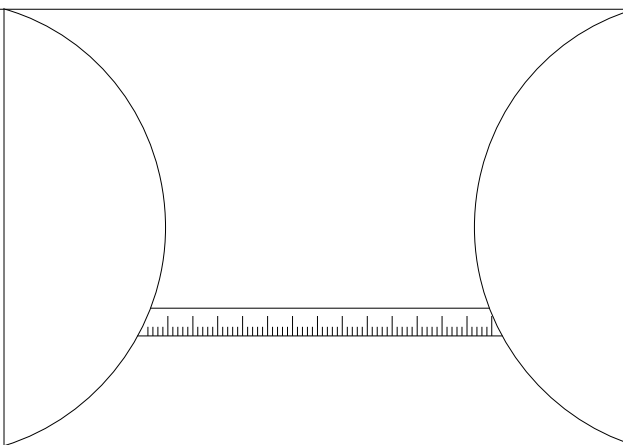


STARVED OF TREATMENT

Anorexia has the highest mortality rate of any psychiatric disorder. Yet the Auckland region has only limited treatment for sufferers and has no specialist inpatient service for acute anorexics, forcing Auckland's district health boards to send patients to Sydney. A decade after the Ministry of Health recognised that eating disorder treatment barely existed in parts of the country, Greg Dixon investigates why Auckland still does not have all the services it needs.



As the illness tightened its grip, nearly every movement she made had one purpose, to burn calories. For a time the constant activity began at 6am, every morning, when Rose* would rise before everyone else and, in the early morning quiet, scrub the kitchen floor. Sometimes, during the day, the teenager would walk incessantly around the second floor of her family's home or she'd go into the kitchen, lean over the bench, place her head on her folded arms and walk on the spot. That could go on for half an hour.

At school Rose would sit at her desk during lessons constantly moving her feet, every step and shuffle counted. Breaks from class meant no break from relentless motion. She'd leave the classroom to run up and down stairwells.

And as the exercise — even the smallest movements to burn calories — went on, she continued to starve herself. Food was the enemy. She would dilute her

GREG DIXON IS A METRO SENIOR WRITER. HIS LAST STORY WAS ABOUT THE BATTLE FOR MT EDEN.



“She was very depressed,” Stamford says, “crying all day, and not wanting to live, without having specific plans about that.”

juice, hide bits of meals in her bra. Any weight gain, no matter how small, would be a devastation — though according to the scales her body mass was falling fast, from 50 to 39 to 36kg in little over six months.

“When the weight gets really low, they get psychotic,” says her father John Stamford*. “Normally she’s a pleasant girl, well behaved, doesn’t swear.” But that had changed. Walking through Cornwall Park, her mother, attempting light, polite conversation with her increasingly erratic daughter, pointed out some dogs. “I don’t like fucking dogs,” Rose fired back.

“She was very depressed,” Stamford says, “crying all day, and not wanting to live, without having specific plans about that.”

Her frantic parents took her first to a GP. The GP referred them to a psychologist, the psychologist to a psychiatrist. A dietician was brought onboard too.

“We had put together a team to try to work out what the story was,” Stamford says. “At that stage there was still no acknowledgment from anybody that it could be anorexia.”

As her weight continued to fall, the psychologist suggested they try another route. Some 10 months after Rose’s illness had begun with her decision to eat more healthily and to cut out chocolate and Coke, she was seen by the Auckland region’s only publicly funded eating disorders clinic, the Eating Disorders Service (EDS), based at Greenlane Hospital. She was finally diagnosed with anorexia.

EDS recommended she immediately be admitted to Starship hospital to stabilise her weight. She was discharged a fortnight later having gained just 2.5kg.

Stamford believes that if Rose had been discharged in Christchurch or Sydney, it is likely she would have been admitted to a 24-hour specialist eating disorders unit. There, for weeks or possibly months, she would have received intensive multi-disciplinary treatment to break the compulsive behaviours she had developed, helping her to lift her weight and putting her on the path to recovery. In an ideal world, she’d then have moved into a five-day-a-week day programme before, all being well, she became an outpatient.

