership with a real commitment to eating disorders, led by the NSW Ministry funded ED Coordinator, Dr Mel Hart and her locally funded district wide ED service and workforce development team. Eating disorder training is included in mandatory training for all LHD staff. My visit to the LHD Executive was also facilitated by Mel, who led the conversation and reinforced the value of the ED Coordinator role in making things happen in each LHD.

Visit to baiyangbaiyaang Eating Disorders Residential Unit with from left to right, Cherie Power, Dr Grant Sara, Caroline Hill, Professor Sarah Maguire, Rachel McGloin, Cath Wood, Stephen Watkins

The team at Hunter New England included service leads Rachel McGloin and Cath Wood. The new facility is a beautiful building connecting with a magnificently landscaped outside space. The service includes residential care and also acts as a hub for day care services which have a long history in the LHD. I met with the eating disorders clinical team in the LHD and was again impressed by their networking to collaborate with a supporting tier of clinicians across Hunter New England. The LHD provides a great case study for the effectiveness of the state wide ED strategy architecture with demonstrable evidence of support for the state strategy, service plan, workforce plan, and comprehensive training offer. I heard about a structured evaluation of the clinical support and development process with 1,300 eating disorders training places made available each year to the staff supporting the 1 million population of Hunter New England. Training is just one aspect of the expansive approach in the LHD where a local ED service plan exists as does an eating disorders governance forum which features representation from all hospitals including appropriate medical leads. The process is also supported by a service user and carer advisory group and receives input from primary health networks.

The scale of the Hunter New England network is impressive as it covers 17 hospitals and has 16 nominated wards for receipt of eating disorder patients. Standards exist for admission and transfer of ED patients with patients expected to be received on nominated ED wards within 24 hours. Wards benefit from a broad range of foundational ED training including meal support therapy, and the multi-disciplinary team is impressive with medical and psychiatry leads, working closely with experienced Nurses and AHPs. Training programmes have helped develop confidence amongst clinicians in supporting ED patients, a key learning point around the scale of the workforce development that would be required to achieve similar confidence in the UK. The commitment to evaluation and evidence-based practice was also clear in a retrospective audit of 600 patients admitted to medical wards in Hunter New England for ED treatment.

InsideOut Institute

I spent a fabulous week with the InsideOut Institute for Eating Disorders (IOI). The Institute are a partnership between Sydney University and Sydney Local Health District and are Australia's national eating disorder research and clinical excellence institute. In addition to supporting a comprehensive ED research programme and helping define clinical standards across Australia, IOI are deeply involved in the development, rollout and implementation of a range of initiatives to help improve capacity and quality across Australian eating disorders care. This includes the development of eating disorder coordinator roles for all local health districts, the development of e-therapies and clinics to widen access to care, and a wide range of workforce development programmes to enhance both the specialist ED workforce and the wider health and care workforce. IOI are a key agency in helping deliver Australia's national eating disorder strategy and also have a long track record of supporting state and territory level strategy delivery.

Since 2018 the InsideOut Institute have published over 200 eating disorders research papers, trained over 10,000 clinicians in eating disorders care, and supported more than 30 research projects. As well as being a recognised and leading centre of excellence, IOI also provide the scaffolding to aid implementation at state / territory, local health district and primary health network levels in Australia. The scope and delivery track record is astonishing for a relatively small (but growing) team. IOI also collaborate effectively with many partner organisations including headspace, Australia's national youth mental health service who have embedded in their pathways many IOI services such as e-therapies, screening tools, and programmes to upskill the workforce.

With Professor Sarah Maguire (left) and Caroline Hill of InsideOut Institute

I was provided with the warmest of welcomes by IOI staff and encouraged to feel part of the team throughout. Of course, at the end of the week I was sad to leave but was inspired by the potential of an agile and motivated agency dedicated to developing and spreading good practice in eating disorders care.

I cannot do justice to everything I saw at IOI and also cannot articulate how motivated and together the team were around their corporate mission. Acknowledging the limitations in describing the energy and shared purpose at IOI I have instead focused on describing some of their tangible initiatives that are helping change how Australians experience eating disorders care. All of these initiatives have mileage in being considered for use in the UK and would help address some of the factors influencing the UK treatment gap.

New South Wales State Plan Support – InsideOut Institute are a key agency in helping deliver the NSW state plan for ED. This includes structured performance reporting against targets to the NSW Ministry of Health and each of the local health districts.

Eating Disorder Coordinators and Lead Clinicians – InsideOut Institute have been instrumental in developing and implementing the role of the Eating Disorder Coordinator across all Local Health Districts in New South Wales. NEDC also aspire to have an Eating Disorder Coordinator in every primary health network in Australia. The ED Coordinator acts as a focal point in each local area taking responsibility for the development and implementation of a local service plan for eating disorders, including both service and workforce development and reporting to the district executive. The role covers eating disorders awareness, advice and guidance, developing new care pathways and supporting existing pathways, workforce development, and elements of problem solving around case management and clinical services. In each LHD, Eating Disorder Coordinators also work alongside a dedicated Eating Disorder Lead Clinician (and in some districts an Eating Disorders Dietician) to further add to the ED specific capacity and provide clinical leadership in ED matters to the district. I heard about how this works in South Sydney where there is now a highly effective eating disorders clinical support team. The teams provide leadership and coordination and ideally hit a sweet spot in providing some additional clinical delivery capability (including examples such as arranging hospital admissions without patients having to go through emergency department triage and assessment).

Workforce development – IOI have developed a hybrid workforce development program for the state focusing on evidence-based treatments, delivered through the coordinators to districts, using online, face-face to face and continuous learning support features. A wide range of online training courses have been developed by IOI to raise skills, knowledge and understanding across both the ED clinical workforce and a wide range of other health and care professionals working in a range of settings. Examples include; training emergency departments in eating disorders recognition and diagnosis, a dietetics training package for Universities, nurse training in eating disorders, primary care training and links with the IOI GP hub, therapy specific training in CBT-E, Family Based Therapy, and Specialist Supportive Clinical Management.

New training programmes are routinely developed at IOI and the introduction of “ARFID Fundamentals” marks a step change in the availability of training for ARFID which in many areas (including my own area of the NHS) is an exclusion criteria from services.

IOI also offer face to face training and ongoing supervision training for eating disorders clinicians to embed skills and change practice. A particular success has been the general training course “Eating Disorders – Everyone Has a Role” which has broad uptake and has been included as mandatory training in one Local Health District.

GP Hub – IOI have developed software for use in GP practices to support GPs in the consultation process via a clinical decision support tool when eating disorder patients present. Around 3,000 GPs in Australia have registered to use the GP Hub with additional users within practices and primary health networks, including practice managers who are a key target to improve practice change within GP clinics. The GP Hub also has the endorsement of the Royal Australian College of GPs and over half of referrals can be sourced to the RACGP website which links directly to the IOI hub. The software is built around the patient journey, offering ready skills and resources based on the nature of the clinical encounter the GP is having with the person at that stage. It includes eating disorder care plans and helps users develop ED awareness and literacy whilst integrating with local GP systems (alongside the federal government Health Pathways product). IOI are working to ensure their GP Hub for eating disorders can be accessed in all LHDs. User feedback on the system is extremely positive with the diagnosis support tool being particularly welcomed (along with guidance on severity, intervention and referral options).

E-Clinics – InsideOut Institute have developed and implemented evidence based online digital therapies housed within their eclinic for use by patients with bulimia nervosa and binge eating disorders, as well as a new transdiagnostic eTherapy. The online therapy is CBT based and supports patients with bulimia nervosa and binge eating disorder to work through a therapeutic programme and build skills. The platform also has a secure interface for health professionals to refer their patient to an effective digital therapy and monitor them as they progress through. The digital therapies have been demonstrated under trial to be effective in a guided format with a health professional, or delivered as a stand along digital intervention. The eClinic also has a Toolbox housing clinical support tools for patients, such as food monitoring, thought challenging and behavioural experiments, and a skill based program for carers. The goal for the first three years of operation was for 6,000 patients in Australia to be able to access and complete the service. Since my visit the e-clinic has been federally funded for a full national rollout and is available free of charge to all users in Australia. This is a first for Australia and is one of the world's largest e-clinic offerings for eating disorders.

Clinical standards – InsideOut Institute have a strong track record in the development of clinical standards for eating disorders. IOI's work supplements a wider network in other states with a culture of collaboration evident across the country. For example, Queensland Health have produced diabetes and eating disorders guidance which is being considered for adoption in New South Wales, whilst IOI have acted promptly to develop guidance on ARFID.

Acute cases of eating disorders are managed through medical admissions into general medical and paediatric settings, the NSW ED steering group and network for medical leads form an effective oversight group for the ongoing management and development of this care pathway. The process is supported by IOI and other specialist trainers to help create a "home ward" within each acute hospital where eating disorder patients can be effectively managed by an empathetic and highly trained clinical team.

Lived Experience - I met with Bronny Carroll who is the lived experience lead for InsideOut. Bronny is also a member of the NSW ED Steering Committee and has a track record in training the workforce, developing co-produced strategies and guidelines, and also plays a key role in the co-design of IOI's research. Bronny leads the development and execution of the Institute's lived experience strategy, programmes and operations across the organisation. One of the assets that has been developed through the IOI's commitment to lived experience involvement is a database of lived experience which ensures user and carer contributions can be mobilised for all IOI work areas. Bronny confirmed to me that "IOI is anything but tokenistic" and spoke of the driven and cohesive team that she felt a central part of. She was particularly positive about spending time with LHD Eating Disorder Coordinators who she regarded as the engine room for the change ("I value their hard work"). This conversation led me to reflect on the NHS's own approach to lived experience involvement. Mental health does better than most areas of the NHS in terms of user engagement, but I sense that eating disorder lived experience is not mainstreamed into either strategic initiatives or operational delivery, with many eating disorder advocates and campaigners feeling like outsiders. Only a small number of NHS providers pay for lived experience advice and input within their teams which I think is a major oversight.

On my final day with InsideOut Institute I said goodbye to the team and had a final conversation with Sarah and Caroline. We were reflecting on the challenges of stitching together small organisations from grant or project based funding (something I did for years at the NHS Benchmarking Network), this can often feel like a patchwork based approach and it can be hard to get a sense of where things are at and whether things are sustainable. My final words were that patchworks are often in hindsight seen as great works of art and now hang in all the world's major art galleries…

Conclusions from Australia

There is a long history of recognition and support for eating disorders care in Australia. State level strategies can be traced back more than 10 years and the development of the 2023 national strategy offers a compelling vision for how Australia responds to its growing prevalence of eating disorders. It was also great to see the Australian system shifting into strategy implementation phase via a clear roadmap containing tangible measures that will improve the availability, consistency, and quality of care for service users and families. The National Eating Disorders Collaboration act as an effective coordinating body to energise strategy implementation across all states and territories and the stepped system of care is a highly effective model for supporting all levels of the care system. One of the main achievements of the state and national strategies is the success in changing the perception of eating disorders being a specialist to a generalist concern. Eating disorders are now recognised as “everyone’s business” across Australia which creates significant opportunities for early detection and intervention, as well as mobilising contributions from the wider healthcare workforce.

I encountered an energetic sector with significant good practice being developed at all levels. I was particularly impressed by the InsideOut Institute’s innovations around eating disorders coordinators, digital care delivery, support for primary care, and workforce development in both the specialist and wider workforce. Many of the innovations I saw would be transferrable to the UK context and would help improve care access and quality.

Summary of key learning from Australia

- Eating disorders demand is rising and this is seen as a national healthcare emergency.
- National and state strategies have been game changers in mobilising a coordinated response based on clear standards.
- Australia’s coordinated care system has standardised practices including the successful management of medical admissions working in partnership with acute hospitals.
- The stepped system of care provides a structured way forward in thinking about how health systems respond, from prevention through to early intervention, treatment and recovery.
- Eating disorders should be everyone’s business in all health systems. Work should take place to ensure eating disorders move from being a specialist concern to one where a wide range of health and care professionals have an interest and an ability to respond.
- Workforce development via awareness raising, skills and competencies development should be done at scale.
- All localities would benefit from implementing active clinical networks for eating disorders with local coordinators and lead clinicians.
- Healthcare is changing and this includes eating disorders, digital therapies can provide an effective and evidence based first response and can be implemented at scale in the UK.
- Innovation from providers should be cherished and cultivated, this can take place safely in the context of the standards and frameworks within a national strategy.
- National strategy implementation should always be monitored and evaluated so that lessons can be learnt.
- Lived experience is essential for effective service design and delivery, this should not be feared in the UK but should be embraced.

