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Closing the gap:

Treatment and prevention of eating disorders in England

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FOREWORD

James Downs

Accounts of eating disorders in research, policy, and clinical practice rightly emphasise their severity, complexity, and profound consequences for individuals, families, and wider society. Much attention has necessarily been directed towards better understanding these illnesses, defining their pathology, and improving the treatment and care available to those affected. These remain urgent and essential priorities, especially in the face of increasing prevalence and suffering. Yet, the realities of severe illness are not only a reflection of the considerable challenges facing research, policy, and services. They should also be understood as failures of prevention.

A growing body of evidence demonstrates that eating disorders and many of their associated harms are preventable. Through my work with people with lived experience and caregivers, including in contributing to this position statement, I have heard countless accounts of missed opportunities to intervene, support that could have made a difference, and harms that might have been avoided. These were matched by examples of interventions and experiences of care that have been profoundly helpful, sometimes transformational, but which were not available when they were most needed. Such experiences offer invaluable insights into what might help, for whom, and at what point, and invite us to imagine how different the course of illness might have been. They are sources of grief for what has been lost and of hope for how things can be different.

This 'invitation to imagine' must give rise to both a vision for the future and action to realise it. My own work is driven by a vision of a society that understands the factors that contribute to eating disorders and creates environments in which people are less likely to become unwell. In such a society, emerging difficulties will be recognised and responded to early, rather than being allowed to develop into more serious illness. Dichotomous approaches that pit prevention and treatment against one another will have no place, recognising that both are essential and mutually reinforcing. Evidence about what works in prevention, for whom, and in which contexts will be developed in partnership with people with lived experience, reflecting the diversity of those affected and the different pathways through which eating disorders emerge.

Realising this vision demands collective action and responsibility for prevention, shared across healthcare, education, research, policy, and wider

society. Crucially, this means shifting responsibility away from an overreliance on individuals to recognise their own difficulties, seek help, and navigate systems of support. Instead, we must ensure that people, particularly those at greater risk of developing eating disorders, live in environments that reduce their vulnerability, where emerging difficulties are identified and responded to, and timely, effective support is readily accessible.

Finally, meaningful change requires an honest acknowledgement of where we are today. Too many people continue to develop eating disorders, experience avoidable suffering, and face considerable barriers in accessing timely and effective support. The figures and evidence presented in *Closing the Gap* make the scale of the changes needed clear but also identify tangible opportunities for improvement. This College Report therefore provides a starting point for meaningful, sustained action towards a society in which more eating disorders are prevented, their harms reduced, and health and wellbeing actively promoted. Implementing its recommendations is an obligation for those living with eating disorders today and for future generations.

EXECUTIVE SUMMARY

Eating disorders represent one of the largest unmet needs in healthcare in England. Despite established clinical guidance and effective interventions[1-3], only a small minority of affected people receive timely treatment, while prevention receives negligible policy attention. England lacks a comprehensive, funded implementation programme linking population need to service capacity, workforce planning, coverage targets and accountability. Failure to align provision with population need impedes the ability of the NHS to fulfil its statutory duty to provide comprehensive and timely services, reduce health inequalities, preserve life, and improve health.

This College Report examines the scale of need, contributing factors, outcomes of treatment and prevention gaps. It also sets out seven required actions to improve the availability of and access to services.

This report's findings and recommendations apply to England, but may be used to inform decision making and practice in the other nations of the UK.. We draw on evidence and expert input, including people with lived experience and families, and UK and international research.

We recommend that the Department of Health and Social Care (DHSC), working with NHS bodies and commissioners, lead development of a funded strategy to improve access to timely, evidence-based treatment, expand prevention coverage, reduce inequalities, and improve outcomes. The strategy should establish measurable targets to reduce unmet need, with implementation and monitoring responsibilities.

Population need: prevalence and trends

Eating disorders affect people of all ages and genders but are most common during adolescence and working-age adulthood. They disproportionately affect females. The prevalence has been rising in recent decades, and predictions indicate it will continue to increase through 2050.[4]

Population estimates differ because surveys measure different aspects of need. Screening instruments identify possible eating problems but do not establish a clinical diagnosis.[5,6] Diagnostic estimates apply formal criteria,[7] while lifetime estimates include anyone who has experienced an eating disorder at any point in their life. These measures are complementary but should not be considered as interchangeable.

Beat, the largest UK charity, estimates that approximately 3.5 million children, young people, and adults in the UK live with an eating disorder.[8]

This figure is derived from recent English surveys, adjusted for screening accuracy, and extrapolated to the UK. The resulting uncertainty range is wide, reflecting limitations in the underlying data and assumptions about screening accuracy and prevalence across the four nations.

In England, an estimated 2.6% of children aged 11-16 and 12.5% of young people aged 17-19 (approximately 360,000 in total) in 2023 met the diagnostic criteria for an eating disorder.[6] In the same survey, 42% of young men and 78% of young women aged 17–19 screened positive for possible eating problems, demonstrating a much wider population experiencing eating and weight related concerns.

Among adults, 16% screened positive for possible eating problems in the 2019 Health Survey for England (HSE), with approximately 4% reporting associated functional impairment.[5] In contrast, the 2023-2024 Adult Psychiatric Morbidity Survey (APMS) estimated a 12-month diagnostic prevalence of 1.3% (95% CI 0.8–2.2%) equivalent to approximately 600,000 adults in England (95% CI 0.4–1.0 million).[7] This estimate is imprecise and may underestimate the prevalence because of the small number of identified cases and under-representation of people who were underweight.

Taken together, the evidence indicates a substantial population with diagnosable eating disorders and a much wider group experiencing clinically relevant eating problems. Current services and public health measures lack the capacity to respond to this level of need.

Consequences

Eating disorders vary in presentation and severity but can cause substantial physical and psychiatric morbidity, impaired functioning and quality of life, and premature death.[9-14] Meta-analyses report standardised mortality ratios of approximately 5–6 for anorexia nervosa and approximately 2 for other eating disorders, with higher risks among people with severe physical or psychiatric comorbidities.[15,16] In contrast, official mortality statistics record few deaths caused by eating disorders,[17] suggesting that the contribution of eating disorders to mortality is incompletely captured.

National inquiries have repeatedly identified avoidable harm associated with delayed diagnosis, inadequate professional training, and fragmented care.[18-20] Failure to address these issues leaves services responding predominantly to crises rather than providing prevention, early intervention, and timely treatment.

The consequences extend beyond health. Eating disorders commonly emerge during critical periods of development.[21] They can interrupt education, employment, relationships, and independent living, while placing substantial emotional, practical, and financial burdens on families and carers.[22] The resulting emotional, practical, and financial effects can persist for many years. The human cost of inadequate treatment cannot be underestimated.[23]

Wider economic impact

The cost of eating disorders in England was estimated between £6.3–£9.6 billion in 2019-2020 through healthcare expenditure, lost productivity, informal care, and long-term disability.[24] Although this estimate requires updating, we can be confident that with increased need it will be even higher now, it still demonstrates that the economic consequences extend well beyond specialist mental health expenditure. Investment into prevention, timely treatment and sustained recovery may reduce downstream healthcare, societal costs and human suffering. Formal economic evaluation is necessary to determine the extent of any cash-releasing savings.

Current treatment and prevention coverage

The central problem is not the absence of evidence or good-practice guidance, but insufficient and inconsistent implementation. Specialist service capacity has not kept pace with population need.

NHS Benchmarking data provide the most comprehensive current picture of specialist community services in England. In 2024/25, community eating disorder services for children and young people (CEDS-YP) reported 202 referrals, and a year-end caseload of 87 per 100,000 population, compared with 115 referrals and a caseload of 49 per 100,000 adults.[25]

There is a marked imbalance between CEDS-YP and adult community eating disorder service (ACEDS) provision. Reported staffing was approximately 13 WTE per 100,000 children and young people compared with 5 WTE per 100,000 adults. Corresponding expenditure was approximately £1.0 million and £0.4 million per 100,000 population.[25]

Pressure is also evident in acute care. In 2024/25, Hospital Episode Statistics recorded 48,194 finished consultant episodes with an eating disorder diagnosis in any diagnostic position.[26] These figures represent

hospital episodes rather than individual patients, and clinical outcomes are not routinely reported. The annual cost has been estimated exceeding £220 million. This level of activity reflects the consequences of gaps in early identification, community capacity, and continuity of care.

Important parts of the pathway remain poorly measured in terms of data. No comprehensive national dataset captures treatment delivered through primary care, non-specialist mental health services, or independent or third-sector providers. NHS Talking Therapies is not commissioned to treat eating disorders as a primary condition, limiting access through the NHS's largest psychological therapy programme.

Prevention is even less systematically implemented. Evidence-based preventive interventions exist,[27] but provision across public health, education, regulation, and healthcare remains fragmented. There is no national routinely reporting on prevention coverage, equity, or outcomes.

Policy context and missed opportunity

NHS England has established policies and service structures relevant to eating disorder care; however, gaps remain in implementation and coverage. There are established national access standards and service reporting for children and young people,[2] but there are no eating disorder-specific adult access standards, minimum service capacity requirements, or an implementation programme explicitly linked to population need. The *Fit for the Future: 10 Year Health Plan for England* sets out three strategic shifts: from hospital to community, analogue to digital, and sickness to prevention. Although eating disorders are not explicitly identified in the Plan, mental health, including severe and enduring mental illness, is an early priority for the development of modern service frameworks, and work is under way to include eating disorders.

International developments demonstrate that more comprehensive approaches are feasible. Australia, Sweden and New Zealand have linked clinical standards with national coordination, workforce development, investment and implementation monitoring.[28]

Required actions

Without sustained political commitment to investment in all parts of the preventative and treatment pathway, avoidable morbidity and mortality will persist, along with increasing pressure on emergency and acute services. The recommendations in this report define the principles, capabilities, and outcomes needed for a funded implementation plan in England, and supported, where relevant, by UK-wide collaboration on data standards, professional competencies, research, and learning from deaths.

We recommend the following actions:

1. Systematic assessment of treatment and prevention gaps

It is essential that DHSC establishes regular population-based assessment of the size of unmet need for eating disorder treatment and prevention, linked to routine reporting of coverage and outcomes. National systems need to demonstrate who needs care, who receives it, what care is provided, and whether outcomes improve.

England has established routine monitoring of specialist NHS service activity and waiting times, but diagnostic prevalence data remain limited, and important parts of the pathway, such as primary care, and prevention data are not routinely collected.

Future needs assessments need to distinguish diagnosed eating disorders, screening-positive symptoms, and functional impairment, and identify inequalities by age, sex, gender, ethnicity, deprivation, and geography. National bodies require sufficient analytical capacity and digital infrastructure to link, analyse, and publish these data for commissioning and quality improvement. Common definitions and a minimum dataset for services in England would support valid comparisons and shared learning. Voluntary benchmarking and audits can complement but not replace routine national reporting.

2. Establish funded cross-government national implementation eating disorder strategy based on population need

We recommend that the UK Government establishes a funded, cross-government eating disorder strategy in England with named accountability, a costed delivery plan, and explicit decisions about the treatment and prevention coverage to be achieved. Such coverage decisions should take account of the size and impact of the implementation gap, benefits and associated economic savings from improved coverage, statutory duties under the Equality Act and Health and Social Care Act, and the right to health.

Strategies should be co-produced with people with lived experience, families, and carers, alongside clinicians, public health, education, and voluntary-sector organisations. Co-production should extend from priority setting and service design to implementation and evaluation.

A whole-life implementation programme bringing together CYP guidance, adult services, specialist inpatient care, prevention and public health would provide the foundation for delivery. The DHSC and HM Treasury need to jointly appraise the workforce, service capacity, and investment required to achieve agreed coverage. Implementation plan require measurable milestones by 2031 and annual public reporting of progress, including remaining unmet need.

3. Improving treatment coverage across the pathway

The DHSC and NHSE should define and fund a minimum whole pathway offer for eating disorders based on population need. Local commissioners and planning bodies play crucial roles in ensuring that individuals receive comprehensive care. This care should encompass all stages, from early detection to inpatient treatment, thereby eliminating unnecessary service gaps.

Access should be determined by clinical need and risk rather than arbitrary BMI, diagnosis, or illness-duration thresholds. Responsibilities for physical and psychiatric care, escalation, transitions, and follow-up need to be explicit. Pathways should be co-produced with people with lived experience and families and evaluated using access, clinical, functional, and patient-reported outcomes.

Primary care. Primary care requires clearly commissioned and resourced responsibilities for recognition, initial assessment, physical monitoring, referral, and continuity of care, with access to specialist advice when

needed. National reporting should capture activity and outcomes in primary care as well as specialist services.

First-line psychological treatment. Access to first-line psychological treatments by NHS Talking Therapies should be expanded to include eating disorders. NHS England should assess the feasibility of safely delivering selected therapies recommended by NICE through this infrastructure for clinically appropriate cases. This would require specialist training, supervision, risk assessment, and clearly defined escalation pathways.

Specialist community and intensive treatments. Specialist community services should form the core of the pathway, with access to greater treatment intensity when first-line outpatient care proves insufficient. Commissioners should use population needs assessments to determine the capacity required for specialist outpatient, intensive community, day, and telehealth treatment and identify where provision is insufficient. Intensive services should provide multidisciplinary psychological, nutritional, psychiatric, and medical care and support timely step-up and step-down.

Acute medical and specialist inpatient care. Inpatient treatment remains necessary for the minority of people whose psychiatric, nutritional, or medical needs cannot be managed safely at lower levels of intensity. Intensive community and day treatment should therefore complement, not replace, adequate inpatient capacity. The DHSC should review specialist inpatient and acute medical pathways across NHS-funded provision, including care delivered by independent providers. Reviews should examine access, admission and discharge criteria, treatment models, multidisciplinary staffing, restrictive practices, length of stay, readmission, costs, outcomes, and continuity after discharge.

Implementation can build on existing national developments. For commissioners, the practical requirement is to translate these principles into service specifications, contracts, and measurable coverage expectations. Where parts of the pathway are unavailable, commissioning plans should identify the gap, the additional capacity and workforce required, the timetable for delivery, and the outcomes by which improvement will be judged.

4. Workforce development and training

Improved coverage of treatment and prevention requires the appropriate number of trained workforce, including in primary care, IAPT, secondary care and other sectors. Service expansion depends on sufficient permanent specialist staff, an appropriate multidisciplinary skill mix, and

the capacity for clinical leadership, supervision, and training. It is essential that NHS England develops a costed eating disorder workforce plan linked to population needs and planned treatment coverage.

The specialist psychiatric workforce is a major concern. In the 2025 RCPsych Workforce Census, eating disorder psychiatry had the highest consultant vacancy rate of any psychiatric specialty in England.[29] This is against an adult population need measured in the hundreds of thousands.

Consultant psychiatrists and SAS doctors provide not only direct clinical input but also management of psychiatric, medical, and legal complexity, multidisciplinary leadership, supervision, training, and service development. Workforce plans require the explicit development of this specialist medical workforce.

At the same time, eating disorders cannot remain the responsibility of a small specialist workforce. They must become everybody's business across healthcare.[30] Doctors in primary care, paediatrics, emergency and acute medicine, psychiatry, and relevant specialities need core competencies in recognition, physical and psychiatric risk, initial management, and escalation. These competencies should be embedded throughout undergraduate education, postgraduate curricula, and continuing professional development,[31,32] with advanced specialist training, such as RCPsych credentialing, available to develop the clinical leaders and supervisors needed to support the wider workforce.

5. Improve prevention

Given that most eating disorders develop prior to adulthood, the most significant opportunities for prevention and early intervention present during childhood and adolescence. The increasing prevalence of eating disorders underscores the urgent need to expand evidence-based prevention through coordinated public health policies. It does not require an entirely separate system; it can be embedded within existing public health, mental health, education, food, healthy-weight, and digital-safety policies.

Therefore, the national strategy should include explicit eating disorder prevention objectives, accountable leadership, identifiable funding, and outcome monitoring. Priorities include poverty and food insecurity, weight stigma, harmful marketing, and exposure to eating disorder content online. Eating disorder expertise and lived experience should inform policy design to reduce unintended harms, such as increased body dissatisfaction, restrictive eating, and stigma. Existing public health frameworks provide practical routes for implementation.

6. A national confidential learning programme on eating disorder-related deaths

Mortality remains persistently high, with little evidence of sustained improvement over time. NHS England should establish a confidential learning programme, with scope for UK-wide collaboration where useful, drawing on NCISH methods, to identify recurrent and potentially modifiable factors contributing to eating disorder-related deaths. Linking mortality and health-service data with the experiences of families and carers would provide a fuller understanding of where care can be improved and help identify opportunities to reduce future risk. Findings should be reported in aggregate and translated into measurable improvements in services, commissioning, training, and clinical practice, with the emphasis on shared learning, safer care, and better outcomes rather than individual blame.

7. Build research capacity

Eating disorder research remains under-resourced relative to the scale of morbidity, mortality, and service need, with limited academic posts, fragmented infrastructure, and insufficient capacity for sustained clinical research across the UK.[33-35] A coordinated eating disorder research strategy addressing evidence and implementation needs should therefore be developed by UKRI and NIHR, while making use of UK-wide collaboration, where relevant.

Research priorities, study design, and interpretation should be shaped through meaningful involvement of people with lived experience and families, with appropriate support and recognition for their contributions.

Priorities include:

- epidemiological studies to monitor population need;
- how to scale up implementation of existing evidence-based interventions to treat and prevent eating disorder including through use of implementation science and comparative evaluation of treatment and service models in routine practice, including community, intensive, day, telehealth, and inpatient care;
- early intervention, relapse prevention, and treatment of severe or long-standing illness;

- prevention and the social, commercial, and digital determinants of eating disorders;
- physical and psychiatric comorbidity, including T1DE, neurodevelopmental conditions, and preventable mortality;
- treatment development for under-researched diagnoses and complex presentations, including ARFID;
- inequalities in access, treatment, and outcomes among underserved populations;
- digital treatment and prevention, including safety, effectiveness, and equity;
- biological mechanisms, treatment mechanisms, and personalised approaches;
- standardised outcome measurement, data linkage and longer-term recovery; and
- economic evaluation and cost effectiveness across prevention and treatment.

The strategy should provide sustained funding for clinical academic careers, research posts, infrastructure, multicentre collaboration, and secure data linkage, with scope for wider research collaboration. Without this capacity, important questions regarding effectiveness, implementation, and long-term outcomes will remain unanswered, and service development will continue to outpace the evidence needed to guide it.

Conclusion

Research evidence and guidelines to improve eating disorder care already exist. The principal challenge is consistent implementation at sufficient scale. Gaps in capacity, workforce, integrated pathways, data, and accountability continue to limit access to effective treatment and prevention.