Well they could forget about all that in Auckland. What angers Stamford and others is that only the last — outpatient services — is available in their city. And

PHOTO: HELEN MCARDLE / SCIENCE PHOTO LIBRARY

the result is desperate parents seeking private specialist care for their daughters here and around the world — sometimes costing them many tens of thousands of dollars. It has resulted, too, in EDS — after years of putting young, acute anorexics into a general mental health ward — seeking specialist care for its clients in Australia. For just over a year, EDS has been paying for acute patients to be treated in a private clinic in Sydney which provides the care not offered in Auckland.

But that too comes at a price — and not just for the taxpayer. Jobs are quit, lives are put on hold and families are split for weeks, sometimes months at a time as they try to provide support and care for their desperately ill daughters in a city not their own. “I can’t begin to tell you what the illness has done to us,” says Sally Oliver*, another frustrated parent of an eating disorder sufferer. “We’ve got other kids and I don’t know whether we’ll ever be quite the same. But if the treatment options were easier and satisfactory here I think it would have made things a hell of a lot easier. If we had the equivalent of Sydney here, it would have made our lives so much better.”

Eating disorders can kill. Indeed anorexia nervosa has the highest mortality rate of any psychiatric illness. One in 100 with anorexia who have sought treatment die each year, and up to 20 per cent of its sufferers die over a 20-year period as a result of complications brought on by the illness and suicide. And even if it doesn’t take life, it typically takes five to six years of treatment to recover. For around a third it becomes a lifetime illness.

Anorexia isn’t the most prevalent eating disorder. Bulimia nervosa is at least twice as common in New Zealand, though it usually affects older woman, while the largest group don’t fit the strict diagnostic criteria for anorexia or bulimia. They have Eating Disorders Not Otherwise Specified or EDNOS, and may have some symptoms of anorexia, bulimia or both.

But it is anorexia that represents the greatest mortal threat. Its higher mortality rate is matched by the youth of its sufferers. The peak age of onset is thought to be 16, with half of all cases starting before 19. Worryingly, the average age of onset appears to be falling — girls as young as eight have been diagnosed — and when children and adolescents with anorexia go downhill, they go fast and can need hospitalisation to save their lives before prolonged intensive treatment to recover.

Anorexia’s core psychological feature is an extreme overvaluation of shape and weight. A recent *British Medical Journal* report says people with the illness have the physical capacity to tolerate extreme self-imposed weight loss achieved typically through a combination of restricting food and over-exercising to burn the few calories ingested.

Anorexia has no single cause. It can be precipitated as a coping mechanism against, for example, life changes, family conflicts and academic pressures. The *BMJ* study says a genetic predisposition is necessary but not sufficient for the anorexia to develop and there

is a tendency for it to be found in families with obsessive, perfectionist and competitive traits.

Everyone thinks they know what that means: it’s a poor little rich girl’s complaint. Well that’s myth number one. Auckland’s EDS sees clients from across the socio-economic spectrum and has patients as old as 60. It’s a myth too that it’s a wholly modern phenomenon. American singer-songwriter Karen Carpenter, who died in 1983 from complications from anorexia, is probably its most famous victim, and certainly since her death the disorder has grown in medical and media profile. However, Cornell University professor Joan Jacobs Brumberg found anorexia occurred in medieval times as a form of religious asceticism, and that it was described medically in the Victorian era. But it is, she says, a “disease of modernity”, one that needs setting against the modern obsession with appearance, weight and dieting.

Research done a decade ago showed girls who dieted severely were 18 times more likely to develop an eating disorder — and the number of girls dieting, particularly young girls, is astounding. A new Australian study of

Worryingly, the average age of onset appears to be falling — girls as young as eight have been diagnosed — and when children and adolescents with anorexia go downhill, they go fast.

8000 children and teenagers found almost one in five girls aged 12 and 13 had used at least one radical weight-control technique.

In New Zealand, by the age of 15 around half of schoolgirls have dieted to lose weight. It seems barely credible, but young girls can be more afraid of becoming fat than they are of nuclear war, cancer or losing their parents.

It follows then that around 90 per cent of anorexics are female. But discerning just how many people may have anorexia — or bulimia or EDNOS — is difficult. Eating disorders are frequently hidden, there is often a delay in seeking treatment and there are differences in assessment methods. So figures for prevalence vary and are educated guesses. Australian studies suggest up to 5 per cent of women presenting to or registered with a GP have an eating disorder, with a shocking 50 per cent going unrecognised — but more on this later.

