Chapter 1

ESTABLISHING A HOME-ORIENTED SERVICE

THE TASK

Providing first-class community care of eating disorders is a challenging task. The service must offer high-quality treatment, including therapies known to be effective, and provide safety so that patients who require admission can be identified and provided with timely and appropriate in-patient care. Systems are required to support staff dealing with difficult and demanding clinical situations, to supervise the provision of high-quality therapy and to make sure that patients are monitored for emergence of risk factors. Systems must be in place to deal with extreme physical and psychological difficulties, while staff continue supporting those in intensive day care and in less intensive outpatient care. When patients are admitted, they, their families and the teams looking after them require continuing support and advice. At the same time the team must be in a position to co-work with other community teams in primary care, general psychiatry, drug and alcohol and child and adolescent psychiatry, so that patients' needs are met and they do not slip through the gaps that can appear between services.

PREDICTING AND MEETING DEMAND

In order to receive health care the prospective patient has to negotiate a number of hurdles. If 100 people in a community suffer from a condition, only a proportion will consult anyone about it. Others will discuss it with family or friends, or consult printed or electronic sources of information. Of those who consult in person, many will go to a general practitioner (GP – family physician), who may or may not diagnose the problem, largely depending on how it is presented (e.g. weight loss or stomach pains) and how inclined the GP is to look for psychological problems. Once the condition is recognised, the GP will make a decision about referral to specialist services. This decision is based on many variables, including the expertise

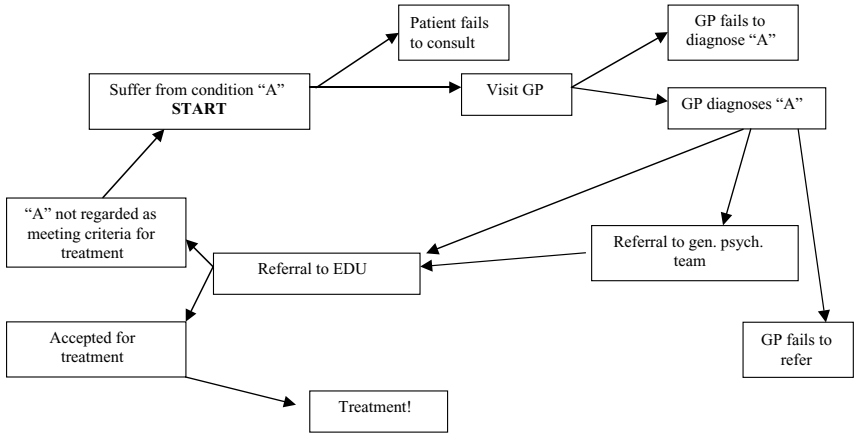

Figure 1.1 Pathways to care: Hurdles that the patient needs to negotiate before obtaining treatment. At every point onward progress may not be made if recognition and appropriate referral fail to occur.

of the GP and resources in primary care, and the availability and quality of specialist services. The sufferer may now have negotiated three of the hurdles (whether to visit the GP, whether the GP will diagnose the problem and refer to a specialist). Between the GP and an eating disorders specialist there may be an additional hurdle, sometimes imposed by the funding agency, in the form of a referral to a general psychiatrist who may or may not refer on to the eating disorders specialist (Figure 1.1). The intrepid patient has now leapt nimbly over three or four fences and arrives at the eating disorders specialist. There is a further hurdle. The specialist has to agree that the patient does have an eating disorder and that it is of sufficient severity to warrant treatment in the specialist unit. These hurdles in referral to specialist care are more substantial and numerous in a government-funded health service as in the UK. They are least in a private service funded by the patient or family and insurance funding tends to make intermediate demands.

Surveys of bulimia nervosa and related disorders in the community in the UK have found that eating disorders are very common, but that consulting a doctor in order to obtain help is relatively rare, generally under 10 % of cases. Reluctance to visit the GP has been attributed to patients' perception of their GPs as sometimes dismissive and uninformed (Newton, Robinson & Hartley, 1993). In a survey sponsored by the Eating Disorders Association and the Royal College of Psychiatrists respondents cited self-help groups, training for GPs and availability of specialist services as key priorities.

