Family Based Treatment Training and Implementation A model of Realistic Medicine?

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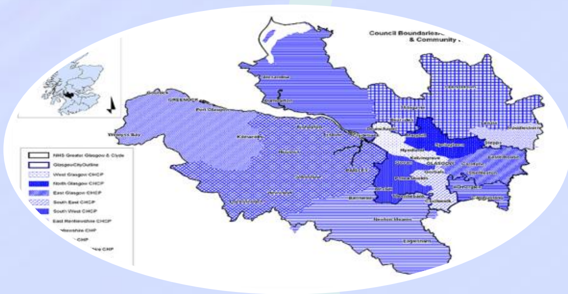
Why FBT?

ible – Practical – Achievable

South London and Maudsley NHS
NHS Foundation Trust



Requirement for better equitable care

New post Empowered to Innovate

...on with Young People families

- BEAT facilitated live chat with young people
- BEAT facilitated focus groups with young people and parents
- Group of families consented to be contacted about service developments

eatment as Normal"
from 12 months prior to FBT

l data collected at 12 months of treatment

Clinical Out comes: Weight gain, Menstruation

Total sample = 4.8 kg (p=.00; d=0.5)

- AN = 8.1 kg (p-.oo5; d=0.7)
- 39% were menstruating at 12 months

Process Outcomes : Total clinical sessions, number of therapists, admission, drop out.

- Total sample = 42.8 clinical sessions
- AN = 60 clinical session
- Number of therapist involved in care 3.6 (same in both)
- Admissions 22 %
- Drop out 26%

