

WESTERN SYDNEY
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**Final Report: Clinical evaluation of the Wandri
Nerida Residential care facility.**
October 2023

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GOVERNANCE

Contract/ agreement

All contracts are completed between the Butterfly Foundation and Western Sydney University. These comprise the Research Activities and two co-funded doctoral scholarships for 3.5 years. Adjustments to timelines of reporting have been made.

Acknowledgements and Authorship

The primary authors are:

Members of the Western Sydney University (WSU) Research Team:

- Phillipa Hay, Lucie Ramjan, Deborah Mitchison, Katherine Gill (Lived Experience researcher), Haider Mannan, Janet Conti, Kathy Tannous.
- WSU Higher degree research students: Caitlin Clague, Sinead Day, Rebekah Rankin
- Indigenous researchers: Aunty Kerrie Doyle (Winninninni/Cadigal/Irish) and Michelle Halliday (Wiradjuri)

We acknowledge the contributions of:

- Wandi Nerida staff: Natalie Valentine and Catherine Houlihan.
- Monash University researchers: Long Le and Cathrine Mihalopoulos
- Queensland Health clinical research team: Warren Ward, Amanda Dearden and Amy Hannigan
- Wollongong University and Indigenous researcher: Elizabeth Dale

Study Design Registration and Human Ethics

Primary outcomes data were collected via the TrEAT survey and secondary (further quantitative and the qualitative data) outcomes by the project entitled "*Clinical evaluation of the Wandi Nerida Residential care facility*" which is registered on the *Australian and New Zealand Clinical Trials Registry*: ACTRN12621001651875p

<https://www.anzctr.org.au/Trial/Registration/TrialReview.aspx?id=383073&isReview=true>

Ethics

Approval for primary outcomes sourced from the TrEAT survey (WSU HREC project number H14478) have Western Sydney University HREC approvals for the TrEAT survey, on 26 August 2021, and the QuEDS site, on 14 June 2022 and the Queensland Eating Disorder Service HREC/2021/QRBW/76879 with the following amendments:

WSU HREC H14478 28 April 2023 Amendment Request to add Caitlin Clague to the research team. Change to the questionnaire: Modification in the wording of the discharge time point survey at the Wandi Nerida clinical site.

Western Sydney University HREC for Project "*Clinical Evaluation of the Wandi Nerida Residential Care Facility*" is H14742 is valid 17 February 2022 until 17 August 2025 with the following amendments:

1. WSU HREC H14742 6 July 2022 Amendment Request approved to add new participant group: Participants identifying as Aboriginal and Torres Strait Islander, add two research investigators: Professor Aunty Kerrie Doyle and Dr Liz Dale and to administer the interview over telephone at participant request, and to amend consent to clarify consent for interviews.
2. WSI HREC H14742: 31 May 2022 Amendment Request approved to add items to a questionnaire, one additional question to the discharge survey, modify several questions

on the interview guide and add student researchers to the project team: Sinead Day and Rebekah M Rankin.

3. WSU HREC H14742: 24 August 2022 Amendment approved to offer participants a \$25 gift voucher for each of the surveys and update participant information sheets.
4. WSU HREC H14742: 29 August 2022 Amendment Request approved to update Information Sheet (PICF experiencing person, PICF parent caregiver), MBS/PBS consent form and extended consent form to comply with Department of Health requirements.
5. WSU HREC H14742: 8 November 2022 Amendment Request approved for incentive gift voucher to participants/carers and changes to the consent form.
6. WSU HREC H14724: 19 October 2022 Amendment Request approved to add Jan Faller to the research team.
7. WSU HREC H14742: 11 April 2023 Amendment Request to add Caitlin Clague to the research team.

GLOSSARY OF TERMS

Eating Disorder (ED)	Broad term used to refer to any eating disorder diagnosis classified in the <i>Diagnostic and statistical manual of mental disorders</i> (5th Edition) (American Psychiatric Association, 2013), including anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant restrictive food intake disorder, other specified feeding and eating disorder, pica and rumination disorder.
Butterfly Foundation	The Butterfly Foundation is the national charity for all Australians impacted by eating disorders and body image issues, and for the families, friends and communities who support them. The organisation operates the national eating disorder helpline, provides evidence-based treatment and supports and funds research into eating disorders in Australia.
B-FREEDT	Butterfly Foundation Residential Eating Disorder Treatment Model of Care
Carer	Any person who is a primary carer, parent, adult sibling, spouse and/or partner of a resident patient at Wandí Nerida.
HREC	Human Research Ethics Committee
Health care provider	Any person who is involved in or associated with the delivery of healthcare to a patient at Wandí Nerida, or caring for patient wellbeing (e.g. nurses, psychologists, psychiatrists, support workers). Including lived-experience service providers.
Lived experience	Refers to any individual who has first-hand experience of an eating disorder and/or has first-hand experience as a carer for or significant other of a person who has experienced an eating disorder.
MDT	Multi-disciplinary team
Non-negotiables	Refers to treatment components that are non-negotiable to prioritise participant safety. These are unable to be changed for an individual because of the potential impact on other participants and the therapeutic milieu.
Participant	Refers to an individual who was admitted as a resident patient to the Wandí Nerida treatment facility.
Quantitative	Refers to quantitative research. This is a research strategy that focuses on quantifying the collection and analysis of data.
Qualitative	Refers to qualitative research. This research strategy relies on data obtained by the researcher from first-hand observation, interviews, questionnaires, focus groups, participant-observation, recordings made in natural settings, documents, and artifacts. This data is generally nonnumerical.
Recovery Navigator	A non-clinical support staff member employed at Wandí Nerida, many of whom have a lived experience of an eating disorder and recovery, either as an experiencing person or carer. The primary purpose of this role is to support participants and assist in daily activities such as providing meal support, portioning of food, observations, assisting in therapeutic activities and outings.

TrEAT	The Clinical and Demographic Correlates of Eating Disorder Treatment-Seekers
Wandi Nerida	The first residential treatment facility for the treatment of eating disorders in Australia. This facility is owned and operated by the Butterfly Foundation.
WSU	Western Sydney University.

1. EXECUTIVE SUMMARY

In 2021, the Butterfly Foundation opened the country's first residential treatment facility, Wandí Nerida. This study examined how well this treatment service helped people and provides valuable insights into whether residential treatment should be made more widely available in Australia. The aims were to investigate the program's effectiveness in working with people with eating disorders to have improved mental and physical health, and to aid realisation of their life's potential. We also explored the experiences of individual's loved ones, Wandí Nerida staff, and compared some outcomes with another health care providers in Australia. Data were collected from residents, carers and staff using online surveys and in-depth interviews.

Seventy residents at Wandí Nerida, 92% of those eligible, participated in the research. Anorexia nervosa was the most common diagnosis and the majority had lengthy illness (more than 3 years) with previous treatment experiences. In comparing their measured outcomes of eating disorder symptoms, general mental health, quality of life and physical health status, there were incremental improvements from entering the centre until discharge. The most positive outcomes were improvements in eating disorder symptoms and mental health related quality of life. The length of stay was longer than for the comparison Day Program and 75% of participants were at Wandí Nerida for at least 17 weeks. Improvements were similar to the same time period (8-weeks) at both facilities but residents at Wandí Nerida continued to receive care and made further improvements over time.

Residents and their carers strongly endorsed the treatment at Wandí and rated all aspects of the program highly. Participants described residential treatment as being like a "Hail Mary" or "last ditch" attempt at holding onto hope for recovery and finding a life beyond the eating disorder. Carers similarly described Wandí as a relief and source of hope for recovery for their loved one. In reflecting on their residential treatment experience, participants emphasised that "recovery takes a village". Participants stressed the value and importance of collaborative care, communication, community and individual motivation for change, as well as the value of normality in small things at Wandí Nerida such as the treatment environment.

Initial findings from this study highlight the complex and multifaceted nature of the residential treatment experience as well as the inherent ideological dilemmas that arise when balancing replicable standardised phase-based treatment protocols with person-centred and recovery-orientated care. Adopting person-centred and recovery-oriented treatment approaches within residential treatment settings likely served to maximise patient autonomy and support participants in reclaiming and living out preferred identities less dominated by the eating disorder. Participants and their carers both identified challenges at discharge, and many struggled to find adequate ongoing care.

Indigenous peoples' experiences at Wandí Nerida were unable to be explored due to very low self-identification and low numbers overall. As in other research (Burt et al., 2020a; Crooks et al., 2019), the low numbers are likely due to reluctance to disclose following known historical injustices and power imbalances. We recommend that one way to mitigate this potential problem in the future is to embed Aboriginal and Torres Strait Islander mental health workers in clinical and research settings that enable Indigenous peoples to feel safe to share their stories.

The staff at Wandí Nerida were very positive about the program. Those with Lived Experience expertise perceived they were highly valued by residents and other staff and there was a high level of the use of their expertise in the program. Overall, the program was perceived to be a holistic treatment of participants with care and respect within a treatment non-negotiable framework.

In sum, this evaluation of the first Australian residential program endorses the effectiveness of Wandí Nerida and its introduction of the B-FREEDT Model of Care to Australia.

Public health statement

The opening of Wandi Nerida Residential Care in 2021 signalled the beginning of the new approach to eating disorder care in Australia. As the first residential treatment facility in Australia, Wandi addresses a critical gap in the system of care. Unlike traditional hospital care, Wandi provides holistic and individualised treatment which includes support from staff with lived experience within a tranquil setting. Wandi's great promise for individuals and their loved ones is the restoration of hope, health and quality of life over the longer term, while for the system it is the potential for a reduction in economic and social costs, including health system savings. The results of this first evaluation show that Wandi is effective in terms of recovery outcomes, as measured by clinical data and participant reflection. It is expected that the principles of the B-FREEDT Model of Care will be replicated in several Australian states and territories in coming years.

Highlights

- There were very high rates of resident (92%) and staff (85%) participation in the research.
- Therapy at Wandi was both highly valued and residents achieved meaningful and measurable positive mental health and quality of life outcomes; at discharge:
 - o an estimated 50% people had eating disorder symptom scores out of the range of a clinical diagnosis, and
 - o an estimated 50% of people had moved from having very poor mental health related quality of life to a level similar to those in the general population.
- Maintenance of the gains from Wandi Nerida presented challenges post-discharge;
 - o findings support end-of-care transition to Day or similar programs to extend improvements.
- Over 90% participants endorsed satisfaction with the quality of care overall;
 - o and similar numbers endorsed the individual therapy components at Wandi Nerida.
- Over 90% carers endorsed satisfaction with their involvement with Wandi Nerida;
 - o and similar numbers endorsed improvement in the relationship with their loved one because of Wandi Nerida.
- Wandi Nerida staff rated the program very favourably with a particularly high level of mutual care and respect;
 - o Average staff median ratings were over 70% for all aspects of care.
- Staff with Lived Experience expertise perceived they were highly valued and their expertise well utilised.

Recommendations

- Program improvements to provide greater levels of support for residents after discharge to maintain improvements, e.g., access to a step-down care facility.
- Extend staff training and supervision in more challenging areas such as self-harm and the unique features of the Wandi Nerida model of care.
- Future evaluations to embed Aboriginal and Torres Strait Islander mental health workers in both the clinical and research settings.
- Consideration of shuttle services for access to other services and offsite activities e.g., eating at restaurants, as residents found the location and distance from transport hubs limiting.

Lay Summary

The opening of the Wandí Nerida Residential Care facility in 2021 was warmly welcomed by people with Lived Experience of an eating disorder. It provided for the first time an alternative to hospital based inpatient programs anywhere in Australia. It uses the B-FREEDT Model of Care which is based on principles of recovery orientated care and respect. It was built in a tranquil rural setting which facilitates the use of horticulture and equine therapies to enhance a person-centred approach and it embodies a positive regard for the wisdom of Lived Experience health care providers.

Over the past two years researchers at Western Sydney University have led an evaluation of the clinical outcomes and treatment experiences of Wandí Nerida residents and their loved ones and the perspectives of staff. The research aimed to find out if the Wandí Nerida treatment program was effective in working with people with eating disorders to have improved mental and physical health, and to aid realisation of their life's potential. We also aimed to explore the experiences of individuals undergoing treatment, their loved ones, and lived experience service providers, and contrast outcomes with another health care provider in Australia.

The research used extensive online surveys of peoples' self-reported mental and physical health status and wellbeing. Carers of individuals receiving treatment and staff were also asked to complete an online survey. The survey information was extended and explored with detailed interviews. The vast majority (92%) of Wandí Nerida residents present participated in the research. Most had anorexia nervosa with many years of illness and many previous treatment experiences.

The results found there were meaningful and measurable improvements in eating disorder and other psychological symptoms and in mental health related quality of life as well as physical health statuses. Improvements were similar to an alternate non-residential program, but people at Wandí Nerida were more unwell and some needed a longer time until discharge.

The residents and their loved ones strongly endorsed the treatment at Wandí and rated all aspects of the program highly. Participants described residential treatment as being like a "Hail Mary" or "last ditch" attempt at holding onto hope for recovery and finding a life beyond the eating disorder. Carers similarly described Wandí as a relief and source of hope for recovery for their loved one. In reflecting on their residential treatment experience, participants emphasised that "recovery takes a village". Participants stressed the value and importance of collaborative care and the homeliness at Wandí Nerida. Participants and their carers did however identify challenges at discharge, and many struggled to find adequate ongoing care. The staff at Wandí Nerida were also very positive about the program. Those with Lived Experience expertise felt highly valued by residents and other staff and that there was a high level of the use of their expertise in the program.

The results of this first evaluation show that Wandí Nerida was endorsed as an effective, person-centred new approach to care in Australia. We anticipate such programs employing similar models of care will become more accessible to all Australians.

OUTCOMES

- ✓ an estimated 50% people had eating disorder symptom scores out of the range of a clinical diagnosis
- ✓ 90% participants endorsed satisfaction with the quality of care overall
- ✓ 90% carers endorsed improvement in the relationship with their loved one
- ✓ it was incredibly empowering (resident)
- ✓ the best experience we have had.. (parent)

2. INTRODUCTION AND AIMS

Eating disorders (EDs) are common mental health problems which present a high level of burden and cost to people of all sociodemographic backgrounds. Whilst there has been increased knowledge regarding ‘treatments that work’ large gaps remain in people accessing these and engaging in care. The Department of Health and Aged Care has instigated important initiatives to improve access to Medicare funded services and the Federal Government has invested in residential care facilities across Australia to improve access to more intensive care and support for those who need it (Hay et al., 2023). This is in line with the evidence that provision of treatment options in the least restrictive environments that purposively employ Lived Experience staff are preferred by people living with an eating disorder, and hence are likely to lead to greater engagement and better outcomes for all (Kemp et al., 2020).

Consumers have long desired a residential eating disorder program in Australia. In the past, Australians who have eating disorders, and who were in a financial position to be able to do so, travelled to the United States to access the Carolyn Costin Monte Nido residential programs. People who failed to get better in the then existing Australian programs have recovered in these residential programs. However, the ability to travel to the U.S. is inaccessible to most people across Australia. Alternative models of care that incorporate a recovery approach and harness the power of lived experience were urgently needed by the eating disorder community. While many people with severe and enduring eating disorders are often labelled as “treatment resistant” it is more probable that this group of people have not been able to access recovery-oriented treatment that meets their needs in a home-like natural and calming environment—treatment that focuses on skill development, step-up and step-down approaches, and one that harnesses the value of the lived experience.

The research evidence base for the use of residential care for people with eating disorders is, however, very weak and prior to this evaluation there was none in Australia (Peckmezian & Paxton, 2020). In this context we are cognizant of the importance of this clinical evaluation of the first residential facility for the treatment of eating disorders in Australia. Our research utilises a participatory principles approach to ensure the voices of people with lived experience are prominent in all aspects of the study.

Opened in 2021, Wandí Nerida is the first residential facility for the treatment of EDs in Australia. Based in Mooloolah Valley on the Sunshine Coast, the purpose-built facility is staffed by a multidisciplinary team who provide 24/7 residential care and support for up to 13 patients in a homelike environment. Wandí Nerida employs the Butterfly Foundation Residential Eating Disorder Treatment (B-FREEDT) Model of Care[®]. This model provides a six-phase treatment structure (outlined in Appendix A) based on the work of Carolyn Costin (Brewerton & Costin, 2011a-b). The B-FREEDT Model of Care[®] is based on the philosophy that each individual presents for treatment with both a “healthy self” and a “eating disorder self”. The goal of treatment is to strengthen the “healthy self” and reintegrate the “eating disorder self” by acknowledging the function/s that the disorder has served (Costin & Grabb, 2017).

For each participant holistic interdisciplinary treatment plans are created following a comprehensive multidisciplinary assessment. These plans are developed in collaboration with them to meet their individual needs and goals. Treatment is designed around three meals and three snacks per day, with most treatment occurring in groups with all patients. Psychological interventions are delivered by clinical and registered psychologists in group and individual formats. Patients also engage in medical and dietetic interventions. Activities that improve general functioning and quality of life, like gentle movement and exercise, are also included in the program as a part of a holistic recovery-based approach. Length of stay varied depending on patient needs and their response to treatment. The

minimum stay to complete the full treatment program is eight weeks. See Appendix B for full outline of admission criterion.

Evaluation Aims

The aims of this clinical evaluation of Wandi Nerida—the first residential facility for the treatment of EDs in Australia, were to:

1. investigate whether this residential ED treatment program is effective at reducing EDs and other mental health symptoms and improving quality of life and ability to engage in everyday activities; and
2. explore the experiences of individuals undergoing treatment at Wandi Nerida, as well as the experiences of their carers and health care providers, including Lived Experience service providers.

3. RESEARCH DESIGN AND METHODOLOGY

The evaluation was conducted simultaneously over a 24-month period. The first 6-months of the evaluation was a development phase where quality assurance outcome evaluation of residents' outcomes was embedded in Wandi Nerida and the Queensland Health Day program (the 'Control' group) facilitated by the TrEAT survey (see Appendix C). Following this and the main evaluation outcome ethics approval a comprehensive evaluation was conducted employing a mixed-method triangulation design, i.e. both a self-report survey followed by in-depth interviews of participants (residents of Wandi Nerida) their loved ones and staff. Eleven residents of Wandi Nerida and eleven carers of a person seeking treatment at Wandi Nerida participated in a semi-structured interview. For carers this was conducted following the discharge of their loved one from Wandi. Information on survey questionnaires and Interview schedules are provided in Appendix D and E.

Development phase

In the first six months of the program processes for data collection were established, and ethics approvals obtained. Procedures were also put in place to ensure adequate participation in the initial and follow-up surveys and interviews.

In a paper under review (see Section 8) the development of the first such centre for eating disorders in Australia is described along with features that were adopted and adapted from existing international programs. Therapist-participant dialogues are presented in the paper to highlight important aspects of the model of care. Preliminary outcomes are provided for participants admitted in the first six months of service delivery. In this period, improvements were observed in eating disorder-related symptoms and impairment from pre- to post-treatment. Finally, reflections on the challenges of establishing a new treatment service are presented, including in the context of the COVID-19 pandemic.

4. MAIN OUTCOMES: LONGITUDINAL SURVEY OUTCOMES

Resident and their carers' recruitment and participation in the research

Between January 1 2022 and August 1 2023, 76 participants were admitted to Wandí Nerida. Five had a repeat admission. Treatment attrition was low, with only 14 (18%) leaving the service for which the most common reason (9/14; 64%) was to take a negotiated and agreed discharge earlier than planned. Other reasons included an early discharge that for medical needs or at the resident's preference.

Seventy residents (92%) consented to participate in this evaluation. Their and their carers' recruitment and participation rates at key points in the research are shown in Figures 4.1 and 4.2. For those with a repeat admission data from the first admission only is presented.

Each of the residents who participated in this evaluation consented for the research team to analyse their de-identified clinical data (as relevant to the study aims) and to complete a self-reported online survey. This was administered longitudinally over time as per Figures 4.1 and 4.2. The survey consisted of closed-ended questions that included demographic information and validated measures of eating disorder symptoms, other mental health symptoms, quality of life, and treatment experiences of care (See Appendix D for the survey questionnaires). Further open-ended free-text response questions were administered alongside the validated quantitative measures in the longitudinal survey administered at baseline, mid-treatment, end-treatment, and three- and six-month follow ups (see Figure 4.1). These open-ended questions were designed to gain insight into participants' hopes for the program at baseline, and to gain feedback regarding the aspects of the program that were perceived to be "helpful" and/or "unhelpful" as the program progressed.

A self-reported longitudinal survey was completed by carers to evaluate their perceptions of treatment experiences and outcomes for their loved one (see Figure 4.2).

