

Assessment of Need for those affected by Eating Disorders in Kent & Medway

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July 2014

Thanks to Dr Hendramoorthy Maheswaran of the University of Warwick, on whose work for Coventry – this report is based.

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1.1 Background

Eating disorders, including anorexia nervosa, bulimia nervosa and related conditions, generally have an onset in childhood or adolescence. They include a variety of types of disordered eating, and range greatly in severity. People with eating disorders often experience acute psychological distress, as well as severe physical complications such as gastrointestinal problems and osteoporosis. The disorders often become chronic, with poor rates of recovery. Eating disorders and their resulting complications may be fatal and some studies have identified them as having the highest mortality rate of all mental disorders. Even in those who recover, the negative impacts on employment, relationships, fertility and parenting can persist for a long time.

There are major gaps in the epidemiological data in this field. It is widely recognized that there is a general under-detection of eating disorders in research and clinical practice, resulting in part from a tendency for people with these conditions to conceal them and avoid seeking help (Judit et al., 2005, Hoek, 1991).

The standardised mortality ratio (SMR) for eating disorders are higher than for any other mental disorder, particularly for anorexia nervosa (where 5% of sufferers die due to the condition). The SMR has been estimated at 538 (Harris and Barraclough, 1998, Herzog et al., 2000). This means that it is more likely that people with anorexia nervosa (in particular) have a far higher risk of death than people with another mental health condition.

1.2 National policies

Policy responses to eating disorders, including those covered by standards two and three of the Department of Health's National Service Framework for mental health, outline the harmful consequences that can result from eating disorders and recommend approaches to improve detection and treatment (DoH, 1999). Guidelines for the identification, management and treatment of eating disorders were also issued by the National Institute for Clinical Excellence in 2004 (NICE, 2004). These highlighted the variability that exists in service provision and stressed the need for early identification and effective screening.

1.3 Aims

The aim of this Health Needs Assessment (HNA) is to provide information and analysis that will help inform discussions and decisions relating to the planning, commissioning and service redesign. This HNA will incorporate a combination of epidemiological and comparative elements. The findings from the following needs assessment are presented in four sections:

- A brief introduction to eating disorders.
- Reviews of the prevalence of Eating disorders and the expected need in Kent and Medway.
- Review of hospital admission data for Eating Disorders across the region.

- Review of the Kent and Medway Eating Disorder Service (CEDS), the service responsible for providing outpatient care for patients affected by Eating disorders.
- Review of Kent and Medway PCT expenditure on Eating disorders

2. Background into Eating Disorders

2.1 Introduction

Eating disorders are syndromes characterized by a persistent and severe disturbance in eating attitudes and behaviour, to an extent that significantly interferes with everyday functioning (Technology, 2007). The ICD-10 lists eight categories of eating disorder (WHO, 1992).

Table 1 ICD Codes for Eating disorders (F50)

F50.0	Anorexia nervosa
F50.1	Atypical anorexia nervosa
F50.2	Bulimia nervosa
F50.3	Atypical bulimia nervosa
F50.4	Overeating associated with other psychological disturbances
F50.5	Vomiting associated with other psychological disturbances
F50.8	Other eating disorders
F50.9	Eating disorder, unspecified

2.2 Anorexia Nervosa

Anorexia nervosa is a syndrome where someone maintains a low weight due to a preoccupation with their body weight, a fear of fatness and a pursuit of thinness. In anorexia nervosa, weight is maintained at least 15 per cent below that expected, or in adult's body mass index (BMI)¹ is below 17.5 kg/m².

Anorexia nervosa, although rare, is one of the most severe and dangerous conditions due to the high rate of mortality (high risk of death) in sufferers (around 5% of sufferers die due to the condition). The lifetime prevalence of anorexia nervosa is 3 times as high among women as men (Hudson et al., 2007).

¹ calculated as weight in kilograms divided by height in meters squared

The course of anorexia nervosa is variable. A summary treatment studies published before 1989², found that 43% of people recover completely, 36% improve, 20% develop a chronic eating disorder and 5% die from anorexia nervosa (Steinhausen, 2002). The all-cause standardized mortality ratio anorexia nervosa has been estimated at 9.6 (95% C.I: 7.8 to 11.5) which is three times higher than other psychiatric illnesses (Nielsen, 2001). The mortality rate appears to be higher for people with lower weight during their illness and those presenting between 20 and 29 years of age.

Symptoms of depression and anxiety disorders, irritability, liability of mood, and obsessional features are frequent accompaniments. Typically these features get worse as weight is lost and improve with weight regain. This loss of weight is primarily the result of a severe and selective restriction of food intake. In some people, the food restriction is also motivated by other psychological processes, including asceticism, competitiveness, and a wish to punish themselves. Patients may engage in a driven type of over exercising, self-induced vomiting or misuse laxatives or diuretics in order to achieve weight control.

As sufferers become underweight their interest in the outside world also declines and they can become socially withdrawn. A number of secondary difficulties may develop including physical adverse effects, social isolation and negative impacts on education and employment. Depression is a common co-morbid diagnosis, with rates of up to 63% in some studies (Herzog et al., 1992), while obsessive-compulsive disorder (OCD) has been found to be present in 35% (Rastam, 1992).

2.3 Bulimia Nervosa

Bulimia nervosa sufferers alternate food restriction with episodes of binge eating, followed by compensatory self-induced vomiting or laxative misuse. Bulimia nervosa typically develops at a slightly older age than anorexia nervosa, and BMI is maintained above 17.5 kg/m².

Bulimia nervosa sometimes arises from a pre-existing anorexic illness. Patients are often distressed by their loss of control over eating and ashamed of it, which makes them easier to engage in treatment than those with anorexia nervosa. However there is often a delay of many years before they seek help. Like anorexia nervosa, the lifetime prevalence of bulimia nervosa is 3 times as high among women as men (Hudson et al., 2007).

