An Update on Eating Disorders

Rachel Lawson
South Island Eating Disorders Service, CDHB
Roger Mysliwiec, Maugan Rimmer, Liesje Donkin
Regional Eating Disorders Service, ADHB
Sharleen Tippett
Central Region Eating Disorders Service, HVDHB

Background

- MOH Future Directions for Eating Disorders document (2008)
  - Shortage of knowledge and expertise in working with clients with eating disorders
  - A shortage of training and professional development opportunities
- Workforce project established 2010 by the Werry Centre
  - Health Goal: To strengthen the capacity and capability of providers working with people with eating disorders
  - An emphasis on training for those working with young people
    - Early detection and Intervention
    - Family Based Treatment (Maudsley)
Family Based Treatment (Maudsley -MFBT)

- Two tiered training (50 participants)
  - First group trained “experts”
    - Provide supervision; Service development (utilising hub and spoke); Potential trainers
  - Second group trained
    - CAMHS (new to model)
- Two part training
  - Two - Three day intensive workshops
    - “Introduction to MFBT”
  - Follow up supervision days
    - online forum

MFBT Evaluation – Two - Three day workshop

- Summary
  - Good coverage of DHBs and professions
  - Enthusiastic praise for the trainers
  - Opportunity to think about service development
  - Opportunity to network
  - Achievement of desired changes in knowledge and skills
    - Every participant agreed or strongly agreed understanding of MFBT and confidence in using it increased
    - 87% strongly agreed practical skills had improved
    - 78% increased level of confidence in supervising others
Capacity established via extra training

- Regional priority on work plans
  - ADHB, Midlands
- Collaboration
  - Nelson
    - places given to identified gaps in Southern and Central regions
- Great word of mouth
  - Everyone wanted to come

Follow up Supervision days

- March 2011 and November 2011
  - Pre reading and case material preparation
  - Presentation of case material via video or written
    - about 60% had seen cases
- Participants found most useful parts
  - Discussion of real cases, and case complexities
  - Consolidation of skills
  - Networking and strengthening links (rural areas)
  - Ongoing discussion of service provision
Follow up Supervision days

- All respondents agreed/ strongly agreed
  - Better understanding of how MFBT translates into clinical decision making for AN
  - Practical skills have improved
  - Better able to identify key MFBT concepts in case material
  - Better able to assess treatment progress in line with the goals of the phases and common barriers to treatment response
  - Aware of a greater range of strategies to deal with clinical impasses during MFBT

Supervision strategy

- National
  - Online Forum (54 participants)
- Regional
  - via “hub and spoke”
  - Telemedicine, telephone, Skype
  - Visit
- Local
- External to NZ
  - Supervise the supervisors
Factors affecting the Implementation process


- Provider characteristics
  - Perceived need for and benefit of innovation
  - Strong existing skill base
  - Self-efficacy

- Specific staffing considerations
  - Leadership
  - Strong backing from management
  - Program champion
    - Passionate clinicians

Factors affecting the Implementation process cont.

- Organizational capacity
  - Positive work climate, open to change

- Integration of new programming
  - Too much change

- Shared vision
  - Different treatment models in place
  - views on implementation
  - Shared Decision making
  - Cooperation and collaboration to make clear pathways
Sustainability

- Workforce Realities
  - Babies; Staff attrition

- On going training
  - Foundation skills
    - Knowledge of eating disorders
      - E-learning supported by hubs and EDLs
  - Once a year two day workshop
  - Advanced training

National Audit

- Multi region ethics approval
- Eligibility Criteria
  - DSM IV - Diagnosis
  - AN / EDNOS

- Data Collection
  - Start of treatment (Any time between November 2010-2011)
  - Follow up – November 2011 / August 2012
  - Across 21 DHBs
    - 18/21 sites
    - 88/107 (82%)
Demographics

- **Gender**
  - Female: 90.9%
  - Male: 9.1%

- **Age at beginning of treatment**
  - Average: 14.84 years
  - Range 10-19 years

- **Diagnosis (DSM IV)**
  - AN-Restricting: 50%
  - AN-Purging: 19.3%
  - EDNOS: 30.7%

- **Menstruation at Start**
  - Primary amenorrhea: 17.5%
  - Secondary amenorrhea: 61.3%
  - On contraception: 6.3%
  - Irregular periods: 6.3%
  - Menstruating: 8.8%

