

The Role of Clinical Peer Supervision Groups in implementing clinical interventions effectively:

A report from the HSE Irish National Clinical Programme for Eating Disorders

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Introduction

Access to evidence based psychosocial treatment is a mainstay of good eating disorder care and is associated with better clinical outcomes and faster recovery⁽¹⁾. Clinician fidelity to treatment model is an important predictor of treatment reliability in mental health, but in eating disorder treatment therapist drift is observed in 66-85% of cases⁽³⁾.

An additional challenge is that comprehensive evaluation of clinical training programmes in healthcare is poorly understood and hard to implement, particularly in terms of impact on clinical practice and patient outcomes⁽³⁾.

The aim of the National Clinical Programme for Eating Disorders is to improve the quality, access and cost effectiveness of its eating disorder services, and this includes investment in specialist clinician training. The HSE therefore sponsored a series of national training initiatives in FBT and CBT-E, the two recommended first line treatments for adolescent and adult anorexia nervosa respectively, in 2014 and 2015. Following this, it supported the development of peer supervision networks across the country with the aim of maximising treatment fidelity and minimising therapist drift⁽⁵⁾.

Aim

To evaluate the impact of clinical peer supervision networks on mental health clinicians who are developing their eating disorder skills, in relation to treatment fidelity and knowledge translation of evidence based practice

Method

Sample:

All clinicians who had attended basic training were invited to participate in peer supervision groups. This included 73 clinicians from Child and Adolescent Mental Health Services (CAMHS) who had had FBT (Family Based Therapy) training and 62 clinicians from adult and CAMHS services who had attended CBT-E training.

Study Instrument:

An anonymised feedback questionnaire, that had been developed for an exploratory IPE project⁽⁶⁾ was expanded to include specific fidelity measures for FBT and CBT-E. The 19 item questionnaire also included items on clinician experience, learning and activity.

Data collection and analysis

The questionnaire was sent electronically to participants at approximately 4 months after the end of their training via Survey-monkey. Up to 2 reminders over a one month period were sent. Follow up surveys take place annually.

Descriptive statistical analysis was completed using Microsoft Excel. More complex analysis was not possible due to sample size.

Ethical approval:

As no patients were involved in this project, ethical approval was not required. The questionnaire included an option for clinicians to indicate if they did not want their feedback to be used in the analysis.

