

EATING DISORDER SERVICES

A CONSULTATION PAPER

Department of Health, Social Services & Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

May 2002

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FOREWORD

Eating disorders, together with their many physical and psychological complications, represent a significant cause of ill health. To address the needs of those suffering locally current services require further development and to inform the process I would be grateful for your comments on the following proposals.

All comments should be returned by **31st July 2002** to:

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EXECUTIVE SUMMARY

Eating disorders have one of the highest levels of mortality of any psychiatric illness.

Around 0.6% of all those with anorexia nervosa die per year giving a cumulative life time mortality of between 5%-20%. Eating disorders are also associated with high levels of psychiatric and physical complications. The physical complications are often irreversible, lead to multiple medical investigations and have significant resource implications in their management.

Each year in Northern Ireland around 50-120 people develop anorexia nervosa and around 170 people develop bulimia nervosa. In terms of overall prevalence here, best available evidence indicates that approximately 340-1,700 people suffer from anorexia nervosa and approximately 17,000 suffer from bulimia nervosa. Around 100 people are admitted to hospital here each year due to eating disorders, which is equivalent to 9.5 in-patient beds being used per year (average length of stay is approximately 5 weeks per patient). With additional demand, equivalent to 2 beds, being generated by the need for specialist in-patient treatment in units in England the overall in-patient need is therefore approximately 11.5 in-patient beds.

Approximately 50% of patients with anorexia nervosa can be expected to recover, 30% make a partial recovery, and 20% remain fully anorexic. Bulimia nervosa tends to run a relapsing and remitting course with about two-thirds recovering within 5 years. Treatment is most effective when provided early, in which case both the long-term physical and psycho-social disabilities are likely to be minimised.

Eating disorders require a stepped model of care involving voluntary agencies, primary care professionals, local psychiatric services and specialised services. Only the most severe and complex cases require in-patient care. Visits to 2 specialised services in London highlighted the range of specialist therapeutic interventions available elsewhere.

Specialised eating disorder services in Northern Ireland currently consist of one Grade H Clinical Nurse Specialist and a Senior House Officer in Psychiatry supervised by a Consultant Psychiatrist in Psychotherapy. The 4 in-patient beds, which were in the past available in Knockbracken Health Care Park, are no longer dedicated for eating disorder patients as they are located in a busy acute admission ward and are therefore thought not to provide a suitable environment. This service is only available to patients in the Greater Belfast area.

Much of the in-patient treatment for medical complications in the past has been at the metabolic unit in the Royal Victoria Hospital. However, with the recent retirement of one of the Consultant Physicians who took a particular interest in these patients and the reduction in bed capacity on this site this service has reduced.

A recent report by the Royal College of Psychiatrists described service provision here as “woefully inadequate”.

This report recommends a regional Eating Disorder Service to be provided through a specialist day hospital, outpatient and community service. This service would be linked with and supported by existing mental health services and primary care professionals.

1. INTRODUCTION

- 1.1 Eating disorders, compared to other psychiatric conditions/syndromes, have a particularly high level of mortality; in many studies for anorexia nervosa the overall mortality rate is consistently reported at between 5%-20%. Death occurs as a result of either medical complications (50%), such as cardiac or renal failure, or suicide (50%). It is recognised that such high mortality is, in part, likely to be exacerbated where service provision is inadequate. It is therefore appropriate that eating disorder specific service provision should be reviewed within Northern Ireland.
- 1.2 Locally concerns have been raised about several factors including availability of in-patient medical and psychiatric beds for the treatment of eating disorder patients, the current lack of service provision for patients at an outpatient level, and also the increased number of children and young adolescents presenting for treatment. A similar increase in demand for eating disorder care has been reported elsewhere.
- 1.3 The profile of eating disorder services in Northern Ireland has been raised by a series of workshops, involving internationally recognised experts, which were organised by Dr Clare Adams, Consultant Psychotherapist. Following these workshops a paper proposing a review of Eating Disorder Services was tabled at the Psychiatry Specialty Advisory Committee in January 2000. At this meeting it was agreed to set up a project team to carry out the review and look at the options for future provision of services. This report contains the findings of that review.

2. **BACKGROUND**

- 2.1 Eating disorders are categorised by severe disturbances in eating behaviour. Usually the term eating disorder is used to describe anorexia nervosa or bulimia nervosa although it may include other disorders such as obesity when used in the wider context. Vomiting or overeating may also be associated with other distressing events such as bereavement or accidents.
- 2.2 Among adolescent and young adult females, anorexia nervosa has a prevalence of 1%-2%, while bulimia nervosa has a prevalence of 1%-3%. Less frequently eating disorders also occur in males and the middle aged and elderly.
- 2.3 The incidence of eating disorders appears to have increased in recent decades. This may in part be due to increased awareness and recognition. Assessing the prevalence of eating disorders is complicated, as some sufferers may actively avoid detection and also can present to a variety of medical specialities under several diagnostic guises.

Anorexia Nervosa

- 2.4 Anorexia nervosa is characterised by a maintained body weight of at least 15% below that expected for the height of individual and is accompanied by a morbid “fear of fatness” and a distorted body image with the person feeling they are fat when they are not. Weight loss is self-induced by voluntary avoidance of food and also sometimes other weight losing methods such as self-induced vomiting, purging, excessive exercise or use of appetite suppressant drugs or diuretics. If the onset occurs before puberty the normal sequence of pubertal changes may be delayed or prevented.