Demographics

- **Illness Length**
  - Average: 14 months
  - Range 2-65 months
  - Median: 11 months

- **Comorbidity**
  - Comorbid Mental Health Condition: 65.9%
  - Depression: 34.1%
  - OCD: 6.8%
  - Other anxiety: 25.0%

- **Hospitalisations Pre-MFBT**
  - 39.7%

- **Intact family**
  - Intact family: 72.7%
  - Separated family: 27.3%
MFBT Data

- **Siblings involved**
  - Siblings involved: 42%

- **Additional treatment during FBT**
  - Individual therapy = 10
  - Generic family therapy = 1

- **Therapist Variables**
  - Average years of experience: 8.98
  - Median: 8.0
  - Specialist family therapy skills/experience pre-MFBT: 69.3%

Comparison of weight outcomes of whole group

<table>
<thead>
<tr>
<th>n=88</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>47.12 (7.18)</td>
</tr>
<tr>
<td>% IBW</td>
<td>89.92 (10.64)</td>
</tr>
</tbody>
</table>

**Paired-samples t-test**

Result (Wt): \( t (87) = 10.038, p < .000 \)
Result (%IBW): \( t (87) = 8.133, p < .000 \)

There was a statistically significant increase in weight and percent ideal body weight from baseline to follow-up
Comparison of treatment status on weight change

<table>
<thead>
<tr>
<th>Treatment status</th>
<th>n</th>
<th>Baseline Mean (SD)</th>
<th>Follow-up Mean (SD)</th>
<th>Change Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed</td>
<td>40</td>
<td>89.23 (12.83)</td>
<td>101.26 (11.89)</td>
<td>12.04 (10.62)</td>
</tr>
<tr>
<td>Ongoing</td>
<td>21</td>
<td>90.36 (7.85)</td>
<td>99.38 (10.04)</td>
<td>9.03 (6.52)</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>27</td>
<td>90.64 (9.11)</td>
<td>92.35 (7.94)</td>
<td>1.71 (5.21)</td>
</tr>
</tbody>
</table>

One-way between-groups ANOVA with post-hoc tests
Result (%IBW): \[ F(2,85) = 12.429 \], \( p < .000 \)

There was a statistically significant difference between treatment status groups on percent IBW change from baseline to follow-up.
Post-hoc comparisons indicated that the mean change score for the Withdrawn group was significantly different from the other groups.

Preliminary Conclusions

- Preliminary evidence that the model can be disseminated with a basic level of training and limited expert supervision
- if the right conditions for implementation are in place
  - Provider characteristics, specific staff considerations, shared vision and organisational capacity
- 31 cases came from South Island Eating Disorder Service
  - Established FBT expertise
  - Training “improved” our provision
  - Task now SUSTAINABILITY

- True for CREDS also

- Audit Showed GAPs in Provision
  - Significant gap at Regional Eating Disorders Service (REDS)
    - Seven cases
The story continues

- Where are we now?
- REDS
  - Northern and Midlands
- CREDS
  - Central
- SIEDS
  - South Island

Regional Eating Disorders Service

- Slow uptake at REDS, resistance in team to give up old MDT model of practice
- No agreement on best model for FBT supervision, variable acceptance and adherence to therapeutic model
- High level of variability in terms of outcomes
  - Lakes; CMDHB
- Few cases achieving expected outcome of full recovery within 20 sessions
Support for Implementation

- July 2012 REDS invited Professor Jim Lock to provide team consultation, workshops and guidance with aim to support implementation of FBT
- September 2012 Agreement with Jim Lock to provide FBT supervision for REDS
- Fortnightly telephone supervision of two most experienced FBT clinicians with the team listening in
- These two clinicians received accreditation as FBT therapists (December 2013)

Building Sustainable Expertise

- Jim Lock now supervising these two clinicians to become certified FBT supervisors.
- These two clinicians will over time engage in process to become certified FBT trainers
- Two new members of team have now started the process to become accredited FBT therapists
Supervision provided by REDS to other services

- Monthly supervision offered to every Auckland CAMHS locally
- Monthly joint regional peer supervision meetings of CAMHS FBT clinicians
- Monthly telephone FBT supervision for Midland and Northland CAMHS clinicians
- FBT orientation training and now advanced workshops offered to Midland region