Clinician Lead
GGC → Scotland

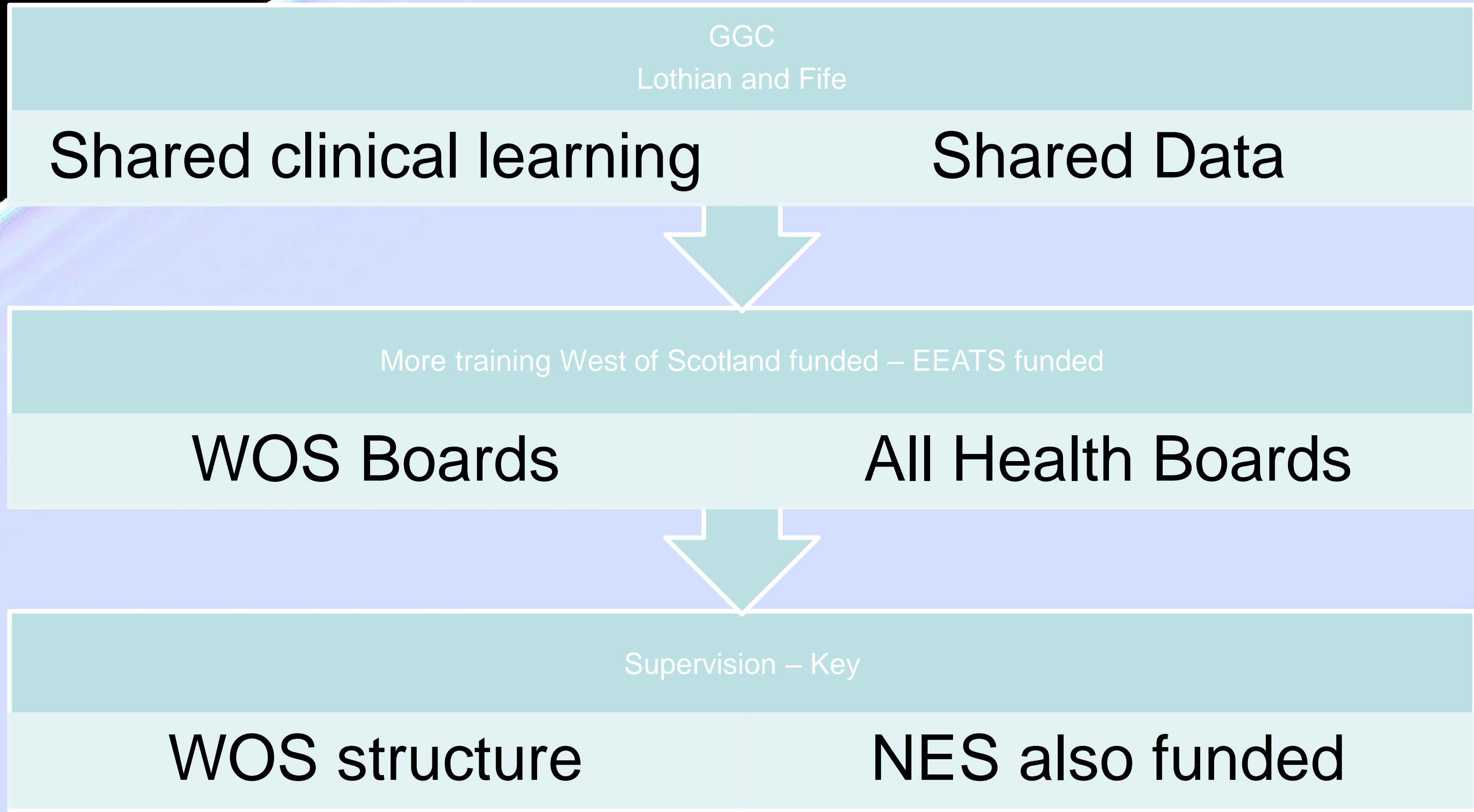
