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Through The Lens of Lived Experience: An Exploratory Analysis of Patient
Experiences Associated with Private Hospital Inpatient Eating Disorder Treatment in
Australia

A thesis presented in complete fulfilment of the requirements for the degree of

Masters of Arts

At Massey University, Auckland

Aotearoa, New Zealand

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February 2026

Abstract

Eating disorders (EDs) are multifaceted and complex psychiatric conditions with associated life threatening physiological and psychological risks, coupled with significantly elevated mortality rates compared to other psychiatric diagnoses. In Australia, ED treatment is delivered on a continuum, commencing in the community, then increasing based on acuity to day-patient, public hospital inpatient, residential care, or private hospital inpatient eating disorder program treatment. The substantial and increasing prevalence of EDs impacts treatment accessibility much of which is inaccessible due to supply and demand, alongside a multitude of barriers. The current study aimed to extend upon the limited existing research within the field of ED privatised treatment, by investigating for the first time, patient experiences associated with private hospital inpatient eating disorder treatment across Australia. Participants ($N = 62$) aged between 19 and 45 years of age ($M = 28.33$, $SD = 4.96$) completed self-report questionnaires assessing their experiences in private hospital inpatient eating disorder programs. Therapy provision, psychiatry, meal plans, supported eating, nursing, social eating, food preparation, independent eating, weigh-ins, and discharge experiences were assessed. Results were indicative of fluctuating levels of satisfaction and dissatisfaction dependant on each niche area assessed. To follow, participants had the opportunity to self-report their experience. The results found some commonalties in satisfaction (e.g., feeling heard, individualised treatment). However, the broader consensus reflected distressing self-reported treatment experiences. Overall, the findings suggest that whilst some aspects of private hospital inpatient eating disorder treatment were satisfactory, the quantity and depth of self-reported distressing treatment experiences warrants future additional research.

Acknowledgements

To those I have met along my own recovery journey, and who are no longer with us today, I hope in some way your voice and experiences are represented in the current review in some way. Despite no longer being earthside, your voice, your journey, and your contributions to society as human beings deeply mattered. Elyse and Lauren, thank you wholeheartedly for all that you did throughout my own journey, we need many more equivalents of you both in society, and in the eating disorder treatment realm.

Kathryn, thank you for not being scared to take this research topic on, it's been an absolute pleasure working with you from afar!

Charlie, as you grow older, you will learn when important things happen, and you choose to speak up, it generally means that meaningful change can be facilitated. Don't be afraid to speak out and go against 'the norm' to use your voice meaningfully – I hope I can make you proud. Love Mum.

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Introduction

Eating disorders (EDs) are complex psychiatric conditions which often lead to life threatening physiological and psychological consequences and present significantly elevated mortality rates and suicide rates in comparison to other psychiatric diagnoses and the general population (American Psychiatric Association, 2022; Barakat et al., 2023; Bryant et al., 2021; Hambleton et al., 2022; Kreg et al., 2021; Mendes et al., 2023; Mendes et al., 2025; Robison et al., 2025; Russell et al., 2019; Sohn et al., 2022; Soullane et al., 2023; Tabuenca et al., 2025; Yang et al., 2021). Of note, the diagnosis evidenced to exhibit the most significant mortality rate is Anorexia Nervosa (AN) (Bryant et al., 2021; Hambleton et al., 2022; Mendes et al., 2023; Russell et al., 2019; Tabuenca et al., 2025; Van Hoeken & Hoek, 2020). In addition to the clearly evidenced elevated mortality rates and suicide rates among the ED populations, ED comorbidity rates are indicative of a further escalation, whereby, those who experience an ED often experience additional psychiatric diagnoses, including, anxiety, mood, trauma, personality, substance, and neurodevelopmental related disorders (Beveridge et al., 2019; Day et al., 2025; Mooney et al., 2023; Moroshko et al., 2025; Morris et al., 2025).

EDs share a key commonality, regardless of specific diagnoses, which is the presence of eating disturbances and/or concerning eating behaviours indicative of substantial disturbance (American Psychological Association, 2022; Bryant et al., 2021; Hambleton et al., 2022; Mendes et al., 2025). In 2023, Australia reported more than 1.1 million individuals (4.5% of population) who experienced an eating disorder, which has increased in prevalence by 36% within the last decade, indicating an exponential increase in prevalence (Deloitte, 2024; NEDC 2023). Given the multifaceted, complex, and often enduring nature indicative of EDs, the society cost of EDs remains monumental, indicated by the annual financial societal

burden directly attributable to EDs exceeding \$66 billion in 2023 (Deloitte, 2024; Van Hoeken & Hoek, 2022).

ED treatment in Australia typically commences in the community (e.g., no hospitalisation), with various health professionals such as a psychologist, dietitian, and general practitioner (GP) typically being involved to support ED patients to address psychological and physiological factors, due to well-functioning multidisciplinary team approaches being the evidenced gold standard for ED intervention in community settings (Clague et al., 2024; McMaster et al., 2022; Naenas et al., 2023; NEDC, 2025; Pehlivan et al., 2022; Rankin et al., 2023; Russell et al., 2025; Yang et al., 2021). When ED patient's acuity, which can be comprised of physiological concerns, psychological concerns, or a combination of both, exceeds that of a manageable level suited to a community-based setting, ED treatment progresses to higher levels of care, indicative of day patient programs (e.g., attending during the day and returning home in the afternoon) and inpatient hospital-based treatment, depending on severity. However, engaging in community, day patient, and inpatient treatment comes as no simple task, and substantial barriers exist to prevent ED patients accessing all forms of treatment, including treatment cost, available trained community clinicians, geographical isolation, travel to engage in all forms of treatment, exponential higher levels of care capacity limitations in all states, a lack of broader clinician and inpatient treatment programs which clearly considering and incorporate dual diagnostic related factors, and patients negative past treatment experiences creating help seeking barriers in addition to the multiple systemic barriers outlined above (Butterfly Foundation, 2020).

The disparities between prevalence, escalation of prevalence, and ongoing societal costs, is not indicative of adequate treatment provision in Australia, indicated by a meagre 43 public hospital beds nationwide to provide specific treatment provision for ED patients in

Australia in 2023 (NEDC 2023; Rankin et al., 2023; Russell et al., 2025; Tobin et al., 2023). Similarly, the private health system also remains greatly in deficit for the demand that is required for ED treatment. Eight private hospital inpatient eating disorder programs were available in Australia in 2023. Of the eight programs, specific localities are indicative of three in Queensland (QLD) (Ramsay Clinic New Farm, Robina Private Hospital, and Cooina Mental Health Service), two in Victoria (VIC) (The Melbourne Clinic and The Geelong Clinic), two in New South Wales (NSW) (Ramsay Clinic Northsides and Ramsay Clinic Wentworthville), and a singular clinic in Western Australia (W.A) (Ramsay Clinic Hollywood). Thus, when both public and private options for ED treatment are collectively considered, they unequivocally indicate limitations in treatment quantity, resourcing, treatment geographic locality (Butterfly Foundation 2020; Byrant et al., 2021; Tobin et al., 2023) and exhibit greater disparities indicative of nil of either treatment option in 2023 in Australian Capital Territory (ACT), Tasmania (TAS), and Northern Territory (NT).

The existing body of research in the realm of private hospital inpatient eating disorder program treatment remains extraordinarily low, with only seven studies published to date. Further, from a ‘collective eight’ perspective, nil current research which examines all eight clinics within a singular study exists. Whilst Northside Clinic has completed two studies which actively examined dual diagnosis (Lojewski et al., 2012; Swinbourne et al., 2012), the five remaining studies unequivocally focused on weight related factors. Therefore, being broadly inconsistent with the need for individualised, person centred, dual diagnostic informed approaches, in the absence of the primary focus being weight gain, and therefore, outdated. The current body of research in the realm of private hospital inpatient eating disorder units remains extremely limited in quantity, with scope limitations not indicative of the broader ED populations. The aim of this research is to address this gap.

A Literature Review: Eating Disorders in Australia

Eating disorders (EDs) are multifaceted, severe, and complex psychiatric conditions which can lead to life threatening physiological and psychological consequences (Barakat et al., 2023; Hambleton et al., 2022; Mendes et al., 2025; Tabuenca et al., 2025 Yang et al., 2021). Given the severity of the psychopathology and cognitions that comprise EDs and subsequent disordered eating behaviours, EDs have a significantly elevated mortality rate compared to other psychiatric diagnoses primarily due to physiological complications or suicide (Bryant et al., 2021; Hambleton et al., 2022; Mendes et al., 2023; Russell et al., 2019; Tabuenca et al., 2025). Further, the mortality risk is particularly elevated in Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Other Specified Feeding and Eating Disorder (OSFED) diagnoses (Bryant et al., 2021; Hambleton et al., 2022; Mendes et al., 2023; Russell et al., 2019; Tabuenca et al., 2025; Van Hoeken & Hoek, 2020). Furthermore, EDs rarely present in diagnostic isolation, with common comorbidities including trauma related disorders, anxiety related disorders, substance use disorders, personality disorders, and mood related disorders (Beveridge et al., 2019; Day et al., 2025; Mooney et al., 2023; Moroshko et al., 2025; Morris et al., 2025).

ED symptoms vary depending on diagnostic factors, but the commonality indicated across all ED diagnoses are significant disturbances in eating and/or eating related behaviours (American Psychological Association, 2022; Bryant et al., 2021; Hambleton et al., 2022; Mendes et al., 2025). Typically, on a sliding continuum of care, ED treatment in Australia varies from low intensity community management and progresses through to higher levels of care, including intensive day patient and inpatient hospital-based treatment, depending on severity (Rankin et al., 2023). However, research indicates that several barriers preventing such access to treatment exist, including, cost, location, travel, prior negative treatment

experience, severely limited specialist treatment providers in the public system, severely limited specialist treatment providers in the private health system, lack of eating disorder trained professionals, and lack of awareness of co-occurring comorbidities in treatment (Butterfly Foundation, 2020).

In 2023, over 1.1 million individuals reported experiencing an eating disorder in Australia, which was approximately 4.5% of the total population (Deloitte, 2024). Distressingly, this number has increased by 36% within the past 10 years, indicating an ongoing and significant escalation in the number of individuals experiencing an eating disorder (Deloitte, 2024; NEDC 2023). In 2023, the annual societal cost of EDs was estimated to be approximately \$66 billion and the healthcare system burden being \$251 million annually (Deloitte, 2024). Therefore, unequivocally indicating the significant economic burden associated with EDs (Van Hoeken & Hoek, 2022;). Despite the significant escalation in prevalence and the significant societal burden, in 2023, there were only 43 public hospital beds allocated for the treatment of ED patients Australia wide (Tobin et al., 2023). Therefore, despite the ongoing increase in the prevalence of EDs as indicated above over the past 10 years, ED research continues to be underfunded (Deloitte 2024; NEDC 2023; Rankin et al., 2023; Russell et al., 2025) and eating disorder treatment continues to be under resourced, underfunded, and under significant pressure (Butterfly Foundation 2020; Byrant et al., 2021; Tobin et al., 2023).

This literature review will broadly discuss ED and ED treatment in Australia, and will explore various factors including ED diagnostic factors, treatment specific options in Australia, dual diagnosis, suicide and non-suicidal self-harm risk, financial and societal burdens, and the perception of eating disorders by health practitioners. To follow, the limited existing research will be explored, along with relevant supporting literature to highlight the

importance of qualitative research and lived experience contributions in the eating disorder treatment realm. To conclude, the current limitations of existing research will be explored and suggestions for future directions for eating disorder research and eating disorder treatment advances will be provided.

Eating Disorders

Eating disorders as a broad concept are characterised by significant disturbances in feeding and eating behaviours, which can directly impact an individual's consumption of food (intake), thus leading to potential and significant detrimental physiological health symptoms, and impaired psychological health and well-being (American Psychiatric Association, 2022; Baenas et al., 2023; Barakat et al, 2023; Tabuenca et al., 2025). Further, evidenced potential consequential medical commodities include dental, reproductive, skeletal, endocrine, and gastrointestinal system risks across many ED diagnoses (Ahmed et al., 2024). Whilst the above is common across all disorders, there are unique differences between diagnoses, which is particularly key for clinical approach and treatment provision (American Psychiatric Association, 2022).

Anorexia Nervosa (AN)

AN is a restrictive eating disorder indicative of severe food and caloric control and restriction, AN presents with clinical indicators indicative of significant weight loss, a body weight considered very low, intense self-evaluation, self-comparison, and extensive appearance concerns (e.g., exponential body image deficits) which notably exceed body or appearance dissatisfaction, and perfectionist traits (American Psychiatric Association, 2022; Baenas et al., 2023; Barakat et al., 2023; Deloitte, 2024; Fitterman-Harris et al, 2024; Meneguzzo & Todisco, 2024; Skalski-Bednarz et al., 2024; Seiler et al., 2025).

AN is characterised by significant caloric restriction, associated substantial weight loss thus leading to low body weight, body images disturbances, intense fear of gaining weight (despite often significant weight loss), maintaining a perceived undesirable weight, significant focus on self-evaluation (e.g., body image, appearance, weight), co-occurring perfectionistic traits, and broader unrelenting high standards of self (American Psychiatric Association, 2022; Baenas et al., 2023; Skalski-Bednarz et al., 2024; Seiler et al., 2025). Individuals with AN experience body image disturbances that extend well beyond body dissatisfaction (Barakat et al., 2023; Deloitte, 2024; Fitterman-Harris et al., 2024; Meneguzzo & Todisco, 2024; Skalski-Bednarz et al., 2024; Van Hoeken & Hans, 2020). Typically, these individuals experience a functionally severe cognitive disposition towards their body, indicative of avoidance of one's body, detachment from one's body, compulsive actions as control methods to manage one's severe body image disturbances, and intensive appearance concerns (Barakat et al., 2023; Fitterman-Harris et al., 2024; Meneguzzo & Todisco, 2024).

AN presents with two subtypes, a restrictive type (nil engagement in compensatory behaviours within 3 months) or binge-eating/purging type, whereby within a 3 month period an individual has engaged in reoccurring purging, laxative misuse, or binge eating behaviours (American Psychiatric Association, 2022). The evidenced risks associated with AN are significant, as starvation effectively all organ systems (Russell et al., 2025; Skalski-Bednarz et al., 2024). Common complications associated with AN include malnutrition, cardiovascular complications (e.g., low systolic blood pressure, orthostatic hypotension, bradycardia, cardiac atrophy, postural tachycardia), gastroparesis, dysphasia caused by muscle wastage in the oesophageal region, endocrine/metabolic complications, pressure ulcers, osteopenia, and osteoporosis with subsequent increased risk of bone fractures, hypoglycaemia, hypokalaemia, and neuropsychological deficits (Baenas et al., 2023; Seiler et al., 2025).

In 2023, whilst AN comprised just 4% of the total estimated ED population in Australia but accounted for 75% of the health system burden (Deloitte, 2024). Moreover, AN has the highest mortality rate of all psychiatric disorders, thus representing a severe, life threatening, and complex eating disorder, which requires significant multidisciplinary team collaboration due to multisystemic involvement (Baenas et al., 2023; Russell et al., 2025; Skalski-Bednarz et al., 2024). AN has a mortality rate that exceeds that of any other psychiatric disorder, therefore, indicative the severity of the multifaceted and multisystem disorder and the subsequent specialist intervention that is required to best support individuals with AN (Baenas et al., 2023; NEDC, 2025; Russell et al., 2025; Skalski-Bednarz et al., 2024).

Bulimia Nervosa (BN)

BN is characterised by repeated episodes of binge eating (eating an excessively large amount of food compared to a societally typically perceived amount) within a discrete period of time, perceived loss of control of eating during such episodes, followed by compensatory behaviours to attempt to mitigate weight gain (e.g., self-induced vomiting, laxative or diuretic misuse, use of other medication, or excessive exercise, with co-occurring body image disturbances and weight dissatisfaction (American Psychiatric Association, 2022; Hou et al., 2022). Due to the purging behaviours seen in BN, known common medical complications include electrolyte imbalances, oral ulcers, oesophageal weakness, and cardiovascular complications (American Psychiatric Association, 2022; Baenas et al., 2024). Further, BN can lead to significant psychological and psychosocial impairments (Deloitte, 2024).

Binge Eating Disorder (BED)

Binge eating can be described as eating a very large quantity of food (compared to how the general population would consume in one sitting) within a discrete time (such as two

hours) (American Psychiatric Association, 2022). BED is characterised by recurrent instances of binge eating within a discrete period, including eating rapidly, eating beyond feeling uncomfortably full, eating when not hungry, eating in secret, marked distress, with commonly occurring feelings of shame, self-disgust, guilt, mood decline post an episode, with nil reoccurring use of compensatory behaviour (as seen in BN) (American Psychiatric Association, 2022; Brytek-Matera et al., 2024; Donker & Hadinata, 2023). Broader risk factors associated with BED include body image disturbances, non-suicidal self-harm risk, suicide risk, physical health complications, and metabolic conditions (American Psychiatric Association, 2022; Donker & Hadinata, 2023). Further, individuals who experience BED often attempt to conceal their binge eating behaviours, and thus, binge eating occurs often in secrecy (American Psychiatric Association, 2022).

Avoidant/Restrictive Food Intake Disorder (ARFID)

ARFID is characterised significant disturbances in feeding or eating with cooccurring lack of interest in eating, sensory based food avoidance, and consequential concerns which can include significant weight loss or failure to meet growth norms in children, nutritional deficiency, reliance on oral nutritional supplements/enteral feeding, and notable psychosocial functioning deficits (American Psychiatric Association, 2022; Archibald & Bryant-Waugh, 2022; Menzel & Taylor, 2024). Commonly commencing in infancy, early childhood, and generally within the first 10 years of life, ARFID can also arise at broader ages (American Psychiatric Association, 2022). For some individuals, their ARFID presents as a conditioned negative response applicable to restricted food intake, due to past adverse experiences including traumatic experiences with food (e.g., choking) or instances of vomiting (American Psychiatric Association, 2022). High rates of co-occurring neurodiversity related diagnoses are common for individuals who experience ARFID, including Attention Deficit

Hyperactivity Disorder (ADHD), Autism Spectrum Disorders (ASD) (particularly evident in males), and intellectual disabilities (ID) (American Psychiatric Association, 2022; Archibald & Bryant-Waugh, 2022). Unlike other ED diagnosis where weight and shape preoccupation are pronounced, this is typically absent in ARFID (Deloitte, 2024).

Other Eating Disorders

Other Specified Feeding and Eating Disorders (OSFED) presents a unique diagnostic category, whereby, individuals may experience symptoms associated with other eating disorders (such as AN, BN, and BED) that cause clinically elevated distress and associated functional impairment in essential areas of life, but simply do not meet the full diagnostic criteria for the relevant diagnostic classification (American Psychiatric Association, 2022; Booij et al., 2025; Deloitte, 2024; Jenkins et al., 2021).

Individuals who meet all criteria for AN but remain in a normal or above normal weight range despite significant weight loss, meet the diagnostic criteria for Atypical Anorexia Nervosa (AAN) (American Psychiatric Association, 2022). However, research indicates that there are limited differences between AN and AAN in consideration of considerably similar psychological comorbidities and ED symptoms, including significant malnutrition, medical instability, and urgent medical reviews (American Psychiatric Association, 2022; Booij et al., 2025; Fitterman-Harris et al., 2024; Seiler et al., 2025). This makes it important for AN to be more broadly conceptualised due to such a lack of disparity between AN and AAN, which at current, remain separated diagnostically by a singular weight related criterion (Fitterman-Harris et al., 2024; Seiler et al., 2025).

Unspecified Feeding or Eating Disorder (UFED) is characterised by symptoms aligned with a feeding and eating disorder that cause clinically significant physical distress, psycho-social deficits, with subsequent impact on important areas of other functioning (e.g.,

work, university) but do not meet any full criteria for any EDs listed within the diagnostic classifications. Clinicians use UFED when choosing to not specify the reason that the criteria isn't met for a specific feeding and eating disorder, or when an individual presents and there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings) (American Psychiatric Association, 2022; Deloitte, 2024; Keel, 2029; Wade & O'Shea, 2025).

Pica is characterised by persistent consumption of non-food and non-nutritious substances (e.g., chalk, clothing, hair, soap, paint) exceeding 1 month in duration with nil cooccurring food aversion, but, associated with both psychological and significant medical risks (American Psychiatric Association, 2022; Deloitte, 2024; Wider et al., 2025).

Rumination Disorder is characterised by the repeated regurgitation of food (e.g., regurgitating and rechewing, re-swallowing, or spitting food out) exceeding 1 month in duration (American Psychiatric Association, 2022; Deloitte, 2024; Sasegbon et al., 2022).

The DSM-5-TR (2022) does not currently include Orthorexia Nervosa (ON). However, emerging research proposes that ON is characterised by an obsessive focus on perceive health or clean food, leading to psychological distress towards perceived unhealthy goods, associated but unintentional weight loss, self-imposed dietary rules indicated by compulsive patterns of preoccupation to achieve 'optimum health', escalation dietary restrictions over time, and anxiety (Dunn & Bratman, 2016; Lasson & Raynal, 2021). Consequently, malnutrition, severe weight loss, severe psychological distress, and positive self-image, body image, and increased self-worth when engaging in self-defined 'healthy' eating (Dunn & Bratman, 2016; Lasson & Raynal, 2021; Walker-Swanton et al., 2020).

Severe and Enduring Eating Disorders (SE-ED) is classed as when ED's persist for more than 7 years despite intervention, they may be classified as a severe and enduring ED (SE-ED

(Meneguzzo & Todisco, 2024; Piñar-Gutiérrez et al., 2021). This equates to approximately 20% of individuals who experience AN and 10% of individuals who experience BN (Kotilahti et al., 2019). However, the existing body of research in the SE-ED realm remains ambiguous and lacks a clear definition, scope, and longitudinal research (Pinar-Gutierrez et al., 2021). Thus far, research current captures SE-ED in the AN, BN, and OSFED diagnostic domains, but it doesn't not broadly extend to broader diagnostic categories in depth thus far (Meneguzzo & Todisco, 2024; Piñar-Gutiérrez et al., 2021). SE-ED patients often exhibit firm ambivalence towards recovery and given the chronic nature that SE-ED presents, the current limited but evolving research indicates that a pivot towards quality of life, rather than moving towards recovery, is more feasible for SE-ED patients (Meneguzzo & Todisco, 2024).

In sum, there is a wide range of specific diagnosis and diagnostic categories. AN remains the disorder with the greatest burden on medical systems and for the people themselves. The presentation and impacts of eating disorders are complex, multifaceted, life threatening, and present multiple risk factors for physiological health, psychological health, and social well-being (Barakat et al., 2023; Bryant et al., 2023; Dann et al., 2025; Hambleton et al., 2022; Mendes et al., 2025; Russell et al., 2019;).

Eating Disorder Treatment

Research indicates that specialist eating disorder services can enhance accurate detection of the presence of disordered eating, facilitate prompter access to treatment provision, provide relevant referral pathways, improve patient care, and collectively improve ED recovery rates (NEDC, 2025; Pehlivan et al., 2022; Sharp et al., 2025). In Australia, ED treatment is offered under the public system (e.g., Medicare) and privately funded systems (e.g., private health, fee for service) (NEDC, 2025). ED treatment is typically facilitated on a

scaled continuum of care, commencing in the community as lower intensity management, and progressing through to higher levels of care including intensive day patient hospital or intensive day patient residential treatment, inpatient residential treatment, or inpatient hospital-based treatment depending on presenting severity (Peckmezian & Paxton, 2020; Rankin et al., 2023). However, current research indicates several barriers which can prevent access to treatment, including, delayed diagnosis, misdiagnosis, the cost of treatment, location of treatment, travel to treatment, negative treatment experiences, severely limited specialist treatment providers in both the public and private health systems, lack trained clinicians, and fear of stigma experienced by individuals who have an ED (Bannatyne & Stapleton, 2015; Butterfly Foundation, 2020; Deloitte, 2024; Pehlivan et al., 2022).

Outpatient Treatment

Multidisciplinary team (MDT) care is the first line standard for eating disorder treatment in Australia due to the various physiological and psychological symptoms requiring input from various community-based health professionals including psychological, medical, and dietetic specialists (Clague et al., 2024; McMaster et al., 2022; Naenas et al., 2023; NEDC, 2025; Russell et al., 2025; Yang et al., 2021). Typically, an initial MDT comprises of a psychologist, dietitian, and general practitioner, and psychological and physiological monitoring is incorporated (Clague et al., 2024; NEDC, 2025; Pehlivan et al., 2022). Outpatient treatment occurs in the community, with nil overnight stay in a hospital or residential setting (NEDC, 2025).

Various psychological approaches are utilised in the treatment of EDs in the community, with Enhanced Cognitive Behavioural Therapy (CBT-E), Specialist Supportive Clinical Management (SSCM), and Maudsley Model of Anorexia Nervosa for Adults (MANTRA) being the three primary modalities for adult patients at currently (Dalle Grave,

2022; Garcia & Marcos, 2024; NEDC, 2025). At current, there is no modality that is broadly superior for the treatment for AN in the community (Hay et al., 2015; McIntosh et al., 2022). However, emerging CBT-E research indicates promising results whereby it has been found to be more effective than other modalities for the treatment of AN with success being based upon patient's weight reaching a healthy range (Dalle Grave, 2022). CBT-E is a transdiagnostic tailored cognitive behavioural approach to AN, BN, BED, and OSFED, which focuses on the key disorder eating disruptions, perceptions around shape, and beliefs about weight that maintain an eating disorder if left unaddressed (Dalle Grave, 2022; Merwin et al., 2023; NEDC, 2025). Originating in 2008 through processes of theoretical extension based upon existing BN CBT interventions, CBT-E was created by Christopher Fairburn to broadly address enduring processes of disorder psychopathology (Cooper & Fairburn, 2013). Research indicates that CBT-E help individuals who experience an ED to initially gain a level of stabilisation through improved and modified eating patterns, then improve self-management skills, gain relapse prevention and relapse management skills, gain weight (if clinically relevant) (Dalle Grave, 2022; NEDC, 2025). CBT-E comprises of four distinct stages, commencing with improved eating behaviours, compensatory behaviour reduction, and psychoeducation regarding the individuals presenting eating disorder (Dalle Grave, 2022; NEDC, 2025). Stage two addresses maintaining factors (e.g., body image disturbances, perfectionist traits, mood deficits) and completing regular reviews treatment progression to pivot if new goals need to be set for the remainder of therapy (Dalle Grave, 2022; NEDC, 2025). Stage three focuses on the maintaining factors identified in stage two in depth, and stage 4 focuses on treatment wins, future planning, and relapse management (Dalle Grave, 2022; NEDC, 2025). In sum, CBT-E is a behavioural modality which aims to address maladaptive cognitive and behavioural processes which maintain AN, however, clinical

implications apply with high treatment dropout rates, and lacks current modules to include and address diagnostic comorbidities (Delle Grave, 2022).

Designed initially by Dr Virginia McIntosh and colleagues as a control comparison to CBT for female adults, SSCM became highly effective for adults with AN who require a more flexible and patient led clinical approach (Kiely et al., 2022). SSCM focuses on supporting individuals to establish a link between their ED symptoms, their subsequent eating behaviours, weight, provide support to gain weight (if clinically relevant) and normalise eating behaviours (Kiely et al., 2022; NEDC, 2025; Purvis et al., 2023). Unlike CBT-E and MANTRA, SSCM is not built from therapeutical or manualised foundations, it is patient led and incorporates psychoeducation, goal setting with patients to set target areas for intervention, acceptability of bringing forward and exploring broader emotional issues, and supportive psychotherapy (SP) (Kiely et al., 2022; Purvis et al., 2023). Whilst treatment outcomes for outpatient eating disorder treatment for AN have persistently indicated high dropout rates and poor treatment outcomes to date, through patient driven, individualised, adaptable, and collaborative care with skilled eating disorder clinicians, SSCM is emerging as an effective and advantageous modality in the treatment of AN in the community (Kiely et al., 2022).

MANTRA was first proposed by clinicians and researchers at Kings College and the National Health System Trust in the United Kingdom in 2006, as a manualised psychological treatment for AN in adult patients (Schmidt & Treasure, 2006). Based on a biopsychosocial and cognitive maintenance model of AN, MANTRA focuses on four intrapersonal and interpersonal factors which maintain disordered eating, communicative deficits with key informal supports, and emotional instability (Schmidt & Treasure, 2006; Zeiler et al., 2024). As a manualised modality, both patient and therapist are employed in tandem, with

interventions typically falling between 20-40 outpatient based weekly sessions dependant on presenting severity (Fernández Garcia & Quiles Marcos, 2024; Zeiler et al., 2025).

Other Common Adult Modalities

Whilst CBT-E, SSCM, and MANTRA are the three more broadly researched and employed adult modalities (Fernández Garcia & Quiles Marcos, 2024), other adult treatment modalities exist. Created by a research team in Germany in 2014, Focal-Dynamic Psychotherapy is focused on restoring individual's autonomy, personal responsibility, self-esteem deficits, ED belief systems, any cooccurring mood disorders or deficits, and collaboration with family when applicable (NEDC, 2025; Wild et al., 2009). Dialectical Behaviour Therapy for Eating Disorders (DBT-ED) was adapted from Marsha Linehan's original DBT model and emerged in clinical research in early 2000's, with additional randomised control trails and adaptations over time (Safer et al., 2001). At present, DBT-ED is primarily utilised for adults diagnosed with BN, BED, or OSFED with binge eating features, and focuses on mindfulness, emotional regulation, distress tolerance, skills training, to learn to adapt and thus ultimately replace maladaptive binge eating patterns (NEDC, 2025). Acceptance and Commitment Therapy (ACT) was developed by Steven C. Hayes in the 1970's (Hayes et al., 2006), and Heffner et al., (2001) adapted ACT to ED treatment for the first time in 2002 in an initial adolescent population. ACT is utilised in eating disorder treatment with the premise that human suffering can manifest when individuals engage in strict and inflexible maladaptive attempts to solve distress through disordering eating and weight control behaviours as mechanisms of avoidance and escape (Merwin et al., 2023; Merwin et al., 2025). ACT comprises of six distinct processes, including acceptance, diffusion, self as the context, the present moment, individual values, and committed actions,

and aims to improve individual's flexibility and capacity to ultimately meet their own emotional and physiological requirements (Merwin et al., 2025).

Other Novel Treatments

Whilst the above options are typically the frontline options in Australia, as technology advances and as research broadens over time, additional intervention and treatment methods have started to be trialled and implemented, including online intervention and artificial intelligence (AI) based options (Merwin et al., 2023). AI generated Chatbot single session interventions (SSI) propose a novel treatment option for individuals who have been waitlisted for intervention (Sharp et al., 2025). Waitlist interventions aim to provide brief and intermediary support whilst individuals remain waitlisted for eating disorder treatment (Tone et al., 2025). Merwin et al., (2023) suggest that ACT has been utilised for short term and self-directed online service provision with a focus on body related thoughts and feelings, with subsequent positive reduction in individuals ED symptomology at the end of their treatment trial. Further, self-directed CBT-E approaches have also been found to be advantageous for binge eating disorder (Murphy et al., 2025).

A Note on Adolescent Treatment Modalities

Whilst the current review focuses on adult experiences, for background and contributory context, it is important to briefly touch on adolescent treatment modalities, as some adults would have experienced adolescent treatment as such. Created by Maudsley Hospital researchers Christopher Dare and Ivan Eisler in the 1970's, Family Based Therapy (FBT) has become known as the "Maudsley Method" due it's developmental origins in England (Loeb & le Grange, 2009). At present, FBT is considered the 'gold standard' for the treatment of children and adolescents with AN and focuses on assisting parents/guardians to feel equipped to manage their child's eating disorder, restore weight loss, and encourage

normative development for the specific child's age, through a very structured three phase process (Clague et al., 2024; NEDC, 2025; Tabuenca et al., 2025). Phase one focuses on refeeding, which nutritionally stabilises the young person, facilitates weight restoration, and with clinician guidance, places the onus on parents to manage their child's disordered eating (NEDC, 2025). Phase two focuses on transitioning the onus of care back to the young person by gradually transitioning the food related self-management, managing relapses into disordered behaviours to prevent a full decline back to their pre intervention state, and co-addresses family related relationship issues, which then takes the focus away from food (NEDC, 2025). Phase three focuses on the broader presenting challenges the young person may be experiencing, strengthening identity separate to eating disorder associations, and treatment provision completion (NEDC, 2025). When considering the occurrence of comorbidities (e.g., anxiety disorders, mood disorders), these complexities can extend the length of FBT intervention accordingly (Lim et al., 2023). Further and alternative child and youth treatment options also include Adolescent Focused Therapy (AFT) which is an individualised approach where adolescents are given the primary responsibility for their weight restoration and Bulimia Nervosa Focused Family Therapy (FT-BN), which is the first line treatment for adolescent BN (Tabuenca et al., 2025).