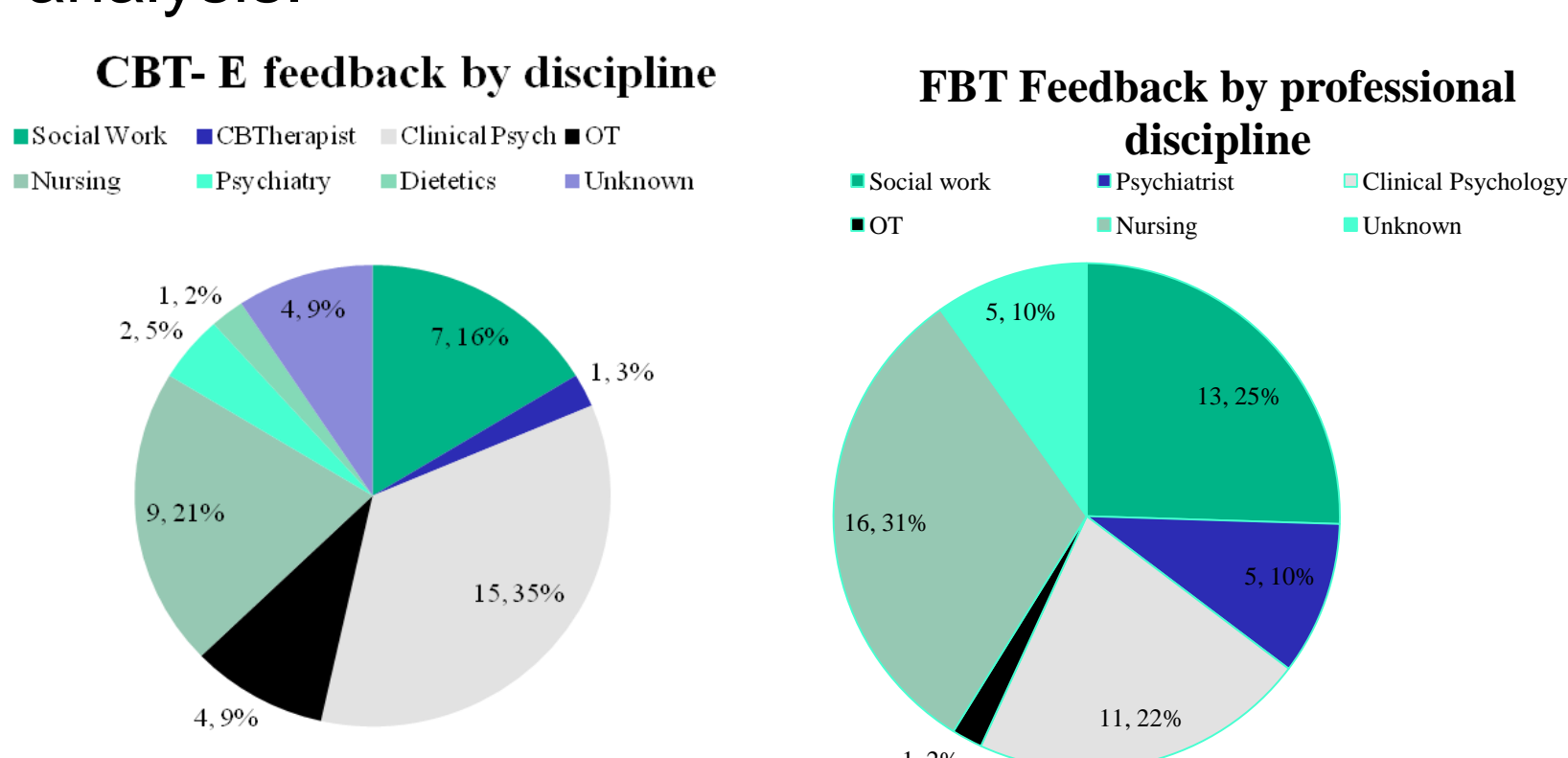


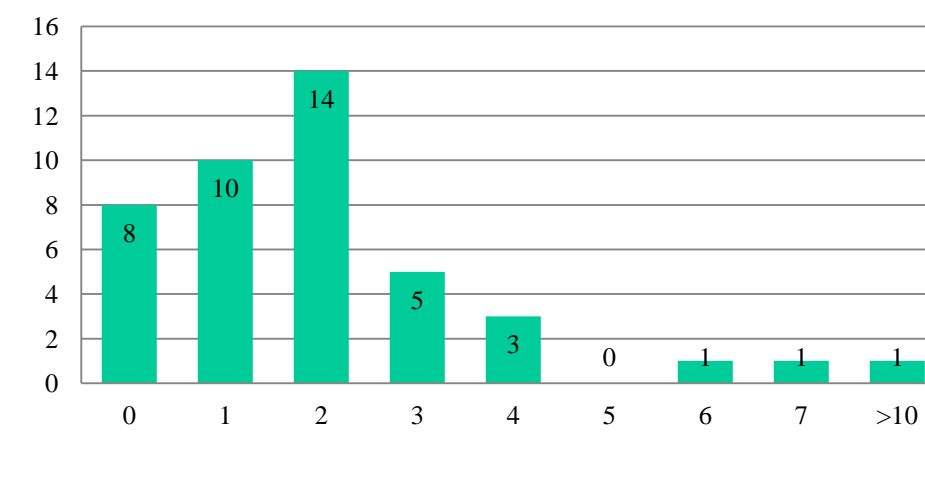
Figure 1: Professional discipline of the participants

Results

A total of 51 (70.8%) and 43 (69.4%) participants responded to the FBT and the CBT-E follow up surveys respectively, and 50% responded overall to the second survey. At time one, 26 (41.9%) of the CBT-E clinicians and 27 (75%) of FBT clinicians attended one of 11 clinical supervision groups nationally. This amounted to 54 clinicians.

