	<p style="text-align: center;">Health Overview and Scrutiny Committee</p> <p style="text-align: center;">16 May 2016</p>
<p style="text-align: center;">Title</p>	<p style="text-align: center;">Report on Eating Disorders - Children and Young People</p>
<p style="text-align: center;">Report of</p>	<p>Eamann Devlin CCG - CAMHS Joint Commissioning Manager (interim) Barnet CCG</p>
<p style="text-align: center;">Wards</p>	<p>All</p>
<p style="text-align: center;">Status</p>	<p>Public</p>
<p style="text-align: center;">Urgent</p>	<p>NO</p>
<p style="text-align: center;">Key</p>	<p>NO</p>
<p style="text-align: center;">Enclosures</p>	<p>Appendix A</p>
<p style="text-align: center;">Officer Contact Details</p>	<p>Eamann Devlin, eamann.devlin@barnetccg.nhs.uk</p>

Summary

This report is a response to Cllr Trevethan’s request that the HWBB be provided with a general report on Eating Disorders issues and specific responses to eight direct questions. It was circulated to clinical and Public Health leads.

The report provides:

- The context for Eating Disorders in the wider Child and Adolescent Mental Health Agenda
- An overview of Eating Disorders as clinical condition
- An overview of the Barnet context for Eating disorders with local and national data where available
- An overview of current commissioning arrangements, provision and development works for the local CAMHS Transformation Programme
- Responses to the specific questions raised by Cllr Trevethans

Recommendations

- 1. That the Committee notes the contents of this report.**

1. WHY THIS REPORT IS NEEDED

- 1.1. This report follows on from a request from Cllr Trevethan for a report addressing Eating Disorders in Barnet. The Joint Commissioning Unit was tasked with responding to the questions along with a more general update on the Eating Disorders Agenda.

2. REASONS FOR RECOMMENDATIONS

- 2.1. The report allows the Committee to be informed as to the policy context of eating disorders. The Committee may resolve to request any further actions they feel necessary upon considering the report.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1. None in the context of this report.

4. POST DECISION IMPLEMENTATION

4.1. Following the consideration of this report, the Committee will be able to determine if they require any future reports or information.

5. IMPLICATIONS OF DECISIONS

5.1. Corporate Priorities and Performance

5.1.1. The report provides insight into Eating Disorders, both current works and future developments in response to a Member enquiry. The report details elements of Children and Adolescent Mental Health Service (CAMHS) activity which are being addressed through the Barnet CAMHS Transformation Programme and Plan .

5.1.2. The Overview and Scrutiny Committee must ensure that the work of Scrutiny is reflective of the Council's principles and strategic objectives set out in the Corporate Plan 2015 – 2020

The strategic objectives set out in the 2015 – 2020 Corporate Plan are

The Council, working with local, regional and national partners, will strive to ensure that Barnet is the place

- Of opportunity, where people can further their quality of life
- Where people are helped to help themselves
- Where responsibility is shared, fairly
- Where services are delivered efficiently to get value for money for the taxpayer

6. Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

6.1. There are no financial implications for the Council in receiving this report

6.2. In October 2015 the Department of Health announced that alongside the allocations that would be made to local areas to support the general CAMHS

Transformation programme and addition, a specific allocation for Eating Disorder and or Self-Harm and Out of Hours services was being made. A degree of flexibility in allocation of spend was given to local areas to enable them to prioritise spend in line with the relative maturity of the services they commission for these vital CAMHS areas. An allocation of £198,000 was made available to Barnet, and the decision was made to place £100,000 against development of the existing service, with the remainder being invested in Out of Hours and Crisis Care related works. This reflected the level of service development in Barnet where we already commissioned a “gold Standard” Eating Disorder service

7. Social Value

- 7.1.** The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders
- 7.2.** There are no specific references to Social Value Act relevant issues within the report, but the wider CAMHS Transformation Plan which frames the five year delivery programme for CAMHS work in Barnet has been developed with Social Value as one aspect of the overarching commissioning principles, specifically the use of Voluntary and Community Sector agencies operatives and resources to both inform, co-produce and deliver specific strands of the CAMHS Transformation Programme