Official figures here suggest a lower number of sufferers. The New Zealand Mental Health Survey, published in 2006, says 1.7 per cent of the population

will experience an eating disorder some time during their life, with 0.6 per cent developing anorexia and 1.3 per cent bulimia. The figures seem small, until magnified by population: 1.7 per cent equals around 22,000 Aucklanders who will develop an eating disorder during their life.

Maree Burns, coordinator for a Westmere-based community treatment centre, the Eating Difficulties Education Network, is convinced eating disorders are much more common. She estimates between 5 and 8 per cent of the population suffer from some kind of eating disorder — which might put the Auckland estimate for all kinds of eating disorders as high as 100,000. “That’s not insignificant,” Burns says, though neither, of course, are the official estimates.

But if the figures for those suffering eating disorders remain moot, the numbers relating to their treatment are precise — and equally troubling.

The Ministry of Health has known some of those numbers for a decade. In December 1998 it published a blueprint for the country’s mental health services. The document was subtitled “How Things Need to Be”.

For eating disorders services, how things needed to be — like much in mental health — was considerably better. Although eating disorders rated only one nine-line section and two lines in a table in the entire 115-page report, the numbers were stark. There were only 15.4 fulltime equivalent (FTE) staff working with eating disorders nationwide. The blueprint recommended staffing levels nearly six times higher, 90.6 FTE. The number of beds or “care packages” for the country was also incongruent. There were just 10 beds around the country; the blueprint said there needed to be 18.9.

That was 1998. It’s at this point we must set our clocks to reflect bureaucratic time. It was to be six years from the publication of the blueprint before the ministry began, well, yet another bout of consultation and report writing to once again establish how things were and how they needed to be. Begun in 2004 at the initiative of the ministry’s Mental Health Directorate, a national framework for eating disorders began gestating; it’s still to produce a final report. According to the ministry’s Mental Health director, Dr David Chaplow, the framework was begun after what amounts to bad publicity. “It was initiated... because of the concern we had with people appearing on telly in a parlous state and that really triggered us to start to gather the people [to talk about the issue].”

We must again adjust our clocks. It wasn’t until May 2006 that a consultation document was issued under the title “National Framework for Eating Disorder Services” confirming services “remain below the recommended levels of the blueprint”. The key concerns included a regional disparity in access to services which had led to “disquiet” among health professionals, sufferers and their families, as well as an “unease” over lack of inpatient beds and the length of waiting lists.

One more time shift. It would be another year, after submissions were received and an eating disorder sector