7. NEW ZEALAND

Acknowledgement of country.

As a visitor to Aotearoa, I acknowledge the unique role of Māori as Tangata Whenua (people of the land) and the importance of the Te Tiriti o Waitangi (Treaty of Waitangi) in recognising the enduring presence and significance of Māori tino rangitiratanga (self-governance) in Aotearoa/New Zealand.

Wellington, New Zealand

Introduction

I visited New Zealand during April 2025 and organised my schedule around the following main reference points:

1. National Government policy on eating disorders and the aim to refresh the national strategy
2. How specialist eating disorders care is managed in New Zealand
3. How minority populations (including Māori, Pasifika, and Asian people) experience eating disorders and interact with the care system

The acknowledgements section of this report highlights the significant help I received from many people in New Zealand. None of my work would have been possible without the huge amount of goodwill and help I received from the eating disorders sector. I would like to thank Richard Woodcock, Robyn Shearer and Abigail McDonald for kick starting the organisation of my schedule, they introduced me to Dr Bronwyn Dunnachie, Dr Kristin Gozdzikowska, Anna Headley, Paul Oxnam and Karla Bergquist who helped fill in much of the detail and make sure my time was well spent. Sarah Rowland at Eating Disorders Carer Support New Zealand was also instrumental in enabling me to meet with the Ministry of Health team leading on the national eating disorders strategy refresh.

Context

New Zealand's eating disorders system has many similarities with the UK but also references Australia for clinical practice and networks. New Zealand's services are mainly publicly funded and offer specialist community based eating disorders care. Inpatient services are similar to Australia in that planned responses are via the acute sector working in partnership with mental health and ED care. There is limited residential capacity in New Zealand and these are typically step-down post-acute in nature. New Zealand is similar to the UK in having capacity issues within its system but has developed a consult and liaise model where specialist services try to broaden their reach into other sectors to try and widen access to care.

New Zealand's healthcare system has recently been reconfigured away from District Health Boards into a centrally coordinated and regionally managed 4 regional structures which are;

- Northern.
- Midland | Te Manawa Taki.
- Central | Te Ikaroa.
- South Island | Te Waipounamu.

Eating disorder services have also been reconfigured to match this reorganisation and I met with 3 of the 4 regions to discuss their approach, as well as joining a national advisory group discussion and also meeting with the government team tasked with developing an updated national strategy. I am grateful for the discussion with the New Zealand government who outlined their approach to refreshing the national eating disorders strategy. I also met with a national carers group (ED Carer Support New Zealand) and heard powerful first-hand stories about difficulties in accessing care that illustrated why the change and strategy update process was underway in New Zealand.

I was only in New Zealand for a week so had a number of follow up conversations when back in the UK with regional teams, Ministry of Health, and carers groups to build as complete a position as possible to support my research.

New Zealand's healthcare system and mental health

The following summary is sourced from the NHS Benchmarking Network's 2022 report on International Mental Health Benchmarking. Aotearoa New Zealand has a population of around 5 million and operates a publicly funded health and disability system (including mental health). New Zealand has a universal healthcare system with most care being free at point of delivery.

In April 2021, the New Zealand Government announced major reforms of the country's health and disability system and created new legislation and policy to drive sector wide transformation. The reforms included the passing of the Pae Ora (Healthy Futures) Act 2022 which came into force on 1 July 2022 and disestablished all 20 district health boards to take a more centralised commissioning and service delivery approach through Health New Zealand. The Act also established the Māori Health Authority as an independent statutory authority to drive improvement in Māori health.

Health New Zealand now operates hospitals and health services (including mental health and addiction services), and national public health services. Around 60–80 localities have also been established in communities around the country.

New Zealand's Budget 2019 included increased investment for the mental health and addiction sector of $1.9 billion and the establishment of a Mental Health and Wellbeing Commission and Suicide Prevention Office. Work had also commenced to expand access to, and choice of primary mental health and addiction supports (including kaupapa Māori, Pacific and youth services), boost crisis services, develop initiatives to prevent suicide and support people bereaved by suicide, strengthen specialist alcohol and other drug services, and expand and enhance school-based health services.

Work was also undertaken to transform the mental health and addiction sector in New Zealand through Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing (2021) which sets out sequenced actions the Government intend to take over the next 10 years.

New Zealand's current government was elected in October 2023 and announced a commitment to update the country's national strategy for eating disorders which was originally launched in 2008.

The "Beehive", Executive Wing of the New Zealand Parliament, Wellington

Current provision arrangements for eating disorders

New Zealand currently uses a hub and spoke model to provide specialist eating disorders services. The Regional Eating Disorders Services, located in Auckland, Hamilton, Wellington and Christchurch, act as specialist hubs. These services deliver specialised assessment and treatment for people with moderate to severe eating disorders and also support a "consult and liaise" model to spokes through clinical advice, training and supervision. Eating disorders liaison clinicians play a key role in contributing to the work of spokes and work in partnership with the district specialist mental health and addiction services, providing local expertise and linking those services to the specialist hubs.

Other contributions are made by General Practice and other primary-level services who provide limited early intervention support along with ongoing treatment and monitoring for patients known to the regional specialist services. Paediatric and general medical inpatient settings provide medical refeeding treatment. These are located in the main centres of New Zealand, including in Auckland, Hamilton, Wellington, Lower Hutt, Dunedin and Christchurch.

Child and Adolescent Mental Health Services have a significant role in the community treatment of many young people with an eating disorder, particularly those who live outside of main centres. Community and volunteer organisations, such as the Eating Disorders Association of New Zealand and Eating Disorders Carer Support New Zealand, provide peer connection, educational resources, training, and other supports for families, and carers.

Around 2,000 people access specialist eating disorder services in New Zealand each year. Most people receive their care in an outpatient or community setting. Activity levels per capita are below UK rates with a current focus on moderate to severe patients (and an acknowledgement that more capacity is needed for mild to moderate patients and early intervention).

Inpatient care is mainly delivered through acute general medical care and paediatric services. There are a small number of residential eating disorder places in Auckland (9), Wellington (6) and a shared residential facility with perinatal services in Christchurch. Gaps exist in current services with limited provision of specialist inpatient care. There is also pressure on specialist community services with waiting times evident for care, and there is no formal provision of new therapies such as digital e-therapies for eating disorders in New Zealand.

The latest prevalence estimates used in the updated national strategy suggest that eating disorders prevalence may be in line with international levels of 7.8% of population, suggesting that up to 400,000 New Zealanders may experience an eating disorder. Demand has been rising with a three-fold increase in service demand described since the Covid pandemic.

National Strategy for Eating Disorders

National Framework 2008

New Zealand National Framework for Eating Disorders "Future Directions" 2008 was influential in informing other national approaches and was New Zealand's first step in an approach towards a national eating disorders strategy. The framework helped implement innovations such as New Zealand's first eating disorders coordinators / liaison clinicians, identified some GPs as lead clinicians in primary care, and highlighted the importance of service user involvement in care. The 2008 strategy estimated a prevalence for eating disorders of 1.7% of population in 2008. The Future Directions framework, although helpful at the time, is recognised to be in need of updating given the growth in morbidity and evolution in clinical practice. The decision to update the strategy is therefore both welcome and timely.

Updated National Strategy 2025

I arrived in New Zealand just as the engagement process for the new strategy was starting. This meant I was able to join the early stage discussions and also meet with the Ministry of Health and stakeholders to learn from an active strategy development process. I stayed in touch with the Ministry of Health team up to the formal launch of the new strategy in September 2025.

National Strategy Development Process

The process for developing the strategy was split into three key phases: an evidence and insights phase, targeted engagement phase, and strategy development phase. This process has been iterative and flexible to ensure that key research, data, and stakeholder perspectives can be incorporated into the strategy.

Stage 1 - Evidence and Insights (March – April 2025) Review of eating disorders quantitative and qualitative research, service use data, and overseas strategies. The literature review had a broad focus on major developments since the release of the previous eating disorders strategy to the present day (2008 to 2025).

Stage 2 – Engagement (May – June 2025) Targeted engagement with the national Eating Disorders/Eating Issues Advisory group, Te Tira Wānanga Māuiui Kai, Executive (expert eating disorders Māori rōpū), specialist services and workforces, individuals with lived experience, and family / whānau, carer groups (EDANZ & EDCS Networks), Health New Zealand, and Whāraurau (child and adolescent mental health workforce development centre) to gather views.

The engagement process aimed to address 3 key areas:

1. Specialist clinical services – noting that demand has risen and services are currently stretched, with a risk that standards are not always operated to and there is a case for more targeted staff training and optimisation of how inpatient care works
2. Lived experience of eating disorders including family, whānau and carers – noting that people can feel excluded and peer support resources and lived experience is underused.
3. Te Tira Wānanga Māuiui Kai Executive (expert Māori rōpū - group) - There is a need for a broad definition that goes beyond eating disorder diagnoses. There would be value in improved understanding of Māori eating disorders service use data and a need to explore gaps in eating disorders services for Māori and other groups with higher and/or unique needs

Stage 3 – Drafting, testing and refining the strategy (July – August 2025) Drafting was completed based on agreed components and focus areas that emerged from the evidence and insights, targeted engagement, and Government priority areas.

My reflections on the strategy refresh process are that it succeeded in being rapid, developed good engagement, highlighted the problems that needed to be addressed, and also came up with a clear vision for the future.

New Zealand National Eating Disorders Strategy 2025 Vision

The national strategy aims to establish a clear framework for operating over the next 18 months, alongside outlining a series of longer term actions that need to include tangible and measurable goals. The vision in the strategy has a recovery focus and emphasises the needs of people and families, whilst developing the workforce to move towards a full continuum of care.

Vision of New Zealand's 2025 Eating Issues and Eating Disorders Strategy

People and their families, whānau and carers are able to access treatment and supports that respond to their unique needs and contexts. They are fully included in their own recovery and that of their family and whānau.

Specialist eating disorders workforces, health workforces and other relevant workforces are trained to confidently understand and respond effectively to eating issues and eating disorders.

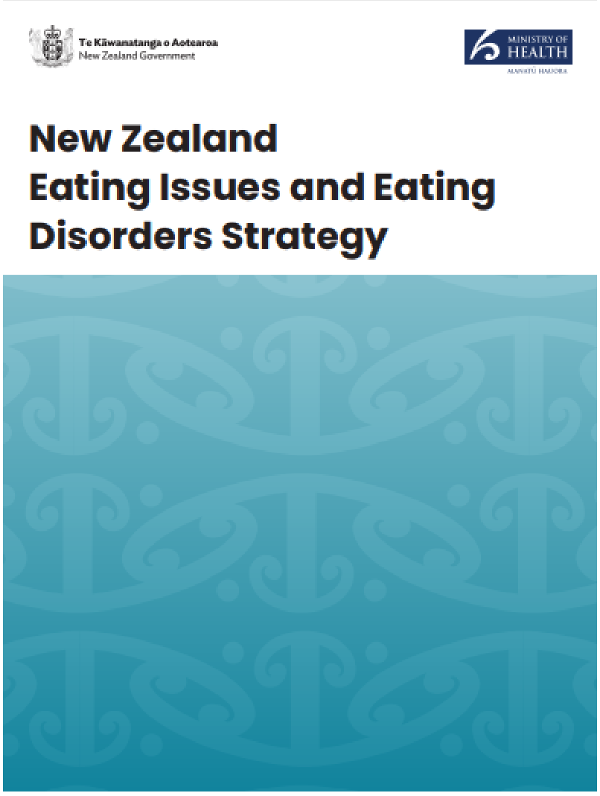
An eating disorders system of care covers the full continuum of treatment and support, spanning early intervention through to specialist community and inpatient services. This includes prevention and public health promotion initiatives to minimise and prevent the risk factors associated with developing eating issues and eating disorders.

New Zealand Ministry of Health

I met the Ministry of Health team leading on the new eating disorders strategy at an engagement event early in the week and was impressed by their commitment to listening to voices from the ED sector. I followed up with a further discussion at the Ministry headquarters in Wellington (with Michael Woodside, Keiran Moorhead and Anne Brebner). The meeting was helpful and confirmed the political commitment to an updated national strategy. Like in Australia, prominent politicians have come forward to support plans for a national eating disorders strategy, in this case Minister for Mental Health Matt Doocey who also confirmed the need for the new strategy to be shaped by the voice of lived experience.