8. Legal and Constitutional References

- 8.1.** The report outlines current and planned activity and service context and specific responses to the members item only. No decisions are being called for and all aspect of the wider CAMHS Transformation programme referred to have been assessed for impacts on Barnet legal and constitutional separately in the sign off process for the CAMHS Transformation Plan in October 2015
- 8.2.** Section 244 of the National Health Service Act 2006 and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218; Part 4 Health Scrutiny by Local Authorities provides for the establishment of Health Overview and Scrutiny Committees by local authorities
- 8.3.** The Council’s Constitution (Responsibility for Functions) sets out the terms of reference of the Health Overview and Scrutiny Committee as having the following responsibilities

“To perform the overview and scrutiny role in relation to health issues which impact upon the residents of the London Borough of Barnet and the functions services and activities of the National Health Service (NHS) and NHS bodies located within the London Borough of Barnet and in other areas.”

9. Risk Management

- 9.1.** There are no risks identified within the report the report itself. Should the Committee not receive this report, there would be a risk in the Committee not being kept abreast of the issues surrounding eating disorders

10. Equalities and Diversity

- 10.1.** The report and the services it describes are specifically designed to address key vulnerable groups including those with protected characteristics and service delivery models are specifically tailored to maximise inclusion in line with the current specification for the service. Work is under way to ensure that the service is able to meet both the waiting times standard for the service
- 10.2.** In addition to the Terms of Reference of the Committee, and in so far as relating to matters within its remit, the role of the Committee is to perform the Overview and Scrutiny role in relation to

“The Council’s leadership role in relation to diversity and inclusiveness; and

The fulfilment of the Council’s duties as employer including recruitment and retention, personnel, pensions and payroll services, staff development, equalities and health and safety.

Equality and diversity issues are a mandatory consideration in decision-making in the council pursuant to the Equality Act 2010. This means the council and all other organisations acting on its behalf must have due regard when exercising a public function. The broad purpose of this duty is to integrate considerations of equality and good relations into day to day business requiring equality considerations to be reflected into the design of policies and the delivery of services and for these to be kept under review. Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports and this Committee should consider these issues when commenting on the reports.

The specific duty set out in s149 of the Equality Act is to have due regard to need to:

Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The relevant protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation. Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports.”

11. Consultation and Engagement

11.1. The development of the CAMHS Transformation Plan included significant consultation and engagement. It is acknowledged that the implementation of the CAMHS Transformation necessitates effective and sustainable mechanisms to not only consult and engage service users and their families but to involve them ('co-production') in all aspects of the programme. This point has been reiterated in national guidelines and in 'Future in Mind', the original policy stimulus for this Transformation programme. Hence the CAMHS agenda in Barnet seeks to continue and extend the co-production and engagement initiatives until the completion of the work in 2020 and beyond

11.2. Insight

11.2.1. A plethora of information resources have informed this paper including local Insight resources, and national specialist data sets. See the report for a full list of references

12. BACKGROUND PAPERS

12.1. The Attached report provides the detailed response requested by item 6A discussed at the Heath Overview and Scrutiny Committee of Monday December the 7th 2015.

(<https://barnet.moderngov.co.uk/mgAi.aspx?ID=15067>)

Appendix A

Introduction:

Barnet Eating Disorders – Response and Report to Members Item 6A HOSC Dec 7, 2015

This report is a response to Cllr Trevethans' request that the HWBB be provided with a general report on Eating Disorders issues and specific responses to eight direct questions.

The report aims to provide:

- The context for Eating Disorders in the wider Child and Adolescent Mental Health Agenda
- An overview of Eating Disorders as clinical condition
- Responses to the Members questions

Context:

In March 2015 NHS England (NHSE) and The Department of Health (DoH) published Future in Mind, promoting, protecting and improving our children's emotional health and wellbeing. The report sets out national transformation of child adolescent mental health services (CAMHS) over a five year period.

