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Dissemination and Implementation of Cognitive Behavioral Therapy for Depression in the Kaiser Permanente Health Care System: Evaluation of Initial Training and Clinical Outcomes

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Notwithstanding its empirical status and strong recommendation in clinical practice guidelines, cognitive behavioral therapy (CBT) continues to be delivered infrequently and with low fidelity on the clinical front lines. Recently, organized efforts and policies within the public sector to disseminate and implement CBT and other evidence-based psychotherapies have yielded encouraging results and provided optimism for bridging the research-to-practice-gap. Following from these efforts, the current article examines the initial impact and experience of the implementation of an individualized approach to CBT training and treatment within the Kaiser Permanente health care system. Initial training outcomes, including changes in general and specific competencies, were assessed using divergent assessment methods within the initial cohort of therapists undergoing training. Initial patient outcomes, including changes in depression and anxiety, were assessed among patients receiving treatment from therapists in training. Results revealed training in and implementation of CBT-D was associated with overall large improvements in therapist competencies and in clinically significant improvements in both depression and anxiety among patients. Findings from the initial phase of dissemination and implementation within a large private system provide support for, and extend recent findings related to, the feasibility and effectiveness of training in and implementation of CBT-D in a real-world context.

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Despite their demonstrated efficacy and recommendation in clinical practice guidelines, frequently as first-line treatments, evidence-based psychological treatments remain infrequently delivered and often poorly implemented in real-world clinical settings (Bruns et al., 2016; Creed, Benjamin, Feinberg, Evans, & Beck, 2016; McHugh & Barlow, 2010). At the same time, psychotropic medication prescribing has increased substantially (Greenblatt, Harmatz, & Shader, 2018). In response to rising awareness of this research-to-practice gap and greater attention to improving mental health care quality in recent years, mental health care authorities have called for increased focus on, and have allocated specific resources for, promoting the delivery of evidence-based mental health treatments (e.g., Institute of Medicine, 2005; McHugh & Barlow, 2010). Yet, with some recent exceptions within specific public systems, progress in achieving the promise of evidence-based psychological treatments has been slow (Bruns et al., 2016).

A spate of implementation science and treatment outcomes research over the past decade has increased understanding of and accounting for the limited delivery of evidence-based psychotherapies (EBPs) and other psychosocial treatments and has elucidated specific barriers to and facilitators of successful implementation. Findings from this accumulating research have identified key factors at multiple levels, including but not limited to system, provider, and patient levels (Aarons, Hurlburt, & Horwitz, 2011; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Tabak, Khoong, Chambers, & Brownson, 2012). Chief among the reasons for the limited delivery of EBPs is limited preparedness of providers to deliver these treatments, including limited competency and unfavorable attitudes or misconceptions regarding EBPs (Herschell, Kolko, Baumann, & Davis, 2010; Rakovshik & McManus, 2010). At the same time, clinicians often overestimate their EBP skills. Findings from a recent study comparing therapist-reported therapeutic orientation with observer ratings of therapy sessions revealed limited evidence of cognitive behavioral therapy (CBT) delivery, despite the fact that 7 in 10 therapists reported CBT as their therapeutic orientation (Creed et al., 2016). Further, the CBT competency scores among therapists in the study were approximately half of what is required for minimum CBT competency (Creed et al., 2016). Although most mental health providers receive training that provides basic exposure to CBT and other EBPs, few clinicians receive *competency-based* training that is needed to successfully change behaviors and promote favorable intention to deliver EBPs (Beidas, Edmunds, Marcus, & Kendall, 2012; Newman, 2010; Ruzek et al., 2016).

In an effort to realize the potential of EBPs for improving the well-being of veterans, the U.S. Department of Veterans Affairs (VA) implemented a national initiative to disseminate and implement 16 EBPs throughout the VA health care system guided by the findings of implementation research (Karlin & Cross, 2014a). A key component of this initiative, which represents the largest dissemination of EBPs in the nation, involved the development of competency-based training programs for each of the treatments included in this initiative. To date, more than 11,000 VA mental health staff have received training in one or more EBPs. Program evaluation results reported across a number of these training programs have demonstrated that EBP training and implementation was associated with, overall, large improvements among therapists, including increases in therapist competencies and favorable attitudes toward EBPs, and clinically significant improvements among patients, including reductions in symptoms and improvements in quality of life (e.g., Eftekhari et al., 2013; Karlin et al., 2012; Karlin, Trockel, Taylor, Gimeno, & Manber, 2013; Ruzek et al., 2016; Walser, Karlin, Trockel, Mazina, & Taylor, 2013). In addition, a major initiative in the United Kingdom to disseminate and implement EBPs has, similarly, demonstrated robust training and clinical outcomes (Gyani, Shafran, Layard, & Clark, 2013).

On the heels of the successful efforts to disseminate and implement EBPs within public systems in the U.S. and the U.K., Kaiser Permanente (KP), one of the nation's largest private nonprofit health care systems, established a pilot initiative to disseminate and implement CBT, with a primary focus on depression, as well as a parallel initiative to disseminate and implement Problem-Solving Therapy. Depression is the most common mental health diagnosis within the KP system and is among the most prevalent mental disorder in the general population (Kessler et al., 2005). Moreover, a key focus on depression within the context of dissemination and implementation is desirable in light of its public health impact, including considerable psychological, physical, financial, and societal consequences (McLaughlin, 2011). In fact, depression is the leading cause of disability worldwide (World Health Organization, 2017), and its economic burden is estimated at $200+ billion annually (Greenberg, Fournier, Sisitsky, Pike, & Kessler, 2015).

