Mind the Gap!
Developing a flexible and seamless transition from CAMHS to Adult Eating Disorder services

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Introductions

• Who we are

• Our service
Learning objectives

• What the evidence says
• What we aspire to
• What our experience has been
• Future directions
Participant Expectations

What do you hope to get out of this workshop?
VSEDS Adult Service Treatment models

Treatment delivered according to:

• NICE Guidelines
• Clinical need
• Patient choice (informed by clinician)
VSEDS Adult Service “Stepped Care” Approach

- Assess
- Carer Groups
- Individual therapy
- Family therapy
- Day Patient
- Inpatient
- Day Patient

Discharge
VSEDS AS Treatment models

**Guided self-help (low intensity)**
- Manual-focused self-help, supported by a clinician

**Cognitive Analytic Therapy (moderate intensity)**
- Patterns of relating to the self and others (often stemming from childhood) which interact with eating difficulties

**Cognitive Behavioural Therapy (moderate intensity)**
- Thoughts, feelings, and behaviours which maintain disordered eating

**Family Therapy (moderate intensity)**
- Family dynamics which drive disordered eating and/or impair recovery
1. Mild to moderate bulimic or binge-eating disorders
   Guided self-help
   8 sessions, over 8 – 12 weeks

2. Moderate to severe bulimic or binge-eating disorders
   16 sessions CBT
   Consider CAT if evidence of personality disorder or interpersonal difficulties perpetuating ED

3. Anorexia Nervosa
   CAT or CBT
   24 – 30 sessions

4. Higher risk disorders (including low weight AN)
   CAT or CBT, plus Family Therapy
5. Specialist Supportive Clinical Management model
   • Nurse led service approach
   • Longer piece of work - high medical/psychiatric risks, complex needs, huge ambivalence
   • Severe and enduring anorexia nervosa

   • Supportive therapy and medical monitoring:
     Phlebotomy, ECG monitoring
     Motivational enhancement
     Flexible psychotherapy (CAT/ CBT informed work)
   Vocational aspects - building a bigger life outside of eating disorder
   Joint working with other agencies to manage ED and all other needs
Evidence base for CYP ED interventions

**Eating disorder - focused family based therapy is main intervention**

Best evidence of effectiveness for young people with bulimia and anorexia

- Family Based Therapy for anorexia (Lock et al., 2010)
- FT-AN (Eisler, et al., 2016)
- Multi family groups for anorexia (Eisler et al., 2016)
- Family Based Therapy for bulimia (Le Grange et al. 2007; 2015)

In contrast to evidence based adult interventions which are individual therapies

**Stages of eating disorder - focused family based therapy**

1. Focus on empowering parents to return to normal eating at home
2. Return responsibility for eating to young person taking age into account
3. Adolescent issues – ED’s freeze or regress development
Evidence base for CYP ED interventions

**Individual interventions**
Some evidence of effectiveness in CYP EDS; all stress parental involvement

- **CBT** for anorexia (Dalle Grave et al., 2013)
- **CBT** for bulimia (Dalle Grave et al., 2015; Schmidt et al., 2007)
- **Focused psychodynamic therapy** for anorexia (Lock et al., 2010)

**Binge Eating Disorder** is an exception
No strong evidence for effectiveness of any therapy including family interventions
In adult population some evidence for brief self guided CBT, and group CBT-ED.
Involvement of parents is likely to be important
# CAMHS vs AMHS

**CAMHS**
- Parents encouraged to take charge
- YP may need to be brought
- Confidentiality may be overridden
- Recovery model
- Physical concerns
- Early response to weight loss
- Family work
- Parents seen as resource
- Siblings involved
- IP if progress slow
- Protective approach

**AMHS**
- Young adult needs to take responsibility
- Young adult makes own decisions re treatment
- Confidentiality preserved
- Adjustment to ED
- Physical damage
- AN internalised part of self
- Very low weight before action taken
- Parents may not be involved
- Sibs rarely involved
- IP admission life-saving
- Responsibility approach
Transition challenges

What challenges have you faced?
Our challenges...

