CBT for eating disorders in primary care settings: Effectiveness with non-underweight cases

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Eating disorders are complex

• Physical risks: weight loss, purging
• Motivation
• Food and exercise

...Your dream team?
Our dream team...

• Past First Step staff:
  
  Will Devlin & Bobby Orchard
First Step administrator

Emma Rea
Therapists

Tricia Worthington, Debbie Clay, Sarah Wilson
Trainee Counselling Psychologists

Louise Davey & Jo Richmond
Mission statement - May 2015 team day

“First Step endeavours to be an accessible service that recognises the impact of AN / BN type eating disorders on quality of life (mood, social, work, relationships, wellbeing, family) regardless of ‘severity’. We aim to respond to people in a timely manner and offer evidence-based treatment”
What’s it like to work in this service?

“As a trainee psychologist, working one day week in the team, I was made to feel incredibly welcome right from the start. This, together with really great supervision, has enabled me to respond to the difficulties that my clients bring in their struggle to change their relationships with food, and to understand the complexity that lies behind their eating disorders”
“I feel very grateful to have the opportunity to work in a primary care eating disorder service; we are able to provide a service to people who may otherwise not be able to access help (due to severity). The work can be challenging but also immensely rewarding when people are able to 'nip things in the bud', or understand and challenge the maintaining processes of their eating disorder enabling them to make positive changes towards the life they want”
“Interesting, challenging and rewarding sometimes frustrating but never dull”

“It’s a positive experience being part of a supportive team with good supervision. Working in a primary care setting means that clients are often well motivated and do recover which is very rewarding!”
'Everyone in the team is helpful, friendly and mutually supportive. Clients are often worried about starting therapy, and it's really gratifying to see them benefiting from a committed and responsive service.'
Other important people...

- Bank staff: Lucy Dunn, Michelle O’Keeffe
- STEPs team
- First Step patients
- Bristol GP’s
- Dr Dominique Thompson
- Commissioners
- AWP NHS Trust
Our local context – before 2013

- NHS eating disorder provision in specialist ‘tertiary’ eating disorder service only: Community and in-patient MDTs.
- GP referral to mental health team.
- ED referral and care co-ordination by secondary mental health team.
- Variety of groups, support, therapies
- Most attend other treatments e.g. motivational group prior to CBT.
- Provided at hospital site.
Your local context

In pairs...

Discuss typical care pathway of an adult attempting to access eating disorder treatment in your area

• Who must they talk to?
• What must they do?
• What criteria must they meet?
• What will they receive?
Treatment settings matter

• Treatment for eating disorders is usually provided within multi-disciplinary services
  • accessed through general mental health teams

• Problems with this approach
  • time delays
  • loss of patients as they have to jump through multiple hoops
  • Focus on urgent cases, slowing the treatment of non-urgent cases
Treatment settings matter

• As a result, there is a greater trend in the UK towards direct GP referral to treatment

• Efforts at treatment without having to go through so many hoops

• Similar to the IAPT initiative for other mental health problems
First Step

• Primary care provision tested in university GP practice (Devlin, 2014)

• Accessible assessment and CBT rolled out across Bristol in 2013

• Unlike a lot of other such developments (which use third sector providers for ‘simple’ cases), this was NHS based
Is there a demand for such a service?

• Might have expected a slow start for a new service

• However, that was not the case

• Clear demand from early on

• Forecast 192 per year
Referrals

- In the first year (2013-14): n = 248
- 2014-15: n = 283
- 2015-16: n = 284
- 36% from University of Bristol Student Health Service
2015-16: 284 referrals

- 87 (31%) did not opt in
- 13 (5%) fast tracked to community ED team
- 184 (65%) booked triage assessments
- 176 (62%) attended booked assessment
- 8 (4%) DNA
- 89 (51%) offered Primary Care treatment
- 81 (46%) transferred to community ED team
- 6 (3%) discharged following assessment
So, there is a demand for the service

• about half of the patients were seen as ‘suitable’ for treatment at this primary care level

• Who is this type of service and setting suitable for?
Quiz!
A) 2 yr onset, male student, binging, fasting, running daily, BMI 22. No expressed motivation to change.
B) 15 yr onset (at time of sexual abuse) female, binging and purging 4 times per week, BMI 24
C) 8 yr onset, female, BMI 18, purging 3 times per week, depression, self-harm, suicidal ideation.
D) 12 yr onset, female, BMI 27, binging and purging daily.
So, two questions...  
• Does evidence-based treatment work in a primary care setting?

• How much of that treatment should we give the patients?
  This has major implications for how many people can be treated within the service resource

So let’s look at the background to each of those, before answering them...
What treatment to offer?

NICE (2004; 2017) recommends CBT for eating disorders:

- Efficacy – works in controlled trials
  - (Fairburn et al., 2009)
- Effective in specialist services
  - (Knott, Woodward, Hoefkens & Limbert, 2015; Byrne, Fursland, Allen & Watson, 2011; Turner et al., 2015)

But will it work in a primary care setting, without a highly trained specialist team?
How long should we make CBT?

Recommendations vary from 15-40 sessions
  • depending on the CBT version and BMI
    (Cooper & Fairburn, 2011; Fairburn, 2008).

How many sessions do we actually offer when therapy is not working?
  • 45 (bulimia) to 50 (anorexia)
    (Cowdrey & Waller, 2016)
How long should we make CBT?

• How should we avoid getting ‘stuck’?