Originally developed for depression and extended to a number of other behavioral health conditions, CBT has been shown to be efficacious for mild, moderate, and severe depression in hundreds of studies (e.g., DeRubeis et al., 2005; Tang, DeRubeis, Beberman, & Pham, 2005). Further, CBT for depression (CBT-D) has appeal within a dissemination and training context as it includes a number of core EBP strategies (e.g.,

modifying thoughts and behaviors, problem solving, relaxation skills) and broad-based skills (e.g., feedback, understanding, interpersonal effectiveness) that can provide a foundational and expandable set of therapy skills for staff.

Similar to the EBP dissemination and implementation initiatives within the VA health care system and the U.K.—and a fundamental strategy for implementing and sustaining EBPs in general (Aarons et al., 2011; Herschell et al., 2010)—the KP CBT-D dissemination and implementation initiative includes as a key component the development of a competency-based CBT-D training program. This training program, tailored to the KP health care system and ultimately designed to serve as a self-sustaining system for promoting and sustaining CBT-D capacity, was designed to be intensive for promoting full skill development and ongoing delivery by staff, as well as highly relevant and feasible for successful completion by very busy clinicians who carry high caseloads within a large, private health care system. With some recent exceptions, a number of past CBT training programs have demonstrated suboptimal clinician engagement or outcomes, limited or no objective assessment of competencies, or have required extended time commitment or absence from work that would not be feasible within KP or many other large health care systems (Herschell et al., 2010; Rakovshik & McManus, 2010). Given the busy schedules of KP clinicians, the approach to the current training process uniquely placed heightened attention to maximizing clinician engagement through a highly personalized training experience. Further, the current treatment protocol and training program include distinguishing features designed to promote the individualization of treatment, including important focus on co-occurring anxiety and monitoring and incorporating patient feedback given the particular significance and priority of these issues within the KP health care system.

The purpose of the current article is to present the approach to CBT-D training in KP and examine initial feasibility and effectiveness of individualized training in and implementation of CBT-D, based on the experience of the initial group of KP therapists and patients and incorporating multiple methods of assessment and assessment domains. At the therapist level, we examine changes in general and specific CBT competencies assessed by expert raters, changes in CBT knowledge, attitudes, and confidence, and therapist assessments of the impact and quality of training, as well as intention to use CBT-D. In addition, we examine therapist training goals and progress achieved over the course of training. Finally, at the patient level, we examine the effectiveness of implementation of the CBT-D treatment among patients treated by therapists in training, including potential changes in both depression and anxiety.

Method

CBT-D PROTOCOL DESCRIPTION

CBT–D is a structured, time-limited psychotherapy that aims to help patients identify and modify negative thoughts and beliefs as well as to change unhelpful behaviors to improve symptoms of depression and overall functioning. The CBT-D treatment protocol adapted for the KP CBT-D Training Program and being implemented in KP is described in detail in a therapist manual (Brown & Karlin, 2017), which also includes illustrative case examples, dialogue, and all required forms, worksheets, and checklists for implementing the protocol. Notably, the treatment protocol includes several distinguishing factors designed to promote the individualization of treatment for enhancing patient engagement and outcomes, while maintaining high fidelity to the CBT model. This important focus on individualization includes placing significant emphasis on the therapeutic alliance and on incorporating feedback throughout treatment. The significant focus on feedback incorporated into the KP CBT-D protocol aligns with and is an important part of a larger initiative to advance feedback-informed care as a key priority within the KP behavioral health care system. The current CBT approach also includes a case conceptualization approach to treatment, with detailed specification of cognitive and behavioral formulations for guiding treatment, to enable tailoring of treatment and selected strategies to the patient. Often, CBT protocols provide more detailed direction on understanding patients from a cognitive perspective, with behaviors part of or secondary to a cognitive conceptualization (e.g., mainly focus on compensatory strategies or provide limited theoretical depth to the process of changing behavior). To provide for a richer understanding of behavioral factors, a Behavioral Formulation Diagram (Brown & Karlin, 2017) was developed for the current protocol. The case conceptualization approach to treatment, in addition to the important focus on relationship and process factors, distinguishes this CBT protocol from purely psychoeducational or skills training approaches to CBT. Finally, consistent with an individualized approach to treatment, the CBT-D protocol provides for monitoring and addressing co-occurring, generalized anxiety symptoms that are often quite common among KP patients presenting for treatment for depression.

