To Contemplate or not to Contemplate

Cardiff and Vale Adult Eating Disorders Services International Conference Workshop 2017
Who we are

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Now Clinical Co-ordinator Jigsaw Dublin 15, Ireland
Contributors

• All the contemplation group facilitators
• All the contemplation group attendees
• Lea Opatz
• Lizzie Brooks
• Caroline Limbert
Objectives

By the end of this workshop each person will...

- Be familiar with the development of the contemplation group intervention in Cardiff & Vale
- Be aware of the outcomes observed following these groups
- Have an opportunity to consider the benefits of delivering this intervention in a clinical setting
Workshop Outline

- The story of contemplation in Cardiff & Vale
- Outline of the group intervention
- Evaluation of group data 2012-2015
- Individual examples
- Lessons learned
- (Addressing some concerns raised in literature)
- Group discussion – to contemplate or not to contemplate....
Workshop Task

• Presenters conscious of critique of this approach and ‘intervention’

• Encourage participants to consider the negatives as we progress through presentation which will be helpful for workshop task
Clinicians’ stance
Prochaska and Diclemente’s (1983) Stages of Change Model
Welsh NHS developing Tier 2 & 3 Services including Cardiff and Vale AEDS
STEMs care pathway for contemplation groups, Jakubowska et al., (2012)

- Steps’ clinicians decide at initial assessment the service user stage of change and those considered to be in contemplation were offered group or individual contemplation work.

- Contemplation groups’ 12 sessions were planned as follows, 2 sessions on setting the scene and then psycho-education, 4 on function of the illness, 2 on impact of the illness, 3 on change, fear, recovery and 1 on evaluation and endings.

- Upon completion all were offered a meeting with their care co-ordinator and a group facilitator to discuss the next step. No pressure was exerted on action based treatment even at this point.
Ouch moment!

75% of people with an ED are in contemplation and yet majority of NHS services offer action work - that struck a chord.
Cardiff and Vale Tiers of ED Service

Tier 4

Tier 3:
Service for High-Risk Eating Disorders (SHED)

Tier 2:
Eating Disorders Service Outpatients Team (EDSOT)

Tier 1
Cardiff and Vale Adult ED Service model – tiers 2 and 3

• Tier 2 – **EDS Outpatient** TT – moderate to severe ED and BMI above 15 if woman 16 if man (not Tier 1).

• Tier 3 – **High risk** ED – severe ED with a BMI below 15 if woman 16 if man or with very high risk ED related behaviours if higher weight (not Tier 4).

Referral routes into above via CMHTs or PMHSS.
Fairburn Action

• Tier 2 - Prior investment in CBT-E ACTION approach and change orientated motivational stance since 2003 with good effect

• Both services sought engagement with new service users via specialist assessment and commencement of specialist change work
Different ways of assessing for contemplation stage

- Clinicians opinion
- Motivation scales
- Service user opinion
- Service user behaviour when attempting action stage

Upon reflection we wondered if we had scope for all of the above, but particularly the last one.
Prochaska and Diclemente’s (1983) Stages of Change Model
Tier 2 offer of Contemplation

Tier 2 – assessed via one or two (maximum) meetings and then placed on WL for 3 ED service options in first phase: dietetics, Guided Self Help or waiting list only, and then second phase - CBT-ED or IPT.

If motivation for change becomes an issue at any point then 8 sessions of individual contemplation work / Fairburn's 3 session motivational change work / contemplation group is offered dependent on timing and service user preference. A review following this is then arranged.
Tier 3 – Offer of Contemplation

- Engagement and motivation woven throughout interaction and intervention, e.g. initial feedback letter
- Same principle as Tier 2 – following delivery of range of interventions if progress not being made, e.g. CBT, Dietetic intervention, Inpatient treatment, Intensive home support
- After period of time has passed since an intervention, e.g. DBT.
- Individual review in collaboration with individual and care coordinator
- Initial recruitment identified a number of people who had many years of treatment. Ongoing recruitment
How many patients take part in the Contemplation Group?

