GLOUCESTERSHIRE EATING DISORDERS CASELOAD SURVEY 1997

Introduction

Most reports on the prevalence of people with an eating disorder, consider the young female population, usually in schools or colleges or occasionally in GP practices (for a review see Hoek 1993). Hoek estimated the point prevalence for Anorexia Nervosa as 0.28% among young women and 1% for Bulimia Nervosa. Estimates for the prevalence of atypical eating disorders vary up to about 5% of young women (Button and Whitehouse 1981, Whitehouse et al 1992).

A study of primary health care in the Netherlands (Hoek 1991) found a point prevalence rate for Anorexia Nervosa of 18.4 per 100,000 total population (0.0184%) and 20.4 for Bulimia Nervosa (0.0204%). These figures confirm that very few people with eating disorders are identified by their General Practitioner (GP). Hoek (1991) found that 82% of people with Anorexia Nervosa and 45% of people with Bulimia Nervosa identified by GPs were within the mental health care system.

Two studies of primary health care in Britain identified similar prevalence rates amongst female GP practice attendees, as were found in schools and colleges. King (1986), found 1% of young women attending their GP practice had Bulimia Nervosa and a further 3% had a partial syndrome eating disorder. Whitehouse et al (1992), found a prevalence of Anorexia Nervosa of 0.2%, Bulimia Nervosa 1.5% and partial syndrome Bulimia Nervosa 5.4%. Half of the people with Bulimia Nervosa had not been identified by their GP and only a quarter of all of them had been referred to secondary mental health services.

Little is known about the prevalence of people with eating disorders within generic mental health services. Most studies have reported on people using specialist eating disorder services. Psychiatric caseload studies tend to report on the incidence, but not the prevalence. A study in New Zealand reported the prevalence of eating disorders in recently admitted psychiatric in-patients (Hay and Hall 1991). They found that 17% met DSM IIIR criteria for eating disorders. The most frequent co-morbid conditions were mood and personality disorders.

This survey attempted to establish the number of people with an eating disorder on the caseload of generic mental health services in Gloucestershire.

Method

The sample was obtained by surveying each of the 13 Community Mental Health Teams (CMHT) (2 Child and Adolescent and 11 Adult) and other mental health staff within Gloucestershire (two NHS Trusts). The survey questionnaire was designed to obtain information about each client and their use of services. CMHTs were asked to identify every client who had a diagnosed eating disorder, on their caseload on 11th February 1997. DSM IV diagnostic criteria were circulated to help the staff to ensure that the client met the criteria for the relevant diagnostic category. One questionnaire per client was returned by the client’s allocated key worker. Data was collated and entered onto an Excel database for analysis.

Results

A total of 121 questionnaires were returned. 118 (97.5%) were female and 3 (2.5%) were male. Their ages ranged from 14 to 66 with an average age of 28. 44 (36.4%) were classified as having Anorexia Nervosa, 44 (37.2%) Bulimia Nervosa and 32 (26.4%) Eating Disorder Not Otherwise Specified. 69 (57%) were single, 40 (33%) married, 10 (8%) divorced, with one widowed and one unknown.

The age of onset of the eating disorder ranged from 8 to 47 (11 unknown), the average age being 18. The age at which treatment for an eating disorder was first received ranged from 11 to 60 (10 unknown, 1 not treated), the average age being 23. 65 (53.7%) had another psychiatric diagnosis, the most common diagnosis being depression, 54 (80%). Other diagnoses were anxiety 16, OCD 6, phobias 4, personality disorder 3, alcohol misuse 3, drug misuse 2, and others 7.

38 (31.4%) had been admitted to a psychiatric hospital at some time. 83 (68.6%) had not. Of those admitted 13 (34.2%) had been admitted once, 9 twice, 8 three times, 2 four times, 1 five times, and 1 ten times. 55.3% of those admitted had been admitted more than once. 4 (10.5%) were unknown.

The duration of stay in hospital ranged from 9 to 540 days, the average being 89 days. 6 (4.9%) had been detained under the Mental Health Act. 112 (92.6%) had not and 3 (2.5%) were unknown.

21 (17.3%) had been admitted to a general hospital for a reason relating to their eating disorder. 90 (74.4%) had not and 10 (8.3%) were not known. The reasons for admission were as follows: 8 for re-feeding, 5 for investigation, 2 for rehydration, 1 due to electrolyte imbalance, 1 unknown and 4 other physical complications.

