Collaborative Care New Maudsley

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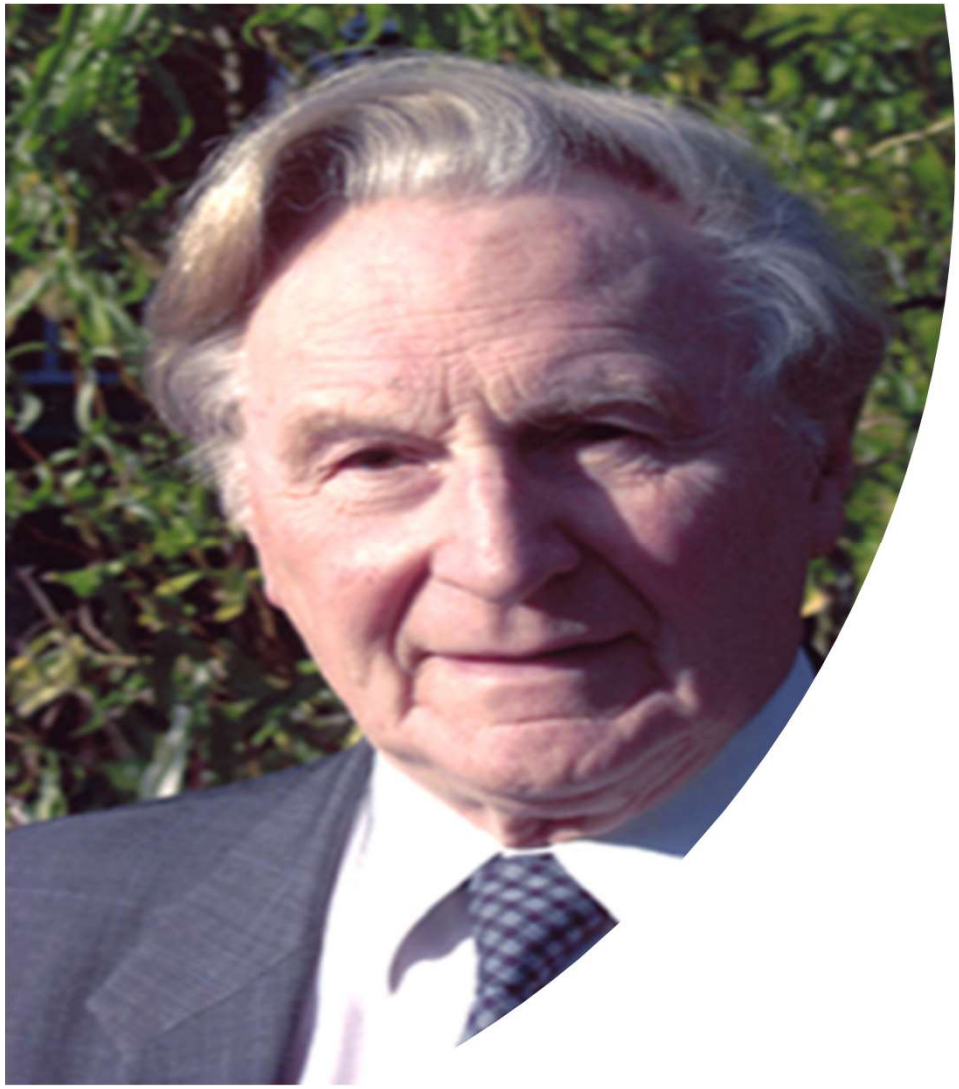
NHS Trust

Talk Map

- Key Issues in ED
- My history in ED
- Risk and maintaining factors.
- Translation into treatment

MY HISTORY IN EATING DISORDERS



THE FIRST PSYCHOTHERAPY TREATMENT TRIALS FOR ANOREXIA NERVOSA

Family therapy versus individual therapy for relapse prevention following inpatient care

(Russell et al 1984, 1989.

Maudsley Anorexia Nervosa Treatment Trial 1980's

Family vs. Individual therapy

To prevent relapse after inpatient treatment

Patients randomised according to age & stage:

1. < 18 y, **Early** < 3years
2. < 18 y, **Enduring** > 3 years
3. Adults

What is the essence of FBT (Maudsley)

- Agnostic on cause
- Externalisation of illness
- Initial focus on symptoms
- Food is medicine
- Non authoritarian stance.

FBT superior only in <18 yr and <3years of illness

Stratified randomisation

Duration of illness moderates the response

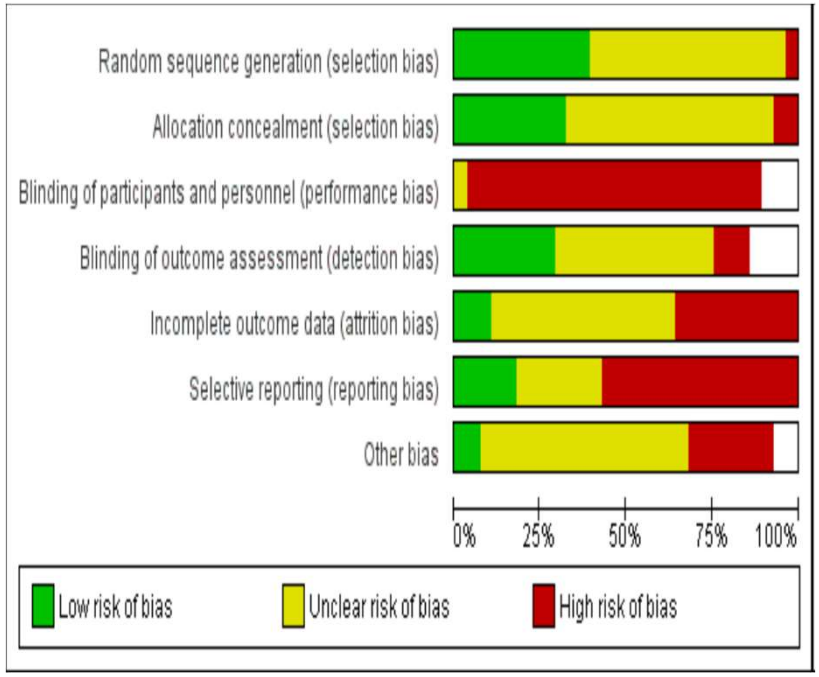
The first example of personalised medicine in ED

What does the evidence say about Family therapy approaches for anorexia nervosa?

Fisher CA et al 2018- Cochrane Review

Limited amount of low-quality evidence that family therapy > treatment as usual.

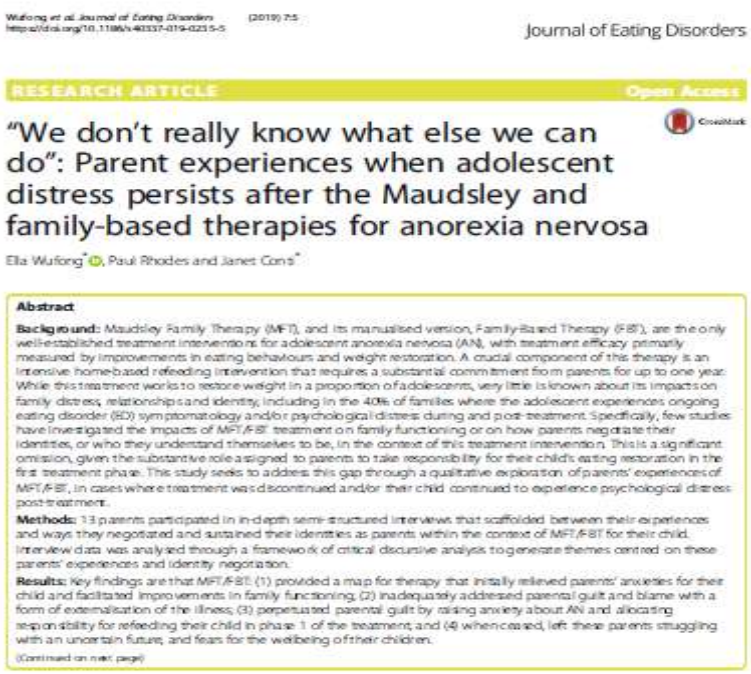
(Based on two small trials with potential bias).



HOWEVER

- FBT = INDIVIDUAL THERAPY (< 18 years old & >3 years ill). (recovery low in both).
- FBT = INDIVIDUAL THERAPY > 18 years old (recovery moderate in both).

Russell et al 1987, Eisler et al1997



Wufong et al. Journal of Eating Disorders (2019) 7:5
https://doi.org/10.1186/s40337-019-0235-5

Journal of Eating Disorders

RESEARCH ARTICLE Open Access

"We don't really know what else we can do": Parent experiences when adolescent distress persists after the Maudsley and family-based therapies for anorexia nervosa

Ella Wufong*, Paul Rhodes and Janet Conti*

Abstract

Background: Maudsley Family Therapy (MFT), and its manualised version, Family-Based Therapy (FBT), are the only well-established treatment interventions for adolescent anorexia nervosa (AN), with treatment efficacy primarily measured by improvements in eating behaviours and weight restoration. A crucial component of this therapy is an intensive home-based refeeding intervention that requires a substantial commitment from parents for up to one year. While this treatment works to restore weight in a proportion of adolescents, very little is known about its impacts on family distress, relationships and identity, including in the 40% of families where the adolescent experiences ongoing eating disorder (ED) symptomatology and/or psychological distress during and post-treatment. Specifically, few studies have investigated the impacts of MFT/FBT treatment on family functioning or on how parents negotiate their identities, or who they understand themselves to be, in the context of this treatment intervention. This is a significant omission, given the substantive role assigned to parents to take responsibility for their child's eating restoration in the first treatment phase. This study seeks to address this gap through a qualitative exploration of parents' experiences of MFT/FBT, in cases where treatment was discontinued and/or their child continued to experience psychological distress post-treatment.

Methods: 13 parents participated in in-depth semi-structured interviews that scaffolded between their experiences and ways they negotiated and sustained their identities as parents within the context of MFT/FBT for their child. Interview data was analysed through a framework of critical discursive analysis to generate themes centred on these parents' experiences and identity negotiation.

Results: Key findings are that MFT/FBT: (1) provided a map for therapy that initially relieved parents' anxieties for their child and facilitated improvements in family functioning; (2) inadequately addressed parental guilt and blame with a form of externalisation of the illness; (3) perpetuated parental guilt by raising anxiety about AN and allocating responsibility for refeeding their child in phase 1 of the treatment; and (4) when ceased, left these parents struggling with an uncertain future, and fears for the wellbeing of their children.

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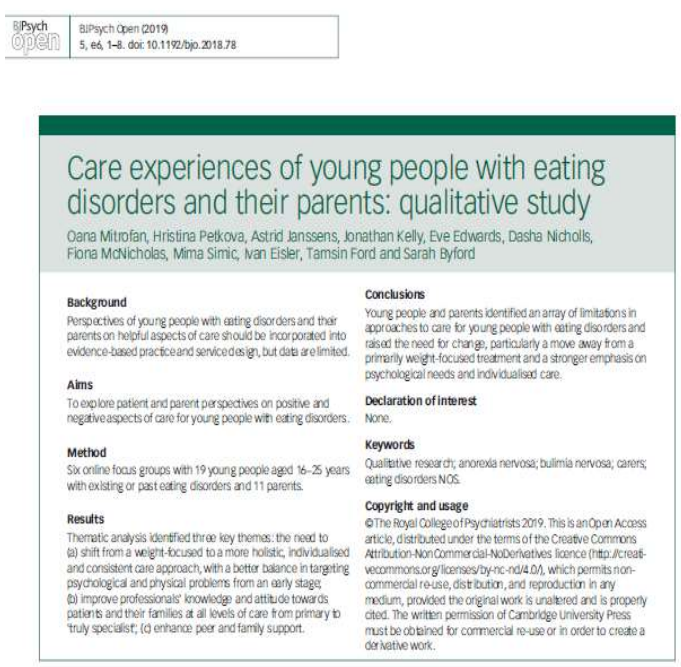


BJPsych Open (2019)
5, e6, 1–8. doi: 10.1192/bjo.2018.78

Care experiences of young people with eating disorders and their parents: qualitative study

Oana Mitrofan, Hristina Petkova, Astrid Janssens, Jonathan Kelly, Eve Edwards, Dasha Nicholls, Fiona McNicholas, Mima Simic, Ivan Eisler, Tamsin Ford and Sarah Byford

Background

Perspectives of young people with eating disorders and their parents on helpful aspects of care should be incorporated into evidence-based practice and service design, but data are limited.

Aims

To explore patient and parent perspectives on positive and negative aspects of care for young people with eating disorders.

Method

Six online focus groups with 19 young people aged 16–25 years with existing or past eating disorders and 11 parents.

Results

Thematic analysis identified three key themes: the need to (a) shift from a weight-focused to a more holistic, individualised and consistent care approach, with a better balance in targeting psychological and physical problems from an early stage; (b) improve professionals' knowledge and attitude towards patients and their families at all levels of care from primary to 'truly specialist'; (c) enhance peer and family support.

Conclusions

Young people and parents identified an array of limitations in approaches to care for young people with eating disorders and raised the need for change, particularly a move away from a primarily weight-focused treatment and a stronger emphasis on psychological needs and individualised care.

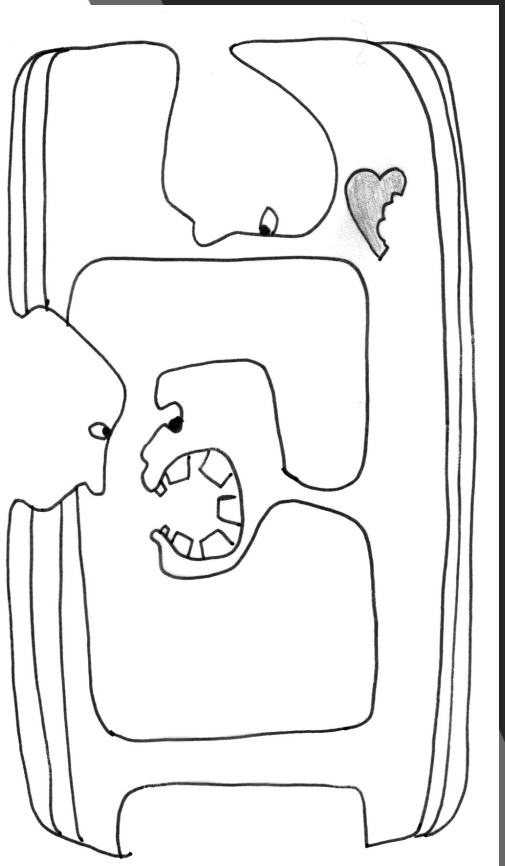
Declaration of interest

None.

