

Breaking Fragmentation, Building Recovery: An Integrated Approach to Value-Based Eating Disorder Care at the Esus Centre in Western Australia

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Key takeaways

- **The criss context:** Eating disorders carry the highest mortality rate of any psychiatric illness after opioid use disorder, but care models are ineffective and highly fragmented.
- **Integrated care:** Esus Centre combines medical, psychological, and nutritional support under one roof to eliminate fragmented treatment.
- **Seamless transitions:** 80% of patients safely step down from the day program to outpatient care with the exact same clinical team.
- **Proven clinical success:** 2025 data show significant weight restoration alongside major drops in anxiety, depression, and eating disorder symptoms.
- **Patient-driven agility:** Use of real-time feedback allows Esus Centre to rapidly launch specialized care
- **Affordable hospital substitute:** This approach delivers high-intensity care at a rate lower than traditional inpatient stays.

1. Background

Over a million Australians are living with an eating disorder right now; fewer than one in three will receive any treatment.(1-4) Of those who do, most will encounter a healthcare system organized around the needs of providers rather than the logic of recovery - geographically fragmented, poorly coordinated, and structurally incapable of the continuity that effective treatment requires.(1, 5) This is not a peripheral failure. Eating disorders carry the highest mortality rate of any psychiatric illness after opioid use disorder, and globally an estimated 55.5 million individuals are affected, with illness persisting in at least a third of patients after treatment.(1, 6) In Australia, prevalence has risen by 21% since 2012, and among young people aged 10–19, by 86%.(1-3) The economic burden reaches AU\$18.1 billion in annual productivity costs and AU\$251 million in direct healthcare expenditure.(4, 7) The crisis is large and the evidence base is clear; yet the systems response has remained, for most patients, inadequate.

Western Australia has not been immune to these trends. In recognition of the growing need in this area, the Western Australian Mental Health Commission released the Western Australian Eating Disorders Framework 2025–2030 which calls for a statewide coordinated approach to prevention, early intervention, treatment, and support services.(7) The Framework explicitly identifies fragmentation of care as a central barrier to effective treatment.(7) In Australia, outpatient services are subsidized by the federal government, while hospital-based care is

funded through state systems or private health insurance, creating a split-funding environment that complicates care coordination and continuity.⁽⁸⁾ Patients are frequently discharged from hospital into fragmented outpatient services where they must see their general practitioner, psychologist, and dietitian in separate locations. Critically, there is often limited communication between providers and the patient is left to coordinate their own care.^(9, 10)

The evidence base for day programs as an effective alternative to inpatient treatment for eating disorders has been growing. A systematic review of 21 day programs for children and adolescents found them effective in restoring body weight, reducing eating disorder symptoms, and addressing comorbid mental health concerns; with improvements usually maintained from three months to two years post-treatment.⁽¹¹⁾ A separate scoping review of adolescent day program models concluded that day programs are an effective alternative to inpatient treatment, achieving equivalent outcomes in weight gain at 12 months from the start of treatment.⁽¹²⁾ Yet, few centers have implemented a truly integrated model where all required disciplines operate under a single roof, share a common medical record, and provide seamless transitions between intensive and outpatient care.

It was against this backdrop that the Esus Centre was established in Perth, Western Australia in March 2024. Founded by Dr. Vash Singh, together with Kerry Mairs (Clinical Director) and Rebecca Godin (Director of Nursing), the Centre was conceived as a hospital substitution model: a licensed day hospital that could deliver the intensity of inpatient care without the disruption of hospitalization, with patients then transitioning to outpatient care within the same organization. The pitch to private health insurers was direct, this integrated model would keep patients out of hospital while delivering superior outcomes. As Dr. Singh explained: “We had to prove our assertion that this model is clinically and financially superior to what currently stands as treatment as usual.”

From its inception, the Esus Centre embedded routine outcomes measurement into every aspect of clinical care. As Kerry Mairs noted: “We put a lot of time into it in the beginning to go, we really want to have good data to prove what we’re doing, because it was so innovative.” The outcomes collected by the team are heavily aligned with those identified in the literature as best practice, including the ICHOM Eating Disorders Set as published in *The Lancet Psychiatry*.^(13, 14) Additionally, Esus Centre has recognized that by engaging with the ICHOM ecosystem there is opportunity for further development in the care they deliver. This case study outlines the inspiring story of where Esus Centre has come from, why their innovative model of care is so effective, and how their commitment to continuous improvement is driving them forward as a leading example in integrated care.