England has policy foundations on which to build a national implementation strategy. The next step is to translate these into funded, measurable implementation matched to population need. The DHSC and commissioners need to make transparent decisions about the coverage

they intend to achieve, the workforce and investment required, and how progress will be measured.

Implementation should be co-produced with people with lived experience and families, not only at the stage of consultation but in service design, delivery, evaluation, and priority setting. Research should develop alongside implementation, using routine outcome data, pragmatic studies, and economic evaluation to identify which models improve access, safety, recovery, and equity in real-world practice.

The priority is no longer to restate the problem but to demonstrate progress in access, outcomes, equity, prevention, and the evidence base required for sustained improvement.

METHODS

Scoping review

A scoping review of the English-language literature published during the previous ten years was undertaken to identify evidence relevant to eating disorder prevalence, risk factors, health and social impacts, treatment, prevention, service delivery, and implementation. Sources included systematic reviews, randomised controlled trials, major observational and population studies, and relevant UK and international policy and regulatory documents.

The review focused on population need, effective treatment and prevention, co-occurring conditions, implementation gaps, service coverage, and relevant national and international policy developments. Earlier landmark studies were included where necessary.

National data sources

The report draws principally on published datasets for England, supplemented by UK-wide and international evidence where relevant to the context, methods, and interpretation. Comparable UK-wide information on prevalence, service activity, workforce, expenditure, outcomes, or treatment coverage is limited.

Key sources included:

- Adult Psychiatric Morbidity Survey; NHS England and NHS Digital hospital and mental health activity data; the NHS England Mental Health Dashboard; and the Royal College of Psychiatrists National Audit of Eating Disorders.
- UK-wide/contextual: NHS Benchmarking Network data on referrals, caseloads, workforce, expenditure, and inpatient provisions. UK aggregates are distinguished from England estimates.
- Mortality: Office for National Statistics data, where eating disorders were coded under ICD-10 F50.

Limitations

Important limitations include limited information from primary care, independent, and third-sector services; and uncertainty in survey-based prevalence estimates. Current data do not permit a robust evaluation of healthcare activity, workforce, expenditure, outcomes, or treatment coverage across all sectors of the eating disorder pathway in England. These limitations support the need for a consistent national minimum dataset and routine reporting of treatment and prevention coverage.

Lived experience and stakeholder input

To contextualise the evidence and better understand the real-world impact of the treatment and prevention gap, perspectives from people with lived experience of eating disorders and from carers and supporters were sought. These perspectives informed the interpretation of the findings and the identification of priority gaps.

Stakeholder survey

Appendix 1 summarises the findings of a stakeholder survey examining perceived gaps in the implementation of eating disorder services across the UK, with most respondents based in England. The survey collected responses from 212 professionals across clinical, academic, and policy roles, focusing on treatment accessibility, service constraints, and priorities for improvement. Free-text responses were analysed using descriptive content analysis to identify recurring themes.

Stakeholder consultation

The draft report was circulated for comments to stakeholder organisations, including professional bodies, third-sector organisations, and academic experts, to ensure accuracy, relevance, and completeness. The feedback was reviewed and incorporated as appropriate.

1. PREVALENCE AND POPULATION NEED IN ENGLAND

Eating disorders impair essential biological functions and are associated with substantial physical, psychological, and social harm. Despite this burden, policy attention, research investment, and surveillance remain insufficient, even as the prevalence has increased globally and nationally and further increase is forecasted.[4,12,36-39]

ICD-11 and DSM-5 diagnostic classifications now recognise anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), avoidant/restrictive food intake disorder (ARFID), and other specified feeding or eating disorders (OSFED), pica, and rumination disorder.

1.1. International context

Lifetime prevalence estimates vary substantially between studies and settings, reflecting differences in populations, case definitions, and methods used (Table 1).

Table 1 Lifetime prevalence of DSM-5 eating disorders in high income countries[40-44]

Eating Disorder	Prevalence in Women (%)	Prevalence in Men (%)
Anorexia Nervosa (AN)	0.8 - 6.3	0.1 - 0.3
Bulimia Nervosa (BN)	0.8 - 2.6	0.1 - 0.2
Binge Eating Disorder (BED)	0.6 - 6.1	0.3 - 0.7
Other Specified Feeding or Eating Disorders (OSFED)	0.6 - 11.5	0.2 - 0.3
Unspecified Feeding or Eating Disorders (USFED)	0.2 - 4.7	0 - 1.6
ARFID	1.3-4.5	2-4.5

1.2. Estimated prevalence in England

No population-based study has assessed the full DSM-5 or ICD-11 diagnostic spectrum across all age groups. NHS Digital has population-based diagnostic estimates for children, young people, and adults, although gaps and methodological limitations remain.

Beat estimates that approximately 3.5 million children, young people, and adults in the UK live with eating disorders.[8] This estimate is derived from

recent survey data for England, adjusted for screening accuracy, and extrapolated to the UK; therefore, it is subject to uncertainty.

Screening tools identify individuals whose responses indicate possible eating problems. They do not establish a diagnosis and may produce both false-positive and false-negative results.[45-47] Diagnostic prevalence estimates the likelihood of meeting the diagnostic threshold from diagnostic interviews. These measures serve different planning objectives. Screening informs public health policies, and diagnostic prevalence should inform service planning.

1.2.1 Children and young people

The median age at onset of feeding and eating disorders is approximately 18 years. An estimated 48.1% begin before the age of 18 years and 82.4% before the age of 25 years.[21]

The Mental Health of Children and Young People in England surveys indicate substantial increases between 2017 and 2023 in both the proportion screening positive for possible eating problems and the proportion of those identified as having an eating disorder. The largest increase was observed among those aged 17–19 years (Table 2).[6]

In 2023, 42.3% of young men and 77.5% of young women aged 17–19 screened positive for possible eating problems. Most of those who screened positive were not identified as having an eating disorder following a full diagnostic assessment; however, these figures indicate a large population with eating-related concerns beyond those who meet diagnostic criteria.

Applying age-specific diagnostic estimates to the population aged 11–19 years suggests that approximately 360,000 young people had eating disorders in 2023. This extrapolated estimate does not include children aged < 11 years.[6] Extrapolated to the UK population, this equates to approximately 420,000 young people aged 11–19 years, representing approximately 7.8% of that age group.

Table 2: Trends in annual prevalence rates of eating disorders in children and young adults in England[6]

Sex	Diagnosis	11–16 yrs 2017	11–16 yrs 2023	17–19 yrs 2017	17–19 yrs 2023	20–25 yrs 2023[2]
All	Anorexia nervosa	0.07 (0.0–0.2)	0.20 (0.0–0.5)	0.15 (0.0–0.4)	3.32 (0.9–5.8)	0.31 (0.0–0.7)
	Bulimia nervosa[3]	0.04 (0.0–0.1)	0.51 (0.1–1.0)	0.14 (0.0–0.4)	1.70 (0.3–3.1)	1.78 (0.2–3.4)
	Other eating disorders	0.42 (0.2–0.7)	1.81 (0.9–2.7)	0.49 (0.1–0.9)	7.79 (4.3–11.3)	4.17 (2.1–6.2)
	Any eating disorder	**0.54 (0.3–0.8)**	**2.58 (1.5–3.7)**	**0.78 (0.2–1.4)**	**12.50 (8.3–16.7)**	**5.95 (3.4–8.5)**
Boys/young men	Anorexia nervosa	0.000 (0.0–0.0)	0.00 (0.0–0.0)	0.00 (0.0–0.0)	0.57 (0.0–1.7)	0.00 (0.0–0.0)
	Bulimia nervosa[3]	0.00 (0.0–0.0)	0.22 (0.0–0.7)	0.00 (0.0–0.0)	0.00 (0.0–0.0)	1.94 (0.0–4.8)
	Other eating disorders	0.21 (0.0–0.4)	0.73 (0.0–1.7)	0.00 (0.0–0.0)	4.54 (0.3–8.8)	1.64 (0.0–3.5)
	Any eating disorder	**0.21 (0.0–0.4)**	**0.95 (0.0–2.1)**	**0.00 (0.0–0.0)**	**5.11 (0.7–9.5)**	**3.58 (0.2–6.9)**
Girls/young women	Anorexia nervosa	0.15 (0.0–0.3)	0.41 (0.0–1.0)	0.30 (0.0–0.9)	6.43 (1.4–11.5)	0.65 (0.0–1.4)
	Bulimia nervosa[3]	0.09 (0.0–0.3)	0.81 (0.0–1.6)	0.28 (0.0–0.8)	3.62 (0.6–6.6)	1.62 (0.4–2.8)
	Other eating disorders	0.64 (0.2–1.1)	2.93 (1.4–4.5)	1.02 (0.1–1.9)	11.45 (5.9–17.0)	6.91 (3.3–10.5)
	Any eating disorder	**0.87 (0.3–1.4)**	**4.29 (2.4–6.1)**	**1.60 (0.4–2.8)**	**20.83 (13.5–28.2)**	**8.52 (4.8–12.3)**

Estimates are presented as percentages with 95% confidence intervals. Eating disorders were identified using the DSM-5 criteria derived from the Mental Health of Children and Young People in England surveys. Estimates for those aged 20–25 years are available for 2023 only. Wide confidence intervals reflect small cell counts and limit the precision of some estimates.

In 2023, the diagnostic prevalence was highest among those aged 17–19 years and was significantly higher among girls and young women than among boys and young men. International screening studies have also

reported higher rates of possible eating problems with increasing age and body mass index during childhood and adolescence [48].

Changes in the data collection mode between the 2017 survey and subsequent follow-up surveys require caution in interpreting trends. Nevertheless, the scale of the observed increase, particularly among those aged 17–19 years, is consistent with international evidence of the increasing prevalence of eating disorders among children and young people.[39]

1.2.2 Adults

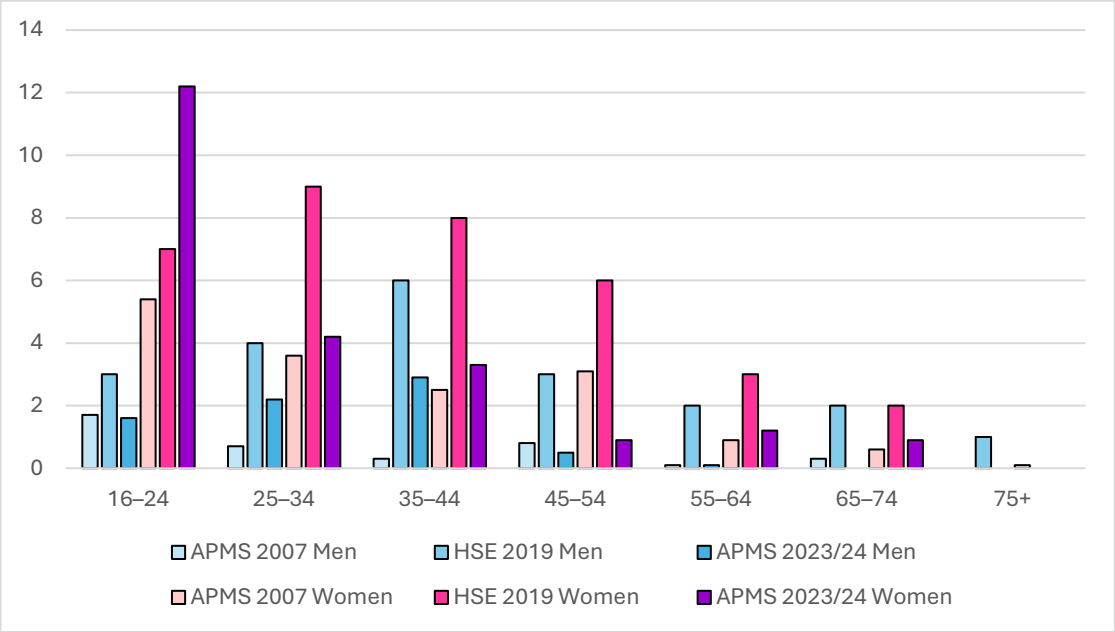
Recent adult prevalence estimates are available from the 2019 Health Survey for England (HSE)[5] and the 2023–24 Adult Psychiatric Morbidity Survey (APMS).[7]

Screening prevalence

In 2019, 16% of adults screened positive for a possible eating disorder (SCOFF ≥2), and approximately 4% reported significant functional impairment (5% women and 3% men).[5]

In the 2023/24 APMS, 9.1% of adults screened positive for possible eating problems, and 2.2% screened positive and reported functional impairment. Screening positivity was higher among women than men and was highest among adults aged 16–24 years. The proportion of positive screening in the APMS increased from 6.4% in 2007 to 9.1% in 2023/24. This increase was evident overall and by sex, although apparent changes within age and sex subgroups had wide and overlapping confidence intervals. (Figure 1).[7,49]

Figure 1. Percentage of adults screening positive for possible eating disorders with significant functional impairment, by age, sex, and survey year [49] 2019[5] and 2023/24 [7]



- *A SCOFF score ≥2 and significant functional impairment refer to interference with work, personal responsibilities, or social life.*
- *Differences between the survey years may reflect both changes in population prevalence and methodological variation. Subgroup estimates should not be interpreted as precise longitudinal trends.*

Diagnostic prevalence

The 2023/24 APMS used a two-phase design. Of the 468 participants who screened positive for SCOFF, 187 completed the SCAN ED diagnostic assessment, and 26 met the diagnostic criteria for an eating disorder in the previous year. The weighted 12-month prevalence estimate was 1.3% (95% CI: 0.8–2.2%).[7] This estimate is imprecise and based on only 26 cases. A further 13 participants underwent SCAN ED for other reasons and met the diagnostic criteria despite screening negative on the SCOFF and were excluded from the prevalence estimation. Few cases, attrition between screening and diagnostic phases, and no included cases in the underweight body mass index category prevented reliable estimation by diagnostic subtype or population subgroup.[7]

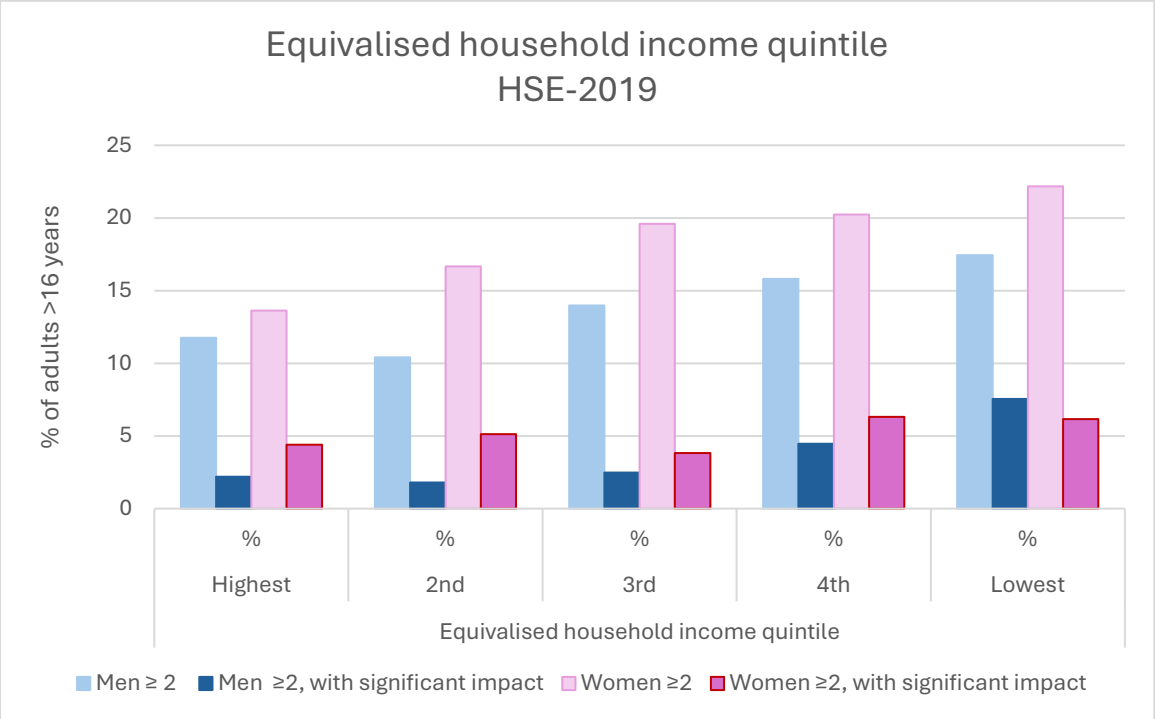
1.2.3 Association with social and demographic inequalities

Eating disorders are associated with socioeconomic disadvantage (Figure 2).[5] Food insecurity is a well-recognised risk factor for BED.[50]

UK data on the prevalence of eating disorders in minority groups are limited.[51,52] However, international evidence indicates similar or higher rates, particularly for BN, BED, and OSFED.[53] LGBTQ+ individuals, particularly gay men, have a substantially higher risk.[54-56] Structural marginalisation and barriers to care are associated with greater symptom severity and poorer outcomes.

These inequalities have implications for equitable access to prevention and treatment. The inclusion of eating disorders within NHS England's Core20PLUS5 framework would support targeted action for underserved groups, including men, socioeconomically disadvantaged populations, and minority communities, and would strengthen national health equity efforts (NHS Core20PLUS5 Framework).

Figure 2. Prevalence of possible eating disorders in adults by equivalised household income quintile in England 2019[5]

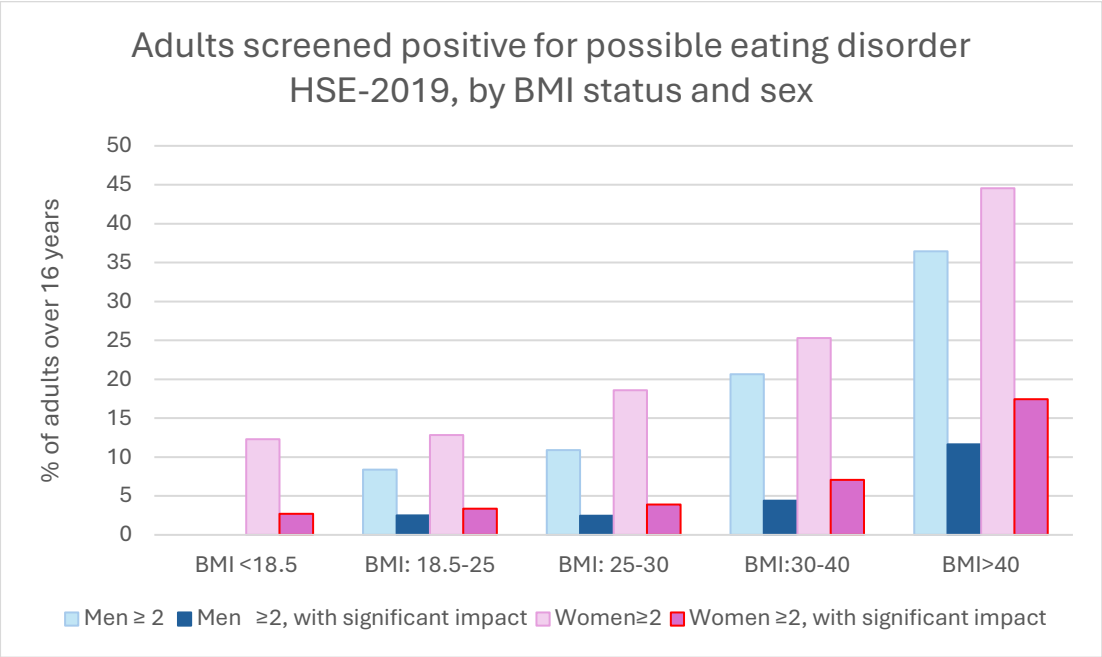


1.2.4 Association with obesity

The 2019 HSE found that the proportion of adults screening positive for possible eating problems increased with body mass index in both women and men (Figure 3). This association is consistent with international findings and may reflect shared risk factors [38,57]. APMS did not publish SCOFF results by BMI.