• No progress by mid-treatment? (Fairburn, 2008)
  • Offer a more intensive plan
  • Extend only where:
    • significant benefits yet still impaired
    • there is a setback at the end of treatment
    • when treatment is disrupted
How long should we make CBT?

Effectiveness studies also adjust duration
• shortening for rapid change
• extending for restrictive presentations/comorbidity trauma focus, or ‘perceived need’
  • (Turner et al., 2015; Byrne, et al., 2011; Knott et al., 2015).

But are we missing something?
• With other disorders, there is often a point where therapy response stops improving
• Around session 10 for anxiety/depression (Clark, 2016)
How long should we make CBT?

• Is it possible that there is a similar issue with eating disorders, where therapy response stops improving? (Bell et al., in press, IJED)

• After a period of early response (eight weeks), there is no evidence that longer therapy duration leads to better outcomes
  • The same across therapies, and across restrictive/bulimic eating disorders
Aims:

• To determine whether CBT for eating disorders can be effective in a routine, primary care clinical setting.

• To assess dose response:
  Does the provision of more treatment sessions continue to facilitate further recovery gains?
Does CBT work with this community group?

Patients
47 treatment starters
• 44 female; 3 male

• AN or BN type eating disorders

• Mean age = 27.1 years (SD= 6.64; range = 18-42)

• Mean duration of their eating disorders = 9.22 years (SD= 6.53; range = 1-23)
Does CBT work with this community group?

Inclusion/exclusion criteria

- All had a BMI ≥ 17
- Not requiring multiagency/multidisciplinary care
- No previous eating disorder admission / CBT-E
- No problematic alcohol or substance abuse and no psychotic diagnosis
- Medically stable and monitored
- Motivation level was not used to exclude
Treatment

Individual CBT with trained and supervised therapists, including:

- individualised formulation
- in-session weighing
- food records
- regular eating
- identification of triggers to eating disorder behaviours
- exposure
- behavioural experimentation.
Dosage increased for lower-weight patients
- Up to 30 sessions if BMI = 17-18
- Up to 20 sessions if BMI > 18

Socratic approach to exploring aims and fears about change
- If this did not influence goals positively, therapists aimed to discontinue after eight sessions
- Such patients were kept in the data set
Measures

Start and end of CBT

- EDE-Q (eating attitudes and behaviours)
- PHQ-9 (depression)
Data analysis: Completer and ITT

- Attrition: chi-squared and $t$-tests.
- Symptom change: paired $t$-tests.
  - Effect size: Cohen’s $d$
- Predictors of change: Pearson’s $r$ correlations.
- Therapy dose and change relationship (completers only): Pearson’s $r$ correlations and curve fit estimates
Results

Attrition
• 74.5% (n=35) completed CBT.
• Similar attrition rate to comparable studies
• No pre-treatment predictors

Dosage of treatment
• 17 sessions attended (range = 7-33)
• 25.2 weeks (range = 10-52)
• No significant difference between AN or BN

Weight gain
• Underweight patients – BMI gain of 1.43
• Others – BMI gain of 0.14
Results: Eating pathology

Changes in EDE-Q scores over treatment

All changes significant, with large effect sizes
Results: Depression

Changes in PHQ-9 scores over treatment

All changes significant, with large effect sizes
Patient characteristics predict improvement?

- Age, duration of ED or BMI did not predict outcome.
- Higher pre-treatment PHQ-9 => greater reduction in depression and eating pathology
- Higher pre-treatment EDE-Q => greater reduction in eating pathology
- **Severity** predicts *better* outcome
- **Duration** is *not* linked to outcome
Treatment duration and level of improvement (Completers only)

- More severe cases did not have longer in therapy

- More therapy did not mean better outcomes after 7-8 sessions
  - Curve estimates (linear, quadric, cubic: all F<1.5) showed no link between number of sessions/weeks in therapy and further improvement
What do those ‘fit curves’ look like?
Those two questions again...

- Does CBT work in a primary care ED service?
  - Yes
  - Good retention
  - Significant improvement in eating and mood, into non-clinical range
  - Unaffected by severity or duration

- Does longer therapy provide better outcomes?
  - Not once one gets past 7-8 sessions
  - Even for anorexia nervosa
Clinical and research implications

• CBT can work in routine primary care settings, improving accessibility for suitable patients
• Extending therapy might be costly but ineffective
  • As shown by Bell et al. (in press)
• So keep it short...
• Importance of focusing on early change, rather than waiting for it to happen later in therapy
  • Behavioural change in the first 4-6 sessions
    • Raykos et al. (2013); Turner et al. (2016)
Research implications

• What needs exploring now, in similar services?
  • Long-term follow-ups
  • Other measures of eating change
  • Impact on other comorbidities

• What about in other service settings (secondary, tertiary)?
  • Change patterns over time
  • Do lower-weight cases show the same pattern?
5 mins in small groups

- What do you know now, that you didn’t 90 minutes ago?
- 3 priorities for next week:
  What will you do, to support more patients to do well in the future?

Pat yourself on the back..? Change track..?
Plan for duration of treatment..?
Gather evidence for something that might work better..?
Clinical implications

• Clinical measures to inform treatment planning and review

• Supervision to explore factors influencing treatment planning

• Earlier identification and action for non-responders
Service implications

• Offer treatment with an evidence-base

• Value in time-limited service to those with BMI over 17

• Gather support from people with influence and power – GPs, MPs, Commissioners

• Present evidence for effectiveness

• Present argument for cost