Author's response to reviews

**Title:** Enhanced Relapse Prevention for Bipolar Disorder: A qualitative investigation of value perceived for service users and care coordinators

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**Author's response to reviews:** see over
To The Implementation Science Editorial Team

Re: MS 1692936382188806: Enhanced Relapse Prevention for Bipolar Disorder: A qualitative investigation of value perceived for service users and care coordinators.

Thank you for your email of 20th July. We are delighted with the positive and helpful comments of the reviewers. We have amended the paper accordingly and describe below how we have addressed the points raised.

Reviewer 1: Ben Haven

Minor essential revisions

1. It was commented that separating the identity of the qualitative team from that of the trial team was a particular methodological strength of the study. Clarification of why this was important and why it is salient to service users and care coordinators has been added (page 7).

2. Whilst our findings are considered in light of May’s normalisation process model (May, 2006), this was not considered during the analysis so is not described within the paper. To avoid confusion of the significance of the model, the sentence beginning ‘ERP was valued by CCs’ on page 27 has been modified and the phrase ‘other ways’ has been omitted.

Points 3-6. Although the results and discussion sections were overall thought to be written clearly, a few sentences have been re-written as suggested for greater clarity.

- Page 5, Sentence beginning ‘The perceived value’ has been reworded
- Table 2, use of capital U has been corrected.
- The conclusions have been re-written to make more grammatical sense and also to address point 2.

Discretionary Revisions

1. Although it was felt by the reviewer that the introduction was written clearly, by moving Table 1 ‘up the page’ the explanation of ERP is better situated for the reader.

2. The last sentence of the results section in the abstract has been clarified that both CCs and SUs held reservations by the addition of the word ‘both’.

3. Page 4, paragraph 1; the word ‘improving’ has been added before social functioning to clarify the nature of the effect of relapse prevention interventions.

4. Page 4, paragraph 1, last sentence; commas have been added to make this sentence easier to follow.
5. Page 5, bottom of page; sentence beginning ‘If an intervention’ an insertion of ‘will’ between ‘certainly’ and ‘be’ has been made.

6. Page 6, under ‘Methods’; sentence beginning ‘Value is’, the word ‘where’ has been omitted.

7. Page 7, first paragraph; the words ‘and CC’s’ have been omitted as the participants describe both SUs and CCs.

8. Page 8, sentence beginning ‘This was achieved in two ways’, the insertion of ‘categorised as’ between the words ‘and themes’ has been done for clarification.

9. Page 13, first paragraph under ‘Developed ways of working’. Whilst these points may be self-evident, they are have not been systematically reported previously and we think the description is necessary.

10. Page 13, paragraph 3; sentence beginning ‘Particularly when SUs…’. Brackets and commas have been inserted to make this sentence read better.

11. Page 14, paragraph beginning ‘However’; as this is supporting previous point ‘however’ has been omitted.

12. Page 15; to remind readers what TAU refers to ‘treatment as usual’ has been added.

13. Page 15; under quote (14: CC: ERP), a quote from a SU has been added to support the point.

14. Page 17, sentence beginning ‘As a consequence’ the words ‘as ERP’ have been deleted.

15. Page 24, paragraph beginning ‘In general ERP was’; a sentence has been added to this paragraph to include the point about SUs becoming dependent on an individual CC through ERP.

16. We agree that data saturation is a marker of good practice. Unfortunately it is not always standard practice and we therefore maintain that a strength of this particular study was continuing data collection until data saturation was obtained.

Reviewer 2: Amy Kilbourne

1. We agree that it is a universal problem that no-one is charged with the implementation of psychological interventions (rather than just that of relapse prevention). Hence the sentence beginning ‘Potentially, RP’ on page 4 has been amended. In addition, greater discussion of the findings within the context of the implementation of other psychological interventions has been added to the discussion (page 21) and included in the conclusion (page 27).
2. To strengthen the paper, the reviewer suggested making specific recommendations regarding the key elements to look at when assessing the acceptability of an intervention. In the conclusion (page 26/7), a sentence has been added about ensuring that SU and CC perceptions of value of an intervention (rather than just the evidence base of effectiveness) is identified and incorporated into an implementation strategy. Considerations that are relevant for promoting the value of an intervention programme before it actually gets developed, tested, and implemented are also discussed.