CBT-D TRAINING PROGRAM DESCRIPTION

The KP CBT-D Training Program includes a competency-based training model that is comprised of two phases: In the first phase (foundational

training phase), training participants participate in a 2.5-day experientially oriented workshop on the theory and application of the CBT-D treatment protocol. The workshop training is designed to promote knowledge, positive attitudes and enthusiasm toward delivering CBT-D, and *initial* skill development. In the second phase of training (training consultation phase), which immediately follows the foundational workshop training, therapists participate in small-group consultation (approximately 4 training participants per group) led by an expert CBT-D training consultant designed to promote full competency development and facilitate local implementation. The weekly, telephone-based training consultation sessions are 90 minutes in length and are held for approximately 6 months. Therapists enroll at least two cases during the training consultation process and audio record their sessions with written patient consent. Therapists were instructed to enroll patients with a primary presenting problem of depression. Patients with co-occurring generalized anxiety symptoms were encouraged. Patients with other comorbid conditions (e.g., substance use disorders, PTSD) are permitted if the comorbid condition is at least in partial remission (treatment is not clinically recommended) or the patient is receiving treatment for the condition.

During the training consultation process, training consultants regularly review session recordings and rate full sessions using the Cognitive Therapy Rating Scale (Young & Beck, 1980). Training consultants rate a full session recording for 2 group members per week. Training consultants provide supportive and constructive feedback on CBT skills and competencies, assign action plans to implement feedback, and facilitate sharing of support and feedback among consultation group members. Review and practice of core CBT skills, through assigned readings and role-plays, is also employed to enhance the learning process and skill development.

Just as the CBT-D treatment protocol emphasizes individualization in the application of treatment to enhance engagement and outcomes among patients, the KP CBT-D Training Program emphasizes the individualization in the training of therapists to maximize engagement and training outcomes among therapists. This unique aspect of the training program includes the development of personalized training goals, based on assessment of therapists' baseline strengths and weaknesses and specific desired areas for improvement. Progress towards these goals is re-assessed throughout training and formally discussed at the midpoint of training. At this time, training goals are revised and new goals established and tailored, as appropriate. Overall progress toward training goals is then further assessed and discussed at the end of training. By personalizing the training experience to individual therapists' experiences and goals, the individualized training consultation process is intended to promote meaning and engagement.

Requirements for successful completion of the training program include: (a) participate in the foundational workshop training; (b) attend at least 75% of the weekly CBT-D consultation calls; (c) enroll at least 2 training cases; (d) provide at least 10 CBT-D sessions for at least one case; (e) submit at least 10 session recordings (across 2 cases) to the training consultant for review; and (f) obtain a total score of 40 or higher on the Cognitive Therapy Rating Scale.

Participation in the training program was made available on a voluntary basis to all mental health staff who provided psychological treatment for depression in the service region. The opportunity to participate was provided specifically to staff who treat adults, given the focus of the initial training phase on this patient population. Providers were informed of the training requirements and were asked to agree to these requirements in order to participate.

PARTICIPANTS

A total of 15 mental health providers participated in the training program. All therapists worked in specialty behavioral health. Of the therapists, 66.7% were female and 33.3% were male; 66.7% were doctoral-level psychologists, and the remaining 33.3% were master's-level social workers.

A total of 36 patients were enrolled by therapists during the training consultation phase of the training program. The mean age of patients was 46.3 (*SD* = 14.6, Range = 19–69); 72.2% of patients were women, and 27.8% were men. In terms of ethnicity, 61.1% of the patients were White, 33.3% were Asian/Pacific Islander (22.2% = Asian, 5.6% = Asian/Pacific Islander–Filipino, 5.6% = Asian/Pacific Islander–Japanese), and 5.6% were unknown.

PROGRAM EVALUATION MEASURES

CBT Competency

The Cognitive Therapy Rating Scale (CTRS; Young & Beck, 1980) is a 19-item observer-rated measure that assesses CBT competency. The CTRS was used by training consultants for assessing CBT competencies of therapists based on audio recordings of full CBT sessions. The core 11 items of the CTRS are scored on a 7-point scale: 0 ("Poor"), 1 ("Barely Adequate"), 2 ("Mediocre"), 3 ("Satisfactory"), 4 ("Good"), 5 ("Very Good"), and 6 ("Excellent"). These items are summed to calculate a total score,

ranging from 0 to 66. The CTRS has been shown to have adequate internal and interrater reliability (Vallis et al., 1986) and moderate item agreement (Williams, Moorey, & Cobb, 1991). Consistent with general use, a total score of 40 or higher was used as the threshold for CBT competency (Shaw et al., 1999).

Therapist Progress Reports

Throughout training consultation, each training consultant completed a Therapist Progress Report for each therapist that described strengths and weaknesses (baseline), specific training goals (baseline and updated at midpoint), and progress and opportunities for further development at midpoint and end of training consultation.

Training Program Evaluation

A 21-item self-report questionnaire assessing CBT knowledge, attitudes, and confidence was administered to training participants immediately prior to the workshop training, immediately following the workshop training, and at the end of the training consultation session. Six items assess level of knowledge related to CBT, with response options ranging from 1 ("Not at all knowledgeable") to 7 ("Extremely knowledgeable"). Five items assess the degree to which respondents hold favorable attitudes toward CBT, including therapists' perceptions of CBT as effective, individualized, driven by a case conceptualization approach to guide treatment, and focused on the therapeutic alliance, with response options ranging from 1 ("Strongly disagree") to 7 ("Strongly agree"). Seven items assess the level of therapist confidence in their CBT skills, such as developing an individualized case conceptualization and employing cognitive and behavioral strategies. In addition, several additional items were administered following the workshop training and training consultation process to assess training participants' satisfaction with and perceived impact of the training program, as well as training participants' intention to use CBT as a result of the training.