In a population of 1 million people, how many are likely to have eating disorders and of that group how many will arrive at the specialist service? Prevalence estimates suggest that 0.4 % and 1 % of young women will have anorexia and bulimia nervosa, respectively. Epidemiology is currently

inadequate but a conservative estimate suggests that an additional 3 % will fulfil criteria for clinically significant eating disorders (eating disorder not otherwise specified or binge eating disorder). The proportion of females aged 16–45 in the UK is 32.1 % (9.733 million). This gives an estimate for eating disorders of 450 000 people (adding 5 % males), or 7500 people per million population. Looked at from the other end of the telescope, the clinical eating disorders service at the Royal Free Hospital, the Russell Unit, receives 300–350 referrals per million population per year. This clearly demonstrates the powerful effect of the hurdles: around 4.6 % of the eating disordered population are referred in one year. In a research project described in Chapter 10, students and staff at a large college in the University of London were circulated by email and offered therapy online. Of 97 people accepted for treatment, only 21 had until then received any form of therapy. On the one hand the small proportion of people contacting healthcare services represents a serious failure to address a public health problem. On the other, GP and specialist services would quickly be overwhelmed if all potential patients turned up at once! Given that a unit providing care for 1 million people attracts, on average, five new referrals a week, how many will have bulimia nervosa (BN) and anorexia nervosa (AN)? Epidemiology suggests the proportion should be around 2:1. In practice those proportions are not too far off. At the Royal Free, over a year, the average proportions are 48 % BN and 19 % AN. The figures for binge eating disorder and eating disorder not otherwise specified (EDNOS) are more at variance with statistics, which suggests that they should be in the majority. In the clinic they form only 27 % of referrals, suggesting that 'typical' patients are being preferentially referred. Five new patients a week can be accommodated in an efficiently run new patient clinic. Length and intensity of treatment are needed in order to make an estimate of ongoing staffing requirements. With an average caseload of 10 and a duration of therapy averaging 1 year, and 150 patients eligible for individual psychotherapy, a staffing of 15 therapists would be required. In practice there will be fewer therapists, and therefore a waiting list is inevitable as assessed patients back up while awaiting therapy. If a day hospital is envisaged, staffing needs to take account of groups, meals and key working, while provision for liaison, outreach and emergencies adds further to the demands. The staff numbers in the Russell Unit are detailed in Table 1.1 (see p. 4). The figures are also given in whole-time equivalents per million population, so that they can be used in service configuration.

LOVE OF MONEY: THE ROOT OF ALL EVIL

In the 2001 report (Royal College of Psychiatrists, 2001) from the Eating Disorders Special Interest Group, we came up with a delightfully simple formula: £1 (€1.42) for each population member will give you enough to

Table 1.1 Staff members on the team serving an area containing 840 000 people

Staff members	Grade	Whole Time Equivalents	WTE per million
Management	Service Manager	1	1.19
Doctors	Consultant*	1	1.19
	Junior Trainee	0.5	0.6
	Senior Trainee	1	1.19
Nurses	Senior	2	2.38
	Junior	2	2.38
Psychologists	Consultant	0	0.0
	Non-consultant	2.1	2.5
Dietitian	Senior	1	1.19
Massage Therapist	Junior nurse	1	1.19
Art/Movement/Drama Therapists		0.4	0.48
Occupational Therapist	Senior	1	1.19
Family Therapist	Senior	0.8	0.95
Administrative (secretaries)	Senior	1.6	1.9
Total		15.4	18.33

* 0.9 Eating disorders psychiatrist
0.1 Consultant psychiatrist in psychotherapy

provide a good, community-based service for over 18s with eating disorders. In this section we assume that you are developing adult eating disorder services for 1 million people with a mixture of urban and rural populations. Almost all healthcare funding organisations are short of money. When there is a well-developed National Health Service (NHS), as in the UK, private funding agencies are able to limit access to private health care funding, especially for long-term conditions, knowing that the NHS will be there to provide ongoing care. Indeed, private insurers will sometimes demand that, as the time for their funding comes towards an end, the clinician has expressly indicated the NHS alternative treatment package that has been set up. Where access to high-quality free health care is restricted, as in the USA, private care has a real ethical dilemma in how to limit care in someone who very much needs treatment, but is unable to continue to pay for it after insurance or public funding has been withdrawn. In much of Western Europe, specialist care can be obtained and the state will pick up all or most of the bill.

Given that money is in short supply, what can a clinician or manager do to encourage a loosening of purse strings in favour of a specific need such as eating disorders? It is important to be aware that your favourite clinical area is in competition with many others, for example drug misuse, forensic services, early intervention and assertive outreach. In general, the money directed towards a particular area is dependent on a finite number of pressures. Broadly they comprise: (1) costs: both of funding new services and of not funding them; (2) profile: the level of interest in an area both locally and

nationally; (3) danger: how dangerous to the public and (less influentially) to themselves are your client group?

