Submission: Victorian Eating Disorders Strategy Discussion Paper

13 November 2022

Thorne Harbour Health

Thorne Harbour Health (THH) is one of Australia's largest community-controlled health service providers for people living with HIV, and the lesbian, gay, bisexual, trans and gender diverse, intersex and queer (LGBTIQ+) communities. THH primarily services Victoria and South Australia, but also leads national projects. THH works to protect and promote the health and human rights of LGBTIQ+ people and all people living with HIV.

THH provides the following services to support the mental health of LGBTIQ+ people:

- General counselling services for people affected by, or at risk of, HIV (many of whom in Victoria are men who have sex with men) as well as people from across all LGBTIQ+ communities.
- Alcohol and drug programs including counselling, care coordination and therapeutic group services for LGBTIQ+ people and people living with HIV.
- Specialist family violence programs for LGBTIQ+ people and people living with HIV including therapeutic counselling, case management, men's behaviour change and brokerage programs.
- LGBTIQ+ inclusive general practice and specialist care for people living with HIV or hepatitis C, and bulk billing general practice and affirmative healthcare services to the trans and gender diverse community.
- The Positive Living Centre, a community centre that supports the health and well-being of people living with HIV, through the provision of social, emotional, recreational, and skills-based services and activities.
- Housing Plus, a state-wide program supporting people living with HIV who are homeless or at risk of homelessness.
- Rainbow Connection, a community program aimed at reducing social isolation of older LGBTIQ+ people; and
- Volunteer participation, peer-led activities and a range of community events which promote acceptance, validation, visibility and community connection.

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Vision

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

a) Targeted support that is designed by and for LGBTIQ+ individuals, with a focus on sexuality, gender and relationship affirmative care.
b) Focus on marginalised populations in the provision of person-centered care, with special attention to the intersectionality that arises from diversity within the LGBTIQ+.
c) Greater availability of specialist eating disorder programs, early identification and intervention services in a community-based setting to address access barriers.

2. Why have you nominated these?

a) Targeted support that is designed by and for LGBTIQ+ individuals, with a focus on sexuality, gender and relationship affirmative care.

LGBTIQ+ adults and adolescents experience higher rates of eating disorders[1] and have unique needs when seeking help[2]. As demonstrated from the Royal Commission into Victoria's Mental Health System[3], *Victorian Population Health Survey 2017*[4], *Private Lives 3*[5], and *Writing Themselves In 4*[6], the Victorian Government's *Pride in our future: Victoria's LGBTIQ+ Strategy 2022-23*[7] and *Suicide Strategy Discussion Paper*[8]*,* it is now inarguable that LGBTIQ+ communities are dramatically underserved as it relates to available, accessible, affordable, culturally safe, and quality mental health care provided by competent and knowledgeable medical practitioners, resulting in significant health inequities. This is particularly pronounced within the field of eating disorders.

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[1] Parker, L.L., Harriger, J.A. Eating disorders and disordered eating behaviors in the LGBT population: a review of the literature. *Journal of Eating Disorders* 8, 51 (2020).
[2] Nagata JM, Ganson KT, Austin SB. Emerging trends in eating disorders among sexual and gender minorities. *Current Opinion in Psychiatry*. 2020 Nov;33(6):562-567.
[3] See, Royal Commission into Victoria's Mental Health System, Chapter 3, 11.
[4] 'The Health and Wellbeing of the Lesbian, Gay, Bisexual, Transgender, Intersex and Queer Population in Victoria: Findings from the Victorian Population Health Survey 2017' (Victorian Agency for Health Information, 2020).
[5] Hill et al., 'Private Lives 3: The health and wellbeing of LGBTIQ people in Australia. ARCSHS monograph series number 122' (Australian Research Centre in Sex, Health and Society, La Trobe University, 2020) ('Private Lives 3 - Australia').
[6] Hill et al., 'Writing Themselves In 4: The health and wellbeing of LGBTQA+ young people in Australia. Victoria summary report, ARCSHS monograph series number 127' (Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne, 2020).
[7] 'Pride in our future: Victoria's LGBTIQ+ strategy 2022-23' (State Government of Victoria, Department of Families, Fairness and Housing, 2022) p. 4.
[8] Suicide prevention and response strategy – Discussion Paper' (Victoria State Government, Department of Health, 2022), p. 25.

