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State of the Art Lecture

State of the Art Lecture: Advances in (Adolescent) Eating Disorders Treatment

SOA0001

Advances in (adolescent) eating disorders treatment

J. Treasure
Institute of Psychiatry, Eating Disorders, London, United Kingdom

Over 30 years ago it was found that involving the family reduced relapse following inpatient treatment in adolescents with a short duration of illness (less than 3 years). This has been replicated, and has since been used as a standalone treatment, with various family permutations (separated parent/individual, multifamily therapy). The treatment is cost effective. For example the length of inpatient stay can be reduced if family therapy is added. Furthermore elements of the intervention have been delivered in self-help forms, sharing skills and information for carers. However 20–30% of cases fail to respond. In particular those who have been ill for over 3 years do not benefit. Non responders may be identified early in the course of treatment. Therefore work to develop new interventions to manage this group of patients is in progress.

Both family therapy and guided CBT are of benefit for binge eating disorder and bulimia nervosa but the evidence base is smaller. In this lecture I will review past evidence and consider new approaches.

Disclosure of interest.– The authors have not supplied a conflict of interest statement.

SOA0002

Planning ahead for acute mental health crises: Methods and outcomes

C. Henderson
King's College London Institute of Psychiatry – Psychology and Neuroscience, Health Services and Population Research, London, United Kingdom

The term 'advance statements' covers a range of interventions which vary with respect to their basis in legislation and the manner in which health professionals are involved in their creation. Advance directives lie at one end of this range because their content is determined solely by the patient. They have not been shown to have an effect on rates of involuntary hospitalisation. The most likely reason for this is that they are enacted only when the holder is deemed to have lost capacity to make treatment decisions.

Routine care plans lie at the other, paternalistic, end of the crisis planning spectrum, as they may be produced without any patient/consumer involvement, although by consensus this is not seen as good practice. Joint crisis plans (JCP) lie toward the centre of this spectrum, as an application of shared decision making. To achieve this, JCPs require an external facilitator, namely an independent third party, to complete the crisis plan. The facilitator, a mental health professional independent of the treatment team, aims to engage the service user and treating mental health professionals in writing the JCP.

The results of a randomized controlled trial of JCPs for people with psychotic or bipolar illness showed reduced use of involuntary hospitalization associated with their use and reported positive views of the plans by service users and mental health professionals, when compared with routine care plans. The larger CRIMSON multi-site trial found a positive effect on service user-rated therapeutic relationships, but no reduction in compulsory admission rate. There was clear evidence that the JCP process had not been fully implemented by many members of staff, because of attitudinal barriers to sharing clinical decision making powers with patients. Increasingly such implementation barriers are being recognised as critical brake on healthcare improvement. Implementation science may therefore be of use for translating the findings of the first trial into routine patient benefit.

Disclosure of interest.– I was the principal investigator for the first trial of joint crisis plans and a coapplicant on the CRIMSON trial.

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