Depression and anxiety disorder are extremely common symptoms in this group, with a subgroup engaging in substance misuse or self-injury. A significant proportion of those with bulimia nervosa have a history of disturbed interpersonal relationships with poor impulse control. Some will abuse alcohol and drugs. A significant proportion also suffer from personality disorders.

Hsu (1995) reported that many people with bulimia nervosa are not receiving any form of help. The majority of those who are unknown to treatment services will suffer

² with a length of follow-up of one to 33 years

chronicity or a relapsing course, maintained by over-valued belief in the importance of appearance and thinness in particular (Fairburn et al., 2000).

Evidence suggests that with effective treatment about 50% will recover 2 to 10 years after assessment, whilst 20% will continue with the full form of bulimia nervosa and 30 % will follow a relapsing and remitting course. One 10-year follow-up study of 50 people with bulimia nervosa found that 52 per cent had fully recovered and only nine per cent continued to experience symptoms of bulimia nervosa (Collings and King, 1994). A larger study of 222 followed-up for a mean of 11 years revealed that 11% still met criteria for bulimia nervosa whereas 70 per cent were in full or partial remission (Keel et al., 1999). The mortality rate associated with bulimia is uncertain but may be higher than in the matched general population (Hsu, 1995).

2.4 Atypical eating disorders (eating disorders not otherwise specified; EDNOS)

A number of people suffer from eating disorders that may resemble anorexia nervosa and bulimia nervosa, but do not meet the precise diagnostic criteria for these conditions. These conditions are often termed 'atypical eating disorders'(Fairburn and Harrison, 2003).

The concern with weight and body shape is present in these disorders, although in some the primary focus is on maintaining strict control over eating. Although the diagnostic criteria may not be met, many atypical eating disorders can still be severe and long lasting as anorexia nervosa and bulimia nervosa and their treatment needs and prognosis may be virtually identical.

Many people with atypical eating disorders have suffered with anorexia nervosa or bulimia nervosa in the past. Movement can also occur in the opposite direction, thus those with atypical eating disorders may go on to develop bulimia nervosa, or more rarely anorexia nervosa.

2.6 Treatment of individuals with Eating disorders

There is one agreed approach to the psychological treatment of anorexia nervosa in adults, either in terms of types of treatment offered, their duration, intensity or the setting in which treatment is provided.

There is evidence suggesting the effectiveness of different psychological therapies for all types of ED but insufficient evidence for recommending one particular treatment for patients with anorexia nervosa.

There is a small amount of evidence to advocate the use of cognitive behavioural therapy (CBT) over other therapies For Bulimia Nervosa. The evidence is better for improved outcomes in binge eating and purging, but lacking for recovery.

In those with atypical ED, CBT offers some benefits with respect to binge eating, but otherwise there is insufficient evidence to advocate one therapy over another.

Only in Bulimia Nervosa patients is there a limited role for pharmacological interventions. The evidence suggesting that anti-depressants are effective at treating the binge-eating and depressive symptoms, with selective serotonin reuptake inhibitors (SSRIs) the drug of choice.

The use of CBT for people with bulimia nervosa was shown as more effective but more costly than antidepressant therapy. The incremental costs per successfully treated bulimia nervosa cases with CBT relative to antidepressant therapy varied between £4807.24, £4942.23 and £4126.41 depending on whether the antidepressant is prescribed in primary care or in secondary care by a more junior doctor or by a consultant psychiatrist, respectively.

These values are likely to be overestimations of the real cost-effectiveness of CBT since potential savings in additional health care costs were not factored into the analysis (NICE, 2004). Also the use of pharmacological interventions is higher in primary care settings, where assessment of risk of self-harm may have been less unclear.

2.5 The Management of Eating disorders – At the Service Level

Only a fraction of people with eating disorders are detected through primary care services (Johnson et al., 2001, Hoek, 2003). Yet evidence points to these individuals consulting their general practitioners significantly more frequently than those without ED (Ogg et al., 1997).

The findings suggest that there are high levels of hidden eating disorder morbidity at primary care level and this emphasises the importance of primary care in the detection and early treatment of eating disorders.

Even in secondary care patients can often spend months or years in non-specialist psychiatric units (Howlett et al., 1995), accounting for 1 in 5 of the inpatient population (O’Herlihy et al., 2001).

In the UK the average length of hospital stay for those with Anorexia Nervosa is 21.5 days per episode, with other types of ED associated with fewer admissions and admissions of shorter duration (NICE, 2004).

There is a lack of knowledge as to whether inpatient services are more effective than outpatient care but it is unlikely that day care could ever abolish the need for inpatient treatment altogether for patients with Anorexia Nervosa.

Whereas for Bulimia Nervosa and those with atypical ED, the recommendations favour the use of outpatient based care, with inpatient care reserved for those whose illness is complicated by psychiatric co morbidities or concerns for self-harm (NICE, 2004). The cost of outpatient treatment is approximately one-tenth of the cost of inpatient treatment for those affected by ED in the UK (Meads et al., 2001).

2.7 The Management of Eating disorders – Policy recommendations

Department of Health's National Service Framework for mental health standards two and three highlights the importance of primary care in identifying and assessing individuals at risk of mental health disorders (DoH, 1999). The recommendation is that care for those affected by Eating disorders should be provided at the primary care level and through specialist centers depending on the severity of the symptoms:

- Mild eating disorders to be mainly managed within the primary care setting, focusing on dietary education and monitoring of food intake.
- Severe eating disorders require specialist assessment, including a full medical and psychiatric assessment. Nice provides further advice regarding services that should be offered to those affected by Eating disorders:

1) The role of the GP

- a. GPs should take responsibility for the initial assessment and the initial co-ordination of care.
- b. Targeted screening: young women with low body mass index (BMI), patients consulting with weight concerns who are not overweight, women with menstrual disturbances, people with gastrointestinal symptoms, patients with physical signs of starvation or repeated vomiting, and children with poor growth.
- c. Screening for eating disorders can be achieved with one or two simple questions: 'Do you think you have an eating problem?' and 'Do you worry excessively about your weight?'
- d. Patients not under the care of secondary care services should be offered an annual physical and mental health review by their general practitioner.

