

Beat

Eating disorders

THERE'S NO PLACE LIKE HOME

The case for intensive
community and day
treatments for eating
disorders

'For a long time, I assumed that this repeated cycle of admission and discharge was to be expected... I could not envisage a treatment programme that did not result in the patient being taken away from family and friends at a time of such great need and vulnerability.'

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EXECUTIVE SUMMARY

Eating disorder services across the UK are under increasing pressure with marked increases in referrals and acuity. Admissions for inpatient treatment have continued to increase despite high risk of relapse and readmission. Patients report hospital admission being restrictive in nature, with significant disruption to daily life. It appears to be used for a large number of patients who could reasonably be treated in the community if suitable alternative options existed, despite offering little additional therapeutic benefit but at much greater cost.

The importance of intensive community and day treatments as an alternative to or a step-down from inpatient care is highlighted in treatment guidelines and service reviews across the UK. They are slowly becoming more available, and increasingly recognised as having a multitude of benefits, including that they offer an effective and less expensive alternative to inpatient care thus reducing the number and length of inpatient stays. They can also be used as a flexible way to step-up the intensity of care. Providing alternative treatment options at any stage of their treatment journey for patients who are not best served by traditional outpatient or inpatient care can also ensure care remains personalised, therapeutic and purposeful.

“My time in day treatment was life changing. After a number of years of outpatient therapy, day treatment supported me in making changes in my eating that felt too scary and overwhelming; it helped me to push through when I would have previously slammed on the brakes. I don’t think I would be where I am today without day treatment support.”

Person with lived experience

This report provides a review of the evidence on intensive community and day treatments, demonstrating why they should be considered, explores the use of virtual treatments in this context, considers situations in which they may not be appropriate, and presents the results of a Freedom of Information (FOI) request on such services. It also presents a number of service case studies as well as findings from an inquiry held by the All-Party Parliamentary Group (APPG) on eating disorders at Westminster that heard from people with lived experience, carers, and clinicians.

Our review of the current evidence and consensus from experts in the field suggests that at the very least, equivalent outcomes can be achieved for many patients through the use of intensive community and day treatments when compared with inpatient treatment. Based on this, a recommended level of intensity and programme design to provide optimum outcomes was defined. The results from our FOI request found limited provision of services meeting this definition, which is as follows:

Patients should be able to access an intensive community treatment programme capable of providing at least four change-focused contacts over at least 3 hours per week, including supervised meal support and the service should have the ability to adjust the intensity flexibly according to the needs of the patient. Patients should be able to move if needed to a more intensive community or day treatment programme capable of providing at least 20 hours of care, spread over a minimum of four days per week including supervised meal support. These treatment programmes should be provided by a multi-disciplinary team and be offered for at least 6 weeks with the ability to extend thereafter if clinically necessary.

Beat’s FOI investigation assessed NHS areas against this definition and found that only 15% - 10 out of 67 - NHS areas in the UK are able to provide the recommended level of intensive community and day treatment for both children and young people, and adults. 6% of areas offered the

recommended level for only children and young people, and 10% of areas offered it for adults only. It indicates that most patients with eating disorders who require this level of treatment are unable to access it, and given their benefits as set out in this report, highlights the urgent need for action in line with our recommendations.

For both adolescents and adults, intensive community and day treatments can significantly reduce eating disorder and other related symptoms, restore body weight (where relevant), and support patients to a point at which they can continue treatment on an outpatient basis. Follow-up data also indicate its sustainability, with outcomes generally well-maintained.

It is well recognised that patients with eating disorders often have co-occurring conditions and because of these may be passed between services, as do those with long-standing eating disorders. Research shows that intensive community and day treatments can be effective for both these groups.

Intensive community and day treatments are also less disruptive to people's educational, work, and social lives, and appear to be preferred because of their flexibility whilst also providing the 'right level' of care. Such programmes can also reduce inpatient admissions, or the length of stay, enabling patients to develop and practice new skills within their own communities, making them more transferable into daily life.

They can also reduce costs, allowing savings to be reinvested into services to facilitate early intervention. Data from NHS England indicates that for children and young people in CAMHS, a day in an inpatient unit is over three times more expensive than a day in day treatment. When adjusted for inflation, the average cost of a day in CAMHS day treatment in 2024/25 will be £462, whilst the average cost of a CAMHS inpatient admission per bed day will be £1573.

Families, friends and partners often play a crucial role in recovery. Research suggests that they are empowered by intensive community and day treatments, experience improvements in their self-efficacy and are enabled to play an active role in their loved one's recovery.

These services can also provide a solution to people who live rurally as they can be delivered virtually or through a combined face-to-face and virtual approach, with evidence showing similar outcomes and improved accessibility. Though there are additional factors to consider and address they can ensure patients can access consistent levels of care regardless of where they live. Patient preferences are a crucial consideration in the delivery of such services. More controlled studies are needed comparing the clinical and cost effectiveness of different models.

The APPG inquiry heard from people with personal experience of an eating disorder and their carers, finding themes such as the ability to apply skills to daily life, avoiding hospital admissions, and the benefits of working with a patient's family and social network. An additional session held with senior eating disorder clinicians heard the importance of providing a continuum of care that addresses the different needs of patients, the role of intensive community and day treatments in reducing costs and disruption to daily life, and the importance of a multidisciplinary team, skilled clinical leadership, and seamless transitions.

Beat therefore recommends the following:

Providing services

1. The NHS should ensure that evidence-based intensive community and day treatment options staffed by multidisciplinary teams able to provide personalised case formulations, appropriate risk assessment and management, and therapeutic approaches with a focus on recovery are available to meet the needs of their local eating disorder population.

2. Patients and their carers should be involved in the initial planning and design, and then ongoing delivery of such services.
3. Services should provide intensive treatments incorporating evidence-based therapies at the required intensity set out in our definition whether that is for patients who have not responded to outpatient treatment and require a step up in care, to provide an alternative to inpatient care, or for those who are stepping down from higher levels of care.
4. Services should provide tailored approaches to their area, considering rurality and accessibility of treatment, which should not prevent patients from accessing effective intensive options

Personalised care

5. Individual outcomes and progress should be regularly reviewed, with patients able to step-down or increase intensity of their treatment as required. Plans for transitioning to more or less intensive care should be in place prior to discharge and occur seamlessly. The consideration of patient preferences (and carers where appropriate) alongside clinical judgement is essential at all stages to facilitate shared decision making.
6. Treatment and care plans should be personalised, incorporating joint-working arrangements where relevant to ensure any comorbid mental health concerns are also addressed, and reasonable adjustments made for any co-occurring conditions such as autism. Protected and other characteristics should also be considered to enable equity of access, experience, and outcomes.
7. Parents, families and carers should be provided with or signposted to support in line with national guidance.

Improving the evidence base

8. Eating disorder services should be incentivised to develop and evaluate different models of intensive community and day treatment and publish these evaluations, so that the models that deliver the best outcomes can be identified and promoted for adoption nationwide. This should include longer-term follow-up data and economic evaluation.
9. Research published on this topic should clearly report the interventions and intensities of models used, and outcomes. Participants should include patients with different diagnoses, genders, and other protected and relevant characteristics. Carer outcomes should also be reported.

Investing and re-investing

10. Investment in intensive community and day treatment services should be resourced prospectively in recognition of the cost savings which will be achieved from the resulting reduction in inpatient care.
11. Financial savings beyond the costs of establishing and expanding intensive services should be re-invested in encouraging and enabling people to seek and start eating disorder treatment at the earliest possible stage in their illness.

INTRODUCTION

Eating disorder services are extremely strained, and face ongoing recruitment, retention, funding and resourcing challenges which often result in people being denied care. Demand for services has continued to rise, with significant increases in referrals, waiting times, and inpatient admissions. (1-8). Research suggests the COVID-19 pandemic has significantly exacerbated this situation (9-11).

In England, hospital admissions for those with a primary or secondary diagnosis of an eating disorder have almost quadrupled from 7260 in 2010-11 (12) to 18633 in 2018-19, to 28371 in 2022-23 (13). Additionally, at least 154 patients from England were admitted to inpatient care in Scotland between 2016 and 2018 (14). In the financial years between 2020 and 2023, 84 patients were admitted for inpatient care in Scotland from England, the cost of which was almost £9m (15).

In Scotland, the number of inpatients admitted with an eating disorder diagnosis has also increased, albeit at a slower rate, from 434 in 2013 to 556 in 2018 (16), with further data unavailable. The Scottish Eating Disorder Review states that for the two regional adolescent psychiatric units able to provide data on eating disorder admissions, there was a combined 161% increase over a year, with 26 in 2019, and 68 in 2020 (17).

In Wales, hospital admissions for those with a primary or secondary diagnosis of an eating disorder increased from 658 in 2018/19 to 900 in 2022/23. Admissions for under 18s with a primary diagnosis of an eating disorder in 2022/23 were double that of pre-pandemic levels and exceeded 5000 bed days (18). Moreover, in the year 2018/2019, there were 22 inpatient admissions for eating disorder treatment where adults resident in Wales were referred and admitted to units outside Wales, the cost of which was £1,354,884. This figure is higher than the total spend by Welsh health boards on specialist tier 3 adult community eating disorder services in that year (19). In the year 2022/23 this figure increased to 26, the cost of which was £2,525,330 (18), indicative of rising costs.

In Northern Ireland, in 2022/23 there were 131 hospital admissions where the primary diagnosis was an eating disorder, and 756 admissions where an eating disorder was a secondary diagnosis (20). Over the five year period of 2017/18 to 2021/22, 26 patients with a primary diagnosis of an eating disorder had to travel outside of Northern Ireland to access specialist hospital treatment (21).

Inpatient treatment will always be necessary for severe and urgent cases of eating disorders, and to safely improve their nutritional state. In doing so it can also have the benefit of providing a space for patients to address their eating disorder thoughts and behaviours alongside cultivating positive relationships with therapeutic staff and peers to model recovery (22). However, it appears to be used for a substantial number of patients who could reasonably be treated in the community if appropriate alternative options existed.

Inpatient treatment also has notable drawbacks. Patients report a lack of agency to the extent of feeling controlled, barriers caused by social restrictions, a lack of personalisation of treatment in relation to their individual needs, the potential for competition and comparison between patients, and a sense of separation and isolation from the outside world which can lead to apprehension and fear about reintegration (22). A disproportionate focus on weight gain and a restrictive environment is not always conducive to recovery (23), and many of these factors are more central to inpatient treatment than other forms of care (24).

The evidence base for inpatient care in contributing to long-term recovery is lacking, with a high risk of relapse in the months following discharge, potentially due to a substantial step-down in care, and research suggests that for many patients follow-up outcomes are poor (25-27). Whilst more research is needed, studies suggest that gradually tapering to less intensive treatments can reduce this risk (28, 29).

Intensive programmes, namely intensive community treatments (ICTs), and day

treatment programmes (DTPs) are becoming more common in the treatment of eating disorders. Although further research is needed on these programmes, they are a promising, less expensive alternative option to inpatient treatment with the potential to address many of the barriers inherent to inpatient treatment, and with encouraging and consistent outcomes across treatment models (30). Research indicates they could be less intrusive to family life, and also allow patients to better transfer the skills they learn to their home environment immediately, and so help to create the conditions in which treatment gains are more likely to be maintained.

“I think it prepared us for [the future], showed us what to do, gave us strength to carry on with it, it got us through that worst time, gave us hope.”

Carer

Moreover, they are models that are well-researched for other severe mental illnesses as an alternative to inpatient care, demonstrating positive clinical and social outcomes, are preferred by patients and their carers, and are also cost-effective (31-33), supporting the growing focus on care closer to home and in the community.

NICE and SIGN guidelines for eating disorders (34, 35) recommend that most patients with eating disorders should be treated on an outpatient basis with evidence-based therapies such as eating-disorder-focused cognitive behavioural therapy (CBT-ED) and family based treatments. However, when an individual’s physical health is severely compromised, NICE guidelines recommend that the patient is referred to either a specialist inpatient or day patient service for medical stabilisation and to initiate refeeding where needed.

A Royal College of Psychiatrists survey conducted in 2012 found that eating disorder services tend to mainly use traditional models of care, such as outpatient and inpatient

treatment, rather than more innovative models such as day treatment (36). Whilst the landscape of services has inevitably changed since then, Beat’s FOI results, described in this report, found that their availability at our recommended intensities is still limited. This is despite the use of intensive community and day treatment options being supported by national guidance and recommendations from ED service reviews in all parts of the UK.

Inpatient units are unevenly distributed across the UK, with large parts of the country having no inpatient beds within easy travelling distance. Many people with eating disorders are therefore admitted to hospitals a very long way from home. Between 2016-18, in five regions of England, over 25% had to travel more than 90 minutes to receive this care (37), with greater journeys reported by patients living in rural areas across the UK.

The increased provision of intensive community and day programmes would both reduce the number of inpatient admissions needed and provide a step-down from inpatient treatment to avoid patients being kept in hospital for longer than necessary. Similarly, they provide a middle ground for patients who are not benefitting from traditional outpatient treatment but require a step-up to more support. Importantly, they also appear to be more acceptable to patients and their families.

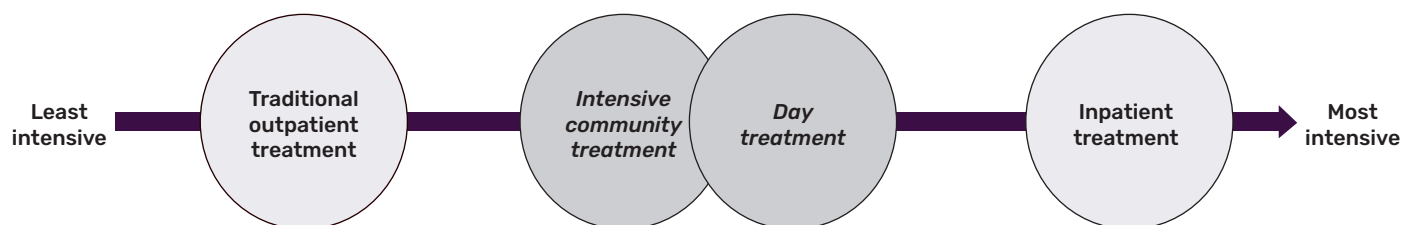
These programmes also have the benefit of being significantly less costly than inpatient treatment. Analysis of NHS England data indicates that while costs vary widely, when adjusted for anticipated NHS inflation, in 2024/25, the average cost of a day in CAMHS day treatment will be £462. The cost of a CAMHS inpatient admission per bed day in comparison will be £1573, which is over three times greater (38-40). This figure is used to account for the limited number of specialist inpatient eating disorder beds for children or young people (41) Using these figures, four weeks of inpatient care is £44044 compared to £9240 for four weeks of day treatment (if it is attended for five days per week). Savings of £34804 could therefore be made for each four weeks that day treatment is used in place of inpatient care where appropriate. There is no equivalent public data for adults,

or in the devolved nations, and whilst the cost of inpatient admissions varies based upon factors such as diagnostic criteria, overhead costs and length of stay, it is indisputably an expensive way for the NHS to deliver treatment (42) with additional therapeutic benefit being questionable. Greater provision of intensive community and day treatments could therefore release funds from hospital treatment to invest in helping a greater number of people faster, reducing waiting lists and providing fully resourced intensive treatment programmes for all patients who need them, in all areas of the UK.

This report presents the results of a review of the evidence available into the effectiveness of intensive community and day treatment programmes, including those delivered wholly or partially using a virtual approach, along with case studies from selected established services in the UK. It also reports the results from a Freedom of Information request that was sent to all UK eating disorder providers, and findings from an inquiry held by the UK All-Party Parliamentary Group (APPG) on eating disorders that heard from people with lived experience, carers, and clinicians.



WHAT ARE INTENSIVE COMMUNITY AND DAY TREATMENTS?



Intensive community and day treatments provide an intensity of care on a continuum that has traditionally only included outpatient and inpatient treatment. They can be used to step-up or step-down care flexibly and ensure people receive the right level of care at the right time.

Intensive community treatment programmes provide an increased frequency of contacts for patients in the community depending on their needs compared to traditional outpatient treatment which is typically once weekly. Day treatment programmes are usually a step-up from this, with patients attending a clinic and, similar to inpatient treatment, with the bulk of interventions typically delivered in a group format, although some will also offer individual or family treatment approaches in addition. There is no overnight stay and the patient typically returns home for evening and weekends. Some intensive community treatment programmes are able to match the intensity of day treatment programmes, although this is variable across the UK. The support offered may include supervised meal support, home visits, individual therapy, family therapy, occupational therapy, groups, dietetic support, education or links with educational settings if relevant, and/or physical health monitoring.

DTPs are commonly delivered using group therapy, which has been suggested to be beneficial when treating eating disorders due to the reduction in patient isolation (43). The optimum size of an intensive community or day treatment programme requires further research (44), and will likely depend on factors such as local demand and the type of programme.