Therefore, whilst there are several treatment modalities for the treatment of eating disorders, the primarily three more longstanding and thus evidenced modalities remain CBT-E, SSCM, and MANTRA (Dalle Grave, 2022; NEDC, 2025; Fernández Garcia & Quiles Marcos, 2024). However, emerging additional modalities are considered promising, for the treatment of broader eating disorders outside of the AN, BN, BED, and OSFED diagnostic domains. Whilst modalities reflect theoretically based structure, or alternatively, take into consideration patient empowerment to build self-efficacy, the broader treatment domain remains predominately indicative of structured and inflexible, which may not broadly

consider presenting morbidities, patient preferences, which ultimately can in part be attributed to the evidenced broader treatment discontinuation rates across diagnoses. Thus, regardless of treatment modality, it is essential that the employed approach finely balances the physiological, psychological, psychosocial functioning, and autonomy of patients (Clague et al., 2024) through a patient centred and trauma informed lens to reduce the evidenced commonly occurring siloing of treatment where the primary focus on acute symptoms is singularly addressed, rather than a whole of person individualised approach (Deloitte, 2024).

Higher Levels of Care

Day Patient

Provided by both public and private health systems alike, day patient treatment programs (DTPs) provide a step-up from MDT community support and typically occur on weekdays for on average 6+ hours per day for several weeks duration (Day et al., 2025; Pehlivan et al., 2022; Matthews et al., 2019). Further, DTPs also act as a step-down post an inpatient hospital admission, to bridge the gap between higher levels of care, back to community-based supports (Day et al., 2025; Matthews et al., 2019; Pehlivan et al., 2022). DTPs typically comprise of an initial suitability assessment and treatment provision planning, regular medical monitoring, individual and group intervention, therapeutic meal support (including opportunities for social eating), and collaborative discharge planning (Matthews et al., 2019; Pehlivan et al., 2022). If commencing DPT as a step down from inpatient care, DPTs provide individuals with a supported transition back into the community whilst being able to practice their acquired skills and strategies learnt in treatment (Pehlivan et al., 2022).

Inpatient Treatment

Public Hospitals

Inpatient treatment typically comprises of nutritional rehabilitation (refeeding), medical stabilisation and often 24-hour close visual observation in collaboration with an MDT including medical and allied health staff (Pehlivan et al., 2022; Rankin et al., 2023). Typically, when ED sufferers require inpatient treatment, in many instances their ED behaviours and ED cognitions are considered long-established, firmly present, and are of considerable acuity (Lojewski et al., 2012). In 2014, there were 25 public hospital inpatient beds for ED patients across Australia (Milligan, 2014), which increased to 37 in 2016 (Davies, 2016). In 2021, this had increased meagrely to approximately 40 beds (Hender, 2021). In 2023, there were approximately 43 public hospital beds allocated for the treatment of eating disorder patients Australia wide, comprised of 17 in New South Wales, 15 in Victoria, five in Queensland, five in South Australia, and 0 in Tasmania, Western Australia, Northern Territory, Australian Capital Territory (Tobin et al., 2023). According to the Australian Broadcasting Commission (ABC) (2016), patients often spend significant periods of time on waiting lists, others may travel interstate to access treatment in a public hospital specialist inpatient bed, with physiological health status being the benchmark for inpatient admission prioritisation, in the absence of other contributing factors. Unsurprisingly, despite the broadly inadequate and meagre increase in public hospital inpatient ED beds between 2014-2023 (24 additional beds), the prevalence of EDs during the same period rose by 36% (e.g., past 10 years) (Deloitte, 2024; NEDC 2023). Thus, indicating an ongoing and significant escalation in the number of individuals experiencing an eating disorder and a clear disparity in treatment capacity (Deloitte, 2024; NEDC 2023; Tobin et al., 2023).

Private Hospital Inpatient Eating Disorder Programs

In 2023, there were eight private hospital inpatient eating disorder programs in Australia. Geographically, they were located as followed: One in Western Australia (Ramsay Clinic Hollywood), three in Queensland (Ramsay Clinic New Farm, Robina Private Hospital – Aurora Health, Cooina Mental Health Service, Buderim Private Hospital - UnitingCare), two in New South Wales (Ramsay Clinic Northsides and Ramsay Clinic Wentworthville), and two in Victoria (The Geelong Clinic and The Melbourne Clinic – both operated by Healthscope). Therefore, in addition to nil publicly funded specialist eating disorder inpatient beds in Tasmania, Northern Territory, and Australian Capital Territory, there were nil private hospital inpatient ED programs in these states either. Due to the extremely high demand for private hospital inpatient eating disorder treatment, patients are commonly placed on extensive wait lists, or they are simply turned away if they do not meet the specific programs admission criteria, which may be based on low body mass index (BMI), or may be diagnosis specific (e.g., AN and not BED).

Residential Treatment

Residential treatment provides less clinical environments compared to inpatient hospital facilities, through recovery oriented, longer term, and multidisciplinary team supports and provide therapeutic meal supports, individual and group therapy, and broader holistic supports (Clague et al., 2024; Pehlivan et al., 2022; Rankin et al., 2025). Wandi Nerida was Australia's first residential ED service which opened in Queensland in 2021 (Day et al., 2025). Due to the infancy of such service in Australia, the current body of research specific to Australian populations for residential treatment remains extremely limited (Day et al., 2025; Rankin et al., 2025). However, research establishes that residential treatment can

address a common systemic gap in service provision between inpatient based treatment and community-based treatment (Day et al., 2025).

Cooccurring Consideration's

Dual Diagnosis

Whilst acknowledging, particularly in AN, medical stabilisation is typically the initial priority, depending on the level of treatment, such as the private hospital inpatient eating disorder programs, individuals often have to complete medical stabilisation prior to entering a private hospital inpatient eating disorder program. Therefore, dual diagnosis is often an importance consideration. Individuals who experience EDs are significantly more likely to have experience serious psychiatric comorbidities including trauma, anxiety, substance, personality, and mood related disorders (Ahmed et al., 2024; Beveridge et al., 2019; Day et al., 2025; Mooney et al., 2023; Moroshko et al., 2025; Morris et al., 2025; Swinbourne et al., 2012). Research further indicates that neurodevelopmental disorders, such as autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD), are other statistically common comorbidities among ED populations and are associated with increased severity of ED symptoms, longer inpatient admissions, and lengthier recovery times (Archibald & Bryant-Waugh, 2023; Christiansen et al., 2025; Cobbaert et al., 2024;). However, treatment is often not addressed from a neurodiversity affirming approach, due to a lack of broader individualised and person-centred care (Archibald & Bryant-Waugh, 2023; Asaria, 2025). Research clearly evidences the significant comorbidity of EDs and anxiety disorders, including generalised anxiety disorder (GAD), specific phobias, and social anxiety, which are estimated to impact over 60% of individuals who experience EDs (Christiansen et al., 2025; Mares et al., 2024; Morris et al., 2025; Swinbourne et al., 2012;). Further, research indicates that social anxiety, when comorbid with EDs, can slow recovery-based processes,

due to significant fear of interpersonal interactions, fear of being perceived and assessed negatively by others, and avoidance of actual treatment engagement due to the multifaceted and broad symptoms that can occur with socially based anxiety (Skalski-Bednarz et al., 2024). GAD is the most common anxiety disorder comorbid with EDs and can both precede and follow an ED diagnosis (Perez et al., 2023; Skalski-Bednarz et al., 2024).

Mood disorders, such as bipolar affective disorder (BD) and major depressive disorder (MDD) are often comorbid with EDs, and when comorbid, they increase treatment complexity and treatment outcomes (Brewerton et al., 2023; McAulay et al., 2021; Velimirovic et al., 2025). Moreover, research indicates that comorbid depression and ED impact approximately 54% of ED patients (Christiansen et al., 2024). Furthermore, Brewerton et al., (2023) research found an estimated 76.4% of patients with depression also experienced an ED. Further, McAulay et al., (2021) found that 33% of individuals experiencing an ED also had comorbid bipolar effective disorder, with cyclic related factors becoming quite evident and thus adding to existing disordered eating behaviours, such as cyclic binge eating related tendencies when experiencing mania. Moreover, EDs and substance use disorders (SUD) are an evidenced common comorbidity, which can lead to increased psychological and physiological risks which extend well beyond that of a singular ED without comorbidity related considerations (MacNeil et al., 2025; Streb et al., 2025; Ware et al., 2024).

Research indicates that borderline personality disorder (BPD) and EDs are significantly comorbid, and this diagnostic co-occurrence can lead to increased treatment complexities, presentations indicative of clinical severity, poorer treatment outcomes, and increased mortality (Loxton & Gleaves, 2025; Miller et al., 2022; Miller et al., 2025; Mooney et al., 2023). Common BPD symptomatology is indicative of notably impulsive decision

making, self-image instability and discomfort, interpersonal skills and interpersonal relationships marked by conflict, and marked emotional regulation deficits (Hein et al., 2024; Loxton & Greaves, 2025; Miller et al., 2022; Mooney et al., 2023). According to Loxton and Greaves (2025), the emotional regulatory deficits and impulsivity which are evident for many individuals with BPD have been evidenced as negative predictors of positive therapeutic changes processes, thus, impacting successful treatment outcomes. Further, Trauma disorders and EDs are also common comorbidities (Brewerton et al., 2023; Day et al., 2025; Liebman et al., 2025; Moroshko et al., 2025). Research indicates that trauma disorders add further complexities to various levels of treatment, and thus, this cooccurrence comes with increased risk of elevated severity of ED presentation and negative impacts on treatment effectiveness (Day et al., 2024; Fatimah et al., 2025; Liebman et al., 2025; Moroshko et al., 2025). Therefore, incorporating trauma disorders in consideration of patients EDs is essential across all levels of care to assist with concurrent treatment delivery and promote more advantageous recovery outcomes (Brewerton et al., 2024; Liebman et al., 2025).

Suicide and Non-Suicidal Self-Harm

Every year, more than 720,000 deaths by suicide occur worldwide (Robison et al., 2025; World Health Organisation, 2025). Research indicates that suicide rates in ED populations significantly exceed that of the general population (American Psychiatric Association, 2022; Krug et al., 2021; Robison et al., 2025; Soullane et al., 2023). Sohn et al., (2023) found that experiences of suicidal ideation among those with an ED were three times higher than both healthy and other psychiatric condition related participants. Moreover, research further evidences elevated risks of non-suicidal self-harm for those who experience an ED (e.g., self-cutting, self-burning), thus impacting approximately 40% of those who experience an ED (American Psychiatric Association, 2022; Amiri & Khan, 2023; Krug et

al., 2021; Robison et al., 2025; Sohn et al., 2023; Soullane et al., 2023). Further, research indicates that individuals with comorbidities, including neurodiversity, schizophrenia, depression, bipolar affective disorder, and BPD (Miller et al., 2022) have an even more significantly raised suicide risk (Chen et al., 2025).

Therefore, individuals who experience EDs are significantly more likely to have neurodevelopmental disorders and/or serious psychiatric comorbidities including trauma, anxiety, substance, personality, and mood related disorders (Ahmed et al., 2024; Beveridge et al., 2019; Day et al., 2025; Mooney et al., 2023; Moroshko et al., 2025; Morris et al., 2025; Swinbourne et al., 2012). Evidence clearly indicates that individuals who have an ED are at significantly higher risk than both the general population and other psychiatric disorders of suicide, and non-suicidal self-harm (American Psychiatric Association, 2022; Krug et al., 2021; Robison et al., 2025; Sohn et al., 2022; Soullane et al., 2023). Thus, it is critical for dual diagnosis and the elevated risks of non-suicidal self-harm and suicide to be considered as essential considerations during treatment, regardless of treatment location and the level of care in question, to provide person centred, trauma informed, and individualised patient care (Asaria 2025; Rankin et al., 2023).

Financial and Societal Implications

EDs have an extensive financial impact on society due to the complex, multifaceted, and often enduring nature of the disorders which have increased rapidly in prevalence over the past 10 years by 36% (Dann et al., 2025; Deloitte, 2024). Further, ED costs have been indicative of being more than 50% higher than non-ED related diagnoses (Van Hoeken & Hoek, 2020). Furthermore, future medical cost complications are considered a direct financial consequence for those who have an (ED history, due increased future fertility, pregnancy, and newborn baby related complications evidenced to be associated with ED histories (Van

Hoeken & Hoek, 2022). Within Australia in 2023, over 1.1 million individuals had an ED, equating to approximately 4.5% of the total population (Deloitte, 2024). In 2023, the broader societal ED financial burden was calculated to be \$66 billion, with \$251 million attributed to the healthcare system burden specifically for the 4.5% of the population impacted by EDs during 2023 (Deloitte, 2024). Therefore, unequivocally indicating the significant economic burden associated with EDs (Merwin et al., 2023; Van Hoeken & Hoek, 2020) and eating disorder treatment continues to be under resourced, underfunded, and under significant pressure (Butterfly Foundation 2020; Byrant et al., 2023; Tobin et al., 2023).

According to Deloitte (2024), reduced productivity is comprised of six distinct types, including reduced employment, absenteeism, presenteeism, premature mortality, search and hiring, and informal care. Individuals who experience an ED may reduce workhours or exit jobs due to the nature of the ED and whilst remaining employed they may be absent more often due to the impact of their ED (Deloitte, 2024). Presenteeism refers to the impact of individuals ED on their ability to perform their work and thus impact their productivity at work, including the impacts of their physiological health and psychological well-being (Deloitte, 2024). Premature mortality is considered a reduced productivity factor due to the loss of working years forgone associated with early deaths in the ED population (Deloitte, 2024). Search and hiring applies to organisations having to source and employ new staff members, after the early death of a staff member who had an ED (Deloitte, 2024). Finally, the final factor is informal care which incorporates the collective friend, family, and unpaid support network burden and unpaid cost associated with caring for someone who has an ED, primarily due to the financial losses experienced by carers due to their reduced work capacity (Deliotte, 2024). Additionally, the broader impact of caring for someone with an eating disorder over time can lead to caregivers experiencing burn out, enduring distress, and emotional burden (Donkin et al., 2025). Ultimately for some carers, they may still experience

these subsequent consequences after the person they have cared for has recovered due to the impact of such journey (Donkin et al., 2025).

Individuals who experience an ED are also impacted by financial costs directly associated with their ED, including travel and accommodation burden when seeking treatment from rural to metropolitan locations and increased grocery expenditure (BN and BED) (Butterfly Foundation, 2020; Deloitte, 2024). ED sufferers incur appointment travel related costs including public transport and fuel related expenses, with rural travel being significantly expensive for those who had to travel interstate or long distances to access adequate treatment options, specialist care, and support not available in their geographical area (Butterfly Foundation, 2022; Deloitte, 2024). Further, when considering the binge related components of BN and BED symptomology, Deloitte (2024) found that individuals with BN and BED diagnoses commonly spent high quantities of money on preferred binge foods, clothing to cover their body, or purchasing laxatives as a compensatory behaviour direct and subsequent financial cost.

The non-financial measures of societal burden can be defined as the intangible losses in ED sufferer's wellbeing due to such illness (Deloitte, 2024). Non-financial measures of social burden include consequential loss of wellbeing, reduced quality of life, and increased premature mortality (Deloitte, 2024). Multiple facets comprise well-being, including financial stress, traumatic treatment experiences, restrictions regarding increasing socioeconomic status through study or employment progressions, the reduction or inability to partake in meaningful activities, and reported shame and guilt associated with lack of financial independence and subsequent reliance on support people to fund treatment (Deloitte, 2024).

Therefore, the financial and non-financial burdens on society, individuals, their families, and employers, are clearly evidenced, and due to underfunding and under resourcing, eating disorder treatment remains under exponential pressure (Butterfly Foundation 2020; Byrant et al., 2021; Dann et al., 2025; Tobin et al., 2023 Van Hoeken & Hoek, 2022;). Due to the escalating increase of ED presentations, the subsequent treatment provision required, and the collective consequential financial impacts on the healthcare system, and society, vital strengthening and improvements by healthcare systems and governing bodies are urgently required to improve outcomes of individuals who experience EDs and their support networks (Butterfly Foundation 2020; Byrant et al., 2021; Dann et al., 2025; Tobin et al., 2023).

The Perception of Eating Disorders

Psychological disorders are associated with negative stereotypes, stigma, judgement, and blame (Aird et al., 2025; Guy et al., 2022). However, research indicates that compared to other psychological disorders such as mood disorders, individuals who experience an ED are at higher risk of experiencing stigma associated with their ED diagnosis (Aird et al., 2025; Asaria, 2025; Guy et al., 2022). Minority populations within the ED realm include men, lesbian, gay, bisexual, and transgender (trans) (LGBT) and gender diverse communities, and indigenous people (Hay et al., 2023; Lubieniecki et al., 2024; Murray et al., 2019; Parker & Harriger, 2020; Williams-Ridgway et al., 2025). Men are a particularly vulnerable population in the realm of EDs, due to the societal enduring misconception that EDs impact women (Lubieniecki et al., 2024; Murray et al., 2019). Compared to the female population, Murray et al., (2019) found that men had a higher mortality rate and experienced shorter long term life expectancy post the onset of AN, BN, and OSFED (Murray et al., 2019). Further, LGBT and gender diverse individuals are at an increased risk of experience mental illness and

disordered eating in consideration of the increased stress they can experience due to prejudice, judgement, and stigma (Hay et al., 2023; Parker & Harriger, 2020). Of clinical elevation in the gender diverse community compared to the subclinical level exhibited within the general population, disordered eating can present as restriction in the trans female population to attempt to align with socially attributed female thinness, and in the trans male population to lose weight to suppress menses commencement or continuation, and to flatten their chests (White et al., 2025). Furthermore, indigenous individuals who experience an ED are statically more likely to experience systemic barriers applicable to treatment accessibility due to stigma, shame, and a lack culturally approximate service access and service provision (Williams-Ridgway et al., 2025).

Perception of Healthcare Professionals

When ED patients report experiencing perceived negative attitudes towards them from health care professionals (e.g., dismissiveness), this can lead to poor therapeutic relationships, increase barriers to treatment accessibility, reduce treatment engagement, reaffirm weight-based stigmas, and cause subsequent, judgement, shame, and isolation (Lubieniecki et al., 2024). Dell et al., (2021) suggest that EDs are often one of the most stigmatised psychiatric diagnoses amongst healthcare professionals. Societal based influences impact both general population based options and perception of EDs, and clinicians can form biased options and perceptions of ED diagnoses and treatment despite their advanced health training (Lubieniecki et al., 2024). Assumptions and misconceptions about EDs by healthcare professionals can fuel harmful stereotypes (such as thinness being required in EDs), aid in discrimination, add to societal and media elicited misrepresentations of what EDs realistically are representative of, and ultimately impact effective treatment provision (Lubieniecki et al., 2024). Further, Kozmer et al., (2025) suggest that patients can experience dismissiveness and

misunderstanding when seeking help, due to clinicians who may not feel comfortable treating EDs or are inadequately trained to treat EDs, which subsequently can lead to patients experiencing additional barriers when seeking further support from such experiences. Research conducted by Stapleton and Bannatyne (2018) found that 91.4% of their ED participants reported their healthcare system experiences to be significantly distressing, including punitive and traumatic, leading to post discharge nightmares and flashbacks due to the significance of their reportedly poor experiences. Additionally, Butterfly Foundation (2022) found 67.9% of participants reported experiencing stigma when accessing eating disorder treatment from a healthcare practitioner, with 27.2% of participants experienced discrimination based on age or gender.

Therefore, it is essential that healthcare providers are mindful of their own biases, areas for self-development, areas for professional-development, and foster inclusivity, comprehensive, and well-informed treatment environments (Lubieniecki et al., 2024). Further research is essential to develop more culturally competent and diversity inclusive based measurement tools to facilitate advancements to improve access to treatment, treatment provision, and to broadly improve the healthcare system on all levels to provide effective and equitable access to healthcare for all individuals who experience an ED (Williams-Ridgway et al., 2025). Furthermore, it is essential that future research incorporates eating disorder stigma related factors, to improve the significant risk of patients experiences such stigma in both clinical and social realms and to reduce the consequential patient and carer burden (Aird et al., 2025).

Existing Specific Research - Private Hospital Inpatient Eating Disorder Programs

This is the first study to collectively assess the current eight private hospital inpatient eating disorder programs in Australia to the knowledge of the author. There is no current

research from a collective perspective that examines all eight clinics, however, broader yet limited research has been conducted by individual hospitals, or, by external researchers which include one, or more, of the eight programs within several studies. Therefore, the latter research has been extensively assessed when examining the current research within this niche, specific, and under researched space from a ‘collective eight’ perspective.

Limited quantitative research has been conducted in the private hospital inpatient eating disorder program space. Whilst acknowledging there were eight programs at the time of the current literature review, only seven key articles appear to remain published. However, what does remain clear from the five of seven academic publications, is a clear quantifiable weight related focus with limited consideration given to research in the broader eating disorder realm specific to private hospital inpatient eating disorder program treatment.

The Northside Clinic

In 2011, Northside Clinic was involved in research that explicitly examined weight-related changes in the refeeding process for underweight female ED patients (Hart et al., 2011). Inpatient refeeding remained the key focus, to examine weight related changes for their specific refeeding protocol during patient’s admissions (Hart et al., 2011). Hart et al., 2011 reported that weight gain was indeed a multifaceted and variable factor, which required further research into the contributing factors to establish a future best practice for weight gain. The second research study produced by Northside Clinic in 2012 was broader in scope and examined patients ED behaviours and diagnostic comorbidities (Lojewski et al., 2012). However, patient gender and broader demographical details were not reported, therefore, the term ‘patients’ is used in generalised terms. Lojewski et al., (2012) found that 88% of patients had at least one psychological comorbid diagnosis, such as, a mood disorder, anxiety disorder, obsessive compulsive disorder, or a trauma disorder. Further, patients admitted to

the inpatient program exhibited eating disorder behaviours that were considered firmly ingrained compared to the assumed, not comparable, outpatient population (Lojewski et al., (2012). Finally, the third research study produced in part by Northside Clinic in 2012 examined the prevalence of cooccurring EDs and anxiety related disorders among female patients admitted to public inpatient and outpatient program, a tertiary psychology service, and Northside Clinic (Swinbourne et al., 2012). Swinbourne et al., (2012) found that 65% of patients had a comorbid anxiety related disorder, with most patients reporting an anxiety related disorder preceding their eating disorder diagnosis.

Ramsay Clinic New Farm

Ramsay Clinic New Farm has produced one research publication to date. Chung (2016) assessed imagery and visualisation processes to establish whether such methods increased the motivation of patients receiving treatment for AN. Chung (2016) proposed that his specific approach, namely, ‘motivational visualisation’ (MV) incorporated a motivational interview with an imagery and visualisation emphasis, with reported subsequent promoted recovery motivation. Chung (2016) further reported that two female patients, including one with comorbid conditions, responded favourably by maintaining a healthy BMI for several months post MV implementation.

Ramsay Clinic Hollywood

Ramsay Clinic Hollywood has produced three research publications to date. In 2015, Ramsay Clinic Hollywood reported examining service delivery efficiencies of the relevant private hospital inpatient eating disorder program (Singh et al., 2015). Singh et al., (2015) inferred that enduring length of patient admissions subsequently impacted service accessibility for others, broadly impacted upon their programs economic cost effectiveness, reduced patient’s quality of life, and impacted upon patient’s social contributions. To address

such factors, ‘intensives’, such as nutritional changes applicable to increased caloric intake, close observation of weight gain, recommencing oral intake quicker, and facilitating transfers to their adjacent day patient program upon discharge, reduced the average admission period from 52 to 35 days and reportedly improved wait list capacity for new admissions (Singh et al., 2015). The second research study produced by Ramsay Clinic Hollywood in 2022 and briefly re-examined service delivery efficiencies over a broader period (2013-2019) (Singh et al., 2022). Similarly, to their prior publication, Singh et al., (2022) reported that increasing refeeding rates (and associated weight gain) reduced the length of patient admissions to 24 days in 2017, and subsequently increased access to the program for individuals awaiting admission. Finally, the third research study produced by Ramsay Clinic Hollywood was published in 2024 and examined their specific refeeding protocol and the associated weight gain and psychosocial change in primarily female patients during a 12-day refeeding protocol (Salter et al., 2024). Salter et al., (2024) reported reducing the average admission duration to approximately 25-38 days, improvements in patients psychosocial functioning, and with weight gain being the primary benchmark for program completion.

Collectively, the seven academic publications produced by the ‘collective eight’ have had a predominant emphasis on weight related factors equating to program efficiencies or success. Therefore, it is vital that broader qualitative measures are independently completed with such private hospital inpatient eating disorder programs, to assess broader measures of patient experiences and expand upon their limited focus evidenced thus far. Lived experience produced research and qualitative research specific to inpatient treatment and residential treatment remains limited (Miskovic-Wheatley et al., 2025; Moroshko et al., 2025; Rankin et al., 2023). Varying limitations exist dependant on treatment type. The biomedical focus of higher levels of care, such as inpatient treatment, ultimately reduces patient choice, individualised care, dismisses patients values and their voice during treatment, and broader

lived experience, which contributes to patients' risk of pseudo recovery thus increasing relapse rates post discharge (Rankin et al., 2023). Whilst acknowledging the current body of research specific to private hospital inpatient eating disorder programs is very limited, it is considered promising that Northside Clinic have actively considered dual diagnosis in their research thus far. It is abundantly clear that the current body of research in the realm of private hospital inpatient eating disorder units is extremely limited. What is unequivocally and explicitly evident is a continued focus on weight related research attributing perceived program success, cost and time efficiencies, and program completion metrics being based on extremely limited factors. Thus, being inconsistent with the broader need for individualised, person centred, comorbidity informed approaches, and not 'one size fits all' in approach.

Summary and Rationale for Research

To conclude, EDs are a leading area of societal concern that research continues to place emphasis on, due to the exponential number of multifaceted risk factors in which EDs encompass and the increasing prevalence of EDs within Australia (Barakat et al., 2023; Deloitte, 2024; Hambleton et al., 2022; Mendes et al., 2025; NEDC, 2023; Tabuenca et al., 2025 Yang et al., 2021). EDs present with multifaceted potential risk factors including, elevated mortality rates, increased risk of suicide and non-suicidal self-injury compared to both the general population and when compared to other psychiatric disorders (Bryant et al., 2021; Hambleton et al., 2022; Mendes et al., 2023; Russell et al., 2019; Tabuenca et al., 2025). Further, EDs present various physiological health risks including cardiovascular, malnutrition, gastrointestinal, endocrine/metabolic complications, pressure ulcers, musculoskeletal impacts, and neuropsychological deficits associated with subsequent psychological risks (Baenas et al., 2023; Russell et al., 2025; Seiler et al., 2025; Skalski-Bednarz et al., 2024). EDs do not discriminate, meaning, individuals of any age, gender,

gender identity, socioeconomic status, culture, or geographical location have been found to experience EDs across the country. Regardless of diagnostic specificity, all eating disorders exhibit one similar factor, being significant disturbances in eating and/or eating related behaviours, thus leading to potential subsequent physiological and/or psychological risk (American Psychiatric Association, 2022; Baenas et al., 2023; Barakat et al., 2023; Tabuenca et al., 2025). ED treatment works on a continuum of care and based on severity, which typically commences with a MDT in the community, and progresses to day patient, residential, and then inpatient treatment facilities (American Psychiatric Association, 2022; Bryant et al., 2021; Hambleton et al., 2022; Mendes et al., 2025; Rankin et al., 2023). However, despite meagre attempts at creating additional patient beds in the public health system, private health system, and whilst acknowledging residential facilities in Australia remain in their infancy, the prevalence of EDs continues to rise (Deloitte, 2024).

Individuals who experience an ED are more significantly more likely to also experience comorbidities, including neurodevelopmental disorders, trauma disorders, anxiety disorders, mood disorders, and personality disorders (Ahmed et al., 2024; Beveridge et al., 2019; Day et al., 2025; Mooney et al., 2023; Moroshko et al., 2025; Morris et al., 2025; Swinbourne et al., 2012). However, dual-diagnosis and broader presenting patient comorbidities are often not adequately included in patient's treatment across all levels of care, thus, leading to a primary focus on their ED despite genuine contributing factors to their broader diagnostic presentation which indeed may contribute to their individual experience. The societal and healthcare related costs associated with EDs in Australia is exponential and represents the disconnect between the continued escalating prevalence of EDs, versus available treatment, thus leading to lack of specialist resources, cost barriers, locationality barriers, geographical barriers, poor prior treatment experiences, lack of trained ED professionals, and the lack of comorbidities inclusion in treatment, thus impacting adequate

treatment access and provision (Byrant et al., 2021; Butterfly Foundation, 2020; Deloitte, 2024; Tobin et al., 2023; Van Hoeken & Hoek, 2022). Due to societal perceptions of ED, those who experience EDs are statistically more likely to experience both societal and health professional initiated shame, guilt, dismissiveness, and gaslighting (e.g., health practitioners causing distress to patients by incorrectly labelling a patients symptoms as exaggerated or non-significant when they are) when seeking or receiving treatment across all levels of care, which is further escalated if an individual is in a minority group (e.g., men, gender diverse individuals) (Aird et al., 2025; Asaria, 2025; Guy et al., 2022; Hay et al., 2023; Lubieniecki et al., 2024; Murray et al., 2019; Parker & Harriger, 2020; Williams-Ridgway et al., 2025).

The current body of research specific to private hospital inpatient eating disorder programs is extremely limited in quantity and scope. Despite eight facilities operating in Australia, only seven research articles have been published to date. Further, whilst acknowledging a small contribution of dual diagnosis research, the broader scope primarily remains focused on success and efficiencies being attributable to refeeding protocols, weight gain, and reduced admission timeframes. Therefore, examining an extremely limited number of factors that will not be indicative of the broader person centred, individualised, adaptive, and inclusive treatment that ED sufferers require, particularly when dual diagnosis and suicide and non-suicidal self-harm risk are collectively evidenced to be elevated in ED populations. Therefore, ED research must first be expanded to be conceptualised as being advantageous to assess broader contributing comorbid factors, with subsequent research produced in collaboration with lived experienced and expert contributors. Thus, EDs must remain a critical focus for researchers, health care professionals, and the health systems, due to the improvements in treatment accessibility, treatment availability, treatment waiting times, clinician and societal knowledge advancements, and equitable care that are all desperately required and in desperate need of positive change.

The aim of this project is to explore, for the first time, patient experiences associated with private hospital inpatient eating disorder treatment in Australia. This project aims to provide participants with an opportunity to report on their experiences, which to date, has not been assessed in Australia. The outcomes of this project are anticipated to provide recommendations, through the lens of the patient, to help shape future and much needed changes in this space.

Method

This study aimed to explore patient experiences associated with private hospital inpatient eating disorder treatment in Australia by collectively assessing all eight programs through the perspective of patients who have been admitted to such services within a singular study. This study aimed to extend the current extremely limited research by providing participants an opportunity to report on their experiences. The outcomes of this project are anticipated to provide recommendations, through the lens of the patient, to help shape future and much needed changes in this space.

Positionality

The author has an intersecting identity as having lived experienced of an eating disorder, and who holds a professional role in clinical service delivery, as a Registered Psychologist and credentialed eating disorder clinician (CEDC-MH) in Australia. Thus, working predominately within the eating disorder, neurodiversity, and broader complex mental health realms. The author is also Caucasian presenting, resides in a first world country, and recognises that regardless of the authors lived experience and latter professional experience, she simply cannot speak to all the broad experiences of those within the eating disorder community. The author aimed to adopt an inclusive approach to demographical information, whereby, participants are provided the opportunity to report diversity and dual diagnostic factors in a participant centred manner, to ensure a holistic and inclusive lens was applied to such research . Importantly, facilitating an option for participants to report their treatment experience in their own words, was pivotal to providing a platform for participants to autonomously voice their experiences. The author further recognises that the concept of eating disorders is largely shaped by past western clinical traditions, and how the results of this study are unlikely to be applicable across every culture and context given its specificity.

The author names these positions to be transparent about how her own lived experience, professional experience, and social experiences, informed the interpretation and presentation of this research report.