Depression

The Patient Health Questionnaire (PHQ-9; Spitzer, Kroenke, & Williams, 1999) is a 10-item patient self-report measure based directly on the nine diagnostic criteria for major depressive disorder in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders*. The first nine items measure the frequency of depressive symptoms ranging from 0 ("Not at all") to 3 ("Nearly every day") and are summed to calculate a total score, ranging from 0 to 27. The PHQ-9 is one of the most extensively evaluated measures of depression severity and has been shown to have adequate internal reliability, test-retest reliability, and criterion validity (El-Den, Chen, Gan, Wong, & O-Reilly, 2018). The PHQ-9 was administered to patients prior to each session.

Anxiety

The Generalized Anxiety Disorder 7-item Scale (GAD-7; Spitzer, Kroenke, Williams, & Löwe, 2006) is a patient self-report measure for assessing anxious symptoms associated with generalized anxiety disorder. The first seven items measure the frequency of anxious symptoms ranging from 0 ("Not at all") to 3 ("Nearly every day") and these nine items are summed to calculate a GAD-7 total score, ranging from 0 to 21. Research has found that the GAD-7 has adequate internal reliability, test-retest reliability, and criterion validity (Spitzer et al., 2006). The GAD-7 was administered to patients prior to each session.

PROGRAM EVALUATION PROCEDURES

Each therapist was assigned a unique training participant identifier by program evaluation staff, and each patient was assigned a unique patient identifier. Training consultant ratings of therapists were provided to the program evaluation team, at minimum, at midpoint and completion of training consultation. Patient responses to assessment measures were provided by therapists to program evaluation staff at similar time points. Therapists obtained written consent for release of information and consent to audio record from all patients for training and program evaluation purposes. Surveys of therapists involved voluntary participation and were administered by the external program evaluation team. Responses were kept confidential and analyzed and reported in aggregate. The Institutional Review Board (IRB) at the Education Development Center determined that the program evaluation procedures did not qualify as human subjects research and were exempt from further IRB review.

ANALYSES

To examine the effects of the training on therapist competence as measured by the CTRS, baseline session (defined as the first tape rating) CTRS item scores were compared to the highest CTRS score that represented Session 9 or higher for any patient that each respective therapist was treating. Hedges' *g*, which corrects for small samples, was calculated to estimate the effect of the difference between the two scores (Hedges & Olkin, 1985). Because one of the 15 therapists' first CTRS ratings represented a session that was later than the fourth session and one therapist did not submit their first recording for review until almost 4 months into the consultation

process, these two therapists were removed from the analysis as their first tape ratings did not represent their baseline level of skill early in the training consultation process.

For the examination of therapist training goals, a Ph.D.-level evaluator (SJH) conducted a systematic content analysis of baseline Therapist Progress Reports to identify and thematically summarize training goals across therapists. Using a grounded theory approach, the evaluator then conducted a line-by-line reading of midpoint and final progress reports and identified themes.

To examine changes in patient outcomes, intent-to-treat (ITT) analyses were conducted including all patients using mixed effects regression model estimation. This was conducted first on the PHQ-9 data and then on the GAD-7 data. Next, we calculated the percentage of all patients demonstrating a decrease of at least 30%, 40%, and 50% on the PHQ-9 and GAD-7, by comparing the first session score to the last available session score. Finally, we calculated depression and anxiety remission rates by computing the proportion of patients scoring at or above established cutoffs (10 on PHQ-9, 8 on GAD-7) at initial assessment and then scored below these thresholds at final assessment, consistent with similar studies examining response to CBT (Kroenke, Spitzer, & Williams, 2001; Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007; Radhakrishnan et al., 2013; Titov et al., 2013).

Results

THERAPIST OUTCOMES

Observer Ratings of CBT Competency

Table 1 displays means for the baseline session and highest scored session from the later phase CTRS ratings for the 13 included therapists. As shown, mean CTRS total scores increased an average of 10.85 points from 35.77 to 46.62. Additionally, therapists evidenced large improvements on almost all CTRS domains, with the exception of Pacing and Efficient Use of Time. At the outset of the training consultation process, 3 clinicians demonstrated minimum competency in CBT (reflected by a score of 40 or above on the CTRS). By the end of the training consultation period, all 15 therapists reached competency.

Self-Report Assessments of Therapists and Training Program

Mean scores on the CBT knowledge, attitudes, and confidence survey at preworkshop, postworkshop, and postconsultation are displayed in Table 2. Total mean scores on self-reported knowledge, $t(14) = -4.27$, $p = .001$ (Hedges' $g = 1.04$); attitudes, $t(14) = -2.60$, $p = .02$ (Hedges' $g = 0.63$); and confidence, $t(14) = -3.50$, $p = .004$ (Hedges' $g = 0.85$) increased significantly from preworkshop to postworkshop. No significant differences in total mean scores were found between post-workshop and post-consultation scores. In some areas, most notably items assessing favorable attitudes toward CBT, there was a ceiling effect evident at post-workshop, which may have limited observation of additional change at postconsultation.