2) Specialist Care

- a. Majority should be treated on an outpatient basis.
- b. Inpatient treatment or day patient treatment should be considered if no improvement with appropriate outpatient treatment, at high or moderate physical risk, or for whom there is a significant risk of suicide or severe self-harm.
- c. Inpatient management is required; this should be provided within a reasonable travelling distance to enable the involvement of relatives and carers in treatment, to maintain social and occupational links and to avoid difficulty in transition between primary and secondary care services.

3. Epidemiology of Eating disorders

3.1 The population of Kent and Medway

The resident population of Kent and Medway has been estimated to be **1,748,383** in 2012³. Kent's population growth is greater than the England average and has been for the past 15 years (10% growth from 1995, 2% more than the England average) with the greatest population growth in Ashford.

Table 1: Kent County Council 2012 mid year population estimates

Sex	15-24	25-34	35-44	45-54	55-64	65-74	75+
Male	93,854	83,089	94,927	104,716	86,920	71,726	52,271
Female	91,267	86,020	99,045	106,318	90,219	77,284	75,797

Table 2: Medway Council 2012 mid year population estimates

Sex	15-24	25-34	35-44	45-54	55-64	65-74	75+
Male	19,562	18,015	18,082	18,873	14,822	10,869	6,780
Female	18,773	17,826	18,225	19,121	14,857	11,417	10,084

Source: Office for National Statistics

3.2 Prevalence of Eating disorders

There are two ways to estimate prevalence of eating disorders. Firstly, counting the number of clinical diagnosis made over a period of time, and secondly via house hold surveys using an eating disorder screening tool (SCOFF).

Studies looking at the incidence and prevalence of eating disorders in the general population, based on clinical diagnosis, estimate:

- The incidence of anorexia nervosa to be about 19 per 100,000 per year in females and 2 per 100,000 per year in males, with rates as high as 50 per 100,000 per year in females aged between 13 to 19 years (Hoek, 1991, Hoek, 2006).
- The prevalence of bulimia nervosa has been estimated between 0.5 per cent and 1.0 per cent in young women (Hoek, 1991, Hoek, 2006).

The problem of these studies however is they are only counting the number of people who present for clinical diagnosis and do not, by and large, take into account unmet need.

The Adult Psychiatric Morbidity Survey (APMS) 2007 gives estimates of the prevalence of a variety of mental health disorders in England and provides a prevalence of treated and *untreated* Eating disorders, using the SCOFF screening tool as recommended by NICE thereby giving an indication of unmet need.

In the Survey the participants were classified along two criteria:

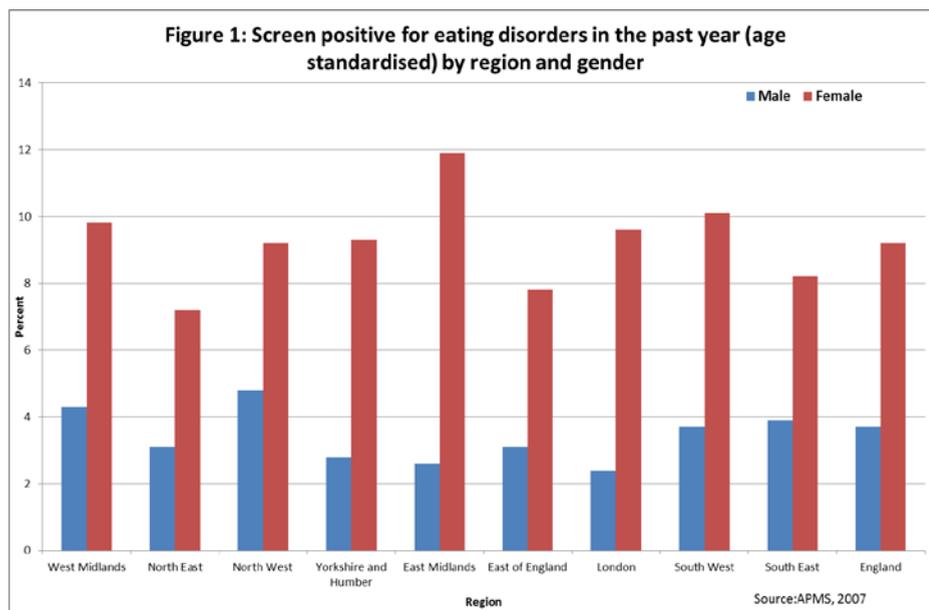
- 1) Screen positive: the numbers in need of further screening for clinical assessment for the possibility of an Eating disorder. These are individuals who potentially have a clinically treatable eating disorder.
- 2) Screen positive (with significant impact) – the numbers in need of further *clinical assessment* for the possibility of an Eating disorder. These are individuals who are more likely to have a serious eating disorder that will need

clinical treatment.

The rationale being that participants who screened positive and reported a significant negative impact on their life would be more likely to be suffering from a serious Eating disorder.

The survey found that only **19%** of those who screened positive for an eating disorder were receiving treatment for a mental or emotional problem at the time of interview i.e **81%** of people screening positive were receiving no treatment. The survey shows that the risk of screening positive for eating disorders:

- Was higher among single men and women
- Was not significantly influenced by ethnicity
- Was not significantly influenced by household income



The South East of England has a smaller rate of females but rate of males screening positive for having an eating disorder then the national average (Figure 1). However, when assessing screening positive with a negative impact (figure 2), then there are roughly the equivalent rate of females and fewer males with eating disorders in the South East then the England average.

