Eating disorders in the UK: policies for service development and training

Report from the Eating Disorders Special Interest Group of the Royal College of Psychiatrists

Council Report CR87
October 2000

Royal College of Psychiatrists
London

Due for review: 2004

Contents

Membership of the Eating Disorders Services Working Group 5

Executive summary 6

Part 1: Background to the present survey, its main findings, and conclusions drawn

1. Background 11
2. Summary of the main findings 15
3. Service developments since the 1991 survey 17
4. Recommendations – what needs to happen now 18
5. Conclusions 24

Part 2: The survey and its results

1. Survey methods 27
2. Main findings 29
3. Results of the survey of health authorities 31
4. Results of the survey of clinics 32
5. Criteria for a comprehensive eating disorders service 37
6. Services for children and adolescents 39

References 44

Appendix 1. 'Eating disorders' – extract from *Health Which*, April 1998 45

Appendix 2. List of eating disorders services responding to the survey 52

Appendix 3. Specialist eating disorders services offering treatment to children under 16 years of age 58

Appendix 4. List of general child and adolescent services responding to the survey 60
Appendix 5. Distribution of NHS eating disorder units in the UK in 1991 61
Appendix 6. Distribution of NHS and private eating disorder units in the UK in 1998 62
Appendix 7. Standardised mortality ratios for mental disorders 63

Membership of the Eating Disorders Services Working Group

The Eating Disorders Services Working Group was formed from the Eating Disorders Special Interest Group of the Royal College of Psychiatrists:

Dr Paul Robinson (Chair), Royal Free Hospital, London
Professor Gerald Russell, Maudsley Hospital, Hayes Grove Priory Hospital, Kent
Professor J. Hubert Lacey, St George's Hospital, London
Dr Bryan Lask, St George's Hospital, London
Dr Harry Millar, Royal Cornhill Hospital, Aberdeen
Dr Lisa McClelland, Wonford House Hospital, Exeter
Dr Robert Palmer, Leicester General Hospital
Dr Tim Newton, Eating Disorders Association
Ms Sue Todd, Consumers' Association
Ms Irit Levy, Researcher for Consumers' Association and Eating Disorders Special Interest Group

Executive summary

1. Eating disorders are serious and common illnesses with among the highest standardised mortality ratios of any psychiatric disorder.
2. A College survey of services for patients with eating disorders published in 1992 (Council Report CR14) demonstrated that local specialist services are often absent, and that patients may have to travel long distances from home for treatment.
3. In order to review national provision for eating disorders, a further survey was undertaken of services in health authorities and boards and all NHS and private services providing specialist treatment for patients with eating disorders. Services for obesity were not surveyed.
4. In addition, services providing care for children and adolescents were identified and separately surveyed, and, finally, a selection of general child and adolescent services was surveyed to assess their contribution to the treatment of young people with eating disorders.
5. In comparison with the position in 1992, the number of NHS units for the treatment of eating disorders increased from 21 to 39. In addition, 18 private clinics were identified. The earlier survey had found that services were irregularly distributed, with proportionately more in the South East. Many areas of the UK remain poorly provided with eating disorder services. Only about half of health authorities had a specialist service within their area, while under two-thirds had a consultant psychiatrist with at least three sessions devoted to eating disorders. There were training positions at senior house officer (SHO) or specialist registrar level (SpR) in only half the clinics.
6. We established criteria for a specialist service as follows:
   (a) There will be least 25 new referrals per annum.
   (b) A multi-disciplinary staff team is required, including at least one consultant psychiatrist, one nurse and one therapist.
   (c) Out-patient and in-patient treatment are provided.
   (d) Patients are offered individual and family interventions.
7. Services for children and adolescents with eating disorders tended to provide a wider range of therapies, but were even more unequally distributed, with four regions, containing 25% of the UK population, having no available specialist service. There was little evidence that children from these areas were either being referred out or treated in generic child and adolescent services.
8. The new survey demonstrates that services for the assessment and treatment of severe eating disorders remain inadequate in large parts of the UK.

9. Our recommendations are summarised as follows:
   (a) Each health authority or health board and/or primary care group (PCG) or primary care trust (PCT) should identify local need for services for adults and for children and adolescents with eating disorders, taking into account the views of users and user groups.
   (b) Purchasers should establish adequate local services, shared with other purchasers when appropriate, led by consultant psychiatrists, to meet locally identified need. A ratio of one full-time equivalent (FTE) consultant post per million population should be provided for eating disorders in adults.
   (c) Services for eating disorders should be planned together with services for patients with psychiatric disorder in both primary and secondary care. Some conditions can be dealt with partly or fully by generic services, with support from local specialist services.
   (d) We recommend the provision of six beds (or a combination of fewer beds and intensive day places) per million population, together with two or three local out-patient clinics, for patients over 16 years of age. The total cost of this per million population is likely to reach approximately £1m. This rule of thumb (£1 per person in a population) should be regarded as a minimum expenditure.
   (e) Recommendations for the treatment of children under 16 years of age should be developed under the auspices of the College's Faculty of Child and Adolescent Psychiatry.
   (f) Consultant numbers: given the current distribution of consultant posts,we believe that around 40 whole-time equivalent (WTE) or 80 half-time consultant psychiatrists will be required to fill the identified need for the treatment of adults (over 16 years of age) with eating disorders. It will be necessary for the College to consider the training and workforce implications at SpR level. The Eating Disorders Special Interest Group (EDSIG) will make its recommendations for training available to the College.

Part 1

Background to the present survey, its main findings and conclusions drawn

1. Background

Eating disorders are common conditions affecting mainly, but not exclusively, young women. They include anorexia nervosa, bulimia nervosa and binge eating disorder characterised by their predominant symptom (Table 1), but many cases represent intermediate forms. Children and middle-aged or even elderly people can be afflicted, and males form a significant minority. In their less severe forms, these disorders produce distress, with physical, psychological and social morbidity, and secondary psychiatric disorder, mainly depression. In their most severe forms, they lead to chronicity, disablement and, at times, death. Surveys suggest a prevalence rate for clinically severe eating disorders of 1–1.5% of young women (Hoek, 1991). Eating disorders are associated with high mortality. The standardised mortality ratio (SMR) for eating disorders (see Appendix 7) has been estimated at 538, compared with 136 to 197 for depression, schizophrenia and alcoholism (Harris & Barraclough, 1998). For anorexia nervosa, observed mortality rates vary in different studies from 0% to 21% with a mean of 5%, and chronicity occurs at a mean rate of 20% (Steinhausen, 1995). Low mortality rates are reported by clinics selecting more highly motivated patients. The higher figures represent less selected samples.

Table 1. Some features of three eating disorders

	Anorexia nervosa	Bulimia nervosa	Binge eating disorder
Defining features	Low weight, morbid fear of fat, amenorrhoea	Normal or increased weight, binges, vomiting (or other compensatory behaviour), body image psycho-pathology	Bingeing without compensatory behaviours
Other features	High mortality, chron-icity and morbidity. Depression common	Often hidden. Physical compli-cations, depression. Mortality unknown	Often associated with obesity. Mortality increased by obesity
Epidemi-ology	Prevalence (in young women) approximately 0.4%. One in 10–20 is male	Prevalence 1.5% in young women. Unrelated to social class	Unknown

Effective treatment is available, and, especially if provided early, can avoid the physical and psychosocial disabilities common in long-term cases. Treatment of eating disorders requires skills acquired in medical, psychiatric and psychotherapeutic training, and professionals who have taken the lead in the study and treatment of the disorders have included physicians, psychiatrists, psychotherapists and psychologists.

Services for eating disorders in the UK were initiated by a small number of interested physicians and psychiatrists, mainly in academic centres. As a result, the services developed in an uneven way, often unrelated to morbidity present in local populations. In 1991, a survey of eating disorder services was undertaken by the Royal College of Psychiatrists Eating Disorders Working Group, later the Eating Disorders Special Interest Group (EDSIG) (Council Report CR14; Royal College of Psychiatrists, 1992). In that survey, only 21 specialist eating disorder services were identified in the NHS (Appendix 5). It was not possible to survey the private sector because of poor response to questionnaires. Services were concentrated in the South East of England, with many areas completely devoid of specialist services. The report ended with a number of recommendations for clinical resources, as follows:

1. Regional services with at least six beds and five additional consultant sessions should be established.
2. Local services spanning one or two districts with at least two consultant sessions should be provided.
3. Supra-regional services should continue.
4. The special needs of children and adolescents should be considered. Services should be provided as near to the patient's home as possible.
5. In addition, recommendations were made regarding the provision of facilities for medical and nursing psychiatric training and research and it was further recommended that the College recognise Eating Disorders as a subcommittee of the Specialist Section of General Psychiatry.

The extent to which these various recommendations have been addressed is discussed in this report.

A survey on consumer attitudes was also performed in 1992, in collaboration with the Eating Disorders Association (EDA). This survey revealed widespread dissatisfaction with existing services, and the majority of respondents recommended improved training for doctors and more availability of health workers specially trained in the treatment of eating disorders (Newton *et al*, 1993).

The NHS reforms of the early 1990s made private services and distant specialist NHS services much more accessible to patients with eating disorders. Public knowledge about eating disorders was becoming greater, particularly as some high-profile personalities, both male and female, discussed their disorders openly.

In the wake of these changes, the College, in 1997, invited the EDSIG to repeat the earlier survey with a view to updating the 1992 Report. Around the same time, the Consumers' Association expressed an interest in looking at similar

questions as research for an article in their publication *Health Which?* With the approval of the College, the EDSIG collaborated with the Consumers' Association and a survey was performed. The article was published in the April 1998 edition of *Health Which?* (Appendix 1).

