

Eating Disorders Services

A Hull LINK Report on Patients' Experiences of Local Services



October 2010

	Page
Introduction	4
Local Services	7
Our Survey	15
Local Experiences	19
Service User Feedback	26
Conclusions	29
Recommendations	32
Next Steps & Acknowledgements	33

What is Hull LINK (Local Involvement Network)?

Hull LINK is an independent network of local people and groups which has legal powers to examine health and social care services. Since 2008 LINKs have been set up across the country to give people more say in how these services are planned and run.

Our role is to find out what people think of local health and care services and enable them to suggest improvements. We can investigate areas of concern, make recommendations to services and get a response. We can also carry out spot checks, when necessary and under safeguards, to see if services are working well.

Background – Why Eating Disorder Services?

In October 2009, Hull LINK hosted a forum named 'Low Flying Heroes'. The aim of this event was to reach the local groups that support people with social care and health related conditions, and provide them with a platform to put forward the issues they would like to see the LINK adopt within its future workplan. Eating disorder services was suggested as an issue for consideration, with the concern being a lack of specialist services available locally.

Based on national prevalence rates (see overleaf in the National Perspective), approximately 7000 people should be presenting with an eating disorder locally. NHS Hull have recognised that there is a shortfall locally between those needing a service and those accessing a service and as a result are in the process of producing a tender for the expansion of the local Eating Disorder Advice and Consultation service in Hull. Due to the issues raised and the proposed changed to local services, it is for this reason that Hull LINK's Steering Group decided that eating disorder services would be a relevant issue for the LINK to examine.

Eating Disorders – The National Perspective

Eating disorders are serious psychological illnesses that can have a severe impact on both a person's physical and mental health. In the UK, eating disorders affect 1.6 million* people with anorexia nervosa being the leading cause of mental health related deaths. Young women in the 12-25 age group are most at risk of developing an eating disorder, however anyone regardless of age, gender or culture can develop this type of illness. On the surface, eating disorders appear to be about food, and often a negative body image and low self-esteem are commonly attributed to causing eating disorders. However, there are usually much more complex, unresolved issues underneath. Beat, an independent UK charity for carers and sufferers of eating disorders, states that it is unlikely that an eating disorder will result from a single cause but rather a combination of factors and events that can include relationship issues, a traumatic event, problems at work, a lack of confidence, a long term illness, or learned attitudes towards food. Controlling food intake through overeating or under eating is used as a coping mechanism for feelings such as stress, anxiety, depression, sadness, anger or other challenging emotions. Beat state that people with eating disorders often say that the eating disorder is the only way they feel they can stay in control of their life, but as time goes on it isn't really the person who is in control, it is the eating disorder.

The direct costs of treating an eating disorder can be vast, ranging from £25,000 per patient for 12 weeks of specialist in-patient NHS treatment, or up to £45,000 per patient for the same period in a private in-patient unit. Due to the lack of specialist services in the UK, some sufferers may receive treatment from general facilities and as a result may return for repeated periods of costly treatment before recovery begins. There are also a number of hidden costs associated with eating disorders. As the average duration of an eating disorder is 6 years, this can have a detrimental impact on the sufferers ability to fulfill their educational or career aspirations, and also it can have an emotionally draining influence on the carers, many of whom have given up their careers to look after a loved one with an eating disorder.

The most common forms of eating disorder are anorexia nervosa, bulimia nervosa, binge eating disorder and A-typical eating disorder, each of which having potentially devastating consequences for both the sufferer and their families:

Anorexia Nervosa

People with anorexia are often very anxious about their weight and keep it as low as possible by strictly controlling and restricting what they eat. They may exercise excessively to burn off what they perceive to be excess calories, and even when they become extremely underweight, they still feel compelled to lose more weight. Purging behaviours such as self-induced vomiting, the misuse of diet pills or laxatives may also be employed. A focus on food can be an attempt to cope with life and demonstrate that they are in control of their body. Ultimately however, chemical changes in the body affect the brain which leads to distorted thinking and an inability to make rational decisions about food. The physical effects of anorexia can include constipation and abdominal pains, poor circulation and feeling cold, loss of periods in females, and a loss of bone mass. In the long term, physical side effects may also include osteoporosis, an impaired immune system, fertility problems, and damage to bodily organs. In addition, psychological side effects can occur, such as a distorted perception of body shape or weight, denial, mood swings and changes in personality.

*Source: beat™ beating eating disorder

Bulimia Nervosa

Bulimia nervosa is typically characterised by frequent episodes of binge eating followed by purging in the form of vomiting or taking laxatives. The person may also starve themselves or exercise excessively in an attempt not to gain weight. Bulimia can often be more difficult for others to notice as weight loss is not so dramatic. As with anorexia, people who develop bulimia become reliant on the control of food as a way of coping with emotional difficulties in their life. Physical effects of bulimia can include rupture of the stomach, choking, erosion of tooth enamel, and painful swallowing and drying up of salivary glands. Again, psychological side effects can occur such as a distorted perception of body shape or weight, mood swings, anxiety, depression and a low self-esteem.

Binge Eating Disorder (BED)

Binge Eating Disorder shares some of the characteristics of bulimia, but the main difference being that the person binges uncontrollably but does not purge. A person suffering from this type of disorder will have regular periods of excessive eating during which they have a feeling of no control over how much they are eating and will continue to eat until they are uncomfortably full. This is then often followed by feelings of shame and guilt. Due to the amount of food eaten, many sufferers can become obese, leading to problems with blood pressure, heart disease and a general lack of fitness.

A-typical Eating Disorder or Eating Disorder Not Otherwise Specified (EDNOS)

These disorders are where the person is demonstrating issues with eating, but does not have all the diagnostic signs for anorexia or bulimia. Behaviours may include calorie restriction, purging, binge eating, and excessive exercise. If these activities are performed with any regularity, they may have the same potential health implications as anorexia or bulimia. Examples of such conditions may include those that have underlying issues with food that may become thinner by restricting calories but still have a menstrual cycle present; or those that have underlying issues with food who may have had binge eating episodes or have lost weight through restricting calories, but have a weight that is considered normal but an absent menstrual cycle.

Our Investigation – What did we do?

For the purposes of this investigation, we worked closely with S.E.E.D., the local support group for people with eating disorders (see page 6 for more details of services). Due to the nature of eating disorders and the related difficulty sufferers and carers can have in talking about their condition, members of S.E.E.D. were invited to come forward informally to talk about their experiences. One to one interviews were conducted with those that were happy to be interviewed, and others emailed their experiences to the LINK team. To make sharing experiences easier, and to also capture the experiences of those that may not be affiliated to S.E.E.D., a survey was also conducted. This survey was sent to all S.E.E.D. members and was promoted to the entire LINK membership via the LINK newsletter and website. In addition the survey was distributed to local colleges and universities and was made available at all public events and visits the LINK attended which was in the region of 50 events during this engagement period. We also met with local organisations, counsellors and service providers to gain a greater picture of the services provided locally and to develop a further insight in to the issues service users face.

