

A new report⁷ from the King's Fund entitled *Bringing Together Physical and Mental Health: a New Frontier for Integrated Care* not only reviews the case for integration, but also provides real practical examples of how it has been achieved. Importantly, the report describes both the barriers to and facilitators of its successful implementation on the basis of interviews of those involved. The barriers are many and not all will be overcome simply by collocation of services (collocation is not integration). They include deeply ingrained cultural factors in the workforce that reinforce division and the separate organisational and payment systems for physical and mental health care. Key facilitators to achievement of integration include strong leadership for change at both clinical and board level and a willingness to innovate in the relevant organisations.

Policy developments in various countries, including the new models of care introduced by the National Health Service *Five Year Forward View* in England⁸ and the growth of accountable care organisations in the USA have the exciting potential to facilitate integration of physical and mental health care. However, this integration will only happen if psychiatrists and other professionals now actively engage with these developments and use them as opportunities to advocate for and lead new forms of collaborative or even integrated working.

The idea of so-called parity of esteem for patients' mental and physical health care, which has been successfully championed by the Royal College of Psychiatrists,⁹ has achieved considerable influence. Indeed, in England, the Health and Social Care Act 2012 created a new legal responsibility for the National Health

Service to deliver parity of esteem between physical and mental health, something that the Government has pledged to achieve by 2020. However, interpretations of parity of esteem vary. One interpretation is simply for existing mental health services to be as well funded and provide as good care as existing physical health services. Although this interpretation is an important ambition, the report from the King's Fund⁷ raises sights much higher than this ambition to a vision in which mental health care is not only as good as physical care is, but is also delivered as part of all health and care services. This challenge should be addressed and the opportunity seized if we are to repair the harm caused by 100 years of separation.

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Eating disorders: the big issue

The eating disorders (anorexia nervosa, bulimia nervosa, binge eating disorder, and related syndromes) are highly distinctive psychiatric disorders. The peak age of onset is 15–25 years—ie, at a developmentally sensitive time. The average illness duration is about 6 years. Young women make up the majority of people with anorexia and bulimia nervosa, with binge eating disorder nearly equally common in both sexes. The prevalence of eating disorder behaviours is rising in high-income countries, especially in combination with obesity.¹ This increase is reflected in

rising numbers of these presentations to health services. Moreover, the illness is affecting people at an increasingly younger age.² One in every six or seven young women have an eating disorder³ and anorexia nervosa is one of the most common chronic disorders in adolescence—at least as common as type 1 diabetes. Mortality rates are almost twice as high for people with eating disorders as in the general population, and nearly six times higher for people with anorexia nervosa. In people aged 15–24 years, the mortality risk from anorexia nervosa is higher than



For more on the **financial cost of eating disorders** see http://thebutterflyfoundation.org.au/wp-content/uploads/2012/12/Butterfly_Report.pdf

For more on **mental health research funding in the UK** see <http://www.joinmq.org/pages/mental-health-research-funding-landscape-report>

for other serious diseases in adolescence, such as asthma or type 1 diabetes.⁴ One in every two to three people with bulimia nervosa or binge eating disorder are obese or will become obese, making them susceptible to obesity-related complications.^{3,5}

Early intervention is key in achieving full recovery, yet many eating disorder cases are undetected and untreated. Talking therapies, including nutritional management, are the treatment of choice. In anorexia nervosa, family-based interventions for adolescents with a short illness are highly effective, but treatments for adults are only moderately effective.^{4,6} For bulimia nervosa and binge eating disorder, a solid body of evidence supports cognitive-behavioural interventions (including self-care and online versions). Medication has a limited role, and hence there is little involvement of so-called Big Pharma in eating disorders. Overall, fewer than half of patients with anorexia and bulimia nervosa fully recover.^{5,6}

Many people with anorexia nervosa have long-term impairments in social functioning and employment. One in four has no paid employment.⁶ In binge eating disorder and bulimia nervosa, roughly half have substantial role impairment (eg, work, close relationships).⁷ Women with any eating disorder are more likely to stay childless, have fewer children, and need fertility treatment to conceive than those without an eating disorder. They have more difficulties feeding their children and interacting with them. These difficulties might contribute to the intergenerational perpetuation of eating disorders. Quality of life in eating disorders is as low as that in symptomatic coronary heart disease or major depression and worsens with illness duration.⁶