• Difficult stage of life for young people
• When is the best time?
• Break in continuity of care
• Information loss
• Different skills and ethos in different services
I’ll be able to decide for myself when I’m 18

Finding a normal life
- Looking ahead
- Changing roles and relationships
- Fresh starts and new identities

Doing it for myself
- Controlled or cared for
- Having a voice
- Owning recovery

I’m worried about the loss of support when she turns 18

Who will hear our concerns?

Lost in the middle
- That magic age 18
- Thrown in the deep end
- The whole BMI thing
- The right time, the right place, the right way

Transition: pros & cons
Transitions in eating disorders

Survey 206 patients in Adult EDS service (Arcelus et al 2008)

- 27.7% previous involvement in CAMHS
- more than half treated by CAMHS as IP
- half referred by GP rather than CAMHS
- Those treated in CAMHS IP significantly lower self-esteem and fears of maturity
Perspectives of patients (Tan et al 2008)

- Qualitative study of patient experience (age 13-21 years)
- Desire for autonomy not always linked to age
  - Some 18 year olds still want parents and others to help
  - Some young people want to be controlled (even after turning 18)
- Decision making can be seen as a group or individual process
From pond to sea

Good Practice
- Consistency
- Information
- Communication
- Developmental needs

Poor Practice
- Confusion
- Distress
- Lack of planning/coordination/information/support
- Needs of carers not addressed

Key Messages
- Listen to YP and families
- Follow good practice guidelines
- Developmental phase of adolescent/young adult
What we aspire to…

Transitions between services improved by a shared ethos for decision making and treatment that is age independent

- Matching treatment to stage of illness
- Balancing patient and family involvement whatever the age

Permeable boundaries

- Period of joint working and handover across CAMHS & AMHS
- Staff working across both services
- Shared staff training, case discussions and team meetings
- Joint carer groups (?)
- Joint multifamily therapy days (?)
Activity 1:

How do flexible and seamless transitions fit with the evidence base?
James

• 17 years 9 months when he was referred to CEDS-CYP.
• He had long standing difficult relationship with food and body image, and also a chronic digestive illness.
• He was diagnosed with Bulimia Nervosa with comorbid symptoms of low mood and anxiety.
• He was motivated to engage in treatment.

How would you have gone about making a seamless transition?
Molly

• 17 years and 4 months
• Diagnoses: AN, OCD and Social Anxiety
• BMI 17
• Input from CAMHS and specialist Tier 4 EDS since the age of 12 years
• Numerous admissions, some detained
• Referred to new CEDS-CYP from community CAMHS for continued treatment
• Acute refusal and highly ambivalent to further intervention
Milly

- 17 years and 11 months
- Diagnoses: AN and OCD
- Current BMI: 14 and dropping
- 1st diagnosed at age 12 years
- Both in-patient and t in the past
- Referred from an external CAMHS for continued input from the Adult team
Activity 2:

Benefits of flexible and seamless transitions, and overcoming challenges
Giselle

• 17 years and 9 months old when referred to CEDS-CYP by her GP regarding anxiety, binge eating and restricted food intake.
• She has a diagnosis of high functioning autism.
• At assessment she is diagnosed with Binge Eating Disorder. The problem has been around for 2 years but no previous help.
• Ambivalent about seeking help for this difficulty. She is embarrassed to talk about the problem and it is difficult for her to engage in the assessment.
Mandy

- 17 years and 9 months
- Diagnoses: BN and harmful use of alcohol (binge drinking)
- Previous AN requiring tier 4 admission, stable for some years
- Self-Referred to CEDS-CYP for support with BN
Future directions

• Measuring outcomes
• Getting service user feedback
• Anxiety of clinicians
• Realistic service capacity
• Ageless services – advantages and disadvantages