New Zealand Ministry of Health, Wellington

The timing of the meeting was helpful given the early stages of the strategy refresh process and the Ministry team were interested in experiences from Australia and the UK. We discussed the various issues around rising prevalence, data on people able to access services, service models, and innovations. We also discussed issues relating to minority populations and the risks around higher incidence for these population groups especially in bulimia nervosa and binge eating disorder. Similar to the UK and many other developed countries, public finances are also tight in New Zealand but despite this constraint the commitment to reshaping the national approach in New Zealand was refreshing and has demonstrable momentum.


Te Kāwanatanga o Aotearoa
New Zealand Government

MINISTRY OF HEALTH
MANATŪ HAUORA

New Zealand
Eating Issues and Eating
Disorders Strategy

The strategy development process impressed me in its honesty, in that current problems were identified along with a process for generating solutions. The limited financial headroom within New Zealand's health system was also not seen as a reason not to act and I was impressed by the creativity in trying to address existing system problems.

One of the central aspirations was to ensure national consistency of approach, implement appropriate infrastructure (e.g. data and prevalence knowledge), make sure that health inequalities were targeted, and ensure that the strategy could connect across other government programmes including those developed in education, community, and digital. I stayed in touch with the Ministry team after my visit and was pleased to be able to continue to share content and learning in the months that followed.

The final refreshed national strategy was launched in September 2025 for Body Image Awareness Week in New Zealand. The strategy confirmed additional government investment in eating disorders services equivalent to a 20% increase in baseline funding. The new investment was to be targeted at; rolling out peer support to all regional eating disorders services, creating sustainable, community-based support for families, whānau and carers, increasing the capacity of specialist eating disorders services, and expanding prevention and early intervention support.

I left optimistic that the new strategy is a big opportunity for eating disorders in New Zealand and that government and the eating disorders sector will use the opportunity of the national strategy refresh to create momentum and optimism.

Specialist Services - Northern Region

Tupu Ora

I visited services for Auckland / Northland delivered by the Tupu Ora service based at Greenlane Hospital in Auckland, the specialist Adult service for the region. I received a fabulous welcome from Anna Hedley and heard about the history of eating disorders care in the region and the current offer and model for care. I was impressed by the comprehensive care pathways including DBT offer, packages for patients with severe and enduring eating disorders, and constant focus on goal based interventions and nutritional management.

The service (like the other specialist regional centres) uses a liaison / consult model of care to try to extend reach for eating disorders care via building skills with partners in acute care, mental health (including community mental health teams), and primary care. The core service for the region consists of the following main provider offers:

- Tupu Ora
- CAMHS
- Starship Children's Hospital (for acute admissions and medical stabilisation)
- Acute hospitals including, Auckland City Hospital, Middlemore Hospital, and North Shore Hospital (acute admissions and medical stabilisation)

Services operating at Tupu Ora included; 9 bed residential service, day care programmes, specialist community care packages, and support to partners via "consult and liaison".

I also heard about how clinical networks have not just developed within regions but also internationally with close relationships maintained with colleagues in Australia via both professional development forums and regular clinical contact.

The multi-disciplinary team at Tupu Ora resembled those we are familiar with in the UK with a Consultant Psychiatrist, psychological therapists, nurses, dieticians, social workers and other therapists. One notable difference though is the presence of both Māori and Asian cultural advisors within the team, targeting their input around ensuring access and inclusivity for these populations. Māori and Pasifika people tend to present with higher rates of bulimia and binge eating disorder, along with atypical anorexia[3].

The residential services offered by Tupu Ora are largely focused on post-acute care in a non-hospital environment. This patient cohort are largely voluntary in nature (i.e. not detained) and care will be of lower intensity (e.g. nasogastric feeding is not administered in normal circumstances with this capability resting with acute hospital colleagues).

Management of Acute Inpatients - Starship Children's Hospital and Auckland City Hospital

I visited Auckland's specialist children's hospital (Starship) which is co-located on the Auckland City Hospital site. I met with Consultant Paediatrician Dr Raewyn Gavin and MDT colleagues which included representation from CAMHS Psychiatry, Liaison Psychiatry, General Medicine / Gastroenterology, and also had the presence of a strong nursing and dietetics team (including Nurse Specialist and healthcare assistants who have all built skills and knowledge in eating disorders). In a similar manner to Australia, New Zealand's model for acute eating disorders care largely looks to acute medical services which are well integrated into eating disorders pathways.

Starship have 7-8 beds generally in use for eating disorder patients with a caseload mainly drawn from anorexia nervosa and ARFID patients, typically presenting with low weight and in need of medical stabilisation and re-feeding. Capacity in the service is not huge but deemed effective with a good skill-mix and MDT.

The CAMHS continuum was viewed as the strongest part of the care model in the region (similar to the UK), although there was also good evidence of a strong acute pathway for Adults with all 3 major hospitals in Auckland now taking people aged 17 and upwards for medical management of acute eating disorders.

Management of medical emergencies

The model for managing medical emergencies in ED is similar to that evident in Australia and is clearly planned. Like in Australia, I was impressed by the integrated working across these teams and this is a major lesson to take back to the UK. Dr Soren explained how medical management is optimised for Adults via an MDT response with highly skilled staff. Eating disorder patients on medical wards in Auckland have a good and coordinated team of physicians, psychiatrists, nurses and AHPs operating under a "home ward" model whereby patients are directed to a specific medical ward for admission and treatment (there were 7 Adult patients in beds on the wards at the time of my visit). This model is particularly effective in coordinating care where co-morbidities are present (e.g. diabetes, Chron's disease, ARFID) and acute hospitals occupy a prime position in their ability to build appropriate MDTs and develop institutional knowledge around urgent case management. Conversations in both New Zealand and Australia suggested the effective management of medical admissions in an acute setting may also have a lower cost basis when compared to trying to replicate this approach in specialist eating disorders facilities.

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[3] Lacey C, Cunningham R, Rijnberg V, et al Eating disorders in New Zealand: Implications for Māori and health service delivery. Int J Eat Disord. 2020 Dec;53(12):1974-1982. doi: 10.1002/eat.23372. Epub 2020 Aug 31. PMID: 32869323.

The stratification of patients into 3 main groups in the hospital was also helpful and meaningful and uses the core / lead ward location also evident in Australia. Patients broadly fit into 3 categories of intensity;

1) short / overnight stays mainly for observation and brief interventions referring on to community eating disorders care

2) medical stabilisation with circa 2 week stays

3) longer stays for highly acute, or difficult to engage, or treatment resistant patients.

During my visit I heard many stories about empathetic and trained security teams in Auckland hospitals helping with the more difficult end of treatment. None of this good practice would be unachievable in the UK if we could recognise the silos that operate in many areas and work to establish effective multi-disciplinary teams working across specialties. Analysis of the 36,183 hospital admissions reported in England in 2023/24 confirms that most people with an eating disorder who are admitted to hospital are admitted into an acute or paediatric ward rather than a specialist ED inpatient unit. There is an opportunity for greater clarity and more effective management of patients through acknowledging the need for an eating disorders MDT to exist in all acute hospitals rather than being surprised when medical emergencies take place. The UK has been using MEED (Medical Emergencies in Eating Disorders) guidance for several years but the implementation can often be without fidelity to the guidance given the lack of eating disorders clinical networks in many areas and shortage of beds in acute hospitals.

The Auckland clinical network appears to function well for acute care for eating disorders and has a recognised team drawn from a wide range of disciplines in mental and physical health. The MDT also benefits from some GP input and inreach care, although with a recognition of the need to make GP input more substantial in future.

Specialist Services - South Island | Te Waipounamu (South Island Eating Disorder Service)

I visited Christchurch to meet with the Whāraurau national eating disorders advisory group and also to visit the South Island Eating Disorder Service (SIEDS). This is a specialist service for people aged 12 to 65 who have a moderate to severe eating disorder. I was kindly hosted by Rachel Lawson who leads the SIEDS service and is also President of the Australia & New Zealand Academy of Eating Disorders. The geographical catchment is huge so telemedicine can feature in clinical pathways as it does elsewhere in New Zealand. SIEDS is based at Hillmorton Hospital in Christchurch which includes a new development with inpatient provision (via a “pod” which can switch between adolescent and adult admissions), alongside specialist day care and outpatient services.

The consult / liaison model is quite clear across New Zealand which is a good basis for extending capacity into acute care, mainstream community mental health services, and primary care. Given the relatively low levels of capacity in specialist services in New Zealand this is an effective way of extending reach and offers a possible path for the future in the national strategy of widening the awareness and ability to respond for eating disorder patients. Tangible examples of the liaison model included community eating disorders staff in-reaching into inpatient wards, and provision of responses in remote communities via telehealth collaborations with local teams. SIEDS presented a positive outlook on trying to bridge demand and capacity gaps through the consult and liaise approach. We discussed telemedicine examples of providing care into geographically distant communities in Queenstown and Invercargill where technology could be used to support local GPs and counsellors via supervised care to service users whilst upskilling local clinicians.

I was also impressed by the Workforce Development organisation Whāraurau (represented by eating disorders lead Dr Kristin Gozdzikowska) and pleased that eating disorders feature in their work programme in terms of extending clinical understanding and capabilities across the wider health workforce.

During my visit I also joined the Whāraurau national ED Advisory Group meeting with the Ministry of Health. The Ministry of Health team outlined their approach to the strategy refresh to the EAG and there was a helpful discussion and dialogue including input from Māori cultural advisors.

Specialist Services - Central Region | Te Ikaroa.

I visited Wellington and was kindly hosted by Emma Thompson and Clarissa Ventress of the Central Region ED Service (CREDS). The team are an impressive group who are working hard to deliver a comprehensive offer of specialist care whilst also aiming to extend skills and reach through the consult / liaise model. We discussed the principles of “Manaaki tangata” as an important part of team culture, this is a Māori phrase that describes a process of bringing people together and showing kindness and respect throughout the treatment process.

The service model at CREDS is similar to that in other regional centres i.e. inpatient admissions for medical stabilisation and / or refeeding are handled in local acute hospitals by physicians and paediatricians, with eating disorder team inreach. The region has a 6 bed step-down ED residential unit for post-acute care and day care. There is also a specialist community based outpatient service alongside consultation, liaison and training for health professionals, and an education and prevention programme for schools and community groups. Like in the other regional services, the team were honest with me about service gaps (e.g. bulimia and binge eating had limited coverage) and a desire to enhance the offer which is currently capacity constrained. However, the team had demonstrated considerable rigour in maximising performance (for example with a 1% Did Not Attend rate), and also agility in aligning their offer with the most pressing needs, this includes a Māori “kaiawhina” cultural advisor and a full time nurse to work in primary care.

The team explained to me the extensive training that has been delivered to staff working in eating disorders in recent years (including leading on eating disorders medical education for Wellington), as well as an aspiration to upskill the workforce in future outside of the eating disorders specialty.

We discussed recruitment and retention which is a common concern in New Zealand who operate in an international recruitment market for specialist healthcare staff. We also discussed the practical application of the New Zealand Health Pathways system in eating disorders. This is a practice based portal which enables GPs to get guidance on a wide range of health conditions in the consulting room. It was reported that the eating disorder pages are high traffic areas subject to a lot of use in primary care (something again that could be applied in the UK with policy support).

Workforce Development – Whāraurau

Whāraurau is New Zealand's national centre for workforce development for the infant, child, and adolescent mental health and addictions sector. Their work is evidence-based, and informed by national and international subject matter experts, including clinical, cultural and youth-lived experience. I met with Kristin Gozdzikowska and members of the Whāraurau expert advisory group on eating disorders. I was impressed that eating disorders features as a prominent part of their workforce development programme and covers; core skills development through a range of courses, e-learning, and a range of web-based resources.

The eating disorders workforce development offer supports the specialist eating disorders workforce, wider mental health teams, and also the wider New Zealand healthcare workforce (including primary care). Some of the most striking elements of support available included;

1. Online training for GPs and Primary Care Professionals. A GP eLearning module was launched and accredited by the Royal New Zealand College of General Practitioners (RNZCGP). Additional resources are also available to other primary care team members including Dieticians e.g. workshops on "Healthy at Every Size".

