

Bringing PEACE to the whole service

Dr Karina Allen

Consultant Clinical Psychologist, Eating Disorders Service, South
London and Maudsley NHS Foundation Trust

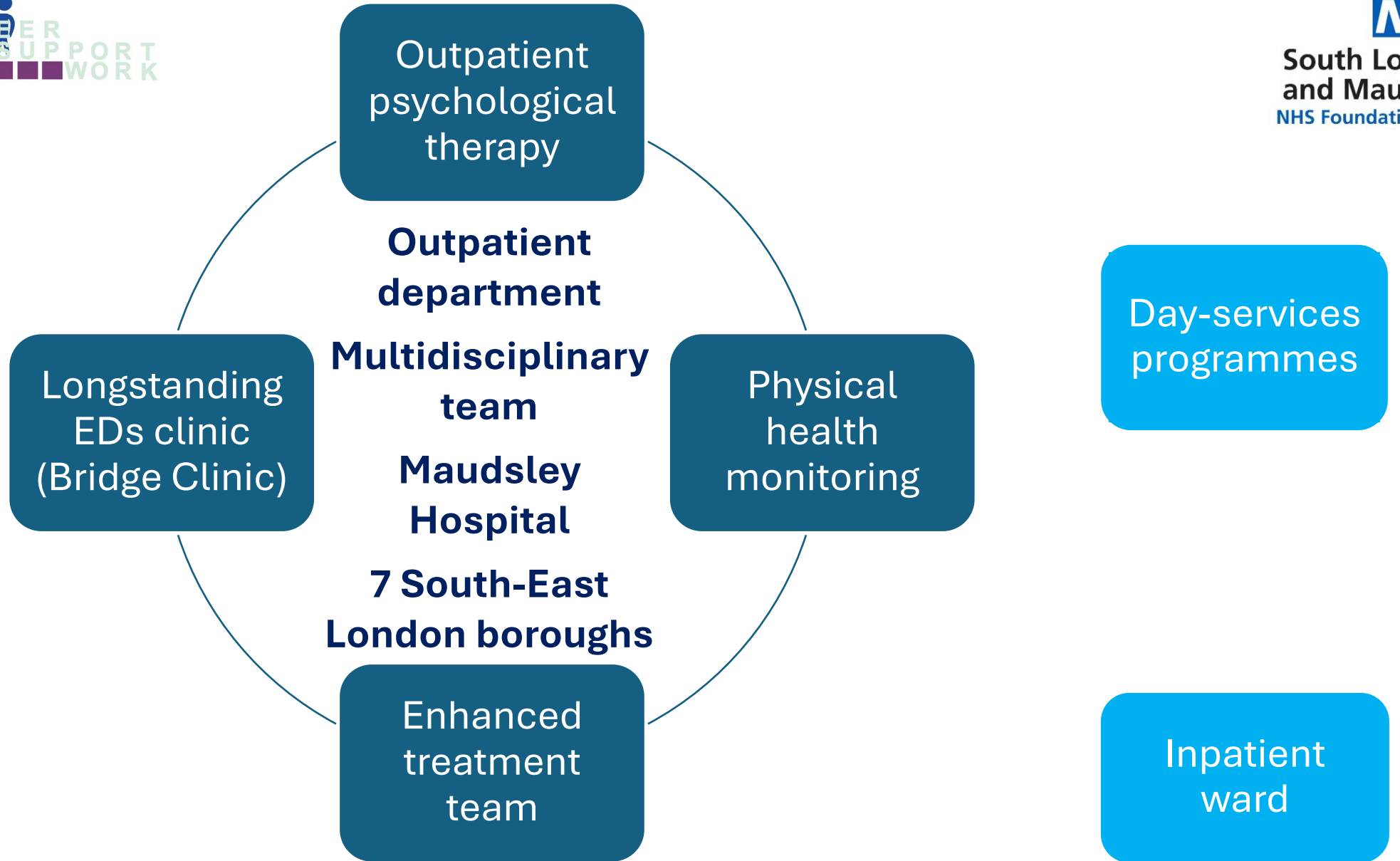
Adjunct Reader, Centre for Research in Eating and Weight Disorders,
Institute of Psychiatry, Psychology and Neuroscience, King's College
London