I will expand on these three essential areas, and provide information on how to maximise their effectiveness in obtaining funding for a new or developing service.

1. Costs
   As far as can be discerned, funding bodies appear to be motivated by cost, safety, consumer opinion and effectiveness, probably in that order. While the cost of something may be high, funders may well provide the money if the cost of not providing it is higher, in other words, could the service save money? In order to argue this you need to find out what is happening to this patient group at present. It may be that other services, such as general medical or general psychiatric, are attempting to do the work. Find out from clinicians who have tried to treat severe eating disorders how it went. If the patient was in a psychiatric ward for weeks, ran rings round the staff and ended up not gaining weight, while the unit was so short of beds that an acutely ill manic patient needed to be admitted to a private unit, you have a case. The new service, you can argue, would work constructively with the patient and family, probably prevent the admission, and obtain a better outcome. The most telling argument is that the acutely ill general patient would have been accommodated without an expensive and inappropriate private admission elsewhere. If patients with severe eating disorders are being admitted to inpatient units, funded by the local health purchasers, find out how much has been spent in the past few years on these placements. It would not be unusual to find that £200 000, (€ 330 000) had been spent per year. Offer to develop a community service with that starting budget which would give you two nurses, a part-time consultant, manager and therapist. Discuss with great care the question of funding inpatient admissions. If the funding body ask you to pay for admissions out of your own budget remember that one admission could easily put your service in the red. The alternatives are: (a) to hold back a proportion of the budget (say £100 000) to cover admissions or (b) to accept a lower budget from the funding body while responsibility for funding admissions remains outside your eating disorders budget. Because admissions for eating disorders can be so expensive, no one wants to hold the hot potato of the financial risk for them.
2. Profile
   Patients with eating disorders are not that popular (see Chapter 6) but that can work both ways in terms of the support you may or may not get from your colleagues. Some might see eating disorders as relatively trivial and definitely second rank to schizophrenia and depression, while very much wanting someone else to deal with the patients because they can be so difficult to manage especially on general psychiatric wards. Have there been any enquiries or surveys of eating disorders in the

area, and what were the recommendations? Is there a local branch of the Eating Disorders Association and what do they think of local services? Is it known that a local dignitary had a relative with an eating disorder, and might lend support to a campaign? (Occasionally a very high profile individual has a family connection with eating disorders, as occurred in France, but in that case, the idiosyncratic services that were set up did not meet with the approval of many eating disorder specialists.) On a national level, look at the guidelines available. In the UK NICE (www.nice.org.uk) has been successful in gathering together the evidence for effective treatments in a variety of areas. It is likely that, in the UK, hospitals will be rated and, perhaps, funded according to whether they comply with NICE recommendations. This will be a tremendous boost for service quality, although where the money will come from to fund the necessary improvements no one knows, as yet. For our clinical gold prospector looking for cash to start or improve a service, the promise of extra funding for a Trust which might come from complying with NICE could well encourage a Trust to 'Spend to Save'.

3. Danger
   This is one of the most powerful influences on funding bodies. Serious incident enquiries following the death or serious disability of a patient can have profound effects on services. Risk to others is often even more influential. In England the murder, by a patient with schizophrenia, of a member of the public sparked off a wave of enquiries and reports that led to a fundamental change in the way discharged patients who might move to another area were managed. The enormous bureaucracy known as the Care Programme Approach in which care in clinical and social spheres is documented and the responsible person identified for each intervention, as well as for coordination of care, was a result of this wave. Obtain reports of any enquiries that have been held in cases of patients with eating disorders in the area and in all adjacent areas, and collate the recommendations. Many such reports conclude that specialist help was not available when it should have been or that it was not accessed or heeded at the appropriate time. These findings are strong arguments to persuade funding bodies to release more money.

WHICH STAFF?

Staff from differing professions are like travellers who reach a caravanserai having come from widely differing directions. They will each have a different and unique story to tell and be able to teach their co-travellers about their particular experience, while at the same time having much in common with the others. It is important to have certain skills in a team, but, as will be seen in the following chapters, a healthy team develops in such a way that people can overlap considerably in role, so that underlying

training becomes less important. What are the essential tasks that the team requires to perform, and how many staff are needed to perform them? The following tasks are among those required in a community eating disorder service (EDS):

- clinical leadership
- managerial leadership
- psychiatric assessment and management
- medical assessment and management
- dietetic assessment and management
- psychological assessment and management
- family intervention
- guided problem solving
- occupational therapy, and occupational advice and training
- liaison skills with other clinical services
- administrative services.