The programmes typically have similar therapeutic goals and components to

inpatient treatment (45). Treatment goals for both inpatient and intensive community and day treatment programmes tend to include medical stabilisation; weight restoration if needed; the cessation of symptoms such as binge eating and vomiting; the normalisation of eating; therapeutic exploration of underlying risk or maintaining factors and the development of coping skills; and the initiation of social and vocational rehabilitation (46).

Day treatment programme is the term most commonly used in the UK, but they are also known as partial hospitalisation programmes (PHPs), day hospital (47) or day care. Intensive community treatment programmes capture a broad range of programmes. This can include home-based treatment and/or regular appointments in clinical or other community settings. Both types may be delivered face-to-face, virtually, or using a hybrid approach.

Day treatment programmes (DTPs) appear to be more researched than intensive community programmes, and therefore whilst much of this report will focus on their evidence-base, existing research for intensive community programmes also demonstrates comparable outcomes (48). A systematic scoping review of adolescent DTPs published in 2021 (30) found that most papers included were published in the prior decade, with over half within the 2 years prior to publication, indicating a growing interest in this topic. As with most eating disorder research, there is also a critical need to increase the diversity of

samples included within studies (30, 49-51).

NHS England's guidance for commissioners and providers of adult eating disorder services (52) defined intensive community treatment as an "increased frequency of community treatment to maintain momentum towards progress" and focuses on treating people in their communities as an alternative to or to reduce the length of an inpatient stay. It defined intensive day patient treatment as "at least four to five times a week" involving "support around main meals as well as encouraging people to learn skills and engage in activities that contribute towards their recovery" that can also be used as an alternative to an admission or to step-down care. Similarly, Thornton et al. (53) argued that services should be able to provide a continuum of outpatient care for patients, so a five-day a week programme is available for those with more intensive needs, allowing patients to step-down the intensity of their treatment as required.

Most studies of adolescents report DTPs operating for 5 days per week for typically 6-8

hours per day (30, 49) with multi-disciplinary teams. A large proportion of DTPs for adults report being multi-modal (54), but with considerable variation in programme design, intensity and duration across DTPs (30, 49, 55-60). There appears to be little in the way of an empirical evidence base to argue for any particular programme design over another (61). Matthews et al. (60) reported the need to look at "what was done in other settings" when designing a DTP for eating disorders, due to the inconsistent and limited evidence available in the treatment of eating disorders.

Studies show that most existing DTPs take patients with anorexia nervosa (AN) and bulimia nervosa (BN), but few appear to admit, report on or have large samples of patients with binge eating disorder (BED), or Avoidant Restrictive Food Intake Disorder (ARFID) (30, 58). This also applies to Otherwise Specified Feeding or Eating Disorder (OSFED), although a number of studies report on outcomes for patients with atypical anorexia nervosa (62-68).

WHY SHOULD INTENSIVE COMMUNITY AND DAY TREATMENT BE CONSIDERED, AND WHAT EVIDENCE EXISTS FOR THEM?

"It is crucial that services, across the country, move towards providing a treatment model that is consistent and allows this all-important continuity of care. In my opinion, patients and families would be best served by an intensive outpatient service that allows both step-up care and step-down care."

Carer

Research shows that intensive community and day treatments can achieve treatment outcomes at least equivalent to those achieved by inpatient or standard outpatient care, with greater treatment acceptability, delivering reduced inpatient admissions, considerable cost savings and increased family empowerment.

1. Equivalent treatment outcomes

Intensive community and intensive day treatments have been found to be effective in the treatment of eating disorders, for both adolescents and adults, with research suggesting that DTPs are at least as effective as inpatient treatment.

Adolescents

Key points

- Intensive community and day treatment programmes for adolescents can restore body weight (where relevant), significantly improve eating disorder symptoms and quality of life, reduce relapses and admissions to hospital, and address comorbid or co-occurring mental health concerns including depression and anxiety
- They can be effective as an alternative to inpatient treatment and for patients who have not responded to traditional outpatient treatment
- Follow-up data, where available, indicate that improvements are typically maintained following treatment
- More research is needed on young people who do not have restrictive eating disorders.

"It is remarkable what can be done when commissioners and clinicians work together... and design a service that offers holistic and compassionate bespoke treatment that is community-based."

Carer

DTPs have been found to be an effective alternative to inpatient treatment for adolescents with moderate to severe eating

disorders (69–94). A systematic review of DTPs for children and adolescents with eating disorders (49), and a systematic scoping review of DTPs as an alternative to inpatient treatment (30) found they are effective in restoring body weight, which was consistent regardless of model or diagnosis. They also address eating disorder symptoms, binge/purge behaviours, and comorbid symptoms, such as depression and anxiety, and improve general functioning and quality of life.

Both reviews show that these improvements are well-maintained where this was measured from 3 months to 2 years following treatment. The average drop-out rate was 21.38%, although definitions of the term 'drop-out' were inconsistent. Much of the research in young people focuses on restrictive eating disorders, and more is needed on the response to DTPs for young people with bulimia nervosa, binge eating disorder, and other presentations.

Studies investigating DTPs for adolescents often incorporate key tenets of family therapy for eating disorders to differing extents, for example, viewing the carers as experts on the sufferer and a crucial resource for recovery (42, 49). It is also common for other modalities such as cognitive behavioural therapy or dialectical behavioural therapy (DBT) to inform parts of the programme (30). Family-based DTPs for adolescents may require carers to attend mealtimes, bring in food from home, and join meetings with family therapists (73). An example of an American DTP based upon the principles of family-based therapy (FBT) was evaluated by Marzola et al. (77). Two forms of short-term intensive family therapy were studied: single and multiple-family therapy for adolescents with anorexia nervosa and EDNOS restricting subtype (n=74). Both forms of intensive family therapy led to significant positive changes in weight and reductions in behavioural symptoms, with 87.8% of patients achieving either full (60.8%) or partial (27%) recovery at the 30-month follow-up.

In the majority of studies the aim of DTPs is reported to be clinical improvements, and as such, the amount of immediate change is likely to be modest, as it is likely to be followed by further outpatient treatment (30). Long-term outcomes appear to be promising. 12 months after discharge from a DTP attended by a mixed diagnostic sample of 265 adolescents (126 of whom completed follow-up measures), Reilly et al. (80) found that 59.7% achieved either a full (40.3%) or partial (19.4%) remission.

DTPs can also be effective in restoring body weight for a majority of patients (76). Martin-Wagar et al. (81) assessed a DTP for adolescents with AN (n=87), finding that 80.5% of adolescents discharged reached at least 90% of their expected body weight (EBW),

including 66.7% who reached at least 95% EBW. It is important to mention that weight should not be viewed in isolation, and that following treatment in DTP, changes to eating disorder thoughts, behaviours and other measures also significantly improve (76, 82).

There are also additional models to the ones described above. Baudinet and colleagues (83) analysed outcomes of a UK-based DTP attended by 131 patients with restrictive eating disorders over a period of four years that incorporated a different model (radically open dialectical behavioral therapy) and found that more than 70% of adolescents within the study had a good-intermediate outcome (defined in relation to BMI, menstruation if relevant, and symptoms), with significant improvements in eating disorder symptoms and mood. Traditional outpatient treatments had previously had little response or been inappropriate.

Dalle Grave and colleagues (84) assessed the efficacy of the intensive Cognitive Behavioral Therapy-Enhanced (CBT-E) model for adolescents with anorexia nervosa before, during and after the COVID-19 pandemic. Further studies on the model – which demonstrates promising results – and its outcomes are outlined in this report. It involves three to four introductory sessions, a planned inpatient admission of 13 weeks aiming for full weight restoration, and 7 weeks of day treatment followed by 20 sessions of outpatient CBT-E. With 132 participants aged between 13 and 17, there were no differences in eating disorder or general psychopathology between the three groups, and approximately 60% had maintained progress at the 20-week follow-up stage, indicative of its potential.

Studies are also emerging on the use of DTPs for ARFID. Ornstein and colleagues (85) found it to be effective for patients (n=130) aged between 7 to 17 years. Patients with ARFID were admitted to the DTP for an average of 7.03 weeks, and significantly improved in both their psychopathology and BMI. These improvements in weight restoration and eating symptomatology were maintained at the 12-month follow-up for those who consented to follow-up data collection (n=62) (86). Lane-Loney et al. (87) presented retrospective

outcome data from a cognitive-behavioural, family orientated DTP in a sample of 81 children and adolescents and found significant increases in weight and in the number of foods accepted, alongside significant decreases on measures with associated symptoms such as anxiety and depression. Studies exploring the use of DTPs for ARFID appear promising with clinical improvements, but studies with larger samples are needed (88-91).

Research on home treatment also suggests it is a viable way to provide support in the community (92, 93). Herpertz-Dahlmann et al. (92) investigated the feasibility, effects, and safety of home treatment for adolescents with anorexia nervosa following 4-8 weeks

of inpatient treatment. They found it to be effective, with significant improvements in BMI and percentage of expected body weight both at the end of treatment and at 1-year follow-up. Carers' care skills also improved significantly and they, alongside patients, reported high treatment satisfaction. The sample size of the study was small (n=22), and the authors also note that considering who is appropriate for such a programme is important.

Studies on intensive treatment options for feeding and eating disorders such as rumination disorder are very limited with some research showing they can be effective (94).

Adults

Key points

- Intensive community and day treatment programmes for adults can restore body weight (where relevant), significantly reduce eating disordered cognitions and symptoms, improve quality of life, and facilitate the identification and resolution of factors contributing to the eating disorder
- Follow-up data, where available, indicates that improvements are typically maintained
- These treatments can be effective for patients who have not responded to traditional outpatient treatment
- The ability to step-down to less intensive care or step-up to a higher intensity is an important factor when considering how to sustain outcomes for patients
- DTPs can be effective for a wide range of eating disorders, although more research is needed on adults who do not have restrictive eating disorders.

"The clinicians have been amazing and have genuinely changed my view of people, kindness and compassion. Their skills to read people, maintain boundaries, but offer genuine care and support has been so touching. It's helped to carry me through a really tough time in my life."

Person with lived experience

DTPs have also been found to be effective in the treatment of anorexia nervosa and bulimia nervosa for those over the age of 16 years (43, 45, 95-108), with treatment effects being sustained over 3 months (101); 12 months (104, 109); 18 months (105, 110, 111); and 26 months (98). For example, an Australian DTP for patients with anorexia nervosa, bulimia nervosa or

eating disorder not otherwise specified (EDNOS – now referred to as OSFED) was evaluated by Willinge et al. (101) to assess outcomes against seven treatment goals. These goals were: 1) weight gain for underweight patients or weight stabilisation, 2) reduction in eating disordered cognitions, 3) reduction in core beliefs contributing to the maintenance of the eating disorder, 4) reduction in unhelpful eating disordered behaviours, 5) increasing patient motivation, 6) improvement in patient quality of life, and 7) identification and resolution of perpetuating factors. Of the 58 participants who completed the initial assessment, 44 (75.9%) completed the DTP. All seven treatment goals significantly improved from admission to discharge, with moderate to large effect sizes. At the 3-month follow-up, results either did not significantly change, or continued to improve.

As with treatment all eating disorders, it is important to consider how to maintain outcomes in the long-term. For example, Fittig et al. (105) performed an 18-month follow-up of 83 patients who had received 16 weeks in a German DTP and 16 weeks of outpatient aftercare for anorexia nervosa or bulimia nervosa. 40.2% of patients with anorexia nervosa and 40.4% of patients with bulimia nervosa who had received treatment were classified as fully remitted. Significant improvements are often made throughout different treatment types, but not all patients are asymptomatic by the end, meaning that they may still meet the diagnostic criteria for an eating disorder (102–104, 112). Understanding how more patients with eating disorders can recover as such treatments grow will be important.

There is also a small amount of evidence to suggest that DTPs may be effective in the treatment of binge eating disorder in adults (98, 103). For instance, Hepburn and Clark-Stone (103) evaluated the short-term effectiveness of a UK DTP, which treated patients over 16 years with anorexia nervosa, bulimia nervosa, binge eating disorder, OSFED, and Unspecified Feeding and Eating Disorder. Of the 14 patients who presented with binge eating symptoms pre-treatment and who received an adequate dose of treatment (at least four weeks), eight patients (57%) were abstinent from binge eating during the last four weeks of treatment. Although the study reports on the binge eating behaviours of the whole sample rather than just those with binge eating disorder, this reduction in binge eating episodes is promising.

A follow-up study to Hepburn and Clark-Stone investigated whether outcomes at discharge were maintained. With 69 participants (56 of whom were retained for the entire duration of the study), there were significant improvements in eating disordered attitudes, BMI for underweight patients, psychosocial impairment, and binge frequency for those engaging in bingeing behaviours, which were maintained at 6 and 12-month follow-ups. 30% were considered to be in remission when discharged (defined as a BMI equal to or above 20, and no bingeing, purging, or restricting for four weeks), and after 12 months, 17% remained fully in remission. 15% were admitted to a specialist eating disorders unit during the study period. It is important to consider how

long-term effectiveness can be maximised and maintained (113).

“I found the support of other group members really helpful. I also felt that the direct assertiveness of the staff at times against the ED is good and helpful when needing to rationalise.”

Person with lived experience

As with adolescents, DTPs for adults report incorporate different types of interventions. Dalle Grave et al. (64) investigated outcomes of a 13-week day hospital programme using CBT-E in 43 adults with anorexia nervosa, bulimia nervosa or OSFED (atypical anorexia nervosa, and purging disorder) for whom outpatient treatment had not been effective and found that of the 86% who completed the treatment (n=37), significant improvements were made in ED symptoms, clinical impairment, general psychopathology, and in weight. A ‘full response’ was measured using the EDE-Q, which assesses the frequency and severity of eating disorder symptoms such as binge eating or purging. It was defined as a global EDE-Q score of 2.77 or below (which is less than 1 SD above the community mean), and for underweight patients, a BMI of or above 18.5. For patients who weren’t underweight it included not engaging in bingeing or purging over the previous 28 days. Over 60% achieved a full response at the end of treatment. 54% of underweight patients, and 64% of non-underweight patients displayed a full response after 20 weeks.

In a scoping review of the literature on intensive community and home-based treatments as an alternative to inpatient care, Ince et al. (48) found that whilst controlled studies with larger sample sizes are needed, results appear promising, with high levels of patient satisfaction and significant improvements in eating disorder related measures.

“It was a really tough experience, challenging the ED. BUT, I honestly don’t think I would have fought it without being in this environment.”

Person with lived experience

Patients with co-occurring conditions and/or long-term eating disorders

Key points

- Co-occurring conditions in eating disorders are common, yet people often report their illnesses being viewed in isolation. People with long-term eating disorders also often report feeling unsupported despite the possibility of recovery at any stage
- Intensive community or day treatments can be effective for people with a co-occurring condition, which should not be a barrier to accessing such programmes
- They can also be effective for people with long term eating disorders, significantly reducing eating disorder and general psychopathology.

"In 2011, we set up an intensive service because we were seeing a 'revolving door' effect. About 50% of patients who were going into long-term inpatient units were coming out, but neither they nor their families had the skills to manage their care, leading to relapses".

Dr Victoria Chapman, Consultant Child and Adolescent Psychiatrist, speaking at the APPG inquiry for clinicians

Day treatment programmes have also been found to be effective for patients with co-occurring conditions and/or long-term eating disorders (109, 114-116). People with eating disorders often report not being accepted into specialist ED treatment because of a comorbidity, or due to the length of time they have had an eating disorder, which far too often leaves them without any support.

A case series (117) exploring the outcomes of a DTP in a sample of 91 participants, two thirds of whom had anorexia nervosa, found a reduction in eating disorder symptoms, and that this occurred regardless of co-occurring psychiatric conditions. The authors suggest that having a psychiatric comorbidity should not be an obstacle to receiving care in a DTP. Other studies have also noted the presence of comorbidities, noting the importance of addressing them in treatment (109, 118-120). Taking an integrated approach to patients with co-occurring conditions within treatment is crucial (121). Research by Brown et al. (109) studied the efficacy of an American DTP for 243 adult patients with anorexia nervosa or

bulimia nervosa. Nearly half of the sample had an illness duration of more than seven years, and over 90% had psychiatric comorbidities. Following an average of 90 days in the DTP, 40.3% of patients met the criteria for full remission at discharge, and 30.8% met these criteria at a 12-month follow-up. Remission rates among those who had an illness duration of more than seven years were comparable with those of the whole sample, reiterating the importance of maintaining hope for all patients with eating disorders.

Similarly, McFarlane et al. (115) studied a Canadian DTP which had been adapted for the treatment of more long-term eating disorders by the addition of two individual sessions per week (n=496). Rates of treatment response, and relapse rates at 6-months were no different between patients who had greater illness duration, or those with higher levels of depression and participation in previous more intensive treatments, when compared with those who were viewed as less 'complex'.

A systematic review (116) on treatment interventions for 'severe and enduring' eating disorders (a problematic term, and one the paper recognises as having no set definition but as being used to refer to high levels of distress and an illness duration of at least 7 years) found that whilst this field of research is heavily focused on anorexia nervosa and weight recovery trajectories vary, there are inconsistent long term results with inpatient treatment despite its efficacy with short-term symptom reduction. However, both DTPs and outpatient programmes appear to be promising for reducing symptoms and improving other areas such as readiness to

recover. These improvements were maintained in the selected studies that reported follow-ups.