2. Implementation

2.1 Outcomes as a foundation

Esus Centre operates two high-intensity day hospital programs. The Intensive Treatment Program (ITP) serves patients aged 16 years and over, while the Adolescent Intensive Treatment Program (AITP) serves patients aged 12 to 18 years. Both programs are designed for individuals requiring intensive, multidisciplinary intervention for eating disorders within an integrated day hospital setting. Patients enrolled in the intensive day hospital programs attend five hours per day, five days per week, over a six-week treatment period. The ITP commenced

in March 2024 and the AITP followed in July 2024, once the outcomes measurement processes had been fully embedded and tested through the ITP pilot.

The implementation of outcomes measurement was woven into the fabric of these services from the outset. Between December 2023 and March 2024, before the first patient was admitted, the team established the governance framework for routine outcomes collection. They selected core outcome measures, designed data collection workflows, trained clinical staff, and configured the electronic medical record (EMR) platform to support data capture. This preparatory phase was critical. As Dr. Singh described: “We spent a lot of time when we were planning Esus, in Kerry’s dining room before we had a building, really thinking and researching what other places had done in terms of outcomes.”

A full suite of clinician- and patient-reported outcomes and case-mix variables are collected at admission and discharge. Prior to admission, patients receive an email containing links to the relevant surveys, which they can complete on their mobile phone or on an iPad provided upon arrival. Completed surveys are automatically uploaded to the EMR, where clinicians can review them. The patient-reported outcome measures (PROMs) used differ slightly between the two programs to reflect the clinical needs and developmental stages of each population. In the ITP, patients complete the Eating Disorder Examination Questionnaire (EDE-Q), the Clinical Impairment Assessment Questionnaire (CIA), the Patient Health Questionnaire-9 (PHQ-9), the Generalized Anxiety Disorder-7 (GAD-7), and the Compulsive Exercise Test (CET). For patients with avoidant/restrictive food intake disorder, the Pica, the Avoidant Restrictive Food Intake Disorder (ARFID), and the Rumination Disorder Interview (PARDI-AR-Q) is also administered. In the AITP, the EDE-Q, PHQ-9, CET, and the Revised Children’s Anxiety and Depression Scale (RCADS) are used for adolescent patients, while parents complete the Burden Assessment Scale (BAS) and the RCADS-Parent version.

Kerry Mairs explained the rationale for the parent-reported measures: “The adolescent program utilizes a family-based model of treatment, which is superior to any other treatment modality in young people with eating disorders. However, what is asked of parents is significant and The Burden Assessment Scale captures the strain on parents and the impact on the family of caring for someone with a mental illness”. The RCADS gives us both a parent and child report on symptoms of depression and anxiety, which is important because you do get discrepancies between parent and child reports.” The Compulsive Exercise Test was included because, as Mairs noted, “it is very rare in restrictive eating disorders that you won’t have an aspect where restriction is facilitated by compulsive exercise. It’s a significant part of many presentations.”

Clinician-reported outcome measures include patient weight, Health of the Nation Outcome Scales, resumption of menses, and general vital status. Case-mix variables span demographic factors (year of birth, sex, sexual orientation, gender identity, living arrangements, education level, Indigenous status, work status); baseline health status, clinical, and historical factors (age at eating disorder onset, previous hospitalizations, adverse childhood experiences, diagnosis, BMI, comorbidities, weight suppression, alcohol and tobacco use, motivation to change); and treatment-related factors (intervention setting and type). These data elements are captured across multiple touchpoints during the admission process and documented in the patient’s Comprehensive Care Plan which is completed within five days of admission, reviewed every three weeks, and updated at discharge. Many of the case-mix variables and clinician-reported outcomes are collected once or twice a week.

2.2 Consumer involvement

Consumer involvement at the Esus Centre goes beyond regulatory compliance. While Australian healthcare accreditation standards require consumer participation, Esus leadership has embedded it as a foundational principle. Outcome measures and aggregated data are reviewed with consumers through the Patient Experience and Clinical Excellence Committee (PEACE) and the Consumer Advisory Group (CAG) on a quarterly basis. At the individual level, outcome data inform clinical reviews and are discussed with patients to support collaborative care and shared understanding of progress.

The Health Outcomes Committee (HOC), established as part Esus Centre's increased involvement in the ICHOM ecosystem, is a multidisciplinary team that includes senior clinical leaders, representatives across disciplines, an administrative team member, and a person with lived experience. The committee is charged with guiding the continued development of their patient-centered outcomes framework that is clinically meaningful, aligned with international standards, and valuable to patients, families, clinicians, and the broader community.

What distinguishes Esus Centre's approach is the depth of clinical leadership engagement. Dr. Singh, Kerry Mairs, and Rebecca Godin all work clinically in the programs they oversee. "So often in a hospital setting, management and decision-makers have clinical representation, but they are not necessarily the clinicians working in the business," Mairs observed. "We get feedback all the time because we are so entrenched in the clinical operations. When one of your patients says 'I felt like my discharge was more anxiety-provoking than it needed to be,' you take it to the multidisciplinary team and say what happened here? What do we need to do?"

