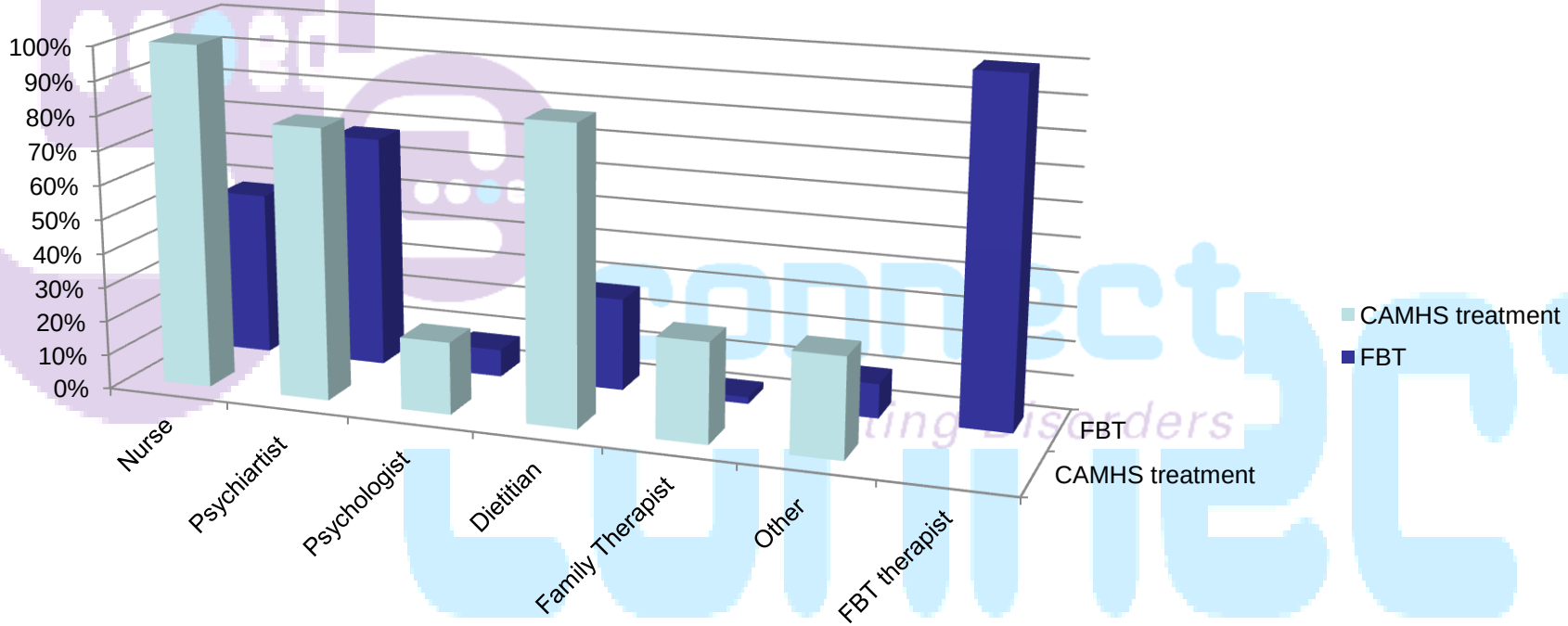
FBT WORKSHOP

CAMHS

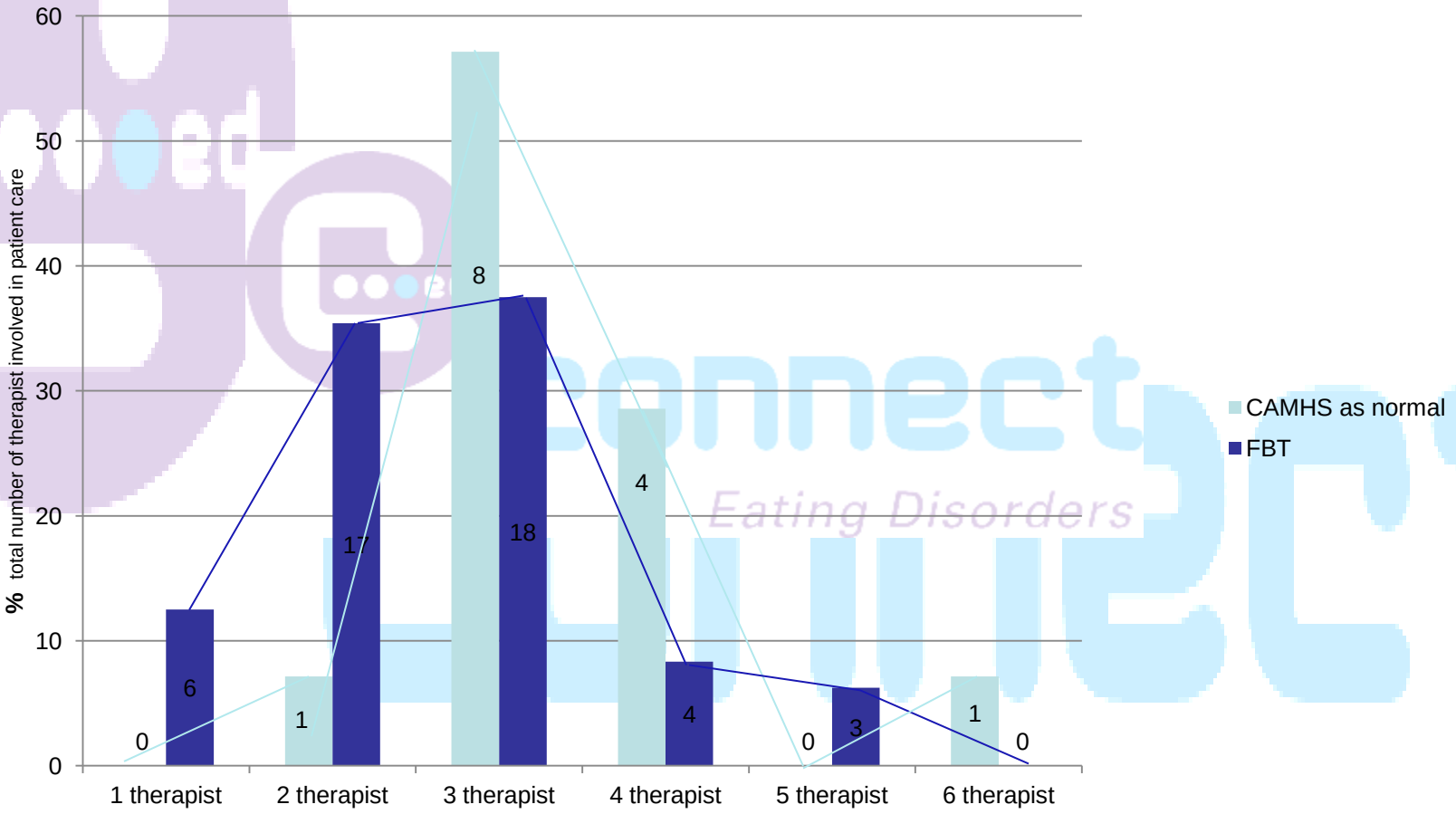
EATING DISORDER CONFERENCE

18th MAY 2016

Bar chart illustrating the percentage of therapists involved in the patients care within the treatment groups, CAMHS as normal and FBT.



The percentage and number of cases who had 1 – 6 therapists involved in their treatment, in the CAMHS as normal and FBT treatment groups.



Difference in the mean number of clinical sessions and the total number of therapists involved in cases, within specialist FBT treatment groups