Keywords

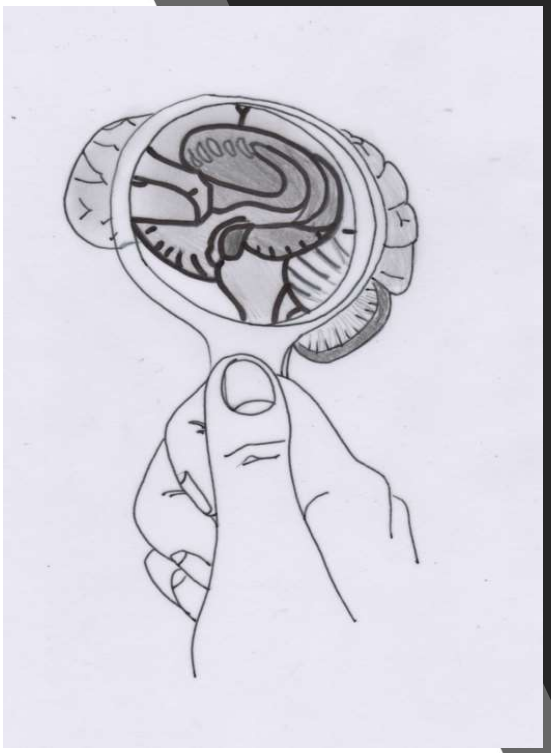
Qualitative research; anorexia nervosa; bulimia nervosa; carers; eating disorders NOS.

What do the patients and carers say?



Parents question the core principles of MFT/FBT (Wufung et al 2019)

- Allocating responsibility to parents for re-feeding and weight restoration with an adversarial framework (parents vs externalised ED).
- Psychological distress (depression, OCD, ASD, social anxiety etc) deferred until the final phase.



Researchers question the core principles of MFT/FBT

- Should we continue to be agnostic about aetiology?
  Over 40 years we have come a long way in what we know and what we do not know now.

Clinical: What sort of anorexia nervosa is it?
Patient & carer: What is acceptable?

Peterson et al. BMC Medicine (2016) 14:69
DOI 10.1186/s12916-016-0615-5

BMC Medicine

OPINION Open Access

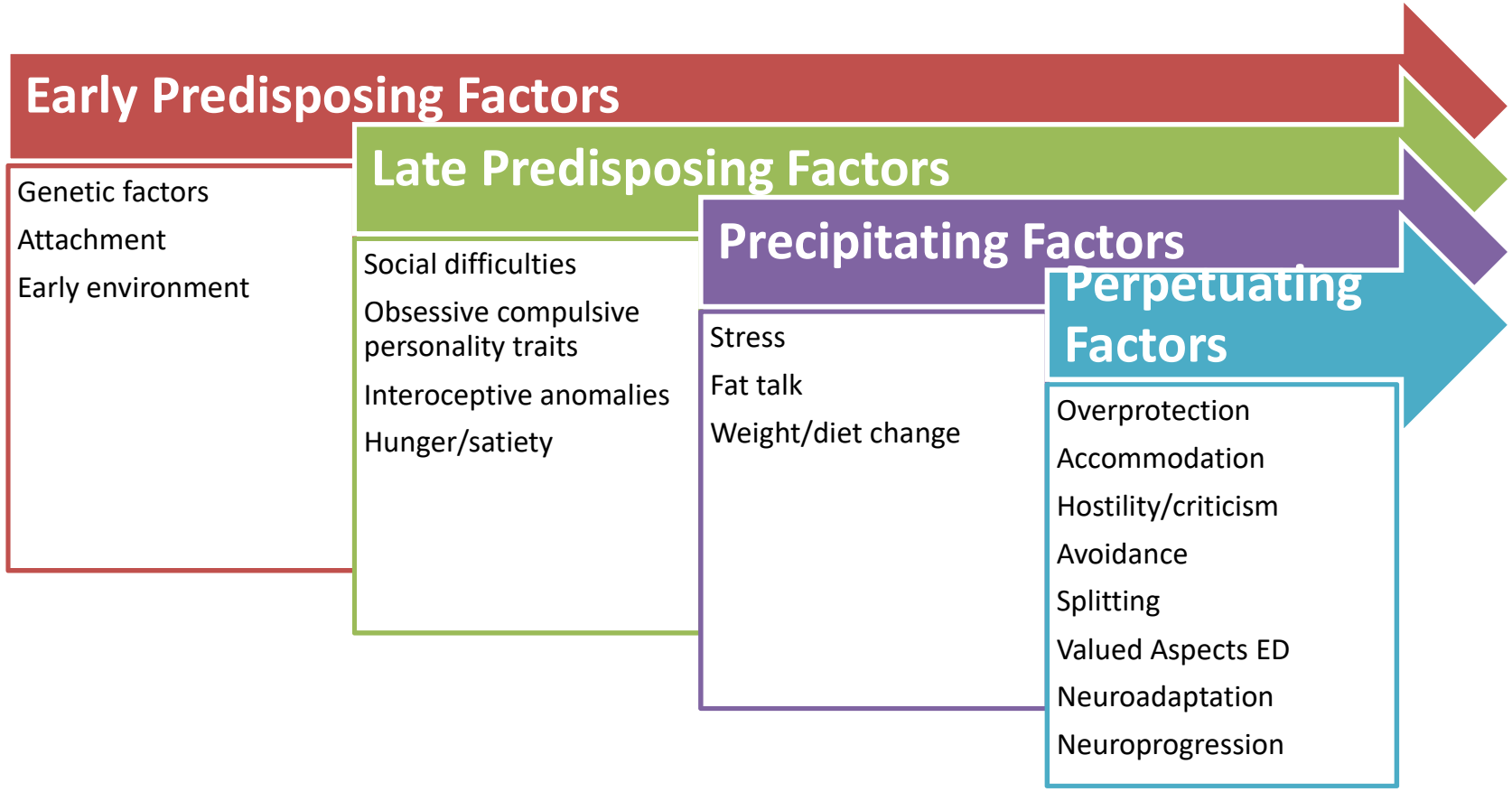
The three-legged stool of evidence-based practice in eating disorder treatment: research, clinical, and patient perspectives

Carol B. Peterson[1,2*], Carolyn Black Becker[3], Janet Treasure[4], Roz Shafran[5] and Rachel Bryant-Waugh[6]

Collaborative care: Step 1

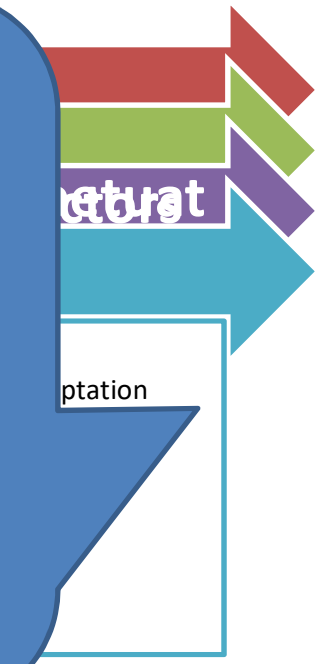
- How do clinicians use developments in neuroscience to formulate the illness in terms of predisposing, precipitating and perpetuating factors?.

Risks and Maintaining factors



The importance of Perpetuating factors

- Treatment targets **modifiable** risk and/or maintaining factors.
- Perpetuating factors may be more changeable
- What are valued aspects of ED?

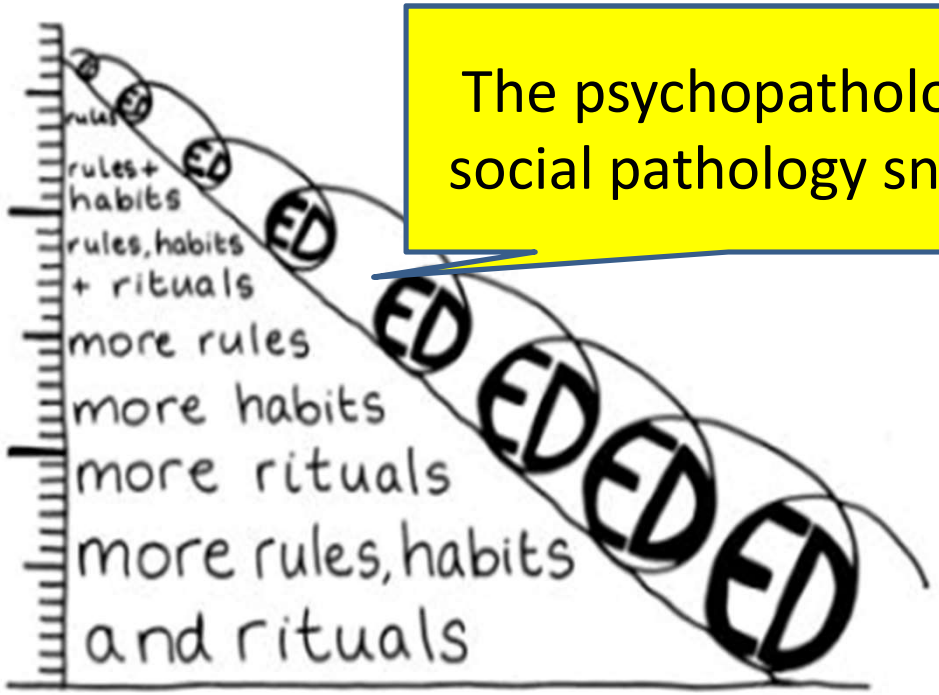


EXAMPLES OF PERPETUATING FACTORS

Valued Aspects of Eating Disorders

- WHAT WOULD YOU FEEL IF YOU ARE ASKED TO LOSE VALUED ASPECTS OF AN?

Treatment Resistance



Treasure et al 2014,2015, 2018, Walsh 2013, Steinglass and Walsh 2016

The Deadly Blue 1993
Elise Warriner
12 years of AN
5 admissions

McKnight et al., 2009, BMJ personal journey

Elise: The red in the picture illustrates the heat outside and yet I am in an ice cube and really cold. The blue represents the coldness. The empty stomach, my situation, the bandage – the **silent suffering.**

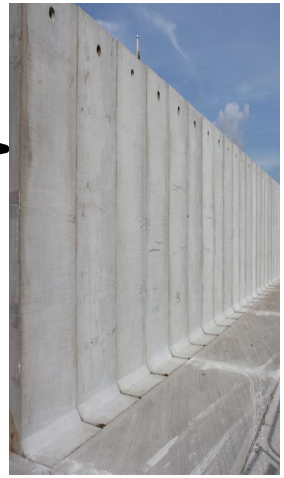
Jo: Asked to sum up my experience of anorexia nervosa in one sentence—actually, I can do it in just one word—**isolation**.

Melissa: It's the **loneliness** that will get you; that's the real killer. The longer you're ill, the worse it is.

ISOLATION: A MODIFIABLE MAINTAINING FACTOR

Carers a walled off solution

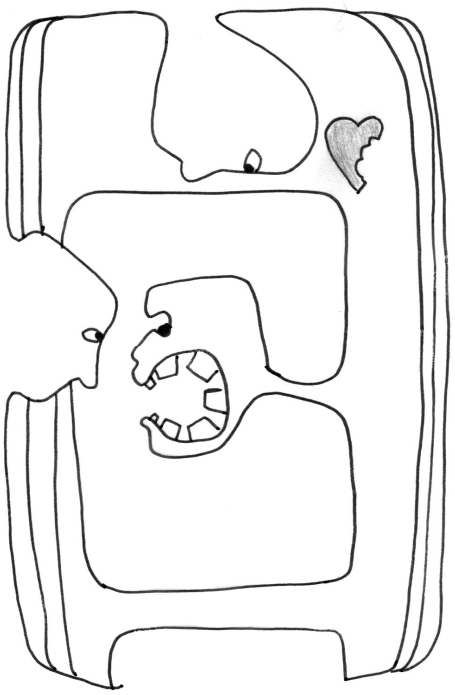
Sorry. Nothing we can do. It's a question of confidentiality

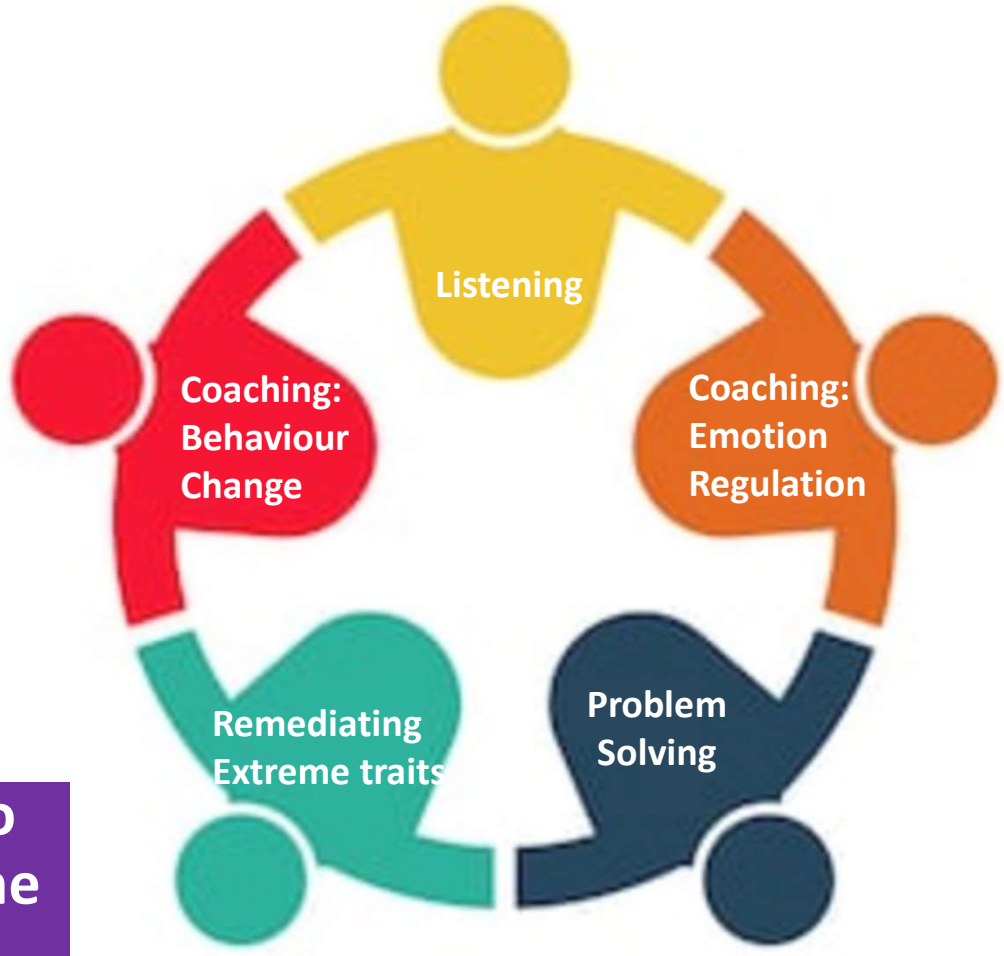


Go away! I do not want you involved.