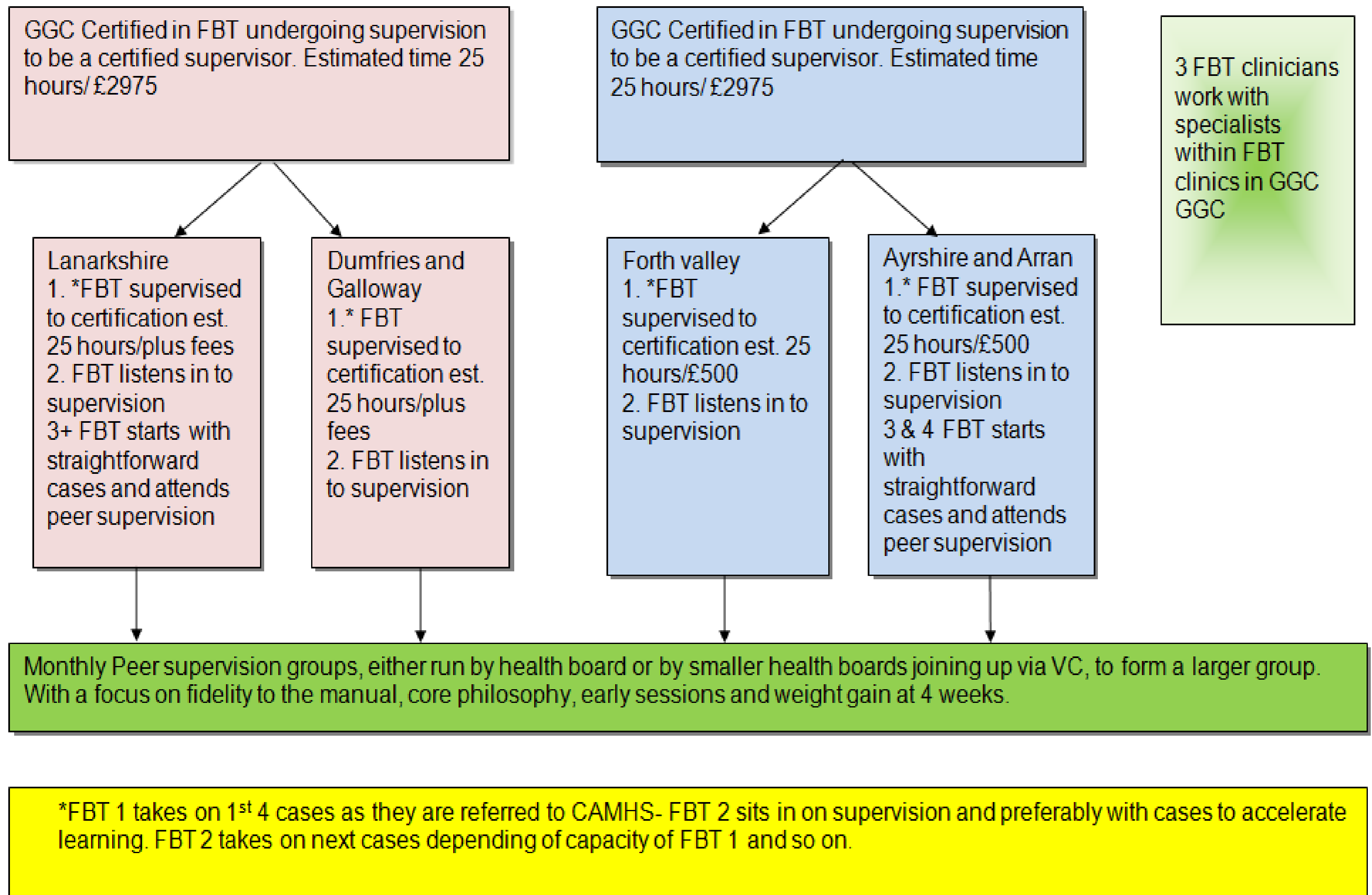
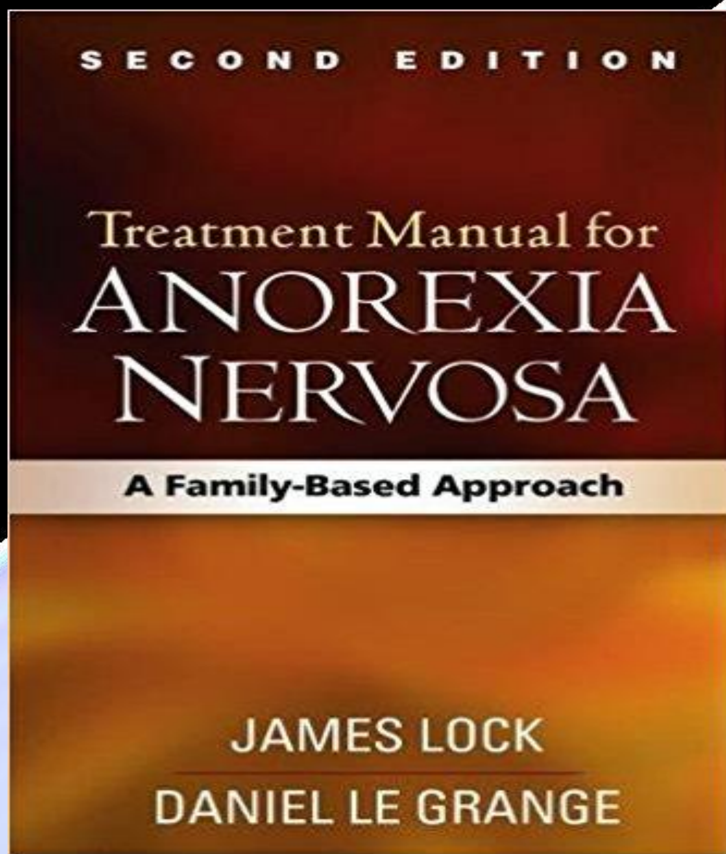


