Delivering Evidence Based Treatment within Community Mental Health

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Overview

- Brief review of the evidenced based treatment for eating disorders in the community
- Groundwork considerations when incorporating eating disorder treatment into community MH services
- Consideration of staffing and training needs
- Building relationships with internal and external providers

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Who delivers eating disorder treatment in the community? A story from the South…

Illawarra Eating Disorders Service

&

Shoalhaven Eating Behaviours Service

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CASE 1 – Adolescent

…Michelle, the mother of Emma, a 16 year old girl calls intake to request treatment. She has noticed that Emma has been avoiding eating dinner and has been getting a bit "obsessive" about her softball training. She thinks she may have lost a bit of weight. Michelle hasn't yet discussed her concerns with Emma or the family GP…

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Triage & Assessment

Phone triage

- Michelle is worried, but doesn't know where to start
- validate her concerns & encourage her to learn more about ED's by guiding her to trustworthy resources – books / internet (butterfly / CEDD)
- Encourage Michelle to discuss with Emma and GP
- Referral for treatment with us must be with a GP referral and a medical assessment

Further triage

- Emma provided with a face-to-face ED-specific triage to ascertain supports, readiness and risks
- We require a single GP for ongoing medical monitoring
- We also now consider appropriateness for specialist services, CAYMHS, psychiatry, or other NGO

Proceed to **comprehensive clinical assessment** .

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Triage and Assessment

- Clinician tools for Assessment
  - SCOFF – useful 5 item screening questionnaire
  - Eating Disorders Examination – Questionnaire (EDEQ; Fairburn and Beglin, 1994)
  - Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ; Rieger et al, 2002)

The SCOFF questions*

- Do you make yourself **S**ick because you feel uncomfortably full?
- Do you worry you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ne stone in a 3-month period?**
- Do you believe yourself to be **F**at when others say you are too thin?
- Would you say that **F**ood dominates your life

*One point for every "yes"; a score of 2 indicates a likely case of anorexia nervosa or bulimia
**One stone is equivalent to 14 lb or 6.35 kg

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What treatment should we adopt?

Key issues

- 16 years old – lives with family – supportive Mum
- Short duration of illness (? <6 mths)
- No previous treatment for any MH
- Medically stable??
- Role of the family

Photo credit: gapingvoid.com

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Treatment Options and Treatment Equivalence

- In eating disorders there are a range of treatment options.
- various treatment settings: outpatient, day patient (partial hospitalization), inpatient treatment
- variety of interventions: pharmacological and / or psychological
- Patients may move from one setting to another, and within any setting often more than one treatment is employed.

"Most adolescents can be effectively and safely managed as outpatients"…

…"Evidence is emerging of advantages in detecting and treating adolescent anorexia nervosa in specialist community-based child and adolescent eating-disorder services accessible directly from primary care"

…

(Espie & Eisler, 2015)

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- At a community level, who does Emma see, at a minimum, for treatment?

ESSENTIAL

- Psychologist
- GP

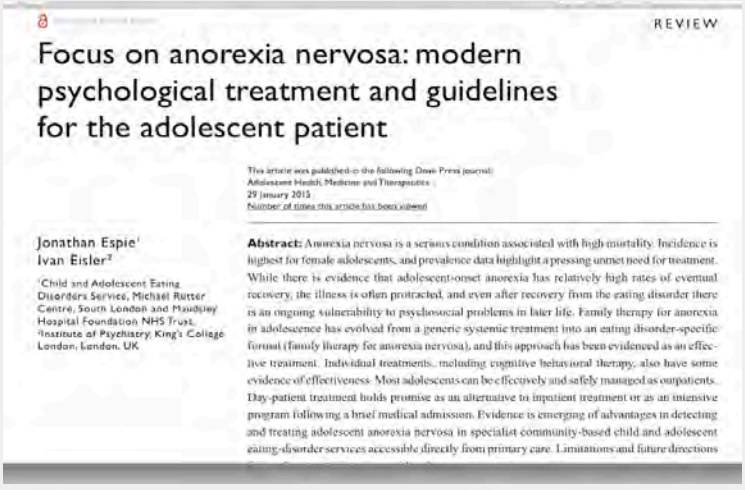
DEPENDING on TX TYPE

- Dietitian

picture credit: mobavitar.com

Maudsley Family Based Treatment for Anorexia Nervosa

- "Maudsley" is the treatment of choice for children & adolescents w AN (Espie & Eisler, 2015)
- RCTs of FBT
  1. FBT > individual supportive psych
  2. Conjoint FBT = separated FBT
  3. Results maintained with manualisation
  4. Short (6mths) = long (12mths)