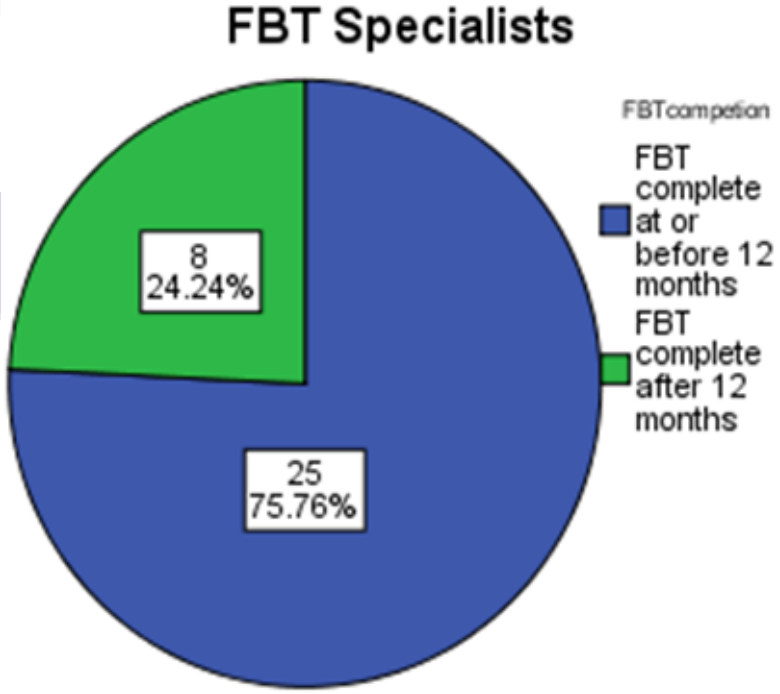
	FBT Specialists (n=33)		FBT Generalists (n=14)					Cohen's
Measures	M	SD	M	SD	*df*	*t*	p	*d*
Clinical sessions	23.3	19	32.6	15.7	46	1.6	.106	
Number of therapists	2.4	1.0	3	0.9	46	2.2	.034	0.3

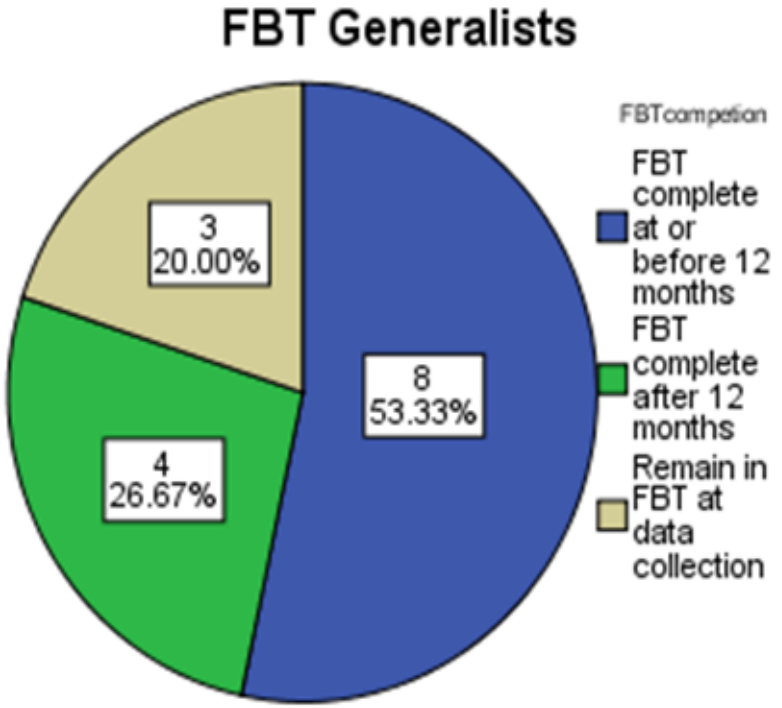
Mean number of sessions and therapists involved in treatment after 12 months of treatment or less if it completed before 12 months, across groups.

	CAMHS as normal Anorexia (n=6)		FBT Anorexia (n=25)		CAMHS as normal Atypical (n=8)		FBT Atypical (n=23)	
Measures	M	SD	M	SD	M	SD	M	SD
Clinical sessions	60	20.8	30	18	29	23.4	22	18.2
Number of therapists	3.6	0.5	2.8	1.1	3.2	1.1	2.4	0.9

