CEED'S VISION IS THAT VICTORIAN'S WILL HAVE ACCESS TO A WORLD CLASS SYSTEM OF CARE FOR THE TREATMENT OF EATING DISORDERS

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Message from CEED Manager

I welcome you to the CEED Newsletter June 2019. Amongst many changes I am stepping into the role of Manager of CEED and aiming to fill the beautiful shoes left by Claire Diffey as she moves onto new things in life. That’s not the only change happening at CEED. Our esteemed colleagues Dr Beth Shelton and Belinda Caldwell are also stepping up to new roles in the field, Beth as Director of the National Eating Disorders Collaboration and Belinda as Interim CEO of Eating Disorders Victoria. I anticipate exciting opportunities for future collaboration on behalf of the sector. You can read more about our departing colleague’s achievements and their thoughts on leaving in this issue.

Of course staff departures means opportunities for passionate and creative clinicians to join the CEED team with permanent and fixed term clinician positions currently available. Details available on our website.

The last six months has been a particularly productive period for CEED. We have run FBT training four times in the last 6 months - in Perth, Hobart, Albury Wodonga & back to Melbourne again next week, two-day Introduction to Eating Disorders and CBT Guided Self-Help training for 100 headspace clinicians and GPs from around Australia.

Into the future we will be running our core FBT & CBT E trainings in the second half of the year as well as continuing the Multi-Family Therapy program in conjunction with 3 CAMHS and service development projects with a number of AMHS to improve access to community treatment for adults experiencing eating disorders.

Looking forward to continuing to work with all of you over the next year.

Michelle Robertson

2019 CONFERENCE
23-24 August 2019 | Adelaide Convention Centre
Enlisting carers in adult eating disorders treatment

In recent years the eating disorders sector has come to recognise the key role family members and others play in the effective treatment of eating disorders. While the role and strategy for including family in treatment of young people with eating disorders has become quite clear and unambiguous, the role in adult eating disorders treatment is much less clear. This article outlines the whys and the hows of enlisting carers in adult eating disorders treatment.

Why?
- The ego syntonic nature of Anorexia Nervosa in particular can make the person with the illness very attached to their illness and lacking in motivation to recover.
- The behaviours one has to interrupt and that cause intense fear are linked to behaviours one has to complete several times a day, every day, in order to recover. These can be hard to commit to using internal motivation, even if present.
- If one is allowed to starve or continue to engage in ED behaviours, serious medical, psychological and social consequences will occur.

Why Parents?
- Many young adults continue to be well integrated in the family system and/or this could be an option for increased support e.g. return home from university. Many young adults are still financially dependent on their families and families are still highly invested and/or feel a strong sense of responsibility for their wellbeing.
- Notwithstanding age and living circumstances, many families remain involved with their person with an ED for much of the lifespan. Reduced working capacity, anxiety, challenges in managing key life stressors and impaired health can make the person with an ED very dependent on family members.

"The rationale for parental involvement in adolescent AN is intended to address the motivational deficits inherent in AN and the unique ego-syntonic nature of this illness. Likewise, motivational deficits and ego-syntonicity are issues in adult AN and may be improved by the enlistment of carers to manage and oversee initiation and maintenance of recovery-oriented behaviours in a modified, age-appropriate manner" (Knatz S, 2015).
- Parents are often very committed and ideally placed to play an active caring role.
Enlisting carers continued

Why partners?
Partners are frequently left out of treatment models despite the following:

“Not including partners in treatment perpetuates a culture of secrecy and maintains “no talk zones” around many aspects of the eating disorder. In many ways, allowing this secrecy to continue colludes in maintaining the disorder… AN effectively mutes partners. Their deep concern is often trampled by the force with which the illness pummelled or scared them into silence. Partners clearly appreciated the gravity of the illness and feared for the patients’ lives, but they were often cornered into positions of learned helplessness, unable to find strategies or approaches that could “get through” to their loved one” (Bulik CM B. D., 2012)

“In a follow-up study of 70 women who had been treated for AN 10 years earlier, we explored the women’s perceptions of factors contributing to their recovery. The most commonly cited factor associated with recovery was having a supportive partner. In fact, women with AN reported that a supportive relationship was the “driving force” in their recovery.” (Bulik CM B. D., 2011)

Impact on family/support network members
Research shows that carer anxiety, depression and stress levels are all very elevated in ED caring role, to the extent that it exceeds levels found in any other mental illness. (Zabala, 2009)

Impact on the carer

How?
Assessment and treatment planning
* Family and supports know the history of the person with the ED, what they were like pre-ED, what might work as motivators or deterrents. And all of this information can be critical in developing a treatment plan that will work for that person.
* Clinicians can negotiate with family/supports regarding the resources they have to bring to the table e.g. meal support, food preparation, transport, financial, distraction, calming of anxiety, emotion coaching, CBT skill reminders, and extended family members/friends.