The Barnet CAMHS Transformation Plan has been developed in response to the letter from Sir Bruce Keogh and Richard Barker in May 2015 which calls for "...a major service transformation programme to significantly reshape the way services for children and young people with mental health needs are commissioned and delivered across all agencies over the next 5 years in line with proposals put forward in Future in Mind...."

Barnet Transformation Plan identifies five areas for priority development across all services including Eating Disorders

- Improving access to effective support
- Care for the most vulnerable
- Promoting resilience, prevention and early intervention
- Accountability and transparency
- Developing the workforce

A priority for both National and Local CAMHS is tackling Eating Disorders.

Eating Disorders and the CAMHS Transformation Plan:

Barnet currently has a high quality eating disorder service and through the Transformation Plan we will improve the service further by reducing waiting times to meet new guidance requirements (4 weeks from first contact, or 1 week for urgent cases: NICE Standards). By 2020 Barnet will have expanded the capacity of the Eating Disorders service to offer intensive community based treatment (Eating Disorder Intensive Service-EDIS)), increased the number of children able to access services. As part of the Transformation Plan Barnet will roll out training for all eating disorder staff as part of the “Improving access to Psychological Therapies for children” (CYP-IAPT), provide outreach education training for eating disorders and provide telephone support for General Practitioners. Early identification and support is known to enhance outcomes for sufferers and reduce hospital admissions

Barnet’s Eating Disorder service: The Royal Free London CAMHS eating disorder service has been running a highly successful and innovative eating disorder service since 2001. It is now one of the largest CAMHS eating disorder services in the country, currently covering six North London boroughs. The service aims to help young people with anorexia nervosa, bulimia nervosa or atypical variations of these disorders, to recover fully in the community. A key aim for the service is to try and help young people avoid admissions into eating disorder residential units. While eating disorder residential units should always have a place in the treatment options for young people the service operates on the assumption that that they should be for the minority and used as a last resort. CCGs are required to work collaboratively to commission a community eating disorder service for children and young people. Accordingly Barnet who are the lead commissioner for the Royal Free Hospital lead the commissioning of the Eating Disorder service for North Central London on the behalf of Enfield Haringey Camden and Islington.

Key Treatment Plan Components

Flexible appointment times

The service aims to offer flexible appointment times and can often offer young people in exam years (years 11, 12 and 13) early or late appointments, eg 9am or between 5pm and 6pm, to reduce potential impact on school.

Eating Disorder Intensive Service (EDIS): An intensive day and inpatient service offering a multi-disciplinary approach and including all of the menu of interventions below. The EDIS service is also supported by an in-house school provision.

Nursing and dietician reviews: Regular nursing and dietician reviews to monitor weight and meal plans.

Nursing key worker sessions: Young people on the ward in EDIS will have regular meetings with both of their nursing key workers. These meetings serve as a useful preparation for future individual therapy.

Psychiatry reviews: Eating disorders rarely occur in isolation, so CYP will have regular meetings with a psychiatrist, consultant and/or a trainee psychiatrist, to assess, monitor and treat any other related conditions e.g. depression, self-harm or OCD (obsessive compulsive disorder).

Family therapy: Family therapy is the most effective treatment for young people with eating disorders. Family therapy aims to discover how resources or strengths in the family can be developed to help young people recover from their eating difficulties.

Parent skills based group: Offered as a preparation for family therapy and offers parents a range of skills, techniques and knowledge to help them support their child with their eating difficulties.

Individual therapy: Individual therapy offers young people a private space to discuss their thoughts and emotions associated with their eating disorder. CYP are offered two main types of therapy: cognitive behavioural therapy (CBT) or psychodynamic psychotherapy. Both have been specially adapted to help young people with eating disorders. Both treatments are equally effective.

Groups for young people: The Royal Free currently offers a creative group to help young people use art materials to find an alternative outlet for emotional expression. There is also a 'food and me' group which seeks to use mindfulness and relaxation techniques to reduce some of the anxieties and stresses associated with eating. Other groups are being planned.