This agility has led to rapid service development in direct response to patient feedback. When parents of adolescent patients reported feeling overwhelmed and struggling with their own emotional regulation, the Centre developed a parent program within weeks. When patients with ARFID indicated that the existing program did not fully meet their needs, a specialized ARFID program was created. "We pivot often when we have feedback," Godin noted. "We can just go: we have a need, we have feedback, we take it to our clinicians and our Consumer Advisory Group and we say let's go and make a change."

2.3 Two programs, one integrated model

A central concept in value-based healthcare is the Integrated Practice Unit (IPU): a dedicated, multidisciplinary team organized around a medical condition (or a family of closely related conditions) that takes responsibility for the full cycle of care; from prevention and diagnosis through treatment, rehabilitation, and long-term follow-up.⁽¹⁵⁾ The IPU was first articulated by Porter and Teisberg in *Redefining Health Care*⁽¹⁵⁾ and has since been developed across a range of conditions.^(16, 17) In Porter's framework, IPUs are the structural answer to the fragmentation that drives poor outcomes and high costs in conventional, specialty-organized care delivery; they re-organize care around what *patients have* rather than around what *providers happen to do*.^(15, 18)

Eating disorders are an unusually clear test case for the IPU framework. Effective treatment is inherently multidisciplinary, requiring concurrent medical stabilization, psychiatric care, nutritional rehabilitation, and psychological intervention.^(2, 17) Separate but closely related

conditions of anorexia nervosa, bulimia nervosa, binge eating disorder, ARFID, and other specified feeding and eating disorders all draw on common clinical infrastructure. Yet in most health systems this infrastructure does not exist as a single organizational entity with care instead being dispersed geographically, lacking in cross-communication, and relying on entirely separate funding sources.(7, 8). Esus Centre brings psychiatrists, general practitioners, nurses, dietitians, psychologists, and peer support workers together in a single location to meet all of their patients' needs during the road to recovery. Thus, the onus to organize care is no longer placed on the patient and is instead facilitated by the system and structure itself.

Crucially, when patients complete the intensive program, they transition into outpatient care within the same center and often with the same team. This continuity, the Esus leadership argues, is one of the most powerful features of the model. "Patients and families consistently tell us they feel held by the integrated model", Dr Singh reflected, "and I think that's doing more therapeutic work than we often acknowledge. Same building, same faces, same team. That continuity becomes a container, and it's within that container that people find the safety to do what recovery actually requires of them."

The characteristics that define a mature IPU include organization around a medical condition; a dedicated multidisciplinary team devoting a significant portion of its time to that condition; co-location in dedicated facilities; responsibility for the full cycle of care; integrated patient education, engagement, adherence, follow-up, and prevention; common scheduling, intake, and financial structures under a clear clinical leader; routine measurement of outcomes, costs, and processes for every patient; joint team accountability for those results; and a regular cadence of formal and informal team meetings to discuss individual care plans, processes, and improvement.(16) As has been shown so far, the Esus Centre possess many of these attributes. Furthermore, the clinical leadership team of Dr. Singh, Kerry Mairs, and Rebecca Godin hold both governance and frontline clinical roles in the programs they oversee, providing the kind of continuous clinical–managerial integration that Porter identifies as a hallmark of mature IPUs.(16) It is this mature IPU structure of the Esus Centre that produces the following outcomes.

3. Outcomes

Esus Centre's 2025 outcomes data represent four implementation cycles and include all ITP and AITP admissions discharged between 1 January 2025 and 31 December 2025. Discharge relates to the movement of a patient out of the day programs, which constitute inpatient care, and into outpatient services. Of the total 109 patients enrolled, 71 had complete matched admission-discharge datasets available for analysis (65% response rate). The analysis was conducted at the level of episodes of care rather than unique individual patients, with incomplete datasets excluded from paired pre-post analysis. The data presented below demonstrate statistically significant improvements across physical health, eating disorder psychopathology, and broader psychological functioning in both programs. Following discharge from the intensive day program, more than 80% of patients remain within the Esus service and transition to outpatient care delivered within the same facility and by the same clinical team. For the 20% of patients who elect to continue with outpatient clinicians external to Esus, a formal transition of care occurs and they are discharged from the service entirely.

Benchmarking against existing day program literature is difficult given variation in population acuity and program structure. What is more distinctive - and what the Esus model is uniquely positioned to demonstrate over time - is not simply the magnitude of improvement within the intensive program, but whether continuity into outpatient care within the same center translates into more durable recovery. Early data examining this aspect is encouraging.