2. Foundational skills through e-learning modules on eating disorders for mental health professionals. In its first 6 months, over 900 users enrolled for this course.

3. Continued national implementation of CBT-10 (ten session CBT programmes for ED) and follow-up online advanced supervision sessions.

4. Supporting a biculturally-adapted Guided Self-Help Train-the-Trainer-Training with subject matter experts and support for ongoing supervision for CBT-10 and Guided Self Help - ED.

5. Youth peer support specific to eating disorders - Whāraurau have an active and engaged working group on the existing landscape of 1) youth peer support, 2) youth peer support specific to eating, and knowledge of existing services and supports. This working group developed "Ngā Māuiui Kai: Eating Disorders and Issues Aotearoa Youth Peer Workforce Guidelines", which provides a professional development and service integration framework for the peer workforce. These guidelines are grounded in the voices of peer supporters and experts-by-experience, as well as research evidence and best practice guidelines. The Guidelines are based on the Australian Butterfly Foundation's Eating Disorders Peer Workforce Guidelines (2024) which have been adapted to focus on youth peer support for eating disorders.

6. Targeted eating disorders support for families - Whānau (family) support specific to eating disorders for whānau with a loved one with ED. "Ngā māuiui kai: Māori whānau experiences of eating disorders" is a resource to help whānau who are supporting a family member with an

eating issue or disorder. Based on kōrero (insights) from Māori who have experienced eating issues, as well as mātua (parent) and kaumātua (grandparent) who have supported tamariki (child) and mokopuna (grandchild), the pukapuka (book) shares their voices and advice.

7. Avoidant Restrictive Food Intake Disorder (ARFID) - A dedicated ARFID working group was established in 2023, bringing together researchers, clinicians, cultural advisors, educators, and experts with lived experience, including youth advisors. This group has been instrumental in developing an agreed approach in Aotearoa, ensuring it is culturally responsive and clinically informed. An online community of practice was also created to serve as a resource hub and forum for ongoing dialogue.

8. Foundational resources for non-specialist inpatient sites on how to support people with eating disorders. The development of this key resource for in-patient sites across Aotearoa directly responds to needs to support health care assistants/watchers.

Cultural Appropriateness for Minority Populations

New Zealand is a bi-cultural nation that excels in its transparency around the difficulties that minority populations can experience in accessing healthcare. Māori report higher rates of eating disorders than the non-indigenous population but access treatment at lower rates. Concerted efforts are being made to enable access to services including this being one of the guiding principles of the new national strategy for eating disorders. The time I spent with the specialist services in North, Central, and South Island regions confirmed that all these teams were committed to enhancing access, outcomes and experience for minority populations. Each of the teams were employing cultural advisors to encourage access and provide culturally appropriate care. Lessons can be learnt in the UK about how the prevalence of eating disorders can manifest differently across cultural groups and how services can respond to ensure health inequalities are minimised.

Whāraurau have worked in partnership to develop a range of resources to ensure that service access for Māori can take place with a culturally appropriate language for eating disorders. This includes resources authored by Te Tira Wānanga Māuiui Kai (The Māori Eating Issues/Eating Disorders Network);

A Māori glossary for Eating Disorders that uses te reo (the Māori language) indigenous terminology for eating disorders and body image difficulties *(left)*.

A guide to Māori stories for Eating Disorders *(right)*

Māori eating disorders glossary and stories publications

Whāraurau also support the Te Tira Wānanga Māuiui Kai (The Māori Eating Issues/Eating Disorders Network) that connects Māori researchers, practitioners, and lived experience experts across the eating disorder sector to build relationships, share resources, collaborate, and plan initiatives focused on prevention, identification, and intervention. The rōpū (group) core purpose is to improve the experiences and outcomes of Māori by ensuring culturally responsive care and integrating culturally specific knowledge.

Since its establishment in September 2022, they have supported treatment teams to develop and utilise culturally responsive skills while also strengthening cultural capacity within the broader workforce. In this time, their members have; developed and launched the te reo Māori glossary for use in eating disorders, and also published research on Māori experiences of eating disorders in leading international journals. They have also presented on Māori experiences of eating disorders at international conferences and wellbeing workforce professional development events. This included the first Indigenous plenary in the history of the Australian and New Zealand Academy for Eating Disorders.

The new national strategy also makes explicit reference to the need to grow the eating disorders offer in line with Māori and minority population health needs. It recognises that work needs to continue on understanding prevalence, needs, and how services are responding to the requirements of Māori and other groups with higher or different needs. This cultural appropriateness is to be commended and was clear in the actions and values of everyone I met during my time in New Zealand.

Support to Service Users and Carers

I met with members of one of the national carer groups one evening (Emma and Victoria from Eating Disorder Carer Support New Zealand). I heard their powerful stories which will stay with me and confirmed the need for ongoing support for improvements in service access and outcomes in future. This aspiration is one of the main aims of the national strategy refresh. I was pleased that service user and carer advocacy organisations had a core place within the engagement process for the strategy refresh (as also took place in Australia) and am hopeful their voices will be heard in future given the central role that lived experience should play in helping to shape strategy and service delivery. The support of the Minister for Mental Health was also tangible in helping lived experience voices be heard. I also had follow up conversations with Sarah Rowland (Co-Chair) on my return to the UK and was deeply impressed by the knowledge and experience within EDCSNZ and how valuable this would be in both the formulation and subsequent implementation stages of the national eating disorders strategy.

Conclusions from New Zealand

I had a fabulous week in New Zealand and managed to cover a lot of ground. Everyone I met was welcoming and went out of their way to help my research. I was impressed by the demonstrable commitment and values of everyone I spent time with in the NZ eating disorders sector. The position of eating disorder services demonstrated a lot of familiarity for me with the UK with issues around how best to manage capacity and rising demand and evidence of service gaps in some areas. New Zealand’s consult and liaise approach had succeeded to some extent in broadening reach and there was clear evidence that the “everyone’s business” approach being used in collaboration with the acute sector for medical emergencies was working well to deliver an effective response for acute cases. The joint clinical and professional development networks in place with Australia are also helpful as are some of the achievements in widening out the scope of care into primary care and through coordinating roles such as eating disorder coordinators where they are in place.

The decision to refresh the national strategy at a time of tight public finances is to be commended and demonstrates a can-do approach to updating the country’s approach in response to rising morbidity. The additional funding made available underlines the government’s recognition that increasing capacity is important to address service gaps and ongoing increases in prevalence. I will be keen to see how the refreshed strategy progresses and how momentum is maintained in coming years, especially around making access to services more broad based and embracing new technologies such as digital therapies.

The work to build inclusive and culturally appropriate services in New Zealand is second to none but rightly regarded as work in progress. The size of the eating disorders treatment gap in developed countries means that both strategies and implementation plans will need to be agile in responding in a way that can start to bridge these gaps and address the health inequalities that are fundamentally evident in eating disorders care. New Zealand’s work in recognising and trying to address the needs of diverse communities deserves acknowledgement and credit and offers much to the UK in terms of future learning.

Summary of key learning from New Zealand

- Eating disorders demand is rising and has been recognised in the prioritisation of an updated national strategy as a response to increasing morbidity.
- The successful and planned management of medical admissions is achieved through partnership working with acute hospital colleagues.
- The new strategy builds from the initial 2008 tiered approach into a wider stepped system of care from prevention through to early intervention, treatment and recovery.
- Eating disorders needs to move from a place of being a specialist concern to one where a wider range of health and care professionals have an ability to respond (a development of New Zealand’s consult and liaise approach).
- Workforce development needs to happen at scale and target the whole health and care workforce (as being developed by Whāraurau).
- Understanding the needs of different populations is central to an effective strategy for eating disorders, backing this up with culturally appropriate services and workforce development is a key enabler.
- National strategies can be implemented in tight fiscal conditions and help bring a renewed focus on standards, whilst providing a focal point for clinical practice and a widening of delivery capabilities.
- Lived experience is essential for effective service design and delivery, including this in the national strategy engagement and core strategic vision is a key learning to be embraced.

8. SWEDEN

View of Stockholm's waterfront from Stockholm City Hall

I visited Sweden during May 2025 and organised my schedule around the following main points:

1. National Government policy on eating disorders and the work of the National Board of Health and Welfare (Socialstyrelsen)
2. How specialist eating disorders care is provided in Sweden
3. How Sweden is playing a major role in global eating disorders research through the Centre for Eating Disorders Innovation (CEDI) at Karolinska Instituten

The acknowledgements section of this report highlights the significant help I received from many people in Sweden. In some respects I approached the research visit to Sweden "cold" without any prior contacts or connections in the eating disorders field. After a few initial approaches I received enormous amounts of help and goodwill from the eating disorders sector. I would like to thank Mikaela Lithman and team at Stockholm Centre for Eating Disorders for being the catalyst that helped open doors for me. I am also grateful to the policy leads in the National Board of Health and Welfare for making time for me as we went through the history and detail of the national strategy (Elisabeth Eidem, Dr Susanne Buchmayer and Dr Anne-Katrin Kantzer). Professor Cindy Bulik also took time to open up contacts for me in Sweden's research community which resulted in some fascinating discussions.

Context and current provision

Sweden has a population of just under 11 million people and a currently estimated prevalence of eating disorders of around 300,000 people. Sweden's eating disorders system has some similarities with the UK but also points of departure. Sweden's services are mainly publicly funded and perhaps come closest to a comprehensive offer of care with a full suite of specialist services available, along with work in the prevention and health promotion space. I was aware that Sweden had good healthcare and mental health services so to some extent was not surprised that their core ED services were comprehensive and of high quality, however, it was pleasing to see that the connections into wider societal help were equally strong and no doubt enhanced the effectiveness of the ED service offer. In Sweden, social care, housing, education, and youth services are all strong and work together in a largely integrated manner. Although healthcare is planned at national level, the responsibility for delivery rests with the 21 Swedish regions who have an ability to flex services to meet local needs. Since 1995, social services in

Sweden have held the responsibility for daily activities and housing support for psychiatric patients.

Despite the overall good level of healthcare provision in Sweden, and many signs that eating disorders also has a good care model, there is evidence of a public discourse around concerns in accessing care and of eating disorders demand being high and rising. This creates a sense of urgency around the need to make extra provision for eating disorders available. This has strong parallels with the UK where the same conversation is evident.

National Board of Health and Welfare (Socialstyrelsen)

The National Board of Health and Welfare is Sweden's knowledge agency for health and social care. The National Board (Socialstyrelsen) aims to support and develop healthcare and social services through cooperation, and the use of knowledge in decision making.

The Board produce regulations, knowledge support and statistics, as well as supporting evaluations. They support decision-makers and staff in healthcare and social services, whilst keeping the public informed.

The Board also supports the development of e-health, issue licences, distributes government grants and performs a coordination role in the event of serious incidents. They aim to ensure that people in Sweden have access to good health and social care on equal terms, regardless of who they are and where in the country they live. One of the Board's current "assignments" is to produce and oversee national guidelines on eating disorders.

These guidelines were published in 2024 following a comprehensive and evidence-based development process. I met with the team who led the development and also the clinical leads for child and adolescent mental health to explore the discourse around eating disorders in Sweden.

Eating Disorders Guidance Development

I met with Elisabeth Eidem who has led the project to develop national eating disorders guidelines in Sweden. Elisabeth explained to me the process of working with stakeholders, including clinical experts and patients, to develop the guidance, a process that took two and a half years to complete. The work brought a sharp focus to considering how best to respond to eating disorders and made a total of 39 recommendations to take forward. The 39 recommendations are targeted at regional decision makers who lead on policy and resource allocation. It is expected that they will respond to the eating disorder guidelines and put appropriate arrangements in place in each region. The national guidance covers all conditions (including ARFID), and succeeds in bringing a wider focus on the scope of eating disorders whilst also addressing anorexia nervosa as a particular issue in terms of demand, risk, and acuity.

The guidance is a government "assignment" which targets the interests of politicians and healthcare professionals within Sweden's regions who are tasked with its implementation. Sweden has a well-developed system of prioritisation in healthcare where conditions are ranked according to severity with conditions of highest ranking receiving the greatest priority. A panel of 250 experts was convened to work through evaluation criteria assessing needs, evidence, best practice, and likelihood of an approach working. Following this structured process anorexia nervosa and ARFID emerged as the 2 highest priority conditions to be addressed in the national guidelines, noting that all other eating disorders also received detailed guidelines on how to be taken forward.

