Towards a Stepped-Care Approach for Child and Adolescent Eating Disorders: The role of Early Intervention

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The treatment evidence base for Eating Disorders

• Most randomized controlled treatment trials for eating disorders show no differences, or differences that diminish over time, between treatment arms
• This does not help much with treatment planning
• A common hypothesis is too much variability within the patient groups
  – some but not all will do well with any treatment
Staging

- Used in a number of medical disorders, most notably cancer
- ‘Way of conceptualizing illness severity, so as to better provide treatments tailored to clinical presentation, to bring a focus to early intervention and to prevent the progression of illness from less to more severe forms’. Specifically its purpose is to:
  - to select appropriate standard treatments;
  - to evaluate the results of new treatments;
  - to acquire data in an orderly fashion for statistical analysis of end results;
  - to estimate prognosis.

Stepped care approach to treatment

• We do not yet have the information we need to give treatment according to stage of illness at presentation

• ‘Predicting prognosis for this disorder with the current level of knowledge is a ‘hazardous endeavour’.

Steinhausen 2002 ‘Outcome of AN in the 20th century’

• A stepped approach to care is therefore needed
  – What to do first
  – How to decide what to do next
  – When to stop doing something

• Not ‘does it work’ but ‘for who does it work’
  – Mediators and moderators of treatment response
Towards a Stepped Care Model for C&A Eating Disorders

Nicholls, Yeo et al. In progress
Early Intervention for Eating Disorders

• Delay in recognition
  – Delay between onset of symptoms and presentation
  – Reactive rather than proactive services

• Early referral
  – AN cases tend to be referred directly to services
  – Need for better identification of BN and EDNOS
Recognition process

- Initial weight loss often seen as positive
- First concerns - rigidity around food
- Delay before parents acknowledge the extent of the problem
- Attempts to address it themselves
- Seek information on the internet
- Chronic failure to effect change → help-seeking

⇒ ......Professionals go through same process

⇒ patient very sick at presentation
Early Intervention

• Two elements distinct from standard care:
  – early detection
  – phase-specific treatment

• Both can be
  – supplements to standard care, or
  – provided through a specialised early intervention team
Theoretical contributors to an Early Intervention model for Eating Disorders
Why a parenting approach?

- Parental/family factors as risk factors
- Parental involvement in effective treatment strategies for C&A ED
- Parents first to seek help
- Prevention literature re age
- Well established evidence base for parenting interventions
  - The case for targeting parents  Treasure & Russell 2011
Elements of effective parenting programmes

- Structured sequence of topics
- Subjects include play, praise, incentives, setting limits, and discipline
- Emphasis on promoting sociable, self-reliant child behaviour and calm parenting
- Constant reference to parent’s own experience and predicament
- Theoretical basis informed by extensive empirical research and made explicit
- Detailed manual available to enable replicability
Effective approaches associated with good outcome

- Collaborative approach acknowledging parents’ feelings and beliefs
- Difficulties normalised, humour and fun encouraged
- Parents supported to practise new approaches during session and through homework
- Crèche, good-quality refreshments and transport if necessary
- Therapists supervised regularly to ensure adherence and to develop skills

National Academy of Parenting Research
www.parentingresearch.org.uk/
Early Intervention

- Where to target?
  - Schools?
  - Primary care?
  - CAMHS?

- Who to target?
  - Family-based Internet-facilitated intervention ‘Parents Act Now’ Jones et al. EEDR 2012
  - 6 session parent group approach Nicholls and Yi Early Intervention Psychiatry 2012
Surrey Early Intervention for Eating Disorders
Parents psycho-education group

Aims
Format
Structure
Mode of Delivery
Aims

• Increase parental confidence
• Increase parents’ understanding of Eating disorders
• Increase parents’ knowledge, skills and confidence to manage their child’s eating
• Increase adherence with meal plans and thereby increase their child’s weight
• To use clinical time more effectively to increase support for parents
Format

• Group format
• 6 sessions X 1.5 hours / session
• Rolling programme running since 2007
• Delivered immediately after initial assessment
• Parallel with weekly key working sessions with young person and parent(s)
Structure of sessions