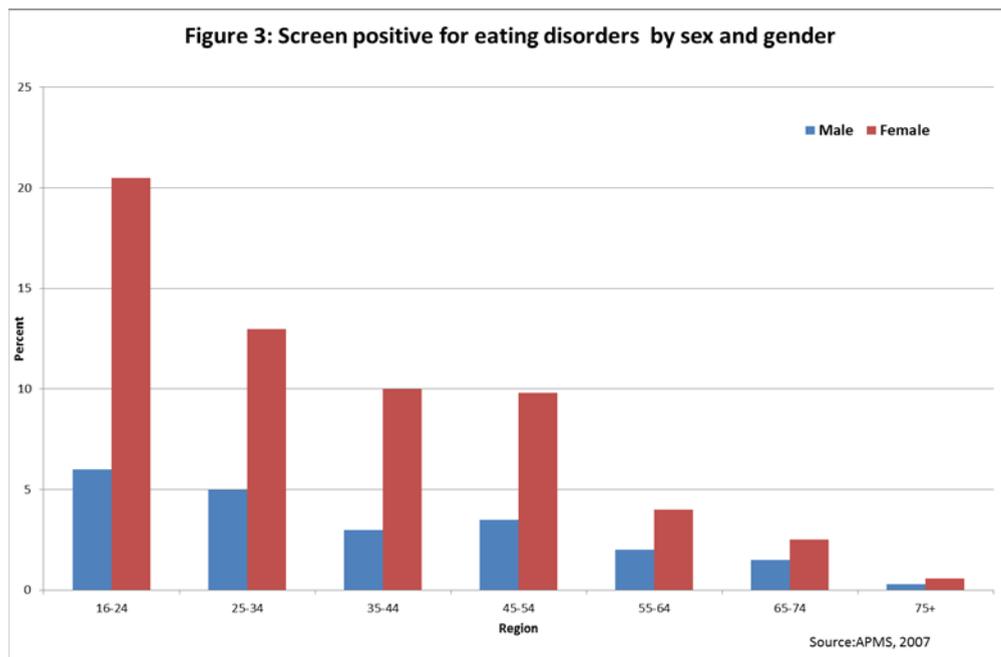
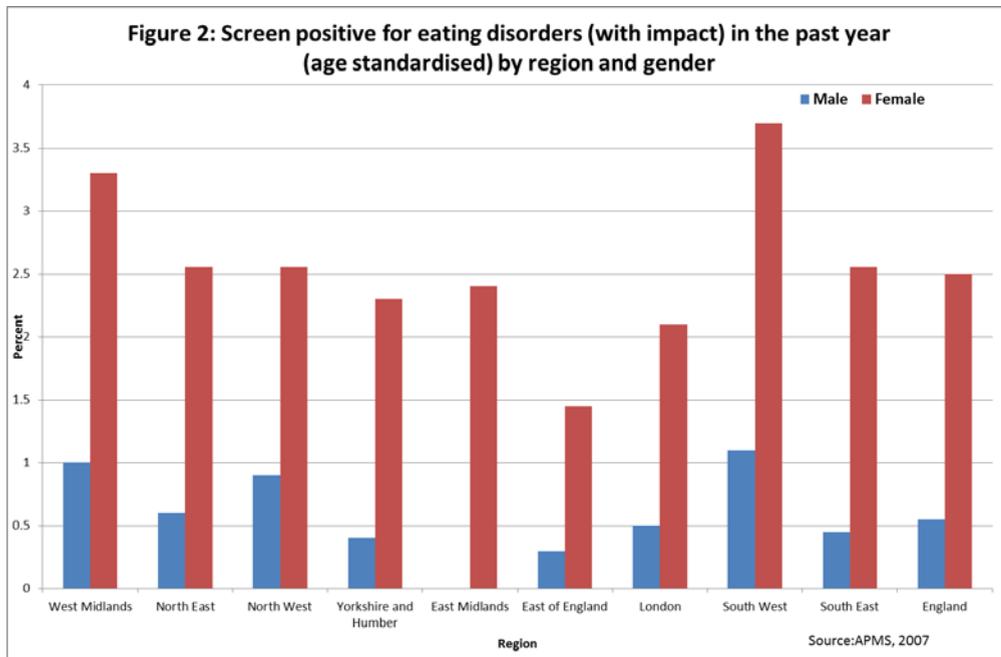
3.3 Estimating the disease burden in Kent and Medway

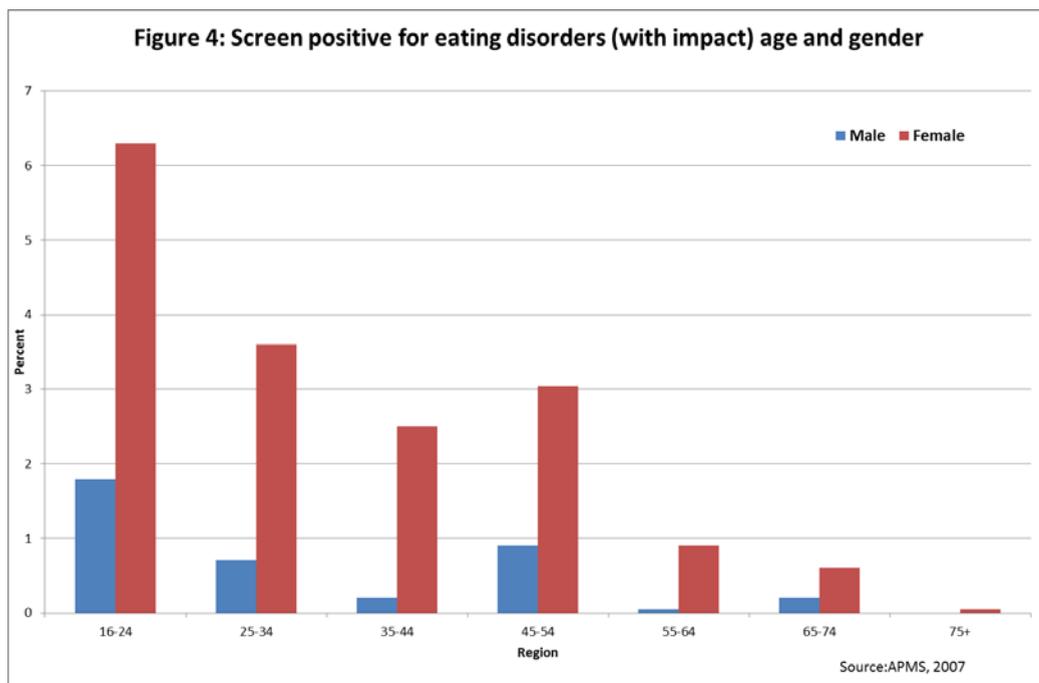
The prevalence of Eating disorders from the APMS and other data highlight the known fact that eating disorders are more common in women and decrease with increasing age. Therefore when designing services, the higher number of younger women should be an important influencing factor.