These findings support closer coordination between obesity and eating disorder policies. Weight-management interventions and public health messaging should be designed to avoid increasing weight stigma, body dissatisfaction, or harmful weight-control behaviours.

Figure 3. Prevalence of possible eating disorder by BMI and sex[5]



SCOFF ≥2 and SCOFF≥2 and significant impairment

1.3 Impact of the COVID-19 pandemic on eating disorder trends

The prevalence of eating disorders was already increasing before the COVID-19 pandemic started in 2020. Further increases in symptoms, incidence estimates, service presentations, and hospitalisation were reportedduring the pandemic, particularly among adolescent girls and young women.[58] Proposed explanations include interacting biological, psychological, and social factors, such as stress, social media exposure, and weight loss messaging.[59,60] These factors may have contributed, but observational evidence does not establish causality. Evidence for a direct biological effect of SARS-CoV-2 remains limited.[61,62]

International data reported increased service presentations and hospital admissions across age groups during this period.[63-65] However, the long-term persistence of these trends remains uncertain and requires further surveillance.

1.4 Implications for population need

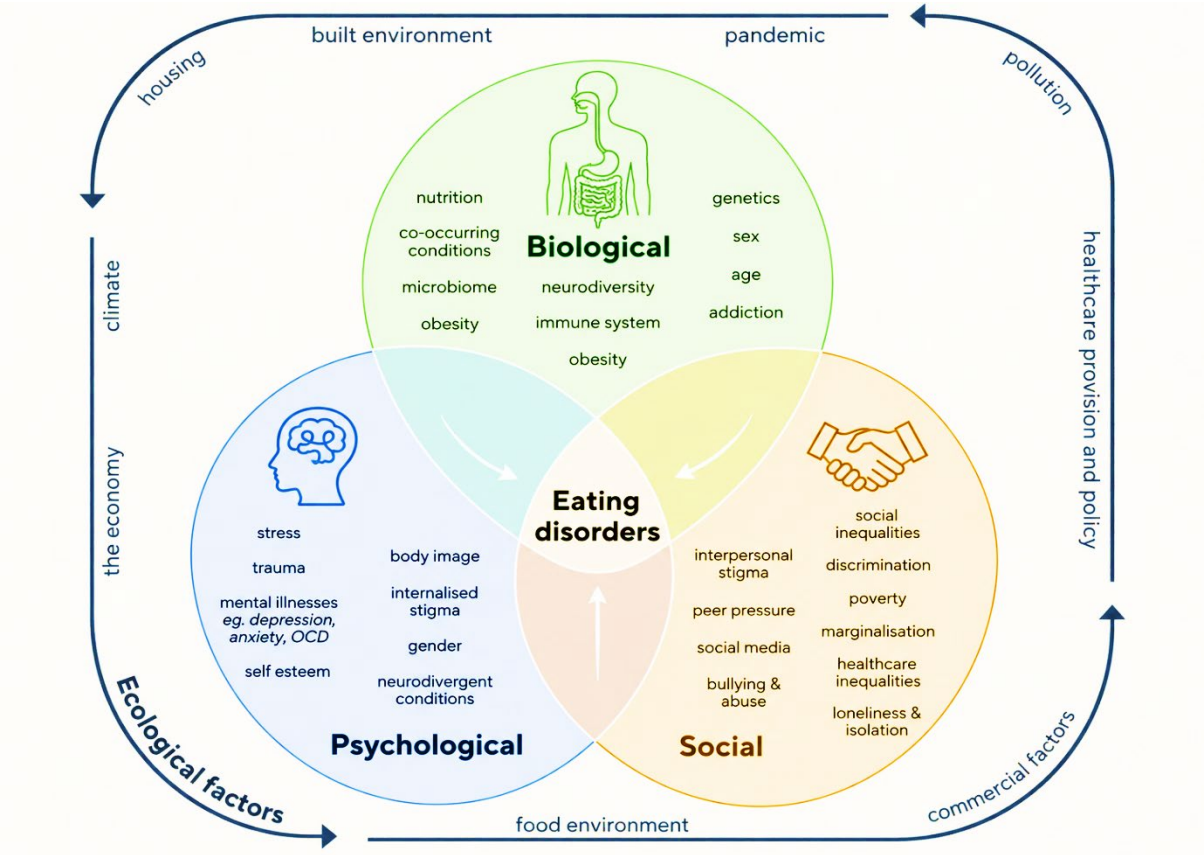
Overall, recent evidence indicates a substantial and increasing burden of eating disorders, much of which remains hidden because population need has not been robustly monitored. Eating disorder screening was included in the 2007 Adult Psychiatric Morbidity Survey but was omitted from the 2014 survey and not restored until 2023–2024, with findings published in 2025. Diagnostic assessment was introduced for the first time in the 2023–2024 survey. This prolonged gap prevented timely assessment of changes in adult prevalence, and there is no diagnostic breakdown data.[7] Screening and diagnostic measures capture different aspects of need and should not be combined, but both are required for policy and service planning.

Population surveillance has instead focused extensively on body weight and obesity as indicators of physical health, while eating disorder symptoms, and diagnoses have received far less systematic attention. This separation is unhelpful because eating disorders and obesity can occur across the weight spectrum and share important social, environmental, and behavioural determinants.

2 RISK FACTORS: THE BIOLOGICAL, PSYCHOLOGICAL, AND SOCIAL DRIVERS OF EATING DISORDERS

Understanding the risk factors for eating disorders is essential for designing effective and proportionate prevention strategies and reducing avoidable morbidity and mortality. Risk factors operate across the biological, psychological, and social domains and contribute to vulnerability across development (Figure 4). Some represent non-modifiable background susceptibility, whereas others are amenable to intervention through public health policies, education, and healthcare systems. Given the limited availability of specialist services, which are currently concentrated on a narrow subset of underweight disorders and the most severely ill individuals, prevention and early intervention informed by population-level risk factors are essential to reduce the overall burden and inequity.

Figure 4. The intersection of biological, psychological and social risk factors of eating disorders



2.1. Biological Risk Factors

Large-scale genetic studies have demonstrated substantial heritability of eating disorders, with genetic liability extending beyond psychological traits to include metabolic, endocrine, and autoimmune pathways.[66-69] These findings have contributed to the reconceptualisation of AN as a metabo-psychiatric disorder, reflecting the integration of biological and psychological mechanisms.[70] Genetic vulnerability alone does not determine illness onset but shapes susceptibility to developmental and environmental exposures.

In addition to non-modifiable genetic risk, several biological factors are potentially modifiable, including chronic stress, nutritional inadequacy, and excessive or compulsive exercise.[71-73] These factors influence physical health and cognitive and emotional functioning and increase the risk of illness onset and relapse.

2.1.1. Medical and metabolic factors

Several medical conditions are associated with an increased risk of eating disorders, including gastrointestinal disorders, autoimmune diseases, obesity, and diabetes [74-77]. These associations are often bidirectional and reflect shared vulnerabilities. For example, the relationship between type 1 diabetes and disordered eating (T1DE) has been well-established.[78]

These associations identify clinical populations that would benefit from targeted prevention, early detection, and integrated care pathways across relevant disciplines.

2.1.2. Age and development

Eating disorders most commonly emerge during adolescence and young adulthood. The mean age of onset is approximately 17–22 years, which is a developmental period marked by substantial biological, psychological, and social changes.[21,79,80]

Early life factors, including extreme birth weight and appetite traits, are associated with the risk of eating disorders in longitudinal studies.[81,82] However, many individuals who develop eating disorders show no identifiable pre-morbid risk factors, limiting the predictive value of these markers.

Evidence linking pubertal transition to an increased risk further strengthens the case for school-based prevention and support during adolescence.[27,83]

2.2. Psychological risk factors

Psychological traits alone do not cause eating disorders but shape vulnerability amid susceptibility to adverse environments. Many are transdiagnostic across disorders, limiting diagnostic specificity while increasing their relevance for population prevention.

Common risk factors include perfectionism, cognitive rigidity, harm avoidance, negative affectivity, low self-esteem, and sensitivity to social evaluation.[76] Neurodevelopmental traits, autism spectrum conditions, and ADHD are overrepresented and may confer vulnerabilities tied to cognitive inflexibility, sensory sensitivity, and emotion regulation difficulties.[84,85] Intolerance of uncertainty and compulsive or avoidant coping styles have also been observed.

These traits may be amplified by malnutrition, stress, and chronic diseases, complicating causal inference. Body dissatisfaction and internalisation of appearance ideals are proximal risk factors, shaped by sociocultural influences and low self-esteem. Dieting and weight suppression are mediators linking vulnerability, social pressure, and biological response, increasing risk across binge eating and restrictive presentations.[86]

2.3. Family and social influences

Families do not cause eating disorders; however, adverse childhood experiences increase the risk of a range of mental health conditions, including eating disorders.[87,88] Peer pressure, weight-related bullying,[89] and harmful social media use further increase this risk.[90]

An umbrella review of observational studies across AN, BN, and BED identified early traumatic and stressful experiences as the most significant risk factors for eating disorders, particularly childhood sexual abuse and appearance-related bullying. These exposures were associated with a two- to three-fold increase in risk. Evidence for most other proposed risk factors is weaker or inconsistent, and robust data on AN remain limited.[88]

These findings have direct implications for prevention policies. Schools provide universal reach during key developmental periods when many risk factors are present. Effective prevention strategies should include anti-bullying programmes with explicit attention to appearance-related teasing, alongside trauma-informed approaches, safeguarding, and early identification of children exposed to adversity.[91] Integrating eating disorder prevention within existing safeguarding, wellbeing, and public mental health frameworks offers a proportionate and scalable response.

Commercial determinants of health

The parallel rise in eating disorders and obesity over the past five decades points to the growing impact of social and commercial determinants of health, which shape food environments, body norms, and health behaviours beyond individual choices. Addressing these determinants through coordinated policy action is increasingly recognised as essential by public health organisations, including the World Health Organisation.[92]

The harmful health impacts of commercial practices across multiple industries are well established. The tobacco, alcohol, fossil fuel, and ultra-processed food industries contribute to non-communicable diseases through product formulation, marketing, pricing strategies, and political influence.[93-95] Ultra-processed foods are particularly relevant to the rise in obesity and binge eating. In the UK, adolescents consume an average of more than 850 g per day, accounting for approximately 66% of their total energy intake, a pattern associated with poor dietary quality and increased obesity risk.[96]

A growing body of evidence links high ultra-processed food consumption to metabolic and mental health harms, including binge eating and loss of control over eating.[97-101] Exposure begins early, with ultra-processed foods prevalent in infant and toddler diets and associated with rapid weight gain and later obesity risk.[102] The modern food environment increases vulnerability to both obesity and eating-related psychopathology, particularly binge eating disorder and other non-underweight presentations that account for most population-level burdens.

Commercial influences extend beyond the food systems. The diet industry, alongside the fashion and fitness sectors, promotes unrealistic body ideals while profiting from body dissatisfaction and repeated dieting, contributing to body image disturbance and disordered eating.[103] Social media platforms amplify these messages at scale, exposing children and adolescents to digitally manipulated body imagery, weight-focused content, and algorithm-driven reinforcement of disordered eating behaviours.[104,105]

Despite this, the role of commercial determinants in the development of eating disorders has received far less attention than that of obesity.[98] The available evidence indicates a substantial overlap in upstream drivers, including food environments, marketing practices, weight stigma, and socioeconomic inequality. Therefore, effective prevention requires coordinated cross-government action spanning food regulation, advertising standards, digital platform governance, and education policy. Without such coordination, obesity policies risk causing unintended harm, and population-level eating disorder prevention remains fragmented and underdeveloped.

3. IMPACT OF EATING DISORDERS

Eating disorders can have profound physical, psychological, and social consequences. Their impact varies according to diagnosis, severity, duration, comorbidity, and stage of life, but may include multisystem medical complications, psychiatric morbidity, disruption to education and employment, family burden, premature mortality, and substantial social and economic costs.

3.1. Physical and mental health impacts of eating disorders

3.1.1. Physical health impacts

Eating disorders affect all body systems.[9] Physical health conditions may precede, coexist with, or arise as complications of eating disorders. AN and ARFID can lead to chronic malnutrition and micronutrient deficiencies, resulting in arrested growth and development in children and young people and progressive organ damage across the lifespan.[106] BN is associated with electrolyte disturbance and dental pathology,[107] while BED is substantially associated with an increased risk of obesity and Type 2 diabetes.[108]

Physical risks can occur across the weight spectrum and should not be inferred from the body mass index alone.[109] For example, co-occurring eating disorders in people with type 1 diabetes (T1DE) are associated with diabetic ketoacidosis, irreversible long-term complications, and increased mortality.[78] Gastrointestinal disorders can both increase vulnerability and perpetuate illness,[110] while cardiac complications occur across the diagnostic spectrum.[111] However, collaboration with medical specialties remains inconsistent, and patients frequently fall between services.[112-114]

Furthermore, individuals with BN and BED are significantly more likely to smoke than the general population.[115] Smoking and vaping are commonly used as weight-control strategies and are associated with worse physical and mental health outcomes;[116-118] however, they are rarely addressed within the eating disorder treatment pathways. These interactions require agreed pathways between specialist eating disorder services, primary care, paediatrics, acute medicine, and relevant medical specialties. The responsibility for medical monitoring, escalation, and follow-up should be made explicit.

3.1.2. Mental and physical health complications and comorbidities

Psychiatric and neurodevelopmental co-occurring conditions

Between 60% and 80% of individuals with a clinical eating disorder have at least one co-occurring psychiatric condition, which substantially increases morbidity and mortality risk (Table 3).[107,119-121]

Genetic studies have indicated shared liability between eating disorders and conditions such as obsessive–compulsive disorder, depression, anxiety disorders, bipolar disorder, schizophrenia, and neurodevelopmental conditions.[66,84,107] These associations suggest shared underlying biological mechanisms; however, malnutrition related to eating disorders can further impair mood, anxiety, and cognitive functions. Therefore, assessment should distinguish pre-existing or co-occurring conditions from symptoms that may be caused or exacerbated by nutritional compromise.

- *"She was allowed to harm herself, even banging her head against walls and basins." (carer)*
- *"It caused huge anxiety and stress... she lost her sense of humour and personality, and it was devastating for those around her." (carer)*

These comorbidity levels have implications for service configuration and integrated care.

Table 3 Summary of common co-occurring conditions of eating disorders[107]

Diagnosis	Common psychiatric and neurodevelopmental conditions	Common medical conditions and complications
Anorexia Nervosa	Depression OCD ASD Bipolar disorder Anxiety disorders and PTSD Personality disorder Alcohol and substance misuse Suicide attempt and suicide	Malnutrition and vitamin deficiencies Cardiovascular complications Electrolyte abnormalities Endocrine disturbances Amenorrhoea and infertility Delayed growth Gastrointestinal disorders Osteoporosis/ reduced bone density Type 1 diabetes (co-occurring)
Bulimia Nervosa	Social anxiety Depression Substance use disorder Bipolar disorder Anxiety disorders and PTSD ADHD Personality disorder Suicide attempt and suicide	Dental erosion and periodontal disease Electrolyte abnormalities Cardiovascular complications Endocrine disturbance Gastrointestinal disorders Reduced bone density Type 1 and type 2 diabetes
Binge Eating Disorder	Social anxiety Bipolar disorder ADHD PTSD Depression Alcohol and substance misuse Suicide attempt and suicide	Type 2 diabetes Metabolic syndrome PCOS Obesity Respiratory, musculoskeletal, and gastrointestinal disorders Fatty liver disease Cardiovascular disease
Avoidant Restrictive Food Intake Disorder	Any psychiatric comorbidity Anxiety disorders ASD	Micronutrient deficiencies Impaired growth and developmental delay

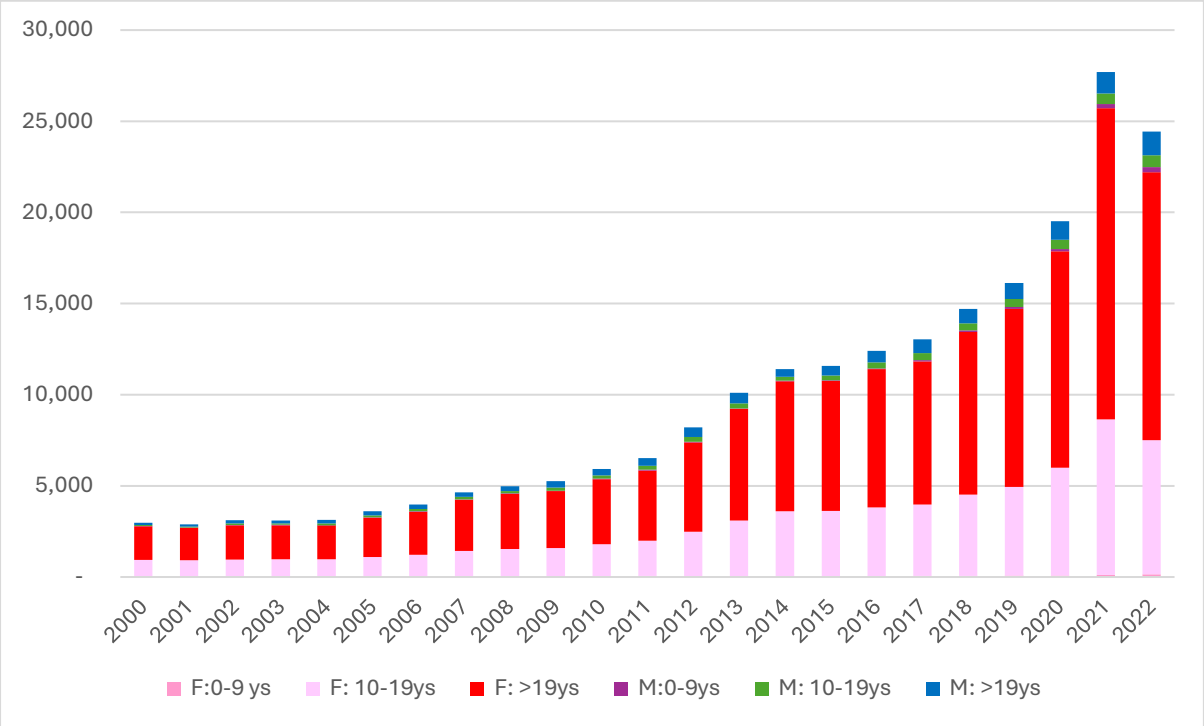
The table is illustrative rather than exhaustive. Reported prevalence varies substantially between studies, and medical conditions may precede, coexist with or arise as complications of an eating disorder

3.1.3. Hospital admissions in England

Hospital Episode Statistics (HES) show a substantial rise in admissions related to eating disorders. The number of finished admission episodes with an eating disorder recorded in any diagnosis position increased from 3,148 in 1999/2000 to 28,054 in 2022/23, nearly a ninefold increase, with a marked rise during the COVID-19 pandemic. Approximately 70% of episodes occurred in women aged ≥ 20 years (Figure 5)[122-124]. These figures reflect episodes rather than individual patients. HES includes activity from acute hospitals, mental health trusts, and NHS commissioned independent providers but does not capture all mental health inpatient activity. In 2024/25, there were 48,194 finished consultant episodes with an F50 diagnosis recorded in any position.[26] This is not directly comparable with previous reports, as a single admission may include multiple consultant episodes, and the data do not provide the same age and sex breakdown used in previous reports.