With Elisabeth Eidem at the National Board of Health and Welfare

The National Board of Health and Welfare worked alongside its sister authority the SBU ("Statens beredning för medicinsk och social utvärdering" the Swedish Agency for Health Technology Assessment and Assessment of Social Services), who are responsible for undertaking independent assessments of interventions used in healthcare. The two organisations worked together and produced a pilot study in 2019 which confirmed that national guidelines for eating disorders would be helpful for decision makers, for workforce planning and development, and in terms of planning implementation requirements. The guidelines would therefore serve a dual purpose of supporting healthcare policy and also providing guidance to clinical staff.

It is important to point out that Sweden operates a devolved system of government with regional independence, guidance would therefore not be mandatory, but the National Board of Health and Welfare could give strong wording recommending its uptake on scientific grounds.

Content of the national guidelines

The Swedish national eating disorder guidelines are rigorous and comprehensive. They are also honest about the problems they are aiming to solve which include a lack of access to care for people with binge eating disorder and ARFID, and also some care pathway issues associated with anorexia.

The guidelines attempt to provide solutions for specific problems as well as set standards and operating guidance for delivering care for all forms of eating disorders. The three main themes addressed in the guidance are; improving access to care, improving knowledge, and adapting care to the individual. Headline examples from each theme include;

Sweden's National Guidelines for Eating Disorders (Main Themes)

Improving access to care – the need to expand access to treatment, have clearer care flows and lines of responsibility. The aim to increase access is significant given that Sweden already operates at a per capita delivery level for ED that is 2-3 times higher than the UK, but there is a sense of demand outstripping capacity and difficulties in accessing care. Amongst the illustrations for improvement given in the guidance are:

- The need to provide care for children with ARFID and ensure that patients receive eating therapy along with their families
- Bulimia and binge eating patients should be able to receive care in primary care with self-help and supervised therapy programmes used to speed access to help
- Anorexia patients should be able to receive "reinforced care" in addition to inpatient and outpatient care, this can be done through offering specialist day care services for anorexia

Improve knowledge – lack of knowledge and resource allocation to eating disorders is one of the reasons for delays and lack of care for eating disorders. The guidelines make a number of recommendations including that;

- Decision makers in each region need to ensure there is broad based knowledge, understanding and competence in eating disorders care.
- That sufficient numbers of therapists are employed with ED knowledge to meet the demand for treatment

Adapt care to the individual – personalised care is important in eating disorders and the guidelines make a number of recommendations including that;

- Transitions between paediatric and adult services should be planned and seamless
- Co-morbid conditions evident in ED patients should be identified and treated alongside the eating disorder
- Several types of psychological treatment should be available, such as eating disorder-adapted cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT). Therapists should choose the type that suits the individual best, and switch if it doesn't work. Other interventions than psychological treatment may also be needed.
- Focus on support to improve quality of life and avoid deterioration in people with severe and long-term anorexia who have not had sufficient recovery from their treatment packages.
- Work multi-professionally with people with ARFID and extensive eating difficulties, focusing on specific individual symptoms.

The guidelines also contain large amounts of insight based on lived experience and clinical and patient opinion on how to best support recovery. Some of the highlights for me also included:

- Remission and recovery care is key to avoid suffering and build trust between patient and services
- Recommending that patients can come back into care to access “booster” sessions if relapse is threatened or recovery compromised
- Outlining how patients in remission don’t have to deteriorate before they can get additional support but can rapidly access care to get help whenever required.
- Eating disorder patients can access social care for support with issues relating to daily life
- Primary care has a proven track record in managing anxiety and depression and needs to build similar confidence in supporting eating disorders
- Primary care and others can play a role in helping to address the stigma and shame associated with many eating disorders
- Regional networks should be built involving a range of clinicians including non-specialists such as primary care, school nursing, maternity services etc

These practical suggestions on helping implementation of a wider service that is recovery focused are highly relevant (as is a recognition that primary care needs to cultivate a mindset that eating disorders are often long-term conditions that need to be managed effectively). The focus on securing help from social services is also tangible and 3 recommendations in the national ED guidance focus on how best to ensure that social care ensures support for daily living is available for eating disorder patients.

Socialstyrelsen

Nationella riktlinjer 2024:

Ätstörningar

Stöd till beslutsfattare och personal i
hälso- och sjukvården och socialtjänsten

Since the launch of the national guidelines in 2024, the National Board and regions have moved into an implementation phase which uses a gap analysis to identify the scale of current treatment and service gaps and attempts to bridge the gap with targeted interventions. Elisabeth described to me how her team will be focused on implementation as a “follow up mission” for the next 3-years. This recognises that policy and its implementation is often a phased and pragmatic process. In Sweden this means that the National Board of Health and Welfare will work closely with the 21 regions to get new standards for ED care adopted, the guidelines and overall strategy push will also be subject to formal evaluation.

Eating Disorders and Children and Young People (BUP)

When visiting the National Board of Health and Welfare I also met with Dr Susanne Buchmayer (Medical Expert in Child and Adult Psychiatry) and Dr Anne-Katrin Kantzer (Medical Officer, Child and Adolescent Psychiatry) who provide clinical leadership to CYP mental health and eating disorders in Sweden. Both are highly respected in Sweden and have led several national initiatives including developing guidance on CYP inpatient care. We had an enjoyable conversation comparing notes and approaches on eating disorders for young people. Like the UK, Sweden could demonstrate considerable demand growth in the last 10 years and had developed new services and an expanded delivery offer in response. The UK response in terms of dedicated CYP ED teams and a national 4-week waiting times target had been particularly effective.

In Sweden services for CYP mental health have grown and most children are seen within 30 days in the community setting. Inpatient care is also responsive and includes Sweden's commitment to family based therapeutic approaches where parents are admitted with their children. The overall volume of community based CYPMH care in Sweden is higher than in the UK (approximately double the per capita UK rate), and admission rates per capita to inpatient beds are also higher due to the much shorter length of stay seen in Sweden (at around 8 days for CYPMH compared to 100 days in the UK).

Despite the successes in upscaling CYPMH services and making them more available, there are pressing issues in Sweden including demand growth for CYP eating disorders which is still escalating. We discussed the use of CYP mental health inpatient beds where the most recent annual data suggests 40,000 occupied bed days were used across Sweden for all young peoples mental health diagnoses.

Dr Susanne Buchmayer (centre) and Dr Anne-Katrin Kantzer at the National Board of Health and Welfare

However, around half of this volume (circa 20,000 bed days) are now attributable to eating disorders, with anorexia nervosa being the most frequent individual diagnosis requiring admission to a young person's mental health bed in Sweden.

We also discussed wider issues relating to the optimisation of ED inpatient care for young people; including the use of MEED guidance (medical management of ED admissions), the use of compulsory care for inpatients, and the use of restraint and tube feeding. What was clear to me was that even in a country like Sweden with good healthcare, one of the world's best places to receive mental healthcare for young people, eating disorders brings new challenges of rising demand and concerns about how to optimise treatment in the most effective and least restrictive manner.

Stockholm Centre for Eating Disorders (Stockholms centrum för ätstörningar)

The Centre (SCA) serves the 2.5 million people who live in Stockholm region and provides a full suite of specialist eating disorders care. General Manager Mikaela Lithman gave me a great introduction and then organised for me to meet with functional leads for care across the Centre's main service areas. I didn't visit the inpatient units but we did discuss inpatient pathways.

The Centre has grown in size in recent years and now employs around 260 staff. Broad demand data suggests around 20,000 patients are known within Stockholm region and 3,000 people were treated in 2024 (aged between 7 and 70) and provided with a total of 67,000 contacts. Capacity is expected to grow during 2025 to support up to 4,500 patients following closure of "Mandometer" clinics elsewhere in the region.

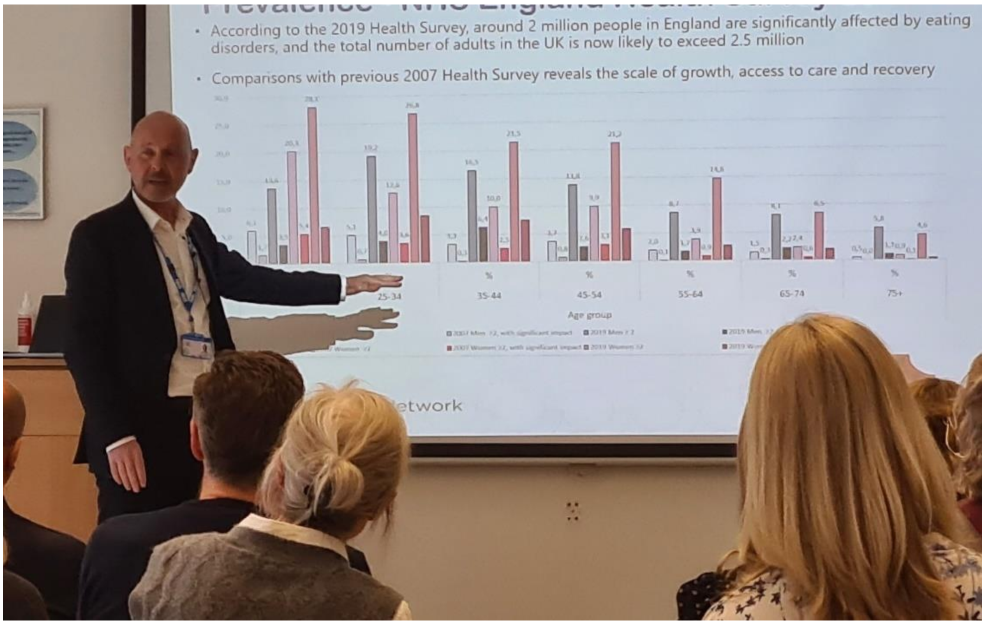
Mikaela Lithman of Stockholm Centre for Eating Disorders

SCA have been successful in managing demand despite the growing morbidity in Sweden, for example, in 2022 there were 1,200 patients on the Centre's waiting list, but this had reduced to 300 by the time of my visit in May 2025. Waiting times tend to be a maximum of 3-weeks which compares favourably with NHS waiting times (especially for Adults). SCA also give a care guarantee to patients that children will never wait more than 30 days to start treatment, and Adults will never wait more than 90 days.

All the teams I met at SCA were highly motivated and very much in command of their brief. The multi-disciplinary team are highly skilled and have the capacity to deliver care at around three times the per capita volumes offered by NHS specialist ED services and also have additional services within their line-up.

In addition to providing the core eating disorders service for Stockholm region SCA are one of 5 designated centres for national highly specialist care (NHV). These services are tertiary and highly specialised and are commissioned directly by the National Board of Health and Welfare. The other 4 specialist centres are located in Gothenburg, Lund, Uppsala, and Västernorrland (Sundsvall).

The specialist care supported by SCA covers inpatient, day care, and community services. SCA provides direct face to face care (individual and group based), as well as a well-developed digital offer, and also mixed / blended therapies. The digital services have been developed in a bespoke manner by SCA and use evidence-based therapies. Digital therapies and guided self-help are supervised by clinical staff and are succeeding in improving access for patients and widening the treatment base within Stockholm region. Digital tools are also used to provide therapeutic input for patients following discharge to aid ongoing recovery.



- According to the 2019 Health Survey, around 2 million people in England are significantly affected by eating disorders, and the total number of adults in the UK is now likely to exceed 2.5 million
- Comparisons with previous 2007 Health Survey reveals the scale of growth, access to care and recovery

Lunchtime lecture with the team from Stockholm Centre for Eating Disorders

SCA Inpatient Care

SCA provide 40 beds for eating disorders care of which 22 are for people aged 18 and over and 18 are Child and Adolescent / BUP eating disorder beds. Self-referral and admission is also enabled with 2 designated beds (for people aged 18 and over). In addition to this Adult psychiatric clinics in Sweden also have inpatient beds. Admission for Adult patients is associated with condition severity and risk and for low weight patients is generally considered at a BMI of 16 or less (compared with an average eating disorder unit admission BMI of 14 in the UK).

Sweden's approach to providing CYP inpatient mental health care is unique in that parents are generally admitted along with their child. This emphasises the family-based therapy approach and is helpful in terms of purposeful admissions and subsequent therapeutic packages of care.