Process will lead to:

- REDS becoming a Centre of excellence in the provision of FBT
- Accredited FBT clinicians
- Accredited FBT supervisors
- Accredited FBT trainers
- REDS becoming affiliated with Stanford University Training Institute for Child and Adolescent Eating Disorders
REDS FBT: Outcomes

- Eating disorder admissions to Starship hospital in under 16 age group occur at the point of medical instability
- In the last 4 years the number of new admissions has doubled
- Young patients with Anorexia are now discharged to REDS for follow up earlier and at a lower weight
- Average length of first admission has reduced by 66% between 2010 and 2013 (from 52 to 18 days)

Length of Stay in Starship

![Graph showing length of stay in Starship from 2008 to 2013]
REDS FBT: Outcomes

- By session 5 of FBT the average weight increase is 2kg and 3.6kg by session 10
- Average patient is just below 95% of their ideal body weight (one of the criteria for full recovery) by 10 sessions

REDS FBT: Outcomes

- Use of FBT has significantly reduced the time in treatment and increased the rate of recovery compared with REDS previous model of care
- There is no waiting list for treatment
- Drop out rates from FBT are low (approximately 5%)
- To date there have been no re-referrals or readmissions in those patients achieving full recovery with FBT
CREDS

- Ongoing FBT supervision days
  - Telephone supervision as required
  - Meet in Palmerton North three times a year
  - Attendance from up to 16 clinicians from Wellington, Kapiti, Palmerston North, Hawkes Bay and Wairarapa

- The focus for FBT is strong in the region and clinicians have a real passion and commitment to work with families in this way

Central Region and CREDS

- All have seen an increase in cases
  - Wairarapa – normally 3-4 cases (2013 – 6-7 cases)
  - Mid Central – currently 20 cases (14 FBT)
    - Good links with paediatrics
    - Improving links with Inpatient medical wards
    - Increased use of CREDS
  - Hawkes Bay – currently six cases
  - CREDS
    - 42 cases over 2013
- Issues
  - Training for New Clinicians
  - What to do when FBT does not work?
SIEDS and the South Island

- SIEDS
  - Data shows we meet the target of 70% recovery
    - Fewer sessions
  - Monthly supervision by telemedicine to SI
  - Yearly training for sustainability
    - 8-10 clinicians
    - Smaller areas use “principles” of FBT for other cases, e.g. school refusal, poor diabetes management
  - Focus on early detection and referral in primary care
    - Part of HeathPathways
      - Education provided to 160 GPs

- Great provision of FBT throughout the SI

SIEDS and South Island

- SIEDS has the eight inpatient beds for SI
  - Due to the good provision of FBT in the SI we have seen a change in population who is admitted
  - Used to be older adolescents who had not been able to get FBT
  - Now only complex cases who make up that 30% who do not get better with FBT
    - We have had to change to reflect the changing population
      - Adolescents with more comorbidity and/ or complex families
    - Currently reviewing the data on our admits to continue to improve our provision to this group
Conclusions

- NZ is well set up for the provision of FBT for young people with AN
- SIEDS, CREDS and REDS with our regional partners need to keep comparing data to ensure consistency across NZ
  - Are our rates of hospital admissions similar?
  - Are our drop out rates similar?
  - Are we meeting the “the FBT gold standard” for getting young people well
- Sustainability
  - Ongoing clinician training through REDS and SIEDS
    - Open to clinicians from other areas

Challenges

- Still some pockets across NZ where resistance exists
  - “my clinicians are too busy seeing other cases”
    - FBT principles are transferable to other cases – our experience is they strengthen skills in teams
- We will continue to work on “What to do when FBT does not work?”
- Understanding more about young Maori with eating disorders
  - Youth Health Survey 2012
- Young people with bulimia nervosa
- Prevention
Thank you

- The clinicians
- The managers
- Werry Centre

- If anyone wants a study...
  - Compare numbers of individuals with Severe and Enduring Eating Disorders 10 years ago with 10 years from now
  - Already seeing some of the benefits of early intervention
    - Best outcome would be seeing a reduction in the number of individuals who go onto develop a chronic illness.