<table>
<thead>
<tr>
<th></th>
<th>No. of active cases (February/March 2017)</th>
<th>No. of patients considered for Contemplation Group in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDSOTT</td>
<td>54</td>
<td>7</td>
</tr>
<tr>
<td>SHED</td>
<td>52</td>
<td>17</td>
</tr>
</tbody>
</table>
Attrition and Engagement with the Contemplation Group in 2016

Initially considered for Contemplation Group n=24

- Tier 2 patients n=7
- Tier 3 patients n=17

Asked if interested n=21
- Not asked n=3

Not invited n=2

Invited to Interview n=19

- Did not attend interview n=4

Attended Interview n=15

- Did not want to attend group n=5

Agreed to attend the group n=10

Attended Group n=10

- Did not complete group n=4

Completed Group n=6

Engaged in Treatment n=2

Discharged from ED services n=3

Low intensity support from ED services n=1

Tier 2 patients n=5
- Tier 3 patients n=1

Tier 2 patients n=5
Tier 3 patients n=1

Cardiff and Vale Adult Eating Disorders Services
International Eating Disorders Conference – 24/03/2017
Contemplation group – method – ENGAGEMENT at first meeting

- Mix across the two services is beneficial
- Opportunity for both main facilitators and all potential participants to meet
- Answer questions
- Acknowledge hopes and fears
- Promote commitment to the group and encourage 'sticking it out' at the beginning
- Discuss participation and 'homework'
- Discuss non-negotiables and procedure around this
- Discuss what happens at end of the group
Description of sample group activities

- Compassionate letter writing to body parts
- Public face and private face – variety of interpretations of homework
- Sociogram
Evaluation

- Small clinical context
- Data gathered over four groups in four years
- Multifaceted evaluation
  - EDE-Q
  - Motivational assessment- Likert scale
  - ANSOCQ and adapted version for those without AN
  - Participant feedback in group and written/ verbal afterwards
  - Analysis of engagement in treatment -
  - Facilitator observation and debrief
# Motivation Questionnaire

## MOTIVATION SCALES

**TO CHANGE OR NOT TO CHANGE?**

<table>
<thead>
<tr>
<th>How motivated are you to change?</th>
</tr>
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<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>Not at all</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you decided to change, how confident are you that you would succeed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>Not at all</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How ready are you to change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>Not at all</td>
</tr>
</tbody>
</table>

(Adapted from Rollnick et al., 1996)
### Effects of Contemplation Work on Motivation

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean Pre</th>
<th>SD Pre</th>
<th>Mean Post</th>
<th>SD Post</th>
<th>Mean Pre</th>
<th>SD Post</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>MFC</td>
<td>6.545</td>
<td>2.345</td>
<td>7.386</td>
<td>2.081</td>
<td>13.093</td>
<td>16.646</td>
<td>21</td>
<td>0.087</td>
<td></td>
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<tr>
<td>CIC</td>
<td>4.818</td>
<td>2.322</td>
<td>5.455</td>
<td>2.539</td>
<td>9.731</td>
<td>10.074</td>
<td>21</td>
<td>0.188</td>
<td></td>
</tr>
<tr>
<td>RTC</td>
<td>5.955</td>
<td>2.339</td>
<td>6.773</td>
<td>2.329</td>
<td>11.937</td>
<td>13.642</td>
<td>21</td>
<td>0.134</td>
<td></td>
</tr>
<tr>
<td>Total Motivation</td>
<td>5.772</td>
<td>1.959</td>
<td>6.536</td>
<td>2.099</td>
<td>13.823</td>
<td>14.603</td>
<td>21</td>
<td>0.069</td>
<td></td>
</tr>
</tbody>
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Data from Contemplation Groups 2012-2016 (Brooks & Opatz)

Cardiff and Vale Adult Eating Disorders Services

International Eating Disorders Conference – 24/03/2017
Changes in the **Stages of Change Model**

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<th>Mean Pre</th>
<th>Mean Post</th>
<th>SD Pre</th>
<th>SD Post</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDSOCQ</td>
<td>2.264</td>
<td>2.572</td>
<td>0.541</td>
<td>0.704</td>
<td>20.074</td>
<td>17.523</td>
<td>22</td>
</tr>
</tbody>
</table>

*Data from Contemplation Groups 2012-2016 (Brooks & Opatz)*
Changes in the *Stages of Change Model*

including data from 2016

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre-contemplation</th>
<th>Contemplation</th>
<th>Preparation</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td>2</td>
<td>11</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Post-contemplation</td>
<td>1</td>
<td>9</td>
<td>8</td>
<td>3</td>
</tr>
</tbody>
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International Eating Disorders Conference – 24/03/2017