Diagram of proposed supervision structure, with estimated costs and time added. Each stage taking approximately 12 months. Stage 1. Completion of 2 x certified FBT supervisors GGC, 1 FBT certified in Lanarkshire, Dumfries and Galloway, Ayrshire & Arran, Forth valley. Enhanced learning for all FBT 2 clinicians in preparation for stage 2.



Stage: 2. Completion of FBT Certification for Dumfries & Galloway, Forth Valley, and for supervisor for Ayrshire & Arran and Lanarkshire



What is FBT?

12 month treatment in 3 phases:

1. Weight restoration parents/carers are in control
2. Control is relinquished back to the young person whilst continuing to restore healthy weight
3. Adjustment to developmental norms

NICE (2004)endorsed family interventions which directly addressed the eating disorder Bulik *et al*. (2007), systematic review of RCTs, family treatment, targeted at supporting parents in the task of re feeding their child, to be efficacious when patients were younger and the illness had not become chronic

…and Realistic Med

…ental principles form the theoretical basis for FBT:

1. an agnostic view of the cause of AN is taken, i.e. causation is not investigated;
2. there is an initial focus on symptoms;
3. a non-authoritarian consultative stance is taken by the therapist;
4. there is an emphasis on parental symptom management and empowerment of parents to take control of the eating disorder;
5. the illness is separated from the adolescent thus externalising the illness.

connect

Eating Disorders

GGC Evaluation Outcomes

Next Stages

Implementation

Dissemination and Implementation of evidence based treatment

- Evidence based therapies (empirically supported) are "rarely available and, even when they are, they are often delivered sub optimally". Shafran et al (2009).

- There is little research into the best way to implement evidence based therapy
  Davidson et al (2004); Sholomskas et al (2005), Sanders and Turner (2005),Trebka (2007), Grey (2008), Scott et al (2008), Shafran et al (2009).

- Adoption of Evidence Based Practice into clinical practice is complex & multifaceted process. Coulturier et al (2012)

Couturier J, Kimber M, Jack S, Niccols A, Van Blyderveen S, McVey G. Understanding the uptake of family-based treatment for adolescents with anorexia nervosa: Therapist perspectives. Int J Eat Disord. 2012

…on and Implementation

…an FBT be taken from the research setting implemented in generic CAMHS and be found to have

"*worked in everyday practice*"

(MRC report into evaluating complex interventions Craig, et al.,2008)

This study's aim was to evaluate the clinical and process related effects of the implementation of FBT

luation of FBT implementation in generic CAMHS in the UK, which s not been reported before.

The study included participants who had atypical Anorexia Nervosa and, although this brought some data analysis problems, this is a group of patients who are rarely studied but are prevalent within clinical settings.

3. The way that FBT was implemented enabled an evaluation of different methods of therapists acquiring therapeutic competence.
4. A greater number of service related outcomes were assessed than those reported in the literature, which enabled a greater depth of understanding in this area which is important at a time of limited resource within the NHS.
5. a pilot questionnaire was developed to assess how acceptable and effective the participants of FBT found the treatment. This is an area which has little previous investigation, despite the complexity of the therapy and demands it places on families
6. Additional analysis was undertaken to help inform further service development.

...nical outcomes

...at 12 months of treatment or before if complete prior to 12 months

Weight: Large treatment effect was found for both weight and W4H outcomes, for participants meeting weight thresholds for AN (p=.0, eta 9)and for the whole group (p=.0, eta 6-7).

- In the FBT group, there were 35 participants with secondary amenorrhea, of which 26 were ≤85% W4H, meeting weight thresholds for AN. Of the 35 participants with secondary amenorrhea at baseline, at the EOT 20 (57%) were menstruating, 14 (40%) remained amenorrheic, and the menstrual status was not recorded for the remaining 1 (3%).
- Wilcoxon signed rank tests found a significant difference in scores across all domains between baseline and EOT (R, p= .033; EC p=.011; WC, p=.027;SC, p=.021; GS p=.018). This therefore strengthened the analysis of a positive change in eating disorders cognitions of participants after FBT, although caution is required due to the small sample size

nical Outcomes

FBT n=60	**W4H %(SD)**	***Mean differenc e***	***df***	***t***	***p***	***eta squared***
84.6 (8.7)	94.5 (7.8)	9.5 (8.4)	59	8.79.	.00	0.6
FBT AN n=29						
77.9 (5.4)	93 (5)	15 (5.7)	28	14	.000	0.9