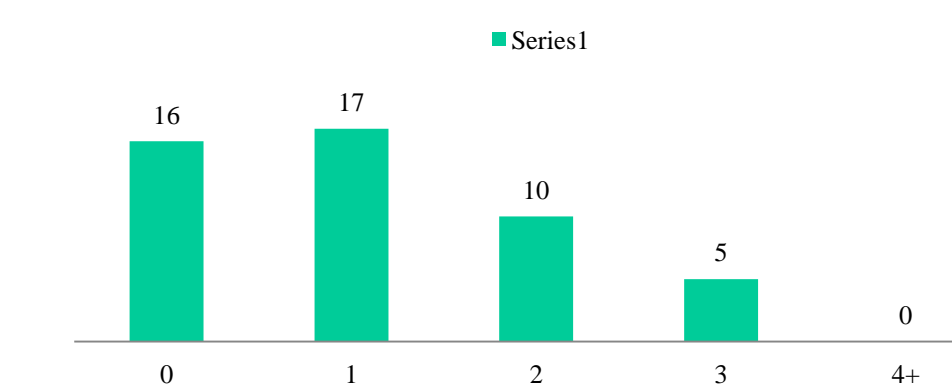
At time 2, due to coming and going of group membership, it was not possible to reliably track individual attendance. Figure 1 summarizes the core professional background of each training group.

CBT-E case activity at 4 months



Figures 2 and 3: New case activity at 4 months:

FBT- Case activity at 4 months



Fidelity to evidence base and FBT Model at 4 months

Thirty four clinicians (66%) had commenced or had switched patients to FBT since the training event, with 29 (56.8%) having updated care plans to include it. Thirty six (70%) had shared information about FBT and its evidence base with CAMHS coworkers. However, although confidence in using FBT increased, fidelity to the FBT model was variable with 19 of (54.3%) reporting that they had completed the family meal with every case (Figure 4). It was found that attendance at a eating disorder peer supervision group was a protective factor in terms of FBT activity, confidence and fidelity (Figure 5).

Fidelity measure	Never 1	Seldom/Occasional 2	Frequent 3	Always 4	not sure	Tot
Providing feedback on weight	2	3	7	28 (70%)	0	40
Externalising the eating disorder	0	4	8	28 (70%)	0	40
Charging the parents with refeeding	1	6	6	29 (69%)	0	42
Remaining focused on the eating disorder	1	4	9	28 (66.7%)	0	42
Modifying family criticism (if present)	0	4	9	25 (64.1%)	1	39
Reducing parental guilt	0	4	12	22 (57.9%)	0	38
Grave but sincere greeting	1	4	10	22 (55.9%)	1	38
Family meal	8	5	3	19 (54.3%)	0	35

Figure 4: Fidelity to core components of FBT

Impact of attendance at a peer supervision group

Attendance at a eating disorder peer supervision group was a protective factor in terms of FBT activity, confidence and fidelity (Figure 5).

ED Hub	Yes (n = 27)	No (n = 22)
Lifetime >10 Childhood ED cases	62.96%	40.92%
Current individual caseload	Median = 4 (1-7); Mean = 4.05	Median = 1 (0-4); Mean = 1.95
Current FBT cases per clinician	Median = 2 (0-6); Mean = 1.48	Median = 1 (0-3); Mean = 0.86
Local ED 'lead'	81.48%	36.36%
Reviewed fidelity measures	87.5%	33.33%
New FBT cases started or switched since training	Median = 1 (0-4); Mean = 1.14	Median = 1 (0-3); Mean = 1.1
Updated care plans	69.23%	50%
Feedback to team	73.08%	80.95%
Confidence in ED treatment	Median = 3; Mean = 3.12/4	Median = 3; Mean = 2.64/4
FBT perceived knowledge	Median = 3	Median = 3
FBT perceived clinical proficiency	Median = 2; Mean = 2.42	Median = 2; Mean = 2.24
Top barriers	Other clinical demands (57.69%); Lack of supervision and groups (54.17%)	Other clinical demands (68.47%); Lack of supervision/ and groups (78.95%)