Figure 4.1: Wandí Nerida Resident Participant Recruitment

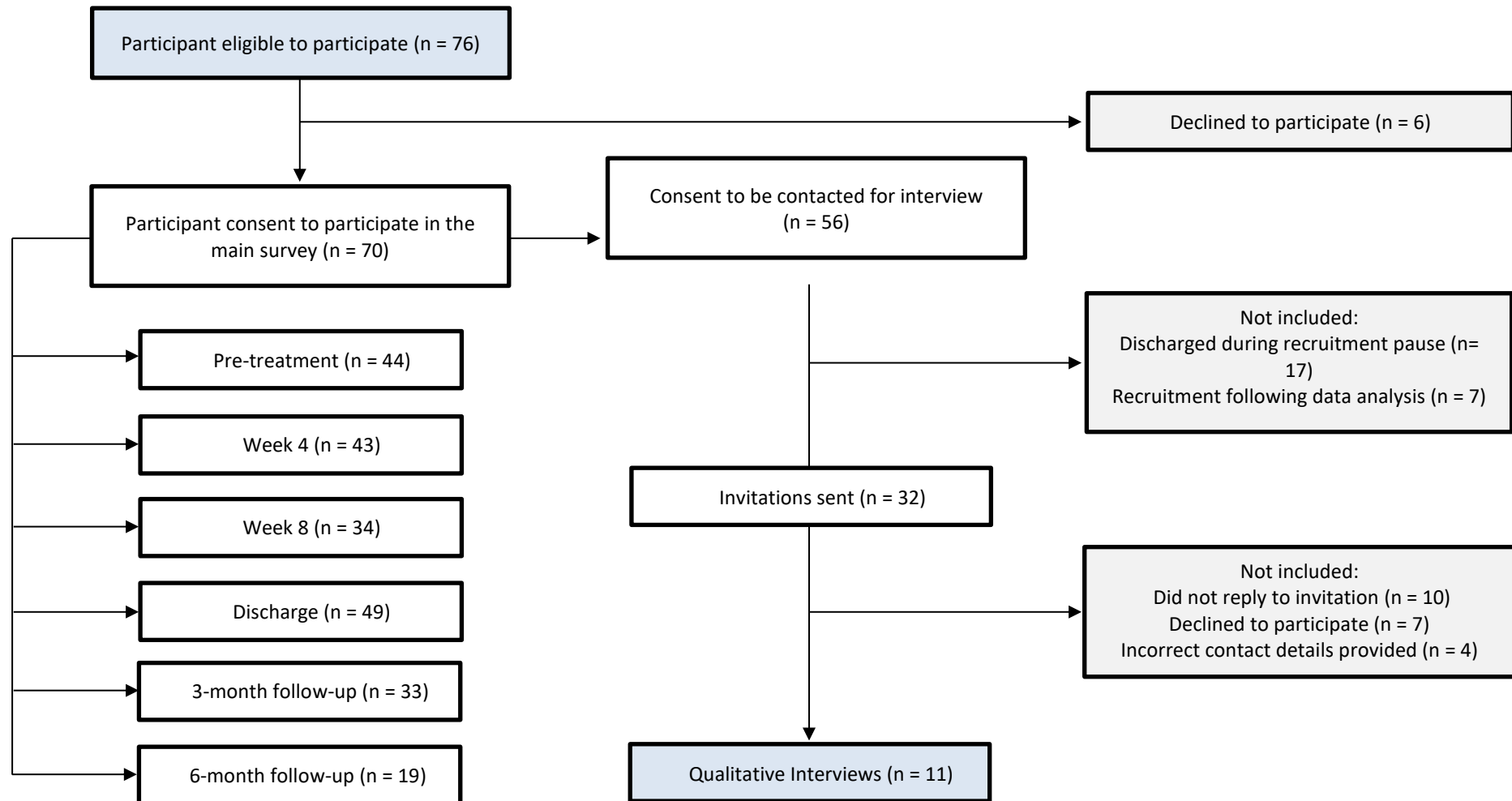
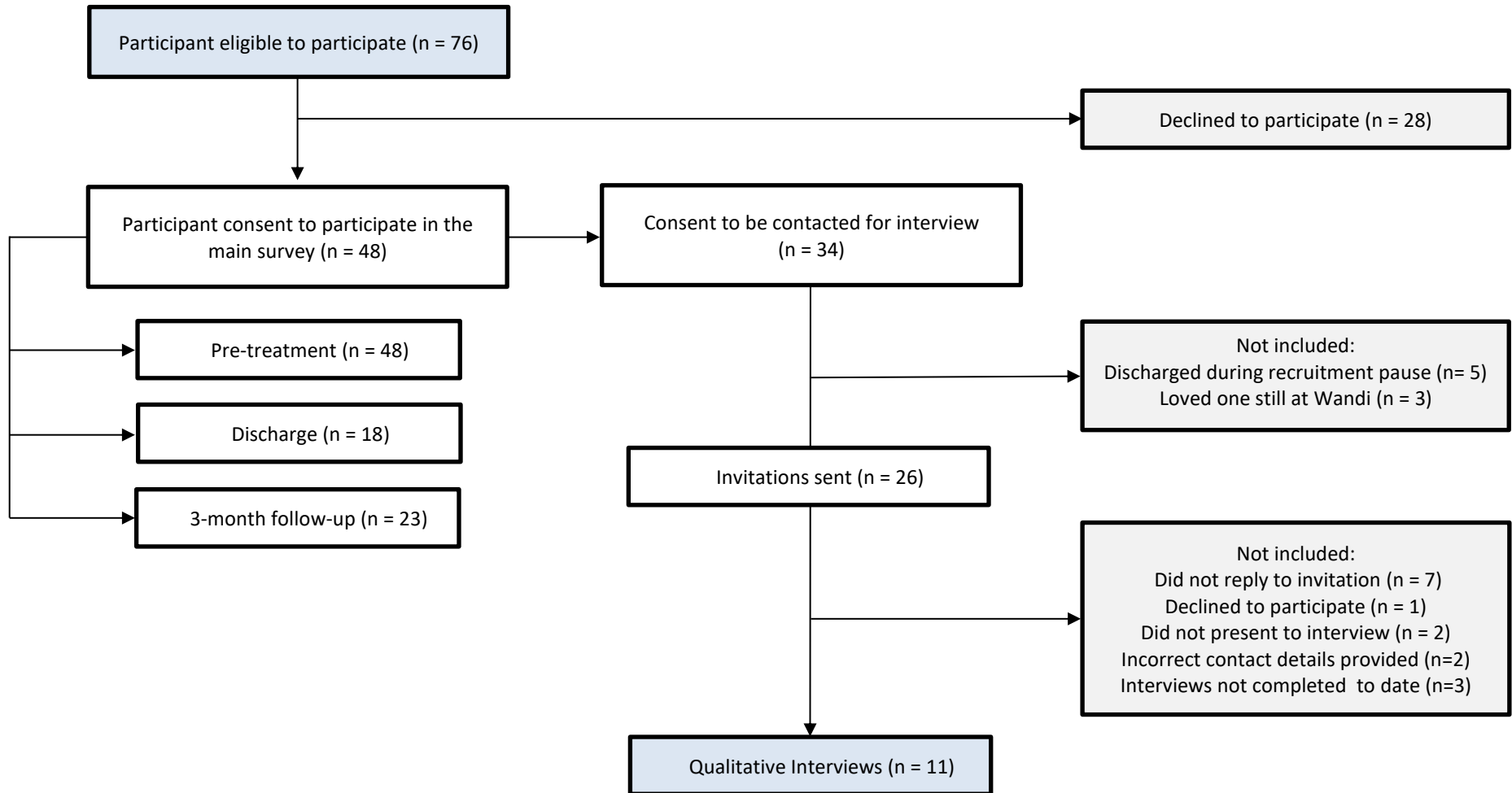


Figure 4.2: Parent/Carer Participant Recruitment



Baseline participant descriptors

The socio-demographic features and eating disorder health histories of Wandí Nerida residents who participated in the research are shown in Table 4.1. The vast majority were women born in Australasia, and the most common employment status was student (37.2%). The average age of residents was 26 years (SD = 6 years).

Almost three quarters of the residents had experienced their eating disorder for more than 3 years and have had previous treatment (85.9%). Most had a diagnosis of anorexia nervosa.

Table 4.1 Baseline features of participants at Wandí Nerida

	<i>N</i>	%
Sex		
Female	69	88.5
Male	0	0
Prefer Not to Answer	9	11.5
Country of Birth		
Australia/New Zealand	64	82.1
Other	4	5.2
Prefer Not to Answer	10	12.8
Employment		
Not Currently in paid employment	12	15.4
Part-time employment	9	11.5
Full-time employment	10	12.8
Student	29	37.2
Unable to work due to disability	5	6.4
Prefer Not to Answer	13	16.7
Nationality/Ethnicity		
Australian	40	51.2
Caucasian/European	8	10.3
Prefer not to answer	30	38.5
Marital Status		
Married/De-facto	8	11.8
Separated/Divorced/Never Married	60	88.2
Missing	10	0
ED Duration for >3 Year?		
Yes	58	74.4
No/Wish Not to Answer	20	25.6
Previous Treatment for ED?		
Yes	67	85.9
No/Wish Not to Answer	11	14.1
Clinical ED Diagnosis		
AN- Restrictive	53	64.6
AN – Binge Purge	18	22.0
BN/BED/OSFED	10	12.2

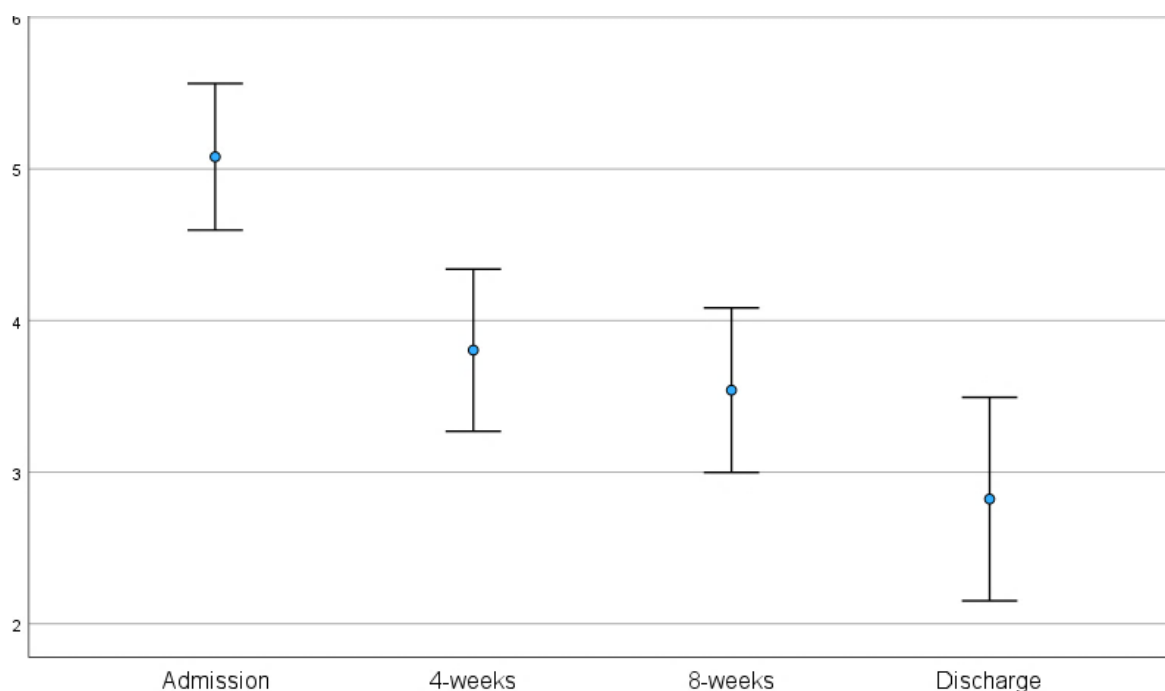
Outcomes: Eating disorder and psychological health status

The primary outcomes are the core targets as presented in the Request for Proposal, namely, (i) eating disorder symptoms including body image perception and body mass index (BMI; kg/m²); (ii) general mental and physical health and comorbidities; and (iii) health-related quality of life (HRQoL) and role impairment.

There were improvements in all main eating disorder symptoms and mental health outcomes with small to large effect sizes as shown in the Table in Appendix G. The largest improvements were in eating disorder symptoms (as reflected in the global score of the Eating Disorder Examination questionnaire (EDE-Q – see Figure 4.3) with an over 60% reduction in median scores and mental health related quality of life. The latter had a very large effect size, and over 50% of people moved from having very poor mental health related quality of life to a level similar to that in the general population. Improvements occurred incrementally over time but the largest improvements in quality of life were seen after 8-weeks at Wandí Nerida.

There were sustained and progressive improvements week by week for body weight at the Wandí Nerida program as shown in Figure 4.4. The figure shows the weight of the participants from admission and weekly weighs for 17 weeks. Only up to 17 weeks is shown, as after this time 75% of the residents had completed their stay at Wandí Nerida and numbers were too small for statistical mapping.

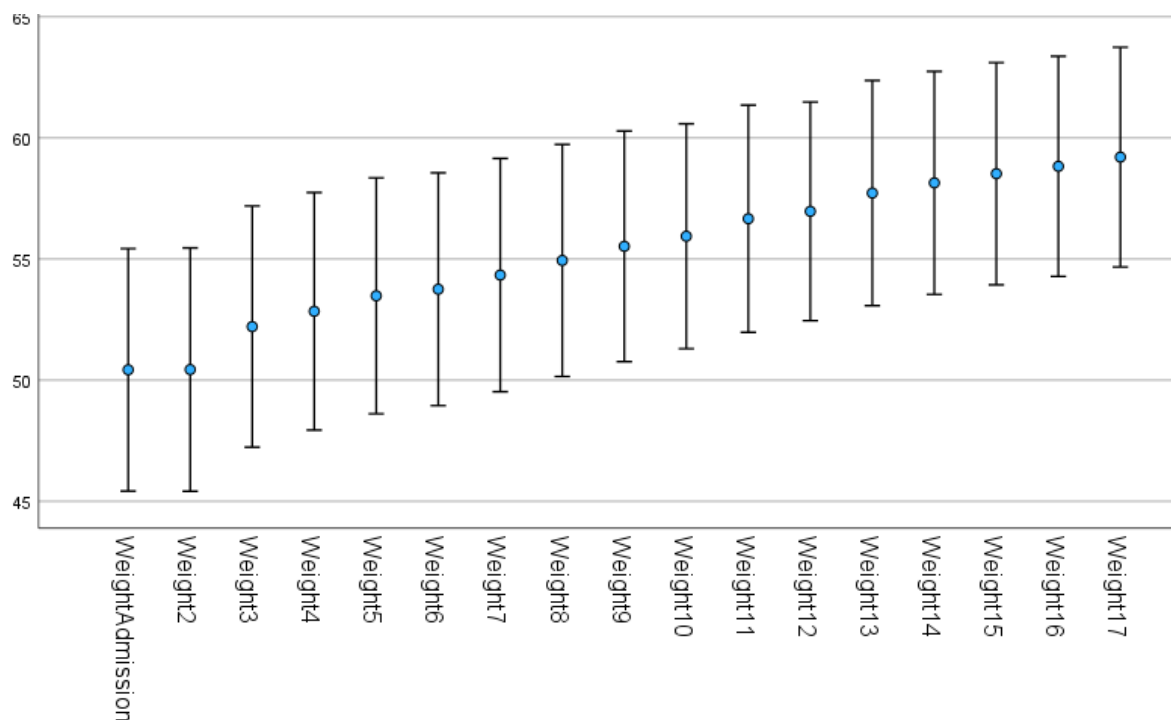
Figure 4.3. Global eating disorder symptom (EDE-Q) scores over time



NOTE: Bars represent 95% confidence intervals of the mean EDE-Q scores represented by diamonds. EDE-Q scores range is 0 to 6; in this figure the median score at discharge is less than 3 which is in the range of someone no longer meeting diagnostic criteria for an eating disorder.

There were no significant differences in outcomes between residents at Wandi and those at the Queensland Health Day program for eating disorder symptoms (global EDE-Q scores) for up to 8-weeks of treatment in either program. Comparisons over time with the Queensland Health Day program favoured those at Wandi Nerida. This was likely due to the longer length of stay which allowed for a more sustained recovery journey. The Day program had a length of stay of no longer than 8 weeks and the median length of stay at Wandi Nerida was 10 weeks with interquartile (between and 25% and 75% of participants) range of 7 to 17 weeks. However, people in the Day Program also started treatment at a median BMI which was close to that of the residents at 8-weeks of the Wandi Nerida program. *This supports the effectiveness of the Wandi Nerida program and that this would be enhanced by follow-up Day or similar program care to not only maintain but extend improvements.*

Figure 4.4 Change in residents' weekly average body weight (kg) over time to 17 weeks of the program.



NOTE: Bars represent 95% confidence intervals of the mean scores of weight (kg) represented by diamonds.

Participants' experiences and perceptions of therapy and care

Residents and their carers each completed the "Your experiences Survey" (YES). This is a 43-item closed response questionnaire that assesses participants' satisfaction with different aspects of treatment, including specific therapeutic components, communication with staff, involvement of family/carers, and overall impact on wellbeing. Completing this questionnaire aided the understanding of the participants' and their carers' perceptions of the effectiveness of the treatment service and whether they found some elements more helpful than others. The reliability of this survey has been investigated and documented by the Australian Mental Health Outcomes and Classification Network (2013)

As shown on Tables 4.1, 4.2 and 4.3 the study’s findings reveal that participants particularly valued and reported positive experiences of treatment components such as meal support, lived experience staff, individual therapy, group therapy, creative therapies, family sessions, exercise therapy, and equine therapy. Permaculture and massage therapies were not as highly rated. However it should be noted that the provision of massage therapy was inconsistently available for participants since the opening of Wandi. In addition, participants reported feeling comfortable, respected, and safe during their time at Wandi, and the facilities met all their needs. However, some participants reported difficulties with staff at times as well as the implementation of some treatment non-negotiables.

Table 4.1 Participant’s experiences and perceptions of care at Wandi Nerida

Thinking about the care you have received from this service within the last 3 months or less, what was your experience in the following areas:	n	mean	SD	Median	IQR
You felt comfortable using this service	45	4.22	0.97	5.00	4-5
Staff showed respect for how you were feeling	45	4.42	0.72	5.00	4-5
You felt safe using this service	45	4.53	0.69	5.00	4-5
Your privacy was respected	45	4.29	0.99	4.00	4-5
Staff were positive for your future	45	4.60	0.72	5.00	4-5
Your individuality and values were respected (such as your culture, faith or gender identity, etc.)	43	4.70	0.67	5.00	5-5
Staff made an effort to speak with you when you wanted	45	4.42	0.75	5.00	4-5
You had access to the staff involved in your support or case when you needed	45	4.18	0.75	4.00	4-5
You would make a complaint to this service if you had a concern about your support or care	41	4.68	1.29	4.00	2-5
You had opportunities for your family and friends to be involved in your support or care if you wanted	43	4.28	1.16	5.00	4-5
Your opinions about the involvement of family or friends in your support or care were respected	45	4.38	1.03	5.00	4-5
The facilities and environment met your needs (such as cleanliness, private space, toilets, access to facilities to make a drink, meeting rooms, etc.)	44	4.50	0.88	5.00	4-5
You had opportunities to help improve the service if you wanted such as attending meetings to give your opinions or views)	45	4.31	0.90	5.00	4-5
You were listened to in all aspects of your support or care	45	3.93	1.12	4.00	3-5
Staff worked as a team in your support or care (for example, sharing information and attending meetings with you)	45	4.27	0.96	5.00	4-5
You had opportunities to discuss your support or care needs with staff	45	4.36	0.83	5.00	4-5
The support care available met your needs	45	4.11	0.91	4.00	4-5
Staff talked with you about your mental health in a way that was useful	45	4.31	0.95	5.00	4-5
Staff talked with you about your physical health in a way that was useful	45	4.02	1.10	4.00	3-5

Note: Scores ranged from 0 to 5, where 0 is the least satisfied and 5 is the most satisfied.