Epistemology and knowledge assumptions

An ontological stance was taken for the purpose of the current research through a critical realism lens. Crotty (1998) infers that critical realism is grounded in the premise that the world is in part reflective of a physical external world where one's awareness and consciousness of such world exist outside of such external world, therefore, being an objective reality. To follow, the second facet of critical realism infers the existence of a social world, where over time, individuals experience the world around them through engagement, therefore, becoming conscious of the world which helps build understanding of such world (Alam, 2019; Crotty, 1998). Moreover, critical realism proposes that both world contexts (physical and social of real) comprise of objects, namely, 'things', which exist regardless of whether an individual can see them, or experience them specifically themselves (e.g., hospitalisation) thus facilitating causal powers which can be observed through the impacts they cause (Alam, 2019; Burr, 2015; Crotty, 1998; Wolfe et al., 2024). Thus, critical realists concede the existence of both an external physical world that exists outside of individuals consciousness, and a social world comprised of knowledge built from social influence (Alam., 2019; Crotty, 1998; Wolfe et al., 2024). Therefore, collectively, individuals understand the world around them through knowledge and social based influences (Alam., 2019; Crotty, 1998; Wolfe et al., 2024). This is the case for individuals who have EDs and experience private hospital inpatient ED treatment in Australia. The author acknowledges there is an independent physical reality which stills exists independent of whether she does, or does not, see the physical reality firsthand.

Galbin (2014) proposes that individuals make sense of the world through social structures and the shared meaning of such social structures, to which they apply to actual reality. Social constructionism denies the mainstream psychological research inference that knowledge is acquired through the generation of and testing of such hypotheses (Crotty, 1998, Galbin, 2014). Opposingly, the premise of social constructionism emphasises knowledge by experience obtained through acquiring understanding via social interaction, language, shared understandings, through individuals explaining their own personal world experiences, which forms shared understanding over time (Crotty, 1998; Galbin, 2014). Therefore, given the qualitative aspects of the current research, a social constructionist approach also was also applied to the current research.

The author has provided an overview of such theoretical perspective, an outline of the authors understanding of private hospital inpatient eating disorder program treatment in Australia will follow. From an ontological perspective, the author understands private hospital inpatient eating disorder program treatment as being one treatment option in Australia that comprises of a voluntary overnight admission period, where patients receive support from a multidisciplinary team (e.g., medical, allied health) to regulate their eating, gain weight (if applicable), and receive comprehensive support when experiencing distress. In this sense, the author views private hospital inpatient eating disorder program treatment as physical object, thus, existing in the physical world, regardless of whether myself or anyone else has experienced it or not, and independent of our observations of such. However, the author understands that private hospital inpatient eating disorder program treatment is used in various terms by health professionals that are, or are not, across the depth of such treatment specificity (such as “inpatient”) in the absence of what such term represents. Additionally, whilst acknowledging the diagnostic variations and medical realities of EDs, it is predominately required to be medically stabilised to be admitted onto such programs.

Therefore, whilst some factors may be perceived as similar, each person's unique experience will differ. Therefore, the author views this to be a socially constructed viewpoint of the perceived meaning and understanding attributed to the experiences of those who do experience such treatment, constructed through language and socially agreeance. Thus, aligning with a critical realist ontological perspective. Therefore, to incorporate the physical reality and subjective nature of private hospital inpatient eating disorder program treatment in Australia, a qualitative survey was decided on.

Procedure

The online survey program Qualtrics was used to host the online survey. Individuals who were aged 18 or over at the time of survey completion who had been admitted to a private hospital inpatient ED program were invited to participate in an online study investigating patient's experiences associated with private hospital inpatient ED program treatment in Australia. Participants had an optional inclusion to go into the draw to win one of six \$50.00 online gift cards, as per approval from the Massey University Human Research Ethics Committee upon survey completion. Full ethics approval was granted by the Massey University Human Research Ethics Committee on 27/04/2023, prior to the commencement of the study (refer to Appendix A for the ethics documents).

Recruitment

Potential participants were recruited from the general community across Australia via advertising on social media platforms, social media paid advertising, flyers, word of mouth, emails to former colleagues, and snowballing throughout community cohorts (see Appendix A for a copy of the advertisement). During recruitment, potential participants were provided with a direct Qualtrics link (or a direct QR code) to access the study which led them to the participant research information sheet, which provided a succinct project description,

eligibility criteria, risks and benefits of partaking, data management processes, participant rights, statement of ethics approval, and importantly, provided participants with support provider information if they required support during or after survey completion. We were aiming for a sample size of approximately 150-200 participants to take part in this study but as this is a primarily exploratory based research, statistic power in this instance is not essential. However, recruitment can be notoriously difficult in eating disorder research (e.g., small sample size) (Feng et al., 2023), so we were aiming to be flexible with the numbers and not worry if certain clinics had greater number of responses than others, because any potential qualitative data to reflect participant experiences was considered valuable.

Survey

Upon opening the survey, participants were then provided with an information sheet and consent page to gain informed consent so they could determine if they wished to proceed in participating in such study. For those who provided informed consent and proceeded, participants were then presented with a demographic information form which captured gender, age, ethnicity, LGBT community identification, locality of residence during private hospital inpatient ED treatment, and current locality of residence. Participants were then asked if they had been diagnosed with an ED, with those who answered yes and thus being eligible proceeding to answer demographical questions regarding specific ED related questions. Note the survey design is outlined in the next section.

Given the exploratory and qualitative approach which required participants to select which hospital they were assessing, nil random allocation by Qualtrics was required as nil distinct groups were required at the commencement of the survey. Participants then completed their selected private hospital location to assess, which included both numeric answer options and free type answer options throughout various components of the survey to assess patient experiences with medical and allied health staff, group therapy, meal provision,

individual therapy, weigh-ins, other program specific factors, and discharge planning. To follow, participants were provided an optional opportunity to report their experiences in their own words through the provision of free type boxes, to report their experience/s, suggested changes, and what message would they give to person considering that program. At the completion of the first survey, participants were presented with an optional opportunity to assess a second private hospital inpatient ED program (if admissions to more than one hospital was applicable), which if proceeding, required participants to complete the same questions above for their second location selection (excluding demographical information). Lastly, participants were debriefed and were provided the contact details for support services if they needed them, they were provided the option of entering a prize draw, and finally, they were asked if they wished to obtain a copy of a post study research summary.

The survey design and the complexity of the ED experience within inpatient settings meant that the survey was very long. Additionally if a person had had treatment at more than one clinic, they could answer the survey more than once. In consultation with my supervisor and within the ethics process the length was considered carefully. However, based on lived experience, the author felt that participants would be motivated to outline all their experiences as with the exception of qualitative research, given this is the first study where individuals with an EDs had the opportunity to be surveyed about every aspect of the treatment they had received within an in-patient facility in Australia.

Materials/Survey design

A copy of the survey can be located in Appendix B. The survey was created in the following sections detailed below but summarised in Table 1.

Table 1

Summary of survey sections

Part 1
1. Demographic Information
2. Eating Disorder Specific Demographic
3. Generalist Private Hospital Inpatient ED Treatment
Part 2
1. Specific Private Hospital Inpatient ED Treatment Survey
2. Group Therapy Experience
3. Psychiatry experience
4. Individual Psychology Experience
5. Individual Dietetics Experience
6. Exercise Physiology
7. Nursing Experience
8. Meal Plans and Supportive Eating Experiences
9. After Meal Support, Social Eating, Meal Preparation, and Independent Eating Experience
10. Weigh-In Experiences
11. Discharge Experience
12. Overall Experience
Part 3
1. Extra Diversity Demographic Questions
2. Dual Diagnosis, Chronic Health, and Disability
Part 4
1. Additional Subsequent Private Hospital Inpatient ED Treatment Survey

Demographic Information

Participants were presented with a demographic form and were asked to self-report age, gender, ethnicity, LGBT community identification, locality of residence during private hospital inpatient ED treatment, and current location within Australia (e.g., which state) at the time of survey completion.

Eating Disorder Specific Demographic

Participants were asked if they had been diagnosed with an eating disorder and answered on a 2-point Likert scale ranging from 0 (no) to 1 (yes). If participants selected no, they were automatically exited from the survey due to ineligibility. Participants who answered yes, were then asked what diagnosis (or diagnoses) they had ever been diagnosed with by responding via clicking on the box next to the item/s they were familiar with to record their answer/s. Participants were then asked questions regarding their specific ED diagnostic considerations, age of onset, age of diagnosis, treatment engagement between age of onset and age of diagnosis, and whether they identified as having recovered from their ED, and responded by clicking on the box next to the item/s to report their relevant answer/s.

Generalist Private Hospital Inpatient ED Treatment

Participants were provided with a simplistic definition of the term ‘private hospital inpatient eating disorder treatment’. Participants were then asked if they had received private hospital inpatient ED treatment within Australia and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes). If participants selected no, they were automatically exited from the survey due to ineligibility. Participants who answered yes, were then asked questions regarding age for first admission, number of admissions experienced, if they had to travel to partake in treatment, and which state they travelled from and travelled to, to receive treatment, by responding via clicking on the box next to the relevant item to report their

relevant answer. To follow, participants were then asked to select every private hospital inpatient eating disorder treatment program they had been admitted to, by clicking on the box next to the relevant item or items to report their relevant answer. Participants were then asked how many admissions they had for their relevant answer options and responded on a 4-point Likert scale ranging from 1 (1 admission, 2-5 admissions) to 4 (6-9 admissions, 10+ admissions).

Specific Private Hospital Inpatient ED Treatment Survey

Participants were then provided with a clear statement to advise that they were about to commence answering specific questions regarding the first hospital they wished to provide answer options for. Participants were provided a second clear statement that advised them that in the instance they wished to complete surveys for more than one hospital (where applicable), they would be provided the optional opportunity to select a second hospital at the completion of their first survey (note: nil participants completed more than two surveys). To follow, participants were asked to select one private hospital inpatient eating disorder treatment program, by clicking on one box next to the relevant item to report their relevant answer. If participants selected more than one option in error, the survey rules prevented them from proceeding to the next question, until they had reviewed their answer and selected a singular option.

Group Therapy Experience

Participants were asked specific questions regarding their engagement in group therapy psychology whilst they were inpatient, including if it was helpful, relevant, outdated, and generic. Participants answered each question on a 5-point Likert scale ranging from 1 (strongly disagree, disagree, neutral) to 5 (agree, strongly agree) by clicking one box next to the relevant item to report their answer. To follow, participants then answered questions regarding group therapy dietetics whilst they were inpatient, including if it was helpful,

relevant, outdated, and generic. Participants responded on a 5-point Likert scale ranging from 1 (strongly disagree, disagree, neutral) to 5 (agree, strongly agree) by clicking one box next to the relevant item to report their answer. To follow, participants were asked three closing questions, including satisfaction for the psychology and dietetics group therapy options targeting disordered eating, if they were able to attend other groups focused on general mental health, and if applicable, relevant participants rated their satisfaction if they did attend general mental health groups, responding on a 2-point Likert scale ranging from 0 (no) to 1 (yes).

Psychiatry Experience

Participants were first asked to enter the number of one-to-one sessions they typically had per week with their psychiatrist into a free-type text box. Participants were asked specific questions regarding their experience with their psychiatrist whilst they were inpatient, including regularity of contact, desire to have more contact, if they felt heard, if they felt included in decision making regarding their care, individualisation of care, communication with their psychiatrist, the willingness of their psychiatrist to collaborate with outpatient practitioners, if they felt their psychiatrist had sufficient ED knowledge, if the psychiatrist installed recovery hope, and overall satisfaction with their psychiatrist. Participants responded on a 5-point Likert scale ranging from 1 (strongly disagree, disagree, neutral) to 5 (agree, strongly agree) by clicking one box next to the relevant item to report their answer.

Individual Psychology Experience

Participants were asked if they were encouraged to remain engaged with their outpatient psychologist whilst admitted and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes). Participants were asked if they were offered one-to-one psychology by the hospital during their admission and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes). Participants who answered no, were redirected to the next relevant question.

Participants who answered yes, were asked to enter the number of one-to-one sessions they typically had per week with a hospital psychologist into a free-type text box. Participants were asked specific questions regarding their experience during one-to-one psychology whilst they were inpatient, including regularity of contact, reported helpfulness, if they felt psychologists had sufficient ED knowledge, and if psychologists installed recovery hope. Participants responded on a 5-point Likert scale ranging from 1 (strongly disagree, disagree, neutral) to 5 (agree, strongly agree) by clicking one box next to the relevant item to report their answer. All participants were then asked if they would like to have additional access to one-to-one psychology whilst inpatient and responded on a 5-point Likert scale ranging from 1 (strongly disagree, disagree, neutral) to 5 (agree, strongly agree). To follow, all participants were asked to report their overall satisfaction and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes).

Individual Dietetics Experience

Participants were asked if they were offered one-to-one dietetics by the hospital during their admission and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes). Participants who answered no, were redirected to the next relevant question. Participants who answered yes, were asked to enter the number of one-to-one sessions they typically had per week with a dietitian into a free-type text box. Participants were asked specific questions regarding their experience during one-to-one dietetics whilst they were inpatient, including regularity of contact, reported helpfulness, if they felt dietitians had sufficient ED knowledge, and if dietitians installed recovery hope. Participants responded on a 5-point Likert scale ranging from 1 (strongly disagree, disagree, neutral) to 5 (agree, strongly agree) by clicking one box next to the relevant item to report their answer. All participants were then asked if they would like to have additional access to one-to-one dietetics whilst inpatient and responded on a 5-point Likert scale ranging from 1 (strongly disagree, disagree, neutral) to 5

(agree, strongly agree). To follow, participants reported their overall satisfaction and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes).

Exercise Physiology

Participants were asked if the hospital had an exercise physiologist as a part of the inpatient treatment team during their admission and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes). Participants who answered no, were redirected to the next relevant question. Relevant participants assessed satisfaction with such exercise physiology involvement and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes). To follow, all participants were asked if they felt including an exercise physiologist as a part of inpatient treatment teams would have been beneficial to their treatment and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes).

Nursing Experience

Participants were asked specific questions regarding nursing care ED knowledge, nursing support during challenging times, and if nursing staff installed recovery hope, and responded on a 5-point Likert scale ranging from 1 (strongly disagree, disagree, neutral) to 5 (agree, strongly agree). To follow, participants reported their overall satisfaction with their nursing care and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes).

Meal Plans and Supportive Eating Experiences

Participants were asked specific questions regarding meal plan experiences, including variety of food, dietician collaboration for meal plans, individuation of meal plans, regularity of eating support, and opportunities to try new foods or fear foods. Participants responded on a 5-point Likert scale ranging from 1 (strongly disagree, disagree, neutral) to 5 (agree, strongly agree). To follow, participants reported overall satisfaction with their meal plan experiences and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes).

Participants were asked if they experienced eating on a supported eating table (e.g., with nursing or allied health staff providing support to the table) and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes). Participants who answered no, were redirected to the next relevant question. Participants who answered yes were asked specific questions regarding their experience on the table, support from staff, if disordered eating behaviours were addressed by staff, distress management, encouragement, and the transition from the table to independent eating. Participants responded on a 5-point Likert scale ranging from 1 (strongly disagree, disagree, neutral) to 5 (agree, strongly agree) by clicking one box next to the relevant item to report their answer. To follow, participants reported overall satisfaction with their experience on the table responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes).

After Meal Support, Social Eating, Meal Preparation, and Independent Eating Experience

Participants were asked if they experienced after meal support (e.g., staff providing support in the room or another room) and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes). Participants who answered no, were redirected to the next relevant question. Participants who answered yes were asked specific questions regarding if they felt they had adequate oversight, engagement in distraction activities, if staff addressed compensatory behaviours of patients, and patient distress management. Participants responded on a 5-point Likert scale ranging from 1 (strongly disagree, disagree, neutral) to 5 (agree, strongly agree) by clicking one box next to the relevant item to report their answer. To follow, participants reported overall satisfaction during after meal support and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes). To follow, participants were asked specific questions regarding opportunities for social eating, food preparation, and independent eating during

their admission, and responded on a 5-point Likert scale ranging from 1 (strongly disagree, disagree, neutral) to 5 (agree, strongly agree) by clicking one box next to the relevant item to report their answer.

Weigh-In Experiences

Participants were provided with a clear statement to clarify that they would not be asked any questions regarding actual weight or numbers associated with the questions to follow. Participants were then asked to report which methods of weigh-ins they experienced during their admission, by selecting up to four options (blind weigh, visible weigh, both blind and visible weighs, or if they were not weighed) via selecting the relevant or relevant boxes. To follow, participants were asked to select their preferred approach to weigh-ins, by selecting up to four answer options (blind weigh, visible weigh, both blind and visible weighs, or no weigh ins) by selecting the relevant box or boxes. Participants were then provided with the optional opportunity to express why they preferred such method/s, by typing their experiencing into a free-type text box. To follow, participants were asked to select what they were required to wear during weigh-ins, by selecting up to five answer options (clothing, underwear) via selecting the relevant or relevant boxes. To follow, participants were asked specific questions regarding their experience during weigh-ins, including support adequacy from staff, staff professionalism, weigh in outcome discussion with psychiatrist, and weigh in outcome discussion with dietetics. Participants responded on a 5-point Likert scale ranging from 1 (strongly disagree, disagree, neutral) to 5 (agree, strongly agree) by clicking one box next to the relevant item to report their answer. To follow, participants reported overall satisfaction with weigh-in experiences and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes).

Discharge Experience

Participants were asked specific questions regarding their experience with discharge processes, including discharge planning, patient and team collaboration, dietetic meal plan support to use upon discharge, discharge notice, if patients felt they were discharged prematurely, encouragement from psychiatry to connect with community-based clinician/s, and the meaningfulness of the discharge process. Participants responded on a 5-point Likert scale ranging from 1 (strongly disagree, disagree, neutral) to 5 (agree, strongly agree). To follow, participants reported overall satisfaction with discharge experiences and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes).

Overall Experience

Participants were asked specific questions regarding their overall experience with the specific private hospital inpatient eating disorder treatment program they reviewed, including person centred care, treatment genericness, collaborative decision making, if a holistic or strengths base approach was taken, and if they felt their treatment would assist them to recover from their ED. Participants responded on a 5-point Likert scale ranging from 1 (strongly disagree, disagree, neutral) to 5 (agree, strongly agree). To follow, participants were asked to report if they would feel content returning for another admission if they needed to, if they recommended the hospital to others considering an admission, and if they were broadly satisfied with their overall experience and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes).

Extra Diversity Demographic Questions

Participants were provided an optional opportunity to report additional demographical details and were asked if they felt their treatment was delivered in a culturally appropriate manner (if applicable), a manner that considered their religion (if applicable), if they identified as gender diverse and treatment was delivered inclusively (if applicable), and if they identified as a part of the LGBT community, and treatment was delivered in a safe

manner (if applicable). Participants responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes), with ‘not applicable’ being the additional option where applicable.

Qualitative Self-Report Questions

Participants were provided with an optional opportunity to report, in their own words, their experience at the private hospital inpatient eating disorder program, what they would like to change about the program, and what message would they like to send to another person who was considering an admission. Participants responded via a typing into a free-type text box with a 250-character limit.

Dual Diagnosis, Chronic Health, and Disability

Participants were provided with an optional opportunity to report dual diagnosis (if applicable to them) and responded via selecting the box (or boxes) that applied to them, from a list inclusive of trauma, personality, dissociative, anxiety, depressive, bipolar, psychotic, neurodevelopmental, obsessive compulsive, somatic, elimination, sleep-wake, disruptive/impulse control/conduct, and neurocognitive related disorders. To follow, relevant participants were asked specific questions regarding if they felt their broader psychological diagnoses were considered in conjunction with their eating disorder, if they felt their eating disorder was the singular focus during their admission, and if they felt it would have been advantageous for dual diagnosis was considered during their admission. Relevant participants responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes).

To follow, participants were provided with an optional opportunity to report if they experienced a chronic health condition (if applicable to them) and responded via typing their answer/s into a free-type box. To follow, relevant participants were asked specific questions regarding if they felt their broader chronic health condition/s were considered in conjunction with their eating disorder, if they felt their eating disorder was the singular focus during their

admission, and if they felt it would have been advantageous if their chronic health was considered during their admission. Relevant participants responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes).

To follow, participants were provided with an optional opportunity to report if they identified as experiencing a disability (or disabilities) (if applicable to them) and responded via typing their answer/s into a free-type box. To follow, relevant participants were asked specific questions regarding if they felt their disability/disabilities were considered in conjunction with their eating disorder, if they felt their eating disorder was the singular focus during their admission, and if they felt it would have been advantageous if their disability/disabilities were considered during their admission. Relevant participants responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes).

Additional Subsequent Private Hospital Inpatient ED Treatment Survey

Participants were then asked if they wished to complete an additional survey for a second private hospital inpatient eating disorder treatment program and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes). Participants who answered no, were redirected to the end component of the survey, where they were provided with a safety and well-being message with key support contacts, a thank you message, and were provided the option of entering the optional prize draw via responding by entering their email address into a free-type text box. Finally, if they wished to receive a copy of the optional post completion research summary, they responded by entering their email address into a free-type text box. Participants who answered yes, were redirected to select one private hospital inpatient eating disorder treatment program, by clicking on one box next to the relevant item to report their relevant answer. If participants selected more than one option in error, the survey rules prevented them from proceeding to the next question, until they had reviewed their answer

and selected a singular option. Participants then completed the exact questions they were offered for completion during their initial survey, in the same format for group therapy experience form, psychiatry experience form, individual psychology experience form, individual dietetics experience form, exercise physiology form, nursing experience form, meal plans and supportive eating experiences form, after meal support, social eating, meal preparation, and independent eating experience form, weigh in experiences form, discharge experience form, extra diversity demographic form, qualitative self-report form, dual diagnostic, and chronic health, and disability forms.

Participants responded on the exact scales they were required to respond on during their first survey, to ensure the accuracy of collected data. To follow, participants were then asked if they wished to complete an additional survey for a third private hospital inpatient eating disorder treatment program and responded on a 2-point Likert scale ranging from 0 (no) to 1 (yes). All participants responded no and were redirected to the end component of the survey, where they were provided with a safety and well-being message with key support contacts, a thank you message, and were provided the option of entering the optional prize draw via responding by entering their email address into a free-type text box. Finally, if they wished to receive a copy of the optional post completion research summary, they responded by entering their email address into a free-type text box.

Participants

Participants were 62 adults aged 19 to 40 years of age ($M = 28.33$, $SD = 4.96$) that identified as female (88.7%), non-binary (9.7%), or male (1.6%). Participants predominately identified as Caucasian (96.8%), and 33.9% of participants identified as a part of the LGBT community. At the time of survey completion, 100% of participants resided within Australia, with specifically residency comprised of Queensland (48.4%), Victoria (19.4%), New South

Wales (16.1%), Western Australia (8.1%), Australian Capital Territory (4.8%), South Australia (1.6%), and Tasmania (1.6%).

All participants reported being diagnosed with one or more eating disorders over the course of their lifetime at the time of survey completion, comprised of Anorexia Nervosa (AN) (82.3%), Bulimia Nervosa (BN) (17.7%), Binge Eating Disorder (BED) (6.5%), Avoidant Restrictive Food Intake Disorder (ARFID) (12.9%), Orthorexia (3.2%), and Other Specific Feeding or Eating Disorder (OSFED) comprised of Atypical Anorexia Nervosa (40.3%), Purging Disorder (6.5%), Bulimia Nervosa of Low Frequency and/or Duration (1.6%), and Rumination Disorder (1.6%).

Participants reported the onset of disordered eating symptoms prior to diagnosis predominately before aged 18 (85.5%) with 56% of participants reporting age of actual diagnosis exceeding 18 years of age. Only 19.4% of participants reported engaging in eating disorder intervention prior to their formal diagnosis. Illness durations were primarily comprised of 10+ years (58.1%), 7-9 years (17.7%), and 4-6 years (16.1%), with 21% of participants reporting having recovered from their eating disorder/s at the time of survey completion.

Participants reported comorbid mental health diagnosis/diagnoses (95.2%). See Table 2 for comorbidity prevalences. The most common were anxiety and mood related disorders. However, anxiety, trauma, and neurodevelopmental related disorders (e.g., autism or ADHD) were also high suggesting that patients admitted to private hospital inpatient ED programs are admitted with comorbidities, get diagnosed with comorbidities whilst inpatient, or that their ED's might be closely related to other mental health disorders.

Table 2*Prevalence of Comorbid Mental Health Diagnosis/Diagnoses*

Condition	Percent
Anxiety related disorders	67.7%
Mood related disorders	59.7%
Trauma related disorders	40.3%
Obsessive compulsive related disorders	38.7%
Neurodevelopmental related disorders	35.5%
Personality related disorders	14.5%
Dissociative related disorders	8.1%
Bipolar related disorders	6.5%
Sleep wake related disorders	4.8%
Psychotic related disorders	1.6%
Somatic related disorders	1.6%
Neurocognitive related disorders	1.6%

Interestingly, patients reported a reasonably high prevalence of comorbid chronic health conditions at 32.3%, with multiple comorbid chronic health conditions occurring at a prevalence of 40%. See Table 3. for self-reported chronic health related comorbidities. This information is important as physical health condition information is often not collected but clearly with almost one third having chronic health conditions this needs to be considered in their treatment.

Table 3*Prevalence of Comorbid Self-Described 'Chronic Health' Conditions*

Condition	Percent
Autonomic nervous system disorder	35%
Digestive or gastrointestinal condition	30%
Bone or bone marrow related condition	25%
Connective tissue disorders	20%
Autoimmune or immune related condition	20%
Neurological condition	20%
Inflammatory condition	15%
Vascular condition	10%
Gynaecological condition	10%
Endocrine condition	10%
Cardiovascular condition	5%
Neurocognitive related disorders	5%

Patients reported a prevalence of comorbid disabilities at 22.6%, with multiple comorbid disabilities occurring at a prevalence of 50%. Of importance to note for the purposes of the following interpretation, given the self-report nature of how relevant participants uniquely defined their disability or disabilities, the societal perception of what disability as a construct represents is more broadly extended upon. Therefore, to respect participant autonomy, all self-reported disabilities were captured in Table 4, as followed.

Table 4*Prevalence of Comorbid Self-Described Disabilities*

Condition	Percentage
Neurodevelopmental condition	49.99%
Mental health condition	28.56%
Automatic nervous system condition	14.28%
Neurological condition	7.14%
Neuromuscular condition	7.14%
Autoimmune or immune condition	7.14%
Connective disorder condition	7.14%
‘Chronic health’ unspecified	7.14%

Participants reported being first admitted for private hospital inpatient eating disorder treatment between 18-25 years of age (50%), 16-17 years of age (19.4%), 26-29 years of age (17.7%), or 30-40 years of age (12.9%). Participants reported predominately having had one or two admissions (35.5%), followed by three to five admissions (32.3%), five to nine admissions (30.6%), or more than 10 admissions (11.3%). Participants reported admissions to multiple private hospital inpatient eating disorder treatment providers, primarily at Robina Private Hospital (20.8%), Ramsay Clinic New Farm (18.1%), The Melbourne Clinic (18.1%), Cooina Clinic (16.7%), Ramsay Clinic Hollywood (11.1%), Ramsay Clinic Northside (12.5%), The Geelong Clinic (9.7%), and Ramsay Clinic Wentworthville (6.9%).

Of the total participants, 16.12% completed a second survey of an additional clinic they wished to review in addition to their first selection. This comprised of Ramsay Clinic

New Farm (40%), The Melbourne Clinic (20%), Ramsay Clinic Wentworthville (20%), and Robina Private Hospital (20%). Therefore, taking total survey completion to $N=72$.

Ethics

The main ethical issues in this study were potential emotional reactivity of participants during survey completion, participant anonymity, and the study being completed through a New Zealand based university, therefore, requiring the Treaty of Waitangi to be actively considered. Firstly, to address the first presenting ethical issue of potential participant emotional reactivity, the survey was designed to be optional for participants (e.g., it was not mandatory to engage in such survey or complete it in full), it included multiple instances of safety touch points (start and finish) to provide participants with a comprehensive list of support services with links and phone numbers for ease of access, and participants had the autonomy to stop the survey at any time they chose. Given such research gained ethics approval to commence and deliver such survey, it was considered that the first ethical issue of potential participant emotional reactivity was transparently reported with appropriate approaches and subsequently approved as suitable to proceed.

Secondly, despite the current study occurring physically on Australian land and nil Māori participants partaking, the Treaty of Waitangi was considered due to the basis of which the author gained approved to conduct research from, Massey University (Te Kunenga ki Pūrehuroa). However, we did consider that Māori participants might be living in Australia and have had treatment in Australia. Te Ara Tika Guidelines were read thoroughly and discussed with Dr Kathryn McGuigan from the Massey School of Psychology, due to Dr McGuigan's extensive history of working within this field of research.

The current research was conducted in accordance with the key principles of such Treaty, participation, partnership, and protection, which served as a guide throughout the entire research process to highlight any ethical issues around responsibilities, roles, and rights when working with Māori. Moreover, the ‘Māori @ Massey 2020: Kia Mārama Strategy’ and Māori health advancement guidelines (Health Research Council of New Zealand, 2019) were discussed this with my supervisor to ensure a thorough approach to inclusivity was taken. However, nil Māori participants completed such study, which therefore, did not require further specific analyses to provide additional research recommendations specific to Māori populations, regardless of where they resided.

Data Analysis

Quantitative research measures were utilised to capture demographical and performance outcomes, to ensure the numeric components of the current study were captured accurately. Simply, the significant quantity of data was required to be succinctly captured, which, required summarisation for the purposes of the presenting wordcount limitations. For the quantitative data, I firstly screened the data, and participants were deleted from the data set if they were identified as bots ($n = 2$), or if they had insufficient completion ($n = 20$) which was measured as having discontinued survey participation before commencing assessing a private hospital inpatient eating disorder location (e.g., lacked adequate completeness). Of the 20 participants, ($n = 2$) who were deleted from the data set were flagged during outlier detection, however, as they were removed due insufficient completion, further outlier assessment was not required. After the deletions were actioned, the remaining participants were retained, including those who had minor missing data. Reverse score transformations were applied to seven items to convert them into measures of negative affect,

including ‘I feel that the content of the group therapy psychology sessions I attended whilst inpatient was outdated’, ‘I feel that the content of the group therapy psychology sessions I attended whilst inpatient was generic’, ‘I feel that the content of the group therapy dietetics sessions I attended whilst inpatient was outdated’, ‘I feel that the content of the group therapy dietetics sessions I attended whilst inpatient was generic’, ‘I feel that my meal plans were generic and that it was not customised to my presentation, unique needs, and individual (non-eating disordered) related preferences’, ‘I feel that I was discharged too early’, ‘I feel that the overall treatment I received was generic (e.g., the same for everyone)’.

The results for the quantitative data are firstly presented per clinic with descriptive statistics under each of the categories of questions. The statistics are means and standard deviations based on the number of respondents for each clinic. Cross organisation analysis was completed to assess the four organisation which comprised the ‘collective eight’, and with the descriptive statistics captured means and standard deviations based on the number of combined respondents for each of the four organisations.

A thematic analysis approach was employed for the participant statement components of the study, as evidenced by Braun & Clarke (2006, 2020) as an effective, advantageous, and evidenced approach to qualitative research in the lived experience and mental health domains, therefore, being suitable for the current study. Congruent with Braun & Clarke’s (2006) stepped approach to TA, the presenting narratives were recorded, coded into possible presenting themes, and subsequent ‘complete themes’ were identified (Braun & Clarke, 2006; DeSantis & Ugariza, 2000; Levy-Fenner et al., 2022). TA was employed to distinctly respond to the ‘through the lens of lived experience’ component of the broader study, where participants were provided the opportunity to respond via a statement-based approach, thus not reflective of numerical data. Commonly utilised in lived experience and mental health

research, TA is an adaptable tool which assists researchers to understand and synthesise data related patterns (such as self-reported statements, participant interviews), supported by comparisons to existing research, to uncover salient themes, through a social and realism lenses (Attride-Stirling, 2001; Braun & Clarke, 2006, 2020; Braun et al., 2019; Crowe et al., 2015; Levy-Fenner et al., 2022).

Congruent with Braun & Clarke's (2006) stepped approach to TA, the presenting narratives (known as 'expressing your story in your own words' for the purpose of the current study), were recorded, followed by the current author coding data into possible presenting themes (and sub-themes) with equal importance given to all items (Braun & Clark, 2006, 2020). Through the collation and subsequent assessment of relevant potential themes and sub-themes, the development of 'complete themes' was facilitated, which represented quintessential meanings of such experiences for multiple individuals across the same broader situational context (e.g., all participants experienced the same overarching treatment model) (Braun & Clarke, 2006; DeSantis & Ugariza, 2000; Levy-Fenner et al., 2022). Through the development of 'complete themes', the author was required to be reflexive and non-biased by acknowledging her own personal experiences and biases to ensure they were not reflected in such representation of the true meanings of participants self-reports (Braun & Clarke, 2006, 2020; Talwar, 2010). Due to the nature of the TA component of this study, risk of misrepresentation was considered substantially reduced, given participants autonomously and optionally reported their own story in their own literal words.

Results

Results are presented as survey results firstly and then qualitative data responses to follow.

Individual Hospital Results

Ramsay Clinic New Farm.