SCA Day Care (Adults)

Day care is provided at scale in Sweden, with around twice the number of places provided than for inpatient care. The SCA service has been established for over 20 years and is generally available for patients of 16 years and older, who have a BMI of more than 15. Day care is available for; people with an acute eating disorder, for patients stepping down from inpatient care, and for patients whose previous treatment may not have worked.

The normal SCA Adult day care programme would run for 12 to 16 weeks with the longer package focused on patients needing additional weight gain. Day care packages are normally followed by around 15 outpatient CBT-E appointments. The day care team consists of psychologists, psychiatrists, and social workers who will all be CBT-E trained (as will dieticians working with this cohort).

Typical Day Care Package

Stage 1 “Starting Well”, a 5-week initial phase that aims to explore problem solving, self-evaluation, and rules around eating. This uses both group work and individual sessions. Each patient will also consume 2 supervised meals (with an aim of 1kg - 1.5kg of weight gain per week).

Stage 2 “Review and Evaluation”, an assessment and taking stock phase which happens early in the treatment process.

Stage 3 “Individual Focus”, an individually targeted programme including both individual and group sessions that also includes weekly review points between patient and therapist.

Stage 4 “Moving towards Wellness”, a stage that focuses on embedding new skills, maintaining gains, sustaining new habits, and reducing the risk of relapse.

Additional Phase if required, “Top Up” via “digi-booster” or other targeted post-discharge support.

Important principles that need to be worked on in day care include; solid preparation and expectation building with patients, how to handle weekends and meals outside the clinic, respecting patient freedoms, and ensuring broad treatment compliance (including eating from day 1). I was impressed by how active and assertive the day care programme is at SCA. The programme is consent based and intensive, requiring sacrifice and commitment. Around 50 patients are on the programme at any one point (possibly in 6 groups), with a general consensus that larger groups tend to be more effective. SCA take EDE-Q patient scores at the start of the programme and then assess at 28 days and then weekly to record progression and outcomes. Understanding patient’s psychopathology and optimising the care offered is a central part of the ongoing care process.

In the UK day care is not a mainstream care offer although a small number of providers have consistently made these programmes available. Since the advent of provider collaboratives more are now reintroducing day care to offer a better line up therapeutic options for patients. In Sweden day care is a highly effective intervention for more complex patients and can be delivered at significantly lower cost than inpatient care. I was impressed by the intensity and highly therapeutic nature of the SCA programme and how it connects with both outpatient and inpatient offers enhancing patient’s chances of better outcomes and recovery.

SCA Community based outpatient care for eating disorders (Adults)

A full range of therapies are available although the core approach is CBT-E. There are no significant patient exclusions from services and ARFID is included within service scope. Face to face care is offered to moderate to severe patients, with patients indicating mild symptoms initially routed via web-based services. Self-referral is allowed in SCA services as well as referral from other sources. The core team is 24 WTE in size with 1.5 WTE Psychiatrists, and also psychologists, nurses, physiotherapist, dietician, and social worker. Community based eating disorder services are provided at a high intensity with offers ranging from 20 to 40 sessions of CBT. Standard care packages having the following input;

- Bulimia Nervosa and Binge Eating Disorder – 20 sessions of psychological therapy
- Anorexia Nervosa – 40 sessions of therapy
- ARFID – 30 sessions of therapy with a new face to face service for under 18s, and a supplementary “ARFID First Aid” service offering online support to families
- Internet based therapies – generally 15 sessions

Blended treatment options of face to face and non-face to face care are also offered.

Although CBT-E is the core therapeutic approach variations are available depending on patient needs including; emotional regulation group therapy, LEAP (shorter group physical therapy), and Acceptance and Commitment Therapy. Therapists and Care Coordinators also receive regular supervision and there are monthly treatment conferences.

SCA’s treatment outcomes for community based eating disorders care are strong and illustrate the effectiveness of their interventions and packages of care;

- EDQ Outcomes – 87.56% on first assessment, reducing to 54.2% during the last year.
- 63.5% on follow up (EDQ scores are typically collected at beginning of treatment, after 6 weeks, and at end of treatment, although like in the UK final scores are not always possible to be collected from all patients).
- Overall recovery rates are reported in excess of 50%

The core community outpatient care offer is well integrated into other SCA services and also connects with additional services for patients with significant co-morbidities and complexity. For example, patients with a primary diagnosis of PTSD will be seen in Psychiatric clinics, young people with addictions and eating disorders will be seen in separate units, and patients with an Autism diagnosis may receive additional support in psychiatric units and also in “Habilitation” centres which focus on optimising care for ASD patients.

SCA BUP children and young people’s outpatient care for eating disorders

Children and young people’s mental health services use the acronym BUP (Barn- och ungdomspsykiatri) in Sweden. This is very much part of the core service offer at SCA and uses Family Based Therapy (FBT) as its core therapeutic approach. In Sweden a child’s problem is generally seen as a family problem and family-based solutions are explored. Patients aged 16 and 17 may be offered CBT-E depending on their circumstances.

There are no major exclusion criteria for the SCA BUP service which includes ARFID and ASD within its scope. Referrals are mainly from primary care, from BUP mental health services, and by self / family referral. Patients are well prepared for treatment and offered a range of educational resources such as films and online tools as part of the assessment and early treatment phases. There is also a workshop for parental preparation. Parents are encouraged to ensure all preparatory work is complete prior to therapy starting.

The service currently has waiting times of less than 1 month for assessment and less than two months for treatment. We had a helpful discussion around UK / English waiting time performance where most young people now start treatment within 2-weeks of referral, helped by a very structured national waiting time standard. Everywhere I went on my fellowship research people were impressed by the UK approach and speed of access for CYP eating disorders. This is a major achievement and should inspire confidence in what could be achieved for adult eating disorder care in the UK if a similar approach was followed.

Children & Young Peoples "BUP" Outpatient Eating Disorder Service

Level 1 – outpatient treatment based on family-based therapy, weight restoration and application of a suitable cognitive framework to support recovery.

Level 2 – If patients become "stuck" or have higher acuity or become more ill, a multi-family therapy approach is adopted based around family day care for group treatment (involving child, parents, and even siblings). This programme runs for 4 days a week and has 6 families in each group. Full support is provided including meal support and a school. Families would stay in the programme for anything from 2-3 weeks up to 6 weeks. Sweden generally provides full support for parental leave during family emergencies.

Level 3 – Inpatient BUP care where parents are admitted along with the child. Weight restoration and therapeutic input run in parallel and patient length of stay is normally 4-5 weeks (with the possibility for weekend leave if the patient is somatically stable), so compares favourably to UK length of stay which is closer to 15 weeks.

Patients can move between levels and step-up and step-down care both function in Sweden.

One of the most impressive things for me about all SCA services was the level of integration and focus around the person. Stepped levels of care were demonstrably available for people who could move up and down the different levels of care according to their needs. The provision of sufficient capacity in terms of team size and skills is a key enabler for this model which creates the best conditions for ensuring good outcomes and recovery. In SCA BUP eating disorders care there were 3 levels of core service which seemed to operate seamlessly.

A final word on BUP eating disorders care and its integration with other aspects of the care system. Close links are maintained with Paediatric services who also provide emergency eating disorders care. The BUP emergency clinic for eating disorders is co-located on the Stockholm Children's Hospital site. SCA, BUP mental Health and Paediatric colleagues work closely together.

SCA SEED

The Stockholm Centre for Eating Disorders have a well-established service for patients with a severe and enduring eating disorder (SEED). The team started as a project 10 years ago and are now part of SCA's core offer. The service focuses on patients who have been in eating disorders treatment for a minimum of 7-10 years (given that recovery from anorexia nervosa averages 6 years). Patients need to be somatically stable to be eligible to join the service and self-referrals into the clinic are possible.

The caseload is currently 100 patients, mostly from Stockholm, with an average age of 38. There are a wide range of co-morbidities in the cohort with the most significant being; ASD, ADHD, ADD, Personality Disorder, PTSD and Trauma, Depression, OCD, and Anxiety. The clinic is an active clinic which is goals based and has a wide range of treatment capabilities to be used in a manner that gives the best opportunities for improvement and recovery. The most frequently offered treatments are; CBT-E, ACT, Motivational Interviewing, General Psychiatric Management, Specialist Supportive Clinical Management, and Compassion Focused Therapy.

The clinic works well with other SCA services so for example, inpatient care is available for one week (which a fifth of SEED patients use), also day care can also be accessed, in addition to intensive outpatient care. Patients can be discharged; when they choose, when they are free of their eating disorder, when their needs are better met elsewhere, or if they choose to leave. Around 2-3 patients become free of their eating disorder each year, and there is also evidence of less trauma and emergency hospitalisations for the cohort, and reduced levels of family stress. Other Nordic countries are taking an active interest in the clinic with plans to replicate the model. UK countries could also learn from this approach which could give hope to the many patients who have long-term eating disorders that have not responded to treatment in conventional NHS timescales.

SCA NHV National Highly Specialised Service

In addition to SEED, SCA offer a further tier of interventions through a highly specialised service available to people with a severe eating disorder who have had at least 2 previous cycles of eating disorder treatment and need additional care. This includes adults and also a number of adolescents. Stockholm provides this service along with the 4 other regions who offer NHV highly specialist services.

The NHV service is targeted at people of the highest acuity, at most risk of death, as an additional option to try and break the cycle of eating disorders and give hope of recovery. Patients typically have co-morbidities which can include; autism, self-harm, personality disorder, OCD, and risk of suicidality. Patients have to consent to be part of the cohort and are able to access a service of highest intensity. Although flexibility is at the heart of the team's offer, the standard package of care would last for around 12 weeks (as per National Board guidelines) and would be followed by a 12-month period of monitoring the patient with support available as required.

Access to inpatient beds is available (up to 10 Adults and 5 young people in Stockholm) in addition to day care, access to patient hotels, and intensive community outpatient support. Given the complex nature of the patient cohort, and previous failed episodes of treatment, NHV do not replicate previous therapeutic approaches and aim to explore different angles and treatments, to make adjustments and aid problem solving. The approach was described to me as a “magic card” that could be brought into play to help break the cycle of eating disorders. Therapies could include DBT, Supported Shared Decision Making, Spontaneous Self-Affirmation Measure, and a range of techniques to address PTSD. It is important to be clear that the team do use Swedish national guidelines but aim for new, flexible, and holistic approaches that embrace learning and making adjustments.

The team has a strong therapeutic core and includes psychotherapists, social workers, dietician, and also help from a psychiatrist for inpatients. The team also provide extensive DBT based training to SCA’s inpatient team. The NHV team network with their peer teams in other regions and an evaluation of the model will be undertaken in future.

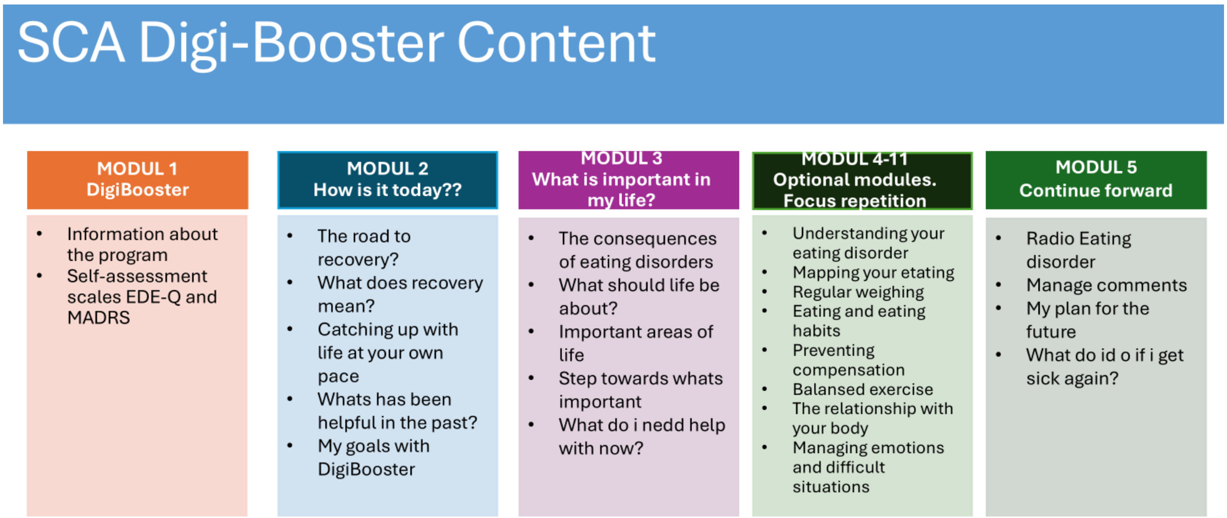
SCA Digital Eating Disorders Care

SCA have a well-developed digital care team which has been providing online therapeutic treatment for eating disorders since 2019. The applications that have been developed are founded on evidence-based psychological therapies. The availability of these therapies is a major learning point for the UK as is the SCA approach which ensures that digital care is supervised and monitored.