Table 4.2. Participant’s experiences and perceptions of individual therapy components

Thinking about the care you have received from this service within the last 3 months or less, what was your experience in the following areas:	n	mean	SD	Median	IQR
Individual Therapy	46	4.46	1.05	5.00	4-5
Group Therapy	46	4.02	0.88	4.00	4-5
Equine Assisted Therapy	46	3.83	1.22	4.00	3-5
Permaculture/Ecotherapy/Gardening/Nature Walks	46	3.72	1.17	3.00	3-5
Creative Therapies (e.g., Art/Drama/Music)	46	3.98	1.13	4.00	3-5
Meal Support	46	4.41	0.88	5.00	4-5
Lived Experience Staff	46	5.00	0.00	5.00	5-5
Family Sessions	46	4.17	1.07	4.00	4-5
Yoga	6	4.50	0.84	5.00	3.75-5
Exercise Therapy	6	4.17	0.98	4.50	3-5
Somatic Massage	4	3.00	1.63	3.00	1.5-4.5
Other	12	3.00	1.19	3.00	3-5

Note: Scores ranged from 0 to 5, where 0 is the least satisfied and 5 is the most satisfied

Table 4.3 Participants’ experiences and perceptions of treatment access and choices

Thinking about the care you have received from this service within the last 3 months or less, what was your experience in the following areas:	n	mean	SD	Median	IQR
Information available to you about this service (such as how the service works, what to expect, how to make a complaint, upcoming changes that may affect you, etc.)	45	3.76	1.13	4.00	3-5
Explanation of your rights and responsibilities	45	3.62	1.19	4.00	3-5
Access to peer support (such as information about peer workers, referral to consumer programs, advocates etc.).	42	3.88	1.31	4.00	3- 5
Convenience of the location of the service for you (such as access to parking or transport, distance from your home, etc.).	43	2.21	1.24	2.00	1-5
Development of a discharge plan for the transition between residential treatment and the community or an inpatient service.	45	3.57	1.27	3.00	2.25-5
Provision of a rationale for program non-negotiables	43	3.51	1.37	4.00	2-4
Consistent implementation of program non-negotiables	42	3.31	1.35	3.50	2-4.25
Fair non-negotiables	45	3.44	1.36	4.00	2-5
Satisfactory non-negotiables	45	3.47	1.36	4.00	2-5
Development of a care plan with you that considered all of your support or care needs (such as accommodation, advocacy, employment, health etc.)	44	3.57	1.27	3.00	2-5
Provision with choices regarding non-negotiables (e.g., choice about how full nutrition is achieved as per the agreed meal plan)	45	3.53	1.12	4.00	3.-4.5

Note: Scores ranged from 0 to 5, where 0 is the least satisfied and 5 is the most satisfied

In response to the four open ended (free text response) questions (see Box 4.1), over the course of their admission, 57 (73%) participants wrote responses at pre-treatment, 43 (55%) at week 4 and 49 (63%) at discharge. These questions were designed to gain insight into participants’ and carers’ hopes

for the program at baseline, and to gain feedback regarding the aspects of the program that were perceived as being “helpful” and/or “unhelpful” as the program progressed.

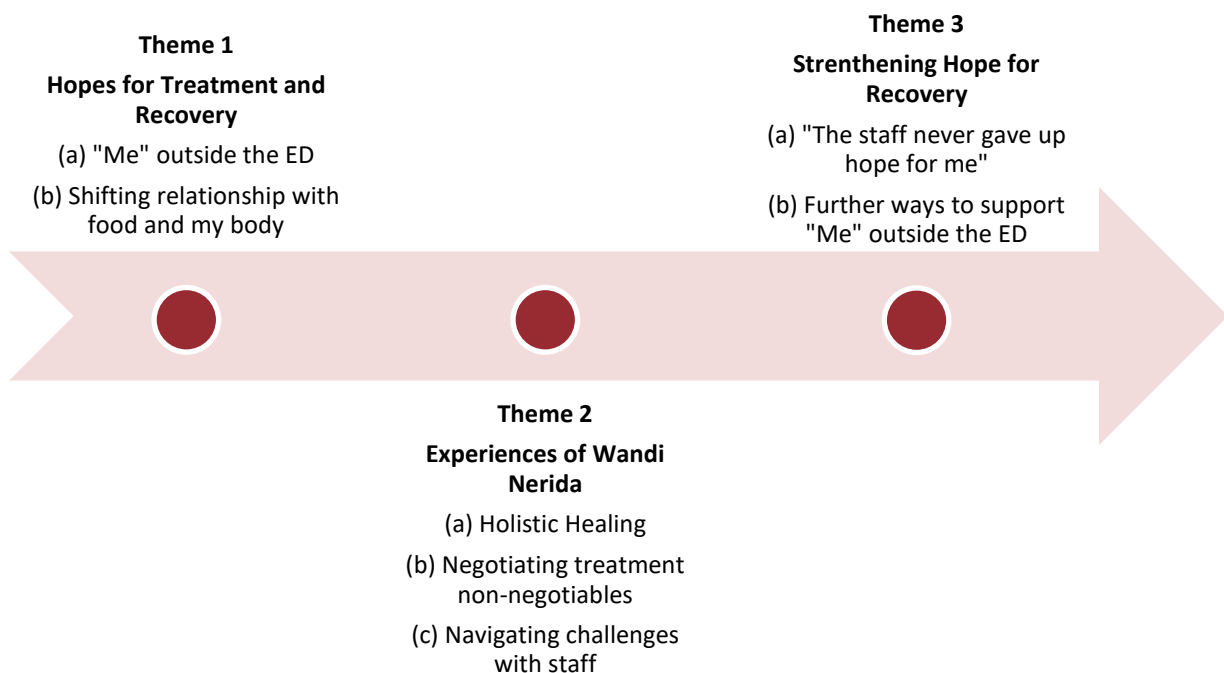
BOX 4.1 The four participant survey questions with free text response

1. *What has been most helpful? Has there been anything that has been helpful about this program? If so, please explain what was helpful?*
2. *What has been unhelpful about this program? If any? If so, please explain what was helpful and why?*
3. *Based on your experience, what would you have liked more of in treatment? Or what was missing in the treatment program that could have been there?*
4. *Based on what you know now, what would you tell person who is about to start Wandí Nerida?*

In a thematic analysis of the free text survey responses, three main themes and 7 subthemes were generated. These are shown in Figure 4.5. Overall, participants expressed *a strong hope for recovery* from the ED and a desire to shift their current relationship with food and their body, thus, reconnecting with their healthy self. This hope strengthened over the admission as they navigated challenges and worked towards living a life without the eating disorder.

Participants spoke of their *varied experiences* at Wandí Nerida, expressing their thankfulness for the holistic approach to their treatment, including lived experience staff, meal therapy, and nature therapy. Particularly helpful for participants was perceived staff (1) understanding of their challenges and (2) standing with them in hope for recovery, for example: *“the staff never gave up hope for me”*. Participants expressed a desire for *more individual therapy* sessions, as well as more involvement with their dietician. However, some participants reported difficulties with the treatment non-negotiables, particularly when these were perceived to be “rules”, which they felt did not apply to them. Further, there were some tensions with individual staff reported, with participants desiring these staff to be more understanding of their distress and struggles.

Figure 4.5 Thematic Representation of lived experiences at Wandí Nerida.



Carers' experiences of therapy and care for their loved one

Most carers who responded to the survey were women, spoke English at home, were caring for a child and had cared for their loved one for at least 2 years (see Table 4.4). Ten carers of a possible 48 gave information on their perceptions of treatment for their loved one.

Table 4.4. Participant carers at Wandí Nerida

	<i>N</i>	<i>%</i>
Sex		
Female	25	52.1
Male	6	12.5
Prefer Not to Answer	17	35.4
Language Spoken at Home		
English	31	64.6
Prefer Not to Answer	17	35.4
Carer of Loved One With Duration for >2 Years?		
Yes	29	60.4
No/Wish Not to Answer	19	39.6
Relationship to Person with ED		
Child (son or daughter including step and in-laws)	29	60.4
Other/Wish Not to Answer	19	39.6

As shown in Tables 4.5, 4.6 and 4.7 carers similarly reported very positive experiences. They endorsed an understanding of what to expect from Wandí Nerida, were given a thorough explanation of legal issues, understood rights and responsibilities, had their values and beliefs taken into consideration, their opinions were respected, and were given opportunities to discuss their loved one. They did comment they were not given a brochure from Wandí Nerida of expectations or explanation on how to make a complaint. They were provided information on carer support which included an after-hours number and additional support meetings.

The respondents noted their relationship with their loved one improved, as did their confidence in their ability and their skills to care for them. They showed improvements in their overall wellbeing and hopefulness for future. They found value in family education groups, family therapy and shared meals.

Table 4.5 Carers' experiences at Wandjina

As a carer with a family member, partner or friend who had contact with this mental health service in the last three months, how often did the following occur?	n	mean	SD	Median	IQR
You understood what you could expect from the mental health service for yourself and your family member, partner or friend	10	3.90	0.74	4.00	3-4.25
You were given an explanation of any legal issues that might affect your family member, partner or friend	10	2.80	1.48	2.50	1.75-4.25
You understood your rights and responsibilities	10	3.90	1.29	3.00	3-5
Your personal values, beliefs and circumstances were taken into consideration	10	4.20	1.40	4.00	3.5-5.25
You were able to obtain cultural or language support (such as an interpreter) when you needed	10	5.70	0.48	6.00	5-6
You were given the opportunity to provide relevant information about your family member, partner or friend	10	4.00	1.49	4.00	3.5-5
You were identified as a carer of your family member, partner or friend	10	4.40	0.97	5.00	4-5
Your opinion as a carer was respected	10	4.30	0.95	4.50	4-5
You were involved in decisions affecting your family member, partner or friend	10	3.40	1.27	3.50	2-4
You were given opportunities to discuss the care, treatment and recovery of your family member, partner or friend (even, if for reasons of confidentiality, you could not be told specific information)	10	4.00	1.06	3.50	2-4
You were involved in planning for the ongoing care, treatment, and recovery of your family member, partner, or friend	10	3.30	1.06	3.50	2-4
You were given the opportunity to enhance your abilities as a carer	10	3.70	0.95	4.00	3-4.25
Staff conveyed hope for the recovery of your family member, partner or friend	10	4.40	0.84	4.00	4-5
You were given information about services and strategies available if your family member, partner or friend became unwell again	10	3.70	1.34	4.00	2-5
Staff worked in a way that supported your relationship with your family member, partner or friend	10	4.40	1.27	5.00	3-5
You had opportunities to communicate confidentially with the treating clinician if you needed (such as by phone, email or in person)	10	4.00	1.25	4.50	2.75-5

Note: scores ranged 0 to 6 where 0 is the least satisfied and 6 is the most satisfied

Table 4.6 Provision of information to carers

As a carer with a family member, partner or friend who had contact with Wandí Nerida, in the last three months have you been given the following?	n	mean	SD	Median	IQR
A brochure or other material about your rights and responsibilities	10	2.00	0.67	2.00	1.75-2.25
An explanation of how to make a compliment or complaint about the mental health service	10	2.10	0.57	2.00	2-2.25
Information about carer support services (such as local groups, carer consultants, counsellors)	10	2.10	0.99	2.00	1-3
Information on opportunities to participate in improving this mental health service	10	1.80	0.79	2.00	1-2.25
A number you could call after hours for the service	10	1.80	0.92	1.50	1-3
Information about taking a support person to meetings or hearings if you wished	10	2.00	0.67	2.00	1.75-2.25
Staff worked in a way that supported your relationship with your family member, partner or friend	10	4.40	1.27	5.00	3-5

As a result of your experience with this mental health service in the last three months, has your life changed in the following areas?	n	mean	SD	Median	IQR
Your relationship with the person for whom you care	10	4.90	0.99	5.00	4-6
Your confidence in your ability to support the person for whom you care	10	4.30	0.68	4.00	4-5
Your skills to support the person for whom you care	10	4.50	0.71	5.00	4-5
Your hopefulness for your future	10	4.40	0.97	5.00	4-5
Your overall wellbeing	10	3.60	1.08	4.00	2.75-4.25

Note: scores ranged 0 to 6 where 0 is the least satisfied and 6 is the most satisfied

Table 4.7 Carers' perceptions of components of the therapeutic program

How would you rate your experience as a carer with each of the following components of treatment at Wandí Nerida?	n	mean	SD	Median	IQR
Family education groups	10	3.70	1.16	4.00	3-4.25
Shared meals with your family member, partner or friend	10	4.70	1.25	4.50	3.75-6
Family therapy sessions (with your family member, partner or friend and their treating clinician)	10	3.90	1.60	4.00	2.75-5.25
Your hopefulness for your future	10	4.40	0.97	5.00	4-5
Overall, how would you rate your experience as a carer with Wandí Nerida over the last 3 months?	10	3.40	0.96	3.50	2.75-4

Note: scores ranged 0 to 6 where 0 is the least satisfied and 6 is the most satisfied

The 23 carers who responded to the survey at 3-months follow-up reported ongoing moderate levels of burden and stress with moderate levels of stress (mean score on the K-10 psychological distress (Andrews & Slade, 2001) scale were in the moderate range of 18.4 (SD 6.7)

5. MAIN OUTCOMES: PARTICIPANT AND CARER INTERVIEWS

Qualitative Methods

Measures

Patients' and carers' experiences, perceptions and satisfaction with care were explored through semi-structured interviews within a few weeks of discharge, as well as through the use of the open-ended questions described above accompanying validated measures at baseline, mid-treatment, end-treatment, and three- and six-month follow up. Interview schedules were developed by the research team in consultation with a lived experience advisory group and were informed by the practice of narrative therapy (McLeod, 1997; Payne, 2000; White, 1995; 2007; White & Epston, 1990). Thus, interview questions were designed to scaffold between participant experience, meaning, identity, and identity negotiations. A copy of these semi-structured interview questions can be found in Appendix E.

Participatory methods

A lived experience advisory panel, consisting of five to six lived experience advisors, with two to three representatives from each of the three participant groups provided consultation at each phase of the clinical elevation. For example, this panel provided feedback during the design of participant interview schedules and participant materials, as well as during data collection, analysis and write up. Participants were also provided the opportunity to review their interview transcript, to provide comment, including removal of any parts of the transcript that they did not want included in the analysis. Consultation with individuals who belong to and/or represent the interests of people with EDs aided the interviewer in conducting research that was informed by the real-world knowledge and experiences, which in turn had the potential to translate into relevant and meaningful research findings.

Participants Interviews

Eleven experiencing persons with mean age of 28.6 years (SD = 3.96; age range 24-36 years) participated in a semi-structured 60–80-minute interview following discharge from Wandri (6 completed their planned stay; 5 discharged early or against medical advice; 3 completed multiple admissions) from WN. Interviews were transcribed verbatim by the interviewer and de-identified with each participant's chosen pseudonym and removal of further identifying information, including in consultation with participants through their review of their transcripts.

All the interviewed experiencing persons identified as being female, 81% identified as being Australian of Anglo European descent. Of those interviewed, 36.4% participants reported having attained a post-graduate university qualification, 36.4% reported having attained an undergraduate degree, 9% reported having a TAFE certificate, and a further 18.2% reported having completed high school. Based on clinical report data, all participants were diagnosed with anorexia nervosa (54% = restrictive subtype; 46% binge purge subtype). Mean illness duration from diagnosis was 11.4 years (SD = 5.40; range 7-19 years). Approximately half of those interviewed described themselves as being in recovery (54.5%), with the remaining participants describing themselves as having active ED symptoms (36.4%) or considering inpatient admission (18.2%).

Eleven parents or carers of a person seeking treatment at Wandri with mean age of 55.2 years (SD = 6.55) participated in a semi-structured 60–80-minute interview following the discharge of their loved one. All parent/carer participants identified as being female and born in Australia of Anglo European descent. Over half (54.5%) participants reported having attained a post-graduate university qualification, 27% reported having a certificate 4-5, and a further 18% reported having completed high school. Of the carers interviewed, 54.5% reported being employed full-time, 18.2% reporting being

self-employed, with a further 18.2 being employed part time. Of the carers interviewed, 72.7% reported being partnered or married, with 54.5% reporting that their loved one lived in the family home at the time of the interview. Self-reported illness duration of their loved one ranged from 4 to 20 years (mean = 9.18, SD = 4.94).

Qualitative findings: “It takes a village”

In exploring participants’ and carers’ experiences, perceptions, and satisfaction with care, over one thousand three hundred and twenty minutes (approximately 22 hours) of interviews were conducted and transcribed by the research team at WSU. These transcripts were thematically analysed by the researchers using a reflexive thematic approach (Braun & Clarke, 2019; 2021).

Five main themes were generated from the data and are reported with exemplar quotes. These themes are explored in narrative sequence following participants’ and their carers’ *Journeys to Wandí Nerida* (Theme 1), *Experiences of Wandí Nerida* (Theme 2 and 3), the *Transitions* associated with admission and discharge (Theme 4), and finally, interviewees’ *Hopes for the future of residential treatment* (Theme 5) are explored. These in-depth interviews extended the data analysis of participant treatment experiences reported from the larger sample in response to the closed-ended responses (for lived experience participants in Tables 4.1-4.3 and carers in Tables 4.5-4.7) and open-ended text responses (for participants as depicted in Figure 4.5) about treatment experiences from the longitudinal survey.

Across all interviews, the interviewees stressed the value and importance of collaborative care, communication and community. As one participant aptly summarised:

I think, eating disorders are not a thing that you can heal alone... Like, “it takes like it takes a small village to raise a child.” I think it's much the same with an eating disorder. It takes a small village and a community to like heal the person and to build up that trust to move to move forward. ... you can't do it by yourself. You can't work it out alone. You can't do it without people around you... it just doesn't work. —Mia, participant

This analysis focuses on the participant experiences of one aspect of this “village” that is, their care at Wandí.

Theme 1: Journeys to Wandí Nerida

1.1. How did you come to hear about Wandí Nerida?

Participants’ journeys to Wandí Nerida were unique and varied. With most participants’ and carers reporting complex and extensive treatment histories along the full continuum of ED care. Participant treatment histories were consistently punctuated by medical instability and hospital admission. While the majority of those participants and carers retrospectively acknowledged the necessity of medical inpatient interventions as part of their treatment journey, the restrictive treatment environment and biomedical focus of these treatment facilities was experienced as also restrictive at times with the reported effects including disqualifying the participant’s voice, individual identity, lived experience, personal values and understandings of the ED symptoms.

Within this broader context, participants and carers described comprehensively searching for treatments over a significant period of time, with their experiences highlighting a determination to find care to meet their needs: for example: *“I was going to find a way to get her to beat this” (Rose)*. As such, most participants and their carers reported having followed the journey of Wandí Nerida’s development long before it opened.

I heard about it [Wandi] when they first started building it. Because obviously I was looking all the time at programs. Googling, researching, trying to find these programs that would help us.
—Amy, parent

So, before the foundations were in place, I've had my eye on it [Wandi]. I told my psychologist, "If I still have an eating disorder by the time this place is built it would be good for me". And I did. —Daphanie, participant

Despite many participants and carers following the development journey of Wandi Nerida, most described holding on to the hope that they or their loved one would not need to access Wandi Nerida as a part of their treatment journey.

...when it opened, I was like, "Oh no, [Daughter] will be better by then. We won't ever need a service like that." So I knew about it. I never thought. I kind of thought it was a life saver, but I never thought we'd be able to access it—and we did! —Sonia, parent

I didn't really think Wandi would ever eventuate during my time in recovery, so I didn't really think too much of it... —Lily, participant

1.2. Wandi Nerida as a "Hail Mary"

When asked to share their stories of the eating disorder, participants and their families frequently reflected wide ranging impacts that the ED had on their lives, relationships, careers and sense of self. Participant and parent reflections alike were punctuated by themes of exhaustion, paralleled by the sense of having "had enough" of the ED and its impacts within the broader context of previous unsuccessful attempts at recovery.

Um, it kind of got to a point in my illness, ... , where I had just had enough. I was exhausted and I was just tired of missing out on life and family and just emotions. ... what other hope did I have? If nothing else had worked, this was something that I hadn't tried. —Hannah, participant

I didn't want to keep living the way I had been living. —Sarah, participant

It's been the most major medical problem in our family that we've ... had to deal with. ... the distress of watching her [daughter] being so unhappy, and the impact that it's had on her life and her quality of life and her functioning is terrible. Um, it's an impact on our mental health... just ongoing sort of anxiety and hypervigilance. —Nicole, parent

Within the context of extensive treatment histories, participants and their loved ones described admission to Wandi Nerida as a source of hope, described by one participant as a "Hail Mary", as a "different" treatment option that provided a sense of "relief", and the promise of life beyond the ED.