Calugi et al. (122) compared adolescents with anorexia nervosa who had an illness duration of less than three years (n=122) with those with an illness duration of more than three years (n=37), both of whom received intensive CBT-E. They found no significant differences in treatment outcomes at the 20-week follow-up stage. Both groups

experienced significant improvements in BMI and percentage of expected body weight, and a significant reduction in eating disorder and general psychopathology. Approximately 60% maintained a full response. The authors propose that the model is effective for those with a longer duration of illness. The same model also displayed significant improvements and similar rates of remission for adults during the COVID-19 pandemic, albeit to a slightly lesser extent in the latter group (123).

Comparison of treatment outcomes with inpatient treatment

Key points

- Inpatient care poses a high risk of relapse and readmission. Whilst it can be effective in the short-term, its evidence base for supporting long-term outcomes is lacking
- There are few randomised controlled trials on this topic, but those that have been published demonstrate that stepped care day-treatment can be just as effective as continued inpatient treatment
- Integrated-CBTE (a planned inpatient admission followed by day treatment followed by outpatient treatment) appears to be a promising model.

"Inpatient was really traumatic, wasn't therapeutic at all. It was a really competitive environment and anorexia is competitive in its nature. So it's not geared towards recovery. It's almost like we're holding you here so you don't die, but that's it."

Person with lived experience

There are few studies exploring the differences in efficacy between DTPs and inpatient programmes, however the evidence available suggests that intensive DTPs are at least as effective as inpatient treatment.

A small randomised controlled trial comparing inpatient and day treatment for adults with bulimia nervosa was conducted by Zeeck and colleagues (124) in Germany. Both treatments significantly reduced eating disorder psychopathology, and there were no significant differences between remission rates at discharge or the 3-month follow-up.

One year after the end of treatment, there was a significant difference in the improvement of bulimic symptoms, with day treatment being advantageous, 5/15 (33.3%) inpatients deteriorated compared to 1/21 (4.8%) of day treatment patients. Despite this, there was no significant difference in the proportion of patients in full and partial remission, 9/15 (60%) inpatients and 10/22 (45.5%) DTP patients were still fully symptomatic (125). After three years, there were no significant differences between patients who had received inpatient treatment and those who received DTP; about one third of patients who were followed up showed complete remission, one third showed partial remission, and one third still continued to meet the criteria for bulimia nervosa (126).

In a landmark randomised controlled trial conducted in Germany, Herpertz-Dahlmann et al. (127) compared stepped care day treatment (three weeks of inpatient treatment followed by day treatment) to continued inpatient care for females with anorexia nervosa aged 11-18 years with a total sample

of 172 patients. The DTP was equivalent to inpatient treatment with respect to increase in BMI and maintenance of this over 12-months, and significant improvements in eating disorder symptoms were made across both treatment groups. This finding that stepped care day-treatment works just as well as inpatient treatment and that it was less costly indicates its advantages, and as the authors assert, justifies its implementation.

Litmanovich-Cohen (128) assessed the efficacy of a DTP following inpatient care for 61 adolescents with predominantly AN by comparing outcomes between those who did not attend the same DTP due to distance or choice, or attended it for fewer than 5 months (n=24), and those who attended the DTP for more than 5 months (n=37). There were no differences found between adolescents who completed the DTP in relation to BMI and severity of ED symptoms, and those who did not enter or complete the programme when admitted to or discharged from inpatient care. At the 1 year follow-up, 20.8% of the former group were considered remitted, whilst 45.9% of the latter group were considered remitted.

“For a long time, I assumed that this cycle of repeated admission and discharge was to be expected for an illness as serious as anorexia. I could not envisage a treatment programme that did not result in the patient being taken away from family and friends at a time of such great need and vulnerability”

Carer

A retrospective pilot study (129) in adolescents with anorexia nervosa compared outcomes of those who received inpatient treatment and those who attended a new day treatment programme in Italy. It found that those in the DTP had a lower number of treatment days, a higher increase in weight, attained the conditions required for discharge faster, and significantly better improvement in outcomes compared to the inpatient group. Whilst the sample size was small (n=34), and the study was non-randomised, the sample was matched for age and severity.

Li et al. (62) investigated audit data from an eating disorder service in London and evaluated the outcomes of an inpatient unit and two DTPs for 476 patients aged 18 or above with anorexia nervosa (including atypical anorexia nervosa). Of the two DTPs, one was a step-up (SU) programme (n=82) that aimed to help patients manage outside of a hospital setting, whilst the day-care (DC) programme (n=88) has a focus on full recovery and comprises more psychological therapy sessions. 45.5% of DC patients showed clinically significant changes in eating disorder symptoms, compared with 35.1% for inpatient, with both also seeing significant improvements in anxiety and depression symptoms, and work and social functioning. The focus of the SU programme was relapse prevention, and thus whilst work and social functioning significantly improved, BMI and psychopathology did not. Whilst direct comparisons are not possible due to the nature of the study, and because of different baseline characteristics for each programme, it indicates positive outcomes. Li et al. (62) also found that screening positive for possible autism was a negative predictor in the DC setting, potentially because DC requires more group participation and has strict adherence boundaries, which means autistic people may face additional challenges and the authors highlight the importance of considering the presence of autism when approaching treatment and ensuring models are effectively individualised.

A longitudinal cohort study (29) with an adult sample (n=212) compared treatment as usual with an integrated CBT-E programme (as described above, this is a planned inpatient admission followed by day treatment, followed by outpatient treatment), inpatient CBT-E without integrated aftercare, and 6-8 week inpatient admissions with partial weight restoration for crisis management. 70% of patients who received integrated CBT-E maintained good outcomes after a year compared to 29% of the inpatient CBT-E group, and fewer than 5% of the treatment as usual group and the 6-8 week admissions for crisis management only. Moreover, readmission rates were 14.3% for the integrated CBT-E group compared to approximately 50% in the other groups, indicating its benefits.

Comparison of treatment outcomes with outpatient treatment

Key points

- Most people will receive traditional outpatient care for their eating disorder comprising weekly or twice-weekly appointments
- For some patients, this is not effective and more input is required to make progress, which can be achieved through an intensive community or day treatment programme.

Kong (69) compared a Korean DTP to traditional outpatient treatments, including cognitive behavioural therapy and interpersonal therapy, for adults with anorexia nervosa, bulimia nervosa or EDNOS (n=43). The randomised controlled trial found that over the same time period, DTP participants showed significantly greater improvement on the majority of psychological symptoms of the eating disorder, frequency of binge eating and purging, BMI, depression and self-esteem scores, compared to outpatient treatments.

Simic and colleagues (130) evaluated treatment pathways and outcomes in a specialist ED service for children and adolescents over a five-year period (n=357) and compared outcomes between people who received any outpatient treatment with those

who also had an enhanced form of treatment through day patient or inpatient treatment, the latter of whom had worse baseline clinical characteristics. Positively, at discharge, there were no significant differences between the groups in relation to ED symptoms, anxiety, depression, OCD symptoms, and quality of life. Combining family, individual, and day programme treatment meant a longer duration of treatment, but also meant that those young people who required more intensive treatment were able to make similar progress by the end of treatment. The same service reported outcomes of its patients after 7 years (119) and found no significant differences in ED symptoms, and global and social functioning between patients who had received day and/or inpatient, and those who had only received outpatient care.

2. Greater treatment acceptability

Key points

- Inpatient care has been criticised by patients for being too restrictive with a disproportionate focus on weight gain
- Receiving treatment in the community can mean outcomes are more sustainable by enabling patients to apply skills into their daily lives
- Intensive community and day treatments are also less disruptive to social, work and educational life than inpatient care, which can lead to social isolation and concerns about reintegrating into daily life
- Patients report preferring intensive community and day treatments due to higher levels of flexibility
- When comparing drop-out rates with inpatient care, those for DTPs appear to be lower, which can be an indicator of acceptability.

"For me, the biggest things about my daughter going into the clinic were a structured day. It helped her understand what had happened to her... It helped her understand nutrition, exercise... It helped her to start to make sense of it and it held her accountable for her making changes to get herself better."

Carer

Qualitative accounts of intensive community and day- treatments are growing. Accounts tend to be positive and highlight that although challenging, these programmes are helpful and acceptable to patients (60, 131, 132). Comments from patients compare the intensive community model of treatment to

inpatient treatment and express that being in the community feels “a bit more normal” and that it is “easier to talk” when in their own environment, as well as the outcomes being more sustainable (132).

Similarly, results from focus groups with six parents or carers of adults with eating disorders and six adults with eating disorders highlighted that better availability and access to specialist outpatient services was preferable to inpatient treatment (37). This was due to reasons such as being able to carry over skills to their everyday environment immediately, less disruption to work, educational and social commitments, and less financial impact to the sufferer and their family. Matthews et al. (60) interviewed 11 patients of an Australian DTP, to learn about their views and experiences of the programme. Patients’ expectations of the programme varied. However, most patients viewed the DTP as helpful and all patients reported that their life had improved due to the programme. Patients viewed the programme as favourable to standard outpatient treatment:

“I’ve come such a long way in such a short amount of time compared to the weekly appointments I was having with my dietitian and my psychologist.”

Some patients report negative experiences of hospitalisation which are likely also to occur with intensive community and day treatment since they are linked to challenging the eating disorder, for example, patients with anorexia nervosa feeling a loss of control and distress when refeeding (133, 134). However, other experiences may be exacerbated through inpatient treatment. Hospitalisation is also associated with increases in social isolation and a loss of normality, with many patients concerned about reestablishing relationships once discharged (133, 135).

Rates of treatment drop-out offer an additional indication of treatment acceptability. Dropout from inpatient treatment is recognised to be high (59), with Olmsted et al. (47) reporting drop-out rates to range from 20% to 51%. Similarly, Gowers et al. (136) found patients (n=215) are more likely to complete treatment when randomised to an outpatient treatment setting, compared to inpatient

treatment. Patients had to be well enough to be randomised to either a community mental health team, specialist outpatient treatment or inpatient treatment. There was high non-take up of inpatient treatment after randomisation. Factors such as the patient feeling like they have a lack of choice over treatment (137) and the belief that inpatient treatment only focuses on tackling the symptoms of the eating disorder (138, 139) have been found to contribute to these high drop-out rates.

Less is known about drop-out from intensive community or day treatments specifically, although a review by Hepburn and Wilson (140) reported drop-out to range from 0 to 41% for DTPs. More recent research has shown drop-out rates including 21.8% (141), and 1.3%. (142). A systematic scoping review of adolescent DTP treatment models and outcomes investigated studies in which DTP is provided as an alternative to inpatient treatment and found that whilst non-completion rates ranged from 8.9-41.5%, most studies showed that this was around 20% (30). This suggests that although there is wide variability in drop-out rates across treatment programmes, DTPs may fare slightly better than inpatient care in this regard.

A study investigating the effectiveness of intensive CBT-E (28) in a sample of adolescent and adult patients (n=155, 75 adolescents and 81 adults) with anorexia nervosa and whether these were sustained over a 60-week follow-up period comprised a stepped-care approach as described above. All had experienced one course of outpatient treatment for AN that had been unsuccessful after at least 8 weeks of treatment. Approximately 70% of eligible patients agreed to start the program, and over 85% of those completed it, suggesting it was well-accepted. Of those who attended follow-up interviews, 48.9% of adolescent patients were in full remission at the 60-week follow up, the equivalent of which for adults was 55.6%. Studies using the same model have provided further evidence for its effectiveness, finding significant improvements in ED behaviours, psychopathology, and BMI, though more research is needed in patients who do not have AN (120, 123, 143).

A study investigating non-routine discharge (for reasons including patient/parent request,

resource constraints, or against medical advice) in adults (n=565) with anorexia nervosa admitted to different intensive settings found that the inpatient group had a lower rate of routine discharges (61%) whilst for the intensive outpatient and partial hospitalisation groups this was 74.4% and 74% respectively, suggesting its greater acceptability (144).

When comparing treatment drop-out from a DTP based on enhanced cognitive behavioural therapy (CBT-E) to outpatient CBT-E, Garte et al. (106) reported that approximately 24% of patients dropped out of a Norwegian DTP based upon CBT-E, compared to drop-out rates of 19% and 36% for outpatient CBT-E (145, 146).

3. Reduced hospital admissions and/or length of stay

Key points

- Inpatient care is often used for patients who could reasonably be treated in the community if alternative options existed
- It also has notable drawbacks for patients, such as a lack of social agency, social restrictions and a sense of separation from the outside world with high rates of relapse
- Enabling patients to remain in their home environment, or returning to it as soon as appropriate maintains elements of normality
- Intensive community and day treatments have been shown to reduce the average lengths of stay in hospital
- They can also be used as an alternative to inpatient care, with evidence showing they can prevent admissions.

"Day treatment support prevented me from being admitted as an inpatient. It allowed me to recover in my home environment, where many of the challenges that maintained my eating difficulties were present, and helped me to navigate these. It also allowed me to keep in touch with those in my life who supported me and helped me build a life away from the eating disorder, something that was so important for my recovery."

Person with lived experience

"Although I acknowledge that acute inpatient care will always be needed for some patients, I believe that were we to offer universal access to intensive community care, the need for admission to hospital would be significantly reduced."

Carer

In circumstances where inpatient treatment is needed, intensive community and day programmes can be utilised to provide a step-down from hospitalisation, thus reducing the length of admission period (34, 37, 45, 52, 147). In England, inpatient providers with stepdown services such as DTPs have been found to have a significantly lower average length of stay compared to those providers which have no step-down services (37).

Similarly, intensive community and day treatment can also be used as a step-up from standard outpatient treatment and can avoid the need for an inpatient admission (52, 101, 105, 148). For example, Serrano et al. (70) found that in the year following the introduction of a Spanish DTP for adolescents with eating disorders (n=77), the average length of stay for those in inpatient treatment was reduced from 30 days to 21 days. Another longitudinal, naturalistic study (142) assessing the effectiveness of a Spanish DTP for adolescents with anorexia nervosa had similar results, with the length of stay at inpatient treatment significantly reducing from 33 to 24 days since the implementation of the programme. The

DTP also reduced the inpatient unit waiting list and the frequency of consultations within the emergency department.

Rates of inpatient admissions following treatment in an intensive community or day treatment setting are likely affected by the type, intensity, quality of the programme offered, and patient factors (such as the severity of illness) and vary as a result. In an uncontrolled case series (n=131) of a UK-based DTP incorporating radically open dialectical behavioural therapy for adolescents with restrictive eating disorders, only 4.6% were referred for inpatient treatment (83).

Intensive community treatments have also been found to reduce or prevent hospital admissions. Flütsch et al. (63) investigated home treatment over 12 weeks as an add-on to FBT for adolescents (n=45) with anorexia nervosa (including atypical AN) and retained all participants. There were significant positive changes in BMI and ED psychopathology, and none of the patients required an admission to hospital. Treatment satisfaction was also high, with 89% of patients and 91% of parents rating it as good or very good.

In a similar pilot study Pauli et al. (66) compared adolescents with anorexia nervosa (including atypical AN) who received solely FBT for AN (n=22) with those who received FBT with home treatment (n=45). Allocation was not based on clinical characteristics or preferences but naturalistically on the basis of availability of the home treatment team. The group who only received FBT had significantly higher total scores on the Eating Disorders Examination at baseline than those who also received home treatment, with no other significant differences. There were no significant baseline differences between groups in relation to age, number of comorbid diagnoses, BMI, age of onset, or level of over-exercising. After three months of treatment the combined FBT+ home treatment group had a significantly greater increase in BMI, with none of the 45 patients requiring a hospital admission, whilst the FBT-only group had three out of 22 patients needing inpatient care. Implementing FBT into home-based settings is a promising approach, although there are challenges that

are important to address, including increased time and travel demands from clinicians, as well as with maintaining privacy, the potential for distractions, and safety of clinicians (149).

A service evaluation conducted by Hayes et al. (150) using a retrospective chart review found a significant reduction in the length of intensive treatment for children and young people from 143.19 to 97.2 days following its transition from a group-based day programme (n=86) to an intensive family treatment approach (n=104). Patients were aged 10–18 and attended the Royal Free Hospital Eating Disorder Intensive Service (which is also described in a case study in the appendix of this report) between March 2017 and April 2023, with the final three years being the period in which the intensive family treatment approach was implemented. In the former group, 33.7% of patients required an inpatient admission, whilst in the intensive family treatment model, 10.6% were referred to inpatient care. A key feature of the programme was its integration with an outpatient service. Whilst there are other possible explanations for these outcomes, admissions have continued to decrease and the data highlights both the benefits of intensive community programmes in reducing admissions and the importance of incorporating evidence-based treatments of the right intensity.