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Australian research has concluded that 10.6% of LGBTIQ+ individuals in Victoria[9] and 10.5% in Australia[10] have ever been diagnosed with an eating disorder. These alarming figures have not included those who have an undiagnosed eating disorder or have experienced stress relating to their body images. Simply put, standard service responses do not work for everybody.

LGBTIQ+ persons, already identified as a priority population by the *Victorian Eating Disorders Strategy Discussion Paper (The Discussion Paper*), must be actively involved in every stage from design to implementation to evaluation to ensure community needs are met in service provision.

b) Focus on marginalised populations in the provision of person-centered care, with special attention to the intersectionality that arises from diversity within the LGBTIQ+.

Whilst Eating Disorders Victoria (EDV) provides a range of treatment for people to seek early intervention services relating to eating disorders, there is a lack of specialist and community-controlled services that recognises the pronounced and specific needs of particular societal groups that are more vulnerable to eating disorders. For example, the utility of an intersectional gender lens has been useful to frame women's' experience of eating disorders.[11]

Despite the *Discussion Paper* identifying priority populations within the drafted strategy, any prospective update of the *Victorian Government's Eating Disorder Strategy* (*The Strategy*) must substantially improve inclusivity in mainstream services and to further invest in the community-based organisations to deliver those service.

c) Greater availability of eating disorder specialist services, early identification and intervention services in a community-based setting to address access barriers.

The eating disorder treatment sector continues to adopt a medical approach to treatment with young women and people with tertiary needs being perceived as the primary targeted cohort of patients. However, our service experience at THH has demonstrated that eating disorders and disordered eating behaviours are very common coping mechanisms to trauma, which impacts *all* marginalised communities. Community-controlled organisations that are staffed, administered and engage daily with the communities they serve are best placed to provide such services. Therefore, wrap-around services that target disordered eating should be established in local communities to ensure improved accessibility and availability of appropriate services.

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[9] Hill, A. O., Bourne, A., McNair, R., Carman, M. & Lyons, A. (2021). Private Lives 3: The health and wellbeing of LGBTQ people in Victoria: Victoria summary report. ARCSHS Monograph Series No. 130. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University, p. 38.
[10] Private Lives 3 - Australia, above n 5, p. 38.
[11] Thapliyal, P., Hay, P. & Conti, J. Role of gender in the treatment experiences of people with an eating disorder: a metasynthesis. J Eat Disord 6, 18 (2018). https://doi.org/10.1186/s40337-018-0207-1 https://link.springer.com/article/10.1186/s40337-018-0207-1

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Service provisions

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

As the classification for eating disorders under the DSM-5 are particularly strict, there still remains a substantial number of individuals from priority populations who 'fall between the cracks' and cannot receive appropriate health interventions they require, particularly those who present with co-morbidities or subthreshold disorders. Additionally, LGBTIQ+ Victorians have differing needs which are not recognised and addressed by current systems. There remains a lack of diversity of service options for LGBTIQ+ persons who do not meet the traditional criteria of an eating disorder or do not feel safe to access mainstream services.

Moreover, current eating disorder treatment has a narrow focus on providing treatment for severe, complex presentations or to those under 18 years of age, thereby limiting the breadth of services available to those who do not meet traditional diagnosis thresholds.

2. Are there any further gaps and issues?

A service system that is reliant upon diagnoses

The current services system has been focusing on people who have been diagnosed with one of the eating disorders as recognised in DSM-5. For example, Medicare rebated Eating Disorder Management and Treatment sessions are only available for people via an eating disorder treatment plan from a GP, psychiatrist or paediatrician. The reliance upon the DSM-5 shows that the Victorian mental health system focuses on providing services to people who have developed a serious eating disorder rather than taking a prevention-based lens. The focus on people with official diagnoses inadequately recognises eating disorders and disordered eating behaviours as a coping mechanism for managing experiences of trauma and social marginalisation. As a result, persons with subclinical disordered eating, orthorexia, body dysmorphia and muscle dysmorphia, or those presenting with comorbidities receive very limited access to mental health practitioners to prevent the escalation of symptoms. Concernedly, these conditions, among others, remain highly prevalent within the LGBTIQ+ population that the *Discussion Paper* has highlighted[12].