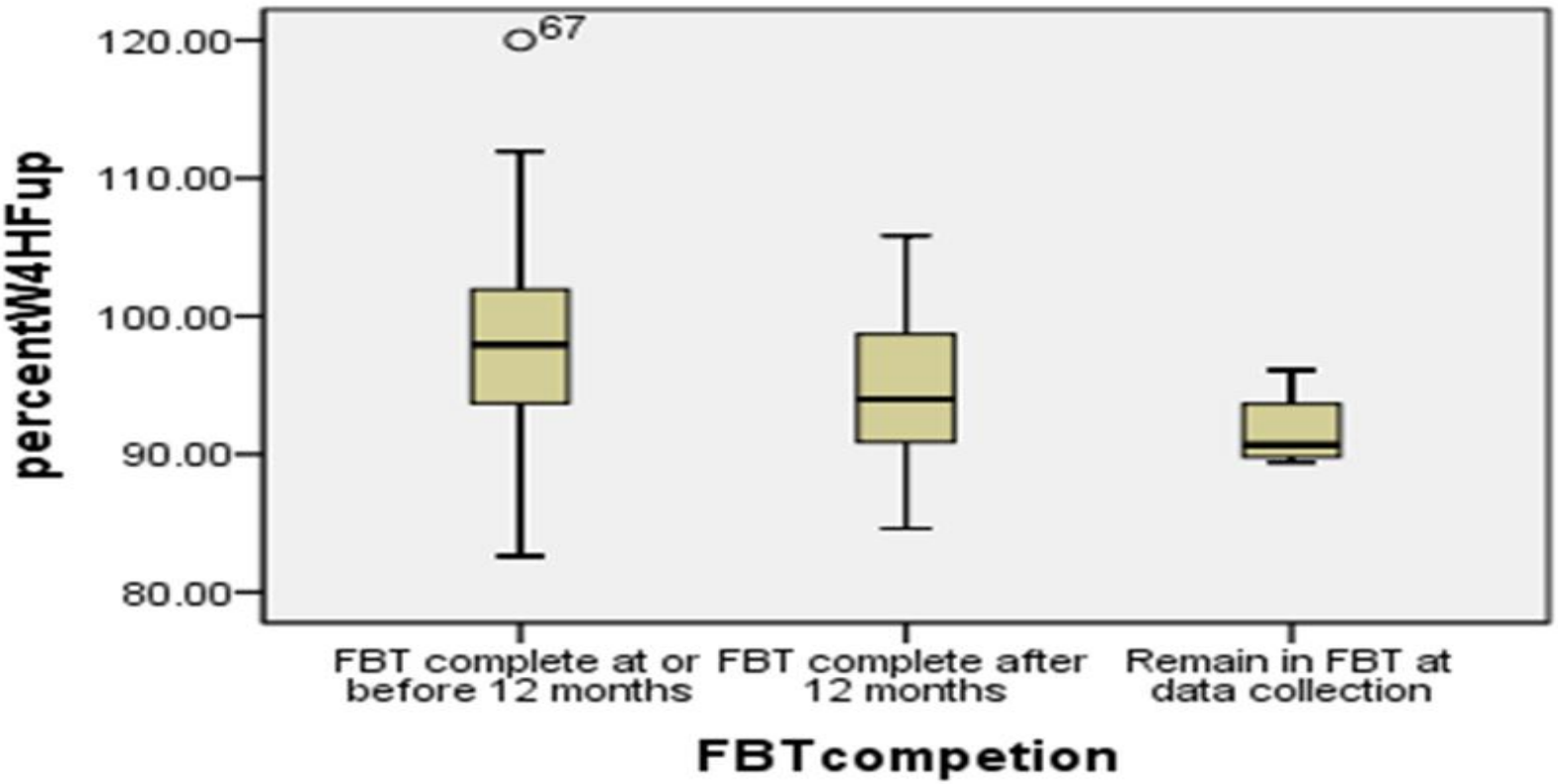
	Specialists Anorexia (n=16)		Generalists Anorexia (n=9)		Specialists Atypical (n=17)		Generalists Atypical (n=6)	
Measures	M	SD	M	SD	M	SD	M	SD
Clinical sessions	28	20	33	3.2	18	16.8	31	20.4
Number of therapists	2.5	1	3.2	1.1	2.2	0.9	2.8	0.4

Proportion of patients completing FBT treatment, before or after 12 months of treatment, by specialisation.