A study investigating the feasibility and acceptability of a home-based intensive treatment programme for adolescents in Spain and Latin America (n=59), with 47.5% of participants presenting with a comorbid mental health condition, had a mix of patients either stepping down (n=36) or stepping up (n=23) care. It found a reduction in hospital admissions, parents described it as 'very safe', and the retention rate was 91.52%, indicating its acceptability. In its first year of operation, over 80% of calls made to the nursing team by carers requesting support due to a crisis situation were able to avoid a referral to the emergency department or inpatient care (120).

"It was just a godsend when I found a clinic who... could take her. And so she spent four months [there]... And it was a bit like a school. It was a structured day and she had to get there at a normal time and she had to eat with other patients... That four months was the difference between a really bad situation at home where she... would have gone inpatient."

Carer

Allowing patients to remain in their home environment or return to it quicker following inpatient treatment maintains elements of 'normalisation', such as social or vocational aspects. This allows therapeutic gains to be transferred and alternative coping mechanisms put in place in the situations which play a role in maintaining the illness, such as family conflict and peer relations (45, 132, 151).

Analysis of a focus group of six parents and carers of adults with eating disorders highlighted concerns that inpatient units were not equipping patients to cope when discharged, due to the focus on restoring someone's weight rather than on their thoughts and feelings (37). This suggests that

allowing patients to step down from inpatient treatment into an intensive community or day programme will reduce relapse rates following admission, as patients continue to receive support to help them work on their thoughts and behaviours in their home environment.

"This new [enhanced treatment] service so far has seen about 50 patients and is doing very well. The service sees people at all illness stages, from those with recent onset who present for the very first time, and those who have a long-standing illness or are at risk of relapse. Over 80% of those, although they were initially flagged as potentially needing admission, didn't need admission once they began the enhanced treatment and were safely treated in this way. Patient motivation and close involvement and support from close others are key in this respect."

Professor Ulrike Schmidt, Professor of Eating Disorders, speaking at the APPG inquiry session for clinicians

4. Lower cost

Key points

- Inpatient stays are widely recognised to be expensive, with hospitalisation being a major contributor to the cost of illness
- Available evidence indicates that implementing intensive community and day treatment programmes as opposed to exclusively inpatient care can reduce costs
- NHS England data shows that for children and young people in 2024/25, average savings of £1111 could be made for each day that is spent in a day service instead of an inpatient unit
- Attributed to a reduction in the number and duration of admissions, service data indicates that such programmes are more cost-effective, and this combined with their other benefits justifies their implementation.

"As the [intensive community] model has demonstrated not only is their approach more compassionate and holistic it is also cost effective."

Carer

This difference in costs between inpatient units and outpatient services in the treatment of eating disorders is recognised by NICE and is well documented (127, 152-154), with hospitalisation being identified as a major contributor towards the cost of illness (142),

with a lack of evidence regarding its superiority (59). Intensive community and day patient treatments cost the NHS considerably less than inpatient treatment for reasons such as fewer resources required and a reduction in the number of days of intensive service needed (45, 155).

In addition to allowing patients to stay at home or return to their home environment quicker, avoiding or reducing inpatient admission time also has the benefit of reducing the overall cost of treatment. As described above, the randomised control trial conducted by Herpertz-Dahlmann et al. (127) in Germany compared continued inpatient treatment for adolescent patients with anorexia nervosa to a 3-week inpatient admission followed by DTP (n=172). Patients were screened for eligibility in the years 2007–2010. The addition of a DTP reduced the cost by about 34% compared to continual inpatient treatment – cost per day for DTP was US\$331 compared to US\$504 for inpatient treatment. This was despite there being no significant differences between treatments with respect to BMI and other clinical outcomes at the 12-month follow-up, or to treatment-related serious adverse events.

Similarly, Williamson and colleagues (152) evaluated the outcomes for patients with severe eating disorders (n=51) when initiating their treatment in a DTP compared to an inpatient unit in the USA, both of which had different criteria. Patients who were initially assigned to DTP spent significantly fewer days in inpatient treatment (mean = 5.7 days), compared to those who were initially assigned to inpatient treatment (mean = 15.8 days), with treatment outcomes significantly improving for both groups. Published in 2001, they found that initially assigning individuals to DTP rather than inpatient treatment led to a cost saving of \$9,645 per patient, 43% of the total cost of those who began with inpatient care. It demonstrates that stepping up or stepping down treatment when appropriate rather than exclusively providing inpatient care can reduce costs.

As mentioned earlier in this report, data from NHS England indicates that in 2024/25, whilst costs vary, the average cost per day in a CAMHS day service will be £462, compared to £1573 per day in a CAMHS inpatient service (38–41),

suggesting that savings of £34804 could be made over the course of four weeks (where the day service is attended for five days per week) when an inpatient admission is appropriately avoided or reduced in length.

Findings from South London and Maudsley's Trust shared with Beat in 2019 (156) report that £87,000 can be saved per young person, for admission to an intensive treatment programme rather than an inpatient unit. These savings are due to a difference in average treatment duration, with fewer days in treatment necessary when the young person attends the intensive treatment programme (38 days compared to 196 days in an inpatient unit).

Similarly, research by Munro and colleagues (157) has demonstrated the cost-saving potential of intensive community services. Prior to expanding their service to treat all the local patients with severe anorexia nervosa needing that level of care in 2008, NHS Lothian's Anorexia Nervosa Intensive Treatment Team (which has been redesigned since the research was published) cost £370,000 and inpatient admissions cost £918,208, giving a total annual cost of care for people with severe anorexia nervosa of £1,288,208. By 2011, after service expansion to meet demand, the total annual cost had fallen to £896,552, with inpatient costs at £347,552 and the ANITT costing £549,000. Therefore, there was a total annual saving of £391,656 in 2011, compared to 2008. This was attributed to a reduction in the number and duration of admissions.

In another study published in 2020, Herpertz-Dahlmann et al. (92) investigated the feasibility, effects, and safety of home treatment for adolescents with AN following 4–8 weeks of inpatient treatment (n=22). There were significant changes in BMI and eating disorder psychopathology, thereafter stabilizing, and the majority of patients had maintained a healthy weight at the one-year follow-up. Carers' skills increased with a significant decrease in caregiving burden, and high levels of treatment satisfaction in patients and carers. The typical IP stay for adolescents with AN in Germany is 17 weeks, which at the study site cost €56,000, whereas this approach cost approximately €41,000, which is approximately 25% lower, and suggests its lower cost.

The cost per day for a home-based intensive treatment programme in Spain and Latin America that led to a reduction in admissions was €874, and compared to conventional inpatient treatment, the program saved a total of €1,762,292 (120) during its first year of activity from July 2021 to the end of June 2022 through avoiding inpatient stays.

The cost-benefits of intensive community and day treatments are also apparent when considering that lower BMI is a significant predictor of higher hospital costs. Toulany et al. (158) performed a cost-analysis of a Canadian inpatient treatment centre for adolescents (n=73) with anorexia nervosa in the period from September 2011 to the end of March 2013. They found that for every unit increase in BMI at admission, hospital costs were reduced by 15.7%. Therefore, even when inpatient treatment is necessary, prior support through intensive day- or home-based treatment increases the likelihood that the patient's BMI will, to a certain extent, have been stabilised, thus reducing the inpatient admission cost.

"It was really clear, at that point in time, that for a large proportion of patients, going into hospital was a temporary fix and not a permanent solution... Using that [home treatment] approach, we kept 70% of young people out of hospital and reduced our use of bed days by 50% when comparing three years prior to having that programme with the three years after. This represented a significant financial saving. The team consisted of five relatively junior staff, band 5, with a band 6 leading them. We were able to successfully run that programme for eleven years."

Sam Clark Stone, Lead Clinician,
speaking at the APPG inquiry session for
clinicians

5. Increased family/carer empowerment

Key points

- The impact of an eating disorder is usually experienced more widely than the person affected, with families and carers often reporting anxiety, hopelessness and fear
- However, families and carers can play an integral role in someone's recovery when empowered and supported to do so
- Providing intensive community and day treatment programmes can improve carers' self-efficacy and confidence in supporting their loved one, with confidence continuing to increase over time
- They prevent challenges caused by separation through an inpatient admission, allow families and carers to take an active role in their loved one's recovery, and are easier to adapt into everyday life whilst also providing routine and structure.

"For what is so often ignored and certainly underestimated is the extent to which our mental health is entwined. A seriously mentally ill individual has a much better chance of long-term recovery if surrounded by those that they love and who love and care for them."

Carer

Families and carers often experience distress and feelings of hopelessness when their

loved one has an eating disorder. This can often be exacerbated by a lack of information and guidance (159), as well as a sense of disempowerment when the person they care for is admitted to an inpatient unit, often reporting feeling like they should have been able to prevent it. They also report feelings of anxiety about how they will manage once the sufferer returns home (1). Although inpatient units are shifting towards adopting a more family-based approach (160), supporting the

family to help their loved one in the community is likely to be more empowering.

Family-based DTPs have been found to increase parents' self-efficacy and confidence in supporting their loved one (160), with many improvements being maintained or improved upon (30) at 3-month (86, 161, 162), and 6-month follow-ups (71, 161, 163). For example, Girz et al. (161) studied a family-based DTP in Canada, and found that parents' self-efficacy increased during the first three months of treatment, whilst their knowledge and confidence in tackling the illness continued to increase between three and six months post-assessment. Van Huysse et al. (65) examined weight gain and parental self-efficacy in the first five weeks of a PHP for adolescents with anorexia nervosa (n=98) or atypical anorexia nervosa and found significant increases in weight. There were also significant increases in maternal efficacy, which improved within two weeks of treatment starting. A study in a sample of 39 adolescents with ARFID and 59 (164) with AN in a PHP also found significant reductions in caregiver accommodation and enabling behaviours, which were also associated with reduced caregiver distress, and eating disorder psychopathology.

In a qualitative study (165) exploring experiences at a day treatment program, parents reported the importance of therapeutic relationships and feeling part of a team, as well as the social benefits of connecting with other parents, an aspect of which was the reduction of feelings of blame. There was also the sense of relief and being reassured that their children were in safe hands, a key part of which was the intensity of the program in that it gave adolescents structure and predictability.

Families also described having a better understanding of eating disorders through a home treatment program, an increase in confidence, the benefits of avoiding separation from their loved one, being able to take an active role in their recovery and the ability to adapt the program into everyday life (120). Challenges were predominantly in relation to family logistics.

“Parents are thought to be experts in their children’s care. So, all the support is given, primarily, to the parents and carers to help them manage... We also do a parent/carer group, which is sort of psychoeducation, but also managing emotions and feelings, and that runs every week for six weeks and that’s online... Parents can phone in at any time and say if they are having a difficult dinner and we talk you through it.”

Dr Victoria Chapman, Consultant Child and Adolescent Psychiatrist, speaking at the APPG inquiry for clinicians

DELIVERING INTENSIVE COMMUNITY AND DAY TREATMENTS USING A VIRTUAL OR HYBRID APPROACH

Key points

- The benefits and drawbacks of delivering psychological treatments virtually are well-documented, with emerging evidence for the effectiveness of delivering intensive community and day programmes virtually – either entirely or partially – much of which was conducted during the COVID-19 pandemic
- Virtual treatments can improve accessibility in rural and remote areas and prevent patients, families, carers, and clinicians having to travel long distances
- Outcomes for virtual programmes appear to be the same as those delivered face-to-face
- Patient preferences should be taken into account, with some preferring virtual to face-to-face and vice versa
- They also make it possible to treat patients out-of-area
- There are additional factors to consider when delivering programmes virtually, including reducing isolation, data protection, transitioning to virtual support after face-to-face treatment, and observing meal support.

The use of telehealth has been recommended in both the Welsh and Scottish eating disorder service reviews (17, 166) the former of which asserts the strong evidence base for its use as a therapeutic medium, and that it is generally well accepted when complementing and augmenting face-to-face approaches, which it asserts is how it should be integrated into the delivery of treatment.

The Scottish eating disorder service review specifies that its use can ensure people with eating disorders and their families can access the full range of SIGN-approved treatments and that there is consistency in the range and quality of treatment provided regardless of where someone lives. It can also facilitate different teams in different areas working together.

The role of virtual platforms in delivering psychological treatments, and in virtual teams is recognised in the Northern Ireland Mental Health Strategy, and in guidance from NHS England respectively (52, 167, 168).

In the context of intensive community or day treatment programmes, virtual delivery – either exclusively or alongside face-to-face treatment – may have a number of advantages, notably in offering a solution to rurality and enabling people to receive treatment in

a familiar environment without having to travel long distances, thus enabling better application of skills developed. This section provides an overview of recent research on virtual and hybrid delivery, and some actions identified to mitigate challenges.

During the COVID-19 pandemic, many eating disorder services adapted their treatments to be delivered in virtual formats and research is slowly emerging on their outcomes. Whilst some of the opportunities and barriers identified are unique to lockdown restrictions and more research is needed exploring and comparing different models and their outcomes, it currently demonstrates advantages and drawbacks to both in-person and online treatments, suggesting that tailored approaches which consider patient preferences should be applied.

Outcomes

Whilst there are additional factors to consider when delivering virtual intensive community or day treatments, some of which are outlined below, outcomes are promising (65, 169-171). Levinson et al. (169) compared patients who attended an in-person American DTP (n=60) and those who attended during the COVID-19 pandemic (n=33) when it was translated into telehealth format and found that both

groups had significantly higher BMI and lower ED symptoms, depression and perfectionism when discharged, with no significant differences between the two groups.

A study of a virtual intensive outpatient program (172) had 57 patients, all of whom completed the 6-week programme, with significant and clinically meaningful improvements on ED symptoms and related measures. Another study comparing outcomes of its PHP when it was delivered in-person (n=49) with outcomes of its virtual intensive outpatient program (n=53) for patients predominantly with anorexia nervosa or atypical anorexia nervosa developed in response to the COVID-19 pandemic found similar outcomes in relation to weight restoration and no significant differences in the frequency of hospital admissions during or after treatment in the 6 months following discharge (67). It suggests virtual programmes could be a cost-effective form of treatment for those who are not geographically close to a treatment centre when this is in line with patient preferences.

In a similar study, Ortiz et al. (173) conducted a retrospective chart review comparing baseline symptomatology and treatment outcomes between an in-person PHP (n=46) and its virtual equivalent (n=46) (also implemented due to the COVID-19 pandemic) for young adults (aged 16-30). This found significant differences in initial symptomatology, but a comparable degree of change in both versions, indicating their effectiveness, and again, their potential utility for those in non-urban areas.

A similar study compared clinical outcomes of its online day treatment programme (implemented due to lockdown restrictions) with its face-to-face version in a sample of 29 adults with AN and found that BMI significantly improved in the face-to-face model, whilst overall eating disorder symptoms, frequency of behaviours, and work and social functioning improved significantly in the online treatment (170).

Penwell et al. (171) compared 70 patients with different eating disorders who attended their traditional face-to-face PHP with 70 patients who attended a virtual version implemented due to the pandemic. They found that whilst

those with AN in the virtual version made significantly less improvements in BMI, those experiencing binge eating episodes in the virtual version reported significantly fewer episodes at discharge than those in the face to face version. No other significant differences were found, including ED severity, anxiety, and depression. Whilst more research is needed and the pandemic may have affected results, such studies indicate that virtual and hybrid treatments can be a viable way of delivering care.

Patient satisfaction

Findings on patient satisfaction are varied, and it is important to note that factors additional to the model of delivery (such as the quality of treatment or the availability of carer support) will likely be contributors to satisfaction ratings.

Brothwood and colleagues (174) report the experiences of both young people (n=14) and their parents (n=19) who transitioned to an online DTP due to lockdown restrictions – with only urgent and crisis appointments offered face-to-face – that then moved to a hybrid model when restrictions eased. The quantitative data show that whilst both young people and parents found the virtual program helpful, young people generally found the online components less helpful than their parents, and more than half expressed a preference to return to face-to-face support, excluding medication and dietetic reviews. Another qualitative study (175) exploring the experiences of adolescents, carers, and healthcare providers of transitioning to a virtual DTP for patients who had not responded to outpatient treatment during the COVID-19 pandemic also had 11/12 of its participants express that an in-person program would be superior to virtual programs (11/12 had had exposure to both settings). The authors suggest a hybrid model of treatment that utilises increased family involvement and in person appointments would improve the model.

Conversely, Rienecke et al. (176) found that patient satisfaction with virtual treatment was high. They investigated a virtual intensive outpatient programme and explored patient satisfaction by age in a sample of 305 adults and 33 children. Those over the age of 40 did not report lower satisfaction scores than other

age groups as hypothesised, and no significant differences were found between adults and children/adolescents, with patient satisfaction high across the different age groups.

Improved accessibility for patients and their families/carers

A key advantage of virtual treatments is improved accessibility.

Webb et al. (177) interviewed clinicians (n=21) who worked with patients with AN in intensive treatment settings during the pandemic, describing the process of moving a DTP online and described that there was a level of flexibility that meant patients were able to focus on life outside of the eating disorder alongside increased flexibility for patients, carers and staff members who were unable to attend face-to-face. They also noted the ability to support patients out-of-area, reducing competitiveness, enabling more involvement of families, and embedding treatment into people's lives. It was also expressed that it could be beneficial for autistic people, or those with social anxiety or physical health vulnerabilities although more research is needed on this.