Additionally, the majority of early identification and intervention services are provided by mainstream organisations and are set in a traditional medical model where it focuses on the identification and mitigation of symptoms. Due to the perceived stigma and lack of recognition of eating disorders within LGBTIQ+ communities, as well as limited mental health clinical expertise on effective and gender, sexuality, and relationship affirmative eating disorder treatment for

[12] Victorian Government, Department of Health, 'Victorian Eating Disorders Strategy: Discussion Paper', p. 18 <https://engage.vic.gov.au/the-victorian-eating-disorders-strategy>. For example, orthorexia and muscle dysmorphia remains particularly prevalent within the gay and bisexual male community.

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LGBTIQ+ people, people from these communities face significant barriers to service provision is community-based, culturally safe and tailored with an understanding of their unique needs.

A lack of appropriate, accessible and culturally safe services for LGBTIQ+ Victorians with subclinical disordered eating and eating disorders

Whilst it has been noted that LGBTIQ+ people most frequently accessed mainstream health and mental health services, mainstream services were also reported to be least likely to respect LGBTIQ+ individuals.[13] This lack of respect can culminate in intentional or unintentional misgendering, stigmatising language, discrimination, hate speech, vilification, even violence, that may engender poorer mental health outcomes for the LGBTIQ+ consumer that can operate as an effective deterrence in seeking future mental health treatment.

Therefore, if an LGBTIQ+ individual is not comfortable in disclosing particular innate characteristics about themselves during medical consultations due to perceptions of possible reprisal, this may, in effect, lead to poorer mental health outcomes, as the clinician cannot appropriately tailor treatment to alleviate symptoms.

Accordingly, studies have concluded that half of LGBTIQ+ individuals indicated they would prefer to access a medical or support service that is known to be LGBTIQ+-inclusive[14], noting that particularly for transgender young people, it was common to encounter inexperienced or transphobic service providers due to long waiting lists to see 'trans-friendly' providers[15].

Further emphasising this point is extrapolated data from *Private Lives 3*[16] that clearly identifies particular communities within the LGBTIQ+ population face higher rates of eating disorders than others.

For example, data shows that 69.6% of trans and gender diverse persons living in Victoria and 66.5% nationally have been diagnosed with an eating disorder ever in their lifetime, whilst 71.2% residing in Victoria and 62.4% nationally had been diagnosed or received treatment for an eating disorder within the past 12 months.

Similarly, data shows that 24.8% those who identified as 'queer' living in Victoria and 19.3% nationally had been diagnosed with an eating disorder ever in their lifetime, whilst 27% of persons who identified as 'queer' in Victoria and 22.2% nationally had been diagnosed or received treatment for an eating disorder in the past 12 months recorded.

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[13] Private Lives 3 - Australia, above n 5, p. 58.
[14] Ibid; Also see Royal Commission into Victoria's Mental Health System, Witness Statement of Commissioner Ro Allen, [80]–[82].
[15] Strauss et al. (2020) Mental Health issues and complex experiences of abuse among trans and gender diverse young people: findings from Trans Pathways. *LGBT Health* 7(3), 128-136.
[16] Private Lives 3 - Australia, above n 5.

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Moreover, 23.9% of bisexuals and 18.5% of gay men living in Victoria had been diagnosed with an eating disorder ever in their lifetime, whilst 24.3% of bisexuals and 16.2% of gay men in Victoria were diagnosed with or received treatment for an eating disorder in the past 12 months.[17]

In this regard, this data demonstrates the differences between the communities within the LGBTIQ+ communities must serve as an impetus for the Victorian Government to disaggregate the LGBTIQ+ communities from one data set or priority population. These differences are distinct and therefore deserve distinct recognition and tailored care.

