editorials

Psychiatric Bulletin (2001), **25**, 241–242

ULRIKE SCHMIDT

Eating disorder services: starved of resources†

The paper in the current issue of the *Bulletin* by Lemouchoux and colleagues from Aberdeen provides a close-up look at service provision for eating disorders in Scotland (this issue, pp. 256–260). The Aberdeen group have previously conducted excellent epidemiological work on eating disorders in North East Scotland, establishing a sound needs-base for service planning (Eagles *et al*, 1995). The present questionnaire-based survey identifies a bleak picture of "substantial variation and significant gaps in service provision across Scotland" with specialist expertise spread very thinly. The range of services offered is limited, with little day care or community facilities. One-third of the Scottish population has no access to NHS specialist eating disorder services and specialist in-patient provision is completely absent from the NHS in Scotland. No mention is made of any after-care provision, e.g. specialist rehabilitation hostels for people with eating disorders or provision of services for carers. I suspect the paper's silence on these topics speaks for itself.

The situation in Scotland is by no means unique. Two College reports have been conducted on service provision for eating disorders in the UK. The first of these reports was released in 1992 (Royal College of Psychiatrists, 1992) and the second, conducted in 1998 in conjunction with the Consumers' Association, is awaiting publication (Royal College of Psychiatrists, 2001). While some progress has been made since the early 1990s in terms of provision of eating disorder services nationwide, there continues to be a 'postcode lottery' of service provision with major under-provision or absence of services in many areas outside the South East of England.

These sobering findings appear in an even starker light when put into the context of what we know about the severity of eating disorders and their treatments. Anorexia nervosa and bulimia nervosa are chronic, often debilitating, disorders with high levels of psychological and physical comorbidity. The average duration of anorexia nervosa is 6 years. There is evidence that the course of the illness has become more severe in the past few decades (for a review see Treasure & Schmidt, 2001). Case register data from Denmark show increasing admission rates for eating disorders over the past decade (Munk-Jørgensen *et al*, 1995), despite an overall reduction in the admissions for all other psychiatric illnesses. The mortality of anorexia nervosa is higher than that of any other functional psychiatric disorder and may be rising (Møller-Madsen *et al*, 1996). The quality of sufferers' lives is poor and the burden on their carers is as high as that in individuals with psychotic disorders (Treasure *et al*, 2001).

Specialist out-patient psychotherapies are the treatment of choice for most cases of anorexia nervosa and bulimia and are more effective than generic out-patient support or medication. For those with severe anorexia nervosa needing admission there is evidence that specialist services are better than generic services at restoring weight and reducing mortality.

The paper by Lemouchoux and colleagues ends with an outline proposal for a national Scottish strategy for the development of eating disorder services. There is an additional challenge for service planners in areas like Scotland with geographically dispersed populations, and this concerns the provision of the infrastructure, training and support for the use of novel technologies. There is encouraging evidence that internet-based interventions (Winzelberg *et al*, 2000) do have a role to play in the treatment of eating disorders and other new technologies like telemedicine may have a lot to offer too.

Why is it that some messages are slow to filter through to the wider psychiatric community and in particular those responsible for strategic planning and purchasing of services? Eating disorders are stigmatised and are still widely seen as self-inflicted conditions (Gowers & Shore, 1999). Health professionals (Fleming & Szmukler, 1992) see these patients in a similarly negative light to those who take recurrent overdoses, another group of patients whose needs are widely neglected.

Are things changing? Gradually, a political will to treat eating disorders seriously seems to be emerging. The recent British Medical Association report (2000) on eating disorders and the Summit of the Cabinet Office's Women's Unit raised many important points about prevention and service provision. The country's new mental health csar, Professor Louis Appleby, made a public commitment to improving services (*Woman's Hour*; Friday 24 June 2000, Radio 4). The topic of eating disorders has been put forward to be addressed by the National Institute for Clinical Excellence. Let's hope this will translate into tangible improvements at the coalface of clinical practice.

†See pp. 256–260, this issue.

https://doi.org/10.1192/pb.25.7.241 Published online by Cambridge University Press

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Ulrike Schmidt Consultant Psychiatrist, Eating Disorder Unit, South London & Maudsley NHS Trust, Maudsley Hospital, Denmark Hill, London SE5 8AZ

Psychiatric Bulletin (2001), **25**, 242–243

ILANA B. CROME

Addiction research and the future of addiction psychiatry

Addiction research in the UK has a long and distinguished history. Over the past 25 years seminal contributions have been made. These include description of the dependence syndrome, an innovative range of psychometric instruments and radical re-thinking about treatment outcome of intensive interventions (Glass, 1989). Review of the past 5 years highlights continued developments in some areas, but significant gaps in others (Addiction Abstracts, 1994–1999). How will this impinge on the future policy and practice of addiction psychiatry in the UK?

Since the 1960s increased availability of drugs and alcohol has led to an escalation in use, harmful use and dependence (Royal College of Psychiatrists and Physicians, 2000). Research evidence is gathered from many different sources; from seizures of drugs, quantities of alcohol sold, offences, surveys and notifications of drug use to a variety of agencies. Sixty per cent of the population use alcohol and 5% are addicted to it (Raistrick *et al*, 1999). Approximately one-third of the population smoke cigarettes, 15% use cannabis, 5% use amphetamine and possibly 1–2% are using opiate drugs in a harmful manner or problematically. Moreover, there is considerable variation in the prevalence of type and route of substance use across the country. Epidemiological research indicates that there is a substantial problem in the young and in the older population. Young women especially are involved in the drug scene. There is an accumulating body of evidence that despite the revelations, and the widespread concern and consensus regarding extent of substance use in the young, for example, this has not been translated into the development and evaluation of good quality services. There are isolated pockets of committed provision, but this is patchy and underresearched.

Likewise, misuse in the older population, also increasing (17% of the adult population is now over 65 years of age), is neglected. On one hand this is not surprising, although on the other it is. Older people with the significant physical and psychological comorbidity that often accompanies ageing are non-compliant with prescribed drugs with misuse potential, which are supplemented by over the counter medications, alcohol and nicotine.

How does our research portfolio compare with the US? What are the similarities and differences? A major difference is the existence of national research policy and strategy. Over the years this has been underpinned by extensive resources for research, training and service provision. This is clearly evident in the research mapping exercise in which America dominates the rest of the world in producing two-thirds of published abstracts. The predominant area of interest for the States, as for the UK, is in the intervention domain. This includes both prevention and education, as well as treatment interventions. Wider policy issues related to advertising and cost of treatment are common to both countries.

In treatment intervention research, both the US and UK are interested in the 'new' range of pharmacological means of detoxification, e.g. lofexidine, naltrexone, levacetylmethadol hydrochloride and buprenorphine. 'Older' issues like methadone substitution, brief interventions, especially in relation to retention and relapse, and differing methods of service delivery are equally acknowledged. A major gap exists in terms of outcome of research for combination of pharmacological and/or psychological treatments administered for this group.

https://doi.org/10.1192/pb.25.7.241 Published online by Cambridge University Press