Core team reviews: CYP, Parents and carers will have regular reviews with the consultant psychiatrist coordinating the CYPs care and any other members of the team that are also involved e.g. nurse, family therapist and individual therapist. The purpose of these meetings is to review and refine treatment plans.

Eating Disorders as Clinical Conditions:

Eating disorders include a range of conditions that can affect someone physically, psychologically and socially. The most common eating disorders are:

Anorexia Nervosa – when a person tries to keep their weight as low as possible; for example, by starving themselves or exercising excessively

Bulimia Nervosa – when a person goes through periods of binge eating and is then deliberately sick or uses laxatives (medication to help empty the bowels) to try to control their weight

Binge Eating Disorder – when a person feels compelled to overeat large amounts of food in a short space of time

Some people, particularly those who are young, may be diagnosed with an eating disorder not otherwise specified (EDNOS). This means you have some, but not all, of the typical signs of eating disorders like anorexia or bulimia.

Eating disorders are a range of conditions that affect people physically, psychologically and socially. They are serious mental illnesses which affect over 725,000 people in the UK and have the highest mortality rate of any mental illness – one in five of the most seriously affected will die prematurely from the physical consequences or suicide. Moreover, it is estimated that annual cost to the NHS of treating eating disorders is £4.6 billion.

Anyone can develop an eating disorder, regardless of their age, sex or cultural background. However, figures show that 1 in 30 school children have diagnosed eating disorder and alarmingly, the number of hospital admissions across the UK for teenagers with eating disorders has nearly doubled in the last three years, from 959 in 2010/11 to 1,815 in 2013/14, a rate of increase that experts say is mirrored by a larger number of cases that don't go to hospital.

The Government has stressed its commitment to improving access to mental health services for children and young people, announcing a further £1.25 billion in 2015 to improve children's mental health services over the next 5 years. Additionally, in

December 2014, £30 million worth of extra funding was announced for eating disorder services in order to improve community provision and cut waiting times; to ensure that 95% of children and young people with eating disorders are seen within four weeks, or one week for urgent cases by 2020.

With most cases of eating disorders beginning in childhood or adolescence, increasing rates of diagnosis and mounting pressures on child and adolescent mental health services (CAMHS), there is growing awareness that a coordinated approach across sectors which promotes early intervention is now crucial for identifying, treating and preventing eating disorders among young people.

Prevalence rates, diagnoses age gender and incidence:

The number of people diagnosed with eating disorders has increased by 15 per cent since 2000, according to a study by King's College London and the UCL Institute of Child Health in 2011. The increase was more pronounced in males with incidences rising 27 per cent. The research looked at incidence of eating disorders in primary care in the UK over a ten-year period (2000-2009) and found that the largest increase was in eating disorders which meet most, but not, all of the criteria associated with anorexia or bulimia. ¹

The study showed a 60 per cent increase in females with these types of eating disorders, known as Eating Disorders Not Otherwise Specified (EDNOS), and a 24 per cent increase in males. Rates of anorexia nervosa and bulimia nervosa remained stable. The researchers analysed information from 400 general practices representing approximately 5% of the general UK population, and identified 9,072 patients with a first-time diagnosis of an eating disorder. It revealed that in 2000 there were 32.3 new cases of eating disorder per 100,000 population aged between 10-49 years, which rose to 37.2 cases by 2009. It is acknowledged that eating disorders can develop at any age, with reported cases in children as young as 6 and women in their 70s.