Many of these tasks are not strictly linked to professions. Clinical and managerial leadership can be provided by any profession. Psychiatric assessment requires psychiatric support and supervision, but much of the information required can be collected by others. The list suggests that a psychiatrist, a psychologist, a dietician, a family therapist and an occupational therapist should be available for advice. Mental health nurses can provide many of the requirements in consultation with the other professions and offer a particularly broad approach, which fits them to act as key workers providing frontline contact to the patient, integrating care and acting as an interpreter of the advice of the other professionals. A team secretary facilitates the work of all members of the team and is a key player.

Table 1.1 shows the current staffing in the Russell Unit and can be used as a guide for services intending to provide a comprehensive community service for eating disorders. The staff required for providing inpatient care to those that require it are not, of course, reflected in these numbers.

This number might be reduced if substantial commitments to work can be obtained from other health agencies such as community mental health teams, primary care, or the voluntary sector. For example, if general practice counsellors can be persuaded to provide guided self-help, many patients with bulimia nervosa could be dealt with in primary care, with supervision from the specialist service.

RECRUITMENT

How to attract people into a service is a major problem in health care. When asked what attracted them to come and work in our team, the most

common reasons are: interest in eating disorders, the reputation of the team, limited unsocial hours, the opportunity to engage in therapeutic work, personal connection with a team member; and a number of negatives, including exhaustion on a general ward and fear of personal injury. It is advisable to recruit the most senior people to key posts. As well as bringing their experience to the work, they may engage in academic work including research and teaching, and may attract trainees whose work can substantially increase the amount of staff time available on the unit. Once a unit has achieved a reputation for good work it attracts other professionals, apart from trainees, who can contribute to the number of hands available. Therapists, sometimes experienced in general work, who wish to enhance their experience of treating eating disorders, may offer their services free as long as they can access clients and medical backup. They will often use external sources of supervision. There are many doctors coming from both the European Union and beyond, who wish to gain expertise in the health service and, sometimes, in eating disorders and who are willing to work until they have the expertise, confidence or qualifications to obtain a paid job in the UK. Doctors who are training in general adult psychiatry may wish to join the team for one or two sessions per week as a 'special interest' for which the eating disorders service bears no cost.

While trainees and unpaid visitors cannot be depended upon to appear and are only variably present, they can increase the effective size of a team substantially. Naturally they have to receive appropriate support and supervision.

WHO DOES WHAT?

This is a very sensitive area. Different professions and training programmes bestow differing skills on their participants. These differences have a number of implications, namely a different range of interventions and professional structures, as well as different status, income and power. Teams are, to some extent, organised by these differences, although certain types of work accentuate them more than others. A cardiac transplant team with surgeons, anaesthetists and nurses would find sharing of many roles quite inappropriate, whereas, in a primary care team, the roles of history taking, monitoring, triage and follow up can be shared between, say, medical and nursing members of the team. In psychiatry, medical and nursing roles are quite defined when inpatient care and particularly compulsory admission are prominent parts of the service. In general, the more community focused a team the more can professional roles be shared. The favoured caricature of a psychiatrist is someone who 'studied medicine but doesn't practice it and practices psychology but never studied it'. The medical side is well represented in eating disorders and hardly a day goes past in which I or

a medical colleague do not interpret an ECG or a blood test. It is recommended that psychiatrists in eating disorders obtain substantial training in one of the therapies with utility in our patients, be it cognitive, family, analytic or one of the others, in order to avoid the criticism implicit in the latter part of the mostly undeserved dictum.

As can be seen in Table 1.2, there are some differences in the way each profession handles each role, although, in general, most things can be done by most of the team. As the team becomes more mature and confident in each other, the range of roles taken on by each team member expands, and within a role, the balance of work taken on between different professions shifts. This is most clearly seen in medical monitoring (Chapter 4). Patients who present risk of physical deterioration and death are, naturally, of extreme concern to professionals, including psychiatrists. One member of the team, usually the consultant psychiatrist, has to take the lead on standards of medical monitoring in the team. As time goes on, non-medical members of the team develop confidence in assessment of medical risk, including body mass index (BMI), muscle testing and ordering investigations such as electrolytes and electrocardiography. Each professional will decide how far he or she is willing to go in taking responsibility for medical data, for example, whether to call a doctor when a slightly increased urea level is reported, and the level of sharing of the medical monitoring role depends on experience, contact with physicians and availability of a doctor's opinion in cases of doubt.