The percentage of the population whom may need either screening or clinical

To predict the numbers of individuals in Kent and Medway that may be in need of screening or clinical assessment for a possible Eating disorders, the data in Fig 3 and 4 is applied to the Kent and Medway population data in Tables 4 and 5.

From this assessment the data shows that some three and half thousand men and around fourteen thousand women in Kent and almost seven hundred men and around two thousand and seven hundred women in Medway are affected by an eating disorder and eight percent are likely not to be known to services.





**Table 3: Kent estimated prevalence using APMS SCOFF
Screening Tool**

Age Band	Eating Disorder		Eating Disorder (with impact)	
	Male	Female	Male	Female
15-24	5,631	18,710	1,689	4,928
25-34	4,154	10,753	665	3,183
35-44	2,848	9,905	190	2,476
45-54	3,665	10,632	942	3,190
55-64	1,738	3,609	87	902
65-74	1,076	1,546	143	464
75+	261	758	-	76
Total	19,374	55,911	3,717	15,219

**Table 4: Medway estimated prevalence using APMS SCOFF
Screening Tool**

Age Band	Eating Disorder		Eating Disorder (with impact)	
	Male	Female	Male	Female
15-24	1,174	3,848	352	1,014
25-34	901	2,228	144	660
35-44	542	1,823	36	456
45-54	661	1,912	170	574
55-64	296	594	15	149
65-74	163	228	22	69
75+	34	101	-	10
Total	3,771	10,735	739	2,930

Who is at risk?

- The CAMHS needs assessment for Kent⁴ shows that there are is a 62% gap between expected and observed cases treated in CAMHS services in Kent.
- Young Women (14 to 35), highest risk is at 14-24
- No effect or variation by ethnicity
- Both men and women with highest SCOFF scores are likely to be single
- No effect or variation by income
- Predictably those with very high or very low BMI are more at risk of eating disorder
- 24% of those in the highest risk category (screen positive) were in contact with mental health services for issues other than eating disorder.

⁴ Mookherjee, J 2011. CAMHS Needs Assessment for Kent. KMPHO

3.4 Prevalence in Kent and Medway of Eating Disorders based on Research from Clinical Evidence.

It is necessary to understand the complexity and severity of eating disorders and although the research is growing in this area, to date there are few accurate prevalence estimates. The recent APMS survey one of the few wide reaching surveys that take into account the rates across all population ages.

However as the rates concentrate on those in the 14 to 35 year old category and the 16 to 24 year old category in particular, clinical studies used by the King's Fund have reported rates for anorexia and bulimia nervosa that are considerably lower than the APMS, at 0.3 per cent for anorexia and 1 per cent for bulimia (females aged 10-34).

Based on these estimates from Hoek (2006)⁵, the expected number of cases for Kent and Medway have been calculated.

Table 5: Estimated number of Anorexia Nervosa cases 2008 and 2015

Council with Social Services Responsibilities	Clinical Commissioning Group	Anorexia Nervosa Cases	
		2008	2015
Kent	Ashford	10	12
	Canterbury & Coastal	29	31
	Dartford, Gravesham & Swanley	21	23
	South Kent Coast	13	14
	Swale	7	8
	Thanet	11	12
	West Kent	36	38
Medway	Medway	25	27

Total predicted cases in 2015 = 165

⁵ HOEK, H. W. (2006) Incidence, prevalence and mortality of anorexia nervosa and other eating disorders. Current Opinion in Psychiatry 19, 389–394.

Table 6: Estimated number of Bulimia Nervosa cases 2008 and 2015

Council with Social Services Responsibilities	Clinical Commissioning Group	Bulimia Nervosa Cases	
		2008	2015
Kent	Ashford	19	21
	Canterbury & Coastal	60	64
	Dartford, Gravesham & Swanley	40	43
	South Kent Coast	26	28
	Swale	11	12
	Thanet	22	24
	West Kent	75	80
Medway	Medway	51	53

Total predicted cases in 2015 = 325

Combined total cases for Kent & Medway = 490

Whilst the prevalence of individuals affected by Eating disorders may be considerable, the numbers seriously affected and hence in need of specialist mental health services is smaller (Table 7). Eating Disorders is a highly specialised clinical area and treatment of those affected can be human and financially resource intensive.

Table 7

Difference in Prevalence estimates of Eating Disorders in Kent and Medway	
K&M SCOFF+ (APMS)	89791
K&M SCOFF + impact (APMS)	22604
K&M Clinical (Hoek 2006)	490

3.5 Summary of findings

- Kent and Medway have a slightly lower proportion of people under the age of 30 years than the UK average, but with slightly higher proportion of 10 to 19 year olds than the England average.
- There are a number of colleges and universities in Kent and Medway (Notably University of Greenwich and Canterbury) which includes a student population of an estimated 41,000 students.
- An estimated 9.7% of women and 4.7% of men in Kent and Medway may need to be assessed for the possibility of Eating disorders.
- An estimated 3.3% of women and 1% of men in Kent and Medway might be in need of detailed clinical assessment for an Eating disorder and possible treatment.
- In our population we would expect about 88,000 individuals to be in need for some form of clinical screening for the possibility of suffering from an Eating disorder.
- 3,100 per 100,000 males in Kent and Medway may be in need of some form of screening
- 8,250 per 100,000 females in Kent and Medway may be in need of some form of screening
- Of these we might expect about 21,000 individuals needing more intensive clinical input.
- 580 per 100,000 males in Kent and Medway warrant more intensive screening and clinical input. 2,230 per 100,000 females in Kent and Medway warrant more intensive screening and clinical input and 1,400 per 100,000 of the Kent and Medway population may need to be assessed clinically for the possibility of an Eating disorder
- The APMS findings suggest that there is a slightly lower burden of Eating disorders in South East than nationally.