Most eating disorders, however, develop in adolescence with those under 20 making up almost half (49%) of all those receiving inpatient treatment for an eating disorder in England. NHS guidance on eating disorders notes that anorexia nervosa commonly develops around the ages of 16-17, while bulimia nervosa develops at 18-19 and binge eating disorder appears later in life, usually between the ages of 30-40

¹ Micali, N. et al "The incidence of eating disorders in the UK in 200-2009: findings from the General Practice Research Database" *BMJ*
Open doi: [10.1136/bmjopen-2013-002646](https://doi.org/10.1136/bmjopen-2013-002646)

Incidences of eating disorders were seen to vary by sex and age with adolescent girls aged 15-19 years having the highest incidence of eating disorders (2 per 1,000). There was a much higher overall rate of eating disorders among females of 62.6 per 100,000 in 2009 compared with a male rate of 7.1 per 100,000. The peak age of diagnosis for girls with all eating disorders was 15-19 years. Other research, however, indicates that up to 25% of sufferers are males. It is possible that because males make up the minority of sufferers, there are issues around diagnosis due to lack of awareness of the problem among men. They may also be reluctant to come forward due to the stigma attached. The peak age for diagnosis for males varied depending on the type of eating disorder: 15-19 years for anorexia; 20-29 years for bulimia; and 10-14 for EDNOS. There is still a significant late diagnoses according to the research literature. The Kings Study reference above noted a large number of late or undetected cases.²

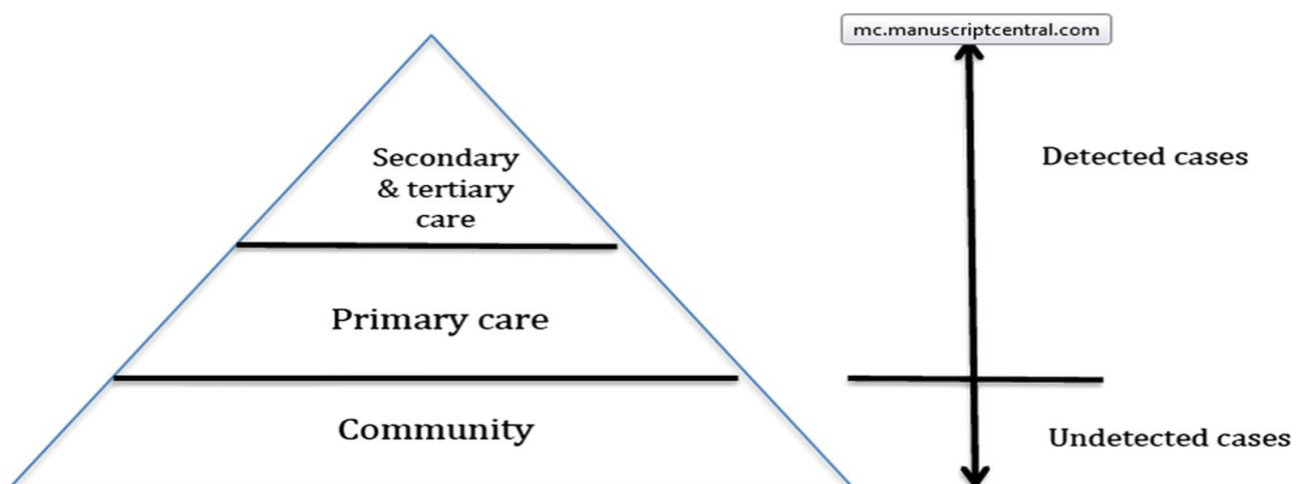


Fig 1 The incidence of eating disorders in the UK in 2000–2009: findings from the General Practice Research Database

Stigma and other societal and cultural pressures can make the task of identification hard to achieve and the evidence suggests that most sufferers wait over a year from first symptoms to seeking help. People with anorexia nervosa often differ from others with mental health problems in that the central characteristics of the illness are perceived as functional and valued by the individual. The individual can be perceived as ambivalent about recovery and resistant to intervention. In (eating disorders) treatment an emphasis is placed on developing a collaborative therapeutic

² <http://bmjopen.bmj.com/content/3/5/e002646.full>

relationship with the individual. The PWC report 2015 also indicates that 62% of sufferers develop symptoms prior to 16th birthday and a further 24% between 16-19yrs, so a total of 86% under 19 yrs. The imperative therefore to improve early identification is significant and this is a major focus of work within the Barnet Transformation Plan

Inpatient treatment³: In a minority of patients, admission to hospital may at times be necessary to stabilise the physical state or even save the life of severely physically impaired patients. Inpatient treatment aimed at recovery usually leads to weight gain at least where admission has been to a unit where such treatment is a regular activity. Such treatment may have lasting effects although weight loss is common after discharge. There is no unequivocal evidence that inpatient treatment confers long-term advantage except as a short-term life-saving intervention in patients at high risk. However, inpatient treatment may well be a rational option for patients who have failed to respond to apparently adequate outpatient treatment.