Meal support
* Family/Support knowledge of and skills in meal support can be a crucial component of treatment planning
* Negotiation of roles of different family/support network team members is needed around the following
  o menu planning,
  o food purchasing,
  o food preparation,
  o at the table meal support coaching,
  o post meal distress support.
Enlisting carers continued

- Families need skills in ‘at the table meal support coaching’ in terms of what to say or not say to support recovery oriented eating
- Families may need information and support on the increased/often significant nutritional requirements of someone in recovery from an eating disorder

**Interruption of or distraction from other ED behaviours**
- Negotiation of roles may be required of different family/support network members re supporting cessation/minimisation of exercise, purging, laxative abuse etc.
- Distraction strategies for supporting someone to resist urges is helpful

**Behavioural contracts/agreed action plans**
Where age or relationship appropriate, negotiating behavioural contracts or plans of actions for when certain circumstances arise can really assist and clarify the way forward for families/supports and the person with the ED. Things that may be included in the agreements:
- Meal plan/support
- Behaviour interruption
- Increase in distress e.g. distractions, when to bring in external resources
- Being unable to complete meals e.g. have plan a, b and c for meal non-completion
- Non-adherence to treatment goals
- Engagement in psychotherapy
- Medical monitoring

**Emotion Coaching/Communication Strategies**
Enhancing family/support network team member skills in effective communication/emotion coaching with the person with the eating disorder will reduce friction in the home/encourage constructive supportive relationships. Strategies to consider include:
- Workshops such as the Collaborative Care Skills Workshops
- Books such as Janet Treasure’s “Skills Based Learning for Caring for a Loved One with an Eating Disorder”
- DBT skills for families, similar to those taught to carers of people with Borderline Personality Disorders e.g. Family Connections, one on one DBT work
- Emotion Focussed Family Therapy resources/scripts e.g. http://www.emotionfocusedfamilytherapy.org

**Boundary Setting**
- Support family/support network team members to set age appropriate and supportive boundaries which enable recovery for the person with ED and protect them.
- It is important to support families to set clear boundaries around inappropriate use of violence and verbal abuse when person with ED in in high distress, by having a clear plan to manage this with appropriate back up with emergency services.

**Support of the families/supports**
- Ideally, in the treatment plan, include plans for ensuring ongoing resilience and mental health of the family/support network team members, including respite if needed, to reduce burnout and make them available as carers for the full duration of the illness.
- Ensure online and face to face peer support options accessible e.g. www.aroundthedinnertable.org, Closed Facebook groups (ATDTfb and Melbourne Eating Disorders Parent Support Group) and face to face groups run by Eating Disorders Victoria or Eating Disorders Families Australia.
Journey of a young adult through our system, from her mother’s eyes

By Stacey Bruggy

There is nothing more disempowering than having an adult child with an eating disorder.

Our story began in October 2016. Our daughter was in year 12, weighed 58kg, and began fussy eating. In January she was accepted into University in Hobart and relocated in February, soon after being accepted into the Elite Athlete Program for the university, which came with a complimentary gym membership. In April she began complaining of feeling sick and bloated and started to disengage socially. She had a full gastroenterological work up which was benign but had dropped to 53kg.

Late November 2017, my daughter returned home to Victoria for the Christmas break and this is when everything started to unravel. She was weighing herself several times a day, she was obsessed with food, recipes, grocery shopping and cooking but was refusing to eat anything she prepared herself, and she was exercising excessively.

I was feeling really concerned, so I spoke to the GP about my daughter and later that week, I took her to speak with him also. By this time she was consuming approximately 300 calories a day and 200ml of water, she was fainting frequently, had symptoms of low blood sugar levels, and was lethargic. The GP had limited insight into eating disorders (ED), and stated “she can’t be drinking so little, her BP is normal. Just go home and drink a bottle of water, it’s not that hard”. He did refer us to a psychologist but unfortunately she was not able to see us for 8 weeks and suggested contacting Mental Health Triage, which I did. It was very clear that she needed close supervision so I made plans to have the following 4 weeks off work. By now her weight was 48kg.