3. Methods, sampling section; to clarify what was meant by ‘experience of training clients with ERP’ this sentence has been replaced with ‘CCs were selected on the basis of how many clients they had trained in ERP their and their occupational background.’ For further clarification of sampling, the number of SUs and CCs interviewed out of the total number of SUs and CCs in the trial has been added. This information has also been added to Tables 2 and 3.

4. The perceived knowledge deficit by CCs has been emphasised in the Results section (page 9) and in the Abstract. Regarding the generalisability of ERP to other conditions, further discussion and emphasis of this point was needed. As such, this point was added to the results section with a quote from a CC (38: CC: ERP; page 17). This point is also discussed in the discussion; ‘Furthermore, although ERP was developed specifically for BD, CCs spontaneously recognised that they could apply the core elements of the intervention when working with clients with other conditions. Demonstrating that an intervention can be applied to other conditions is an important selling point for its implementation’.

5. The reviewer suggests that the results could be reorganised by SU and CC separately. This had previously been considered by the authors in an earlier stage of analysis where it was found the results became repetitive, and consequently further analysis led to the current thematic structure as the most effective way of presenting the data. Nevertheless, the inclusion of Table 4 which organises the perspectives of SU and CC separately for each theme was retained. As this addresses the reviewers point, we wish to maintain the current organisation of the results.

6. The typing errors of ‘per cent’ has been corrected to ‘percent’

Reviewer 3: Michael Kauth

Major essential revisions

1. The reviewer commented on the usefulness of this study being situated within the context of the trial outcomes. Since the trial follow-up is not yet complete, the quantitative outcomes remain unknown and cannot be reported in this paper. Perceived value of ERP for CCs and SUs is important regardless of the outcomes of a feasibility trial. We are concerned that the reviewer has interpreted the data reported in Table 3 to mean the intervention was ineffective. As the sampling for this study was purposive, the selected individuals used in this study are not
representative of those who were in the ERP and TAU group. Therefore the percentages reported in Table 3 are not an indicator of effectiveness. Indeed we purposively sought individuals from both arms who had relapsed. The data are presented to illustrate at the time of interview the range participants who had experienced a relapse. This is indicated in the Table footnote.

2. Information has been added as to the Methods section (page 6) about the length of time after completion of ERP for interviewees. This point has also been discussed with reference to future research in Discussion (page 26).

3. The study (and data arising from it) set out to explore perceived value of ERP from the perspectives of CC and SUs. Hence the paper is not concerned with barriers per se, rather implications of the perceptions of value (as presented in Table 4). We agree that understanding potential barriers is important and have examined this in relation to trial feasibility elsewhere (Lobban et al, in prep).

4. The reviewer wanted the paper to provide an explanation of the strength of the perceived value and for whom it was most valuable for. As the study has used a qualitative approach, no attempt was made to measure the strength of the perceived values. Rather, the focus was to identify categories of values perceived by SUs and CCs.

5. Table 4 already outlines the value and clinical implications of ERP as identified by SUs and CCs which is a feature of catalytic validity. Here we illustrate the potential to change clinical practice or research. To emphasise this, the word ‘clinical’ has been added to the table title.

6. In response the reviewers comments about bias in the data because of participants telling the interview what they think they want to hear, this point has been addressed in the discussion (page 25). In our study we took steps to minimise this bias through the importance placed on the independence of the qualitative team. This has been further described in the Methods section (see comment 1 from reviewer 1).

**Minor essential revisions**

1. The reviewer suggests the paper would read better if it was more concise and reduced the number of quotes. We have (at suggestions from reviewer 1) rewritten several sentences to make them more concise. However, we wish to maintain the current number of quotes as it is good practice to provide data to support the analysis. We disagree that quotes from service providers are more easily dismissed that those from SUs, as it is perceptions of service providers that often determine how successfully services are implemented and why (May, 2006).

2. Given the methodological approach of this study it is not appropriate (nor possible) to report the frequency of how many participants raised each theme. It is noted however, that themes were present in both groups of participants.
3. The Townsend deprivation scores reported in Table 2 and 3 are the best indicator of material deprivation and disadvantage currently available in the UK (Townsend 1998). For greater clarification of Townsend deprivation indices a sentence of explanation has been added as a footnote to Table 2 and 3. Further explanation of Townsend deprivation scores can be found in the reference included in the footnote to the tables.

We consider the changes have improved the manuscript and hope that it will be considered acceptable for publication in Implementation Science. We look forward to hearing from you in due course.

Yours sincerely

Eleanor Pontin