Among children and young people, admissions increased by 515% between 2012–13 and 2021–22, with the steepest rise in those aged 11–15 years. Young people with eating disorders are at an elevated risk of prolonged hospitalisation and readmission. In 2021–22, 8% of eating disorder–related admissions lasted over one week compared with 3.5% of all-cause admissions, and 13% of CYP were readmitted within six months.[125]

Figure 5. Acute hospital admissions in England with primary and secondary diagnosis of an eating disorder for males and females between 2000/2001-2022/2023[122,124]



F: Female, M: Male

Admission primarily for the treatment of an eating disorder typically indicates severe physical compromise or acute psychiatric risk, such as suicidality. Mortality following hospitalisation is substantially elevated, particularly in patients with AN [126,127]. Early identification and timely specialist community treatment may prevent crisis admissions. NHS hospitalisation costs exceed £220 million annually.[128] Emerging evidence suggests that intensive community and day programmes can achieve outcomes comparable to inpatient care, reduce hospitalisation, and lower costs. However, access remains limited, and further research is needed to guide national commissioning.[129]

3.1.4. Mental health inpatient admissions

Current national data do not permit a complete evaluation of specialist inpatient provision, activity, or outcomes. The 2025 National Audit of Eating Disorders identified 33 adult and 54 children and young people's inpatient teams in England. Independent providers accounted for 42% of adult and 27% of children and young people's teams delivering NHS-funded care.[130]

Based on the number of beds and average length of stay, this equates to approximately 1,200–1,500 adult specialist admissions per year. However, treatment outcomes are not routinely reported. Published UK cohort studies indicate substantial variation in length of stay, treatment approach, outcomes, relapse, and readmission following inpatient treatment.[131-133] However, cohort studies cannot replace national monitoring of service performance. Routine reporting should cover admissions, unique patients, length of stay, clinical and patient-reported outcomes, readmissions, use of general medical and psychiatric wards, and continuity following discharge.

3.2. Social Impacts

Given that eating disorders emerge during critical stages of development, they can disrupt educational, social, and vocational trajectories, generating long-lasting consequences for individuals, families, and the wider economy. Stigma and shame worsen social withdrawal, relationship difficulties, and reduced quality of life (QoL).[12,134,135]

In adults, these disruptions are associated with unemployment [136], relationship instability, and financial insecurity. Evidence suggests worse outcomes in minority groups, where stigma and structural barriers further limit access to care.[137] Families and carers may experience substantial emotional, practical, and financial effects, particularly when the illness is severe or prolonged [138].

- *"An inquest into her death has recently concluded that the acute ward on which she was placed was ill-equipped to meet her complex needs. The coroner was concerned about the delay in transferring her to a specialist eating disorder unit, the length of time she spent on an inappropriate ward, the lack of a clear escalation process, and the failure to ever find a long-term solution for her care." (MP)*

3.3. Excess premature mortality

Eating disorders are associated with excess premature mortality. Meta-analyses consistently report standardised mortality ratios of 5–6 for AN and approximately 2 for other eating disorders, including BN, OSFED, and BED.[16,119,139] Mortality risk is particularly high among people who require hospital treatment and those with serious physical or psychiatric comorbidities, including type 1 diabetes.[126,140,141]

Linked population data show markedly increased rates of severe physical illness, psychiatric morbidity, and death compared to those in matched controls. Excess mortality emerges within the first year of diagnosis and

persists for at least a decade, with particularly high risks of suicide, self-harm, renal and liver diseases, and other unnatural deaths.[9]

Deaths in AN are frequently due to potentially treatable physical complications, including malnutrition, metabolic disturbance, cardiovascular disease, infection, and gastrointestinal pathology. Risk is further amplified by co-occurring treatable psychiatric disorders, substance misuse, and self-harm.[141,142]

These patterns are consistent with delayed recognition and fragmented care rather than an inevitable disease course. Some international studies have reported improved outcomes in integrated services.[143-146]

UK mortality statistics record very few eating disorder deaths.[17] The Parliamentary and Health Service Ombudsman has repeatedly identified systemic contributors to avoidable deaths, including underinvestment in adult services, inadequate medical training, poor coordination of care, and failures to learn from harm.[18] Subsequent reviews have found insufficient progress in implementing these recommendations despite repeated calls for urgent action.[19,147,148]

3.4. Economic impact

Eating disorders impose substantial costs on individuals, families, health services, and the broader economy. A cost-of-illness analysis estimated that eating disorders could have generated social costs of £6.3bn - £9.6bn in England and £7.5–£11.2 billion in 2019-2020 across the UK, (expressed in 2019 prices).[24] This estimate should be treated as indicative. The analysis used two different prevalence sources: Beat's estimate of 1.25 million people affected, and a separate estimate derived from the HSE screening data[5] (Table 4). The analysis also relied largely on English data extrapolated to the UK. Prevalence estimates and patterns of service use have since changed, and no updated national economic modelling is available.

Table 4. Estimated UK social and economic costs of eating disorders in 2019-2020[24]

Area	England	UK	Commentary
Direct healthcare costs (anorexia and bulimia only)	£1,200m - £1,400m	£1,500m - £1,700m	Costs of ED healthcare costs (not split between direct and indirect costs)
Indirect healthcare costs			Difficult to quantify due to insufficient data
Carers costs (anorexia and bulimia)	£600m - £1,000m	£700m - £1,100m	
Personal financial cost	£500m - £700m	£600m - £900m	Out of pocket costs to individuals associated with anorexia and bulimia
Productivity cost	£2,600m - £4,100m	£3,100m - £4,800m	Wider economic impact including lower involvement in the workforce and lost taxation revenues
Total Cost	£8bn (£6.3bn - £9.6bn)	£9.4bn (£7.5bn - £11.2bn)	High and low-cost estimates and range provided along with England and UK estimates
Cost per person impacted			EY estimate £5,000 per person impacted

These estimates are consistent with international findings, including costs of AUD $66.9 billion in Australia[149] in 2023 and $64.7 billion in the United States in 2018-19.[150] Economic evidence played a central role in the development of Australia's 10-year National Eating Disorders Strategy, which integrates prevention, treatment, and workforce investment.[151]

Economic costs are particularly impactful on working-age adults and their families, reflecting disrupted education, reduced participation in employment, lost income, and lower productivity. Because eating disorders often begin early in life and may persist or recur, annual estimates do not capture their cumulative economic impact across the life course.

This economic burden is consistent with the substantial morbidity, premature mortality, and use of health and social care described in earlier sections. It strengthens the case for investment in prevention, early intervention, and effective treatment models that support sustained recovery, reduce relapse, and avoid preventable emergency and inpatient care.

4. TREATMENT GAP FOR EATING DISORDERS

The eating disorder treatment gap reflects the disparity between the population's need for and access to timely, evidence-based treatment. Effective interventions are recommended by NICE and other national bodies; however, only a minority of affected individuals receive appropriate treatment in any healthcare system sector. This is consistent with structural under-provision rather than low population need or lack of guidance.

A recent systematic review and meta-analysis identified treatments associated with improved recovery rates across various diagnoses. For AN, family-based treatment in adolescents and CBT-based or structured nutritional interventions in adults show benefit. For BN and BED, CBT, self-help, dialectical behaviour therapy, and pharmacological interventions are associated with higher recovery rates. For OSFED, CBT and psychodynamic therapy are beneficial.[16] Delayed treatment and prolonged waiting times are associated with increased mortality. Therefore, the treatment gap reflects failures in access and timeliness, rather than the absence of effective interventions. The treatment gap extends beyond access to specialist eating disorder services.

Insufficient capacity leaves services responding predominantly to crises rather than providing prevention and early intervention, contributing to avoidable morbidity, mortality, and long-term costs.

Eating disorder treatment gap across sectors

The following analysis examines the evidence available on treatment provision across different sectors in England. There is no complete account of population need, treatment coverage, and outcomes across the eating disorder pathway. Existing datasets cover different parts of the system and use definitions that are not always comparable. This prevents a reliable assessment of unmet need, equity, and outcomes.

4.1. Primary care

Primary care plays a central role in early recognition, initial assessment, referral, physical monitoring, and continuity of care. However, no routine national dataset shows how eating disorders are identified or managed in general practice.

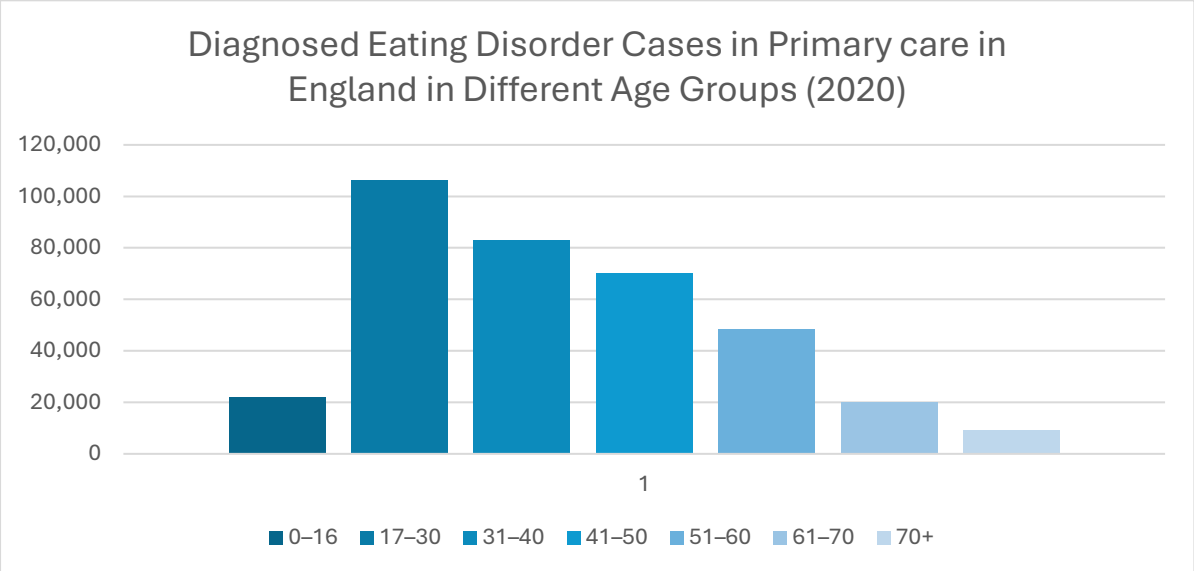
In the 2019 HSE, 82% of adults who screened positive for a possible eating disorder reported seeing a GP during the previous year, compared with 74% of other adults.[5] This demonstrates substantial contact with primary care but does not show whether eating disorder symptoms were discussed, recognised, or treated.

An analysis of electronic health records from 12 million GP patients in England estimated that 1.1% of females and 0.2% of males had a recorded eating disorder diagnosis in 2020, predominantly among working-age adults, with a mean age of 37.5 years (range 27–49) (Figure 6).[52] Across all age groups, GP-recorded diagnoses were estimated at 330,000, representing a minority of cases projected by population-based studies. This number exceeds those recorded for type 1 diabetes or schizophrenia.

Most recorded diagnoses originate from secondary care and are subsequently coded into primary care records. Therefore, GP data largely reflect lifetime diagnoses following specialist contact rather than systematic case identification in primary care.

Taken together, these findings indicate a substantial gap between population-level screening prevalence and recorded primary care diagnoses. In the absence of routine national monitoring of identification, brief intervention, referral, and follow-up, commissioners cannot assess the effectiveness of primary care in the early detection or continuity of care.

Figure 6. Estimated number of diagnosed eating disorder cases in primary care in England[52]



- *"We faced a year of back-and-forth GP visits before anorexia was diagnosed."(carer)*
- *"The GP would not make a referral as he 'was confident that this wouldn't spiral out of control'—and her BMI was still within a healthy range." (carer)*
- *"It wasn't until about 18 years after first struggling with food that I was told I had binge-eating disorder." (patient)*

4.2. Treatment gap for psychological therapies

NICE recommends psychological interventions as first-line treatment for all eating disorders. In the 2019 HSE, only 23% of adults with probable eating disorders reported receiving any psychological treatment in the previous year, and 4% reported evidence-based therapies, such as CBT. Much of the care accessed was non-evidence-based and was delivered outside the NHS.[5] By comparison, 1.2 million adults accessed NHS Talking Therapies for anxiety and depression in 2024–25,[152] eating disorders remain excluded from eligibility, thus limiting access to first-line psychological treatment at scale.

4.3. Specialist community eating disorder services

Table 5 summarises NHS specialist community eating disorder activity and resources in 2024/2025. The main value of the comparison is to show the service scale and the clear difference in resourcing between children and young people's and adult services.

The difference in capacity across the life course is substantial. Relative to the population size, adult services receive approximately half as many referrals, maintain smaller caseloads, and deliver substantially fewer contacts than CYP services. The adult specialist workforce and expenditure are approximately 40% of CYP levels per head of population, while the average wait time to a second appointment is more than twice as long. These data do not establish the optimal level of provision, but they demonstrate a marked imbalance in current specialist capacity.

Access to the full range of eating disorders remains uneven. The 2025 National Audit found that BED was within the remit of 66% of teams serving children and young people and 60% of teams serving adults; the corresponding figures for ARFID were 45% and 29%. These figures cover teams across service settings, with all-age teams included in both age

groups, and should not be interpreted as community service coverage alone. Nineteen per cent of teams reported BMI-related eligibility criteria and 41% excluded some patients because of comorbidity, potentially fragmenting care.[130]

Specialist provision for complex groups also remains limited. Only four nationally commissioned services exist for eating disorder and type 1 diabetes comorbidity, while shared-care protocols are uncommon for physical comorbidity and neurodivergence. Duration of illness alone should not restrict access to active treatment.[1]

Table 5. Specialist community eating disorder service activity and resources in England, 2024/25

Metric	CYP specialist services	Adult specialist services
Access and activity		
Referrals per 100,000 population	202	115
Referrals accepted	82%	76%
Year-end caseload per 100,000	87	49
Share of wider mental health caseload	5.3%	1.7%
Contacts per 100,000 population	3,557	1,411
Mean wait to first appointment	2.4 weeks	3.9 weeks
Mean wait to second appointment	3.7 weeks	8.3 weeks
Caseload characteristics		
Female	84%	86%
Ethnic minority background	14%	12.6%
Workforce and expenditure		
Average workforce per team	21.7 WTE	29.3 WTE
Workforce per 100,000 population	13.1 WTE	5.34 WTE
Average expenditure per provider/team	£1.85m	£2.25m
Expenditure per 100,000 population	£1.01m	£0.40m

Sources: NHS Benchmarking Network 2024/25 Analysis, supplied by Stephen Watkins.

WTE: whole-time equivalent. Benchmarking data cover participating services only. Rates are standardised to the population aged 0–17 for CYP services and 18 years and older for adult services. These denominators do not define local service eligibility; transition arrangements and all-age provision vary. Completeness varies by metric. Waiting time measures refer to first and second appointments and are not necessarily equivalent to referral-to-treatment times.

4.3.1. Children and young people's services

In 2024/25, services received 15,719 referrals and accepted 83%. The National Audit identified 93 CED-YP teams. Median waits were 14 days for assessment and 4 days for treatment, but maximum waits reached 137 and 450 days respectively.[130]

NHS England reported 11,174 treatment starts in 2024/25, an increase of nearly 40% since 2019/20. In late 2025, 78.4% of urgent and 81.7% of routine referrals met the waiting time standards. Self-referral was available in 62% of teams. Intensive community care existed in 88% of areas, but day-patient provision in only 38%, showing uneven intermediate care capacity.[130]

The new NHSE guidance (2026) requires integrated pathways across community, intensive, day, and inpatient care and states that BMI alone should not restrict access. It also emphasises the coverage of all eating disorder types, including ARFID and binge eating disorder.[2] Delivery will depend on the workforce and local implementation.

4.3.2. Adult specialist community services

Adult services received 31,072 referrals in 2024/25 and accepted 84%, delivering 394,316 contacts to 22,251 people.[25] Despite higher activity, the workforce and funding per head were much lower than in children and young people's services.

The National Audit identified 69 adult teams. The median wait times were 28 days for assessment and 42 days for treatment, with maximum waits up to 700 days, reflecting geographical variations. There is no national waiting-time standard for adult services. Only 15% of teams accepted self-referrals. Intensive community care was available in 62% of areas and day-patient care in 48%, leaving gaps between outpatient and inpatient treatment. FREED (early intervention for ages 16–25) is now commissioned nationally, but only 51% of eligible teams reported an active pathway.[130]

Evidence on transition is limited. A pre-pandemic multicentre audit found that only 3.7% of adult referrals originated from children and young people's services, suggesting that transition pathways cannot be understood from referral data alone.[153]

4.4. Medical and acute hospital care

There is no national dataset that links physical health complications, medical care, and outcomes across eating disorder pathways. Reporting focuses mainly on mental health activity. As discussed in Section 3, In 2024/25, HES recorded 48,194 finished consultant episodes with an F50 diagnosis.[154] Some patients are treated in non-specialist acute settings, where access to eating disorder expertise is variable. Research has highlighted the risks, including inconsistent care and the use of restraint or security staff in some acute hospitals.[155] Therefore, clear local pathways for medical management and specialist input are essential.