Background Research

The provision of eating disorder services locally has gone through a number of changes in recent months and years, and further changes that impact on how eating disorder services are delivered are continuing to be implemented. We therefore met with all local service providers to determine how at this present time services are being delivered, and to gain an insight into any changes that are being planned.

S.E.E.D. Eating Disorder Support Service

SE.E.D. Eating Disorder Support Service raises awareness of eating disorders and offers support to sufferers and carers in the Hull and East Yorkshire area. The service is self-funded but receives a small contribution from NHS Hull to cover core costs. The service works with the City Healthcare Partnership Eating Disorder Advice and Consultation Team to improve service provision, and also they are working in partnership with NHS East Riding to provide an online resource for carers called 'Anorexia on Line'. In addition to this, S.E.E.D. also provide a number of other services including; a monthly support group for both sufferers and carers; a monthly self help group for sufferers only that concentrates on motivational work and confidence building; a telephone and email buddy scheme that provides support to sufferers who may not want to attend a group or are having difficulties accessing appropriate services; access to a nutrition and well being advisor; quarterly 'Walking on Eggshells' workshops aimed at enhancing support skills for carers; a social club that meets on a monthly basis; and an information and advice service supplied via a telephone helpline and website. In addition, S.E.E.D. raises awareness within schools, colleges and universities and provides training and awareness for healthcare professionals. They are also working in partnership with Hull University to provide a monthly health and wellbeing drop-in service that covers eating disorders.

Eating Disorder Advice and Consultation Service

This service, which is provided by City Healthcare Partnership CIC, was introduced at the end of 2008 to provide advice and consultation services to professionals working with people with eating disorders. The philosophy of the service is to support a range of professionals in delivering the best evidence-based interventions to clients experiencing eating disorders. The team consists of a multi-disciplinary mix of nurses, an occupational therapist, a dietician and administrative staff. The aim of this multi-disciplinary approach is to improve and embed best practice in the management of eating disorders within primary, secondary and tertiary services.

The team do not provide direct treatment to sufferers, but work alongside professionals that do. Such support includes assisting in assessments and identifying appropriate services outside the Hull area for those that have needs that local services cannot meet. For those placed in specialist out of area treatment units (the most commonly used being located in London, Stafford and York), the team case manage their care on behalf of the PCT and ensure plans are in place for clients to continue receiving support from local services when they are discharged.

In providing advice and consultation, the team have been working proactively to build capacity of skills within local services. This has included the provision and development of:

- a screening tool for GP practices to help identify eating disorders in patients.
- a comprehensive eating disorder assessment and physical risk assessment tool for use by the Single Point of Access service. These tools have been developed based on NICE guidelines and provides clinicians with information on what questions to ask patients, the rationale behind these questions, advice to give patients, and what information they need to obtain from GPs (i.e. blood test results, etc).

In addition to this, the team has also conducted a number of research and training initiatives to improve local eating disorder services. The team have:

- facilitated body image training with clinicians from City Healthcare Partnership and Humber Foundation Trust.
- delivered a series of training sessions for staff in children's homes.
- undertaken a pilot for consultation clinics in secondary care.
- designed and conducted a Link Worker training programme with clinicians working in adult services. The aim of this training has been to provide clinicians with the knowledge, skills and resources to effectively become a resource themselves to cascade information out to their teams with an aim to create a network of knowledge.
- undertaken a pilot for a 'teen clinic'.

Over the last two years since the service formed, the team have been able to identify a number of gaps in local services where interventions are felt to be insufficient for the needs of this client group. These include the need for more G.P training, improved risk assessment and monitoring, and increased specialist interventions specifically for clients with eating disorders. The team have also reported voids in the following areas:

- service provision for those clients for whom weekly outpatient therapy is insufficient but in-patient services are too much.
- intensive treatment services for children and adolescents based in the community.
- intensive home treatment for chronic adult sufferers. These clients invariably become 'revolving door' in-patients to expensive specialist treatment units, who on discharge back to the community are unable to sustain their progress and gradually deteriorate until readmission is essential.

To meet the needs of those that fall between services or those that require more intensive support, the team believe that a day patient service would be highly appropriate.

The team are keen to develop specialised intervention services to fill the above voids and are currently looking to expand and work in partnership with local organisations to develop a spectrum of services for sufferers of eating disorders.

Single Point of Access (SPA)

The Single Point of Access service has been established to manage access to all adult mental health services in Hull. The service is responsible for the initial screening, assessment and triage to ensure that the user has access to the right part of the service for their needs. Referrals to the services are largely made by GPs, or people can self refer. With regard to eating disorders, how a patient is assessed and triaged varies depending on the severity of the condition, but in general the process is as follows:

Screening:

Upon receiving the initial referral, the SPA team will assess the information to ensure sufficient details have been provided. If there is not enough information, the SPA team will go back to the referrer to get the additional details required. They will also contact the person that has been referred to ensure they are aware a referral has been made.

Assessment:

In a small number of cases, where the eating disorder is relatively well controlled and usually in the early stages, a face to face assessment may not be needed. In these cases, the person may be referred on to S.E.E.D. to obtain self-help and support, or if more intervention is required they will be referred to low intensity IAPT (Improved Access to Psychological Treatment) which is provided by the City Healthcare Partnership (CHP). Here the person will have access to emotional eating motivational groups and will receive guided self help in the form of talking therapies. For the majority of referrals of an eating disorder, the patient will be offered a face to face assessment. A SPA assessment usually lasts for around one hour and is conducted by a qualified clinician who takes a full mental health history in order to get a rounded understanding of the problems being experienced and of the issues that are contributing to the problems. For more severe or complex cases, a person may be invited back for a structured eating disorder assessment or a joint assessment with the Eating Disorder Advice and Consultation Team.

Triage:

Where the person is triaged to is very dependent on the individual, the severity of the condition, the person's Body Mass Index (BMI) and the risks imposed. Onward referral pathways may include:

- S.E.E.D. (for support and self help)
- IAPT (for low intensity support such as one to one talking interventions)
- Community Mental Health Team (for support such as occupational therapy, psychotherapy, psychiatry, or support from Community Psychiatric Nurses and Social Workers)
- Acute setting (for stabilisation of physical affects of the condition)
- Mental health setting (for cases that require more intense support)
- Out of Area Specialist Eating Disorder unit (for complex cases that require more intense support)

Treatment and Intervention:

As the nature of eating disorders are complex with sufferers having individual needs and underlying issues, there is not a 'one size fits all' package of treatment. Some sufferers may engage and disengage in services or they may not feel ready to proceed with treatment and may disengage and return at a later date. Some sufferers may have co-existing conditions that have greater immediate risks that need addressing, or there may also be some sufferers that

do not have the ability to engage due to their BMI level. A BMI of 15 is generally used as a benchmark to determine if a person is able to engage in psychological intervention, as those with a BMI lower than this are regarded as having more immediate physical symptoms that require addressing first. SPA however recognise that a person's treatment cannot be judged on BMI alone and so now take a flexible approach to a person's BMI, taking into account any other positive factors that may indicate a person's ability to engage. Overall therefore, the treatment or intervention that is required is dependent on a range of factors including risk, other issues and how much a person is willing and able to engage in treatment at a period in time. Therefore over a course of treatment, the need for and types of intervention will be reviewed, with a view to changing intervention when the person feels ready, or ceasing intervention if it is no longer needed.