Participants were adults ($n = 11$) aged 21 to 35 years of age ($M = 28.82$, $SD = 4.87$) that identified as female (90.9%) and non-binary (9.1%). 90.9% of participants identified mental health comorbidities, 33.3% identified chronic health comorbidities, and 11.1% identified disability/disabilities.

Group Therapy

The respondents all (100%) reported engagement in group therapy was mandatory. 54.6% of participants reported they didn't find group therapy psychology relevant and helpful ($M = 3.55$, $SD = 1.29$). 54.6% of participants felt the content of group therapy psychology was in date ($M = 2.82$, $SD = 1.33$). 63.7% of participants found the group therapy psychology content to be generic ($M = 3.73$, $SD = .905$), 9.1% of participants reported finding the group therapy dietetic sessions relevant and helpful ($M = 3.55$, $SD = 1.04$), 45.5% reported they did not find group therapy dietetics content outdated ($M = 2.65$, $SD = 1.21$), and 90.9% of participants thought the group therapy dietetics content was generic ($M = 1.55$, $SD = 0.69$). Overall, 72.7% of participants reported the collective ED group therapy was not helpful or beneficial. 100% of participants ($n=11$) reported being able to attend broader mental health group therapy options, with 27.3% of relevant participants finding broader group therapy options helpful and beneficial.

Psychiatry

90.9% of participants reported seeing their psychiatrist two or more times per week ($M = 2.18$, $SD = 0.75$), 54.6% of participants felt their one-to-one psychiatry sessions were

regular enough ($M = 3.18$, $SD = 1.25$), and 72.8% of patients reported dissatisfaction with the adequacy of one-to-one psychiatry ($M = 3.73$, $SD = 1.42$). 81.9% of participants reported desire to see their psychiatrist more often ($M = 1.82$, $SD = 0.98$), 45.5% of participants reported feeling heard by their psychiatrist ($M = 3.36$, $SD = 1.63$), 63.6% of participants felt their psychiatrist involved them in their care decision making ($M = 2.64$, $SD = 1.21$), and 45.5% of participants reported they felt their psychiatrist individualised their treatment ($M = 3.09$, $SD = 1.58$). 54.6% reported dissatisfaction with their psychiatrist's communication with them ($M = 3.18$, $SD = 1.25$), 27.3% felt their psychiatrist's communication with the MDT regarding their care was satisfactory ($M = 3.45$, $SD = 1.44$), and 54.5% felt their psychiatrist was unwilling to collaborate with their outpatient team ($M = 4.00$, $SD = 1.67$). 72.8% of participants felt their psychiatrist had adequate ED knowledge ($M = 2.27$, $SD = 1.42$), 54.6% of participants felt their psychiatrist installed recovery hope ($M = 2.64$, $SD = 1.63$), and overall, 36.4% of participants were satisfied with the overall care provided by their psychiatrist.

Individual Psychology

54.5% of participants reported being encouraged to remain connected with their outpatient psychologist whilst inpatient. 36.4% of participants were provided with individual psychology provided by the hospital ($M = 1.64$, $SD = 0.51$), with participants reporting one to three sessions per week ($M = 1.75$, $SD = 0.96$). 50% of patients felt they were provided with regular individual psychology ($M = 3.00$, $SD = 1.41$), 15% of participants were satisfied with the regularity of individual psychology ($M = 3.75$, $SD = 1.26$), and 50% of patients found individual psychology helpful and beneficial ($M = 2.50$, $SD = 1.30$). 75% of participants felt the psychologist/s had adequate ED knowledge ($M = 2.27$, $SD = 1.42$), 100% of participants felt the hospital psychologist's installed recovery hope, and 100% of

participants reported desiring more individual psychology. Overall, 18.2% of participants reported being overall satisfaction with individual psychology.

Individual Dietetics

100% of participants reported experiencing individual dietetics with 54.5% of participants reporting one session per week ($M = 1.73$, $SD = 1.19$). 54.6% of patients felt they were provided with regular individual dietetic sessions ($M = 2.73$, $SD = 1.35$), 45.5% of participants reported satisfaction with the regularity of individual dietetics ($M = 3.09$, $SD = 1.45$), 54.6% of did not find their individual dietetic sessions helpful or beneficial ($M = 3.55$, $SD = 1.37$), and 63.7% felt the dietitian/s had adequate ED knowledge ($M = 2.45$, $SD = 1.44$). 36.4% of participants felt the dietitian/s installed recovery hope ($M = 3.09$, $SD = 1.30$), 54.6% of participants reported desiring more individual dietetics sessions ($M = 2.36$, $SD = 1.12$), and overall, 54.5% of participants reported overall satisfaction with individual dietetics.

Exercise Physiology

27.3% of participants reported being provided with exercise physiology whilst inpatient, with 66.6% of relevant participants reporting satisfaction such provided exercise physiology, and 90.9% of all participants reported they felt it would have been beneficial to have had access to exercise physiology.

Nursing Care

45.5% of participants felt nursing staff displayed sufficient ED knowledge ($M = 3.00$, $SD = 1.55$), 63.7% of participants felt nursing staff did not provide adequate care during challenging times ($M = 3.36$, $SD = 1.57$), and 36.4% of participants felt nursing staff installed recovery hope ($M = 2.91$, $SD = 1.30$). Overall, 45.5% of participants were satisfied with the nursing care they received.

Meal Plans

63.7% of participants felt their meal plans lacked variety ($M = 3.64$, $SD = 1.20$), 81.9% of participants desired more variety of their meal plans ($M = 1.82$, $SD = 0.98$), 54.6% of participants felt the dietician/s did not collaborate with them for some shared meal plan decision making ($M = 3.18$, $SD = 1.25$), and 81.8% of participants felt their meal plans were not generic and were individualised ($M = 1.55$, $SD = 0.82$). 81.8% of patients felt meal plans helped them to engage in regular eating ($M = 2.27$, $SD = 0.65$), 54.6% of participants felt meal plans did not help them to try new foods or to attempt fear foods ($M = 3.45$, $SD = 1.13$), and overall, 72.7% of participants were dissatisfied with their meal plan experiences.

Supported Eating

100% of participants reported experiencing eating on the specific supported ED table, with 27.3% of participants reporting feeling supported by staff whilst on the table ($M = 3.36$, $SD = 1.36$). 36% of participants reported that staff addressed disordered behaviours by patients ($M = 3.09$, $SD = 1.30$), 18.2% of participants reported feeling staff adequately addressed patient distress ($M = 3.73$, $SD = 1.27$), and 45.5% of participants reported experiencing encouragement and support from staff during more difficult moments on the table ($M = 3.09$, $SD = 1.58$). 18.2% of participants felt prepared to transition off the table ($M = 3.82$, $SD = 1.40$), and overall, 72.7% of participants were dissatisfied with their ED table experiences.

After Meal Support

100% of participants experienced after meal support, with 54.6% of participants feeling unsupported by staff during after meal support. 54.6% of participants felt staff encouraged engagement in helpful and relevant distraction activities, 54.6% of participants felt staff did not adequately address disordered behaviours during after meal support ($M = 3.27$, $SD = 1.56$), and 63.7% of participants reported they felt staff did not adequately address

patient distress ($M = 3.64$, $SD = 1.43$). Overall, 54.5% of participants were dissatisfied with their after-meal support experiences.

Social Eating, Food Preparation, and Independent Eating

63.7% of participants felt they had adequate opportunities to engage in social eating outside of the hospital ($M = 2.36$, $SD = 1.12$), 81.8% of participants reported not being offered food preparation opportunities, and 63.6% of participants reported the time they spend on independent eating prior to being discharged was insufficient ($M = 3.45$, $SD = 1.70$).

Weigh-Ins

63.6% of participants reported being blind weighed, 18.2% of participants reported visible weigh-ins, 9.1% of participants reported a combination of visible and blind weighs, and 9.1% of participants were not weighed. To follow, 54.5% of participants preferred a visible approach to weigh-ins. 72.7% of participants reported being weighed whilst wearing general clothing (e.g., pyjamas), 18.2% reported wearing a hospital provided gown, and 9.1% reported being weighed in their underwear. 54.6% of participants felt staff completed their weigh-ins in a professional, informed, and supportive manner ($M = 2.33$, $SD = 1.22$), 36.4% of participants felt supported post their weigh-in (if support was required), and 45.5% of participants felt their psychiatrists did not address the outcome of their weigh-ins in a professional or supportive manner ($M = 3.78$, $SD = 1.09$). 27.3% of participants felt the dietitian/s addressed the outcome of their weigh-ins in a professional or supportive manner ($M = 3.78$, $SD = 1.72$). Overall, 45.5% of participants were satisfied with their weigh-in experiences.

Discharge Experience

63.7% of participants did not feel adequate discharge planning was completed prior to discharge ($M = 3.90$, $SD = 1.45$), 63.7% of participants felt their treating team did not

involve them in discharge planning ($M = 3.70$, $SD = 1.50$), 63.7% felt they were not supported by dieticians to prepare a meal plan for discharge ($M = 3.90$, $SD = 1.50$), and 41.5% of participants felt they were given insufficient notice of discharge ($M = 3.30$, $SD = 1.50$). 27.3% of participants felt they were discharged too early ($M = 2.60$, $SD = 1.50$), 54.6% of participants felt their psychiatrist did not ensure appropriate outpatient support was in place prior to discharge ($M = 3.40$, $SD = 1.35$), and 63.7% felt their discharge process was not meaningful ($M = 3.90$, $SD = 1.20$). Overall, 72.7% of participants reported overall dissatisfaction their discharge experience.

Overall Experience

54.6% of participants did not feel their overall treatment was individualised to their unique presentation, needs, and preferences ($M = 3.50$, $SD = 1.65$), 72.8% of participants felt treatment was generic for all ($M = 1.80$, $SD = 1.03$), 36.4% of participants felt their voice was heard and actively contributed to decision making ($M = 3.20$, $SD = 1.48$), and 45.5% of participants reported they did not feel a holistic and strengths based approach was taken ($M = 3.50$, $SD = 1.50$). 54.6% felt their admission would not help them/has not helped them recover from their ED ($M = 3.70$, $SD = 1.57$). Further, 54.5% of patients felt they would not feel content returning for future additional admissions, 63.6% of participants did not recommend the private hospital ED program to others, and 54.5% of participants were dissatisfied with their overall experience.

Robina Private Hospital.

Participants were adults ($n = 12$) aged 23 to 35 years of age ($M = 29.50$, $SD = 3.50$) that all identified as female (100%) 100% of participants identified mental health comorbidities, 41.7% identified chronic health comorbidities, and 30% identified disability/disabilities.

Group Therapy

100% of participants reported engagement in group therapy was mandatory. 83.3% of participants found group therapy psychology relevant and helpful ($M = 1.75$, $SD = 2.00$). 33.3% of participants felt the content of group therapy psychology was outdated ($M = 3.00$, $SD = 0.85$), and 58.3% of participants found the group therapy psychology content was not generic ($M = 2.50$, $SD = 0.91$). 58.3% of participants found the group therapy dietetic sessions relevant and helpful ($M = 2.42$, $SD = 0.79$), 41.7% did not find group therapy dietetics content outdated ($M = 2.92$, $SD = 0.90$), and 50% of participants found the group therapy dietetics content was generic ($M = 2.58$, $SD = 1.08$). 83.3% of participants found collective ED group therapy helpful or beneficial, 58.3% of participants were unable to attend broader mental health group therapy, and 60% of relevant participants found broader mental health group therapy helpful and beneficial.

Psychiatry

75% of participants reported seeing their psychiatrist five times per week ($M = 4.33$, $SD = 1.37$). 83.3% of participants felt their individual psychiatry sessions were regular enough ($M = 1.83$, $SD = 1.12$) and reported satisfaction with the adequacy of individual psychiatry ($M = 3.75$, $SD = 0.87$). 33.3% of participants felt heard by their psychiatrist ($M = 3.00$, $SD = 0.93$), 50% of participants felt their psychiatrist involved them in their care decision making ($M = 2.67$, $SD = 0.99$), 33.3% of participants felt their psychiatrist individualised their treatment ($M = 2.92$, $SD = 1.00$), 66.7% reported satisfaction with their psychiatrist's communication with them ($M = 2.50$, $SD = 0.80$), and 66.7% of participants felt their psychiatrist's communication with the broader MDT regarding their care was satisfactory ($M = 2.50$, $SD = 1.00$). 41.7% of participants felt their psychiatrist was not willing to collaborate with their outpatient team ($M = 2.92$, $SD = 0.90$), 66.7% of participants felt their psychiatrist had adequate ED knowledge ($M = 2.17$, $SD = 1.27$), and 25% of

participants felt their psychiatrist installed recovery hope ($M = 3.00$, $SD = 0.74$). Overall, 75% of participants were satisfied with the overall care provided by their psychiatrist.

Individual Psychology

66.7% of participants reported being encouraged to remain connected with their outpatient psychologist whilst they were inpatient. 41.7% of participants reported being provided with individual psychology provided by the hospital ($M = 1.58$, $SD = 0.52$), with participants reporting one to two sessions per week ($M = 1.20$, $SD = 0.84$). 60% of patients felt they were provided with regular individual psychology sessions ($M = 3.00$, $SD = 1.41$), 60% of participants were satisfied with the regularity of individual psychology sessions ($M = 3.00$, $SD = 1.41$), 60% found their individual psychology sessions helpful and beneficial ($M = 2.80$, $SD = 1.30$), and 80% of participants felt the psychologist/s had adequate ED knowledge ($M = 2.40$, $SD = 1.52$). 80% of participants felt the hospital psychologist/s installed recovery hope ($M = 2.40$, $SD = 1.52$), 58.3% of participants reported not desiring additional individual with a hospital provided psychologist ($M = 2.25$, $SD = 1.14$), and overall, 80% of participants reported being broadly satisfied with individual psychology experiences.

Individual Dietetics

100% of participants reported experiencing individual dietetics whilst inpatient, with 66.7% of participants reporting two sessions per week ($M = 2.00$, $SD = 1.05$). 50% of participants felt they were provided with regular individual dietetic sessions ($M = 2.33$, $SD = 1.30$), 50% of participants reported satisfaction with the regularity of individual dietetics ($M = 2.67$, $SD = 1.37$), 50% of patients did not find their individual dietetic sessions helpful or beneficial ($M = 2.33$, $SD = 1.12$) and 83.3% of participants reported they felt the dietitian/s had adequate ED knowledge ($M = 1.83$, $SD = 0.94$). 58.3% of participants felt the hospital provided dietitian/s installed recovery hope ($M = 2.25$, $SD = 1.14$), and 41.7% desired more

individual dietetics sessions ($M = 2.67$, $SD = 1.23$). Overall, 58.3% of participants reported overall satisfaction with individual dietetics.

Exercise Physiology

0% of participants reported being provided with exercise physiology whilst inpatient, and 100% of participants felt it would have been beneficial to have had access to exercise physiology.

Nursing Care

83.3% of participants felt nursing staff displayed sufficient ED knowledge ($M = 2.17$, $SD = 0.94$), felt nursing staff provided adequate care during more challenging times ($M = 2.00$, $SD = 0.60$), and felt nursing staff installed recovery hope ($M = 1.83$, $SD = 0.72$). Overall, 83.3% of participants were satisfied with the nursing care they received.

Meal Plans

75% of participants felt their meal plans included adequate variety ($M = 2.33$, $SD = 0.89$), 66.6% of participants desired nil increased variety of their meal plans ($M = 3.92$, $SD = 1.00$), 100% of participants felt the dietician/s collaborated with them for some shared decision making towards their meal plans ($M = 1.67$, $SD = 0.50$) and 58.3% felt their meal plans were generic ($M = 3.33$, $SD = 0.89$). 100% of patients reported they felt meal plans assisted them to engage in regular eating ($M = 1.67$, $SD = 0.50$), 58.3% felt that meal plans helped them to try new foods or to attempt fear foods whilst inpatient ($M = 2.50$, $SD = 1.09$), and overall, 100% of participants were satisfied with their meal plan experiences.

Supported Eating

100% of participants reported experiencing eating on the specific supported ED table whilst inpatient, 83.3% of participants felt supported by staff whilst on the table ($M = 2.00$, $SD = 0.85$), 66.7% of participants felt staff addressed disordered behaviours by patients at the

table ($M = 2.17$, $SD = 0.94$), and 83.3% of participants felt staff adequately addressed patient distress ($M = 2.00$, $SD = 0.60$). Further, 83.3% of participants experienced encouragement and support from staff during more difficult moments ($M = 2.00$, $SD = 0.60$), and 41.7% of participants felt prepared to transition off the table ($M = 2.92$, $SD = 1.17$). Overall, 83.3% of participants were satisfied with their ED table experiences.

After Meal Support

75% of participants reported experiencing after meal support whilst inpatient. 41.7% of participants felt unsupported by staff during after meal support ($M = 3.44$, $SD = 0.73$), 44.4% felt staff encouraged engagement in helpful and relevant distraction activities during after meal support ($M = 2.89$, $SD = 0.93$), 33.3% felt staff did not adequately address disordered behaviours ($M = 3.11$, $SD = 0.93$), and 41.7% of participants felt staff did not adequately address patient distress ($M = 3.11$, $SD = 1.17$). Overall, 50% of participants were dissatisfied with their after-meal support experiences.

Social Eating, Food Preparation, and Independent Eating

66.6 % of participants reported inadequate opportunities to engage in social eating outside of the hospital when inpatient ($M = 3.42$, $SD 1.08$), 58.3% reported insufficient food preparation opportunities whilst inpatient ($M = 3.58$, $SD = 1.31$), and 50% of participants felt the time spent independently eating prior to discharge was insufficient ($M = 3.42$, $SD = 1.08$).

Weigh-Ins

50% reported experiencing visible weigh-ins, 41.7% experienced a combination of both visible and blind weighs, and 8.3% of participants were blind weighed. To follow, 41.7% of participants predominately preferred a blind weighing approach, 83.3% of participants reported wearing a hospital provided gown, and 16.7% reported being weighed

wearing general clothing (e.g., pyjamas). 50% of participants felt staff completed their weigh-ins in a professional, informed, and supportive manner ($M = 2.50$, $SD = 1.17$), 50% of felt they were not supported by staff post their weigh-in ($M = 3.17$, $SD = 1.03$), 41.7% felt their psychiatrist addressed the outcome of their weigh-ins in profession and supportive manner ($M = 2.92$, $SD = 1.17$), and 66.7% felt the dietitian/s addressed the outcome of their weigh-ins in profession and supportive manner ($M = 2.58$, $SD = 1.44$). Overall, 50% of participants were satisfied with their weigh-in experiences.

Discharge Experience

50.% of participants felt adequate discharge planning was completed prior to discharge ($M = 2.83$, $SD = 1.40$), 66.7% felt their treating team involved them in discharge planning ($M = 2.17$, $SD = 0.72$), 75% felt they were supported by dieticians to prepare a meal plan for discharge ($M = 2.17$, $SD = 0.84$), and 83.3% felt they were given sufficient notice of their discharge ($M = 2.00$, $SD = 0.85$). 16.6% of participants felt they were discharged too early ($M = 2.67$, $SD = 1.16$), 83.3% of participants felt their psychiatrist ensured they had appropriate outpatient support prior to discharge ($M = 2.25$, $SD = 0.87$), and 41.7% of patients felt their discharge process was not meaningful ($M = 3.42$, $SD = 1.00$). Overall, 58.3% of participants reported being satisfied with discharge experiences.

Overall Experience

41.7% of participants reported their overall treatment was individualised to their unique presentation, needs, and preferences ($M = 2.83$, $SD = 0.84$), 66.6% of participants felt the treatment was generic for everyone ($M = 3.58$, $SD = 0.90$), 58.3% of participants reported they felt their voice was heard and actively contributed to decision making ($M = 2.67$, $SD = 0.89$), 41.7% of participants reported they did not feel a holistic and strengths based approach to treatment was taken ($M = 3.08$, $SD = 0.90$), and 58.3% of participants felt their admission would help them/has helped them recover from their ED ($M = 2.75$, $SD = 1.21$). Finally,

75% of patients reported they would feel content returning for a future admission, 83.3% participants recommended the private hospital ED program to others, and 75% of participants were satisfied with their overall experience.

Cooinda Clinic Buderim Private Hospital.

Group Therapy

58.3% of participants ($n=12$) reported engagement in group therapy was not mandatory. 50% of participants found group therapy psychology relevant and helpful ($M = 2.83$, $SD = 1.40$), 50% felt the content of group therapy psychology was outdated ($M = 3.33$, $SD = 1.56$), and 75% of participants reported finding the group therapy psychology content generic ($M = 3.83$, $SD = 1.40$). 50% of participants felt the group therapy dietetic sessions were relevant and helpful ($M = 2.58$, $SD = 1.31$), 16.6% found the group therapy dietetics content outdated ($M = 2.50$, $SD = 1.17$), and 50% of participants found the group therapy dietetics content was generic ($M = 3.42$, $SD = 1.17$). Finally, 58.3% of participants found collective ED group therapy helpful and beneficial, 75% of participants reported being able to attend broader mental health group therapy, and 58.3% of relevant participants found broader mental health group therapy unhelpful and non-beneficial.

Psychiatry

58.3% of participants reported seeing their psychiatrist two or more times per week ($M = 3.08$, $SD = 3.80$). 58.3% of participants felt their individual psychiatry sessions were regular enough ($M = 2.42$, $SD = 1.24$), 50% of participants were satisfied with the actual regularity of individual psychiatry ($M = 2.83$, $SD = 1.11$), 41.7% felt heard by their psychiatrist ($M = 2.75$, $SD = 1.60$), and 66.7% of participants felt their psychiatrist involved them in their care decision making ($M = 2.67$, $SD = 1.49$). 58.3% of participants felt their psychiatrist individualised their treatment ($M = 2.75$, $SD = 1.49$), 66.7% reported satisfaction

with their psychiatrist's communication with them ($M = 2.75$, $SD = 1.42$), and 83.3% of participants felt their psychiatrist's communication with the MDT regarding their care was satisfactory ($M = 2.33$, $SD = 1.30$). 41.7% of participants felt their psychiatrist was not willing to collaborate with their outpatient team ($M = 3.75$, $SD = 1.60$), 75% felt their psychiatrist had adequate ED knowledge ($M = 1.83$, $SD = 1.03$), and 41.7% of participants felt their psychiatrist installed recovery hope ($M = 2.83$, $SD = 1.33$). Overall, 75% of participants were satisfied with the overall care provided by their psychiatrist.

Individual Psychology

50% of participants reported being encouraged to remain connected with their outpatient psychologist whilst they were inpatient. 58.3% of participants reported being provided with individual psychology provided by the hospital whilst inpatient ($M = 1.42$, $SD = 0.52$), with participants reporting one to two sessions per week ($M = 1.14$, $SD = 0.38$). 71.4% of patients felt they were provided with regular individual psychology sessions ($M = 2.00$, $SD = 0.82$), 71.4% of participants reported dissatisfaction with the regularity of actual provided individual psychology ($M = 3.71$, $SD = 0.82$), 85.7% of patients found their individual psychology helpful and beneficial ($M = 1.86$, $SD = 1.47$), and 85% felt the psychologist/s had adequate ED knowledge ($M = 1.43$, $SD = 0.79$). 71.4% of participants felt the hospital provided psychologist/s installed recovery hope ($M = 1.57$, $SD = 0.98$), 91.7% of participants desired additional individual psychology ($M = 1.50$, $SD = 0.67$), and overall, 50% of participants reported overall satisfaction with individual psychology.

Individual Dietetics

91.7% of participants reported being provided with individual dietetics whilst inpatient, and 81.8% of participants reporting one or more session per week ($M = 1.81$, $SD = 2.75$). 72.7% of participants felt they were provided with regular individual dietetic sessions ($M = 2.36$, $SD = 0.92$), 58.3% reported dissatisfaction with the regularity of individual

dietetics ($M = 3.36$, $SD = 1.03$), 72.7% found their individual dietetics helpful and beneficial ($M = 2.09$, $SD = 1.30$) and 72.7% of participants felt the dietitian/s had adequate ED knowledge ($M = 1.73$, $SD = 1.27$). 72.7% of participants felt the hospital provided dietitian/s installed recovery hope ($M = 2.09$, $SD = 1.58$), 75% of participants desired more individual dietetics sessions ($M = 1.83$, $SD = 1.03$), and overall, 66.7% of participants reported overall satisfaction with individual dietetic sessions.

Exercise Physiology

66.7% of participants were provided with exercise physiology whilst inpatient, 50% of relevant participants were satisfied with such exercise physiology, and 66.7% of all participants felt it would have been beneficial to have had access to exercise physiology.

Nursing Care

41.7% of participants felt nursing staff did not display sufficient ED knowledge ($M = 4.08$, $SD = 0.90$), 58.3% felt nursing staff did not provide adequate care during more challenging times ($M = 3.67$, $SD = 1.23$), and 41.7% of participants felt nursing staff did not install recovery hope ($M = 3.42$, $SD = 1.08$), Overall, 50% of participants were satisfied with the nursing care they received.

Meal Plans

41.7% of participants felt their meal plans included adequate variety whilst inpatient ($M = 2.75$, $SD = 1.21$), 75% of participants desired nil increased variety of their meal plans ($M = 2.17$, $SD = 1.03$), 66.7% of participants felt the dietician/s collaborated with them for some shared decision making towards their meal plans ($M = 2.50$, $SD = 1.09$), and 41.7% felt their meal plans were generic ($M = 3.25$, $SD = 1.36$). 83.3% of participants felt meal plans assisted them to engage in regular eating ($M = 1.92$, $SD = 0.67$), 66.7% felt that meal plans

helped them to try new foods or to attempt fear foods ($M = 2.58$, $SD = 1.38$), and overall, 66.7% of participants were satisfied with their meal plan experiences.

Supported Eating

91.7% of participants reported experiencing eating on the specific supported ED table whilst inpatient. 41.7% of participants reported feeling supported by staff whilst on the table ($M = 3.45$, $SD = 1.04$), 58.3% of participants felt staff did not address disordered behaviours by patients ($M = 3.73$, $SD = 1.10$), and 66.7% of participants felt staff did not adequately address patient distress ($M = 3.82$, $SD = 1.08$). Further, 41.6% of participants felt they did not experience encouragement and support from staff during more difficult moments ($M = 3.36$, $SD = 1.50$), 50% of participants felt unprepared to transition off the table ($M = 3.64$, $SD = 1.29$), and overall, 66.7% of participants were dissatisfied with their ED table experiences.

After Meal Support

91.7% of participants reported experiencing after meal support whilst inpatient. 58.4% of participants felt unsupported by staff during after meal support ($M = 3.64$, $SD = 1.03$), 41.7% felt staff did not encourage engagement in helpful and relevant distraction activities ($M = 3.36$, $SD = 1.12$), 58.4% of participants felt staff did not adequately address disordered behaviours ($M = 3.36$, $SD = 1.43$), and 58.4% of participants felt staff did not adequately address patient distress during after meal support ($M = 3.64$, $SD = 1.03$). Overall, 66.7% of participants were dissatisfied with after-meal support experiences.

Social Eating, Food Preparation, and Independent Eating

58.3% of participants reported inadequate opportunities to engage in social eating outside of the hospital when inpatient ($M = 3.67$, $SD = 1.30$), 83.3% reported insufficient food

preparation opportunities ($M = 4.83$, $SD = 0.39$), and 66.7% of participants reported insufficient time independently eating prior to discharge ($M = 3.75$, $SD = 1.42$).

Weigh-Ins

91.7% of participants reported being blind weighed, with 8.3% of participants reporting not being weighed. 33.3% of participants predominately reported preferring a blind weighing approach, 16.7% of participants reported preferring viable weigh-ins or a combination of blind and visible weight-ins, and 25% of participants reporting preferring nil weight-ins. 91.7% of participants reported wearing a hospital provided gown, with 16.7% also reporting being weighed in their underwear. 50% of participants felt staff did not complete their weigh-ins in a professional, informed, and supportive manner ($M = 3.27$, $SD = 1.35$), 66.7% of participants felt they were not supported by staff post their weigh in ($M = 4.00$, $SD = 1.18$), 45.5% of participants felt their psychiatrist addressed the outcome of their weigh-ins in a professional and supportive manner ($M = 2.73$, $SD = 1.27$), and 63.6% of participants felt the dietitian/s addressed the outcome of their weigh-ins in profession and supportive manner ($M = 2.55$, $SD = 1.51$). Overall, 54.5% of participants were dissatisfied with their weigh-in experiences.

Discharge Experience

50% of participants felt inadequate discharge planning was completed prior to discharge ($M = 3.50$, $SD = 1.31$), 41.6% felt their treating team involved them in discharge planning ($M = 3.25$, $SD = 1.49$), 41.7% felt they were supported by dieticians to prepare a meal plan for discharge ($M = 3.08$, $SD = 1.68$), and 41.7% of participants felt they were given sufficient notice of their discharge ($M = 3.17$, $SD = 1.59$). 41.7% of participants felt they were discharged too early ($M = 3.42$, $SD = 1.17$), 41.7% felt their psychiatrist ensured they had appropriate outpatient support prior to discharge ($M = 3.25$, $SD = 1.36$), and 75% of

patients felt their discharge process was not meaningful ($M = 4.00$, $SD = 1.48$). Overall, 58.3% of participants reported being dissatisfied with their discharge experience.

Overall Experience

50% of participants reported their overall treatment was not individualised to their unique presentation, needs, and preferences ($M = 3.71$, $SD = 1.52$), 50% felt their treatment was generic for everyone ($M = 3.50$, $SD = 1.44$), 41.6% felt their voice was not heard or actively contributed to decision making ($M = 3.08$, $SD = 1.17$), 58.3% did not feel a holistic and strengths based approach to treatment was taken ($M = 3.25$, $SD = 1.21$), and 41.7% felt their admission would help them/has helped them recover from their ED ($M = 3.00$, $SD = 1.28$). Finally, 58.3% of patients felt content returning for a future additional admission, 66.7% of participants recommended the private hospital ED program to others, and 50% of participants were satisfied with their overall experience.

Ramsay Clinic Hollywood.

Participants were adults ($n = 7$) aged 23 to 35 years of age ($M = 30.71$, $SD = 4.03$) that identified as female (85.7%) and male (14.3%). 100% of participants identified mental health comorbidities, 50% identified chronic health comorbidities, and 16.7% identified disability/disabilities.

Group Therapy

100% of participants reported engagement in group therapy was mandatory. 42.9% of participants found group therapy psychology relevant and helpful ($M = 2.57$, $SD = 1.40$), 57.2% \ felt the content of group therapy psychology was outdated ($M = 3.14$, $SD = 1.58$), and 85.7% of participants found the group therapy psychology content generic ($M = 4.43$, $SD = 0.79$). 71.4% of participants found the group therapy dietetic sessions relevant and helpful ($M = 2.43$, $SD = 1.81$), 71.4% found the group therapy dietetics content outdated ($M = 3.29$,

$SD = 1.60$), and 85.7% of participants found the group therapy dietetics content was generic ($M = 4.14$, $SD = 0.70$). Finally, 57.1% of participants reported that collective ED group therapy was helpful or beneficial, 71.4% of participants were unable to attend broader mental health group therapy options, and 28.6.3% of relevant participants found broader mental health group therapy helpful and beneficial.

Psychiatry

71.5% of participants reported seeing their psychiatrist two or more times per week ($M = 3.00$, $SD = 1.92$). 57.1% of participants felt their individual psychiatry sessions whilst inpatient was regular enough ($M = 2.57$, $SD = 1.51$) and 42.9% of participants reported satisfaction with the actual regularity of individual psychiatry ($M = 3.29$, $SD = 1.38$). 71.4% of participants desired more individual psychiatry ($M = 2.29$, $SD = 1.60$), 42.9% felt heard by their psychiatrist ($M = 3.14$, $SD = 1.57$), 57.2% felt their psychiatrist did not involve them in their care decision making ($M = 3.29$, $SD = 1.60$), and 42.9% of participants felt their psychiatrist individualised their treatment ($M = 3.14$, $SD = 1.57$). 42.9% reported satisfaction with their psychiatrist's communication with them ($M = 3.14$, $SD = 1.57$), 42.9% of participants felt their psychiatrist's communication with the MDT regarding their care was satisfactory ($M = 3.00$, $SD = 1.53$), 42.9% of participants felt their psychiatrist was willing to collaborate with their outpatient team ($M = 3.71$, $SD = 1.89$), and 71.4% felt their psychiatrist had adequate ED knowledge ($M = 2.14$, $SD = 1.68$). 42.9% of participants felt their psychiatrist installed recovery hope ($M = 3.14$, $SD = 1.87$) and overall, 57.1% of participants were satisfied with the overall care provided by their psychiatrist.