Bulimia Nervosa

- 2.5 Bulimia nervosa is characterised by a pre-occupation with eating, episodic craving for food and episodes of overeating. There is accompanying distortion of body image with a morbid “fear of fatness”. Body weight is controlled by self-induced vomiting, purging, alternating starvation and overeating and use of appetite suppressant or diuretic drugs.

NOTE: A proportion of cases fluctuate between these two syndromes.

COMPLICATIONS

- 2.6 Both **psychiatric** and **medical** complications may arise:

Psychiatric

- 2.7 Over half of patients with anorexia or bulimia have an episode of depression at some time during their lives. Almost two thirds of those with anorexia suffer from anxiety disorders during their lifetime, with obsessive compulsive disorder and social phobia being the most common. In bulimia there is an increased rate of alcohol and drug misuse with the majority of these patients having underlying personality disturbances.
- 2.8 Approximately one third of patients presenting with anorexia and bulimia have a history of childhood neglect and/or abuse.

Medical

- 2.9 Malnutrition can lead to vitamin deficiencies, loss of muscle tissue (including heart muscle), and also lower the body’s immune defences to infection. Due to osteoporosis 30%-40% of patients with anorexia are three times more likely than the

general population to suffer a bone fracture. Female patients with anorexia have markedly reduced fertility rates and seven times the average perinatal mortality rate for children.

- 2.10 With appropriate treatment and recovery from the eating disorder the majority of the physical effects are reversible however some, eg loss of tooth enamel, osteoporosis and problems with fertility, can be irreversible.

Prognosis

- 2.11 Eating Disorders present within a wide range of severity and response to treatment is variable. Patients with eating disorders often undergo extensive physical investigation prior to beginning treatment. Approximately 50% of patients with anorexia nervosa can be expected to recover, 30% make a partial recovery and 20% remain fully anorexic. Around 0.6% of all those with anorexia nervosa die per year giving a cumulative lifetime mortality of around 5%-20% for all cases. Bulimia nervosa tends to run a relapsing and remitting course with about two-thirds recovering within 5 years. Treatment for eating disorders is most effective when provided early in which case both the long-term physical and psychosocial disabilities are likely to be minimised.

3. **ASSESSMENT OF LOCAL NEED**

3.1 Relatively little epidemiological-type data is available with respect to Eating Disorder incidence/prevalence in Northern Ireland. However, it is unlikely that local epidemiology differs markedly from indicative levels and trends reported within the UK in general. Over the last 2 years, locally derived research has begun to provide baseline data outlining the apparent need for specialist 'Eating Disorder' in-patient service provision. This research has used hospital admission data as a proxy for actual need (such data, however, is more likely to reflect available levels of service provision and less so actual need).

3.2 Both indicative UK data and locally derived in-patient data are presented here:

Indicative Epidemiological Type Data

3.3 Incidence and prevalence figures for anorexia nervosa and bulimia nervosa vary among published studies; such variation is attributable to different case definitions/diagnostic criteria and lack of homogeneity among study groups.

3.4 Overall, around 1%-2% of adolescents/young adults develop some form of Eating Disorder with cases being much more common among females. Most cases develop between 13-25 years, however, an increasing number are now being reported among those aged less than 10 years.

3.5 While rates are marginally higher among those in non-manual social class groups a social class gradient is not particularly evident.

Anorexia Nervosa

3.6 Anorexia nervosa incidence and prevalence:

- Incidence is around 3-7 new cases per 100,000 *general population* per year, increasing to approximately 20-40 new cases per 100,000 females aged 15-25yrs per year (Incidence is 8-11 times higher among females than males).
- Prevalence is around 20-100 cases per 100,000 (0.02% - 0.1%) *general population*, increasing to 400-2000 per 100,000 (0.4% - 2.0%) females aged 13-25yrs (peak age: 16yrs).

Indicative incidence/prevalence (Northern Ireland)

3.7 Applying the above indicative estimates to Northern Ireland suggests that around 50 to 120 new cases of anorexia nervosa arise each year and there are 300-1700 cases at any one time (Table 1).

	INCIDENCE	PREVALENCE
NHSSB	13 – 30	85 - 426
EHSSB	20 – 47	135 - 675
SHSSB	9 – 22	62 - 308
WHSSB	8 – 20	56 - 280
N.I.	51 - 118	338 - 1689

TABLE 1

Bulimia Nervosa

3.8 Bulimia nervosa is much more common than anorexia nervosa.

- Incidence is around 10 new cases per 100,000 *general population* per year, increasing to approximately 60 new cases per 100,000 females aged 15-25yrs per year.
- Prevalence is around 1000 cases per 100,000 (1%) *general population*, increasing to up to 5000 per 100,000 (5.0%) females aged 13-25yrs.

Indicative incidence/prevalence (Northern Ireland)

3.9 Applying the above indicative estimates to Northern Ireland suggests that around 170 new cases of bulimia nervosa arise each year and 17,000 cases exist at any one time.

	INCIDENCE	PREVALENCE
NHSSB	43	4255
EHSSB	68	6750
SHSSB	31	3077
WHSSB	28	2804
N.I.	169	16886

TABLE 2

Analysis of Hospital Admission/Discharge data

3.10 Data was collected from Hospital and Social Service Trusts across Northern Ireland of admissions/discharges (both psychiatric/medical) relevant to the International Classification of Disease codes covering 'Eating Disorders'. The data, provided by

Department of Health, Social Services & Public Safety Regional Information Branch, is presented covering the period 96/97 to 98/99 in relation to profile of admissions (Tables 3, 4 & 5), length of stay (Table 6) and bed usage (Tables 7 & 8).