Figure 5: Impact of peer supervision group participation on activity

Fidelity to CBT-E model and evidence base.

Of the 35 clinicians who reported that they had used CBT-E, 28 completed the fidelity section as displayed in figure 6. Clinicians tended to underestimate their overall fidelity to CBT-E compared with individual items

CBT-E Fidelity measures	Never				Always	N.
	Occasionally	Frequently	Always	N.		
Introducing regular eating	1	2	25 (89.3%)	28		
Weekly collaborative weighing	2	1	23 (82.1%)	28		
Providing psycho educational material	1	7	19 (67.9%)	28		
Introducing real time recording	1	8	19 (67.9%)	28		
Sharing the personalised formulation	1	1	18 (64.3%)	28		
Taking stock after stage 1	1	5	14 (51.8%)	27		
Initial CIA	5	7	14 (50%)	28		
Setting the agenda	2	3	14 (50%)	28		
Use of stage 3 pie chart	2	5	14 (50%)	28		
Address dietary restriction	1	2	11 (45%)	28		
Address body image issues	2	4	11 (39.3%)	28		
Initial EDE-Q	4	6	11 (39%)	28		
Involving significant others if appropriate	4	4	10 (35.7%)	28		
Address feeling fat	2	2	9 (32.1%)	26		
Rate your overall fidelity to the CBT-E model	2	7	6 (21.4%)	28		

Figure 6: Fidelity to core elements of CBT-E

Impact of attendance at peer supervision group

19 of the 43 CBT-E trainees (44.2%) were also attending regular monthly peer supervision groups. Their median caseload did not differ between groups (Med =2), but the mean was higher in those who were attending peer supervision (2.83 v 2.1), as was confidence in working with CBT-E

Barriers

Both groups reported similar barriers to implementing evidence based treatments in practice including not having enough referrals or cases (1/3), no protected time for eating disorder work, other work priorities (27.9%), comorbidity i.e. the team made a decision to support another treatment (36.9%) and a lack of coworkers.