Overview

- Challenges and opportunities in implementing a new whole-service pathway
- Lessons learnt
- Positive changes
- Challenges and next steps

Challenges and opportunities in implementing a new whole-service pathway







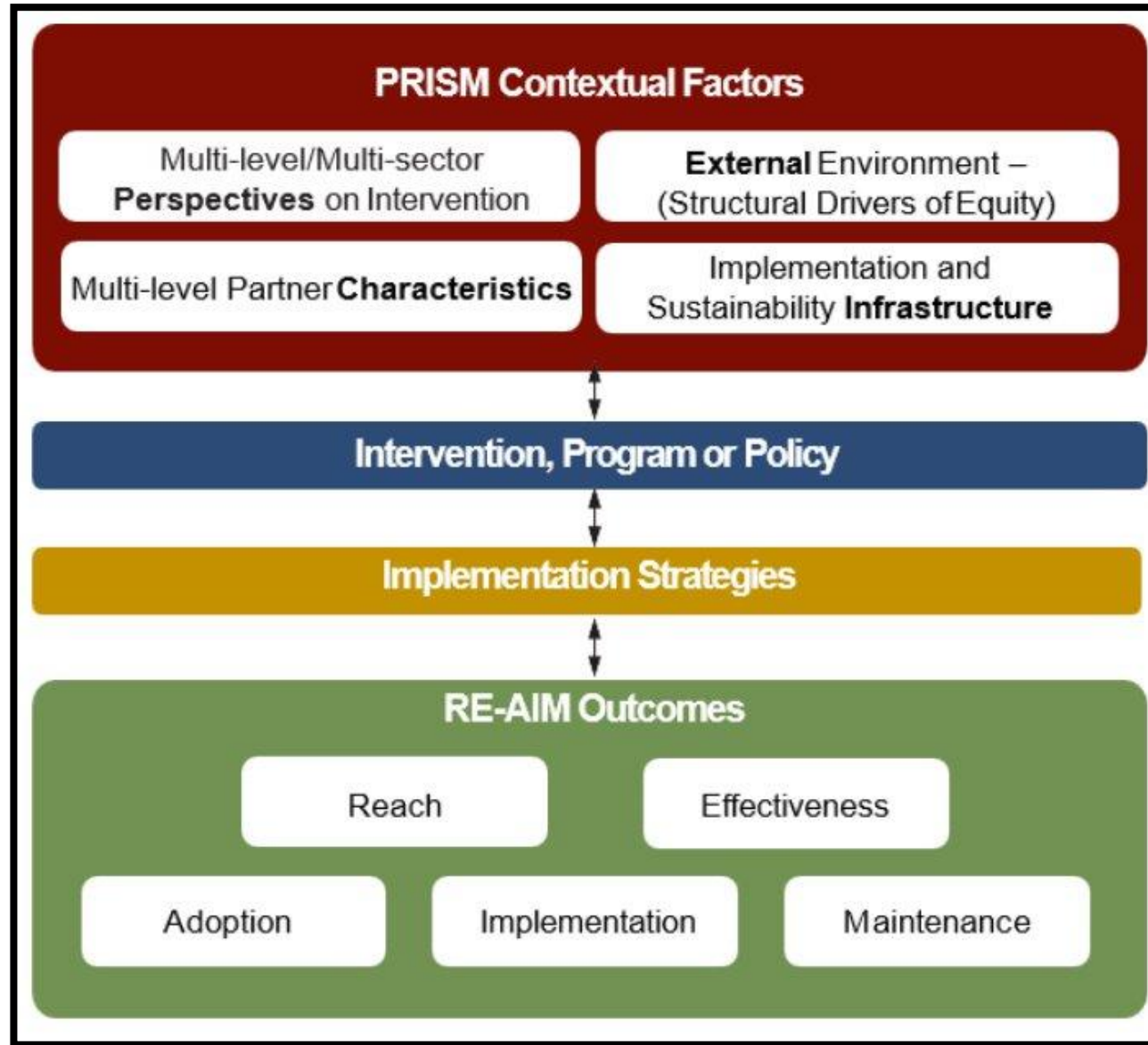


WELCOME TO RE-AIM AND PRISM: IMPLEMENTATION IN CONTEXT



RE-AIM and PRISM guide users to plan, implement, evaluate, and sustain programs
with contextual factors in mind, increasing equity and public health relevance

