CBT-E in adolescent inpatient care: a commentary

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NICE on Inpatient treatment

* Admit people with an ED whose physical health is severely compromised for medical stabilisation and to initiate refeeding, if these cannot be done in an outpatient setting.
* Do not use an weight or BMI threshold when deciding whether to admit, but take the following into account:
  * The person's BMI or weight, and whether these can be safely managed in a day patient service or whether the rate of weight loss means they need inpatient care.
  * Whether inpatient care is needed to monitor medical risk
  * Whether the parents or carers of children and young people can support them and keep them from significant harm as a day patient.

* Do not use inpatient care solely to provide psychological treatment for eating disorders
* Do not discharge people solely because they have reached a healthy weight
* Admit to age-appropriate facilities, near to their home, that have the capacity to provide appropriate educational activities during extended admissions.

NICE also says

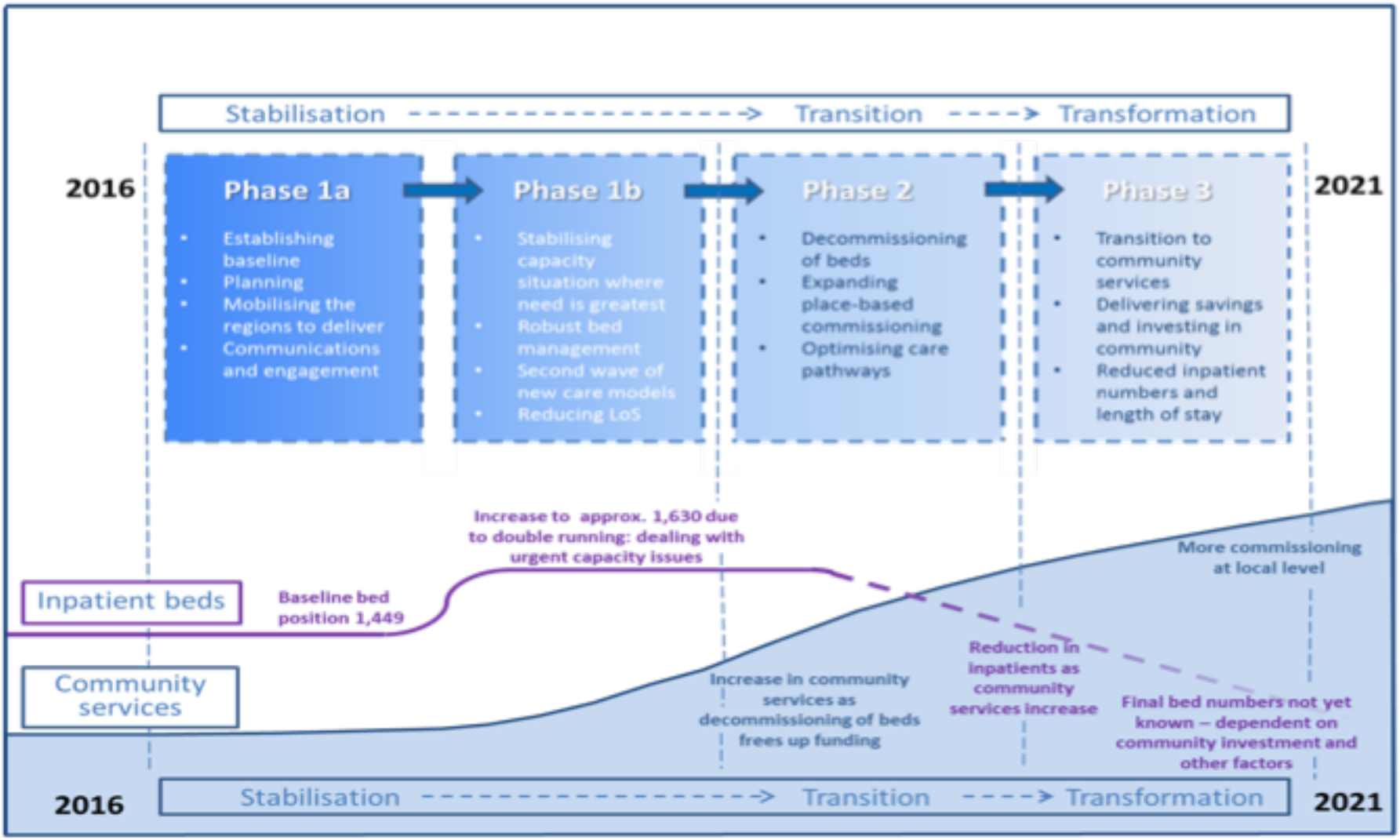
* When a person is admitted to inpatient care for medical stabilisation, specialist eating disorder or liaison psychiatry services should keep in contact with the inpatient team **to advise on care and management**, during the admission and when planning discharge, and keep the person's family members or carers involved, and **consider starting or continuing psychological treatments** for the eating disorder.