The Government, in recent publications, has indicated that eating disorders require more consistent and comprehensive services:

The National Service Framework (NSF) for Mental Health (Department of Health, 1999) notes that eating disorders vary greatly in severity and respond to a variety of treatments:

> "Severe eating disorders such as anorexia and bulimia can result in long term ill health, and may cause death.
>
> Most mild eating disorders can be managed within primary care. Dietary education and monitoring of food intake are effective components of treatment. Antidepressants may be effective in panic and eating disorders.
>
> Individuals with severe disorders should be referred for specialist assessment, including a full medical and psychiatric assessment.
>
> While family therapy seems very effective in younger people, adults with anorexia are more likely to respond to individual eclectic psychotherapy, and those with bulimia to group or individual cognitive behavioural therapy. Antidepressants can reduce purging and bingeing whether or not the person is also depressed. Computer programs can be used to give individuals accessible, structured information." (NSF, p. 33)

The NHS Plan proposes improved services for women:

> "*Services for women*
> **14.33** Mental health services are not always sensitive to the needs of women. Yet women are more likely to suffer from mental health problems, particularly anxiety, depression and eating disorders." (NHS Executive, 2000)

The NSF recognises the importance of specialist services:

> "Commissioning in the new NHS (HSC 1998/198) identified a number of more specialised services, including medium and high secure psychiatric services, services for severe eating disorders, mother and baby units, early dementia, and gender dysphoria. These services will continue to be provided within specialist mental health NHS trusts." (NSF, p. 14)

The vital role played by primary care in collaboration with specialist services was discussed in the NSF:

> "The most common mental health problems are depression, eating disorders, and anxiety disorders. Many of these disorders can be treated effectively in primary

care, but some will need fast referral to specialist services. Effective interventions include medication and psychological therapies, alone or combined." (NSF, p. 32)

"*Strengthening primary mental health care*
Primary care groups should work with primary care teams and specialist services to agree and implement assessment and management protocols across the primary care group, initially for people with depression, including the assessment of any risk of suicide. Further protocols should be implemented for postnatal depression, eating disorders, anxiety disorders, and for people with schizophrenia. The majority of mental health care will remain within primary care as at present. The protocols will ensure that more complex cases receive ready access to skilled specialist assessment and treatment, including psychological therapies, and continuing care." (NSF, p. 38)

The NSF recognises the role of collaboration between different agencies in the management of severe eating disorders:

"People with recurrent or severe and enduring mental illness, for example schizophrenia, bipolar affective disorder or organic mental disorder, severe anxiety disorders or severe eating disorders, have complex needs that may require the continuing care of specialist mental health services working effectively with other agencies. Most people manage well with this care and benefit from living in the community, posing no risk to themselves or others." (NSF, p. 46)

Lastly, the importance of having in place financial systems capable of facilitating access to specialist care was also described in the NSF:

"*Finance: revenue, capital and estates*
Aim
To ensure health authorities, primary care groups and local authorities make the best use of resources from mainstream allocations, the Mental Health Modernisation Fund, and Mental Health Grant in delivering comprehensive local mental health services to the standards set out in this Framework."

Present position
The National Service Framework sets standards and defines service models for the promotion and treatment of mental health. Carrying through the programmes required to support local delivery of standards and models will need commitment and investment at national and local level. Vital core functions that must be in place to provide comprehensive services are:

- agreed protocols between primary care and specialist mental health services to ensure speedy access to primary care and specialist services
- agreed protocols to guide referrals for specialised services, such as medium secure care or eating disorder units." (NSF, p. 108)

2. Summary of the main findings

The methodology and detailed results of the survey can be found in Part 2 and the accompanying tables. The main findings of our survey are as follows:

1. The distribution of services in the UK has improved markedly since 1991, the time of the last survey, when 21 clinics were found in the NHS. There are now 39 NHS clinics, and, in the private sector, from which far more responses were obtained, 18 clinics were found.
2. There is a concentration of services in the South East, with many other parts of the country still relatively impoverished. This finding is confirmed whether provision is measured in terms of clinics, referrals, staff or extra-contractual referral (ECR) expenditure. An improvement in services in Northern and South Western England, Northern Ireland, Scotland and Wales is required to match the services provided in the South East.
3. Many local health authorities use services outside their areas, and only 33% have specialist services within the area.
4. There is expenditure of over £8.3m on ECRs for treatment of eating disorders in the UK. Given the response rate of 70% of health authorities, the true figure is likely to be of the order of £12m, or about £204 000 per million population. Even if local services are providing care for patients with eating disorders, this indicates that spending on local services for eating disorders is inadequate in much of the country. Estimates of the likely prevalence of eating disorders by health authorities demonstrates very poor information about local need, with most authorities grossly underestimating the scale of the problem. Many failed to answer.
5. Consultant psychiatrists are found in only three-quarters of clinics, and make up a similar proportion of lead clinicians.
6. There are relatively few psychiatry trainees in clinics, indicating that training opportunities are not being properly utilised.
7. A range of treatments is being provided. However, the use of family therapy and day care is lower than that of other accepted methods.
8. Using a range of pieces of clinic information, based on activity level, staff provision, range of treatments available and intensity of treatment, a set of minimum criteria for specialist clinics were developed. Only 56% of clinics fulfilled all criteria, with individual clinics falling short on a variety of criteria.
9. Services for young people with eating disorders were sampled. Inequality of provision around the country of these services in particular was found to an even greater degree than that found in general. The range of treatments found was broader than those found in adult services. Access to some educational activity is available in most clinics, but there is room for improvement. The level of liaison with paediatric services is

surprisingly low. In a small survey of generic adolescent services, willingness to treat young people with eating disorders was found universally. However, it appeared that relatively few patients are actually being treated as in-patients or day patients in generic units.

In brief

1. Since 1991, the number of NHS clinics has increased from 21 to 39.
2. Many areas outside the South East remain starved of services.
3. Spending on eating disorders is grossly inadequate.
4. Existing training opportunities are not being utilised.
5. Of existing clinics, only half meet minimal criteria.
6. Treatment of children with eating disorders is inadequate.

3. Services developments since the 1991 survey

Recommendations of the 1991 survey are in italics.

1. *Regional services with at least six beds and five additional consultant sessions should be established.*
   Each region, except Wales, had a service, sometimes private, most commonly NHS, which met this criterion.
2. *Local services spanning one or two districts with at least two consultant sessions should be provided.*
   Only one-half of local purchasers had specialist services within the area. Most were using ECR arrangements to fund specialist treatment.
3. *Supra-regional services should continue.*
   All such services identified in 1991 have continued to function.
4. *The special needs of children and adolescents should be considered.*
   There has been no fully systematic survey specifically aimed at this age group, but services for young people with eating disorders were sampled.
5. *Services should be provided as near to the patient's home as possible.*
   Local treatment has still not been achieved in many places.
6. *Facilities should be provided for the inclusion of eating disorders in medical and nursing psychiatric training.*
   There appeared to be more placements potentially available for experience in the field but, because of workforce restrictions on the appointment of new trainee psychiatrists at senior house officer (SHO) and specialist registrar (SpR) level, these were often not being utilised.
7. *Research into eating disorders should be promoted.*
   This was not specifically addressed in this survey.
8. *The College should recognise Eating Disorders as a subcommittee of the Specialist Section of General Psychiatry.*
   Eating Disorders was indeed recognised as a subcommittee of the Specialist Section of General Psychiatry. It later separated to form a Special Interest Group of the College (the EDSIG).

4. Recommendations – what needs to happen now

Working groups

Each health authority or health board and/or primary care group (PCG) or primary care trust (PCT) should set up working groups with the following brief:

1. To identify local need for services through primary and secondary care and voluntary sector surveys and focus groups.
2. To meet local need for services by appointing a consultant psychiatrist with the requisite number of sessions and staff and other support.
3. To identify the types of services needed (out-patient, in-patient, day patient, domiciliary, etc.) and to work with other authorities at a regional level to establish appropriate services available to more than one authority area.
4. To identify local need for the treatment of children and adolescents with eating disorders, and to establish the degree to which local provision meets those needs.
5. In all efforts to determine local needs for services, potential users of services and their families should be consulted and included in planning groups wherever possible.
6. Services should be planned so that existing services in primary and secondary care are supported in identification and treatment of eating disorders and in the rapid referral of patients requiring specialist services to the local specialist. The thresholds for referral between the three types of service will vary in different settings, depending on local expertise and morbidity.

Recommended service provision for adults (aged 18 years or over) and adolescents aged 16–18 years with eating disorders

We recommend the provision of six beds (or a combination of fewer beds and intensive day places) per million population, together with two or three local out-patient clinics, for patients aged over 16 years. The total cost of this per million population is likely to reach approximately £1m. This rule of thumb (£1 per person in a population) should be regarded as a minimum expenditure. A suggested staff budget for such a service is provided in Table 2, based on the recommendations of the EDSIG and the EDA. It should be noted that the budget applies only to staff costs, and does not include additional costs often applied by trusts that can amount to an extra 25%.

The suggested budget, although substantial, should take into account the ECR/out-of-area treatment (OAT) spending of authorities (estimated at £12m) and the expenditure by general psychiatric and medical services on care for these patients.

Table 2. Approximate staff budget for an eating disorders service per million population (over 16 years)[1]

	WTE	Total approx. cost (£)
Medical budget		
Consultant psychiatrist	1.0	50 000
SpR	1.0	28 000
SHO	1.0	24 000
Consultant psychotherapist	0.5	25 000
Nursing budget		
Costed at F grade	24.0	504 000
Dietician	1.0	20 000
Psychologist	2.0	70 000
Family therapist	2.0	70 000
Occupational therapist/ creative therapist	3.0	60 000
Secretary	2.5	50 000
Chef	0.5	10 000
Administrator/manager	1.0	35 000
Total		**946 000**

1. One central unit with beds and/or intensive day care.One or more community eating disorder units (out-patients and outreach).

It is likely, however, that substantial numbers of patients receive inadequate care, and this indicates that most authorities and other purchasers will need to spend more on eating disorders than they have hitherto.

Recommendations for the treatment of children under 16 years of age should be developed under the auspices of the Faculty of Child and Adolescent Psychiatry. Management of patients aged 16–18 years should be negotiated locally between adult and adolescent services so that the patient receives the best available care, if possible avoiding transfers of care mid-treatment.

The recent White Papers and the proposed dismantling of the always imperfect internal market in health care has important implications for the provision of specialist services to people with severe eating disorders. Hitherto, the ECR mechanism has been widely used. The new pattern involves the substitution of OATs and service-level agreements in the context of a framework of specialist commissioning. Regions have a responsibility to oversee and coordinate services that are ‘specialised’ in the sense that they are sufficiently rare and/or expensive to make their commissioning by PCGs or districts inappropriate. ‘In-patient anorexia nervosa’, ‘in-patient eating disorders’, ‘anorexia nervosa’ or simply ‘eating disorders’ have been mentioned in various documents as falling within this

category and it seems certain that at least a part of specialist practice in relation to eating disorders will come under the provisions of specialist commissioning. In the long run, this holds the promise of greater coordination and perhaps rationality. However, there is the need to address the dilemma involved in providing services that are locally accessible but also able to offer highly specialised interventions, such as admission, to those who need them. Some sort of 'hub and spoke' system as advocated by the Audit Commission (1997) document *Higher Purchase* may well be the best way of approaching this dilemma. However, in the short term, the new context may well destabilise present patterns of provision without providing the means for new services to develop.

