



Shorter communication

Therapist effects and moderators of effectiveness and efficiency in psychological wellbeing practitioners: A multilevel modelling analysis

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ABSTRACT

Objectives: The study investigated whether psychological wellbeing practitioners (PWPs) working within the UK government's Improving Access to Psychological Therapies (IAPT) initiative are differentially *effective* (i.e., therapist effect size) and differentially *efficient* (i.e., rate of clinical change), and the moderating effect of demographic and process factors on outcomes.

Design and Methods: Routine clinical outcome data (depression, anxiety, and functional impairment) were collected from a single IAPT service. A total of 6111 patients were treated by 56 PWPs. Multilevel modelling (MLM) determined the size of the therapist effect and examined significant moderators of clinical outcomes. PWPs were grouped according to below average, average, and above average patient outcomes and compared on clinical efficiency.

Results: Therapist effects accounted for 6–7% of outcome variance that was moderated by greater initial symptom severity, treatment duration, and non-completion of treatment. Clinically effective PWPs achieved almost double the change per treatment session. As treatment durations increased beyond protocol guidance, outcomes atrophied. Treatment non-completion was particularly detrimental to outcome.

Conclusions: PWPs appear to be differentially effective and efficient despite ostensibly delivering protocol driven interventions. Implications for services, training, and supervision are outlined.

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1. Introduction

Accumulating evidence suggests that individual therapists differentially affect outcome – that is, *therapist effects* exist regardless of treatment modality (e.g., Crits-Christoph et al., 1991; Lambert & Okiishi, 1997; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007). Methodologies that reflect and model hierarchical data are vital in therapist effects studies. Multilevel modelling (MLM) enables the variance at multiple hierarchical levels to be analysed, reflecting the fact that patient outcomes are nested within therapists (Raudenbush & Bryk, 2002). MLM also models random effects (Crits-Christoph, Tu, & Gallop, 2003). Therapist effects for high intensity therapists typically account for between 5 and 10% of outcome variance, with 8–9% most commonly reported (e.g., Crits-

Christoph et al., 1991; Crits-Christoph & Mintz, 1991; Kim, Wampold, & Bolt, 2006). This evidence base has, however, been criticised for being founded on studies with typically small sample sizes (e.g., often around 20–120 patients with 5–20 therapists). Accordingly, studies utilising large-scale routine practice data sets have been recommended (Elkin, Falconnier, Martinovich, & Mahoney, 2006).

In contrast to traditional or high-intensity delivery models of therapies, considerably less attention has been paid to therapist effects with low-intensity interventions (e.g., Almlöv, Carlbring, Kallqvist, Paxling, & Cuijpers, 2011), despite increasing use of such interventions in clinical practice. Improving Access to Psychological Therapies (IAPT) is a UK-based national initiative that has created a new workforce of Psychological Wellbeing Practitioners (PWPs). PWPs provide low intensity interventions for mild to moderate anxiety and depression, within a cognitive behavioural therapy (CBT)-based stepped care model. PWPs act as 'self-help coaches' rather than traditional therapists. To date, two studies have examined therapist effects during the delivery of PWP

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interventions. Green, Barkham, Kellett, and Saxon (2014) carried out a multisite study and found that PWPs ($N = 21$) accounted for 9–11% of patient ($N = 1122$) outcome variance, but the findings may have been confounded by unmodelled service level effects. Ali et al.'s (2014) single site study found that PWPs ($N = 38$) accounted for only 1% of patient ($N = 1376$) outcome variance. The study included sessions as a level in the model, which may have accounted for the lower effect and was limited by not controlling for patient severity.

The present study addresses potential limitations in the reported studies by using a large N routine dataset meeting stringent guidelines for MLM sampling (Maas & Hox, 2004) as well as ruling out undetected service level effects by drawing on a single service setting. The study also extends the PWP evidence base by investigating moderators of outcome for low intensity interventions. Vocisano et al. (2004) found that increased caseloads negatively impacted on high intensity therapist effectiveness. Intake severity has been found to be a significant predictor of outcome (Gyani, Shafran, Layard, & Clark, 2013) and a moderator of therapist effects (Saxon & Barkham, 2012). Similarly, patient dropout from treatment relates to both poorer outcome (Brorson, Arnevik, Rand-Hendriksen, & Duckert, 2013) and therapist effect moderation (Kim et al., 2006). Patient deprivation is also associated with poorer outcomes (e.g., Muntaner, Eaton, Miech, & O'Campo, 2004), whereas employment is related to more positive outcome (e.g., Ostler et al., 2001). Given this range of factors, the current study placed an emphasis on the following: patient deprivation, employment status, initial patient severity, treatment completion, and PWP caseload.