"[Wandi] it's kind of like a Hail Mary. It's like a last ditch. You feel like this no life after this. It seems that you've been in this so long that you can't imagine your life without it [the eating disorder]." —Daphanie, participant

Yeah, I'd pretty much say, she'd exhausted all treatment opportunities in [state capital city] and still had a really bad eating disorder at the end of it—prior to Wandi. —Nicole, parent

... things got to a point where I was really stuck and... umm... the treatment plan that my team had for me was counterproductive. I wasn't being listened ... I need to see something different... —Abigail, participant

There was no other facility that was going to help her... Thank God she got in! —Heather, parent

Theme 2: Participant Experiences of Wandí Nerida

When asked to describe their experience of Wandí Nerida, often the first thing participants would speak to was a feeling of safety and security. Participants' experiences clustered around the following themes: 1) treatment environment; 2) treatment approach; 3) experience of staff; 4) experience of the milieu; 5) connection and identity; and 6) motivation and identity. These themes highlight the complex and multifaceted nature of the lived experiences of residential treatment. What also arose within these themes was the inherent ideological dilemmas when balancing replicable standardised phase-based treatment protocols with the desire for person-centred and recovery-oriented care with the latter aligning particularly with participants' preferences for their treatment.

2.1. Treatment environment

Participants spoke of the treatment environment, commenting on the value of normality in the small things in the treatment environment. Such as the grounds, bathrooms, presentation of meals and warm environment. The value of normality in the small things was highlighted by participants particularly in the context of comparison to previous inpatient treatment experiences.

I didn't expect it to feel so homely straight away.—Lily, participant

... the chef would present the meals, making them look pretty... it wasn't hospital food. It was presented on normal plates. We use normal cutlery. Normal glasses. It was at a real table, not in a bed. We wore "normal" clothes, not hospital gowns.—Enolia, participant

Hands down best food in a facility. Yeah, it's one thing to not want to eat, but like to not want to eat and its shitty hospital food is another story. ... The food there was nice... like very healthy but not in a disordered sort of way.—Daphanie, participant

While many participants expressed a strong dislike of treatment non-negotiables (e.g., no coffee) and aspects of the treatment environment that they perceived as restrictive, they also reported experiencing the same environment as instrumental in creating a therapeutic space that allowed them to engage in treatment by removing barriers to treatment. Within this space, they emphasised the importance of the homely environment in contributing to the sense that they were a person rather than a patient. For example:

... something that I needed without realising, was the being away from just everything to focus solely on recovery. ... it was just liberating to be not a patient but a person... Being able to do normal everyday things and practice those things. Yeah, I guess it was just having a safe space. ... I expected it to be like hospital, but it wasn't, it was more like a home...—Hannah, participant

Participants also regularly reflected on the helpfulness of the integration of the natural environment into the Wandí experience in cultivating a sense of calmness and connection to self and others.

... the grounds and the setting—it's just beautiful. ... It's really calm.—Megan, participant

Yeah, and we used to do, as well, like we would lie outside on the grass under the trees and like, like we kind of sit together but we wouldn't talk about anything we just lie there.—Mia, participant

2.2. Treatment approach

When reflecting on the treatment approach participants rarely referred to a treatment modality or specific evidence-based interventions, but rather most participants spoke of treatment as being collaborative and non-punitive. The collaborative approach in combination with consistent and compassionately supported meal exposure were perceived as helpful, particularly in the context of previous treatment experiences that were perceived by some as being restrictive and punitive.

Wandi is both so different to other treatment options, but the foundation is the same. Like, it's the same psychoeducation groups and it's the same treatment model in terms of food and nutrition and restoration and that kind of stuff. But the thing that really set it apart, for me personally was the people and the non-punitive approach and I think that that's what made the difference. —Lily, participant

... it [Wandi] was different to what I expected.... it was incredibly empowering. —Bourke, participant

I think it was the personalized approach and it was seeing me as [Enolia] and not "a girl with anorexia". It was, you know, looking... talking to me about things other than my eating disorder. Doing things other than the eating disorder. ... Giving me an identity. —Enolia, participant

Participants with longer illness durations often reflected that it took time for them to adjust to the more collaborative treatment approach. When reflecting on the advice they would give to a person about to start at Wandí Nerida one participant commented: "It's very, very different and it's going to feel strange, and you might even feel inclined to push back against the support because it is so genuinely supportive" (Megan). Similarly, Lily and Enolia reflected:

... it was the first time I had been in treatment that I didn't feel like I was fighting my treatment team and that did take a lot to adjust too. I think, even the first 30-days I was very guarded and didn't want to talk to my treatment team.... But just, yeah, once I kind of allowed myself to accept that people were there to help me genuinely, ... that's when I noticed proper change happening. —Lily, participant

I felt very independent and that I was doing it on my terms, and it was aligning with my views, and I was a part of my own treatment team. —Enolia, participant

Participants also almost unanimously reflected on the value of meal supports and practical behavioural challenging through planned exposure tasks.

... one of the most helpful thing was just the consistent meal exposure and, the meal and snack outings where we really had to challenge ourselves. ... We were actually doing the thing. —Bourke, participant

... the fact that, like even two days after you got there [to Wandí] you got to go out for breakfast... that was wild. ... the last hospital admission I had was there for five weeks, and I had leave twice, and one of those times is to go a [medical procedure] at the hospital next door. —Abigail, participant

Making food curious again and I don't think that couldn't have been done without the laughter and the fun and the jokes, and just the constant interactions and the community feel of it. That I haven't had anywhere else. ... once I actually felt the joy that comes from that connection, there was no turning back. —Sarah, participant

2.3. Experience of the Staff

2.3.1 Caring and compassion

When reflecting on their experience of Wandí Nerida, participants frequently spoke of the compassion and care provided by the range of staff at Wandí Nerida. Participants, including those who left Wandí Nerida earlier than planned, reflected on feeling “seen” and cared for by both clinical and non-clinical staff members.

... from even the cleaners, to the cooks, to the nursing staff, the recovery navigators, to the doctors, to every single person on that property was absolutely phenomenal. I've never felt so supported and so understood and “seen”. I didn't feel like a number. I felt like someone that needed care. —Enolia, participant

I think the staff were really caring and compassionate. —Grace, participant

Well, to start off, it was incredibly empowering. The support from the staff was, on the whole, excellent. —Bourke, participant

Having people listening and the support. It... it was firm but it was fair—I suppose. —Hannah, participant

I had never been in a place where the staff really trained so much compassion, ... —Megan, participant

Participants commented on the value of staff modelling at Wandí. For example, *Jannah* reflected on the value of having dieticians sit down and eating brownies that cultivated a sense of “trust”:

... So they [the staff] were sitting there with three brownies and some ice cream. And we [the participants] were like, “Oooooh!!!... You don't look at your servings for the day and think there's not enough veggies in that. You are happy to eat three brownies because you want to try the different ones.” ... Them being real people was the most useful thing there because you trusted what they said.. —Jannah, participant

Within the context of compassion and care, participants also talked about some of the interpersonal challenges with staff who had become invested in their progress. For example, one participant wanted staff to know not to take some of the ED behaviours personally:

I can see how much of their heart and soul goes into the role... but [my advice would be] to not always take things personally. I think, by virtue of putting your heart and soul into a role, it's easy to take people's eating disorder behaviours personally – but most of the time the intention [of the participant] is absolutely not to hurt staff, it's just the eating disorder acting out when it feels threatened.. - .Lily, Participant

2.3.2 Perceptions of care from staff with lived experience

A unique aspect of Wandí Nerida is the high proportion of lived experience staff members—both clinical and non-clinical. All of the participants reflected on the perceived value that lived experience staff members added to their journey within Wandí Nerida. This included in meeting and interacting with individuals who had been through and recovered from an eating disorder as this not only supported their voice and instilled hope, but modelled a vision for recovery.

All these people with lived experience and they have them on every day. Because they have been through it themselves you are able to speak to them and you feel heard. I never felt so heard and so understood in a facility like that every before. —Daphanie, participant

Like the people with the lived experience were incredibly crucial. —Megan, participant

Having that lived experience, like, work there... Like psychologists, dieticians and the rest being like, “yeah, I recovered.” And you’d be like, “Oh, I would never have known. Look at you! You’re vibin’ life. ... And being able to talk to them [the staff] about that, I was like, “Oh okay, here’s a lot of different ways you can recover, and all these people have.” And having them right there to back when you. —Jennah, participant

Participants most frequently spoke about the value of Lived Experience staff members in the context of the role of the recovery navigator who was a non-clinical staff member. This role was regarded by participants to be unique to Wandí Nerida. Many considered recovery navigators to play an important role in fostering feelings of safety within the clinical treatment context. Participants valued being able to ask a non-clinical staff member for support or seek practical advice on how to navigate challenging parts of the recovery journey.

... the position of recovery navigators, which is a position I had never encountered before... Because they have been through it themselves you are able to speak to the and you feel heard. I never felt so heard and so understood in a facility like that every before. —Daphanie, participant

...we could always go to a rec-nav and just talk about anything. —Bourke, participant

So having that practical lived experience being shared in terms of, even if it's different—it likely will be different from your own—but it provides a starting point for exploration for yourself and what will work. So you can be like “yeah, no that doesn’t work”. —Mia, participant

Several participants also perceived that the role of the recovery navigator was, at times, “underutilised” (Megan) and participants frequently commented that they felt that “their role hasn’t quite been blended in properly” (Mia). Some participants suggested that having recovery navigators as a support person was especially helpful where the participant’s family lived out of the state of NSW.

Allowing or facilitating the recovery navigators to accompany us on outings on Saturday. Because we [the participants from out of state] are stuck at the house while everyone is on leave with their families. —Daphanie, participant

2.3.3 Consistency

Participant narratives frequently highlighted the tensions between the balancing of replicable standardised phase-based treatment protocols and person-centred care. While all participants spoke to the value of the personalised approach, a number also spoke to the importance of consistency and structure.

... I guess consistency. I know everyone's journey is different that decisions are going to be made for difference circumstances. But I guess sometimes it [Wandí] lacked constancy amongst staff... —Hannah, participant

The inconsistencies observed in treatment approaches, adherence to treatment non-negotiables and quality of care received between staff members, at times, created uncertainty. As Sarah observed:

[...] you knew that if you were with [staff member] you were in good hands. But then if someone else would turn up, and you'd be like, “oh, I don't know what to expect” ...I think yes, you need that personalized approach but it's also really nice to know that the structure of the program... It [the program] was very much dependent on particular staff members being there do their job. Um rather than knowing that this is a very this is the

established program that you can trust in, and we know what's happening. —Sarah, participant

While all participants stressed the value of personalized relationships with staff, they differed in their perceptions of the limits of certain relationship boundaries. This highlighted some of the challenges in maintaining professional boundaries within a treatment approach that is homelike with kind and caring staff who are invested in the care and outcomes of participants. As Jennah explained:

... we kinda ran into a couple of problems with staff being in trouble for being almost too... not unprofessional, but almost too close to us? And there's a bit of conversation around, "Okay, where should boundaries be?" ... I understand they [the staff] need privacy. I understand that needs to be a line, but ... them being real people was the most useful thing there. —Jennah, participant

2.4. Experience of the Milieu

A unique aspect of inpatient and residential treatment for an eating disorder is living in an environment with others experiencing similar difficulties. For many participants, the inpatient community at Wandí Nerida functioned as a formative experience that was central to the narrative of their treatment experience. Participants frequently highlighted differences in their experience of the Wandí Nerida patient milieu and previous inpatient treatment experiences. This included in relation to the development of a community where the dynamic was more about participants standing together in their recovery and less about unhelpful comparisons that invited competitiveness around eating and body weight/shape.

... I think what kind of hit me straight away was, "oh, everyone here they're not competing to be the sickest. There's no competition here." ... yes people struggle [and] some people are doing well. But everyone here really wants to be here [at Wandí]. And they are all trying.. —Jennah, participant

... everyone was there because they wanted the same thing, they wanted recovery. It wasn't that this was the only place that they could go. Um, everyone gave up a lot to go there. —Hannah, participant

It [the milieu diversity] didn't allow for much comparison. —Lily, participant

Participants also spoke of drawing hope from their peers, particularly those who were further along in their treatment journey with Wandí Nerida.

*Researcher: What did you find most helpful about Wandí?
Participant: ... Just that I felt safe. I guess... And also, that there were other people who were further along in their stay there who were really committed to recovery, and you could see that and hear that. That had a really positive impact. —Abigail, participant*

"...other participants picked up that burger, picked up that chip, and showed me that they didn't die after it. So I can do it too." —Enolia, participant

In reflecting on her journey, Jennah shared that in her experience of inpatient treatment *"You never saw people get better. You saw people at their worst, and you quite often saw them come back—around and around and around."* Whereas, *"at Wandí people were from all different stages in their journey, you saw people making a lot of progress."* Furthermore, Lily commented that her struggles to eat were responded to with support at Wandí, contrasting this to past experiences of being "shamed".

If I or someone else was struggling at the table it wasn't shamed or frowned upon or seen as annoying. That person would get extra support. ... It wasn't seen as punitive if

you needed a supplement or if you couldn't finish your meal that was just where you're at that day. —Lily, participant

On the other hand, the participants also mentioned challenging aspects of the Wandí Nerida milieu. These included the close proximity of other participants who were at a lower weight. For example, Daphanie commented that it was difficult having a roommate with a much lower body weight: *"I don't need to be seeing... I just don't want to be exposed to this right now."* Other patients commented on the everchanging dynamic within the milieu:

... there are times when people would be really quite upset. And that would be a bit of tension. It would be stressful. But then there'd also be times when, I mean, you'd just having fun with other people. Just play games and have a good time. —Abigail, participant

... there was some issues, I guess, with the milieu. So, while other participants were the best part of it [treatment]... There was some, I guess that with personality clashes and competitiveness... —Enolia, participant

Lily reflected that an everchanging milieu was not unexpected given shifting interpersonal dynamics as participants came and left Wandí Nerida: *"There's going to be interpersonal things that come up amongst the milieu..."*. She observed that the dynamic of the milieu shifted *"vastly"* during her time at Wandí Nerida as new participants arrived and other participants left:

The milieu that I entered into was very diverse in terms of bodies and what people were struggling with and I found that really helpful, because eating disorders, really thrive on comparison. But then, by the point that I was leaving it was primarily people in underweight bodies who were struggling with restrictive eating. —Lily, participant

Many participants reflected on the pivotal role of the core process group—a psychotherapy group offered three times per week with a focus on sharing recovery successes and challenges and addressing dynamics within the milieu—in managing interpersonal challenges and dynamics within the milieu that was described by Megan as *"a small space"*:

So they've got like groups, where because you're living in a big group of people, a couple of times a week, you'd have like a debrief on what's going on in the group—can't remember the name of it—but they were very good. They kinds, they are conversations that need to be had, for people living together in a small space. —Megan, participant

2.5. Motivation and negotiating treatment non-negotiables

Participant narratives of their experience of Wandí Nerida were frequently characterised by ambivalence and dilemmas as they negotiated their relationship with themselves and the eating disorder. Participants readily acknowledged that their experience of Wandí Nerida was largely dictated by their motivation and readiness to engage in the program. For example, when reflecting on the advice she would give someone who is about to start their journey at Wandí Nerida, Jennah said:

It's gonna be hard. ... it's probably harder than all the other stuff you've done. Cause it requires proper commitment. Like, if you don't wanna be there, you can leave. And Wandí's pretty good. They have the interview beforehand. They do check in to see how you are. Because you have to make the most of Wandí. —Jennah, participant

This participant went on to share her observation that participants who were *"forced"* to be at Wandí Nerida by loved ones often struggled to engage in the program. Conversely, it was consistently observed by participants that individuals who independently made the decision to come to Wandí

were more likely to “fully embrace” the program. In reflecting on their motivation and journey to Wandi Nerida, Bourke shared:

Like it was my choice [to come to Wandi Nerida] to begin with, but then it kind of got hijacked by my [family member], who was like, “you will go into Wandi! I don't care what it takes!” And [they] really took control of the whole situation. ... this thing that I had chosen to do, then became not my choice.

They went on to say that the experience of reduced autonomy leading up to Wandi made it difficult for them to fully lean into the program: “... there's no reason for me to want it, because [family member is] going to make it happen anyway.” Participants frequently reflected on the importance of the treatment goals being aligned with their own personal values and goals. For example as Lily explained:

I don't think that by default going to Wandi you're going to recover like you really need to want to want to engage in the treatment and get what you can out of it. —Lily, participant

Similarly, in reflecting on her journey with Wandi Nerida, Jennah spoke to the concept of “performative recovery”. She shared that:

[Early in treatment] I wanted to get better, but I think I was very much doing the right thing. Almost like, the words I've used are “performative recovery.” ... I want to do the right thing so I get rewarded. Like, if I eat my meals, I will go up the phases.

She went on to say that later in treatment, she came to the realisation that she could not sustain recovery for the MDT or milieu: “Ultimately... I'm the one with me for my life... This is my recovery. What do I want to do for the rest of my life? What am I ready to do now?” —Jennah, participant

Some participants described actively engaging in recovery for themselves, whereas others described struggling with the treatment non-negotiables resulting in them being discharging from Wandi Nerida earlier than anticipated. Interestingly these experiences were talked about in ways that also highlighted the healing that they experienced in their engagement in the program, despite this being shorted than anticipated. For example:

I got out of it what I could at that time, for me personally, and staying longer it wouldn't have really done anything more. —Daphanie, participant

I just ended up not really embracing it [Wandi] fully and I also felt a bit pushed into a corner. There was a [medical concern] that kind of dictated how much food I was given and what privileges I was given. ... I didn't feel like I was involved in the goals setting or like I didn't feel like I had any say in my treatment. But I did feel that the staff were really caring and compassionate, and I did feel like it was a healing environment. —Grace, participant

All participants commented on the value of Wandi Nerida being a voluntary program. When reflecting on their decision to decline an extension to her stay at Wandi, Enolia reflected on the dignity afforded by “doing” treatment “on my own terms” with the opportunity to leave meant that a sense of entrapment in treatment was ameliorated:

When I go to public places and I'm [often] under the Mental Health Act, [and] the fear of not knowing when I'm going to leave makes me procrastinate as long as possible. Not having the freedom of choice to leave when I want to or have any kind of freedom is quite scary, and it doesn't allow you to keep going. Whereas, if you know that I'm doing it on my terms and I'm doing it because I want to get better, ..., allowed me to keep

going.... I didn't feel trapped. And I also felt welcome to come back if I needed to.... — Enolia, participant

2.6. Connection and identity

Toward the end of each interview, participants were asked: 1) “What stands out to you as you reflect on what your time at Wandí Nerida and its impacts on you?” and, 2) “What have you learned about yourself as a person through your time at Wandí Nerida?” In responding to these questions lived experience participants rarely commented on their eating disorder or specific behavioural changes. Rather, they almost exclusively reflected on themes of self, identity, connections or hoped-for futures.

[Wandí] has been one of the most transformative experiences of my life. It has..., taught me about myself. —Bourke, participant

I learned that I am someone who values human connection. —Sarah, participant

I learned about myself that I can be fun. ... I guess a lot of my personality has been hidden because of the eating disorder. ... towards the end of my stay [at Wandí] my real personality came out and I began to feel emotions again... it gave me hope that there is—I suppose—a life better than the life I had been living for so many years. —Hannah, participant

I am more than my eating disorder... There are more things to me than that. I'm not just anorexia. —Enolia, participant

I think, for a long-time life looked one way... ...realizing that oh, it [life] doesn't have to be perfect. Like, perfection is not the only standard that's acceptable. ... The eating disorder has happened. I can't change that, but I can recover and do something after that. —Jannah, participant

Theme 3: Carers' Experiences of Wandí Nerida

When asked to describe their experience of Wandí Nerida, often the first thing carers would speak to was a feeling of relief. Their experiences spoke to the following themes: 1) Leaving a loved one at Wandí Nerida; 2) Helpful aspects of Wandí Nerida; 3) Autonomy and collaborative care; and 4) The line in the sand between then and now. These themes highlighted some of the often unspoken challenges of being a parent or carer of a loved one with an eating disorder.

3.1. Leaving a loved one at Wandí Nerida

When asked to describe their experience of Wandí Nerida, the first thing carers spoke to was a sense of relief and hope when leaving their loved one at Wandí Nerida.

I just felt relief. ... because there was just... Because they [the staff] all knew what they were doing. They were specialists in that field and some of them had gone through it [an eating disorder] themselves. They were professional and, um, their approach. It was all those things put together that when I left her I knew she was in the best hands. —Rebecca, parent

I think Wandí took the weight off my shoulders for me. —Megan, parent

It was so nice to... It was actually a relief when I spoke to them, and they said, “You don't have to worry from here, we're taking over”. And I was just like, “Wow!” —Hope, parent

Carers also described tentatively holding onto hope that Wandí Nerida would provide a different treatment experience, and ultimately the outcome of recovery was in sight for their loved one.