Cardiff and Vale Adult Eating Disorders Services
Summary of Patients’ Treatment Activity after attending the Contemplation Group (2012-2015)

Four Contemplation Groups n=33

Completed Group n=22

Sought/Received Treatment n=12

Did not seek/receive Treatment n=10

Did not Complete Group n=11

Elizabeth Brooks, 2015
Case example

• Description of engagement with service:
  • Assessment & engagement – December 2013.
  • CBT-E intervention delivered. Limited progress
  • Disengagement – work commitment
  • Contact maintained – considered re-engagement with treatment. Individual not ready
  • Invitation to contemplation and attendance – Commitment
  • Group participation observed & feedback
  • Review – honesty regarding previous treatment
  • After a period re-engaged with treatment (CBT-E & ACT informed)
  • Currently making considerable progress
Qualitative Feedback
What participants liked...

- Learning about others’ experiences and views through group discussions
  - Talking to others in a similar situation
  - Talking openly with the group
- Having support without judgement or pressure – peers and facilitators
- Group work – “builds confidence, shifts focus of attention off individuals, talk about the positives of getting better and the damage of eating disorders”
- Self-reflection through letters to self
- Homework
Challenges

• Group dynamics – competition
• Experiencing distress as part of group process or content (e.g. life stories)
• Awkward/ prolonged silences
• Hunger for change & tolerating wait time after group completed
• Pragmatic issues – instructions & handouts
• Desire for group to continue “to show we care about each other”
“Although it was hard it was helpful”
“They (the activities) were all useful even if the idea seemed strange sometimes”
“Extremely challenging and thought provoking”
“Really apprehensive at the start but came out with more than you expected”
“You’ve got to give it a try”
Lessons learned

- Awareness and management of dynamics – encourage responsible participation
- Emotional nature of the group
  - Orient participants to this aspect – allow time and identify supports
  - Need for facilitators to debrief and allow time
- Build participants’ commitment (e.g. allow a settle-in period)
- Providing summaries/handouts to group members
- Phone calls to those who have missed sessions or those who were in distress
TO CONTEMPLATE OR NOT
TO CONTEMPLATE...

THAT IS THE QUESTION...
Advert

• Divide into small groups of 4-6 people
• Half of the groups to prepare an advert ‘for’ contemplation groups
• Half of the groups to prepare an advert ‘against’ contemplation groups
• Be creative – anything goes. Let loose...
• Enjoy!
Advantages/ benefits of running group

- Collaborative working across teams
- Benefits of peer support and interaction
- Therapeutic pathway for those who have not made changes or have become stuck
- Maintain relationship with individuals to enable them to re-engage with service or intervention, supportive structure
- Observed improvement in motivation for some individuals
- Enables agreed exit from service
Advantages/ benefits of running group

continued

- Never give up – maintain hope
- Pathway seen as aversive to some individuals and can promote change
- Space to acknowledge and experience emotions
- Mitigates against inertia
- Enables patient throughput and reduces waiting list
Disadvantages

- Intensive time commitment
- Fewer individuals with long-term, severe, complex eating disorders complete the group intervention or re-engage with treatment
- Are participants attending for the ‘right’ reasons?
- High attrition rate
- False hope or misunderstanding of purpose
Further disadvantages?

Please contribute...
References


Thank You
STEPS contemplation groups

• Steps’ clinicians decided at initial assessment the service user stage of change and those considered to be in contemplation were offered group or individual contemplation work. Of those then invited to a group, 50% began (which amounted to 149 service users). No other interventions were offered when the group was running, except GP physical health monitoring.

• Of those who began the 16 groups that were included in this study 68%, (101/149 service users), completed.

• Upon completion all were offered a meeting with their care co-ordinator and a group facilitator to discuss the next step. No pressure was exerted on action based treatment even at this point.
Jakubowska et al., (2012) found that *of the service users that completed* the 12 week course:

- 43% went on to seek and receive ED orientated action-treatment (with only 2% not completing this),
- 6% looked for further help from other services such as phobia treatment, mindfulness,
- 2% wanted to repeat the contemplation groups, and finally,
- 38% were discharged at the end of the 12 weeks either because they felt no more help was needed or because they still did not feel ready to change – this joint decision was viewed as a positive outcome, allowing the service user sense of completion and full discovery of their rationale for not making a change while allowing the service to let them go (with the understanding that they can come back).

The remaining 11% of the patients either moved away or did not keep in contact with the service so their outcome is unknown.