REVIEW

Focus on anorexia nervosa: modern psychological treatment and guidelines for the adolescent patient

This article was published in the following Dove Press journal:
Adolescent Health, Medicine and Therapeutics
29 January 2015

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Abstract: Anorexia nervosa is a serious condition associated with high mortality. Incidence is highest for female adolescents, and prevalence data highlight a pressing unmet need for treatment. While there is evidence that adolescent-onset anorexia has relatively high rates of eventual recovery, the illness is often protracted, and even after recovery from the eating disorder there is an ongoing vulnerability to psychosocial problems in later life. Family therapy for anorexia in adolescence has evolved from a generic systemic treatment into an eating disorder-specific format (family therapy for anorexia nervosa), and this approach has been evidenced as an effective treatment. Individual treatments, including cognitive behavioral therapy, also have some evidence of effectiveness. Most adolescents can be effectively and safely managed as outpatients. Day-patient treatment holds promise as an alternative to inpatient treatment or as an intensive program following a brief medical admission. Evidence is emerging of advantages in detecting and treating adolescent anorexia nervosa in specialist community-based child and adolescent eating-disorder services accessible directly from primary care. Limitations and future directions

FBT for AN

- Staged approach
  - Phase I: Refeeding – parents in charge
    - Includes family meal
    - Families encouraged to work it out for themselves
  - Phase II: New patterns of relationships
    - Transfer of control gradually and tentatively back to adolescent
  - Phase III: Termination
    - Adolescent development back on track

Basic tenants of FBT

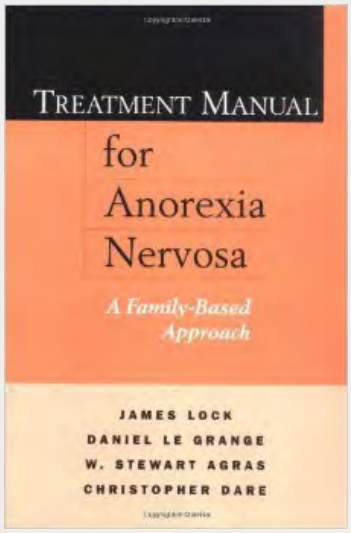
- No assumptions of aetiology
- Behavioural recovery rather than insight & understanding
  Basic behavioural management approach

  FBT is a team approach, i.e., primary therapist, child & adolescent psychiatrist, pediatrician
  Siblings play supportive role and protected from the job assigned to the parents
  Parents are responsible for weight restoration – therapist consults to them and encourages them to find solutions

- Externalisation of the illness
  - Adolescent is sick, not regressed/ immature/ difficult etc.
  - Adolescent nor family is not to blame

Training requirements for FBT

- Specialist training and supervision is required for best practice
- Manual available
- Can our team provide this?
  - Who do we train?
  - How do we access training?
    - Westmead unit
    - CEDD online training (coming soon)



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Alternative treatments – CBT for Adolescent AN / BN

- Individual therapy can lead to significant improvement for many adolescents with AN.
  [Studies by Lock et al (2010) and Robin et al (1999)]
- 2 studies compared indiv. CBT with behavioural FT for AN = equivalent outcomes (Ball & Mitchell, 2004; Gowers et al. 2007)
- Enhanced CBT (CBTE – Fariburn 2008) for adolescent AN also shows promise (Dale Grave et al, 2013)

…"It seems then that while evidence for the effectiveness of treatment may be strongest for FT-AN, it is not the only evidenced treatment, and such alternatives as CBT might be useful when FT-AN is not applicable"… (Espie & Eilser 2015)

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CBT for Eating disorders overview (CBT-E; Fairburn)