3.1 Intensive Treatment Program (ITP)

The ITP cohort comprised 71 admissions during 2025. The population was predominantly female (93%), with a mean age of 27.0 years (SD = 10.1, range 16–61). The diagnostic profile was dominated by anorexia nervosa (81.7%), followed by bulimia nervosa (9.9%), avoidant/restrictive food intake disorder (7.0%), and binge eating disorder (1.4%) (**Figure 1**).

3.2 Adolescent Intensive Treatment Program (AITP)

The AITP cohort comprised 38 admissions during 2025. The population was predominantly female (92.1%), with a mean age of 15.2 years (SD = 1.3, range 12–18). The diagnostic profile consisted of anorexia nervosa (89.5%) and ARFID (10.5%) (**Figure 1**).

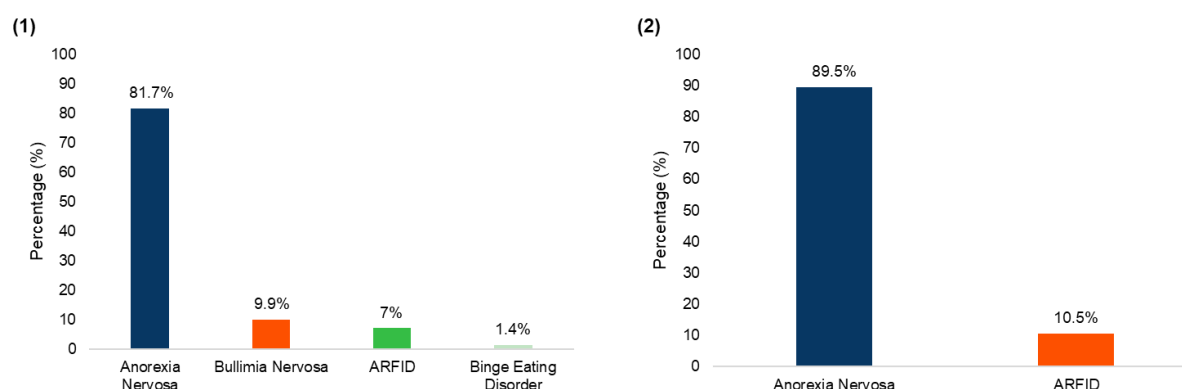


Figure 1: Distribution of eating disorder diagnoses across the **(1)** Intensive Treatment Program (ITP, n = 71) and **(2)** Adolescent Intensive Treatment Program (AITP, n = 38) for admissions during 2025.

3.3 Weight restoration

Patients in the ITP gained an average of 4.3 kg from admission to discharge, a statistically significant improvement ($p < .001$). Adolescent patients in the AITP gained an average of 5.7 kg ($p < .001$). This proportionally larger weight gain is consistent with the physiological demands of growth and development in this age group (**Figure 2**).

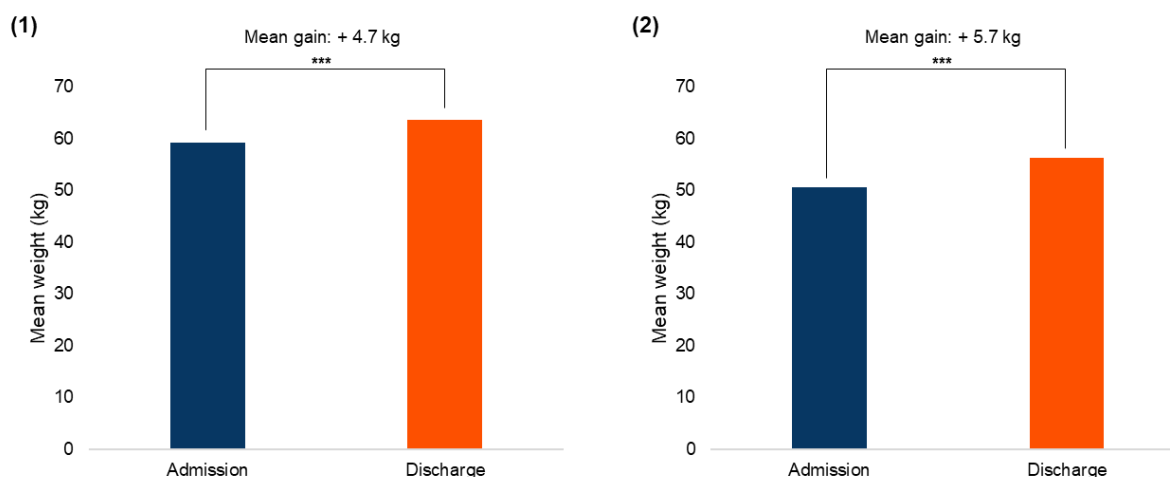


Figure 2: Mean weight at admission to intensive day programs and discharge into outpatient care for the (1) ITP (n = 71) and (2) AITP (n = 38). Both programs showed statistically significant weight gain, *** $p < .001$.