The NSF for Mental Health (Department of Health, 1999), quoted in the report, recommends that treatment of severe eating disorders be commissioned from specialist services. It also recommends the importance of effectiveness of services, the prevention of suicide, access through primary care, the welfare and support of carers and the promotion of mental health. Our recommendations, by bringing specialist care within reach of local populations, address these important objectives.

Summary of recommendations

1. Each purchasing group should establish local needs and plan appropriate services.
2. Consultant psychiatrists should be trained and appointed in areas currently lacking specialists.
3. Per million population:
   (a) one WTE consultant psychiatrist;
   (b) one unit of six beds or a combination of fewer beds and intensive community treatment;
   (c) two or three out-patient clinics; and
   (d) a minimum budget of £1m.

Consultant numbers

1. The number of training positions available is inadequate to meet the demand for consultants in this area of care.
2. The low numbers of training grade psychiatrists reflects, in part, difficulty in obtaining approval from the Department of Health for additional posts.
3. Specialist training in eating disorders is required because of the unique mixture of psychiatric, physical and psychosocial problems faced by sufferers and their families.

The above recommendations would suggest a total of about 60 WTEs for the country for the treatment of adults with eating disorders, one WTE consultant post per million population. Adding up consultant sessions available at present

gives a total of about 23 WTEs, with many of the sessions in the private sector. This suggests that at least 37 consultant WTEs are required to bring the country average up to one per million population. This could be implemented differently in different areas, but, in one model, there would be, per million population, one service with out-patient, community, day patient and in-patient services, and one providing out-patient and community services. A suggested distribution of staff over the two types of service is provided in Table 3.

Our recommendation that one WTE consultant be employed per million population could be realised in a number of ways, with whole-time, part-time and shared posts all being feasible. A half-time post could be combined with

Table 3. Suggested distribution of staff across two teams serving a population of one million

	WTE
High-intensity treatment team providing out-patient, day patient, in-patient and outreach services	
Consultant psychiatrist	0.6
SpR	0.5
SHO	0.5
Consultant psychotherapist	0.3
Nurse	20.0
Dietician	0.6
Psychologist	1.0
Family therapist	1.0
Occupational therapist/creative therapist	3.0
Secretary	1.5
Chef	0.5
Administrator/manager	0.6
Total staff	**30.1**
Out-patient treatment team providing out-patient and outreach services	
Consultant psychiatrist	0.4
SpR	0.5
SHO	0.5
Consultant psychotherapist	0.2
Nurse	4.0
Dietician	0.4
Psychologist	1.0
Family therapist	1.0
Occupational therapist/creative therapist	0.0
Secretary	1.0
Chef	0.0
Administrator/manager	0.4
Total staff	**9.4**

academic sessions (in university senior lecturer posts, for example), general hospital liaison psychiatry or psychotherapy. We understand that there is cautious support for this suggestion from the Faculty of Psychotherapy, with which body we would welcome discussions. The possible combination with a general adult post requires careful planning, so that the workload on the general adult and eating disorders services is roughly balanced.

The implementation of this plan would require the creation of around 80 new posts with eating disorders as a half-time responsibility around the country. This figure is based on the assumption that each of the new consultants would have five sessions devoted to eating disorders.

In order to make a start on this process, we recommend that at least 40 consultants with specialist training in eating disorders be trained and appointed over the next few years. This will require extra approved training posts to work, at least half-time, in each of the specialist services identified, as long as an approved consultant trainer was in post. We are of the view that such posts should be at both SHO and at SpR level. The EDSIG is developing recommendations for the training of consultants in this field, and these should be applied when new consultant appointments are being made.

The recommended staffing in Table 2 calls for consultant psychotherapist time to be available for assessment and supervision of the broad range of therapies required by patients with eating disorders. The training implications of this are substantial, in that each population base of one million would have access to a half-time consultant psychiatrist in psychotherapy.

It is conceivable that the lead consultant for eating disorders could be a consultant psychiatrist in psychotherapy (as it now is in at least one service), which might reduce a little the overall requirement for consultant time. We would welcome comments from the Faculty of Psychotherapy on this proposal.

The role of the College

1. To establish criteria for training of new consultants in eating disorders.
2. To encourage specialist training posts at both SHO and SpR level.
3. To develop quality standards for specialist services.
4. To commission a comprehensive survey of services for children with eating disorders.

Models of care

The pattern of care provided in the substantial number of centres that exist appears to be a stepped care model with access to out-patient and in-patient care, with a large number of developing day care facilities. The preferred model of care is one in which the least disruptive effective treatment is provided as near to the patient's home as possible. The provision of local care is consistent with day care as a prominent part of treatment for more severe cases, with in-

patient care reserved for those who fail to respond or whose life or health are immediately at risk. Support of local community mental health teams, and of teams based in primary care by means of advice, education, consultation and joint working, form an essential part of this model.

We strongly recommend that specialist eating disorder services are led by a consultant psychiatrist. The frequent occurrence of serious, life-threatening physical complications as well as psychiatric disorder in these patients demands the leadership of a physician trained in both medicine and psychiatry in planning, managing and supervising services, as well as providing medical backup to non-medical therapists and nurses.

Child and adolescent services

Funding for the treatment of children with eating disorders must be brought up to a high standard around the country. It is undesirable for a child to be treated in a unit far from home, and local services to meet the needs of local populations are mandatory. However, some children require very intensive and specialised treatment, and the local provision of appropriate services for this small group provides a substantial dilemma. While a unit providing high-intensity care for adults may be justified per million population, for children the figure may be nearer five million, and for very young children the figure would be higher still. In view of the age of onset of many eating disorders in late adolescence, the provision of services to young people aged 15–25 years could be seen as a logical development that would require contributions from services oriented to both adolescents and adults.

A detailed survey of the specific needs of children and adolescents is required and should be undertaken by the Faculty of Child and Adolescent Psychiatry so that recommendations can be made to inform the local provision of services for children and younger adolescents with eating disorders.

The role of the private sector

It has already been mentioned that services in private clinics have, since the NHS reforms of the early 1990s, become available to NHS patients. They have filled in gaps in NHS services that exist in most parts of the country and have introduced many patients and families to treatment of the highest quality. This process may have contributed to the completely justified demand that the best treatment should be available to all those who require it under the NHS. However, until the NHS can itself respond to this unmet need and provide an acceptable level of service, it is very important that the contributions from the private sector are not undermined.

5. Conclusions

Services for eating disorders are excellent in some parts of the country. However, they are inadequate and potentially dangerous in other parts, with patients living many hundreds of miles from specialist services. It has been demonstrated that specific treatments, delivered by experts, can greatly improve prognosis in severe cases, while there is a clear role for primary and secondary care in the early detection of cases, in the treatment of less severe forms of the disorders and in the sharing of care in patients with chronic eating disorders. We believe that the variation in level of provision from one part of the UK to another is wholly unacceptable. It means that the quality of a patient's treatment depends to a large extent on the patient's address. We call upon the College, health purchasers and the Government to work to improve the quality of training and care throughout the UK, so that it is up to the standard available in parts of the South East of England.

Part 2

The survey and its results

1. Survey methods

In order to prepare the present report, a working group was formed from the members of the EDSIG. The data collected by the Consumers' Association were scrutinised in detail and agencies were contacted in an attempt to increase the proportion of responders in the survey.[1]

The Consumers' Association survey, in which there was full participation at all stages by the Chair of the working group (Dr Paul Robinson), was performed in a number of stages:[2]

1. All health authorities were surveyed.
2. All eating disorder units were surveyed.
3. Eating disorder units seeing children were surveyed.
4. A sample of generic child and adolescent services was surveyed.

The first stage was designed to identify as many specialist clinics as possible, and the second to document the services offered by each clinic.

In order to survey in more detail the provision of services for children and adolescents, two small-scale surveys were performed among specialist units providing treatment for children, and a sample of general adolescent units.

Stage 1

In this phase, all the health authorities and boards in the UK were sent a questionnaire. This requested information on the way in which the treatment of eating disorders was managed in the area, including the name of the service used by the authority and the expenditure on ECRs for out-of-area referrals. The authority was also asked to estimate how many people with eating disorders were likely to be living within the catchment area of the authority, and whether the authority had conducted a survey to establish local needs for services. Authorities that did not reply were sent a second questionnaire, and were then contacted by telephone to encourage a response.

Stage 2

In the second phase, the services identified by the health authorities, as well as those known to the EDSIG, were sent a second survey questionnaire. This was a

1. It is acknowledged that some clinics providing excellent care may have been missed by the survey.
2. The expert assistance of Irit Levy in the collection of data is gratefully acknowledged.

wide-ranging questionnaire, requesting information on clinical activity, staff and treatment. Services failing to reply were contacted, sent a further questionnaire if necessary, and contacted again.

Further study of child and adolescent services (Stages 3 and 4)

After the main results had been collated, a further questionnaire was sent to all services that identified themselves as treating children or adolescents under the age of 16 years. This small survey was aimed at documenting the degree to which services in which children were treated were appropriate for children. In order to provide information on general child psychiatry services, a sample of adolescent units, not identified as specialising in eating disorders, was contacted to establish some simple information about their treatment of eating disorders.

2. Main findings

Stage 1 (Table 4)

England

Sixty-seven out of 100 health authorities replied.

Expenditure on ECRs. Of the 65 health authorities responding to this question, the average ECR expenditure for 1996–1997 was £117 029. Twelve reported zero spending on ECRs. Of these, six had a specialist unit within the health authority. Six reported referring to specialist units outside the health authority, but only three of these had a separate contract for eating disorders.

Overall, 35 authorities out of the 65 reported having a specialist service within the area.

Estimated number of cases in the area. Of the 37 authorities giving estimates, the average number of cases of eating disorders estimated as living within the catchment area was 682, or 138 per 100 000.

Epidemiological studies would suggest that around 1% of young women (163 per 100 000 total population) can be expected to be suffering from severe eating disorders at one time (Fairburn, 1990). Twelve authorities gave the estimated number of cases (converted to prevalence per 100 000) as under 25. The other 30 authorities indicated that they did not know the prevalence or were unwilling to give an estimate.

Table 4. Results of Stage 1

	No. of health authorities surveyed	No. of health authorities responding	Total ECR spend (£k)	Mean ECR spend (£k)	Estimated numbers[1]
England	100	67	7500	117	138 (37)
Scotland	15	12	374	41	52 (5)
Wales	5	4	400	100	3 (1)
N. Ireland	4	3	86	29	No reply
UK	**124**	**86**	**8360**	**71.75**	**118 (43)**

1. Number of people with eating disorders estimated by the health authority as residing within its area. Responses were converted to numbers per 100 000 population for comparison. Number of authorities responding are given in brackets.