ECHO (**E**xperienced **C**arers **H**elping **O**thers)

Bridging to social connection & recovery

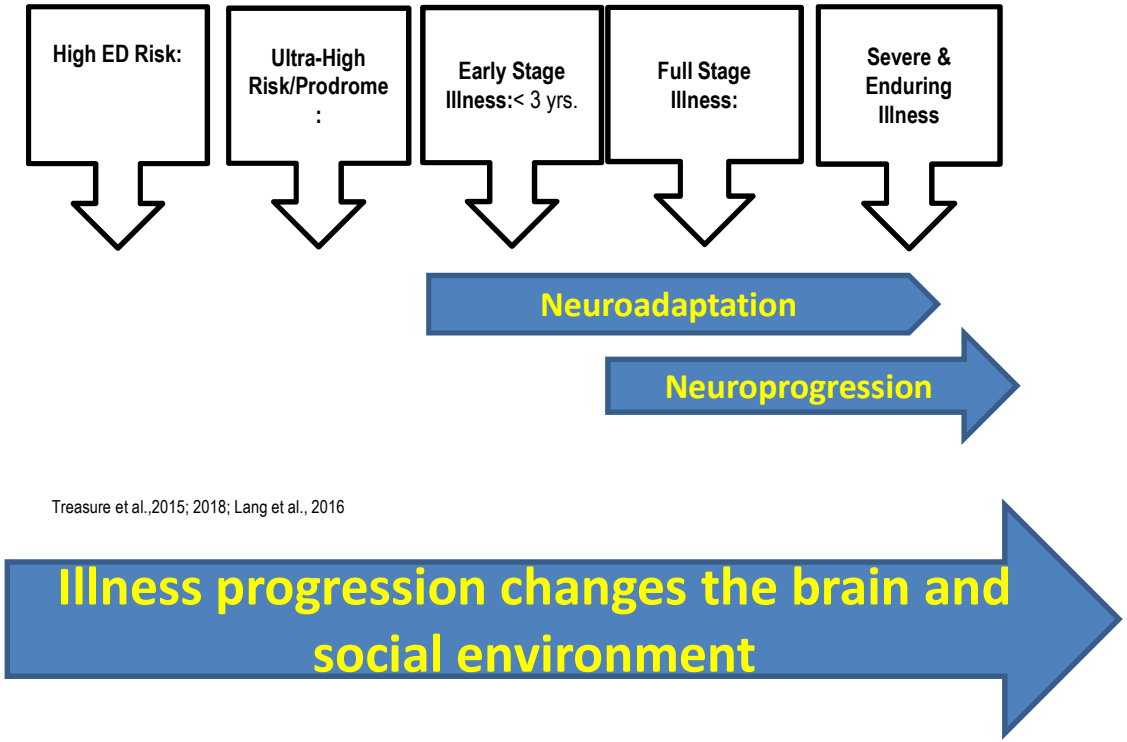




ECHO: Skill sharing solutions to provide windows & doors in the wall.

WHAT SORT OF ANOREXIA NERVOSA IS IT?

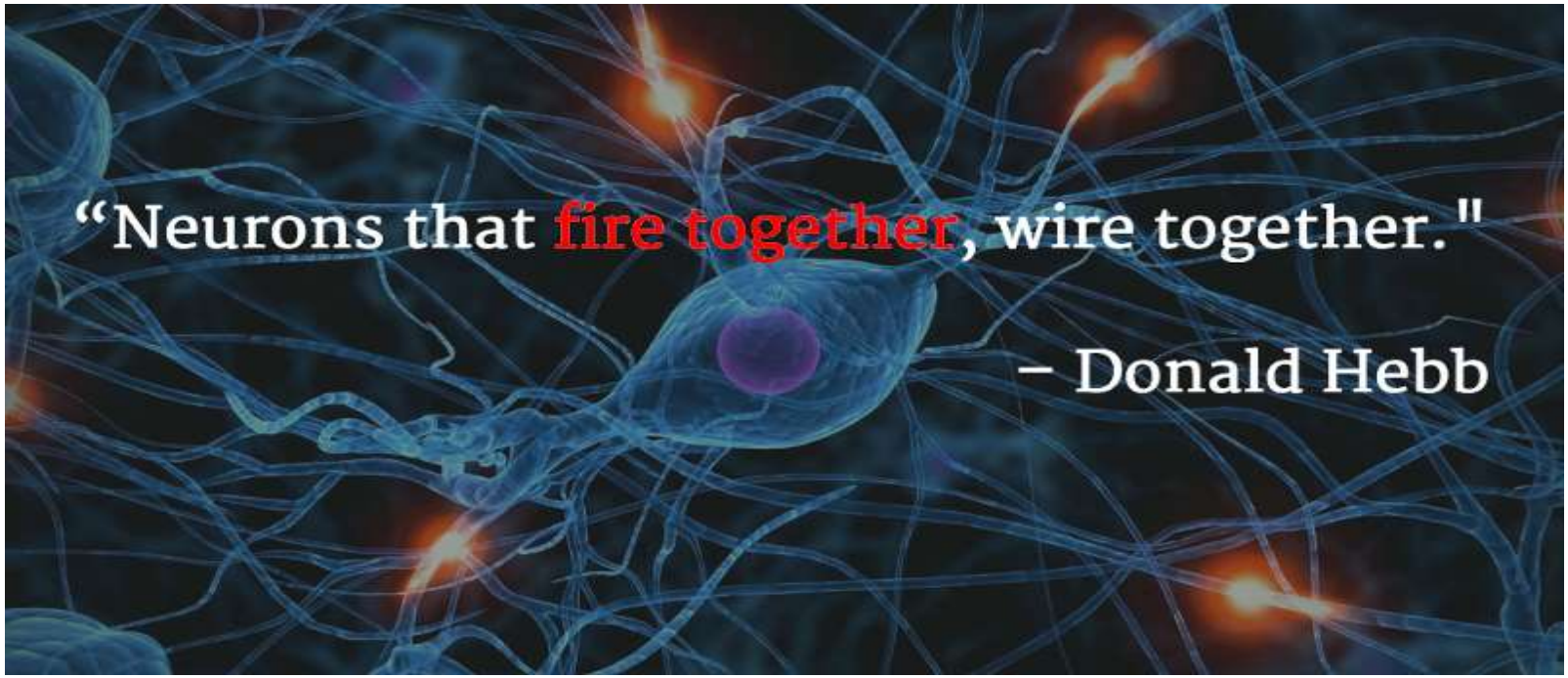
Stages of Anorexia Nervosa



Treasure et al.,2015; 2018; Lang et al., 2016

Illness progression changes the brain and social environment

Neuroadaptation



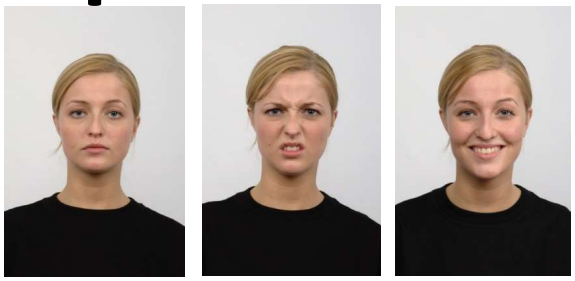
Chronic Stress: Brain on fire

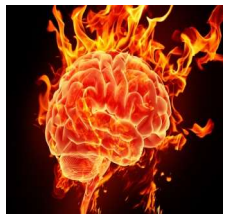
Neuro adaptation: Emotion learning

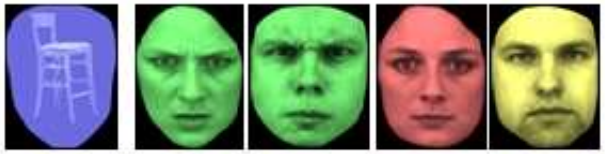
Damage to hippocampus (↓ new learning/neurogenesis)

Attention to rejection & neutral facial expressions

AN> BN
Related to early
Trauma
Chronic Stress

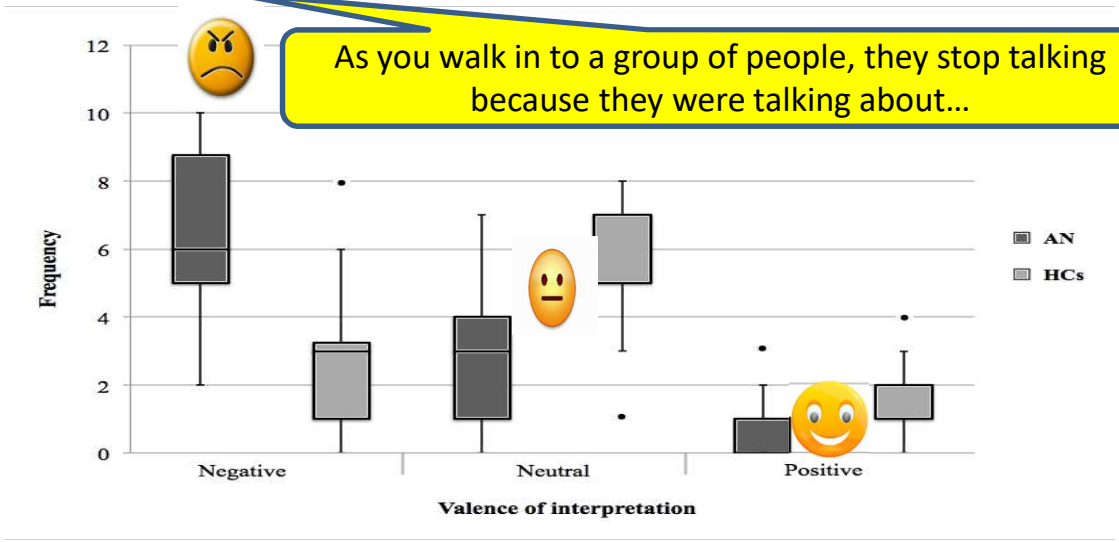






Harrison et al 2012; Cardi et al., 2013, 2015

Interpretation of Ambiguous scenarios



Cardi et al.,2016, 2017

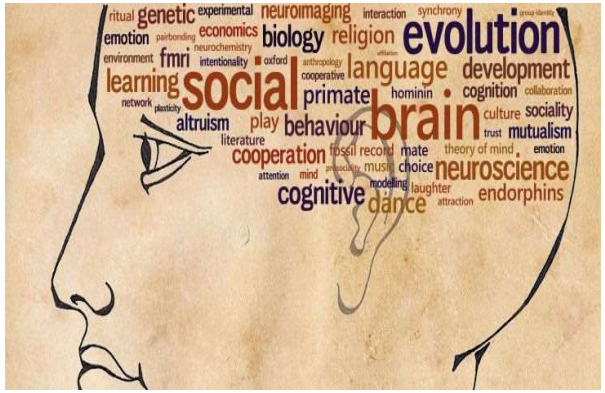
Problems in Social Cognition

Caglar-Nazali et al *Neuroscience and Biobehavioral Reviews (2013)*

Domain	Effect
Negative self evaluation	2.2
Lack facial affect	2.0
Attachment insecurity	1.3
Sensitivity to social ranking	1.1
Alexithymia	0.66
Avoidance emotion	0.44
Low parental care	0.55
Reduced agency	0.39
Parental overprotection	0.29

SOCIAL CUES:
ATTENTION FOCUS THREAT
INTERPRETATION FOCUS ON NEGATIVE
WHAT ARE THE IMPLICATIONS FOR CARERS

CONSIDER THE IMPACT ON INTERPERSONAL RELATIONSHIPS



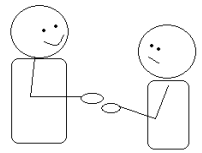
Brain needs 500 Kcal/day- deficits with malnutrition.

2% of body mass but 20% of energy

- The social brain hypothesis: Brain Size @Social Network (Dunbar).

NEUROPROGRESSION

Social communication: facial expressions



- Acute AN: large +ve/medium-ve ↓expression. Adult>Adolescent.
- Recovered AN: ↑ positive emotions.

Davies et al., 2016 Neurosci Biobehav Rev

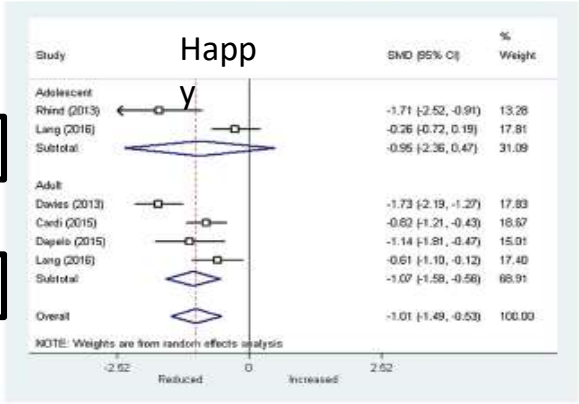


Fig. 2. Forest plot of the meta-analysis for facial emotional expression in response to positive affect in patients with AN.

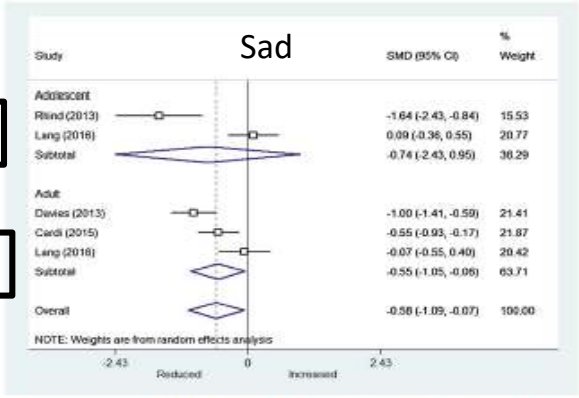


Fig. 3. Forest plot of the meta-analysis for facial emotional expression in response to negative affect in patients with AN.

Problems in Social Cognition

Caglar-Nazali et al *Neuroscience and Biobehavioral Reviews (2013)*

Domain	Effect
Negative self evaluation	2.2
Lack facial affect	2.0
Attachment insecurity	1.3
Sensitivity to social ranking	1.1
Alexithymia	0.66
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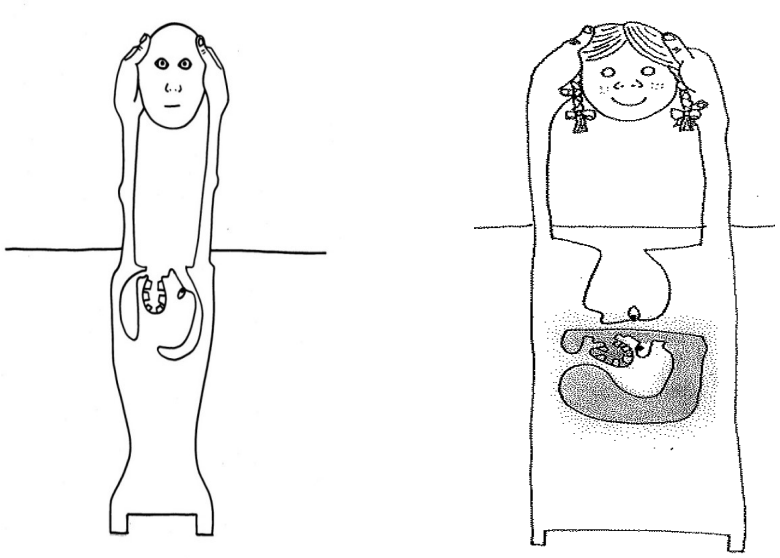
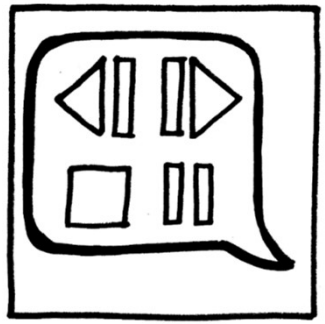
Social communication inhibited: A blank mask or fake pleasing



Davies et al., 2011, 2013; Dapelo et al., 2016; Lang et al., 2016; Leppanen J. et al . (2017)

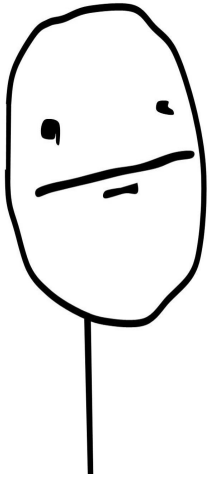
Still face paradigm

The Still face paradigm

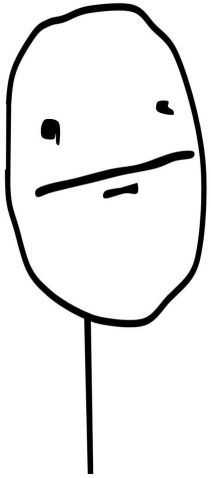


- https://www.youtube.com/watch?v=apzXGEbZht0
- Also this is recognised in robots/CGI as the uncanny valley effect.
- In adults dislike and autonomic arousal when interact with still face (Gross et al 2003)

Lack affect & interpersonal relationships



Lack affect & interpersonal relationships



Adults: Dislike and autonomic arousal when interact with still face and lack of emotional reciprocity (*Gross et al 2003, Hess et al 2013, Schneider et al 2013, Szczurek et al 2012) .*

Infants*:* Still face paradigm https://www.youtube.com/watch?v=apzXGEbZht0

AI: the "uncanny valley effect".