The length of the treatment offered also can vary depending on the type of treatment or intervention, and on the severity and how engaged people are. Some interventions have longer waiting lists than others, with access to a psychologist being one of the longest waits. A sufferer will not however be left without help and so will be offered sessions of support by SPA during this time.



Child and Adolescent Mental Health Services (CAHMS)

For children and adolescents, a separate service operates for referring young people in to services. Referrals for young people are made to the Primary Mental Health Team which works in the community. Each worker is able to make referrals for any type of mental health condition, and all workers receive regular training in the identification of eating disorders (the most recent refresher was provided to workers in August 2010).

If an eating disorder is identified in a young person, the Primary Mental Health Workers will make a referral on to the Core Team who will then conduct an assessment. This assessment is made using a risk assessment tool that has been created based on NICE guidelines and helps indicate the level of need. If during this assessment an eating disorder is confirmed, just like adult services, a number of routes could be taken. These may include:

- Admission to Tier 4 services as either an out-patient or an in-patient
- Admission to an acute hospital if physically unwell

To meet the needs of those that require a stay in an acute hospital, a new role has now been developed by CAHMS, whose purpose is to go in to wards and offer advice where it is needed and to also provide a liaison service if the ward needs help or support. Therapy may also be offered to the young person, depending on their ability to cope or respond to it.

If upon discharge from hospital the young person is physically well but is in need of mental health support, they will be admitted to Tier 4 services. For those that require in-patient care within Tier 4 services, a package of intensive support is provided that includes:

- Residential care service.
- One to one observations.
- Maudsley model of family therapy.¹
- Individual therapy which may include CBT, play therapy, attachment work.
- Group work.
- Bed rest where deemed necessary.
- School services to encourage re-engagement into education and support for returning to school.
- Care programme approach that continues after discharge from the unit.
- Weekly reviews with the patient and 6-weekly reviews with parents.
- System for capturing patient experience upon initial assessment, admission, and at discharge.
- Monthly forum for patients and annual forums for patients to share feedback.

The length of an in-patient stay for eating disorder sufferers used to be around 9 months to one year. Due to the implementation of a more intense package of support, this has now been reduced to 4 to 6 months.

¹ The Maudsley Model is a model developed by a team of child and adolescent psychologists and psychiatrists from the Maudsley Hospital in London. The model works on the belief that recovery will be more effective if disruption to an adolescent's family, social and education life, caused by in-patient admissions, are minimised. Reducing in-patient admissions is achieved by assisting the parents to play an active role in helping their child in their recovery.

Currently, this service is only a 5 day service, meaning that the young person is required to return home on weekends. For care over the weekend, CAHMS will liaise with the parents and will develop a contract for care over the weekend. If a person's needs escalate to the point where they need a 7 day service, CAHMS then have to liaise with commissioners for funding to place the person in an out of area service that can offer a 7 day service. Currently, Affinity Healthcare in Cheadle is used to provide this service, and they are able to offer an intensive in-patient eating disorder service, as well as specialist day care and out-patient services. The Trust now has clearer guidelines on the point when a person is deemed as needing 7 day care, and also greater measures are now being taken to ensure that a young person's discharge plans are determined prior to them leaving the out of area service. Upon leaving the out of area service, depending on the young person's needs, they will either be referred back to local Tier 4 in-patient services, or in to local community care.

In addition to those changes already discussed, CAHMS, in conjunction with the City Healthcare Partnership and other local services, are undertaking a number of measures to improve local eating disorder services. These include:

- Training has been conducted with school nurses and other professionals that work with young people to help them identify eating disorders, and these people can access the Primary Mental Health Workers for further advice if they need it. Trends have also been monitored to identify the areas of the city that have the highest prevalence rates of eating disorders, which has allowed for schools in those areas to be specifically targeted.
- A master class on eating disorders has been held for people to find out more about the condition.
- Work has been conducted with GP Practices to help raise their awareness of eating disorders and a date has now been secured to deliver information and updates on eating disorders at a GP PTL (Protected Time for Learning) day.
- For both parents and young people that have been referred in to services, an 8 week course has been established which is delivered by two professionals that have completed training in the Maudsley model.
- Work has been conducted looking at the nutritional value of foods which has informed the menus at in-patient units.
- A training programme is being developed to enable shared learning between community services when working with eating disorder sufferers.
- With a view to presenting a case for a 7 day residential service to be available locally, research has been conducted looking at the number of people that have been placed out of area and how many could have been managed locally if a 7 day service had been available.
- The waiting time for CAHMS services has been reduced from 58 weeks to 11 weeks, which is now within the government guidance of 18 weeks. Like in SPA services, the area where there may be longer waiting times is if there is need for a specific intervention such as psychotherapy. Again, during this wait the person will not be left without help and other support will be provided.
- A skills escalator, for people working with eating disorders, is being developed to determine the current skills base and identify where further training is needed.
- Improvements have been made to local Tier 4 accommodation.

Other Local Services - Planned changes

Care Clusters

Humber Foundation Trust are currently in the process of moving to the Care Cluster model which provides a framework of assessment, planned interventions, discharge and evaluation. Within the model there are 21 diagnostic categories based on levels of need, grouping people with similar characteristics together in a clinically meaningful way. As service users within each cluster are relatively similar in their care needs, the resources they require will also be similar. A standardised care package has therefore been developed for each cluster that describes the care required to meet the needs of people in that cluster. Services users will be allocated to Care Clusters following an assessment by a Mental Health Professional who will use a scoring tool and their clinical judgment to determine which cluster is the most appropriate. Broad diagnostic and historical information is then used to identify individual needs within the care packages. The care cluster the person is allocated to is then reassessed during formal reviews and on the occurrence of any unplanned changes e.g. urgent hospital admissions. The aim of the model is to provide a person centred approach, providing a comprehensive range of evidence based interventions, giving people choice based on their individual needs and enabling them to move between clusters depending on how their needs change.

A change as a result of this model will be to the Community Mental Health Teams. Currently there are 4 geographical teams that deal with caseloads of all conditions. On the implementation of the new model, this will change to 6 teams, 3 of which will handle complex psychotic illnesses and 3 teams will handle conditions needing psychological interventions. This will allow each team to have more specialist knowledge that is matched to the users they are working with, and will also allow for a broader range of interventions that can be offered to the service users. With regard to eating disorders, this new model will provide more defined pathways for the different levels of severity of the conditions, whilst also providing the sufferer with more choice from a broader range of interventions.