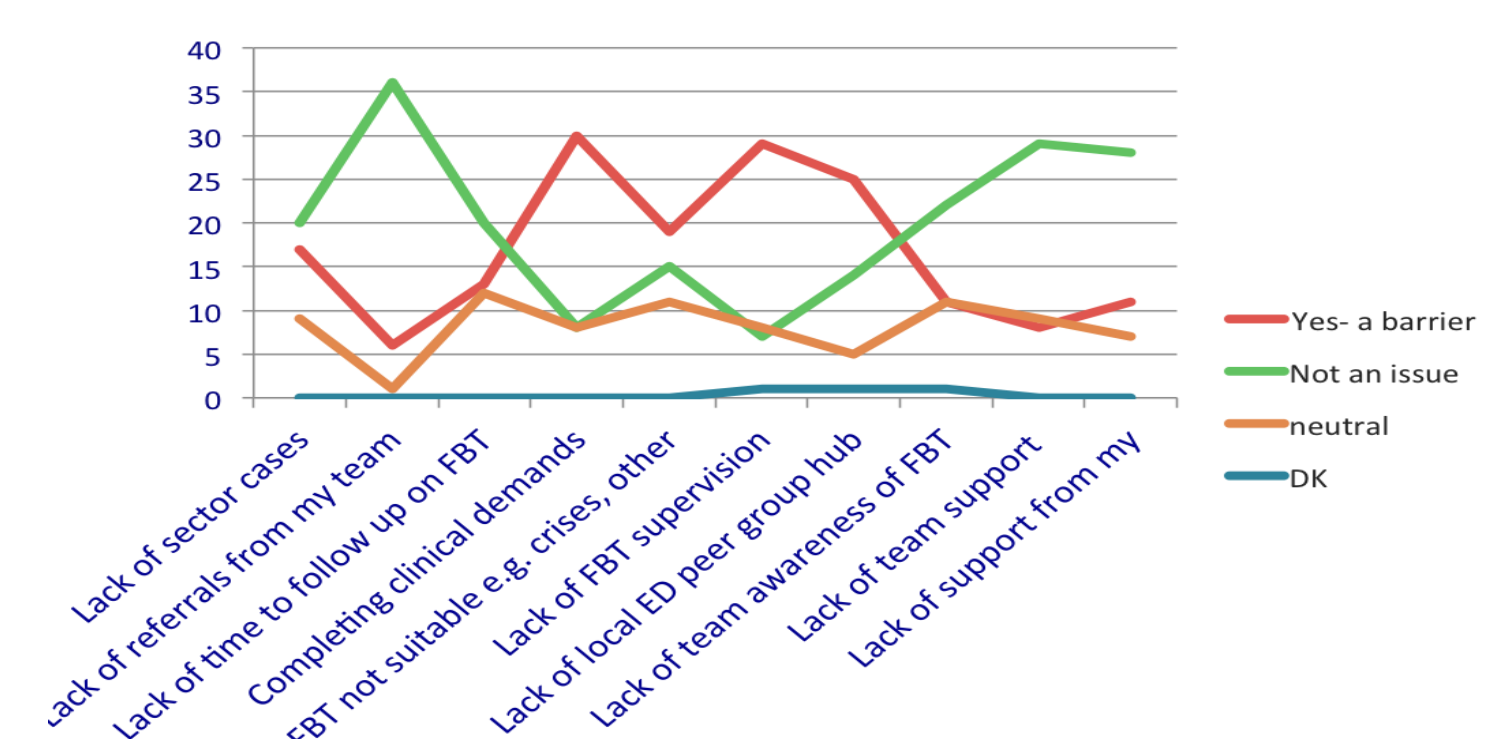


Figure 7: Barriers to implementation of FBT

Discussion

Our findings support the view that it is challenging for clinicians working in a generic mental health services to develop and implement their specialist skills in eating disorders following training, irrespective of treatment model. Clinicians in such services often do not see enough patients with eating disorders or have enough coworkers to work with. This has implications for the delivery of eating disorder care as many patients do require access to local mental health services for their eating disorder treatment.

The tendency we found towards the protective effects of peer group supervision has implications for line managers, and suggests that they should ensure that clinicians have protected time for peer supervision groups if any training to be optimised for patient benefit. It was interesting to note that even in the FBT group, which had involved just one training event, participation in a peer CPD group was associated with a tendency towards improved clinical confidence, better use of fidelity measures and higher number of cases started..

Limitations to this study include the self report nature of the study instrument and small sample size in terms of analysis.

References

- NICE (2017) Eating Disorders Recognition and Treatment. Full Guideline-Methods, evidence and recommendations
- Waller G (2009) Evidence- based treatment and therapist drift. Behaviour Research and Therapy; 119-127
- Peterson, CB, Becker, CB, Treasure J al (2016) The three legged stool of evidence- based practice in eating disorder treatment: research, clinical and patient perspectives. BMC Psychiatry, 2016,14:69
- Goldie J (2006). AMEE education Guide No 29: evaluating educational programmes. J Med Teach 29(1):66
- HSE (2018). Model of Care for Eating Disorder Services
- McDevitt SC and Passi V (2015) Evaluation of a pilot interprofessional education programme for eating disorder training in mental health services. IJMP, DOI: 10.1017/ijmp.2015.61. 1-11