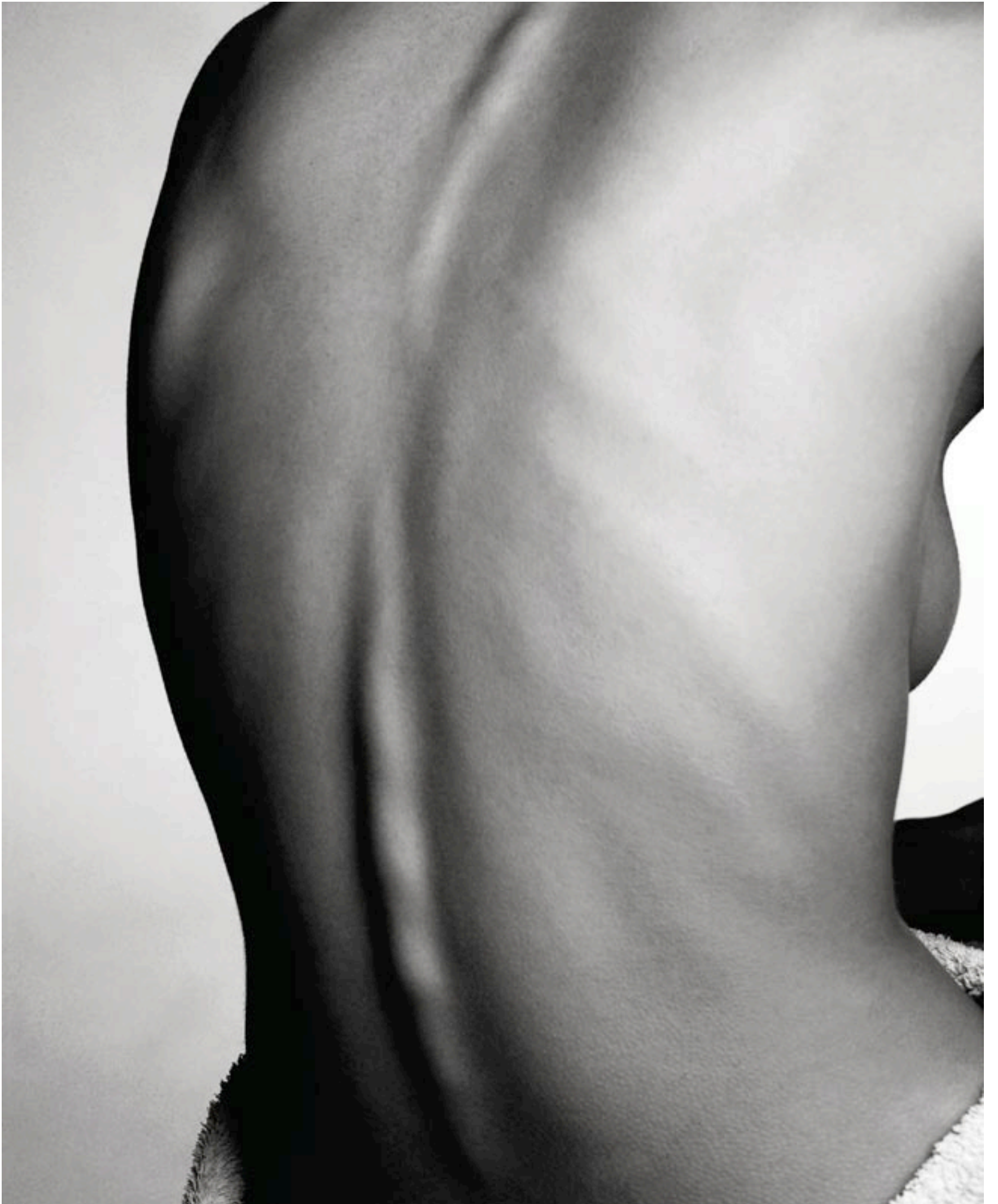


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meeting held, before the slow machine of the ministry produced another document, this with a name nearly as long as a waiting list: "Future directions for the care, management, and treatment for service users with eating disorders in New Zealand." If the blueprint had hinted at a pressing need for more resources, "Future directions" reported a shocking catalogue of deficiency.

According to nationwide submissions, patients are being turned away from acute services because they "weren't sick enough", there are long waiting lists for those who are accepted for treatment, and general medical wards with no specialist expertise are being used to treat eating disorder patients.

There was more. GPs are failing (sometimes repeatedly) to diagnose people who "go on to develop very serious eating disorders". There are insufficient community-based services offering early intervention treatment despite growing demand. There is a lack of skilled workers, with high numbers of casual staff whose lack of training is leading to "poor outcomes" for sufferers.

And finally, while population increases since 1998

mean the blueprint's ideal levels have risen to 96 FTE staff nationwide and the number of beds to 20, only in the South Island are there specialist inpatient units with a total of only 13 specialist beds. Six to seven of those are at Princess Margaret Hospital in Christchurch — and can be accessed only by South Islanders — and up to six more (paid for by the ministry) at the private Ashburn Clinic in Dunedin, a unit which doesn't treat children or adolescents.

For most of the remainder of the country there is a mix of outpatient and day-patient programmes, and in Wellington there is a residential unit offering "step down" — a middle ground between acute and outpatient treatment — for out-of-towners. However in the regions of Northland and Midlands (Waikato, Bay of Plenty, Taranaki and Gisborne) there are no specialist eating disorders services at all.

Who's fault is all this? Well, not the ministry's apparently, even if it is the ministry which administers the country's health policy. Chaplow emphasises — as does a stack of reports, consultation documents and

drafts — that delivery of eating disorder services is entirely out its hands and entirely in those of the district health boards. The ministry — evidently all care no responsibility — doles out the cash. It's up to the boards how it's spent. And in Auckland, some parents believe, what is being spent on eating disorders is providing little more than a holding pen for their desperately ill children.

