

TREATMENT SERVICES FOR PEOPLE WITH EATING DISORDERS IN THE YEAR 2000

The Eating Disorders Association has been at the forefront of campaigning for improvements in services for people with eating disorders in Britain. Despite the development of services in various parts of the country, up to 90% of people with an eating disorder are still not receiving treatment. On average it takes 5 years from the onset of the illness to the first referral for treatment. During this time, people with eating disorders often suffer severe emotional and physical problems and their families suffer intense worry and emotional distress. Some people seek help for their other psychiatric problems from general mental health services, but keep their eating disorder secret. However, treatments that do not address the eating disorder are often ineffective.

Sufferers or family members who approach their GP often find that their doctor is inexperienced and lacks knowledge regarding eating disorders and appropriate clinical management. But GPs deal with people with eating disorders infrequently and only have to refer to mental health services occasionally.

The NHS resources that are spent on eating disorders tend to be concentrated on the needs of patients in hospital. Whilst a small number of people with eating disorders have very complex needs and require specialist in-patient care, this often means that large amounts of money are spent on very small numbers of people, with only limited effectiveness. Those people with eating disorders who are not treated by specialist teams (the vast majority of sufferers) are often likely to meet NHS staff who have limited knowledge and experience of treating eating disorders. Consequently, sufferers and their families often receive inadequate information, guidance, treatment and support.

Clearly, treatment services for people with eating disorders are not as well organised and effective as they could be. Attempts have been made to survey services at a national level over the past decade. Three surveys since 1993 have found a wide variety of services differing in size of team, catchment area, population served, staff skill mix, treatment approaches, referral rates, source of referrals and availability of resources. Many areas of the country have no access to specialist services whatsoever.

In 1998, Health Which? surveyed Health Authorities and found that only 42 out of 89 who responded were using any local specialist eating disorder services. On average, Health Authorities spent £ 130,000 in the financial year 1996-97 on funding specialist treatment out of their own area. The Eating Disorders Association knows of 77 specialist services country-wide, but they differ drastically in terms of the comprehensiveness of the service.

The Royal College of Psychiatrists have defined a “comprehensive” Eating Disorders Service as one which includes staff with experience of eating disorders, a Consultant Psychiatrist who spends a third of their time on eating disorders, offers a range of psychotherapies including family therapy, offers in-patient and/or day care places with medical support to critically ill patients and sees at least 25 patients a year.

Only 28 of the specialist services qualify as “comprehensive” and 10 of those are in the private sector.

There are no “comprehensive” NHS services in Wales, West Scotland or South West England. In fact over half the “comprehensive” services are in South East England. Nearly half of all specialist services and over a third of “comprehensive” services are in the private sector. These services grew following the changes in the NHS implemented by the previous Government which resulted in the use of extra contractual referrals (ECR) to specialist units when services were not available locally. Although this resulted in more people receiving specialist in-patient care, vast sums of money left the NHS in an unplanned and uncoordinated fashion, leaving local services still unable to offer effective help.

Whilst there are clearly huge discrepancies in services around the country and a desperate need for a national strategy, it is important that we don’t fall into the same perfectionist thinking that people with eating disorders and their families can sometimes get stuck in. For example, assuming that all specialist eating disorder services are bound to be highly skilled and effective and non-specialist services are bound to be unskilled and ineffective. This is especially important when we know that at least 20% of people with an eating disorder will not make a good recovery in the medium to long-term, despite intervention from even the best teams in the world.

Some years ago, Gloucestershire Health Authority recognised the lack of strategic planning that was taking place around eating disorders and decided to appoint a Clinical Co-ordinator to undertake a health needs assessment and to develop a strategy supported by a multi-agency project group. The health needs assessment considered the following areas:

- Definition of eating disorders, projected prevalence (the number of people with a disorder at any one time) and incidence (the number of new cases referred in a year).
- The evidence of effectiveness of health care interventions and accepted good clinical practice.
- A review of current service provision and consideration of national guidance.