Fortunately she was triaged quickly and had a clinician allocated who recommended CBT because “if we can fix her brain then she will be able to fix herself.” The clinician was the lead for the ED clinic but was on a secondment from the memory clinic.

Over the next month, my daughter lost 2kg a week and by the end of February she was a mere 38kg. She had been commenced on mirtazapine and had several increases in doses, she was violent, aggressive, suicidal, suffering from blackouts and fainting, headaches, tremors and had pressure areas on her shoulders, spine and hips. I was sleeping on the floor of her bedroom to stop her from exercising during the night and was dispensing her medication from a locked safe.

It was very obvious at this stage that things were out of control. After sourcing books and information from websites such as CEED and EDFA, I took things into my own hands and commenced refeeding. And I took another 2 months off work, no pay.

During these 8 weeks we had twice weekly appointments with mental health, one with the dietician, one with the psychiatrist, one with the GP and 2 with pathology. She was totally dependent on me as she was not able to drive due to her health state and she would not have attended independently anyway.

She gained 8kg and I had hoped that weight gain occurred, the demons would silence. But that was not to be. At the end of March she was experiencing suicidal ideation and intent, but was discharged from community mental health because they were not making progress with her mental state. Knowing we were going to lose her if we continued down this path, I went back to the GP for a referral to Melbourne Clinic. She was seen by the psychiatrist within 3 days and was admitted immediately.
In April I moved to Melbourne and she spent 9 weeks as an inpatient and then another 9 weeks as a day patient. There was no communication with me as her carer during this 18 weeks.

Things turned around in August as she secured a job as a calf rearer in her chosen field of agriculture. This gave her purpose and a reason to be well again. We sought a private psychologist and dietician in Melbourne and attended anywhere from weekly to monthly.

There have been many occasions during our journey that the health care system has not adequately supported us. From the very beginning it was clearly evident that my daughter was not going to be able to manage this alone and yet every practitioner, with two exceptions, refused to acknowledge us as carers. Engaging with me as her primary carer could have decreased the toll this disease took on her physical well-being and mental state, as well as the collateral damage to our family, relationships and friendships. It could well have minimised the time that she had to spend in a psychiatric hospital, if any at all, decreased the time I had off work and the ongoing financial burden, and minimised the social isolation that our family has experienced.

I believe this is because there is a significant lack of understanding of EDs in the mental health system and GP sector, both evidenced by comments made to us by the GP and the community mental health clinician. This acts to decrease the patient’s confidence in the whole system. Trust is such an integral component of this disease and I cannot emphasise enough the importance of language which fosters this relationship. The lack of understanding decreases the urgency that clinicians have in responding to ED’s, yet research clearly demonstrates that early intervention leads to the best outcomes. I think that those professionals who families, like ours, come into contact with as first line of treatment, need to be educated around this. EDs do not have a treatment pathway like any other mental health diagnoses, yet with timely treatment and intervention, we can avoid EDs reaching the depths which we experienced.

In our situation, I was solely responsible for planning her ED care. I researched through websites, social media pages, books, and advice. I am petrified to think of where my daughter would be right now had I not taken that initiative, learnt what I needed to know, and started refeeding at home. But I am lucky. I had the resources to be able to do this, and I feel for the families who do not have this background knowledge, skills and confidence to take this on without the clinician support.

The mental health system is complex and difficult to navigate. There are many aspects within mental health treatment specific for families which need greater attention and guidance; psychological support for the families and carers, financial assistance, accommodation support when treatment is outside the family’s regional area, education about the illness and management planning, and peer support. All of these are critical in minimising the impact of the mental health condition on the patient, family and supports and all could be achieved with education for all health care providers in our system, clear referral pathways, and a centralised treatment management centre for EDs and for carers.