4. Hospital use and Eating disorders

4.1 Hospital admissions in Kent and Medway.

In England from 2008 to 2010, the average hospital admission rate for individuals aged 10 to 25 was 35 admissions per 100,000 hospital admissions. In Kent & Medway the rate for this age group is 12 per 100,000 (95% CIs 0.6 to 20) which is significantly lower than the England rate.

In Kent & Medway there were 144 admissions to hospital for eating disorders from April 08 to March 2011. The admissions were primarily for females and aged 16-24. Admissions for eating disorder increased year on year up to 2010/11, however the number of admissions in subsequent years has fluctuated between a high of 67 admissions (2010/11 and 2012/13) and 50 admissions (2013/14).

Figure 4:

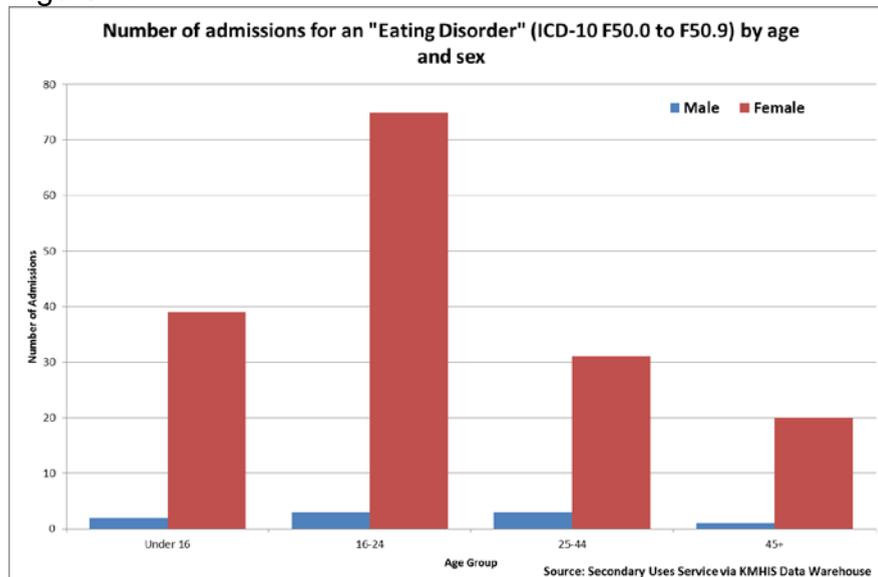


Figure 5:

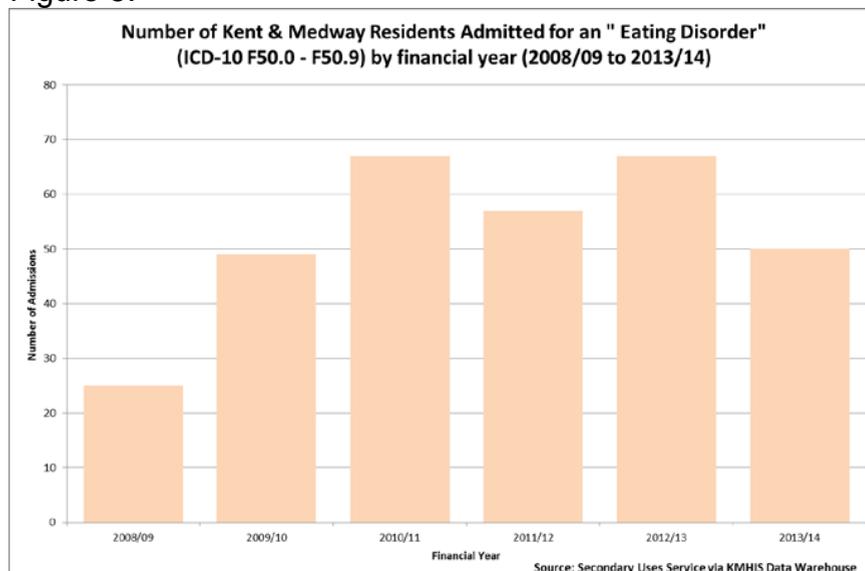


Table 8: Kent & Medway residents admitted for an "Eating Disorder" (ICD-10 F50.0 to F50.9) by Provider Trust - 2011/12 to 2013/14 (pooled data)

Provider Trust (Place of Admission)	Under 16	16-24	25-44	45+	Total
Kent & Medway Community and Social Care Trust		39	22	16	77
South London & Maudesley Hospital Trust	18	12	1		31
Maidstone & Tunbridge Wells NHS Trust	8	14	1	1	24
East Kent Hospitals Trust	8	5	7	2	22
Kings College Hospital Trust	2	3			5
Dartford & Gravesham NHS Trust	3	1			4
Medway NHS Trust	1	2			3
All Others		2	3	2	8