NHS England future vision for inpatient services

NHS England is focussed on

* eliminating inappropriate out of area placements;
* improving local bed availability aligned with community services;
* eliminating inappropriate under-18 placements in adult beds;
* ensuring a sufficient national bed stock for surge management;
* integrating and collaborating with local commissioners and providers;
* developing service specifications that support these ambitions

Three Phases of Implementation



Areas where consensus is lacking

* When (in the treatment process) and how (for what purpose) is **inpatient treatment** for ED (esp AN) most useful?
  * What are the benefits of brief admissions for those who are not progressing as outpatients who are stuck at a low weight but medically stable?
  * Should we be admitting earlier for shorter periods?
  * What therapeutic model works best in inpatient setting for the few people who need this?

* Are there some patients for whom the therapeutic milieu approach, with a relatively long admission, is the best/most cost effective route to recovery?
* Are structured inpatient programmes (i.e. unit led e.g. 12 week plan) preferable to individually goal focused admissions (referrer and patient led)

and

* Experts by experience views are mixed
  * Some for whom IP treatment has clearly been life saving
  * Others who are traumatised
* Anecdotal reports that coercive practices are increasing
* This is an area where further knowledge is needed
  * RCPsych survey and qualitative interviews

Total cost - over 12-months follow-up

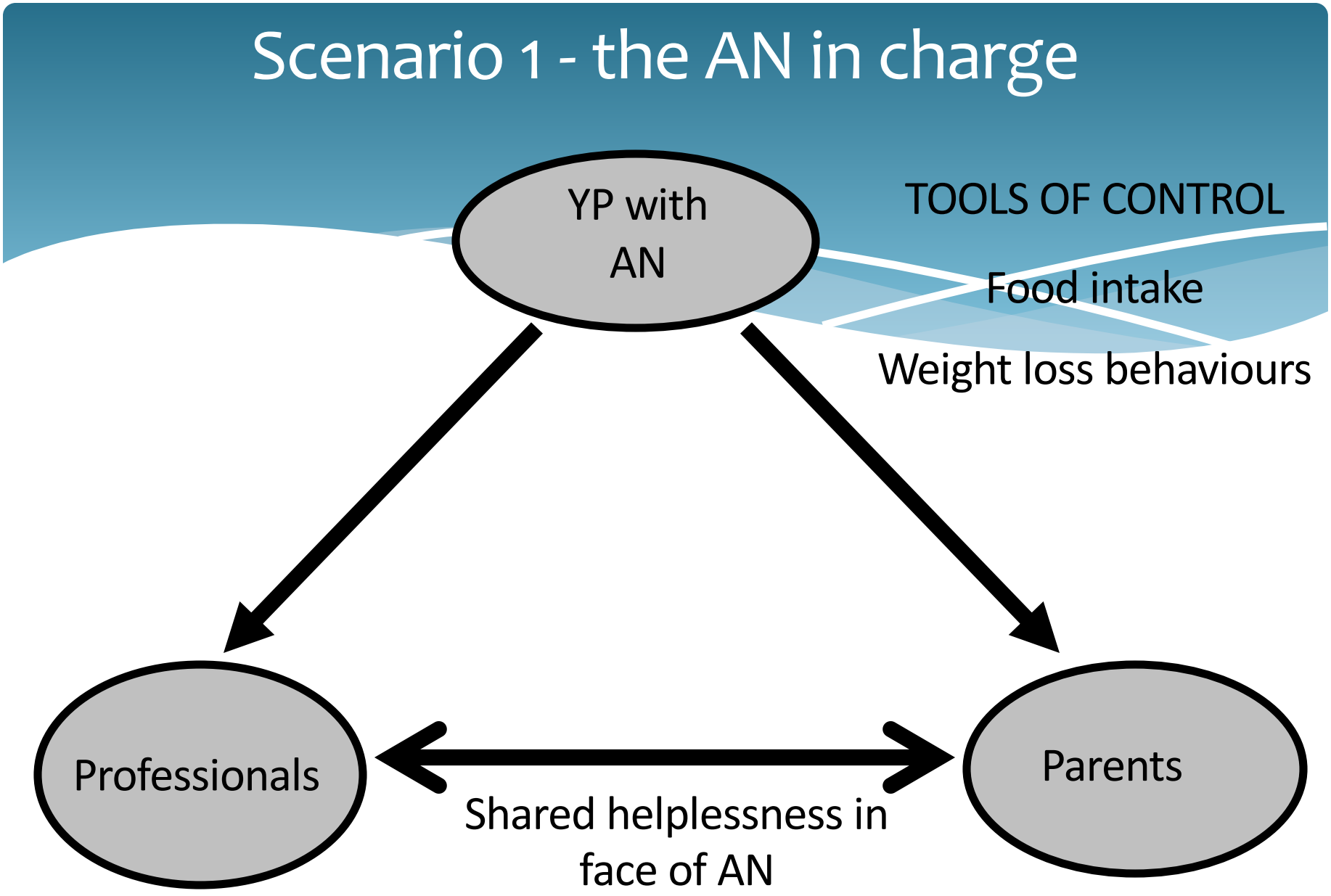
	Specialist	Generic	Adjusted*	
	Mean	**Mean**	**Mean diff.**	**p-value**
Inpatient	£19462	£19755		
Outpatient	£7955	£7470		
Day-patient	£1284	£246		
Total	£28700	£27471	-7106	0.396