These figures are consistent with outcomes reported in the systematic literature for eating disorder day programs, where weight restoration across an intensive program episode is recognized as a primary indicator of medical stabilization.^(8, 9) The proportionally greater weight gain in the AITP cohort reflects both the physiological demands of adolescent growth and the family-based treatment model, which has the strongest evidence base for weight restoration in young people with anorexia nervosa. Importantly, the clinical significance of each kilogram gained must be contextualized against individual admission weight and degree of medical compromise. For many patients, even modest weight gain at this stage of illness represents a critical step toward safety.

3.4 Patient-reported outcomes

Eating disorder psychopathology, as measured by the EDE-Q, showed significant improvements across all subscales in both programs (**Figure 3**); including dietary restraint, eating concern, shape concern, weight concern, and global score. These findings indicate meaningful reductions in the cognitive and behavioral symptoms that characterize eating disorders.

Beyond eating disorder-specific symptoms, significant improvements were observed in depression (PHQ-9, $p < .001$), anxiety (GAD-7, $p < .001$, ITP only), psychosocial impairment (CIA, $p < .001$, ITP only), and compulsive exercise (CET, $p < .001$ in both programs). These broad improvements across multiple outcome domains suggest that the integrated model addresses not only the primary eating disorder, but also the comorbid conditions that frequently complicate recovery. Co-occurring depression and anxiety are particularly common in eating disorders, with the ICHOM Set recommending that these be measured in all patients.⁸

Parent-reported measures in the AITP also showed significant changes: the RCADS-Parent version demonstrated improvements in parent-reported anxiety and depression symptoms ($p < .05$ to $p < .001$), suggesting that clinical improvements are also perceived by parents and carers—an important validation given the known discrepancies that can exist between self-report and informant-report measures in this age group.

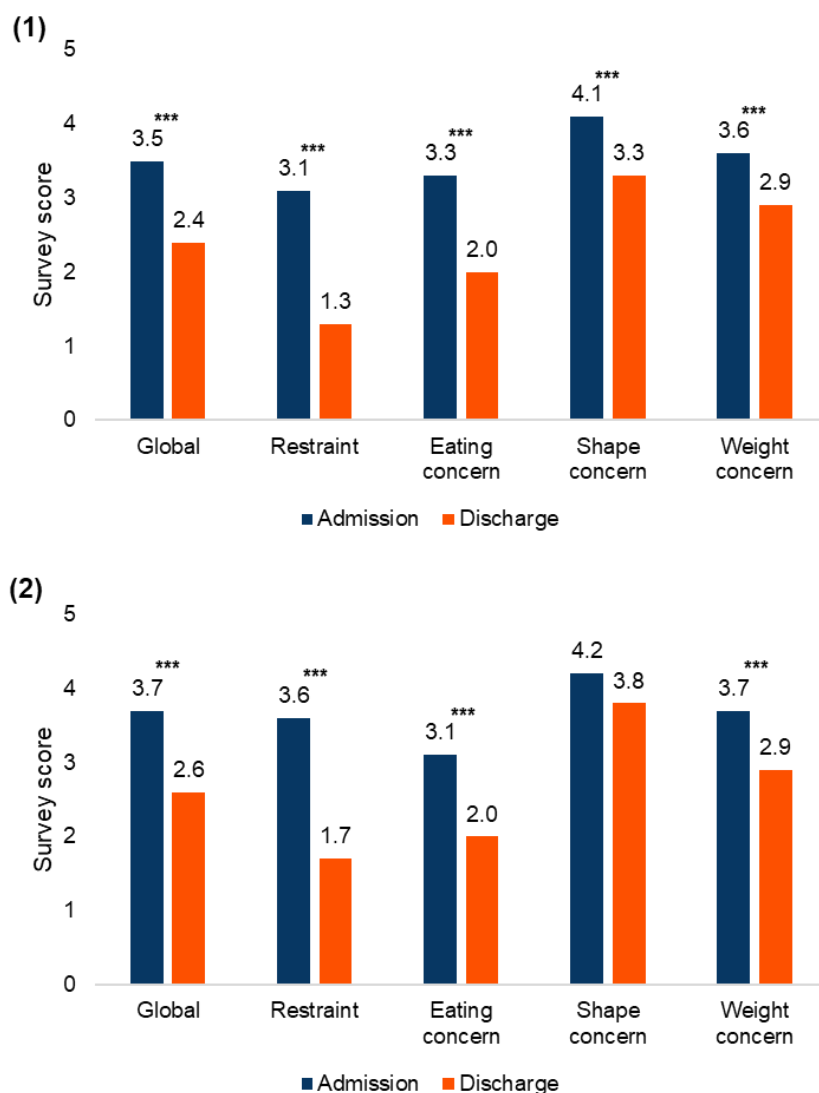


Figure 3: Summary of statistically significant improvements in patient-reported EDE-Q subdomain outcomes from admission to intensive day programs to discharge across the (1) ITP and (2) AITP. *** $p < .001$.