- Focuses on the interaction between overvalued ideas regarding weight and shape, associated maintaining thoughts, and strict dieting that result in disordered eating (Fairburn et al., 1991)
- prescription of regular normalised eating, graded exposure to feared foods, monitoring and challenging distorted thoughts about weight, food and the self.
- Also targets perfectionism, mood intolerance, low self-esteem, and interpersonal problems

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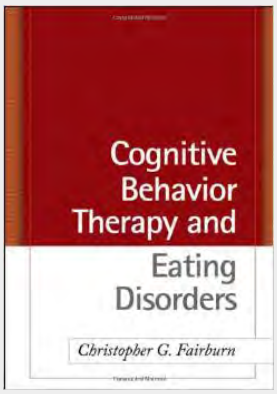
CBT – E



Relatively useful across eating disorders in adults (Fairburn 2008 – published guide with some adaptations for adolescents noted)

Phase 1

Help clients think afresh about their current state and the processes maintaining it

Analyze pros and cons of tackling their eating disorder.

(MET like)

Phase 2.

if willing, helped to regain weight, address their eating disorder psychopathology and the processes maintaining it. Esp shape and weight concerns

Phase 3

Maintain the changes that they have made

Develop strategies for setbacks.

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CBT-E for Adolescent AN (Dale Grave 2013)

- N=49. 40 sessions over 40 weeks individually
- Parent involvement: 1 hour at assessment, and eight 15-min child/parent sessions immediately after child sessions weeks 1–4, 8, 12, 20 & 40
- No other health professionals involved unless specific indication
- Substantial increase in weight (1/3 reached 95% IBW) & marked decrease in eating disorder psychopathology
- Held at 60 week f/u

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Essential components for delivering any form of treatment within the community

- Relationship building…
  - Within treatment team
  - communication, “same page”, clear roles, trust, awareness of traps
- Network holistic treatment teams

  e.g.

  IEDS + GP + family + paediatrician + hospital

  IEDS + GP + school counselor + family

  IEDS + GP + CAMHS + family + school + hospital etc etc…

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For our case : Maudsley Treatment progress

- Start Phase 1 of Maudsley
- Family struggling to get on board and enforce eating
- Emma is getting distressed and angry, and emphatically denies that externalisation of the eating disorder is applicable to her
- Now what??

  Go back to our Relationships…

  –Supervision and Professional Networks

  OR…

  –Refer inpatient? (Where? Public? Private)

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Supervision for clinicians - Making do with limited resources

- Ideally regular supervision with specialist clinician
- Eating Disorder Clinician Interest Groups
- Network Eating Disorder Co-ordinators and CEDD
- RPA/ Westmead/ SCH

Treatment progress – Inpatient admission locally

- Emma is admitted to general medical ward at local hospital due to low BMI, poor intake
- Limited experience and knowledge on the ward re eating disorders and the family wants you to step in and see her and "talk to" the ward staff
- How to manage the expectations of the service?
- What resources are there?
  - CEDD
  - Network coordinators
  - Documents for staff re inpatient management
  - C/L Psychiatry
  - Encourage parents to take charge

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Treatment progress

After a 2 week admission, Emma has gained some weight and the family returns for family therapy. The parents are more on board as the admission has scared them.

Progress through Phase 1 and 2.

Emma at IBW but anxiety and OCD symptoms very prominent.

What now?

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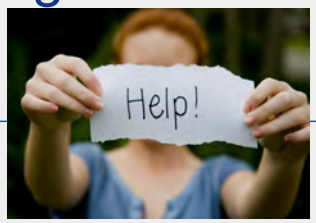
CASE 2 – Adult with longstanding disordered eating



Jodie calls intake as her private clinical psychologist, whom she has seen on and off for years, is going on maternity leave and she wants some support. She has expired all her Medicare sessions and says can't afford to continue privately. Jodie is 25, is studying dietetics part time and lives with a flat mate. She does not want her parents involved in treatment as she said treatment for anorexia when she was 15 involved her parents and was "awful". She says her parents are over the eating disorder. At the moment Jodie reports she is BMI 19.5 and bingeing and purging daily. She says she only exercises intermittently, and "gets stressed out easily". She does not want to gain any weight.