Mental Health Acute Strategy

Humber Foundation Trust, in conjunction with the Hull & East Yorkshire Hospital Trust and also the PCTs and Councils from both Hull and East Riding, are currently in the process of developing a mental health strategy for the acute hospital trust. The key aspects of this strategy that relate to eating disorders are that firstly all clinical and non-clinical acute hospital staff will have a baseline knowledge of mental health, including better knowledge of the relationship between mental and physical health, enabling them to better recognise and react appropriately to people presenting with mental health conditions. Secondly it will provide a single point of access system so that those presenting with a mental health condition in an acute setting can be referred on to appropriate mental health services in a quick and easy way. These changes will enable both physical and mental health issues to be addressed when they are needed, with care pathways being in place for ongoing emotional support if required upon discharge from the acute setting. This greater supply of information will also enable patients to make more informed choices of their ongoing care and treatment.

Out of Area Services

For more severe or complex cases, a patient may be referred to a specialist service outside of the local area to receive more intensive treatment that local services cannot currently provide. Such services often offer a seven day service and a stepped care approach with a range of treatment programmes including in-patient services, day care services and out-patient services. The patient will have access to a multidisciplinary team and may receive the following levels of treatment and support:

- In-Patient Services:** For patients with a very low body weight. Services may involve a period of intensive psychological and medical assessment to achieve physical stabilisation, combined with bed rest and nasogastric re-feeding.
- Day Care Services:** This service is for those that have been discharged from in-patient treatment but still require ongoing support, or for those suffering a relapse and need preventative measures to limit the extent of their relapse. Services at this stage may include physical monitoring, meal support, nutritional advice as well as psychological interventions.
- Out-Patient Services:** This service is for patients that do not have the need for in-patient or day services, or for patients that have progressed from the more intensive services. Patients can reside at home whilst still receiving ongoing support such as group or one-to-one therapy via out-patient clinics.

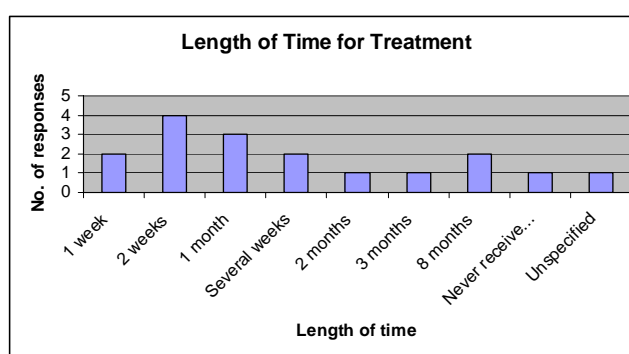
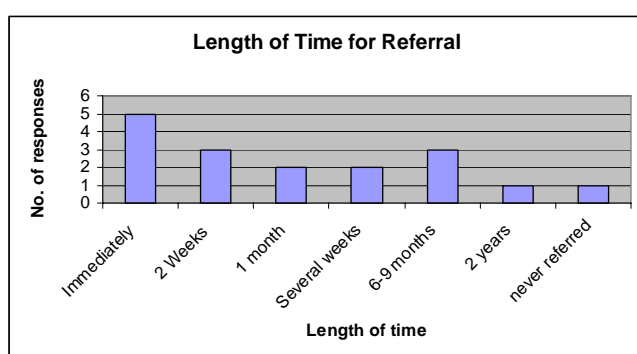
In recent years, sufferers from Hull have been referred on to centres in London, Cheadle Sheffield, York, and Leeds, with the average cost per person being £500 per day. Generally, an in-patient stay at a specialist centre will last around 3 to 6 months, however there have been instances of a person's stay lasting as long as 15 to 18 months.

Feedback from surveys

A total of 17 people completed our survey, with an additional 15 people coming forward directly to share their experiences. All respondents were female, with the majority being aged 16 to 29. There was however a small response from those aged between 30 and 49. With regard to how recent people’s experiences were, this was quite varied.

Diagnosis

When asked how long they had been suffering with their condition before being diagnosed, people gave quite a wide response, ranging from 2 months to 6 years, and some stating as long as 20-plus years. In the majority of cases, people stated that they had been diagnosed by their GP; with others stating that they had been diagnosed by their school nurse or by a psychiatrist. Overall, with regards to referral and treatment, people reported a mixed response in terms of the length of time they had to wait and the care pathway they were provided with. Whilst some people received either an immediate or a short wait for a referral followed by a short wait for treatment (within 2 weeks), there were however some people that reported they had to wait up to 8 months before actually receiving the service they had been referred to.

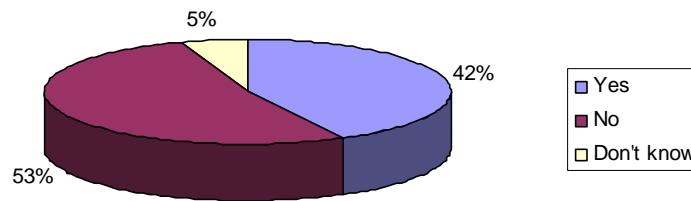


We also asked if any information was provided to them upon initial diagnosis. Quite interestingly it was those that had to wait several weeks or months that did receive some initial interim guidance, whereas it was those that had only a short wait for a referral that did not receive any initial information.

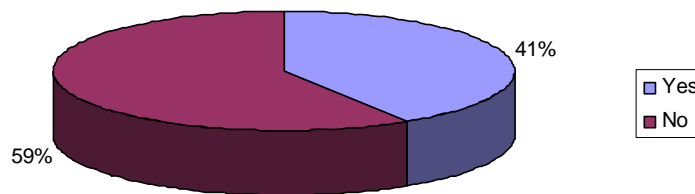
Treatment

We also asked respondents a number of questions about the treatment they received, including whether they thought the treatment they received was appropriate, if they felt they had been provided with enough treatment and if their condition has improved with the treatment received.

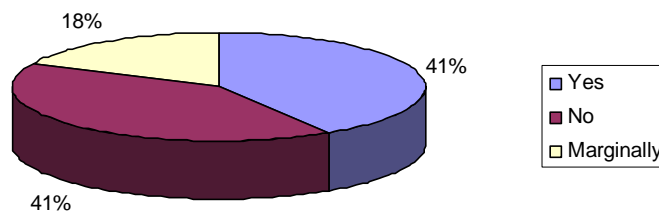
Do you feel the treatment received was appropriate?



Do you feel you have been provided with enough treatment?



Has your condition improved with the treatment received?



