Author's response to reviews

Title: Implementing Cognitive Behavioral Therapy in the Real World: A Case Study on Innovation in Public Mental Health

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Dear Editors:

We appreciate the opportunity to respond to suggestions from you and the reviewers to improve our manuscript, now entitled, “Implementing Cognitive Behavioral Therapy in the Real World: A Case Study of Two Mental Health Centers” (#6499768001287739). We have significantly revised this manuscript to reflect the concerns notated in both reviewers’ reports:

Reviewer #1:

- “I recommend the authors edit the manuscript to focus more squarely and concisely on the “real world” aspects (such as the data summary provided in the paragraph above and on pages 7-8) and remove much of the speculation presented in the “conclusion” section (most of page 11).” The results section has been modified to more clearly emphasize the findings summarized by Dr. Fixsen. Specifically, we detail the number of eligible clinicians trained, number of clinicians providing CBT, number of adolescents receiving CBT, and number of sessions in which CBT is provided. We have also revised the discussion section so that it primarily addresses these results and incorporates comments by clinicians that may inform future implementation efforts.

- “I am not sure what Table 2 adds to the study. Having one more list of “reasons why I think things did not work” may not be useful.” Table 2 has been revised to provide specific comments from clinicians supporting the various categories of inhibiting/activating variables. This format is more consistent with a manuscript based, in part, on qualitative data.

Reviewer #2:

- “The review of Rogers’ work does not note that there are characteristics of the adopter that influence when in the technology life-cycle an innovation is likely to be adopted. Individual provider readiness and behavior are very important in this study, so some of this literature should be reviewed.” We have included a brief summary of Rogers’ work regarding adopter characteristics and the prominence these play in early adoption versus later adoption in the background section.
• “The methods section needs more detail on each clinic, e.g., number and percent of clients served, number and percent of clinicians from each site, and more detailed demographic characteristics.” We have provided additional information about the centers and participating clinicians in the methods section, page 7.

• “Please provide a better estimate of the number of clients served at each site. The overall estimate of 1000-2000 is not precise.” Please see the response to the comment above.

• “It would be helpful to know the average caseload per provider.” On average, full-time clinicians are expected to bill 24-26 hours per week, depending on their other administrative or supervisory responsibilities. Average caseload is 35-60 clients, depending on length of employment with the agency. This information is now provided in the text of the manuscript, page 7.

• “What are the usual organizational and supervisory structures and processes at each site that would support EBP implementation? For example, is individual and/or group supervision required for licensed or unlicensed staff? Is the introduction of once monthly supervision for the CBT implementation a change in usual activities?” Information on supervision requirements for licensed and unlicensed clinicians is provided on page 10.

• “Please specify the actual “n” and proportion of the sample that was female.” All clinicians were female with one exception; this male therapist was enrolled in the intervention group (see page 12). There were 21 (62%) female and 13 (38%) male adolescents enrolled in the study (see page 13).

• “On page 14 in the “Adoption” section, there is insufficient documentation to assure that the chart reviews are accurate. Is it possible that CBT was being provided but not documented in the case notes?” The medical record review process is elaborated on page 8. It is highly unlikely that therapists were providing undocumented CBT according to the manual, given that they were aware that session records would be reviewed for presence or absence of CBT. In addition, the medical record reviews were consistent with spot audiotaping and clinician statements from the qualitative interviews.

• “The fidelity measures appear weak because the actual number of therapy audiotapes is not specified.” Additional information on the audiotapes is provided on pages 8-9. Supervisory notes and qualitative interviews were also used to confirm whether clinicians were providing CBT according to the manual, were modifying CBT and providing only select components, or were not providing CBT to any extent.

• “The 100% concordance rate between chart(s) and tape(s) does not really support that the methodology was rigorous because we do not know how many of each
were assessed and for how many different clinicians and clients.” Given that therapists provided only eight audiotapes (out of 16 enrolled adolescents), we were unable to consider them a fidelity check and have revised our language accordingly. Instead, we were only able to confirm whether the therapist provided CBT for that session consistent with what was recorded in the medical record. This issue is addressed in the limitations section of the manuscript.