However, as highlighted above, what is perhaps missing from the analysis in both *Private Lives 3* and the *Discussion Paper* is the eating disorders and determinants thereof that fall outside of the scope of traditional DSM-5 diagnoses.

For example, research has identified the disproportionately higher use of performance enhancing drugs (PEDs), the most commonly used being anabolic androgenic steroids, among gay and bisexual men[18]. The use of PEDs within this community is intrinsically linked to any discussion of eating disorders, as research has identified that users of PEDs are more likely to "experience greater eating disorder symptoms"[19] that may be influenced or associated with disordered eating patterns, or as identified by the *Discussion Paper*, compulsive exercise, muscle dysmorphia or orthorexia[20].

Importantly, research has confirmed that gay and bisexual men from culturally and linguistically diverse backgrounds (CALD) are more likely to use PEDs[21], highlighting the importance of an intersectional lens to be applied by service providers.

The Victorian Government has defined 'intersectionality' as referring to 'the ways in which different aspects of a person's identity can expose them to overlapping forms of discrimination and marginalisation that relates to aspects of a person's identity can include social characteristics such as:

- Aboriginality

[17] Australian Research Centre in Sex, Health and Society, Private Lives 3: Prevalence of eating disorders experiences among LGBTQ+ people residing in Victoria. Personal Communication, (20 October 2022) [Unpublished Manuscript].
[18] Scott Griffiths et al. (2021) Androgen abuse among gay and bisexual men. Current Opinion in Endocrinology & Diabetes and Obesity: December 2021, 28(6), p 589-594; Scott Griffiths et al. (2017). Anabolic steroid use among gay and bisexual men living in Australia and New Zealand: Associations with demographics, body dissatisfaction, eating disorder psychopathology, and quality of life, *Drug and Alcohol Dependence*, 181, p. 170-176.
[19] See, Griffiths et al. (2017), above n 18: "Actual AAS [anabolic androgenic steroid] users were more likely to be… experiencing greater eating disorder symptoms."
[20] Victorian Eating Disorders Strategy - Discussion Paper (October 2022), p 10.
[21] Ibid.

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- gender
- sex
- sexual orientation
- gender identity
- ethnicity
- colour
- nationality
- refugee or asylum seeker background
- migration or visa status
- language
- religion
- ability
- age
- mental health
- socioeconomic status
- housing status
- geographic location
- medical record
- criminal record'[22]

The Victorian Government elucidates that, '[w]hen these aspects or characteristics combine: '…people find it harder to get the help they need due to systemic barriers'[23]. As mentioned by the Victoria Government's *Suicide Strategy Discussion Paper*[24], '…a young person from the LGBTIQ+ community living in a regional area may be more likely to face stigma and discrimination and experience barriers to receiving safe and appropriate mental health and healthcare, including assistance for eating disorders.

It is therefore critical that the prospective update of the Victorian Government Eating Disorders Strategy recognises and reflects the importance of intersectional disadvantage that increases the likelihood in delaying avoiding or prematurely ceasing assistance for disordered eating treatment. The effectiveness of this strategy will depend on intersectional needs being recognised and addressed during service delivery to priority populations.

Therefore, more intensive and diverse support is required to meet the needs of individuals who experience distress related to feeding and eating, body image, shape, size or weight.

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[22] 'Understanding intersectionality' (Victorian Government) <https://www.vic.gov.au/understanding-intersectionality>.

[23] 'Understanding intersectionality' (Victorian Government) <https://www.vic.gov.au/understanding-intersectionality>.

[24] Suicide prevention and response strategy – Discussion Paper' (Victoria State Government, Department of Health, 2022), p. 25.

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

The strategy should prioritise the following gaps in service provision as key priorities:

a) Provision of targeted early intervention and prevention services for priority populations;

b) Increase the capacity of LGBTQI+ community-controlled organisations to provide health promotion and community outreach services for LGBTQI+ Victorians who experience distress related to feeding and eating, body image, shape, size or weight; and

c) Provision of training and professional opportunities for mental health practitioners to work with people with eating disorders and/or people experiencing distress related to feeding and eating, body image, shape, size or weight.