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Wait list management

- The current waiting list for medically stable adults is 6 months.
- How do we manage that?
  - Thorough assessment prior to wait listing
  - Identify supports
  - Waitlist management issues
  - Develop group programs

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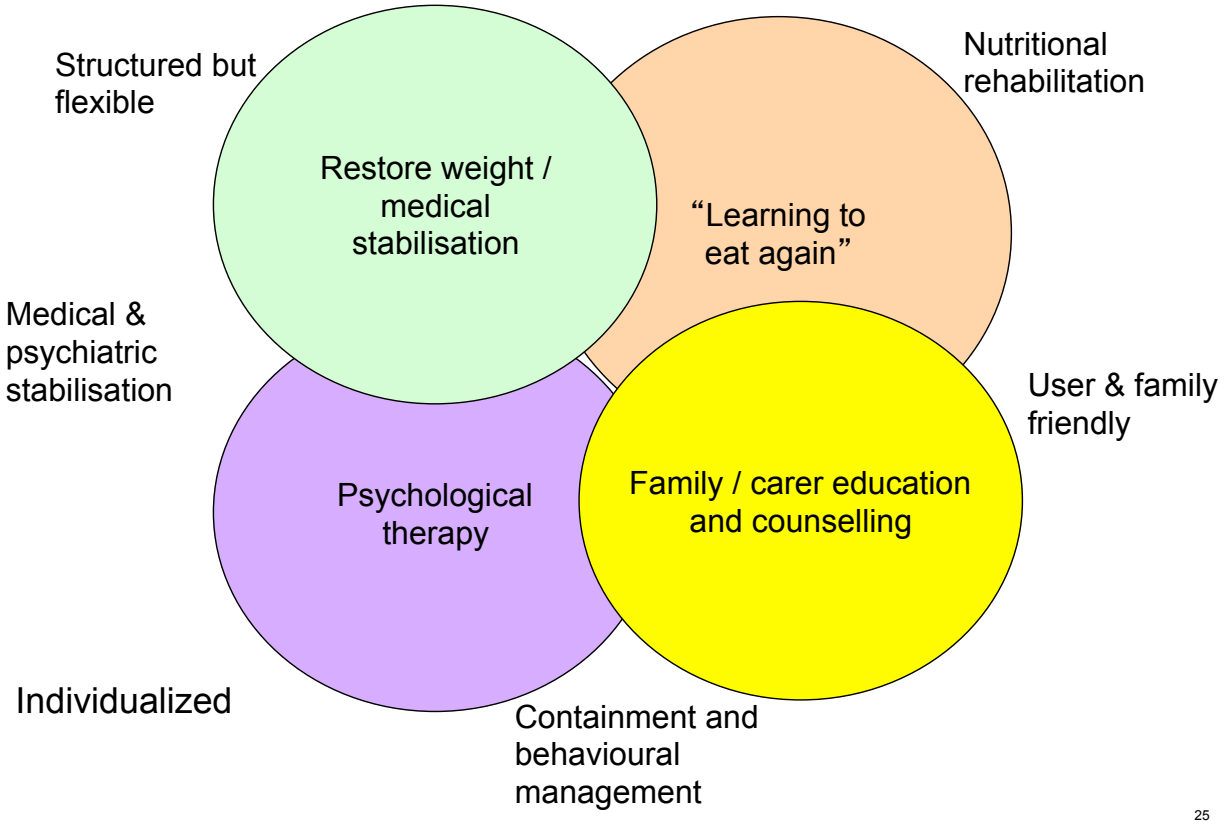
Treatment components



