The Development of a Community Eating Disorders Service: A Public Health Informed Approach

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Aims and Objectives

• To briefly describe the process of health needs assessment and its potential impact on service development
• To describe the development of the service over time including the public health informed principles adopted
• To describe how the service functions including the different teams and treatments used
• To describe the home treatment and day treatment programmes in more detail
• To present data on the impact of the service
• To encourage participants to reflect on how their own service has developed and to share their challenges and successes
Health Needs Assessment

- Health needs assessment (HNA) is an essential tool to inform commissioning and service planning, and can be defined as a systematic method of identifying the unmet health and healthcare needs of a population, and making changes to meet those unmet needs. HNA allows for appropriate targeting of resources, and often involves working in partnership with other agencies, communities and service users.

## Elements of a Health Needs Assessment

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<thead>
<tr>
<th>Epidemiological</th>
<th>Description of the problem</th>
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<tr>
<td></td>
<td>Incidence &amp; prevalence (applied to local population), expected morbidity and mortality</td>
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<td>Availability, effectiveness and cost effectiveness of possible interventions/services</td>
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<td>Examination of the current and other possible models of care</td>
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<td>National and international guidance and standards</td>
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<td>Outcome measures</td>
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<td>Corporate</td>
<td>Assessment of stakeholders’ views including patients, carers and professional groups</td>
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<tr>
<td>Comparative</td>
<td>Contrasts the services provided in one region with those available elsewhere</td>
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</table>
Distribution of people with an eating disorder

- In-patients
- Community Patients
- Undetected Cases
Distribution of resources

- In-patients
- Community patients
- Undetected Cases
Prevention

• **Primary prevention**: interventions that prevent the problem from ever occurring e.g. needle exchanges and use of condoms for prevention of HIV and Hepatitis infections

• **Secondary prevention**: detection and intervention as early as possible following commencement of the problem e.g. behavioural interventions in schools

• **Tertiary prevention**: prevention of unnecessary morbidity and mortality in chronic illnesses e.g. diabetes care
The original Eating Disorders Strategy devised from the first HNA

The strategy aims to:

• decrease the length of time between the onset of eating disorders and access to appropriate help

• limit the physical and psychiatric morbidity, social disability and mortality caused by eating disorders

This will be achieved by:

• increasing and improving early identification and intervention in the community and primary health care

• improving specialist clinical and resource management within mental health services
Eating Disorders Strategy - Improve early identification and intervention

- Establish a public telephone helpline
- Distribute a public information leaflet
- Establish a support group
- Provide training for primary care, school nurses, education, youth services and voluntary agencies
- Produce guidance for management in primary care
Helpline monitoring

• Helpline receives calls from sufferers, carers and professionals
• Monitoring demonstrated a reduction in the length of eating disorder prior to seeking help
• Reduction in the length of concern for sufferers and carers
• Increase in the number of callers who had not previously received NHS help
• Increase in the number who were not currently receiving NHS help
Raising awareness

- Press releases and media interviews to raise awareness of the project
- Multi-agency guidance developed for dealing with eating disorders in schools and colleges
- On-going training programmes available
- Specific training available on request
The first decade

- 1996 - Clinical Co-ordinator appointed to undertake needs assessment, train staff and develop strategy
- 1997-2001 - Clinical Co-ordinator worked with Link Workers in local mental health teams (adolescent & adult) providing joint assessments and clinical work, consultation, supervision and training
- 2001 - 3 clinicians and admin appointed to support the work of the Clinical Co-ordinator. ED clinics established in Child & Adolescent Mental Health Service
- Team trained in Interpersonal Psychotherapy (IPT) with Professor Chris Fairburn of Oxford University
- 2003 - Team trained over the course of a year in the new transdiagnostic Cognitive Behaviour Therapy Enhanced (CBT-E) for eating disorders with Professor Chris Fairburn
The second decade

- 2007 - Commissioners requested a health needs assessment and service re-design with the intention of improving local services and reducing out of county in-patient costs

- 2010 – Child and Adolescent Home Treatment Team recruited. We took an initial 3 weeks to team build, train staff and design the service model plus write the operational policy. 4.6 WTE staff