- 3.11 Over the period under analysis, there was an average of 104 admissions to hospital per year; only 5% were male and most, ie 90% were people aged less than 45 years. The average length of stay was 33.5 days per admission with overall the equivalent of 9.5 inpatient beds being used per year across Northern Ireland. This bed usage does not include patients who required inpatient treatment outside Northern Ireland.
- 3.12 For all tables the Health & Social Services Boards identified refer to location of admitting Health & Social Service Trust and not necessarily the residence of the patient.

Profile of admissions

Average number of admissions per year (96/97-98/99)

AGE	Male	Female	Total
0-15	0.9	18.4	19.4
16-18	0.0	11.4	11.4
19-24	0.5	20.3	20.8
25-34	1.9	23.2	25.1
35-44	1.4	13.7	15.1
45-54	0.9	4.7	5.7
55-64	0.0	3.3	3.3
65-74	0.0	2.8	2.8
75+	0.0	0.5	0.5
Total	5.7	98.4	104.0

TABLE 3

Average number of admissions per year versus age (96/97-98/99)

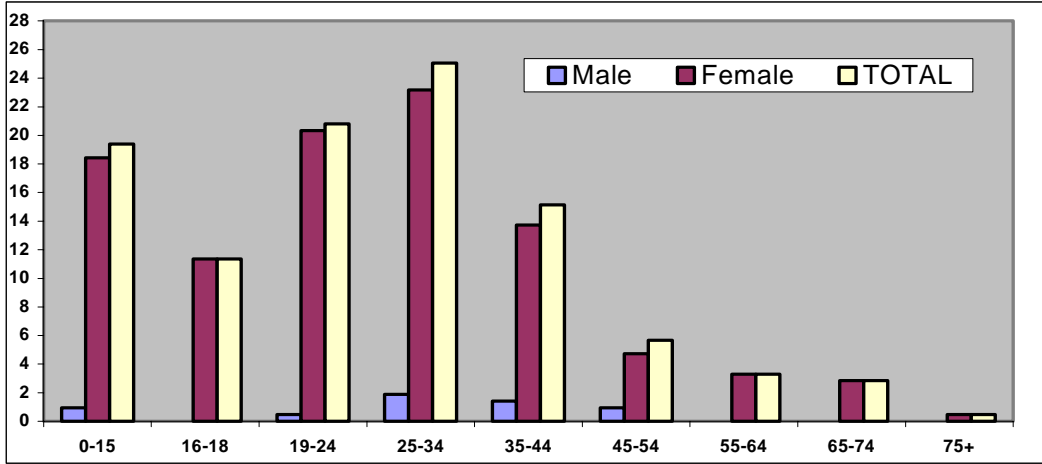


TABLE 4

Average number of admissions per year (96/97 - 98/99)

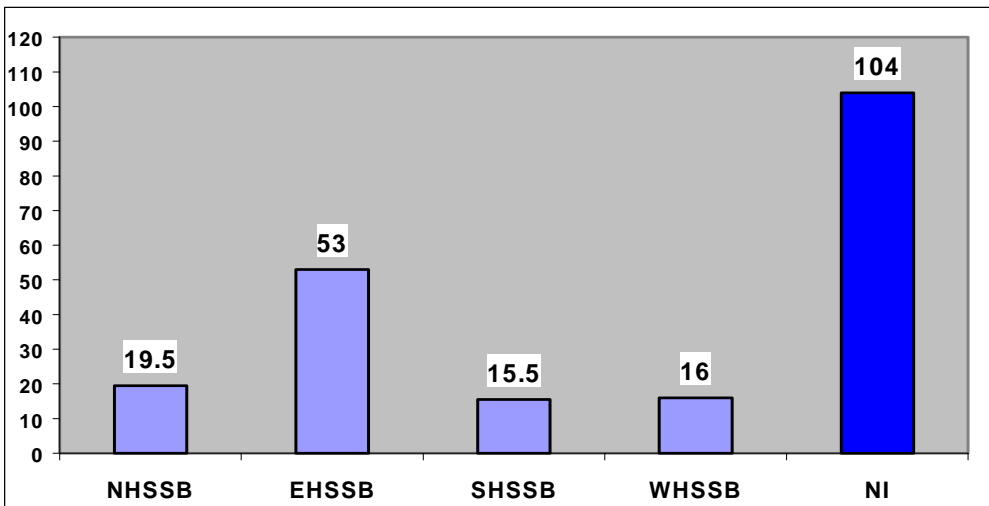


TABLE 5

Length of Stay

Average length of stay (96/97 - 98/99)

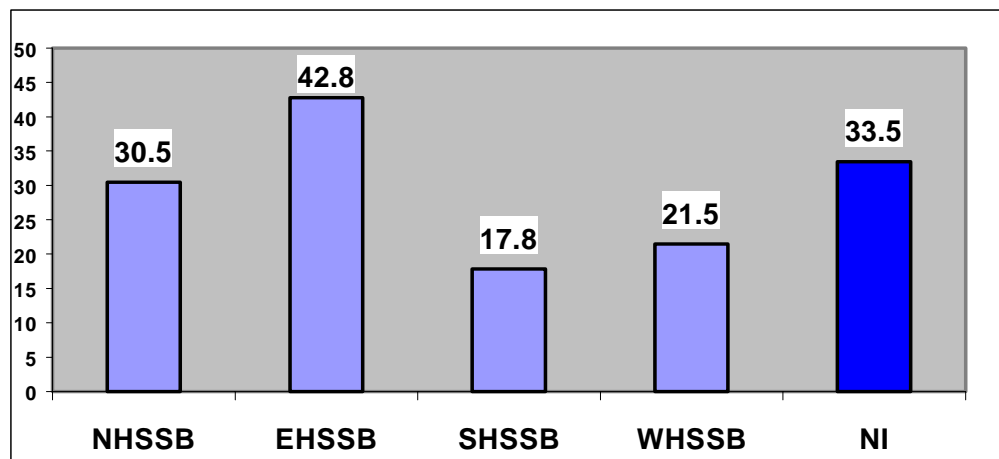


TABLE 6

Bed Usage/In-Patient Beds Required

Average equivalent beds used per year (96/97, 97/98)