3.5 Completion rates and data quality challenges

Across both programs, the overall PROM response rate was 65%, with 71 of 109 patients having complete admission-discharge datasets. The gap was disproportionately concentrated in the AITP, where missing discharge data, particularly from parent questionnaires, was the primary driver. As Kerry Mairs explained: “Once they’ve walked out the door, even if they’re walking back in the door to outpatient, we find that it’s very difficult to get them to complete the measures.”

The team has already implemented process changes in response. Discharge-day completion has been built into the AITP workflow so that adolescents complete their measures on-site

before leaving. The leadership has also acknowledged the burden that multiple pre-admission questionnaires place on families. “What it really shows us is the burden of the family,” Rebecca Godin reflected. “We’ve got two parents and a young person, sometimes a 12-year-old, and it just reiterates the burden that it is for the family.” The Centre continues to refine its processes to balance the clinical imperative of data completeness with the emotional reality of families in crisis.

4. Discussion

4.1 Outcomes collection, sharing, and continuous improvement

The measurement of the outcomes that matter most to patients is essential when it comes to delivering high-value care. The leadership team at Esus Centre acknowledged this reality from the beginning and used it as a guiding principle. Robust outcomes collection has enabled them to accurately identify areas where their care delivery is working well and achieving the goals it set out to achieve. The visualization of these outcomes provides context and positive encouragement for patients, parents and staff alike. It cannot be understated how important this can be at various points in a patients’ journey towards better health.

Outcomes measurement can also drive forward continuous improvement when those outcomes are shared widely. This is because sharing creates ample opportunity for unjustified variation in outcomes to be identified. From there, the variation can be analyzed to determine the root cause and a suitable solution initiated. This is a cultural approach that Esus Centre has adopted wholeheartedly. Outcomes data are disseminated widely whether that is in PEACE and CAG quarterly meetings, to all clinical staff via the Esus Hub and noticeboard, to the nursing team, to ITP and AITP teams through meetings and quarterly planning days, to allied health teams through weekly consulting meetings, and to external organizations including the Mental Health Professional Network (MHPN) and the Australia and New Zealand Academy for Eating Disorders (ANZAED).

Outcomes data has also been shared with payers. The Esus Centre reports outcomes to private health insurers on a quarterly basis as part of its commitment to transparency and accountability. This is particularly significant given the Centre’s founding proposition to insurers; an integrated day hospital model would deliver better outcomes at lower cost than traditional inpatient care. The data now being collected provide the evidence base to evaluate that proposition.

4.2 Esus Centre as a case for IPU adoption in mental health care

Given the societal and economic impact of eating disorders, the fragmented nature of the support that is offered, and the low level of support utilization; a rework of the approach to care in Australia and globally is necessary.(2-4, 6) In Porter’s framework, IPUs are the structural answer to the fragmentation that drives poor outcomes and high costs in conventional, specialty-organized care delivery.(15) Yet, the IPU concept is often only discussed in the context of surgical or oncological care pathways. In a sector that has historically struggled, Esus Centre offers a working example of what integration looks like when it is built into the architecture of the service rather than negotiated across it.

This is because several features of the Esus model are particularly distinctive when viewed through an IPU lens. The first is the seamless transition between intensive day-based and outpatient care within the same facility. In conventional pathways, the move from intensive treatment back to community-based care is one of the highest-risk moments in the recovery journey, with discontinuities frequently associated with relapse and re-admission.(7, 12) In the Esus model, that transition is structurally absorbed within the same care cycle. The building does not change, the team does not change, and the patient does not have to re-establish a therapeutic relationship at the moment of greatest vulnerability.

The second is the agility with which the team adapts the program to address common comorbidities and patient subgroups—a quality Porter explicitly identifies as a marker of a functioning IPU.(16) This responsiveness is enabled by the same structural features that define an IPU: co-location, shared accountability, embedded leadership, and continuous measurement. All these elements collapse the time it takes for a clinical insight to become an operational change.