Qualitative research exploring experiences of young people (n=14) and their parents (n=19) during the COVID-19 pandemic (174) found that for parents it allowed for work schedules and family life to be accommodated. For young people, there was greater flexibility with online therapy in relation to appointment timings. Some young people cited the screen as a barrier that disrupted therapeutic relationships, whilst some found the distance helpful in opening up. Online meal support could be delivered whilst they were at school, and virtual meal support at home felt more translatable into daily life, but face-to-face meal support was still rated more helpful. Alongside providing a more accessible service in relation to travel costs and schedules, additional benefits include better communication with staff for some patients, increased parental involvement and importantly, the ability for participants to have meals culturally appropriate to them in their own environment (175).

Reducing isolation

A loss of connection and building relationships, between young people themselves and between their parents/carers, is a challenge with virtual treatments identified by Blalock et al. (172). Working online required adjusting to a new method of social communication and young people cited barriers in developing therapeutic alliances with their team, but that it did help having initially met in-person. In another study (178) some patients preferred waiting for face-to-face therapy, and new patients suggested a virtual program is not as intensive due to the lack of support between different elements such as mealtimes. Given the isolating nature of eating disorders, it is possible a hybrid approach with additional opportunities for support and communication could mitigate this challenge.

Additional factors to consider when delivering virtual treatment

Ensuring that clinicians are well-supported and trained when delivering intensive community and day treatments virtually is also important. Whilst some of the challenges and benefits identified in recent research are specific to lockdown restrictions there are key issues to highlight. Clinicians interviewed by Webb et al. (177) reported concerns about moving meal support online in relation to attendance and monitoring food intake, worries about the potential for progress slowing down, having to rely on self-reported weights, social isolation, needing to ensure patients had a private space, and the potential to increase pressure on carers.

Blalock et al. (172) also described considerations such as additional training for staff on ethics and conducting virtual therapy before recruitment began for the study, and factors such as instructing patients on how to hide self-view on virtual platforms if necessary. Other factors to consider include data protection, internet access and visual impairments (178).

Transitioning to a virtual programme when it follows more intense face-to-face support also requires careful management. A qualitative study exploring experiences of adults (n=10)

transitioning from inpatient care to a DTP that was virtual due to the COVID-19 pandemic highlights that the period following discharge from inpatient care is a vulnerable one, with patients needing to develop effective support systems (179). Whilst all participants described finding the virtual programme helpful, they also experienced challenges such as feeling a sense of disconnect from staff and peers, doubts about recovery, and difficulties related to seeing themselves on screen.

Some of the above concerns are relatively easy to address, whilst others require careful consideration (180). In another study, patients reported being able to conceal disordered eating during virtual meal support (175), which is a challenge also identified by Plumley et al. (178), who implemented additional observation measures. They also found that some groups were easier to do online, such as those that had a clear structure and activities, whilst creative groups that required more interaction were more difficult, and they found that inviting contributions from each member worked best.

LIMITATIONS OF INTENSIVE COMMUNITY AND DAY TREATMENT PROGRAMMES

The use of intensive community or day treatment programmes in place of an inpatient admission is not risk free. Treatment is less intensive and offers increased freedom to patients, thus allowing more opportunities for disordered behaviours to be maintained. However, this must be set against the risks of patients deteriorating in response to the highly controlled (and potentially controlling) environment of an inpatient setting (22-27), particularly when they no longer need to be admitted for their own safety.

Regardless of treatment approach, physical and psychological risks can be significant among those with eating disorders. Assessment and management of risk is as central to intensive community or day treatments as it is to inpatient care. Following the Medical Emergencies in Eating Disorders (MEED) guidance is a key part of ensuring those with eating disorders who need urgent care can be identified and treated as soon as possible (181).

When someone is at a high level of physical risk, suicide risk or risk due to their home environment, it is likely that inpatient treatment is more appropriate than continuing care in the community, at least until these risks have reduced sufficiently. Additionally, if a patient's home life is unsafe or is driving the illness, then a period away from this may be more beneficial to them.

Intensive community or day treatments may also feel like a greater commitment to the patient, due to the demands of programme attendance such as travel arrangements and costs, which will be a particular challenge in rural and remote areas (45). As research continues to be published, hybrid treatments may be a factor in addressing some of these challenges.

Consent to treatment should also be considered. Treatment cannot be given without consent, and consent is required for patients to engage in an intensive community or day treatment programme as the use of the Mental Health Act in the community is limited.

POLICIES SUPPORTING PROVISION OF INTENSIVE COMMUNITY AND DAY TREATMENT PROGRAMMES

England

NHS England's guidance to commissioners and providers to support implementation of the Access and Waiting Time Standard for Children and Young People with an Eating Disorder (167, 182) highlights the importance of intensive community (including home treatment) and day patient treatment. NHS England states that community eating disorder teams for children and young people should "...have the experience to be able to provide home treatment..." (167; p.45) and that: "The recommended approach to treating an eating disorder is NICE-recommended care in the community with a CED service, supported by intensive day care or brief inpatient management for addressing acute complications." (167; p.8).

Similarly, NHS England's guidance for commissioners and providers of adult eating disorder services (52) states that the optimal model of service delivery involves community eating disorder services being able to provide intensive community treatment and delivering or supporting day treatment to reduce inappropriate inpatient admissions.

NHS budgets for specialised inpatient mental health care in England are managed by NHS-led Provider Collaboratives, following delegation from NHS England in 2020 (183). These collaboratives are partnerships between NHS Trusts, independent sector providers and others involved in providing these services. They are expected to minimise the need for inpatient admission and the length of hospital stays in their areas. They are able to retain financial savings and re-invest these in improving care locally. This incentivises greater investment in intensive community and day treatment programmes (183).

NHS-led Provider Collaboratives cover large geographic areas that typically span more than one Integrated Care System (ICS). NHS England intends to delegate the commissioning of these partnerships to groups of ICSs, via a

lead Integrated Care Board (ICB), from April 2025 (184). This will offer the potential to more directly join-up budgets across the whole care pathway, and further incentivise investment in shifting care closer to home, which is also in line with the findings of the Darzi report (185).

Scotland

The national Mental Health and Wellbeing strategy set several national priorities, including: "...supporting care as close to home as possible and promoting independence and recovery." (186; p.21)

The National Review of Eating Disorder Services found that patients and carers "...experience a postcode lottery with variability in services across the country" (187; p.7). It recommended that: "The Scottish Government should commission and fund equitable provision of high-quality accessible specialist community-based services for eating disorders across Scotland for all ages, which see all types of eating disorders across the range of severity" (17; p.25).

The Scottish Government has recently consulted on a draft 'National Specification for the Care and Treatment of Eating Disorders in Scotland'. This is being developed to help guide implementation of the recommendations from the National Review. The draft section on service structure states that "...when individuals cannot be managed in the community due to physical or psychiatric risk, there is a need for a range of more intensive service structures inclusive of day patient, intensive outreach, and inpatient treatment." (188; p.19).

The draft calls on Health Boards to "ensure a range of services, with varying intensities of provision are developed" and to "ensure a range of options in the delivery of care are offered which are person-centred and responsive" including "day services" and "outreach including intensive outreach services" (188; p.20). It states that different service models may be needed in Health Boards with small

populations to enable them to offer equitable access to intensive treatment and suggests the development of regional specialist eating disorder multi-disciplinary teams (188).

Recommendation 3 of the review included establishing a National Eating Disorder Network to guide implementation of the reviews' recommendations on an ongoing basis (187). In its progress report on the first year of implementation the Scottish Government stated that, this network will be tasked with assessing "...what services should be available across Scotland and the staff required to support these services." (189).

Wales

The draft national Mental Health and Wellbeing Strategy 2024-2034 that the Welsh Government consulted on in early 2024 prioritises "...early intervention, more support in the community and alternatives to hospital admission." (190; p.49).

The Welsh Government Eating Disorder Service Review 2018 found major variation in the availability and quality of treatment, gaps at the interfaces between services rather than integrated care, and families often not properly informed, supported and empowered (166). The review set out an ambitious vision for Wales to become world-leading in its response to eating disorders. It called for a shift towards prevention and early intervention and equitable access to evidence-based treatment and support across the whole of Wales.

The Mental Health Specialised Services Strategy for Wales 2024/25-2028/29 stated that a feasibility study will be conducted "to

consider an Eating Disorders Unit for Wales for both in-patient and Day Service Provision across all ages" (191; p.73). The strategy explains that the consideration of day patient provision will consider whether this should be attached to the potential new inpatient unit or provided via "satellite services". (191; p.41).

It also suggests that input from health care support workers should be available for all Health Boards to enable adult community eating disorder services to provide meal support in the community. It argues that this would help minimise hospital admissions and improve the support available to patients after discharge from inpatient care. (191).

Northern Ireland

The current Regional Care Pathway for the treatment of Eating Disorders advocates a stepped care approach that incorporates 'High intensity mental health services' including "intensive day programmes" (192; p.15).

The Mental Health Strategy 2021-2031 included an action to "Ensure there are specialist interventions available to those who need it. In particular:... Enhance the regional eating disorder service." (Action 29). The strategy pledged to provide additional investment in eating disorder services to equip them to "... deliver effective care across the pathways", including by developing "intensive day treatment facilities" (168, p.76). Implementation of these commitments would support achievement of the recommendations made by phase 3 of the Review of Eating Disorder Services in Northern Ireland, that was published in 2019 (193). This review concluded that such investment would be likely to reduce long term costs.

PROVISION OF INTENSIVE COMMUNITY AND DAY TREATMENT BY THE NHS ACROSS THE UK

To investigate the provision of intensive community and intensive day patient treatment programmes for eating disorders across the UK, Beat submitted Freedom of Information (FOI) requests to all 62 providers of NHS eating disorder services in England, all 14 NHS Health Boards in Scotland, all 7 Health Boards in Wales, and all 5 Health and Social Care (HSC) Trusts in Northern Ireland. These were sent on 21 December 2023.

All of these organisations responded except for 1 of the NHS Trusts in England (a 99% response rate). Within the FOI we also sought information on whether patients are referred to receive intensive community or intensive day patient treatment from another NHS or non-NHS provider (such as services provided by a non-profit or private sector organisation).

To analyse the results, a recommended level of intensity and programme design was defined from the current evidence-base and expert opinion obtained from the project's advisory group. That definition was:

“Patients should be able to access an intensive community treatment programme capable of providing at least four change-focused contacts over at least 3 hours per week, including supervised meal support, and the service should have the ability to adjust the intensity flexibly according to the needs of the patient. Patients should be able to move if needed to a more intensive community or day treatment programme providing at least 20 hours of care, spread over a minimum of four days per week including supervised meal support. These treatment programmes should be provided by a multi-disciplinary team and be offered for at least 6 weeks with the ability to extend thereafter if clinically necessary.”

The headline results are reported in Table 1 below, broken down by country/region.

Across the UK:

- 10 out of 67 NHS areas* (15%) offered the recommended level of intensive community and/or day patient treatment for both children and young people and adults.
- 4 out of 67 NHS areas* (6%) offered the recommended level of intensive community and/or day patient treatment for children and young people but NOT for adults.
- 7 out of 67 NHS areas* (10%) offered the recommended level of intensive community and/or day patient treatment for adults but NOT for children and young people.

* 'NHS areas' is used here as a term to encompass Integrated Care Systems (ICS) in England, Health Boards in Scotland and Wales, and Local Commissioning Groups (LCGs) in Northern Ireland. We were unable to consider the level of service provision in one ICS due an NHS Trust based in that area not responding to our FOI request. It should be noted that the terminology of 'NHS' is not used in Northern Ireland, where health and social care services are integrated under Health and Social Care (HSC). Like the NHS, HSC is free at the point of delivery. Local Commissioning Groups (LCGs) in Northern Ireland are due to be replaced by AIPBs (Area Integrated Partnership Boards) covering the same geographic areas in late 2024.

| | NHS areas*: Integrated Care Systems (ICS)/Health Boards/Local Commissioning Groups | Number and proportion of NHS areas offering the recommended level | |
|------------------|--|---|-----------|
| | Number | Number | % |
| England** | 42 [41] | 7 | 17% [17%] |
| Scotland | 14 | 2 | 14% |
| Wales | 7 | 1 | 14% |
| Northern Ireland | 5 | 0 | 0% |
| Total** | 68 [67] | 10 | 15 [15%] |

Table 1. Number and proportion of NHS areas providing the recommended level of intensive community and/or day patient treatment for both children and young people and adults
 **Figures in square brackets are presented to account for missing data due to 1 NHS Trust not responding to the FOI request, making it impossible to assess service provision in 1 ICS.

The responses showed that a significant number of areas provide intensive treatment programmes where patients receive over 20 hours per of care per week but do not provide a less intensive option between this and standard outpatient care. This was the case for 17 ICSs in England, and 1 Health Board in Scotland although only 4 of these areas within this group (all ICSs) provided such programmes for both children and young people and adults.

To determine whether an intensive community and/or day patient treatment programme met the specification in our definition on the minimum duration of treatment, any programmes described as being offered to patients for up to 6 weeks (or less) as a maximum, with no reference to the possibility of flexible extension were excluded. Among the programmes assessed as meeting our standard, the maximum duration of treatment varied widely, ranging from 8 weeks to 1 year, with some alternatively stating that this was flexible, and based on clinical/patient need.

Analysis of the responses also found that the criteria for patients to access the intensive community and/or day patient treatment programmes varies widely, although some answers offered limited detail.

Some providers described a flexible approach to access criteria, such as “... It would be done in an individualised way, depending on risk and level of engagement.” or “All patients with an eating disorder who

are at risk of an SEDU [Specialist Eating Disorder Unit] admission”. Others outlined several factors that would all be considered.

Many providers stated that their programmes were only for people with a diagnosis of anorexia nervosa. Many cited specific criteria based on BMI or, in the case of children and young people, expected weight for height, contravening NICE guidance (34). It is impossible to reliably quantify the proportion of providers that this represents due to the limited detail given in some of the answers to this question. Some providers reported applying the risk criteria from the MEED guidance, within their inclusion/exclusion criteria. One NHS Trust stated that to access its intensive community treatment programme children and young people must have “not previously had an Eating Disorder”. Only a minority of providers/programmes reported being resourced to support the treatment of patients that require NG Tube feeding.

The FOI request also sought data on the size of the caseloads (in terms of the number of accepted referrals) at the intensive community and/or day patient treatment programmes on two specific dates in 2023. Amongst the Providers that were able to extract and report these data the caseload sizes varied widely. This is not surprising as the size of the catchment areas/populations served will vary significantly too. However, many reported caseloads of fewer than 5 patients, which suggests limited capacity to meet local needs.

Some NHS Trusts that responded to the FOI provided data evidencing the impact of their intensive community and/or day patient programmes that appears not to have been published. One trust provided data showing positive clinical outcomes at the end of treatment and at follow-up, while two other Trusts provided data suggesting that their programmes have led to a reduction in inpatient admissions.

It should be noted that these findings are not comparable to those of the FOI request conducted by Beat on the provision of such intensive treatment programmes in 2019. A different recommended level of intensity of treatment has been applied in this analysis, and there have been structural changes within the NHS in England during this time including the merger of some NHS Trusts.

CONCLUSION

Intensive community and day treatments have been found to be at least as effective as inpatient care in the treatment of eating disorders, can be used to treat patients with comorbidities, are more preferable for patients, can reduce the number and length of hospital admissions, empower families and carers, and are provided at a significantly lower cost than inpatient care.

There is sufficient research and practice-based evidence to support the effectiveness, cost efficiency and acceptability of intensive community and day treatment programmes to justify the necessary investment and impetus for ensuring all those who could benefit from such a programme are able to access one.

At present, less than a fifth of NHS areas offer the recommended level of intensive community and/or day patient treatment for both children and young people, and adults. Addressing the considerable challenges faced by eating disorder services in the UK requires treatment options that provide the 'right level' of care across a spectrum, instead of care on either side of it.

The views of patients, their families and friends, and expert clinical opinion also support the use of intensive community and day treatments in eating disorders. In light of the significant advantages demonstrated, Beat encourages the NHS to ensure that patients of all ages in all parts of the UK can readily access an appropriate service. We encourage increased innovation and urge the develop and evaluation of new models of intensive community and day based treatment so that the most effective models can be identified and shared.

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APPENDIX A: LITERATURE REVIEW METHODOLOGY

A literature review of academic research relating to intensive community treatments for eating disorders was conducted and forms part of this report. A previous version of this report was published in 2019, in which three databases were searched, Embase, PsycInfo, and Medline. Search terms were “eating disorder” AND “day treatment” OR “partial hospital” OR “partial hospitali*ation” OR “day hospital” OR “day hospitali*ation” OR “intensive outpatient service” OR “intensive community”.

