HEALTH COMMITTEE

Tuesday 18 January 2005

Session 2

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HEALTH COMMITTEE
2nd Meeting 2005, Session 2

CONVENER

Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*Mr David Davidson (North East Scotland) (Con)
Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Shona Robison (Dundee East) (SNP)
*Mike Rumbles (West Aberdeenshire and Kincardine) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Robert Brown (Glasgow) (LD)
Paul Martin (Glasgow Springburn) (Lab)
Mr Stewart Maxwell (West of Scotland) (SNP)
Mrs Nanette Milne (North East Scotland) (Con)

*attended

THE FOLLOWING GAVE EVIDENCE:

Dr Roelf Dijkhuizen (Grampian NHS Board)
Patrick Duffy (North East Eating Disorders Support)
Dr Alan Green (Ayrshire and Arran NHS Board)
Deirdre Macdonald (North East Eating Disorders Support)
Dr Harry Millar (Royal Cornhill Hospital)
Gráinne Smith (North East Eating Disorders Support)
Dr Alex Yellowlees (Priory Hospital)

CLERK TO THE COMMITTEE

Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Viewmount, Stonehaven

Scottish Parliament

Health Committee

Tuesday 18 January 2005

[THE DEPUTY CONVENER *opened the meeting at 12:46*]

Eating Disorders Inquiry

The Deputy Convener (Janis Hughes): I open the Health Committee's second meeting of 2005. We are delighted to be in Stonehaven; for some of us, it is our first time. Some of us from the west battled through some bad weather conditions this morning, but it is nice to be here and I am sure that we will have a fruitful meeting.

I welcome a large number of members of the public to the meeting. One of the benefits of the Parliament getting out and about is that it allows local people with a particular interest in the subjects that we are discussing to come along, listen and participate. The discussion that we are having today is part of an inquiry into the diagnosis and treatment of people who suffer from eating disorders, and we have a number of witnesses who will talk to us about that subject. I thank the petitioners who brought the subject to the committee's attention and allowed us to examine it and consider that it merited further investigation. We agreed to come to Stonehaven because people who live here and in the surrounding areas had raised particular concerns.

I welcome our first panel of witnesses for today. We have Deirdre Macdonald from North East Eating Disorders Support, Gráinne Smith, who is from NEEDS and the Scottish Eating Disorders Interest Group, and Patrick Duffy from NEEDS.

Before we start questions to the witnesses, I remind committee members that, due to the sensitive nature of the discussions, we should be very considerate when we ask questions of the panel members and observe completely the confidentiality that they wish to maintain on the part of anyone with whom they are connected.

Do the witnesses wish to make an opening statement before we start the questions?

Gráinne Smith (North East Eating Disorders Support): I thank the Health Committee for undertaking the inquiry. I look forward to a positive outcome and I hope that things will change for the sufferers and their families.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): Your written submissions to the committee are informative and make clear the problems that have occurred with the treatment of eating disorders. However, I want to focus on a specific matter. When we evaluate the written and oral evidence, what should we focus on as the potential solution to the problem? We are well aware of what the problem is, but we want to consider the solution. Are the 15 health boards in Scotland, including Grampian NHS Board, not fulfilling their role? Is the Scottish Executive not being directive enough or not providing funding for problem-solving solutions? Is there a more fundamental problem? Are general practitioners not aware of the facilities for people? Will you focus on the solution in your response?

Gráinne Smith: All those things are factors. We must raise awareness of the problems for sufferers and their families and of how those problems affect many people's lives. They do not affect only the sufferer—they affect whole families and they affect society. If someone is ill for many years, they cannot make their proper contribution to society. Their talents and skills will be lost to the community. Eating disorders also cause sufferers huge unhappiness. Often, sufferers do not understand how ill they are—in fact, some of them deny that anything is wrong when everybody else can see that something is wrong.

On the solution, leadership is crucial, and the first step is co-ordination of efforts from the very top. Many mistakes have been made in the past, but there is not much point in dwelling on them. We must learn from mistakes and move on.

I have prepared a plan of action that shows a possible way forward. Implementing the eating disorders section of the framework for mental health services in Scotland—which was written several years ago but has not been implemented—would be a major step forward. The National Institute for Clinical Excellence guidelines that have been implemented in England are excellent and could be incorporated. A good step forward would be issuing the NICE guidelines to every professional so that they could work with and to them. Those two steps would be major steps forward.

Training for GPs would be my number 1 priority. GPs have very little training in eating disorders, despite the incidence of such disorders in our society. They need much more training, with a stress on initially recognising the possibility of an eating disorder, diagnosis and recognising the steps that are involved to pass on sufferers to the next stage. There should be training for all GPs in their general medical training, but I would also like all GPs—or at least one representative from each practice in Scotland—to be sent to an initial conference in each area. That might be a way forward.

There should be specialist training for general psychiatrists. Although general psychiatrists are expected to treat eating disorders, I can cite at least one case in which they have not been able to. After waiting for many months, a girl who was losing huge amounts of weight finally got an appointment with a general psychiatrist. He said, “I don’t know why you’re here. I don’t do eating disorders.” That experience is echoed by many people. General psychiatrists need much more specialist training in working with people with eating disorders. There should be specialist training for psychiatric nurses, community psychiatric nurses and dieticians.

There should also be training for social workers, who often encounter eating disorders during their work and who do not have a clue about what to do. I was invited to speak to a group of social workers and was amazed when they said that they had no training in eating disorders, as they come across such conditions frequently. Upper primary teachers need some training, as do physical education teachers, who are often the first people to notice that there is a problem, and guidance teachers in secondary schools. Greater awareness in the general community is necessary, too.

A major problem arises when people need hospitalisation. There need to be facilities much nearer home. It is all very well to send someone away from their family and their community to a wonderfully safe and secure environment—some of the specialist hospitals are excellent—but when that person is discharged, they face huge problems, such as those of integrating back into the family and getting proper support. When such support is lacking, a relapse is often the result. I would like the provision of small national health service units of four or eight beds to be developed in several hospitals in Scotland. That would be a big step forward. It would be difficult to implement all those measures immediately, but they are my main priorities.

Co-ordination of services is important. There does not seem to be any co-ordination; I have certainly not seen any. Health boards do not seem to work together. That is needed, especially when adolescents are being transferred to adult services. A great deal of attention should be paid to that. I have already mentioned the problems that patients face on discharge from hospital. To avoid relapse, there is a huge need for the provision of proper, on-going support. Volunteer groups can help with that, but they need support. It is wrong to expect people who are already living under stress to give their time and energy and to put in huge amounts of effort. We cannot rely on that because if those people burn out, we will lose whatever was there in the first place. That is an important point.

There should be some sort of a co-ordinator to bring everything together, work towards those aims and liaise with the Scottish Executive, NHS Health Scotland and so on. Those are the main priorities that I have identified.

The Deputy Convener: Do any other panel members have anything to say at this stage?