- 2011 - Day Treatment Team recruited. Training provided by Service Director from Toronto Day Treatment Program. 4.5 WTE staff plus Chef

- 2014 – Community Team expanded and to become a specialised all age service. Total 10.8 WTE staff
Principles devised from the second HNA

• The service should be organised as one comprehensive specialist team.
• There should be an ongoing focus on prevention, especially early intervention.
• The service should comply with NICE guidance.
• There should be equity of service provision across all communities within Gloucestershire.
• The service should create systems of referral that increase the likelihood of people being able to access appropriate treatment and maintain working practices that take account of the barriers that might make compliance with ongoing treatment difficult.
• The service should be able to treat people of any age, ensuring continuity of care across the normal age boundaries that mental health services utilise, but ensuring a developmentally appropriate approach to treatment is provided.
Principles devised from the second HNA

• The service should provide a range of support, education and treatment to the families of people affected by eating disorders, recognising the burden of care that eating disorders can produce and the potential role of carers in the recovery process.

• Treatment should be community based except when the physical health of the patient might be compromised. This will help to avoid the lengthy periods of disruption to development, education, work and family life that current hospitalisation involves.

• The service should be able to assess and treat the majority of co-morbid mental illness presented by patients, but should maintain close links with other mental health services and work collaboratively with them in cases of severe co-morbidity. The service should also liaise closely with primary care, general hospital and other relevant agencies.
What does the service consist of?

• **Community Team** - assesses and treats children, adolescents and adults, so no transition at age 18

• **Child and Adolescent Home Treatment Team (ChAHTT)** - intensively supports severely ill young people and their parents in their homes, aiming to enable them to avoid hospital admission

• **Day Treatment Team** – (age 16+) provides 2 meals and 2 snacks, 5 days per week in a group only therapy setting as an alternative to hospital admission
An accidental multi-disciplinary team

• All staff are employed as “Eating Disorder Clinicians” apart from Admin, 0.6 WTE Psychiatrists, 0.5 Dietitian in Day Treatment and Chefs

• Range of professional backgrounds including mental health nurses, social workers, occupational therapists, psychology graduates, social workers
Referral process

• Direct referral from any professional with patient consent or parental consent if patient is below age 16
• Self referral
• Parental referral (including without patient consent if age below 16)
• All patients are expected to remain under the medical care of their GP whilst in treatment and to comply with any necessary medical investigations
Community team therapeutic approaches

• **Family Based Treatment (FBT)** with young people with Anorexia Nervosa, Bulimia Nervosa or atypical variants which focuses on helping parents to temporarily take charge of the young person’s eating

• **Clinical management** with people in acute crisis or Severe Enduring Eating Disorders with major risk or Avoidant/Restrictive Food Intake Disorders (ARFID) presenting with significant low weight, significant psychosocial impairment or failure to grow

• **Specialist in-patient treatment** available out of county if required
Therapeutic approaches

• **Cognitive Behaviour Therapy-Enhanced (CBT-E)** specifically designed to address the core psychopathology and behaviours associated with eating disorders. 20-40 sessions depending on weight

• **Interpersonal Psychotherapy (IPT)** which focuses on changing current relationships rather than addressing the eating disorder directly. 16-20 sessions

• **Interpersonal Psychotherapy (IPT-G)** time limited group therapy for obese patients with Binge Eating Disorder

• Clinicians are actively encouraged to read and make use of the treatment manuals available to them
Whole team training

• Since 1996, trainers from around the world have been asked to provide whole team training workshops.

• We have hosted the following trainers (some more than once) Marilyn Lawrence, Chris Dare, Greg Dring, Rachel Bryant-Waugh, Dasha Nichols, James Lock, Roz Shafran, Johan Vanderlinden, Jenny O’Dea, Chris Fairburn, Joanne Dolhanty

• We have been trained on the following topics, Psychodynamic Approaches, Family Therapy, Assessment Diagnosis and Treatment of ARFID, Physical Aspects of Early Onset Eating Disorders, Family Based Treatment, Treatment of Perfectionism, Treatment of Trauma, Prevention of Eating Disorders and Obesity, Interpersonal Psychotherapy, Cognitive Behaviour Therapy-Enhanced, Emotion Focused Family Therapy
Clinical Supervision