The local Health Service strategy adopted by Gloucestershire Health Authority aims to decrease the length of time between the onset of eating disorders and access to appropriate help and limit the physical and psychiatric morbidity, social disability and mortality caused by eating disorders. The strategy aims to achieve this by increasing and improving early identification and intervention in the community and primary health care and improving specialist clinical resource management within Mental Health Services.

Following the acceptance of the strategy, a service specification was written and the Clinical Co-ordinator was set a three year work plan to implement aspects of the strategy. Attempts to improve early identification and intervention aim to raise awareness in the community and improve accessibility of help.

To do this a well-publicised telephone helpline was set up for public and professional use, so that people concerned about eating disorders could immediately receive specialised guidance. An information leaflet on eating disorders self-help and how to access services was produced and distributed to all community organisations relevant to eating disorders. The local Eating Disorders Association Support Group was re-launched and re-advertised with a new group of facilitators combining people who had suffered from an eating disorder with mental health workers with a special interest in eating disorders. Training has been offered to relevant staff in primary health care, education, youth and community services and voluntary counselling agencies. Written guidance on the management of eating disorders has been provided to GPs.

In an attempt to improve the clinical services offered by Community Mental Health Teams (CMHT), each team identified a Link Worker to liaise closely with the Eating Disorders Clinical Co-ordinator. Each CMHT was offered training and an ongoing series of training events has taken place over the last couple of years. Mental health team members are now able to access supervision regarding cases that can include joint assessment or consultation with the Clinical Co-ordinator so that appropriate planning of care can be adopted. Ongoing supervision and support is provided as well as access to relevant professional literature. This approach has resulted in many staff gaining skills and confidence in working with people with eating disorders. The outcome of treatment is being measured at six months, one year, two years and five years by the use of the Eating Disorders Examination Questionnaire (Fairburn and Beglin 1994).

A review of all the patients who were treated in in-patient units out of the county during 1996 to 1997 found that although the admissions were generally appropriate, lengths of stay were often very long with little communication between the specialist unit and the local Mental Health Service. Following the review, guidelines for the management of out of county referrals were written which laid down standards for admission, liaison and discharge planning and the Clinical Co-ordinator took over responsibility for authorisation of Health Authority funding. This meant that a clinician with experience of eating disorders was directly responsible for the appropriate use of the financial resources being spent on specialist in-patient care.

Gloucestershire Health Authority already had a contract with a private hospital for some specialist in-patient care and this contract was re-negotiated so that the Health Authority were able to stipulate the care they required which generally now involves refeeding as an in-patient up to 75% of average expected weight followed by day care for those patients who want to continue to work towards recovery. The changes implemented following the adoption of the eating disorders strategy appear to have resulted in significant financial savings, which have led the Health Authority to feel able to commit further resources to the development of locally based specialist services. This is likely to include the extension of the current Eating Disorders Project, plus specialist groups (on a daily basis if required) for those with more intensive needs.

The Gloucestershire Eating Disorders Project is one example of how limited resources can be used effectively to improve a wide range of services across several organisational boundaries.

Whilst the results of the project are by no means ideal, observable changes have been brought about, hopefully resulting in easier access to more effective services with resources being spent wisely. A recent review of eating disorder treatment services (Palmer & Treasure 1999) quoted the Audit Commission's suggestion that specialist services should be commissioned by Regional NHS organisations using a "hub and spoke" approach with specialist in-patient services being available for each region and local specialised services liaising with and feeding into the regional specialist service. The Gloucestershire Eating Disorders Project is one possible way forward.

Although Eating Disorder Services vary across the country there is room for major improvement, the outlook is perhaps more encouraging now than it has been for many years. Regional NHS Specialist Commissioning offers hope that a rational approach to eating disorder services can be adopted nation-wide, ensuring equity of services across the country. An input of supervision and training can dramatically increase the quality of service provided by local Mental health Services where there is much interest amongst mental health staff, but a lack of confidence due to inexperience. There is also a possibility that services can be improved with minimum cost and occasionally even cost savings.

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Reference

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Fairburn C and Beglin S (1994) *Assessment of eating disorders: Interview or self report questionnaire?* International Journal of Eating Disorders, 16, 363-370.

This article appeared in "Signpost" the newsletter of the Eating Disorders Association, in 2000.