A new search was conducted for this report. Four databases were searched, Embase, PsycArticles, PsycInfo, and Medline, with a cut-off date of 31/05/2024. Search terms were “eating disorder*” AND “day treatment” OR “day patient” OR “day hospital” OR “day hospitali*ation” OR “partial hospital” OR “partial hospitali*ation” OR “intensive outpatient” OR “intensive community” OR “intensive treatment” OR “home treatment” OR “home-based”.

APPENDIX B: CASE STUDIES

The below case studies provide an insight into some of the different types of intensive community and day services currently available in England. They were written in conjunction with and with approval from the relevant services. Whilst we sought case studies across the UK, this was not possible due to limited capacity within services, and we will seek to include further case studies on our website.

INTENSIVE COMMUNITY AND DAY TREATMENTS FOR ADULTS IN HULL AND EAST RIDING OF YORKSHIRE

Evolve – Hull Community Eating Disorder Service offers 1) an intensive day programme, and 2) an intensive community treatment programme, provided by City Health Care Partnership CIC, both of which are described below.

“Thank you so very much for all your help, support and guidance. I really do feel you have given me the best chance to start a process that will hopefully help me to have a much better life. I know my journey has had its ups and downs but I feel I am making progress and will continue to do so.”

– Patient who attended the day service

Accessing the services

The eating disorder service is for adults aged 18 and over, accepting self-referrals and referrals from any healthcare professional. Referrals for both intensive programmes are through the eating disorder team, neither of which have any exclusion criteria.

Patients must have a GP in Hull or East Riding

of Yorkshire to access either treatment programme.

At the first point of contact with the service, all patients have a full holistic assessment in line with national best practice guidelines and quality standards, including a full physical assessment. It is conducted by an experienced eating disorder practitioner and includes service outcome measures, including the CIA, EDQLS, and the EDE-Q.

For access to the intensive community treatment programme or the day programme, patients have additional assessments by a dietitian and occupational therapist to establish their level of skill with meal preparation using EMPISA (Eating and Meal Preparation Skills Assessment) and the impact of the ED on life via tools such as OCAIRS (Occupational Circumstances Assessment Interview and Rating Scale). The

dietetic assessment involves understanding refeeding risk, nutritional status, foods that are challenging and creating a dietetic plan.

Patients on the day programme also have an initial assessment period of 2 weeks to ensure that it is an appropriate intervention to meet their needs.

The services are commissioned by NHS Humber and North Yorkshire ICB.

What the services provide:

The intensive community treatment is able to offer support in-person and virtually in a variety of locations including hospitals, at university, in shops and cafes, at home and in the community. The day service is delivered in a healthcare setting, but can include virtual treatment dependent on the patient needs.

Intensity and duration of treatment offered

Both models are delivered Monday to Friday, between 8am and 6pm. Patients can attend the intensive day programme full time and can then step down to receive support within the community. Patients on the intensive community treatment programme can also receive support for all of the week and throughout those hours, with the number and duration of contacts reflecting the patient's individual treatment plan and needs.

The length of treatment on the intensive day programme is up to 14 weeks and patients can have as many episodes on the programme as needed. There is no time limit for the intensive community treatment programme.

Interventions and support offered to patients

Nice-concordant treatment interventions are provided (MANTRA, CBT-T, CBT-E, and Guided Self Help).

Patients can receive meal support (up to 3 meals a day plus snacks), post meal support, skills based-treatments, diversional activities, graded exposure, DBT

Skills, self-care activities, nutritional support, medical monitoring and management, and interventions for safe exercise.

Staff are trained in motivational interviewing and use this approach in all interactions with patients. There is a focus on lifestyle redesign to develop interests away from their eating disorder. Patients on the day programme have a graded step down and are supported to engage in community activities, work or education as their health improves.

The services also have staff trained in Multi Family Therapy and FT-AN.

Supporting and engaging carers

Carers views are sought initially at the assessment stage. All carers are invited to carers education and support sessions and are encouraged to be actively involved in the patient's treatment if consent is gained.

Carers attend reviews and are encouraged to be actively involved in the evening and weekend support of their loved ones and report back to the clinical team. Carers are given the reference to the New Maudsley Model resource, and Beat's Peer Support and Online Development platform (POD) and advised to learn skills to effectively support their loved one. During intensive treatment and support in a patient's home, carers receive coaching to develop skills such as effective meal support, portioning, and supporting with spotting eating disorder behaviours.

Carers also have access to the day service phone and can call or text the number to have direct access to day service staff during opening times.

The staff team

The full skills of the MDT can be mobilised to support as required and consists of psychiatrists, eating disorder practitioners (social workers, general nurses and mental health nurses), occupational therapists, dietitians, health care assistants, and support, time and recovery workers.

Patients on the day programme and those receiving intensive community treatment are reviewed in relation to presenting risks and their treatment plan for that day within a daily full MDT meeting (Monday to Friday).

Capacity of services

Four full time day programme places can be offered at one time. There is no maximum number of patients that can be supported on the intensive community treatment programme as resources are mobilised to support the need.

Outcomes

Outcome data is collated on discharge from the service using the service outcome measures, which includes the CIA, EDE-Q, and the EDQLS. Some treatment specific outcome measures are also used i.e. ED-15 (CBT-T) and FREED Specific (CORE-10 PHQ9 and GAD-7).

Weight restoration is not used as a sole indicator of treatment efficacy, as some patients have treatment goals such as maintaining their weight, reducing purging and eating disorder behaviours, and receiving support with challenging foods.

For all patients receiving intensive community treatment and/or attending the day treatment programme between June 2023 and August 2024, 54% have been discharged from the service, 13% remained in the service as outpatients, and 13% were admitted to inpatient care, with the remaining still on one of the two programmes.

On average, patients experienced an increase in BMI, and improvements in eating disorder thoughts and behaviours, mood, and quality of life.

The day service has reduced hospital admissions, notably when admitted early in their treatment journey. It has also enabled earlier discharge from eating disorder inpatient treatment as step-down care.

"Thank you so much for helping me get a second chance at recovery and at Life! I could not have turned it around without your support. You are all truly life savers I've enjoyed the giggles but won't be coming back for more"

- Patient who attended the day service

Contact details

For more information about the current service, please contact Kim Flockton, Clinical Manager: kim.flockton@nhs.net

INTENSIVE FAMILY-BASED PROGRAMME FOR CHILDREN AND YOUNG PEOPLE IN NORTH CENTRAL LONDON

Royal Free London NHS Foundation Trust provides an Eating Disorder Intensive Service (EDIS), described below.

Accessing the service

The EDIS is able to support children and young people with eating aged 8 to 18 years old, and referrals to the service are accepted from the CAMHS community eating disorder service (CEDS), and the paediatric team.

It is designed for patients with anorexia nervosa, atypical anorexia nervosa, or bulimia nervosa who:

- Have not made progress with treatment in CEDS
- Require closer assessment to understand what is happening or clarify diagnosis
- Are at risk of admission to a paediatric ward or Tier 4 specialist eating disorder unit
- Are in a Tier 4 specialist eating disorder unit to shorten the length of stay and support a transition back to the community team.

The service is available to those who meet this referral criteria in Barnet, Camden, Enfield, Haringey, and Islington.

The majority of referrals to the EDIS come from CEDS, who it shares dedicated accommodation with. The teams have regular joint meetings which enable joined up discussions about appropriate referrals into the intensive service.

A full multi-disciplinary assessment is conducted using a formulation-based approach. The purpose is to come to a shared understanding of current difficulties and to create a treatment plan, with the goals of treatment fully discussed and agreed with the patient and their family.

The service is commissioned by North Central London Integrated Care Board (ICB) and North Central East London Collaborative.

What the service provides:

The EDIS offers face-to-face support in a dedicated eating disorders setting, virtual meal support, and in the locality. It also provides outreach to the home or community for specific interventions or assessment and in-reach into paediatric wards or tier 4 specialist units to help facilitate better communication and earlier discharges.

Intensity and duration of treatment offered

The EDIS is open for 12 hours per day, from 8am to 8pm, for seven days a week. The intensity of treatment within these hours is flexible and dependent on patient need.

Some young people attend daily at the start of treatment (for one or more meals, or for NG feeding), which reduces over time as families become more confident with meals at home. Key sessions are weekly and face to face, with weekly family support sessions.

The service has a flexible approach to treatment length, and uses the Care Programme Approach (CPA) to think about each patient individually. The service's goal is to avoid hospital admissions where possible, which can result in longer EDIS admissions. NG feeding in the community can also lengthen an EDIS stay but keeps young people medically stable and often avoids a hospital admission. In the year 2023-2024, the average length of treatment was 112 days.

Interventions and support offered to patients

The EDIS follows an enhanced family treatment model, with family meetings, meal supervision and parent training around meal support. Individual key worker sessions are provided to help engage patients and build therapeutic relationships. Treatments and interventions are adapted to the needs

of the patients and family using a formulation based therapeutic approach.

Therapies include cognitive behavioural therapy, psychodynamic psychotherapy, and enhanced Family Therapy for Anorexia Nervosa. The service also provides psychiatry input, specialist dietetic support, family meal support/coaching, medical monitoring and support from acute paediatrics.

Support for up to three main meals and two snacks is available. NG insertion and feeding is also offered onsite if clinically indicated.

Young people and families attend frequently at the start of the admission to the intensive service, the initial focus is about supporting families to establish the meal plan, portion sizes, managing distress at meals and building relationships. As families become more confident with meals, they will spend less time receiving meal support in the department.

Key workers will make attendance plans with families each week tailored to the needs of the family.

The model aims to keep young people at home as much as possible so that they can attend school and retain community/peer links. There is close liaison with school and community services.

The service is integrated into the outpatient service so there is multi-disciplinary team clinical support with continuity of care between outpatient and day patient. There is close working with the acute paediatric service so that acutely unwell patients can remain in the community.

The CPA model is used to review the treatment plan and goals every 4 weeks. This includes healthcare, education and any other additional services involved.

Supporting and engaging carers

As noted above, the EDIS follows an enhanced family treatment model, and support for families/carers is integral.

When a young person is referred into the intensive programme, the service facilitates an admission meeting with the young person and parents/ carers to explain what treatment will look like in EDIS. Parents are required to attend the clinic for supported meals with the aim of skilling the parents up around the meal plan, providing psychoeducation around the illness and live coaching throughout the meals.

Parents/carers are offered weekly appointments with members of the multi-disciplinary team for support and treatment using the Family Therapy for Anorexia Nervosa (FT-AN) model of care. These appointments can be face to face or remote. A family liaison worker also offers parental support.

Parents are also offered daily telephone contact with the team, and an online 4-week psychoeducation group.

The staff team

There is full multi-disciplinary team involvement with the intensive service. It includes psychiatry, specialist nursing, psychology, psychotherapy, dietetics, and paediatrics.

Capacity of service

The EDIS currently has capacity to support 15 patients. This is increasing to 20 at the time of writing.

Outcomes

Adapting the programme and reducing inpatient admissions

Following its transition in 2020 due to the COVID-19 pandemic from a group-based day programme to its current intensive family treatment approach, a service evaluation¹ using a retrospective chart review between March 2017 and April 2023 found a significant reduction in the length of intensive treatment from 143.19 to 97.2 days. In the former group, 33.72% of patients required an inpatient admission, whilst in

the adapted model, 10.58% of patients in the intensive service were referred to inpatient care.

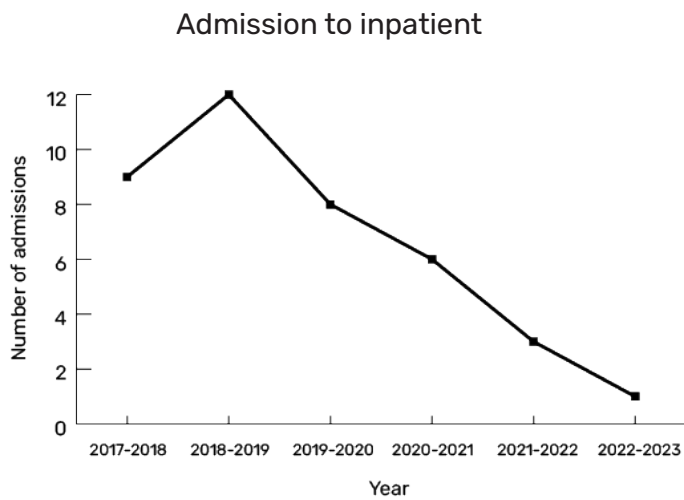


Figure 1: Number of admissions to Tier 4 inpatient units from Royal Free Hospital intensive service by year

In the year 2023-2024, 4.5% of referrals required a specialist hospital admission to an eating disorders unit. There were a total of 42 admissions (24% of all referrals to the eating disorder service) to the EDIS, and all were at risk of an admission.

The majority of patients in the programme either gain or maintain their weight.

Patient satisfaction

The below diagram demonstrates patient satisfaction in the year 2023-2024.

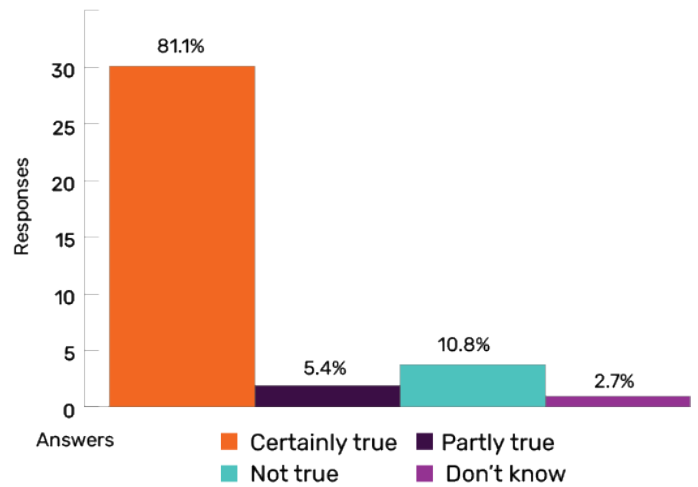


Figure 2: 2023-2024 Summary of service users responses as to whether they would recommend the service

Contact details

For more information about the current service, please contact Vic Chapman at vic.chapman@nhs.net or Mimoza Qoba at mimoza.qobal@nhs.net

INTENSIVE COMMUNITY AND DAY SERVICES FOR ADULTS, CHILDREN, AND YOUNG PEOPLE IN SOUTH EAST LONDON

South London and Maudsley NHS Foundation Trust provides 1) an enhanced treatment service for adults, 2) a day programme for adults, and 3) a day programme for children and young people. These services are described below.

1) Enhanced Treatment Team

Accessing the service

The Enhanced Treatment Team (ETT) is for adults aged 18 and over, with referrals decided on an individual basis, informed by a commitment to treatment.

The trust covers the following boroughs within South East London: Bexley, Bromley, Croydon, Greenwich, Lambeth, Lewisham, and Southwark.

The assessment process includes an exploration of day-to-day challenges to help inform what the ETT can provide, such as emotional challenges faced when challenging the eating disorder, daily routine, exercise levels, purging behaviours, food restriction, and bingeing.

The assessment process also includes an exploration of the patient's support network from friends and family as the ETT is an intensive treatment. Motivations and protective factors are also discussed to find out what is important to the patient.

A risk assessment is conducted to assess whether the patient can be safely treated in the community. Potential follow-up upon discharge from ETT is also explored to ensure that recovery can continue and to determine which services may be needed. At the start of treatment patients complete different measures including the EDE-Q, DIALOG, CORE-10, and the AQ-10. Adaptations are made to allow for neurodivergence.

What the service provides:

The ETT is an intensive community programme offered in person.

Intensity and duration of treatment offered

The ETT is running 5 days a week usually between 9am and 5pm.

The intensity of treatment within these hours is individualised for each patient and assessed alongside clinical risk to determine the number of appointments per week, including meal and snack support. There are typically more appointments at the start of the programme, which will taper down. Appointments are usually for a minimum of an hour (excluding physical health monitoring, which are less).

ETT is for 6–8 weeks and is used to prevent inpatient admissions or to support discharge from specialist inpatient care.

Interventions and support offered to patients

Care plans vary for each patient based on their needs and preferences. Support offered by the ETT includes food planning, food preparation, meal support, and support after meals. Occupational therapy is also offered. Community activities are planned to engage with what is available in the community.

Family therapy and peer support is offered. Physical health monitoring is also provided with bloods taken once or twice a week, with further investigations as needed.

All ED behaviours (i.e. restriction, exercise, physical activity, purging levels, fluid intake) are discussed at least once a week in physical monitoring with each patient. Levels of each behaviour are reported and recorded. Depending on the patient and their care plan, these behaviours may be discussed at multiple appointments with multiple members of the team. This will be recorded each time they are discussed. Goals are set on a weekly basis around these behaviours to try and

reduce them. Openness and transparency is encouraged with patients through promoting a non-judgmental space for patients to discuss behaviours driven by their eating disorder.

Supporting and engaging carers

Carer and family support includes skills training and educational resources. Families and carers are also invited to join any of the practical sessions.

The staff team

The ETT team is made up of a multi-disciplinary team including a consultant psychiatrist, nursing staff, a dietitian, an occupational therapist, a family therapist, outreach workers, and peer support workers. Together these staff members make a person-centered plan tailored to the patients' needs to support them best in the community.