Auckland's Eating Disorders Service has spartan digs, and they're not easy to find. After locating the right building, traipsing down a long corridor, taking a few false turns after misreading signs, visitors find themselves on the second floor of one of Greenlane Hospital's ageing, scruffy tower blocks.

EDS has been running in one form or another for 25 years. Around 10 years ago there were just 3.3 fulltime equivalent clinical staff. There are now 16.8 FTE — with two vacancies — which is less than half a region the size of Auckland should have. EDS's manager Adele Wakeham says EDS should have between 30 and 33 FTE.

The unit's 2006-07 annual budget was just over \$2 million, with the "principal provider" the Auckland District Health Board (ADHB) stumping up about 47 per cent of the budget, Waitemata DHB 42 per cent and Counties-Manukau DHB the remaining 11 per cent.

To be treated by EDS, patients must be referred by their GP, a Community Mental Health Centre (CMHC) or a hospital, and in the 2006-07 year there were 175 people referred.

The service treated about 250 people in the year to June 2007 and expects to be treating about 300 in the year to June 2008. Of these, about 40 per cent are teenagers, while two-thirds of all patients are 24 years and under. The youngest is 10.

Inevitably there is a waiting list. EDS says urgent cases can wait up to two weeks. For non-urgent cases it can be months — during which time the patient can spiral downwards and become an urgent case. Some families who spoke to *Metro* say their daughters were, initially, not sick enough to get into EDS and then became so sick they needed to be admitted to Starship.

The treatment of eating disorders is not straightforward. Worldwide a variety of different models have evolved involving different kinds of therapy for the different eating disorders and different age groups. "The [EDS] model has developed and evolved over the years," says Wakeham. "If you picture the 3.3 clinicians 10 years ago to what it is now, it has evolved that way rather than somebody coming in with a grand plan and a wish list. I think it's important to put it in that context."

According to best-practice guidelines, treatment for children and adolescents should be separate to adult care. But while EDS offers two streams of treatment, it doesn't separate adults, children and adolescents. The ADHB's clinical leader for mental health services, Dr Nick Argyle, says this again is because of the way EDS developed, but says, as the service gets larger, the age groups will be treated separately.

In the meantime, the first of EDS's treatment streams

for all ages is the “shared care programme” for those with bulimia or mild to moderate anorexia. It features individual sessions with clinicians as well as different types of group therapy.

The second treatment stream, the “intensive programme”, is for those with anorexia and/or severe medical complications. This stream offers a variety of care options including nutrition management, occupational therapy, art therapy, snack and meal groups, day programmes a couple of times a week and psychotherapy. Clients receive some or all of this treatment for as long as two years.

Parents of young patients praise the professionalism of EDS staff. As one said, “They’re doing the best they can.” However, families spoken to by *Metro* share a frustrated anger and disbelief at what EDS offers when patients — mostly anorexic and young — become severely ill.

While the majority of EDS patients might never need inpatient treatment, there are four to five at the acute stage at any one time, and between 10 and 12 of its clients need intensive inpatient care each year.

To stabilise patients who are acutely unwell — basically starving to death — short-term medical inpatient care is available at Auckland, North Shore, Middlemore or Starship hospitals to refeed and stabilise them.

From there, there’s no specialised inpatient treatment for eating disorders in the city. For adults, admission to a general mental health ward has been an option. The only specialist alternative is Dunedin’s Ashburn Clinic.

David Green*, whose daughter Emily* was admitted to Ashburn Clinic, is convinced she’d have died if she hadn’t gone there. But that treatment, after a diagnosis by the third GP Emily saw, was delayed. It was some months after the GP referred Emily to EDS before she was seen — by which stage she weighed a little over 30kg.

When Emily did not respond well to outpatient care, EDS began looking for alternatives, including overseas. “It seems my daughter had to get critically ill to get the right treatment for her. I’m sure EDS does help people. Don’t get me wrong, the EDS staff are fantastic and do the very best they can. But all they’re doing is managing [patients] in their current state. I believe firmly you need an inpatient facility to treat the disorder in as short a time as possible.”