13:00

Patrick Duffy (North East Eating Disorders Support): I will add one thing. I back up everything that Gráinne Smith has said. I just want to present a bit of evidence. My own son caught anorexia when he was 12. He was diagnosed within three months of when he stopped eating and started exercising excessively. Within a month of the diagnosis, he had an appointment at the Royal Cornhill hospital. The doctors there have seen this before and they know their stuff. With their guidance, help and support, my wife and I, and my son, managed to take him out of the illness within six months, probably. We knew within six months that he was recovering. It is now a year later and he has entirely recovered. I have great faith in that.

Because of what happened to us as a family, I have got to know an awful lot of people who have been affected by anorexia. I have also read literature on the subject. People of 16 and 17 wait eight or nine months for an appointment. I am not a psychiatrist, but I see this illness as two-fold: it is both biological and mental. They undernourish both their bodies and their minds and they go into a biological depression. If that condition is left to carry on, it becomes behavioural. They learn a set of behaviours and they condition themselves. The quicker that that is recognised, the behaviour is altered and they are reconditioned and rewound back to what we would call normal, the quicker the recovery and the less chance of relapse.

Therefore, everything that Gráinne Smith said is important. To my mind, the key is having resources available immediately after diagnosis to provide support, guidance and direction. If that happens, a lot of people can be captured and taken back on to the level, so avoiding all the chronic stages of the disease.

Deirdre Macdonald (North East Eating Disorders Support): My daughter became ill at an age that was similar to the age at which Gráinne Smith’s daughter became ill and she has now been ill for six years. She started off in the young people’s department at Cornhill hospital and went from there to the Priory hospital.

My daughter has a lot of self-knowledge about how she is, who she is and what stage she is at. She has not got the whole knowledge, because she is suffering the illness. However, when a person presents themselves for help, they have reached the stage where they are coming out of denial a bit about the illness that they are suffering. It is vital for the support to be given then and not eight months later, because some people will have died during that time and others will have got used to existence with anorexia, bulimia or whatever, which means that they will have gone a long way backwards.

I asked my daughter what one thing has helped her in the past six years. I agree with her that it is the 24-hour support that she has been lucky to receive, either by being an in-patient in a specialist unit or by having the kind of relationship with the unit that means that she can pick up the phone and call it at any time of day or night. For many years a sufferer could still say, "I'm fat," or whatever. Progress is made in dealing with the illness through support, but there are many pitfalls and every week brings a new one on the road to recovery. There are many similarities with alcoholism, drug dependence and so on.

Gráinne Smith: Addictions.

Deirdre Macdonald: Yes, because the person also becomes addicted to the eating disorder. My daughter has been lucky in that, recently, because she had been an in-patient at the Priory a few years ago, we were able to get support at the support group at the Priory by going down weekly to Glasgow from Aberdeen. As she had contact with some of the staff from when she was there they were able to give her support that was not possible in Aberdeen, where she was still on a waiting list and was only six months into the wait. Fortunately for her—it is wrong that I should be saying "fortunately for her" because, although we all feel fortunate that our children are alive today, there are those who are less fortunate. We are all here today because we want everyone to be able to say, "Thank you to the health services that we pay our taxes for." Everybody should have access to the facilities at the right time and at the level that is right for them.

Mr David Davidson (North East Scotland) (Con): From first-hand knowledge, I share the experience of our witnesses today and the many who have written to the committee.

I will address the points that Gráinne Smith made about the things that she is looking for. I have no disagreement with any of them, but I want to clarify one or two points. She did not say whether she wanted a nationally co-ordinated scheme or a regional scheme, although she gave the impression that she would like regional facilities. She talked about having dedicated six or eight-bed wards and I presume that that would be done on a regional basis, because not every health board has the facilities or the staff to do that.

I would like to know your thoughts on an idea that is being pushed forward by several people. The suggestion is that at some stage after assessment—we understand the problems of getting early assessment—and the commencement of a patient's treatment, in some form or another, the same team that deals with the in-patient service should deal with the out-patient service so that there is total co-ordination of care and there is no need for either the carers or the patient to get to know someone else. In particular, when the patient is very vulnerable it takes them a long time to open up to anybody.

You mentioned the NHS's use of private facilities in Scotland. As well as the Priory, there is now the Huntercombe hospital outside Edinburgh, which is for younger people. Can you talk from your experience about how the use of such facilities could be co-ordinated into the NHS system?

Gráinne Smith: I am not an expert, but I feel that a Scottish co-ordinator who can address the overall situation might be a good way forward. I do not know what is possible. I can make suggestions and put forward ideas, but the resources have to be there.

There would be a huge advantage in having more local services that are accessible and having more day care so that people could go into a unit daily. They could perhaps go with a member of their family to stay in a hospital in Aberdeen, Inverness or Dundee when they need to rather than in-patient admissions being a very last resort when someone is dying. That is often what happens. They try to struggle on—as do the professionals—and in-patient admission is a last resort. If possible, there should be a variety of services. Indeed, in an ideal world, everyone would be working together.

Developing more services in the areas where sufferers live would have huge advantages, because of the continuity with the family setting. Although sufferers would go back to their families, they would also have a lot more contact with them if they were admitted somewhere. I know from working on the Eating Disorders Association helpline for six years that people from the Western Isles, Moray and so on are sent to Glasgow and even to the south of England and it is extremely difficult, if not impossible, for some families to visit them. Such a situation also creates huge problems for discharge.

Some private services are wonderful. For example, the facilities at the Priory hospital are tremendous. However, they are accessible only to a small number of people who are in extreme circumstances and need to be admitted. If possible, we should have a range of services to address need when it arises. Does that answer your question, Mr Davidson?

Mr Davidson: It goes a long way towards doing so.

You said that people are sent to England, where a number of health service and private sector facilities have contractual agreements with health boards. The patients who use those facilities are funded through the national services division, not through the local health board. Obviously, as we have seen in the press, health boards are facing different pressures at this time. Might NSD involvement provide some short-term funding relief? For example, the rules might be changed in order to fund what goes on in Scotland and inspire health boards to try to set up more professional units in Dundee, Inverness, Aberdeen or wherever.

Gráinne Smith: I do not feel competent to answer questions about the details of health board funding, the funding of other contracts and so on. I leave that to other people who have more experience of applying financial resources.

However, in response to your question, I shall cite a case that I know of. A 16-year-old girl from the north of Scotland suffers from an extreme form of the illness, but she is now in an NHS hospital in the south of England. I find that tragic. If facilities had been available in Scotland, things might have been different. Moreover, if we had early recognition and diagnosis of the condition and the provision of support at the right time, many admissions could be avoided. People should be trained to ask simple questions so that they can at least eliminate the possibility that the person in question has an eating disorder. In short, I think that a range of resources and facilities is needed, but I shall leave the financial details of your questions to other people.

The Deputy Convener: Wise decision.