Distrubution of follow up % weight for Height in groups who completed at 12 months of treatment and those that did not.



FBT Specialist Clinics

2 clinics- 1 covering Glasgow
1 covering Clyde (satellite clinics)

2 FBT specialist clinicians deliver FBT and provide supervision to generic clinicians joining the clinic on a sessional basis

Live/ case supervision built in to clinic structure

Clinicians joining clinic will work towards accreditation in FBT

AIMS

- To identify early responders and non responders to FBT approach.
- To consider adjunctive treatment if required.
- To assist with the identification of factors that potentially impede progress
- To enhance the delivery of evidence based intervention as early as possible in the problem life cycle.

Considering Fidelity

- The aforementioned factors will influence the way in which the treatment is delivered in practice and will have an impact on Fidelity.
- Treatment Fidelity is the extent to which a therapeutic intervention is delivered as intended.
- Assessment of treatment fidelity is crucial to evaluating the effect of a treatment.
- In 2007 a review of 147 child and adult RCT's demonstrated that only 3.5% adequately measured fidelity.

What Fidelity ?

- Only one FBT dissemination study has reported on therapist fidelity to manualised FBT (Couturier 2014). Measured adherence only.
- Many clinicians continue to use the model without high fidelity to the manual (Couturier, Kimber & Jack et al 2013, Kosmerly, Waller and Robinson 2014)
- Research- practice gap; disjuncture between research evidence and what is routinely delivered in clinical practice.

Why try to close the Research Practice Gap ?

Measuring Fidelity

- FBT Fidelity Rating Forms (Research Interventions in AN)
- A coding manual and rating scale have been developed to assess therapist fidelity to the treatment model and techniques(Fitzpatrick et al 2015)
- Psychometric qualities (reliability and validity) of this rating scale are currently being studied and established.
- Makes explicit what is expected when implementing major strategies of FBT.

Components of Fidelity

- Adherence

"How well am I 'sticking to' the manual, delivering what is prescribed and avoiding what is proscribed?"

- Competence

"How skilled am I in delivering the intervention?"

Aspects of Fidelity

- Separating how well a task is executed from its outcome is key to assessing Fidelity.
- Focus is on how well therapist does at implementing the tasks and how faithful they are to the model.
- At times if an intervention is unsuccessful then the therapist may try a different approach and improve their fidelity rating by showing flexibility in implementation.
- Part of fidelity is noticing when a family is not on target the way we expect and taking time in the session to work towards this goal e.g./ parental alignment.

A session where Fidelity has been demonstrated throughout should build in intensity like Ravels Bolero skills building one on top of the other until the crucial point of charging the parents with renourishment.

Daniel Le Grange

Supervision

- The manual is a guide that regular supervision helps to bring alive.
- How you integrate the skills is important and improves with confidence and reflection.
- Opportunities come round again and again and represent key areas of learning.
- Integration of art and science. Playing the piano by sheet music versus playing by ear.

Learning in relation to implementation of FBT

Consolidating skills is complex and requires:-

- Adherence to FBT philosophy by clinician/team
- Fidelity to model/manual
- Sufficient caseload
- Supervision
- Preparation and reflection time
- Flexibility especially early in treatment

References

Couturier et al (2013) Understanding the Uptake of Family-Based Treatment for Adolescents with Anorexia Nervosa: Therapist Perspectives, Int JEatDisord 2013;46:177-188

Couturier et al (2014) Using a Knowledge Transfer Framework to Identify Factors Facilitating Implementation of Family Based Treatment, Int J Eat Disord 2014;47:410-417

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Fitzpatrick et al (2015) Conceptualizing Fidelity in FBT as the Field Moves Forward: How Do We Know When We're Doing it Right? ; Family Therapy for Adolescent Eating and Weight Disorders, New Applications ,Routledge

Forsberg et al (2015) Development and Evaluation of a Treatment Fidelity Instrument for Family-Based Treatment of Adolescent Anorexia Nervosa. Int J Eat Disord 2015; 48:91-99

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