There is no consistent national data on length of stay, cost, or outcomes across inpatient settings. Future linkage studies are required to monitor effectiveness across the care pathway.

4.5. Psychiatric workforce and multidisciplinary skill mix shortages

Eating disorder psychiatry had the highest consultant vacancy rate of any specialty surveyed in England in the 2025 RCPsych Workforce Census. Among the responding organisations, 20.4% of consultant posts recorded under eating disorders psychiatry were vacant, compared with 14.4% across psychiatry. Including locum-filled posts, 37.4% lacked a substantive appointment, compared with 27.3% overall. Among specialty and specialist (SAS) doctor posts, 26.5% were vacant or non-substantively filled, compared with 17.1% across psychiatry.[29]

The census received responses from 40 of the 48 NHS mental health trusts and counted posts, not whole-time equivalents. As CYP eating disorder posts were not separately identified, the findings cannot establish the CYP workforce or vacancy rates.

The 2025 National Audit of Eating Disorders found consultant psychiatrists in 75.4% of adult and 84.5% of CYP community teams, compared with 96.7% and 97.7% of inpatient teams, respectively.[130] However, it did not report whole-time equivalents or distinguish permanent from non-permanent posts.

NHS Benchmarking data show a further detail: The reported inpatient workforce contains a higher proportion of nursing and healthcare support staff, and a lower proportion of psychological and other therapeutic staff, than adult community teams (Table 6).[25] The data describe vacancies, substantive staffing, and multidisciplinary composition but do not

measure whether clinical input is sufficient to meet patient needs. Staffing adequacy depends on clinical time, competencies, and supervision in relation to caseload, illness severity, treatment delivered, and outcomes.

This distinction is particularly important in specialist eating disorder units, which care for people with severe illnesses and complex physical and psychiatric needs. Nutritional rehabilitation, evidence-based psychological treatment, management of co-occurring conditions, and preparation for discharge require adequate multidisciplinary capacity. Nursing and healthcare support are fundamental, alongside sufficient psychiatric, psychological, dietetic, occupational therapy, and medical expertise. Staffing must enable active treatment and rehabilitation, not only observation, meal support, and short-term stabilisation.

In acute hospitals, safe treatment requires staff trained in refeeding and medical risk management, supported by specialist advice and implementation of *MEED* guidance.

Table.6 Reported workforce composition in adult community eating disorder services and NHS specialist inpatient units, provisional 2025/26 data

Profession	ACEDS MDT share %	SEDU MDT share %
Registered Nursing	23.5	39.5
HCA / Unregistered Nursing	10.6	39.3
Psychology	33.7	4.8
OT	5.3	4.3
Admin	11.2	3.6
AHP & Dietician	6.9	3.1
Medical - Other	2.1	2.4
Consultant Psych	3.1	2.1
Other staff	1.0	0.6
Peer Support	1.0	0.3
Social Worker	1.0	0.1

4.6. Provider Collaboratives and specialised inpatient care

In England, specialised adult eating disorder inpatient services are delivered through NHS-led Provider Collaborative arrangements, including NHS-funded care provided by independent-sector organisations. Approximately £86 million was spent on NHS commissioned adult specialist inpatient eating disorder services in 2024. Independent providers deliver a large share of inpatient care: 42% of adult and 27% of children and young people's units, with 93% of patients NHS-funded.[130]

Pathways vary widely. Some areas provide integrated inpatient, step-down, and community care, whereas others rely on fragmented provisions. Access to intensive and day services is inconsistent.[153,156,157]

Outcome measurement remains limited. The National Audit reported that 82% of the teams collected paired outcome measures. However, only 22% reported quality-of-life measurement, 14% measured outcomes before and after transition to adult services, and 8% reported mortality outcomes. Commissioners should require consistent reporting of outcomes, length of stay, transitions, readmissions, and continuity of care across all providers.

4.7. Private Sector and Third Sector Organisations

No systematic data are available from private providers or third-sector organisations. The private therapy sector is unregulated, and access is limited by the ability to pay.

5. GAPS AND OPPORTUNITIES IN THE PREVENTION OF EATING DISORDERS

As outlined in Section 2, eating disorders are associated with a range of potentially modifiable social, environmental, and commercial factors, including childhood adversity, socioeconomic disadvantage, food insecurity, weight stigma, and harmful digital and commercial influences. Many of these factors are socially influenced and contribute to inequalities in risk.

Recent increases in eating disorder symptoms and diagnoses strengthen the case for addressing modifiable population-level risks, although trends over time cannot establish their causes. Therefore, prevention needs to operate at several levels: universal measures that create safer environments, selective interventions for groups at increased risk, and indicated interventions for people with emerging symptoms.

Existing public health, education, mental health, and regulatory systems provide potential routes for implementation. However, England does not currently have a comprehensive system that routinely reports the coverage, equity, and outcomes of eating disorder prevention.

- *"If only I'd known then what I know now about eating disorders and the impact of starvation on the brain—this needs to be everybody's business." (carer)*

5.1. Population-level prevention

Eating disorders commonly emerge during adolescence and young adulthood.[21,79] This provides a strong rationale for preventive action during childhood, adolescence, and early adulthood, as well as timely intervention when symptoms first emerge.

5.1.1 Childhood adversity, bullying and weight stigma

As described in Section 2.3, childhood sexual abuse and appearance-related teasing are consistently associated with an increased risk of eating disorders.[88] School-based programmes are also effective in preventing bullying and disordered eating.[91,158] Safeguarding and anti-bullying policies should explicitly address harassment relating to appearance, body size, weight, race, disability, gender identity, and sexuality.

These measures have broad benefits for children's safety and mental health. However, their specific effect on the incidence of eating disorders has not been established. Therefore, they should be combined with staff training, appropriate responses to emerging eating problems, and clear routes to further assessment.

5.1.2 Socioeconomic disadvantage and food insecurity

Socioeconomic deprivation and food insecurity are associated with an increased risk of some eating disorders, particularly BED.[50,159] Policies that reduce deprivation and improve access to nutritious food, including freshly made school meals, are likely to have broader mental and physical health benefits.[160,161] Consequently, prevention programmes should assess their reach and outcomes based on socioeconomic status, ethnicity, and other characteristics related to inequalities to ensure that preventive interventions do not exacerbate existing disparities.

5.1.3 Addressing commercial determinants of eating disorders

Commercial practices influence the environments in which attitudes towards food, eating behaviours, weight, and appearance develop.[92,98] Marketing by the diet, fashion, fitness, and beauty industries promotes weight dissatisfaction and disordered eating. Young people are particularly vulnerable and are often targeted by industry.[103,162] Social media platforms amplify exposure to appearance-focused content, particularly among children and young people, and observational studies report associations with disordered eating symptoms.[90,105,163]

Regulation provides one route to reducing potentially harmful exposures.[164] Children's safety duties under the Online Safety Act came into force in July 2025. Online services must protect children from content that encourages, promotes, or provides instructions for eating disorders. Ofcom's framework also identifies body-stigma content as a potential source of significant harm and requires services to assess the risks arising from content moderation, recommender systems, and platform features (Ofcom, 2026).

The implementation should be monitored to determine whether these safeguards reduce children's exposure and associated harms. Evaluation should examine recommendation systems and platform design, rather than focusing solely on the removal of individual posts

Further policy options include restricting weight-loss supplements and regulating harmful body image messaging.[164] Broader food policy measures, including restrictions on advertising ultra-processed foods, may also address the determinants shared with obesity and other non-

communicable diseases. It is necessary to evaluate the direct impact of food policy measures on the incidence of eating disorders.

5.1.4 Aligning healthy-weight and eating disorder policy

Obesity and eating disorders should not be treated as separate public health problems. They share determinants, including food insecurity, weight stigma, commercial marketing, and unequal access to supportive environments. Eating disorders can occur across the weight spectrum and are more common among people with severe obesity.

Obesity prevention policies should promote nutrition, physical health, and wellbeing without reinforcing shame, restrictive eating, or the assumption that individual behaviour alone determines body weight. Eating disorder expertise and lived experience should inform policy design, health-impact assessment, professional training, and public communications.

Qualitative research has reported distress and changes in eating behaviour among some people with restrictive eating disorders following the introduction of calorie labelling.[165-167] Therefore, new and existing policies should be evaluated for their intended benefits and possible adverse effects, including changes in body dissatisfaction, restrictive eating, binge eating, help-seeking, and inequalities.

Educational settings

Schools, colleges, and universities provide scalable settings for universal prevention and targeted interventions among young people with emerging risk factors. A 2025 systematic review found that media literacy and dissonance-based programmes produced small to medium improvements in eating disorder symptoms immediately after the intervention, but the effects were inconsistent across populations or at follow-up.[168] Schools should therefore use well-specified programmes, train those delivering them, and monitor fidelity, acceptability, and outcomes.

Broader approaches include curriculum reform, anti-bullying policies, staff training, and reducing weight stigma, including de-emphasising weight in health messaging [169]. CBT-based prevention programmes show sustained benefits in higher education settings [170].

Peer-led programmes such as the Body Project reduce eating disorder symptoms and long-term risk.[171] Systematic reviews report significant reduction in eating disorder onset, alongside reductions in body dissatisfaction and improvements in media literacy [27,172]

Digital adaptations, including the eBody Project and Student Bodies, reduce body dissatisfaction and may improve their reach and acceptability. Digital CBT-based prevention shows moderate effects but requires further evaluation to optimise engagement and equity of access.[173,174]

Existing national initiatives provide potential implementation routes. NHS England's 2026 guidance strengthens links between schools, school nurses, primary care, and specialist services for earlier identification and referral.[2] This provides useful infrastructure, but it does not constitute a comprehensive eating disorder prevention programme, and routine data on programme coverage or eating disorder outcomes are not currently reported.

5.3. Prevention of eating disorders in higher-risk groups

Targeted prevention is required for higher-risk groups to avoid widening these inequalities. Family-focused prevention for people considered genetically vulnerable has been proposed but remains a research agenda rather than a basis for genetic screening or routine commissioning.[175,176]

The perinatal period is a key potential prevention window. Eating disorders are prevalent among women of reproductive age and are associated with adverse fertility and pregnancy outcomes. Embedding screening and training within fertility pathways may reduce harm, although UK evidence is limited.[177]

Cognitive dissonance models adapted to T1DE have been developed but require further study.[178]

Comparable approaches require development for other high-risk clinical groups and occupations with elevated prevalence, including athletes and performing artists; however, the evidence is not yet sufficient to support a single commissioned model.[179,180]

5.4. Cost-Effectiveness of Interventions to Prevent Eating Disorders

Economic evidence is promising but remains largely international and dependent on modelling assumptions.[181] Reviews indicate that universal school-based programmes yield the greatest long-term cost savings, with benefits accruing over 30 years.[169]

International studies report net savings per case averted for cognitive dissonance programmes and positive returns on investment for digital delivery.[182] Australia's Healthy Weight Programme generated health-adjusted life years and healthcare savings.[183]

These findings support further implementation and evaluation but should not be interpreted as meaning that prevention programmes will necessarily be cost-saving in UK settings. Economic evaluation should include programme costs, participation and completion, effects across population groups, unintended effects, subsequent service use, and longer-term clinical outcomes.

5.5. Coverage of interventions to Prevent Eating Disorders

England does not currently have routine national reporting of the coverage, reach, or outcomes of eating disorder prevention interventions. Information on implementation in schools, higher education, primary care, and community settings is not systematically collected. Consequently, it is not possible to reliably determine which preventive interventions are being delivered, which populations they reach, or whether they reduce inequalities or subsequent service need.

6. CAUSES AND IMPACT OF THE EATING DISORDER TREATMENT AND PREVENTION GAPS

The previous sections demonstrated a substantial mismatch between the population's needs and the current capacity for eating disorder prevention and treatment. Access to evidence-based treatment and prevention programmes remains limited across diagnoses and age groups. The scale of unmet need also raises questions about whether health systems are meeting their responsibilities to assess population need, reduce inequalities, and provide effective care. In England, ICBs have statutory duties to assess population need and plan services accordingly.

6.1. Consequences of the treatment and prevention gaps

Delayed recognition, restricted access to treatment, and fragmented care exacerbate eating disorders, thereby increasing preventable morbidity, mortality risk, and dependence on emergency, acute, and inpatient services. Additionally, these factors disrupt education, employment, relationships and family life.

6.1.1 Avoidable harm and premature mortality

NICE recommends prompt referral from primary care to specialist eating disorder services. In practice, only a minority of those needing treatment access specialist services. Approximately 80% of referrals to participating specialist community services are recorded as anorexia nervosa, while provision for binge eating disorder, ARFID, and OSFED remains uneven.[25,130,153] Service-use data also suggest the under-representation of men, minoritised groups, and people with type 1 diabetes and eating disorders.

Inadequate or delayed access to evidence-based treatment has documented negative consequences. National inquiries and population studies have identified potentially avoidable harm associated with delayed diagnosis, inadequate professional training, and fragmented care.[9,18,19,147,184] Furthermore, practice varies substantially between services, yet outcomes are not systematically monitored nationally. In AN, discharge after partial weight restoration remains common.[185] Partial weight restoration, comorbidity and poor continuity of care and limited aftercare are associated with high rates of relapse and readmission.[16,186,187] By contrast,

integrated pathways combining nutritional rehabilitation to a healthy weight, evidence-based psychological treatment and continuity across inpatient and community care have reported lower relapse and better longer-term outcomes, although comparative studies remain limited.[133,188-190]

Routine real-world outcome monitoring is therefore essential to identify effective practice, reduce unwarranted variation, and support evidence-based commissioning.

6.2. Causes of implementation gap

The treatment and prevention gaps do not have a single cause. They arise from gaps in population surveillance, national leadership, commissioning, workforce capacity, training, service integration, and public awareness.

6.2.1 Insufficient national planning, accountability and capacity

A key barrier to closing the treatment and prevention gaps is the absence of a national implementation programme linking clinical guidance to population need, service capacity, and funding.

England has established national guidance and access standards for children and young people but there is no equivalent, whole-life implementation framework and does not currently align population needs with explicit expectations for treatment and prevention coverage, ongoing workforce and resource planning, or systematic reporting of outcomes throughout the entire pathway.

Clinical guidelines define what good care should look like, but they do not specify the amount of care a health system should provide, and the resources required to deliver them. Without clear coverage expectations, implementation plans and accountability, under-provision can persist despite evidence-based guidance.[191]

This is reflected in the current service capacity. As shown in Section 4, adult specialist community services have substantially lower workforce and expenditure relative to population size than services for children and young people, while staffing and service configuration vary geographically.[25] Limited capacity affects both access and the range of care available. Some services continue to use BMI, diagnosis or comorbidity thresholds, while provision for BED, ARFID and complex co-occurring conditions remains inconsistent.[130,153]

Without nationally defined expectations and accountability for implementation, these gaps may persist despite established clinical guidance. The DHSC and NHS England should define the national requirements for treatment and prevention coverage, while ICBs and providers should be accountable for implementation and reporting against the agreed standards.

6.2.2 Fragmented pathways and workforce capability

Eating disorders cross conventional boundaries between mental and physical healthcare. People may require input from primary care, specialist eating disorder services, paediatrics, acute medicine, diabetes and other medical specialties, general mental health services, and inpatient care. When responsibilities are unclear, patients can fall between services.

- *"There was no therapy provided, leaving patients to struggle with their thoughts between meals, with little structure to their days." (patient)*
- *"After 6 months I got sent to a day hospital, but it wasn't specialised, just a general psych unit so there was zero support." (patient)*
- *"I was discharged without being involved in the decision for being 'disengaged' despite showing up to the appointments." (patient)*
- *"The first thing I noticed missing from [her] treatment was compassion… she spent much of her time on a feeding tube, frequently restrained." (carer)*

Although national guidance advocates for coordinated care, significant deficiencies persist in intensive community and day-patient services, medical support, the transition between paediatric and adult services, and post-discharge continuity.

The same fragmentation is evident in workforce capability. Eating disorders require integrated psychological, psychiatric, nutritional, and medical care, yet access to these disciplines varies between settings. Medical and consultant psychiatrist input is particularly inconsistent in adult services.

- *"Suddenly I didn't hear anything from the eating disorders team, and I later found out I was discharged without being informed" (patient)*
- *"Not well coordinated and very bad communication between services." (carer)*
- *"The way transitions between services were handled was a disaster." (carer)*
- *"After hospitalisation, there was zero support… no specialised support available." (patient)*
- *"We were repeatedly told by the NHS that there is no more therapy they can provide me since nothing seemed to work." (patient)*
- *"There was no support in the community after discharge, despite us knowing how crucial ongoing care is in preventing relapse." (carer)*
- *"A comprehensive approach, including tackling stigma and better community support services, is essential to prevent hospitalisation and*

Insufficient training exacerbates these problems. Training gaps have been repeatedly identified in national reviews and professional surveys.[30,32,184] In primary and acute care, limited knowledge may contribute to delayed recognition, overreliance on BMI, failure to identify medical risks, and inappropriate referral thresholds. In specialist and inpatient settings, variation in expertise and skill mix may limit delivery of evidence-based psychological, nutritional and medical care.[192]

- *"It was evident that my GP had no knowledge of EDs other than using BMI as a diagnostic tool."*
- *"GPs should receive better training to recognise the symptoms of eating disorders."*
- *"Even after I was discharged from an inpatient unit, there was zero understanding of eating disorders from the community mental health team"*

Core competencies are therefore required across primary care, medicine, paediatrics, psychiatry and other relevant professions, alongside sufficient specialist expertise within eating disorder services.[193]

6.2.3 Stigma, misconceptions and recognition

Eating disorders continue to be perceived as uncommon conditions affecting mainly young, underweight women with AN. These stereotypes are inconsistent with population evidence and may affect help-seeking, professional recognition and service design.[194-196]

- *"I faced judgement and isolation from peers and from community services where I was excluded" (patient)*
- *"Parents are seen as neurotic or overly involved... this wouldn't happen with other physical illnesses" (carer)*
- *"We faced huge stigma—particularly with two daughters being diagnosed... I was excluded and treated as 'the problem'" (carer)*
- *"The idea that eating too much is not just greed and gluttony, but a real symptom of illness is too much for the average person to take seriously" (patient)*
- *"The dismissal in A&E and general hospitals has been detrimental to both my physical and mental health" (patient)*
- *"There is so much misunderstanding around what defines an eating disorder in the public eye" (carer)*
- *"I was told repeatedly that I was too 'big' to have an eating disorder" (patient)*

This can lead to over-reliance on body weight as an indicator of illness, delayed recognition of non-underweight presentations, and lower visibility of BED, ARFID, and OSFED.