Digital therapies are now recommended at SCA for first line treatment which extends the reach of eating disorder services within Stockholm. The core digital offer focuses on bulimia nervosa and binge eating disorders (via a tool called NARA). Both these conditions are associated with considerable stigma so the availability of care that can feel more remote and anonymised is a great asset in encouraging uptake.

The SCA team providing and supervising care includes psychologists, psychiatrist and dieticians. The team can see patient’s medical notes and provide active monitoring with interventions available if required. Initial assessments are provided by video and care is available for patients aged 16 and upwards (sometimes with parental involvement for younger patients). Analysis of outcomes data suggests that 80% of patients report improvement following access to the service.

Other digital programmes are available at family level for children with ARFID (“ARFID First Aid”). Another programme of note is “Digi-Booster” which is a programme of support for people post-care at risk of relapse. Digi-Booster was developed in partnership with patients following a needs analysis and offers blended care with access to a CBT-E based digital support tool as well as access to therapists as required. Digi-Booster is therefore a digital program with therapist support. It last 5-12 weeks and includes 3-5 contacts with a therapist. The contacts take place remotely. The first contact is via video and includes an assessment of eating disorders and suicidality. Remaining contacts are primarily text-based. The program consists of 12 modules, of which 7 are elective. The programme’s additional input is specifically targeted at avoiding relapse and can be initiated at patient request.



SCA Digi-Booster Content

MODUL 1
DigiBooster

- Information about the program
- Self-assessment scales EDE-Q and MADRS

MODUL 2
How is it today??

- The road to recovery?
- What does recovery mean?
- Catching up with life at your own pace
- Whats has been helpful in the past?
- My goals with DigiBooster

MODUL 3
What is important in my life?

- The consequences of eating disorders
- What should life be about?
- Important areas of life
- Step towards whats important
- What do i nedd help with now?

MODUL 4-11
Optional modules. Focus repetition

- Understanding your eating disorder
- Mapping your etating
- Regular weighing
- Eating and eating habits
- Preventing compensation
- Balansed exercise
- The relationship with your body
- Managing emotions and difficult situations

MODUL 5
Continue forward

- Radio Eating disorder
- Manage comments
- My plan for the future
- What do id o if i get sick again?

Overview of Digi-Booster module content, via SCA

The tangible use of supervised digital therapies as an aid to widening access to care has been of clear benefit in Sweden and has the same potential for use in the UK. The new NHS Ten Year Plan (national strategy for health) outlines a clear strategic shift that is expected from analogue to digital care and eating disorders is a condition where this could be safely adopted.

Conclusions – Stockholm Centre for Eating Disorders

My visit to SCA was nothing short of inspiring. I met a team of highly skilled and motivated people who were able to offer a fully integrated range of services to Stockholm region. The care offer had all the recognised components of a high quality specialist service along with additional elements for severe and enduring and highly complex patients. The service is democratic, allows self-referral, demonstrates clinical leadership, and is rapidly broadening its reach through using digital care. SCA provide a service at scale, at around 2-3 times the per capita rate available in the UK but still have issues with capacity and demand due to rising morbidity. They are moving quickly to try to meet demand growth and do this within a framework of standards enabled by Sweden’s national guidelines for eating disorders. SCA offer a great illustration of how UK services could look in future if a successful national plan for eating disorders could be implemented in the UK.

Visit to Skane Region

Skane region is located in South West Sweden and includes the cities of Malmo, Lund, and Helsingborg. The region has a population of around 1 million and like Stockholm also hosts both local, regional, and national specialist services. I visited the Skane specialist eating disorder service in Lund and met with Dr Ulf Wallin, Dr Emelia Mellegard and team. The Skane ED service includes inpatient provision, day care, and outpatients, with a mobile team also scheduled to start operations. The ED service integrates closely with local CYPMH / BUP services. Skane are also one of the 5 sites providing national highly specialist (NHV) ED care and take referrals from across South Sweden.

The Skane service in Lund includes a 10 bed Adult eating disorders ward, day care service (established for 20 years), and outpatient clinics.

The day care service provides both step-up and step-down care and is co-located with inpatients and outpatients to offer a more integrated approach.

There is also a CYPMH / BUP ED facility in Malmo which is fully integrated into local BUP services.

With Dr Ulf Wallin (left) and Dr Emelia Mellegard at Lund's eating disorders clinic

Inpatient care works under a broad 12 weeks of care model in Lund and also has capacity to host NHV highly complex patients (normally 4 of the 10 beds). The Skane service doesn't have large numbers of patients overflowing into acute medical care so most demand is handled directly by mental health services. Inpatient care is also based on CBT-E, with a main focus on weight restoration. Within the NHV ED care, the team in Lund also put a lot of emphasis on the collaboration with the referring caregiver to plan for the transition after the NHV care episode.

Outpatient and day care uses CBT-E as its core therapy alongside intensive meal support. The overall therapeutic aim is around a recovery based and harm reduction model with a focus on patient goals and quality of life.

The Lund service has a good multi-disciplinary team included Psychiatry, Psychology, Nursing, Dietetics, and physical therapists.

Helsingborg is located around 50km north of Lund and also offers outpatient and day care ED services. Kristianstad to the north east also provides outpatient services and has a day care offer after closing its inpatient ward. The Skane offer is therefore on a broadly similar basis to Stockholm when compared on a per capita basis. Capacity is higher than in the UK and there are 3 established day care services for 1 million population, in addition to inpatient care and outpatient clinics.

Similar to Stockholm region, the service in Lund ensures that outpatient clinics can respond to a need for intensity and offer more than 1 appointment per patient per week, this is another learning point for the NHS around how intensity can enhance recovery outcomes.

Digital care for eating disorders is also available in Skane. The main focus is on services for young adults with digital care being available for both bulimia nervosa and binge eating disorder. Like in Stockholm, digital therapy is available through a blended and supervised approach. In Lund patients have an outpatient appointment at the start of treatment, and another appointment on completion to ensure care is personal and outcomes can be assessed. This model offers considerable opportunity for the NHS given the low access rates of BN and BED patients and the need to expand access to eating disorders care.

The Skane team also play a role in educating the psychiatry and wider healthcare workforce on eating disorders. Like in the UK, core medical and nurse education on eating disorders is limited outside the mental health specialty in Sweden. The Skane team provide additional online and in-person training to enhance knowledge on the intricacies of eating disorders presentations and care. This includes training on ARFID where 3 teams in Skane work with Paediatrics and Speech and Language Therapy to enhance understanding and patient management.

Ulf Wallin was a member of the group who developed the national eating disorder guidelines in Sweden. It was good to test the experience of involvement with an active participant and hear how the process of consensus was reached with use of available evidence and clinical judgement statements. It was good to hear that the transparency around the process was welcomed and that there was a sense of ownership of the national guidelines.

Research at the Karolinska Instituten, Centre for Eating Disorders Innovation

Sweden hosts world leading research into eating disorders at the Centre for Eating Disorders Innovation (CEDI) at the Karolinska Instituten. This is a specialist unit funded by the Swedish Research Council who are dedicated to rapidly advancing the understanding of eating disorders. CEDI work with scientists from a variety of disciplines and aim to build a comprehensive understanding of the role that both genetics and environment play in eating disorders risk and maintenance. They aim to understand and promote the causes of and treatments for eating disorders.

CEDI host the Eating Disorders Genetic Initiative (EDGI) which is the world's largest study on how genetic and environmental factors affect the risk of eating disorders. EDGI is a global initiative with similar studies taking place in the USA, England, Australia and New Zealand. Professor Cynthia Bulik is a responsible researcher for EDGI globally and leads the CEDI team in Sweden. Cindy was very gracious in introducing me to her team and also advising on how best to conduct my research in Sweden. I met with Professor Ata Ghaderi and also Elisabeth Welch. Ata is a Professor of Clinical Psychology and Elisabeth is an Affiliated Researcher who also leads the eating disorder service in Uppsala, one of the NHV specialist eating disorder centres in Sweden. Their research included areas such as; web-based CBT-E therapies, self-esteem and eating disorders, ED prevention, childhood BMI and ED risk, binge eating disorders, and the evaluation of the effectiveness of different therapeutic approaches.

I was most interested in how eating disorder research is helping to inform clinical practice in Sweden and discovered a number of active collaborations between CEDI and Swedish providers and national policy organisations. This suggested a virtuous circle was now in play with the use of research and evidence helping guide how clinical practice evolves in Sweden. Both Ata and Elisabeth had been working in the ED research sector for a number of years and were able to reflect on the process of national guidelines development which could be traced in its early stages back to 2016/17. There was broad agreement that there had been improvements in service quality, access, and equalities since the aspiration to develop the guidelines had emerged and there was tangible evidence of collaboration between the clinic and research world.

We discussed how the service in Uppsala (a city 50km north of Stockholm) had evolved and shared many characteristics with those I had seen in Stockholm and Lund. Uppsala has 4 inpatient beds which have high utilisation, along with day care and outpatient clinics, with e-therapies also becoming available in 2025. Day care is available 7-days a week and provides a real alternative to inpatient care for many patients. In Uppsala even on a Sunday day care is available from 09:30 until 18:00 and offers psychiatric support as well as input from care assistants who focus on physical healthcare needs and meal support. Services in Uppsala are co-located with physical healthcare and patient hotel facilities and offer the ability for care to be both integrated and flexed as required. Patients who choose to stay in patient hotels whilst receiving treatment are supervised by the Nursing team, relatives can also accompany patients whilst staying in patient hotels. As in other parts of Sweden too, the eating disorder team work in partnership with social care colleagues to make available assistance for daily living.

Sweden has a very active eating disorders research community and hosts world leading research projects. These do not exist in isolation but frequently collaborate with service providers to address issues relating to optimising both current and future clinical practice.

Conclusions from Sweden

The time I spent in Sweden was inspiring and memorable. People were very welcoming and interested to share knowledge and understanding. I was impressed by the scientific approach to national policy development and how democratic and inclusive the approach to ED national guidelines had been. For this reason, there was a consensus about good practice and appropriate clinical models and people seemed to own the national recommendations and were now busy implementing the comprehensive standards across the country. Sweden is developing its ED services at pace but still has a sense that demand is not being fully met and aims to do more to better serve patient needs. There was a sense of a mission to do more by everyone I met in the eating disorders sector.

In visiting specialist centres in Stockholm and Skane (and also hearing about the Uppsala service), I saw examples of some of the best clinical practice available in Sweden’s eating disorders sector. Sweden’s geography is large and varied and includes many rural areas and sparse populations. It was openly discussed that the challenge for policy makers and regions is to make service access equitable and consistent across regions, especially where specialist care may not be available. This is a challenge in all three countries I visited and was an acknowledged concern of policy makers and providers. However, in this context, national guidelines and strategies can only be helpful in underpinning aims for a consistent approach.

What was also fascinating was the connectivity of the eating disorders sector with other parts of Swedish society. Help for eating disorder patients is available from social care, housing, and education sectors and barriers to acquiring help with daily living were relatively small compared to the difficulties that can exist in the UK in these areas. There was also a clear focus for younger people around the significance of the family unit with family-based therapy being the default approach to problem solving.

Above all though, it is the completeness of the Swedish eating disorders model that is most impressive. Patients with an eating disorder in Sweden will, dependent on their needs, be able to access inpatient care, day care, specialist outpatient treatment of different intensities, and have access to supervised e-therapies. There are also additional tiers of services available for patients with severe and enduring eating disorders, and national specialist services for patients where previous therapeutic approaches have failed. Services are well staffed and generally have good access with low to medium waiting times. However, even with these favourable conditions there are concerns about the scale of rising demand in Sweden and a need to optimise the response and further upscale how the country and individuals respond. The national guidelines for eating disorders offer a great platform for moving forward that recognises all eating disorders, aims to improve access to treatment, optimise care pathways, improves the knowledge base and ability of people to respond, and makes care as personal as possible.