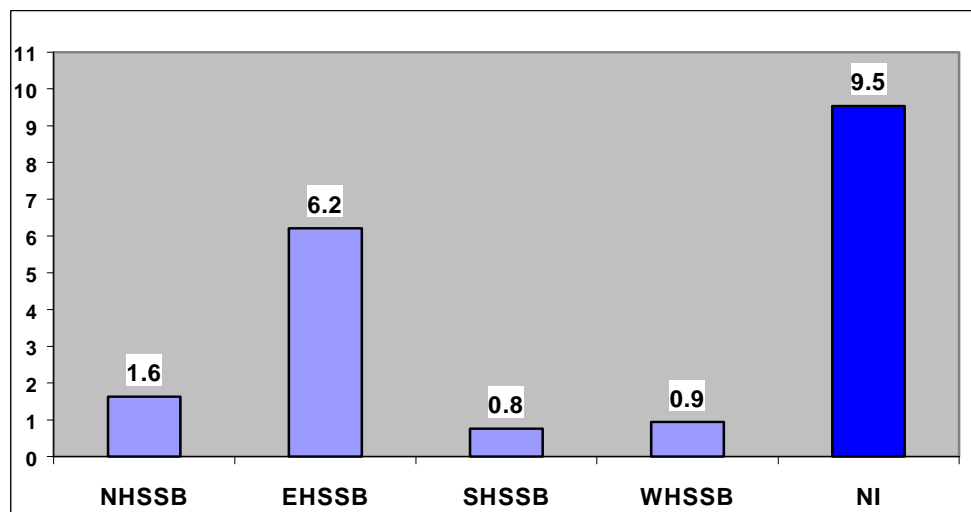


TABLE 7

Average number of admissions per year (96/97 - 98/99)

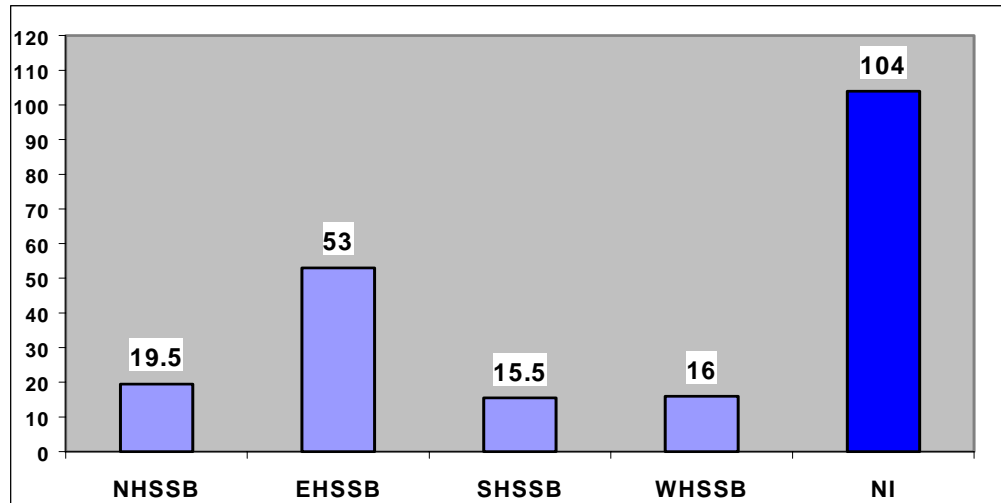


TABLE 8

Referrals for Assessment and Treatment outside Northern Ireland

3.13 Some patients require treatment currently not available within Northern Ireland and this results in a small number of patients traveling elsewhere for care. Between 1997–1999 there were 26 such individuals. Such treatment can be very expensive and also there are other costs such as travel and subsistence for the family and carers while visiting the patient.

3.14 Conclusion

- Around 50-120 people develop anorexia nervosa each year in Northern Ireland; around 170 develop bulimia nervosa.
- There are 100 admissions for ‘Eating Disorders’ each year.

- Overall, in-patient demand is equivalent to around 9.5 beds per year, not including patients requiring in-patient treatment outside Northern Ireland who on average account for approximately a further 2 beds per year.

Does the above describe local need and how do you feel the need for Eating Disorder Services should be measured?

4. **SERVICES ELSEWHERE**

4.1 In Great Britain the structure for the management of eating disorders varies widely between different Health Authorities. General medical and psychiatric services are often supported by a specialist eating disorder service which functions in both a consultative and a treatment role appropriate to the needs of the individual patient. Links may also in place with a tertiary specialist unit. It should be noted that neither the specialist team nor the tertiary unit need be located within the district's boundaries.