A decision to compulsorily treat people with eating disorders occurs infrequently. Treatment in this context refers to inpatient treatment of anorexia nervosa in adults, children and adolescents. However in the case of children and adolescents compulsory treatment can take place on an outpatient basis under parental authority, under the Mental Health Act 1983 and more rarely, with specific Court Orders.

A further aim of employing compulsion under the MHA 1983 is to offer the individual the protection that is provided for them in the Act. It is important to remember that compulsory treatment does not equate with 'feeding against the will of the person' or 'force feeding'. It is helpful to hold in mind the distinction between treatment carried out under the legislation with which the individual complies (for whatever reason) and that which the individual resists.

Responses to the Members Questions:

1. What is the prevalence of eating disorders amongst young people (under 18 year olds) in Barnet? Is the prevalence increasing?:

There has been no detailed needs assessment for Eating Disorders in Children and Young People in Barnet and prevalence levels are uncertain. This gap is common across most areas of the UK. Public Health England estimates suggest that 7% of

³ This section is taken from the NICE guidance *ibid*.

people of all ages ⁴ will have an Eating Disorder in Barnet (18,902) at some stage. No specific figures are provided for Children in PHE data but it is estimated that in Barnet 5,146 16-24 yr olds have two or more indicators of an Eating Disorder that would require further investigation ((Adult Psychiatric Morbidity Survey 2007 <http://www.ic.nhs.uk/pubs/psychiatricmorbidity07>)).

Anorexia Nervosa commonly starts in the teenage years in the UK around 1 fifteen-year-old girl in every 150 or 1 fifteen-year-old boy in every 1000 is affected. For Bulimia approximately 4 out of 100 women will be affected but the condition at some stage in their life with typical onset at mid teenage years, with far fewer men being affected..

The introduction of the Mental Health Minimum Data Set will over the next two years significantly improve the data available regarding prevalence in Barnet. Barnet has a higher rate of referrals to the specialist unit than surrounding boroughs

Referral Rates for NCL to Specialist RFH Unit

During the period 2013/2014 there were 157 referrals to Royal Free CAMHS Eating Disorder Service.

CCG	Number of referrals received	Number of referrals accepted
Barnet	64	62
Camden	23	22
Enfield	25	23
Haringey	15	13
Islington	18	16
Other	12	12
TOTAL	157	148

⁴ Barnet ADPH Report 2015

In the following year the number of referrals for Barnet had reduced by 20% but for the whole catchment area by 7%. This should not be considered a statistically significant change. We are awaiting final year figures for 2015.16 but understand these have risen slightly on last year.

2014/2015

CCG	Number of referrals received	Number of referrals accepted
Barnet	49	49
Camden	18	17
Enfield	31	29
Haringey	17	14
Islington	18	17
Other	13	8
TOTAL	146	134

2. What are understood to be the common causes of eating disorders and what research is taking place at a local or national level to identify possible causes and/or contributory factors?

Eating Disorders are complex, multi-factorial in their causation and the interrelation of these issues on individuals are still to be fully understood. Factors can include genetic, biological, social and cultural influences. Eating disorders arise from a combination of personal, family, physical or genetic factors as well as life experiences that may cause someone to be both emotionally vulnerable AND sensitive about their weight and shape. Dieting has a role to play in the development of an eating disorder, in fact in most sufferers the eating disorder grew out of dieting behaviour.

3. Information on a treatment plan/referral plan for a young person diagnosed with an eating disorder but not requiring inpatient treatment?