I look forward to a day when EDs are given the attention and support they deserve.
Latest research

Ella Wufong, Paul Rhodes and Janet Conti. 2019. "We don’t really know what else we can do": Parent experiences when adolescent distress persists after the Maudsley and family-based therapies for anorexia nervosa. Journal of Eating Disorders
The structure of MFT/FBT provided initial relief with some improvements in family communication patterns, however, when the adolescent experienced protracted ED symptoms and/or ongoing psychological distress post-treatment, these parents were left with uncertainty as to how to navigate their shifting roles and their child’s ongoing struggles. This research highlights the need for treatments for adolescent AN that more comprehensively address both the adolescent and parents’ psychological distress and also (re)build their senses of identity that have been challenged by AN and its effects.

Eating disorders, particularly ‘other specified’ syndromes, are common in adolescence, and are experienced across age, weight, socioeconomic and migrant status. The merit of adding a criterion for clinical significance to the eating disorders, similar to other DSM-5 disorders, warrants consideration. At the least, screening tools should measure distress and impairment associated with eating disorder symptoms in order to capture adolescents in greatest need for intervention.

CBT-ED merits consideration as a second-line approach for adolescents with eating disorders when FBT has not been effective or could not be applied. There is no evidence that previous failure to benefit from FBT impairs outcome from subsequent CBT-ED, and severity and duration of the eating disorder did not influence outcome. Treatment matching for adolescents with eating disorders might consider the role of previous treatment outcomes and family availability in determining optimum treatment strategies for individuals.
CEED is thrilled to be a partner in this research project and look forward to engaging services and providers in Victoria in this important work.

"InsideOut Institute has been awarded $3.67 million from the Million Minds Research Mission to develop a health system research centre, to monitor early detection and treatment of eating disorders across the national health system, and design new methods to ensure early treatment in mainstream health settings. InsideOut Institute for Eating Disorders will lead the project to deliver a newly-established Centre for Health System Research and Translation in Eating Disorders based at the University of Sydney.

The project brings together a coalition of University of Sydney researchers, including Professor Stephen Touyz from the School of Psychology, national health system leaders and researchers including Professor Natasha Nassar and her epidemiological team from the Charles Perkins Centre, Professor Ian Hickie and his team from the Brain and Mind Centre, Professor Warren Ward and his team from Queensland Health, Ms Claire Diffey and her team from Victorian Centre of Excellence in Eating Disorders (CEED), headspace National and Primary Health Networks.

The Centre will have four key strategies, which involve nationwide ongoing data collection, and the development of new, scalable models of care for health settings, where young people present, that focus on early detection and treatment.

“This is essential and important work that we have been funded to do. At the moment there is no way of tracking early identification, or any stage of identification actually, in the system. Eating disorders have an unacceptably high death rate but can be cured. There is an imperative to identify early and get treatment that works to people early,” InsideOut Director Dr Sarah Maguire says.

“At the moment, none of the different health system data systems talk to each other, hospital data does not talk to community which does not talk to GPs or headspace – what this means is we cannot track what happens to a person when they present to the health system, let alone whether it works.

“This centre will form the foundation of quality care. If we know when people are and are not being detected and treated we can design new systems and interventions to ensure quality,” Dr Maguire says.

Over the next decade there will be unprecedented investment into clinical care for eating disorders, through both the introduction of a specific Medicare item (providing up to 60 additional community therapy sessions), and the reform of state health systems.

“We’ve been heartened to see multi-million-dollar funding injections into eating disorders in recent months, at both the Federal and state levels,” Dr Maguire says.

“There has historically been an under-investment in clinical care and research. Eating disorders have had the lowest research dollar spend of all the major mental illnesses, so this investment is absolutely necessary.”

“But without rigorous evaluation there is a risk these investments will not lead to the improvements in health outcomes they are intended to deliver. This research centre will monitor how well these investments work when they hit the system.”

“All available evidence suggests that the single most important thing we can do to reduce the personal and social burden of eating disorders is intervene early,” Dr Maguire says.

Changing of the guard

“Change is the law of life. And those who look only to the past or present are certain to miss the future.”

John F Kennedy

The current changes and opportunities in the broader eating disorders sector is being reflected within the CEED team. Claire Diffey has made the life changing decision to retire from her lengthy career in mental health and eating disorders, Beth Shelton is taking on the role of Director of the National Eating Disorders Collaboration and Belinda Caldwell is taking up the role of Interim CEO of Eating Disorders Victoria. Both Beth’s and Belinda’s appointments reflect the respect with which CEED is viewed in the eating disorders sector. Michelle Roberton has been appointed the Manager, CEED and will lead a team who remain committed to ensuring Victorians with eating disorders and their families have access to a world class system of care which will only be enhanced by greater collaborations with other stakeholders such as NEDC and EDV.