Needs assessment. Twenty authorities out of the 65 replying to the question had commissioned a needs assessment in their area.

Wales

Four out of five health authorities replied.

Expenditure on ECRs. Average ECR expenditure was £99 800. Only one health authority reported having a specialist unit in the health authority. The other three referred to outside units. A separate contract was cited in none.

Estimated number of cases in the area. Only one authority gave an estimate. This was equivalent to a prevalence of 3.4 cases per 100 000.

Needs assessment. No authority had commissioned a needs assessment in its area.

Scotland

Twelve out of 15 health boards replied.

Expenditure on ECRs. Of the nine health boards giving data, the mean expenditure was £41 600. Three health boards reported zero ECR expenditure, of which two had a specialist unit, and one referred to a unit outside the health board.

Overall, four health boards reported having a specialist service within the area.

Estimated number of cases in the area. Five boards were willing to estimate the number of cases in their area. These areas estimated that, respectively, 0, 1, 8, 15 and 238 cases were to be found per 100 000 of the population.

Needs assessment. One board had commissioned a needs assessment in its area.

Northern Ireland

Three out of four health and social services boards replied.

Expenditure on ECRs. One reported zero ECR expenditure, and this authority referred to a specialist unit outside the area.

One out of the three health authorities reported having a specialist service within the area.

Estimated number of cases in the area. None of the three areas replying was able to estimate the prevalence of eating disorders in its area.

Needs assessment. One authority had commissioned a needs assessment in its area.

3. Results of the survey of health authorities

Key results of the health authority survey

1. Only 48% of health authorities had a local specialist service.
2. A number of authorities estimated the number of eating disorders in their area as zero.
3. Many authorities were spending very small amounts on specialist care.

The response rate, overall 69% of authorities and boards, although not ideal, was reasonable. No NHS region was unrepresented.

Overall, expenditure on ECRs was £8.3m. In view of the fact that 31% of authorities failed to respond to the questionnaire, the true ECR expenditure in the country may well be around £12m per annum or £100 000 per health authority, or £204 000 per million population. Actual expenditure on eating disorders needs to take into account purchasers securing services from local specialist services, or more distant services under a block contract, in addition to ECRs. However, as only 48% (*n*=41) of authorities and boards reported that they had access to an eating disorders service within their area, it is very likely that, in many areas, very little is being spent on eating disorders treatment. Indeed, in 60 authorities that reported neither a local service nor a separate eating disorders contract, an average of only £7200 per health authority was being spent on outside treatment.

The estimation by health authorities and boards of the prevalence of eating disorders ranged from 0 to 238 per 100 000, with epidemiological surveys indicating an expected number of around 160. This question revealed a serious underestimate by many authorities when guessing the size of the problem.

Lastly, only 24% (*n*=21) of authorities and boards reported that a needs assessment exercise had been carried out to estimate the size of the local problem.

4. Results of the survey of clinics

Key results: services located

1. Of the responding 57 clinics in the UK, 29 were in the South East.
2. The South East had 60% of consultant sessions serving 33% of the population.
3. Only about half the clinics had a psychiatric trainee.

Of 71 clinics identified in the UK, 58 provided usable responses to the questionnaire. One of these indicated that there was no longer an eating disorders service at that location, leaving 57 active clinics. Of these, 39 were in the NHS sector and 18 were privately run. Table 5 gives the breakdown of services by NHS region, indicating the number of clinics that reported accepting children or adolescents. It is acknowledged that since this survey was performed, the boundaries have changed, and this document refers to the old boundaries.

From Table 5 it can be seen that the South East of England (the two Thames Regions and Anglia and Oxford) is host to more clinics per unit of population than other parts of the country, with 51% of clinics (*n*=29) serving 32.5% of the population. Although the distribution has improved since 1991, in large parts of the country, such as Devon and Cornwall, the North of England, Northern Ireland, Scotland and Wales, provision remains woefully inadequate. It is also apparent that some regions (Northern Ireland, Scotland, Trent and Wales) have no specialist provision for treatment of children or adolescents within the region.

Table 5. Services available in the different NHS Regions

		Adults		Children/ adolescents		Both	
Region	**Total no. of clinics**	**NHS**	**Private**	**NHS**	**Private**	**NHS**	**Private**
Anglia & Oxford	11	3	0	1	0	2	5
North Thames	10	3	1	3	1	0	2
North West	7	4	1	1	0	0	1
Northern & Yorkshire	3	0	1	1	0	1	0
N. Ireland	1	1	0	0	0	0	0
Scotland	4	3	1	0	0	0	0
South Thames	8	1	1	2	0	3	1
South & West	5	2	0	2	0	0	1
Trent	2	2	0	0	0	0	0
Wales	1	0	1	0	0	0	0
W. Midlands	5	4	0	0	0	0	1
Total	**57**	**23**	**6**	**10**	**1**	**6**	**11**

Patients seen and consultant sessions (Table 6)

This table, in which breakdown of patients seen per year and available consultant sessions are corrected for regional populations, gives further information on distribution of resources. Of all referrals, 47.5% are seen in the three regions in the South East. Expressed in terms of consultant sessions, 60.4% of sessions are available in the South East serving a local population of 32.5% of the total. It seems likely that the South East serves as a reservoir of services used by patients who succeed in being referred as ECRs, and this was confirmed in the survey.

Different professions (Tables 7 and 8)

A specific recommendation of the 1992 report was that a consultant psychiatrist with a special interest in eating disorders should be available in each health authority area, and that the consultant should devote at least two sessions to the treatment of eating disorders.

In this analysis, we used three sessions as the minimum acceptable for a local specialist service, to accord with the recommendations of the EDA (see Section 5 'Criteria for a comprehensive eating disorders service'). We have already seen that only 48% of authorities had a specialist service within the area. In Stage 2 of the survey, we established that 88% of clinics had a consultant psychiatrist. Further, it was reported that in 68% of the clinics (39 out of the 57) consultants spent three sessions or more on eating disorders. We would conclude that services have gone a considerable way towards meeting the recommendation, but that many areas still have no local specialist.

Table 6. Number of patients seen per year in each region per million population, and consultant sessions per million population

Region	Population	Patients seen per year	Patients seen per million population	Total consultant sessions	Consultant sessions per million population
Anglia & Oxford	5 360 900	793	147.9	41	7.6
North Thames	6 933 700	1025	147.8	94	13.6
North West	6 605 100	661	100.1	29	4.4
Northern & Yorkshire	6 338 000	403	63.6	23	3.6
N. Ireland	1 663 305	152	91.4	5	3.0
Scotland	5 128 000	788	153.7	33	6.4
South & West	6 594 400	191	29.0	21	3.2
South Thames	6 819 100	594	87.1	51	7.5
Trent	5 121 200	215	42.0	6	1.2
Wales	2 921 100	0	0.0	0	0.0
W. Midlands	5 316 600	258	48.5	5	0.9
Total	**58 801 405**	**5080**		**308**	
Mean	**5 345 582**	**461.8**	**82.8**	**28.0**	**4.7**

Table 7. Details of medical staff available in the different NHS Regions

Region	No. of clinics	No. of clinics with indicated staff		
		Consulant psychiatrist	Consultant psychiatrist with three or more sessions	Training psychiatrist (SHO/SR/ SpR)
Anglia & Oxford	11	9	5	5
North Thames	10	10	10	8
North West	7	6	5	2
Northern & Yorkshire	3	3	3	1
N. Ireland	1	1	1	1
Scotland	4	4	4	2
South & West	5	5	4	4
South Thames	8	8	5	4
Trent	2	1	1	1
Wales	1	1	0	0
W. Midlands	5	2	1	2
Total	**57**	**50**	**39**	**30**
(% of clinics)	**100**	**88**	**68**	**53**

SR, senior registrar.

Trainee psychiatrists, whether at SHO or SR/SpR level, were rarer than consultants, being reported in only 53% of clinics. This is a worrying finding, and indicates that training opportunities for future consultants in eating disorders are being lost.

Nurses and dieticians were next in frequency to consultants followed by psychologists. Psychotherapists, occupational therapists, social workers and physiotherapists were least likely to be employed in clinics.

Clinics were asked to indicate the name and profession of the lead clinician. Out of the 57 services, 75% of clinics (*n*=43) cited a consultant psychiatrist, a consultant psychiatrist in psychotherapy, or a consultant child psychiatrist. Of the remainder, 7% (*n*=4) were headed by a psychologist (three clinical psychologists and one counselling psychologist) and 7% (*n*=4) by a nurse. Five per cent (*n*=3) were led by a dietician and three by a doctor, not a consultant psychiatrist.

Treatment available (Table 9)

The majority of clinics offered cognitive–behavioural therapy (CBT), with ‘counselling’ coming a close second. Family therapy was less likely to be available, being offered in only 79% of clinics.

Most clinics offered out-patient and in-patient care, but only 63% provided day care. Five clinics did not offer in-patient care at all. Of the majority that did, under half used specialist eating disorder beds, about a third used general psychiatry beds, and a small number (9%) used medical beds.

Table 8. Details of non-medical staff available in the different NHS Regions

Region	Psychologist	Nurse	Occupational therapist	Dietician	Psychotherapist	Physiotherapist	Social worker
Anglia & Oxford	8	8	4	10	5	4	5
North Thames	7	9	6	4	7	2	5
North West	2	6	3	5	1	3	2
Northern & Yorkshire	1	3	0	1	1	1	1
N. Ireland	0	1	0	0	0	0	0
Scotland	3	4	1	4	0	0	1
South & West	4	4	1	4	2	3	1
South Thames	5	7	5	7	5	1	3
Trent	1	1	1	0	1	0	0
Wales	0	1	1	0	0	0	0
W. Midlands	2	2	0	2	0	0	0
Total	**33**	**46**	**22**	**37**	**22**	**14**	**18**
(% of clinics)	**58**	**81**	**39**	**65**	**39**	**25**	**32**

Table 9. Range of therapy, treatment location and bed location in clinics

Region	Therapy offered			Location of treatment			Location of beds		
	Counselling	CBT	Family therapy	Out-patient	In-patient	Day patient	Specialist	Medical	Acute psychiatric
Anglia & Oxford	9	10	8	10	9	7	6	1	2
North Thames	10	10	10	10	10	7	6	2	2
North West	7	6	5	7	6	3	2	1	3
Northern & Yorkshire	3	3	3	3	3	2	1	0	2
N. Ireland	1	1	0	1	1	0	0	0	1
Scotland[1]	2	4	2	4	3	3	1	1	3
South & West	5	5	5	5	5	4	4	0	1
South Thames	8	7	8	7	8	5	6	0	2
Trent	1	2	1	2	2	1	0	0	2
Wales	1	1	1	1	1	1	1	0	0
W. Midlands	3	4	2	4	4	3	1	0	3
Total	**50**	**53**	**45**	**54**	**52**	**36**	**28**	**5**	**21**
% of clinics	**88**	**93**	**79**	**95**	**91**	**63**	**49**	**9**	**37**

CBT, cognitive–behavioural therapy.
1.One unit used both medical and acute psychiatric beds.