In addition, therapists were asked to rate the quality of and satisfaction with the training program, the extent to which training improved CBT and overall therapy skills, and their intention to use CBT in their work as a result of the training. All questions were rated on a 7-point Likert scale, with 1 representing "Strongly Disagree" or "Not at all satisfied" and 7 representing "Strongly Agree"

Table 1
Cognitive Therapy Rating Scale (CTRS) Total and Item Scores During Baseline and Later Phases of Treatment

	Baseline Session		Later Phase			
Item	Mean	*SD*	Mean	*SD*	*p*	*Hedges' g*
Agenda	3.31	1.18	4.23	0.60	.004	0.90
Feedback	2.69	0.75	4.00	0.82	.001	1.10
Understanding	4.15	0.90	5.15	0.80	< .001	1.32
Interpersonal Effectiveness	4.46	0.88	5.23	0.73	.002	0.99
Collaboration	3.46	0.66	4.54	0.78	< .001	1.32
Pacing and Efficient Use of Time	3.15	0.80	3.54	0.66	.14	0.41
Guided Discovery	3.00	0.71	3.85	0.80	.002	0.98
Focus on Key Cognitions/Behaviors	2.92	1.19	4.54	0.66	< .001	1.26
Strategy for Change	3.54	1.13	4.46	0.66	.008	0.83
Application of CBT Techniques	2.38	0.87	3.54	0.52	< .001	1.56
Homework	2.69	0.85	3.46	0.52	.01	0.77
CTRS Total	35.77	6.71	46.62	4.81	< .001	2.10

Note. $n = 13$; CBT = Cognitive Behavioral Therapy. Possible CTRS scores range from 0 = *Poor* to 6 = *Excellent*.

Table 2
CBT Knowledge, Attitudes, and Confidence Scores at Pre- and Post-Workshop and Post-Consultation

Item	Pre-Workshop		Post-Workshop		Post-Consultation	
	Mean	*SD*	Mean	*SD*	Mean	*SD*
Knowledge	30.17	3.97	34.27	2.67	35.29	3.12
How knowledgeable about how behaviors contribute to depression?	5.60	0.74	6.00	0.53	5.86	0.36
How knowledgeable about how to change behaviors that contribute to depression?	5.13	0.92	5.70	0.46	6.07	0.62
How knowledgeable about how specific thoughts and core beliefs contribute to depression?	5.50	0.73	6.00	0.53	6.00	0.68
How knowledgeable about how to change specific thoughts and core beliefs that contribute to depression?	5.13	0.83	5.50	0.78	5.64	0.63
How knowledgeable about how to develop cognitive case conceptualization?	4.47	0.92	5.40	0.74	5.50	1.02
How knowledgeable regarding how to use specific structure in delivering CBT?	4.33	0.98	5.67	0.59	6.21	0.80
Attitudes	30.20	3.78	32.43	2.37	32.71	2.43
CBT is an effective treatment for patients with depression.	6.27	0.88	6.40	0.51	6.64	0.50
I am likely to recommend CBT for depression.	6.20	0.77	6.30	0.59	6.50	0.65
CBTs and other EBPs are individualized treatments.	6.00	1.25	6.57	0.51	6.57	0.65
Use of a case conceptualization to tailor and guide treatment is emphasized in evidence-based practices like CBT.	5.60	1.12	6.53	0.52	6.50	0.76
CBT and other EBPs place significant emphasis on the therapeutic relationship	6.13	0.99	6.60	0.63	6.50	0.65
Confidence	34.77	4.79	39.20	4.33	41.93	3.45
I can effectively deliver CBT for depression.	4.73	0.80	5.17	0.88	5.86	0.66
I can develop a theoretically-informed and individualized case conceptualization to tailor CBT-D.	4.47	0.74	5.23	0.78	5.71	0.61
I can guide patients in how to identify cognitions that contribute to depression.	5.27	0.80	5.70	0.92	6.07	0.62
I can guide patients in how to modify cognitions that contribute to depression.	5.03	1.08	5.47	0.90	5.86	0.66
I can guide patients in how to use behavioral strategies to change behaviors that contribute to depression.	5.14	1.10	5.77	0.78	6.14	0.66
I can effectively use homework in treatment to solidify and extend work done in session.	4.87	0.83	5.47	0.64	5.93	0.83
I can effectively incorporate brief assessment measures into therapy sessions to regularly monitor therapy progress.	5.43	1.28	6.40	0.71	6.36	0.63

Note. $n = 15$ for Pre-Workshop and Post-Workshop; $n = 14$ for Post-Consultation. Likert scales for each item ranged from 1 to 7, with 1 = *not at all/strongly disagree* and 7 = *a great deal/strongly agree.*

or "Extremely Satisfied." Results at postworkshop and postconsultation time points are presented in Table 3. Therapists provided very high ratings of satisfaction with respect to the training program and program resources. Therapists also reported that they felt the training program, particularly the training consultation process, improved both their overall skills as therapists as well as their skills in CBT specifically. Finally, therapists reported a high degree of intention to use CBT in their work as a result of the training, both following the workshop and training consultation process.