Individual Psychology

42.9% of participants reported being encouraged to remain connected with their outpatient psychologist whilst they were inpatient. 28.6% of participants reported not being provided with individual psychology whilst inpatient ($M = 1.42$, $SD = 0.52$). 100% of

relevant participants reported 3 sessions per week ($M = 3.00$, $SD = 0.00$). 100% of relevant participants felt they were provided with regular individual psychology ($M = 2.00$, $SD = 0.00$), 100% of relevant participants reported satisfaction with the actual regularity of individual psychology sessions ($M = 2.00$, $SD = 0.00$), and 100% found their individual psychology sessions helpful and beneficial ($M = 1.00$, $SD = 0.00$). 100% of relevant participants reported they felt the psychologist/s had adequate ED knowledge ($M = 2.00$, $SD = 0.00$), felt the hospital psychologist/s installed recovery hope ($M = 1.00$, $SD = 0.00$), and desired additional individual psychology whilst inpatient ($M = 1.29$, $SD = 1.00$). Overall, 100% of participants who were offered with individual psychology whilst inpatient were satisfied.

Individual Dietetics

85.7% of participants reported being provided with individual dietetics whilst inpatient, and 83.3% of participants reported one to three sessions per week ($M = 2.67$, $SD = 1.51$). 83.3% of patients felt they were provided with regular individual dietetic sessions ($M = 2.17$, $SD = 0.98$), reported satisfaction with the actual regularity of individual dietetics ($M = 1.67$, $SD = 0.82$), and found their individual dietetic sessions helpful and beneficial ($M = 2.33$, $SD = 0.82$). 83.7% of participants felt the dietitian/s had adequate ED knowledge ($M = 1.33$, $SD = 0.52$), felt the hospital provided dietitian/s installed recovery hope ($M = 1.83$, $SD = 0.75$), and 71.4% of participants desired additional individual dietetics whilst inpatient ($M = 2.00$, $SD = 1.16$). Overall, 71.4% of participants reported overall satisfaction with individual dietetics.

Exercise Physiology

85.7% of participants reported being provided with exercise physiology whilst inpatient, 100% of relevant participants were satisfied with such exercise physiology, and

100% of total participants felt it would have been beneficial to have had access to exercise physiology.

Nursing Care

57.1% of participants felt nursing staff displayed sufficient ED knowledge ($M = 2.43$, $SD = 0.98$), felt that nursing staff provided adequate care during more challenging times ($M = 2.86$, $SD = 1.47$), and felt nursing staff installed recovery hope ($M = 2.29$, $SD = 1.11$). Overall, 57.1% of participants were satisfied with the nursing care they received.

Meal Plans

57.1.7% of participants felt their meal plans included adequate variety whilst inpatient ($M = 2.71$, $SD = 1.38$), 71.4% of participants desired increased variety of their meal plans ($M = 2.43$, $SD = 1.51$), 71.4% of participants felt the dietician/s collaborated with them for some shared decision making towards their meal plans ($M = 2.43$, $SD = 0.79$), and 71.5% felt their meal plans were generic ($M = 4.14$, $SD = 0.90$). 100% of patients reported they felt meal plans assisted them to engage in regular eating ($M = 1.86$, $SD = 0.38$), 71.4% felt that meal plans helped them to try new foods or to attempt fear foods ($M = 2.43$, $SD = 1.30$), and overall, 85.7% of participants were satisfied with their meal plan experiences.

Supported Eating

100% of participants reported experiencing eating on the specific supported ED table whilst inpatient, and 57.1% of participants felt supported by staff whilst on the table ($M = 2.43$, $SD = 0.54$). 42.9% of participants felt staff addressed disordered behaviours by patients at the table ($M = 2.75$, $SD = 0.98$), 57.1% of participants felt staff adequately addressed patient distress ($M = 2.71$, $SD = 0.95$), and 71.4% reported experiencing encouragement and support from staff during more difficult moments on the table ($M = 2.14$, $SD = 1.07$). 71.4%

of participants felt prepared to transition off the table ($M = 2.14$, $SD = 1.47$), and overall, 85.7% of participants were satisfied with their ED table experiences.

After Meal Support

85.7% of participants reported experiencing after meal support whilst inpatient. 50% of participants felt supported by staff during after meal support ($M = 2.67$, $SD = 1.21$), 50% of participants felt staff encouraged engagement in helpful and relevant distraction activities during after meal support ($M = 2.67$, $SD = 1.21$), 50% of participants felt staff adequately address disordered behaviours ($M = 2.50$, $SD = 1.05$), and 50% of participants felt staff adequately addressed patient distress during after meal support ($M = 2.67$, $SD = 1.21$). Overall, 50% of participants were satisfied with their after-meal support experiences.

Social Eating, Food Preparation, and Independent Eating

57.2% of participants reported inadequate opportunities to engage in social eating outside of the hospital when inpatient ($M = 3.57$, $SD = 1.28$), 71.4% reported insufficient food preparation opportunities ($M = 4.14$, $SD = 1.47$), and 57.2% of participants felt the time they spent independently eating prior to discharge was insufficient ($M = 3.29$, $SD = 1.70$).

Weigh-Ins

42.9% of participants reported being blind weighed, 28.6% reported visible weigh-ins, and 26.6% reported a combination of blind and visible weigh-ins. 46.9% of participants predominately reported preferring a visible weigh approach, 28.6% preferring blind weighs, and 14.3% preferred a combination of blind and visible weighs. 57.1% of participants felt staff completed their weigh-ins in a professional, informed, and supportive manner ($M = 2.14$, $SD = 0.90$), 57.1% felt they were not supported by staff post their weigh-in ($M = 3.00$, $SD = 1.30$), and 42.9% of participants felt their psychiatrist addressed the outcome of their weigh-ins in a professional and supportive manner ($M = 2.57$, $SD = 0.98$). 85.7% of

participants felt the dietitian/s addressed the outcome of their weigh-ins in profession and supportive manner ($M = 2.29$, $SD = 1.26$), and overall, 57.1% of participants were satisfied with their weigh-in experiences.

Discharge Experience

57.1% of participants felt adequate discharge planning was completed prior to discharge ($M = 2.86$, $SD = 1.57$), 57.1% felt their treating team involved them in discharge planning ($M = 2.71$, $SD = 1.38$), 85.7% felt they were supported by dietitians to prepare a meal plan for discharge ($M = 1.86$, $SD = 1.46$), and 85.7% of participants felt they were given sufficient notice of their discharge ($M = 2.14$, $SD = 0.90$). 57.1% of participants felt they were not discharged too early ($M = 3.00$, $SD = 1.63$), 85.7% felt their psychiatrist ensured they had appropriate outpatient support prior to discharge ($M = 2.29$, $SD = 1.25$), and 42.9% of participants felt their discharge process was meaningful ($M = 3.14$, $SD = 1.35$). Overall, 71.4% of participants reported being satisfied with their discharge experience.

Overall Experience

42.9% of participants reported their overall treatment was not individualised to their unique presentation, needs, and preferences ($M = 3.43$, $SD = 1.27$), 85.7% of participants felt treatment was generic for everyone ($M = 4.43$, $SD = 0.79$), 42.9% of participants felt their voice was heard and actively contributed to decision making ($M = 2.86$, $SD = 1.57$), and 57.2% of participants felt they did not experience a holistic and strengths based approach to treatment ($M = 3.43$, $SD = 1.40$). 57.1% of participants felt their admission would help them/has helped them recover from their ED ($M = 2.86$, $SD = 1.77$). Overall, 57.1% of patients reported they would not feel content returning for an additional admission in the future, wouldn't recommended the private hospital ED program to others, and were dissatisfied with their overall experience.

Ramsay Clinic Wentworthville.

Participants were adults ($n = 5$) aged 23 to 40 years of age ($M = 30.00$, $SD = 6.67$) that identified as female (100%). 60% of participants identified mental health comorbidities, 25% identified chronic health comorbidities, and 25% identified disability/disabilities.

Group Therapy

80% of participants reported engagement in group therapy was mandatory. 80% of participants found group therapy psychology relevant and helpful ($M = 4.20$, $SD = 0.84$), 60% felt the content of group therapy psychology was outdated ($M = 2.00$, $SD = 1.00$), and 80% of participants found the group therapy psychology content generic ($M = 4.43$, $SD = 0.79$). 71.4% of participants did not find the group therapy dietetic sessions relevant and helpful ($M = 2.40$, $SD = 1.51$), 60% found the group therapy dietetics content outdated ($M = 2.80$, $SD = 0.84$), and 60% of participants found the group therapy dietetics content was generic ($M = 2.60$, $SD = 1.34$). Finally, 80% of participants reported that collective ED group therapy was not helpful or beneficial, 20% of participants reported being able to attend broader mental health group therapy, and 100% of participants who attended broader group therapy did not find it helpful and beneficial.

Psychiatry

100% of participants reported seeing their psychiatrist one to two times per week ($M = 1.60$, $SD = 0.55$). 60% of participants felt they had regular individual psychiatry sessions whilst inpatient ($M = 2.80$, $SD = 1.30$), 42.9% reported satisfaction with regularity of sessions adequacy ($M = 3.60$, $SD = 1.14$), and 80% desired more individual psychiatry ($M = 2.00$, $SD = 0.71$). 60% of participants felt unheard by their psychiatrist ($M = 3.80$, $SD = 1.30$), felt their psychiatrist did not involve them in their care decision making ($M = 3.80$, $SD = 1.30$), reported they felt their psychiatrist didn't individualised their treatment ($M = 3.60$,

$SD = 1.14$), and reported dissatisfaction with their psychiatrist's communication with them ($M = 3.80$, $SD = 1.30$). 80% of participants felt their psychiatrist's communication with the broader MDT regarding their care was dissatisfactory ($M = 4.00$, $SD = 0.71$), felt their psychiatrist was willing to collaborate with their outpatient team ($M = 4.60$, $SD = 0.89$), and 40% of participants felt their psychiatrist had adequate ED knowledge ($M = 3.60$, $SD = 0.89$). 40% of participants felt their psychiatrist installed recovery hope ($M = 3.00$, $SD = 1.00$), and overall, 80% of participants were dissatisfied with the overall care provided by their psychiatrist.

Individual Psychology

80% of participants reported being discouraged to remain connected with their outpatient psychologist whilst they were inpatient. 100% of participants reported not being provided with individual psychologist provided by the hospital whilst inpatient, and 80% of total participants reported wanting to have engaged if offered.

One-to-One Dietetics

100% of participants reported being provided with individual dietetics whilst inpatient, and 100% of participants reported one to two sessions per week ($M = 1.40$, $SD = 0.55$). 40% of patients felt they were provided with regular individual dietetic sessions ($M = 3.00$, $SD = 1.00$), 60% of participants reported dissatisfaction with the regularity of individual dietetics ($M = 3.40$, $SD = 0.89$), 60% of participants did not find individual dietetics helpful and beneficial ($M = 3.80$, $SD = 1.30$) and 40% of participants felt the dietitian/s had inadequate ED knowledge ($M = 2.80$, $SD = 1.48$). 20% of participants felt the hospital provided dietitian/s installed recovery hope ($M = 1.83$, $SD = 1.10$), 60% of participants desired more individual dietetics ($M = 2.60$, $SD = 1.34$), and overall, 80% of participants reported overall dissatisfaction with individual.

Exercise Physiology

20% of participants reported being provided with exercise physiology whilst inpatient, the singular relevant participant reported satisfaction with such exercise physiology, and 80% of total participants felt it would have been beneficial to have had access to exercise physiology.

Nursing Care

20% of participants felt nursing staff displayed sufficient ED knowledge ($M = 3.60$, $SD = 1.34$), 40% felt nursing staff provided adequate care during more challenging times ($M = 3.00$, $SD = 2.00$), and felt nursing staff installed recovery hope ($M = 3.60$, $SD = 1.52$). Overall, 60% of participants were dissatisfied with the nursing care they received.

Meal Plans

60% of participants felt their meal plans included adequate variety whilst inpatient ($M = 2.50$, $SD = 1.00$), 40% desired increased variety of their meal plans ($M = 2.75$, $SD = 0.96$), 60% felt the dietician/s didn't collaborate with them regarding shared decision making towards their meal plans ($M = 4.00$, $SD = 1.41$), and 40.5% of participants felt their meal plans were not generic ($M = 2.50$, $SD = 1.30$). 100% of patients reported they felt meal plans assisted them to engage in regular eating whilst inpatient, 75% of participants felt meal plans helped them to try new foods or to attempt fear foods whilst inpatient ($M = 2.50$, $SD = 1.00$), and overall, 50% of participants were satisfied with their meal plan experiences.

Supported Eating

75% of participants reported experiencing eating on the specific supported ED table whilst inpatient. 66.7% of participants felt unsupported by staff whilst on the table ($M = 4.67$, $SD = 0.58$), 100% of relevant participants felt staff didn't address disordered behaviours by patients ($M = 4.33$, $SD = 0.58$), and 100% of relevant participants felt staff

inadequately addressed patient distress ($M = 4.67$, $SD = 0.58$). 100% of relevant participants felt they didn't receive encouragement and support from staff during more difficult moments ($M = 4.67$, $SD = 0.58$), 33.3% of relevant participants felt unprepared to transition off the table ($M = 3.67$, $SD = 1.16$), and overall, 100% of relevant participants were dissatisfied with their ED table experiences.

After Meal Support

50% of participants reported experiencing after meal support whilst inpatient. 100% of relevant participants felt unsupported by staff during after meal support, felt staff didn't encourage engagement in helpful and relevant distraction activities during after meal support, and 50% of participants reported they felt staff inadequately addressed disordered behaviours ($M = 4.00$, $SD = 2.42$). 100% of participants reported they felt staff inadequately addressed patient distress during after meal support, and overall, 100% of relevant participants were also dissatisfied with their after-meal support experiences.

Social Eating, Food Preparation, and Independent Eating

75% of participants reported inadequate opportunities to engage in social eating outside of the hospital when inpatient ($M = 3.75$, $SD = 1.26$), 100% of participants reported insufficient food preparation opportunities ($M = 5.00$, $SD = 0.00$), and 75% of participants felt the time spent independently eating prior to discharged was insufficient ($M = 4.00$, $SD = 1.41$).

Weigh-Ins

50% of participants reported visible weigh-ins, 25% of participants reported blind weighs, and 25% reported a combination of blind and visible weighs. To follow, 40% of participants predominately preferred a combination of blind and visible weights, and 60% of participants reported wearing a hospital provided gown. 50% of participants felt staff

completed their weigh-ins in a professional, informed, and supportive manner ($M = 3.50$, $SD = 0.58$), 80% of participants felt they were not supported by staff post their weigh-ins ($M = 4.75$, $SD = 0.50$), and 75% of participants felt their psychiatrist didn't address the outcome of their weigh-ins in a professional or supportive manner ($M = 4.25$, $SD = 0.96$). 50% of participants felt the dietitian/s didn't address the outcome of their weigh-ins in profession and supportive manner ($M = 4.50$, $SD = 1.30$), and overall, 75% of participants were dissatisfied with their weigh-in experiences.

Discharge Experience

75% of participants felt inadequate discharge planning was completed ($M = 4.50$, $SD = 1.00$), but felt their treating team involved them in discharge planning ($M = 4.25$, $SD = 0.96$), and 25% of participants felt they were supported by dietitians to prepare a meal plan for discharge ($M = 3.25$, $SD = 1.26$). 50% of participants felt they were given insufficient notice of their discharge ($M = 3.50$, $SD = 1.30$), 25% felt they were not discharged too early ($M = 2.75$, $SD = 1.26$), 75% of participants felt their psychiatrist didn't ensure they had appropriate outpatient support prior to discharge ($M = 4.50$, $SD = 1.00$), and 75% felt their discharge process was not meaningful ($M = 4.25$, $SD = 0.96$). Overall, 80% of participants were dissatisfied with their discharge experience.

Overall Experience

75% of participants reported their overall treatment was not individualised to their unique presentation, needs, and preferences ($M = 4.75$, $SD = 0.50$), 75% of participants felt the treatment was generic for everyone ($M = 1.75$, $SD = 0.96$), 75% of participants felt their voice was not heard to actively contribute to decision making ($M = 4.00$, $SD = 0.82$), and 80% of participants felt a holistic and strengths based approach to treatment was not taken ($M = 4.50$, $SD = 0.58$). Further, 60% of participants felt their admission would not help them recover from their ED ($M = 4.25$, $SD = 1.50$). Finally, 80% of participants reported they

would not feel content returning for a future admission, they wouldn't recommend the private hospital ED program to others, and they were dissatisfied with their overall experience.

Ramsay Clinic Northside.

Participants were adults ($n = 8$) aged 20 to 40 years of age ($M = 28.50$, $SD = 6.93$) that identified as female (100%). 87.5% of participants identified mental health comorbidities, 40% identified chronic health comorbidities, and 40% identified disability/disabilities.

Group Therapy

100% of participants reported engagement in group therapy was mandatory. 25% of participants found group therapy psychology relevant and helpful ($M = 3.00$, $SD = 1.20$), 50% felt the content of group therapy psychology was outdated ($M = 3.25$, $SD = 1.39$, and 75% of participants felt the group therapy psychology content was generic ($M = 4.13$, $SD = 1.13$). 50% of participants found the group therapy dietetic sessions relevant and helpful ($M = 2.88$, $SD = 1.36$), 25% found the group therapy dietetics content outdated ($M = 3.00$, $SD = 0.76$), and 75% of participants found the group therapy dietetics content was generic ($M = 4.00$, $SD = 0.54$). Finally, 75% of participants reported that collective ED group therapy was not helpful or beneficial, 62.5% of participants reported being unable to attend broader mental health group therapy, and 25% of relevant participants who were able to attend broader group therapy found it helpful and beneficial.

Psychiatry

75% of participants reported seeing their psychiatrist one to two times per week ($M = 2.13$, $SD = 0.99$). 62.5% of participants felt they had regular one-to-one psychiatry sessions whilst inpatient ($M = 2.63$, $SD = 1.06$) and reported satisfaction with the actual regularity adequacy ($M = 2.63$, $SD = 1.06$). 50% of participants desired more individual psychiatry (M

= 3.00, $SD = 1.41$), 50% of participants reported not feeling heard by their psychiatrist ($M = 3.13$, $SD = 1.89$) and felt their psychiatrist did not involve them in their care decision making ($M = 2.50$, $SD = 1.69$). 50% felt their psychiatrist didn't individualised their treatment ($M = 3.25$, $SD = 1.75$), 37.5% reported satisfaction with their psychiatrist's communication with them ($M = 3.13$, $SD = 1.73$), and felt their psychiatrist's communication with the broader MDT regarding their care was dissatisfactory ($M = 3.38$, $SD = 1.51$). 25% of relevant participants felt their psychiatrist was willing to collaborate with their outpatient team ($M = 4.00$, $SD = 1.85$), 50% of participants reported they felt their psychiatrist had adequate ED knowledge ($M = 2.75$, $SD = 1.49$), and 50% of participants felt their psychiatrist didn't install recovery hope ($M = 3.25$, $SD = 1.75$). Overall, 50% of participants were satisfied with the overall care provided by their psychiatrist.

Individual Psychology

87.5% of participants reported being discouraged to remain connected with their outpatient psychologist whilst they were inpatient, 87.5% of participants reported not being provided with individual psychologist provided by the hospital whilst inpatient, and 100% of all participants reported wanting to have engaged in individual psychology if offered.

Individual Dietetics

100% of participants reported being provided with individual dietetics whilst inpatient, and 100% of participants reported one to two sessions per week ($M = 1.38$, $SD = 0.52$). 62.5% of patients felt they were provided with regular individual dietetic sessions whilst inpatient ($M = 2.50$, $SD = 1.07$), 12.5% of participants reported satisfaction with the actual regularity of individual dietetic sessions ($M = 3.25$, $SD = 1.17$), 37.5% found their individual dietetic sessions helpful and beneficial ($M = 3.00$, $SD = 1.07$) and 75% of participants reported they felt the dietitian/s had adequate ED knowledge ($M = 2.13$, $SD = 0.99$). 62.5% of participants felt the hospital provided dietitian/s installed recovery hope ($M =$

2.63, $SD = 1.06$), 50% of participants reported desiring more individual dietetics sessions ($M = 2.38$, $SD = 1.30$), and overall, 50% of participants reported overall satisfaction with the individual dietetics.

Exercise Physiology

12.5% of participants reported being provided with exercise physiology whilst inpatient, the singular relevant participant reported satisfaction with such exercise physiology, and 75% of total participants felt it would have been beneficial to have had access to exercise physiology.

Nursing Care

62.5% of participants felt nursing staff displayed sufficient ED knowledge ($M = 2.63$, $SD = 1.30$), 50% of participants felt that nursing staff provided adequate care during more challenging times ($M = 2.75$, $SD = 1.28$), 25% of participants felt nursing staff installed recovery hope ($M = 2.88$, $SD = 1.13$), and 62.5% of participants were satisfied with the nursing care they received.

Meal Plans

87.5% of participants felt their meal plans included adequate variety whilst inpatient ($M = 4.00$, $SD = 0.54$), 50% of participants did not desire increased variety in their meal plans ($M = 3.13$, $SD = 1.13$), 37.5% felt the dietician/s didn't collaborate with them regarding shared decision making towards their meal plans ($M = 3.00$, $SD = 1.07$), and 62.5% of participants felt their meal plans were not generic ($M = 3.63$, $SD = 1.51$). 62.5% of participants felt meal plans assisted them to engage in regular eating whilst inpatient ($M = 2.50$, $SD = 1.07$), 50% of participants felt that meal plans helped them to try new foods or to attempt fear foods whilst inpatient ($M = 2.75$, $SD = 0.89$), and overall, 50% of participants were satisfied with their meal plan experiences.

Supported Eating

100% of participants reported experiencing eating on the specific supported ED table whilst inpatient. 50% of participants felt supported by staff whilst on the table ($M = 3.00$, $SD = 1.41$), felt staff did address disordered behaviours by patients at the table ($M = 3.00$, $SD = 1.51$), and felt staff adequately addressed patient distress ($M = 3.13$, $SD = 1.56$). 37.5% of relevant participants felt they received encouragement and support from staff during more difficult moments ($M = 3.00$, $SD = 1.41$), 62.5% felt ready to transition off the table ($M = 2.38$, $SD = 0.92$), and overall, 62.5% of relevant participants were satisfied with their ED table experiences.

After Meal Support

87.5% of participants reported experiencing after meal support whilst inpatient. 25% of relevant participants reporting feeling supported by staff during after meal support ($M = 3.14$, $SD = 1.35$), 50% felt staff didn't encourage engagement in helpful and relevant distraction activities during after meal support ($M = 3.29$, $SD = 1.38$), 62.5% of participants felt staff inadequately addressed disordered behaviours ($M = 3.47$, $SD = 1.51$), and 50% of participants felt staff inadequately addressed patient distress during after meal support ($M = 3.43$, $SD = 1.51$). Overall, 62.5% of relevant participants were dissatisfied with their after-meal support experiences.

Social Eating, Food Preparation, and Independent Eating

12.5% of participants reported adequate opportunities to engage in social eating outside of the hospital when inpatient ($M = 3.25$, $SD = 0.71$), 75% of participants reported insufficient food preparation opportunities whilst inpatient ($M = 4.13$, $SD = 1.36$), and 62.5% of participants reported insufficient independent eating opportunities prior to discharge ($M = 3.75$, $SD = 1.28$).

Weigh-Ins

62.5% of participants reported being blind weighed, 25% reported visible weigh ins, and 12.5% reported a combination of blind and visible weighs. To follow, 50% of participants predominately preferred visible weigh-ins, and 100% of participants reported wearing a hospital provided gown. 62.5% of participants felt staff completed their weigh-ins in a professional, informed, and supportive manner ($M = 2.75$, $SD = 1.17$), and 50% of participants felt they were not supported by staff post their weigh-ins ($M = 3.63$, $SD = 0.74$). 25% of participants felt their psychiatrist addressed the outcome of their weigh-ins in a professional and supportive manner ($M = 3.38$, $SD = 1.41$) and also felt the dietitian/s addressed the outcome of their weigh-ins in a professional and supportive manner ($M = 4.00$, $SD = 1.30$). Overall, 50% of participants were dissatisfied with their weigh-in experiences.

Discharge Experience

25% of participants felt adequate discharge planning was completed ($M = 3.38$, $SD = 1.51$). 50% felt their treating team didn't involve them in discharge planning ($M = 3.25$, $SD = 1.75$), reported they were supported by dieticians to prepare a meal plan for discharge ($M = 2.75$, $SD = 1.28$), and felt they were given sufficient notice of their discharge ($M = 3.00$, $SD = 1.51$). 50% felt they were discharged too early ($M = 2.63$, $SD = 0.74$), 37.5% of participants felt their psychiatrist didn't ensure they had appropriate outpatient support prior to discharge ($M = 3.00$, $SD = 1.41$), 62.5% of patients felt their discharge process was not meaningful ($M = 3.63$, $SD = 1.77$) and overall, 62.5% of participants were dissatisfied with their discharge experience.

Overall Experience

72.5% of participants felt their overall treatment was not individualised to their unique presentation, needs, and preferences ($M = 3.88$, $SD = 1.36$), 87.5% felt treatment was generic for everyone ($M = 4.38$, $SD = 0.74$), and 25% of participants felt their voice was

heard to actively contribute to decision making ($M = 3.25$, $SD = 1.04$). 75% of participants felt a holistic and strengths-based approach to treatment was not taken ($M = 4.25$, $SD = 0.89$) and felt their admission would not help them recover from their ED ($M = 3.75$, $SD = 1.49$). Finally, 50% of patients reported they would not feel content returning for a future additional admission, 62.5% wouldn't recommended the private hospital ED program to others, and 50% were dissatisfied with their overall experience.

The Melbourne Clinic.

Participants were adults ($n = 14$) aged 23 to 37 years of age ($M = 28.00$, $SD = 4.02$) that identified as female (76.8%) and non-binary (21.4%). 100% of participants identified mental health comorbidities, 23.1% identified chronic health comorbidities, and 25% identified disability/disabilities.

Group Therapy

92.9% of participants reported engagement in group therapy was mandatory. 50% of participants found group therapy psychology relevant and helpful ($M = 2.86$, $SD = 1.17$), 35.7% of participants felt the content of group therapy psychology was outdated ($M = 3.07$, $SD = 1.02$), and 71.4% of participants found the group therapy psychology content generic ($M = 3.79$, $SD = 0.80$). 42.9% of participants found the group therapy dietetic sessions relevant and helpful ($M = 2.79$, $SD = 0.98$), 35.7% found the group therapy dietetics content outdated ($M = 3.29$, $SD = 0.99$), and 57.1% found the group therapy dietetics content was generic ($M = 3.79$, $SD = 0.80$). Finally, 50% of participants reported that collective ED group therapy was not helpful or beneficial, 28.6% of participants reported being able to attend broader mental health group therapy, and 75% of relevant participants who were able to attend broader group therapy found it helpful and beneficial.

Psychiatry

57.2% of participants reported seeing their psychiatrist two to three times per week ($M = 3.50$, $SD = 2.28$). 57.1% of participants felt they had regular one-to-one psychiatry sessions whilst inpatient ($M = 2.50$, $SD = 1.22$), 35.7% reported satisfaction with the actual regularity ($M = 3.07$, $SD = 1.39$), and 50% of participants desired more psychiatry contact whilst inpatient ($M = 2.57$, $SD = 1.09$). 50% of participants felt unheard by their psychiatrist ($M = 3.21$, $SD = 1.37$), 42.8% felt their psychiatrist did not involve them in their care decision making ($M = 3.21$, $SD = 1.37$), 50% felt their psychiatrist individualised their treatment ($M = 3.00$, $SD = 1.47$), and 50% reported dissatisfaction with their psychiatrist's communication with them ($M = 3.21$, $SD = 1.25$). 42.9% felt their psychiatrist's communication with the broader MDT regarding their care was dissatisfactory ($M = 3.21$, $SD = 1.19$), 28.6% of relevant participants felt their psychiatrist was willing to collaborate with their outpatient team ($M = 4.00$, $SD = 1.84$), 50% of participants felt their psychiatrist had adequate ED knowledge ($M = 2.57$, $SD = 1.28$), and 35.7% of participants felt their psychiatrist installed recovery hope ($M = 3.14$, $SD = 1.41$). Overall, 64.3% of participants were dissatisfied with the overall care provided by their psychiatrist.

Individual Psychology

50% of participants were encouraged to remain connected with their outpatient psychologist whilst they were inpatient, 100% of participants reported not being provided with individual psychology provided by the hospital whilst inpatient, and 92.9% of total participants reported wanting to have engaged in individual psychology if it was offered.

Individual Dietetics

78.6% of participants reported being provided with individual dietetics whilst inpatient, and 63.6% of participants reported one to three sessions per week ($M = 2.64$, $SD = 1.21$). 54.5% of participants felt they were provided with regular individual dietetic sessions ($M = 2.64$, $SD = 0.81$), 45.5% reported satisfaction with the actual regularity of individual

dietetics ($M = 2.82$, $SD = 0.87$), and found their one-to-one dietetic sessions helpful and beneficial ($M = 2.82$, $SD = 1.17$). 63.6% of participants felt the dietitian/s had adequate ED knowledge ($M = 2.45$, $SD = 1.37$), 63.6% felt the hospital provided dietitian/s installed recovery hope ($M = 2.64$, $SD = 1.43$), and 57.1% of participants desired more individual dietetics ($M = 2.50$, $SD = 0.94$). Overall, 64.3% of participants reported overall satisfaction with the individual dietetics.

Exercise Physiology

7.1% of participants reported being provided with exercise physiology whilst inpatient, the singular relevant participant reported satisfaction with such exercise physiology, and 64.3% of total participants felt it would have been beneficial to have had access to exercise physiology.

Nursing Care

57.1% of participants felt nursing staff displayed sufficient ED knowledge ($M = 2.36$, $SD = 1.01$), felt that nursing staff provided adequate care during more challenging times ($M = 2.57$, $SD = 1.40$), and felt nursing staff installed recovery hope ($M = 2.21$, $SD = 0.98$). Overall, 64.3% of participants were satisfied with the nursing care they received.

Meal Plans

50% of participants felt their meal plans included adequate variety ($M = 2.43$, $SD = 1.02$), 57.1% of participants desired increased variety in their meal plans ($M = 2.50$, $SD = 1.23$), 50% of participants felt the dietitian/s collaborated with them regarding shared decision making towards their meal plans ($M = 2.86$, $SD = 1.35$), and 35.7% of participants felt their meal plans were generic ($M = 3.07$, $SD = 1.33$). 64.3% of participants felt meal plans assisted them to engage in regular eating whilst inpatient ($M = 2.36$, $SD = 0.93$), 57.1% felt that meal plans helped them to try new foods or to attempt fear foods whilst inpatient (M

= 2.86, $SD = 1.17$), and overall, 71.4% of participants were satisfied with their meal plan experiences.

Supported Eating

92.9% of participants reported experiencing eating on the specific supported ED table whilst inpatient, with 53.8% of participants reported feeling supported by staff whilst on the table ($M = 2.54$, $SD = 1.27$). 30.8% felt staff addressed disordered behaviours by patients at the table ($M = 3.15$, $SD = 1.14$), 38.5% of participants felt staff adequately addressed patient distress on the table ($M = 3.00$, $SD = 1.41$), 38.5% of relevant participants felt they received encouragement and support from staff during more difficult moments on the table ($M = 3.08$, $SD = 1.19$), and 30.8% reported feeling ready to transition off the table ($M = 3.31$, $SD = 1.11$). Overall, 53.8% of relevant participants were dissatisfied with their ED table experiences.

After Meal Support

71.4% of participants reported experiencing after meal support whilst inpatient. 40% of relevant participants felt supported by staff during after meal support ($M = 3.10$, $SD = 1.29$), 30% felt staff encouraged engagement in helpful and relevant distraction activities during after meal support ($M = 3.20$, $SD = 1.23$), 40% of participants felt staff adequately addressed disordered behaviours during after meal support ($M = 3.00$, $SD = 1.25$), and also felt staff adequately addressed patient distress ($M = 3.00$, $SD = 1.25$). Overall, 50% of relevant participants were dissatisfied with their after-meal support experiences.

Social Eating, Food Preparation, and Independent Eating

42.9% of participants reported adequate opportunities to engage in social eating outside of the hospital when inpatient ($M = 2.86$, $SD = 1.10$), 85.7% of participants reported

insufficient food preparation opportunities ($M = 4.64$, $SD = 0.75$), and 50% reported insufficient time independently eating prior to discharge ($M = 3.43$, $SD = 1.40$).

