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Development of a scale to measure fidelity to manualized group-based cognitive behavioural interventions for people with intellectual disabilities

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ABSTRACT

The context for the present study was a cluster-randomized controlled trial of a group-based anger-management intervention, delivered by day-service staff. We aimed to develop a scale to measure the fidelity of manualized cognitive-behavioural therapy (CBT) delivered to adults with intellectual disabilities in group-based settings. A 30-item monitoring instrument (the MAnualized Group Intervention Check: MAGIC) was adapted from an existing fidelity-monitor instrument for individual CBT. Two sessions for 27 groups were observed by pairs of monitors who had no other contact with the intervention. 16 observers participated, in 15 unique pairings. Observers recorded high levels of inter-rater reliability and the scale had good internal consistency. Fidelity ratings predicted two key outcomes of the intervention, and were themselves predicted by the therapists' clinical supervisors.

1. Introduction

Cognitive-behavioural therapy (CBT) is the treatment of choice for many psychological disorders (DoH/CSIP, 2007; Roth & Fonagy, 2004). However, there is evidence that the effectiveness of therapeutic interventions decreases as therapies move from university-based research studies into routine clinical practice (Curtis, Ronan, & Borduin, 2004; Henggeler, 2004). In some cases, interventions that appear clearly efficacious may be ineffective in a community setting (Stevens, Glasgow, Hollis, & Mount, 2000), although equivalent outcomes may also sometimes be reported (Houghton, Saxon, Bradburn, Ricketts, & Hardy, 2010). The generally accepted 'technology model' of psychotherapy research (Carroll & Rounsaville, 1990; Waskow, 1984) involves three elements: specification of treatments in manuals; training and supervision of therapists to ensure that

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treatment is delivered as uniformly as possible; and monitoring of treatment delivery. Therefore, treatment integrity or fidelity checks are needed, in order to be able to monitor the extent to which treatments are delivered appropriately (Moncher & Prinz, 1991). There is evidence that community therapists who claim to deliver evidence-based interventions may do so to a very limited extent (Santa Ana et al., 2008; Waller, Stringer, & Meyer, 2012). This is despite the fact that the fidelity with which proven interventions are administered is known to be important for maintaining high levels of effectiveness (Bellg et al., 2004; Eames et al., 2009; Saini, 2009). The need for further development of CBT measures "to provide the needed technology for advancing CBT dissemination and implementation" has recently been highlighted (Simons, Rozek, & Serrano, 2013).

CBT is becoming increasingly available to people with intellectual disabilities, and has been shown to be effective, albeit the evidence base is small (Hatton, 2002; Lindsay, 1999; Taylor, Lindsay, & Willner, 2008; Willner, 2005). Much of the evidence comes from case studies, but there are also controlled trials in two areas, anger (Willner, 2007) and depression (McCabe, McGillivray, & Newton, 2006). However, there are as yet few manualized treatments, and none of the published studies have monitored the fidelity of treatment delivery. The present study was conducted within the framework of a cluster randomized controlled trial of a manualized anger-management intervention for people with intellectual disabilities (Willner et al., 2011, 2013a, 2013b). Anger is an area where the inclusion of fidelity checks is associated with better clinical outcomes in the general population (Saini, 2009). Like much of the published literature on CBT for people with intellectual disabilities, our intervention was group-rather than individual-based. Fidelity-monitoring instruments are usually developed for use with individual therapy, and while some of the existing instruments have been adapted for use in a group-based context (Young & Beck, 1980), they do not take into account the particular social and communication skills that are needed when working with people who have intellectual disabilities (Lindsay, Jahoda, Willner, & Taylor, 2013). In order to monitor treatment fidelity in our randomized controlled trial, we therefore needed to develop an instrument that would take into account both the group context and the client group. Another feature of the trial was that the intervention was to be delivered by 'lay therapists' (day-service staff). There is evidence that 'paraprofessionals', working under supervision following minimal training, can deliver effective manualized CBT (Montgomery, Kunik, Wilson, Stanley, & Weiss, 2010), and this strategy has previously been used to deliver interventions for anger (Willner, Brace, & Phillips, 2005) and depression (McGillivray, McCabe, & Kershaw, 2008) to people with intellectual disabilities. The use of 'lay therapists' in our trial made it particularly important to be able to monitor the fidelity of treatment implementation, in order to evaluate the effect of this factor on outcomes.

The scale developed for the purpose of this study was an adapted version of the Cognitive Therapy Scale for Psychosis (CTS-Psy) devised by Haddock et al. (2001) to assess the competence of therapists carrying out CBT with people who have psychosis. The scale includes ratings on both structural and process elements of therapy, along with global quality ratings. Structural components include setting an agenda and the use of homework tasks, whereas process elements include an attempt to foster a collaborative relationship and promoting understanding through communicating effectively. A key aim of Haddock et al. (2001) was to make the scale sensitive to the therapists' ability to apply the therapeutic processes flexibly, to ensure the approach remained accessible to people with psychosis who had impairments such as an inability to pick up social cues or problems with emotional regulation. This goal of examining the therapists' ability to make CBT accessible to people with psychological impairments is what makes this scale applicable for therapists using CBT with people who have intellectual disabilities. It has already been successfully used to examine the treatment fidelity of psychologists working with people who have intellectual disabilities and a range of emotional difficulties, including anxiety, depression and anger problems (Jahoda et al., 2009). Hence, the published scale (Haddock et al., 2001) was considered an appropriate starting point for the development of a measure to examine the fidelity and competence of therapists implementing group-based CBT interventions for people with intellectual disabilities.

To summarize, while there are fidelity scales suitable for monitoring CBT interventions with groups (Young & Beck, 1980) and with individuals with intellectual disabilities (Haddock et al., 2001), the aim of the present study was to develop and validate an instrument that would be suitable for monitoring the delivery of a CBT intervention to groups of people with intellectual disabilities. Bellg et al. (2004) identified five areas in which researchers should strive for fidelity: study design, training providers, delivery of treatment, receipt of treatment, and enactment of treatment skills. The instrument described here, the MAnualized Group Intervention Check (MAGIC), addresses the third of these areas, the delivery of treatment, in relation to a manualized group-based intervention.

2. Methods

2.1. Setting

The setting for this study was a cluster randomized controlled trial (RCT) of a manualized CBT intervention (Willner et al., 2011). Ethical approval for the trial was granted by the South East Wales Research Ethics Committee. Participants attended local authority or independent sector day services, and were included in the trial on the basis that they were identified by service staff as having problems in managing anger, wished to learn to improve their anger management skills and were able to provide informed consent and complete the assessments. Potential participants were excluded if they were attending the service for a reason other than a diagnosed intellectual disability, currently receiving or requiring an urgent referral for individual treatment of anger or aggression, or experiencing circumstances indicating that a Protection of Vulnerable Adults