Gráinne Smith: I just feel that I do not know enough to answer Mr Davidson's question.

The Deputy Convener: That is absolutely fine.

Shona Robison (Dundee East) (SNP): The written and oral evidence that we have received highlights the impact of waiting times on the individuals involved. Help must be available when and where people need it.

Your comments show that because the illness often lasts a number of years the service that works for sufferers is quite personal. For example, relationships are built up. As a result, I wonder where new developments should be located and the new services provided. Is it fair to say that people need a degree of choice in that respect? What is provided in their local area may suit them and they may want on occasion to travel to get the service that works for them. What we require is a range of services, some of which are based on out-patient treatment and some of which are based on in-patient treatment, and those will be required on a more local basis. However, it strikes me from what we have heard this afternoon that some people will want to go where they feel comfortable, which may be some distance away. How do you marry those two things? There are differences of view. Do you concentrate on the local or do you allow people to go to what works for them?

13:15

Gráinne Smith: I would say that flexibility should be inbuilt. That is what I mean when I talk about co-ordination and discussion between health boards. That is key. I do not have details. I know the situation and I have ideas about how it can be addressed, at least in the beginning, but things would obviously have to develop as we went on. I am happy to offer whatever I can to help to set up whatever services are needed. Flexibility, co-ordination, co-operation and communication are the keys.

In an ideal world, everybody would have what they need. My major concern when people travel long distances is the difficulty of reintegration when they leave the specialist, secure and safe places where they have everything they need and tremendous support 24 hours a day. I have been in hospital several times. I was away from home for six weeks for a back operation and being discharged from that took a bit of reintegration before I could get back into the rhythm of life. Before they are discharged, people will have lived in a tremendously safe, structured ward for quite a while, and the difficulty of reintegration is multiplied 100 times when you have a mental illness.

Shona Robison: Would it be fair to say that, for some people, being removed from their environment is the best thing for them at that time and that that may be what they need?

Gráinne Smith: Yes, it would.

Shona Robison: You drew an interesting analogy with addiction services. I know that many people have to leave their environment because that is where some of the triggers are. I suppose that it is a question of having a range of services, because one size will not fit all. When there are limited resources, it is a question of trying to agree where those resources should go, and that will be the difficulty, because different people have different needs.

Deirdre Macdonald: I would like to illustrate the contrast. At the moment, as far as I am aware—Dr Millar will correct me if I am wrong—if you are an adult with an eating disorder in Aberdeen and you need to become an in-patient, you go into a mixed mental health ward. Which ward you go into is decided geographically, by where you live. That is the only thing that decides which ward you go into. The alternative is to plead with the health board to fund a private place. That is the choice at the moment. I am conscious that there are many carers who do not have the energy, or sometimes the skill, to plead in the way that has been necessary.

You are right to say that one size does not fit all. However, whatever level of service is available for eating disorders, there should be knowledge and understanding of the illness. That knowledge is continually growing. There is a difference between the therapies that are offered at the Priory now and those that were offered five years ago. Knowledge of why people become ill is growing at a brisk pace. I am sure that Dr Yellowlees will speak about that.

Gráinne Smith: It was said that sometimes the triggers are within the family or the home.

Shona Robison: There is a range of factors.

Gráinne Smith: Yes. The result may be that the person has to go away. Stress seems to be the main trigger, and may arise from bullying, bereavement, problems within the family, moving school, moving home, going to university for the first time or going away from home. There is a wide range of triggers. Stress is individual. Eating disorders affect the families of farmers and fishermen. The range of those affected is wide, and one size does not fit all. The right balance must be struck, so that the right thing is offered at the right time. Some people do need to go away, but at present many are sent so far away that it makes a huge difference. Often, the stress of going back and trying to readjust causes a relapse.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): The one thing that comes over in the evidence is the powerlessness of individuals at a time when they need help, but the help is not there. That is true also of the professionals. I have a general practice background, and I had some idea that eating disorders existed. Even with addictions, when a patient comes in requiring help you want to be able to give it, but sometimes help is not available at the time.

It is obvious that people did not think that many people suffered from eating disorders. Maybe it has been a Cinderella illness as a result. We obviously need to train a lot of people, but we cannot do that overnight. You are at the sharp end, and are in a position to know many people who have been dealing with the situation. Could there be a network of lay people? You mentioned one already, in the form of the helpline. How can information get about within the community?

People can help others. For example, you can phone Alcoholics Anonymous and be given a mentor, who you can speak to. Do you have any other ideas? I am sure that school nurses get landed with picking up on things, but that is usually best done by a teacher highlighting something. Education in the wider sense is essential. I am sure that there are many people in the community who suspect that somebody may have a disorder. While we are waiting for change and for things to improve, what can be done to help?

Gráinne Smith: The Eating Disorders Association runs a national helpline. If possible, we should set up a helpline based in Scotland, and advertise it in every GP surgery, school and social work department. We could also provide the number on a card in venues such as shopping centres.

Deirdre Macdonald: I work in adult learning. When people phone the national big plus helpline, their call gets diverted to a local adult literacy worker such as me. I would then get in touch with the person and arrange to meet them. It is important to have a national service for literacy, which then provides a local source of help. People have the courage to phone a number anonymously and they might then get real support. Something similar for eating disorders might be useful.

Dr Turner: Early diagnosis is by far the most important factor. Anyone who meets up with someone who they suspect has an eating disorder should be able to highlight it and find someone to help them. You are saying that it is extremely important to recognise that people do not have to go into hospital; we can keep them out of hospital if we can support them to live normal lives in their community. If they need to go into hospital, they should go to a local district general hospital with the facilities for feeding them if they are seriously ill. Is that right?

Patrick Duffy: I agree with what you said about providing more resource for out-patients, particularly the over-16s. Younger people are catered for quite well. I have heard that as children get older and reach 16, 17 and 18, the level of resource drops and there are eight-month waiting lists. This disease has devastating effects and diagnosing it within two months can make a huge difference. The psychiatrist who dealt with my son was definite in saying that there was no point looking for the reason and that we had to change the behaviour, because my child was suffering biological depression and was undernourished and we had to get him out of it. The treatment that was prescribed to him, as an out-patient, was in effect the treatment that he would have got as an in-patient. After the behaviour changes, the psychiatrists consider undertaking psychotherapy. The problem was that my son was losing weight and the solution was for him to eat more and exercise less or not at all. That is the first treatment that in-patients get.

Deirdre Macdonald: I cannot remember whether Shona Robison or Jean Turner talked about private and public facilities.

Dr Turner: I did. I was interested in the joining up of private and public facilities. The NHS could probably learn a lot from the private sector and vice versa. There needs to be communication.

Deirdre Macdonald: That is what I was going to say. It is important that we capitalise on what little we have in Scotland for the good of everybody.

The Deputy Convener: Thank you. We have asked all our questions. I thank you sincerely for raising the issue with the Parliament and for sharing your experiences with us of what are sensitive and often difficult situations.