Practical, Robust, Implementation and Sustainability Model (PRISM)



<https://re-aim.org/learn/prism/>

The process of implementation: RE-AIM

- **Reach:** How do we reach the target population for PEACE (patients, clinicians + services)?
- **Effectiveness/Efficacy:** How do we know PEACE is effective?
- **Adopt:** How do we facilitate organisational support to allow for the adoption and delivery of PEACE?
- **Implementation:** How do we ensure PEACE is delivered properly?
- **Maintenance:** How can PEACE become standard practice, delivered over the long term?

Lessons learnt

Reach

- Good communication of rationale
- PEACE website
- PEACE huddles
- Induction pack & timetable

Effectiveness/Efficacy

- Continued evaluation + cross-site learning
- Ongoing research (Kate's group)

Adopt

- Buy-in at all levels (service users, clinicians & managers in all parts of the service)
- An enthusiasm for change + improvement with good existing clinical processes

Implementation


- PEACE website
- PEACE huddles
- **Continued attention** to necessary adaptations, to different patients and in different parts of the service

Maintenance

- **Ongoing work**
- Encouragement of collaboration across the service
- PEACE huddles, Lunch & Learn refreshers, PEACE conference and related training

Positive changes

- **AQ-10** embedded at assessment for all patients in all parts of the service
 - Facilitating consideration of autistic traits in formulation and treatment planning, right from the start
- Looking past **historical diagnoses**
 - ‘EUPD’ / ‘BPD’ can sometimes mean undetected autism (particularly if there is also historical trauma)

 AQ-10 Questionnaire

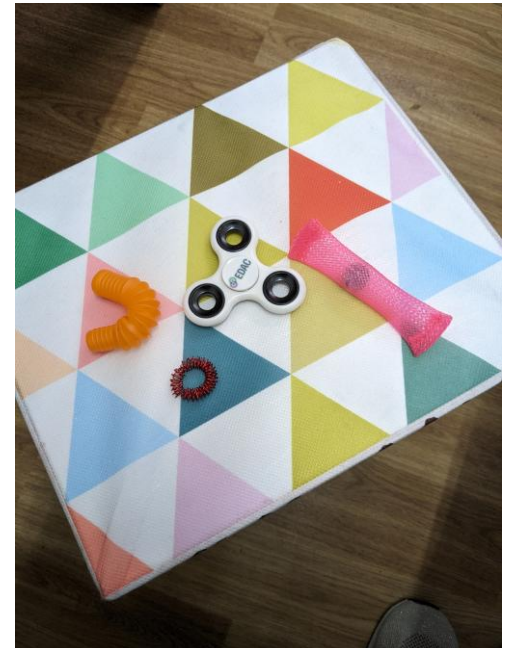
Patient Code: 4M4T7

These questions ask about your thoughts, feelings and behaviours. Please answer the questions below to the best of your ability.

I often notice small sounds when others do not	<input type="radio"/> Definitely agree <input type="radio"/> Slightly agree <input type="radio"/> Slightly disagree <input type="radio"/> Definitely disagree
I usually concentrate more on the whole picture, rather than the small details	<input type="radio"/> Definitely agree <input type="radio"/> Slightly agree <input type="radio"/> Slightly disagree <input type="radio"/> Definitely disagree
I find it easy to do more than one thing at once	<input type="radio"/> Definitely agree <input type="radio"/> Slightly agree <input type="radio"/> Slightly disagree <input type="radio"/> Definitely disagree
If there is an interruption, I can switch back to what I was doing very quickly	<input type="radio"/> Definitely agree <input type="radio"/> Slightly agree <input type="radio"/> Slightly disagree <input type="radio"/> Definitely disagree
I find it easy to 'read between the lines' when someone is talking to me	<input type="radio"/> Definitely agree <input type="radio"/> Slightly agree <input type="radio"/> Slightly disagree <input type="radio"/> Definitely disagree