- Monthly family therapy group 3 hours provided by an external Family Therapist
- Weekly CBT-E group 2 hours
- Monthly IPT group 3 hours
- Monthly psychotherapeutic group 90 minutes (one group for each team) provided by an external Psychotherapy Supervisor
- Monthly case management (individual)
Links with Physical Health Services

• Direct referral to on-call paediatric consultant for assessment at the Children’s Centre of the local general hospital
• Paediatric service in-patient referrals to Eating Disorders Service prioritised as urgent
• Agreed in-patient protocol for eating disorders
• Teaching sessions for paediatric staff
• In-reach by ChAHTT for young people on the ward
• Access to consultation with 2 local adult Gastroenterologists
• Developing a shared care pathway for in-patient refeeding of adults at local general hospitals
• Developing a service level agreement with a GP practice to manage high risk patients
Rationale for home treatment

• There were no dedicated beds or day services for adolescents in county, so some young people with severe anorexia nervosa needed admission in specialist units a long way from home.

• Audit of treatment at out of county in-patient units showed that it was usually successful in returning the young person to a healthy weight, but was lengthy and 70-80% of patients relapsed to an unhealthy weight following discharge.

• Although the number of patients treated out of county had remained fairly stable over 10 years, the cost involved had doubled.
Rationale for home treatment

• Only about 10% of our patients with AN needed admission.
• A review of previous admissions estimated that bed days could be reduced by 46% if an intensive home treatment service was commissioned. It was never intended that all admissions should be avoided.
• The home treatment team now treats around 15 patients per year and about 50% avoid hospital. They also carry a small community team caseload.
Child and Adolescent Home Treatment

An adjunct to Family Based Treatment

Phase 1: Parents in charge of weight restoration

Phase 2: Parents hand control over eating back to adolescent

Phase 3: Address adolescent developmental issues

• ChAHT operates within Phase 1 of treatment, as an addition to normal Family Based Treatment when parents are unable to initiate progress
Principles we follow in home treatment

• Parents in charge
• Making treatment a priority (6 weeks off school, with a parent always available)
• Pre-meal support
• Modelling meal support
• Parents actively involved in treatment plan changes
• Supporting parents with problem solving
• Externalisation (separating the illness from the child)
Theoretical models

Step down approach (Practice Continuum Tool)

- Clinician Led Care/Family Involvement
- Clinician Led Care/Family Participation
- Equal Status/Family Participation
- Parent-Led Care/Clinician Consulted Care

“Parents know child best” at forefront when care planning
How we work

Setting up treatment within week one:

• Initial home visit and treatment plan
• Getting to know the young person
• Observation of a family meal
• Providing information to families about support available
How we work

Weeks One to Three

• Intensive support for meals, snacks and time away from the table
• Meal support modelled to parents
• Parents encouraged to take charge
• Every Friday discuss changes to meal plan empowering parents to make appropriate decisions
How we work

Week three – formal review with the family

Weeks Four to Six
  • Step-down approach and continue with the above structure
  • Week six – formal review and hand back to community clinician
% specialist adolescent eating disorders bed days used compared to previous 3 year average

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<tr>
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<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
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<tbody>
<tr>
<td>% of bed days used</td>
<td>35</td>
<td>48</td>
<td>59</td>
</tr>
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Previous 3 year average: 100
The Day Treatment Programme

• Open, group only programme with 12 places, but 2 pathways

• Symptom Interruption which is 6 weeks full time and 2 weeks step down

• Weight Restoration which is not time limited and restores graduates from a minimum of BMI 13 to BMI 20 with 2 weeks stabilisation there and then 2 weeks step down. Ongoing progress is expected

• Graduates of both programmes are offered individual CBT-E immediately following discharge
Day Treatment Programme

The day treatment programme operates five days a week Monday to Friday with the exception of public holidays.

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<thead>
<tr>
<th>Day</th>
<th>Start Time</th>
<th>Finish Time</th>
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<tbody>
<tr>
<td>Monday</td>
<td>10am</td>
<td>6.30pm</td>
</tr>
<tr>
<td>Tuesday</td>
<td>10am</td>
<td>6.30pm</td>
</tr>
<tr>
<td>Wednesday</td>
<td>12noon</td>
<td>6.30pm</td>
</tr>
<tr>
<td>Thursday</td>
<td>8.30am</td>
<td>2.00pm</td>
</tr>
<tr>
<td>Friday</td>
<td>8.30am</td>
<td>2.00pm</td>
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Day Treatment Programme

• The overall treatment goal of the programme is to normalise eating behaviour and to restore weight where applicable. This goal is achieved through a variety of group therapy treatments.