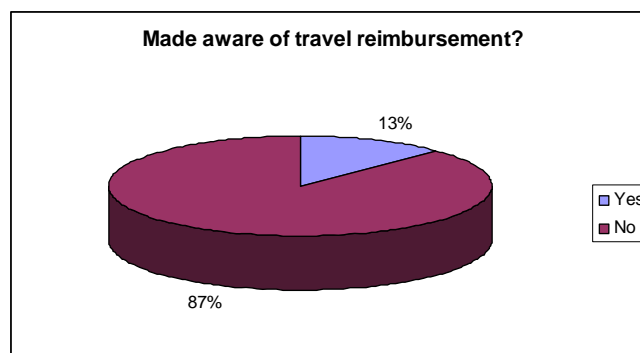
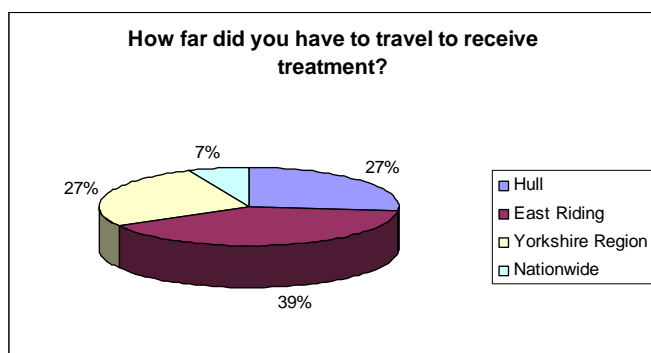
When asked if there was any other treatment people would have liked to have received, responses included:

- Cooking/meal planning advice
- Access to a dietician
- Body Image training
- Self-esteem training
- More general information about condition
- More support with physical symptoms

We also asked if people had ever been refused treatment. For those that had, the reasons given included:

- BMI under 16
- Told no longer needed help due to BMI no longer being dangerously low

With regard to the distances sufferers had to travel to receive treatment, a significant proportion of those that had to travel outside of the Hull and East Riding area were not made aware of any travel reimbursement they were entitled to.



Acute Hospital and Specialist Unit admissions

Eight respondents to our survey stated that they had been admitted to a general hospital in the last three years. Seven of these people responded that during their stay they received contact with specialist services (these being CAHMS and the Crisis Resolution Team), and one person responded that they had no contact at all with specialist services. When asked which support services they were referred on to following discharge to hospital, only three were referred to specialist services.

With regard to specialist unit admissions, four respondents stated that they had been referred as an in-patient at the Yorkshire Centre for Eating Disorders in Leeds. Three of these respondents stated that they were referred back in to local services following discharge from this unit, and one respondent stated that upon discharge they were informed that all previous provision of support had been withdrawn as it was not normal practice to engage in services locally following in-patient out of area treatment.

Support Services

Respondents were also asked to rate how helpful they found the support services provided to them. The following chart outlines the number of responses for each rating:

Very Helpful		Satisfactory		Not helpful		Service not used	
Service		Service		Service		Service	
Antidepressants	2	Antidepressants	2	Antidepressants	4	Antidepressants	9
CAHMS	1	CAHMS	0	CAHMS	5	CAHMS	11
CMHT	1	CMHT	5	CMHT	5	CMHT	6
Counselling	2	Counselling	0	Counselling	4	Counselling	11
CPN	3	CPN	0	CPN	8	CPN	6
Dietician	2	Dietician	3	Dietician	3	Dietician	9
Email/telephone buddy	4	Email/telephone buddy	1	Email/telephone buddy	0	Email/telephone buddy	12
Family Therapy	2	Family Therapy	1	Family Therapy	5	Family Therapy	9
GP	7	GP	7	GP	1	GP	2
Practice Nurse	2	Practice Nurse	3	Practice Nurse	3	Practice Nurse	9
Private Counselling	1	Private Counselling	2	Private Counselling	0	Private Counselling	14
Psychology	1	Psychology	4	Psychology	4	Psychology	8
Psychotherapy	2	Psychotherapy	1	Psychotherapy	4	Psychotherapy	10
Self help/support group	10	Self help/support group	1	Self help/support group	1	Self help/support group	5
SPA	0	SPA	0	SPA	5	SPA	12
Specialist unit in-patient	3	Specialist unit in-patient	2	Specialist unit in-patient	2	Specialist unit in-patient	10
Specialist unit out-patient	1	Specialist unit out-patient	3	Specialist unit out-patient	4	Specialist unit out-patient	9

Service User Experiences

During the interviews we conducted and as part of our survey, people were given the opportunity to talk more specifically about their experiences. These experiences related to various aspects of the service which we have grouped as follows:

- Knowledge among health professionals
- Waiting time for referrals
- Assessments and diagnosis criteria
- Acute hospital services for children and adolescents
- Transition
- Out of area services and handover with local services
- Continuity of services and discharge from services

Knowledge among Health Professionals

One of the recurring themes that emerged from the interviews we conducted was people expressing the need for health professionals to have a greater understanding of eating disorders and the options for treatment. With regard to GPs, some people felt that not enough was being done to detect the condition in the early stages. Others reported that they found their GP to be helpful in identifying the problem, but on many occasions the GP did not know where or how to go about referring people on for further help. There were some people that reported failings on the part of their GP and spoke of the distress they felt from overcoming the barrier of accepting they had a problem to only then be told that they did not have a problem or there was nothing that could be done for them. Some of the people we spoke to that had more complex conditions spoke of barriers they sometimes faced in being able to have their general observations regularly monitored by their GP. With regard to mental health services, many of the people we spoke to felt that they would have benefitted from having access to a practitioner with specialist knowledge in eating disorders, as opposed to having solely generic support.

“GP's to be more informed and sympathetic. One GP we saw very unsympathetic.”

“I wish doctors had better mental health training. My first doctor told me to just start eating more and that I did not need to look like Kate Moss!”

“I strongly believe there is a complete lack of psychologists who have knowledge of eating disorders. After 18 months, I still haven't found one.”

“The psychiatrist was not a specialist and I had to explain some things to him. Then I received nothing further.”

“Frankly the medical and psychiatric services locally were worse than useless, allowing my daughter to believe that she did not have an eating disorder and did not need to change her behaviour.”

Waiting Times for Referrals

Another key concern that was raised by many was in respect to having to wait a long time to be referred onto a specialist service once diagnosed. Many people we spoke to again attributed these long delays to GPs not knowing where to refer people to.

“I self-referred to my GP, whose initial response although positive was that he did not know anything about eating disorders, but that he would try to find out. I had to ring the surgery on a number of occasions, and explain my issue to the receptionist each time. Eventually I received a letter asking me to attend Miranda House for an assessment. I spoke with a psychiatrist there who agreed that I probably had an issue and that he would look at referring me to a specialist service. I heard nothing more.”

“Local services and waiting lists are appalling. (You are) indirectly more ill due to the length of time waiting to be assessed.”

“I feel that I was forgotten by services, I had to chase my GP for a referral for a psychological assessment.”

“Despite still having issues, I have not received any further contact from the NHS in respect of this, and I do not at present intend to chase any further.”

“Given the nature of eating disorders it was very very difficult for me to self-refer to my GP, even harder for me to keep trying to chase up the referral. I felt that I no longer wanted to pursue chasing people up.”

Assessments & Diagnosis Criteria

A number of people reported inconsistencies in terms of assessments. Many people felt that the criteria used did not always necessarily identify the eating disorder, particularly when there were many symptoms present but no significant change in their BMI.

“One thing I have found with the service is the inconsistencies that arise if you happen to get a different assessor. Also in my case that assessor blocked a reassessment. That should not be allowed to happen, so are there safeguards to prevent that happening to someone else?”