Before I introduce the members of the second panel, I would like to advise the witnesses who are here of how the committee will progress the inquiry. Next week, we will take evidence from the Deputy Minister for Health and Community Care, after which we will discuss how to proceed.

I welcome the members of our second panel. We have Dr Harry Millar, who is wearing two hats today: he is representing the Royal College of Psychiatrists and appearing in his personal capacity as a consultant psychiatrist at the Royal Cornhill hospital. I also welcome Dr Alex Yellowlees, who is the medical director of the Priory hospital. The submissions that we received from both witnesses were circulated to the committee today. As I said to the previous panel members, if Dr Millar or Dr Yellowlees would like to make a brief opening statement, they should please do so.

13:30

Dr Harry Millar (Royal Cornhill Hospital): I am happy to have heard the evidence from my colleagues who have so much experience in the field. Nothing was said that I would not endorse: indeed, because much of what was said raises problems, it merits further discussion. Many pertinent points have been made already today.

Dr Alex Yellowlees (Priory Hospital): I thank the convener very much for inviting me to appear before the committee today—it is a real pleasure to do so. We are giving evidence largely because of the fact that eating disorders are killing the young people of Scotland—up to 20 per cent of those who have an eating disorder may die. I am delighted that we are now becoming aware of that fact and that we are getting together to see how best to reverse that.

The Deputy Convener: Thank you. I call Mike Rumbles.

Mike Rumbles: I have looked through the submissions. I will focus for a moment on that section of your submission, Dr Millar, in which you talk about the current level of service provision. You say:

> "A comprehensive review of eating disorder services in Scotland was undertaken a few years ago by the Health Services Research Unit in Aberdeen. This showed that half of Scotland had no specialist provision for eating disorders and there were no specialist NHS beds for eating disorders in the whole of Scotland.

What is the situation at the moment? Could you bring us up to date on the subject?

Dr Millar: It is a little difficult to do that. A study like that is a major undertaking; it requires funding and research assistance. It is difficult to find out about the present situation in an accurate way. I am aware—as is Dr Yellowlees—that around the time of the review, Tayside NHS Board effectively shut down its specialist out-patient service.

The information that I have on the other health authorities has been gathered through the grapevine. I am aware of a service for adolescents in Glasgow. Obviously, it deals only with patients up to the age of 18, but the majority of patients are over that age. I am aware of a new service in Lothian, which is a home-treatment service. I think that the committee received information from Dr Freeman on that service.

I am also aware of one or two health boards that have appointed one or two staff on a sessional basis to do something for patients with eating disorders. I know that Highland NHS Board has a couple of consultant sessions and one or two nurse and dietitian sessions. There may be some other developments of that nature in one or two other health boards, but I have no detail on them.

Mike Rumbles: My next question may seem to be taking things the wrong way round. We will have the Deputy Minister for Health and Community Care before us next week, and will ask her to respond to some pertinent questions on this subject. I am fairly sure that, if I were to ask the deputy minister what services across Scotland are like, she would respond by saying something like, "The Executive provides guidance and resources to health boards, but it is for health boards to decide." If that statement were to be made, how would you react to it?

Dr Millar: I would react by saying that about three or four years ago the health department produced the framework document that was referred to earlier. However, most health boards have done nothing or very little. They may have had discussions and drawn up plans, but on the ground nothing has happened. Two health boards have set up and run significant services for adults.

I should say, by the way, that I am an adult psychiatrist, so I deal with patients aged 18 and over. I have less at my fingertips regarding services for younger patients. Younger patients get quite a good deal within a general child and adolescent service—we heard some reference to that earlier—whereas older patients do not get a very good deal from general adult services. I am aware of only two health authorities—Lothian NHS Board and Grampian NHS Board—that have a substantial adult service, with a multidisciplinary team that provides a range of treatments for people with eating disorders. It seems that the health authorities have done little or nothing since the framework document was produced. When we talk about organising services we refer to different tiers of service. There has been some reference to that already. We are talking about an intermediate tier—it might be called tier 3 in the framework document—that represents specialist services for eating disorders. That is one of the issues in the document that health authorities have not addressed.

The tier 4 level is the in-patient story. Again, health authorities appear to have done little or nothing to address that problem. There have been discussions between health authorities, and in the context of regional planning groups. There have been meetings of relevant managers and some interactions with the private sector, but as I understand it the current situation is that patients go on an individual, ad hoc basis. There are no contractual agreements and there has been no serious negotiation about funding.

Mike Rumbles: I know that I should not be putting words in the minister’s mouth, but she may come back to us and say, “It’s all down to the establishment of the managed clinical networks.” I think that you have something to say about that in your written evidence. One of the things that we will probably be told is that the solution is to ensure that the managed clinical networks work. You seem to be saying in your written evidence that we need much more than that.

Dr Millar: Managed clinical networks are a good idea, and we are close to taking action to set up a managed clinical network for the north of Scotland. They give us a mechanism for considering the situation on a regional basis and for taking things to a population base above the level of individual health boards, which are not big enough to sustain consideration of the complete range of services, including in-patient provision. Having a managed clinical network on a regional basis gives us a context in which we can do that, but it does not give us a service. It does not give us clinicians trained to see patients. That requires resource for the people on the ground who have the ability to provide the service. No amount of managing or networking will provide people who have the skills, the training and the knowledge to provide a service.

Mike Rumbles: What you are saying is that the Executive is setting up a framework and it is encouraging managed clinical networks. The Executive may be doing the right thing, but you are telling us that only a couple of health boards—Grampian being one of them—are doing the right thing. Are you suggesting that the resources that you are focusing on should be ring fenced for this particular field? The minister would probably be reluctant to ring fence money. Do you see what I mean?

Dr Millar: I understand absolutely the reluctance to ring fence. I know that that is always difficult, although it is done if health authorities are not prepared to, or cannot, invest in things.

All my discussions with the local health board have been on the basis of the budget deficit that is planned. The idea of putting in bids for development is laughed out of court. For several years, no one has been encouraged to discuss how new developments in the health service could be made; therefore, it is difficult to see how that could be taken forward at health board level. In any case, some elements of the service have to be provided at the regional or national level. In particular, the thinking about in-patient provision has to be done on a national level because only a relatively small number of patients require admission to hospital. That requires a steer from the centre—from the Health Department—that is not coming. It appears that the framework document has been issued and just left to gather dust. I do not have a sense that anyone at the centre is following it up and asking what is being done about implementing the framework for eating disorders.

Mike Rumbles: I will follow that up with the minister next week.

Kate Maclean (Dundee West) (Lab): I would like Dr Millar to clarify something that Deirdre Macdonald said earlier in response to a question about adults with eating disorders being admitted to psychiatric hospitals. She said that people are put in mixed wards and that the admission criterion is the geographic area in which someone lives rather than anything to do with their condition. Is that correct? Are those acute wards, in which people are assessed before they move on, or do people stay in those mixed wards on the basis of their geographic areas?