Barnet CCG commissions a comprehensive Outpatient Eating Disorder service⁵ from the Royal Free NHS Foundation Trust. This comprises of a combination of service offers according to the needs of the Children and Young People accessing the service. – SEE KEY TREATMENT PLAN COMPONENTS ABOVE

4. At what stage/severity would admission to hospital be required?

The decision to admit a patient is made on a case by case basis. Overall the key factors in admission are the severity of symptoms, the need to stabilise physical conditions or provide symptom interruption. Sometimes in extreme circumstances the provisions of the Mental Health act to detain and impose treatment are required in life threatening circumstances, but this is unusual.

- Physical Health Risks - Medical stabilisation, re-feeding or other medical complications
- Mental health Risks – e.g. suicidality
- A combination of the two: e.g. refusal to engage with a community team and an eating disorder of such severity that it is likely to cause significant harm without treatment being provided.

Some patients may require detention under the Mental Health Act when it is necessary for their health or safety. The Junior MARSIPAN (Management of Really Sick Patients with Anorexia Nervosa) guidance highlights how eating disorders risk in children and adolescents can be recognised by any clinician working with them and when hospital admission would be necessary.

5. What are the long-term complications arising from eating disorders; and national rates of recovery and mortality?

Long term complications do vary according to the specific Eating Disorder under consideration but can include combinations of the following: Painful swallowing,

⁵ See <https://www.royalfree.nhs.uk/services/services-a-z/child-and-adolescent-mental-health-services/eating-disorder-treatment/>

drying up of the salivary glands, imbalance or dangerously low levels of essential minerals in the body, increased risk of heart disease, and problems with other internal organs, severe damage to the stomach, esophagus, teeth, salivary glands and bowel, poor functioning of the body: specifically the brain, heart, liver and kidneys, difficulty conceiving, infertility, osteoporosis (brittle bones), restricted growth, high blood pressure, high cholesterol, Obesity, diabetes. Research into recovery rates by condition suggests that around 46% of anorexia patients fully recover, 33% improve in their condition and 20% remain chronically ill. Similar research into bulimia suggests that 45% make a full recovery, 27% improve considerably and 23% remain chronically unwell. Individuals with eating disorders have significantly elevated mortality rates, with the highest rates occurring in those with Anorexia Nervosa (AN). The mortality rates for Bulimia Nervosa (BN) and Eating Disorders Not Otherwise Stated (EDNOS) are similar. Studies have found age at assessment to be a significant predictor of mortality for patients with AN⁶. Eating disorders have the highest mortality rates among psychiatric disorders. Anorexia Nervosa has the highest mortality rate of any psychiatric disorder in adolescence⁷. The overall mortality in long-term studies of Eating Disorders ranges from 0–21 per cent from a combination of physical complications and suicide. The all-cause standardised mortality ratio for anorexia nervosa has been estimated at 9.6 (Nielsen 2001) which is three times higher than other psychiatric illnesses.⁸ In AN, excess mortality is explained in part by the physical complications and in part by an increased rate of suicide.

6. Does evidence suggest that suffering from an eating disorder increases an individual's risk of suicide and attempted suicide?

Yes there is significant evidence to suggest the eating disorders and suicide ideation or risk of suicide are related. Across studies, approximately 20% to 40% of deaths for Anorexia Nervosa are thought to result from suicide. Individuals with eating disorders have significantly elevated mortality rates, with the highest rates occurring in those with Anorexia Nervosa. Depressed mood is a common feature, partly because of these adverse consequences and also because of the distressing nature of the central symptoms of these disorders. The adverse physical consequences of dieting,

⁶ <http://archpsyc.jamanetwork.com/article.aspx?articleid=1107207#RESULTS>

⁷ Arcelus J, Mitchell AJ, Wales J. et al, "Mortality Rates in Patients with Anorexia Nervosa and Other Eating Disorders: A Meta Analysis of 36 Studies." Arch Gen Psychiatry 2011, 68: 724-31. Sonnevville K, Micali N et al., "Common Eating Disorders Predictive of Adverse Outcomes are Missed by the DSM-IV and DSM-5 Classifications." Paediatrics 2012; 130:e289-95

⁸ NICE Guidelines 2004 page 7. "Eating Disorders Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa, and Related Eating Disorders"

weight loss and purging behaviours are can sometimes prove fatal

7. What work is taking place to improve data on eating disorder prevalence and can we have a timescale as to when up-to-date data for England and for the local area will be published?