“I received a second SPA assessment, which was only granted after a formal complaint was lodged regarding the initial assessors conduct. He ignored the fact I had not eaten for 10 days and was under 7 stone (BMI below 15). He refused entry of a chaperone and for a year blocked attempts by dieticians, GPs and myself to get a reassessment.”

The whole system is illogical, inconsistent and too fixated on the checklist of physical symptoms. I personally have always been naturally 2 stone underweight, therefore I never lost a significant amount of weight. I also was on the pill so couldn't not have periods, another box I couldn't tick, which equaled a diagnosis of you are fine.”

“At Castle Hill Hospital I was evaluated for over an hour, told to come back in a month only on the return visit to be told I was not ill enough to be helped by them. That was totally devastating as I thought it was finally going to get help and didn't. It left me feeling really traumatised as I had gone by myself; I was so upset I couldn't even get the bus back home. That experience set me back a lot.”

“In my experience as I have always been small and severely underweight, I had not as the tick sheet for eating disorders states lost a large amount of weight. I was on the pill so I had not and could not lose my menstrual function so another one I could not tick, but both my reasons were legitimate and something I could not change so that should not have led to a misdiagnosis. I believe more specialist training in diagnosing eating disorders is required as in my experience the tick sheet for eating disorders is so religiously used, even in cases when some points on it simply can't apply.”

“Often people who binge eat/starve and do not purge get overlooked (due to their BMI seeming normal), until the point at which they are either severely ill / clinically obese / suicidal. Do they even offer support for those individuals?”

Acute Hospital Services for Children and Adolescents

Many parents that we spoke to expressed concerns with the service provided to eating disorder sufferers on the children's ward at Hull Royal Infirmary. Issues raised included a lack of understanding of eating disorders amongst staff, particularly in regard to identifying weight loss tactics a child may undertake. There were also concerns raised over the appropriateness of an acute ward being used for re-feeding measures and there being a lack of contact time on the ward with mental health professionals for support with re-feeding or to address the underlying mental health issues.

“The treatment at Hull Royal Infirmary largely lacked understanding, consistency and psychiatry. They initially restored her essential fluids but nothing was really done to address any re-feeding or wider mental health issues. Within 48 hours she was given a nasal gastric feed. Over the two months she was in hospital she was extremely unhappy and received mixed levels of staff support and understanding.”

“We passionately feel that Ward 130 West needs a regular mental health practitioner to liaise with staff, offer counselling, therapy and re-feeding support without resorting to the nasal tube so readily. They also need a specialist eating disorders dietician and graduated menus suitable for anorexics that are in the early stages of re-feeding.”

“Staff on Hull Royal Infirmary 130 ward need specialist training.”

‘That was totally devastating as I thought it was finally going to get help and didn't. It left me feeling really traumatised as I had gone by myself; I was so upset. That experience set me back a lot.’

Comment from a service user

Transition from Child to Adult Services

The LINK report, 'Mental Health Services for Young People' reported earlier in the year that young people were having problems with the transfer from child to adult services. This was a concern that was raised by some people during this investigation also:

"My daughter was 17 years old when she first became ill and was treated by the adolescent team and made good progress and gained weight. We felt that the service she received was good during an extremely harrowing and traumatic time. However, when she was transferred to adult services within 3 months she had lost all the weight she had struggled to gain. The transition period and hand-over was appalling."

"I am concerned about the services that are provided to me now that I am 18. There are no in-patient clinics that can provide support for someone like me. In this area there is only Hull Royal Infirmary however that doesn't provide help; you just get force fed if you are at a dangerous weight. Sometimes I feel like I have to go down to a deadly weight in order for something to take place for me."

Out of Area Services and Handover with Local Services

Probably the biggest concern that was raised by people is the lack of specialist services available locally and the problems associated with funding and logistics of having to travel out of area. People also raised concerns about their fitness to travel long distances and also the affect that being away from home can have. The expense of having to travel long distances to visit their children was also an issue raised by many parents.

"If there are no in-patient or residential services for the very ill provided locally, how do patients access regional/national centres if required?"

"I can't travel all the way to Leeds to get treated because I would like to be in my own comfort zone and have some of my life at home at the same time."

"It is very important that coordination/handover with local services occurs or else relapse is inevitable."

"Local services, in-patient and out-patient for eating disorders are absolutely dire! Coordinated approach between acute hospital and CAMHS is also appalling. Problems in accessing out of area funding makes the constant unwillingness of local services to refer jeopardises patient treatment. The process is made as difficult and slow as possible in order to deter families from pursuing help they so desperately need."

"Coping with an eating disorder is difficult enough without having to fight for adequate local services. It is very wearying. Sending young sufferers off to clinics far away from home is not always the best option. They become even further removed from their families and ordinary day to day life."

Continuity of Services and Discharge from Services

Some respondents raised concerns with people being discharged from services too soon and there not always being a seamless continuous service:

“I do not believe someone with an eating disorder should ever be discharged and told there is nothing else for them as they had received help last time. The nature of an eating disorder is that there will be relapses and that you can never say never to it happening. I think that should be acknowledged by the 'professionals' and there be a special way back into the services for people with eating disorders. They are too desperate to discharge people as they are overwhelmed with people needing help, but that only shows there is a lack of proper help out there. Discharging people too soon only creates more problems.”

“I was seeing an art therapist (very rarely), and he has now retired. What is the policy regarding transferring a patient to another therapist? I have been left with no support.”

‘They are too desperate to discharge people as they are overwhelmed with people needing help, but that only shows there is a lack of proper help out there. Discharging people too soon only creates more problems.’

Comment from a service user

Feedback from Counselling Services

During our research, a number of workers that provide counselling services within the education and voluntary sectors also came forward to share their views. In total we spoke to eight local counsellors and quite interestingly they each raised similar issues and experiences, stating that as many as one in three people they see have a problem with eating. Most of the counsellors echoed each other in saying that the majority of people they see are female and at the reduced eating of the scale. For this reason, they feel that males are often overlooked, so too are people that are morbidly obese. One counsellor suggested that when it comes to males it seems more 'normal' if a man is underweight as males are generally regarded as being more active or sporty, therefore potential issues may not be being identified. With people who are overweight, she says they tend to just be told about the potential health implications of being overweight and told to diet without considering if these people actually have control over their eating.

Each counsellor highlighted that all too often, finding the underlying cause of the emotional attachment to food is neglected with the focus tending to be on the here and now, so resulting in a series of relapses. Also, the person is often regarded as having control over their eating, however both those that under-eat and those that are overweight do not have control of their actions when it comes to eating.

Many of the counsellors also reported that a lot of the people they see will present with another problem, and as counselling progresses, the eating problem will emerge. Two counsellors had shared experiences of people presenting in this way, and then disengaging from counselling once the eating issues had emerged. They both put this down to the person being in denial about the problem, and stated that this denial can often carry over when they are referred on to more formal services, therefore GPs and services may not pick up on the problem.

With regard to GPs, one counsellor stated many of her clients have been in touch with their GP about their condition but received varying levels of support. Another stated that often people have difficulty in talking to their GP as they do not feel they have formed enough of a relationship to open up.