Dr Millar: As far as I know, throughout Scotland the in-patient service for psychiatry is almost wholly within general wards that are mixed in the sense of diagnosis, and usually mixed-sex as well, although the ward will be divided by gender. People with schizophrenia, manic depressive illness and substance misuse problems are put together in those wards. In some areas, there are specialist wards for substance misuse and for people who need a degree of security or people who may have been through the prison system—through the forensic legal system. However, the majority of patients, including patients with eating disorders, will go into a general mixed ward.

Kate Maclean: Do they remain in those wards?

Dr Millar: Yes. There is nowhere else for them to go. Those are the only wards that are available, apart from a few long-stay wards for which most patients with eating disorders would not be considered.

The Deputy Convener: With your Royal College of Psychiatrists hat on, can you tell us something about training for psychiatrists? We heard that previous witnesses feel that there is a lack of training in eating disorders for general psychiatrists. In one written submission that we received, it is claimed that schizophrenia has a similar incidence to anorexia, but that anorexia is not included in general training for psychiatrists. What is your comment on that?

Dr Millar: It is not quite true to say that it is not included at all; however, less time is spent on training in eating disorders than is spent on training in schizophrenia.

Today's discussion has been dominated by anorexia nervosa, which is relatively uncommon. Psychiatrists tend to get more involved in anorexia nervosa than in bulimia nervosa, but it is relatively uncommon. In many parts of the country—I am thinking of the United Kingdom rather than Scotland—patients with anorexia nervosa are normally treated by people with a special interest, so not many would be in the case load of a general psychiatrist in England, anyway. In Scotland, anorexia nervosa is still relatively uncommon. Even where specialist services are not available, most general psychiatrists do not deal with many patients with anorexia nervosa.

Bulimia nervosa is much more common and much more commonly dealt with by non-medical people in the mental health services, such as nurse therapists and clinical psychologists. For that reason, it might be argued that psychiatrists do not require the same level of training, but they do require some training. I contribute formally to our postgraduate training in north and east Scotland at a day-release course, so some training is provided, but it is relatively limited.

The other difficulty is that Scotland does not have a structure to develop training for specialists in eating disorders, partly because specialist posts are not available, because nobody is developing services. That is a chicken and egg situation. In any case, a limited number of people can provide training.

13:45

Shona Robison: I ask both doctors to respond to our earlier discussion about the balance of local and national services. Dr Yellowlees has a service that has gained much experience over the years and to which people want to go. How do you balance that with the need for more local services? Are in-patient beds further away from patients with out-patient day care and support being more available locally? How do you balance needs and take into account the fact that everybody is different and has different needs, as has been said? If we can obtain more resources they will be finite and priorities will have to be set.

Dr Yellowlees: The question is excellent and I am glad to have the opportunity to answer it. I worked in the health service for 25 years, during which I worked for 10 years in the eating disorders out-patient service that I established in Tayside. For the past three years, I have worked in the independent sector at the Priory hospital. I know how both sides can work.

Expansion is needed in the breadth and depth of eating disorders service provision in Scotland. Ideally, out-patient and day-patient services should be provided at local and regional levels by small, discrete, specialised and trained teams of eating-disorders professionals that include psychiatrists, psychologists, community psychiatric nurses and specialist dietitians. Eating disorders are complex and need a team of people with the relevant skills to work together to obtain the best outcome.

In-patient provision is a different and more complex matter. That is an important issue to which the committee—I am sure that it will—needs to give much thought. As Dr Millar said, if the infrastructure in the community is at the level that I mentioned—the small, discrete teams throughout the country—the number of patients who require specialist in-patient treatment should be relatively small.

Nonetheless, such provision is extremely important. The Priory has developed ways to collaborate and integrate with NHS teams, for example with Dr Millar's team and Dr Freeman's team at the Cullen centre. We hold case conferences in Aberdeen or Edinburgh and our colleagues visit us at the Priory for case conferences and so on. We are developing videoconferencing to link with the more remote parts of the country, which is working extremely well. There are practical and useful ways to make an integrated service work. I hope that that answer goes some way towards addressing your point.

Shona Robison: Does demand outstrip your service's ability to respond?

Dr Yellowlees: Yes, it does. We have 23 specialist in-patient eating disorder beds and we usually have a waiting list of between five and 10. Those are severely ill people; they could not easily be managed on an out-patient or even on a day-patient basis. They are usually quite critically unwell and their weight is low when they come in.

It is not only anorexic patients who require in-patient treatment; sometimes patients who have severe bulimia nervosa are extremely chaotic and are bingeing and vomiting 20 or 30 times a day. They need to be removed from their environment and given, temporarily, a different environment and set of rules that enables them to make the changes that are necessary if they are to break the vicious circle that they are in.

Dr Millar: On in-patient provision, there are two debates. Should we be trying to develop a national unit for in-patient provision or should we allow for regional provision? My view is that we should go for regional provision. The population structure is such that we will be able to sustain a good service in three or four units around Scotland. That would offer as much provision as possible as close as possible to where people live. Although I take Shona Robison's point that, sometimes, people have to get away from the family home, that does not mean that they have to go 200 miles away; they can be out of the family home to the same degree in their local hospital.

Another issue—which is perhaps represented by the two of us who are sitting before you—concerns what should be in the national health service and what should be in the private sector. The current arrangement is completely unplanned; at least, that is the case as far as the NHS is concerned. I think that the Priory organisation's arrangement is quite skilfully planned. Care happens by default.

In my written submission, I tried to get across the fact that, although people talk about lack of resources, the reality is that in an odd and unplanned way resources have somehow emerged for this purpose and have gone up exponentially in the past few years. Furthermore, I do not think that anyone knows how much money is being spent nationally. I have been trying to encourage colleagues in NHS management to keep tabs on that. We get information from time to time, but it is always incomplete. We get a sort of cross-section, but there is no on-going monitoring of the amount of money that is spent. The sum is large and could be used in other ways. I feel a little uncomfortable about saying this with my colleague sitting beside me—

Dr Yellowlees: Not at all.

Dr Millar: I should underline the fact that there is a good working relationship between the two sectors and that it is possible for the NHS to work with independent clinics. However, tension and difficulties arise because of the way in which the structure makes us work across geographical and organisational boundaries. We propose that there should be an in-patient unit to serve the north of Scotland—we make no secret of that. There are other views, but that is mine. There needs to be some sort of national direction and thinking. The Scottish Executive needs to give a much clearer lead to local health authorities and regional planning authorities to ensure that that happens.

Mr Davidson: My child's patient journey involved the facilities with which the witnesses are involved as well as facilities in Edinburgh as well as NHS facilities, so I have some sort of handle on the differences that are involved.