No reciprocity to warmth, a frosty, “aloof” response.

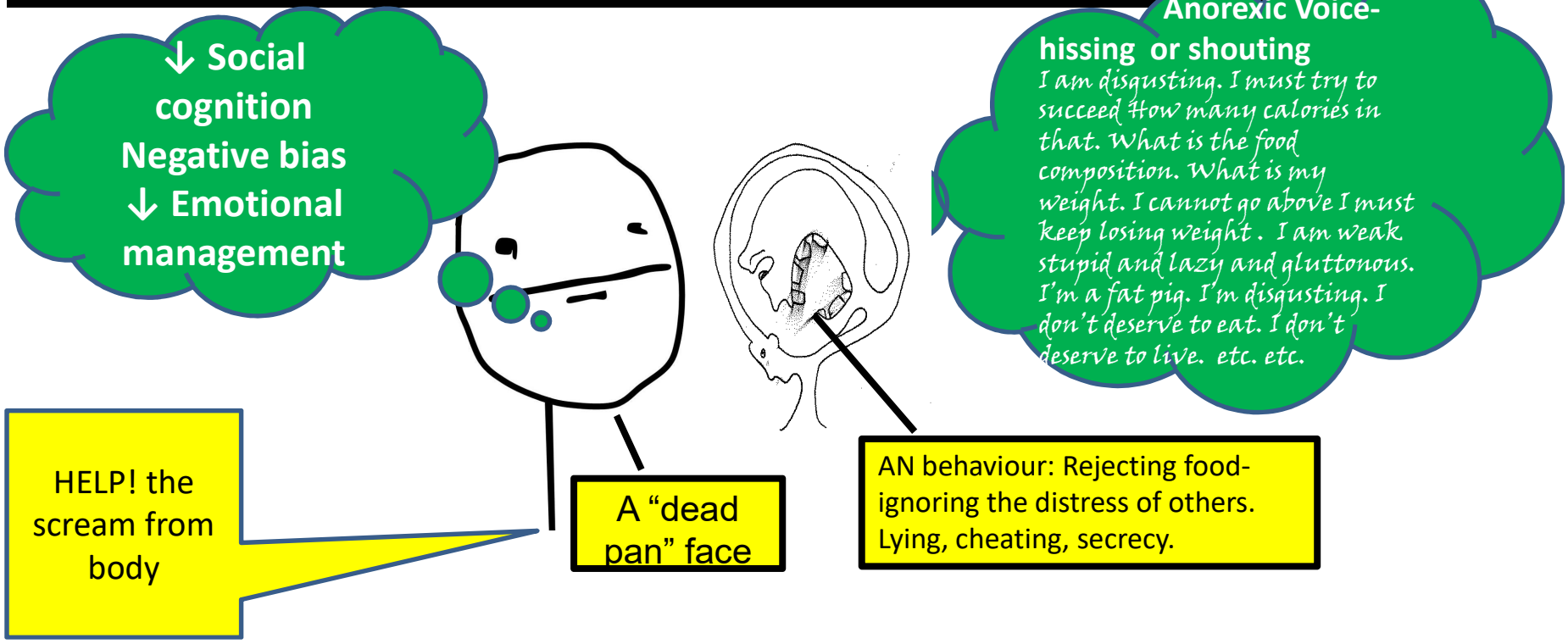
I was known as the “**ice queen**” at Uni

Tutors would get annoyed as **they thought I did not care.**

They did not know what was **going on inside**.

Davies et al 2013, 2014, 2016, Cardi et al 2014, Rhind et al 2014, Ambwani et al 2016

Confusing Social Signaling



Problems in Social Perception

- Difficulty detecting intimacy (Costanzo & Archer, 1993)
- Respond coldly to warm feedback (Ambwani et al 2016)
- Less appropriate social problem solving (Sternheim et al., 2012)

- Problems in social cognition impact on the therapeutic alliance and family& peer relationships.
- They can be modified

Professional Interpersonal relationship

RESEARCH ARTICLE

First do no harm: Iatrogenic Maintaining Factors in Anorexia Nervosa

Janet Treasure*,†, Anna Crane, Rebecca McKnight, Emmakate Buchanan & Melissa Wolfe

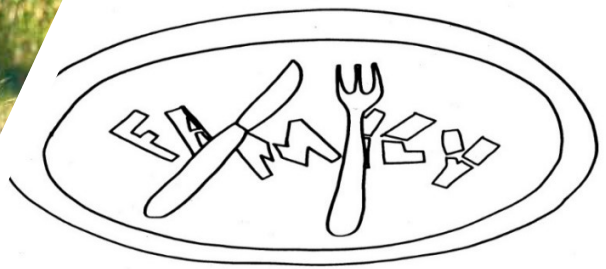
Department of Eating Disorders, Psychological Medicine, Kings College London, Institute of Psychiatry, London, UK

Abstract

The aim of this paper is to reflect on the way that we as clinicians may play an inadvertent role in perpetuating eating disordered behaviour. This is considered within the theoretical framework of Schmidt and Treasures' maintenance model of anorexia nervosa (AN). The model includes four main domains; interpersonal factors, pro-AN beliefs, emotional style and thinking style. Interpersonal reactions are of particular relevance as clinicians (as with family members) may react with high expressed emotion and unknowingly encourage eating disorder behaviours to continue. Hostility in the form of coercive refeeding in either a hospital or outpatient setting may strengthen conditioned food avoidance and pessimism may hamper motivation to change. Negative schema common to eating disorders, for example low self-esteem, perfectionism and striving for social value may augment existing or initiate new eating disorder behaviour. Services can become a reinforcing influence by providing an overly protective,

Eur. Eat. Disorders Rev. 19 (2011) 296–302

DISCUSS IN PAIRS PROBLEMS WITH THERAPEUTIC ALLIANCE, DIFFICULTIES AS A TEAM OR REACTIONS TO LIVING WITH AN EATING DISORDER



Care giving reactions

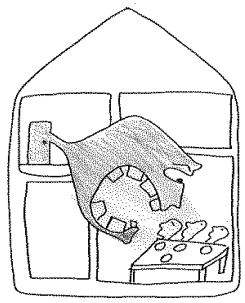
- High anxiety and frustration
- Eventually accommodate or enable or withdraw from illness

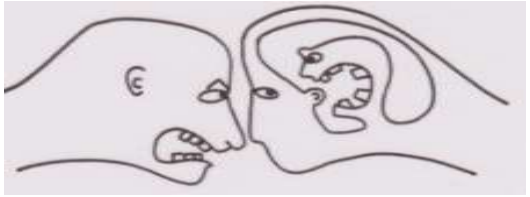
Animal metaphors to describe unhelpful interpersonal styles

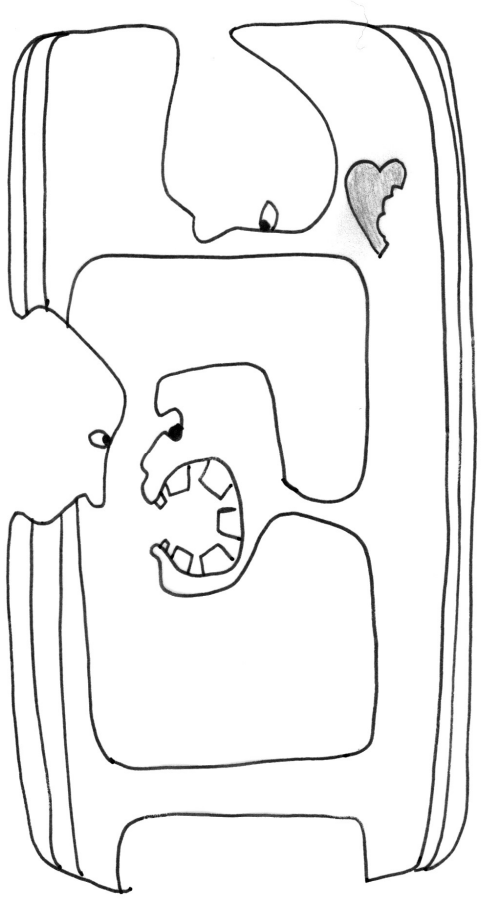
INTERPERSONAL RELATIONSHIPS AT HOME MIRROR THOSE IN HOSPITAL

Interpersonal factors

- Living with or caring about someone with AN is exhausting, relationships can rupture.
- Carers swing from being bullied
- *"I really want you to come out to dinner with us, so we'll make sure we go somewhere that serves plain salad"* **(Accommodating)**
- or exasperated
- *"You're being ridiculous and ruining everyone else's meal by being so demanding"*. **(Hostile)**



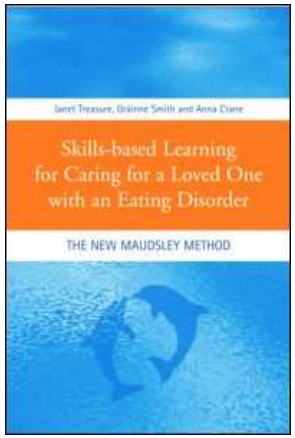


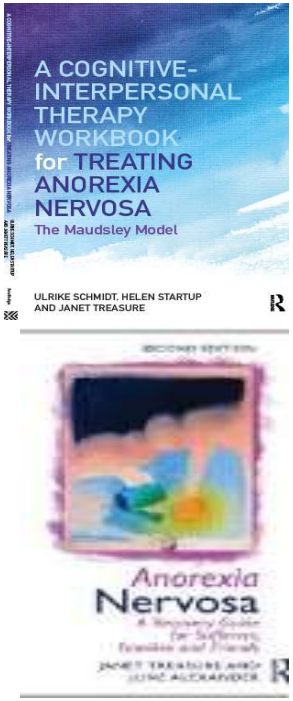


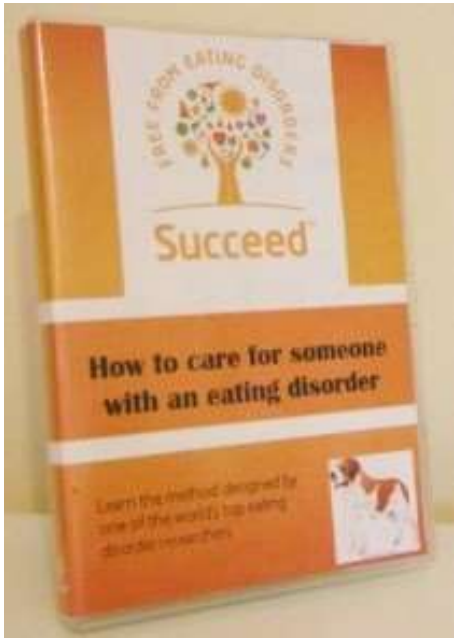
Windows & doors in walls : Knowledge & Skill Sharing between non/professional carers

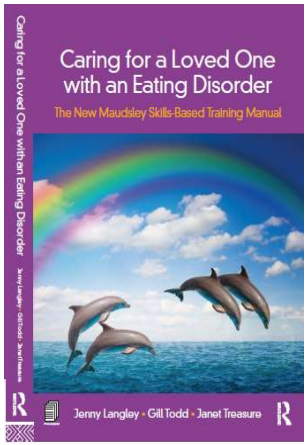
- Shared formulation
- Listening with motivational interviewing skills.
- Solution based/positive psychology frame.
- Coaching emotional regulation.
- Experiental learning from habit change (accommodating, enabling)
- Remediating extreme cognitive styles with flexibility and big picture thinking.
- Coaching behaviour change techniques

Treasure et al 2011.First do no harm, Treasure & Nazar 2016, Cardi et al 2018





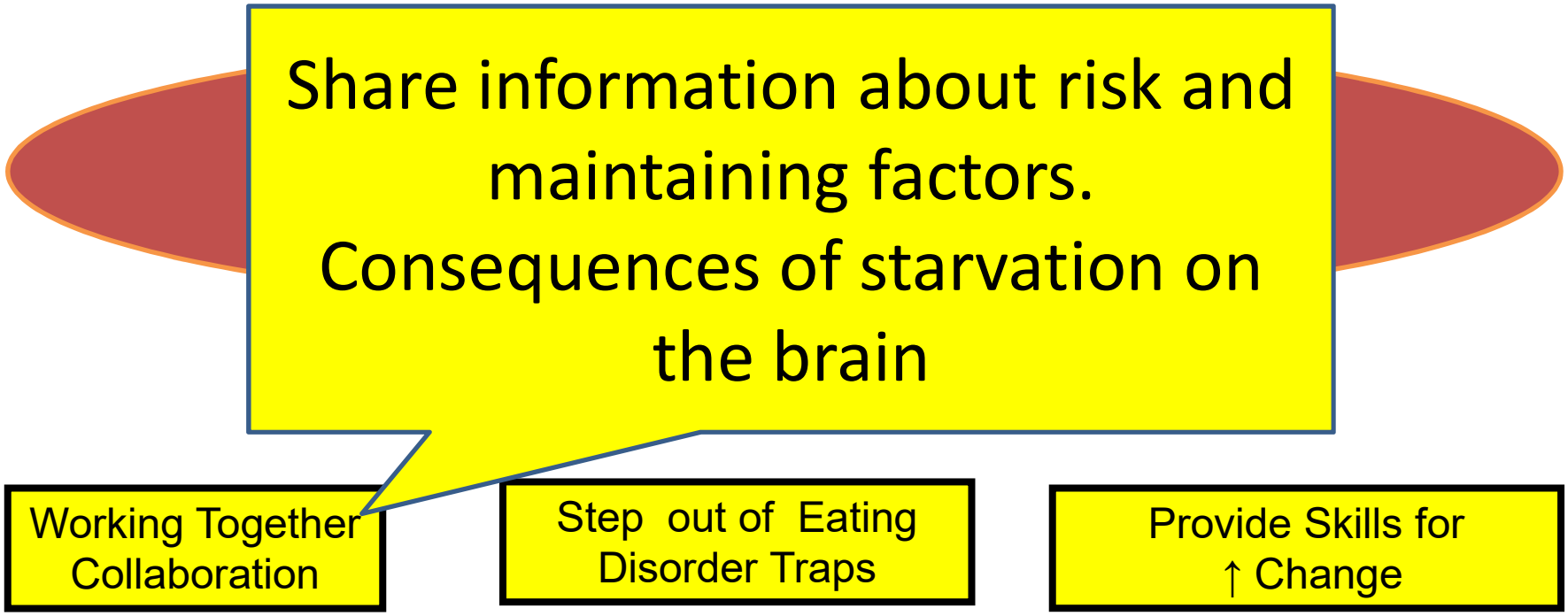




Materials used for guided task sharing with carers. Skills to reduce interpersonal maintaining factors