Concerns were raised about people not knowing where to go to get further information or to get help with their condition. One counsellor stated that someone with an eating disorder may not necessarily know that they can call SPA about their eating disorder and could be put off by having to have an assessment rather than being able to speak to a specialist straight away.

One counsellor we spoke to said that she feels that there is not sufficient support locally and feels she is 'holding' the client until the point that person can get the medical help they need. Due to this lack of local support, she says she is worried that at some point she will have a client that is in need of immediate medical intervention however they will not be taken seriously. Another counsellor stated,

"It feels like hard work to find any support. This is a powerful issue. The ripple effect can be quite huge and can leave professionals quite powerless in knowing what to do."

The counsellors we spoke to made a number of suggestions for improvements to local services including:

- Sufferers to be able to access a full team of support (i.e. therapist, dietician, physical health practitioner, etc) and a team that can be accessed by counsellors also for referral and advice.
- Greater partnership working between statutory services and counselling services to offer clients a wider service.
- More training to be available locally for counsellors that focuses on the practical help they can offer and case studies of where things have helped.
- More publicity about eating disorders, particularly highlighting that men can be affected also.
- Services to be more approachable and accessible so that they do not deter people from engaging.
- GPs to be more aware of eating disorders, both those that under-eat and over-eat, and to be more proactive in identifying conditions and picking up on tell tale signs – i.e. when someone has issues but are covering up the problem.
- More awareness of the issues to help remove the stigma.
- More intervention at an early age and awareness training in schools and colleges to inform pupils about nutrition and how to look after their health and wellbeing.

'It feels like hard work to find any support. This is a powerful issue. The ripple effect can be quite huge and can leave professionals quite powerless in knowing what to do'

Comment from a counsellor

How could services be improved?

People we spoke to also raised a number of suggestions of how services could be improved. Again these fell in to similar themes.

Local Unit with Specialist Services:

The key improvement to local services that people would like to see is a specialist centre or medical team for eating disorders locally. Many people we spoke to had experience of specialist centres from across the country and felt that they would benefit significantly from having something similar locally that both adolescents and adults could access.

“A specialist local in-patient unit along with a one stop shop to include the support group.”

“There needs to be a specialist adolescent eating disorder service within the local area i.e. 40 mile radius. A unit totally dedicated to eating disorders with specially trained staff and consultants who are specialists in eating disorders.”

“There needs to be much more robust patient programme with specialist support.”

“Specialised local in-patient care.”

“Local help like Seacroft in Leeds supplies.”

“Specialist support team to allow sufferers to do more to help themselves.”

“Instead of paying out thousands to treat local patients in Leeds, Sheffield, York etc, why doesn't someone turn the situation on its head by funding a local centre of our own and financing it by outsourcing the facilities to areas without a specialist unit e.g. Lincolnshire.”

“Appoint a consultant with expertise in the treatment of eating disorders and develop liaison with a pediatrician or physician locally to coordinate treatment of the severely physically unwell.”

‘There needs to be much more robust patient programme with specialist support’

Comment from a service user

Better access to treatment and support:

A number of respondents also reported that they would like to see better access to treatment and support. For some this simply means more accessible appointments and the opportunity to talk to someone without their parents being present. Others felt that they would benefit from more clearly defined pathways of care and easier access to specific types of intervention. Access to a dietician was also an area that was reported as severely lacking.

“Local specialist services, easier access to psychotherapy. CPN with greater knowledge.”

“Shorter waiting lists to see a specialist, more access to CBT psychotherapy - counselling often inadequate.”

“Establishment of referral pathways.”

“Clear pathway of treatment that all services are aware of and adhere to.”

“The main changes I think need to happen is making help available to more people.”

“Better access to psychotherapy, more seamless services. Transition from adolescent to adult more streamlined.”

“A weekly appointment for an informal chat to talk about stress and trigger without parents. More accessible appointment times.”

“An advocate allocated to each referral to ensure that services are put in place.”

“Dietician locally specialising in weight gain not loss.”

Partnership Working:

Some of the people we spoke to felt that sometimes services were fragmented and suggested that more partnership working was needed to result in a more seamless service and to prevent physical aspects of the condition from being treated in isolation:

“More community based services where workers help sufferers/carers within their home environment. More liaison between in-patient and community services.”

“More collaborative working across all agencies.”

“More continuity between the services, so maybe a bridging team as an eating disorder is complex. It needs physical and mental services to communicate. In my experience this does not happen.”

“Local CAMHS need to have a specialist eating disorders team who are readily available to offer the support families need on a daily basis in the most difficult days. They must work to marry up physical and mental health services. They must liaise effectively with Ward 130. The therapy offered needs to be consistent, specialised, authoritative and focussed.”

More Information:

As our survey results showed, people received mixed levels of information regarding their condition, and people commented further regarding the need for more information, support and self-help resources:

“Access to more information (had to find out off internet).”

“I don’t feel there is a lot of support for people with an eating disorder. You can often feel alone as people don’t understand what you are going through unless they have been through it themselves.”

“Having been through the system several times, I feel more communication and involvement is needed between services, carers and sufferers.”

“I would like to see more self help/support groups in our area as we weren't aware of any the first time.”

“Working on body image and self esteem.”

“Self help support groups in the area that work on body image.”



What did we learn from producing this report?

The service user feedback in this report demonstrates a high level of dissatisfaction with local eating disorder services and poor patient experience at all stages of the care pathway. The 'Local Services' section of this report however also demonstrates that over recent months a considerable number of positive changes have either occurred or are being planned. Due to the negative experiences had in the past, some service users may now have disengaged from services and so may not be aware of the changes that have taken place. For others, the reputation of previous poor service has made them quite hesitant of what service they will receive and in return are reluctant to enter services. The LINK recognises that one of its key duties is to not only provide local providers with patients views of local services, but also to keep members of the public informed of changes to local services and how these changes may impact on them. This report therefore aims to act as a tool for communicating these changes to service users, as well as providing service providers with further suggestions for change that local people would like to see.

In summary, there are several key themes that have emerged from this report that for some improvements are underway, and for others further improvement is needed. These themes are:

GP and Health Professionals

For many, a routine visit to a GP or a school nurse can present the first opportunity to detect any signs of an eating disorder being present, and so proactive screening on the part of these health professionals is imperative in detecting the condition and also in preventing it from reaching more severe levels. With regard to GPs however, people have reported problems in terms of them not fully understanding the condition or treatment available, in not being proactive in screening for the conditions, and for not knowing where to refer sufferers on to. The introduction of SPA, the development of the GP screening tool and the forthcoming PTL training session will help alleviate these problems. In addition, the work that has been conducted with school nurses provides a further opportunity for any potential conditions to be picked up in young people. The ongoing support of these measures on the part of GPs and nurses is therefore vital in minimising the number of conditions that go undetected and in preventing unnecessary delays in people being able to access the support they need.