I guess I didn't quite know what it would be. But I guess I was hopeful that it would be different to anything else that she'd been in before, and it was. So, yeah. We, I... We and I found Wandj, the experience amazing. Like it. It really did seem, you know, very conducive to healing, conducive, and you know from what I've now read up, you know, evidence based in its approach to eating disorder recovery. —Nicole, parent

They were giving us some hope that things could be different and that things could change. And I think that was really important that we had not the promise of the cure—we knew that wasn't ever offered—but just some hope that things could be different. —Stephanie, parent

3.2. Helpful aspects of Wandj Nerida

When asked to reflect on what was most helpful about Wandj carers consistently reflected on the physical environment, non-punitive treatment approach, and staff.

[Wandj] was a beautiful place and people have asked me what it's like. I said it's like a retreat but hospital based. The hospital part if it was very unintrusive. Like it was, yeah, like a retreat. It was just a beautiful setting... Um peaceful and all that sort of thing. Which I think you need for that sort of environment. —Heather, parent

I was taken around the facilities. I was made to feel that this was a very professional experience. That they took it seriously, and that everyone there, everyone working there was devoted to the recovery of someone with an eating disorder. —Claire, parent

"When I arrived at Wandj Nerida, I was introduced to a staff member who said, "I've had lived experience." and I actually walked away going, "Thank goodness for that." That makes me feel better. Because I know how important it is for the recovery. And the psychological recovery." —Claire, parent

"It [Wandj] just was a life changer for us. [Daughter]'s alive now, and I honestly don't think she would have been." —Jessica, parent

The carer supports offered by Wandj were generally perceived as being of benefit. Weekly virtual meetings fostered carers' sense of collaborative care and community among carers. While family days offered the opportunity for carers to engage with their loved one in a group treatment setting. Several carers reflected that the weekly education meetings were the first time they were offered support and education specific to their loved one's condition:

And they would have Zoom Meetings once a week that the parents could attend if we had questions, and maybe educating us a bit more about how to go about certain things. Yeah, I really liked them. I found them supportive, and I found them some of the points we're really useful for me. So, I found that support, and when it all stopped I said, "Oh, can I still go to the Zoom Meeting or something" and they were like "No". —Rebecca, parent

There was a Wednesday night—I don't know if that's still going—but it was like a support group for parents, which was really good. The family days were really good, because you met the girls, saw the environment. That was really, really good. —Sonia, parent

The dietician who presented on RAVES—I found that brilliant. I still use that you know what I learned in that session, I still used to to this day. It's good to be able to talk to [Daughter] in the correct term terminology and that sort of thing. —Megan, parent

3.2. Autonomy and collaborative care

In reflecting on their journey with Wandí Nerida, many carers commented on being included by staff in the care of their loved one. This was, for many carers, a new experience as —Nicole, parent explained:

Until I went to Wandí, there's always a perceived conflict with the treating team... they clearly, you know, identify as part of the problem, and not necessarily part of the solution.

Whereas Wandí, and it's funny that they managed to achieve this from a distance, ... you were certainly made to feel like you're part of the process, in a very non-judgmental way. Um, that you know they were very clear in saying, you know, "Yes, we know there's all these precipitants of an eating disorder, but we can't do anything about that now. Let's just move forward and move on from a plan from here." Which took away a lot of that guilt and enabled carers to be the best carers. —Nicole, parent

Similar reflections were shared by multiple others, particularly the parents of loved ones who still lived in the family home. As Rose shared:

Wandí Nerida worked with us, they worked with [Daughter]. —Rose, Parent

While the importance of participant autonomy in their treatment journeys, carers with adult loved ones often reflected that they felt excluded from their loved one's care and treatment journeys:

To be really candid there wasn't an awful lot of communication. But then, you know, she's a grown up, and it was her journey—and I understand that. ... So if I guess I didn't mind it, but it might have been nicer to have heard from her treatment team or from someone a month in, or two weeks in to kind of go, "this is how she's going and this is what the plan is" or whatever. ... —Sonia, parent

It almost. It felt that we were sometimes it felt that we were just the bank, ... but we're not really involved in any further. Other times if felt that we needed to do lots and lots of things... Trying to work out where our position in it all, where we fitted, was hard. —Stephanie, parent

3.3. Then and now: A line in the sand

In asking carers what they wanted to remember from their loved one's time at Wandí Nerida the theme of a metaphorical line in the sand between before and after Wandí Nerida. Irrespective of if their loved one maintained progress, all carers reflected that Wandí Nerida represented a transitional period in their relationship with their loved ones eating disorder. As such, an admission to Wandí Nerida represented a significant disruption to both the family and illness narrative.

I guess, you know, a line in the sand between then and now. ... I had hoped it would be life changing for [daughter], and it has been life changing for her. Um, she's certainly not recovered, but —you know—2-months out I would never have imagined she could be this physically and mentally capable. —Sonia, parent

So, overall Wandí Nerida is the best experience we have had, and the best experience [Daughter] has had. She came home and she was not bulimic. She had only been there two months. —Claire, parent

I feel like, ... I can resume the role more of a loving parent that maybe just checks in on a medical condition the way you would with any other medical condition. —Nicole, parent

Carers also commented on the impact that Wandí Nerida had on their relationship with their loved one, for example as Rose explained:

It's allowed us to be a family again. You know, we have always been a very close family unit. We are back together again. We are less anxious. Um, there is less uncertainty a whole lot less worry. We see friends again.. —Rose, parent

Theme 4: Transitions

Participants and carers alike acknowledged that the Wandí Nerida program is still in its early phases of development. As one parent summarised:

I think there are lots of things about Wandí that I think are really great. Um... There are some things that I think I'm not sure how I feel about, and then there are some things that I think just should be changed. —Stephanie, parent

When asked, what could have been done differently in the Wandí Nerida program, the most constant theme within both parent and participant feedback related to transitions. Participants and carers frequently commented on challenges leading up to and following discharge from Wandí Nerida and the burden of the financial cost of the treatment. Participants also commented on challenges related to treatment transitions and how these were communicated by the MDT.

4.1. Reflections on the waitlist

Participants and carers frequently lamented the length of the waiting list and the admissions criteria for Wandí Nerida, and the lack of communication received while on the waitlist.

At the time I was shitty at how long the waitlist was. —Sarah, participant

My main issues were that I was below the intake BMI threshold... And just the lack of communication that I had leading up to the admission. Like they told me it would be... 6 weeks, and every time I called it was like, "Oh, no, another 3 months, no another 3 months.... —Bourke, participant

I had no more energy left, and I just had to let it [the eating disorder] run rampant while we sat on a waiting list for Wandí. —Amy, parent

... she put her application in and we had no idea whether that there was a place going to come in a month or in 6-months. That was very frustrating... So very, very challenging from a participant point of view, because you don't know how long you've got to stay alive... There was no communication [from Wandí to the participant]. —Sonia, parent

Given participants' diagnoses, and the medical implications of low weight, a number of participants required a planned hospital admission in order to reach the minimum weight required for admission to Wandí Nerida. The perceived lack of forward communication regarding possible admission dates made it difficult for many participants to coordinate the required admissions:

So it was the beginning of last year where we decided with my treating team to put the referral in. Um, yeah, I guess it didn't go exactly to plan. I had a planned admission beforehand to get some more nutrition in beforehand, just so I was able to—I guess—take the most of what I could get out of the program. But obviously the waiting list was a lot longer than expected so the gap in-between admissions was significant—I suppose. —Hannah, participant

In retrospect, a number of participants felt the longer period of time spent on the waiting list was perceived to be of benefit: *"in hindsight I think that worked out to be the best way possible in that I*

spent so long doing the prep work and doing the motivational interviewing stuff essentially on myself. That I was just I was so... I essentially hit the ground running as soon as I got there". (Sarah) However, the general consensus was that the length of the waitlist was too ambiguous to facilitate optimal planning.

4.2. Reflections on discharge

Participants and carers universally found discharge from Wandí Nerida to be difficult. As Mia explained: *"... your recovery journey doesn't end with Wandí. ... you kind of go through it [the Wandí program] and it gives you the tools to recover for sure, but it stops and cuts off... and the journey doesn't end there all the time—it keeps going."*

Participants described the transition home from Wandí Nerida as being "very difficult" (Grace) and "jarring" (Mia). Many participants reported being unable to access or link in with sufficient supports when returning to the community. This was particularly apparent for clients who were interstate or from rural and remote regions.

The transition home was very difficult. I think going from that level of all around support 24-hours to kind of being on your own is... I found it really hard to stay on top of things and hold all of that motivation for myself. But it was also the first time that I'd left treatment wanting to continue recovery. I didn't have any intention of relapse. —Lily, participant

I think the discharge planning is probably not working as thoroughly or as well as it should be... So I think more thorough for discharge planning is needed. Because there is no step down into the community. And integrating that with other health services to sort of ensure that it's cohesive. —Megan, participant

Other carers expressed frustration and disappointment with the discharge process from Wandí Nerida:

I think, Wandí is life changing. I think the staff are amazing. I think the environments wonderful. I think the program—I know it's evolving— I think, following Carolyn's program is amazing. My biggest criticism is when they come out there's nothing... You know literally, once the door closes and everyone hugs them, it's just you—you know. You could build a team and you can have a plan, but you know that amazing positivity and environment and language and whatever is gone. —Sonia, parent

So [daughter] has a long-term psychologist, that has been amazing, and she had also tried to contact Wandí Nerida. But there was no contact from [Wandí Nerida] them, no hand over, no discharge summary, no contact with any of [daughter]'s community supports. And I think if we're not going to have that overlapping transference of care, we sort of leave them a bit floundering. —Stephanie, parent

... it really is very hard when they come out. And I don't think I realised how hard it was. —Sonia, parent

Some carers attributed that the lack of supports on discharge to the limited community resources along the continuum of care. Particularly the lack of day programs and more intensive community treatment options:

... it was my hope that maybe she'd go back into that day program in [state capital city]. ... [but the public day program] were sort of the ones that sort of said no to taking her

on board. ... Although I've got that little bit of disappointment, that's not directed at Wandi, it's just the lack of local resources..—Nicole, parent

4.3. The phase system and the multi-disciplinary team meetings

A core component of the Wandi Nerida treatment program is the phase system outlined in the Butterfly Foundation Residential Eating Disorder Treatment (B-FREEDT) Model of Care[®] (outlined in Appendix A). Participant privileges and supports within the Wandi Nerida program are informed by the treatment phase a participant is in (e.g. lower phases of treatment are associated with increased supports and reduced freedoms in relation to food and unsupervised activities). In reflecting on the phase system, Jennah observed that *“how we all looked at phases, that was probably the only place the competitiveness did come in between us.”*

As such, participants perspectives of the multi-disciplinary team (MDT) meetings were diverse. Some found them to be “punitive” and “disorganised” (Bourke) while others felt they were walking into a “room of cheerleaders” (Sarah).

I have to say from my personal journey it was... I walked into every MDT meeting. Um, essentially to a room full of cheerleaders. ... but I just know from others if they had had a week where potentially they hadn't met certain goals and they'd been... they'd stalled a little bit. They would definitely come out [of the MDT meeting] feeling like they'd had a slap on the wrist.—Sarah, participant

It [the MDT] did not give us, as participants very much of a voice, ... a lot of the times it did feel quite punitive, what the MDT decided. And only having that meeting once a week with a psychiatrist [who] came in for the meeting, and at no other time.—Bourke, participant

Participants' relationship with the MDT appeared to shift as they moved through the various treatment phases as treatment goals were met. Participants tended to describe the MDT as more challenging in earlier phases of the program. Additionally, several participants felt that the feedback provided in the MDT meeting was at times incongruent with the messaging they had received throughout the remainder of the week. As such, a number of participants expressed a desire to receive more regular feedback during the week to support them in knowing how they were progressing in relation to the goals set by the MDT.

4.4. Barriers to access

Both carers and experiencing person participants spoke of the financial barriers to accessing treatment at Wandi Nerida. Carers spoke of their reliance on health insurance, one parent spoke of withdrawing money from their super, another parent spoke of only being able to afford Wandi due to the bursary program.

“It was expensive. Phenomenally expensive. I had to take money out of my super to pay for it.”—Hope, parent

I would hate to be one of those families that finds out the price ... as a parent you would feel like I'm letting my child down because I can't afford to give them the treatment that they need. ...—Jessica, parent

...I was lucky I had a bursary. If we didn't have a bursary. There is no way I could have afforded it—no way. —Amy, parent

Participants spoke of only being able to access Wandi through their carers' support, health insurance and/or the bursary. As above, one participant requested their inheritance early to attend Wandi.

I wasn't the only interstate person. And, there were other people from interstate and financially had to sacrifice a lot. Um so I think everyone was there because they wanted recovery desperately—I suppose. —Hannah, participant

I approached my mum and kind of said, Look, it's a big cost... what if you wrote it into your will... —Sarah, participant

Both participants' and their carers acknowledged that finances were a barrier to either the extension of their stay—to complete higher phases of care—and readmission

I would like to see it [Wandi Nerida] more affordable. Because ... when [loved one] relapsed ... Wandi just couldn't come into it. —Jessica, parent

If I could afford it... I would go back. —Megan, participant

Additionally, participants and carers who resided outside of Queensland frequently commented on the location of Wandi Nerida being a significant consideration and barrier to access.

Australia desperately needs a facility like Wandi in every State and Territory. They need to be more financially accessible—I know that's basically impossible—but it's hard... and it needs to happen soon. In the [Home State] we are stuck with just [public hospital]... Public hospital, you know, is less than unhelpful. It is detrimental to my recovery. The [home State] needs a proper treatment program. —Bourke, participant

I wasn't the only interstate person and there were other people from interstate. And financially, had to sacrifice a lot. Um so I think everyone was there because they wanted recovery desperately—I suppose. Yeah, it made for a more positive environment. Hannah, participant

Theme 5: Hopes for the future of residential treatment

In reflecting on their treatment experiences, every interviewee also reflected on the service gaps they had experienced along the continuum of care. Carers and participants alike highlighted the limited community supports, particularly for the “in-between” phases of treatment.

[Treatment] it's gotta be a little bit more individualized. And I know in a hospital setting it's about trying to get them medically stable. Unfortunately, then they're back out in the community again. But there needs to be more of a step-down care. Rose—parent

There's no midstream. It's high level or lower level where you're basically out of the system sort of care. There's nothing that actually supports that part in the middle, where sometimes you need more and sometimes you need less. Sometimes you need meal support sometimes you don't... at the moment, your options are very much either: you're unwell enough to be in in a place where they can support you full time with meals or you're okay enough to be at home ... that's where I get stuck—in that middle. Mia—participant

In exploring these gaps, interviewees held hope that the number of residential based treatments for eating disorders would increase across Australia.

I think there needs to be a hundred more Wandis. I think there needs to be one certainly in every State. —Sonia, parent

I just hope that places like Wandi open not as far as Queensland from [State]. In more states for sure and more beds than 13 for the country... —Daphanie, participant

Yeah, if everyone could have the opportunity to attend a Wandí, rather than inpatient or the cycle of medical hospitals, I think there would be a lot less treatment trauma—which tends to exist in our sort of spaces. —Lily, participant

[Wandí Nerida] far outweighs any other treatment I have been to, in the past. It's something that, I guess, if one of my kids was to become unwell, it is a place that I would send them to. It is not something I would tell them not to go to. —Hannah, participant

I think it's [Wandí Nerida] the best the best treatment opportunity available. ...I would have no hesitation on recommending the Wandí Nerida experience. And, in fact, I would strongly recommend anyone with a complex eating disorder have an opportunity to go to participate in something like this. —Nicole, parent

Concluding summary

Participants described residential treatment as being like a “Hail Mary” or “last ditch” attempt at holding onto hope for recovery and finding a life beyond the eating disorder. Carers described Wandí as a relief and source of hope for recovery for their loved one. Participant treatment narratives were marked by internal conflict as they moved through liminality in their relationship with themselves and the eating disorder towards a rediscovery of self and identity. In reflecting on their residential treatment experience, participants emphasised that “*recovery takes a village*”. Participants stressed the value and importance of collaborative care, communication, community and individual motivation for change, as well as the value of normality in small things such as the treatment environment.

Initial findings from this study highlight the complex and multifaceted nature of the residential treatment experience as well as the inherent ideological dilemmas that arise when balancing replicable standardised phase-based treatment protocols with person-centred and recovery-oriented care. Furthermore, these findings support previous research suggesting that recovery may be more about the reclamation of self and identity outside of the eating disorder than it is the illness process. As such, adopting person-centred and recovery-oriented treatment approaches within residential treatment settings may serve to maximise patient autonomy in the face of a dominant biomedical discourse and support participants in reclaiming and living out preferred identities that are not dominated by the ED identity.

6. ABORIGINAL AND TORRES STRAIT ISLANDER EXPERIENCES

Eating disorders in First Nations peoples of Australia

Colonial hangovers from past policies of genocide, removal, protectionism and assimilation have estranged First Nations peoples from their ways of being knowing and doing (Smith, 2013) with disastrous effects that pervade all aspect of life including eating disorders. Limited evidence suggests that there is a high incidence of eating disorders in First Nations peoples of Australia (Burt, Mannan, Touyz & Hay, 2020a) including adolescents (Burt, Mitchison, Dale, Bussey, Trompeter, Lonergan & Hay, 2020b). Moreover, lower socioeconomic status and racism lead to higher levels of psychological distress in First Nation (FN) peoples (Paradies, 2020) and FN peoples' experience poorer mental health outcomes particularly when it comes to ED (Burt, Mitchison, Doyle & Hay, 2020c).

The data in this report lists few First Nations people. It is plausible that there are more in this dataset given 23 individuals did not disclose their ethnicity. Evidence suggests that First Nation peoples are hesitant to declare their identity (Burt et al., 2020a) due to the politics of identity (Harris, Nakata & Carlson, 2013) and general feelings of “shame, fear of judgement and identity confusion” (Burt et al.,

2020a, p. 6). This reluctance can also be seen in health settings due to historical injustices, distrust, social mobility, power imbalances and the fluidity of Indigenous identity (Crooks, Carlson & Dalton, 2019). Data collection tools that are culturally responsive may mitigate this lack of First Nations identification (Burt et al., 2020a). A small subset of the participants in this cohort identified as Indigenous but were hesitant to declare their Indigenous status in the surveys. They stated their hesitancy was due to feelings that their family does not have current connection with the community in which the relative(s) was/were a part of, and/or feeling they do not have any formal acknowledgement of being Indigenous. This provides further evidence of the complications associated with First Nations peoples' cultural identification, particularly in health settings (Burt et al., 2020a). It is recommended that one way to mitigate this potential problem in the research is to embed Aboriginal and Torres Strait Islander mental health workers in clinical and research settings that enable Indigenous peoples to feel safe to share their stories.

7. PERSPECTIVES OF STAFF AT WANDI NERIDA

Thirty-three of a possible 39 (85%) staff responded to the clinician survey. Data analysis focused on staff perspectives on the program and its relationship to treatment outcomes and the role of lived experience expertise.

Staff perspectives on the program and its relationship to resident outcomes

As shown in Table 7.1, the Wandi staff who participated in the study regarded the program as respectful, supportive of the multi-disciplinary team and sufficiently resourced. Perceptions of care at Wandi Nerida received average median ratings of over 5 for a maximum score of 7 (i.e. over 70%). All therapies offered were also rated highly by staff (Table 7.2).