- “For ‘Assimilation’ on page 15, the fact that therapists did not use CBT but reported ‘still’ using it is troubling. This would imply that their reports may not be valid. Does this draw the study methods and results into question? This should be addressed in some way. Can the qualitative results address this?” We have thoroughly reviewed the qualitative interviews again and incorporated these results into Table 1. As opposed to a dichotomous variable (clinicians are/are not using CBT), we modified the responses (clinicians report they are still following the manual, clinicians report they are using components of CBT, clinicians report they are not using CBT at all.). We have also included comments from two of these clinicians in the results section (page 16).

- “Was there staff turnover for any of the participant service providers at any point in the study?” As indicated on page 14, there were 2 intervention clinicians who either left the agency or were reassigned to other clinics. There were also three clinicians in the usual care group who left the agency. Turnover rates in both clinics during this time were approximately 20%. Data gathered from qualitative interviews also suggest retention was a problem during this period (see Table 2).

- “The authors refer to high turnover, inadequate staffing and other ‘disruptive conditions’ but never really describe these aspects of the two clinics in detail. If these issues are at play, it should be evident in the data and results as well as the discussion.” This information is discussed in more detail on page 15. In addition, quotes from clinicians in Table 2 document their perceptions of the organizational climate during the study.

- “It does not appear that the ‘champions’ for the CBT intervention did much in the way of real leadership to move the process forward. These people should be more accurately described in the manuscript.” We have changed the label for these individuals and described their role on page 9.

- “It could be argued that this study demonstrates that CBT can barely be implemented in usual care publicly funded mental health settings and that the implementation was quite inadequate. It seems that the real failure here was the lack of agency buy-in and strong leader support for the implementation of CBT.” Several issues contributed to the lack of implementation by the clinicians, which are discussed in more detail in the results and discussion sections. Although clinician use of manualized CBT was limited, all had very positive perceptions about the intervention, and the majority stated they would continue to use “components” of the CBT in their work with adolescents in these settings.
“While the paper is framed in terms of an adaptation of Rogers’ stages, there is a bit of forcing the data to fit the stages or that the data informs factors that lead to failure, rather than success, at each of these stages.” We have chosen to focus less on the stages and activating/inhibiting variables at each stage in the results and discussion sections. It is hoped that this will improve the readability of the manuscript and the clarity of the findings.

“Generalizability is not just limited, it is virtually non-existent. In order to assess generalizability, more information about the agencies would be required.” As discussed above, we have provided more information on the agencies to improve the reader’s ability to determine the generalizability of the findings. However, it may also be that these two clinics are not representative of other publicly funded clinics outside of Arkansas, which we note in the limitations section on pages 19-20.

“The most important finding is that adopters didn’t really perceive barriers, but non-adopters did. Thus, the role of the clinician appears large in this study. What other solutions might be adopted by agencies? Should agencies try to select and hire providers who are more open and motivated to use EBPs?” The clinician’s willingness to engage in CBT was influenced by his or her own characteristics as well as the organizational climate. These issues are discussed in more detail now in the results and discussion sections, as supported by data from the qualitative interviews (see Table 2).

“In the first paragraph, provide percent with number for recruitment and participants.” We have included this information on page 13.

“Table 2…provides very little data to suggest which factors and specific items would be important and how all of those individual variables were derived. How frequently were individual variables noted? Were variables rated in regard to level of importance?” As noted above, we have revised Table 2 to more accurately reflect comments by intervention clinicians about the CBT implementation. We have also provided information as to which categories were more frequently mentioned by clinicians as barriers or facilitators.

“The formative evaluation does not appear to have impacted the implementation to a great extent. It might be helpful to address this issue in the discussion. The formative evaluation influenced many aspects of the implementation, including screening, training format and duration, and supervision structure. We have described this in greater detail in the methods section.

“[The authors should address] remedies for the ‘intrusion’ of researchers, such as research-practice partnerships, community-based participatory research, and participatory action research.” We have included CBPR as one option to address clinician buy-in as well as sustainability in the discussion section.
We hope these modifications (both major and minor) respond fully to the reviewers’ concerns. Please feel free to contact us if there are any remaining questions or concerns.

Sincerely,

[Signature]

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