Nationally in the United Kingdom

4.2 This data is taken from a survey of available eating disorder services carried out by the Royal College of Psychiatrists which described provision in several regions, including Northern Ireland, as “woefully inadequate”. The survey found:

- 39 NHS units for treatment of Eating Disorders (and 18 private clinics)
- Only about half of health authorities had a specialist service within their area
- Services concentrated in the South East of England
- Lack of specialist services for children and adolescents – none in Northern Ireland.
- Lack of local needs assessment

Eating Disorder Services in Scotland

- 4.3 A recent survey of eating disorder services in Scotland found substantial variation and significant gaps in service provision. Six of the mainland health board areas, with a total population of 1.5 million, were not covered by any (self-defined) “specialist” service. Although most services had access to in-patient facilities there was only one designated bed in Scotland for eating disorder patients, and this was in a non-specialist service.
- 4.4 Out of the fifty two services surveyed only 8 were specialist services, the rest were designated general adult psychiatry (18), clinical psychology (10), child and adolescent (12) and dietetic (4).

Two London Based Services

- 4.5 Two nationally recognised leading centres in this field are based at St George’s Hospital and the Royal Free Hospital which are both in London but have contributed to workshops in Northern Ireland regarding eating disorder services. The St George’s service contains in-patient services while the Royal Free Hospital service does not.

St George’s Hospital Eating Disorders Service

- 4.6 The one building houses 16 adult in-patient beds, 10 child and adolescent in-patient beds and an outpatient service. The catchment population for the service is 622,000 (with 30%-40% of their patients from outside their catchment area). There is the equivalent of 35.6 full-time specialist staff employed covering a range of disciplines including medical, nursing, psychology, psychotherapy and occupational therapy.

Adult In-Patient Unit

4.7 The adult in-patient unit provides 3 treatment programmes - the emergency treatment programme, the 10-week short-term programme and the recovery programme.

a. Emergency Treatment Programme

Aimed at patients with very low weight who on gaining a target weight are returned to the referring agency until ready to enter further treatment programme.

b. 10-Week Short-Term Programme

Aimed at chronic patients who are not likely to recover fully but require help to learn how to maintain their weight at a safer level.

c. Recovery Programme

Aimed at majority of patients.

Separate approaches, a restrictive behavioural programme for anorexia and an impulsive behavioural programme for bulimia, are used and patients will also have undergone preparatory work prior to admission. The patient is engaged in a therapeutic alliance and multiple therapies including group psychotherapy, individual therapy, family therapy, art therapy, assertiveness therapy etc are available.

Hostel Accommodation

- 4.8 Following discharge the St George's Service has a 4-bedded hostel nearby where patients, including those from Northern Ireland, can be accommodated while attending as day patients. Initially, they attend as day patients from 9.00am-5.00pm approximately 7 days per week but this is gradually reduced with increased emphasis placed on normal socialising and support from voluntary groups. In-patients are usually followed up for approximately 2 years with those from Northern Ireland being contacted by phone and also returning at 3 monthly intervals to be seen.

Child and Adolescent In-Patient Unit

- 4.9 The Child and Adolescent In-patient Unit admits persons aged 7-18 years. They are mostly eating disorders but occasionally some suffer from food refusal. Similar approaches are used in treatment, however, less responsibility is put on the patient for their behaviour.

Outpatient Service

- 4.10 The Outpatient Service offers initial assessment of patients to decide if they are suitable for treatment and if so whether this should be as an in-patient or an outpatient. Preparatory work is also done with patients prior to them becoming in-patients at the Unit. Currently 4 outpatient treatment programmes are available consisting of family therapy, cognitive behavioural therapy, dynamic behavioural programme and finally a nurse-based programme with follow up lasting approximately 2 years and aimed at chronic patients maintaining their weight and improving the quality of their life.

Royal Free Hospital Eating Disorder Service

- 4.11 This service provides day patient and outpatient care and is evolving with an increasing emphasis on outreach services. On the rare occasions that an in-patient bed is required this is purchased outside the service from either statutory or voluntary providers.
- 4.12 The service is for patients aged 18 or over who suffer from anorexia nervosa, bulimia nervosa, binge eating disorder, atypical eating disorders and anorexia nervosa or bulimia nervosa complicated by severe personality disorder.
- 4.13 Care is provided by a specialist multi-disciplinary team equivalent to 15 full-time specialist staff and comprising: psychiatrists, specialist psychiatric nurses, psychologists, family therapists, dietician, welfare rights worker, occupational therapist and a range of creative therapists. The service is backed up by the extensive medical facilities available at the Royal Free and the team is supported by 2 full-time secretaries.
- 4.14 The Royal Free service has a catchment population of 1.2 million. Referrals are accepted from GPs, Consultant Psychiatrists or other hospital consultants and patients are usually offered a full assessment within 6-8 weeks of the referral being received. Prioritised cases can be seen within a week.
- 4.15 Prior to assessment patients are asked to complete and return a questionnaire containing demographic and personal information. They are also welcome to bring a relative or friend with them to their assessment appointment, which consists of a detailed semi-structured interview conducted by an experienced member of the clinical team. The interview takes approximately one hour and the patient is then asked to complete three further questionnaires for initial assessment purposes.

Depending on individual circumstances patients may be weighed, offered a full physical examination and have blood and/or bone density investigations ordered.

- 4.16 Referrers receive a copy of the history and the outcome of the assessment. They also receive regular progress reports about treatment. If the patient fails to attend and is discharged, referrers are informed and asked to reassume responsibility. Work is often undertaken jointly with GPs in more complicated cases.

Outpatient Treatment:

- 4.17 The service offers a wide variety of outpatient treatments, which may include one or more of the following:

- Cognitive behavioural group therapy
- Cognitive behavioural individual therapy
- Individual therapy with a nurse, psychologist or doctor
- Family therapy
- Medical monitoring including weight
- Consultation with the dietician
- Use of self-help books
- Massage therapy
- Welfare rights service
- Relatives/carers support group
- Home care in exceptional circumstances

Day-Patient Treatment:

- 4.18 The specialist day hospital runs on weekdays and provides day care for patients who are in immediate need of intensive treatment or have not responded to outpatient treatment.