Experienced Carers helping Others (ECHO)
A carers – self management intervention.
PPI involvement at every phase

Working Together Collaboration	Step out of Eating Disorder Traps	Provide Skills for ↑ Change
Shared Understanding Shared Skills	Regulate emotion Care for self. ↓ accommodation ↓ over protection ↓ hostility & criticism ↓disagreement & division	Compassion Positive communication Behaviour Change Skills



Shared Understanding
Shared Skills

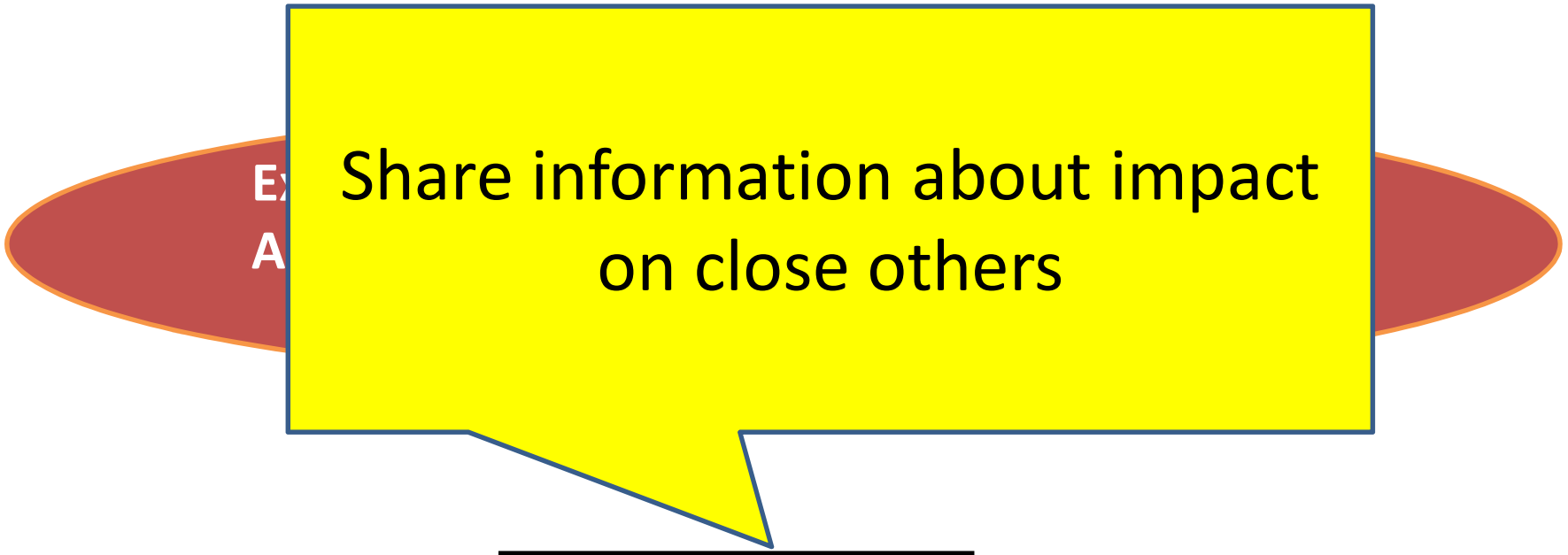
Regulate emotion
Care for self.
↓ accommodation
↓ over protection
↓ hostility & criticism
↓disagreement & division

Compassion
Positive communication
Behaviour Change Skills

DESCRIBING HOW RISK AND MAINTAINING FACTORS MAKE CHANGE DIFFICULT

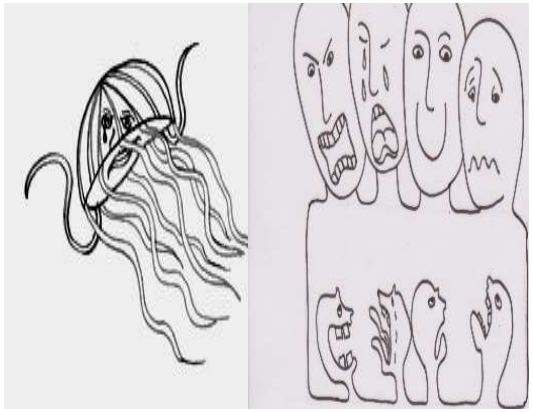
- a. “Please get out a piece of paper and pencil.”
- b. “Choose a partner (if clients are with supports, then a client and their support are ideal partners.”
-
- Shift your pen/pencil to your non-dominant hand”. Write with your Non-dominant hand all of the statements below:
-
- 1. Write: “I am writing with my non-dominant hand.”
-
- a. “Show your partner what your writing looks like.”
-

- “Turn to your partner. Choose one person to be ‘it’. Once the partners have chosen who is ‘it’, then instruct that ‘it’ is to write while the partner is to interrupt you and verbally pressure you to hurry up and is critical and bullying as ‘it’ writes this next sentence with his/her non-dominant hand:
-
- . “I am trying to write with my non-dominant hand”
-
- How do the two compare?
-
-
- . Ask: “If you were told that you would need to write with your non-dominant hand the rest of your life, what you would do?” (write only the answer with non-dominant hand)

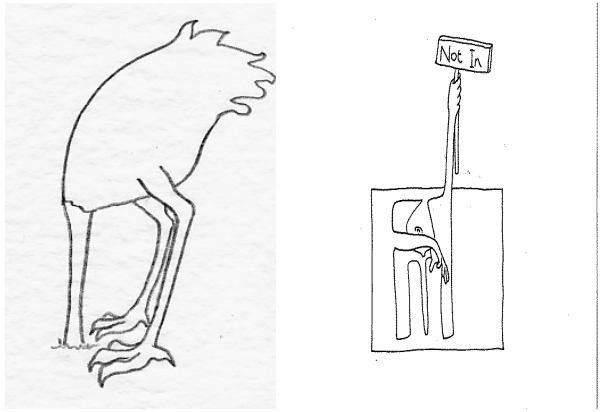


Working Together Collaboration	Step out of Eating Disorder Traps	Provide Skills for ↑ Change
Shared Understanding Shared Skills	Regulate emotion Care for self. ↓ accommodation ↓ over protection ↓ hostility & criticism ↓disagreement & division	Compassion Positive communication Behaviour Change Skills

Carer's emotional responses (too much, too little).



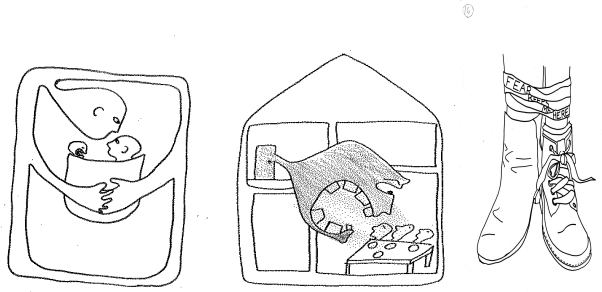
High intensity emotion-jelly fish



Avoidant Emotional Response

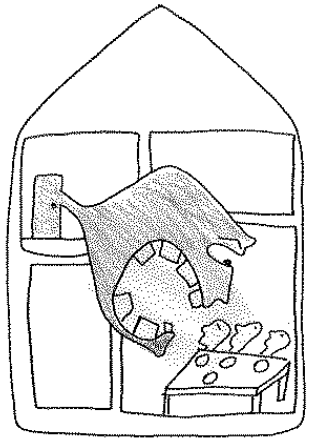
Carer's emotionally driven behaviours (too much push or too much pull).

Push towards growth Rhino & terrier



Pull to perfect safety/nurture -kangaroo, accommodating, reassuring

The vicious circle of accommodating & enabling



AN mode: Starved

AN impacts on relationships

Family very concerned & make exceptions for AN

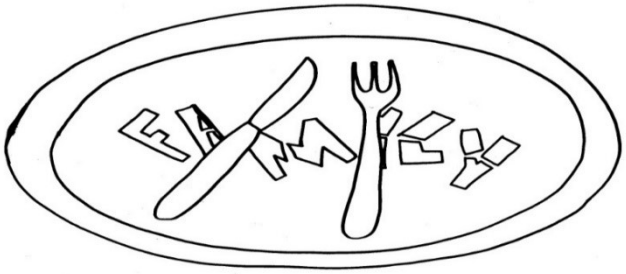
Parents may have high anxiety and walk on egg shells.

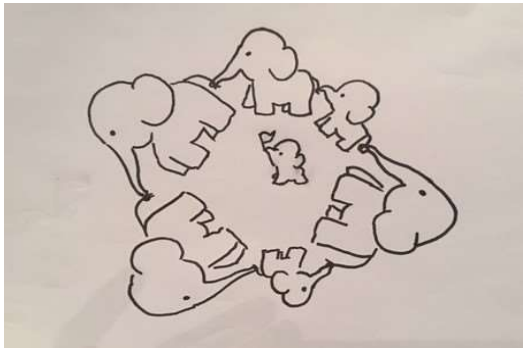
Become less flexible

AN symptoms increase

AN becomes stronger

Division vs Consistency & Co-operation



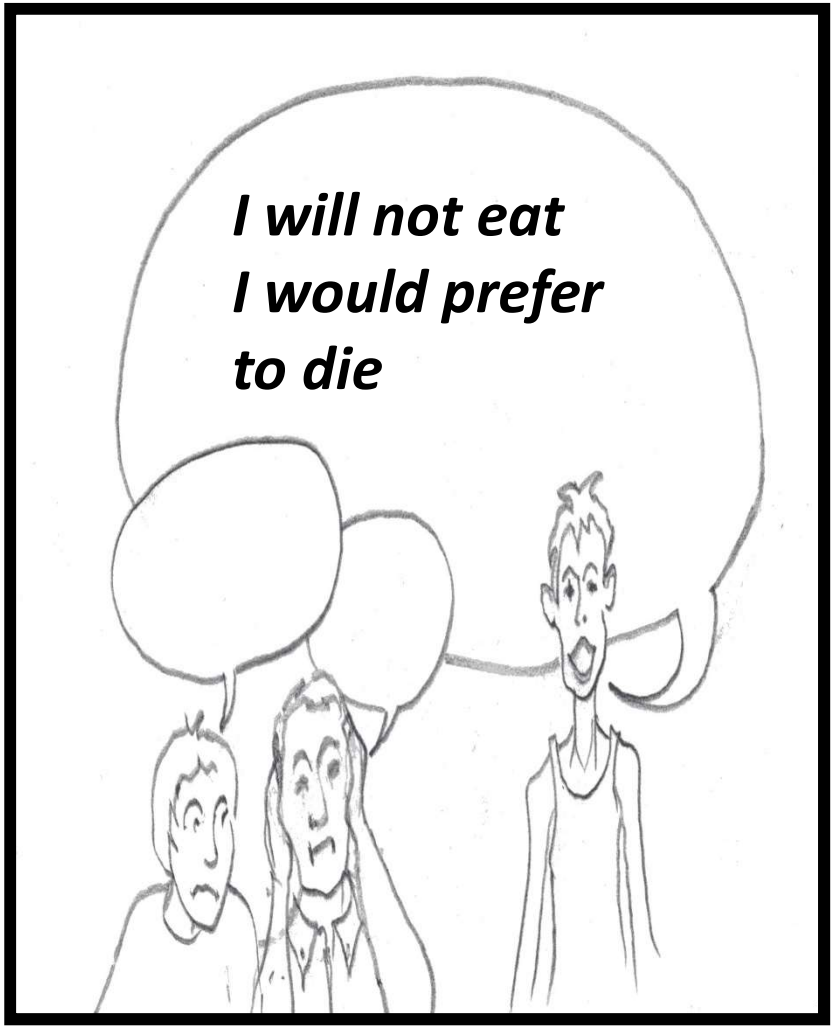


Divide and Rule

- Parents take polarised positions.
- Tension between total nurture & growth.

Team work essential
A network of support.

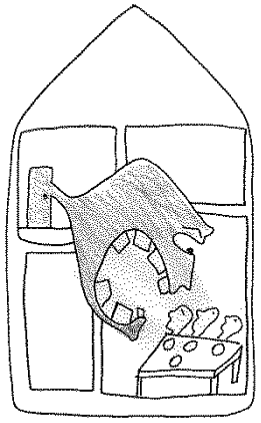
Accommodating



Families accept:

- Food & meal rituals.
- Safety behaviours (exercise etc.) .
- OCD behaviours with reassurance.
- Calibration and competition with other family members.

Accommodation: the dependence trap

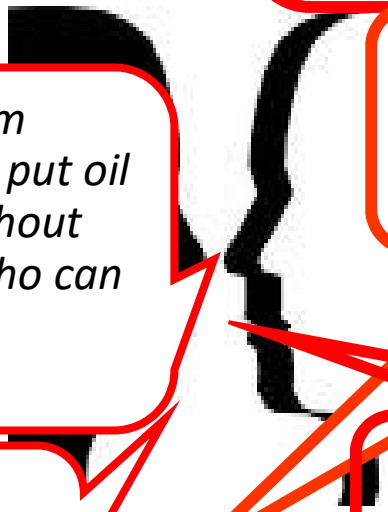


- Directly participating in ED behaviours eg food rituals.
- Avoiding triggers (eg following rules, time of eating, what to buy, how to store, what implements to use etc) .
- Accommodating ↓ distress.
- Not accommodating ↑ distress and aggression (verbal & physical), pestering, badgering and emotional blackmail (e.g., accusing the caregivers of not loving or caring if they do not accommodate).

Families: OCD Accommodating

I have to have different crockery for preparing and cooking my meals. They are kept separately.

Edi sometimes comes down in the morning and says she dreamed about eating a chocolate mousse. She will then keep asking throughout the day- I did not eat a mousse did I? She goes on and on.



Edi will ask me a hundred times a day whether she ate too much at her last meal.

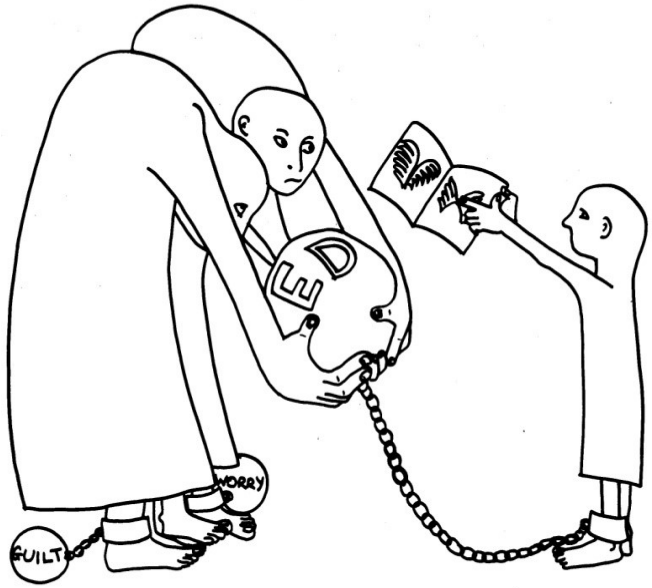
"She stands over me when I am cooking to ask whether I have put oil in the food and checks throughout the meal. I am the only one who can cook for her.