Emily received more than 18 months’ treatment at Ashburn. The distance between Emily and her family was hard, but Green’s greatest concern is what happens if she relapses.

He has asked whether she would be able to get a bed at Ashburn as soon as possible. “[They told me], ‘No... you go through your GP and get a referral and then you go through the whole process again.’ Now that’s a scary thought.”

If Dunedin seems far flung, at least it’s in the same country. Since December 2006, EDS has been sending adolescents who need inpatient treatment to Australia. The Wesley Private Hospital in Sydney’s inner west is a private clinic which treats a number of

psychiatric maladies, but has specialist inpatient beds for eating disorder sufferers, a five-day-a-week day programme as well as an outpatient service. At the time of writing, Auckland’s three district health boards had dispatched six patients for treatment at an average cost of \$68,000 per 10- to 12-week admission.

According to figures obtained by National’s associate spokeswoman for health, Dr Jackie Blue, the total cost of sending just six patients to Sydney since December 2006 has been more than \$426,000.

It seems odd that EDS has been sending patients to Sydney for only a year or so. Given that it’s never had specialist inpatient beds for eating disorders, why start sending patients there now?

Well evidently it was only recently that EDS has seen cases that clinically required the inpatient care available in Sydney, says the woman who made the decision to spend the money on Sydney, ADHB general manager of mental health Fionnagh Dougan.

It’s not wholly true to say there have been no beds at all for those suffering acute eating disorders. Ashburn is available — when one of its very few beds is vacant

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— for adults. For children and adolescents the only choice until a year ago for those needing inpatient care has been Starship’s Children and Family Unit (CFU), a general mental health ward for children and adolescents. However, in 2006 Dougan decided CFU was no longer the place to treat the kind of acute eating disorders patients EDS was now seeing. “I would say that [recent acute patients] presented with greater complexity than people had previously [and who had] been able to be supported in CFU.”

Dr Nick Argyle, the ADHB’s clinical leader for mental health services, says CFU is increasingly seeing more and more unwell, non-eating disorder patients. “[CFU] is a general mental health [unit] for children and adolescents. The average age [of its patients] has gone up, while with the eating disorders girls the age is going down. [At CFU] we’re seeing more older, more male adolescents with quite severe psychotic illness so it becomes a more and more difficult environment in which to have relatively vulnerable young adolescent girls.”

So the decision was made to use Sydney. Parents of those sent to Sydney have been impressed by the

treatment offered at Wesley Private Hospital but there are also concerns that the stress of uprooting a family can negate the gains made there.

And does what has been achieved in Sydney risk being undone when the girls return to Auckland? Having been in a highly structured inpatient programme, some of the girls graduate to Sydney’s five-day-a-week day programme to continue the therapy. On returning to Auckland, however, the girls simply return to the outpatient service offered by EDS.

EDS’s Adele Wakeham concedes EDS doesn’t have a five-day-a-week programme because of the numbers of clients it sees, and the cost of putting them in such a programme. “What we have done is set up smaller modular days which have a whole variety of treatments and meals. So some of the Sydney girls have gone into that. Sometimes they don’t want to, there is a motivation issue. But we’ve worked really closely with the Sydney team so all discharges are planned and a programme will be set up for the person when they come back. So they don’t just come back to once a week [treatment], they come back to a really intensive programme. But it does feel quite different for them coming from the really bounded inpatient setting to a less bounded outpatient centre.”

Sally Oliver says the different types of therapy used in Auckland compared to Sydney was a real concern. “To go from an inpatient to a five-day-a-week programme to a three-day-a-week programme, in my opinion, is the only way you are ever going to get that whole thing to work because they need structure and they need someone to be really, really firm.

“[EDS] can’t provide what she had over there. The therapy she was doing gave her some real strategies to deal with her illness and she’s come back to a much more wiffly-waffly psychotherapy programme.”

Oliver despairs that, having been to Sydney, her daughter will struggle to fully recover in the EDS programme. “It’s friggin’ hard. I don’t know where it will end. In our view she needs a lot more treatment and... it’s very difficult when you’re potentially looking at another admission out of the country. If [EDS] could mimic the Sydney service it would be wonderful.”

Bleak choices beget tough decisions. For families with a member whose weight loss and mental health is spinning out of control, it is entirely common to cast around — usually using the internet and social networks — for a solution to the seemingly insoluble.