A similar process pertains in the case of individual therapy. This is in some teams seen as the domain of qualified therapists. This has the advantage that each patient sees an expert in therapy, but in the Russell Unit apart from the psychologist team members we have largely avoided appointing psychotherapists and from the outset encouraged nurses to take on individual patients with appropriate support and supervision (Chapter 2). This allows nurses with basic psychiatric training to gain experience in therapy, has inspired some to take advanced courses in a range of psychotherapies, and is very much appreciated by patients. This sophisticated role for nurses and, more recently, other professions, can only be pursued safely (for both staff and patient) with appropriate supervision from experts in different forms of psychotherapy. The way we have achieved this is described in Chapter 2.

STAFF MANAGEMENT STRUCTURE

Here we must consider two forms of management, professional and line. Professional management is almost always by a more senior member of the individual's own profession, be it nurse, doctor, psychologist etc. The function of such management is to help the individual function as a member of their professional group and to progress professionally and academically.

Table 1.2 Some roles (left hand column) and the way different professions approach them (top row)

	Doctor	Nurse	Psychologist	Family Therapist
Individual therapy	Yes, but rarely available	Yes, routine	Yes, more complex cases	Yes, if available
Meal support	Yes, but rarely available	Yes, routine	Yes	Yes
Medical monitoring	Yes, more severely ill cases	Yes, routine	Yes, routine	Yes, if Key Working
Advice to other teams	Yes, routine	Yes	Yes	Yes
Family therapy	Yes, as trainee	As trainee or Key Worker	Occasionally	Yes, routine
Key working	Rarely	Yes, routine	Yes, routine	Yes, if available

For someone who has recently undergone transition, for example from trainee to qualified worker, or by moving posts, there will be many issues to be dealt with in professional supervision with someone who has traversed the same territory. The professional manager can also be involved in any difficult meeting the person might be required to attend, such as disciplinary hearings.

The line manager has quite a different role. This is to represent the next level of management, right up to the board of management, with the aim of enhancing the individual's contribution to the team with a view to increasing its effectiveness and efficiency. The line manager should support and praise what is going well, but not be afraid to tackle what is not.

The two roles are not uncommonly combined in one person, with the effect that many people are line managed by someone from the same profession. We have found, in the Russell Unit, that in time, as clinical skills become shared and confidence within and between professions increases, line management can cross professional boundaries. Our current staff diagram and the equivalent diagram five years ago are given in Figure 1.2, and it can be seen that, in the later team structure, more line management is done across professions. Cross-disciplinary management can only work when individuals within a team trust each other so that they do not feel the need to retreat behind professional groupings in their management arrangements. In one team known to the author, anxiety in the nursing team was so great that nurses were prevented from consulting other staff groups, with a resulting split in the team that was irremediable.

COPING WITH DISTANCE IN A COMMUNITY ORIENTED EATING DISORDERS SERVICE

Just as in a crisis resolution team in general psychiatry, the aim of the community oriented eating disorders service is to treat people with eating disorders in their homes, or, at least, out of hospital. The different ways in which this can be achieved are described in this book under the headings of outpatient, domiciliary, hostel and day hospital care. Different areas, however, demand differing solutions, and a largely rural area will utilise more peripatetic treatment delivery than a compact urban area. There are several factors that impact on, for example, people's ability to take advantage of a day service. The first is accessibility, and this in practice means the time and effort it takes to get from home to the clinic by private or public transport. Patients seem to manage up to an hour each way and this is a reasonable upper limit, although it could be stretched to 1½ hours. Ask the patient to make the journey, perhaps with a friend or relative, and report back. Some areas are covered by journey planners on