No one can go in the kitchen when she is there.

She will only drink from a new bottle of water. The fridge is stocked with her water.


All the family need to be involved
Small amounts of accommodation in other family members keeps illness going.
(Salerno et al 2015)

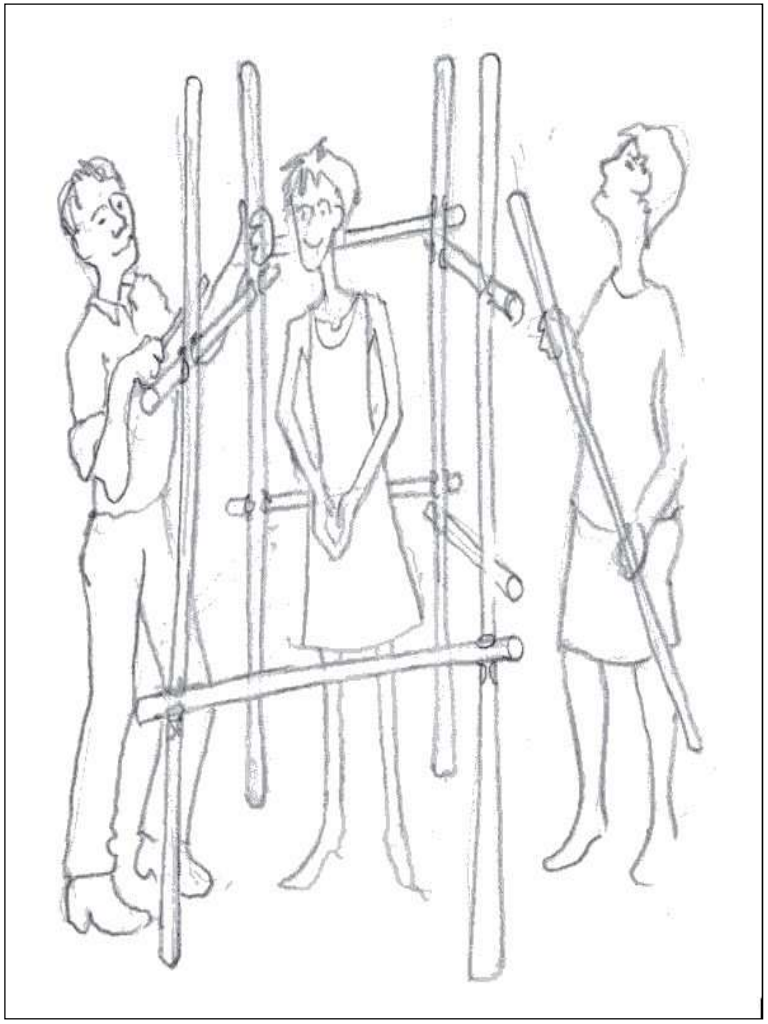
Enabling



Emotions: Fear, Guilt, Anxiety, shame

The family try to protect the individual and the family of the consequences of an eating disorder.
They clean up mess in kitchen or bathroom.
They cover up for lost food or money .
They give money or resource to allow the behaviour

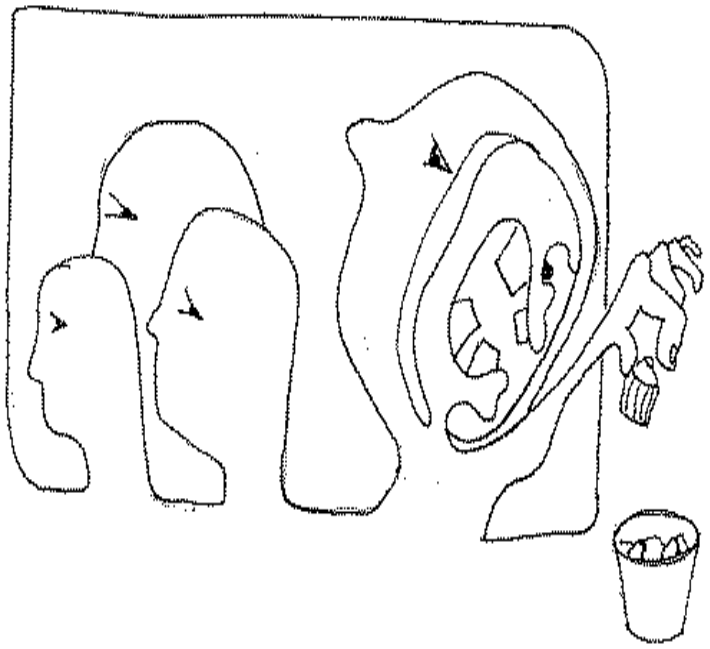
Enabling ED. Avoidance & modify routine



Covering up for:

- Plumbing toilet problems
- Stealing (food and money)
- Mess
- Social & family

WHAT ACCOMMODATING AND ENABLING BEHAVIOUR HAVE YOU SEEN?



Turning a blind eye

Family enabling bulimic behaviours

"If I go down to the kitchen and find that she has finished off all the cereal I have to go off and drive to the supermarket so that the others can have breakfast

•*Her car was out of action, so I drove her to the supermarket at 11.0 pm. I did not want her to go locally as it is expensive and people know us.*

•"I know that money has gone from my purse so I take more care to hide it but my husband does not take as much care- so I am sure she is taking his money.

•*I have to clean up the toilets; it's not nice for the rest of the family.*

Families: calibration and competition

Edi has to see me eat every night before she will eat anything and judges what she eats by the type of food and amount I have eaten that night.

She often buys cream cakes etc. that she makes me eat even when I do not want them.

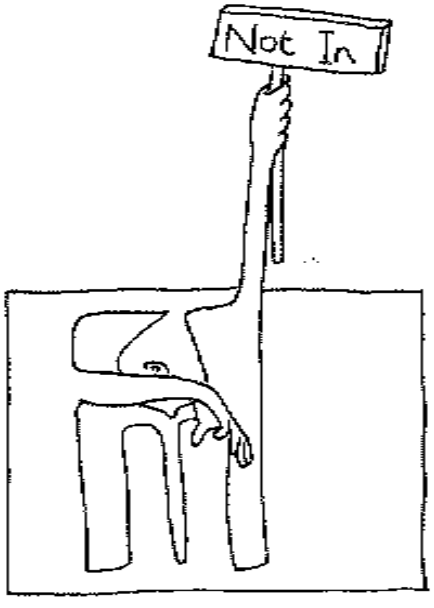
Every time I go up/down any stairs she then has to go up/down them twice as many .

She does not like it when I buy healthy foods for me to eat.

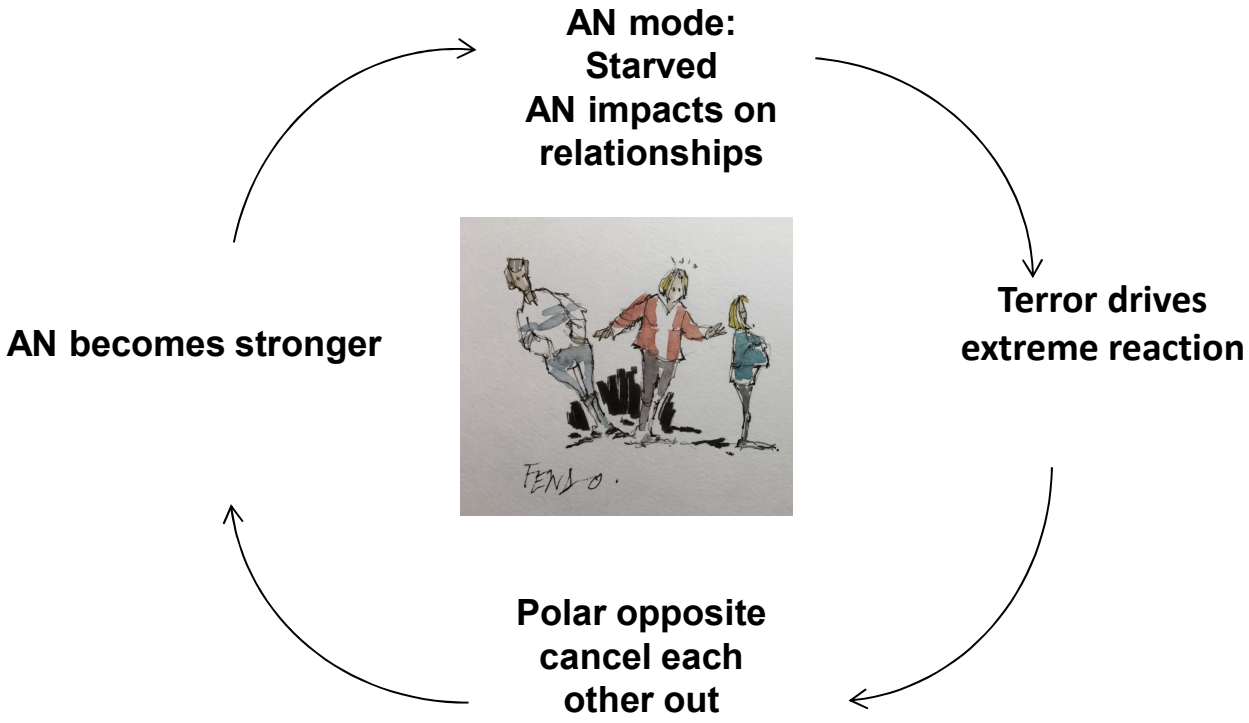
She gives her younger sibling money to go to the tuck shop every day. She opens the cupboard door that contain snacks to tempt my other daughter when she comes home

Interpersonal factors

- Burn out and fragmentation can occur



The vicious circle of Fragmentation



ITS MY CHILD THAT HAS GOT TO CHANGE NOT ME!

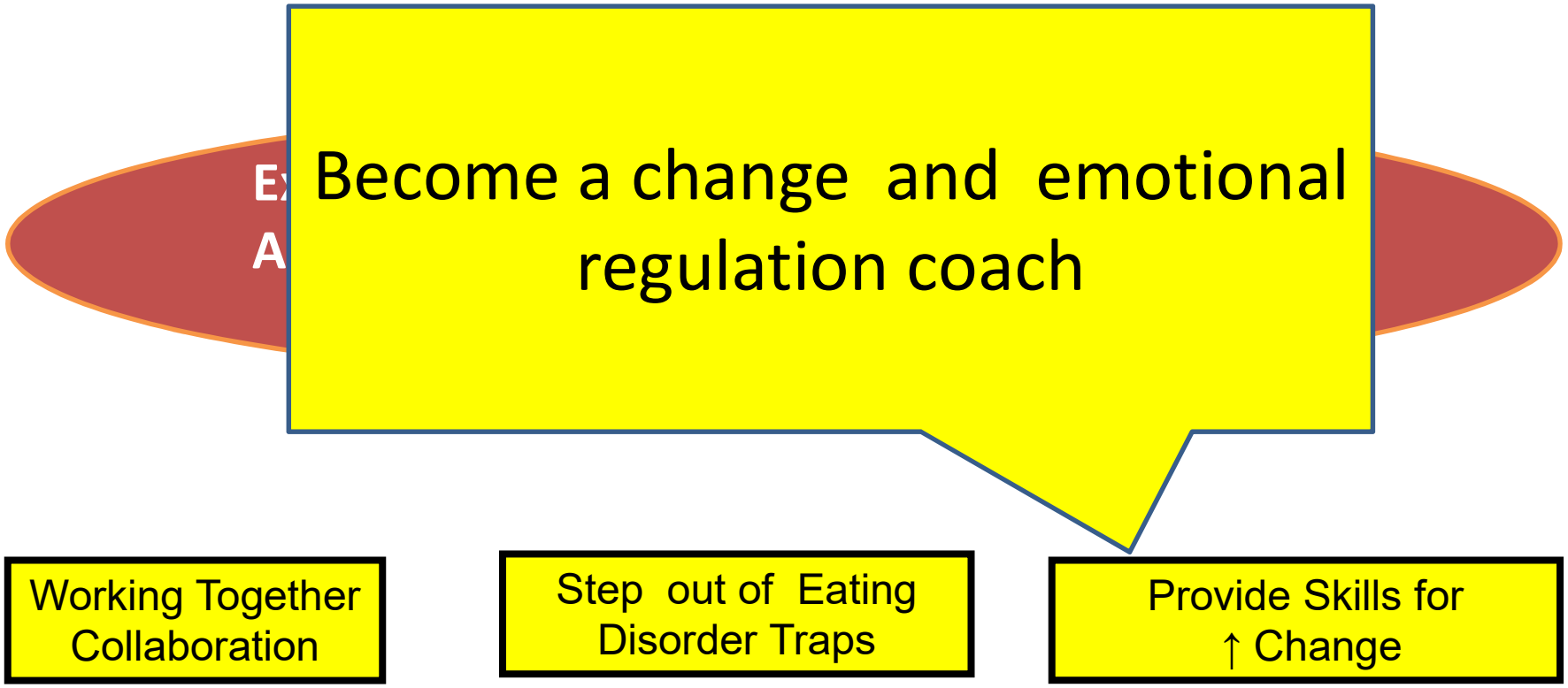
Working for change with carers

Strategies to reduce emotionally driven behaviours

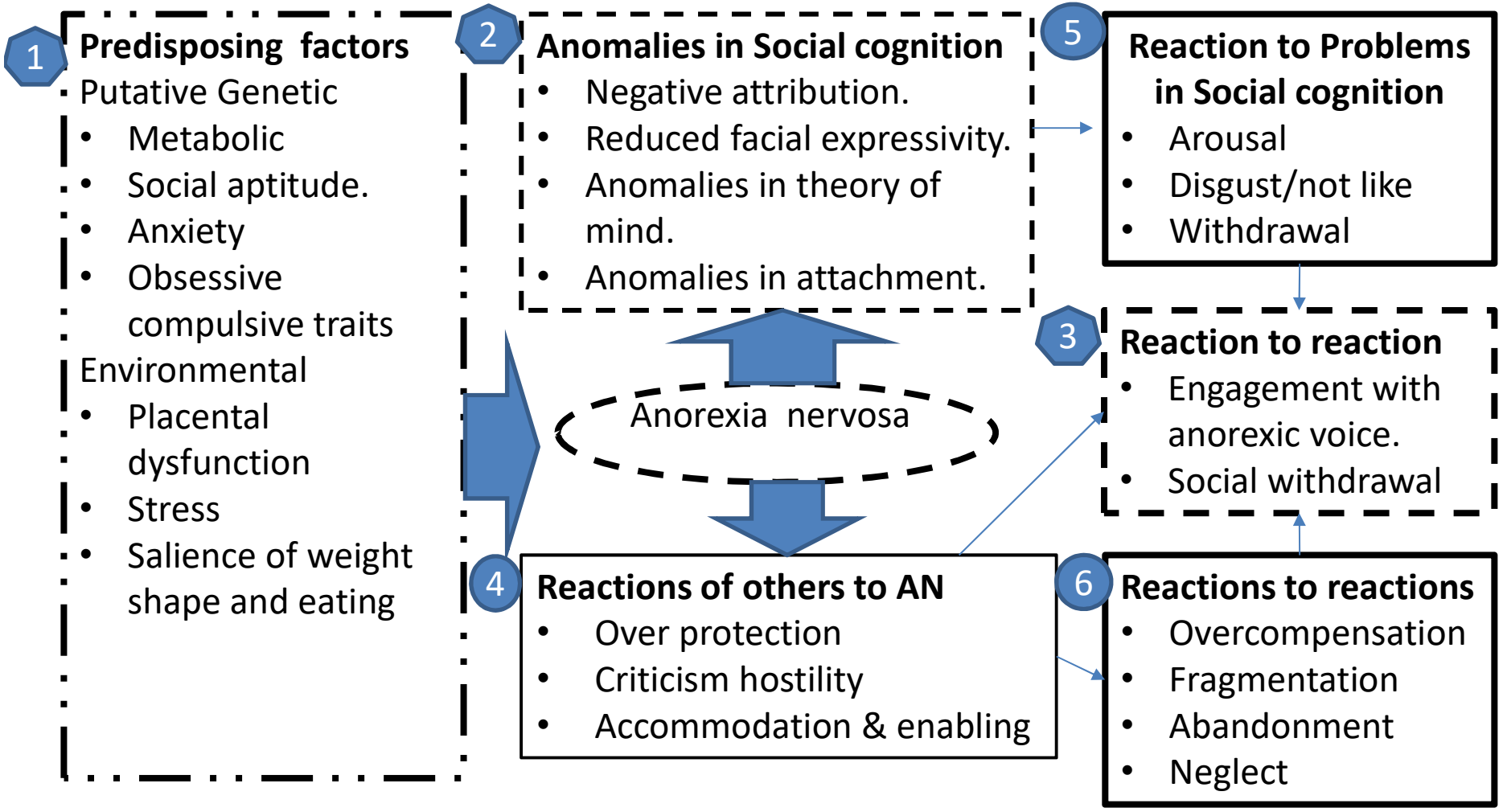
- You can’t control the child, only yourselves!
- You don’t have to win each battle, but only to persist in the war!
- Strike the iron, when it is cold.
- Letters and written plans are useful.