Claire Diffey

Claire commenced at CEED in 2007 as a senior clinician and took on the mantle of Manager of CEED in 2008. Her leadership and management has been pivotal in enabling CEED to be a productive and creative resource for service change and workforce capacity enhancement in eating disorders care and treatment in Victorian public mental health services.

She has overseen the introduction and implementation of many training and service innovations whilst at the helm at CEED. Notably, she drove the introduction to online introductory training in EDs which freed up the CEED clinical team to focus on building workforce capacity to treat eating disorders in CAMHS and AMHS. A key element of this was the training of over 1000 clinicians in FBT, fundamental to the current service position, that EDs are core business in all Victorian CAMHS/CYMHS. More recently, Claire has continued to lead CEED in navigating the challenge of several rounds of project funding to address early intervention and supporting the larger system of care for eating disorders in Victoria. Claire’s management style and care has allowed her team to grow and flourish. Claire has been a true advocate for CEED, establishing partnerships and collaboration with many other services, locally Australia wide and internationally.

“"It has been a career highlight to provide leadership to CEED over the last 12 years. The CEED team are a passionate, innovative, knowledgeable and skilled group of clinicians who have worked towards CEED’s vision for Victorians to have access to a world-class system of care for eating disorders. It has been a privilege and pleasure to work with so many of you across Victoria, interstate and overseas who are working towards a similar vision. As systems transformation takes more than a decade, being at CEED for 12 years means I have been able to be part of and witness significant changes; key for me are the innovations of a Carer Consultant being a member of the team, early intervention web tools and service projects, Multi-Family Therapy, and eating disorders increasingly being ‘core business’ with pathways to and care in mental health services. The Victorian system has been remarkable in the changes made. I depart CEED with joy at its achievements tinged with the sadness at leaving this great service”
Changing of the guard

Dr Beth Shelton

Beth started at CEED in 2009 as part of the senior clinician team. Beth came to us from Pr. Susan Paxton’s research team via Monashlink Community Health Service and Monash Wellness Recovery Centre. A clinical powerhouse and courageous leader, Beth has been key to building CEED’s reputation in case consultation, training and service development and has been pivotal in range of new initiatives including, early intervention/prevention policy and procedure development with the Australian Ballet School and Victorian College of the Arts, developing and piloting an early intervention guided self-help treatment model in collaboration with 4 Orygen headspace centres, piloting and establishing MFT in CAMHS Victoria, and overseeing service development projects in adult eating disorders at NWMH and at SWH. Whilst she was with us Beth also took a very active role nationally, in the ANZAED, eventually rising to the position of President, along with important roles in the Steering Committee of the NEDC and Clinical Governance Committee of the Butterfly Foundation.

“I would like to thank everyone I have had the privilege of working with in my more-than-a-decade at CEED. For me, the biggest loss in leaving CEED is the constant enrichment of the collaboration within the CEED team and with people in the broader Victorian mental health sector. I have learnt so much working at CEED - and done so many case consultations, and trainings and service development projects. I am not going too far, though. I will be based in Melbourne as the Director of the National Eating Disorder Collaboration (NEDC). If you want to talk about national issues in eating disorders, talk to me! Again, thank you for your contribution to the work we all do.”

Belinda Caldwell

Belinda joined our team almost 5 years ago, and in that time has created a role which has become integral and precious to the team at CEED. In her role as Carer Consultant, Belinda has touched and guided the trajectory of hundreds of Victorian families. The demand for her consultations has multiplied exponentially as clinicians have seen the unmistakable value of the work to families. Belinda’s characteristic warmth, energy and generosity plus her clinical acumen and heart for those experiencing eating disorders has infused and enriched all of CEED’s work and vision. Belinda has also worked as a Project Manager for CEED, designing and overseeing the implementation of early intervention and treatment projects.