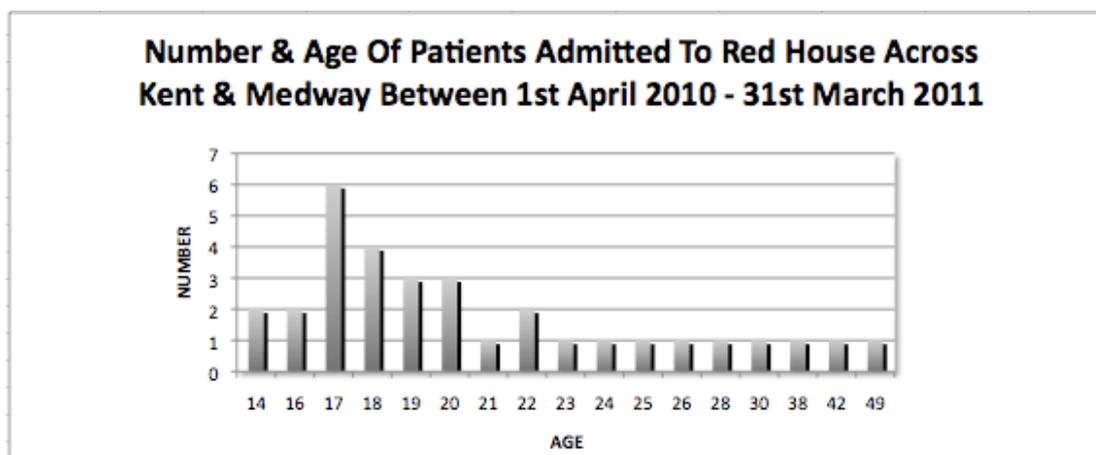
Source: Secondary Uses Service via KMHS Data Warehouse

The majority of admissions (45%) for eating disorders in Kent and Medway are in Kent and Medway NHS & Social Care Trust (KMPT) and the average length of stay for these admissions is 36 days (2011/12 to 2013/14) this is up from an average length of stay of 32 days (2008/09 to 2010/11).

5. Kent and Medway Eating Disorder Service.

Red House is the Eating disorder in-patient service for Kent and Medway. The total number of patients is 32 admitted to Red House between 1st April 2010 to 31st March 2011 (Figure 6). Patient's ages range between 14 and 48, with the highest number of admissions being aged 17 to 20.

Figure 6



Source: Red House

Table 9: Number of Bed Days in Red House by patients from each PCT patch.

PCT PATCH	NUMBER OF BED DAYS
EAST AND COASTAL PCT	842
MEDWAY PCT	376
WEST KENT PCT	567

Summary of Red House In Patient Data from 1st April 2010 to 31st March 2011

- 2009/2010 - 17 people admitted to Day care Intensive Treatment & 14 discharged and in 2010/2011 - 19 people admitted to Day care Intensive Treatment & 17 discharged, which gives an indication of through-put of patients.
- Average length of treatment in this setting was 51 days in 2009/2010, & 55 days in 2010/2011
- 29 people were admitted to Red House In-patient in 2009/2010. The average length of stay was 44 days, 30 people were admitted to Red House In-patient in 2010/2011. The average length of stay was 51 days. This is higher than the national average.
- Red House Bed occupancy was 69% in 2009/2010, and 82% in 2010/2011
- Secondary Care EDS – 70% of service users offered an assessment within 8 weeks of referral, 2 people waited more than 12 weeks for an assessment
- There were 54 referrals to Primary Care Liaison EDS Nurses in 7 months during 2010/2011, the average caseload per nurse was 10.
- The majority of clients seen in Red House are women, aged 16-24 and white, in keeping with the expected demographics of those affected by Eating disorders. The majority of patients were referred by the community mental health teams, with very few referrals from GPs.
- Whilst the combination of HES and Service data provides information on inpatient and outpatient usage respectively, there is no data available on the expected incidence, and hence inferences about need were made from the expected prevalence data.
- There is no data from primary care level into service provision and prescribing habits and therefore this was not investigated.

6. Summary

6.1 Conclusions

- Kent and Medway has an increasing and disproportionately larger number of adults aged 15-24, the population most at risk of Eating disorders.
- The burden of Eating disorders in Kent and Medway is expected to be around the national average.
- The expected prevalence of the general population of Kent and Medway who may need clinical assessment for the possibility of an Eating disorders may be as high as 1,400 per 100,000.
- More analysis of hospital services in Kent and Medway is need to compare demand to the national average. The use of acute and in-patient services in Kent and Medway appears relatively high given the prevalence estimates and recommendations for out-patients and community treatment, although this is hard to assess accurately from the data in this report. The average length of stay is higher in Kent and Medway than the national average.
- Kent and Medway has a specialist Eating disorder service that covers a wide geographical area and may be hard to access by some service users.
- Presently the usage of ED services is significantly lower than the expected need. This could be due services not being demanded by those at risk population, services not being offered to those at risk population, or a combination of the two.
- GP's need to be aware of the availability of specialist outpatient care
- There is a need for a community pathway and GP referral into services

6.2 Limitations

- The lack of robust data makes analysis difficult, and conclusions open to bias.
- The small numbers seen in secondary services means that data often needs to be suppressed, making comparisons at the local level especially difficult.
- Whilst the combination of HES and Service data provides information on inpatient and outpatient usage respectively, there is no data available on the expected incidence, and hence inferences about need were made from the expected prevalence data.
- There is no data from primary care level into service provision and prescribing habits and Therefore this was not investigated in this report.
- Close links to CAMHS services are needed given the ages of the patients affected.

6.3 Recommendations

1. Increase awareness amongst the population. It is likely than some of those affected by ED are reluctant to acknowledge their problem; some may acknowledge it but are reluctant to seek treatment. To address this there needs to be efforts to increase awareness of ED, reduce associated stigma, and increase awareness of services available.

2. Early Identification and intervention. The burden of illness secondary to ED is likely to be far greater than that is presently recognised by medical services. Although there is a lack of data to investigate the present care provided by primary health services, it is likely it is insufficient, considering the expected burden of disease.

3. Improve identification and early intervention in Primary Care. It is recommended that there needs to be an improvement in identifying cases in the general population in the primary care setting to not just detect cases earlier during their illness, but importantly to offer treatment earlier. Guidelines from NICE and the Department of Health also highlights the importance of services at the primary care level in tackling the burden of disease attributed to ED (DoH, 1999). This will mean that measures will need to be put in place to support primary care to do this work. Importantly, if increased screening is introduced at the primary care level, there needs to be also increased capacity at the secondary care level, or possibly increased capacity at the primary care level to manage milder forms of the illness.

Increased case detection would results in increased caseload for the service. Monitoring the service caseload and waiting times would provide early indication for the need to expand services. Commissioners will need to agree how meeting this potential increase in unmet need will be managed.