The third is the embedding of routine outcome measurement into the model from inception, rather than as an after-the-fact research exercise. The Esus team established its measurement framework before the first patient was admitted, aligned it with the outcomes that matter most to patients as outlined in the ICHOM Eating Disorders Set(13), and now reports outcomes back to clinicians, consumers, and payers on a defined cadence. In Porter's framework, this is not an optional accessory to an IPU, but one of its defining characteristics (18)

The Esus model demonstrates that meaningful IPU implementation does not require a perfect structural environment, with bundled, condition-level reimbursement remaining aspirational in the Australian context. Additionally, the technological infrastructure for real-time outcome feedback is still being implemented. However, the structural foundations are impressively well established for a service that opened its doors only two years ago. It is this strong foundation that has allowed the Esus Centre to achieve much of what it has so far.

5. Future direction

For Esus Centre there is ample room for future improvements. As Dr. Singh highlighted, they are continuing to see clinical turning points in how outcomes are being used at the individual level. One pertinent example was with a patient who was very sick. “We were talking about the food, we were talking about ‘she can’t go out and eat at a restaurant’ and I asked her; what are the outcomes that matter to you?” This shift from clinician-defined goals to patient-defined outcomes represents a fundamental reorientation that the ICHOM framework is designed to identify and support. Esus Centre is looking to continue to build out their approaches to shared-decision making and other uses of patient-defined goals to better deliver care.

Looking ahead, the Centre has identified several strategic priorities including building a clinician-patient dashboard for real-time data visualization; developing meaningful patient questionnaires tailored to the Esus population; using aggregated outcomes more actively for quality improvement and program development; and continuing to strengthen consumer and lived experience involvement. Additionally, tracking outcomes across the full care episode - from intensive day program through to outpatient discharge or remission - is identified as a priority for the next phase of the service's development.

A critical and underexplored dimension of the Esus model is its economic logic. The center was conceived explicitly as a hospital substitution model: delivering the clinical intensity of inpatient care within a day hospital structure, at substantially lower daily cost to private health insurers. The average cost of an inpatient psychiatric admission in Australia exceeds AU\$1,500 per day; the Esus day hospital rate represents a significant reduction in direct expenditure, while the integrated outpatient step-down reduces the likelihood of costly acute re-admission. Esus Center reports outcomes to private health insurers quarterly, and is actively developing the evidence base for condition-level, bundled reimbursement — an approach Porter identifies as the logical complement to integrated practice unit care delivery. The Esus Centre would not be able to undertake such an approach if it were not for its structural position: a single organization which delivers the full care cycle with outcomes data to demonstrate value.

6. Practical advice from the Esus team

Esus Centre's experience offers several practical lessons for services considering a similar approach. The first is to begin measuring before you feel ready. Esus established its outcomes framework before the first patient was admitted, using the freely available ICHOM [Sets](#) as the structural foundation. Condition-specific, validated tools generate data that can be tracked over time and benchmarked against comparable services. Starting imperfectly is far preferable to waiting for a perfect system.

The second is to integrate PROMs directly into clinical workflow, not as a parallel administrative task. When PROM scores are available in the electronic health record and visible to both clinician and patient before a consultation, they change what gets discussed in the room. They support shared decision-making, improve communication, and when used intentionally function as a therapeutic tool rather than a bureaucratic one. Patients who understand that their responses directly shape their care, and who can see their own trajectory over time, engage differently with treatment.

The third is to use outcomes data to set expectations at the point of referral. When referring to a specialist mental health service, GPs and other referring clinicians are well placed to ask whether that service measures outcomes systematically and can share data back. Services that benchmark their performance against their own prior results and against comparable providers are more likely to identify and close gaps in care. Expecting an answer to that question is a reasonable and legitimate standard.

Finally, integration - structural, not just philosophical - is worth building from the beginning. The features of the Esus model that most reduce risk at critical transition points (the same building, the same team, the same therapeutic relationships across the step-down from intensive to outpatient care) are not expensive to design in at inception, but are very difficult to retrofit. The question to ask at the design stage is not "what can we afford to connect?" but "what should never be separated?"

7. Conclusions

The Esus Centre represents a novel model of eating disorder care in Australia. It is one that integrates all disciplines under a single roof, provides seamless transitions from intensive to

outpatient treatment, and places routine outcomes measurement at the center of clinical practice. The outcomes data from 2025 are encouraging. Across both the adult and adolescent programs, patients demonstrated statistically significant improvements in weight, eating disorder psychopathology, depression, anxiety, and psychosocial functioning. These results are consistent with the growing evidence base supporting day programs as effective alternatives to inpatient care for eating disorders(11, 12), while also speaking to the particular strengths of an integrated model that maintains continuity of care throughout recovery.