1. Information about eating disorders
2. Using your strengths
3. Understanding change
4. Communication
5. Effective meal planning and the task of re-feeding
6. Managing behaviours (eating disorder / adolescence)
Mode of Delivery

• Didactic and collaboration
  – Keep to topic but also allow acknowledgement of parents’ experiences
• 2 facilitators, one permanent and one floating
• 5th session run by Dietician (effective meal planning)
• Encourage sharing of experience
• Pre and post questionnaires
### Evaluation: Before/after

Nicholls and Yi 2012

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<th>Baseline</th>
<th>Follow-up</th>
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<td>Knowledge</td>
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<td>Understanding</td>
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<tr>
<td>Relevance</td>
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*** sig <0.005
## Most helpful elements

<table>
<thead>
<tr>
<th>Element</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Opportunity to express personal experience</td>
<td>93%</td>
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<tr>
<td>Distinct weekly topics</td>
<td>82%</td>
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<tr>
<td><strong>Formal teaching</strong></td>
<td><strong>54%</strong></td>
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<tr>
<td>Info about ED</td>
<td>93%</td>
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<tr>
<td>Info about managing ED</td>
<td>96%</td>
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<tr>
<td>Group discussion</td>
<td>93%</td>
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<tr>
<td>Meeting other parents</td>
<td>96%</td>
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<tr>
<td>Flexible format</td>
<td>75%</td>
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</table>
Some feedback

• Recommend to others?
  – “Absolutely. An excellent and much needed service”

• Meeting other parents
  – “Misery loves company”

• What was useful?
  – “The confidence it gives you to trust your own instincts”
Early Intervention for Eating Disorders: a Phase II Study

• Aims
  – Effect size to calculate sample size for a clinical trial
  – Hypothesis generation for mediators and moderators of treatment response

Dasha Nicholls (PI), Irene Yi, Lucy Harvey, Beth Watkins, Russell Viner
Exploratory questions:

• Does the 6 week parents group intervention result in greater changes in weight than TAU?
• Does good response at 6 weeks predict outcome at 6 months?
• Is good response at 6 weeks better predicted by parent factors (such as parental confidence), than by markers of illness severity (e.g. weight at presentation)?
• New patients (7-18 yrs) and parents referred to Surrey ED Service
  • No previous ED diagnosis

• Initial assessment to determine eligibility
  • Parents offered group intervention
  • Consent sought from both patients and parents at initial appointment

• Consent ing patients’ routine baseline data collection

  • Patients whose parents do not attend the group receive treatment as usual (TAU)
  • Patients receive TAU + attend parents group

• Follow-up data collected 6-8 weeks after initial assessment
  • Follow-up data collected 6-8 weeks after initial assessment
  • Follow-up data collected at 6 months

• Data analysed and disseminated
Measures

• At T0 (assessment)
  – %BMI (Primary outcome measure)
  – Eating disorder psychopathology (EDE-Q)
  – Depression (BDI-II)
  – ED and OCD sections of the DAWBA (Parents)
  – Parent questionnaire (Parents)

• At T1 (First review; 6-8 weeks)
  – Assessment measures are repeated, with the exception of the parent questionnaire.

• At T2 (6 months)
  – As above

• For those attending groups
  – Pre-and post-intervention questionnaires.
Parent group study: Recruitment

- Those not recruited:
  - Re-referral/previous seen in ED service
  - Clinical contraindication
  - Language
  - Opting-out
What are we hoping to find?

• That for some young people and families, 6 sessions will be enough
• That we can predict which those young people and families will be
• That we can get an estimate the effect size
Prognostic factors in clinical trials

- Binge purge features – ‘ominous variant’
- AN – extremity of cognitive inflexibility
- Comorbidity
- Severity of weight loss at presentation
- Hospitalisation
Other factors likely to be relevant

- How early in the illness they present (stage)
- Attending all the sessions
- Both parents attending
  - i.e. treatment full dose of treatment received
- Early response to treatment
  - Response at 6 weeks predicts outcome
We’re along way from this yet.....
but I live in hope.....

Thank you!