*Adjusted for baseline CGAS, baseline %mBMI, age, gender and region

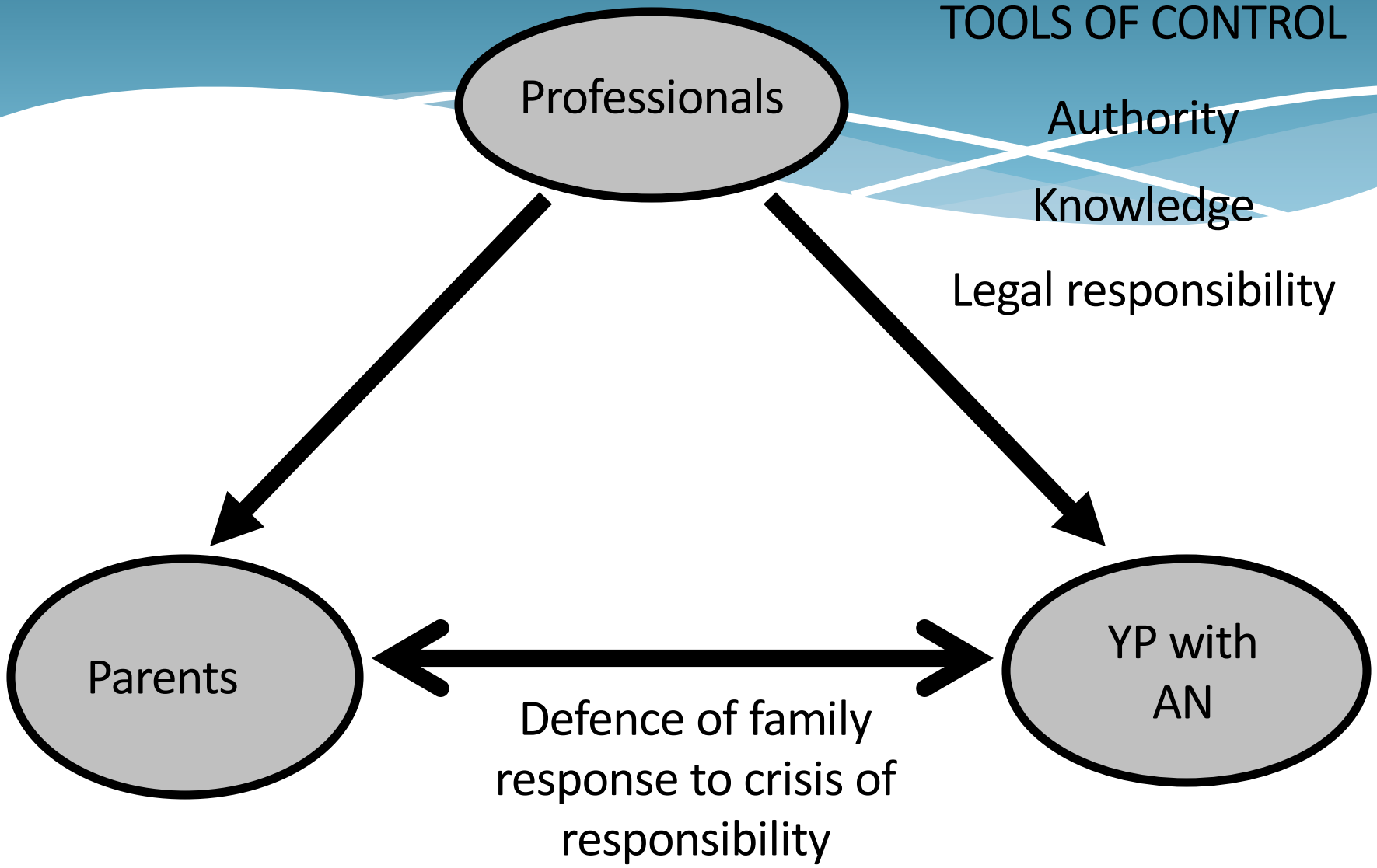
The need to change and the courage to change