Care givers Emotional regulation

- Mirroring fear when your child shows fear and anxiety. is understandable However it signals that you are afraid of child's fear his fear. The fear escalates.
- Staying calm and ….. can break the fear trap.
- Explain your plans & use emotional regulation strategies (eg deep muscle relaxation, imagery, self talk).
- I know that you are strong . So now, when I feel afraid for you I take a deep breath and visualise my yoga class to calm down. Maybe you could come with me and use tools like that as well.'"


Become a change and emotional regulation coach
Working Together Collaboration
Step out of Eating Disorder Traps
Provide Skills for ↑ Change
Shared Understanding Shared Skills
Regulate emotion
Care for self.
↓ accommodation
↓ over protection
↓ hostility & criticism
↓disagreement & division
Compassion
Positive communication
Behaviour Change Skills

The interpersonal element of the cognitive interpersonal model

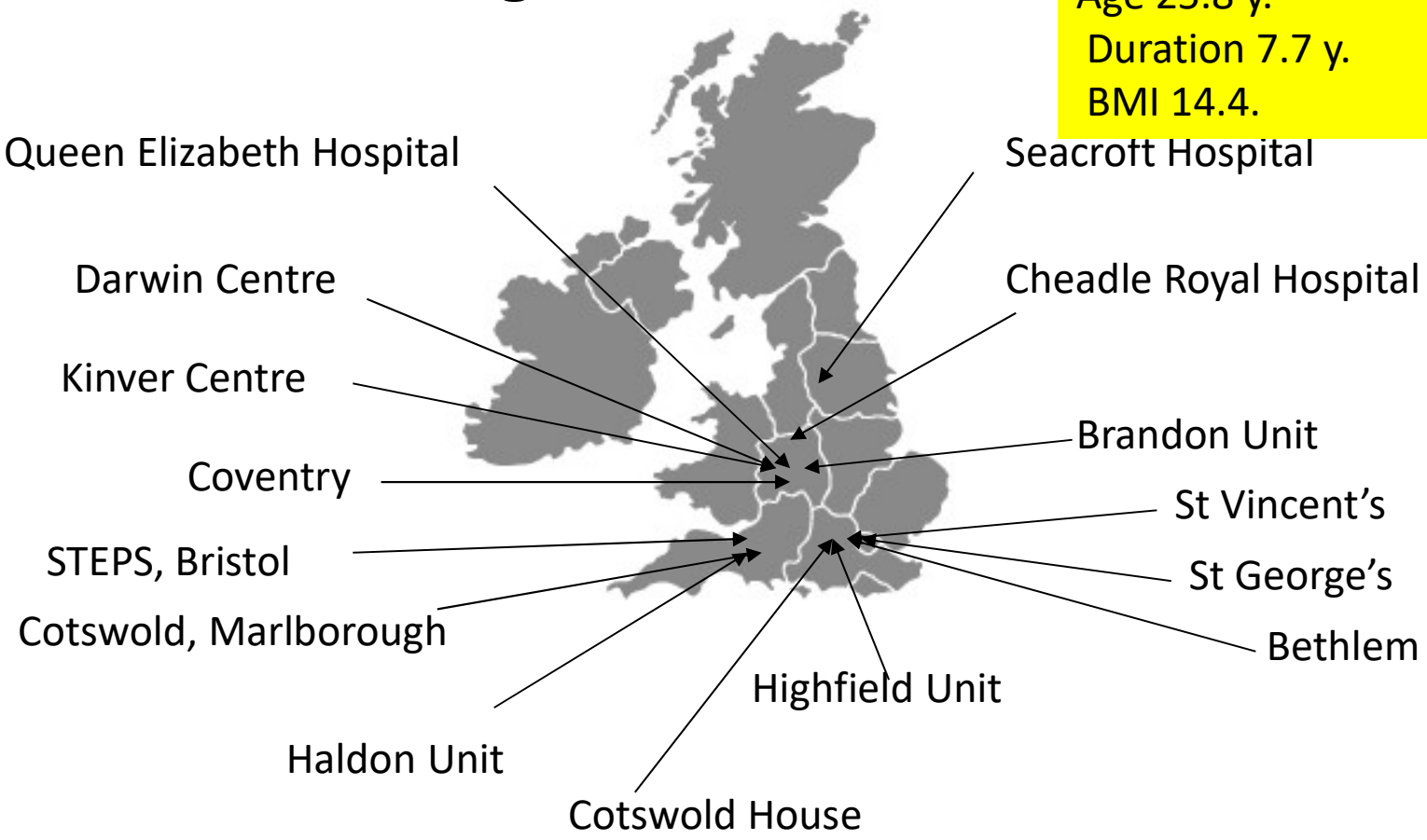


WHAT IS THE EVIDENCE?

The addition of ECHO to TAU as aftercare for AN inpatients mainly SEED (CASIS).

15 Collaborating sites

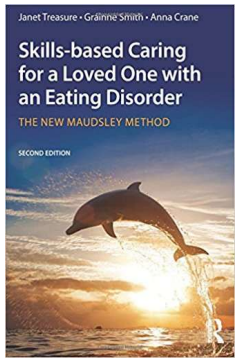
N=178
Age 25.8 y.
Duration 7.7 y.
BMI 14.4.



ECHO: a collaboration of **P**arents (Partners) , and **P**rofessionals (**2 P's**).

WORKBOOK

Focus on **illness maintaining factors** and **goal planning**



VIDEO CLIPS

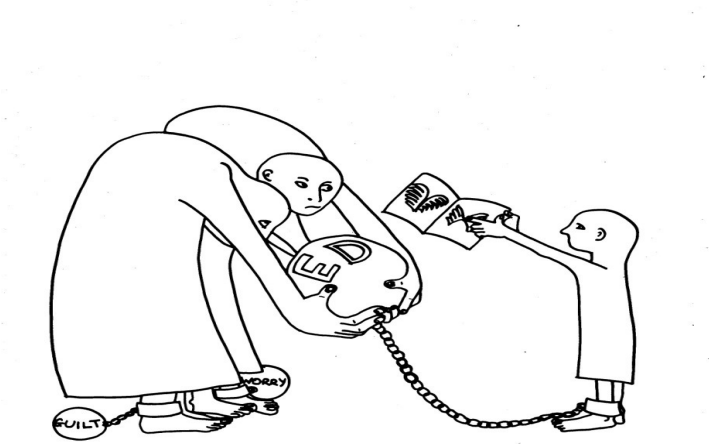
Expert by experience: Expert by knowledge

FREE FROM EATING DISORDERS
Succeed™

GUIDANCE

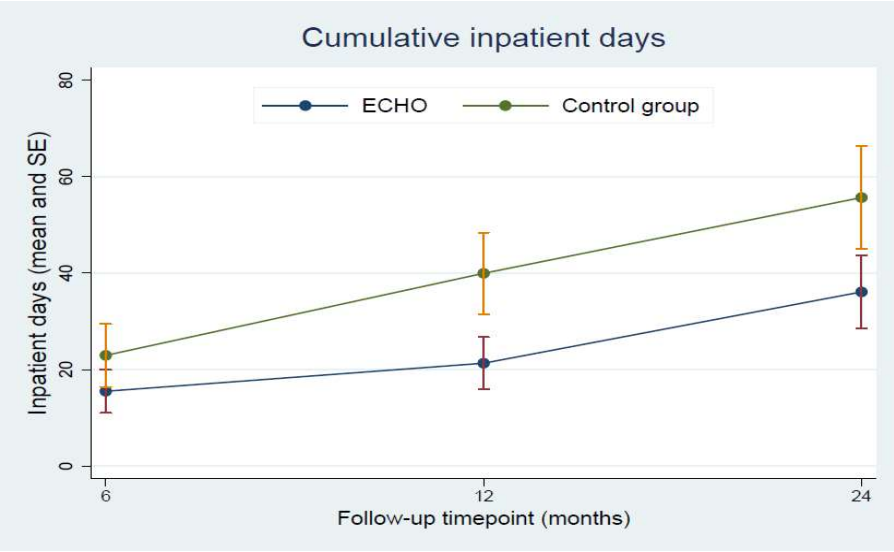
ECHO ↓ carer and service burden

- ↓ **Carers' burden** (ES: 0.5)
- ↓ **Emotional behaviours** (ES: 0.3-0.5)

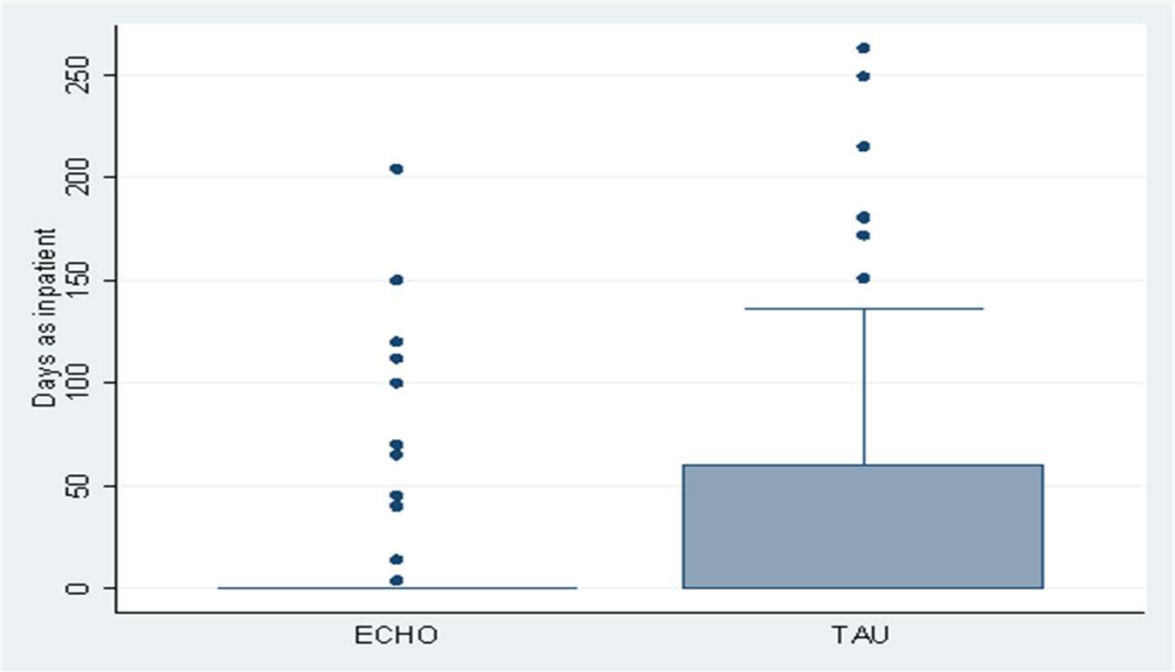


Hibbs et al 2016; Magill et al 2017

- ↓ **Length of admission** (148 vs 168 days)
- ↓ **Re-admission rate** (27% vs 32%; *p*=0.04)



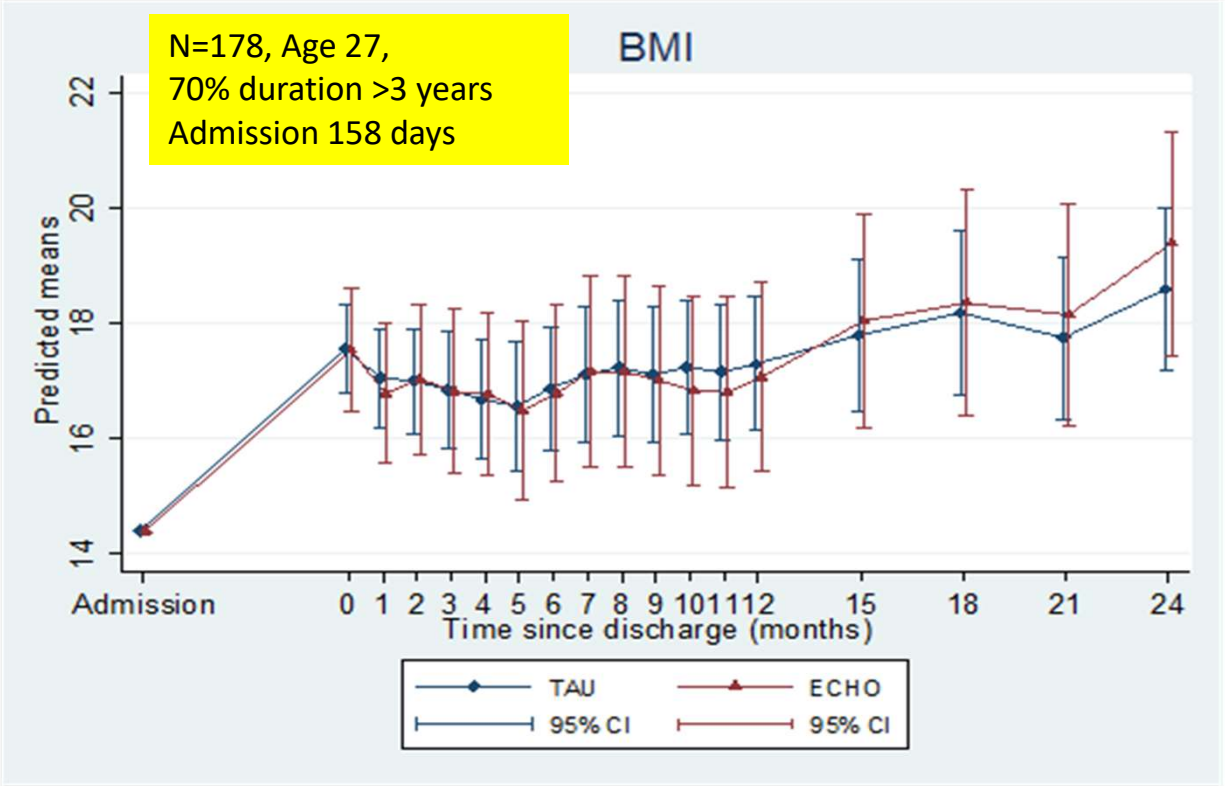
Adult : Bed Usage in first 6 months after admission



Hibbs et al BJPsych Open 2015;1(1):56-66.