“I am sad to be leaving CEED but so grateful to have had the opportunity over the last 5 years to innovate and explore the inclusion of the lived experience into all aspects of CEED’s work. It has been a privilege to consult with families out in the services, be part of clinical training, help project manage some incredibly innovative early intervention projects and develop resources which will remain here long after I leave. The experience of sitting in a service and a service system which is constantly striving to do better has healed me in many ways from much of the trauma that accompanies caring for someone with an eating disorder and I will take each and every experience with me into my next foray in the eating disorders sector”
Connected

Upcoming Training

Specialist Supportive Clinical Management (SSCM)

Presented by CEED clinicians
September 13th 2019
Registrations: https://www.trybooking.com/BAAMX

Specialist supportive clinical management (or SSCM) is a psychotherapy with a growing body of evidence, showing promising potential for the treatment of anorexia nervosa. It has two distinct components: clinical management, which involves alleviation of the symptoms of anorexia nervosa, particularly focusing on weight gain via resumption of normal eating; and a supportive psychotherapeutic approach to issues identified by the patient as important, including life issues that may impact on the eating disorder. SSCM commenced as a credible and ethical control treatment in an RCT with CBT-E in adult outpatients with AN (McIntosh et al., 2005, 2006) as the TAU. Since then, SSCM has been included in other clinical trials, with results comparable to those of other evidence based treatments, and eating disorder specialist services in New Zealand and other countries are now using SSCM as a first-line treatment for anorexia nervosa.

Introduction to Radically Open Dialectical Behaviour Therapy (RO-DBT) for issues of over-control

Presented by Dr Sophie Rushbrook, Consultant Clinical Psychologist, Head of the Intensive Psychological Therapy Service in Dorset
September 24th 2019 Registrations: https://www.trybooking.com/BDDDL

The aim of this workshop is to introduce clinicians to the theoretical foundations and new skills underlying Radically Open-Dialectical Behaviour Therapy (RO DBT) for disorders of over-control (Lynch, in press). RO DBT is fully manualized and supported by three randomized controlled trials (RCTs) for refractory depression, two open-trials targeting adult Anorexia Nervosa, and one non-randomized trial targeting treatment resistant over-controlled adults.

Upon completion of this one-day training, participants will be able to:

- Explain a new biosocial theory for Over-Control
- Describe the RO DBT treatment structure
- Describe new RO DBT treatment strategies designed to enhance willingness for self-inquiry and flexible responding
- Describe the RO DBT treatment hierarchy
- Describe a novel treatment mechanism positing open expression = trust = social connectedness
- List examples of strategies designed to improve pro-social cooperative signaling via activation of the parasympathetic nervous system’s social-safety system
CBT-E: Cognitive Behaviour Therapy for Eating Disorders

*Presented by CEED clinicians*

**October 23rd & 24th 2019**

**Registrations:** [https://www.trybooking.com/BAAQC](https://www.trybooking.com/BAAQC)

This 2 day workshop provides a comprehensive introduction to Enhanced CBT (CBT-E), the latest version of the leading empirically supported, outpatient psychological treatment for eating disorders. The workshop draws on the work of Prof Christopher Fairburn, Director of the Centre for Research on Eating Disorders at Oxford University (CREDO), internationally recognised researcher and author, and Dr Anthea Fursland, researcher & principal psychologist of the Eating Disorders Program at the Centre for Clinical Investigations WA (CCI), and current president of the Australian & New Zealand Academy of Eating Disorders.


*Presented by CEED clinicians*

**November 8th 2019**

**Registrations:** [https://www.trybooking.com/BAAMQ](https://www.trybooking.com/BAAMQ)

CBT Guided Self Help is a highly structured yet client driven and collaborative therapy using evidence-based cognitive behavioural techniques to overcome Bulimia Nervosa (BN), Binge Eating problems (BED) and subclinical disordered eating. The model provides clinicians and clients with a time-limited, six step, cumulative framework for helping clients move to recovery.

Family Based Treatment for Adolescents with Anorexia Nervosa

*Presented by Michelle Roberton and Jessica Ryan*

**November 14th & 15th 2019**

**Registrations:** [https://www.trybooking.com/ZZWN](https://www.trybooking.com/ZZWN)

Family-Based Treatment (FBT) is recognised as the first line, evidence-based, early intervention model of care for adolescents with anorexia nervosa (AN). FBT for AN has been developed and researched worldwide since the 1990s. CEED has developed and delivered FBT training over several years to provide workforce development in this model to suit Victorian Service conditions. In the last ten years CEED has trained to over 1000 clinicians and provided service development and consultation support to implement the FBT model of care in many Victorian CAMH / CYMH Services.