Elements of care include:

- Medical and psychiatric assessment and monitoring
- Nutritional support and treatment
- Nurse therapy
- Family therapy
- Home assessment
- Full occupational therapy assessment
- Extensive group programme
- User consultation group
- Relatives/carers support group
- Welfare rights service
- Massage therapy

What other examples of services elsewhere should be considered?

5. CURRENT LOCAL SPECIALIST SERVICE PROVISION

- 5.1 Within Northern Ireland there has been increasing concern amongst medical professionals and voluntary groups regarding the lack of services for the treatment of patients with Eating Disorders. In line with other Western societies there has been an increase in the number of patients suffering from these disorders over the past two decades. More recently, the age of onset has been falling leading to an increase in the numbers of children and young adolescents presenting to Child and Adolescent Psychiatric Services.
- 5.2 The majority of patients over the age of 18 years outside the Belfast area are treated within their local Community Mental Health Teams. Where professionals have appropriate training and skills this may be satisfactory for those patients requiring outpatient treatment, but problems can arise particularly where more intensive and complex interventions are required.
- 5.3 Patients requiring admission are currently admitted to local acute medical or psychiatric units. These are often unable to provide the necessary skilled treatment or appropriate environment required for this group of severely ill patients. This has resulted in an increasing number of patients being transferred to Specialist Units in England and Scotland.
- 5.4 Within the Belfast area there is a small specialist service, which can provide a range of treatment modalities to patients at an outpatient level. With an increasing number of referrals leading to long waiting lists this service is now unable to provide a treatment service to patients in other Boards or an emergency assessment service within its own area. Its ability to provide training is limited and further development of the service is currently not possible due to a lack of resources. This specialist

service does provide limited support and training to the voluntary organisations involved with patients and their families and staff from other Boards.

This specialist service is located at the Department of Psychotherapy in Belfast and is currently staffed as follows:-

- 1 H grade Clinical Nurse Specialist;
- 5 ½-day sessions of a Senior House Officer in Psychiatry
- Administrative back-up of 1 secretary.

The service is supervised by a Consultant Psychiatrist in Psychotherapy.

There are approximately 175 patients on the Eating Disorder team caseload and there is currently a 4 month waiting list for new patients. Due to lack of capacity of the Eating Disorder team they currently only accept patients from the Greater Belfast area. There is an increasing demand on services for advice and Second Opinions from professionals outside the Belfast area.

Is this an accurate picture of local specialist services?

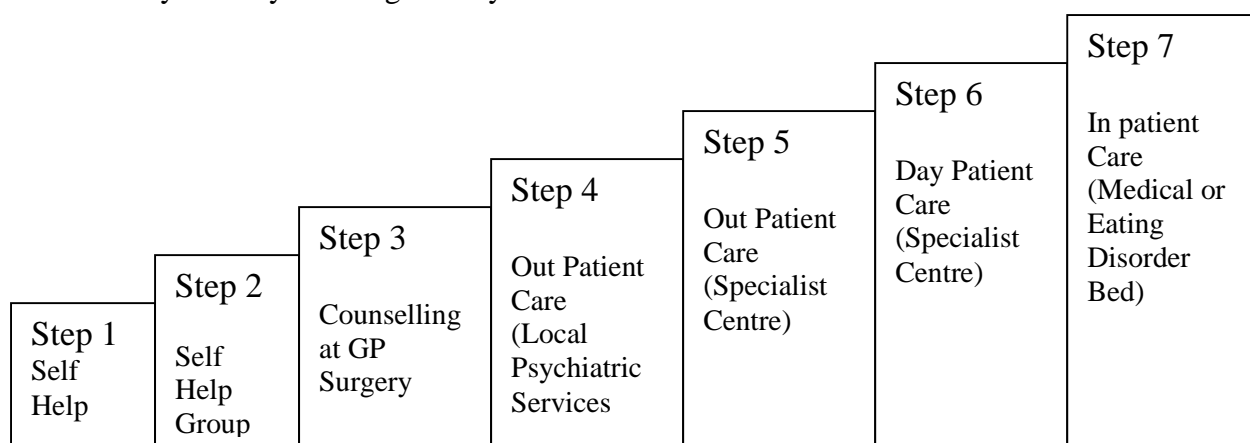
6. GENERAL PRINCIPLES FOR SERVICE PROVISION IN NORTHERN IRELAND

6.1 There have been various models proposed for eating disorder services.

a) The Eating Disorders Association* produced the reports “Eating Disorders – A Guide to Purchasing” and “Providing Services and Eating Disorders – A Guide for Primary Care”. Their recommendations for a model service include:

- a. capacity to recognise eating disorders early in disease cycle;
- b. provision of training and guidance for primary care team;
- c. provision of training for local mental health services;
- d. individual agreed and regularly reviewed care plans;
- e. provision of specialist services;
- f. services specifically for children and adolescents;
- g. funding for self help groups;
- h. systems to monitor the quality of services provided.

b) A Stepped Model of Care for Eating Disorders was put forward by the Royal College of Psychiatrists in 1992.



Stepped Model of Care (Robinson 1998)

*The leading national voluntary organisation providing information, help and support for people affected by eating disorders.