Table 3
Therapist Evaluation of Training Program, Skill Development, and Intention to Use CBT at Post-Workshop and Post-Consultation

Item	Post-Workshop		Post-Consultation	
	Mean	*SD*	Mean	*SD*
Program met identified objectives [a]	6.33	0.72	n/a	n/a
Training and clinical resources were helpful	6.60	0.63	6.50	0.65
How satisfied with workshop/overall training experience	6.13	0.83	6.57	0.65
To what extent did training improve overall skills as a therapist	5.43	.98	6.36	0.84
To what extent did training improve skills in CBT	5.57	1.05	6.69	0.63
I plan to use CBT approaches in my work as a result of the training	6.57	0.56	6.43	0.65

Note. $n = 15$ for Post-Workshop; $n = 14$ for Post-Consultation. Likert scales for each item ranged from 1 to 7, with 1 = *strongly disagree/not at all satisfied* and 7 = *strongly agree/extremely satisfied.*

[a] Item was specifically related to workshop training.

Therapist Progress Reports

Baseline training goals. Qualitative analysis of training goals revealed that initial training goals collaboratively established by training participants and training consultants were based primarily on identified baseline weaknesses on the CTRS. The most common goals (in descending order of frequency) related to:

1. Setting clear and specific agendas efficiently.
2. Selecting appropriate CBT strategies to address agenda items based on case conceptualization and treatment goals.
3. Adequately implementing CBT strategies by introducing the rationale and teaching skills, eliciting feedback, and identifying obstacles for implementing strategies.
4. Improving case conceptualization skills.
5. Slowing down pacing and redirecting patients to stay focused on the agenda.
6. Developing specific behavioral treatment goals with each patient.
7. Eliciting feedback from the patient to check for understanding and satisfaction.
8. Using guided discovery to guide patients to new conclusions.

Progress at end of training consultation. Four themes emerged in the final progress report with respect to therapists' overall progression during the course of the training. The first theme related to therapist global progress during the course of training. All reports ($n = 15$) described a meaningful degree of progress, including descriptions such as "significant progress," "good progress," and "excellent progress."

The second theme related to therapist progress in specific areas, with 14 progress reports describing improvement on at least one specific CBT skill. The most common identified areas of progress (presented here and below in descending order of frequency) included the implementation of specific CBT strategies, case conceptualization, choosing appropriate CBT strategies, eliciting feedback, session structure (including agenda setting), pacing, homework assignment and review, focusing on key cognitions and behavior, and guided discovery.

The third theme identified related to demonstrating some progress with additional improvement still needed ($n = 8$). For example, one therapist was "able to collaborate with clients, however, as treatment progressed . . . was challenged to let clients take more of a lead in both identifying skills and completing each step of the skill to ensure the client had mastery." Other areas of improvement with need for continued growth included: regularly eliciting feedback, collaboration, pacing, use of guided discovery, and setting specific treatment goals.

The final theme exhibited in the final therapist progress report was areas in need of continued focus in the future ($n = 8$), including balancing CBT structure with pacing, setting specific treatment goals, expanding CBT-skill repertoire by incorporating additional strategies as appropriate, and implementation of CBT strategies.

PATIENT OUTCOMES

The mean number of CBT-D sessions across all patients was 11.42 ($SD = 5.88$, Range = 2–26 sessions). The median number of sessions was 11.50. The results of ITT analyses examining changes in depression revealed that PHQ-9 scores significantly decreased over the course of treatment ($b = -0.45$, SE = 0.10, $t[35] = -4.54$, $p < .001$), from 13.42 to 8.75 (SE = 0.88), $t(35) = 9.97$, $p < .001$. When comparing first session to last available session score, the percentage of all patients demonstrating a decrease of at least 30%, 40%, and 50%, respectively, was 67%, 56%, and 39%. ITT analyses examining changes in anxiety revealed that GAD-7 scores also significantly decreased over the course of treatment ($b = -0.27$, SE = 0.08, $t[35] = -3.61$, $p = .001$), from 11.08 to 7.70 (SE = 0.71), $t(35) = 10.88$, $p < .001$. When comparing first session GAD-7 score to last available session GAD-7 score, the percentage of all patients demonstrating a decrease of at least 30%, 40%, and 50%, respectively, was 50%, 44%, and 33%.

Calculation of rates of remission from depression revealed that, of the 27 patients (75% of full sample) who met the PHQ-9 cutoff at the first session, 18 (66.7%) achieved remission. Calculation of rates of remission from anxiety revealed that, of the 26 patients (72.2% of full sample) who met the GAD-7 cut-off at the first session, 9 (34.6%) achieved remission.

Discussion

CBT and other evidence-based psychotherapies remain infrequently available in routine clinical settings. And when delivered, they are often delivered with limited integrity to the empirically established model. The current article examined the impact of training in and implementation of CBT for depression on therapists and patients within real-world treatment settings in one of the nation's largest private health care systems. The approach to CBT training and implementation in the Kaiser Permanente health care system places unique and specific emphasis on the individualization of treatment and training to promote engagement and outcomes, while also maintaining high fidelity

to the CBT model. Further, the specific focus of the protocol on the regular assessment of, and application of treatment for, co-occurring anxiety symptoms provides an opportunity for examining the effectiveness of core CBT skills in treating anxiety as well as depression. The specific objectives of the current evaluation were to describe and examine the initial impact of CBT training and implementation on increasing therapist preparedness (i.e., general and specific competencies, knowledge, attitudes, and confidence) to deliver CBT and on improving depression and co-occurring anxiety among patients.