5. Criteria for a comprehensive eating disorders service

The EDA has produced a helpful guide to provision of general and specialist services to patients with eating disorders (EDA, 1995). Their criteria for specialist services are summarised as follows:

1. a trained and experienced consultant psychiatrist, spending one-third of the time (3–4 sessions) treating eating disorders;
2. an experienced multi-disciplinary team with a psychologist, psychotherapist or counsellor, dietician, occupational therapist, nurse and social worker;
3. training provided to staff from other districts;
4. monitoring outcomes, audit and research; and
5. support to GPs and community psychiatric services.

The criteria used in this survey derive in part from the EDA criteria for specialist services and from the recommendations of the 1992 College survey. Some of the EDA criteria were not explored in this survey and could not, therefore, be included.

The criteria for a comprehensive service in the present survey were set as follows:

1. Activity: The clinic needed to receive in excess of 25 new referrals per annum. This criterion accorded with the level used in the 1991 survey to identify specialist services.
2. Staff: A multi-disciplinary staff team was required including at least one consultant psychiatrist, one nurse and a therapist, who could be a psychologist, a psychotherapist or a well-trained counsellor.
3. Intensity: At least out-patient and in-patient treatment were required.
4. Treatment range: Patients were required to be offered at least individual and family interventions.

It is recognised that these criteria are not particularly stringent. No sessional minimum for consultants is given and the professions and therapeutic skills of therapists are not prescribed. However, only just over half the clinics (56%) fulfilled all the criteria. Reasons for failing to meet them varied:

1. Activity: In 13 clinics, under 25 patients had been referred in a year. In two of these cases, the service was too new to provide referral figures.
2. Staff: Eleven clinics did not meet the staff criteria. In two cases, no consultant was present, in eight there was no nurse and in one there was no psychologist, psychotherapist or counsellor. In three cases, no information was provided about staff.

3. Intensity: Four clinics did not report having access to in-patient care, two did not have out-patients, and one did not give information.
4. Treatment range: Eleven clinics failed on this criterion, none of them providing family intervention. In seven cases, absence of family interventions was the only missing criterion. Information was not given in one case.

Table 10. Meeting criteria for a comprehensive service

Region	No. of clinics	No. of clinics meeting criteria in terms of: Activity	Staff	Intensity	Treatment range	All
Anglia & Oxford	11	9	8	9	8	6
North Thames	10	8	9	10	10	8
North West	7	7	6	5	5	4
Northern & Yorkshire	3	1	3	3	3	1
N. Ireland	1	1	1	1	0	0
Scotland	4	4	4	3	2	2
South & West	5	3	4	5	5	3
South Thames	8	6	7	7	8	6
Trent	2	1	1	2	1	1
Wales	1	0	1	1	1	0
W. Midlands	5	4	2	3	2	1
Total	**57**	**44**	**46**	**49**	**45**	**32**
% of clinics	**100**	**77**	**81**	**86**	**79**	**56**

6. Services for children and adolescents

Staff available (Tables 11 and 12)

The most striking finding is that we were unable to locate a specialist service for children and adolescents in four regions, together representing a population of 14.8 million people, over 25% of the UK population. It was reasoned that local child psychiatry and adolescent services might regard eating disorders as properly within their domain of expertise. In order to test this, a limited sampling of generic child and adolescent services was performed, and is described below.

In line with overall findings, it can be seen that the three South Eastern regions (Anglia and Oxford, North Thames and South Thames) commanded higher-than-average resources, with 69% of clinics.

Treatments available in children's units (Table 13)

Provision of therapy appears to be better distributed than for clinics seeing adults only, with most clinics providing the three forms of therapy and both in-patient and out-patient care. Only just over half provided day care, however.

Services for children and adolescents

1. Four regions (25% of the UK population) had no specialist services for children.

Table 11. Clinics seeing children and adolescents: medical staff available

Region	Total no. of clinics	Consultant psychiatrist	Trainee psychiatrist
Anglia & Oxford	7	6	3
North Thames	6	6	5
North West	2	2	2
Northern & Yorkshire	2	2	1
South & West	3	3	3
South Thames	6	6	2
W. Midlands	1	1	1
Total	**27**	**26**	**17**
% of clinics	**100**	**96**	**63**
N. Ireland	No service		
Scotland	No service		
Trent	No service		
Wales	No service		

2. Sixty-nine per cent of clinics for children were in the South East.
3. Few clinics provided a service for the vulnerable children of mothers with an eating disorder.

Table 12. Clinics seeing children and adolescents: non-medical staff available

Region	Psych-ologist	Nurse	Occupa-tional therapist	Diet-ician	Psycho-therapist	Physio-therapist	Social worker
Anglia & Oxford	5	5	3	6	3	4	3
North Thames	3	5	2	1	4	1	4
North West	0	2	0	2	0	0	1
Northern & Yorkshire	0	2	0	1	0	0	1
South & West	1	1	1	1	0	1	0
South Thames	3	5	3	5	2	1	2
W. Midlands	1	1	0	1	0	0	0
Total	**13**	**21**	**9**	**17**	**9**	**7**	**11**
% of clinics	**48**	**78**	**33**	**63**	**33**	**26**	**41**
N. Ireland	No service						
Scotland	No service						
Trent	No service						
Wales	No service						

Table 13. Clinics seeing children and adolescents: range of therapies and location of care

Region	Couns-elling	CBT	Family therapy	Out-patient	In-patient	Day patient
Anglia & Oxford	6	7	5	7	6	4
North Thames	6	6	6	6	6	4
North West	2	2	2	2	2	1
Northern & Yorkshire	2	2	2	2	2	1
South & West	2	2	2	2	2	1
South Thames	5	5	5	4	5	3
W. Midlands	1	1	0	1	1	1
Total	**24**	**25**	**22**	**24**	**24**	**15**
% of clinics	**89**	**93**	**81**	**89**	**89**	**56**
N. Ireland	No service					
Scotland	No service					
Trent	No service					
Wales	No service					

Second survey of units accepting children (see Appendix 3 and Table 14)

Using this limited questionnaire, the provision of child-trained staff, education and paediatric liaison were assessed. Of the 27 clinics indicating on the first questionnaire that they treated children (under the age of 16 years), 24 gave further information.

Child-trained staff

Seventy-three per cent (15/24) had a trained child psychiatrist on the staff. Other child-trained staff were present in one-third to one-half of clinics. At least one child-trained member of staff was present in 88% (21/24) of clinics.

Table 14. Child and adolescent specialisation of clinics seeing children under 16 years of age

	Present	Total	%
Staff			
Child psychiatrist	15	24	62.5
Child nurse	13	24	54.2
Child psychologist	13	24	54.2
Child psychotherapist	8	24	33.3
Child social worker	12	24	50.0
Any child staff	21	24	87.5
Educational facilities[1]			
School in clinic	12	23	52.2
Teacher in clinic	12	23	52.2
Child's teacher visits	17	23	73.9
School sends work in	11	23	47.8
School liaison	17	23	73.9
Any educational provision	22	23	95.7
Any on-site teaching	20	23	87.0
Paediatric liaison			
Paediatrician on clinic staff	2	24	8.3
Liaison with paediatrician	13	24	54.2
Visiting paediatrician	5	24	20.8
Joint care in paediatric beds	5	24	20.8
Any paediatric links	15	24	62.5
Use of paediatric investigations			
Growth charts	20	24	83.3
Ovarian ultrasound	10	24	41.7
Bone age	13	24	54.2
Services for children of women with eating disorders	9	24	37.5

1. Excluding one out-patient-only service.

Education in clinics (excluding one out-patients-only service)

About half the services had a school within the clinic. In other cases, a teacher was employed on the clinic staff, the school sent work in for children, there were visits from the child's teachers or there was liaison with schools. Overall, there was some attention to education in 96% of clinics (22/23), and this involved on-site teaching in 87% (20/23).

Paediatric liaison

Only two clinics had a paediatrician on the clinic staff. About half the clinics had liaison with a paediatric team, and, overall, only 63% of clinics (15/24) had any paediatric contact at all.

Use of paediatric investigations

Most clinics, 83% (20/24), used growth charts to monitor progress. However, only about half used ovarian ultrasound and half bone age.

Services for the children of mothers with eating disorders

In spite of the literature on this problem, which was recently the subject of a conference at the Royal Society of Medicine ('Anorexia nervosa: impaired growth of children of affected mothers, 11 May 1999, RSM Section of Psychiatry, only 38% (9/24) of clinics provided a service for the mothers of these potentially at-risk children.

Sampling of generic child and adolescent services (see Appendix 4 and Table 15)

This limited survey requested information from a random sample of child and adolescent services around the UK. Services were included if they had either day care or in-patient care. All saw their role as treating anorexia nervosa and most as treating bulimia nervosa. However, the number of patients was rather low, with 15 out of the 23 clinics having four or fewer cases per year. With low numbers, it might be thought that patients would often be referred to specialist units. This did not happen at a high frequency, with half the clinics reporting no use of other facilities. These facilities varied, with some units using private clinics, sometimes several hundred miles away, and others using the regional adolescent unit. Several respondents indicated that many patients with eating disorders were treated as out-patients and such services were not systematically studied in this survey, which was restricted to patients requiring day care or in-patient care. The rather low numbers of patients treated as in-patients or day patients and the lack of referral to specialist clinics on a large scale suggests that some units may be failing to treat intensively or to refer for specialist care young people with severe eating disorders.

Table 15. Limited survey of 23 child and adolescent units: treatment of eating disorders (in various parts of the UK and Northern Ireland)

	Anorexia nervosa			Bulimia nervosa			
	Treat?[1]	No. now[2]	No. in year[3]	Treat?[1]	No. now[2]	No. in year[3]	Send away?[4]
Total	23	44	102	19	2	6	12
Number of clinics responding	23	23	23	23	23	23	23
%	100			82.6			52.2
Mean number per clinic		1.91	4.43		0.09	0.26	

1. Do you treat anorexia/bulimia nervosa?
2. How many patients with anorexia/bulimia nervosa are currently in- or day patients?
3. How many patients with anorexia/bulimia nervosa have been treated as in- or day patients in the past year?
4. Have you ever sent a child for treatment at an outside eating disorders service?