- c) The Audit Commission document “Higher Purchase – Commissioning Specialised Services in the NHS” recommend a “hub and spoke” model of service provision and includes in-patient eating disorder services within this category. This model has a centralised element providing very specialised health technology (in the case of eating disorders this consists of in-patient beds or other intensive care provision) with several “feeder” clinics possibly providing “franchised” care. The model recognises that the recovery period from an eating disorder continues beyond in-patient admission and continuity of care is therefore of prime importance. There is a need for a strong relationship between the specialist centre and local services – the hub and spokes – to allow continuity of care when admission or discharge occurs. Patients would thus move across the boundaries of primary, community and secondary care. Such a model would also allow a hub to develop as a centre for training and research, and could thus contribute to clinical governance with responsibility to provide quality control for any service.

- 6.2 An Eating Disorder Service in Northern Ireland therefore needs to include prevention and early detection, voluntary and self-help groups, primary care based services, local mental health and medical services and a regional specialist service. The service must be co-ordinated across the spectrum of care and must be delivered by well-trained professionals. Treatment provided at all levels should be in keeping with current best practice. It is important to remember that voluntary agencies have an important role in all areas.

Prevention and Early Detection

- 6.3 The majority of eating disorders commence during school age so within schools information should be disseminated on eating disorders and related issues eg self-

esteem and coping with stress. Such information should be made available for teachers and health care workers connected with schools.

Self-Help /Primary Care Services

- 6.4 Early detection of eating disorders and intervention is critical to successful outcomes. A disorder of less than 18 months duration often responds quickly to relatively short-term treatment. This is particularly the case with bulimia nervosa. Unfortunately, due to the secretive nature of these disorders they are frequently not diagnosed until they are well established.
- 6.5 Services including self-help and support groups should be publicised in GP practices and a trained professional available to carry out a physical and psychological assessment, give advice and deliver short-term treatments to appropriate cases as well as initiating referral to the local mental health team.

Local Mental Health Services

- 6.6 Local mental health services should include a named professional with lead responsibility for eating disorders, who has training and experience in this area. There should be support from a multi-disciplinary team and access to day hospital care.
- 6.7 These services should be able to provide treatment for the majority of eating disorder patients within the locality and provide support to the primary care services. Close links should be maintained with the Specialist Service for training, support and referral of complex or resistant cases. The Specialist Service should refer patients back to this service for follow-up.

Local Medical Services

- 6.8 There should be a named consultant physician within each Health and Social Services Board area who is willing to give advice on the physical aspects of these disorders to both primary care and the local mental health services. This physician should be able to provide outpatient and in-patient medical treatment for eating disorder patients and have access to appropriate training. There should also be access to a dietician trained in the care of eating disorder patients.

Specialist Services

- 6.9 These services should undertake a number of key roles.
- Consultation and assessment service to local mental health services and service providers in acute hospital settings such as medical or paediatric units.
 - Training and supervision for primary care and local mental health staff.
 - Specialist treatment for patients with severe disorders along a continuum of care from outpatient to day-patient/in-patient.
 - Monitoring the long-term effectiveness of treatment.
 - A research lead role.

Referrals Outside Northern Ireland

- 6.10 The need for costly referrals outside Northern Ireland will be reduced with the development of a more local specialised service, however, a few patients will continue to require this option and there would be advantages in using only one or

two external units for this service and developing assessment and aftercare programmes in partnership with each unit.

Staff Training

- 6.11 A significant barrier to developing services is the lack of appropriately trained staff. Such training could be arranged on a modular basis and provided for those working at primary care level, community mental health teams and those who may be working as specialist practitioners exclusively with eating disorder.

What amendments would you suggest to the above principles?

7. PROPOSED MODELS FOR SERVICE PROVISION IN NORTHERN IRELAND

7.1 A well developed model for eating disorder services should be based on treatment services being available at all levels of care and delivered by well trained professionals. We propose a four-tier model:

Tier 1 – Primary care and voluntary groups.

Tier 2 – Existing generic mental health services

Tier 3 – Specialist community team/outpatient/day hospital provision.

Tier 4 – Specialist in-patient services

7.2 Since the focus of this document is specialist services Tiers 1 and 2 will only be briefly mentioned.

Primary Care, Voluntary Agencies and existing Generic Mental Health Services

7.3 Not all patients with eating disorders require intensive specialised services. Early interventions may be effective in preventing progression to a more serious condition. These services require additional resources to support greater role/input from community mental health teams, voluntary agencies and primary care in the diagnosis and management of eating disorders. It must be emphasised however, that these developments are dependent on the nature of support available from tiers 3 and 4.

How do you feel Tiers 1 and 2 could be best developed?

Specialist Community Team/Out-Patient/Day Hospital Provision

7.4 Responsibilities of the proposed Tier 3 service:

- Providing an outpatient and day patient service for complex and severe eating disorders and those who have not responded to treatment within the local services.
- Training and supervision of mental health care professionals working at primary and secondary care levels.
- Research and clinical evaluation of the overall service.

7.5 We have considered three options for the future configuration of tier 3 services for eating disorders:

- 1 Maintain existing services
- 2 Establish single regional centre with associated outreach service.
- 3 Establish single regional centre with one or two “outposts”.

7.6 Option one is the situation that will apply if no immediate development of services for eating disorders is possible. It is included here to highlight the fact that this option is not without consequences and costs both monetary and in terms of optimum patient care. The other two options are similar in envisioning a single service for Northern Ireland with a centrally located resource - emphasising the need for a critical mass of expertise - and a model of service at a distance from this centre - tackling the issue of ease of access for residents from all parts of Northern Ireland.