43% of the sample were seen by a key worker who was a Nurse (CPN 31, Other Nurse 21). A Physiotherapist who specialises in counselling for eating disorders, saw 23 (19%) of the sample. Other key workers came from the following professional groups, Psychiatrist 18 (14.8%), Psychologist 10 (8.3%), Psychotherapist 10 (8.3%) and Occupational Therapist 8 (6.6%).

73 (60.3%) of the sample were seen by staff from East Gloucestershire NHS Trust and 48 (39.7%) were seen by staff from the Severn NHS Trust. 17 (14%) were seen by Child and Adolescent Services and 104 (86%) were seen by Adult Services. The number of clients with an eating disorder, on the caseload of a CMHT ranged from 2 to 24, the average being 9.

90 GPs referred the 121 people in the sample. This represented 27% of the 334 GPs within Gloucestershire. These GPs came from 55 different practices, representing 64% of the 86 practices within Gloucestershire.

46 people (38%) were referred for a problem other than eating disorder, the eating disorder being identified at assessment or subsequently.

The problems mentioned in the referral letters included anxiety, sexual abuse, obsessional compulsive disorder and substance abuse, the largest categories being depression with 23 people (54% of those referred for a reason other than eating disorder) and deliberate self harm with 7 people (15%).

Over half of the sample had been on the caseload for less than one year (52%). 9 people had been seen for more than 5 years (7.5%). The amount of face to face contact with mental health services varied considerably, but 91 people (75.2%) spent less than 4 hours per month with mental health staff.

35 people (28.9%) were only in contact with one health worker. 41 (33.8%) were seeing two disciplines, but the most frequently listed second discipline was GP (54 in total). 45 people (37.1%) saw 2 or more disciplines.

33 people (27.3%) had received treatment for their eating disorder outside of Gloucestershire, 12 of them from a specialist eating disorder team (9 different teams).

Discussion

This survey attempted to identify the number of people with an eating disorder who were on the caseload of mental health teams in Gloucestershire in February 1997. Statistical systems already in place were not able to deliver information of this nature, so a manual survey was required. Despite the co-operation of all the teams involved, it is likely that at least a small number of cases were missed.

Although standardised diagnostic criteria were used, the validity of each diagnosis was not checked, so it is possible that not all the cases actually met the full diagnostic criteria. However, this survey was intended to supply baseline information about actual clinical practice, where adherence to strict diagnostic categories becomes less important.

Lack of statistical data makes it difficult to establish the prevalence of eating disorder cases within the total caseload of Gloucestershire mental health teams, but the small numbers recorded by most teams would suggest that eating disorder cases comprise a very low proportion of the total caseload.

Several interesting results arose from this survey. Nearly one third of the sample had been admitted to a psychiatric hospital at some point suggesting a fair degree of severity of mental health problems. About one sixth of the sample had been admitted to a general hospital for a problem related to their eating disorder confirming the need for assessment of physical health. The survey provided further evidence of the chronic nature of eating disorders showing on average a 5 year gap between onset of eating disorder and first treatment.

60% of the sample were seen by staff from East Gloucestershire NHS Trust although the majority of the population of Gloucestershire live within the Severn NHS Trust area. This probably reflects the larger numbers of students residing in east Gloucestershire and the difference in social class distribution between Cheltenham in the east and Gloucester in the west.

Only 27% of GPs had a patient with an eating disorder on the mental health team caseload and over a third of practices had no one on the caseload. This suggests that GPs have little experience of identifying and treating people with moderate to severe eating disorders. In-fact only 3 GPs had more than 2 patients on the caseload.

Over one third of the sample had been referred to mental health services for a problem other than eating disorder. There could be several explanations for this finding. People with eating disorders often have co-morbid psychiatric problems and might be more motivated to seek help for anxiety or depression than for their eating disorder. Shame, guilt and embarrassment can prevent them from admitting their eating difficulties. The lack of a specific eating disorder service might encourage GPs and their patients to present with other problems rather than the eating disorder.

These results indicate that assessment for eating disorder should be a routine part of generic mental health assessment, particularly for women referred with depression or following deliberate self harm.

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