Dr Millar's submission states that the general adult psychiatric wards are completely unsuitable. It is not for me to agree or disagree about that, but I think that I have a fairly good view of the issue. The submission then talks about specialist needs. I know the history of the unit that you were trying to set up with people in Inverness. I talked to the health board about the matter because I wondered why—if all that was being suggested was shuffling beds around in an existing building—it was so difficult to do. The only answer I was given that made any sense was that there were not enough staff to deal with such a unit and with out-patient services. The general psychiatric ward that was used for anorexic patients did not have specialist nursing staff, which caused difficulties at certain times of the day for the staff and everybody else. I am not sure why your bid for your system did not get through your own health board.

I turn now to Dr Yellowlees. Again, I know how your system works. You say in your written evidence that, if you had a contract, there would be sharing of risk and that that would reduce the cost to the health service. Would the independent sector be interested in renting space in the Royal Cornhill hospital, or wherever, to provide support for residential services, while working closely with the local team? I do not know whether that would be possible; we are looking for solutions and it is up to you people to explain things to us.

How many patients in Scotland will need dedicated residential care? We need an estimate of that to understand the logic. Would changes to services in the community limit the need for residential care? How could that be done?

Dr Yellowlees: There were interesting questions in that. I have no doubt that the independent sector and the NHS can work together in a way that benefits patients. I can see how things are evolving and developing, which has changed my previous views. It is time that we were more visionary and thought more broadly, so that we can move on from the old private-versuspublic prejudices—those days are past. We are moving into a new era and it is time to think more imaginatively.

David Davidson's suggestion is one of many that could be considered. Its working would depend on the integrity and will of individuals on both sides and on the infrastructure's being in place. Simply to have a meeting such as this allows us to see the possibilities.

Mr Davidson: The minister has started work already, but how many patients could we be talking about?

Dr Yellowlees: That is difficult to answer. We are talking about raising awareness and about early identification. In the Priory hospital in Glasgow, we treat about 500 patients a year—severely ill day patients and extremely ill in-patients. Those figures could be reduced if there were more structure in local NHS services. However, if we work on raising awareness and on early identification, the number of people who present for treatment could increase. At the moment we see only the tip of the iceberg; for many reasons, this is a hidden disorder. It can therefore be difficult to give a clear answer on possible numbers.

Mr Davidson: Dr Freeman and Dr Millar both spoke at a conference last year; you highlighted some of the points that you have made just now about how money could be better spent in the health service. If the cost of independent support dropped because of a contractual system, would that answer any questions for you?

Dr Millar: Although I have made statements about money, I find the real world of money baffling—I honestly cannot answer questions about the money. Obviously, if there was a predetermined contractual arrangement that brought the price down, that would release money that could be used in other ways, which would make sense financially.

We are still up against geographical and organisational structures. Although we have what is, in the circumstances, a good working relationship, it would be better if we were part of the same system and the same organisation.

14:00

Mr Davidson: Earlier, I asked about the history of your push to have a dedicated unit in Aberdeen to share with Highland NHS Board.

Dr Millar: I do not know why that was not achieved—you would need to ask people from the health authority.

David Davidson also asked about the number of beds that would be needed. We could spend a lot of time on a theoretical calculation of what would be needed, but the best guess that we have is an assessment that was made by the Royal College of Psychiatrists in a report that was published a few years ago. Its conclusion was that something in the order of six specialist beds for eating disorders should be provided per million people, which would mean 30 or so beds for Scotland. Between the Priory and Huntercombe hospital we have that number, but none of those beds is in the NHS and none is north of the central belt.

Dr Turner: I agree that adolescents should have their own space, regardless of their illness. When adolescents with diabetes and other conditions are moved from a child treatment area into an adult area, they need their own space. Will you elaborate on that and explain where adolescent units would fit into the scheme of out-patient services?

Should out-patient clinics be attached to psychiatric hospitals and facilities or just to ambulatory care and diagnostic units as out-patient facilities next to a general hospital? You are telling us that you do not need many beds, but if diagnoses were made more frequently, although that could reduce the number of beds it might also increase the number. You seem to be saying that, if you can provide services in the regions, you will not need many specialist units for in-patients. As the Priory is a commercial organisation, I wonder why it has not expanded to provide another unit somewhere else if there is need to be met.

Why should adolescents be treated separately and why are normal psychiatric wards not the place for them? Also, should out-patient clinics be attached to psychiatric hospitals or should there be an outreach team that could go to other areas? A lot of things are going through my head.

Dr Millar: There were many questions there. I am not sure whether I can remember them all.

Dr Turner: I just wanted to stimulate some thought.

Dr Millar: On where adolescents should be treated, in many places services for patients aged under 18 or under 16 are provided through units that are not necessarily on the site of a mental hospital. If they are, they are often in separate parts of the mental hospital setting. As I said, they are often quite well served by general teams because of the style of working in child and adolescent services, which is conducive to the needs of those patients.

There is an entirely different problem regarding in-patient provision for adolescents and children in mental health services. There are very few units—I think that there is one in Glasgow and one in Edinburgh, and there used to be one in Dundee—and patients usually have to travel a long way from home to a general adolescent unit. Some of those units cater well for people with eating disorders.

Occasionally, people who are under 18 or even under 16 come into adult wards. I think that I was quoted as saying that those wards were completely unsatisfactory, but I do not go that far; they can sometimes be helpful for periods, but they have many shortcomings. Some younger and some older patients with eating disorders come into adult wards and some of them can do quite well in such wards, but they are a minority; most patients require specialist wards.

A good local service will not necessarily reduce the need for in-patient care. What seems to have happened in the Grampian NHS Board area is that, once we know that there is the option of a good in-patient service, we use it more. We would previously have been more reluctant to admit patients to non-specialist wards, which might have been to their detriment. If we have a good comprehensive service, we might admit patients more, perhaps for shorter periods, rather than wait until they are about four and a half stone and have to admit them because we cannot do anything else. We need a comprehensive service that includes a range of services. It is a case of trying to get all the pieces together to provide what patients need at any particular time and to make services available to them immediately at that time.

The Deputy Convener: Does the Priory look after adolescent patients?

Dr Yellowlees: We take patients of 16 years and over. It is a moot point and a matter of debate at the Royal College of Psychiatrists as to when somebody is an adolescent and when they are an adult in modern society. It is a grey area.

Dr Turner: As yours is a commercial service, why has it not spread? If it is a good business, what has prevented your opening another unit? Is it lack of staff or training? Do the same issues apply as in the national health service?

Dr Yellowlees: The Priory would be keen to expand, grow and develop. It realises that it has an effective and high-quality in-patient specialist service and we would be pleased to expand that. The Priory would definitely like to collaborate in an integrated way with colleagues and move into new territory, rather than maintain the old divide between the private and public sectors, which is outmoded.

Mr Davidson: Earlier, we heard evidence about carers' needs. Will you tell us what your two sectors do for carers?

