

6.7 Eating Disorders

Eating disorders are serious psychological conditions that can lead to severe physical and psychosocial complications. The most commonly recognised eating disorders are anorexia nervosa (characterised by self-starvation and marked weight loss) and bulimia nervosa (recurrent binge-eating accompanied by extreme weight-control measures); presentations that resemble these but do not meet their specific diagnostic criteria come under the category of 'eating disorder not otherwise specified'.

The onset of anorexia nervosa is typically in the mid-teenage years and that of bulimia nervosa in the late-teenage/early adulthood stage.

Overarching Standard 40: Eating disorders – assessment and early intervention

A person with eating concerns/difficulties should have an initial assessment of their needs at primary care level and onward referral to age appropriate mental health specialist services if required. A standardised outcome measurement tool should be used in the assessment in accordance with the Northern Ireland Care Pathway for Eating Disorders and NICE guidelines.

Rationale

Early detection and intervention has been proven to lead to improved outcomes of this debilitating illness.

A standardised care pathway allows equity and consistency while taking into account best practice.

Evidence

Users and carers and voluntary groups testimonials

Bamford Review: The Reform and Modernisation of Mental Health and Learning Disability Services (May 2007) <http://www.rmhdni.gov.uk/>

Regional Care Pathways, Professor Lash/Dr R Bryant-Waugh 2007

National Institute for Health and Clinical Excellence (NICE) (2004). Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders
<http://guidance.nice.org.uk/CG9>

Responsibility for delivery/implementation

HSC Board

Public Health Agency

HSC Trusts

Primary Care

In partnership with other statutory and non-statutory agencies

Quality Dimensions

Person centred – There should be an agreed holistic care plan.

Timely - As in accordance with Regional Care Pathways

Effective - Time managed to access service quickly

Safe - Minimises risk to self

Efficient - Questionnaires for GP's/Users/Carers/Voluntary groups

Equality - Across the trust/across population

Performance Indicator	Data Source	Anticipated Performance Level	Date To Be Achieved By
Agree and implement standardised outcome measurement tool	HSC Trust report	Establish baseline Performance levels to be determined once baseline established	March 2013
Percentage of people being treated where outcome measurement shows improvement after 12 months	HSC Trust report	Establish baseline Performance levels to be determined once baseline established	March 2014

Overarching Standard 41: Eating disorders – treatment and ongoing care

A person with an eating concern/difficulty should have prompt access to therapeutic and medical interventions appropriate to their individual need to include medical monitoring, initial supportive management, psychological therapies, dietetics, occupational therapy and physiotherapy in line with NICE guidelines and the Northern Ireland Eating Disorder Pathway

Rationale

Psychotherapeutic interventions are the mainstay of treatment for these complex psychological conditions that can lead to marked physical and psychosocial complications without such interventions/assistance. Offering a range of interventions promotes a person's engagement with, collaboration in and ownership of therapy. Several structured psychological interventions (e.g. cognitive behavioural therapy for bulimia nervosa and specific family interventions for children and adolescents with anorexia nervosa) are evidence-based treatments for eating disorders. Children and young people with a severe eating disorder can become dangerously unwell in a relatively short space of time. Effective psychological treatment is dependent on achieving initial physical stabilisation and nutritional restoration. Untreated eating disorders can lead to longer-term physical complications (e.g. osteoporosis, infertility) that can have a major negative impact on a patient's quality of life. People with severe and enduring eating disorders have high levels of physical and psychological morbidity and can present with ongoing risk issues. Due to the complexity of need, the necessary input to manage this client group traverses usual mental health boundaries. A planned treatment approach aimed at achieving stability in the community can help avoid repeated crises and recurrent hospitalisation. Even people with severe and longstanding conditions retain the potential to move towards fuller recovery.

Evidence

National Institute for Health and Clinical Excellence (NICE) (2004). Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders

<http://guidance.nice.org.uk/CG9>

Northern Ireland Care Pathway for Eating Disorders (2008)

American Psychiatric Association (2006). Practice guideline for treatment of patients with eating disorders, 3rd edn

DOI:10.1176/appi.books.9780890423363.138660

http://www.psychiatryonline.com/pracGuide/PracticePDFs/EatingDisorders3ePG_04-28-06.pdf

NHS Quality Improvement Scotland (2006). Eating disorders in Scotland: Recommendations for management and treatment

http://www.healthcareimprovementscotland.org/previous_resources/best_practice_statement/eating_disorders_in_scotland_.aspx

Waller et al (2007). Cognitive Behavioural Therapy for Eating Disorders: A Comprehensive Treatment Guide. Cambridge University Press

Yager J & Powers P, Eds (2007). Clinical manual of eating disorders. American Psychiatric Association

Responsibility for delivery/implementation

HSC Board
Public Health Agency
HSC Trusts
Primary Care

Quality Dimensions

Person Centred – People and what is important to them, their family and friends are central to the assessment and early intervention/treatment process. Options should be explored in regard to what would work best for the person given their unique context and lifestyle.

Timely: Appropriate early intervention enhances treatment and eventual outcomes

Equitable: Available in a range of settings in a variety of modalities

Effective: Treatment should be evidence-based where possible

Efficient: Clear referral pathways and treatment protocols

Safe: Risk management is a vital aspect of care

Performance Indicator	Data Source	Anticipated Performance Level	Date To Be Achieved By
<p>Percentage of people (young people and adults) assessed as requiring treatment in:</p> <ul style="list-style-type: none"> • Special Teams • Co-working with Community Teams • Other services • By length of time from assessment to treatment 	HSC Trusts / Regional Eating Disorders Network baseline audit	<p>Establish baseline</p> <p>Performance levels to be determined once baseline established</p>	March 2013
<p>Percentage of people with eating disorders requiring medical and psychiatric admissions by:</p> <ul style="list-style-type: none"> • Length of stay • Re-admission 	Eating Disorder Research by Health Development Officer	Interim Report Performance levels to be determined after interim report	March 2013
<p>Percentage of people referred to specialist eating disorder services who have had appropriate initial assessment and referral in primary care in previous 12 months</p>	Eating Disorders Network	<p>Establish baseline</p> <p>Performance levels to be determined once baseline established</p>	March 2013