

Employing Preventative Care in Eating Disorders

It is estimated up to 3.4 million people in the UK suffer from a type of eating disorder (ED), with the average age of onset ranging from 16-19⁽¹⁾. This is comparable to other very common conditions, such as Diabetes, which an estimated 3.9 million suffer from⁽²⁾, and more common than others, such as COPD, which 1.8 million live with in the UK⁽³⁾. As such, it wouldn't be unreasonable to call the rise of eating disorders an epidemic, affecting primarily the youth of the UK. Using this terminology is not just descriptive, but describes the relatively recent shift in the ideology surrounding most non-communicable diseases, such as cardiovascular disease, COPD, and cancer. This shift has started to put emphasis on addressing risk factors and preventing patients from progressing far into the disease - before they require invasive or expensive interventions. This is the logic behind medications such as statins and practices such as social prescribing. However, for some reason, this same approach has not been applied to the field of psychiatry and mental health, which has similar prevalence and effect on quality of life as many of these physical conditions. When asked what should change about the care of EDs to better aid patients and carers, this is what should be at the forefront of the discussion. In this instance, the psychiatric service would benefit from utilizing public health strategies, as the numbers of ED patients are rising while beds are decreasing across the country. Adopting a preventative care approach, focused on early intervention, to the care of those suffering from eating disorders will decrease burden of disease, hospitalizations, and limit the amount of long-term complications for these patients. This can specifically be achieved by adapting the three scopes of health promotion: disease prevention, health protection, and health education⁽⁴⁾.

Firstly, disease prevention refers to developing "screening programmes" that pick up ED patients early in the course of their disease. This would reduce the burden of disease much later on in their lives. According to a study completed at the University of California San Francisco, approximately 21% of eating disorder patients actually achieve full recovery after psychiatric intervention⁽⁵⁾. Unfortunately, for most patients, eating disorders follow a more relapsing-remitting course for the rest of their lives. Very few patients are "cured" of their eating disorder. Once the patient reaches the point of their illness that they present to the psychiatric service, their mental health and relationship with food is often too malformed, requiring years of therapy and mental distress to undo. This is without mentioning the cost to the NHS (and often the patient) that all these interventions accrue. Physical conditions often rack up similar psychological and fiscal costs, and therefore there have been many public health campaigns working to encourage the public and health providers to engage with screening services that pick up the disease amongst "healthy" individuals and allow for early intervention. Very successful examples are the cervical smear and FIT tests that are now commonplace in general practice, leading to massive improvements in the prognoses of both cervical and bowel cancer respectively. These same principles can be applied to EDs, and mental health disorders in general. By developing a network of care providers surrounding each patient, made up of psychiatrists and GPs, but also those who have a more personal connection to the patient, such as parents, teachers, school nurses, and counsellors, a programme could be devised in schools where the question is asked: "Could this pupil be suffering from an eating disorder?" for each student. Oftentimes, parents or teachers have an idea or fear that their child could have an ED,

but are ambivalent about raising the concern themselves. Having a system in which schools bring this question to parents or teachers or even pupils who might have concerns about themselves or their friends, and then being able to triage these concerns with a GP who might decide to refer this patient to a psychiatrist, would allow many more patients to be picked up much earlier. This could allow GPs, teachers, and parents to sit down with the pupil and address the stressors they might have in their life together as a team. It could allow for much more individualized education about healthy habits, which will be discussed later in this essay. By developing a system in which those who know the young person are able to raise concerns in a structured and systemized manner, potential ED patients could be picked up earlier and have their risk factors addressed before they require intensive psychiatric input.