4 Model of Care: These conditions are chronic and often associated with a relapsing and remitting course that may necessitates continuing support after discharge from specialist units. The aim is to provide a structured and consistent approach to help local health and social care partners shape the way they deliver integrated long term care locally. In achieving this much of the recommendations relate to services at the primary care level at detecting new clients, and following up those recovered to minimize relapses. In commissioning services, the aim is to match the level of care to the level of need. Focussing of the levels of care allows us to consider what improvements can be made at these levels, and goals that we hope to achieve in return (Figure 7). Following NICE (2004) guidance for service improvements will also be an important step in developing a service model (Table 10).

Figure 7 Level of Care and Level of Need : Suggested Model.

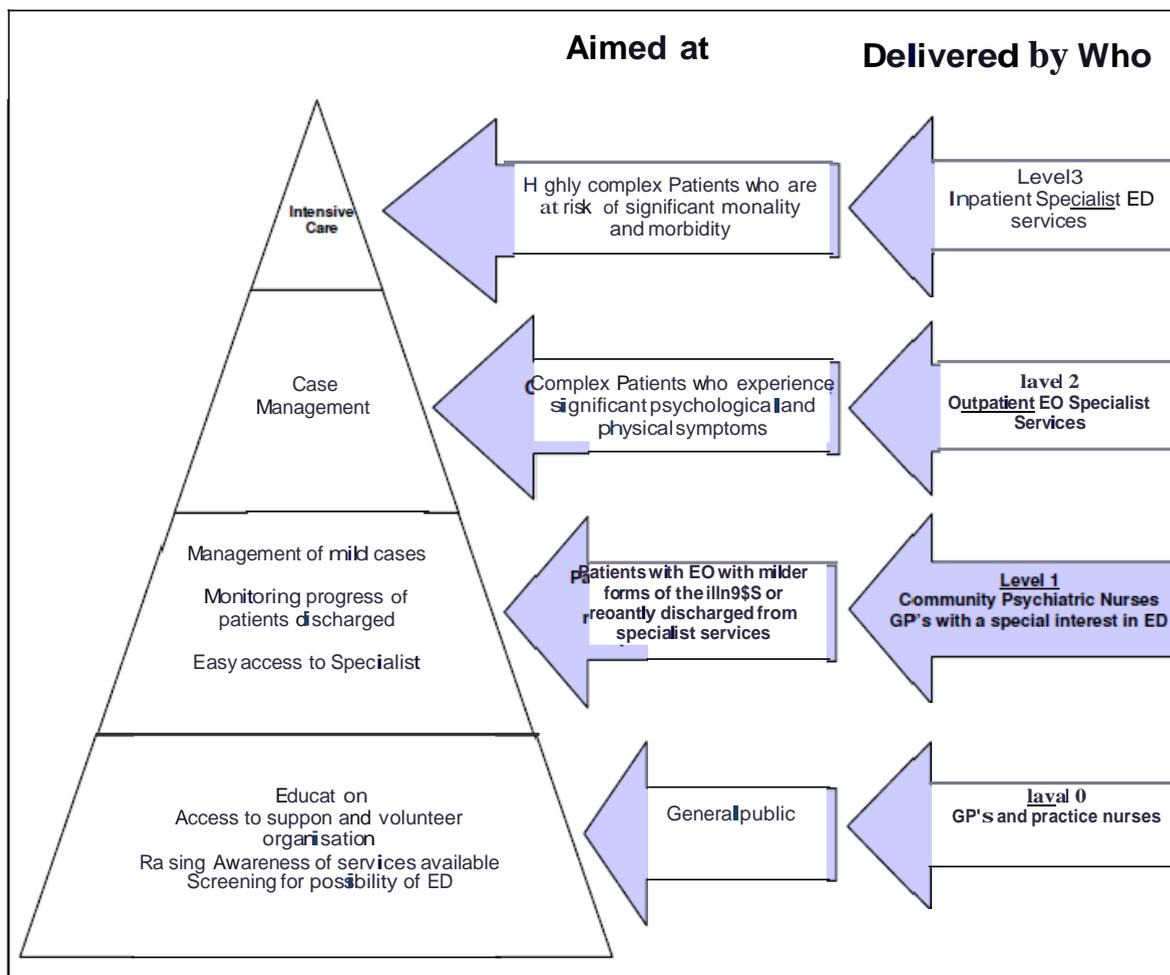


Table 10

Table 8 Service level improvement for tackling Eating Disorders		
Service	Adlon	Iqaect
0	<p>Provide accurate information to the community on ED</p> <p>Provide information of services available</p> <p>Encourage development of voluntary community and patient organisations</p>	<p>Improve awareness of illness</p> <p>Improve health seeking behaviour</p> <p>Improve awareness amongst family members and carers about ED.</p> <p>Enhance support available locally to people and their carers</p> <p>Reduce stigma</p>
1	<p>Increase awareness among GP and Practice nurses of ED</p> <p>Increased screening for ED</p> <p>Increased awareness of physical symptoms that may be a clue to existence of an underlying ED</p> <p>Improve links to specialist ED services</p>	<p>Earlier detection</p> <p>Early intervention to minimise effects of disease and associated complications</p> <p>More effective medicines management;</p>
2	<p>Develop community based health care staff with major interest in eating disorders and their management</p>	<p>Provide support for those with milder forms of Eating disorders</p> <p>Reducing risk of relapse in those with ED after discharge from specialist services</p> <p>Access to better quality services closer to home</p> <p>Enhance independence among patients allowing them to take control of their lives</p> <p>Identification of patients at increased risk of unplanned admissions or long term institutionalization</p>
3	<p>Monitor caseloads seen at specialist services</p>	<p>Keep waiting times short</p> <p>Timely expansion of services</p>
4	<p>Review the provision of very specialized services including the commissioning of specialist inpatient care</p>	<p>Improved management of those with severe forms of ED</p> <p>Reduce mortality and morbidity</p>

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