Table 7.1 Staff perceptions of Wandi Nerida (n = 33)

Perceptions:	Mean	SD	Median	IQR
Wandi Nerida has team-based collaboration and infrastructure	5.6	1.7	6	5-7
Wandi Nerida engages external medical teams and community partnerships as appropriate	4.9	1.7	5	4-6
Wandi Nerida engages the patient and family as stakeholders.	5.4	1.8	6	4-7
There is respect for all stakeholders involved in the service	5.5	1.8	6	4.5-7
Wandi Nerida clearly outlines roles and responsibilities for all staff.	4.8	1.8	5	4-6
Staff receive ongoing feedback and training	4.9	1.8	5	4-6
Consistent review of evaluation and monitoring of patient outcomes & used to inform care	5.7	1.7	6	5-7
Wandi Nerida has feasible and sufficient resources (e.g., time, space, funding) to achieve its goals	4.2	1.8	4	3-6
Wandi Nerida is associated with improvement in patient outcomes that is clinically meaningful	5.8	1.6	6	5.5-7

Note: Scores ranged from 0 to 5, where 0 is the least and 7 is the most

Table 7.2 Wandi Nerida therapy contribution ratings to improved patient outcomes (n=33)

Therapy	n	Mean	SD	Median	IQR
Individual	33	6.0	1.6	7	6-7
Group	33	5.7	1.5	6	5-7
Equine-assisted	33	5.3	1.7	6	4-7
Permaculture/ecotherapy/gardening/nature walks	33	4.9	1.6	5	4-6
Art	33	4.4	1.5	4	4-5
Drama	33	5.8	1.5	6	5-7
Music	28	3.4	1.9	4	1-4
Family	33	5.0	1.7	5	4-6
Family education sessions	33	5.4	1.6	6	5-6.5
Meal support	33	6.1	1.7	7	6-7
Staff with Lived Experience	33	5.9	1.6	6	5-7

Yoga	28	5.2	1.5	5	5-6
Exercise	28	4.5	1.5	5	4-5
Somatic massage	28	4.9	1.7	4	4-5.75

Note: Scores ranged from 0 to 5, where 0 is the least and 7 is the most

Staff perspectives on the role and value of Lived Experience expertise.

Wandi Nerida is unique in its strong endorsement and employment of staff with Lived Experience. In the survey 18 (46%) identified as a person with Lived Experience and/or with a diagnosis of an eating disorder or disordered eating and all reported they had disclosed this to Wandi Nerida residents. There was high agreement on support for staff with Lived Experience, the working environment, and staff well-being. Those with Lived Experience expertise perceived they were highly valued by residents and other staff and there was a high level of the use of their expertise in the program (Table 7.3).

Table 7.3 Perspectives on care from staff with Lived Experience and staff well-being

Wandi Nerida:	<i>n</i>	Mean	SD	Median	IQR
Respects the perspectives of staff with lived experience	33	5.8	1.9	7	5-7
facilitates staff using their lived experience when implementing clinical care	33	5.1	1.9	6	4-7
The amount of work I am expected to complete each week is reasonable	32	5.1	1.9	6	4-7
My contributions are valued by other staff members	32	5.3	1.8	6	5-7
provides me with a sense of accomplishment.	32	6.0	1.7	7	6-7
is supportive of my personal wellbeing	32	5.6	2.1	6.5	5-7
I am offered adequate opportunities for training and supervision.	32	5.0	2.1	5	4-7
Those with Lived Experience - My lived experience:					
is valued by patients	24	5.5	1.8	6	4.25-7
is valued by other staff	24	4.8	1.8	5	4-6
helps me fulfill my professional role	24	5.5	1.6	6	5-7
How often used as part of work at Wandi Nerida	24	4.9	1.9	5.5	3.25-6.75

Note: Scores ranged from 0 to 5, where 0 is the least and 7 is the most

Clinician experiences and reflections

Overview

Twenty-eight (72%) of the staff who completed the survey provided free text responses when invited to provide additional reflections within the survey (see Box 7.1 for the free text survey questions). They were asked to provide these around areas of what they thought was helpful and where there were opportunities for improvements.

Overall, the staff open text responses indicated a positive attitude towards the Wandi Nerida program. Staff perceived Wandi program to be a holistic intervention that treated participants with care and respect within a treatment non-negotiable framework. There were a number of improvements that staff suggested for consideration to build on and improve the treatment provided at Wandi Nerida, particularly in the areas of stepped down care for participants post discharge from Wandi and staff support.

BOX 7.1 The five staff survey questions with free text response

1. *What have you found to be the most helpful components of the Wandí Nerida program? Please explain what has been helpful and why?*
2. *What have you found to be the least helpful components of the Wandí Nerida program? Please explain what has been helpful and why?*
3. *Are there any supports you feel are missing? If so, please outline what would have been helpful.*
4. *Are there any professional/organisational supports you feel would benefit you in your work with Wandí Nerida?*
5. *What stands out for you as you reflect on your time working with Wandí Nerida?*

Helpful aspects of the Wandí Nerida Program

When asked about what was helpful about the Wandí program, the staff open text responses clustered around four main areas that included the environment, treatment context, spirit of Wandí, and staff support.

1. *The environment*

A number of staff depicted Wandí Nerida as a “homely” environment to support eating disorder recovery (“The homely feel of the residence”). This was also evident in responses that contrasted this environment with inpatient hospital-based ED treatments, for example where Wandí was perceived as: “Being less 'clinical' and more supportive” and “takes away from the feeling of being 'trapped' or 'hospitalised'.”

The location of Wandí in Australian bushland extended this notion of “homely” to the broader environment where staff noted the importance of activities that cultivated participants’ (re)connection with the environment and each other. For example:

“Wandí takes advantage of its natural surrounds as a way for participants to engage with the natural world and each other”.

“The location, creativity and variety of complementary therapies, utilising the skills (gardening, craft, yoga etc) of workers that may be outside their role that they are employed as.”

2. *The treatment context*

The treatment program was perceived as mainly positive, including in navigating the complexities of person-centred care within a safe treatment non-negotiable framework. For example:

“Wandí provides a safe environment with strict boundaries for the participants. ... ”

“The participants are involved in a structured program however the flow of the space and the diverse number of activities available to the group, I believe, create a very safe and relaxed environment”.

The program was described as holistic in its focus to support eating disorder recovery. The diverse treatment components were collectively mentioned by the staff responses. These included:

- “On the ground” day to day care of participants by nursing staff and recovery navigators “understanding, emotion regulation, and treatment journey”.
- Comprehensive meal support from the production of high-quality food and practical skills support in meal preparation to the staff supporting participants at mealtimes.
- Individual and group psychological and dietetic treatment, for example:

When patients have well a nourished brains and two individual psychological, and one individual dietetic consult a week the outcomes in my opinion are hard to beat in other inpatient or outpatient therapies.

- *Group therapy - the empathetic and collaborative nature of the groups. Individual therapy - time to work on individual and specific goals/needs.*
- *Complimentary therapies (yoga, drama and creative arts, and equine assisted therapy) that were perceived to invite participants into a range of ways engaging in “expression and healing” for example:*
- *Equine Assisted Therapy - for some participants this therapy has been really helpful in allowing them to feel and understand their emotions and begin to learn regulation and how to be present / mindful. Drama - hearing the participants enjoy and become more confident and comfortable in the group. Being themselves and letting go of rigidity.*
- *Lived experience staff and recovery navigators who were perceived to contribute to understanding through the insider experience for “hope for the long-term rewards of recovery”.*
- *Inclusion of carers and loved ones in the treatment; and*
- *Multidisciplinary team communication*

Furthermore, one staff member noted how this milieu of support was built on a spirit of collaboration between the participants in the program: *[...] the support of the milieu, especially from higher phase participants, shows short term rewards of recovery and well as relatable challenges and strategies. I find that when they see advice from therapy matches to what other participants say has worked it is more effective.*

3. The person-centred spirit of Wandí

The spirit of person-centred care was evident in the experiences of staff where participants were perceived as being treated as “real people” people through the following practices:

“Including the patient in their own care”;

“processes used to engage participants in decision making and reduce power imbalance btw worker and participant, including worker dress code, participants having decision-making power over outings, activities etc; milieu meetings”.

One clinician emphasised the importance of a community spirit of shared “decision-making” and “having chores and responsibilities” at Wandí Nerida and perceived this to empower participants in both their own recovery and in contributing to a “sense of ownership of Wandí Nerida and its future”.

4. Staff support

The majority of staff indicated that they felt supported at Wandí, including in the areas of team support, training and supervision of staff. For example:

The team are really the heart and soul of Wandí Nerida. I believe we all contribute to ensuring the program runs in a successful way.

The wonderful supportive team and the sense of ‘making a difference’.

I love being part of such an incredible organisation. While it is challenging, the work we do is important ... The team is the most adaptable, flexible workforce I have ever come across.

The level of commitment and innovation at all levels of Wandí Nerida.

Training opportunities with Carolyn Costin and being able to implement changes as required.

Areas for improvement in the Wandí Nerida program identified by staff

The staff also perceived some aspects of the treatment at Wandí could be improved. These clustered around perceived gaps in treatment and consistency in staff support.

1. *Perceived gaps in treatment*

The following areas were reported by some staff to need improvement in the participant's experiences and engagement with the program:

- Increased access to expressive therapies
- Mindfulness groups being taken *"more seriously"* by staff and participants.
- Supports for participants for transport to the closest town and *"more age-appropriate group outings"*
- Greater involvement of participants in MDT decision-making indicating room for improvement in the challenging area of implementation of treatment non-negotiables, for example: *"... lack of taking the participants desires and opinions into their care, enforced approaches to care and 'punishment' for non-compliance"* and *"When the participants feel that they have not been listened to ... The patient often feels that the MDT have made up their minds about the ongoing care/phase etc prior to the patient even being in the room"*.

2. *Consistency in staffing, staff support and team dynamics*

Although there were fewer areas of concern noted by staff in terms of their support and the team dynamics, a few staff noted difficulties in ongoing staff recruitment and the need for more staff training. Workplace relational challenges were reported by some staff members, however most of these comments were reported alongside positive experiences of the Wandí program:

- Team dynamics: for example, *"Staff splitting - either caused by patients or just clashing personalities"* and *"Staff disagreements, the culture of name, blame and shame"*.
- Power dynamics related to staff feeling there was communication difficulties with the executive.
- The nature of the work: *"Challenging work ... where I rarely feel valued for my contribution"*.

Staff recommendations for improvements

In addition to addressing the perceived gaps in treatment, the staff recommended the following areas for improvement:

1. *Stepped down care post-treatment*

Some of the staff expressed concern with the processes of stepped down care and the need for increased awareness of support services that are available to prepare participants for leaving Wandí Nerida. For example:

The ending for participants is often difficult due to feelings of fear, doubt around transitioning home. Would be good to look at stepped transition. Perhaps a facility on the grounds that allows participants to stay with little monitoring for last week or so. Would like to see participants involved in community action strategies such as community arts projects, training, community education.

Important for WN to look at who is accessing the service and how to increase referrals for other target groups such as young men, LGTBQI+ people, Indigenous people etc.

...needs to be a 'step-down' program from WN upon discharge. Pt's need help / motivation to keep up with their appointments and keep on track with goals etc.

2. Organisational staff supports

Although many of the staff felt well supported at Wandi, there were recommendations about how this could be improved given the nature of the work and to assist with what one participant termed “a sustainable workforce”:

- Training for staff prior to commencing at Wandi Nerida
- More ongoing training in residential care for eating disorders, trauma informed care, mental health first aid, and working with co-morbidities including self-harm and suicide.
- Ongoing supervision, including opportunity for debriefing and support
- Linking with professional providers

8. PUBLICATION AND DISSEMINATION PLAN

In addition to report, the dissemination of the scientific findings of the Wandi Nerida clinical outcome evaluation is primarily being led by two PhD candidates, Sinead Day and Rebekah Rankin, and a Masters student Caitlin Clague. A complete list of dissemination plans and theses outlines are included in appendix H.

Presentations to date

- Conference: ANZAED 2022 Aug 12
Title: Study protocol and preliminary findings for an outcome evaluation of residential treatment for eating disorders
Presenter: Sinead Day and Rebekah Rankin
- Conference: ANZAED 2023 – full day pre-conference workshop
Title: Building the village: Developing specialist treatment services for eating disorders: examples from residential & other models of care
Co-presenters: Dr Catherine Houlihan, Dr Carly Roukos and Rebekah Rankin

Papers Under review

- Sinead Day, Catherine Houlihan, Deborah Mitchison, Janet Conti, Katherine Gill, Haider Mannan, Kirstin McMahon, Lucie Ramjan, Rebekah Rankin, Kathy Tannous, Ranjani Utpala, Phillipa Hay. Developing a Residential Treatment Service for Eating Disorders: Preliminary Outcomes, Challenges, and Adaptations for an Australian Context

Planned Publications

Sinead Day:

- Clinical and quality of life outcomes of the Wandi Nerida program

Rebekah Rankin:

- Patients’ experiences, perceptions and satisfaction with care (qualitative)
- Carers’ experiences, perceptions and satisfaction with care (qualitative)
- Health care providers’ experiences, perceptions and satisfaction with care
 - a mixed method triangulation paper
 - a qualitative exploration

Caitlin Clague:

- Participant's lived experiences and perceptions of treatment at Wandi Nerida (thesis submitted)

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APPENDIX A: WANDI NERIDA TREATMENT PHASES

The following table briefly outlines the six phases of the B-FREEDT Model of Care[®]. Treatment is designed around three meals and three snacks each day. Most treatment occurs in groups with all patients. However, there is the opportunity for individual consultations with their primary psychologist (2-3 times per week), a dietitian and psychiatrist as needed.

Phase	Phase description
Welcome Phase	<p>This phase is intended to orientate the patient to the unit and the treatment program. The treatment in this phase includes:</p> <ul style="list-style-type: none"> – Multidisciplinary assessment, formulation, collaborative development of individualised treatment plan. – Patients are observed for 1.5 hours following meals and snacks. – Patients will be placed on a refeeding protocol due to low weight.
Phase 1	<p>Commences following week 1 (welcome phase). This phase is intended to provide gentle challenges and a higher level of supports as it is anticipated that patients are still struggling with eating disorder behaviours and may be ambivalent about change. This phase includes:</p> <ul style="list-style-type: none"> – High-level support to build accountability and assist patients in abstaining from eating disorder behaviours. – Patients are served pre-portioned food (self-select breakfasts) – Continuation of Welcome Phase observation
Phase 2	<p>Commences following completion of necessary assignments of Phase 1. This phase is intended to encourage patient participation in food selection and portioning. In this phase there is:</p> <ul style="list-style-type: none"> – Decreased observation – Increased patient participation in food choices and portioning – Limited engagement in planned exercise.
Phase 3	<p>Commences when patient shows mastery of Phase 2. Hallmarks of this phase is that patient begins to show recovery leadership. In this phase patients are:</p> <ul style="list-style-type: none"> – Self-selecting all food and portioning all meals/snacks with minimal prompting – Medically and physiologically able to participate in programmed exercise – No longer requiring nutritional supplements
Phase 4	<p>This phase is intended to instil independence and prepare patients for the step down from residential care. In this phase patients:</p> <ul style="list-style-type: none"> – Take responsibility for food (may prepare some of their own meals) – May select off menu foods – Are encouraged to challenge themselves with eating percentages
Graduation Phase	<p>Extended support for those not ready to return home. This phase aims to assist patients with additional preparation for real-life situations.</p>

APPENDIX B: WANDI NERIDA ADMISSION CRITERION

The Wandí Nerida treatment facility admission criterion, are as follows:

- The service is sex/gender inclusive
- Age > 16 years (dependent on developmental maturity). In line with OLD licensing requirements, the facility will be licensed to take individuals > 14 years of age.
- Primary diagnosis of Eating Disorder (DSM-5), particularly Anorexia nervosa, Bulimia nervosa, Binge eating disorder and Other Specified Feeding or Eating Disorder (OSFED)
- Patients should ideally be at a BMI of > 13.5kg/m² (>75%IBW for adolescents)
- No significant self-harm/suicidal ideation
- Classified as a voluntary patient (not subject to detention under Mental Health Act 2016). Must be willing and able to consent to treatment
- Independent management of mobility
- No active substance dependence
- Residential treatment is the most appropriate mode of treatment at the time (Stepped care philosophy). Environmental stressors making treatment at home prohibitive (e.g. severe family conflict, lives alone). For younger patients, residential treatment will be considered for patients for whom FBT had not been successful or to whom FBT is not available.
- Manageable dietary restrictions (No veganism but religious and/or cultural dietary considerations will be catered for). Anaphylactic allergies will be considered on a case-by-case basis
- Medically stable as evidenced by: systolic BP 90mm (>80mm for adolescents) or above; heart rate >50 and <100 bpm; no significant postural tachycardia or hypotension; normal ECG; and, normal electrolytes

APPENDIX C: THE TREAT STUDY

Study Title: The Clinical and Demographic Correlates of Eating Disorder Treatment-Seekers study (The TrEAT Study).

Purpose: The purpose of the TrEAT study is to describe the characteristics (e.g., gender, type of eating disorder) of people who are referred to and receive treatment for an eating disorder at specialist treatment centres, as well as to describe what factors predict recovery among patients in Australia and New Zealand.

Methods: With participant consent, demographic and clinical information are gathered at baseline using self-report qualitative measures. Participants are asked to complete shorter surveys, to monitor and evaluate any changes in eating disorder symptoms at multiple timepoints including: weekly, short 5-minute surveys; week 4, a longer 15-minute survey; end treatment (week 8), longer survey; and, follow up surveys at 2- and 4-months post discharge. Data relating to participant treatment type and treatment duration are provided by the treatment centre. Data are analysed using quantitative measures using data from multiple specialist treatment centres across Australia and New Zealand.

Approval Number: #H14478

APPENDIX D. SURVEY QUESTIONNAIRES

Survey questionnaires

The following is a list of measures completed at the Wandi Nerida site within the TrEAT registry (HREC protocol no. H14478).

- Body Image Acceptance and Action Questionnaire: (BIAA-Q 5 items)
 - Sandoz, E. K., Wilson, K. G., Merwin, R. M., & Kellum, K. K. (2013). Assessment of body image flexibility: the body image-acceptance and action questionnaire. *Journal of Contextual Behavioral Science*, 2(1-2), 39-48.
 - Basarkod, G., Sahdra, B., & Ciarrochi, J. (2018). Body Image–Acceptance and Action Questionnaire–5: An Abbreviation Using Genetic Algorithms. *Behavior therapy*, 49(3), 388-402.
- CIA: Bohn, K., & Fairburn, C. G. (2008). The clinical impairment assessment questionnaire (CIA). *Cognitive behavioral therapy for eating disorders*, 315-317.
- EQ- 5D –5L (EuroQoL Research Foundation, 2018) <https://euroqol.org/eq-5d-instruments/eq-5d-5l-about/> Accessed 23 Nov 2021
- ED-15: Tatham, M., Turner, H., Mountford, V. A., Tritt, A., Dyas, R., & Waller G. (2015). Development, psychometric properties and preliminary clinical validation of a brief, session-by-session measure of eating disorder cognitions and behaviors: The ED-15. *International Journal of Eating Disorders*, 48, 1005-1115.
- EDEQ-V6: Fairburn CG, Beglin SJ. (2008) Eating Disorder Examination Questionnaire (6.0). In Fairburn CG. *Cognitive Behavior Therapy and Eating Disorders*. New York: Guilford Press.
- Generalised Anxiety Disorder Screener (GAD-7): Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of internal medicine*, 166(10), 1092-1097
- Patient Health Questionnaire (PHQ-9): Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ - 9: validity of a brief depression severity measure. *Journal of general internal medicine*, 16(9), 606-613.
- Role Impairment – Days out of role – see Korten, A., & Henderson, S. (2000). The Australian national survey of mental health and well-being: Common psychological symptoms and disablement. *The British Journal of Psychiatry*, 177(4), 325-330.
- Your Experience of Service Survey (YES survey)..<https://www.amhocn.org/your-experience-service-surveys>. Accessed 24/11/2021.

Wandi Nerida Additional Measures

Adverse Childhood Experience (ACE) Questionnaire:

Murphy, Anne, et al. "Adverse childhood experiences (ACEs) questionnaire and adult attachment interview (AAI): Implications for parent child relationships." *Child abuse & neglect* 38.2 (2014): 224-233.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, 14(4), 245-258.

Zarse, E. M., Neff, M. R., Yoder, R., Hulvershorn, L., Chambers, J. E., & Chambers, R. A. (2019). The adverse childhood experiences questionnaire: two decades of research on childhood trauma as a primary cause of adult mental illness, addiction, and medical diseases. *Cogent Medicine*, 6(1), 1581447.

International Trauma Questionnaire (ITQ):

Cloitre, M., Shevlin, M., Brewin, C. R., Bisson, J. I., Roberts, N. P., Maercker, A., ... & Hyland, P. (2018). The International Trauma Questionnaire: Development of a self - report measure of ICD - 11 PTSD and complex PTSD. *Acta Psychiatrica Scandinavica*, 138(6), 536-546.

12-Item Short Form Survey version 2 (SF-12 v2):

Ware Jr, J. E., Kosinski, M., & Keller, S. D. (1996). A 12-Item Short-Form Health Survey: construction of scales and preliminary tests of reliability and validity. *Medical care*, 220-233.