References

Audit Commission (1997) *Higher Purchase: Commissioning Specialised Services in the NHS.* London: Audit Commission.

Department of Health (1999) *A National Service Framework for Mental Health*. London: Stationery Office.

Eating Disorders Association (1995) *Eating Disorders. A Guide to Purchasing and Providing Services.* Norwich: EDA.

Fairburn, C. G. (1990) Studies of the epidemiology of bulimia nervosa. *American Journal of Psychiatry*, **147**, 401–408.

Harris, E. C. & Barraclough, B. (1998) Excess mortality of mental disorder. *British Journal of Psychiatry*, **173**, 11–53.

Hoek, H. W. (1991) The incidence and prevalence of anorexia nervosa and bulimia nervosa in primary care. *Psychological Medicine*, **152**, 455–460.

Newton, T., Robinson, P. & Hartley, P. (1993) Treatment for eating disorders in the United Kingdom. Part II. Experiences of treatment: A survey of members of the Eating Disorder Association. *European Eating Disorders Review*, **1**, 10–21.

NHS Executive (2000) *The NHS Plan*. London: Stationery Office.

Robinson, P. H. (1993*a*) Treatment of eating disorders in the health service. What is available and where? *International Review of Psychiatry*, **5**, 19–23.

—— (1993*b*) Treatment for eating disorders in the United Kingdom. Part I. A survey of specialist services. *European Eating Disorders Review*, **1**, 4–9.

Royal College of Psychiatrists (1992) *Eating Disorders*. Council Report CR14. London: Royal College of Psychiatrists.

Steinhausen, H.-C. (1995) The course and outcome of anorexia nervosa. In *Eating Disorders and Obesity: A Comprehensive Handbook* (eds K. D. Brownell & C. G. Fairburn), pp. 234–237. New York: Guilford Press.

Appendix 1. 'Eating disorders' – extract from *Health Which?*, April 1998

Often it's the most extreme stories about eating disorders that hit the headlines: the skeletal images of the Kendall twins; or a hospital going to court to find out whether it can force-feed a patient. Such stories can leave the impression that services to help people with eating disorders are inadequate and disorganised – too little, too late. Indeed, although the number of people diagnosed with eating disorders is rising, there's no national strategy to provide an appropriate level of specialist, accessible care for everyone affected.

So how is the NHS coping at a local level? *Health Which?* surveyed services for people with eating disorders throughout the UK. We found that, although some health authorities are providing appropriate specialist support and treatment, the quality and level of planning and back-up varies widely. And the type of support and care people get very much depends on the way that mental health services are set up in their area, whether there is an eating disorders service nearby, or whether the local health authority is prepared to fund treatment at a specialist unit outside their area.

The size of the problem

Eating disorders often affect young women, although one in ten of those affected is male. *Anorexia nervosa* and *bulimia nervosa* (often known simply as anorexia and bulimia) are the two main types of eating disorder; another, *binge-eating disorder*, has also recently been identified. However, not everyone with an eating disorder will fit neatly into one category or another.

It's difficult to give an exact figure for the numbers of people affected – especially since these conditions are often concealed and may go unnoticed and untreated. But best estimates suggest that in a population of 100,000 about seven new cases of anorexia and 14 new cases of bulimia will be diagnosed every year. Some experts think that binge-eating disorder may be even more common. As many as four in every 100 young women under 35 may have an eating disorder.

It's not known exactly what triggers eating disorders, although they are thought to involve a combination of factors: genetic predisposition, social pressure to be thin, and crises which knock confidence and lower self-esteem. While the surface issues in eating disorders appear to be food and body image, people with eating disorders face problems in their lives and need some means of controlling them – food and eating can seem to provide that control.

However, common to all eating disorders is the fear of becoming fat, the drive to be thin and an obsession with weight and calories. People with anorexia restrict what they eat to a minimum and their weight can drop rapidly and

become critically low. Those with bulimia have powerful, irresistible urges to binge-eat – as much as 5,000 calories at a time – and then take extreme measures to get rid of the food, by making themselves sick or abusing laxatives, for example. Those with binge-eating disorder also regularly binge, but without vomiting. People with bulimia and binge-eating disorder are often normal in weight or slightly overweight.

As our case studies [below] show, eating disorders can have a big impact on an individual's life and cause distress to family and friends. The longer the condition remains untreated, the greater the likelihood of physical complications. In anorexia, these include osteoporosis at a young age, and temporary infertility; and in bulimia, heart, kidney and teeth damage. And long-standing eating disorders make other mental health problems, such as depression, self-harm and suicide, more likely.

People with eating disorders are adept at hiding problems and are often reticent in asking for help. And this can be compounded by difficulties getting access to appropriate care and treatment once they've decided they need it. According to a 1991 Eating Disorders Association survey, half of those who sought help from their GP felt their problems weren't taken seriously or that they were inappropriately dealt with. This raises concerns that some GPs aren't adequately trained to detect or offer an initial level of help for people with eating disorders, and also that they may not always be aware of the appropriate services to refer on to.

Actually, eating disorders can be successfully treated in a number of ways. In less severe cases, it is sometimes possible to use a self-help approach, guided by a GP or nurse, or in a group. A number of psychological therapies – again, some individual and some group – can also be used. Family therapy, for example, has been shown to be effective in treating anorexia. Other treatments may be given by a range of health professionals, and usually involve: getting body-weight back to a safe level if the individual has anorexia; promoting a change in attitudes to body perception and food; and addressing underlying psychological problems. People either have individual sessions as out-patients, or take a full programme of activities as day-patients. If someone's weight falls critically low, then he or she may need to be admitted to hospital as an in-patient.

What is a good service?

With no national standard for eating disorders services, *Health Which?* drew on guidelines produced by the Eating Disorders Association and the Royal College of Psychiatrists to define what a good service should look like.

According to these expert groups, everyone with an eating disorder should have access to some kind of specialist care. This is likely to take different forms locally. However, as a rule of thumb, an average health authority covering 300,000 people will need an out-patient eating disorders service (without in-patient or

day-care facilities) to provide an appropriate level of specialist treatment in less severe cases.

Such a service also needs back-up from a 'comprehensive' service – to give people with eating disorders any intensive or emergency in-patient treatment they might need, and to provide specialist support and training to health professionals working at a local level.

Ideally, there should be one of these services for every million people in the population. Although most health authorities aren't large enough to justify providing their own comprehensive services, we might expect to see around 60 around the UK.

A comprehensive service should:

- include staff with experience of eating disorders (for example a clinical psychologist, dietitian, psychiatric nurses)
- include, and preferably be led by, a consultant psychiatrist who spends at least a third of his or her time treating patients with eating disorders
- offer a range of psychotherapies, including family therapy
- offer in-patient and/or day-care places, and medical support to anyone with anorexia who becomes critically underweight
- see at least 25 patients a year (to ensure the service has enough experience with eating disorders).

What we did

That's the ideal, but what's actually happening with eating disorders services around the UK? To find out, *Health Which?* first surveyed the UK's 124 health authorities in collaboration with the Eating Disorders Special Interest Group of the Royal College of Psychiatrists. We wanted to find out whether there were any specialist services for people with eating disorders within each health authority. If there weren't any, where was the health authority sending patients, and how much were they spending on these referrals? We also asked health authorities if they'd taken the needs of local people with eating disorders into account when planning services.

Where health authorities told us they were using specialist services, we then followed these up, along with additional services known to the Eating Disorders Association and the Royal College of Psychiatrists – a total of 77. We wanted to find out where these services were and what they were providing, how many were able to offer a comprehensive service, and how many were private rather than NHS.

What we found

Our survey showed a very uneven spread of eating disorder services, both between health authorities and around the UK.

Of the 89 health authorities that responded, less than half (42) were using any local specialist eating disorders service – out-patient or otherwise. On average, health authorities had spent £130,100 in the financial year 1996/97 sending patients outside their area for specialist treatment.

Of the 51 specialist eating disorders services that replied to our survey, only 28 met the criteria for a comprehensive service. Ten of these were private and 18 were NHS.

It also looks likely that some large areas of the UK have no comprehensive eating disorders services at all. We found no NHS services which met our criteria in Wales, west Scotland, or the south-west of England (although there was a private unit in Bristol). Overall, more than half (17) of the comprehensive services were in the south-east of England. Not surprisingly, some comprehensive services were seeing people from long distances: for example, a unit in Berkshire was seeing people from Yorkshire and Cornwall; and a unit in Bristol was seeing people from west Wales and Cornwall.

The remaining 23 eating disorders services – five private and 18 NHS – that weren't comprehensive varied in size and style: a lone part-time dietitian for one health authority; some out-patient units; and other units with a fuller service, but either seeing only a limited number of patients, or offering a limited range of therapies.

Need for a national strategy

Our survey shows that some areas of the country are well served for eating disorders services. However, we have a number of concerns about the current state of play across the UK, some of which were echoed by those providing the services.

There is a clear need to ensure that health authorities provide the right kind of local specialist services and forge better links with the private sector.

Where health authorities don't have a local specialist service, it's possible that people with eating disorders may not be getting the right help at the right time. Local general mental health staff are less likely to be experienced in treating them, and more severe cases may end up having to be transferred as emergencies to specialist services elsewhere.

Having to rely on a specialist service outside the area may also be a false economy in the long-term, particularly for good-sized health authorities. What's more, being treated a long way from home can be a problem for people with eating disorders, particularly when it comes to follow-up care after intensive treatment. Seeing the same professionals throughout helps to build trust, and is particularly important when regular sessions are needed over a long period of time.

With private services accounting for nearly half of all specialist services in our survey – and over a third of comprehensive services – it's clear that many health authorities are relying on the private sector. There's no doubt that private services

give some people a much-needed opportunity to get specialist treatment, although like some NHS services they may be many miles away. Some private units felt they could offer a rapid response to acute problems, but others found health authorities had refused to pay for treatment that they felt patients needed. Others had concerns about the follow-up care people were receiving after intensive treatment. It's also possible that diverting significant funds into the private sector may limit the development of local NHS services.

Given that eating disorders are relatively rare, and there's currently no national strategy for dealing with them, it's perhaps not surprising that our survey has revealed such a patchy picture – or that large areas of the UK don't have the support of a comprehensive service.

However, a recent report of the Government's Health Committee, looking at mental health services for children and teenagers, recognised that leaving individual health authorities to provide and fund specialist care for eating disorders wasn't working. It recommended that the NHS Executive should plan specialist services and encourage health authorities to get together to provide them. Based on the findings of our research, we'd support that view for all eating disorders services.

