Dudley
Metropolitan Borough Council

Agenda Item No. 11

**Health Scrutiny Panel, 29 September 2010**

**Report of the Strategic Commissioning Lead for Children, Young People and Families**

**Eating Disorder Service**

**Purpose of Report**

1. To update the members on the current service provision for people with eating disorders in Dudley.

**Background**

2. The Mental Health Commissioning Strategy was considered by the Council's Cabinet on March 17th. A number of issues were raised regarding the current service arrangements, numbers of individuals affected and how people access the services.

**Current Service Provision**

3. NHS Dudley commissions an Eating Disorder (ED) Service from Dudley and Walsall Mental Health Trust (D&WMHT). The service is for both NHS Dudley and NHS Walsall.

4. The service operates from Netherton Health Centre and comprises 2 WTE Clinical Nurse Specialist and 0.33 Specialist Dietician. The age range is 14 years and over. A definitive diagnosis is, more often than not, made by a Consultant Psychiatrist.

**Prevalence and Incidence**

5. The National Prevalence date for people with Eating Disorders is 6.4 % of which 9.2% are female and 3.5% male. This equates to 27,000 females and 10,500 males in Dudley.

6. The Eating Disorder service is currently working with 64 people who have been *diagnosed with ED as the primary diagnosis*. 14 of these are under 18 years old.

7. There are young people who have eating problems but not necessarily diagnosed as diagnosis must be in the young person's best interest and it must be the primary diagnosis.

**Waiting Times.**

8. Access and the referral pathway to the service differ for adults and young people aged 14-18.

9. For over 18s this is dependant upon when the Primary Care Liaison Team (PCLT) performs the initial assessment and the severity of the disorder. The initial assessment is performed by a Gateway/Link Worker. The patient could be initially referred to the PCLT and, after the assessment, referred to the Community Mental Health Team (CMHT) for initial treatment and then subsequently referred on to the ED service. Alternatively the initial assessment could be by the CMHT. If a patient has a BMI lower than 15 this is classed as an emergency and would be seen by a medic as soon as possible. Presently the maximum waiting time to access the ED service, from the CHMT, is 2 weeks for over 18s.

10. For the 14-18 age group an initial assessment could be made by any primary health care professional and then referred into CAMHS. A routine assessment will be dependant on how good the referral was in describing the symptoms as the diagnosis might not be eating disorder. There is always a request for a BMI centile on the appropriate chart but this is not always available. Patient's referred with a BMI less than the 2.4$^{th}$ centile of the reference population are diagnostic and they are seen as an emergency. Following the initial assessment, the young person will be managed by the CMHT, and in some cases supported by the ED team, or escalated to the ED service. Once there is an Eating Disorder identified there is no waiting time to receive support. Clearly physical pathology needs to be excluded as a cause and multi-disciplinary working with the GP is an important part of managing these clients.

**Primary Care Awareness**

11. Not all Eating Disorders are identified in Primary Care; the referral may be regarding other symptoms but includes poor appetite. For over 18s a potential Eating Disorder is identified following assessment by the Mental Health Gateway/Link worker in primary care. A definitive diagnosis is and then made in the ED Service. Those that are identified with a potential ED in Primary Care or in ED Service follow the pathway recommended in NICE Guidelines i.e. those with a BMI under 17 are seen as an emergency. Those with a Mild /Moderate Eating Disorder are to be seen in Primary Care. See point 14 for 14-16 year olds.

12. Training is provided for staff in Primary Care on identifying and managing Eating Disorders.

**Family Support**

13. Family interventions follow NICE Guidelines and include Family Therapy. There is also a pan Black Country Family Support Group.

14. Healthy Eating is supported through Children Centres activity and through parenting programmes indirectly. There is no specific reference to eating disorders in the parenting strategy. As with all patients a lack of regard for treatment would result in a safeguarding referral.

15. If there is a safeguarding or child protection issue for child or young person who has an eating disorder, then normal safeguarding procedures are followed. Support around healthy eating can be provided by health visitors and school health advisors during their routine contact with children and families, or as a specific piece of work as part of a child or young person's child protection plan if appropriate

**Eating Disorders and Obesity**

16. There is no evidence that addressing the issues of obesity can in advertently precipitate anorexic behaviour. The social and cultural influences in the wider world are much stronger. We live in an obeseogenic environment i.e. it is easier to make poor health choices & with much greater pressure to be unhealthily thin from the fashion and media world than from anything offered locally. Additionally population based obesity work is aimed at maintaining a 'healthy weight' not losing weight and the losing weight messages are only targeted at those already obese via the patient weight loss pathways.

**Perspective**

17. Reviewing access to ED Services, and subsequent treatment, based on a definitive diagnosis presents a number of clinical and ethical challenges. There are many young people who have eating problems who benefit from treatment from the ED Service. There are also other clinicians, who provide services to these clients, who would benefit from the advice and consultation of ED workers. This cohort of young people would **not** be diagnosed as having an eating disorder per se but would receive treatment and support from the D&WMHT. In children who are still growing, but who do not eat, their weight is affected first and subsequently their height. This means that they may not appear unduly thin. It is therefore imperative that appropriately trained staff have access to previous measurements and undertake a robust assessment.

18. The definite diagnosis is made by the Consultant Psychiatrist and is only made as the primary diagnosis.

19. Many cases of eating disorders are never diagnosed. This may be due to patients being in denial of their symptoms or too embarrassed and ashamed to come forward. This group of young people can have very deviant behaviour.

20. There are also have a number of young people in CAMHS who are depressed and have eating problems with loss of appetite and will receive treatment for depression. Treatment for the depression often results in the patient progressing to having an ED secondary diagnosis. Often referrals from primary care are made to CAMHS where an ED is not suspected and it is only after much work that it is apparent that there is an underlying ED.

**Recommendation**

21. It is recommended that:-

- *This report is for information.*

**Strategic Commissioning Lead for Children, Young People and Families**

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