* Imperative to demonstrate cost effectiveness of any treatment
* Need to work with community services to create sustainable change
* Need to balance risk (e.g. medical, self harm) versus risk taking to help patients take responsibility

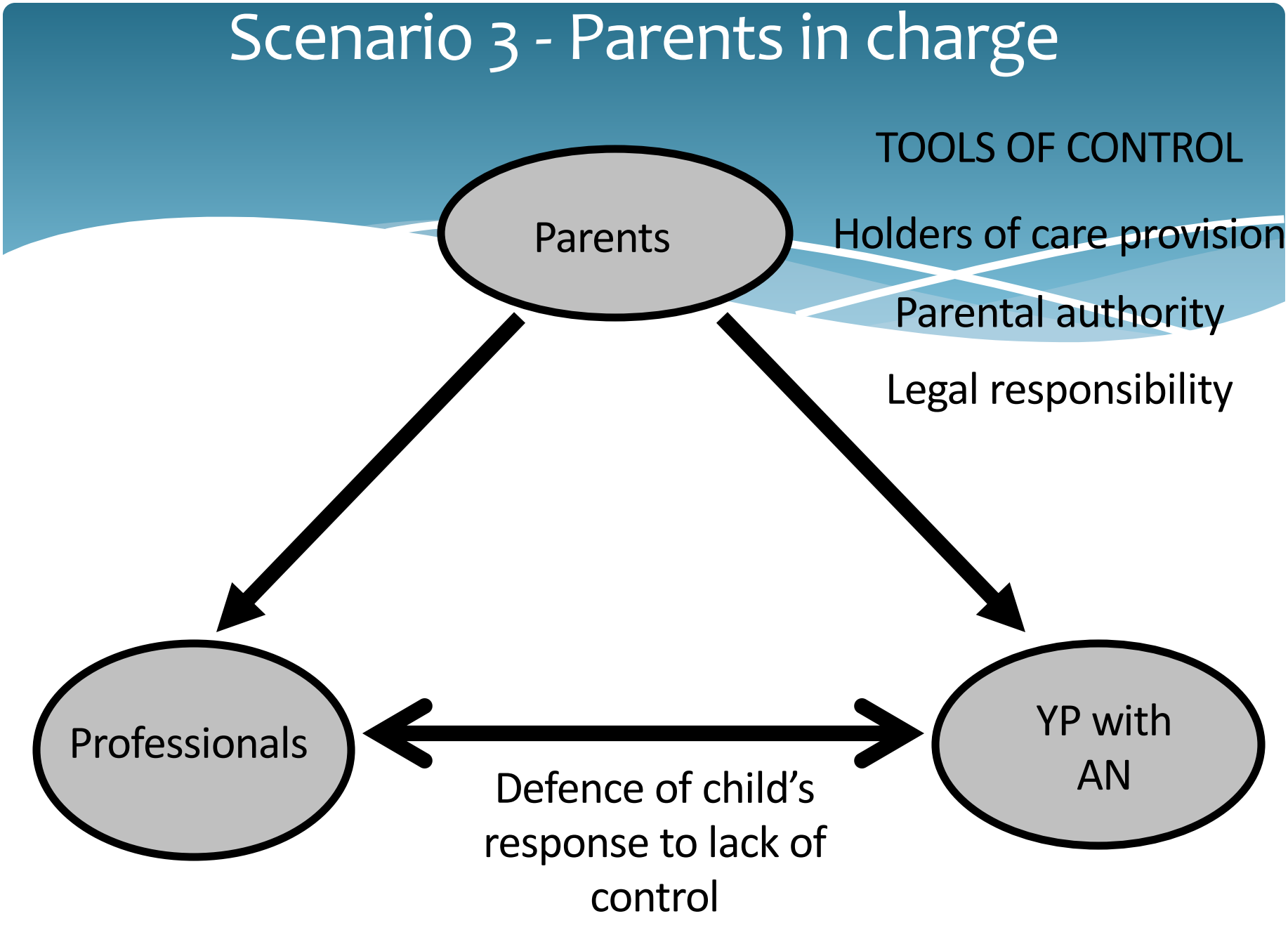
Scenario 1 - the AN in charge



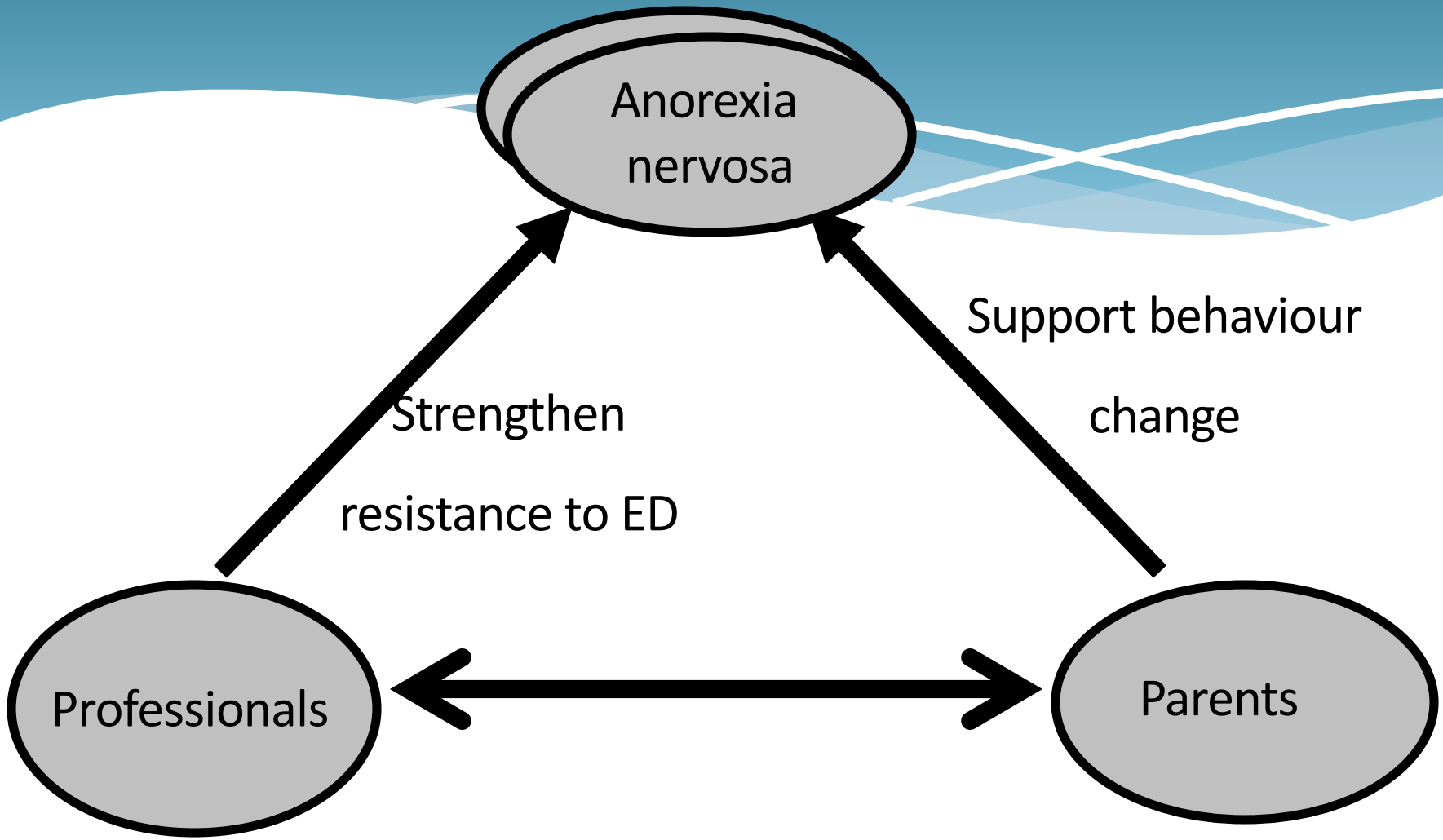
Scenario 2 - The professionals take over