The results with respect to initial therapist training outcomes reveal that clinicians who participated in the KP CBT for Depression Training Program demonstrated large improvements in general and specific CBT competencies, as assessed through behavioral observation by expert raters. At the beginning of the training consultation process, only 3 clinicians demonstrated minimum competency in CBT; by the end of the training consultation process, all clinicians demonstrated CBT competency and successfully met all requirements for program completion. Notably, the degree of change observed with respect to overall and specific competencies on the CTRS and the rate of competency development compare very favorably to results reported for similar competency-based EBP training programs focused on the treatment of depression in public health care systems (Creed et al., 2016; Karlin et al., 2012; McManus, Westbrook, Vazquez-Montes, Fennell, & Kennerley, 2010; Stewart et al., 2014; Walser, Karlin, Trockel, Mazina, & Taylor, 2013). For example, while direct comparisons would require a larger sample of therapists, the rate of 100% competency achievement in the current training cohort compares to a rate of 82% of training participants in the VA CBT-D Training Program and to 78% of therapists submitting follow-up session recordings for rating in community mental health settings (Creed et al., 2016). These very positive training outcomes may, in part, reflect the individualized nature of the training, a specific focus of the current approach to training in CBT.

The results with respect to initial patient outcomes reveal that CBT-D was associated with not only clinically significant reductions in depression, but also clinically significant reductions in anxiety, improvements that are consistent with past research and recent outcomes reported by real-world CBT-D training and implementation initiatives conducted within public systems (Karlin et al., 2012; Lopez & Basco, 2015; Radhakrishnan et al., 2013; Simons et al., 2010; Twomey, O'Reilly, & Byrne, 2015). The observed improvements in anxiety provide support for the utility of the treatment for patients with co-occurring generalized anxiety symptoms. It is noteworthy that the overall mean score on the GAD-7 at baseline was 11, which is indicative of a moderate level of anxiety and above the recommended cut-point of 8 for a possible anxiety disorder (Kroenke et al., 2007). This finding reflects a rather high prominence of anxiety symptoms among patients seeking treatment for depression and provides further support for assessing anxiety symptoms initially and throughout the treatment process for monitoring outcomes and helping to inform treatment.

In addition to the encouraging results related to the attainment of overall competency, as rated by expert training consultants, therapists overwhelmingly reported that training notably improved both their CBT skills *and* their overall skills as a therapist, a theme also directly reflected in the CTRS data. For example, the domain on the CTRS on which therapists demonstrated the lowest baseline skill (2.69 out of 6) and among the greatest change during training was Feedback (eliciting and responding to patient feedback). Other CTRS domains on which therapists demonstrated the greatest improvement—largely reflecting therapeutic alliance and treatment process skills—were Understanding (use of verbal and nonverbal skills to demonstrate understanding and empathy), Interpersonal Effectiveness (demonstration of warmth, concern, genuineness, and professionalism), Collaboration (working as a team with the patient), Guided Discovery (use of nondirective methods to help patients draw their own conclusions), Focusing on Key Cognitions or Behaviors (focus on key thoughts or behaviors most relevant to the patient's problems), and Application of CBT Techniques (how skillfully therapist applied cognitive-behavioral techniques). In addition, qualitative information from Therapist Progress Reports revealed that therapist training goals focused largely on skills not specific or exclusive to CBT, such as eliciting feedback from the patient to check for understanding and satisfaction, slowing down and guiding patients to new discoveries, setting specific, measurable treatment goals, and developing individualized case conceptualizations.

The improvement in relational and other general therapy skills demonstrated by therapists is directly in line with the specific emphasis of the training program on increasing evidence-based *therapy* skills, in addition to specific CBT skills. This includes enhancing skills in the use of a case conceptualization and goals-based approach to guide therapy, the application of personally

relevant strategies and skills, ongoing assessment and feedback to promote engagement and outcomes, and significant attention to the therapeutic alliance. Furthermore, the improvements in core therapy skills also reflect and reinforce the individualized and developmental approach of the training program, which was designed to meet clinicians where they were at baseline in terms of their clinical experience and skill level and to personalize the training process by establishing and continuously tracking, refining, and updating training goals. This approach to personalizing the training experience, and the use individual feedback sessions, was also very much welcomed by the training participants. We believe a significant focus on the individualization of training (like the individualization of treatment), though infrequently incorporated with specific emphasis into clinical workforce training programs, represents a significant opportunity for promoting therapist engagement and training outcomes in the future.

It is unfortunate that evidence-based psychotherapies, such as CBT, are often represented in a dichotomy with "common factors" approaches—that is, that EBPs and approaches that emphasize the therapeutic alliance or relationship elements are mutually exclusive. The current findings demonstrating the impact of training on general and specific skills further suggest an opportunity in integrating the two approaches to maximize engagement and outcomes (Karlin & Cross, 2014b; Laska, Gurman, & Wampold, 2014). While not specifically examined, it is possible that the focus placed on the alliance and common factors in the KP CBT-D protocol contributed, at least in part, to the average treatment length of 11 sessions, a figure much higher than is typical across health care systems (Olfson, Mojtabai, Sampson, Hwang, & Kessler, 2009).