Dr Millar: The short answer is that we do not do nearly enough. That is an area of service that we ought to develop. Generic child and adolescent services often adopt a family approach from the start, whereas those who—like me—are trained in adult psychiatry and adult mental health professions do not tend to have training in family therapy, so any work that we do with families tends to be in parallel with individual work with patients. That is a deficiency in our service. If we had the resources, we ought to develop an improved provision that would involve families in the therapies that we provide.

Dr Yellowlees: We do some family work with individual patients, particularly when families visit. We are looking to expand staff training and the resources for that area of work. We have a carers support group that meets regularly, and parents travel—sometimes significant distances—to attend that and combine it with visiting their family member in hospital. That is another area that we would like to expand. We are thinking of using our newly developing videoconferencing facilities to develop videoconferencing visiting between patients and families so that the families are able to visit two or three times a week by videoconference rather than once a week or once a fortnight. We are trying to think in different and more imaginative ways about how we can develop the service.

We have not made much reference to carers in general, or to voluntary organisations. As one of the previous witnesses said, there is a real need to bring bodies such as the Eating Disorders Association and its Scottish representative on board in a national development plan for eating disorder service provision.

The Deputy Convener: I thank you both for your time and your written submissions. Before we move on to the next set of witnesses, we will have a short break.

14:10

Meeting suspended.

14:22

On resuming—

The Deputy Convener: I welcome our third and final panel of witnesses. We have with us Dr Alan Green, the medical director of Ayrshire and Arran NHS Board. The second witness will have to help me with the pronunciation of his name, I am afraid.

Dr Roelf Dijkhuizen (Grampian NHS Board): My name is Roelf Dijkhuizen and I am medical director of Grampian NHS Board.

The Deputy Convener: We welcome both of you to the meeting. We have received written submissions from Ayrshire and Arran NHS Board and the north of Scotland regional planning group. Obviously the latter reflects the position of

Grampian NHS Board, which is why we have a representative from it. Do either of you wish to make a short opening statement? It is not compulsory to do so.

Dr Alan Green (Ayrshire and Arran NHS Board): I am pleased to be here and I have listened with interest to the debate. I certainly have no disagreement with anything that has been said. My background is that I was a GP for 21 years before becoming a medical director five years ago.

Dr Dijkhuizen: Similarly, I am pleased to be here to discuss eating disorders. Again, I have followed the discussion and many good points have been made. My background is as a hospital doctor in emergency general medicine. I have been medical director of NHS Grampian since April last year.

Shona Robison: You probably heard in the earlier evidence, particularly in Dr Millar's, criticisms of health boards' priorities. I suppose that, like everything else, there are always competing priorities. However, if we take eating orders in the round, it strikes me that there are a number of problems. One is the lack of central direction; the second is that specialists in the area have so many other things on their plate that they are unable to lobby their health boards for resources; and the third is that, because of the nature of the illness, the patient group and their carers cannot shout very loudly for additional resources.

How do you, as medical directors, feel about the criticism that health boards do not give patients with eating disorders the support that they require? What should be done about that? Perhaps you could reply with reference to your own health boards.

Dr Green: There is certainly some truth in the criticisms. To an extent, this patient group has been ignored. However, we must consider an aspect that has already been mentioned, which is the hidden money that is spent. Two years ago within Ayrshire and Arran NHS Board, a bid was submitted to develop an eating disorders service. That could only be funded if we could guarantee that we would not use the in-patient facilities at the Priory hospital. We could not guarantee that. We could guarantee that there would be a reduction in the number of people going into the Priory, but we could not say that, if we introduced a service, we would not need in-patient beds, because we would continue to need them, albeit for a small number of people.

Shona Robison: That is an important point. You were told that you had to make a choice between developing a local service and maintaining your ability to send people to the Priory. That seems a bit of a Hobson's choice.

Dr Green: It was about redesigning the service and using existing money to develop a service. At present, we spend on average about £300,000 per annum on in-patient services at the Priory. The idea was to reduce that amount and to try to develop our own services. We have very limited services in Ayrshire at present. We have sessional work from a clinical psychologist, dietitians and behavioural therapists. In addition, one of our consultants has a special interest in eating disorders.

Shona Robison: What would you want to happen so that you could develop local services? I presume that you would need new money.

Dr Green: My personal belief is that we need to look at a regionalisation of in-patient services. We also need to consider developing a managed clinical network, which was mentioned earlier. That is about developing good practice that can be shared between regions. There are similarities with what happened in coronary heart disease and in cancer, where managed clinical networks were set up, managers were funded and there was ring-fenced funding for the services for two years. If we want to be serious about developing a service for eating disorders, we would need that sort of direction from the Scottish Executive.

The Deputy Convener: What regional discussions has Ayrshire and Arran had about managed clinical networks?

Dr Green: There have been no discussions specifically about eating disorders, but there have been discussions about child and adolescent services for eating disorders, which are a major issue for several of the boards in the west. Involved in that are young children who require admission to the Gartnavel royal hospital unit. We have two patients there just now. The situation is extremely difficult because there are so few beds in the adolescent unit, and any other children have to be looked after in the acute paediatric ward, which is not suitable.

Mr Davidson: In written evidence that we received, the point was made that if someone has cancer, they get a care plan. People with many other conditions also get that service. What are your boards' views of the need for care plans for people with eating disorders?

Dr Dijkhuizen: I agree that a care plan is needed for people with eating disorders, once they have been identified. There cannot be much disagreement about that. They are a particularly vulnerable group of people, who need an integrated care plan.

Mr Davidson: You agree that a care plan should be given. Is not there an assumption that whatever is specified in a care plan should be deliverable? Could you deliver a care plan? How would you do so?

14:30

Dr Dijkhuizen: Any care plan would be an integrated plan, in that it would be multidisciplinary and would set out where care starts and where it could lead to—scenarios. We would expect care plans to include everything from out-patient day appointments to stays in in-patient facilities. However, as members know from the discussion that we have had today, not all of those aspects are delivered satisfactorily. We cannot automatically assume that every aspect of a care plan would or could be delivered. That is one of the reasons why managed clinical networks do not give the service, as Dr Millar rightly pointed out, although they at least enable a co-ordinated approach to the resources that are available in a region and aim to spend them wisely and to the benefit of patients.

Mr Davidson: You mentioned Dr Millar's comments. I know that you have been in post for only a short time, but are you in a position to say why Grampian NHS Board has not taken his project forward?

Dr Dijkhuizen: I was not around when the business case was considered, but thanks to the advocacy of Dr Millar the proposal has been in the region for the past 10 years and has been voiced vociferously and with a lot of passion. That is a good thing, and we are lucky that the developments in Grampian have been facilitated by that enthusiastic support.

On the reason why the in-patient facility was not taken forward, the board would have considered that if 30 beds are needed in Scotland and 10 per cent of the Scottish population lives in Grampian, we could expect three beds to be needed in the region. When the matter was considered, regional networking had not developed to its current level. It still leaves a lot to be desired, but at that time it was up to boards to provide for their patients, as if the 12 boards were 12 small countries. The board thought that only a small number of patients were involved and that the cost of an in-patient facility was relatively high.