Outcomes

A key goal of the ETT is to support people to restore weight in the community to avoid inpatient admission and to support patients on discharge from the inpatient unit. For patients treated from January 2023 to July 2023, patients gained weight, and for those who completed the measures, there was an increase in quality of life and treatment satisfaction at the end of treatment when compared with the start.

Reducing inpatient admissions

A total of 33 patients were accepted onto the programme from January 2023 (which is when the ETT officially launched) to July 2024. Of those 33 patients, a total of only 8 patients were admitted to a hospital, 5 of whom were admitted to inpatient during or at the end of ETT, whilst the remaining 3 patients subsequently had inpatient admissions after a period out of ETT. The remaining patients avoided an admission, with four patients transitioning to day programmes.

For the pilot of the programme, one of the objectives of the ETT was to maintain average length of stay for South London patients in hospitals (Avalon ward and Tyson West ward) to and under 122 days (4 months). This objective was met. Another ETT objective was

to reduce South London average bed usage to 12-14 beds which was also met.

Patient satisfaction

Treatment completion rates and patient feedback indicate that there is good evidence for patient satisfaction. Treatment completion rates are defined by completing 6-8 weeks' worth of treatment. From January 2023 – July 2024, 33 patients were accepted onto the programme and 76% of these patients went on to complete the full course of treatment.

Patient feedback is collected at the end of treatment and includes qualitative data on patient satisfaction. A thematic analysis completed on patient feedback collected so far found the following positive themes:

1. Patients found that the treatment offered a personalised approach that tailored the support according to their current needs and goals, and challenged areas that were necessary to make significant progress.
2. Patients found that the treatment is flexible and works around the individual's personal commitments.
3. Patients noted that they had found it helpful to access a wide range of expertise on the team and that there was good medical oversight throughout the treatment.
4. Patients found the regular appointments helpful as it provided spaces for check ins.
5. Patients had found it helpful to involve their family in their treatment, providing opportunities for upskilling family members and encouraging patients to be open about their difficulties with their loved ones.
6. Patients found it helpful receiving treatment close to home, practicing skills in environments that they would regularly use (home, community spaces).

Cost savings

The business case for the ETT emphasised that the sustainability of ETT service would rely on its ability to release inpatient bedded capacity. An evaluation of the pilot found in most clear terms, cost per patient care through the ETT service is much lower than that of inpatient care.

Contact details

For more information about the current service, please contact the team on EatingDisorderEnhancedTreatmentTeam@slam.nhs.uk

INTENSIVE COMMUNITY TREATMENT FOR ADULTS IN THE EAST MIDLANDS

Leicestershire Partnership NHS Trust and Northamptonshire Healthcare Foundation Trust provide a collaborative Inpatient Prevention Programme (IPP), described below.

"I honestly feel that Waterlily has changed my life for the better. 16 weeks ago I felt so hopeless, physically weak and unhappy that I did not know if I had the capacity to attempt to recover as I felt so stuck in my struggles. Waterlily has put me in the best place I have been mentally since being diagnosed and the support and knowledge of the staff and fellow patients has helped me to address and admit to things which have held me back in the past and hindered full recovery previously."

Patient who attended the IPP

Accessing the service

The Inpatient Prevention Programme accepts referrals for adults aged 18 and above. It is for patients with a diagnosis of anorexia nervosa, who are receiving treatment (individual or group therapy, or regular sessions with a clinician) from the eating disorder team. Referrals are taken from regional eating disorder community teams.

Patients must be willing to take part in group activities online. They may be losing weight and feel unable to turn this around, or feel stuck in terms of weight gain and are struggling to make the changes discussed in therapy, but wanting to work towards recovery and are prepared to restore weight. Patients must also be cognitively able to take part, are willing to commit to a plan of attendance, and have access to IT equipment. There are no BMI cut offs in criteria but there is an expectation that

the patient will not have reached such a low weight or a level of physiological deterioration that they are unsafe to be managed through the programme, or unable to restore weight without more intensive input.

The service will be available to patients in Leicestershire, Northamptonshire, Nottinghamshire, Derbyshire, and Lincolnshire.

Clients are assessed on referral through the team's assessment process, which includes formulations, an overview of the history of treatment and a risk assessment.

Although it is funded by the East Midlands Adult Eating Disorder Provider Collaborative, it is in an extended pilot phase and a decision regarding ongoing funding is imminent.

"I honestly cannot credit this programme enough. The difference between my mental and physical wellbeing at the start of the programme compared to now is massively noticeable. I rarely experience physical difficulties/symptoms now that are caused by my anorexia. In terms of my mental well-being, I have learnt many new skills to help me process and manage my emotions, identify thoughts and behaviours that this can lead to. My eating disorder can still be loud however I am finding better ways to cope and manage due to this programme."

Patient who attended the IPP

What the service provides:

The Inpatient Prevention Programme is provided virtually and in-person.

Intensity and duration of treatment offered

Treatment intensity varies but averages at four hours per day and patients attend for five days per week.

It is a 12-week programme with an additional four week step-down for most attendees. The step-down option is offered to support transition out of the programme once the 12-week programme has been completed. This supports patients practicing their meal planning and community goals with less virtual support whilst still maintaining weight gain.

Support offered includes a keywork session, a face-to-face community session, and daily groups which are 1-2 hours.

Virtual supervised meal support is fundamental to the programme. It includes breakfast, mid-morning and mid-afternoon snack, lunch, and post-meal distraction support. Support is also offered for one evening meal, whilst the remaining evening meals and snacks are self-directed, although planned with staff.

Supporting and engaging carers

Carers are invited to virtual and/or face to face group support. Fortnightly telephone contact is also offered. Carers are also invited to 3-weekly review meetings at the request of the patient.

The staff team

The team consists of occupational therapists and occupational therapy assistants, assistant psychologists, a peer and a carer support worker, and mental health nurses.

Capacity of service

When at full workforce capacity, the service could support 16 patients at one time.

Demographics

The graphs below display the ethnicities and the ages of the patients referred to the IPP

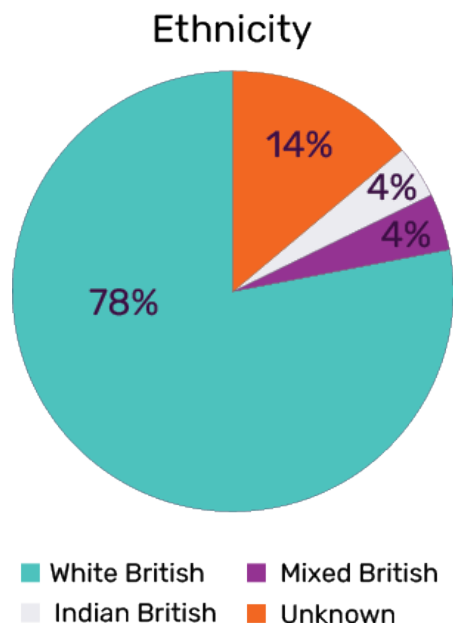


Figure 1. Ethnicity of patients referred

Outcomes

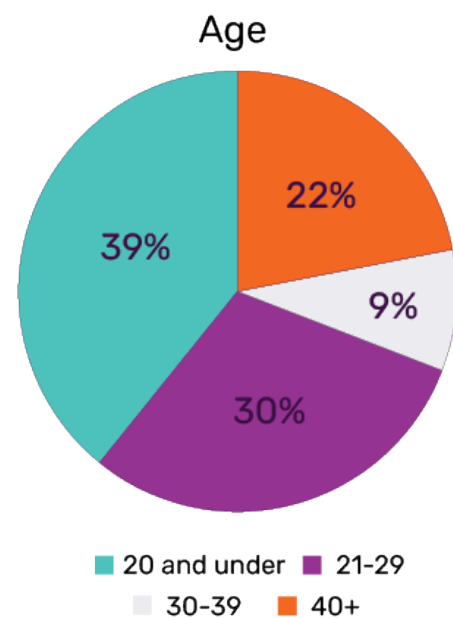


Figure 2. Age of patients referred

“When I look back to where I was in my wellbeing prior to Waterlily, it shocks me. I hadn’t been able to take any steps towards recovery prior to starting the programme. I feel that I am in a much safer place both physically and mentally since completing the programme. I have gained a much deeper understanding of the illness thanks to the programme and am able to spot triggers, which I was never aware of before. I feel that this has helped to prepare me for any possible slips into relapse and I hope that I will be able to stop that from happening now that I know the signs to be aware of.”

Patient who attended the day service

Of the 13 patients who have completed the programme (the pilot commenced in July 2023) at the time of writing, all 13 have gained weight ranging from 0.8kg to 8.05kg.

The comparison of average scores at the start and at the end of Waterlily for each outcome measure are depicted below (N=13). These outcome measures represent improvements in symptoms and behaviours other than weight:

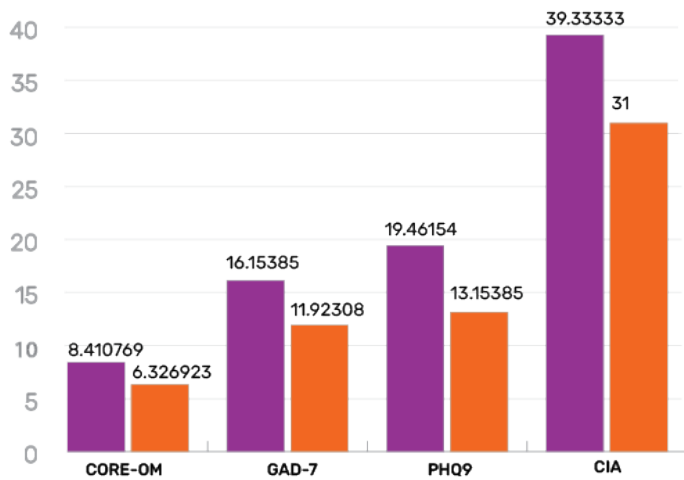


Figure 3. Comparison of average outcome measure scores at the start and at the end of Waterlily (lower scores indicate improvement in symptoms)

BMI progressions

Only patients who have completed the programme are included in the data set below (N=13):

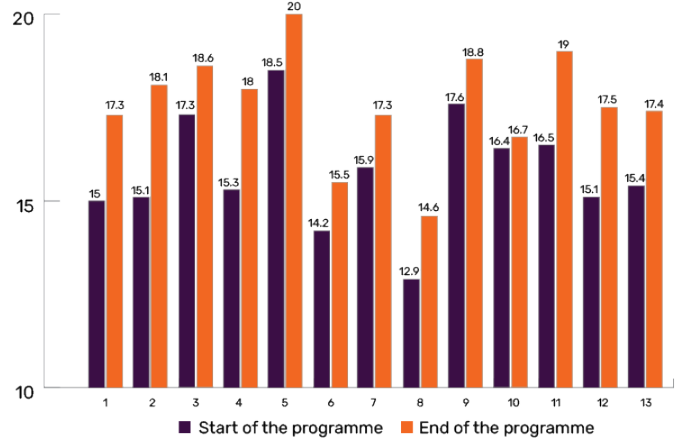


Figure 4. BMI at the start and at the end of the programme

Six admissions to inpatient care have been avoided through the IPP. Cost savings are significant compared to inpatient care.

Patient and carer satisfaction levels are also high.

“Honestly saved my life, physically out of immediate danger and mentally challenging my anorexia everyday, can’t thank the team enough.”

Patient who attended the IPP

Contact details

For more information about the current service, please contact Sandra Marshall, Project Lead on Sandra.marshall10@nhs.net

Reducing inpatient admissions and implementing intensive community and day services in the North Central and East London (NCEL) CAMHS Provider Collaborative (PC)

Due to successful collaboration since October 2020, the NCEL CAMHS Provider Collaborative has been able to deliver significant service improvements through reducing the number and length of hospital stays, which has enabled the reinvestment of resources into community services.

East London Foundation Trust (ELFT) is the lead provider for the North Central and East London Provider Collaborative, which is responsible for the commissioning and delivery of children and young people's inpatient mental health care across 13 London boroughs, and across two integrated care systems: North Central London and North East London.

Some of the key objectives for the provider collaborative, aligned to their service user aims, are to reduce out of area treatment, reduce length of stay, reduce unwarranted variation, improve outcomes, and to identify need for and agree new services and procurement. This is linked to moving away from specialist inpatient care where clinically appropriate, so that young people can be treated within their community.

Part of this work arose due to concerns about the long lengths of stay for children and young people in specialist eating disorder unit settings, and an awareness of the research that suggests long lengths of stay are not necessarily associated with better outcomes. There was a misconception that an inpatient admission was always the 'gold standard of care', however, alongside long lengths of stay there were patterns of repeated admissions and concerns about the levels of NG feeding. The PC were also concerned that there were patients being admitted for inpatient care who didn't 'neatly' fit into available services, which was often neurodiverse children, who were unable to access care because of service thresholds. Actions taken to address some of these concerns are outlined below, and work is ongoing to ensure better outcomes for those who do require an inpatient admission.

To achieve the initial objectives, the NCEL CAMHS Provider Collaborative worked to understand the whole pathway to identify opportunities to intervene sooner for young

people experiencing prolonged delays to discharge. They also conducted a deep dive to understand what the barriers to discharge were for this cohort, and are working collaboratively with children's social care and education colleagues to create an integrated model of support. Other specific actions that have been taken or are being taken to support young people with eating disorders, to achieve the objectives for the collaborative include:

- Setting up an eating disorders clinical network to support the community eating disorder services across the PC footprint. This allows for a complex case discussion space and shared learning.
- Establishment of the Hospital at Home teams (now well into the second year). These teams are able to offer intensive (and if needed, daily) input to young people who would otherwise require a psychiatric inpatient admission. The teams can provide in-reach to A&E and paediatric wards to start engagement whilst a child or young person is being medically stabilised and also can actively engage with general adolescent units and specialist eating disorder units to facilitate earlier discharge and integration back into the community teams by offering a more intensive package of therapeutic care. In some cases they have been able to support NG feeding in the community with young people who are engaged and willing to accept this.
- The NCEL Provider Collaborative have also employed eating disorder expertise on a six-month basis to support further development of their

clinical strategy for eating disorders. This is from a Senior CAMHS Eating Disorders consultant psychiatrist and an experienced CAMHS practitioner. The aim is to support the development of a more consistent offer from the three hospital at home teams, to share good practice and to look at innovative ways of working elsewhere, particularly with organisations supporting underserved communities. They will also be focused on considering the most appropriate support for patients currently requiring support associated with complex trauma or neurodiversity. There are also substantial overlaps with autism and eating disorders, and this is another current area of focus for the PC.

- There is quality improvement expertise within the central collaborative team, and a very experienced PICU nurse. They are working closely with the independent service provider in the footprint to support development of aspects of clinical quality, including care planning, particularly management of emotional dysregulation, understanding the needs of neurodiverse children and young people, and reducing the use of restrictive practice, including NG feeding.

In FY2022/23 the PC successfully reduced significant variation across North East and Central London providers, with the average length of stay reducing to 86 days, out of area placements were significantly reduced by 95%, and the use of specialist eating disorder beds reduced by 50%. In FY2023/24, only 3% of admissions were out of area, and this was due to better placements clinically and personally, for example when an out of area unit was closer to a patient's home.

Cost savings have been made by managing to maintain children and young people in the footprint of the collaborative (thus not needing to use beds out of area) and by reducing the

length of stay across the PC bed base. These savings have been invested into a number of services, including £1.5M which was invested into 'Hospital at Home Eating Disorder Services', providing physical health and therapeutic support to children and young people, and their carers at home, enabling them to stay out of hospital.

The existing Royal Free Eating Disorder Intensive Support Service was used to inform the development of the hospital at home services. Participation champions were integral in the approach to improving care, from the procurement process for organisations to apply to deliver an intensive home treatment service, to setting contractual obligations. Since their launch, there has been a 20% reduction in length of stay in specialist eating disorder units.

Contact details

For more information about the work being done by the PC, please contact the NCEL outreach team, who also coordinate the eating disorders group for the PC: elft.nceloutreachteam@nhs.net

APPENDIX C: ALL-PARTY PARLIAMENTARY GROUP (APPG) ON EATING DISORDERS INQUIRY

APPG inquiry session with people with personal experience of an eating disorder, and their carers: key insights and themes

The All-Party Parliamentary Group (APPG) on Eating Disorders conducted an inquiry session on 5 December 2023 to learn from the experiences of individuals and families/carers and their perspectives on intensive community and day treatment programmes. The session was chaired by Wera Hobhouse MP and was structured into two segments. The first segment featured testimonies from two individuals who had personal experience with an eating disorder. The second segment was dedicated to hearing from two family members who had provided support to loved ones with an eating disorder.

This summary reflects the key points discussed during the inquiry session, where individuals with lived experience of eating disorders and their families/carers shared their perspectives. The discussion focused on their expectations for treatment, experiences during treatment, and views on its effectiveness. It also explored whether intensive community and day treatment was offered and how supported they felt during transitions or discharge. Families/carers provided insights into their involvement in the treatment process and their readiness to support their loved ones post-discharge.