Stigma and structural barriers may also contribute to lower access among men, minority ethnic groups, LGBTQ+ people, and neurodivergent populations. Improved awareness is necessary, but awareness alone will not close the implementation gap. Earlier recognition must be matched by sufficiently resourced pathways able to respond when people seek help.[148]

6.3 Overall implications

The treatment and prevention gaps are primarily failures of implementation rather than absence of effective interventions or clinical guidance. Closing these gaps requires population-based planning, explicit accountability for coverage, adequate workforce and funding, integrated care pathways, routine outcome monitoring, and equitable access.

7. ADDRESSING THE TREATMENT AND PREVENTION GAP: INTERNATIONAL EXAMPLES AND POLICY OPPORTUNITIES FOR ENGLAND

The UK has played a leading role in developing guidelines for good practice. However, national eating disorder policy should be judged by improvements in access, treatment outcomes, and prevention, not simply by the publication of guidance. Standards of care must be supported by the workforce, funding, and accountability needed to deliver them.

The All-Party Parliamentary Group on Eating Disorders called for a national strategy in 2025.[197] The BMA has since also called for a comprehensive review of eating disorder services across the UK to reduce preventable harm and deaths, highlighting under-resourcing, delays in treatment and gaps between physical and mental healthcare.[198]

This section examines international approaches and policy developments across the UK to identify lessons for implementation in England.

7.1. International lessons for service planning and investment

International developments offer practical lessons for England: define responsibilities across the whole care pathway, link commitments to investment, and measure whether patients receive timely and effective treatment. For example, Australia's *National Eating Disorders Strategy 2023–2033* makes eating disorder care a shared responsibility across the health system, rather than relying on specialist services alone. It sets minimum standards and assigns actions across prevention, identification, initial response, treatment, and recovery support, backed by workforce development and national coordination. Its evaluation framework distinguishes implementation activity from improvements in access, clinical outcomes and population health.[151] Medicare arrangements also provide funded access to psychological and dietetic treatment for eligible patients, extending provision beyond specialist services.[28]

The lesson is to specify and fund the responsibilities of primary care, general mental health services, medical specialties, and specialist teams. Better recognition must be matched by the capacity to assess and treat those identified. Shared responsibility should expand access to care and not create additional referral steps.

Sweden's 2024 national guidelines connect clinical standards with resource allocation, prioritising access across diagnoses, professional expertise, individualised care, and transitions between children's and adult services.[199] Stockholm provides a concrete service example. Watkins

reported that the Stockholm Centre for Eating Disorders' waiting list fell from 1,200 people in 2022 to 300 in May 2025.[28] The centre offered outpatient, day-patient, inpatient, and supervised digital treatment, alongside highly specialised care for severe illness.

The commissioning lesson is to develop connected levels of care, with treatment intensity matched to clinical need. Community, digital, and day treatment should form part of a comprehensive pathway that also provides specialist inpatient care. Performance should be assessed across the pathway, combining access measures with clinical outcomes rather than judging individual services in isolation.

New Zealand's *Eating Issues and Eating Disorders Strategy*, published in September 2025, linked service development to more than NZ$4 million in additional recurrent annual investment. Funding spans specialist capacity, prevention and early intervention, peer support, and support for families and carers.[200] This provides a relevant model for investment across different levels of need. Prevention and early intervention should be expanded alongside effective treatment for severe and established illnesses, not funded by reducing it.

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7.2. Lessons from policy developments across the UK

Successive reviews and policy initiatives across the UK have identified consistent priorities for improving eating disorders. These include national leadership, equitable access across age groups and diagnoses, workforce development, integrated care pathways, and routine monitoring of treatment coverage and outcomes.

Scotland's 2021 National Review of Eating Disorder Services identified geographical variation, barriers to access, and workforce shortages. Its 15 recommendations proposed a ten-year programme of service improvement.[201] Scotland subsequently published SIGN 164 and the 2024 National Specification for the Care and Treatment of Eating Disorders, establishing an all-age framework for service delivery.[202,203]

In Wales, the 2018 Eating Disorder Service Review identified similar concerns about access and coordination of care.[204] The Mental Health and Wellbeing Strategy 2025–2035 and Delivery Plan 2025–2028 include commitments to prevention, workforce development, and outcome monitoring. The NHS Wales Joint Commissioning Committee's 2026/27 commissioning intentions include reviewing population needs and adult eating disorder service provision.[205,206]

These reviews and policy initiatives identify remarkably consistent gaps in eating disorder treatment and prevention, closely reflecting the findings of

this report. They also make similar recommendations for improving access, workforce capacity, and coordination of care. However, translating these recommendations into measurable improvements requires funded implementation plans, clear accountability, and routine monitoring of coverage and outcomes.

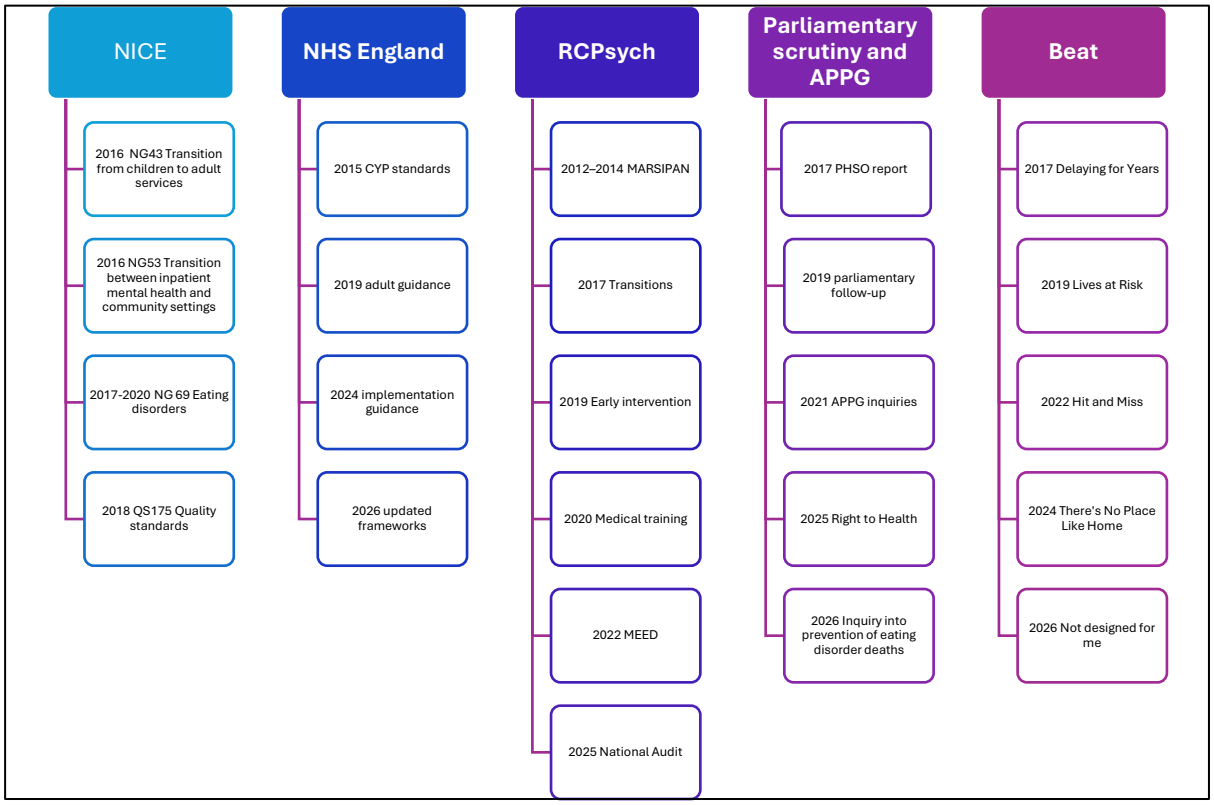
7.3. Applying these lessons in England

International examples demonstrate different approaches to translating national policies into funded services and measurable improvements in care. Reviews across the UK have identified similar gaps and priorities, but implementation remains the central challenge. In England, the priority is to expand access to effective interventions through sustained funding, workforce development, and accountability for coverage and outcomes, with equitable access to effective prevention and care wherever people live.

Over the past 15 years, NICE, NHS England, and the Royal College of Psychiatrists have published extensive guidance on eating disorder assessment, treatment, and service provision. Parliamentary inquiries and independent reviews have repeatedly identified gaps in access, workforce capacity, care coordination, and patient safety (Figure 7).

These publications identified a consistent set of priorities: accountable national leadership, greater parity between child and adult services, workforce and training reform, better integration of physical and mental healthcare, removal of inequitable access thresholds, stronger prevention within public health systems, and routine monitoring of coverage, outcomes, and mortality. The direction of the policy is already clear; the remaining challenge is funded implementation.

Figure 7: Major eating disorder reviews, guidance and policy developments relevant to England, 2012-2026



Despite this consistency, England has not established a comprehensive, funded implementation programme covering treatment and prevention across all ages. The 2015 access and waiting time standard for children and young people was supported by dedicated investment, expanded specialist community eating disorder services and improved access to early treatment.[207] Subsequent growth in demand has placed this capacity under sustained pressure.[208]

Adult services have not received equivalent national access standards or investments. The 2019 NHS England guidance set out a model for adult community eating disorder services, but implementation remained locally determined, contributing to substantial variation in capacity, waiting times and provision.[1,25,153] There are also persistent gaps affecting men, minoritised ethnic groups and people with co-occurring conditions, including type 1 diabetes and eating disorders.[209]

These concerns have been repeatedly documented by parliamentary inquiries, professional bodies and charities, including Beat and the All-Party Parliamentary Group on Eating Disorders.[129,197,210-212]

The implementation gap is also evident in early intervention. Although FREED has received political support, services have reported difficulty sustaining the programme without protected funding, while also meeting

the needs of people requiring urgent and intensive care.[198] The 2025 National Audit found that only 51% of eligible teams reported an active FREED pathway. Evidence on treatment outcomes following national implementation remains limited. Therefore, expanding earlier interventions requires additional capacity rather than diversion of resources from people with severe or established illnesses.

Recent policy developments create an opportunity to address these gaps. The updated national guidance for children and young people strengthens expectations for coordinated care across community, intensive, and inpatient services.[2] The 2026 *Mental Health Personalised Care Framework* explicitly includes eating disorders and requires coordinated care, named responsibility, timely access to further support, and routine measurement of outcomes and patient experience. Eating disorders are also being considered within the development of the modern service framework for severe mental illness.

The repeated identification of service gaps, alongside successive national guidance and policy initiatives, demonstrates that further recommendations alone are insufficient. The outstanding requirement is a funded implementation programme that defines expected population coverage, workforce, service capacity, and accountability for delivery across all age groups. Section 8 sets out the proposed actions.

8. REQUIRED ACTIONS TO ADDRESS THE TREATMENT AND PREVENTION GAP FOR EATING DISORDERS

Eating disorders represent one of the largest unmet healthcare needs in England. Only a minority of affected individuals receive timely, evidence-based treatment, and the coverage of prevention interventions remains minimal. These gaps persist despite established clinical guidance and effective interventions, contributing to avoidable morbidity and mortality, inequalities, emergency healthcare use, and wider societal costs.

The NHS in England can draw on a shared international evidence base for treatment and prevention, but responsibility for scaling up, commissioning and delivering services lies within its own health and wider system. The primary objective is to convert evidence into equitable access, effective care, and measurable improvements in England. Existing statutory arrangements for joint strategic needs assessments and integrated care strategies provide a framework for assessing population need and informing local commissioning decisions

The following seven required actions build on the evidence described in the previous sections. Implementation requires national leadership with clear responsibilities for commissioners and providers. A UK-wide collaboration may support research, data standards, professional competencies, and learning from deaths. Prevention and early intervention should be expanded alongside effective treatment for severe and established illness, not at its expense.

8.1. Systematic assessment of treatment and prevention gaps

The DHSC and NHS England should strengthen existing national surveys, service datasets, and audits to assess population need, treatment and prevention coverage, and outcomes. This should build on the Mental Health Services Data Set and National Audit of Eating Disorders, linking existing information and addressing gaps rather than creating parallel reporting systems. Improving data collection should proceed alongside implementation and should not delay action to address gaps already established by existing evidence.

Four gaps require coordinated action:

- Population need: strengthen repeated population studies across ages and diagnoses, distinguishing diagnostic prevalence, screening-positive

symptoms, functional impairment, and lifetime experience. Service records alone cannot identify people who have not reached care.

- Treatment coverage: link referrals, acceptance, unique individuals treated, and interventions delivered across primary care, community, intensive, and inpatient settings. Referrals, contacts, and hospital episodes must not be treated as counts of people receiving treatment. Needs assessments should also examine risk factors, high risk populations and expenditure on treatment across sectors.
- Sustained outcomes: record clinical and patient-reported outcomes, physical health, functioning, quality of life, relapse, readmission, and outcomes after discharge.
- Prevention coverage: report on the interventions delivered, who they reach, whether benefits are sustained, and any unintended effects.

Standardised definitions and a minimum dataset are essential to facilitate comparisons across services in England. Coverage estimates must use compatible populations and reporting periods. Data should identify inequalities by diagnosis, age, sex, gender, ethnicity, deprivation, and geography, with comparisons accounting for case mix, missing data, and provider participation.

Measures should be selected with people with lived experience, families, carers, and clinicians, and used to guide care and improvement, not simply performance reporting. National bodies should fund staff time, analytical capacity, and secure digital infrastructure for collection, linkage, analysis, and timely feedback.

Needs assessments should follow a defined cycle, with annual public reporting of coverage, outcomes, and remaining gaps. Voluntary benchmarking should complement, not replace, comprehensive national reporting. Success should be judged by whether these data guide investment and demonstrate that unmet need is falling.

8.2. Development of national cross-government strategy for eating disorders based on population need

The College recommends that the DHSC lead the development of a funded, cross-governmental eating disorder strategy, building on the existing national foundations. The strategy should establish named ministerial accountability, a costed implementation plan, and clear delivery responsibilities.

A central purpose of the strategy would be to make transparent decisions about the level of treatment and prevention coverage to be achieved. These decisions should take account of:

- population prevalence, inequalities, and projected demand;
- the scale and cost of preventable harm arising from inadequate implementation;
- the clinical and economic benefits of improved coverage;
- statutory duties under the health and equality legislation applicable in England;
- the right to health; and
- the United Nations Sustainable Development Goal of universal health coverage.

Agreed coverage needs to be matched by recurrent funding and workforce capacity. Implementation plans would specify the provision required across prevention, primary care, psychological therapies, specialist community services, intensive treatment, and inpatient care, together with how identified gaps will be addressed. Prevention and early intervention need to expand alongside effective treatment for severe and established illness, not at its expense.

Guidance and service redesign alone cannot close the implementation gap where capacity is insufficient. The DHSC, NHS England, and HM Treasury should appraise the workforce, training, service capacity, and data infrastructure required to achieve agreed coverage and determine the associated recurrent investment.

Where full implementation cannot be achieved immediately, a phased plan can make explicit what additional capacity will be delivered, by when, and what needs will remain unmet.

The available expenditure data and illustrative investment scenarios are presented in Appendix 2 to indicate the scale of the current provision and the further economic appraisal required.

Strategies should be co-produced with people with lived experience, families and carers, alongside clinicians, public health, education and voluntary-sector organisations. Cross-government implementation should also connect eating disorder prevention with relevant food, healthy-weight, digital, and wider public health policies.

In England, this would mean bringing CYP guidance, adult commissioning, and wider mental health reforms into a funded, all-age implementation programme with clear coverage plans and associated evaluation. Priorities

include adult access and waiting time standards, explicit treatment coverage expectations, and the implementation of care coordination and outcome monitoring requirements in the *Mental Health personalised care framework*.

Progress should be monitored through annual public reporting against population need, treatment and prevention coverage, outcomes, and inequalities, with clear milestones by 2031.

. Health and finance departments would also need to appraise the investment required, distinguishing improvements in health and wider societal benefits from savings that can be released directly from healthcare budgets.

8.3. Improve treatment coverage across the pathway

The College recommends that NHS England define a minimum whole-pathway service specification. covering the entire eating disorder care pathway. ICBs and commissioners can use this framework to ensure access to primary care, early intervention, evidence-based psychological treatment, specialist community care, intensive community and day treatment, acute medical care, and specialist inpatient treatment.

Specifications should draw on relevant national guidance and define the following:

- coverage and outcomes of treatment by different parts of the treatment pathway including for high risk groups
- access and referral criteria, without inappropriate reliance on BMI, diagnosis, or illness duration;
- the range and intensity of treatment available according to clinical need;
- medical and psychiatric assessment, monitoring and support;
- escalation and transfer between community, medical and inpatient settings;
- continuity of care, including transitions and follow-up after discharge;
- provision for higher-risk and underserved groups, including people with T1DE, neurodevelopmental conditions and complex comorbidity; and
- responsibility for monitoring access, treatment delivered, and outcomes.