Contacts

Eating Disorders Association
Wensum House
103 Prince of Wales Road, Norwich NR1 1DW
Helpline 01603 621414 (Mon–Fri 9am–6.30pm)
Youthline 01603 765050 (Mon–Fri 4pm–6pm)

Further reading

Eating disorders: the facts. S. Abraham and D. Llewellyn-Jones

Self-help books

Getting better bit(e) by bit(e): a survival kit for sufferers of bulimia nervosa and binge-eating disorder. U. Schmidt *et al.*
Overcoming binge eating. C. Fairburn

Which? Healthline

0645 245, then
082 Anorexia
276 Bulimia
251 Psychological services
Calls are charged at your phone company's local rate.

[The following are case examples included in the article:]

A long journey to find the right help

Rosemary Shelley, 24, first developed anorexia when she was 15. Some time later, she was referred to a psychiatrist by her GP. After a four month wait, the psychiatrist found out that she was only 16 and wouldn't see her. 'It was a real disappointment – I was very angry and rejected,' says Rosemary. It was another four months before she was referred to a child and adolescent psychiatrist. 'In my view it was too late, really. If it had been dealt with properly at the beginning it might not have continued so long.' Rosemary saw a psychiatrist weekly for two years, and stabilised at six stone. But A-levels and university triggered two further relapses and intensive treatment in an adolescent unit. 'My parents didn't know who else to turn to, so I went back there, even though I was 20.' Her parents then arranged a referral to a private unit in London, funded by medical insurance. She was an in-patient there for four months and was then transferred to a day programme, which involved travelling from Surrey to London every week-day. Although her weight is now stable, and she has set up a local support group where she lives, Rosemary still sees a therapist regularly.

Private counselling for bulimia

Sally (not her real name) had been overweight and had eating problems in her late teens. 'I would sometimes starve myself and take laxatives and most of the time I was either on or about to go on a diet.' When she got married, she started to eat normally and her weight dropped naturally. But then the sudden and unexpected breakdown of her marriage triggered off episodes of bulimia. 'When I was feeling fed-up I would binge on things like cakes and biscuits and then take laxatives – handfuls at a time.'

She took a job in the Middle East and her bulimia gradually got worse as she became more unhappy 'I didn't know what I was doing with my life or where I was going. I started bingeing more often, and I would make myself sick afterwards. I would starve myself during the day and I became obsessive about exercise.' She tried to get help while abroad, but was only offered anti-depressants, which she didn't want. She then contacted the Eating Disorders Association who sent her information and a list of contacts. She found it helpful to write to a recovered bulimic while she was away. But the only way that she could see an end to her bulimia was to come back to the UK. 'I was fairly desperate at that time to find support,' she says. When she returned she found a counsellor through the Eating Disorders Association, whom she has been seeing privately for two and a half years. 'I consider myself recovered, and I feel very happy now.'

Health authority review prompted new local service

One health authority which has recently taken a fresh look at what it has to offer people with eating disorders is Southampton and South West Hampshire. Two

years ago, with more and more people coming forward for treatment, it decided to review the care they were getting. At the time, there was no local specialist team, and services were unco-ordinated and fragmented. Self-help groups and health professionals wanted change, including quicker access to specialist treatment and follow-up care. GPs were worried that they couldn't always refer people to an interested and enthusiastic expert. And the health authority itself was concerned about how much it was spending to send people outside the area for treatment – so it decided to set up a local service for eating disorders.

The new clinic offers day-care and out-patient facilities, and is linked with a unit in neighbouring Dorset for in-patient beds if needed. It is also funded to train and support GPs and other health professionals to spot, treat and refer on people with eating disorders. It's still early days for the clinic, which opened in March. But Dr Rachel Bryant-Waugh, its clinical psychologist, believes staff will be able to provide tailored treatment for people with eating disorders.

The working group thank the Consumers' Association for its kind permission to reproduce this article from Health Which?, *April 1998.*

Appendix 2. List of eating disorders services responding to the survey

Lead clinician	Profession of lead	Hospital/clinic (NHS/private, N/P)	Address	Children accepted?	Met survey criteria?	Missing criteria
Anglia and Oxford Region						
Ms M. Page	D	Ipswich Hospital (N)	Health Road, Ipswich IP4 5PD	Y	N	F,C,N
Dr Guiguis	CP	St Clement's Hospital (N)	Ipswich IT3 8LS	Y	N	F,N,P,IP
Dr L. De Silva	CP	Cardinal Clinic (P)	Bishops Lodge, Oakley Green, Windsor SL4 5UL	Y	Y	
Dr J. Clarke	Dr	International Eating Disorder Clinic (P)	119–121 Wendover Road, Aylesbury HP21 9LW	Y	N	R
Dr M. Tattersall	CP	Huntercombe Manor Hospital (P)	Huntercombe Lane South, Taplow, Berkshire SL6 0PQ	Y	Y	
Dr H. J. Dowson	CP	Addenbrookes Hospital (N)	Cambridge CB2 2QQ	N	N	F
Dr L. De Silva	CP	Heatherwood Hospital (N)	Ascot, Berkshire SL5 8AA	N	Y	
Ms N. Boughton	Clin psy	Warneford Hospital (N)	Warneford Lane, Headington, Oxford OX3 7JX	N	Y	
Dr Liam Callinan	CP	Newmarket House Clinic (P)	133 Newmarket Road, Norwich NR3 6SY	N	N	R,N,OP
Dr Penny Lloyd	CP	St Andrew's Hospital (P)	Billing Road, Northampton NN1 5DG	Y	Y	
Dr A. Jaffa	CP	Phoenix Centre (N)	Ida Darwin, Fulbourne, Cambridge CB1 5EE	Y	Y	

North Thames Region						
Dr M. Hodes	CCP	St Mary's Department for Child & Adolescent Psychiatry (N)	17 Paddington Green, London W2 1LQ	Y	N	R
Dr Sean Maskey	CCP	Great Ormond Street Hospital (N)	Great Ormond Street, London WC1N 3JH	Y	Y	
Dr M. Beary	CP	Grovelands Priory (P)	The Bourne, Southgate, London N14 6RA	Y	Y	
Dr P. Flower	CCP	Rhodes Farm Clinic (P)	The Ridgeway, London NW7 1RN	Y	Y	
Dr E. Stonehill	CP	Charter Nightingale (P)	11–17 Lisson Grove, London NW1 6SH	Y	Y	
Dr E. Sabine	CP	St Ann's Hospital – London (N)	St Ann's Road, London N15 3TH	N	Y	
Dr P. Robinson	CP	Royal Free Hospital (N)	Pond Street, London NW3 2QG	N	Y	
Dr M. Berelowitz	CCP	Royal Free Hospital – Children and Adolescents (N)	Pond Street, London NW3 2QG	Y		
Dr B. Rooney	CP	Peter Dally Clinic (N)	Osbert Street, London SW1P 2QU	N	Y	
Dr R. Cohen	CP	Bowden House Clinic (P)	London Road, Harrow on the Hill, Middlesex	N	N	R
North West Region						
Prof. S. Gower	CCP	Pine Lodge (N)	79 Liverpool Road, Chester CH2 1AW	Y	Y	
Dr B. T. Monteiro	CP	Altrincham Priory Hospital (P)	Rappax Road, Cheshire WA15 0NX	Y	Y	
Dr J. Jones	CP	Withington Hospital (N)	Nell Lane, West Didsbury, Manchester M21 2UD	N	Y	
Ms A. Wakefield	D	Clatterbridge Hospital (N)	Community Services, Bebington, Wirral, Merseyside L63 5JY	N	N	F

Lead clinician	Profession of lead	Hospital/clinic (NHS/private, N/P)	Address	Children accepted?	Met survey criteria?	Missing criteria
Dr K. Callender	CP	Ramsgate House – Eating Disorder Centre (N)	43 Ramsgate Street, Lower Broughton, Salford M7 2YB	N	Y	
Ms B. Douglas	Coun psy	North West Centre for Eating Disorders (P)	Gatley Health Centre, Stockport, Old Hall Road, Gatley, Cheshire SK8 4DG	N	N	C,N,IP
Dr M. Launer	CP	Burnley General Hospital (N)	Castleton Avenue, Burnley BR10 2PQ	N	N	F
Northern and Yorkshire Region						
Dr G. Richardson	CP	Limetrees Child, Adolescent & Family Unit (York) (N)	31 Shipton Road, York YO3 6RE	Y	N	
Dr L. Pieri	CP	Seacroft Hospital (N)	York Road, Leeds LS14 6UH	Y	Y	
Dr P. Morgan	CP	Lindisfarne Suite, Newcastle Nuffield (P)	Clayton Road, Jesmond, Newcastle-upon-Tyne NE2 1JP	N	N	R
Northern Ireland						
Dr C. Adams	Consultant psychotherapist	Belfast City Hospital (N)	Lisburn Road, Belfast BT9 7AB	N	N	F
Scotland						
Dr C. Freeman	CP	The Cottage, Royal Edinburgh Hospital (N)	Morningside Crescent, Edinburgh EH10 5HF	N	Y	

Dr H. Millar	CP	Royal Cornhill Hospital (N)	Fulton Clinic, 26 Cornhill Road, Aberdeen AB25 2ZH	N	N	IP,F
Dr A. Yellowlees	CP	Murray Royal Hospital (N)	Muirhall Road, Perth PH2 7BH	N	Y	
Dr C. Downie	CP	Langside Priory Hospital (P)	38 Mansionhouse Road, Langside, Glasgow G41 3DW	N	N	F
South and West Region						
Dr R. Bryant-Waugh[1]	Clin psy	Harefield Clinic (N)	Exford Avenue, Harefield, Southampton SO18 5DJ	N	[Y]	R New service
Dr A. Cockett	CCP	Orchard Lodge – Young People's Unit (N)	Dene Road, Norton Fitzwarren TA4 1DB	Y	N	R,N
Dr I. Macguire-Samson	CP	Heath House Priory Hospital (P)	Heath House Lane, Staton, Bristol BS16 1EO	Y	Y	
Mr C. Newell	Nurse	St Ann's Hospital – Poole (N)	67 Haven Road, Canford Cliffs, Poole, Dorset BH13 7LN	N	Y	
Dr J. Eastgate	CCP	Marlborough House (N)	Princess Margaret Hospital, Okus Road, Swindon SN1 4JU	Y	Y	
South Thames Region						
Prof. J. H. Lacey	CP	Springfield Hospital (N)	61 Glenburnie Rd, SW17 7DJ	Y	Y	
Dr B. Lask	CCP	Springfield Hospital, Children's Depart-ment (N)	61 Glenburnie Rd, SW17 7DJ	Y	[Y]	R New Service
Mr M. Brolly[2]	Nurse counsellor	Castlewood Therapy Centre (N)	25 Shooters Hill, London SE1 4LG	Y	Y	
Dr D. Cassell	CP	Eating Disorder Centre for Young People (Surbiton) (N)	Child Adolescent and Family Centre, 84 Ewell Road, Surbiton KT6 6EX	N	R,OPY	
Dr S. Carman	CP	The Red House (Maidstone) (N)	22 Oakapple Lane, Maidstone ME16 9NW	Y	Y	