7.7 Outreach teams or outpost staff will provide satellite services to residents of areas where access to the central unit is difficult. They will also provide training to local mental health and primary care professionals. The principal difference between the two models is that an outreach team would be based at the regional centre, using existing health (and other) service facilities for their outreach work. An “outpost” would be a dedicated facility located at a distance from the centre.

Option One – Maintain Existing Services

7.8 Current Tier 3 services exist only within the Greater Belfast area and are described in Section 5. Failure to develop tier 3 services within Northern Ireland will result in continuing dependence on external providers. The development of a single contract with a preferred external unit will be difficult in the absence of a local co-ordinated tier 3 service. Together with the continuing, and probably rising cost of transfers outside Northern Ireland for specialist services, the issues of continuity of care and later diagnosis leading to increased morbidity will also feature in the management of patients with severe eating disorders.

Option Two – Single Regional Centre with Outreach Service

7.9 The Regional Centre would be a centrally located unit, which would serve as a base for all the staff working within the specialist service. A range of therapies would be provided via a regional day patient service as well as outpatient facilities. This unit would be responsible for providing training and supervision to its own staff and co-ordinating training provided to local mental health and primary care professionals. An important role for the regional centre would be in the clinical evaluation of the service and in initiating and participating in single and multi-centre research projects.

7.10 To provide a broad range of appropriate therapies the following are the estimated staff requirements for a regional centre:

- Medical - 1 Consultant Psychiatrist
 1 Staff Grade Psychiatrist
 1 Specialist Registrar
- Nursing - 1 Specialist Clinical Nurse
 2 H Grade Nurses
 4-6 Nurse Therapists (Grade F/G)
- 1 Psychologist
1 Social Worker
- PAMs - 1 Dietician
 1 Occupational Therapist
 2 other Therapy Staff
- 2 Administrative Staff

The annual staffing cost would be approximately £675,000

7.11 The advantages of the outreach service include

- Lower capital costs, although the regional centre may need to be larger than in the outpost model.
- Lower revenue costs permitting, subject to resources, establishment of additional teams.

- Greater geographical flexibility - allowing team members to travel nearer to patients.
- Greater consistency of approach.

7.12 An outreach team requires at least 1 social worker, 1 psychologist, 2 nurses (1G,1H) and 1 administrative staff and overall the annual staffing cost for a team would be approximately £165,000.

Option 3 – Single Regional Centre with Outpost Service

7.13 The regional centre would be as described in 7.3.2

7.14 The advantages of the outpost service include:

- A greater range of therapeutic activity may take place at the outpost.
- Locally based specialised staff may have better communications with local professionals and be better placed to assess their training and support needs.

7.15 An outpost service requires at least 1 social worker, 1 psychologist, 4 nurses (1G,1H,2F), 1 administrative staff and 1-day per week split between a dietician and an occupational therapist. The annual staffing cost for an outpost would be approximately £222,000

7.16 The estimated staff costs of possible variations of combined models are:

Regional Centre and one outreach team	£840,000
Regional Centre and two outreach teams	£1,005,000
Regional Centre and one outpost	£897,000
Regional Centre, one outreach team and one outpost	£1,062,000
Regional Centre and two outposts	£1,119,000

7.17 Ideally we would wish to develop at least two outreach teams/outposts. However, apart from resources, the immediate lack of appropriately trained staff may require expansion of the service to be incremental. Other costs which would need to be considered include travel, subsistence, training, recruitment, equipment and drugs.

7.18 Capital expenditure will be required for the regional centre for new build or refurbishment of an existing building. Costs will depend on the nature and location of the centre. An estimate of the costs of a new build regional eating disorder unit was approximately £1.5m, which would provide a 625m² unit to accommodate the staff listed above.

Specialist In-Patient Services

7.19 There is a debate about whether a local eating disorder service should have local in-patient specialist services (Tier 4). The cost of a local specialist in-patient service would appear to be prohibitive both in absolute terms and in relation to its effect on other levels of the service (out/day patient, community-based and primary care). The experienced professionals required to staff such an in-patient unit are currently not available in Northern Ireland in sufficient numbers for a sustainable service.

- 7.20 We therefore feel that, where specialist in-patient services are required, they should continue to be provided as at present from units located outside Northern Ireland. We would suggest that a preferred provider should be identified to whom all such specialised referrals would be made. Funding would therefore be agreed through a contract on a Northern Ireland wide basis so that extra contractual referrals to other provider units would not be possible other than in exceptional circumstances. Apart from the probable savings resulting from a contractual approach, this would have the benefit of allowing consistent and sustained communication between the in-patient unit and local professionals regarding treatment following discharge. Additionally, local professionals could be seconded to the designated unit for short periods of time to enhance their skills in the management of eating disorders.
- 7.21 Assuming a new more streamlined arrangement can be established for in-patient care with a preferred provider and that appropriate services are developed at tiers 2 and 3 in line with the proposals in this document, overall need for in-patient care within Northern Ireland should be reassessed after an appropriate interval (e.g. 3-5 years). Any such review should be within the strategic context of the 4 tiered model.

CONCLUSION

- 7.22 As mentioned above we do not favour the development of a specialised in-patient unit in Northern Ireland. Neither do we feel that a stand alone regional centre would be sufficient to meet the needs of Tier 3, as this would not address the problem of access from outlying areas. Conversely setting up a number of independent outpost type units would dilute the level of expertise available and ultimately prove to be a more costly approach. We feel the choice lies between maintaining the existing situation and establishing a regional centre with either the outreach or outpost approach.

Which of the options do you favour and why?

What other options do you wish to suggest?

How should specialist services link with other generic mental health services, voluntary agencies, primary care and physical medicine?

How should in-patient services be provided here?

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