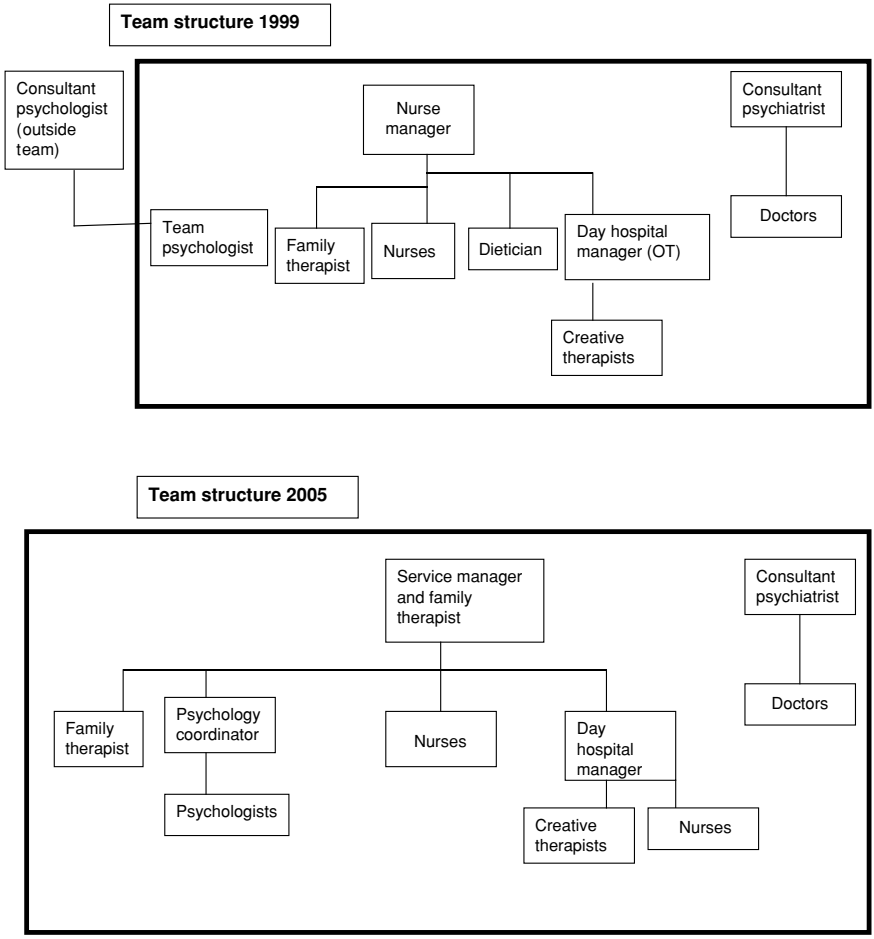

Figure 1.2 Showing changes in management structure of the team between 1999 and 2005. There is increased cross-disciplinary management.

the internet (e.g. www.transportforlondon.co.uk) and these will provide information on recommended routes and journey duration. The second factor is the state of the patient. It is clearly not feasible for a patient with a BMI of 13 and weakness of her legs to make a substantial journey on public transport, including walks, even though she herself may relish the idea of using up all those calories. Related to this is the perception of relatives. Carers, especially parents, who have lived with a child with an anorexic illness for many years may be extremely cautious about them attending a day hospital and some careful family work may be required in order to persuade the family of the safety and benefits of such a course of treatment.

Clinical description 1.1

A young man of 18 was referred to the service. He had developed anorexia nervosa at the age of 13, had a current BMI of 13.5 and had symptoms of bulimia and over-exercising, in which he engaged on an exercise cycle in the home. He was judged as fit for the day programme, but his mother regarded him as too unwell and frail. Two family meetings at the home led to the arrangement, by the clinic, of taxis to collect him from home and bring him back in the evening. This continued until his BMI was 15 when he began to attend using public transport until his full recovery and discharge.

The third factor is motivation of the patient and family. When a patient is safely housed in an inpatient unit, turning up to a therapy group is relatively easy. However, in order to attend a day or outpatient service, particularly on a daily basis, motivation has to be higher, and influences such as ambivalence about treatment and alternative activities, including eating disorder behaviours when the clinic is an hour's journey away may all conspire to keep the patient away. Close attention to motivational enhancement, involvement of the family in a supportive and informative way and adherence to firm rules in the clinic can all help to keep this to a minimum.

The service can respond to the dilemma by enhancing the ability of the patient to get to the clinic, for example by providing taxis, by offering accommodation near to the clinic, in the form of a hostel or using a local hotel, or by bringing treatment to the household, thereby helping and supporting the family in providing care. In planning a service for a mixed urban and rural population, a combination of weekly outpatient treatment, part-time day hospital, full-time day hospital, outreach and satellite clinics, and hostel or hotel accommodation can be provided, giving a wide range of interventions for management of different types of patient at varying distances from the EDS base.

BRICKS AND MORTAR

Clinical description 1.2

A local businessman has a daughter with anorexia nervosa who is admitted with hypokalaemia to a medical ward. She is seen by members of your service and makes a miraculous recovery. He is so impressed he gives the hospital £1 million to spend on providing a good facility for eating disorders.

Given this admittedly unlikely scenario, how should you spend the money?