Positive changes

- **Communication passports** used routinely regardless of neurodivergence
 - Benefitting all patients, and improving transitions between different parts of the service
- **New perspectives** on long-standing patients
 - Picking up autism which may have been historically missed
- **Sensory / grounding boxes**
 - Originally led by STRIDE team but recognised links with neurodivergence



Positive changes – day-services

- Day services **building** built with neurodiversity in mind
 - Colour scheme, possibility to change the temperature of rooms and lighting, low stimulus room and quiet room
- Access to **sensory boxes / ice packs / PEACE menu** if necessary
- **Sensory workshops** offered to the group

Positive changes – An example

- 37-year-old cisgender woman, 'J', known to our service for 15 years
- Oldest of two children, culturally diverse parents
- Dad diagnosed with autism in adulthood after a serious accident leading to short-term neurological damage
- Early unmet emotional needs secondary to maternal miscarriage and then postnatal depression after brother was born
- Emphasis in the family on achievement, 'good behaviour', social respectability and appearance

14 years: ~75kg, started to restrict eating

14 years: 44kg, diagnosed with AN-B/P

14 years: CAMHS input – mostly focused on restriction

14-18 years: ED a source of significant family stress/distress

19 years: Started university, BMI ~17

19-24 years: Severe BN, BMI 17-24

~22 years: Group CBT (NHS), individual CBT (privately)

24 years: Assessed in SLaM – deferred university

BMI 18.8, potassium <3.0

Referred to day-care

Eating disorder treatment age 24-37yrs

Treatment

Outpatient therapy (70 sessions alongside day-care) – CBT based with attention to emotion regulation and interpersonal difficulties

BMI 18.5-
19.5

Daycare (8 months) – discharged due to unauthorised absences

Step up day programme (1 month)

Inpatient admission (3 months) (including individual & family therapy)

BMI 14 –
17

Step up day programme (6 months)

Outpatient therapy (5 months) – risk management + formulation

Residential treatment (12 months) (including individual & family therapy)

BMI 15.5 –
~17.5

Medical monitoring/support + OT input

Longstanding EDs clinic

Outpatient schema therapy

Positive changes – Spotting autism

- Early sense of not fitting in
 - Obsessive detail-focused researching of suicide methods in 2015
 - Obsessive detail-focused preoccupation with physical health concerns in 2021
 - Perseverance of very rigid eating disorder routines
 - Interpersonal style – periods of poor eye contact, slow verbal responses, interactions that suggested dissociation but may instead reflect autism
 - Easily overwhelmed by interpersonal interactions and public spaces
-
- **Autism Quotient-10 (AQ-10):** 8/10 (screening threshold = 12)
 - **Ritvo Autism & Asperger Diagnostic Scale (RAADS-14):** 39 / 42 (screening threshold = 14)

Positive changes – Tailoring treatment

- Linking autism traits to our formulation and historical experiences
 - Links with early unmet emotional needs and a mismatch between resource and demand
 - Understanding of why things may have felt so hard and why ED symptoms became such a valued way of coping
 - Autistic identity – explored tentatively, not immediately engaged with by J
 - Links with Dad – somewhat challenging
- Communication passport
- Sensory toolkit
 - Hyper-vigilant to noise and light
 - Sensitive to certain textures – body image links
- Acknowledging need for routines and thinking on what could be an alternative to ED
- Referred for formal assessment (J's request)
- Ongoing story and still unwell with her ED...

Challenges and next steps



Challenges and next steps

- Updating learning as the team changes – and as evidence develops and our understanding evolves
- Keeping PEACE a priority in a challenging world
 - Regular review of PEACE huddle attendance and ways to maintain attention amongst competing priorities
- Embedding neuro-affirming care alongside detection of neurodivergence
- *Evidence-based* tailoring of outpatient therapies to autism (and ADHD)
- Continued collaboration with lived experience experts

Thank you

Questions?

Karina.allen@slam.nhs.uk