

Letter

Eating disorder service transitions: integrated models, knowledge gaps and opportunities, Ragnhildstveit et al

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Keywords

Eating disorder service transitions; integrated models; knowledge gaps; opportunities.

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In high-income countries, patients with eating disorders are supported by child and adolescent mental health services (CAMHS) until 18 years of age, according to service provisions. Thereafter, patients must transition to adult mental health services (AMHS) for ongoing specialty care. Many stakeholders have criticised this binary care model, as transitions coincide with peak eating disorder onset (15–19 years of age) and other important life changes (e.g. moving away from home, beginning employment, or pursuing higher education). During this time, many eating disorder patients are lost to follow-up, with only 11% directly transitioning to AMHS.¹ For those who do transition, the process can be complex and challenging to navigate, causing ‘avoidable delays in commencing or continuing treatment, disruptions to the therapeutic alliance, and even death’.²

To address such challenges, eating disorder experts have proposed and increasingly supported age-integrated services.³ Under this model, age boundaries prompting transitions are either increased (e.g. from 18 to 25 years), providing a ‘window of flexibility’ for optimal transitions, or abandoned altogether (i.e. no age restraints), with services available across the lifespan. The main advantage of these approaches is service continuity, averting possible treatment delays and drop-out at a critical point of mental healthcare. In addition, integrated services have the potential to improve provider trust and service alliance, both of which are low when transitions are poor. This model can also give rise to shared knowledge, clinical standards, and cultures across development, thereby catering to various age groups. ‘People with [eating disorders]... can turn to a single doorway of access for care, beyond which works a single team, with shared expertise and consensus around principles of care’.⁴

However, the practicality and benefits of integrated services need to be critically evaluated. Despite 91% of eating disorder specialists (researchers and providers) and 94% of stakeholders (patients and caregivers) describing this model as essential or important, the cost of integrating services is largely unknown and would require substantial service reform, as well as support from the public and private sectors.⁵ This particularly applies to countries such as England, where the majority of eating disorder services are age-segregated and growing further apart, not closer together. For example: ‘in our own large catchment area in South East London, young people under the age of 18 can self-refer, whereas those age 18 or above have to overcome multiple gate-keeping hurdles to access [eating disorder] services’.⁶



Moreover, countries trialling integrated services have yet to document clinical improvements in patients. Since the Better Access and Headspace initiatives (2006–2007), Australia has provided integrated services for young people aged 12–25 years with

mental health disorders. From 2001 to 2018, there was a large increase in patients accessing services, according to state and national data-sets, but no significant improvement in mental health.⁷ In fact, trends showed a worsening in psychological distress beginning in 2015, even after adjusting for methodological differences. Canada has likewise tested an integrated lifespan programme for patients with eating disorders.⁶ This service has recently been described as ‘challenging’, with some staff members resenting the loss of their former CAMHS or AMHS identities. The need to broaden their expertise has also resulted in ‘discomfort’. Nonetheless, positives have emerged from this programme, with clinical teams and services becoming more uniform. This has facilitated ‘an increasingly flexible matching of therapeutic skills to specific client needs’.⁴ Although this is encouraging, a lack of outcome data suggests that it is too early to ascertain this programme’s effectiveness.

On a fundamental level, the impact of eating disorder transitions is poorly understood. This is evidenced by an underdeveloped literature dominated by qualitative and descriptive research. In a recent systematic review, we identified ten qualitative, two cross-sectional and two longitudinal studies reported over a 15 year period (2008–2023).⁸ Only one study quantitatively examined eating disorder symptoms post-transition, using validated measures. This underscores critical knowledge gaps. For instance, are transitions problematic for eating disorder patients, above and beyond the process itself? Do certain factors (e.g. patient readiness, caregiver involvement, mental health support, or service collaboration) reliably predict symptom trajectories? What stakeholder, healthcare, and societal costs are linked to service drop-out, relative to those transitioning to AMHS (e.g. accident and emergency visits, in-patient and community services, educational disruptions, and loss of productivity)? Rather than putting the ‘cart before the horse’ concerning radical healthcare reform, further research is warranted to understand transition outcomes, which 24 international experts have recently stated is ‘important’ for young people with eating disorders, ‘who often find themselves caught between child and adult services’.⁹

Looking ahead, we encourage funding bodies to support well-designed, longitudinal studies that prospectively follow eating disorder patients after discharge from CAMHS. Ideally, this would involve collecting mental health data from patients, caregivers, and providers. Retrospective studies should also be supported as an appropriate alternative, given the difficulty of prospective designs, owing to patients being lost to follow-up at this challenging juncture. Longitudinal data can also be obtained through linkage to healthcare records, but only for those who have accessed services. Overall, such research on eating disorder transitions will help

address existing knowledge gaps, improve transition experiences, and advance eating disorder care across the lifespan. The severity and sequelae of eating disorders in young people demand that their transitions are thoroughly investigated.

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First received 27 Feb 2024, accepted 13 Mar 2024

Funding

A.R. was supported by the Reginald John Smith Studentship, King's College Studentship, and Cambridge Commonwealth, European, and International Trust. S.A.S.N. was supported by a Wellcome Trust Early Career Award (226392/Z/22/Z). T.J.F. was supported by the Place2Be, a third sector organization that provides training and mental health support in schools, for research methods consultancy. All research at the Department of Psychiatry in the University of Cambridge was supported by the NIHR Cambridge Biomedical Research Centre (NIHR203312) and the NIHR Applied Research Collaboration East of England. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

Declaration of interest

None.

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