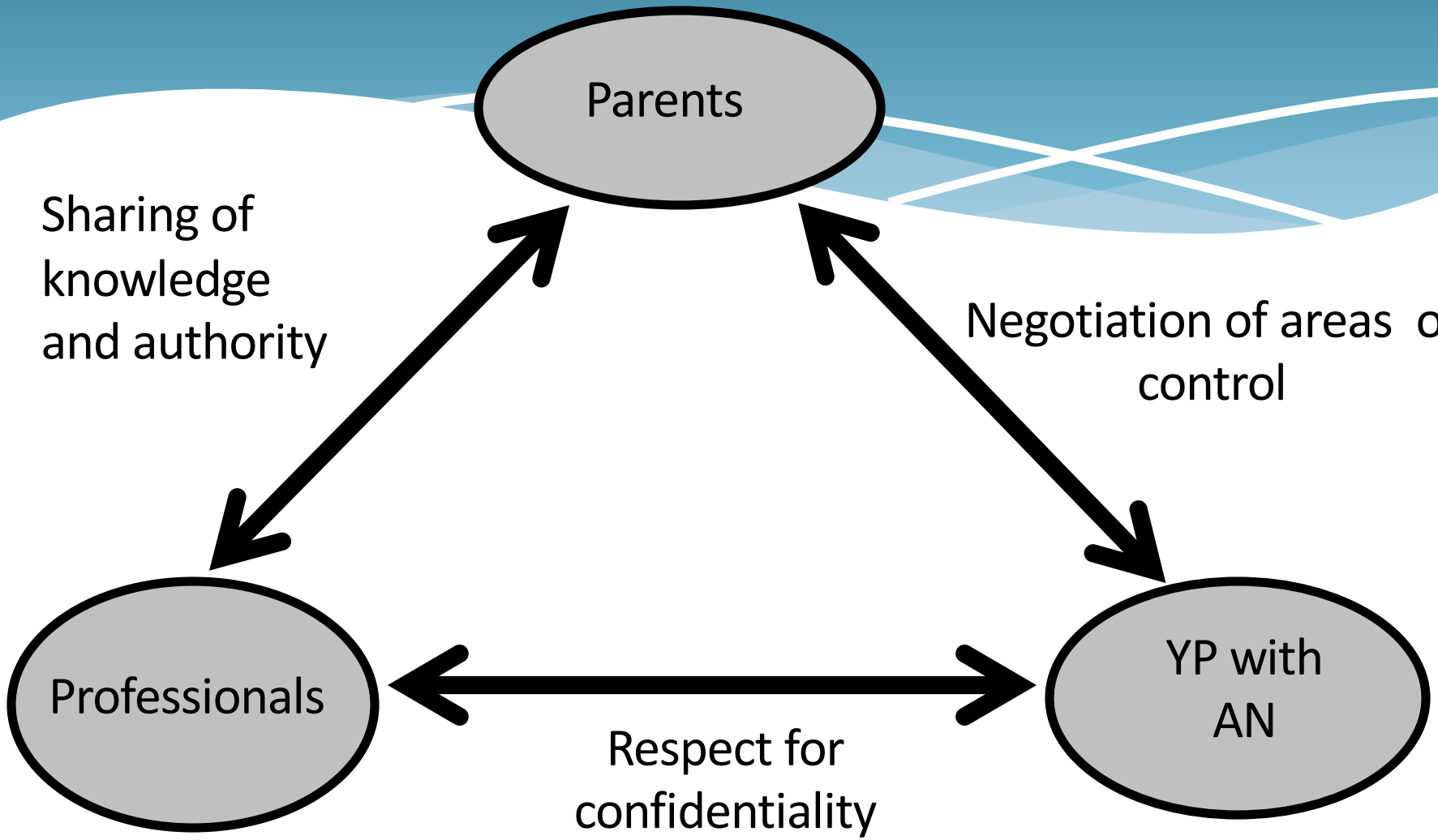
Scenario 3 - Parents in charge



Scenario 4: Adolescent in charge



Age appropriate distribution of power



Final comments

* Decision making
* Protocols and philosophy
* Clinical skill!
* Systemic and commissioning barriers
* Trailblazers and champions