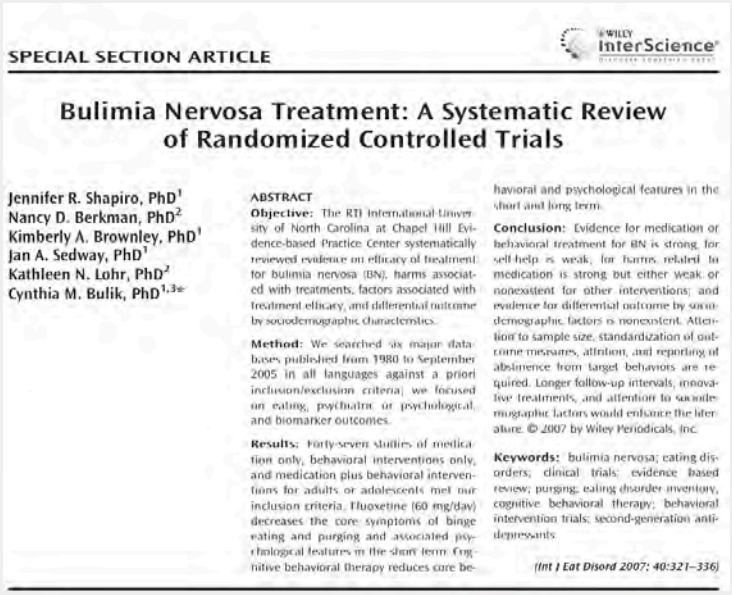
Treatment planning

The goals may be based on:

- physical and psychiatric stabilisation
- family education, support and involvement
- weight and health restoration
- development of healthy eating behaviours
- enhancement of motivation to change
- facilitation of normal socialisation
- improvement of maladaptive thoughts, attitudes and feelings about food, weight and body image
- treatment of associated conditions including depression and anxiety
- cessation of compensatory behaviours (e.g. vomiting, laxatives, over exercise

What type of outpatient therapy?

- **Supportive psychotherapy NSCM**
- Psychoeducation / nutritional counselling
- **CBT / CBT-E**
- **IPT,** DBT, MET, ACT, Narrative
- **Family based therapy**
- Psychoanalytic



SPECIAL SECTION ARTICLE

WILEY InterScience

Bulimia Nervosa Treatment: A Systematic Review of Randomized Controlled Trials

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ABSTRACT

Objective: The RTI International-University of North Carolina at Chapel Hill Evidence-based Practice Center systematically reviewed evidence on efficacy of treatment for bulimia nervosa (BN), harms associated with treatments, factors associated with treatment efficacy, and differential outcome by sociodemographic characteristics.

Method: We searched six major databases published from 1980 to September 2005 in all languages against a priori inclusion/exclusion criteria; we focused on eating, psychiatric or psychological, and biomarker outcomes.

Results: Forty-seven studies of medication only, behavioral interventions only, and medication plus behavioral interventions for adults or adolescents met our inclusion criteria. Fluoxetine (60 mg/day) decreases the core symptoms of binge eating and purging and associated psychological features in the short term. Cognitive behavioral therapy reduces core behavioral and psychological features in the short and long term.

Conclusion: Evidence for medication or behavioral treatment for BN is strong, for self-help is weak, for harms related to medication is strong but either weak or nonexistent for other interventions; and evidence for differential outcome by sociodemographic factors is nonexistent. Attention to sample size, standardization of outcome measures, attrition, and reporting of abstinence from target behaviors are required. Longer follow-up intervals, innovative treatments, and attention to sociodemographic factors would enhance the literature. © 2007 by Wiley Periodicals, Inc.

Keywords: bulimia nervosa; eating disorders; clinical trials; evidence based review; purging; eating disorder inventory; cognitive behavioral therapy; behavioral intervention trials; second-generation antidepressants

(Int J Eat Disord 2007; 40:321–336)

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Current best practice for adults

- For **Bulimia Nervosa** a specific form of Cognitive Behavioural Therapy (CBT-BN/ CBT-E; Fairburn et al) that targets eating disorders cognitions and behaviours has shown some benefit. Interpersonal psychotherapy (IPT) which addresses patterns of relational interactions may be useful. Dialetical Behaviour Therapy (DBT) may be useful if there are personality disorder traits or self harm.

- For **Anorexia Nervosa**, a variety of talking therapies including general supportive counselling, CBT/ CBT-E, IPT, anxiety management strategies, and Motivational Enhancement Therapy are often used.