Weigh-Ins

78.6% of participants were blind weighed, 14.3% reported a combination of blind and visible weigh-ins, and 7.1% were not weighed. To follow, 42.9% of participants predominately preferred a combination of blind and visible weigh-ins, 8.6% preferred blind weighs, and 21.4% preferred visible weighs. 100% of participants reported wearing a hospital provided gown. 53.8% of participants felt staff completed their weigh-ins in a professional, informed, and supportive manner ($M = 2.54$, $SD = 1.40$), 57.2% of participants felt they were not supported by staff post their weigh-in ($M = 3.77$, $SD = 1.09$), and 53.8% of participants felt their psychiatrist addressed the outcome of their weigh-ins in a professional and supportive manner ($M = 2.69$, $SD = 1.25$). 38.5% felt the dietitian/s addressed the outcome of their weigh-ins in a professional and supportive manner ($M = 3.38$, $SD = 1.71$), and overall, 53.8% of participants were dissatisfied with their weigh-in experiences.

Discharge Experience

28.6% of participants felt adequate discharge planning was completed ($M = 3.50$, $SD = 1.23$), 25.7% felt their treating team involved them in discharge planning ($M = 3.36$, $SD = 1.28$), 35.7% reported they were supported by dietitians to prepare a meal plan for discharge ($M = 3.36$, $SD = 1.22$), and 42.9% felt they were given sufficient notice of their discharge ($M = 3.00$, $SD = 1.04$). 42.8% of participants felt they were discharged too early ($M = 3.29$, $SD = 1.27$), 57.2% of participants felt their psychiatrist didn't ensure they had appropriate outpatient support prior to discharge ($M = 3.36$, $SD = 1.50$), 64.3% of patients felt their discharge process was not meaningful ($M = 3.86$, $SD = 0.95$), and overall, 71.4% of participants were dissatisfied with their discharge experiences.

Overall Experience

21.4% of participants felt their overall treatment was individualised to their unique presentation, needs, and preferences ($M = 3.50$, $SD = 1.16$), 57.2% of participants felt the treatment was generic for everyone ($M = 3.36$, $SD = 1.22$), 35.7% of participants felt their voice was heard to actively contribute to decision making ($M = 3.29$, $SD = 1.33$), 64.3% of participants felt a holistic and strengths based approach to treatment was not taken ($M = 3.71$, $SD = 0.99$), and 28.6% of participants felt their admission would help them recover from their ED ($M = 3.14$, $SD = 1.17$). Finally, 50% of patients reported they would not feel content returning for a future admission, that they wouldn't recommended the private hospital ED program to others, and they were dissatisfied with their overall experience.

The Geelong Clinic.

Participants were adults ($n = 3$) aged 19 to 26 years of age ($M = 21.67$, $SD = 3.79$) that identified as non-binary (66.7%) and female (33.3%). 100% of participants identified mental health comorbidities and 33.3% identified chronic health comorbidities.

Group Therapy

100% of participants reported engagement in group therapy was mandatory. 100% of participants found group therapy psychology relevant and helpful, 66.7% of participants felt the content of group therapy psychology was outdated ($M = 4.33$, $SD = 1.16$), and also found the group therapy psychology content generic ($M = 3.67$, $SD = 0.58$). 33.3% of participants found the group therapy dietetic sessions relevant and helpful ($M = 3.67$, $SD = 1.53$) and found the group therapy dietetics content outdated ($M = 3.33$, $SD = 1.53$). 66.7% of participants found the group therapy dietetics content generic ($M = 2.33$, $SD = 0.58$). Finally, 100% of participants found the collective ED group therapy was helpful and beneficial, 66.7% of participants reported attending broader mental health group therapy, and 100% of

relevant participants who were able to attend broader group therapy found it helpful and beneficial.

Psychiatry

100% of participants reported seeing their psychiatrist between one to three times per week ($M = 2.00$, $SD = 1.00$). 66.7% of participants felt they had regular individual psychiatry sessions whilst inpatient ($M = 2.00$, $SD = 1.00$) and reported satisfaction with the regularity adequacy ($M = 2.00$, $SD = 1.00$). 33.3% of participants desired more individual psychiatry whilst inpatient ($M = 2.67$, $SD = 0.58$), 66.7% of participants felt heard by their psychiatrist ($M = 2.00$, $SD = 1.00$), 100% felt their psychiatrist involved them in their care decision making ($M = 1.33$, $SD = 0.58$), and 66.7% felt their psychiatrist individualised their treatment ($M = 1.67$, $SD = 1.16$). 66.7% reported satisfaction with their psychiatrist's communication with them ($M = 2.00$, $SD = 1.00$), 100% felt their psychiatrist's communication with the broader MDT regarding their care was satisfactory ($M = 2.00$, $SD = 1.00$), and 100% of relevant participants were undecided if their psychiatrist would have collaborated with their outpatient team. 100% of participants felt their psychiatrist had adequate eating disorders knowledge, felt their psychiatrist installed recovery hope, and were satisfied with the overall care provided by their psychiatrist whilst inpatient.

Individual Psychology

33.3% of participants reported being encouraged to remain connected with their outpatient psychologist whilst they were inpatient. 100% of participants reported being provided with individual psychology provided by the hospital whilst inpatient and were all provided one session per week. 66.7% of patients felt they were provided with regular individual psychology sessions ($M = 2.33$, $SD = 0.58$), and were satisfied with the actual regularity of individual psychology sessions they had ($M = 2.67$, $SD = 1.16$). 100% of patients found their individual psychology sessions helpful and beneficial, felt the

psychologist/s had adequate ED knowledge, found the psychologists installed recovery hope, and they desired additional individual psychology. Overall, 100% of participants reported being satisfied with individual psychology whilst inpatient.

Individual Dietetics

100% of participants reported being provided with individual dietetics whilst inpatient and reported one to two sessions per week ($M = 1.33$, $SD = 0.58$). 33.3% of participants felt they were provided with regular individual dietetics ($M = 2.67$, $SD = 1.52$), 66.7% reported satisfaction with the actual regularity of individual dietetics ($M = 2.67$, $SD = 1.16$), 66.7% did not find their one-to-one dietetic sessions helpful and beneficial ($M = 3.33$, $SD = 2.08$), and 66.7% of participants reported they felt the dietitian/s had adequate ED knowledge ($M = 2.33$, $SD = 1.53$). 33.3% of participants felt the hospital provided dietitian/s installed recovery hope ($M = 2.67$, $SD = 1.53$), and also desired more one-to-one dietetics sessions whilst inpatient ($M = 3.33$, $SD = 1.53$). Overall, 66.7% of participants reported dissatisfaction with the one-to-one dietetics sessions they had whilst inpatient.

Exercise Physiology

66.7% of participants reported being provided with exercise physiology whilst inpatient and being satisfied with such exercise physiology, and 100% of total participants felt it would have been beneficial to have had access to exercise physiology.

Nursing Care

66.7% of participants felt nursing staff displayed sufficient ED knowledge ($M = 2.00$, $SD = 1.00$), felt that nursing staff provided adequate care during more challenging times ($M = 2.00$, $SD = 1.00$), and felt nursing staff installed recovery hope ($M = 1.33$, $SD = 0.58$). Overall, 100% of participants were satisfied with the nursing care they received whilst inpatient.

Meal Plans

66.7% of participants felt their meal plans included adequate variety whilst inpatient ($M = 2.00$, $SD = 1.73$), 33.3% of participants desired increased variety in their meal plans ($M = 3.67$, $SD = 1.53$), 66.7% of participants felt the dietician/s collaborated with them regarding shared decision making towards their meal plans ($M = 1.67$, $SD = 1.53$), and 33.3% of participants felt their meal plans were generic ($M = 3.00$, $SD = 1.00$). 100% of patients felt meal plans assisted them to engage in regular eating whilst inpatient and felt that meal plans helped them to try new foods or to attempt fear foods whilst inpatient. Overall, 66.7% of participants were satisfied with their meal plan experiences.

Supported Eating

66.7% of participants reported experiencing eating on the specific supported ED table whilst inpatient. 50% of participants reported feeling supported by staff whilst on the table ($M = 2.50$, $SD = 0.71$) and felt staff addressed disordered behaviours by patients at the table ($M = 2.50$, $SD = 0.71$). 100% of participants felt staff adequately addressed patient distress, felt they received encouragement and support from staff during more difficult moments on the table, felt ready to transition off the table, and were overall satisfied with their ED table experiences.

After Meal Support

100% of participants reported experiencing after meal support whilst inpatient. 66.7% of relevant participants felt supported by staff during after meal support ($M = 2.33$, $SD = 1.53$), felt staff encouraged engagement in helpful and relevant distraction activities during after meal support ($M = 2.33$, $SD = 0.58$), and felt staff adequately addressed disordered behaviours ($M = 2.33$, $SD = 1.53$). 100% of participants felt staff adequately addressed patient distress, and overall, 100% of relevant participants were satisfied with their after-meal support experiences.

Social Eating, Food Preparation, and Independent Eating

33.3% of participants reported adequate opportunities to engage in social eating outside of the hospital when inpatient ($M = 3.00$, $SD = 1.00$), reported insufficient food preparation opportunities whilst inpatient ($M = 2.67$, $SD = 1.53$), and 66.7% reported sufficient time independently eating prior to discharge ($M = 2.33$, $SD = 1.53$).

Weigh-Ins

66.7% of participants reported visible weighs and 33.3% experienced blind weighs. 66.7% of participants predominately preferred no weigh-ins, and 66.7% of participants reported wearing general clothing during weigh-ins. 100% of participants felt staff completed their weigh-ins in a professional, informed, and supportive manner. 66.7% of participants felt they were supported by staff post their weigh-in ($M = 2.00$, $SD = 1.00$), felt their psychiatrist addressed the outcome of their weigh-ins in a professional and supportive manner ($M = 2.00$, $SD = 1.00$), and felt the dietitian/s addressed the outcome of their weigh-ins in a professional and supportive manner ($M = 2.33$, $SD = 1.53$). Overall, 100% of participants were satisfied with their weigh-in experiences whilst inpatient.

Discharge Experience

100% of participants felt adequate discharge planning was complete., 33.3% felt their treating team involved them in discharge planning ($M = 2.33$, $SD = 1.16$) and felt they were supported by dieticians to prepare a meal plan for discharge ($M = 3.00$, $SD = 1.00$). 66.7% of participants felt they were given sufficient notice of their discharge ($M = 2.00$, $SD = 1.00$), felt they were discharged too early ($M = 2.33$, $SD = 1.53$), and felt their psychiatrist ensured they had appropriate outpatient support prior to discharge ($M = 1.67$, $SD = 1.16$). 33.3% of patients felt their discharge process was meaningful ($M = 2.67$, $SD = 0.58$), and overall, 33.3% of participants were satisfied with their discharge experience.

Overall Experience

66.7% of participants reported their overall treatment was individualised to their unique presentation, needs, and preferences ($M = 2.00$, $SD = 1.73$). 66.7% of participants felt the treatment was generic for everyone ($M = 3.67$, $SD = 1.53$), felt their voice was heard to actively contribute to decision making ($M = 1.67$, $SD = 1.16$), and felt a holistic and strengths-based approach to treatment was taken ($M = 1.67$, $SD = 1.16$). 33.3% of participants felt their admission would help them recover from their ED ($M = 2.67$, $SD = 0.58$). Overall, 66.7% of patients reported they would feel content returning for a future admission, they would recommend the private hospital ED program to others and were satisfied with their overall experience.

Combined Overall Key Outcomes

In sum, in terms of psychological support and satisfaction with treatment, 51.4% of combined participants reported satisfaction with ED focused group therapy ($M = 1.49$, $SD = 0.50$). Only 43.1% of combined relevant participants reported being encouraged to remain connected with their outpatient psychologist whilst inpatient ($M = 1.71$, $SD = 0.70$), but possibly concerningly, 68.1% of participants were not provided with individual psychology whilst inpatient ($M = 1.68$, $SD = 0.47$). Additionally, only 54.2% of combined participants were overall satisfied with the care they received from their psychiatrist ($M = 1.47$, $SD = 0.50$). Perhaps surprisingly, only 93.1% of participants reported being provided with individual dietetics whilst inpatient ($M = 1.07$, $SD = 0.26$) when ideally this should be 100%. Furthermore, 69.4% of participants reported they did not have access to exercise physiology whilst inpatient ($M = 1.69$, $SD = 0.47$), but 81.9% of participants felt having access to an exercise physiologist whilst inpatient would have been beneficial ($M = 1.18$, $SD = 0.39$). Lastly in terms of care, 61.1% of participants were satisfied with their overall nursing care, and 66.2% of patients were satisfied with their meal plan experiences whilst inpatient ($M =$

1.34, $SD = 0.48$). Further, 94.4% of participants reported experiencing eating on the ED specific supported table ($M = 1.06$, $SD = 0.32$), 54.2% of participants were satisfied with their experience on the ED specific supported table. 83.1% of participants reported they experienced after meal support whilst inpatient, and 59.3% of participants were dissatisfied with the experienced they had during after meal support ($M = 1.59$, $SD = 0.50$). 33.8% of participants felt they were provided with adequate social eating opportunities outside of the hospital whilst inpatient ($M = 3.18$, $SD = 1.16$), 78.9% of participants did not feel they were provided with the opportunity to engage in food preparation whilst inpatient ($M = 4.27$, $SD = 1.16$), and 57.7% of participants felt they did not spend sufficient time eating independently prior to discharge ($M = 3.55$, $SD = 1.40$). To follow, 50.7% of participants were satisfied with their overall weigh-in experiences whilst inpatient ($M = 1.49$, $SD = 0.50$). 61.4% of participants were dissatisfied with their overall discharge experience ($M = 1.61$, $SD = 0.49$). Refer to Table 5. for overall satisfaction outcomes.

Table 5

Overall satisfaction with some aspects of care

Overall Private Hospital Inpatient ED Treatment satisfaction	Combined results N=72
Group Therapy satisfaction	51.4%
Psychiatry experience satisfaction	54.2%
Nursing Experience satisfaction	61.1%
Meal plan satisfaction	66.2%
ED supported table satisfaction	65.2%
Weigh-In Experiences satisfaction	49.3%
Discharge Experience	38.6%

Table 6 highlights the percentage of respondents who would be happy to return to the same clinic for treatment, whether they would recommend to others and overall satisfaction score.

Table 6

Overall and Combined Satisfaction Outcomes

	Satisfaction %	M (SD)
Combined participants who reported they would feel content returning to the private hospital inpatient eating disorder program in the future	51.4%	1.49 (0.50)
Combined participants who recommended the private hospital inpatient eating disorder program to others	51.4%	1.49 (0.50)
Combined participants were satisfied with their overall experience	50%	1.50 (0.50)

Organisational Comprised Outcomes

When considering the ‘collective eight’ comprised of four distinct organisations, satisfaction from an organisational perspective deemed relevant for the purpose of the current study. Ramsay Health Care comprised of Ramsay Clinic New Farm, Ramsay Clinic Hollywood, Ramsay Clinic Northside, and Ramsay Clinic Wentworthville ($n = 31$). Healthscope comprised of The Melbourne Clinic and The Geelong Clinic ($n = 17$). Aurora Healthcare comprised singularly of Robina Private Hospital ($n = 12$). Finally, UnitingCare Health comprised singularly of Cooina Clinic at Buderim Private Hospital ($n = 12$). Therefore, Ramsay Health Care remains the predominate provider, having control of 50% of total private hospital inpatient ED treatment programs in Australia. See Table 7 for a combined overview of satisfaction based on organisational association.

Table 7

Organisational Comparison of Participant Overall Satisfaction

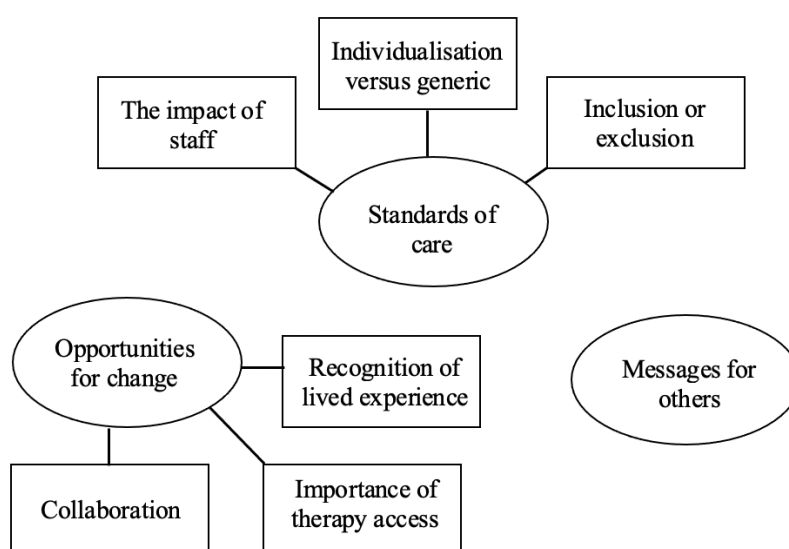
Organisation	Overall Experience Satisfaction %	Willing to have Future Admission/s %	Would Recommend to Others %
Aurora Healthcare	75%	75%	83.3%
UnitingCare Health	50%	58.3%	66.7%
Healthscope	52.6%	52.6%	52.6%
Ramsay Health Care	37.9%	37.9%	31%

Qualitative Themes

Three final themes, and six subthemes were established, and are shown below (Figure 1). To ensure anonymity, the following participant accounts were given an alias, commencing at “A” to fully mitigate any instances of alias-based names if utilised (e.g., “Anna”) matching to the names of actual participants and their self-reports.

Figure 1

Final thematic map, showing three final themes, and six sub-themes



Standards of Care: Just a number or the disorder

The Impact of Staff: Power, invisibility, and invalidation

Numerous participant experiences were indicative of staff interactions that were maladaptive. Some participants told of being distinctly labelled as a number, felt they were a number in the system, and others turned to self-preservation to internally withdraw to get by.

Participant “A” reported *‘It was extremely isolating and clinical. I felt that I was viewed as a disorder rather than a person, and any anxiety, question or disagreement I had was disregarded as ‘the eating disorder’, such that I learnt not to share any of my thoughts because I was sooo scared that if I did, I’d be viewed as ‘less recovered’ and those with power would prolong my stay based on their judgment of how ‘recovered’ I was. It was survival through playing a part as a ‘compliant patient’ which involved repeating the same opinions that you were told were ‘healthy’ and ‘normal’ and generally keeping your head down and not causing fuss. I distinctly remember a group therapy session in which each one of us were reprimanded for not eating at the table with our families for dinner each night and were told it was “not normal” to watch tv or do dinner in any different way. The inpatient program felt militant and like you were being punished for having an eating disorder. You were expected to be devious, and nurses judged you as such. individuality was not acknowledged let alone respected. Labels like ‘perfectionist’ and ‘anxious’ and ‘body dysmorphic’ were assigned to everyone on the basis that we had ended up in inpatient - no matter whether or not we understood or identified with these terms, and ultimately I think they did more harm than good’* (Ramsay Clinic Hollywood).

Notably, the participants often felt that they were treated as a number or the disorder. Individual differences, preferences or even lifestyle were not considered in treatment or

understandings of the eating disorder. This was seen to be particularly the case for in-patient treatment.

Similarly, participant “B” reported *‘some of the nurses I will always hold in the highest regard, and they helped me hold on in my own way when times were devastatingly tough. However, some staff were actively unhelpful, and made comments or responded in a way that was upsetting - both to myself and others’* (Ramsay Clinic Northside).

The survey results pointed to largely average levels of satisfaction with staff in the different clinics. While nurses had the highest level of satisfaction at over 60%, the qualitative statements indicate that staff were not universally helpful either in care practices or what they said to the patients. Participant D also felt undervalued and that she was not believed. Participant E felt this was largely about lack of education about different types of eating disorders or what other issues might need to be considered as mentioned by Participant F.

Participant “D” reported their experience was *‘absolutely awful. I have a somewhat unique presentation (no body image/food/weight issues at all) and I was repeatedly told that I was lying about this (for what reason I still do not know)’* (Ramsay Clinic Northside).

Participant “E” had a reported a particularly difficult experience, *‘some staff members were not adequately trained in eating disorders. There was limited meal support provided at the table. Majority of the nursing staff wouldn’t check in with their patients each shift. Patients were yelled at by staff being called children and ‘a bunch of eating disorders. Some staff would refer to patients by their room number rather than name’* (Ramsay Clinic New Farm).

Participant “F” reported *‘I struggled with my inpatient experience. I have autism and none of my food sensitivities were taken into account, nor was my sensory needs considered. The dining table was often noisy which resulted in meltdowns, and I would be called “disruptive”. Staff often commented on weights or patients could overhear the staff talking about other patient’s weights. Staff often dismissed my concerns or told me to take a Valium. I received barely any one-on-one time with my allocated nurse and felt really isolated’* (Ramsay Clinic New Farm).

The survey responses did indicate different levels of satisfaction with all aspects of treatment in the different clinics and those who had been in more than one clinic often compared the clinic, the staff and their sense making of the experience. For participant C, their psychiatrist was seen as a gatekeeper possibly from the narrative the psychiatrist spins about the patient in staff meetings at the time of admission as they felt their experience was shaped by this psychiatrist.

Participant “C” reported they *‘The care received at TMC is hugely dependent on your admitting psychiatrist. I had a more positive experience in my most recent admission, as I had changed psychiatrists. In the past, I have been degraded, disrespected, bullied, and tested with huge disrespect. I have needed to do trauma work in my private psychology sessions around the experiences I have had at the Melbourne clinic’* (The Melbourne Clinic).

Distressingly, participant “G” reported *‘I was sexually assaulted by my psychiatrist. He has been convicted now. The clinic were terrible. The way they never protected us and kept us chronically unwell for years, profited from our anorexia and left us in the hands of a predator is disgraceful’* (Ramsay Clinic Northside).

Participant H spoke at length about an entire experience that was negative. So while for some there were just elements that were poor, in other cases the entire admission was seen as poor and not helpful for recovery.

Participant "H" reported *'The psychological group therapy sessions were not evidence-based (i.e., were more so unstructured 'check ins' led by participants). There weren't regular therapists (all casual or part time) so no relationship was established. When I presented to the GP/doctor on the ward with significant distress about the size of my stomach I was told "if you keep crying and acting like this your fiancé will think you're crazy and leave you." No support was provided throughout mealtimes, despite experiencing significant distress. No support was provided post mealtime. We all sat in a room being monitored for engaging in compensatory behaviours however no emotional support was provided. I requested to have blind weigh ins as being exposed to my weight at the time of admission was extremely distressing and I would have fixated on this number. Despite this request the nurses openly left my written weight on the table in front of me'* (Ramsay Clinic Wentworthville).

The staff in these clinics have both the power to help and to aid in recovery or the power to contribute to distress and trauma for some participants. The experiences reported ranged from very supportive to abusive. Emotions, power imbalances, staff perceptions, and manipulative tactics were used against the participants and staff concerningly conceptualised genuine patient distress as disruptive behaviours. Much of the reports suggested the participants were silenced and invalidated by staff through reductionist methods of communication and actions. There seemed to be a lack of knowledge of different disorders, presentations, comorbidities and their considerations, and patients were lumped into a category of disorder.

Inclusion or Exclusion: Am I sick enough and gate keeping

Multiple participants reported exclusion based on various factors, including psychiatric comorbidities, health commodities, or admission preferences.

Participant “H” also reported *‘This was a horrible experience for me and has prevented me from seeking any further private hospital admissions for treatment (even if they were required). I quit my full time job to take a break and enter into a private hospital program with the intention of staying quite some time and committing to recovery. Despite having been on a waitlist to enter this private hospital for some time each time I would call to check in on the wait time i would be told another 2-3 weeks. When I was admitted after 2 months wait, I learnt that patients who had already been seeing a psychiatrist at the hospital (i.e., as an outpatient) were being given preferential treatment and admitted before those on the waitlist who weren't already linked in with the psychiatrists (Ramsay Clinic Wentworthville).*

Participant “T” reported *‘Perth is struggling. Only one psychiatrist is “allowed” to admit patients. They hardly understand eating disorders and they can be punitive and controlling. The food is horrible. The staff are busy and distracted - they can barely help when it’s needed. All they do is give you drugs. I’ve just cancelled my private health insurance because I can’t bear the thought of going back there again and I can no longer afford nearly \$80 p/f for such shitty treatment. I’ve had an ED for 20+ years and I’m lost. There is nowhere trauma informed and safe for me to go. The harmful nature of ED treatment has caused additional ptsd symptoms. I’m honestly shocked at how terrible the Hollywood clinic was. If I ever needed inpatient treatment again I’d rather go public’ (Ramsay Clinic Hollywood).*

Participant “J” reported *‘the psychiatrists all know each other and make it impossible for you to change psychiatrists even if you’re not happy with your treatment under one of them’* (Ramsay Clinic Northside).

Finally, participant “K” reported *‘it was hugely traumatic. I have multiple diagnosed physical medical conditions that the hospital were informed about and accepted me. While there, I had a medical episode and was denied basic care and my usual medication’* (Cooinda Clinic Buderim Private Hospital).

The process of being excluded by psychiatrist choice and control, initial admission perimeters reflective of opposite actual experiences, and subsequent trauma symptoms as a direct result of experiences was damning.

Individualisation versus Generic – Am I worthy of customised care, or am I just a bed number

Multiple participants reported feeling as though their treatment was either individualised to their unique needs, or alternatively, reported treatment through a generic lens.

Participant “L” reported *‘my experience was this program was traumatic and harmful. It was not a safe or respectful environment for me as a human being, and the program only treated people as eating disorders with generic approaches with staff who were uneducated. When progress wasn’t made it was the individual’s fault despite myself advocating for my individualised needs’* (Ramsay Clinic New Farm).

Participant “M” reported *‘I was told my discharge date the day I arrived and I wasn’t given any opportunity for that to change even if I felt I needed to stay longer’* (Ramsay Clinic Wentworthville).

Participant “N” reported their experience to be *‘Very generic. Often bad psychiatrists or invalidating or triggering nurses. Did not really help me recover just provided acute care’* (Robina Private Hospital).

Alternately, participants “L” reported *‘I was treated as an individual’* (Robina Private Hospital)

Participant “O” reported *‘I was treated with respect and given special consideration’* (Ramsay Clinic New Farm).

Individualisation fell on two ends of a continuum. The experiences reported were reflective of individualised care indicative of respect and consideration to heavily reflective of generic, invalidating, inflexible, prescriptive, and traumatising experiences. Much of the reports suggested the participants were further invalidated by staff, lacked adequate levels of care, and simply, were reported to be harmful.

Opportunities for Change

Recognition of Lived Experience – Expertise by personal experience

Multiple participants reported desiring access to lived experience clinicians/workers, which was heavily reflected in qualitative statements.

Participant “P” reported *‘I think the whole program needs a fresh younger perspective with LIVED-EXPERIENCE. There are no lived-experience workers even on the team to support the patients and instil hope’* (The Melbourne Clinic).

Participant “Q” reported *‘Reduction of intensive weight focus, increase of groups put forward by patients, more lived experience workers/involvement, more regulation about*

disordered table behaviours, more mealtime and bed rest support, more outings’ (Ramsay Clinic Northside).

Further, participant “R” reported desiring *‘more recovered lived experience staff (particularly nursing) and ++eating disorder education to nursing staff is needed. I don’t have any strategies yet but navigating a group setting for ED treatment can be hard. Lots of comparison, competition and learning new behaviours’ (Cooinda Clinic Buderim Private Hospital).*

Finally, participant “S” reported *‘the most positive influences during my stay were the peer support worker (once a week for 1 hour), and the exercise physiologist’ (Ramsay Clinic Hollywood).*

Passionate and desperate reports indicative of desiring future inclusion of lived experienced staff, broad improvements of support throughout the program from staff, and the inclusion of practical opportunities for real world skill practice for future discharge were reported. When lived experience staff were provided, they were unsurprisingly advantageous.

Importance of Therapy Access – Reasonable expectations but predominately unreasonably unavailable

Participants reported mixed experiences with therapy accessibility.

Participant “T” reported *‘I enjoyed the group therapy sessions and felt well supported by the nurses and hospital staff’ (Robina Private Hospital).*

Participant “U” reported *‘the overall treatment was good. Initially we had access to a hospital psychologist, but the psychologist soon left which significantly affected my treatment’ (Cooinda Clinic Buderim Private Hospital).*

Participant “V” passionately reported *‘Everything. More support for all patients and not just those deemed the "sickest", less focus on weight as a measure of sickness. Stop discharging people so early and actually learn some bloody skills and have some one-to-one psych sessions to address the issues rather than generic groups’*(Ramsay Clinic Hollywood).

Finally, participant “W” reported *‘I would like to see more one-on-one treatment options in conjunction to group therapy sessions. While I appreciated being around others with similar difficulties as myself, I would have liked the opportunity to share my concerns and struggles in a more private setting’*(Robina Private Hospital).

As private hospitals, they are positioned financially to be able to provide adequate therapy provision in comparison to public hospitals, period. The experiences reported ranged from good and supportive, to utterly inadequate, isolating, and distressing. Staff patient preferences impacted available or delivered care, a lack of or completely unavailable individual psychology provision were evident, and staff exclusive measure of illness severity were reported.

Collaboration – More talking, less assuming, more engagement, less exclusion

Participants felt collaboration was predominantly lacking.

Participant “X” reported desiring *‘more options for negotiating around admission parameters and more options to negotiate meal plans and challenges’* (Robina Private Hospital).

Participant “Y” reported *‘these places are NOT trauma informed; they do not consider neurodiversity; they treat people like numbers. Lost autonomy and dignity’* (Ramsay Clinic Hollywood).

Participant “Z” reported *‘I discharged after three weeks against medical advice because I saw my weight at weigh in and had a break down, I was slumped on the floor outside the room sobbing and staff just ignored me’* (Ramsay Clinic Wentworthville).

The experiences reported ranged from very supportive reports to losing basic dignity and self-efficacy. Further power imbalances, comorbidities were disregarded, and set expectations with no flexibility were reported. Much of the reports suggested the participants were further impacted by reductionist and exclusion-based lack of adequate treatment provision.

Messages for Others: Recommendations

For the current section, participants were allocated a number-based alias (e.g., “1”) to ensure anonymity was retained. Participant messages to others considering the program they completed included encouraging statements, and particularly adverse self-reports. Conversely, numerous participants made damning recommendations.

Participant “1” reported *‘do it, it saved my life, but remember the importance of challenging health information that doesn’t feel right for you. Engage in group therapy and do the hard work because unfortunately at this clinic no one will push you’* (Ramsay Clinic Wentworthville).

Participant “2” reported *‘engage wholeheartedly in the program, the challenges are worth it in the end. This program is the best you’ll get in NSW and you’ll no doubt be supported and encouraged to heal and work on your ED behaviours and thought pattern’s’* (Ramsay Clinic Northside).

Participant “3” reported *‘it’s hard but ensure you voice your worries and concerns don’t let things go under the radar’* (Robina Private Hospital).

Participant “4” reported *‘go for it, they’re welcoming and kind. Definitely supportive and make it easier to get better, or at least aim for harm minimisation if needed’* (The Geelong Clinic).

Participant “5” reported *‘this program is harmful and traumatising. If you choose to go, trust your gut and advocate for your basic rights and needs, even if you have to do it over and over again’* (Ramsay Clinic New Farm).

Participant “6” reported *‘remember that you will get out of the program what you put in, but ultimately it is a business and not a healthcare facility’* (The Melbourne Clinic).

Participant “7” reported *‘please please please try recover from home. Please don’t think you need to go into hospital to be “sick enough”. More often than not you leave with more trauma. I really think hospital should be an absolute last resort’* (Ramsay Clinic New Farm).

Finally, participant “8” reported *‘get in and get out. It is not a safer way to live, and it is not freeing for your disorder to live in a place that solely focuses on your ED as the most notable and important aspect of who you are and your life. Restore and rest and then sell out the best community supports available, friends, therapists, family, school, hobbies, get distracted and develop your life outside of the ED. You won’t be fixed by an admission, and it will be difficult to recover wherever you go and in whatever circumstances’* (Ramsay Clinic Hollywood).

Numerous recommendations captured avoiding private hospital inpatient eating disorder treatment programs reflected desperation, utilising community supports instead, preferencing treatment as harmful and traumatising, and requiring self-advocacy. Noting some recommendations of supportive and welcoming experiences, the majority of patients

self-reports reflected avoidance of future admissions and prioritisation of community supports and having experienced harm.

Discussion

The present study aimed to extend upon the extremely limited existing body of research within the field of ED research, by for the first time in research, collectively assessing the eight private hospital inpatient eating disorder treatment programs in Australia through the lens of patients who have experienced such treatment. When the surveys were evaluated, participants identified that there were lacks in individualised psychology involvement, of which, they significantly reported desiring, felt significantly dissatisfied with their after-meal support from staff, and were significantly dissatisfied with their discharge experiences. When we consider the nature of EDs, clear and respectful communication, collaboration, and consistency are essential, given those with EDs at higher risk of experiencing stigma, judgement, dismissiveness, isolation, can increase barriers to future treatment accessibility, and can also reinforce negative health professional based options, including biased treatment provision, collectively risking patients experiencing significant subsequent distress (Aird et al., 2025; Asaria, 2025; Dell et al., 2021; Guy et al., 2022; Lubieniecki et al., 2024; Stapleton & Ballatyne, 2018). Therefore, the consistent lack of adequate provision in these areas is highly concerning.