For two families, those of Dr Anne O’Reilly and Kim and James Russell*, the solution has been found not in Auckland or even Sydney and not through the New Zealand health system. Both families have, at great cost, sent their daughters to other countries for a treatment developed at the Karolinska Institute in Sweden by doctors Cecilia Bergh and Per Södersten.

Simply put, the treatment began with a paradigm shift. Instead of viewing eating disorders as a psychiatric illness which leads to disordered eating, the view of Bergh and Södersten is that disordered eating results in

mental ill health. Therefore if you teach the patient to eat properly again this will restore them mentally as well as physically. To that end, the pair developed an electronic device called a Mandometer — essentially electronic scales attached to a computer — which monitors and provides feedback on the rate of eating and the amount of food consumed.

The institute claims astonishingly high levels of recovery, with 75 per cent of patients achieving “full remission” — more than double the roughly 30 per cent recovery rate delivered by conventional treatment. The institute also claims 90 per cent of its patients never relapse.

But conventional eating disorder experts doubt the high recovery figures. Says EDS’s Adele Wakeham: “The international eating disorders community doesn’t accept fully the [institute’s] view yet because it’s not based on robust enough evidence. I think what they do provide is really good inpatient treatment, really good boundaries. But the adjunct is this machine and how they talk about what they do; they frame it differently. But what they actually do is very similar to what lots of specialist inpatient units do.”

Södersten has dismissed Wakeham’s doubts — as do O’Reilly and the Russells. Both families, after what they view as unsatisfactory access to treatment through EDS, sent their daughters to Mandometer clinics. O’Reilly’s daughter Caroline went to Stockholm for two treatments totalling around six months, while the Russells’ daughter Fiona* went to the institute’s centre in San Diego for a similar period.

The cost to each family has been huge emotionally and financially. O’Reilly has spent in the order of \$150,000, while the Russells won’t put a figure on it.

“We decided to do what it took,” say James Russell. “We were looking down the barrel of a long time anyway. Luckily we had a house we could sell and we had an understanding bank manager. There was a huge financial cost. I had to take time off work because we were determined that we wouldn’t let the other two children slip away while we were dealing with Fiona.”

O’Reilly too says the cost was irrelevant. “At the stage we were at and... you thought your daughter was going to die any moment, if you said, ‘It’s \$10 million’ then you say, ‘Right, well, for the rest of my life I’ll be paying this back.’ The financial thing is immaterial.”

“We felt,” say James Russell, “we were forced offshore because of the lack of options here.”

Much of this story has principally concerned itself with the ambulance at the bottom of the cliff, and whether that ambulance should be in Auckland. But if treatment for eating disorders — specifically inpatient and five-day patient care based in Auckland — is missing, there are major problems at the top of the cliff too. All the families *Metro* spoke to complained of tardy diagnosis by GPs, with their daughters’ eating disorder being picked up only when the illness had become severe.

EDS’s Adele Wakeham says anorexia can be slow to develop, is covert and can be hard to pick if someone is dieting — and so many girls are. She concedes, however, that diagnosis does depend on the GP. “There are some really good GPs and there are GPs who perhaps don’t have those skills. Many GPs will never have seen anyone with an eating disorder.”

To that end EDS has put together an extensive booklet for GPs. She says “many will have it”. Which is all very well, according to Dr John Cameron, the medical executive of Procure, an Auckland general practitioners organisation of about 550 GPs looking after some 650,000 patients. “But lots of the hospitals send us out lots of lovely booklets and lots of lovely referral pads which we just throw away because you can never find them when you want them.”

“There was a huge financial cost. I had to take time off work because we were determined that we wouldn’t let the other two children slip away while we were dealing with Fiona.”

He says the information needs to be accessed centrally through an internet site. “We need to know where to get the information [on the internet], not on a piece of paper.”

In any case Cameron says it can be hard to get teenagers into a general practice and diagnosis can be dependent on the patient talking about the problem. He says GPs screen for at-risk behaviours like eating disorders, but success can be dependent on the GP and patient having a well-established relationship.