Personal experiences and the role of intensive community and day treatments

Participant A's experience

Participant A shared her struggle with an eating disorder that began after her grandfather's death. She said that her GP initially dismissed her concerns and provided advice that she felt exacerbated her condition. Participant A's treatment journey included stays in various facilities, from a private hospital to an eating disorder unit and finally a secure unit where she felt safer. She described a competitive environment in the eating disorder unit, which hindered her recovery, contrasting it with a more supportive atmosphere in a care home. Her experience in a care home and supported accommodation highlighted the need for knowledgeable support – meaning care from healthcare professionals who truly understood her eating disorder – and the critical role of receiving therapy at the right time, where she was ready and able to fully engage with it. She noted that this combination was crucial to her progress.

Role of intensive community and day treatments in participant A's experience:

Participant A required tube feeding, which

could not be managed locally outside of a hospital admission. However, she highlighted the importance of independence and appropriate support in her recovery journey, suggesting that better-tailored services could have been beneficial.

Participant B's experience

Participant B discussed the stark contrast between her inpatient and daycare treatment experiences. She found the inpatient care to be traumatic, with a competitive and non-therapeutic environment, while the daycare programme provided essential structure and support. She described the inpatient setting as highly competitive, where patients often engaged in harmful behaviours, potentially to gain attention or feel a sense of control. In contrast, she felt that the daycare programme offered a supportive structure. The consistency and smaller patient groups in this form of care helped build trust and facilitated significant progress in her recovery.

Role of intensive community and day treatments in participant B's experience:

Participant B highlighted the critical role of daycare in providing a manageable transition from inpatient settings to real life. She found

that the structured routine and support helped her practise real-life skills, leading to better recovery outcomes and reduced risk of relapse. She noted that the programme's gradual reduction in attendance days allowed for a smoother transition back to normal life.

Participant C's experience (carer)

Participant C, a parent and campaigner, shared her decade-long struggle with her daughter's eating disorder. She described facing delays and inadequate care from under-resourced Child and Adolescent Mental Health Services (CAMHS), resulting in multiple hospitalisations far from home. These experiences disrupted family life and strained their mental health. The lack of continuity in care and abrupt/poorly managed transitions back home often caused relapses. Participant C stressed that the current treatment system must better address these issues by providing consistent, long-term care to mitigate such setbacks.

She also spoke about the role of trauma in her daughter's condition and the need for trauma-informed therapeutic approaches that address the individual needs of patients. In particular, she mentioned the importance of developing a trusting, therapeutic relationship, which is often hindered by the lack of continuity of care. This, in turn, makes recovery more challenging for individuals like her daughter.

Role of intensive community and day treatments in participant C's experience (carer):

Participant C advocated for intensive community-based treatment models, like that provided by the Royal Free Hospital in London, which she said provide holistic and compassionate care within the home environment. She asserted that such models are cost-effective and significantly aid recovery by maintaining a normal routine and preventing hospitalisations. She highlighted the importance of working with the patient's family and social network in a person-centred open dialogue approach which her daughter is now accessing.

Furthermore, she highlighted the need to train clinicians in compassionate, relational

listening skills and incorporating peer workers into treatment programmes. Participant C highlighted the importance of these elements in creating a more supportive and effective care environment, where patients feel heard and valued.

Participant D's experience (carer)

Participant D described her 14-year-old daughter's rapid and severe onset of anorexia, noting that the initial response from their GP was inadequate, leading to a crisis and subsequent hospitalisation without a proper care plan. However, following this, her daughter gained access to intensive community-based treatment, which provided a structured daily routine and essential support. She emphasised that the clinic's informal but timetabled environment and consistent care were vital to her daughter's recovery.

Role of intensive community and day treatments in participant D's experience (carer):

Participant D emphasised the importance of consistent, trusting relationships between patients and clinicians, along with the positive impact of structured, intensive community treatment programmes. She highlighted that these consistent relationships help patients understand their condition, develop accountability, and work towards recovery. Additionally, she pointed out that such services contribute to the prevention of hospitalisations and support long-term recovery. Participant D also noted systemic issues, particularly the challenge of balancing treatment with educational obligations for children under 16. She stressed the importance of flexibility in integrating educational support within day patient services, ensuring that young people can continue their education (if they are in a position to be able to) while receiving the necessary treatment. This integration is crucial for maintaining access to treatment and focusing on recovery without disrupting or minimising any disruption on the educational development of young patients.

Key themes and recommendations

- 1. Structure and routine:** The significance of structure and routine in recovery was a major theme. Participant B noted that daycare programmes offered a structured daily routine that facilitated her transition back to normal life. Similarly, Participant D's daughter benefited from an informal school-like daily routine provided by the intensive community treatment clinic, which offered consistent care and accountability.
- 2. Gradual transitions and 'real-life' practice:** A phased approach and opportunities to apply skills and strategies in the 'real world' were deemed essential for effective recovery. Participant B's gradual reduction in attendance days and Participant C's observation that practising skills and strategies at home significantly aided recovery highlighted the importance of a smooth transition from inpatient to outpatient care.
- 3. Preventative role and intermediate care:** Participants stressed the preventative role of intensive community and day treatments, in helping to avoid the need for inpatient treatment. Participant D emphasised the importance of intermediate care to prevent hospitalisation, citing a backlog of untreated teenagers with eating disorders. The Chair noted that timely intervention through these treatments can prevent hospital admissions and support recovery after discharge from any inpatient care.
- 4. Consistent relationships and trust:** Building consistent relationships and trust between patients and clinicians was highlighted as crucial for supporting recovery and reducing risk of relapse. Participant B noted the benefits of smaller

patient groups and consistent care teams. Participant D found that her daughter's recovery was significantly aided by consistent, trusting relationships with her care team.

- 5. Addressing systemic issues:** Participants called for systemic changes to improve mental health services, reduce waiting times, and ensure timely intervention. Participant C and Participant D advocated for the wider adoption of intensive community-based treatment models that provide holistic and compassionate care, which can be delivered within the home environment or through day patient clinics. The Chair noted the potential of intensive community and day patient programmes. She stressed the importance of learning from successful models and highlighted programmes provided by Gloucestershire Health and Care NHS Foundation Trust, and the Royal Free Hospital in London (Royal Free London NHS Foundation Trust).

Conclusion

The testimony provided to this APPG session highlighted the transformative potential of intensive community and day treatments in the recovery journey of individuals with eating disorders. Key themes included the necessity for structure and routines, gradual transitions, preventative care, consistent relationships and trust, and the need to address systemic issues. These elements are vital for enhancing access to quality care and supporting long-term recovery for individuals and their families.

APPG inquiry session with eating disorder clinicians: key insights and themes

The All-Party Parliamentary Group (APPG) on Eating Disorders conducted an inquiry session on 26 February 2024 involving three clinicians with extensive experience in intensive community and day treatment for eating disorders. The session was chaired by Wera Hobhouse MP.

The session aimed to explore their professional experiences, the benefits of these treatment modalities, the essential components for successful programme implementation, how these services are integrated with other services, the barriers encountered in establishing and maintaining them, and the potential role of virtual services in delivering care.

Participants:

- **Professor Ulrike Schmidt OBE**, Professor of Eating Disorders at King's College London and Consultant Psychiatrist at the South London and Maudsley NHS Foundation Trust.
- **Dr Victoria Chapman**, Consultant Child and Adolescent Psychiatrist and Medical Lead, Royal Free CAMHS Eating Disorder Service (North Central London)
- **Sam Clark-Stone**, Lead Clinician at the Gloucestershire Health and Care NHS Foundation Trust Eating Disorders Service.

This summary reflects the key points discussed during the inquiry session, providing an understanding of the experiences, benefits, challenges, and potential of intensive community and day treatment for eating disorders as shared by the participating clinicians.

Experience with intensive community and day treatment

Dr Victoria Chapman provided insight into the development of her service, which was established in 2011 to address the significant issue of frequent readmissions among under-18 patients discharged from long-term inpatient care. These patients often lacked the necessary skills to manage their condition independently, leading to what is commonly referred to as the "revolving door" phenomenon. Recognising this, Dr Chapman's service was designed to provide intensive support in the community, operating within an acute trust and specifically based within paediatrics. This setting allows the service to manage seriously unwell patients within

the community, ensuring they receive the care they need while remaining in a familiar environment.

Sam Clark-Stone shared his extensive experience, having developed home and day treatment programmes since 2010. These programmes were designed to provide intensive care in the community, with the home treatment programme offering six weeks of intensive support, including pre-meal, during-meal, and post-meal support, alongside weekly family-based treatment sessions. His day treatment programme, inspired by the Toronto Day Treatment Programme, provided five days a week of structured care, including supported meals, snacks, and group therapy sessions. These services proved highly effective, with a 70% success rate in keeping young people out of hospital and a 50% reduction in the use of inpatient beds over three years. However, the overwhelming demand during the COVID-19 pandemic and workforce challenges led to the eventual closure of these programmes, despite attempts to modify and reopen them.

Professor Ulrike Schmidt, with her extensive background in adult services at King's College London, discussed her role in overseeing a range of services, including day services and a new home-/enhanced outpatient treatment programme (Enhanced Treatment Team ETT), aiming to reduce the need for admissions. The latter is inspired by similar programmes for adolescents from Germany, Switzerland and Sam Clark-Stone's model. Her service caters to a diverse patient population, ranging from young adults experiencing their first episode of illness to those with long-standing and/or recurrent conditions who may have had multiple admissions and are often quite isolated. Professor Schmidt's experience highlights the importance of providing a

continuum of care that addresses the varying needs of different patient groups within the community and allows flexible stepping-up or down in intensity of treatment as needed. In this respect, the addition of ETT which offers rapid intensive support and care has been invaluable.

Benefits of intensive community and day treatment

Dr Victoria Chapman emphasised the significant impact that intensive community and day treatment has had in reducing the need for long-term inpatient admissions, which are not only costly but can also be disruptive to the lives of young patients and their families. By offering structured, ongoing support within the community, her service has been able to keep young people in a familiar environment, which is crucial for their recovery. This approach also allows for the involvement of families in the treatment process, which has been shown to improve outcomes and support the development of essential healthy coping skills.

Sam Clark-Stone highlighted the benefits of fostering a strong group culture within day treatment programmes. By enforcing firm boundaries and creating a supportive environment, his service was able to maintain patient commitment and reduce the need for inpatient care. This approach offered a less disruptive alternative to hospitalisation, particularly for younger patients who might find the transition to inpatient care more challenging. The ability to provide intensive support in the community also meant that patients could continue to engage in daily lives, including education and family activities, which are important factors in long-term recovery.

Professor Ulrike Schmidt highlighted the importance of having intermediate services that bridge the gap between standard outpatient therapy and inpatient care. These services are particularly valuable in managing patients who might otherwise require hospitalisation, thereby reducing the pressure on inpatient units. She also pointed out that intensive community and day treatment programmes can lead to better social outcomes, as patients

are able to remain at home with their families and maintain connections with their social networks, which are typically important factors supporting recovery.

Essential components for functioning

Dr Victoria Chapman described the multidisciplinary team approach as essential to the success of intensive community and day treatment services. Her service relies on a team that includes nurses, psychologists, psychotherapists, psychiatrists, dietitians, and family therapists. This diverse team allows for a comprehensive approach to care, addressing both the medical and psychological needs of the patients. Strong governance and established care pathways are crucial in ensuring that all staff members are aligned in their approach, providing consistent and effective care. Additionally, close collaboration with paediatric and educational services enables the service to address the broader needs of young patients, including their academic and social development.

Sam Clark-Stone emphasised the importance of structured programmes with clear communication and firm boundaries. His experience showed that having a skilled and experienced team is critical in delivering effective care. Flexibility in the design of the programme is also important to accommodate the varying needs of patients, ensuring that the treatment is tailored to each individual's situation. Sam's approach demonstrated the need for adaptability within the service, particularly when dealing with the complexities of eating disorder treatment.

Professor Ulrike Schmidt highlighted the need for skilled clinical leadership in such teams from a consultant psychiatrist, given the high medical and psychiatric risks of the patients seen and the potentially high need/demand for such services. The consultant plays a key role in assessing whether patients are suitable for and likely to benefit from intensive/enhanced community-based care, in safely managing patients' risks and comorbidities and if necessary, helping contain team anxieties. She pointed out that the role of the consultant is crucial in maintaining the effectiveness and efficiency of the service, to ensure that

patients receive the appropriate level of care in response to their needs.

Integration with other services

Dr Victoria Chapman explained that her hospital's service is fully integrated within the broader healthcare system, allowing for seamless transitions between community-based and inpatient care. This hospital level integration is facilitated by strong collaboration with other agencies, such as schools and other hospitals, which is essential in providing comprehensive support to young people. By working closely with these partners, the service is able to address the full spectrum of needs that young patients may have, from medical and psychological care to educational and social support.

Sam Clark-Stone described how his services served as alternatives to inpatient care, with strong ties to community-based support. The ability to "step up" care when needed was a key feature of his approach, allowing the service to provide more intensive support when required, while also offering a step down in care as patients progress in their recovery. This flexibility is crucial in ensuring that patients receive the right level of care at the right time, without the need for unnecessary hospitalisation.

Professor Ulrike Schmidt emphasised that while intensive community and day treatment services are valuable, they should complement rather than replace inpatient care. Maintaining adequate inpatient backup is essential to ensure that patients receive the care they need, particularly in cases where community-based care alone is insufficient. Professor Schmidt's experience highlights the importance of having a continuum of care that includes both community-based, day patient, and inpatient options, allowing for a more responsive and comprehensive approach to treatment.

Barriers encountered

Dr Victoria Chapman identified several challenges in providing intensive community and day treatment services, including securing funding and recruiting experienced staff. She noted that while her service has been

fortunate to have supportive commissioners who understand the value of these services, funding remains a significant challenge for many teams across the UK. Additionally, the recruitment of experienced staff has been difficult, particularly given the demanding nature of the work. Dr Chapman highlighted the importance of having a structured model with clear care pathways to support staff and ensure that they are able to deliver effective care.

Sam Clark-Stone discussed the issue of accessibility for patients in remote areas, suggesting that more creative solutions, such as providing accommodation for those who need to travel long distances, could help address this problem. He also mentioned the need for the NHS to think "outside the box" to improve accessibility, especially in the post-COVID environment. Sam's experience underscores the importance of ensuring that all patients, regardless of their location, have access to the care they need.

Professor Ulrike Schmidt pointed out workforce challenges, particularly the risk of staff burnout, and stressed the need for strong support systems to maintain the effectiveness of the service. She noted that without adequate support, the pressures of working in intensive community and/or day treatment can lead to high levels of stress and burnout among staff, which in turn can impact the quality of care provided. Professor Schmidt's insights highlight the importance of addressing these workforce issues to ensure the sustainability of these services.

Use of virtual services

Dr Victoria Chapman acknowledged that online treatment can be helpful, particularly for families managing meals, but also noted its limitations, including patients' reluctance to appear on camera. She highlighted that while online services can provide valuable support, they are not a complete substitute for in-person care, particularly for young people who may struggle with the isolation of online treatment. Dr Chapman's experience suggests that online services should be used as a complement to, rather than a replacement for, face-to-face care.

Sam Clark-Stone recognised the advantages of online services, especially for patients in remote areas where travel to treatment centres may be difficult. However, he maintained that in-person treatment is preferable where possible, as it allows for more direct interaction and support. Sam noted that within his Provider Collaborative, online treatment has become the main model for intensive services, but he emphasised that this approach should be adapted to the needs of each individual patient.

Professor Ulrike Schmidt supported a hybrid approach, combining online and in-person services to offer flexibility. She stressed that while online treatment can provide a valuable alternative, particularly in situations where in-person care is not feasible, face-to-face interactions are generally more effective and should be prioritised when possible. Professor Schmidt's insights suggest that the integration

of online services should be carefully considered within the context of each patient's needs and the overall goals of the treatment programme.

Conclusion

The insights shared by the three clinicians offer valuable guidance for the development and implementation of intensive community and day treatment services within the broader healthcare system. Their experiences highlight the importance of a flexible, multidisciplinary approach, strong integration with other services, and adequate support for staff to ensure effective care. While online services can be beneficial, particularly in remote areas, in-person care remains essential. These lessons should guide the development of future policies to improve access and outcomes for individuals with eating disorders.

ABOUT BEAT

We're Beat, the UK's eating disorder charity.

In the UK, about 1 in 50 people of all ages, genders and backgrounds have an eating disorder, a group of complex and often misunderstood mental illnesses. Eating disorders can do serious harm – emotional, physical, social, and financial.

But there is hope. With better understanding, faster diagnosis and proper treatment, people can recover from eating disorders. That's why we're here.

We offer people with eating disorders and those caring for them emotional support and expert advice. We work with professionals in healthcare and education to help people get the early treatment they need. We campaign tirelessly to change policies, perceptions, and lives.

And together, we'll end the pain and suffering caused by eating disorders.



Our Helplines

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Northern Ireland:

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Use helpfinder.beateatingdisorders.org.uk to find support in your area.

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