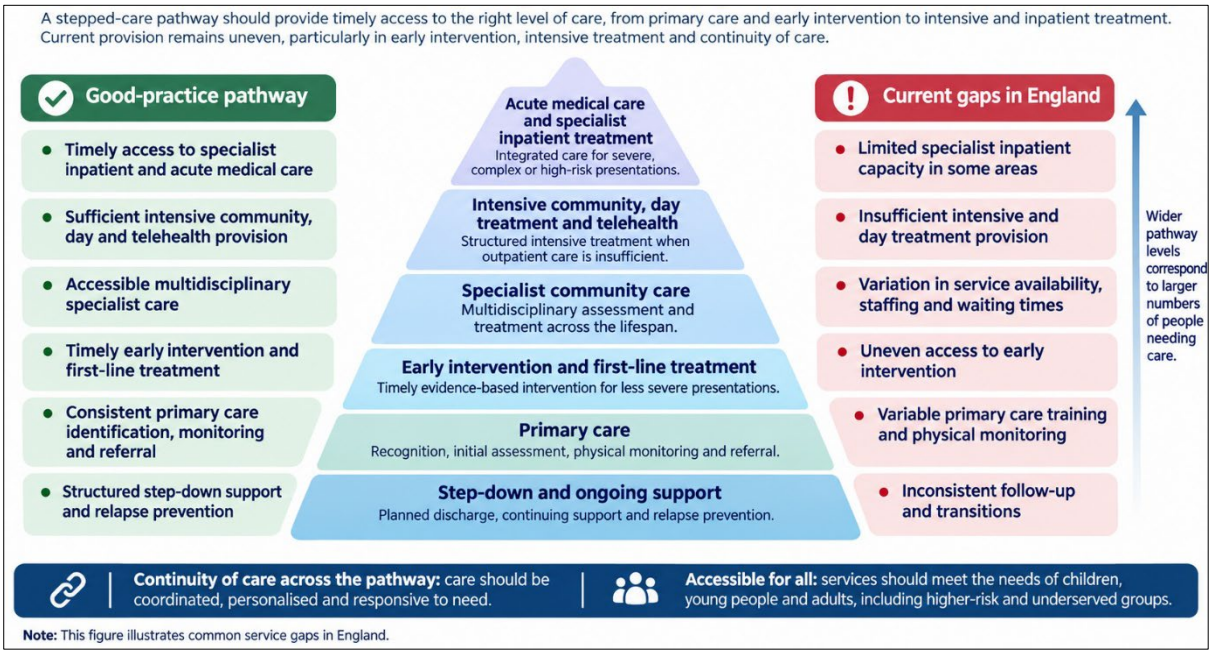
Responsibilities need to be clear across primary care, psychological therapies, specialist eating disorder services, acute and other medical specialties, and inpatient care. Access should be determined by clinical need and risk. Patients should not have to deteriorate, reach an arbitrary weight threshold, or complete unsuitable lower-intensity treatment before being offered appropriate care.

Where part of the pathway cannot be provided locally, commissioners can establish arrangements for timely access elsewhere and continuity of care before and after transfer. The workforce and service capacity required to meet the specifications should be included in the costed implementation plans. Appendix 2 presents the illustrative estimates of additional investments.

A minimum specification would define what care people should be able to access, while allowing local systems in England to organise and deliver services according to population need. This would reduce unwarranted geographical variation without imposing a single organisational model.

Commissioners should be able access use population needs assessments and service activity and outcome data to identify gaps, commission the required range of treatment, and hold providers accountable for continuity and outcomes. Psychiatrists have an important role in highlighting the size and impact of the treatment gap, required actions to address it, clinical leadership, service design, defining safe access and escalation pathways, multidisciplinary decision-making, and ensuring that physical and psychiatric risks are integrated throughout the pathway.

Figure 8: NHS eating disorders current position against good practice stepped care model



8.3.1. Primary care and first line treatment

Primary care plays a central role in early recognition, initial assessment, physical monitoring, and continuity of care. Local pathways can support GPs through clear referral criteria, access to specialist advice, and shared-care arrangements that define responsibility for monitoring and responding to deterioration.

The DHSC should work with the Royal College of General Practitioners and specialist services to strengthen training and referral pathways.

The potential role of eating disorder registers and structured reviews warrants formal evaluation, including the possible use of the Quality and Outcomes Framework..

Targeted case-finding may be useful in higher-risk settings, including diabetes, gastrointestinal, fertility, perinatal services, and services for neurodivergent people. It should be linked to capacity for assessment and treatment; screening without a pathway for responding to positive findings risks increasing unmet need.[73,78,84,110,213,214]

NHS Talking Therapies is not commissioned to treat eating disorders as the primary presenting condition. NHS England should evaluate whether selected NICE-recommended interventions could be delivered through

this established psychological therapy infrastructure for clinically appropriate presentations. Pilots would require eating disorder training and supervision, physical and psychiatric assessment, clear escalation pathways and routine outcome monitoring.[215,216]

Physical healthcare should remain integral to the pathway. Primary care and specialist services can also address preventable complications, including smoking and oral health, through established cessation and dental pathways.[115,118] Psychiatrists can support primary care through consultation, shared care protocols, education, and rapid specialist advice, particularly where physical and psychiatric risks coexist.

8.3.2. Early intervention and scalable treatment

The College recommends expanding timely access to evidence-based treatment early in the course of illness including in primary care. FREED provides an established model for people aged 16–25 with an eating disorder of less than three years' duration.[217,218] Effective implementation requires protected capacity, clear referral pathways, and monitoring of access and outcomes.

Further evaluation could examine adaptations for other age groups and illness durations. The expansion of early intervention should increase overall treatment capacity rather than displace treatment for people with severe or established illnesses.

Evidence-based digital, guided self-help, and blended interventions may extend access to appropriate presentations, including BN, BED, and some forms of OSFED.[104,219,220] National health bodies and commissioners can evaluate these interventions as part of the wider pathway rather than as stand-alone alternatives to clinical services.

Commissioned programmes require clinical oversight, physical risk assessment, escalation arrangements, data protection, and monitoring of coverage, effectiveness, and adverse outcomes. Patients should retain access to face-to-face and specialist treatment where clinically required. AI-enabled tools require separate evaluation and should not be assumed to have the effectiveness or safety of established digital psychological treatments.

Charities and other commissioned providers can contribute to access and support, provided that referral, safeguarding, escalation, and outcome-reporting arrangements are integrated with the wider clinical pathway.

8.3.3. Specialist community, intensive and inpatient treatment

Specialist community services are the core of treatment for people requiring multidisciplinary care for eating disorders. A comprehensive pathway also requires access to greater treatment intensity when outpatient care is insufficient.

NHS England and ICBs, working with NHS-led Provider Collaboratives according to their commissioning responsibilities, should use population needs assessments to determine the required capacity for specialist outpatient, intensive community, day, and inpatient treatment. Commissioners can then identify gaps and incorporate their closure into funded implementation plans.

Intensive treatment may be delivered through in-person, telehealth, or blended models, as clinically appropriate. Telehealth can support frequent multidisciplinary contact, supported meals, psychological and dietetic treatment, physical health coordination, and the involvement of families or carers without daily travel to a treatment centre. This may be particularly valuable for geographically dispersed populations.[156]

Telehealth intensive treatment should be commissioned as a distinct clinical service, rather than being regarded as merely an enhanced form of remote outpatient care. Appropriate staffing, eligibility criteria, physical monitoring, escalation arrangements, and outcome measures are required. Virtual and blended models should be evaluated against the same standards as face-to-face services, including clinical and functional outcomes, safety, completion, hospital use, patient and carer experience, and equity of access.

Inpatient treatment remains necessary when psychiatric, nutritional, or medical needs cannot be managed safely at lower levels of intensity. Intensive community and day treatment therefore complement, rather than replace, adequate specialist inpatient capacity.

Across specialist services, the minimum specification would include the following:

- access based on clinical need and risk rather than diagnosis, BMI, or illness duration alone;

- clear criteria for increasing or decreasing treatment intensity;
- appropriate psychological, nutritional, psychiatric, and medical expertise at each level;
- continuity of treatment across settings, including planned follow-up after discharge; and
- routine measurement of clinical outcomes, functioning, patient experience, readmission, and sustained recovery.

Commissioners can use these measures to compare provision, identify unwarranted variation, and determine whether investment in intensive treatment improves outcomes rather than simply reducing admissions.

Psychiatrists can provide clinical leadership across these pathways, particularly in complex formulation, psychiatric and medical risk, treatment planning, escalation and discharge decisions, multidisciplinary supervision, and coordination with acute medical services. Their role is especially important for patients with severe illness, T1DE, ARFID, neurodevelopmental conditions, and other complex comorbidities.

8.4. Workforce development and training

Improved coverage of treatment and prevention requires the appropriate number of trained workforce including in primary care, IAPT, secondary care and other sectors. The College recommends that DHSC develop a costed eating disorder workforce plan aligned with population need and planned service coverage. Closing the treatment gap will not be possible without sufficient numbers of appropriately trained staff, an effective multidisciplinary skill mix to deliver evidence-based treatment, and the capacity for clinical leadership, supervision, and continuing professional development.

Workforce planning must address both capacity and capability, including in primary care and psychological services. Specialist services require appropriate expertise and training in eating disorders for psychiatry, nursing, psychology, psychotherapy, dietetics, occupational therapy, and medical expertise to deliver evidence-based multidisciplinary care. The wider health and care workforce also needs competencies appropriate to its role in recognition, physical risk assessment, referral, shared care, and management of co-occurring conditions.

Training cannot compensate for insufficient staffing. It needs to be supported by the required number of funded posts, recruitment and

retention, sustainable caseloads, protected learning and supervision time, and access to specialist advice. Turnover can swiftly diminish capability, particularly in acute services and among junior staff. Therefore, it is crucial to implement ongoing training, which includes periodic refresher courses and practical support for application.

Existing structures provide delivery routes. The NHSE 2026 CYP guidance requires specialist eating disorder teams to support training and supervision across primary care, education, community, and wider mental health services, with this activity reflected in workforce capacity. Comparable expectations are needed across adult pathways and acute healthcare.

Progress should be assessed through workforce stability and capability, as well as training activities. Relevant measures include vacancies and turnover, multidisciplinary skill mix, supervision capacity, competency, treatment fidelity, patient access, and outcomes.

8.4.1. Medical and specialist psychiatric capacity

Specialist eating disorder services require an adequate number of consultant psychiatrists and medical expertise to effectively manage complex psychiatric and physical risks across community, intensive, and inpatient settings. Current specialist medical capacity is insufficient in many services, as outlined in Section 4.

Consultant psychiatrists provide clinical leadership as well as direct patient care. Their roles include diagnostic formulation, management of complex psychiatric and medical comorbidity, risk and medico-legal decision-making, treatment planning, supervision, and multidisciplinary leadership. Workforce plans therefore need to provide sufficient consultant capacity and protected time for these functions, rather than measuring provision solely by caseload.

Services also require reliable access to relevant medical expertise. Joint working with paediatrics, acute medicine, endocrinology, gastroenterology, diabetes, and other specialties is particularly important for people with T1DE, ARFID, and complex co-occurring conditions. Acute hospitals, general psychiatric wards, and specialist eating disorder units need clear arrangements for senior psychiatric and medical advice, escalation, and shared care.

8.4.2. Improving medical education and advanced training

Eating disorder competencies need to be embedded throughout medical education and postgraduate training. Current provision remains inconsistent, with limited teaching and variable clinical exposure reported in medical schools.[32,184]

All doctors in relevant specialties should acquire core competencies in recognition, differential diagnosis, nutrition, physical and psychiatric risks, emergency management, and collaborative care. Specialty curricula should define the competencies required for each discipline. The Academy of Medical Royal Colleges' 2025 *Treating patients well* framework and eating disorders exemplar provide a cross-specialty basis for this approach.[31]

Advanced training is also required to develop specialist expertise, clinical leadership, and supervision capacity. The Royal College of Psychiatrists' Eating Disorders Credential provides one route in England. Advanced training requires recurrent funding, protected learning time, and sufficient supervision, and should form part of workforce planning rather than operate as a stand-alone educational initiative.

8.4.3. Multidisciplinary training and supervision

Universities, professional bodies, and employers also need to strengthen eating disorder education for nurses, psychologists, dietitians, occupational therapists, and other relevant professions. Whole-team training should cover the full diagnostic range, physical and psychiatric risk, evidence-based treatment and adaptations for co-occurring conditions.[221]

Online training can extend access to specialist skills, including CBT-E, but requires protected time, supervision and organisational support to translate learning into clinical practice.[222,223]

8.5. Improving prevention

The College recommends that the DHSC Government and NHS England ensure the embedding of eating disorder prevention within existing public health, mental health, education, and food-policy frameworks, with clear national accountability and identifiable funding. Prevention needs to operate at three levels: universal action to reduce population-level risks, selective interventions for higher-risk groups, and indicated support for people with emerging symptoms.

Implementation can build on modifiable determinants, including childhood adversity, bullying, food insecurity, weight stigma, and harmful commercial and digital influences. Eating disorder expertise and lived experience should inform healthy-weight, food, and digital policies so that intended health benefits are balanced against possible unintended effects on restrictive eating, body dissatisfaction, and stigma.

Existing frameworks provide practical routes for implementation: NHS England's 2026 national CYP eating disorder guidance gives specialist services a role in prevention, schools, primary care, and community settings. This provides a platform for consistent implementation and extension of an all-age prevention approach.

UK-wide regulation also has an important role in addressing determinants that affect cross national boundaries. The implementation of the Online Safety Act and related Ofcom duties provides an opportunity to reduce harmful digital exposure and should be evaluated alongside national prevention policies.

Prevention programmes need evaluation of effectiveness. National reporting should identify what is delivered, who is reached, whether access is equitable, and whether benefits and unintended effects are sustained. Funding for prevention should be identifiable and additional to, rather than diverted from, treatment for people already affected.

8.6 A national confidential learning programme on eating disorder-related deaths

Given the persistently high risk of premature mortality associated with eating disorders, with limited evidence of sustained improvement, the College recommends a confidential learning programme in England on eating disorder-related deaths, drawing on NCISH methods and existing mortality-review systems. The aim is continuous learning and safer care, not retrospective attribution of individual blame.

The principal benefit would be to identify recurrent, potentially modifiable system factors that are not visible from individual investigations alone. These may include delays in access, gaps between physical and mental healthcare, failure to recognise deterioration, unsafe transitions, and poor continuity after discharge. Findings could be linked to NICE quality standards and used to improve service design, commissioning, training and clinical practice.[224]

Findings should be reported in aggregate and translated into a small number of measurable quality improvement priorities. Confidential participation would support clinicians to contribute openly, while families and carers could provide important perspectives on gaps in care.

8.7. Build capacity in eating disorder research

Eating disorder research requires sustained investment in people and infrastructure, not only individual projects. A UK Delphi study identified limited funding, scarce research opportunities, insecure employment and unclear career pathways as barriers to retaining researchers in the field.[225] These findings support a coordinated approach to developing academic capacity alongside clinical services.

UKRI and NIHR should develop an eating disorder research strategy focused on needs and implementation in England, working with charitable funders, including the Wellcome Trust, and UK-wide research partners where relevant. The strategy should map existing research investment and academic capacity, identify gaps, and provide sustained funding for priority research programmes.

Universities, funders, and healthcare organisations should establish supported clinical academic career pathways, including fellowships, substantive research posts, mentorship, and protected research time for consultants and multidisciplinary clinicians. Funding should also support research delivery staff, analytical capacity, and secure data linkage.

People with lived experience, families, and carers should help determine priorities, design studies, interpret and disseminate findings, and receive appropriate support and remuneration. This should include people whose experiences are poorly represented in existing research, consistent with recent calls for more participatory and equitable research.[226]

Priority research areas

Population need and inequalities. Repeated epidemiological studies should use comparable methods to establish the diagnostic prevalence, incidence, impairment, and unmet need. Research should extend beyond specialist service populations and include underserved groups, particularly men, minority ethnic groups, LGBTQ+ individuals, neurodivergent individuals, and those with long-term physical conditions. It is essential to maintain a clear distinction between screening-positive symptoms, diagnosed disorders, and the need for treatment.

Implementation: Most evidence-based interventions to treat eating disorder, prevent associated impacts and prevent eating disorder from arising are not implemented to scale. Therefore, research is required to support the scale up of such interventions.

Treatment effectiveness and service models. Future research should examine both how to deliver established treatments more consistently and how to improve outcomes for people who do not benefit sufficiently. A meta-analysis of 99 psychological treatment trials found little change over time in abstinence outcomes for bulimia nervosa and no consistent improvement for binge eating disorder, reinforcing the need for treatment development alongside wider access.[227]

Pragmatic trials, prospective cohorts, and service evaluations should compare community, intensive community, day, telehealth, and inpatient models. Priorities include treatment intensity, nutritional rehabilitation, psychological treatment, transitions, relapse prevention, and sustained recovery. Research should include people with severe or long-standing illness, alongside evaluation of early-intervention approaches beyond current age and illness-duration criteria. Comparisons should account for case mix, treatment received, and completeness of follow-up.

Comorbidities, safety, and mortality. A recent meta-analysis identified psychiatric comorbidity, including substance use disorders, as associated with increased mortality in eating disorder populations.[15] Research should identify modifiable contributors to this risk and evaluate integrated physical and mental healthcare, rather than studying eating disorder symptoms in isolation. Priorities include TIDE, cardiovascular and metabolic complications, neurodevelopmental conditions, and other complex presentations. Treatment development should also address under-researched diagnoses, including ARFID, and examine adverse effects, restrictive practices, and patient experiences.

Prevention and modifiable determinants. Prevention research should establish which interventions produce sustained benefits, for whom, and under what delivery conditions. A recent school-based meta-analysis found short-term symptom improvements but inconsistent effects at follow-up, highlighting the need for longer-term evaluation and better implementation evidence.[168] Studies should examine programme reach, acceptability, inequalities, unintended effects, and, where feasible, subsequent disorder onset. Research on food insecurity, weight stigma, marketing, and digital environments should include longitudinal studies and evaluation of policy changes, distinguishing associations from causal effects.

Digital and blended care. A 2026 meta-analysis of 36 randomised trials found benefits from digital interventions for eating disorder symptoms and several associated mental health outcomes.[228] Research should now establish how to implement effective approaches in routine care, including the clinical support required, engagement, digital exclusion, safety, and cost-effectiveness. Intensive telehealth services require evaluation appropriate to their treatment intensity and patient population; evidence for digital self-help should not be assumed to establish their suitability for patients requiring intensive care. AI-enabled tools should undergo separate assessment of effectiveness, safety and clinical oversight.[229]

Biological mechanisms and treatment development. Recent genomic analyses have extended research beyond anorexia nervosa to binge-eating behaviour, identifying shared and distinct genetic associations across these phenotypes.[230] Research should connect genetic, metabolic, neurobiological, and psychological mechanisms with treatment development and response.[231] Studies should include a wider range of diagnoses and ancestries, with clinical validation before biological findings are used to guide individual treatment.

Research embedded in routine care

Existing collaborations, including the Eating Disorders Clinical Research Network, provide a foundation for multicentre studies and the evaluation of outcomes across services. Their development should support participation across England, with wider UK research collaboration where relevant, with funded arrangements for recruitment, data governance, analysis, and feedback to clinical teams.

The minimum dataset proposed in Section 8.1 should support research on treatment received, health, functioning, and sustained recovery. Economic evaluation and longer-term follow-up should be incorporated across research programmes, distinguishing health and societal benefits from savings that can be released from healthcare budgets.

Progress should be assessed through sustainable academic capacity, inclusive recruitment, completed studies, and implementation of findings in practice. Research should accompany service improvement, not delay access to treatments already supported by evidence.

APPENDIX 1: SUMMARY OF THE EATING DISORDER IMPLEMENTATION GAP SURVEY

This appendix summarises the findings from a 2025 Royal College of Psychiatrists Faculty of Eating Disorders survey examining perceived gaps in the implementation of eating disorder services in the UK. The survey included 212 professionals from a range of clinical and commissioning roles. Most participants were based in England, so the findings provide predominantly England-based professional perspectives rather than a representative estimate of need or provision.