Perhaps most importantly, the Esus Centre has shown that an integrated practice unit approach for mental health can be coupled with outcomes measurement and implemented in a high-acuity clinical setting from day one as a routine component of care delivery and not as a retrospective research exercise. The challenges they have encountered, technological limitations, family burden, adolescent completion rates, fragmented funding models, are real. However, they have responded with characteristic agility: changing workflows, listening to consumers, investing in governance structures, and committing to transparency with both patients and payers.

As Dr. Singh reflected: “This is how mental health should be delivered, not just for eating disorders, but for any mental health condition. What we’re aiming to do is show that this model is both financially and clinically successful. That’s the only way we’ll get other people to do it.”

Esus Centre is still early in its journey. With only two years of operational data much remains to be demonstrated. However, in a healthcare landscape where eating disorders remain undertreated, underfunded, and fragmented, the Esus model offers a compelling proof of concept. Integration, transparency, and a relentless focus on the outcomes that matter to patients can transform care delivery.

8. References

1. (NEDC) NEDC. Eating disorders in Australia [Available from: <https://nedc.com.au/eating-disorders/eating-disorders-explained/eating-disorders-in-australia/>].
2. Foundation TB. The reality of eating disorders in Australia 2024: Crows Nest, NSW: The Butterfly Foundation; 2024 [Available from: <https://butterfly.org.au/wp-content/uploads/2024/02/The-reality-of-eating-disorders-in-Australia-2024.pdf>].
3. Hay P, Aouad P, Le A, Marks P, Maloney D, Touyz S, et al. Epidemiology of eating disorders: population, prevalence, disease burden and quality of life informing public policy in Australia—a rapid review. *Journal of Eating Disorders*. 2023;11(1):23.
4. Treasure J DT, Schmidt U. Eating Disorders. *Lancet*. 2020;395:899-911.
5. Dann KM, Schneuer FJ, Miskovic-Wheatley J, Cunich M, Ahmed M, Sidari M, et al. Healthcare utilization for eating disorders in Australia: 10 years of health data linkage. *Australian & New Zealand Journal of Psychiatry*. 2025;59(12):1115-26.
6. Arcelus J, Mitchell AJ, Wales J, Nielsen S. Mortality rates in patients with anorexia nervosa and other eating disorders: a meta-analysis of 36 studies. *Archives of general psychiatry*. 2011;68(7):724-31.
7. Economics DA. Paying the price: the economic and social impact of eating disorders in Australia: Crows Nest, NSW: The Butterfly Foundation; 2012 [Available from: chrome-extension://efaidnbnmnnibpcajpcglclefindmkaj/<https://butterfly.org.au/wp-content/uploads/2024/10/deloitte-au-eco-paying-the-price-second-edition-180724-new-Oct-24.pdf>].
8. Baudinet J, Simic M. Adolescent eating disorder day programme treatment models and outcomes: a systematic scoping review. *Frontiers in psychiatry*. 2021;12:652604.
9. Krishnamoorthy G, Shin SM, Rees B. Day Programs for children and adolescents with eating disorders: A systematic review. *European Eating Disorders Review*. 2023;31(2):199-225.
10. Herpertz-Dahlmann B, Bonin E, Dahmen B. Can you find the right support for children, adolescents and young adults with anorexia nervosa: Access to age-appropriate care systems in various healthcare systems. *European Eating Disorders Review*. 2021;29(3):316-28.
11. Krishnamoorthy G, Shin SM, Rees B. Day Programs for children and adolescents with eating disorders: A systematic review. *European Eating Disorders Review*. 2023;31(2):199-225.
12. Baudinet J, Simic M. Adolescent eating disorder day programme treatment models and outcomes: a systematic scoping review. *Frontiers in psychiatry*. 2021;12:652604.
13. Austin A, De Silva U, Ilesanmi C, Likitabhorn T, Miller I, Fialho MdLS, et al. International consensus on patient-centred outcomes in eating disorders. *The Lancet Psychiatry*. 2023;10(12):966-73.
14. Bryant E, Broomfield C, Burrows J, McLean S, Marks P, Maloney D, et al. Gaining consensus on clinical quality outcomes for eating disorders: Framework for the development of an Australian national minimum dataset. *BMJ open*. 2023;13(4):e071150.
15. Porter ME, Teisberg EO. Redefining health care: creating value-based competition on results: Harvard business press; 2006.
16. Porter ME, Lee TH. The strategy that will fix health care. *Harv Bus Rev*. 2013;91(10):50-70.
17. Van Harten W. Turning teams and pathways into integrated practice units: appearance characteristics and added value. *International journal of care coordination*. 2018;21(4):113-6.
18. Porter ME. What is value in health care? *New England Journal of Medicine*. 2010;363(26):2477-81.