The burden on caregivers of people with eating disorders is substantially higher than that of caring for a relative with depression or schizophrenia. Compared with people caring for adults with serious physical or mental disorders (eg, cancer, psychosis, dementia), time spent caregiving in severe anorexia nervosa is nearly twice as high (24 h per week vs 14 h per week).^{8,9}

Previous attempts to estimate size and cost of eating disorders in Europe¹⁰ have severely underestimated the problem because the most common eating disorders (binge eating disorder and eating disorder not otherwise specified) were not counted, and key resource items, cost of lost productivity of families, and indirect costs due to reduced length of life and health were not

included. Recent comprehensive estimates suggest that 20 million people in the European Union (EU) have an eating disorder, with a cost of about €1 trillion per year (financial costs of about €249 billion plus burden of disease costs of about €763 billion). The financial costs of eating disorders are similar and the burden of disease costs higher than those of anxiety and depression.

Given the size and cost of the problem, research funding for eating disorders is inadequate—eg, in the UK, only 0.4% of mental health research expenditure is for eating disorders, compared with 7.2% for depression and 4.9% for psychosis. This funding disparity is reflected in relatively low research activity in eating disorders. In the past decade, only 15 615 articles were published worldwide on eating disorders, compared with about 200 000 papers on depression (Web of Science, Nov 16, 2015). Most papers were about the psychology of eating disorders (42%) with only 10.5% about neurobiology. Within Horizon 2020—the biggest-ever EU research and innovation programme—no specific eating disorders funding is currently planned.

Broad priorities for European mental health research have recently been outlined¹¹ and are to be welcomed. A strategic plan for eating disorder research that builds on and expands this plan is now needed. Such a plan should establish a pan-European transdisciplinary framework that addresses stakeholder (eg, patients, carers, clinicians) research priorities.

Further, no formal training structures are in place for young researchers in Europe that reflect the transdisciplinary needs of the eating disorders specialty. EU-funded research and research-training initiatives in eating disorders have focused mainly on sociocultural risk and e-health. However, substantial advances will only arise if young researchers are trained and are familiar with state-of-the-art and emerging neurotechnology. Any such research training in eating disorders should be integrated across the weight spectrum, although eating disorder researchers have traditionally worked separately from those in obesity. It will also need to be a bench-to-bedside programme and span a range of neurobiological approaches used to assess cause, prevention, and treatment, and combine animal and human studies. It is unlikely that the required doctoral or post-doctoral research training programme needed to address this gap can be set up in individual countries, thus highlighting the need for an EU-wide initiative on capacity building.

In summary, eating disorders are serious disorders that have a major impact on individuals, families, and wider society. Data indicate funding for eating disorders research is inadequate given the size of the problem. Notably, eating disorders are highly stigmatised, more so by men than by women.¹² This stigmatisation could possibly play a part in funding decisions, because many policy makers and research funders are male. Although different EU countries have strengths in specific aspects of eating disorders research, no EU strategic plan exists for setting research priorities. No formal training structures exist for young researchers to provide the interdisciplinary skills required to advance in the field. To tackle the large and rising problem of eating disorders, and improve patients' and families' lives, the EU needs to recognise this big issue as a priority area to facilitate adequate funding for large-scale research endeavours and capacity building. For further references see the appendix.

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See Online for appendix

Mental health in Europe's Syrian refugee crisis



Since 2011, the war in Syria has resulted in mass displacement of its population both inside and outside the country.¹ Although neighbouring countries have hosted most of the refugees, since the summer of 2015 a surge of Syrian citizens have crossed through Turkey into Greece, with the ultimate aim of reaching western Europe. Thousands of Syrians are being subjected to harsh natural and manmade obstacles on their journey, while receiving poor medical care along the way.²

Although the prevalence of mental illness among these refugees is not available at present, it is expected to be greater than that of the general population,

which is consistent with estimates from refugees in the countries neighbouring Syria.^{3,4} Longitudinal studies on the change in manifestation of psychological distress in Syrians have not been done. However, in other war-surviving populations, the prevalence of traumatic reactions and post-traumatic stress disorder (PTSD) declines over time, except in those with severe prolonged and complicated traumatic reactions.⁵ Hence, in the European refugee crisis, especially in the early stages of resettlement, individuals who face language barriers, unemployment, and acculturation issues might have a pervasive sense of demoralisation and hopelessness.⁶ In view of all these factors, care providers

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