The findings provide a comprehensive summary of the professional perceptions held by relevant stakeholder groups. Any illustrative comments included are presented for context and were not subjected to formal qualitative analysis.

Key findings include:

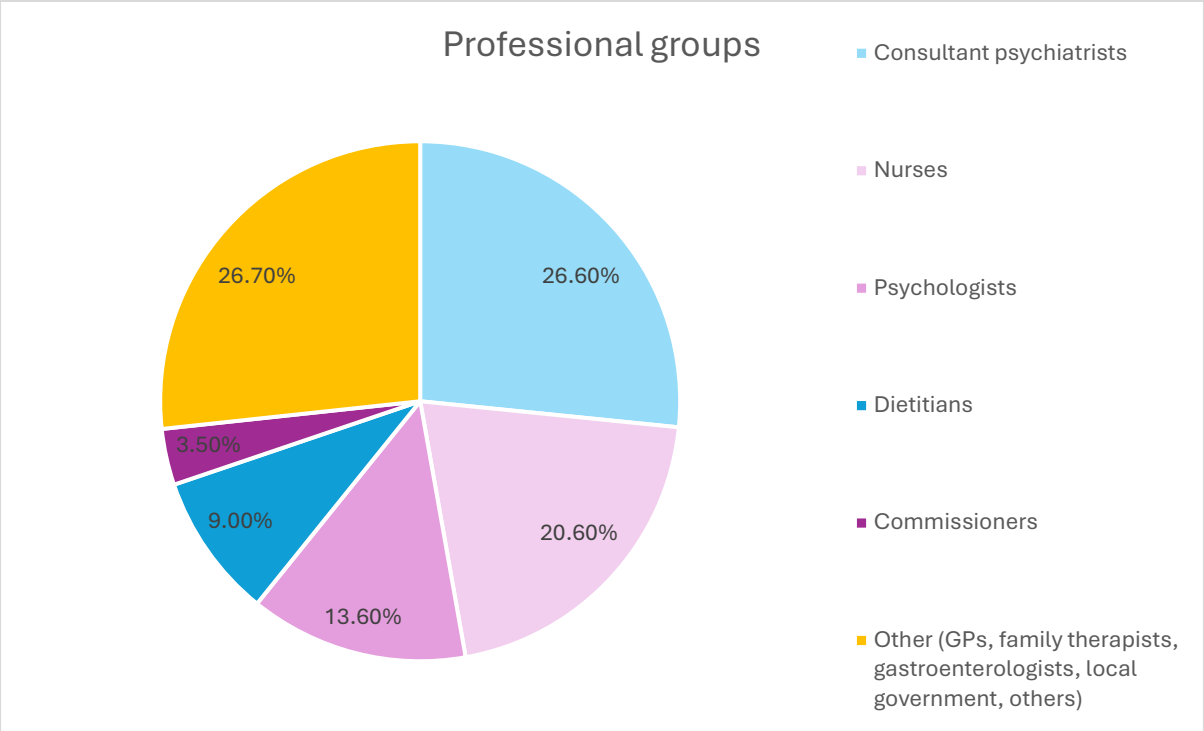
- Insufficient workforce (67.7%) and limited service capacity (63.1%) were identified as the principal barriers to effective service delivery.
- Over 80% of participants estimated that only a fraction of individuals with eating disorders received treatment.
- Patients with comorbidities, such as autism, and those lacking family support, were most frequently identified as challenging to manage within the current service models.
- Participants prioritised earlier intervention (86.2%), improved cross-sector integration (80.3%), and school-based prevention programmes (82.8%).

Participant profile

A total of 212 professionals participated. The geographical distribution was predominantly England (88.8%), with smaller representation from Scotland (9.1%), Northern Ireland (1.0%), and Wales (0.5%).

Workplace settings included adult eating disorder services (34.2%), CEDS-CYP (33.2%), inpatient units (13.1%), and all-age services (6.0%).

Figure 9: Participating professional groups



Perceived system-level challenges

"There are not enough trained professionals in eating disorder care, leading to patients waiting months for treatment."

Participants identified the following barriers:

- Insufficient workforce: 67.7%
- Limited service capacity: 63.1%
- Underfunding: 62.1%
- Fragmented care coordination: 55.1%
- Long waiting lists: 40.4%
- Low public awareness: 38.9%

These responses indicate perceived structural constraints across the services.

Perceived treatment coverage

When asked to estimate the proportion of individuals with an eating disorder receiving treatment in the UK:

- 47.6% estimated 30–40% coverage.
- 34.6% estimated 10–20% coverage.
- 1.0% estimated coverage above 90%.

These figures represent professional estimates rather than validated national coverage data.

Clinical complexity

> "Autistic patients often require tailored interventions that are not currently available."

Participants identified particular challenges in managing the following:

- Patients with limited family support: 69.1%
- Comorbid autism and eating disorders: 67.5%
- Emotionally dysregulated patients: 62.4%
- Severe psychiatric comorbidity: 61.9%

Prevention barriers and priorities

> "Many GPs and frontline professionals lack confidence in recognising early signs."

The following barriers to prevention were identified:

- Lack of professional training: 79.1%
- Resource limitations: 70.9%
- Absence of national prevention policy: 70.4%
- Limited effective interventions: 68.4%

The prevention priorities included the following:

- School and workplace-based interventions: 82.8%
- Training and resources for scale-up: 70.2%
- Targeted support for high-risk groups: 69.2%

Service reform priorities

> "Rigid eligibility thresholds mean patients can be refused treatment despite significant psychological distress."

Participants highlighted:

- Improved cross-sector integration: 80.3%
- Enhanced professional education: 75.8%
- Increased public awareness: 69.2%
- Greater research investment: 69.2%
- Reduction in waiting times: 68.7%
- Increased funding: 56.6%

Long-term priorities

> "Delays in accessing care increase medical risk and worsen long-term outcomes."

The highest-rated priorities were as follows:

- Earlier intervention: 86.2%
- Improved identification and diagnosis: 85.1%
- Increased investment: 79.0%
- Wider adoption of MEED guidance: 57.4%

Conclusion

The survey revealed four consistent themes:

1. Workforce shortages and limited service capacity emerged as the primary obstacles to effective service delivery.
2. Participants indicated a low perceived treatment coverage, with over 80% estimating that only a minority of individuals with eating disorders receive treatment.
3. Clinical complexity was emphasised, particularly concerning comorbid autism and the absence of family support.
4. Finally, participants prioritised earlier intervention, enhanced cross-sector integration, and school-based prevention programmes.

Despite being based on perception, these findings align with the national coverage and prevalence data detailed in Sections 4 and 5 of the main report. Collectively, these findings support the conclusion that the implementation gap is indicative of constrained capacity, limited early identification, and inadequately integrated prevention and treatment pathways.

APPENDIX 2: INDICATIVE INVESTMENT SCENARIOS FOR EATING DISORDER SERVICES IN ENGLAND

Delivering the treatment coverage proposed in Section 8 requires sufficient recurrent funding for clinical services, workforce development, and implementation. This appendix sets out illustrative annual investment scenarios to inform a costed programme for England. It distinguishes reported expenditure from planning assumptions and potential savings; it is not a final business case or an estimate of the cost of meeting all population need.

The scenarios cover primary care, psychological therapies, specialist community and intensive treatment, and hospital care.

Data sources and interpretation

The 2024/25 NHS Benchmarking Network mental health datasets provide the most comprehensive information on specialist eating disorder service activity, workforce, and expenditure in England. Specialist community eating disorder services are predominantly provided by NHS mental health trusts, and participation in the benchmarking programme is high. The resulting data therefore provide near-national estimates of NHS specialist community provision in England, although completeness varies between individual metrics.

These data should not be interpreted as a complete account of all NHS expenditure on eating disorders. Primary care, acute hospital care, and some specialised inpatient activities are funded and reported through different routes.

The analysis has been developed with Stephen Watkins, co-author of this report and former Director of the NHS Benchmarking Network, drawing on extensive experience of national mental health benchmarking and NHS expenditure.

A formal national options appraisal would require reconciliation of expenditure across commissioning routes, use of a common price year, and explicit allowance for implementation, prevention, research, capital, and transition costs. The absence of quantified estimates for these elements does not imply that they can be delivered without additional funding.

Primary care

The scenario proposes £100 million annually for recognition, initial assessment, registers, structured review, physical monitoring, and coordination with specialist services. A QOF-linked approach or another primary care contractual mechanism could support delivery, subject to appraisal. Review frequency would reflect clinical need; an annual review would not replace more frequent monitoring where required.

The £100 million is a planning assumption rather than a bottom-up costing. Appraisal needs to specify the eligible population, consultation frequency, staff time, training, information systems, and access to specialist advice. Existing primary care expenditure attributable to eating disorders is not separately identified and is not assumed to be zero.

Widening access to psychological therapies

Patients with eating disorders are currently excluded from national talking therapy services in England, and there are no nationally available digital therapies available for eating disorders. Both of these areas could be helpful in providing rapid access to eating disorder care to support early identification and treatment. The scenario proposes £130 million annually for 100,000 treatment episodes at an assumed average cost of £1,300, combining suitable psychological and supported digital interventions. This is a proposed extension of access, not an assumption that all presentations can be managed outside specialist services. Eligibility, medical monitoring, supervision, and escalation arrangements would follow the pathway described in Section 8.

The 2024/25 NHS Talking Therapies annual report recorded an average of 8.4 treatment sessions among referrals completing a course (NHS England, 2025). Applying the draft's supplied contact cost of £169.49 gives £1,423.72 per completed course, approximately £1,424. The contact-cost source and reporting year require confirmation before this is used as a validated costing benchmark.

The lower £1,300 blended episode cost is therefore a modelling assumption, not an observed eating disorder treatment cost or evidence that digital delivery is necessarily cheaper. At £1,424 per episode, the same 100,000-episode scenario would cost approximately £142.4 million. Appraisal needs to include assessment, incomplete courses, treatment intensity, clinical oversight, physical monitoring, and platform costs, and distinguish treatment episodes from unique people.

Specialist community and intensive treatment

Investment in specialist community and intensive services is required to expand access across diagnoses, provide treatment at the appropriate level of intensity and improve continuity between outpatient, intensive and inpatient care.

The scenarios below are illustrative planning options. Activity, workforce, and expenditure are closely related, but increases in funding cannot be assumed to produce proportionate increases in treatment capacity without a detailed workforce and activity model. A targeted, well-funded national approach will ensure timely access to treatment, improve patient outcomes, and optimise resource allocation across healthcare settings.

Children and young people

In England, approximately £106 million was allocated for children and young people's community eating disorder services in 2024/25. In the same year, 11,174 children and young people started treatment, almost 40% more than in 2019/20.

An illustrative doubling of current expenditure would therefore imply an annual budget of approximately £212 million. The proposed ambition of supporting up to 40,000 children and young people each year should be treated as a service-planning target rather than an automatic consequence of doubling expenditure. Formal modelling would need to specify the workforce, treatment intensity, caseload, and activity required to achieve this level of coverage.

Additional investment could support broader access across AN, BN, BED, OSFED, ARFID, and complex co-occurring conditions; strengthen collaboration between specialist eating disorder and paediatric services; and expand early-intervention, crisis, and intensive home-treatment capacity. NHS England has already identified the expansion of crisis care and intensive home treatment as a priority for CYP eating disorder services.

NHS Benchmarking provides complementary information on workforce, activity, and expenditure, but its UK aggregates should not be used as England totals. In particular, the 15,180 people accessing care reported in the benchmarking dataset should not be divided by an England prevalence estimate to calculate treatment coverage.

Adult community eating disorder services

Specialist services in England are predominantly delivered by NHS mental health trusts, among which benchmarking participation is high. For

2024/25, participating English adult community eating disorder services reported approximately 1,143 WTE staff and £74.3 million expenditure.

The illustrative scenario proposes an annual budget of £480 million for adult specialist community services, including intensive community and day treatment. The planning assumptions include a capacity for approximately 150,000 referrals and 110,000 people accessing care annually.

The proposed capacity of 110,000 adults receiving specialist community care annually is a planning target, not an estimate of total need. Other adults may receive appropriate treatment through primary care, psychological therapies, or other services.

APMS 2023/24 estimated 12-month eating disorder prevalence in England at 1.3% (95% CI 0.8–2.2%). However, the estimate was based on only 26 cases, with none in the underweight BMI category, and reliable estimates by diagnosis were unavailable. The survey authors acknowledged that prevalence may be underestimated (Ridout et al., 2025). Planning therefore needs to assess population need, diagnostic mix, and treatment intensity, including provision for anorexia nervosa, rather than derive specialist capacity from APMS alone.

NHS Benchmarking provides the most comprehensive and current picture of specialist adult community provision. Participating English services reported approximately 1,143 WTE staff and £74.3 million expenditure in 2024/25. The proposed £480 million scenario represents a substantial expansion from the current provision and requires a bottom-up workforce and activity model rather than a simple extrapolation from existing services.

The £480 million adult community scenario includes expansion of intensive community, day, and telehealth treatment, rather than treating these as a separate funding stream.

Models may include intensive CBT-E, structured day programmes, home-based treatment and telehealth or blended services. These can provide greater treatment intensity when conventional outpatient care is insufficient, support step-down following admission and, for selected patients, offer an alternative to hospital treatment and be delivered in specialist clinics, day hospitals, or patients' homes, with remote technologies.[232,233]

Since the pandemic, intensive community services have grown, demonstrating the feasibility and effectiveness of remote intensive treatment for eating disorders. Strengthening these services can reduce hospital admissions, enhance continuity of care, and provide scalable, cost-effective treatment options..[129,234] While early data is promising, a robust

evaluation is needed to optimise effectiveness and prevent hospital admissions.[232,235,236]

Review and integrate hospital treatment pathways

Hospital care represents a substantial component of current eating disorder expenditure. NHS Benchmarking analysis estimated that acute hospital admissions involving an eating disorder diagnosis cost the NHS in England more than £220 million in 2023/24. These admissions reflect acute medical care.

Adult SEDUs provide a separate, highly specialised component of the pathway. NHS Benchmarking estimates suggest approximately 450 specialist beds in England, supporting around 1,200–1,500 admissions annually across NHS and independent providers. Most independent-sector SEDU care is NHS funded through specialised commissioning arrangements. In 2024, NHS England estimated annual expenditure on specialised adult eating disorder inpatient services at approximately £86 million**.** These figures relate to different services, reporting periods and commissioning routes and should not be added or compared directly without further reconciliation.

MEED provides a national framework for recognising and managing medical emergencies in eating disorders. Consistent implementation requires clear local leadership, staff training, access to specialist advice and agreed escalation pathways between acute hospitals and eating disorder services.

SEDU capacity also needs to be considered in terms of treatment quality, not bed numbers alone. These units care for people with the most severe and complex illness and require sufficient multidisciplinary expertise to provide nutritional rehabilitation, evidence-based psychological treatment, psychiatric and medical care, rehabilitation and safe discharge planning. Workforce instability and reliance on temporary staffing can undermine continuity and treatment delivery.

Hospital care should therefore be planned as part of an integrated pathway linking acute hospitals, SEDUs, specialist community teams, intensive community and day services, and primary care. The objective is to ensure access to the appropriate level of care, with effective step-up, step-down and continuity after discharge, rather than simply to reduce admissions.

Expansion of community and intensive treatment may reduce some avoidable hospital use and support earlier discharge, where clinically appropriate. However, any reduction in acute or SEDU expenditure should be treated as a potential benefit to be tested through modelling and

prospective evaluation, not assumed in advance. The illustrative reduction in acute hospital costs from £220 million to £100 million is therefore best presented as a sensitivity scenario**, not a forecast.**

Table 6 summarises the indicative investment scenarios. Implementation could be phased, with expansion of community and intensive treatment occurring alongside a review of acute and specialist inpatient pathways. Any efficiencies arising from reduced avoidable admissions should be demonstrated through routine activity and outcome monitoring and incorporated into subsequent investment decisions.

Table 6. Illustrative annual investment scenarios for eating disorder services in England

Service component	Annual scenario	Basis and interpretation
Primary care	£100m	Proposed register, assessment, review, monitoring, and shared-care functions. Bottom-up costing is required.
Psychological and supported digital therapies	£130m	100,000 episodes × assumed £1,300. A £1,424 episode cost gives an alternative £142.4m scenario.
CYP specialist community services	£212.6m	Twice the reported £106.3m England spend. The 40,000-person activity ambition requires validation.
Adult community, intensive and day services	£480m	Proposed budget covering outpatient, intensive, and day services, including telehealth and blended care.
Adult specialist inpatient care	£150m	Illustrative annual budget, including NHS-funded independent provisions. Capacity and costs require appraisal.
CYP psychiatric inpatient eating disorder care	£150m	Illustrative annual budget across general adolescent and specialist eating disorder units. Eating disorder-attributable costs require confirmation.
Acute medical and paediatric hospital activity	£220m	Working cost assumption retained without a savings offset; source, period, and attribution require confirmation.
Arithmetic total of the components above	**£1,442.6m**	**Approximately £1.44bn annually for the included components only. Not a complete national strategy costing or an estimate of additional funding.**

Sensitivity illustration: substituting £100 million for acute hospital activity reduces the arithmetic total to £1,322.6 million. This tests the draft's savings assumption; it does not validate it. The decimal places reflect arithmetic, not the precision of the underlying estimates.

A net additional funding requirement cannot be calculated reliably until current expenditure is reconciled. Some baseline figures are incomplete or

use different geographical coverage, accounting definitions, and reporting years. The scenarios also do not quantify every cost of prevention, implementation or research.

From scenarios to a costed implementation programme

The purpose of these estimates is to make the resources associated with expanded treatment coverage explicit. The next stage is a formal DHSC and HM Treasury options appraisal linking population need, service design, workforce availability and costs, with input from commissioners, providers, people with lived experience, and families.

Appraisal needs a reconciled England expenditure baseline, a common price year, and phased delivery assumptions. It needs to test treatment intensity, staff productivity, recruitment and retention, implementation, capital costs, and the effects of increased identification on demand. Patients moving between services need to be distinguished from unique people receiving care so that activity and costs are not double counted.

Benefits can be assessed through access, clinical and patient-reported outcomes, functioning, continuity, and reduced avoidable harm, alongside healthcare use and wider societal effects. Cost effectiveness, cost avoidance and cash-releasing savings are different outcomes and need separate reporting. Expansion of prevention and earlier treatment requires funding alongside effective care for severe and established illness, not reliance on unproven reductions in hospital expenditure.

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