Summary of key learning from Sweden

- A scientific and evidence-based approach to policy development is essential in meeting needs for a condition where demand is rising.
- Sweden's national guidelines have a welcome focus on improving knowledge and understanding and also on relapse prevention
- The national guidelines also recognise that eating disorders needs to move from a place of being a specialist concern to one where a wide range of health and care professionals have greater knowledge and skills and an ability to respond.
- Sweden's national guidelines have helped bring a renewed focus on standards, whilst providing a focal point for clinical practice and a widening of delivery capabilities.
- The tiered model of care exists in Sweden and is working effectively.
- The national guidelines are explicit that all eating disorders are important, with a need for greater prioritisation for anorexia and ARFID, as well as greater involvement by primary care in bulimia and binge eating disorders.
- Digital therapies are enabling wider access to care in Sweden, the UK would also be able to do this in a safe manner by using appropriate supervised and blended care models.
- UK ED services will need to expand to be able to offer the same reach as in Sweden, gaps in UK services would also need to be addressed.
- Partnership working in Sweden is very evident between healthcare sectors, and also with other sectors including social care and housing.
- There is a positive relationship with the eating disorders research sector. Learning is embedded in evidence based national guidelines and in successful collaborations between government, service providers, and researchers.

9. Conclusions

The case for change in UK eating disorders services is clear. Rising demand is an issue in the UK and also in the three countries I visited on my fellowship. The national lifetime prevalence of eating disorders in the UK is now estimated at up to 3 million people but only around 35,000 people are able to access specialist eating disorder services each year. This makes eating disorders one of the largest treatment gaps in UK healthcare. It is important to note that UK services have improved for children and young people's eating disorders care as a direct result of the focus, investment, and workforce development that was made possible by successive national strategies for CYP mental health. The most substantial element of the UK treatment gap is for Adult ED care which has not been subject to a national strategy and is currently subject to capacity restrictions and high acuity thresholds. Many of the building blocks of an effective stepped system of care are also missing including; primary care capability, the availability of broad based digital first line routes into ED care, early intervention services, day care, effective inpatient capacity to avoid unplanned overflow into NHS urgent care services, and an expansive approach to improving ED knowledge and associated workforce development.

The work of the UK All Party Parliamentary Group on Eating Disorders is to be commended and shows that there is political support for improvements in ED care. One of the core learnings from my fellowship was that each country I visited had clear political support for a national ED strategy. In Australia this has a long history at state and federal government level, in New Zealand the new Government acted quickly to update a strategy in need of refresh, and Sweden's evidence based approach to healthcare strategy and planning highlighted eating disorders as a national priority which needed a clear framework of guidelines.

In each country it was also possible to see the demonstrable benefits that national strategies and frameworks offered in being able to illustrate a vision for eating disorders care and also describe the clinical standards that were expected to be delivered. Each country could demonstrate tangible benefits from its ED strategy. In Australia the stepped care model and mantra of ED as "everyone's business" in healthcare had succeeded in raising awareness and capability, improving access to care, clarifying care pathways, and standardising how care is provided. In Sweden the system of prioritisation and national guidelines had succeeded in raising the profile of all eating disorders, whilst bringing a particular focus to the need to enhance care for anorexia and ARFID. Sweden was also able to clarify its recommended care model and introduce a structured care offer including national specialist care based in regional hubs and brought a refreshing approach to relapse prevention. New Zealand has also succeeded in refreshing its national strategy, with an aim of fixing known access problems, developing the workforce outside of traditional specialist ED services, and making services more culturally specific and accessible for minority populations.

I was also impressed by the confidence that each country demonstrated in developing and implementing their national strategies. Confidence was particularly important in empowering the ED workforce to be expansive in their approach and bringing other healthcare professionals into the scope of the eating disorders care offer. Australia had been particularly effective at shifting eating disorders from a specialist to a generalist context given that eating disorders are now common conditions that warrant understanding and an ability to respond from large sections of the healthcare workforce.

One of the other bi-products of the confidence that national strategies bring is an encouragement to innovate. I saw many examples of innovations that could deliver demonstrable benefits if applied in the UK. The country specific sections of my report outline many of these innovations and probably most memorable for me were; the role of eating disorder coordinators and lead clinicians working as clinical leaders in localities, the use of digital therapies (often supervised) to offer rapid first line interventions and also relapse prevention, the support provided to primary care in building confidence and capability in the consulting room, the use of day care as an effective alternative to acute inpatient care, the novel approaches applied to therapies for severe and enduring eating disorders, at scale approaches to skills and workforce development, and targeted attempts to address health inequalities and the needs of minority populations. All three countries also embraced the importance of lived experience in their strategy development and subsequent implementation work and it was important to check in on the voices of carers and service users.

I haven't focused on financial issues as a major part of my fellowship but instead have targeted the art of the possible and benefits of eating disorders strategies. Of course, I always have a keen eye on issues relating to finance, value, and the need to always make the best choices. I did look at comparative investment and costs for eating disorder service across the UK, Australia, New Zealand, and Sweden and concluded that the UK spends more per capita then both Australia and New Zealand. However, it achieves lower reach than Australia and also suffers from substantial unintended costs mainly around overflow into acute healthcare and also the wider societal disbenefits where economic assessments of the £9b annual costs of eating disorders position the UK at the top of the range for economic impact. New Zealand's new 2025 strategy was released with the promise of 20% additional funding to the ED sector which will be a welcome boost to capacity. Australia's federal and state governments have also got behind their national strategy with targeted investment for workforce development, Medicare benefits, residential services, and digital care expansion. Sweden already invest at good levels in mental health care and through their evidence-based approach have made good choices on their stepped system of care. Patients can move up and down their stepped system and Sweden has managed to avoid many of the costs of not providing sufficient ED care such as substantial overflow of patients into acute hospital beds. Even with this excellent platform and system to make good choices, Sweden have used their 2024 national guidelines to target additional support for anorexia, ARFID, and relapse prevention.

Public finances are tight across the developed world and the need for health systems to make the best choices is paramount. The response of New South Wales Chief Psychiatrist that their eating disorders strategy was "born out of necessity" provides clear direction that strategies are needed and should always be bold in setting out a vision for clinical services and be clear about how an evidence based national approach can help to raise clinical standards, improve access to care, and improve outcomes and experience for service users and families. The UK would benefit from a national approach to eating disorders, this should not be feared but embraced in the way demonstrated by Australia, New Zealand and Sweden. The benefits could be substantial as well as improving value for the NHS, and experience and outcomes for patients.

10. Recommendations

These recommendations are made in light of the learning from my fellowship with a view as to the actions required to improve UK eating disorder services for patients, families, providers, government, and UK taxpayers.

- A national strategy for eating disorders should be developed by UK governments.
- The case for a coherent plan is strong and should be generated regardless of the scale of fiscal opportunities or difficulties (plans can be cost neutral or more expansive to plug gaps), a tight public expenditure position should not be seen as a reason not to act.
- The UK should aim to increase knowledge and understanding of eating disorders and move towards a position where they are acknowledged as a common mental health condition that should be "everyone's business" in the health and care system. A full prevalence study will be an important aid in this process.
- In parallel with the development of knowledge and understanding, the NHS should aim to enhance workforce capabilities through both generalist and specialist education programmes (including the potential for inclusion in NHS mandatory training).
- The NHS should support the development of multi-professional clinical networks for eating disorders involving professionals from mental health, paediatrics, medical specialties, and primary care with wider connections into education, social care and youth services.
- Consideration should be given to developing the role of Eating Disorder Coordinators who can provide clinical leadership and coordination at a locality level
- The NHS should adopt a stepped care model that addresses some of the current service gaps with an emphasis on developing capacity and capability in the following areas;
    - Support for public health campaigns and development of protective factors around body image awareness
    - Primary care support to improve confidence in diagnosis and initial response
    - Integration of eating disorders response into national telephone helplines
    - First line digital interventions for bulimia nervosa, binge eating disorder, and for ARFID support to families
    - Additional digital support for post-discharge relapse prevention
    - The inclusion of eating disorders within NHS Talking Therapies in England
    - The development of day care services as an alternative to inpatient care for step-up care and earlier discharge / step-down care
    - The effectiveness of the current approach to specialist inpatient care should be reviewed, this includes addressing the current acuity threshold where the average BMI admission value of 14 is too low and causes harm and suffering.
    - The current overflow into acute medical and paediatric admissions should be acknowledged and optimised with the development of "home wards" for eating disorders in acute hospitals where skills and capabilities can be developed in line with MEED guidelines and clinical leadership advanced
- The UK should continue to network with countries who have advanced their approach to eating disorders and are demonstrating success in positively influencing morbidity and patient outcomes.

11. My work in sharing my fellowship

My fellowship started in July 2024 and although my travels didn't begin until March 2025, I began work early in sharing details of the areas I would be researching and developing interest in the UK. My prime objective was to develop and share evidence-based content that could be used in making the case for a national eating disorders strategy for the UK.

I developed a data analytics pack and briefed the NHS England mental health policy team on four occasions. I also attended two national NHS clinical reference groups for eating disorders in England and shared data analytics and some of the early results from my fellowship research. I also briefed the Scottish government eating disorders leads at around the same time.

I was also pleased to be invited to speak at the All Party Parliamentary Group on Eating Disorders report launch in Westminster in January 2025. I shared some highlights from my early data analysis and also outlined the scope of my fellowship research.

Since this point I have undertaken a number of additional briefings at Integrated Care Board, Provider Collaborative, and Trust Board level including to groups in South Yorkshire and the North West.

I was also fortunate to be able to speak at a symposium at the Royal College of Psychiatrists International Congress in June 2025 where I shared the headline findings from my research.

At the Royal College of Psychiatrists International Congress in June 2025 speaking alongside (from left to right). Dr Ashish Kumar, Dr Jonathan Campion, Dr Adrian James, Dr Agnes Ayton

I welcome any opportunity to speak about my research and will be keen to further engage with the eating disorders sector and health policy makers in the UK and wider.

Bibliography

National Strategies for Eating Disorders

National Eating Disorders Collaboration (NEDC). National Eating Disorders Strategy 2023-2033. NEDC; 2023. (Australia's National Strategy for Eating Disorders) nedc-national-eating-disorders-strategy-2023-2033.pdf

Ministry of Health. 2025. New Zealand Eating Issues and Eating Disorders Strategy. Wellington: Ministry of Health New Zealand Eating Issues and Eating Disorders Strategy | Ministry of Health NZ

Socialstyrelsen. Sweden National Guidelines on Eating Disorders 2024 Nationella riktlinjer 2024: Ätstörningar (artikelnr 2024-12-9352) kan laddas ner från www.socialstyrelsen.se/publikationer

Other

Butterfly Foundation. 2024. Paying the Price, Second Edition: The economic and social impact of eating disorders in Australia. URL www.butterfly.org.au/who-we-are/research-policy-publications/payingtheprice2024/

Clark MTR, Manuel J, Lacey C, et al. 2023. Reimagining eating disorder spaces: a qualitative study exploring Māori experiences of accessing treatment for eating disorders in Aotearoa New Zealand. Journal of Eating Disorders 11(22).

Ernst and Young, Hope Virgo. The costs of eating disorders in the UK 2019 and 2020, September 2021, The Cost of Eating Disorders in the UK 2019 and 2020 (with annex)

Lacey C, Clark M, Manuel J, et al. 2020. Is there systemic bias for Māori with eating disorders? A need for greater awareness in the healthcare system. New Zealand Medical Journal 133(1514): 71–6.

Lacey C, Cunningham R, Rijnberg V, Manuel J, Clark MTR, Keelan K, Pitama S, Huria T, Lawson R, Jordan J. Eating disorders in New Zealand: Implications for Māori and health service delivery. Int J Eat Disord. 2020 Dec;53(12):1974-1982. doi: 10.1002/eat.23372. Epub 2020 Aug 31. PMID: 32869323.

NHS Benchmarking Network, International Mental Health Comparisons 2022, Title

NHS Digital (NHS England), Health and Social Care Information Centre, The Health Survey for England (National Statistics), 2019

NHS England, Hospital Admissions for Eating Disorders Hospital admissions for eating disorders - NHS England Digital

NHS England, National Commissioning Guidance for Eating Disorders, 2018