THH herewith provides evidence regarding the above gaps below:

a) Provision of targeted early intervention and prevention services for LGBTIQ+ Victorians.

The current system has consolidated the majority of community-based early intervention services into the EDV Hub. While EDV hubs provide generalist services for people who have or are at risk of developing eating disorders, there is a lack of recognition that this approach may not be able to meet the complex needs of LGBTIQ+ Victorians. Both international and Australian literature have shown that the underlying causes of an eating disorder within gay and bisexual men to include:

- Their attempt to conceal their sexuality[25];
- The pressure to conform to the particular physical aesthetic ascribed to gay adults, which was associated with needing to be viewed as sexually attractive to other gay adults;[26]
- Previous experience of greater levels of body shame and body objectification than heterosexual men.[27]

[25] Meyer, I. H (2015). Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity*, *2*(3) 209.
[26] Parker, L. L., & Harriger, J. A. (2020). Eating disorders and disordered eating behaviors in the LGBT population: a review of the literature. *Journal of Eating Disorders*, *8*(1), 1-20.
[27] Wiseman, M. C., & Moradi, B. (2010). Body image and eating disorder symptoms in sexual minority men: A test and extension of objectification theory. *Journal of Counseling Psychology*, *57*(2), 154.

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In addition to these causes, LGBTIQ+ people are also more vulnerable to the experience of trauma and other mental health diagnoses, such as depression and anxiety, which can result in disordered eating behaviors and distress relating to feeding and eating. Due to the complexity of early intervention and prevention approaches there is a need that treatment is to be designed specifically to address these concerns.

> b) Increase the capacity of LGBTQI+ community-controlled organisations to provide outreach services for LGBTQI+ Victorians who experience distress related to feeding and eating, body image, shape, size or weight; and

Contemporary academic research has consistently identified that sexual minorities continue to demonstrate higher rates of disordered eating, which is most pronounced amongst males[28]. The LGBTIQ+ population, in particular, gay and bisexual men and trans and gender diverse individuals, are especially vulnerable to eating disorders and other distress related to feeding and eating, body image, shape, size or weight and correspondingly experience greater incidence of eating disorders and disordered eating behaviours compared to their heterosexual and cisgender counterparts[29].

Some people are so isolated, alienated, unwell or disabled that they are unable or unwilling to attend services and keep appointments. Assertive health promotion and community outreach are required to identify LGBTIQ+ Victorians who are at risk of developing an eating disorder and integrate them into existing service systems. An LGBTIQ+ community-controlled organisation[30] or an LGBTIQ+ specialist service is best positioned to undertake this task as their abilities to provide a culturally safe environment for the LGBTIQ+ Victorians and their understanding of cultures within the community.

> c) Provision of training and professional opportunities for mental health practitioners to work with people with eating disorders and/or people experiencing distress related to feeding and eating, body image, shape, size or weight.

The provision of eating disorder treatment requires a higher level of clinical skills that are often not taught and assessed in a tertiary qualifying degree. Medicare has outlined that allied health workers, including Occupational Therapists and Social Workers are required to obtain a higher-level credential to become a provider for Eating Disorder Psychological Treatment (EDPT). For example, it is compulsory for Social Workers to acquire a mental health social worker credential through the Australian Association of Social Workers to become an eligible provider under

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[28] See, Calzo, J.P., Blashill, A.J., Brown, T.A. et al. (2017) Eating Disorders and Disordered Weight and Shape Control Behaviors in Sexual Minority Populations. *Curr Psychiatry Rep* 19(49) (2017). https://doi.org/10.1007/s11920-017-0801-y.

[29] See, Parker, L.L., Harriger, J.A. (2020). Eating disorders and disordered eating behaviors in the LGBT population: a review of the literature. *J Eat Disord* 8(51). https://doi.org/10.1186/s40337-020-00327-y.

[30] 'Community-controlled organisation' refers to organisations run by the community, for the community.