ECHO Intervention -2 years

(Magill et al 2017)



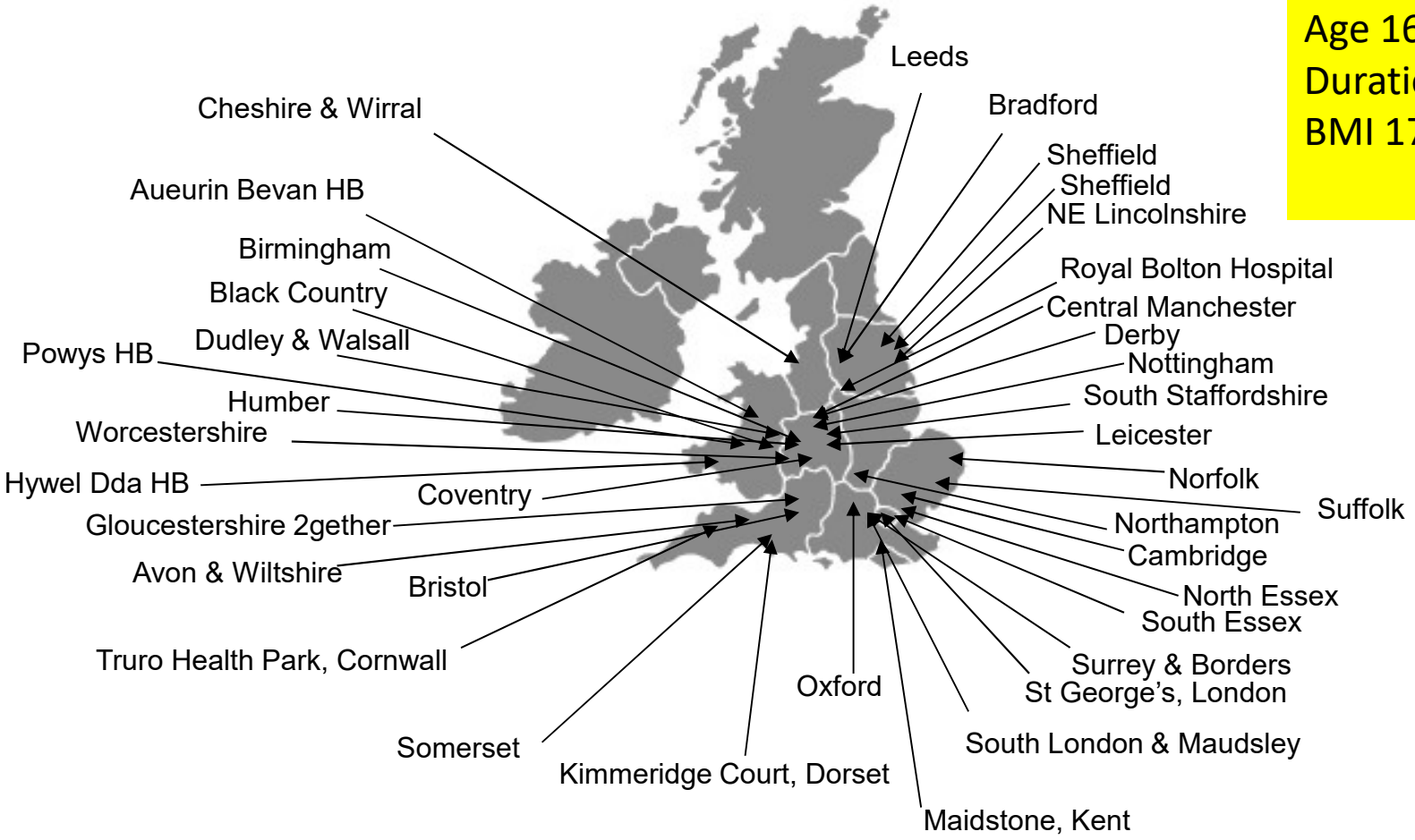
Improvement in Carer Function

	ECHO	TAU
Care Time -Baseline	70	70
Care Time -12m	17	20
Expressed emotion-Base	48	48
6m	43	45
AESED-baseline	41	41
AESED-12m	28	33

Multi centre RCT (ECHO) for outpatients under 21years

38 NHS ED services (17 CAMHS, 13 adult, 8 both)

N=149
Age 16.5 y.
Duration 1.8y.
BMI 17.1



Number of Hospital Admissions

Patient/carer Group	6 months	12 months
ECHO	12%	9%
TAU	16%	8%

Changes in Carer Behaviour

	ECHO	TAU
Care Time -Baseline	49 (15-100)	51 (19-132)
Care Time -12m	**12 (2-47)***	19 (3.3-90)
CASK-baseline	176 (36)	179 (35)
CASK-12m	**195 (38)***	189 (40)
AESED-baseline	50 (21)	49 (22)
AESED-12m	42 (21)	49 (24)

Changes in Carer Behaviour

	ECH	
Care Time -Baseline	49 (15-100)	
Care Time -12m	**12 (2-47)***	
CASK-baseline	176 (36)	
CASK-12m	**195 (38)***	189 (40)
AESED-baseline	50 (21)	49 (22)
AESED-12m	42 (21)	49 (24)

Reduced Caregiving Time

Increased caregiver skills

ECHO (Experienced Carers Helping Others) improves patient outcomes?

Peer Problems		
	ECHO	TAU
Baseline	3.1 (2.3)	2.8 (2.2)
12months	**2.2 (1.8)***	2.8 (2.2)

ECHO group fewer peer problems

Prosocial Behaviours		
	ECHO	TAU
Baseline	7.0 (2.3)	7.5 (2.1)
12months	**7.6 (2.0)***	6.8 (2.2)

ECHO group higher pro social behaviours

Hodsall et al 2017

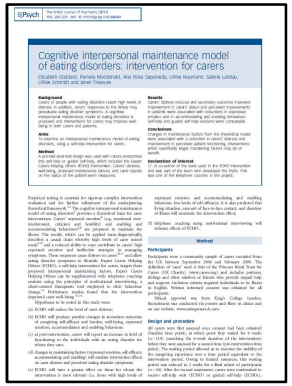
Social connection for Transition

ECHO

Intervention to optimise **carers** support role

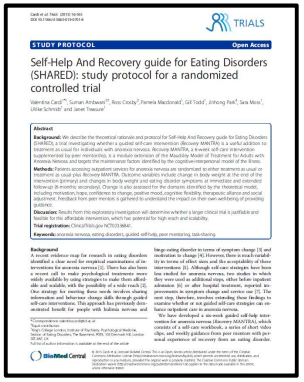
ECHOMANTRA

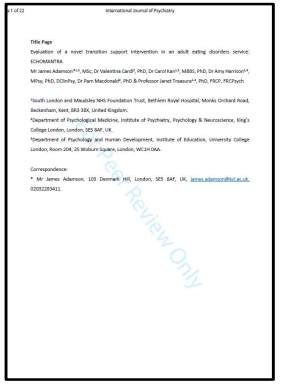
Hybrid Interventions for Patient and carers


Cognitive interpersonal maintenance model of eating disorders: intervention for carers


Clinical effectiveness of a skills training intervention for caregivers in improving patient and caregiver health following in-patient treatment for severe anorexia nervosa: pragmatic randomised controlled trial


Two-year Follow-up of a Pragmatic Randomised Controlled Trial Examining the Effect of Adding a Carer's Skill Training Intervention in Inpatients with Anorexia Nervosa


Self-Help And Recovery guide for Eating Disorders (SHARED): study protocol for a randomized controlled trial


Evaluation of a novel transition support intervention in an adult eating disorders service: ECHOMANTRA

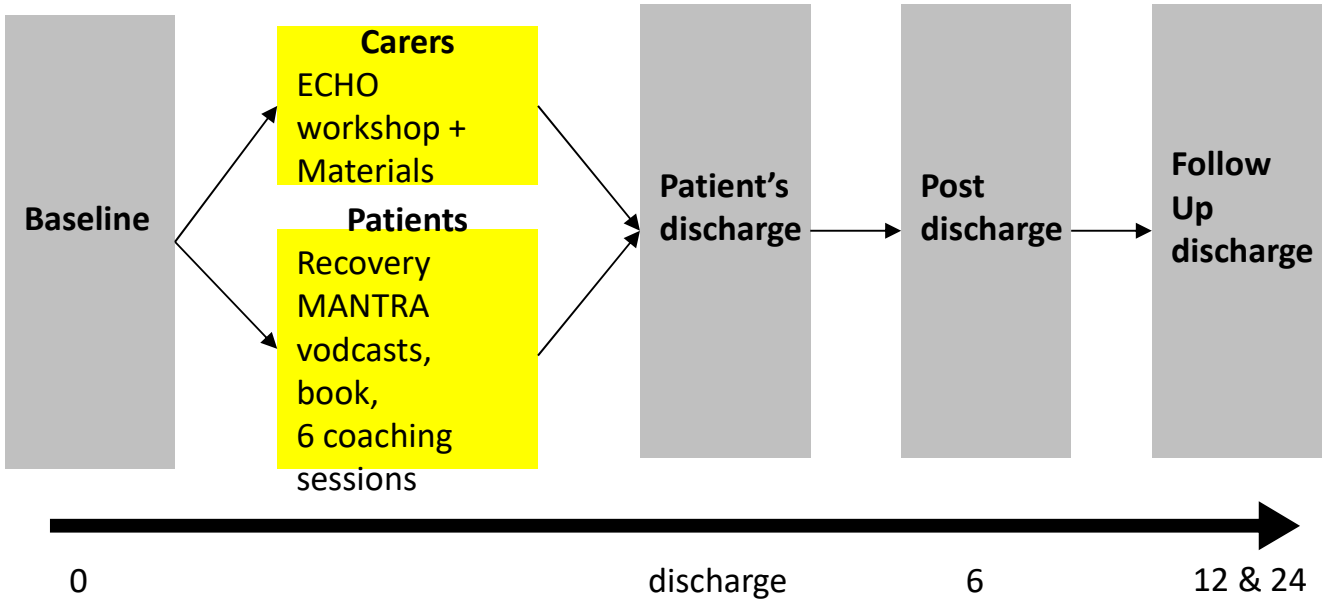

Transition Care in Anorexia Nervosa Through Guidance Online from Peer and Carer Expertise (TRIANGLE): Study Protocol for a Randomised Controlled Trial

Does ECHO MANTRA improve transition from inpatient care for patients with severe enduring anorexia nervosa? A case series study.

The Health Foundation

TRANSITIONS RESEARCH PROJECT iCASK EDU INPATIENTS BRH Step Up

Assessment carer (n= 21) and patient (n=31)



Adamson et al., 2018

BMI =13.7 (1.4) ; Age 24 (16-49); Duration 7.6 (1-32)

ECHOMANTRA value for the NHS without burdening the carers

- ↓ Length of admission by 4.5 weeks
- ↑ Weight gains by 0.11 kg/week

Potential saving of £180 millions/year

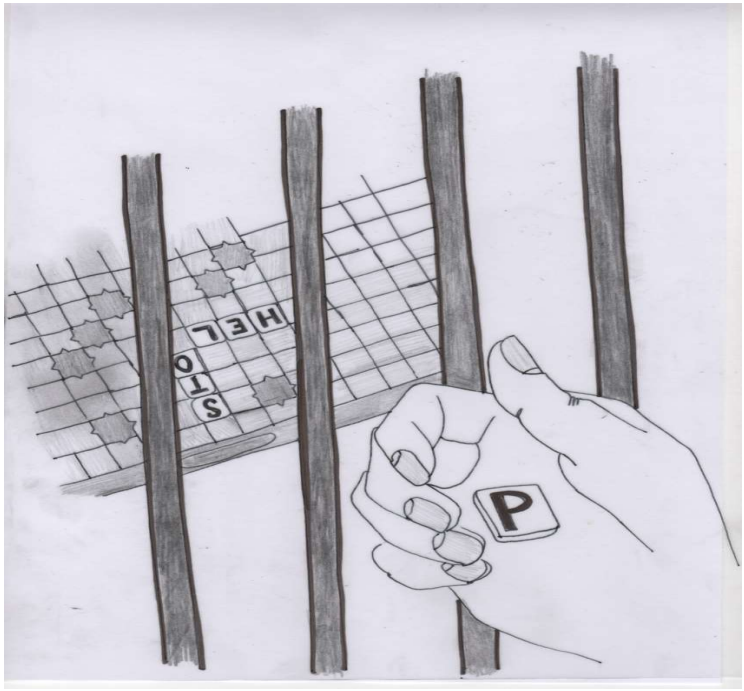
(Adamson et al 2019, Int Rev Psych)

I felt less like a burden after my partner had done ECHOMANTRA.

It was a turning point for us in my recovery. It was the first time we have been offered support as a couple and involved both of us in my treatment, we feel that this was crucial to my recovery.

ECHOMANTRA: a collaboration of **P**arents (Partners,Peers) **P**atients and **P**rofessionals (**3 P's**).

- Shared Digital Resources coproduced by 3 P's.
- Anonymous shared peer and patient/carers and workshop/groups facilitated by psychology graduates.



(Adamson et al 2019, Int Rev Psych)

References to evidence of collaborative care

- 1 Hibbs, R. *et al.* Clinical effectiveness of a skills training intervention for caregivers in improving patient and caregiver health following in-patient treatment for severe anorexia nervosa: pragmatic randomised controlled trial. *BJPsych Open* **1**, 56-66, doi:10.1192/bjpo.bp.115.000273 (2015).
- 2 Hibbs, R., Rhind, C., Leppanen, J. & Treasure, J. Interventions for caregivers of someone with an eating disorder: A meta-analysis. *Int J Eat Disord* **48**, 349-361, doi:10.1002/eat.22298 (2015).
- 3 Magill, N. *et al.* Two-year Follow-up of a Pragmatic Randomised Controlled Trial Examining the Effect of Adding a Carer's Skill Training Intervention in Inpatients with Anorexia Nervosa. *Eur Eat Disord Rev* **24**, 122-130, doi:10.1002/erv.2422 (2016).
- 4 Hodsoll, J. *et al.* A Pilot, Multicentre Pragmatic Randomised Trial to Explore the Impact of Carer Skills Training on Carer and Patient Behaviours: Testing the Cognitive Interpersonal Model in Adolescent Anorexia Nervosa. *Eur Eat Disord Rev*, doi:10.1002/erv.2540 (2017).

Additional Reading

- Birmingham CL, Treasure . Medical Management of eating disorders. Cambridge : Cambridge University Press; 2010.
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