Staffing Support

Common themes of a lack of individual therapy provision were evident across participants. Individual psychology and exercise physiology were broadly reported to be limited, or not available at all. Of further concern, were the patterns of private hospital inpatient ED programs offering either individual psychology or exercise physiology to some patients, but not all, which risked contributing to patients experiences of invalidation, negative attitudes towards them from health care professionals (e.g., dismissiveness), decrease individual treatment accessibility, and cause subsequent, judgement, shame,

isolation, and distress (Kozmer et al., 2025; Lubieniecki et al., 2024; Stapleton & Bannatyne (2018). Furthermore, the given psychiatrists are the admitting doctors in lead of patient's broader treatment when it comes to private hospital inpatient ED treatment programs, an overall satisfaction rate of 50% simply indicates that of an equal dissatisfaction. Given the existing body of broader ED treatment research indicates those with EDs often report their healthcare system experiences to be significantly punitive, traumatic, distressing, stigma, and broadly having a poor experience, this is unsurprising (Butterfly Foundation, 2022; Kozmer et al., 2025; Lubieniecki et al., 2024; Stapleton & Bannatyne, 2018).

Meal Support

A key area identified in the research was a lack of support around meals as 59.3% of participants were dissatisfied with their experience's during after meal support and after meal support (e.g., being released back to rooms upon after meal support completion). As supporting ED patients with meals and relationships with food is considered one of the most important facets of private hospital inpatient ED program treatment, this deficit is concerning. Simply, the patients had EDs and did not receive adequate care provision and support during what would be considered one of the highest distress eliciting periods where they could not (or were not meant to) engage in compensatory behaviours and required practical emotional support from clinical staff during this peak period of vulnerability.

Food Preparation

Research found that 78.9% of participants were dissatisfied with the clear lack of practical food preparation opportunities during their private hospital inpatient ED treatment. As adults, it would be reasonable to assume that many would return to the community and need to reengage in practical food preparation as a part of their daily life (e.g., preparing their own food and cooking). Therefore, inpatient experiences were indicative of lacking essential,

practical, and realistic food preparation opportunities. Therefore, likely adding additional adjustment stressors upon discharge from a reintegration to the community perspective, which could indeed, in most instances, have been mitigated with a practical inclusion of food preparation during their inpatient stay. As nil prior research exists to compare this component to, the author recognises the above statements regarding food preparation cannot currently be compared, assessed, or invalidated from an existing research perspective. However, based on the body of current research which indicates that ED patients broadly desire individualised, practical, inclusive, and supportive recovery-based care, the lack of practical food preparation opportunities is therefore inconsistent with the broader desire to reduce ‘one size fits all’ approaches.

Organisational Outcomes

From an organisational comparison perspective, Ramsay Health Care comprised of 50% of total provision in the private hospital inpatient ED treatment program space in Australia. Therefore, holding the monopoly of service provision. Despite this, our research identified their satisfaction rates across all three final overall questions were significantly lower than all other organisations, for overall satisfaction (37.9%), participant willingness to readmit if needed in the future (37.9%), and if they would recommend the programs to others (31%). Whilst acknowledging Healthscope comprised of 25% of total hospitals, and Aurora Healthcare and UnitingCare Health each comprised of 12.5% of total hospitals, Ramsay Health Care had the predominate opportunity to provide impactful, comprehensive, and adequate service provision. In 2024, Ramsay Health Care’s annual financial year profit after tax was \$888.7 million (Ramsay Health Care, 2024). Therefore, the question remains, how financially impactful would the service provision of individual psychology, broader admission parameters, an exercise physiologist on staff, and upskilled trauma informed nursing staff be, to deliver improved individualised and comprehensive care? According to

participants, the impact of such would have been exponential. Due to Healthscope's placement into receivership in 2025 due to severe financial difficulties (Healthscope, 2025, December 24), there is no comparable financial report to compare Ramsay Health Care and Healthscope as the first and second largest providers of private hospital inpatient ED treatment programs in Australia. In 2023, Aurora Healthcare, owned by Luye Pharma Group, listed a \$140.7 million net loss in Australia for the 2023 financial year (Thompson et al., 2025). Despite this, Robina Private Hospital's broader satisfaction remained the highest of all private hospital organisations. Further, Uniting Care Health Care was the singular charity-based organisation, operating Cooina Clinic Buderim Private Hospital from the 'collective eight'. Whilst this differs from the for-profit organisations operating the seven other private hospital inpatient ED treatment programs in Australia, it is important to note that Uniting Care Health Care (QLD state only) had a net deficit of -\$101, 721, 000 million in the 202/2024 financial year (Australian Charities and Non-for-profits Commission, 2024). Therefore, Ramsay Health Care was singular organisation in a position of profit, and thus, begs the question of profit prioritisation over service quality, specificity, relevance, quality of care, and patient experiences., the latter of which are identified in current research as factors broader ED patients desire during treatment provision (Byrant et al., 2021; Butterfly Foundation, 2020; Deloitte, 2024; Tobin et al., 2023).

In sum, for the combined overall outcomes, participants only just exceeded a predominant level of satisfaction regarding willingness to return for a future admission if required (51.4%), if they would recommend the program to other people considering an admission (51.4%), and they reported overall dissatisfaction for their overall experiences at 50% satisfaction, Whilst acknowledging the first two percentiles indicative summed participant predominant satisfaction, having 48.6% of participations reported no desire to return for a future admission if they required it, and 48.6% of participants also reporting they

would not recommend private hospital inpatient ED treatment to others, therefore, reflect an alarming level of patient dissatisfaction which warrants future additional research.

Qualitative Participant Self-Reports

Participants were provided with the optional opportunity to report their experiences in their own words at the end of the survey. Of the participants who completed the optional self-reports, of those who participants who reported positive based self-reports, there were some commonalities among this specific cohort. Such commonalities included acknowledging program difficulty, but inferring it was worth giving it a go, some participants expressed gratitude for their experience at a second private hospital inpatient eating disorder program after a disappointing comparative first experience elsewhere, others felt their experience was indicative of structured and supportive environments to reinstate normalised and adequate eating patterns, and others reported they felt they were provided support at the, or one of the, hardest periods of their life. Therefore, there were various positive self-reports provided by a component of participants. Whilst acknowledging the above participants positive self-reports, what was unequivocally and abundantly clear from the other participants self-reports, were self-reported distressing, traumatising, unethical, but brave and honest self-reports by such participants. Numerous participants reported clinical staff spoke to, or about, patients in derogatory ways, such as referring to patients as their room number not their name, multiple patients reported being yelled at by staff, judgmental and shame-based commentary was also reported (e.g., referred to as their eating disorder, using invaliding terms when distressed, and feeling taken advantage of financially, some participants having to complete trauma work based specifically on their reported adverse treatment experiences, and for one participant, the reported being sexually assaulted by their admitting psychiatrist. Therefore, indicating mixed experiences of participants based on their self-reports, which simply, range from being indicative of gratitude, positivity, and hopeful self-reports, to undeniably unacceptable self-

reported treatment experiences. These findings and their practical implications are now further discussed below.

Limitations

A small number of limitations need to be acknowledged. Firstly, unique to our study, no prior studies have been completed to compare, confirm, or conflict any existing research in the current field from a ‘collective eight’ perspective, as simply, this does not exist. Whilst acknowledging the importance of the current study, it is considered unlikely for a similar study to be repeated across the ‘collective eight’ and completed by an independent researcher. This is considered unlikely from an independent researcher perspective due to this approach being reflective of nil vested interest in any specific facility, nil vested interest in any broader companies overseeing one or more of the ‘collective eight’, and it being considering unlikely for another independent researcher with no vested interest receiving a research grant in Australia for such study to occur. Quite simply, the complexities of the eating disorder research, clinical governance, and peak bodies in Australia, are intertwined to the extent that an unbiased account of participant experiences would not be likely to be considered as a priority, whilst the power imbalance within the above combined eating disorder treatment, governance, and research realms in Australia remain as they currently stand.

Secondly, the nature of a combined quantitative and qualitative design has resulted in the current publication requiring a much more extensive word count to facilitate the extended reporting that such an extensive study and the associated data it comprises of. In hindsight, the current study would have likely been better suited to a PhD level study, rather than master’s level. Thirdly, when assessing each private hospital inpatient eating disorder program, the author acknowledges that programs can indeed change in format and clinical

governance over time, and it would be considered simply impossible to assess every distinct facet of each hospital's program. Therefore, the essential commonalities were assessed across the 'collective eight' to ensure an adequate level of data obtainment which was relevant for the broader satisfaction measures across all eight locations. Finally, from a qualitative perspective, the brave, honest, and inspiring personal accounts of participants' experiences could have been warranted additional analysis regarding locational specificities. However, again due to the limited nature of the current study's word count, this was unable to be facilitated.

Future Recommendations

Worldwide, ED treatment requires substantial advancements to move away from a generic approach to facilitate treatment with vastly improved person-centred, trauma-informed, and individualised care (Asaria 2025; Rankin et al., 2023). Contributions by lived experience researchers and qualitative research specific to inpatient treatment, residential treatment, and research through the lens of lived experience in eating disorder treatment, are considered essential for future development of safe, trauma-informed, and effective treatment options (Miskovic-Wheatley et al., 2025; Moroshko et al., 2025; Rankin et al., 2023;). By including minority populations (e.g., LGBT, culturally diverse individuals, individuals whom have been unable to access treatment) within the lived experience cohort when creating future programs, initiatives, in research, and when developing essential service provisions, this will start to change the voice of minority populations and apply broadly applicable changes to the eating disorder space in future to facilitate broad, meaningful, impactful, and much-needed changes (Carrino et al., 2023; Williams-Ridgway, 2025).

It is essential for dual diagnosis to be considered as an essential part of the treatment of EDs in the future, given the evidenced, multiple, and significant comorbid conditions

which cooccur with EDs, including anxiety disorders, mood disorders, personality disorders, trauma disorders, and neurodevelopmental disorders (Christiansen et al., 2025; Cobbaert et al., 2024; Loxton & Gleaves, 2025; Miller et al., 2022). The behaviours and attitudes of health care professionals can negatively impact ED patient's treatment experiences (Butterfly Foundation, 2022; Kozmer et al., 2025; Lubieniecki et al., 2024; Stapleton & Bannatyne, 2018). Therefore, future research should also focus on healthcare providers being broadly upskilled to be able to facilitate patient experiences to be based on respect, recognise patient preferences, authentically attempting to help patients to feel like they have been understood, and to apply an inclusive lens to individualised care, in order to improve treatment outcomes and foster a more supportive environment for recovery (Kozmer et al., 2026; Lubieniecki et al., 2024; Stapleton & Bannatyne, 2018). Therefore, eliminating a 'one size fits all' approach is critical.

Broader demographical information must be a priority for future research consideration, to move away from the historical, out of date, and non-inclusive age, gender, and location approach to demographical information gathering. Including minority populations, including broader cultural details, whether individuals identify as gender diverse, and capturing indeed why some individuals cannot access treatment, are collectively important for representational factors (Carrino et al., 2023; Williams-Ridgway, 2025).

From a lived experience contribution perspective, future research must consider including independent lived experience contributors in research, program development, and in service delivery, so that future ED treatment changes to be more representative of positively impactful, practical, and advantageous changes for those who experience an ED (Carrino et al., 2023; Williams-Ridgway, 2025). ED treatment as a stand-alone factor requires ongoing continuous improvement and advancements to shift from a common generic

approach to treatment, to reflect individualised, trauma informed, and person-centred care in the future (Asaria 2025; Rankin et al., 2023). As indicated in the current study, patients across all hospitals reported varying levels of satisfaction and dissatisfaction with the approach taken during their treatment, which for a significant proportion of participants, was indicative of generic content and non-individualised care. Therefore, providers must incorporate ED providers having adequate skillsets, or being further adequately trained, to facilitate authentic, respectful, patient centred, and individualised care through the provision of skilled health professionals (Kozmer et al., 2026; Lubieniecki et al., 2024; Stapleton & Bannatyne, 2018). Further, through the provision of such training and subsequent skilled skillsets, it would be hoped that the behaviours and attitudes of health care professionals subsequently not negatively impact ED patient's treatment experiences (Butterfly Foundation, 2022; Kozmer et al., 2025; Lubieniecki et al., 2024; Stapleton & Bannatyne, 2018). Ultimately, it would be advantageous for additional research to assess the 'collective eight' in one distinct study. However, as clearly outlined prior, the possibility of this occurring is met with substantial current barriers based on the predominant intertwined nature of private hospital inpatient eating disorder treatment, clinical governance, and the low likelihood of independent non-vested research in this space within Australia at present.

Practical Implications

The results of the current study are consistent with the current research in the broader lived experience and qualitative research realms specific to ED treatment, which simply, represents the need for improvements to be broadly made to facilitate improved patient outcomes through the delivery of trauma-informed, patient-centred, and effective treatment options (Miskovic-Wheatley et al., 2025; Moroshko et al., 2025; Rankin et al., 2023;). Despite the limitations outlined above, this study contributes to the field of ED research by

assessing the current eight private hospital inpatient eating disorder treatment programs in a singular study for the first time. The findings suggest that whilst a level of patient satisfaction varies, and whilst acknowledging that patient satisfaction is indeed evident for just over the predominate proportion of participants for broader three key satisfaction questions, the dissatisfaction, distressing experiences, and the impact of such latter treatment, has been clearly self-reported by participants. This is useful for future research purposes, if it is able to be further researched from an un-vested ‘collective eight’ perceptive, as this is the first study to not focus on weight factors amongst the current seven ‘collective eight’ publications, it sets a platform for the voice of lived experience to be heard, and it provides the future opportunity for repeated studies to measure longitudinal patient self-reported outcomes now a platform has been established from the current study.

Practically, this demonstrates multiple avenues of necessary change which is broadly required by the private hospital inpatient eating disorder programs to more frequently provide adequate, trauma informed, individualised, and safe treatment, as clearly indicted as being essential, captured through the lens of participants self-reports in the current study. Refer to Table 8. for a succinct summary of future recommendations.

Table 8

Recommendations for Improving Private Hospital Inpatient Eating Disorder Treatment

Recommendation	Actionable Steps
Increase access to individual psychology	Utilise current staff, or hire additional staff, to facilitate essential service provision.
Reduce genericity of treatment	Upskill staff to ensure patient centred and trauma informed lenses are applied to all facets of treatment and actively incorporate lived experience staff members in the MDT.

Treatment equity	Minimise preferential admission criteria, eliminate psychiatry preferential treatment of some patients, reduce weight-based admission metrics to ensure those in non-AN diagnostic categories can access treatment when they are severely unwell and require the service as such.
Practical service provision and offerings	Incorporate structured and supportive post meal support through upskilling staff to provide adequate care provision and provide patients with the essential food preparation skills whilst inpatient.

Note. MDT = Multi-Disciplinary Team, AN = Anorexia Nervosa

Conclusion

The current study aimed to investigate patient experiences associated with private hospital inpatient eating disorder treatment in Australia. Further, as the first study to assess all eight hospitals within a singular study (known as the ‘collective eight’, we aimed to provide participations with the additional optional opportunities to report their own experience in their own words through self-reports, to ensure the voice of participants were indeed captured. The findings suggest that treatment experiences and satisfaction broadly differ depending on participants unique experiences. Consistencies were reported in participants overall satisfaction, whereby, satisfaction levels just exceeded dissatisfaction for overall treatment satisfaction, whether participants would return for additional admissions if required, and, if they recommended the private hospital inpatient eating disorder program to other people considering an admission.

Dissatisfaction was abundantly clear regarding the lack of individualised psychological support offerings, post meal support, and discharge planning. This demonstrates that individualisation, adequate planning, and broader support were reported to be lacking across the programs. Participant self-reports ranged from positive experience’s

indicative of stable, supportive, and consistent treatment experiences to self-reported traumatising, generic, militant, and unethical experiences. Therefore, the latter demonstrated the distinct difference between numerical based outcomes of satisfaction, versus lived experience reported firsthand self-reported accounts of positive, and negative treatment experiences, the latter of which are indeed powerful and impactful to read. Overall, the findings demonstrate that patient experiences associated with private hospital inpatient eating disorder treatment in Australia vary, with the significant of dissatisfaction reflected self-reported traumatic, distressing, and inadequate treatment experiences. However, future research is necessary to explore longitudinal patient outcomes, broader measures of patient satisfaction (e.g., specific group therapy content), and to continue to elevate the important voice of those with lived experienced. Simply put, *'People with eating disorders are complex and multi-faceted, we are more than just an eating disorder - treat us with respect as human beings.'*

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Appendices

Appendix A – ethics information

Ethics approval



25/05/2023

Dear: Samantha Fitzsimon Spicer

Re: Ethics Application - OM2 23/19 - Survey of Patient Experiences Associated with Private Hospital Inpatient Eating Disorder Treatment in Australia.

Thank you for the above application that was considered by the Massey University Human Ethics Committee:

Ohu Matatika 2 at their meeting held on **Thursday, 27 April 2023**

On behalf of the Committee I am pleased to advise you that the ethics of your application are approved.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely



Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Information sheet and consent section

School of Psychology
Massey University
Private Bag 102-904
North Shore
Auckland 0745
Tel: +64 9 414 0800 ext 43116



Survey of patient experiences associated with private hospital inpatient program eating disorder treatment in Australia

PARTICIPANT RESEARCH INFORMATION SHEET

Thank you for your interest in this research project. My name is Samantha Fitzsimon-Spicer, and I am a postgraduate psychology research student at Massey University. In conjunction with Dr Kathryn McGuigan, we are inviting individuals aged 18 years and over, who have experienced private hospital inpatient eating disorder program treatment in Australia, and who were a resident of Australia or New Zealand at the time of treatment, to take part in this anonymous study, which aims to explore patient experiences. This information sheet will provide you with additional information so that you can decide if you would like to participate.

Project Description

This research project aims to explore patient experiences associated with private hospital inpatient eating disorder program treatment in Australia. The reason for inviting individuals across Australia and New Zealand, is in consideration of the limited specialised treatment options across both countries. We hope to better understand patient experiences, patient satisfaction, and patient preferences, and we are also interested in participants expressing themselves and their experiences in their own words, whereby, several optional open-ended questions will be available to participants throughout the survey to facilitate these opportunities.

Participant Identification and Recruitment

This study is being advertised on several eating disorder related group pages and organisational related pages in the eating disorder space, both on Facebook and/or Instagram (with the permission of each group's administrator). Further, snowballing throughout our professional and research related networks via email will also occur. Individuals who are interested in participating in this study are invited to complete the survey. If you know of anyone else who may be interested in participating, and meets the inclusion criteria, please feel welcome to pass the details of this study on.

Please consider participating in this study if you:

- Are aged over 18 years of age

- Have had an admission to a private hospital inpatient eating disorder treatment program in Australia
- Were a resident of Australia or New Zealand at the time of your admission/s
- Participants must feel they are in a space where they consider answering this survey safely

You are not eligible to participate in this study if you:

- Have not had a clinical diagnosis of an eating disorder
- Are currently receiving treatment in a private inpatient facility for eating disorders at the time of survey completion
- Feel that you are not in a space whereby you can complete the survey safely
- We're not a resident of Australia or New Zealand at the time of your admission/s

If you participate, what will you be required to do?

If you decide to participate in this study, you will be required to complete an online survey that follows this information page. You can complete the survey in your own time, and it will take approximately 20 minutes to complete. If you have been admitted to more than one of the private hospital inpatient eating disorder programs, you will be asked to consider completing the survey for each option. We feel that this is an important consideration, as it will help us to understand the commonalities and differences between each private hospital. The survey will be open until 30th April 2024.

The survey consists of several sections which will ask you questions about your background information (demographics), your eating disorder history, your experience during private hospital inpatient eating disorder treatment, and your broader health. You will also be provided an opportunity, in your own words, to voice your treatment experience/s if you choose to do so. Your identity will remain anonymous, and you will only be known as a participant number. However, if you would like to go into the draw to win one of six \$50.00 online gift cards, you will be asked to provide an email address at the end of the survey. This will be stored separately to your other survey answers. As you complete the survey, your progress will be automatically saved. This means that you do not have to finish the survey in one sitting, and you can take time to think about how you would like to answer any of the questions.

You are free to withdraw from the study at any time. To do this, simply close your browser window the survey is presented on without submitting your responses. While your progress will be automatically saved, your responses will not be recorded, and your progress will be deleted when the survey closes.

Risks and Benefits

It is not anticipated that involvement in this study will involve any risks or discomfort to participants. In fact, we hope that this research will give us a unique perspective into the journeys of patients, to help us understand treatment through the lens of the patient. However, due to the challenges associated with living with an eating disorder, we understand that it may be difficult to share some aspects of your journey, and some participants may find this an experience that may be emotive.

As such, there is no pressure to share anything you are not comfortable with sharing. If you do not feel comfortable responding to a question or feel the question is irrelevant to your journey, you can either leave the answer field blank or select the 'not applicable' option. We have also included a list of free supports available in both counties (which is located at the end of this document), and we would encourage you to engage with your own support networks.

Data Management

All personal information and data collected during this study will be stored securely on a password-protected network that only myself, the researcher, and my supervisor, Dr Kathryn McGuigan, can access.

All data will be destroyed once the project is completed in February 2025. We will be responsible for making sure that your data will only be used for the purposes mentioned in this information sheet.

Participants Rights

You are under no obligation to accept this invitation. If you decide to participate in this study, you have the right to:

- Decline to answer any particular question;
- Withdraw from the study up until you submit your responses;
- Ask any questions about the study at any time during participation;
- Provide information on the understanding that your name will not be used;
- Be given access to a summary of the project's findings when it has been concluded.

Support Information

Australia

- Your GP, Psychologist, Counsellor, Psychiatrist, Recovery Coach
- Your support people, such as friends, and family
- The Butterfly Foundation – 1800 334 673, or online chat (8.00am-midnight)
- Lifeline – 13 11 14, text, and chat online (24/7)
- Beyond Blue – 1300 224 636, and chat online (24/7)
- SANE Australia – 1800 187 263, or chat online (10am-10pm Monday-Friday)
- Suicide Call Back Service – 1300 659 467 (24/7)

- QLife – 1800 184 527 (3pm-12am)

New Zealand

- Your GP, Psychologist, Counsellor, Psychiatrist, Recovery Coach
- Your support people, such as friends, and family
- [Lifeline](tel:0800543354) – 0800 543 354 (0800 LIFELINE) or free text 4357 (HELP)
- [Youthline](tel:0800376633) – 0800 376 633, free text 234 or email talk@youthline.co.nz or online chat. (up to 24 years of age).
- [Samaritans](tel:0800726666) – 0800 726 666
- [Suicide Crisis Helpline](tel:0508828865) – 0508 828 865 (0508 TAUTOKO).
- [Healthline](tel:0800611116) – 0800 611 116
- [OutLine](tel:08006885463) Aotearoa– 0800 688 5463

We greatly appreciate your consideration of this study, and we welcome your participation if you choose to partake in this important body of research. If you have any questions about this study, please feel welcome to reach out to either myself, or my supervisor, Dr Kathryn McGuigan, as per the details outlined below:

Researcher: Samantha Fitzsimon-Spicer

Supervisor: Dr Kathryn McGuigan

Email: [REDACTED]

Email: K.Mcquigan@massey.ac.nz

Statement of Ethical Approval

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 2, Application OM2 23/19. If you have any concerns about the conduct of this research, please contact Associate Professor Fiona Te Momo, Chair, Massey University Human Ethics Ohu Matatika 2, telephone 09 414 0800 x 43347, email humanethics2@massey.ac.nz.

Participant Consent:

- ☐ I have read and understood the above project information. I consent to participate and for my anonymous data and information to be used for this project that is being undertaken by this research team.

I have read and understood the above project information. I do not wish to partake in this study.

Advertisement

Interested in participating in important eating disorder research?

~ Are you aged over 18? ☒

~ Have you ever been admitted to a private hospital inpatient eating disorder program in Australia? ☒

~ Were you a resident of Australia or New Zealand at the time of your treatment? ☒

~ Do you feel you are in a space to answer this survey safely? ☒

If so, please partake in this important eating disorder research opportunity!

In conjunction with Dr Kathryn McGuigan, we are undertaking research to assess the patient experiences associated with private hospital inpatient eating disorder program treatment in Australia. This anonymous and voluntary online survey will take approximately 20 minutes to complete, and participants can choose to go into the draw to win one of six \$50 online gift cards after completing the survey, by entering their email address. Please scan the QR code to participate in this study.

We greatly appreciate your consideration of participating in this important study. If you have any questions pertaining to this study, please feel welcome to contact us via email as per the following details:

Researcher: Samantha Fitzsimon-Spicer: [REDACTED]

Supervisor: Dr Kathryn McGuigan: kathryn.mcguigan@massey.ac.nz



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KI PŪREHUROA | **UNIVERSITY**
UNIVERSITY OF NEW ZEALAND



Appendix B – copy of the survey

Research Information Sheet

Survey of patient experiences associated with private hospital inpatient eating disorder treatment in Australia

Thank you for your interest in this research project. My name is Samantha Fitzsimon-Spicer, and I am a postgraduate psychology research student at Massey University. I am currently on a placement at the time of treatment, to take part in this study. In conjunction with Dr Kathryn McGuigan, we are inviting individuals aged 18 years and over, who have experienced private hospital inpatient eating disorder treatment in Australia, and who were a resident of Australia or New Zealand at the time of treatment, to take part in this anonymous study, which aims to explore patient experiences. This information sheet will provide you with additional information so that you can decide if you would like to participate.

Project Description

The aim of this research project is to survey patient experiences associated with private hospital inpatient eating disorder treatment in Australia. The reason for inviting individuals across Australia and New Zealand, is in consideration of the limited specialised treatment options across both countries. We hope to better understand patient experiences, patient satisfaction, and patient preferences, and we are also interested in hearing your voice, whereby, several open-ended questions will be available throughout the survey.

Participant Identification and Recruitment

This study is being advertised on several eating disorder related group pages and organisational related pages in the eating disorder space, both on Facebook and/or Instagram (with the permission of each group's administrator). Further, snowballing throughout our professional and research related networks via email will also occur. Individuals who are interested in participating in this study are invited to complete the survey. If you know of anyone else who may be interested in participating, and meets the inclusion criteria, please feel welcome to pass the details of this study on.

Please consider participating in this study if you:

- Are aged over 18 years of age
- Have had an admission to a private hospital inpatient eating disorder treatment program in Australia
- Were a resident of Australia or New Zealand at the time of your admission/s
- Participants must feel they are in a space where they consider answering this survey safely

You are not eligible to participate in this study if you:

- Have not had a clinical diagnosis of an eating disorder
- Are currently receiving treatment in a private inpatient facility for eating disorders at the time of survey completion
- Feel that you are not in a space whereby you can complete the survey safely
- We're not a resident of Australia or New Zealand at the time of your admission/s

If you participate, what will you be required to do?

If you decide to participate in this study, you will be required to complete an online survey that follows this information page. You can complete the survey in your own time, and it will take approximately 20 minutes to complete. If you have been admitted to more than one of the private hospital inpatient eating disorder programs, you will be asked to complete the survey for each option. This is important, as it will help us to understand the commonalities and differences between each private hospital. The survey will be open until 31st August 2023.

The survey consists of several sections which will ask you questions about your background information (demographics), you're eating disorder history, and your experience during private hospital inpatient eating disorder treatment. You will also be provided an opportunity, in your own words, to voice your treatment experience/s if you choose to do so. Your identity will remain anonymous, and you will only be known as a participant number. However, if you would like to go into the draw to win one of six \$50.00 online gift cards, you will be asked for an email address at the end of the survey. This will be stored separately to your other survey answers. As you complete the survey, your progress will be automatically saved. This means that you do not have to finish the survey in one sitting, and you can take time to think about how you would like to answer any of the questions.

You are free to withdraw from the study at any time. To do this, simply close your browser window the survey is presented on without submitting your responses. While your progress will be automatically saved, your responses will not be recorded, and your progress will be deleted when the survey closes.

Risks and Benefits

It is not anticipated that involvement in this study will involve any risks or discomfort to participants. In fact, we hope that this research will give us a unique perspective into the journeys of patients, to help us understand treatment through the lens of the patient. However, due to the challenges associated with living with an eating disorder, we understand that it may be difficult to share some aspects of your journey and it is possible that some participants may find this an emotional experience.

As such, there is no pressure to share anything you are not comfortable with sharing. If you do not feel comfortable responding to a question or feel the question is irrelevant to your journey, you can either leave the answer field blank or select the 'not applicable' option. We have also included a list of free supports available in both counties (which is located at the end of this document), and we would encourage you to engage with your own support networks.

Data Management

All data collected during this study will be stored securely on a password-protected network that only myself, the researcher, and my supervisor, Dr Kathryn McGuigan, can access.

All data will be destroyed once the project is completed in February 2024. We will be responsible for making sure that your data will only be used for the purposes mentioned in this information sheet.

Participants Rights

You are under no obligation to accept this invitation. If you decide to participate in this study, you have the right to:

- Decline to answer any particular question;
- Withdraw from the study up until you submit your responses;
- Provide information on the understanding that your name will not be used;

- Be given access to a summary of the project's findings when it has been concluded.

Support Information

Australia

- Your GP, Psychologist, Counsellor, Psychiatrist, Recovery Coach
- Your support people, such as friends, or family
- The Butterfly Foundation – 1800 334 673, or online chat (8.00am-midnight)
- Lifeline – 13 11 14, text, and chat online (24/7)
- Beyond Blue – 1300 224 636, and chat online (24/7)
- SANE Australia – 1800 187 263, or chat online (10am-10pm Monday-Friday)
- Suicide Call Back Service – 1300 659 467 (24/7)
- QLife – 1800 184 527 (3pm-12am)

New Zealand

- Your GP, Psychologist, Counsellor, Psychiatrist, Recovery Coach
- Your support people, such as friends, or family
- Lifeline – 0800 543 354 (0800 LIFELINE) or free text 4357 (HELP)
- Youthline – 0800 376 633, free text 234 or email talk@youthline.co.nz or online chat. (up to 24 years of age).
- Samaritans – 0800 726 666
- Suicide Crisis Helpline – 0508 828 865 (0508 TAUTOKO).
- Healthline – 0800 611 116
- OutLine Aotearoa– 0800 688 5463

We greatly appreciate your consideration of this study, and we welcome your participation if you choose to partake in this important body of research. If you have any questions about the study, please feel welcome to reach out to either myself, or my supervisor, Dr Kathryn McGuigan, through the details outlined below:

Researcher: Samantha Fitzsimon-Spicer

Email: [REDACTED]

Supervisor: Dr Kathryn McGuigan

Email: K.Mcguigan@massey.ac.nz

Statement of Ethical Approval

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 2, Application OM2 23/19. If you have any concerns about the conduct of this research, please contact Associate Professor Fiona Te Momo, Chair, Massey University Human Ethics Ohu Matatika 2, telephone 09 414 0800 x 43347, email humanethics2@massey.ac.nz.

Participant Consent:

- ☐ I have read and understood the above project information. I consent to participate and for my anonymous data and information to be used for this project that is being undertaken by this research team.
- ☐ I have read and understood the above project information. I do not wish to partake in this study.

The following questions will ask you some basic non-identifiable questions about your personal details.

1. Please select your gender identity:

Female Male Gender Diverse Prefer not to say

2. Age (anyone below the age of 18 will be exited from the survey)

[In years]

3. Ethnicity

Aboriginal or Torres Strait Islander Caucasian/White/Pakeha Asian
African

New Zealand Māori Other

4. Do you identify as a part of the LGBTIQIA+ Community?

Yes No Prefer not to say

5. Which country did you permanently reside in when receiving **PRIVATE HOSPITAL** inpatient eating disorder treatment in Australia? (anyone outside of Australia and New Zealand will be exited from the survey)

Australia New Zealand Other

6. If you currently reside within Australia, which state do you normally reside in?

QLD NSW VIC ACT TAS SA WA NT OTHER
N/A

The following questions will ask you about your eating disorder history.

7. Have you ever been diagnosed with an eating disorder? (anyone who answers no will be exited from the survey)

Yes No

8. From the list of options below, please select the eating disorder or eating disorders that you have ever been diagnosed with:

Anorexia Nervosa Bulimia Nervosa Binge Eating Disorder
Orthorexia

Atypical Anorexia Nervosa Rumination Disorder ARFID PICA

Other Specified Feeding or Eating Disorder

9. If you selected “Other Specified Feeding or Eating Disorder”, please select the relevant diagnosis or diagnoses from the following options:

- Bulimia Nervosa of Low Frequency and/or Duration
- Binge Eating Disorder of Low Frequency and/or Duration
- Purging Disorder
- Night Eating Syndrome
- Unspecified Feeding or Eating Disorder

10. At what age do you remember first experiencing disordered eating (before receiving a formal eating disorder diagnosis)?