The improvement in overall therapy skills reported by providers was most pronounced following the training consultation process, providing further support for the critical importance ongoing consultation or supervision for improving provider skills and competencies. These findings, along with the current CTRS data, add to the accumulation of data demonstrating the importance of consultation or supervision for developing therapy competencies (Beidas et al., 2012; Herschell et al., 2010; Wiltsey-Stirman et al., 2017). It is also worth noting that the therapists in the KP CBT for Depression Training Program reported very high levels of satisfaction with the training consultation and attributed particular value to the unique opportunity to receive specific feedback and to do so within a supportive and individualized training environment. For example, one training consultant reported on the final progress report, "the therapist found that small group discussions have a remarkable impact on improving the quality of care that patients receive." In addition, clinicians reported significant improvements in CBT knowledge, attitudes, and confidence which occurred primarily after the workshop training. These findings further indicate that foundational training may significantly improve intellectual and perceptual domains important (but not sufficient) for learning and delivering treatments, as opposed to skill-based behavioral domains that require ongoing consultation and feedback.

The current evaluation has several limitations that should be considered when interpreting the findings. Given the nature of the current project as an effectiveness evaluation within a real-world treatment context, the project, like other similar real-world effectiveness studies, did not include a control group. While the real-world, quality-improvement nature of the study increases the generalizability of findings, this comes at the expense of internal validity. Thus, we cannot, for example, conclusively state that the observed improvement among patients was due to CBT. However, the attribution of patient improvements to CBT is supported by the fact that the current findings are consistent with and extend previous results from both efficacy and effectiveness studies of CBT and were observed concurrent with favorable therapist outcomes and ratings of CBT competency. In addition, as a program evaluation effort, data on co-occurring medical or mental health conditions and concurrent service use, which could affect outcomes, were not collected. Furthermore, reflecting the initial phase of CBT dissemination and implementation in KP, the current evaluation included a relatively small number of participants within one region of the system. This limitation of *breadth* is accompanied by important emphasis on *depth*, including the incorporation of diverse assessment methods (e.g., observer ratings, self-report surveys, reports). In addition, the ethnic composition of the patient sample, which included proportionally large representation of individuals of Asian descent, included few individuals of other ethnic minority groups. In light of the small size and ethnic makeup of the sample, caution should be exercised in generalizing results to groups outside of this evaluation.

Furthermore, similar to other studies, training consultants were not blind to the training participants they rated during training consultation. Therefore, it is possible that knowing the identity of clinicians could have influenced training consultant ratings. However, this is unlikely given that the

CTRS includes specific, behaviorally oriented anchors for rating clinician behaviors. Further, all training consultants were external CBT training experts with extensive experience rating CBT sessions and had no prior or other relationship with the training participants outside of the training consultation. Finally, the findings of the prework-shop CBT knowledge, attitudes, and confidence survey reveal that participants had generally positive attitudes towards CBT (though lower levels of self-reported knowledge and confidence), which may have made them more motivated to engage in the training process than those with less favorable attitudes. Training of clinicians in future training cohorts will allow for assessing the extent to which positive attitudes may impact outcomes.

Following the successful experience of the initial phase of CBT-D training and implementation in Kaiser Permanente, actions are now underway to promote sustainability and expansion. This includes the establishment of internal CBT-D training consultation capacity— the key rate-limiting step to the implementation of competency-based training. Clinicians from the initial training cohort who demonstrated particular proficiency in CBT were identified and invited to become KP CBT-D training consultants. These clinicians were provided with in-person and distance-based training consultation training and support. A CBT-D Training Consultant Manual and additional training resources and tools were created to support the development of new training consultants. In addition, a CBT Training Consultant Rating Scale (Brown, Karlin, & Creed, 2017), modeled after the CTRS, was developed through an expert consensus process for rating and providing feedback to training consultants on their leading of consultation group sessions. Additional initiatives underway designed to support CBT-D sustainability, leveraging recent and practice innovations for addressing patient, therapist, and system barriers to sustained EBP delivery (e.g., Marques et al., 2016; Sayer et al., 2017; Scudder et al., 2017), include, but are not limited to, the development of structured peer consultation groups (following formal training consultation groups), the implementation of a process of pre-treatment motivation and engagement with patients, and the piloting of a CBT-D Specialty Clinic—a designated work unit of CBT-D clinical champions that will include specific processes and procedures designed to facilitate the delivery of CBT-D and to make the treatment a more formal part of the treatment structure. Ongoing and careful attention to these and other implementation factors will be essential for promoting ongoing delivery and spread of CBT-D.

In short, the results of the current evaluation reveal that individualized training in CBT-D resulted in large increases in CBT and general therapy competencies and skills within an initial training cohort of therapists in the Kaiser Permanente health care system. In turn, the implementation of the CBT-D protocol, emphasizing the personalized application of treatment and ongoing attention to the therapeutic alliance, by therapists still in training was associated with, overall, robust clinical improvements among patients, including clinically significant reductions in both depression and anxiety. Together, these findings, generated in a real-world context within a large private health care system, provide additional support for, and extend previous findings related to, the translation of EBPs to routine practice settings.

Conflict of Interest Statement

The authors declare there are no conflicts of interest.

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