Lead clinician	Profession of lead	Hospital/clinic (NHS/private, N/P)	Address	Children accepted?	Met survey criteria?	Missing criteria
Prof. G. Russell	CP	Hayes Grove Priory Hospital (P)	Prestons Road, Hayes, Bromley BR2 7AS	Y	Y	
Dr J. Treasure, Dr U. Schmidt	CP	Bethlem and Maudsley Hospital (N)	Denmark Hill, London SE5 8AZ	N	Y	
Dr P. Rowan	CP	Roehampton Priory Hospital (P)	Priory Lane, Roehampton, London SW15 5JJ	Y	Y	
Dr C. Dare	CCP	Maudsley Hospital Children's Department (N)	Denmark Hill, London SE5 8AZ	Y	N	R
Trent Region						
Dr D. Goodhead	Dr	Doncaster Royal Infirmary (N)	Armthorp Road, S. Yorks DN2 5LT	N	N	R,C,N,F
Dr R. Palmer	CP	Leicester General Hospital (N)	Brandon Unit, Leicester General Hospital, Leicester LE5 4PE	N	Y	
Wales						
Ms R. Bartlett	Nurse	The Priory Clinic (P)	45 The Parade, Cardiff CF2 3AB	N	[Y]	R New service
West Midlands Region						
Dr M. McCreadie	Clinical assistant psychiatrist	Warwick Resource Centre (N)	24 Cake Road, Warwick CV34 4JP	N	N	Inadequate information
Ms C. Atton	D	Eating Disorder Centre (West Bromwich) (N)	1st Floor, Edward Street Day Hospital, Edward Street, West Bromwich B70 8NY	N	N	Inadequate information
Ms K. Moore	Nurse specialist	St George's Hospital (N)	Corporation Street, Stafford ST16 3AG	N	Y	

Mr S. O'Loughlin	Clin psy	Kidderminster General Hospital (N)	Bewdley Road, Kidderminster, Worcester, DY11 6RJ	N	N	F
Dr A. Villa	CP	Woodbourne Clinic (P)	21 Woodbourne Road, Edgbaston, Birmingham B17 8BY	Y	N	F

1. Currently at Hospital for Sick Children, London.
2. No longer at Castlewood.

C, consultant; CCP, consultant child psychiatrist; Clin psy, clinical psychologist; Coun psy, counselling psychologist; CP, consultant psychiatrist; D, dietician; F, family therapy; IP, in-patient care; N, nurse; OP, out-patient care; P, psychologist/psychotherapist; R, referral rate <25 per annum; [Y], new services that meet all criteria but the referral rate.

Appendix 3. Specialist eating disorders services offering treatment to children and adolescents under 16 years of age

	Consultant child psychiatrist	On-site education	Paediatric liaison	Services to mothers with eating disorders
Anglia and Oxford				
Ipswich Hospital	Y	N	N	N
St Clement's Hospital	No information			
Cardinal Clinic	Y	Y	Y	Y
Huntercombe Manor Hospital	Y	Y	Y	Y
St Andrews Hospital	N	Y	Y	N
Phoenix Centre	Y	Y	Y	N
North Thames				
St Mary's Department for Child & Adolescent Psychiatry	Y	Y	Y	Y
Great Ormond Street Hospital	Y	Y	Y	N
Grovelands Priory	N	Y	N	N
Rhodes Farm Clinic	Y	Y	N	N
Charter Nightingale	Y	N	Y	N
Royal Free Hospital, Child and Adolescent Service	Y	Y	Y	Y
North West				
Pine Lodge	Y	Y	N	N
Altrincham Priory Hospital	N	Y	Y	N
Northern and Yorkshire				
Limetrees Child	Y	Y	Y	Y
Seacroft Hospital	N	Y	Y	Y
Northern Ireland	No specialist service for children			
Scotland	No specialist service for children			

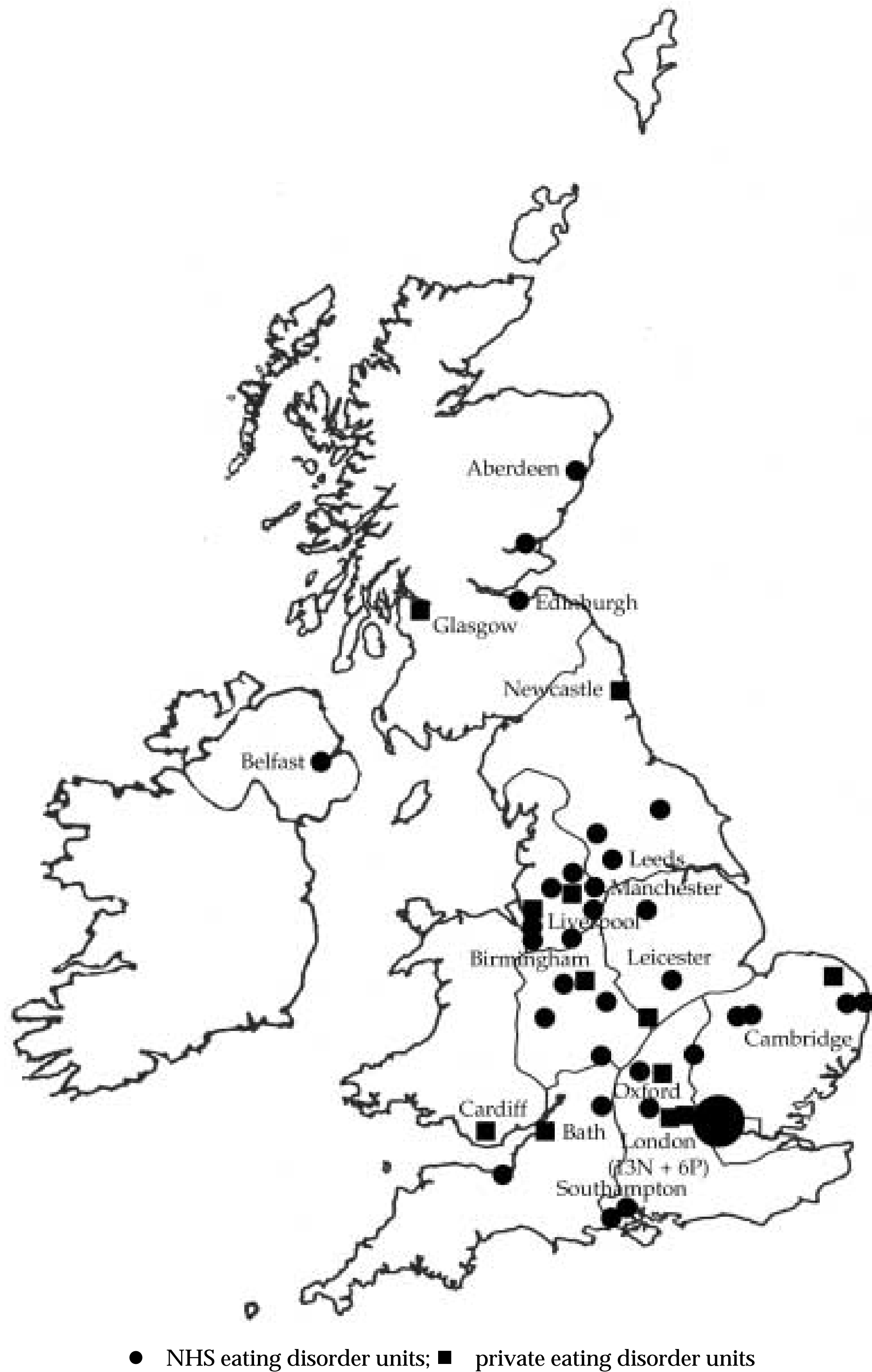
	Consultant child psychiatrist	On-site education	Paediatric liaison	Services to mothers with eating disorders
South and West				
Orchard Lodge	Y	Y	Y	Y
Heath House Priory Hospital	N	Y	N	N
Marlborough House	Y	Y	Y	N
South Thames				
St Georges Child & Adolescent Service	Y	Y	Y	Y
Castlewood Therapy Centre	No information			
Eating Disorder Centre for Young People	No information			
The Red House, Maidstone	Y	N	Y	N
Hayes Grove Priory	N	Y	N	Y
Bethlem and Maudsley	N	Y	N	N
Maudsley Child and Adolescent	Y	N/A	N	N
Trent	No specialist service for children			
Wales	No specialist service for children			
West Midlands				
Woodbourne Clinic	N	Y	N	N

Appendix 4. List of general child and adolescent services responding to the survey

Clinic	County
Oakham House	Leicestershire
Ash Villa	Lincolnshire
Thorneywood	Nottinghamshire
Brookside	Essex
Roseberry	Cleveland
Dewi Jones Unit	Merseyside
Berkshire adolescent Unit	Berkshire
Leigh House	Hampshire
Highfield	Oxford
Larchwood	West Sussex
Whitestone Children’s Centre	North Warwickshire
West End	Humberside
High Royds	West Yorkshire
Riverside	Bristol
Mount Gould	Devon
Young People's Centre	Northern Ireland
Ladyfield West	Dumfries and Galloway
Ladyfield East	Dumfries and Galloway
Gartnavel Royal	Glasgow
Whitchurch Hospital	Cardiff
Gwent Child & Adolescent Mental Health Services	Gwent
Forest House	West Hertfordshire
Birmingham Children’s Hospital	West Midlands
Number of clinics responding:	**23 out of 35 approached**

Appendix 5. Distribution of NHS eating disorder units in the UK in 1991

Appendix 6. Distribution of NHS and private eating disorder units in the UK in 1998



● NHS eating disorder units; ■ private eating disorder units

Appendix 7. Standardised mortality ratios for mental disorders

All cause standardised mortality ratios (SMRs) with 95% confidence intervals, by mental disorder, in descending order of SMR. Reprinted from Harris & Barraclough (1998).