Efficient use of time and resources is a key aspect of stepped care (Care Services Improvement Partnership, 2008), with low intensity treatments defined partly by their brevity. Ali et al. (2014) called for future therapist effects studies to embrace a wider variety of outcome indices. Accordingly, a second research question focused on the extent to which effective PWPs were also differentially *efficient* in their clinical work (i.e., generating greater change per session). Efficiency is distinct from effectiveness in that it is possible for a practitioner to be effective in achieving good patient outcomes but to take, for example, twice as many sessions to achieve the same outcome as another practitioner. Low intensity work generates high throughput using low level psychological input and large caseloads (CSIP, 2008; Richards & Whyte, 2009). Hence, PWP efficiency is critical.

Accordingly, the aims of the study were three-fold: (1) to determine the magnitude of PWP therapist effects, (2) to investigate the impact of moderating factors, and (3) to determine whether more effective PWPs were also more efficient.

2. Method

2.1. Design and participants

Routinely collected data over three years (2011–2014) were used from patients receiving one-to-one treatment at step two from a single citywide IAPT service. Ethical approval for the research was granted by the National Research Ethics Service

(NRES) London, City and East Committee (ref 13/LO/0505).

Treatment episodes were defined as two or more consecutive treatment sessions with the same PWP within the same care episode. Outcome and session data for 7454 low intensity one-to-one treatment episodes (7123 patients treated by 85 PWPs) were provided by the service. Three inclusion criteria were applied: (1) first and last session scores were required, as well as data for all variables under consideration, (2) the maximum gap between any two sessions in a treatment episode was <180 days, and (3) only the first instance of treatment per patient was included. A fourth key inclusion criterion was applied to practitioners to ensure there was sufficient data to determine therapist effects as well as following recommendations in the literature (Soldz, 2006). This required PWPs to have treated ≥ 30 patients.

Applying these inclusion criteria yielded the final study sample of 6111 treatment instances (6111 patients treated by 56 PWPs). Of these included treatment instances, 98% ($N = 5996$) had ≤ 90 days maximum between treatment sessions and 92% ($N = 5637$) had ≤ 60 days maximum between treatment sessions.

Almost every outcome score corresponded to a PWP session. However, outcome measures in computerised CBT (cCBT) cases were frequently completed outside of sessions, due to the nature of the work. cCBT outcome scores were therefore assigned to sessions if: (a) the session and the non-session score were adjacent (i.e., no other sessions in between), (b) no score was available for the session, and (c) the measure was completed within 30 days of the session.

2.2. Measures

A battery comprising three outcome measures was administered each session. Higher scores on all three measures indicate greater severity.

The Patient Health Questionnaire-9 (PHQ-9) is a measure of depression (scored 0–27) with strong validity and reliability (Cronbach's $\alpha = 0.89$, intraclass correlation = 0.84; Kroenke, Spitzer, & Williams, 2001).

The Generalized Anxiety Disorder-7 (GAD-7) is a measure of anxiety (scored 0–21) with similar validity and reliability (Cronbach's $\alpha = 0.92$, intraclass correlation = 0.83; Spitzer, Kroenke, Williams, & Löwe, 2006).

The Work and Social Adjustment Scale (WSAS) is a measure of functional impairment (scored 0–40) with good internal validity and test-retest reliability (Chronbach's α range = 0.70 to 0.94, test-retest correlation = 0.73; Mataix-Cols et al., 2005; Mundt, Marks, Shear, & Greist, 2002).

An index of multiple deprivation (IMD) derived nationally from weighted area-level aggregations of specific deprivation dimensions (Noble, McLennan, Wilkinson, Whitworth, & Barnes, 2008) was associated with each patient based on geographical postcode (0–100 continuous scale, higher scores indicate greater deprivation). Employment status and treatment ending type were both categorical variables. Ending type was determined by PWPs and their supervisors using standardised IAPT categories and procedures. An estimate of caseload per clinic day was calculated using the formula below (given PWP j).

$$\text{Average caseload}_j = \frac{\text{total sessions}_j}{\text{clinic days per week}_j \times \text{weeks from PWP's first session to last session}_j}$$

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