- | | | |
|----------------|----------------|----------------|
| Below 10 years | 10 to 13 years | 13 to 15 years |
| 15 to 18 years | 18 to 25 years | 25 to 30 years |
| 30 to 40 years | 40 to 50 years | 50 + years |

11. At what age were you formally diagnosed with an eating disorder?

- | | | |
|----------------|----------------|----------------|
| Below 10 years | 10 to 13 years | 13 to 15 years |
| 15 to 18 years | 18 to 25 years | 25 to 30 years |
| 30 to 40 years | 40 to 50 years | 50 + years |

The next questions will ask you about the duration of your eating disorder/s and eating disorder recovery.

Recovery from an eating disorder can mean different things for different people. For the purpose of this study, recovery is defined as yourself identifying that you are in a place of recovery currently. Please consider this definition before answering the follow questions.

12. Have you recovered from your eating disorder/s?

Yes No

13. What is the length of time that you have experienced an eating disorder (or disorders) for? If you have recovered, please select the applicable timeframe that you experienced an eating disorder for, from the options listed below:

- | | | | |
|------------------|--------------|--------------|--------------|
| Less than 1 year | 1 to 3 years | 3 to 5 years | 5 to 8 years |
| 8 to 10 years | 10+ years | | |

The following questions will ask you a variety of questions relating to **PRIVATE HOSPITAL** inpatient eating disorder treatment. As the purpose of this study is to assess the **PRIVATE HOSPITAL** inpatient eating disorder treatment across Australia, privatised

rehabilitation clinics, e.g., private treatment options that are **NOT** provided in a **PRIVATE HOSPITAL**, are not included in this study.

14. Have you ever received **PRIVATE HOSPITAL** inpatient eating disorder treatment within Australia? (If you answer no you will be exited from the survey)

Yes No

15. At what age were you first admitted for **PRIVATE HOSPITAL** inpatient eating disorder treatment within Australia?

16 to 18 years	18 to 25 years	25 to 30 years
30 to 40 years	40 to 50 years	50 + years

16. How many admissions have you had, or did you have, in total for **PRIVATE HOSPITAL** inpatient eating disorder treatment within Australia?

1	2	3	4	5
6	7	8	9	10+

17. At any point in your journey, did you have to travel from interstate, or overseas (New Zealand to Australia), to receive **PRIVATE HOSPITAL** inpatient eating disorder treatment within Australia?

Yes No

18. Which location did you travel **FROM** to receive to receive **PRIVATE HOSPITAL** inpatient eating disorder treatment within Australia?

QLD	NSW	VIC	TAS	NT	Other
SA	WA	ACT	New Zealand		

19. Which location/s did you travel **TO**, to receive **PRIVATE HOSPITAL** inpatient eating disorder treatment within Australia? (select all that apply)

QLD	NSW	VIC	WA
-----	-----	-----	----

20. If applicable, why did you have to travel from your place of residence to receive **PRIVATE HOSPITAL** inpatient eating disorder treatment?

Free type box

The following two questions will ask you specific questions regarding the **PRIVATE HOSPITAL (OR HOSPITALS)** that you have been admitted to for inpatient eating disorder treatment within Australia.

21. Please select the **PRIVATE HOSPITAL (OR HOSPITALS)** that you have been admitted to for inpatient eating disorder treatment within Australia (select all that apply):

- Ramsay Clinic New Farm, Brisbane, Queensland
- Robina Private Hospital, Gold Coast, Queensland
- Cooina Clinic, Buderim Private Hospital, Sunshine Coast, Queensland
- Ramsay Clinic Northside, St Leonards, New South Wales
- Ramsay Clinic Wentworthville, Wentworthville, New South Wales
- The Melbourne Clinic, Melbourne, Victoria
- The Geelong Clinic, Geelong, Victoria
- Ramsay Clinic Hollywood, Perth, Western Australia

22. Please indicate how many admissions that you have had by selecting the relevant option (or options if applicable) below:

- | | | | | |
|---|-------|-----|-----|----------------|
| ○ Ramsay Clinic New Farm, Brisbane, Queensland | | | | |
| 1 | 2 - 5 | 6-9 | 10+ | Not Applicable |
| ○ Robina Private Hospital, Gold Coast, Queensland | | | | |
| 1 | 2 - 5 | 6-9 | 10+ | Not Applicable |
| ○ Cooina Clinic, Buderim Private Hospital, Sunshine Coast, Queensland | | | | |
| 1 | 2 - 5 | 6-9 | 10+ | Not Applicable |
| ○ Ramsay Clinic Northside, St Leonards, New South Wales | | | | |
| 1 | 2 - 5 | 6-9 | 10+ | Not Applicable |
| ○ Ramsay Clinic Wentworthville, Wentworthville, New South Wales | | | | |
| 1 | 2 - 5 | 6-9 | 10+ | Not Applicable |
| ○ The Melbourne Clinic, Melbourne, Victoria | | | | |
| 1 | 2 - 5 | 6-9 | 10+ | Not Applicable |
| ○ The Geelong Clinic, Geelong, Victoria | | | | |
| 1 | 2 - 5 | 6-9 | 10+ | Not Applicable |
| ○ Ramsay Clinic Hollywood, Perth, Western Australia | | | | |
| 1 | 2 - 5 | 6-9 | 10+ | Not Applicable |

IMPORTANT: Please note, if you have selected multiple **PRIVATE HOSPITALS** in the prior two questions, you will be asked to complete the following questions for **EACH PRIVATE HOSPITAL**. The survey will provide you friendly reminders throughout each **PRIVATE HOSPITALS** survey, to assist you to remember which **PRIVATE HOSPITAL** you are providing answers to for each survey.

The following questions will ask you about how your connectiveness with your outpatient psychologist whilst you were inpatient.

23). I was encouraged to remain connected with my outpatient psychologist to continue one-to-one psychology sessions whilst I was inpatient:

Yes No Not Applicable, I had no outpatient psychologist

The following questions will ask you about your experience with **GROUP THERAPY** whilst you were inpatient.

24). Engagement in **GROUP THERAPY** was a mandatory component of my inpatient treatment (e.g., it was not optional):

Yes No

25). I feel that the **GROUP THERAPY** psychology sessions I attended whilst inpatient were relevant and helpful:

Strongly Disagree Disagree Neutral Agree Strongly Agree

26). I feel that the content of the **GROUP THERAPY psychology** sessions I attended whilst inpatient was outdated: (*Reverse Score*).

Strongly Disagree Disagree Neutral Agree Strongly Agree

27). I feel that the content of the **GROUP THERAPY** psychology sessions I attended whilst inpatient was generic: (*Reverse Score*).

Strongly Disagree Disagree Neutral Agree Strongly Agree

28). I feel that the **GROUP THERAPY dietetic** sessions I attended whilst inpatient were relevant and helpful:

Strongly Disagree Disagree Neutral Agree Strongly Agree

29). I feel that the content of the **GROUP THERAPY** dietetics sessions I attended whilst inpatient was outdated: (*Reverse Score*).

Strongly Disagree Disagree Neutral Agree Strongly Agree

30). I feel that the content of the **GROUP THERAPY** dietetics sessions I attended whilst inpatient was generic: (*Reverse Score*).

Strongly Disagree Disagree Neutral Agree Strongly Agree

31). In general, I found that the **GROUP THERAPY** sessions targeted towards eating disorder treatment were helpful and beneficial:

Yes No

32). I was able to attend other **GROUP THERAPY** options relevant to my broader mental health, that were not specifically regarding eating disorder related treatment:

Yes No

33). In general, I found that the **GROUP THERAPY** options targeted towards my broader mental health were helpful and beneficial (if applicable)

Yes No

The following questions will ask you specific questions regarding your experience with your **PSYCHIATRIST** whilst you were inpatient.

34). On average, how many one-to-one sessions per week did you have with your **PSYCHIATRIST** whilst you were inpatient?

Free type box

35). I feel that I had had regular one-to-one sessions with my **PSYCHIATRIST** whilst I was inpatient:

Strongly Disagree Disagree Neutral Agree Strongly Agree

36). I feel that the regularity of the one-to-one sessions I had with my **PSYCHIATRIST** whilst I was inpatient was adequate:

Strongly Disagree Disagree Neutral Agree Strongly Agree

37). I would have liked to have seen my **PSYCHIATRIST** more regularly whilst I was inpatient:

Strongly Disagree Disagree Neutral Agree Strongly Agree

38). I felt heard by my **PSYCHIATRIST**:

Strongly Disagree Disagree Neutral Agree Strongly Agree

39). I feel that my **PSYCHIATRIST** involved me in decision making regarding my care whilst I was inpatient:

Strongly Disagree Disagree Neutral Agree Strongly Agree

40). I feel that the treatment I received from my **PSYCHIATRIST** was individualised to suit my unique presentation, needs, and preferences:

Strongly Disagree Disagree Neutral Agree Strongly Agree

41). I feel that the communication between with my **PSYCHIATRIST** and I whilst I was inpatient was satisfactory:

Strongly Disagree Disagree Neutral Agree Strongly Agree

42). I feel that the communication between with my **PSYCHIATRIST** and the broader inpatient team (e.g., nursing staff) regarding my care was satisfactory:

Strongly Disagree Disagree Neutral Agree Strongly Agree

43). I feel that my **PSYCHIATRIST** was willing to collaborate with my outpatient team (e.g., my psychologist in the community) whilst I was inpatient:

Strongly Disagree Disagree Neutral Agree Strongly Agree

44). I feel that my **PSYCHIATRIST** had sufficient knowledge in the area of my specific eating disorder/s:

Strongly Disagree Disagree Neutral Agree Strongly Agree

45). I feel that my **PSYCHIATRIST** installed hope that I could recover:

Strongly Disagree Disagree Neutral Agree Strongly Agree

46). Overall, I was satisfied with the care I received from my **PSYCHIATRIST** whilst I was inpatient:

Yes No

The following questions will ask you specific questions regarding your experience with one-to-one **PSYCHOLOGY** whilst you were inpatient.

47). I was provided with one-to-one **PSYCHOLOGY** sessions with a hospital provided **PSYCHOLOGIST** whilst I was inpatient:

Yes No

48). On average, how many one-to-one sessions per week did you have with a hospital provided **PSYCHOLOGIST** whilst you were inpatient?

Free type box

49). I feel that I was provided with regular one-to-one **PSYCHOLOGY** sessions with a hospital provided **PSYCHOLOGIST** whilst I was inpatient:

Strongly Disagree Disagree Neutral Agree Strongly Agree

Not Applicable

50). I feel satisfied with the regularity of the one-to-one **PSYCHOLOGY** sessions I had with a hospital provided **PSYCHOLOGIST** whilst I was inpatient:

Strongly Disagree Disagree Neutral Agree Strongly Agree

Not Applicable

51). I would have liked to have more one-to-one **PSYCHOLOGY** sessions with a hospital provided **PSYCHOLOGIST** whilst I was inpatient:

Strongly Disagree Disagree Neutral Agree Strongly Agree

Not Applicable

52). I found my one-to-one **PSYCHOLOGY** sessions with a hospital provided **PSYCHOLOGIST** helpful and beneficial:

Strongly Disagree Disagree Neutral Agree Strongly Agree

Not Applicable

53). I feel that the **PSYCHOLOGIST/S** that provided me with one-to-one **PSYCHOLOGY** sessions whilst I was inpatient had sufficient knowledge in the area of my specific eating disorder/s:

Strongly Disagree Disagree Neutral Agree Strongly Agree

Not Applicable

54). I feel that the **PSYCHOLOGIST/S** installed hope that I could recover:

Strongly Disagree Disagree Neutral Agree Strongly Agree

Not Applicable

55). Overall, I was satisfied with the one-to-one **PSYCHOLOGY** sessions I had with a hospital provided **PSYCHOLOGIST/S** whilst I was inpatient:

Yes No

The following questions will ask you specific questions regarding your experience with one-to-one **DIETETICS** whilst you were inpatient.

56). I was provided with one-to-one **DIETETICS** sessions with a hospital provided **DIETICIAN** whilst I was inpatient:

Yes No

57). On average, how many one-to-one sessions per week did you have with a hospital provided **DIETICIAN** whilst you were inpatient?

Free type box

58). I feel that I was provided with regular one-to-one **DIETETICS** sessions with a hospital provided **DIETICIAN** whilst I was inpatient:

Strongly Disagree Disagree Neutral Agree Strongly Agree

Not Applicable

59). I feel satisfied with the regularity of the one-to-one **DIETETICS** sessions I had with a hospital provided **DIETICIAN** whilst I was inpatient:

Strongly Disagree Disagree Neutral Agree Strongly Agree

Not Applicable

60). I would have liked to have more one-to-one **DIETETICS** sessions with a hospital provided **DIETICIAN** whilst I was inpatient:

Strongly Disagree Disagree Neutral Agree Strongly Agree

Not Applicable

61). I found my one-to-one **DIETETICS** sessions with a hospital provided **DIETICIAN** helpful and beneficial:

Strongly Disagree Disagree Neutral Agree Strongly Agree

Not Applicable

62). I feel that the **DIETICIAN/S** that provided me with one-to-one **DIETETICS** sessions whilst I was inpatient had sufficient knowledge in the area of my specific eating disorder/s:

Strongly Disagree Disagree Neutral Agree Strongly Agree

Not Applicable

63). I feel that the **DIETICIAN/S** installed hope that I could recover:

Strongly Disagree Disagree Neutral Agree Strongly Agree

Not Applicable

64). Overall, I was satisfied with the one-to-one **DIETETICS** sessions I had with a hospital provided **DIETICIAN/S** whilst I was inpatient:

Yes No

The following questions will ask you specific questions regarding your experience with **EXERCISE PHYSIOLOGY** whilst you were inpatient.

65). This **PRIVATE HOSPITAL** had an **EXERCISE PHYSIOLOGIST** as a part of the inpatient eating disorder treatment team:

Yes No

66). Overall, I was satisfied with the **EXERCISE PHYSIOLOGY** education I had with a hospital provided **EXERCISE PHYSIOLOGIST** whilst I was inpatient:

Yes No Not Applicable

67). I feel that having access to an **EXERCISE PHYSIOLOGIST** whilst I was inpatient to learn how to move my body in suitable way during the different stages of eating disorder treatment and eating disorder recovery would have been beneficial to my journey:

Yes No

The following questions will ask you specific questions regarding your experience with **NURSES** whilst you were inpatient.

68). The **NURSES** on the inpatient eating disorders program displayed sufficient knowledge in the realm of eating disorders:

Strongly Disagree Disagree Neutral Agree Strongly Agree

69). The **NURSES** on the inpatient eating disorders program provided me with adequate care during challenging times:

Strongly Disagree Disagree Neutral Agree Strongly Agree

70). I feel that the **NURSES** installed hope that I could recover:

Strongly Disagree Disagree Neutral Agree Strongly Agree

71). Overall, I was satisfied with the **NURSING** care I received whilst I was inpatient:

Yes

No

Well done! You are over halfway through the survey! We thank you greatly for your time thus far, and the time to continue to answer the remainder of the survey questions - Your experiences matter!

The following questions will ask you specific questions regarding your experience with your **MEAL PLANS** whilst you were inpatient.

72). I feel that the variety of food on my **MEAL PLANS** whilst I was inpatient plan was adequate:

Strongly Disagree

Disagree

Neutral

Agree

Strongly Agree

73). I would have liked more variety on my **MEAL PLANS** whilst I was inpatient:

Strongly Disagree

Disagree

Neutral

Agree

Strongly Agree

74). I feel that I was able to collaborate with the dietician/s to contribute to some of the decisions regarding my **MEAL PLANS**:

Strongly Disagree

Disagree

Neutral

Agree

Strongly Agree

75). I feel that my **MEAL PLANS** were generic and that it was not customised to my presentation, unique needs, and individual (non-eating disordered) related preferences: *(Reverse Score)*.

Strongly Disagree

Disagree

Neutral

Agree

Strongly Agree

76). I feel that my **MEAL PLANS** helped me to engage in a regular pattern of eating whilst I was inpatient:

Strongly Disagree

Disagree

Neutral

Agree

Strongly Agree

77). I feel that my **MEAL PLANS** helped me to try new foods and fear foods whilst I was inpatient:

Strongly Disagree

Disagree

Neutral

Agree

Strongly Agree

78). Overall, I am satisfied with the **MEAL PLAN** experiences I had whilst I was inpatient:

Yes

No

The following questions will ask you specific questions regarding your experience with supervised eating on the inpatient eating disorder program **TABLE**:

79). I feel that I was supported by staff (e.g., nurses, psychologists, dieticians) on the **TABLE** whilst I was inpatient:

Strongly Disagree Disagree Neutral Agree Strongly Agree

80). I feel that staff addressed eating disordered behaviours displayed by patients whilst on the **TABLE** adequately:

Strongly Disagree Disagree Neutral Agree Strongly Agree

81). I feel that staff addressed patient distress whilst on the **TABLE** adequately:

Strongly Disagree Disagree Neutral Agree Strongly Agree

82). I feel that I was provided encouragement and support from staff during moments of struggle whilst on the **TABLE**:

Strongly Disagree Disagree Neutral Agree Strongly Agree

83). I feel as though I **WAS** prepared enough to be transitioned **OFF THE TABLE** whilst inpatient:

Strongly Disagree Disagree Neutral Agree Strongly Agree

84). Overall, I was satisfied with the care I received from staff whilst on the **TABLE**:

Yes No

The following questions will ask you specific questions regarding your experience with **AFTER MEAL SUPPORT** whilst you were inpatient.

85). I feel that staff provided me with adequate support during **AFTER MEAL SUPPORT**:

Strongly Disagree Disagree Neutral Agree Strongly Agree

86). I feel that staff encouraged the engagement in appropriate, relevant, and helpful distraction activities during **AFTER MEAL SUPPORT**.

Strongly Disagree Disagree Neutral Agree Strongly Agree

87). I feel that staff addressed eating disordered behaviours during **AFTER MEAL SUPPORT** adequately:

Strongly Disagree Disagree Neutral Agree Strongly Agree

88). I feel that staff addressed patient distress during **AFTER MEAL SUPPORT** adequately:

Strongly Disagree Disagree Neutral Agree Strongly Agree

89). Overall, I was satisfied with the care I received from staff during **AFTER MEAL SUPPORT**:

Yes No

The following questions will ask you specific questions regarding your experience with **SOCIAL EATING, FOOD PREPARATION, and INDEPENDENT EATING** whilst you were inpatient.

90). I was provided with adequate opportunities to engage in **SOCIAL EATING** outside of the hospital when I was inpatient:

Strongly Disagree Disagree Neutral Agree Strongly Agree

91). I was provided with opportunities to engage in **FOOD PREPARATION** whilst I was inpatient:

Strongly Disagree Disagree Neutral Agree Strongly Agree

92). I feel as though the time that I spent on **INDEPENDENT EATING** was sufficient prior to my discharge:

Strongly Disagree Disagree Neutral Agree Strongly Agree

93). I feel that **INDEPENDENT EATING** gave me an opportunity to practice my skills prior to my discharge:

Strongly Disagree Disagree Neutral Agree Strongly Agree

The following questions will ask you specific questions regarding your experience with **WEIGHT IN'S** whilst you were inpatient.

94). How were you **WEIGHED** during your inpatient admission/s:

Blind weigh (unable to see my weight)	I was able to see my weight
A combination of blind and visible weighs	I wasn't weighed

95). What approach to **WEIGH IN'S** do you prefer:

Blind weigh (unable to see my weight)

Visible weigh in's

A combination of blind and visible weighs

No weigh in's

96). Why do you prefer this approach to **WEIGH IN'S**?

Free type box

Prefer not to answer

97). What were you required to wear during your **WEIGH IN'S**? (Please select all options that apply from the list below).A hospital provided gown
box)

My underwear

Other (free type

General clothing (e.g., pyjamas
or a usual outfit)

Not applicable, I wasn't weighed

98). I feel as though my **WEIGH IN'S** were conducted by staff in a professional, informed, and supportive manner:

Strongly Disagree

Disagree

Neutral

Agree

Strongly Agree

Not Applicable (I was not weighed)

99). I feel as though staff provided me with adequate support if I required it after my **WEIGH IN'S**:

Strongly Disagree

Disagree

Neutral

Agree

Strongly Agree

Not Applicable (I was not weighed)

100). The outcome of my **WEIGH IN'S** were addressed by my **PSYCHIATRIST** in a professional and supportive manner:

Strongly Disagree

Disagree

Neutral

Agree

Strongly Agree

Not Applicable (I wasn't weighed)

101). The outcome of my **WEIGH IN'S** were addressed by the **DIETICIAN/S** in a professional and supportive manner:

Strongly Disagree

Disagree

Neutral

Agree

Strongly Agree

Not Applicable (I wasn't weighed)

Not Applicable (The Dietician/s didn't address the outcome of my **WEIGH IN'S**)

102). Overall, I was satisfied with the **WEIGH IN'S** experiences whilst I was inpatient:

Yes No

The following questions will ask you specific questions regarding your experience with the **DISCHARGE PROCESS** whilst you were inpatient.

103). I feel that adequate **DISCHARGE PLANNING** was completed by my treatment team prior to my **DISCHARGE/S**:

Strongly Disagree Disagree Neutral Agree Strongly Agree

104). I feel that my treatment team actively involved me in **DISCHARGE** planning:

Strongly Disagree Disagree Neutral Agree Strongly Agree

105). I feel that the dietician/s helped me to prepare a meal plan to transition to when I was **DISCHARGED** from hospital:

Strongly Disagree Disagree Neutral Agree Strongly Agree

106). I feel that I was advised, with sufficient notice, the anticipated timeframe of my **DISCHARGE**:

Strongly Disagree Disagree Neutral Agree Strongly Agree

107). I feel that I was **DISCHARGED** too early: (*reverse score*)

Strongly Disagree Disagree Neutral Agree Strongly Agree

108). My psychiatrist ensured that I had community supports (e.g., psychologist, dietician, recovery coach, outpatient day program) in place for my eventual **DISCHARGE**:

Strongly Disagree Disagree Neutral Agree Strongly Agree

109). I feel that the **DISCHARGE** process was made a meaningful experience for me (e.g., my wins were celebrated).

Strongly Disagree Disagree Neutral Agree Strongly Agree

110). Overall, I was satisfied with the **DISCHARGE** process at this **PRIVATE HOSPITAL**:

Yes No

The following questions will ask you to consider your **OVERALL EXPERIENCE** with your treatment at this **PRIVATE HOSPITAL's** inpatient eating disorder program.

111). I feel that the treatment I received was customised to my individual presentation, unique needs, and preferences:

Strongly Disagree Disagree Neutral Agree Strongly Agree

112). I feel that the treatment I received was generic (e.g., the same for everyone) (*Note: Reverse Score*)

Strongly Disagree Disagree Neutral Agree Strongly Agree

113). I feel that my voice was heard, and that I actively contributed to decision making regarding my care during my admission/s?

Strongly Disagree Disagree Neutral Agree Strongly Agree

114). I feel that a holistic and strengths-based approach to my treatment was taken:

Strongly Disagree Disagree Neutral Agree Strongly Agree

115). I feel that my inpatient eating disorder treatment at this **PRIVATE HOSPITAL** will help me to/or has helped me to, recover from my eating disorder/s:

Strongly Disagree Disagree Neutral Agree Strongly Agree

116). If I needed to return to inpatient eating disorder treatment again in the future, I would feel content coming back to this **PRIVATE HOSPITAL:**

Yes No

117). I would recommend this **PRIVATE HOSPITAL'S** inpatient eating disorder program to others:

Yes No

118). Overall, I am satisfied with my experience as a patient on the inpatient eating disorder program at this **PRIVATE HOSPITAL:**

Yes No

The next three questions provide you with an opportunity to share your experience, in your own words. We consider the role and voice of lived experience as immensely important and valuable, and YOUR insights into YOUR treatment matter. If you do not wish to share your experiences in your own words, please feel welcome to skip over questions 119, 120, and 121, and finish off the home stretch of the survey!

119). In your own words, describe your experience at this **PRIVATE HOSPITAL'S** inpatient eating disorder program (250-word limit) (optional).

Free type box for participants

120). In your own words, what would you like to change about this **PRIVATE HOSPITAL'S** inpatient eating disorder program: (250-word limit) (optional).

Free type box for participants

121). In your own words, what message would you send to another person who was considering an admission to this **PRIVATE HOSPITAL'S** inpatient eating disorder program: (250-word limit) (optional).

Free type box for participants

You are on the home stretch! Less than 5 minutes to go! Thank you very much for your time!

The following questions will ask you about important individual's factors that may be applicable to you, such as **CULTURE, GENDER IDENTITY, LGBTIQ+ identification, and RELIGION.**

122). I feel that my treatment was delivered in a **CULTURALLY** appropriate manner:

Yes No Not Applicable

123). I identify as **GENDER DIVERSE**, and I feel that my treatment was delivered in an appropriate manner (e.g., correct use of pronouns, not deadnaming):

Yes No Not Applicable

124). I identify as a part of the **LGBTIQ+ Community**, and I feel that my treatment was delivered in a safe and considerate manner:

Yes No Not Applicable

125). I feel that my treatment was delivered in a manner that considered my **RELIGION**:

Yes No Not Applicable

The following questions will ask you about your **BROADER MENTAL HEALTH**, and how this was, or was not, considered as a part of your inpatient eating disorder treatment at this **PRIVATE HOSPITAL**:

126). Have you been diagnosed with any of the following? (please select all that apply):

- No - I don't have any other mental health related conditions

Those who answer no will be bumped by Qualtrics to the **CHRONIC HEALTH** section.

- Trauma related disorder (e.g., Post Traumatic Stress Disorder, Adjustment Disorders)
- Personality related disorder (e.g., Borderline Personality Disorder)
- Dissociative related disorder (e.g., Dissociate Identity Disorder)
- Anxiety related disorder (e.g., Generalised Anxiety Disorder, Panic Disorder)
- Depressive related disorder (e.g., Major Depression)
- Bipolar related disorder (e.g., Bipolar Affective Disorder)
- Schizophrenia Spectrum or Other Psychotic related disorder (e.g., Schizophrenia, Catatonia)
- A Neurodevelopmental related disorder (e.g., Autism Deficit Disorder, Attention Deficit Hyperactivity Disorder, Intellectual Disability)
- Obsessive Compulsive and related disorders (e.g., Obsessive-Compulsive Disorder, Body Dysmorphic Disorder)
- Somatic Symptom and related disorders (e.g., Illness Anxiety Disorder, Conversion Disorder)
- Elimination related disorder (e.g., Encopresis)
- Sleep-Wake related disorder (e.g., Insomnia Disorder)
- Disruptive, Impulsive Control, and Conduct related disorders (e.g., Oppositional Defiant Disorder, Conduct Disorder)
- Neurocognitive related disorder (e.g., Mild or Major Neurocognitive Disorder)
- **Other** (free type box will be available for participants)

127). Do you feel that the other diagnosis or diagnoses you have just selected in question **126** were treated in conjunction with your eating disorder, as a whole of person approach to treatment, whilst receiving inpatient eating disorder treatment at this **PRIVATE HOSPITAL?**

Yes No

128). Do you feel as though your eating disorder has been the sole focus of your admission, and your other relevant mental health related diagnosis (or diagnoses) and associated symptoms that you experience have been negatively impacted as a result?

Yes No

129). Do you feel that you would have benefited from a more holistic approach to treating your broader mental health whilst receiving inpatient eating disorder treatment at this **PRIVATE HOSPITAL?**

Yes No

130). Do you feel as though you would be better equipped to manage your eating disorder in the community if a more holistic approach to treating your broader mental health whilst receiving inpatient eating disorder treatment at this **PRIVATE HOSPITAL** was taken?

Yes No

The following questions will ask if you experience a **CHRONIC HEALTH CONDITION** and how this was, or was not, considered as a part of your inpatient eating disorder treatment at this **PRIVATE HOSPITAL:**

131). Have you been diagnosed with a **CHRONIC HEALTH CONDITION** (or conditions)?

Yes No

Those who answer no will be bumped by Qualtrics to the **DISABILITY** section.

132). What **CHRONIC HEALTH CONDITION/s** have you been diagnosed with?

Free type box

Prefer not to answer

133). Do you feel as though your **CHRONIC HEALTH CONDITIONS** (or conditions) were treated in conjunction with your eating disorder, as a whole of person approach to treatment, whilst receiving inpatient eating disorder treatment at this **PRIVATE HOSPITAL?**

Yes No

134). Do you feel as though your eating disorder has been the sole focus of your admission, and your **CHRONIC HEALTH CONDITIONS** (or conditions) and associated symptoms that you experience have suffered as a result?

Yes No

135). Do you feel as though you would be better equipped to manage your eating disorder in the community if a more holistic approach to treating your broader health (including **CHRONIC HEALTH CONDITION(S)**) whilst receiving inpatient eating disorder treatment at this **PRIVATE HOSPITAL?**

Yes No

The following questions will ask if you experience a **DISABILITY** and how this was, or was not, considered as a part of your inpatient eating disorder treatment at this **PRIVATE HOSPITAL:**

136). Have you been diagnosed with a **DISABILITY or DISABILITIES?**

Yes No

Those who answer no will be bumped by Qualtrics to the post survey participant well-being message.

137). What **DISABILITY or DISABILITIES** have you been diagnosed with?

Free type box

Prefer not to answer

138). Do you feel as though your **DISABILITY or DISABILITIES** were treated in conjunction with your eating disorder, as a whole of person approach to treatment, whilst receiving inpatient eating disorder treatment at this **PRIVATE HOSPITAL?**

Yes No

139). Do you feel as though your eating disorder has been the sole focus of your admission, and your **DISABILITY or DISABILITIES** and associated symptoms that you experience have suffered as a result?

Yes No

140). Do you feel as though you would be better equipped to manage your eating disorder in the community if a more holistic approach to treating your broader health (including **DISABILITY or DISABILITIES**) whilst receiving inpatient eating disorder treatment at this **PRIVATE HOSPITAL?**

Yes No Not Applicable

Participants who have selected multiple hospitals will then be sent to the next survey which will have reminders of which hospital they will then be reviewing a second, third time etc.

Note: Participants select each hospital at the top of the survey, and then Qualtrics will link them into each survey with a name prompt throughout 😊

Safety and Well-Being Message for Participants

If you are experiencing, or anticipate experiencing, any distress as a result of completing this survey, we would encourage you to please reach out to the following supports:

Support Information

Australia

- Your GP, Psychologist, Counsellor, Psychiatrist, Recovery Coach
- Your support people, such as friends, or family

- The Butterfly Foundation – 1800 334 673, or online chat (8.00am-midnight)
- Lifeline – 13 11 14, text, and chat online (24/7)
- Beyond Blue – 1300 224 636, and chat online (24/7)
- SANE Australia – 1800 187 263, or chat online (10am-10pm Monday-Friday)
- Suicide Call Back Service – 1300 659 467 (24/7)
- QLife – 1800 184 527 (3pm-12am)

New Zealand

- Your GP, Psychologist, Counsellor, Psychiatrist, Recovery Coach
- Your support people, such as friends, or family
- [Lifeline](#) – 0800 543 354 (0800 LIFELINE) or free text 4357 (HELP)
- [Youthline](#) – 0800 376 633, free text 234 or email talk@youthline.co.nz or online chat. (up to 24 years of age).
- [Samaritans](#) – 0800 726 666
- [Suicide Crisis Helpline](#) – 0508 828 865 (0508 TAUTOKO).
- [Healthline](#) – 0800 611 116
- [OutLine](#) Aotearoa– 0800 688 5463

End of Survey Participant Message

Thank you for completing this survey! Your time has been greatly appreciated! Importantly, your voice and your experience matters, and we hope that by completing this survey, you realise that your experience will hopefully be able to guide future recommendations to foster improvements in the eating disorder treatment space.

If you have any questions about the study, please feel welcome to reach out to either myself, or my supervisor, Dr Kathryn McGuigan, through the details outlined below:

Researcher: Samantha Fitzsimon-Spicer

Email: [REDACTED]

Supervisor: Dr Kathryn McGuigan

Email: K.Mcguigan@massey.ac.nz

Optional Prize Draw!

If you would like to go into the draw to win one of six \$50.00 online gift cards, please enter your email address below. Upon completing an anonymous draw, if

you are selected, you will be notified via email. Please note, your email address will be stored separately to your survey responses to ensure anonymity.

Email box

Optional Research Summary

If you would like to receive a research summary of the study outcomes, at the completion of the research project, please provide your email below. Please note, your email address will be stored separately to your survey responses to ensure anonymity.

Email box