Overall research is continuing globally and there are specific research hubs within the UK, such as those at Kings College Hospital Eating Disorders Research Group⁹ and internationally, the Academy for Eating Disorder Research¹⁰ and UK Mental Health Research Network¹¹ that have a focus on improving analysis of data and assessing prevalence rates. The introduction of a national Mental Health Services Data Set (MHSDS) requirement for the NHS in January 2016¹² will significantly improve the responsiveness of data sets addressing CAMHS conditions including Eating Disorders local data collection of the MHSDS will commence on 1st April 2016. Central data submission will commence at the end of May 2016. From July 2017 extracts from this data set will be available for review. A fuller picture of Barnet Prevalence rates will emerge from that point and be robust after a full year data has been examined at some point in 2017. In tandem with this the 2004 NICE guidance is under review with a new guideline for Eating Disorders scheduled for publication in 2017. It is anticipated that the guidance will have a fully updated section on prevalence morbidity and mortality data.

8. How important is early diagnosis in patient outcomes and what factors would assist early and correct diagnosis?

Early identification for Eating Disorders as for other conditions is clearly desirable. Given that evidence based therapies are available and that they are successful in meeting the needs of CYP affected by Eating disorders, and given the complexity and high levels of morbidity and mortality inherent in the field, there are clear advantages to addressing the mental health issues manifesting through Eating Disorders. Early access to specialist diagnosis and advice is difficult to encourage in Primary Care settings given that patients may be slow to self-present and many remain undetected for a significant period.

Royal Free Hospital Eating Disorder Service-Waiting Times

⁹ <http://www.kcl.ac.uk/ioppn/depts/pm/research/eatingdisorders/index.aspx>

¹⁰ <http://www.aedweb.org/>

¹¹ <http://www.mhrn.info>

¹² <http://www.hscic.gov.uk/mhsds>

CCG	Waiting Times to first face to face contact (weeks)	Number of patients	Percentage of patients
Barnet	0 - 3	28	48.2%
	4 - 6	25	43.1%
	7 - 9	3	5.2%
	10 - 12	2	3.4%
	13 – 18	0	0%
	18+	0	0%

To improve early identification and reduce waiting times for treatment Barnet is directing an additional £100k of Transformation Funding to Eating Disorders per-year 2015.16-2019.20. The target is to have 90% of young people seen within 4 weeks by 1st April 2018 and urgent cases under 1 week. High-risk groups within the general CYP population will be targeted for prevention support. A Public Health orientated approach that addressed the cultural issues among young people, encouraged self-efficacy support and access to help at an earlier stage would be of significant benefit within the wider School or community context. To this end the CCG CAMHS lead and Public Health are working jointly to develop programmes with professionals, targeted cohorts and the wider community.

Targeted groups will include young women 11 yrs+, patients with a low or high BMI, adolescents consulting with weight concerns, menstrual disturbances or amenorrhoea, gastrointestinal disorders and psychological problems. Screening tools and simple questionnaires can be used for such high-risk groups. Questionnaires of this type may have a role for screening in very high-risk groups in special settings, e.g. in ballet schools, fitness and sports facilities. In addition there is a need to roll out prevention work across primary school age groups.

They may have occasional application in general practice, when a CYP with a probable eating disorder has already been identified. Identification of clinical presentations should also be noted for example, adolescent girls with concerns about weight, and young women consulting with menstrual disturbances, gastrointestinal or psychological symptoms.

The role of school nursing services in supporting school environments deliver healthy weight and wellbeing strategies would be essential here to augment CAMHS services within schools.

Best practice suggests most important factor in the identification of eating disorders in generalist settings is for the practitioner to consider the possibility of an eating disorder and to be prepared to inquire further in an empathic and non-judgmental manner.