Location, location, location

The two main issues are the unit's accessibility to staff, patients and other users, and the question of medical support. It makes sense for the service to be located near to bus and rail transport so that it can be reached in a reasonable time. If it is in an area with very expensive housing (that is, in most inner city locations) it should also be accessible to staff living in less costly areas. If there are two or more population centres, consider establishing two centres, perhaps within the geographical area of two funding bodies. In very thinly populated areas consider a mobile outreach service (see Chapter 7) and a day hospital with a hostel (Chapter 8).

Whatever model of care, include as much flexibility as possible. An outpatient unit should be usable as a day hospital or liaison and outreach base so that the service can adjust to changing clinical demands. The proportions of the different elements of community care can be varied depending on the waiting lists for each form of intervention, with staff spending, for example, more time on outreach and liaison when demand for that approach increases and that for day care diminishes.

Staff areas

Adequate accommodation for staff is essential to the welfare and functioning of the team. Individual offices have the advantages of privacy and their potential for interviews with patients or other staff, and the disadvantages of isolation. Individual offices are notoriously difficult to maintain in a state that is suitable for interviews with patients or relatives with abundant opportunities for breaching rules of confidentiality and safety. Open plan arrangements foster team cohesion but some find close proximity with colleagues difficult to sustain. A combination of an open area together with a few rooms for either individual occupation or 'hot desking' for confidential meetings would seem sensible.

Team meetings

A room capable of accommodating the whole team is essential. It should be comfortable so that a meeting of three hours is not unbearable and this means attention to seating, lighting, heating and ventilation as well as the dimensions of the room.

Interview rooms

A few bookable interview rooms will be needed. Patients with eating disorders are not known for their risk of violence to staff. However, alcohol and drug abuse are quite common and precautions such as alarms and escape routes for staff are advisable, especially when new patients are assessed.

In the treatment of eating disorders, from time to time allegations are made that a therapist has acted in a sexually inappropriate manner. No accurate figures are available but there is a perception that misconduct occurs more frequently when the patient has an eating disorder compared to other psychiatric or non-psychiatric consultations. Whether the apparent excess in eating disorders is, in fact, significantly greater than, say, psychotherapy for personality disorder or gynaecology is uncertain. However, a definitive study, in such a sensitive area, is unlikely to be done and all therapists, particularly but not exclusively males, should take precautions to avoid even the suspicion of wrongdoing. Interview rooms should be unlocked and should have a window or peephole fitted in the door. Other staff should be aware that the interview is taking place. Patients should not be interviewed in rooms that are not clearly interview rooms without a chaperone. Such rooms include sitting rooms and bedrooms (during home or hospital visits). If the therapist is aware of a risk of misconduct, because of the patient's behaviour and/or his own feelings, it should be discussed as a matter of urgency with a mentor or supervisor. Allowing a third party to know about the potential for trouble acts as both prevention and a potential source of help should a complaint be made. Lastly, a team should have a clear mechanism for discussing concerns in a manner that does not leave either the concerned staff member or the subject of the concern open to unwarranted adverse consequences. This matter should be addressed as a clinical governance issue before any problem has arisen, just as dealing with potential violence is a routine item for discussion in a forensic team.

Family therapy

A room for seeing families will need comfortable accommodation for up to eight people. The requirement does not end there, however, as will be described in Chapter 5, and the room may need to accommodate a further two to four people for other members of staff joining the session, while a supervising team requires an adjacent room, with a large one-way screen separating it from the therapy room, as well as a sound system allowing the supervising team to hear what is going on in the therapy room, and a microphone allowing the supervisor to speak to the therapist via an