Kim, S. H., Jo, M. W., Ahn, J., Ock, M., Shin, S., & Park, J. (2014). Assessment of psychometric properties of the Korean SF-12 v2 in the general population. *BMC Public Health*, 14(1), 1-7.

Accommodation and Enabling Scale for Eating Disorders (AESED)

Sepulveda, A. R., Kyriacou, O., & Treasure, J. (2009). Development and validation of the accommodation and enabling scale for eating disorders (AESED) for caregivers in eating disorders. *BMC Health Services Research*, 9(1), 1-13.

Caregiver Burden Inventory:

Bertelli, S., Ferrara, P., Di Modica, S., Terzoni, S., Bergamelli, E., Gambini, O., ... & Destrebecq, A. (2021). Adaptation and validation of the Caregiver Burden Inventory in Eating Disorders.

Kessler-10:

Kessler, R.C., Andrews, G., Colpe, .et al (2002) Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine*, 32, 959-956.

Andrews, G., Slade, T (2001). Interpreting scores on the Kessler Psychological Distress Scale (k10). *Australian and New Zealand Journal of Public Health*, 25, 494-497 .

Mental Health Carer Experience Survey (CES; AMHOCN, 2017)

<https://www.amhocn.org/mental-health-carer-experience-survey-0>. Accessed 24/11/2021.

For health care providers: Clinical Sustainability Assessment Tool

Malone, S., Prewitt, K., Hackett, R., Lin, J. C., McKay, V., Walsh-Bailey, C., & Luke, D. A. (2021). The clinical sustainability assessment tool: measuring organizational capacity to promote sustainability in healthcare. *Implementation science communications*, 2(1), 1-12

APPENDIX E: QUALITATIVE INTERVIEW SCHEDULES

Interview Guide: Person Experiencing or Who Has Experienced an Eating Disorder

A selection of questions was used with each participant and scaffolded between:

- Experience (e.g. Can you tell me about ...?)
- Meaning (What does ... mean to you?)
- Identity (e.g. How does ... have you seeing yourself as a person?)
- Positioning on experience/identity conclusion (e.g. Is this OK for you? Why or why not?)

A) The interview was augmented with a timeline for narrative/discourse

1. Can you tell me your story of your eating disorder?

Prompts:

- a. When did you or someone you know notice you may be experiencing eating problems? How long did you experience eating problems before you were diagnosed with and eating disorder?
- b. Can you tell me about some of the impacts of the eating disorder on your life? Relationships? And what you do?
- c. How have these experiences shaped you as a person? Was this helpful or not? Why? Or Why not?
- d. What is your relationship with the eating disorder now? (Prompts: Do you feel this is in the past? Current? Problematic or not?)
- e. What does having experienced an eating disorder mean to you?

B) Experiences and Perceptions of Wandí Nerida

1. How did you hear about come to participate in the Wandí Nerida treatment program?
2. Can you tell me about your experience of Wandí Nerida?
3. Is it what you thought it would be? If not, how does it differ?
Deeper dive areas:
 - a. Care and/or support?
 - b. Perception of staff (e.g. Can you tell me about the staff at Wandí Nerida? Examples of encounters with staff)?
 - c. Centre location/facilities?
 - d. Perception of therapeutic relationships?
 - e. How do you feel about the content of the program/intervention?
 - f. Respect for beliefs/culture?
4. What was most helpful about the Wandí Nerida program? Why?
5. What was least helpful about the Wandí Nerida program? Why?
6. What could have been done differently in the Wandí Nerida program? What difference could doing things differently have made?
7. Do you feel that your cultural beliefs and values were taken into consideration by the treatment team? If not please outline what would have been helpful for you.
8. What sustained you during your time at Wandí Nerida?
9. Have you ever been admitted to an inpatient facility prior to your stay at Wandí Nerida? If so,

how do you feel Wandi compares to your past residential experiences? Day-program?

Answer (C) OR (D)

C) If the individual COMPLETED Wandi Nerida program

1. What stands out to you as you reflect on what your time at Wandi Nerida and its impacts on you?
Deeper dive questions:
 - a. Was this helpful? Why or why not?
 - b. *Is this what you were hoping for? If not, what were you hoping for?*
 - c. *What does this say about you and your hoped for the future? What matters to you as a person?*
2. What have you learnt about yourself as a person through your time at Wandi Nerida?
3. When did you finish Wandi Nerida?
4. What has your relationship with the eating disorder been like since you completed Wandi Nerida?
5. Do you anticipate this relationship changing in the future? 2 years time? 5 years time? How so?
6. How would you rate your satisfaction with the Wandi Nerida experience on a scale of 1 (totally dissatisfied) to 10 (totally satisfied)? Why did you rate your satisfaction with the treatment at Wandi Nerida as (number selected)? What would have increased/decreased this?

D) If the individual DISCONTINUED their time with Wandi Nerida

1. Can you tell us about the circumstances/your experiences that led you to no longer continue your journey with Wandi Nerida?
2. What have you learnt about yourself as a person through your time at Wandi Nerida?
 - a. Is this helpful or not?
 - b. Why or why not?
3. When did you leave Wandi Nerida?
4. Looking back, how do you make sense of why you chose not to continue with Wandi Nerida?
Prompt: Are you settled with the decision? Why or why not?
5. What has your relationship with the eating disorder been like since then? What has this been like for you?
6. Did you have any fears/concerns about your decision to discontinue Wandi Nerida?
7. Did you have any fears about continuing with Wandi Nerida? If so, what were they?
8. What were you hoping for as you made the decision to cease Wandi Nerida?

E) Questions to all participants regardless of whether completed or discontinued Wandi Nerida

1. What do you want to remember about your experiences at Wandi Nerida?
2. Based on what you know now, what would you tell a person who is about to start at Wandi Nerida? What might be important for them to know?
3. What feedback would you give to the team at Wandi Nerida?
4. What would you like more of in future treatments for eating disorder?
5. What would you like less of in future treatments for eating disorder?
6. What does this say to you about what matters for you/your family?
7. Do you have hopes for future treatment/therapy in terms of the sort of work you would like to engage in? Why and what does this say to you about what matters to you as a person?
8. What has stood out for you from our conversation today? (*Prompt: Has our conversation today been helpful or unhelpful or both? Why?*)
9. What are the key messages you want us to note as we explore the information from this interview?



Interview Guide: Parents/Carers/Partners

A selection of questions was used with each participant and scaffolded between:

- Experience (e.g. Can you tell me about ...?)
- Meaning (What does ... mean to you?)
- Identity (e.g. How does ... have you seeing yourself as a person?)
- Positioning on experience/identity conclusion (e.g. Is this OK for you? Why or why not?)

A) The Interview was augmented with a timeline for narrative/discourse

1. Can you tell me your story of the eating disorder as a family/couple?
Prompts:
 - a. When did you notice the eating disorder starting to have an influence over your child/partner's life?
 - b. What was this like for you as a parent/carer/partner?
 - c. How have your lives changed with your child/partner's experience of eating disorder?
 - d. How have these experiences shaped you as a person? As a parent/carer/partner? Was this helpful or not? Why?
2. Can you tell me a bit about your child/partner's relationship with the eating disorder now? How does this affect your life? Relationships? How you see yourself as a person/partner/parent?
3. Do you consider your child/partner's relationship with eating disorder to be problematic for them now? If so, how? If not, why?
4. What does your child/partner's having experienced an eating disorder mean to you as a parent/carer/partner?

B) Experiences of Wandí Nerida

1. How did you come to be involved with Wandí Nerida?
2. Can you tell me about your experience of Wandí Nerida? Is it what you thought it would be? If not, how does it differ?
Deeper dive areas:
 - a. Care and/or support?
 - b. Perception of staff?
 - c. Centre location/facilities?
 - d. Supports offered to families/parents/carers?
3. What was most helpful about Wandí Nerida? Why?
4. What was least helpful about Wandí Nerida? What could have been done differently? What difference could doing things differently have made?
5. Do you feel that your cultural beliefs and values were taken into consideration by the treatment team? If not please outline what would have been helpful for you.
6. What sustained you during your association with Wandí Nerida?
7. Has your child/spouse/partner ever been admitted to an inpatient facility prior to their stay at Wandí Nerida? If so, how do you feel Wandí compares to your past experience with residential services?
8. What role did the cost of the program play in a) your decision to participate? B) your impression of value for money? C) your decision to continue / discontinue?

Answer (C) OR (D)

C) If their child/partner COMPLETED Wandí Nerida

1. What stands out to you as you reflect on what your time at Wandí Nerida and its impacts on you?
Deeper dive questions:
 - a. Was this helpful? Why or why not?
 - b. *Is this what you were hoping for? If not, what were you hoping for?*
 - c. *What does this say about you and your hoped for the future? What really matters to you and your family?*
2. How has participating in the Wandí Nerida treatment programs affected how you see yourself as a person/parent/carer/partner? Is this helpful? Why or why not?
3. When did your family complete Wandí Nerida? What have you noticed about your child/spouse/partner's relationship with eating disorder since they completed their time at Wandí Nerida? Looking into the future, how do you anticipate this shifting?
4. How would you rate your satisfaction with the Wandí Nerida experience on a scale of 1 (totally dissatisfied) to 10 (totally satisfied)? Why did you rate your satisfaction with the treatment at Wandí Nerida as (number selected)? What would have increased/decreased this?

D) If their child/partner DISCONTINUED Wandí Nerida

1. Can you tell us about the circumstances/your experiences that led your family to no longer continue with Wandí Nerida?
2. When did your child/spouse/partner leave Wandí Nerida?
3. What has your child/spouse/partner's relationship with the eating disorder been like since then? How has this been for you as a person and as a parent/carer/partner since discontinuing Wandí Nerida?
4. Looking back, how do you make sense of the decision not to continue with Wandí Nerida?
Prompt: Are you settled with the decision? Why or why not?
5. How did participating in Wandí Nerida programs affect how you see yourself as a person/partner/parent? Is this helpful? Why or why not?
6. Did you have any fears/concerns about what might happen if your child/spouse/partner continued or discontinued Wandí Nerida?
7. Did you have any fears about continuing with Wandí Nerida? If so, what were they?
8. What were you hoping for as you made the decision to cease treatment at Wandí Nerida?

E) Questions to all participants regardless of whether completed or discontinued Wandí Nerida

1. What do you want to recall about yourself/child/partner/family from Wandí Nerida?
2. Based on what you know now, what would you tell a person or family who is about to start at Wandí Nerida? What might be important for them to know?
3. What feedback would you give to the team at Wandí Nerida?
4. What would you like more of in future treatments for eating disorder? What would you like less of in future treatments for eating disorder? What does this say to you about what matters for you/your child/ your family?
5. Do you have hopes for future treatment/therapy in terms of the sort of work you would like to engage in as a support person/carer? Why and what does this say to you about what you value as a person/parent/carer?
6. Do you have hopes for future treatment/therapy in terms of the sort of work you would like to engage in? What does this say to you about what you value as a person?
7. What has stood out for you from our conversation today? (*Prompt: Has our conversation today been helpful or unhelpful or both? Why?*)
8. What are the key messages you want us to note as we analyse the data from this interview?

APPENDIX F: ANALYTIC METHODS

Quantitative and participant demographic data were analysed as part of the broader clinical evaluation using SAS (Version 9.4) by Haider Mannan based at WSU. Baseline univariate between group tests were executed to compare groups on outcome variables as well as clinical and demographic data. Data were analysed following the “intention-to-treat” principle (Montori & Guyatt, 2001) for linear mixed effects modelling (Henderson et al., 1959), to test for between group differences in the continuous outcome measures, namely levels of ED symptom change, adaptive function, quality of life, depression and anxiety levels, and BMI. Analyses controlled for confounding variables at baseline, if any. Based on the Wandu participants who completed the follow-ups, mean, standard deviation, median and interquartile range were calculated for these continuous outcome measures at baseline and the follow up time points and Cohen’s d statistic was calculated as a measure of effect size for the longitudinal change in these outcome variables.

Qualitative data was analysed using reflexive thematic analysis (Braun & Clarke, 2019; 2021), with sensitised concepts (Gilgun, 2019) drawn from the key areas of the recovery model, as cited in the B-FREEDT Model of Care[®], such as symptom improvement, hope, recovery and identity shifts that include a reconnection with a sense of meaning and purpose. Identity shifts and participant experiences will be further analysed through qualitative methodologies such as grounded theory (Charmaz, 2006) and discourse/discursive qualitative methods (Burr, 1995; 2015). Transcripts will be exported to NVivo (Qualitative Research Solutions, 2020) before being coded, and a set of themes and subthemes inductively developed according to Braun and Clarke’s (2012; 2020) recursive six-phase approach to thematic analysis. Extracts that most richly represent the final set of themes and subthemes will be embedded within an analytic narrative to create a coherent/meaningful representation of participants’ experiences (Nowell et al., 2017).

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APPENDIX G: PRIMARY OUTCOMES TABLE

	Assessment	4-weeks	8-weeks Wandi Nerida only	Discharge	Cohen's d	3-month follow up	6-month follow up	Cohen's d
Measure	<i>n</i> mean (SD) Median (IQR)							
EDE-Q Global	70; 4.93 (1.36); 5.60 (4.5-6.0)	43; 3.45 (1.42); 3.53 (2.63-4.75)	34; 3.72 (1.13); 3.73 (3.2-4.6)	49; 2.69 (1.56); 2.23 (1.6-5.2)	-0.58174	33; 3.54 (1.51); 3.60 (2.07-4.82)	19; 3.64 (1.77); 4.43 (2.05-5.15)	0.04298
Global (Control)	24; 4.40 (1.18); 4.56 (3.59-5.40)	17; 4.48 (0.93); 4.4 (3.63-5.15)		17; 4.46 (0.98); 4.69 (3.51-5.11)	0.02835	7; 4.13 (1.83); 4.64 (2.04-5.5)	8; 3.90 (1.91); 4.44 (1.67-5.51)	-0.08695
Restraint	70; 4.62 (1.47); 5.20 (3.4-5.8)	43; 2.09 (1.66); 1.60 (1.0-3.6)	34; 1.94 (1.54); 1.70 (0.6-2.86)	49; 1.52 (1.70); 0.80 (0.3-2.3)	-0.62367	33; 3.32 (1.93); 3.20 (1.7-5.0)	19; 3.40 (2.03); 3.60 (1.55-5.1)	0.02869
Restraint (Control)	24; 4.02 (1.59); 4.6 (2.7-5.2)	17; 4.04 (1.38); 4.2 (3.0-5.2)		17; 4.13 (1.30); 4.20 (3.2-5.3)	0.024737	7; 3.80 (2.21); 4.80 (1.0-5.6)	8; 3.65 (2.13); 3.60 (1.4-5.9)	-0.04887
Weight concern	70; 4.93 (1.36); 5.60 (4.55-6.00)	43; 4.24 (1.71); 5.00 (3.2-5.6)	34; 4.72 (1.99); 5.20 (3.7-6.0)	49; 3.40 (1.99); 3.60 (1.6-5.2)	-0.00981	33; 3.76 (1.63); 3.60 (2.3-5.4)	19; 4.00 (1.94); 4.40 (1.6-6.0)	0.09472
Weight concern (Control)	24; 4.68 (1.34); 5.0 (4.2-5.8)	17; 4.87 (0.93); 4.8 (4.2-5.7)		17; 5.0 (0.89); 5.20 (4.2-5.7)	0.12043	7; 4.31 (1.81); 5.20 (2.6-6.0)	8; 4.13 (2.12); 4.80 (1.8-5.8)	-0.06457
Shape concern	70; 5.32 (1.52); 5.88 (5.12-6.00)	43; 4.83 (1.56); 5.63 (4.0-6.0)	34; 5.21 (1.07); 5.63 (4.69-6.0)	49; 3.96 (1.68); 4.00 (2.44-5.56)	0.10375	33; 4.27 (1.56); 4.75 (3.1-5.7)	19; 3.96 (1.99); 3.50 (2.5-6.0)	-0.1226
Shape concern (Control)	24; 5.04 (1.33); 4.0 (2.75-4.8)	17; 5.18 (0.83); 5.25 (4.56-6.0)		17; 5.15 (0.92); 5.38 (4.25-6.00)	0.037421	7; 4.98 (1.61); 5.88 (2.8-6.00)	8; 4.56 (1.87); 5.60 (2.6-6.0)	-0.1702
Eating Concern	70; 4.05 (1.19); 4.40 (3.6-4.8)	43; 2.66 (1.41); 2.60 (1.6-3.8)	34; 2.94 (1.20); 3.00 (2.1-4.0)	49; 1.88 (1.53); 1.60 (0.6-3.2)	-0.24887	33; 2.80 (1.50); 3.00 (1.3-4.1)	19; 3.03 (1.68); 3.00 (1.6-4.8)	0.10212
Eating (Control)	24; 3.87 (1.33); 4.00 (2.75-4.80)	17; 3.8 (1.33); 3.8 (2.9-4.9)		17; 3.61 (1.38); 3.80 (2.1-4.6)	-0.07151	7; 3.43 (1.97); 4.00 (1.8-4.6)	8; 3.28 (1.79); 3.80 (1.4-4.8)	-0.05635

Body Acceptance Q	70; 28.40 (7.13); 33.00 (27.0-35.0)	43; 29.79 (5.47); 31.00 (25.0-35.0)	34; 28.40 (10.65); 32.00 (27.0-35.0)	49; 24.00 (9.78); 25.00 (19.0-33.0)	-0.01353	33; 25.65 (8.42); 27.00 (19.00-33.25)	19; 23.90 (10.51); 24.00 (18.25-34.50)	-0.05635
EQ5D-5L- Utility Item	69; 0.72 (0.18); 0.72	43; 0.75 (0.17); 0.76	33; 0.71 (0.18); 0.89	47; 0.82 (0.18); 0.89	0.1320	32; 0.77 (0.18) 0.79	19; 0.78 (0.15); 0.76	0.04268
ED5D-5L - Utility Item (Control)	23; 0.96 (N/A); 0.97	17; 0.72 (0.15); 0.68		16; 0.72 (0.18); 0.71	n.a.			n.a.
Eating disorder-related impairment	70; 42.04 (8.24); 44.50 (40.0-48.0)	43; 33.91 (12.55); 36.00 (24.0-45.0)	34; 35.51 (10.65); 37.00 (30.5-45.0)	49; 26.09 (14.74); 25.00 (10.75-39.0)	-0.0586	33; 31.44 (12.65); 35.00 (18.25-41.75)	19; 35.12 (13.20); 41.00 (23.0-48.0)	0.20128
Mental Health related quality of life	65; 25.5 (9.1); 23.9 (19.5-31.1)	42; 27.7 (9.9);27.9 (21.1-35.5)	32; 25.7 (9.0); 24.9 (19.5-31.4)	46; 52.8 (7.3); 54.1 (49.1-58.1)	2.33855			n.a.
Physical Health related quality of life	65; 46.3 (8.9); 46.5 (39.3-51.7)	42; 49.6 (7.7); 50.7 (42.7-54.6)	32; 50.4 (7.6); 50.1 (44.6-56.8)	46; 37.7 (9.8); 41.3 (29.8-47.0)	-0.0519			n.a.
Role impairment/ days out of role	68; 17.19 (10.76); 20.00 (7.0-28.0)	43; 31 (12.76); 28.00 (0.0-28.0)	33; 16.03 (13.22); 28.00 (0.0-28.0)	44; 15.20 (13.46); 24.50 (0.0-28.0)	.00289	32; 8.81 (10.97); 3.50 (0.0-17.25)	19; 12.15 (12.07); 6.00 (0.0-28.0)	0.20478
Depression	70; 20.17 (6.17); 21.00 (16.0-25.5)	43; 15.46 (7.21); 15.00 (10.0-22.0)	34; 17.40 (6.19); 18.00 (12.5-22.5)	49; 12.01 (7.10); 11.00 (7.0-17.0)	-0.07626	33; 15.84 (8.07); 16.00 (9.25-22.75)	19; 15.89 (5.98); 14.00 (12.0-21.0)	.004978
Anxiety	70; 15.84 (5.28); 17.00 (12.5-21.0)	43; 13.56 (6.56); 13.00 (9.0-20.0)	34; 15.45 (5.16); 17.00 (11.5-21.0)	49; 10.47 (6.63); 9.00 (5.0-16.0)	-0.0550	33; 12.75 (7.17); 14.00 (7.5-20.75)	19; 14.79 (6.30); 18.00 (8.0-20.0)	0.21373
BMI kg/m ²	77; 18.49 (5.39); 16.85 (16.0-20.3)	67;19.65(5.77); 17.94 (16.7-21.3)	63;20.41(5.86); 18.77 (17.2-22.4)	63;22.31(5.35); 20.83(18.9- 24.8)	0.060			n.a.
BMI (control)	10; 23.29 (7.07); 20.0 (18.3-29.1)	13; 22.17 (5.48); 20.0 (19.2- 26.4)		7; 22.80 (6.44); 21.8 (18.6- 23.0)	0.06931			n.a.