Weight gain Total sample 6.3 kg (4.8)
Weight gain AN 9 kg (8.1)

w many were well ”
on at 12 months of treatment

Remission criteria	FBT The current study		Comparative Studies	
	Sample	Met criteria (%)	Sample	Met Criteria (%)
1.≥95% W4H	50	24 (46)	78 14	26 (33)* 8 (57)**
2.≥85% W4H+Menses	29	18 (62)	167	32 (19)***
3.EDE-Q 1 SD of Norm + ≥95% W4H	16	11 (69)	61 13	26 (42)**** 4 (31)**
4. EDE-Q 1 SD of Norm + ≥85% W4H	16	16 (100)	13	7 (54)**

***Agras *et al.* (2014) FBT only **Couturier *et al.* (2010) *** Gowers *et al.* (2010) all participants ****Lock *et al.* (2010) FBT only.**

31 % Had not completed treatment when data was collected

Process related Outcomes

… was more efficient than 'CAMHS as normal …, with statistically significant differences in the total number …sions and the number of professionals involved in each case

FBT Process Outcomes : Total clinical sessions, number of therapists, admission, drop out.

- Total sample = 26 clinical sessions (42.8)
- AN = 39 clinical session (60)
- Number of therapist involved in care 2.6 (same in both) (3.6)
- Admissions 15% (22%)
- Drop out 10 % (26%)

Treatment Length

69% (n=33) had completed treatment at or before 12 months (mean length 6.9 months sd 3.1 months),

25 % (n=12) had completed after 12 months of treatment (mean length after 12 months 8.2 months sd 9.2 months)

6 % (n=3) remaining in treatment after the time of data collection

milies experience

- sponses were positive to both quantitative and qualitative ons, with little difference between responses of young people d carers, although carers were generally more positive

The experience and views participants had of the therapist was highlighted in both quantitative and qualitative responses as the most positive aspect of FBT.

- Median scores for all participants were 4 or above (i.e. a positive or very positive response) for domains Experience of treatment process, of therapist, of the treatment and Global, only exception for the expectation of treatment median score of 3.
- is there anything else you would like to share’ 93% were positive, expressing gratitude to the therapist/team, the effectiveness of FBT and recommending FBT
- a minority of participants highlighted a need for individual time, both for young people and carers.

usions / next Stages

ble to conclude that the way that FBT was implemented was "effective in everyday practice" *(*Craig, *et al.*, *2008, p. 7).*

- **Service considerations:** Ensure organisational support that is consistent with that employed in the current study by: Funding and capacity building: ensuring resources to employ FBT specialists – to build therapeutic competency, developing practitioner competency .

- **Clinically considerations:** to improve the efficiency of the service, patients should be highlighted when the following are present:
    1. Low baseline weights - <80% W4H
    2. Non-intact families
    3. Gained < 2.88 % W4H by 4 weeks of treatment
    4. Remain in stage 1 of FBT after 10 weeks of treatment

Next Stages

arch required to support the recommendations for policy
r FBT implementation:

Develop a method of assessing therapists buy-in to the FBT model and their motivation to improve their therapeutic skills

2. Develop an online test to ensure basic knowledge of the FBT manual
3. Develop a self-assessment fidelity check list based on Forsberg *et al.* (2015) measure.
4. Develop a measure of FBT therapist competence
5. Investigate the supervision requirements required to meet FBT therapeutic competence among a range of therapists with differing characteristics.

Scotland
ational Picture Unique

- Implementation ground up – clinician lead
- Whole nation approach – CAMHS ED Steering Group
- Training and supervision arrangement continue to rely on Stanford team
- Attempts are being made for FBT to stand alone in Scotland. Clinicians not able to do this alone.

Conclusions
Realistic Medicine?

Model of realistic medicine?

– What do you think?

Challenge of continued support for implementation training and sustaining gains made thus far

... Implementation

Model of realistic medicine?

- What do you think?