• All staff are involved in the treatment and most groups are co-led by two members of staff. The team aims to make groups as interactive as possible.

• Staff compliment = 5.5 WTE, 0.5 Dietitian, 1 Chef, 1 Senior Clinician, 3 Clinicians
Day Treatment Programme

• Patients are expected to complete all meals and snacks
• Patients expected to complete self monitoring of eating, behaviours, thoughts and feelings. These are reviewed by staff and feedback given by staff and patients in the group
• Groups focus on planning an appropriate regular pattern of eating and diminishing unhealthy behaviours plus psychoeducation and therapy
• 1 meal and 1 snack out together per fortnight in a local café or restaurant
• Family sessions are offered in addition
## Preliminary results

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<th>Completers</th>
<th>Non-completers</th>
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<tr>
<td></td>
<td>Admission</td>
<td>Discharge</td>
</tr>
<tr>
<td><strong>BMI</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n = 24)</td>
<td>17.0 (1.8)</td>
<td>18.9 (1.9)</td>
</tr>
<tr>
<td><strong>Monthly binge frequency</strong></td>
<td>(n = 19)</td>
<td>11.8 (10.0)</td>
</tr>
<tr>
<td>(n = 19)</td>
<td>1.5 (2.3)</td>
<td></td>
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<tr>
<td><strong>Monthly vomit frequency</strong></td>
<td>(n = 18)</td>
<td>23.5 (17.3)</td>
</tr>
<tr>
<td>(n = 18)</td>
<td>7.5 (9.5)</td>
<td></td>
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<tr>
<td><strong>Psychosocial impairment</strong></td>
<td>(n = 40)</td>
<td>39.2 (6.4)</td>
</tr>
<tr>
<td>(n = 40)</td>
<td>26.6 (10.8)</td>
<td></td>
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<tr>
<td><strong>Global EDE-Q score</strong></td>
<td>(n = 40)</td>
<td>4.6 (1.1)</td>
</tr>
<tr>
<td>(n = 40)</td>
<td>3.4 (1.2)</td>
<td></td>
</tr>
<tr>
<td><strong>Dietary restraint</strong></td>
<td>(n = 40)</td>
<td>3.9 (1.6)</td>
</tr>
<tr>
<td>(n = 40)</td>
<td>2.1 (1.5)</td>
<td></td>
</tr>
<tr>
<td><strong>Eating concern</strong></td>
<td>(n = 40)</td>
<td>4.1 (1.2)</td>
</tr>
<tr>
<td>(n = 40)</td>
<td>2.7 (1.3)</td>
<td></td>
</tr>
<tr>
<td><strong>Shape concern</strong></td>
<td>(n = 40)</td>
<td>5.3 (1.1)</td>
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<tr>
<td>(n = 40)</td>
<td>4.7 (1.2)</td>
<td></td>
</tr>
<tr>
<td><strong>Weight concern</strong></td>
<td>(n = 40)</td>
<td>5.0 (1.2)</td>
</tr>
<tr>
<td>(n = 40)</td>
<td>4.0 (1.5)</td>
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Overall effect of the day programme

• Remission rates in respect of weight restoration, bingeing and vomiting are comparable with those reported elsewhere.

• The drop-out rate for this Day Treatment Programme (23%) was found to be consistent with rates reported by other programmes.
Challenges for the service

- Establishing the case for expansion of the community team (£240,000 investment) after it had initially been suspended due to lack of resources
- Managing the number of referrals (c 400+ pa)
- Negotiating relationships with other local mental health teams
- Managing physical care in collaboration with GPs
- Managing really sick patients when no specialist bed is available
- Liaising with in-patient units nationally
Discussion

• Comments & questions?
• How did your service develop?
• How is it commissioned now?
• Is there a local health needs assessment?
• Who contributes to the commissioning process?
• What challenges are there to the commissioning process?