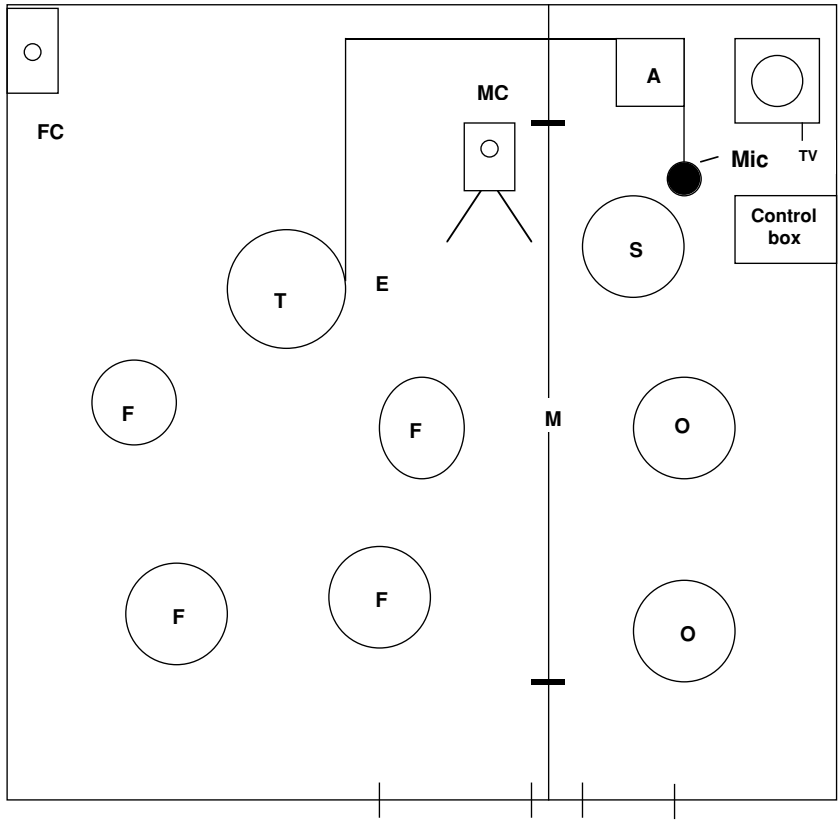

Figure 1.3 Suggested diagram for a family therapy suite.
Notes: T = Therapist; E = Earpiece; A = Amplifier; Mic = Microphone; TV = TV monitor/video recorder; MC = Mobile camera (pan and tilt); FC = Fixed camera (wide angle); F = Family member; S = Supervisor; O = Observer/team member; M = One-way mirror.

earphone. If videotaping is required, a recorder linked to fixed and mobile cameras will be required. If adjacent rooms cannot be provided, the video monitor can act as a tolerable second best for supervision in a distant room. A rough design for such a family therapy suite is shown in Figure 1.3.

Groups

Therapy groups in outpatients (cognitive behaviour therapy, family support, outpatient support groups) and day care require a room with capacity for up to 12 people for up to two hours. Depending on the anticipated room usage, group, team meeting and family therapy rooms can be used for all these purposes.

Activity and large groups

Groups such as dance and movement therapy and art therapy requiring a large group of patients to use equipment or to engage in physical activity require a large room, perhaps two or three times the area of a group room. This sort of room can also be useful for multi-family groups, in which up to 25 people may be using the room at one time, for several hours. Such activities may occur once or twice a week, and this sort of room would not generally need to be exclusively for the use of the eating disorders service, but booked as needed.

Eating

If a day hospital is planned, provision of meals (see Chapter 6) will very likely form a part of the programme. Depending on how meals are provided, a kitchen for serving meals and a dining room for consuming them are the least that will be required. It is useful to have room for a 'beginners' table and a less supervised table, and some patients may require one-to-one help with eating when they are finding the act of eating very hard to perform. Sometimes it is useful for family members to come in to the unit and have a meal with the patient and staff, and this could take place in a number of different areas, or be part of a family therapy session.

SO, WHAT SHOULD WE ASK FOR?

Adding up the above facilities, we get:

- Team office: with enough desk space for all team members required to use it, plus a few for medical, nursing, psychology and other students and trainees.
- Team meeting room: with enough room for the whole team, plus a few more (family, students, visitors).
- Individual offices: for those that require them.
- Interview rooms: depending on number of outpatients seen, and the possibility of borrowing other, generic rooms.
- Group rooms: perhaps doubling with team meeting room.
- Family therapy suite: one room for 3–4 staff and one for a family with one therapist, with occasional visitors.
- Large group rooms: booked as required.
- Kitchen: for preparing or serving.
- Dining room: for day patients, individual and family supported meals.

HOSPITAL OR COMMUNITY?

The location of the eating disorders unit requires some thought. On the one hand, a community location has clear advantages. There is no geographical sharing with an inpatient psychiatric service and there is, therefore, congruence between the 'community' label on the unit and its location. Some patients and families object to the identification of eating disorders as a psychiatric illness, although this is, perhaps, a bit of denial that we should discourage. While a community location is desirable, it is also important that hospital facilities, particularly medical, should be quickly accessible. Given unlimited choice the ideal would be a comfortable house in the vicinity of a general hospital. Given unlimited finance, the house next door would make a fine rehabilitation hostel! (See Chapter 8.)