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Supportive psychotherapy

- Supportive techniques (Luborsky, 1984):
  - Demonstration of support, acceptance, and affection
  - emphasis on working together
  - Communication of a hopeful attitude that the goals will be achieved;
  - respect of the client's defences
  - focus on the client's strengths
  - conversational style, using active listening, open questioning, reflection, praise, advice, and therapist self-disclosure

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Clinician training required?

- Depends what experience and skill clinicians bring to the team
- What are their backgrounds and training – CBT/ DBT/ IPT
- May need specific support to adapt their training to EDs
- Ongoing training required? Of course!
- Online resources (cedd.org.au)

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Treatment progress

At assessment, Jodie is offered a group treatment for Bulimia, and agrees to see the private psychologist until the group starts, to maintain support and continue the work she has been doing.

Because her diagnosis is BN, and the outpatient clinic runs a BN group, Jodie enters the CBT-BN based group program after waiting for 8 weeks, not the full 6 months...

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CBT – BN Group program (Chen et al., 2003)

- Chen and colleagues (2003) compared individual CBT-BN with group CBT-BN and found equivalent outcomes
- Resource friendly
  - Possible to treat up to 10 people at a time over 20 weeks
  - 90 minute, closed group sessions
- Group members were given the option to have a family and friends' information evening if all members agreed

***** RPA eating disorders outpatient clinic runs a group CBT program for Binge Eating & Bulimia see cedd.org.au for details****

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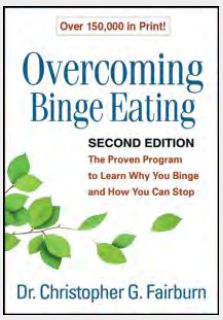
The group program at IEDS

- Average 8 clients per group
- Co-run by psychologist and dietitian
- First four weeks it is one hour twice a week
- Remaining 16 weeks an hour a week
- Based on Fairburn's Overcoming binge eating



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Treatment progress

Unfortunately, despite CBT-BN group programs being useful for many, Jodie doesn't really progress. She appears to be ambivalent about recovery, which is common when she does not have an experience of "normal eating" as an adult.

She reports that she mainly addressed stress and depression with the private psychologist and wants to look at that again more than the eating disorder.

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What are our options??

Picture credit: eatingrecoverycentre.com

Discharge/ Time out?

Consider adding SSRI?

Motivational work?

Individual supportive psychotherapy?

Agree to a set treatment course?

Carers' Group?

Other?

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Challenges in working with ED's across the spectrum

- Secrecy aids the ED – building trust
- ED's are functional – why would they want to give up something that is helping to meet their needs?
- Medical risk – but wait I'm just a psychologist/dietitian!
- Changing intensity of treatment – what do you mean there are no beds?!
- Length of time to treat – no we cant get this done in 6 sessions
- Co-morbid diagnoses – isn't this just a "straight eating disorder"?
- Families – not just 2 parents and 2.3children…
- Age range – I thought this was just a teenage thing?!
- Cognitive capacity – but she is an intelligent girl!

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Lessons learned about treating ED's in a community setting

- Having teams in place
  - Clear roles
  - GP's in your LHD willing *and* able
  - Joint comprehensive assessments
  - Links :local hospital for medical admissions
    : local public and private psychiatry
- Continuum of care
- Confidence to treat

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Lessons learned about treating ED's in a community setting

- Managing referrals to allow best use of resources
- Services need clear procedures, so when sticky situations arise the non-negotiables have already been put in place
- With established parameters, and having built a relationship that engenders trust and confidence, clinicians can follow-through with tough but essential decisions
- Access ongoing supervision and MDT clinical review
- Access ongoing training

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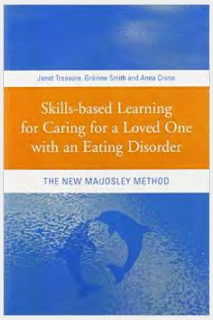
Lessons learnt continued…

- Improving quality of life, rather than recovery focus when treating enduring Anorexia
- Utilising group work such as those for Bulimia Nervosa (based on Christopher Fairburn's work) and for Carers (based on the work from UK's Janet Treasure)



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Picture credit: earlychildhoodwisdom.blogspot.com

Thank you