Next, health protection refers to working with government and organisations to develop legal and fiscal controls that reduce exacerbating factors that may push young people into developing EDs. According to the National Eating Disorders Collaboration, bullying, increasing prevalence of anxiety, and the rise of social media are all major contributors to the rise of EDs amongst young people⁽⁶⁾. This is well-known, and initiatives have already been started by companies and organisations to address the effects social media has on mental health. Several social media platforms have begun requiring accounts to disclose how they have filtered photos, so that viewers know what they are looking at has been digitally altered⁽⁷⁾. Ideally, this would be a legal requirement for social media platforms, magazines, and other media frequently used by at-risk populations, where any digital manipulation of photos or videos would have to be disclosed at the outset. This would increase awareness of what is and is not a realistic body image, and encourage celebration of natural bodies over unrealistic or unhealthy standards. There is some improvement in this regard, with more and more companies involved in beauty or cosmetics opting for diversity in body types and appearances. This is a good change, however there are no controls or incentives in place to promote this positive trend, so there is fear that it could revert back to harmful old practices. By instituting legal requirements and fiscal incentives for the media to promote healthy body image, many psychological and social risk factors for developing an eating disorder could be limited and possibly lead to fewer young people being unhappy in their bodies.

Finally, the single greatest tool care providers have in the fight against eating disorders is health education - the use of accurate, factual information to address the misconceptions patients may have about their bodies, health, and eating disorders in general. While there has been more awareness spread in recent years through social media by charities and organizations such as BEAT, formal education addressing the stigma surrounding EDs and what a healthy relationship with food looks like has been sorely lacking. BEAT refers to the areas of the curriculum that can be adapted to talk about EDs, but there are no strict guidelines or rules from the Department of Education⁽⁸⁾. Pupils are not always aware of what services are in place if they have questions, often because there are no services in place. While they can always go to the GP for answers, most students feel more comfortable in the school environment, receiving teaching from professionals they know. Additionally, age may play a large part in whether young people seek help from the GP, as younger patients may never have approached the GP with questions before. However, every student knows their teacher and has

asked them questions. As such, similar to how a network of care between the school staff, parents, and medical staff should be created to screen for at-risk students, a curriculum should be devised as well, informed by psychiatric/medical services and charities, and delivered by teachers, school staff, and parents. Working medically-informed material into health and physical education delivered across schools would be the single most effective method of reducing the amount of young people who suffer from EDs. While this may already exist in some capacity, it needs to be standardized and be more inclusive, addressing the issues of social media and what healthy social media habits are, what health may look like for different people, and how to minimize the stigma surrounding EDs. Emphasis should be put on the prevalence of these conditions, which may surprise students who may not be aware of how common they are. This would require the coordination of government agencies such as the Department of Education and Ofsted to deliver at a large scale, but the health benefits to both potential ED patients and the mental health of young people in general could not be understated. Information is the greatest tool against ignorance and stigma, and would be most effective in the hands of young people. Systems must be devised, tested, and implemented that give them that information, and could prevent years of suffering, distress, and potentially death.

For any illness or long-term condition, waiting until people are sick is not just an ineffective health strategy, it is also a costly one. It costs millions of pounds to the health service, years off a patient's life, and the general happiness of 3.4 million across the UK. Out of all psychiatric disorders, eating disorders have the highest mortality and morbidity⁽¹⁾. The current ED service is very focussed on individual, curative practices, working to reduce complications and improve quality of life for each patient. While that must be maintained, EDs are too common of an issue to rely solely on this approach for all patients. This can be observed in the growing numbers of those suffering from EDs and the decreasing number of beds in psychiatric hospitals around the country. Young people must be treated before they present at the hospital with starvation, or collapse, or following a suicide attempt. They must be treated earlier, before it ever gets close to that stage. Doctors and nurses, however, are unable to do this alone. It is essential that the ED multidisciplinary team expands to include those closest to the patient, such as teachers and parents, not just in theory but also in practice. Only by doing this through devising screening programmes, implementing regulations on social media, and collaborating on a standard curriculum, will we be able to reduce the number of young people who are suffering from an unhealthy relationship with food. This is how to adapt the care of eating disorders for the future and how to take care of our young people.

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