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Medicare. To bulk up the workforce that can provide eating disorder treatment, support is required to upskill the current generalist workforce. This can be done by embedding eating disorder training into professional development of mental health workers who work with people who are vulnerable to eating disorders.

4. What currently works well or could work well for consumers, their families, carers and supporters and / or providers? In providing your response, please include links to any literature, evidence or examples that you think can support development of the strategy.

The combination of Medicare rebated EDPT sessions and the clinical services provided by EDV offer a variety of access for specialist services for people with a diagnosed eating disorder. However, this fee-for-service model further exacerbates the health inequality experienced by LGBTIQ+ Victorians, considering the LGBTIQ+ community has on average worse socio-economic outcomes[31]. Therefore, it is important for the current service system to offer low-cost to free specialist services for LGBTIQ+ people and other societal groups that are more vulnerable to eating disorders and could not afford current specialist services via Medicare.

Additionally, training modules provided by the Victorian Centre of Excellence in Eating Disorder (CEED) can assist the current generalist mental health workforce to acquire the skills to work with people. THH's service experience is that LGBTIQ+ service users often experience comorbidity of an eating disorder and PTSD. Therefore, the presentation of eating disorders in non-eating disorder service is very common. Greater awareness needs to be raised within the mental health service systems that training is available at a free-to-low cost for mental health workers who work with priority populations and to develop the intervention skills required for effective treatment. In addition, specialist treatment guidelines and training resources need to be developed for people working with LGBTIQ+ to ensure that service provision is culturally safe and effective. THH welcomes the opportunity to collaborate with the Department of Health to develop such resources.

[31] For example, see: Victorian Government, 'Snapshot: LGBTIQ+ Homelessness in Victoria' <https://www.vic.gov.au/sites/default/files/2021-03/LIT1021_DPC%20LGBTIQ%20Homelessness%20FA2%20SINGLEPAGES.pdf>

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Priority populations

1. In the discussion paper we have listed a series of groups that may need a greater focus in the strategy. Is this list appropriate? (Yes/No)

No.

2. If not, which other higher risk groups do we need to prioritise in the strategy for targeted action?

Despite good intentions as outlining the LGBTIQ+ population as a priority population within the Discussion Paper[32], these communities must be disaggregated so as to highlight specific needs of gay and bisexual men and transgender and gender diverse individuals, as supported by academic research provided above[33].

To adjoin the experiences of all of those who are within the LGBTIQ+ as one group is unfortunately, at best, disingenuous and misleading.

Furthermore, *the Discussion Paper's* priority populations must be better targeted. Simple descriptors of 'men' and 'women'[34] are suboptimal. Any prospective strategy must highlight distinct, well defined, and nuanced groups of persons with pronounced needs for assistance.

For example, despite an inference being able to be made at being 'male' and 'LGBTIQ+', an express inclusion of gay and bisexual men and trans and gender diverse persons are required given the grossly disproportionate rates of disordered eating within these groups as highlighted above.

In this regard, at a minimum, the strategy could retain its priority population, however it is critical that such strategy includes a description of intersectionality[35] and how being part of multiple priority groups increases the risk of disordered eating and potential barriers to access appropriate and inclusive treatment of disordered eating.

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[32] Victorian Government, Department of Health, 'Victorian Eating Disorders Strategy: Discussion Paper', p. 18 <https://engage.vic.gov.au/the-victorian-eating-disorders-strategy>.
[33] See, above n 17.
[34] Victorian Government, Department of Health, 'Victorian Eating Disorders Strategy: Discussion Paper', p. 18 <https://engage.vic.gov.au/the-victorian-eating-disorders-strategy>.
[35] See above, 'Service Provisions'.

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Conclusion

This *Discussion Paper* is a positive step forward to recognise the underdiagnosis of eating disorders and a lack of specialist services in Victoria. However, the *Discussion Paper* does not address the issue relating to the lack of treatment options for LGBTIQ+ Victorians with an eating disorder and the gaps within the current system to build up the workforce that can provide culturally safe services for LGBTIQ+ people. THH welcomes the opportunities to work with the Victorian Government to progress the further development of this strategy and its eventual implementation.

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