Waiting Time for Referrals

As comments in this report demonstrate, for sufferers of eating disorders it is imperative that they get the support they need whilst they are at the stage of accepting that they need help, otherwise they may disengage if they have to wait too long. People reported to us that they had varying levels of waiting times for referrals and often had to keep chasing services for a referral. Again, the introduction of SPA provides a referral pathway for GPs to refer people on to mental health services, as well as allowing people to self refer. Key to this therefore is people being aware that they can self-refer and that the process is approachable and accessible so as not to deter people.

Assessments

Inconsistencies have been reported with the SPA assessment process with people feeling that different assessors may lead to different outcomes. Concerns were also raised over BMI or weight reduction being assessed in isolation from other symptoms. Earlier in this report we documented that SPA now have a physical risk assessment screening tool for assessing people with eating disorders, and they also have the assistance of the Advice and Consultation Team in assessments. In addition, the new Care Clusters model will bring with it further assessment tools. As a result of these new changes, people will be seeking reassurance that their concerns will be met and that people will not be directed on a path of no or inappropriate support.

Access to Treatment

Again, recent changes including SPA's aim to offer treatment within 14 days of first contact, and the reduction in waiting time for access to CAHMS, show encouraging signs that people with eating disorders now have better access to treatment than they once did, and planned measures should improve this even further. However there is clearly shortage in access to both dieticians and psychotherapists and people feel that referral pathways are not as clear as they could be.

Acute Services

Concerns have been raised regarding the treatment of eating disorder sufferers within acute settings, with people raising concerns over the lack of understanding of eating disorders by hospital staff and also the lack of contact time with mental health practitioners during a stay in hospital. Recent improvements include the addition of a CAHMS support worker and also the forthcoming Mental Health Acute Strategy. Whilst these measures will form a link between acute and mental health services, a number of people stated they feel that an acute hospital is not the best setting for ongoing nasogastric re-feeding and the lack of an alternative setting causes disruption to a person's recovery and highlights a void in local services.

Discharge from Services

There were instances reported of people feeling that they had been discharged from services too soon with roughly half of respondents stating that they did not feel they received enough treatment. There was also belief by many service users that if they encountered a relapse, they may not necessarily be able to re-access services. SPA reported to us that people are able to re-access services and do not always need to attend a re-assessment thus speeding up their access to treatment. This therefore demonstrates that more needs to be done to communicate to service users what they can expect to happen under such circumstances and in what instances they may be denied treatment.

Transition

Concerns were raised regarding the transition from child to adult services, with some reporting they had suffered a relapse during handover and others fearing that they would be left without adequate support due to there not being a local in-patient or day service for adults. The LINK report 'Mental Health Services for Young People' also reported this issue, and as a result Humber Foundation NHS Trust has agreed to develop joint protocols between child and adult services to ensure service users do not suffer as a result of transition between the two services. As part of our ongoing work, we are monitoring progress with the Trust that this improvement happens.

Information & Awareness

The responses we received highlighted that both sufferers and carers need greater levels of information at all stages of their care pathway. This includes greater awareness and publicity generally around eating disorders; more information about their condition when first diagnosed; where and how to get support; what their treatment pathway is likely to be and how long they will have to wait; what will happen in the event of having to go out of area for treatment and any support available with travel costs; and what services they can expect to receive if needed after discharge. In addition, people stated they would also benefit from having access to more self-help resources such as body image training, self-esteem training, and advice regarding meal planning and nutrition.

Level of local specialist services

On the whole, people do not feel that the current service provision meets the needs of either adult or adolescent eating disorder sufferers. Respondents felt that a more specialist service is needed and suggested that a local centre that provides some of the services that some sufferers currently have to travel out of area for would be of benefit. It was highlighted that such a centre would help improve partnership working between services, would prevent extended stays within both CAHMS and acute hospitals, and would reduce the disruption caused by having to travel out of area for services.



What do we want to see happen as a result of this report?

Hull LINK makes the following recommendations under its legal powers:

1. As part of the specification for the forthcoming tender for the expansion of local eating disorder services, NHS Hull to consider the comments and suggestions made by service users in this report, with particular attention to the provision of a facility that can provide centralised advice, self help, training, dietetic support and coordination of services and care pathways with the support of specially trained staff. Whist Hull LINK appreciates that demand and resources may not necessitate a local specialist in-patient unit, disruption to day to day life could be minimised and a greater impact upon local people could be achieved if more of the current out of area provision could be provided locally. Therefore consideration is also to be given to the additional services that could be provided by a local facility such as nasogastric re-feeding, physical monitoring, motivational work, meal support, and support in the home.
2. To overcome the concerns raised regarding consistencies in assessment, referral pathways and treatment, Humber Foundation NHS Trust to devise a system whereby a patient's journey can be tracked and audited and then matched to NICE guidelines. This will identify any gaps in service or differences in decision making, and will provide an ongoing measure of effectiveness and a baseline for future improvement.
3. Our report has highlighted a high demand for specific treatment and support services. Whist we appreciate that capacity cannot necessarily be increased due to availability of resources, service users will benefit in knowing what plans or alternatives are in place to minimise the delays for people in need of specific help.
4. Humber Foundation NHS Trust, NHS Hull, City Healthcare Partnership and Hull and East Yorkshire Hospitals Trust to consider holding a joint event to provide service users and members of the public with up to date information regarding the current service provision for eating disorders and any anticipated changes to the service in the future. Hull LINK would be willing to assist in facilitating this event.
5. Hull LINK recognises and welcomes the fact that a number of measures have been undertaken to increase the awareness of and encourage the early identification of eating disorders among GPs. It would be beneficial to monitor the outcome of these measures and maintain momentum by delivering regular training and resources to GPs.
6. Past and present service users have highlighted the need for there to be better access to information. Greater awareness and publicity is needed, with information relating to the types of eating disorders, the signs to look out for and where people can go for help. Sufferers, carers and counsellors would also benefit from being able to contact the Advice and Consultation Service if they suspect they have a problem or want more advice or information about the kind of support they could receive. In addition, greater promotion that people can self-refer to SPA will make the service more accessible and help reduce the delays people have encountered by accessing services via their GP.

What will happen next with this report?

The report will be submitted to the local NHS under the LINK's power to make reports and recommendations. Services have 20 days from receipt to respond.

Hull LINK will monitor responses to our recommendations and keep our members and stakeholders informed of progress and actions to deliver improved services.

Acknowledgements

Hull LINK would like to thank all those that contributed to our research:

The staff, volunteers and users of S.E.E.D. Eating Disorder Support Services.

Everyone involved with Hull LINK who completed our survey.

The Counselling and Support Services that came forward to share their views.

The staff of the Humber Foundation NHS Trust, NHS Hull and City Healthcare Partnership that contributed information to this report.



The Strand
75 Beverley Road
Hull
HU3 1XL

tel: 01482 324474
fax: 01482 580565
email: link@hull-cvs.co.uk
website: www.hull-link.org.uk

Hull CVS is the host organisation for the Hull LINK



Hull CVS
'community and voluntary services'

Hull Community and Voluntary Services Ltd.

Registered in England No. 1570120 Registered Charity No. 514311

Registered Address The Strand 75 Beverley Road Hull HU3 1XL Tel: 01482 324474