Wakeham says EDS has a special triage team to assess referrals made by GPs, but it can only deal with cases it knows about. “Unfortunately what has happened to some of the families [*Metro*] spoke to is we didn’t get to see their daughters until they were extremely urgent.” Early diagnosis can be as much in the hands of the patient as the GP.

The Ministry of Health’s “Future directions” document says there needs to be more eating disorder services provided by community-based organisations but Auckland’s only such provider, the Eating Difficulties Education Network (EDEN), in Westmere, is struggling to survive. EDEN receives hundreds of calls, emails and visits each year, and provides a resource centre, support groups, counselling, and school and health professional education programmes. It does all this with 2.25 FTE.

EDS has referred people to EDEN (and vice versa). This is no doubt the reason the ADHB asked — Burns claims — EDEN to apply for ADHB funding. Bizarrely, it then declined to give it money. Linzi Jones, the ADHB’s planning and funding manager for mental health services, says EDEN was declined because “there were higher priorities.” At the time of writing, EDEN had less than six months’ funding left.

Some time in the very near future — perhaps even this month — the slow grind of the bureaucratic machine will cease and another report, hopefully the definitive report on this country’s eating disorder services, will be delivered. When it does arrive it will be four years since work started on a national eating disorders framework and 10 since the Ministry of Health blueprint on “How Things Need to Be”.

Metro has obtained the final draft of the framework document, dated last October, which essentially distils previous documents and the submissions and feedback each garnered. It again underlines that the greatest gaps exist in services for children and adolescents (and for Maori and Pacific peoples) and that there is significant regional variation in access to treatment.

Among its easy phrases like “seamless service delivery”, “wider range of choices and approaches” and “increasing the number and range of available services”, it calls for an integration of regional services, an eating disorders liaison person in each district health board, and making sure each patient has a “care co-ordinator”. But perhaps its most significant recommendation is that, whereas now there is only one, there should be two eating disorder centres for specialist care in the country.

Neither the ADHB nor the ministry would comment on the contents of the final report before its release. But what we do know is that, in July, the ADHB’s board committed to provide inpatient beds for its population. ADHB’s general manager of mental health, Fionnagh Dougan, says ADHB is working with the two other Auckland health boards on a “regional solution” under the soon-to-be-released framework. However “the individual DHBs have the right to prioritise what they need for their population”.

The ADHB’s clinical leader for mental health services, Dr Nick Argyle, says there “probably needs to be two or three specialist centres in the country so it needs to be planned nationally, so we’d be very supportive of that”.

In the meantime, speculation. If we assume that Christchurch and the South Island already have one of those services at Princess Margaret Hospital, then it would be reasonable to assume that the second centre will be in the North Island, in Auckland.

The Princess Margaret inpatient unit, which has a budget of about \$1.13 million (which paid for 1686 inpatient bed days in 2006–07), is funded by all the South Island DHBs. It’d be reasonable to assume then that a North Island inpatient centre would have to be funded by all North Island DHBs — a situation



confirmed by Dr Sandy Simpson, the Auckland region's acting regional director for mental health. But who would pay? How long will that take? "I can't answer that," Simpson say, "I don't know the final versions of the [ministry's] directions."

In any case a prime issue for timing, apart from who pays what, will be the shortage of trained staff. EDS's Adele Wakeham says even if she was funded for 15 more clinicians it could take three years to find the right people. "Sometimes being given everything you want in a package doesn't mean it can happen overnight."

Let us return to Wellington then. The ministry's

mental health director Dr David Chaplow says the aim is to be "self-sufficient" within the country in terms of eating disorder services and that, in terms of inpatient beds, would be around 20 beds.

The question is how many more years will that take? "I would expect within five years we would be moving towards adequate services, that would be a reasonable suggestion."

Or perhaps an unreasonable suggestion, at least for families such as the Greens, the Stamfords, the Olivers, the Russells and others like them who have formed a ginger group they're calling the Eating

Disorders Association of New Zealand (EDANZ) to lobby for better services.

If it takes five years, it will have been 15 years since the ministry's blue paper. The lobby group's spokesman Peter Jeffries reckons he's heard it will be a slightly more palatable two years before Auckland gets an inpatient clinic — though he heard that six months ago. "I haven't seen that anything's moved. Eventually, if we all sit tight, something might happen." Something close to how things need to be. •

** Names have been changed.*