The statistics show that by default—in Dr Millar's words—a lot of money has been spent on in-patient facilities. We think that in Grampian expenditure on in-patient facilities for eating disorders will exceed £400,000 in the current year. It is high time that the regions put their heads together and discussed how they can provide in-patient facilities together.

Mr Davidson: Dr Green, do you agree with those comments about the regional operation of services?

Dr Green: We have to consider the provision of in-patient beds on a regional basis rather than by individual boards.

Mr Davidson: As board directors, do you have any thoughts on why the framework that was published in 2001 has not been delivered?

Dr Green: In large part, the reasons are monetary: there is a lack of funds to implement the framework. In Ayrshire and Arran, we implemented the first year of our mental health strategy and put a lot of mental health services into the community, but funding was not available in the second year because of external pressures on the board.

Mr Davidson: Does Dr Dijkhuizen agree with that?

Dr Dijkhuizen: Yes. The approach is fragmented. It is easy to say that boards must do certain things, but some of them, such as the island boards, are very small. Boards are geographically different—some boards are rural and some are urban—and the implications of a directive that says, "Thou shalt set up these services" vary among boards. That applies particularly to in-patient facilities for eating disorders. I am not saying that there should be national delivery of such services, but we need a national approach to which each board contributes—that would help our board enormously.

Mike Rumbles: I am interested in what you have said about a national approach and local delivery, which seems to be a theme that has emerged. I want to focus specifically on money and to ensure that I understand the figures that are cited in the written submission from the north of Scotland regional planning group. Under the heading, "Funding currently available to support these services", it refers to "out-of-area provision". I assume that that means outwith the health board area.

Dr Dijkhuizen: Yes.

Mike Rumbles: It states that the funding for Tayside and Grampian only was £830,000 two years ago, and that it slumped to £600,000 last year. What is the reason for that?

Dr Dijkhuizen: The figures that you refer to will relate to referral for in-patient care, the vast majority of which is referral for in-patient care at the Priory. I assume that the figure goes up and down a bit, although the trend over the years has been for there to be a consistent rise in out-of-area referral for seriously ill patients with eating disorders.

Mike Rumbles: I am trying to compare like with like. Four years ago, the figure was £350,000 for the whole of the north of Scotland, but the recent figures are for Tayside NHS Board and Grampian only.

Dr Dijkhuizen: One explanation could be that no patients from the other board areas were referred for in-patient treatment. The other possible explanation is that the boards were not able to give a figure for referrals for in-patient treatment.

Mike Rumbles: It struck me as strange that, if we are increasing our awareness and increasing treatment, expenditure should slump by more than 25 per cent between 2002-03 and 2003-04; that is all.

Dr Turner: The Ayrshire and Arran submission showed that the funding currently available to support eating disorder services was £30,000 for sessional work, which was

> "two sessions from Clinical Psychology, two sessions from Dietitians and four sessions from a Behavioural Nurse Therapist. This is on a weekly basis."

In some ways, that is good value for money, because that team work will keep people out of hospital.

If you had more money, could you employ more dietitians and behavioural nurse therapists? Are the people there to come and work for you, or would you need to do more training? I know that more training will be needed, but are there already people who would fill those posts if there was more money?

Dr Green: I can talk only for Ayrshire, but I know that we have several people who are extremely interested in eating disorders and that we would be able to present a strengthened team. We should remember that the sessional payments that you mention are to cover a population of 370,000, so there are not that many sessions for that number of people. The incidence of eating disorders is about 0.3 per cent for anorexia and about 10 per cent for combined eating disorders, so there are not an adequate number of sessions for a team to deliver the service.

My personal view is that we need to have an individual team that would deal with eating disorders in Ayrshire and would then link in with in-patient services. We already have good established child and adolescent mental health teams. What we lack are consultant child and adolescent psychiatrists. The teams work independently and provide most of the treatment and therapy for younger children and adolescents with eating disorders. My view is that they should link in with in-patient services and be an integral part of the in-patient service, so that before any person—adult or child—is discharged, the teams go in as part of the discharge planning. That way, they would have a rapport with the people from long before they come out of hospital.

However, we must remember that only a tiny minority of people with eating disorders end up in hospital. The majority of treatment has to take place in the community, in day centres and, if need be, in beds that can be used for up to 18 hours a day. People can be brought in with a member of their family and if they need nutrition support, they can be given that and then go home at night.

Dr Turner: Are you saying that you could use a district general hospital bed for a short time if you had a team that could deal with the patient?

Dr Green: I would prefer to use our community hospitals, which are much friendlier and are nearer to patients' homes. We have a fair spread of those in Ayrshire.

Dr Turner: That would be better.

Dr Green: Yes.

Mr Davidson: Jean Turner mentioned the use of community hospitals. Large parts of Scotland—particularly in the Highlands, the Borders and parts of Grampian—are pretty well spread out and might have such facilities, but a lot of travel time would be involved in sending a central team to deliver services, especially if that involved going to the islands as well. I like the idea of treatment in community hospitals, because it would be friendly and in the community, but how many extra bodies would we need to deliver support to such units, which are scattered around Scotland?

Dr Green: I honestly could not answer that question for the whole of Scotland. I can answer only for Ayrshire, where I think that we would probably need two teams.

Mr Davidson: How many people would you need?

Dr Green: In each team there would be a half-time psychiatrist, a full-time clinical psychologist, a specialist dietitian and a nurse practitioner who could do cognitive behavioural therapy. There would probably be four or five people in each team.

Mr Davidson: Do you have any views on that, Dr Dijkhuizen?

Dr Dijkhuizen: As things stand, we have five full-time equivalents in the multidisciplinary team in Grampian, which provides a service across the region. It does so to the best of its ability, because it is—we would argue—under-resourced. More could be done through imaginative use of video links to the shire and to the islands. To be honest, I would be keen to take advice from the managed clinical network on how the service should be delivered. We are very close to setting up the network and to appointing a lead and administrative support for it, and I would like that team to explore the best method of service delivery. I have little doubt that a funding issue will roll out of that.

Mr Davidson: It would be helpful if you could send the committee clerks any thoughts that your team—especially the eating disorders team for the north of Scotland—might have, particularly in relation to the number of places where you could deliver care and the number and type of people who would be required to deliver the service in the community.

Dr Dijkhuizen: Yes. I can do that.

The Deputy Convener: I thank you both for your time today and for your written contributions.

I thank again all our witnesses and all the members of the public who turned up to take an interest in the committee today. We have been made to feel welcome in Stonehaven, and I thank Aberdeenshire Council for its hospitality. In particular, I thank the Kincardine and the Mearns area committee, which I understand vacated this room so that we could meet here today. I thank everyone at the council who helped out and everyone who has come along. I am sure that you will all follow the progress of our deliberations on the subject with great interest.

Meeting closed at 14:43.

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