Notes: n.a. = not applicable; Control refers to data from the participants at the Queensland Health (QH) day program where all discharge was at 8-weeks.; BMI is calculated using a calibrated scale and height stadiometer obtained at admission from health professional assessment; Effects sizes were calculated without data imputation; statistical testing between groups was not done as it was compromised by the >50% missing data on BMI in the QH group.

APPENDIX H: HIGHER DEGREE RESEARCH STUDENTS

Master's thesis: Research Outputs - Caitlin Clague

Publications

Caitlin Clague (Master's Thesis and Systematic Review)

Paper: Participant's lived experiences and perceptions of treatment at Wandu Nerida

Paper under review: Caitlin A. Clague, Janet Conti, and Phillipa Hay Outcomes and Associated Clinical Features of People with Eating Disorders Participating in Residential Treatment Facilities: A Scoping Review

Doctoral thesis: Research Outputs - Sinead Day

Publications

Day, S., Hay, P., Tannous, Wadad. K., Fatt, S. J., & Mitchison, D. (2023). A Systematic Review of the Effect of PTSD and Trauma on Treatment Outcomes for Eating Disorders. *Trauma, Violence, & Abuse*, <https://doi.org/10.1177/15248380231167399>

Day, S., Houlihan, C., Mitchison, D., Conti, J., Gill, K., Mannan, H., McMahon, K., Ramjan, L., Rankin, R., Tannous, K., Utpala, R., & Hay, P. (2023). Developing a Residential Treatment Service for Eating Disorders: Preliminary Outcomes, Challenges, and Adaptations for an Australian Context. Manuscript submitted for publication.

Fatt, S. J., George, E., Hay, P., Jeacocke, N., **Day, S.,** & Mitchison, D. (2023). A Systematic Review and Meta-synthesis of Qualitative Research Investigating Disordered Eating and Help-Seeking in Athletes. Manuscript submitted for publication.

Oral Presentations

- Presentation of study methodology and preliminary findings at Wandu Nerida staff meetings (21/7/22, 12/11/22).
- *Study Protocol and Preliminary Findings for an Outcome Evaluation of Residential Treatment for Eating Disorders* at the Australia and New Zealand Academy for Eating Disorders conference (12/8/22).

Additional PhD Specific Outcomes

- Completion of all tasks associated with preparing for and completing PhD confirmation of candidature. Confirmation of candidature completed on 4/4/22.
- Research design and ethics approval.
- Collection, cleaning, and analysis of data from Wandu Nerida and comparison site at Queensland Eating Disorders Service (QuEDS) hospital day program.
- In-person and virtual attendance of Wandu Nerida family days to provide information about the evaluation to carers and facilitate carer data collection.
- Completion and publication of systematic review (citation above).
- Completion of paper with preliminary treatment outcomes from first 6 months of program (citation above).
- Preparation of paper on prevalence of trauma-related symptoms.
- Fortnightly supervisory meetings with Dr Deborah Mitchison. Monthly supervisory meetings with Prof Phillipa Hay and A/Prof Kathy Tannous. Fortnightly meetings with full clinical evaluation team.

Planned outcomes

Abstracts submitted for oral presentation at the International Conference on *Eating Disorders* March 14-16th, 2024:

- Treatment outcomes and predictors of symptom improvement in an Australian residential program for eating disorders.
- Prevalence of PTSD and complex PTSD in individuals receiving eating disorder treatment.

Planned publications

Paper 1: Developing a residential treatment service for eating disorders: preliminary outcomes, challenges, and adaptations for an Australian context.

Objective: The aim of this paper is to outline the development of the Wandi Nerida residential service and provide preliminary outcomes from the first six months of data collection. These outcomes were analysed separately due to substantial changes that occurred within the treatment service and to describe the process of establishing a clinical evaluation.

Method: The paper begins with a summary of the evidence base for residential treatment for eating disorders and a comprehensive description of the Wandi Nerida treatment program. Additional information about program components was provided by former clinical director of Wandi Nerida, Catherine Houlihan. Analyses of preliminary treatment outcomes were conducted to assess changes in eating disorder symptoms and other variables from pre- to post-treatment. Findings showed improvement in eating disorder-related symptoms and impairment at discharge.

Status: Under review.

Paper 2: Predictors of treatment outcomes from an Australian residential program for eating disorders.

Objective: This paper will provide a cross-sectional evaluation of quantitative outcomes from pre-, mid-, and post-treatment at Wandi Nerida. These findings will build on the preliminary outcomes of paper 1 and will explore changes in symptoms during treatment.

Method: Data will be used from in-treatment surveys containing validated self-report measures of eating disorder symptoms, anxiety, depression, eating disorder-related impairment, and disability at admission, week 4, and end-of-treatment. Additional clinician-reported data will be used for eating disorder diagnosis and BMI. The paper will analyse changes in treatment outcomes between each of the three timepoints and will examine early change in eating disorder symptoms as a predictor of post-treatment psychopathology.

Status: In preparation. Expected completion early 2024.

Paper 3: Comparing longitudinal outcomes from a residential and hospital day program for eating disorders.

Objective: To provide a longitudinal account of the effectiveness of the Wandi Nerida residential service, which will determine whether treatment gains are maintained post-discharge. This paper will also compare the effectiveness of the service with that of a hospital day program for eating disorders.

Method: As outlined above, data on treatment outcomes will be gathered through in-treatment surveys as well as surveys distributed via email at 3- and 6-months post-discharge. The same method will be applied to the hospital day program comparison site, the QuEDS hospital day program. It is expected that multilevel modelling techniques will be used to examine longitudinal changes in treatment outcomes.

Status: Awaiting further data collection. Expected completion late 2024.

Paper 4: Carer outcomes in residential treatment for eating disorders.

Objective: Although previous research has established detrimental impacts of eating disorders on the carers of affected individuals, there has been no prior investigation of the effects of residential treatment on the carers of participants. This paper aims to analyse changes in carer outcomes following the Wandi Nerida residential program. This will have implications for whether treatment benefits extend beyond the program participant to members of their support circle.

Method: Data will be used from online surveys of carers of Wandi Nerida participants. The surveys include quantitative measures of carer burden, distress, accommodation and enabling of eating disorder symptoms, and treatment satisfaction. Surveys are distributed at admission, discharge, and 3-months post-treatment. Survey links are provided to carers by Wandi Nerida staff members.

Status: Awaiting further data collection. Expected completion mid 2024.

Paper 5: A systematic review of the effect of PTSD and trauma on treatment outcomes for eating disorders.

Objective: There is substantial literature on the role of trauma in the aetiology of eating disorders but relatively less research on how it may affect treatment outcomes. This paper aimed to provide a systematic review of previous research on how a history of traumatic experiences and trauma-related symptoms (including PTSD) affect eating disorder treatment outcomes. The findings of this review have implications for the investigation of potential moderating variables of treatment outcomes in the Wandi Nerida evaluation.

Method: A systematic review was conducted according to PRISMA guidelines. Sixteen papers met inclusion criteria and their results were synthesised. Findings suggested a negative effect of trauma and PTSD on eating disorder treatment outcomes.

Status: Published.

Paper 6: Prevalence of PTSD and complex PTSD in individuals receiving eating disorder treatment.

Objective: CPTSD is a newly established diagnosis that may be particularly relevant to eating disorders given previous research on the effects of childhood trauma on eating disorder development. However, there has been no prior studies of CPTSD prevalence in eating disorder populations. The aim of this paper is to determine the prevalence of PTSD, CPTSD, and childhood trauma exposure across three eating disorder treatment groups.

Method: Data were used from online pre-treatment surveys of Wandi Nerida participants, QuEDS participants, and individuals receiving outpatient psychological treatment at one of the other TrEAT clinical sites. The surveys included a validated measure of PTSD and CPTSD according to ICD-11 diagnostic criteria and a measure of childhood trauma experiences. Descriptive statistics are used to provide the prevalence of PTSD and CPTSD symptom clusters and probable diagnoses, and the occurrence of specific forms of childhood trauma. Further analyses compare the prevalence of PTSD and CPTSD across the differing levels of care and their association with eating disorder symptoms.

Status: In preparation. Expected completion late 2023.

Paper 7: The effect of PTSD and CPTSD symptoms on eating disorder treatment outcomes

Objective: Given systematic review findings of the potential negative effects of trauma-related symptoms on eating disorder treatment outcomes, and the established prevalence of such symptoms in the evaluation sample, it is important to investigate whether outcomes at Wandi Nerida are affected by PTSD and CPTSD symptoms. This paper will explore different types of trauma-related symptoms as potential moderators of key treatment outcomes.

Method: As described above, data will be used validated trauma-related measures included in online surveys of Wandi Nerida participants. Outcomes will be compared from pre- to post-treatment. If sufficient sample sizes are available, outcomes will also be included at six-months post-treatment and compared to those from the QuEDS hospital day program. Analyses will include whether CPTSD symptoms predict a differential treatment response.

Status: Awaiting further data collection. Expected completion late 2024.

Thesis outline

Chapter 1: Introduction to eating disorder treatment and residential programs.

This introductory chapter will provide a generalised background on eating disorders and existing treatment approaches. Further information will be provided on the approach of residential services and their current evidence base, as well as research on potential moderators of treatment outcomes.

Chapter 2: Project aims.

This chapter will establish the aims of the thesis in relation to the limitations of and gaps in the literature discussed in the previous chapter.

Chapter 3: Overview of methodology and methods.

Methods will be described for the quantitative aspects of the clinical evaluation of the Wandi Nerida treatment facility and comparison site QuEDS.

Chapter 4: Development of the Wandi Nerida service and preliminary outcomes.

This chapter will consist of paper 1, containing an account of the development and content of the Wandi Nerida program and findings from the first six months of the service.

Chapter 5: Cross-sectional outcomes from residential treatment.

This chapter will be based on paper 2. It will include Wandi Nerida clinical outcomes at pre-, mid-, and post-treatment and analysis of predictors of better outcomes at end-of-treatment.

Chapter 6: Longitudinal outcomes from residential treatment.

This chapter will explore the findings from Wandi Nerida at 3- and 6-month follow-ups, and the effectiveness of the program in comparison to the QuEDS hospital day service, as outlined for paper 3.

Chapter 7: Carer outcomes.

Quantitative outcomes for carers of participants in the residential service will be provided as per paper 4.

Chapter 8: Systematic review of the effect of trauma on eating disorder treatment outcomes.

Trauma will be explored as a potentially important variable affecting eating disorder treatment outcomes, as outlined for paper 5.

Chapter 9: Prevalence of trauma-related symptoms in eating disorder treatment samples.

This chapter will consist of paper 6, establishing the prevalence of childhood trauma experiences, PTSD, and CPTSD in Wandi Nerida residential treatment participants as well as participants from a hospital day program and outpatient care.

Chapter 10: The influence of trauma on residential treatment outcomes.

As per paper 7, this chapter will examine the influence of PTSD and CPTSD symptoms on outcomes from the residential service.

Chapter 11: Discussion and Conclusions.

The final chapter of the dissertation will consist of an overall discussion and triangulation of findings from each of the studies. It will discuss the contributions the research has made, as well as implications and limitations of the project, in addition to overall concluding remarks.

Doctoral thesis: Research outputs - Rebekah Rankin

Publications

Hay, P. J., **Rankin, R.**, Ramjan, L., & Conti, J. (2023). Current approaches in the recognition and management of eating disorders. *Medical Journal of Australia*.
<https://doi.org/10.5694/mja2.52008>

Rankin, R., Conti, J., Ramjan, L., & Hay, P. (2023). A systematic review of people's lived experiences of inpatient treatment for anorexia nervosa: living in a "bubble". *Journal of Eating Disorders*, 11(1), 1-17. <https://doi.org/10.1186/s40337-023-00820-0>

Rankin, R., Conti, J., Touyz, S., Arcelus, J., Meyer, C., and Hay, P. (2021). Dancing with change: A qualitative exploration of in-session motivation to change in the treatment of anorexia nervosa. *Australian Psychologist*, 58(2), 119-130.
<https://doi.org/10.1080/00050067.2022.2151338>

Oral Presentations

- Rebekah Rankin co-facilitated a full-day pre-conference workshop with Dr Catherine Houlihan (previous Director, Wandí Nerida) and Dr Carly Roukos (clinical psychologist, Wandí Nerida) at the ANZAED conference (24/082023). The goals of this workshop were to provide training in new service development, and borrowed heavily from the team's experiences in developing and evaluating Wandí Nerida. The workshop was titled *Building the Village - Developing Specialist Treatment Services for Eating Disorders: Examples from Residential and Other Models of Care*.
- In addition, Sinead Day and Rebekah Rankin co-presented the study protocol and initial findings for the Wandí Nerida evaluation at the August 2022 Australia & New Zealand Academy for Eating Disorders (ANZAED) Conference.
- Presentation of study methodology and preliminary findings at Wandí Nerida staff meetings (11/07/2022 and 21/08/2023)
- *Living in a "bubble": A systematic review of people's lived experiences of inpatient treatment for anorexia nervosa* at the *Eating Disorders and Body Image* early career presentation showcase (17/08/2022)
- *Dancing with Change: In-Session Motivation to Change in the Treatment of Anorexia Nervosa* at the *Eating Disorders and Body Image* early career presentation showcase (05/08/2022).

Additional PhD Specific Outcomes

- Completion of all tasks associated with preparing for and completing PhD confirmation of candidature. Confirmation of candidature completed on 13 May 2022.
- Research design and ethics approval.
- Data collection and analysis
- Completion systematic review and meta-analysis of participant experience of inpatient or residential treatment of anorexia nervosa
- Fortnightly supervisory meetings with Dr Janet Conti and A/Prof Lucie Ramjan. Monthly supervisory meetings with Prof Phillipa Hay.

Planned outcomes

Abstracts submitted for oral presentation at the International Conference on *Eating Disorders* March 14-16th, 2024:

- Patient lived experiences of residential treatment for an eating disorder in Australia
- Dancing with Change: In-Session Motivation to Change in the Treatment of Anorexia Nervosa
- Living in a "bubble": A systematic review of people's lived experiences of inpatient treatment for anorexia nervosa

Planned publications

Paper 1: Systematic Review

Background and Objective: The candidate was unable to find any reviews of qualitative literature regarding the lived experience of participants in ED treatment facilities—inpatient, residential, and day programs. This paper aims to synthesise current literature pertaining to patients lived experience of residential, inpatient and day program ED treatment. This will provide a greater understanding of the current literature as well as provide information to direct future research and interventions.

Method: A systematic review will be conducted following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. The candidate, in consultation

with the librarian, has independently searched the PubMed, PsychINFO, SCOPUS, CINAHL, Web of Science and ProQuest databases using a multi-field search on April 20, 2023. The following search terms and Boolean operators were employed where the terms appeared in either the title or abstract of the article: (“eating disorder*” OR “ano-rex*” OR “anore*” OR “bulimi*” OR “binge eating disorder*” OR “EDNOS*”) OR “OSFED*” AND (“In-tervention*” OR “treat*” OR “residential*” OR “partial hospitalization” OR “Inpatient*”) AND (“qualitative*” OR “perspective*” OR “experience*”). The candidate manually reviewed the reference lists of articles obtained in the primary database search to identify additional relevant studies.

Status: Published.

Paper 2 and 3: Clinical evaluation qualitative research findings—patients and carers

Background and Objective: Current evidence for the use of residential care for people with EDs is limited, and there is only one residential facility for the treatment of EDs in Australia. The author was unable to find any controlled trials of residential care versus other treatment settings. Furthermore, little attention has been paid to patients’, carers’ and health care providers’ perceptions, satisfaction and lived experiences of ED residential treatment programs. These papers will aim to investigate patients’ and carers’ experiences, perception and satisfaction with care at Wandu Nerida.

Method: Patients’/patients’, carers’ and health care providers’ experiences, perception and satisfaction with care will be explored in semi-structured interviews post treatment, as well as through the use of open-ended questions accompanying validated measures at baseline, mid-treatment, end-treatment, and 3- and 6-month follow up. Interview schedules, developed by the candidate in consultation with her supervisors and a lived experience advisory group will be informed by the practice of narrative therapy to explore ways participants perceive and ascribe meaning to their treatment experiences, and their identity negotiations within these contexts. Transcripts will be analysed using reflexive thematic analysis. Participant identity shifts and experiences will be further analysed through qualitative methodologies including, grounded theory and discourse/discursive qualitative methods.

Status: Data analysis ongoing. Anticipated publication early to mid 2024.

Paper 4 and 5: Clinical evaluation qualitative research findings—health care professionals

Background and Objective: While preliminary research and anecdotal stories and feedback point to the value of lived experience practitioners in supporting the recovery and wellbeing of people with a mental illness, offering hope, and providing a source of inspiration and tested recovery strategies, the discipline and unique role of the lived experience practitioner remains under-researched (Graham et al., 2020). Understanding the lived experiences of health care providers and staff in ED treatment services is critical given that the clinician–patient alliance has been shown to affect treatment outcomes (Graves et al., 2017). Furthermore, evaluation of the lived experience workforce is critical for quality improvement and to ensure the wellbeing of people with a lived experience, including identifying the need for support and appropriate supervision and training of the lived experience workforce, including ways that they sustain themselves in their work. This final paper will aim to investigate health care professionals’ experiences, perception and satisfaction with care at Wandu Nerida, of which some will have lived experience.

Method: Health care providers' experiences, perception and satisfaction with care will be explored through mixed methods (open-ended questions accompanying validated measures at a single time point and through semi-structured interviews). Qualitative data will be analysed using reflexive thematic analysis with sensitised concepts. Participant identity shifts and participant experiences will be further analysed through qualitative methodologies including grounded theory and discourse/discursive qualitative methods. Quantitative data will be analysed using IBM SPSS Statistics (Version 28) by research persons based at WSU.

Status: Final data collection ongoing. Anticipated publication mid to late 2024.

Thesis Outline

Chapter 1: Setting the Scene – an introduction to eating disorders and eating disorder treatment

This introductory chapter will provide a generalised background to EDs, focusing on the diagnostic criteria, prevalence, health risks and mortality rates for varying categories of EDs. This chapter will also briefly describe current models of care and treatment for EDs, with a particular emphasis on the growth of the residential treatment industry.

Chapter 2: Patient lived experience of residential and inpatient eating disorder treatments—a systematic review

This chapter will consist of a systematic review (Study 1), identifying and synthesising current literature pertaining to patients' lived experience of residential and inpatient ED treatment. This will provide a greater understanding of the current literature as well as providing information to direct future research and interventions.

Chapter 3: Overview of methodology and methods

This chapter will provide an overview of the methodologies used for the qualitative aspects of the clinical evaluation of the Wandí Nerida treatment facility. An outline of the Wandí Nerida treatment facility and structure will be provided.

Chapter 4: Patients' experiences, perceptions and satisfaction with care

This chapter will explore the qualitative results—interview and open-ended survey question data—of the Wandí Nerida clinical evaluation. Specifically, those results pertaining to patients'/patients' experiences, perception and satisfaction with care at Wandí Nerida. This chapter will house the second study, aiming to understand the experiencing person's treatment experience journey from the position of their sense of self, identity, culture and autonomy.

Chapter 5: Carers' experiences, perceptions and satisfaction with care

This chapter will explore the qualitative results—interview and open-ended survey question data—of the Wandí Nerida clinical evaluation. Specifically, those results pertaining to carers' (e.g. parent, spouse, partner) experiences, perception and satisfaction with care at Wandí Nerida. This chapter will house the third study, aiming to understand the treatment experience and journey of carers' who have a child or significant other undergoing treatment at the Wandí Nerida treatment facility.

Chapter 6: Health care providers' experiences, perceptions and satisfaction with care

This chapter will both quantitative and qualitative results of the Wandí Nerida clinical evaluation. Specifically, those results pertaining to health care professionals—including health care professionals with a lived experience of an ED—experiences, perception and satisfaction with care at Wandí Nerida. This chapter will house the fourth and fifth study, aiming to understand health care professionals' experiences, perception and satisfaction with care at Wandí Nerida.

Chapter 7: Discussion and Conclusions

The final chapter of the dissertation will consist of an overall discussion and triangulation of findings collated from relevant results from all five studies. It will discuss the contributions the research has made, as well as implications and limitations of the study, in addition to overall concluding remarks.